Northampton General Hospital NHS
NHS Trust

AGENDA AND PAPERS

Public Trust Board

Thursday 25 September 2014

09:30

Board Room
Northampton General Hospital

Northampton General Hospital NHS
NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 25 September 2014
09:30 in the Board Room at Northampton General Hospital

Time		Agenda Item	Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2.	Declarations of Interest	Note	Mr P Farenden	**Verbal**
	3.	Minutes of meeting 31 July 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.**
09:50	**CLINICAL QUALITY AND SAFETY**				
	7.	Medical Director's Report	Assurance	Dr M Wilkinson	**D.**
	8.	Director of Nursing & Midwifery Care Report	Assurance	Mrs J Bradley	**E.**
10:15	**OPERATIONAL ASSURANCE**				
	9.	Integrated Performance Report and Corporate Scorecard	Assurance	Mrs D Needham	**F.**
	10.	The Patient-Led Assessment of the Care Environment (PLACE) Programme 2014	Assurance	Mr C Abolins	**G.**
	11.	Finance Report	Assurance	Mr S Lazarus	**H.**
	12.	Improving Quality and Efficiency Report	Assurance	Mrs J Brennan	**I.**
	13.	Workforce Report	Assurance	Mrs J Brennan	**J.**
11.05	**ANNUAL REPORTS**				
	14.	Security Management Review 2013-2014	Assurance	Mr C Abolins	**K.**
	15.	Health and Safety Annual Report	Assurance	Mr C Abolins	**L.**
	16.	Safeguarding Vulnerable Adults and Children Annual Report	Assurance	Mrs J Bradley	**M.**
	17.	Infection Prevention Annual Report	Assurance	Mrs J Bradley	**N.**

Time	Agenda Item	Action	Presented by	Enclosure
11:45	**STRATEGY**			
	18. End of Life Strategy	Decision	Mr C Pallot	**O.**
	19. Stakeholder Engagement Strategy	Decision	Mr C Pallot	**P.**
	20. Communications Strategy	Decision	Mr C Pallot	**Q.**
12:15	**GOVERNANCE**			
	21. TDA Self-Certification	Decision	Mr C Pallot	**R.**
	22. Report from the Finance Committee	Assurance	Mr P Zeidler	**Verbal**
	23. Report from the Audit Committee	Assurance	Mr N Robertson	**Verbal**
	24. Report from the Integrated Healthcare Governance Committee	Assurance	Mr G Kershaw	**Verbal**
12:35	**25. ANY OTHER BUSINESS**		Mr P Farenden	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Trust Board will be held at 09:30 on Thursday 27 November 2014 in the Board Room at Northampton General Hospital

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

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

The Themes for discussion in the closed agenda are strategy for oncology service, HR issues and forthcoming contractual matters.

Northampton General Hospital NHS
NHS Trust

Minutes of the Public Trust Board

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

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
	Mr G Kershaw	Non-Executive Director
	Mr S Lazarus	Director of Finance
	Mrs D Needham	Chief Operating Officer
	Mr D Noble	Non-Executive Director
	Mr C Pallot	Director of Strategy and Partnerships
	Mrs L Searle	Non-Executive Director
	Dr S Swart	Chief Executive Officer
	Dr M Wilkinson	Interim Medical Director
	Mrs S Wright	Associate Director of Workforce Development
In Attendance		
	Dr A Jeffrey	Consultant Physician & Director Of Medical Education (Agenda Item 17)
	Mrs S McKenzie	Committee Secretary
Apologies		
	Mrs J Brennan	Director of Workforce and Transformation
	Mr N Robertson	Non-Executive Director
	Mr P Zeidler	Non-Executive Director (Vice Chair)

TB 14/15 042 Introductions and Apologies

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

Apologies for absence were recorded from Mrs Brennan, Mr Robertson and Mr Zeidler.

TB 14/15 043 Declarations of Interest

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

TB 14/15 044 Minutes of the meeting 26 June 2014

The minutes of the Trust Board meeting held on 26 June 2014 were presented for approval.

The Board resolved to **APPROVE** the minutes of the 26 June 2014 as a true and accurate record of proceedings subject to the following amendment:

TB 14/15 028 Patient Story – Mrs Bradley requested that the minute reflected that the Chronicle and Echo's version of the high profile complaint which Mrs Bradley referred to was not the Trust's version of events and not factually correct. Mrs Bradley further commented that all in patient call bells had been checked and not just bathroom call bells. **Action: Mrs McKenzie**

TB 14/15 045 Matters Arising and Action Log 26 June 2014

The Matters Arising and Action Log from the 26 June 2014 were considered.

Matters Arising Ref 30: Same Sex Accommodation Audit and Update.
Mr Pallot reported that to date the Trust had not received the requested information from the CCG.

Further actions were noted and would be added to the log and circulated**.**

Action: Mrs McKenzie

The Board **NOTED** the Action Log and Matters Arising from the 26 June 2014.

TB 14/15 046 Patient Story

Dr Swart presented the Patient Story.

Dr Swart presented two letters received from patients who wrote expressing their thanks at the care they had received at A&E and various other departments in the hospital. The patients commented on the first class compassionate care they had received and the kind and courteous manner in which they were treated ranging from consultants to administrative staff. Dr Swart commented that she replied to both patients advising them that she would pass on their thanks to the staff involved and that it was a great pleasure to receive their letters.

Mr Farenden commented that it was good to receive recognition of the Trust's constant quest to provide excellent care to patients.

The Board **NOTED** the Patient Story

TB 14/15 047 Chief Executive's Report

Dr Swart presented the Chief Executive's Report.

Dr Swart informed the Board that talks via the mediation service ACAS had resulted in a negotiated settlement to the dispute between the Trust and 55 members of pathology staff. The deal had been accepted by the staff at a meeting convened by their union, Unite, last week. The new agreement would see changes to the pathology staff contracts effective from March 2015 and acceptance of the new terms had seen staff return to work from 28th July 2014. As part of the agreement a pathology development forum would be set up to take forward implementation of the new working arrangements and to drive further improvements in the services provided. Mr Farenden and Dr Swart extended their thanks to the Executive Team and to members of the pathology team who remained at work and managed to maintain a high quality pathology service.

It was almost 3 months since the Trust's CQC inspection report had been published and Dr Swart informed the Board that the Trust anticipated receiving an unannounced inspection visit at some point during the coming month. Dr Swart informed the Board that future reports would not need to be as comprehensive and that all urgent matters had been addressed. Staff had been provided with updates of progress against the recommendations in the report and the Trust's action plan, so that they were aware of developments across the wider organisation and not just within their own area of work.

Dr Swart reported that following the Challenged Health Economy work, the Trust had agreed to work with colleagues from Kettering General Hospital on how four specialties; rheumatology, ophthalmology, orthopaedics and radiology could be redesigned for mutual benefit and provided across the county, in a way that delivered both enhanced clinical quality as well as efficiencies. The aim was to understand if the concept was viable and the work must be completed by the end of August 2014. A series of clinical meetings were planned and the Board would be kept informed of developments. Clinical meetings have been planned and further updates would be

provided in due course. A Board to Board meeting with health partners across Northamptonshire took place last night and discussion was had around working together and delivery of services in a different way. Dr Swart reported that progress was being made.

The Northampton Chronicle & Echo had helped the Trust formally launch the hospital's chemotherapy appeal to raise £350,000 for the refurbishment of the chemotherapy suite. Dr Swart commented that the Trust was grateful to the Chronicle & Echo and their readers for their consistent and generous support of the hospital.

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

TB 14/15 048 CQC Action Plan

Dr Swart presented the CQC Action Plan.

Dr Swart reported that the Trust sent a letter to the CQC on 27 June 2014 giving a detailed response to the CQC comments contained within their letter. This response contained an outline of the evidence the Trust had from its High Level Action Plan and confirmed that the Trust had met the requirements to become compliant with the regulations.

Whilst all the actions relating to the letter and High Level Action Plan had been completed a number of actions relating to the Quality Report Compliance Action Plan were on-going and the Governance Department continued to support the Executive Team and action owners in collating the evidence and were providing constructive challenge ensuring the availability of robust evidence.

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

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

Dr Swart commented that it was now important to focus on maintaining the standard. Mr Kershaw and Mrs Searle advised that they had received clear assurance at the Integrated Healthcare Governance Committee last week and extended their congratulations to the Management Team.

The Board **NOTED** the CQC Action Plan

TB 14/15 049 Medical Director's Report

Dr Wilkinson presented the Medical Director's Report.

Dr Wilkinson provided a detailed overview of the content of the report and informed the Board that the Hospital Standardised Mortality Ratio data in the report related to March 2014. Overall improvement had been sustained and there had been no new

areas of significant concern to investigate. A programme to roll out specialty specific dashboards for use by clinicians and managers in each directorate was underway to enable improved local ownership of performance data. However this had been slower than intended due to restrictions on the access to data by individual users within the organisation following the recent changes in licence terms between Health and Social Care Information Centre and Dr Foster.

The latest Standardised Hospital Mortality Indicator was down below 100 and or the rolling year was significantly lower at 108.

He reported that crude mortality remained one of the lowest in the region and 50 notes death review had recently been completed and the report would be available at the end of September.

Dr Wilkinson advised that 6 new serious incidents were reported and 2 of the 6 Serious Incidents reported in June 2014 were classified as causing severe harm or death, this represented a reporting rate of 0.24%, which was below the national average. Aggregated mortality resulting from the 5 high risk diagnosis groups (acute myocardial infarction, stroke, fractured neck of femur, pneumonia and heart failure) was better than expected for 2013-4 at 75.

Dr Wilkinson informed that Board that 0% of Serious Incidents this month were reported on STEIS within 2 working days; compared to 66% in May 2014 and 60% in April 2014. The delays had predominantly been associated with the validation and notification of Grade 3 pressure ulcers.

He further reported that 9 Serious Incidents were submitted for closure. 1 report was submitted in breach of the 45 day timescale. The timescales for internal submission of Pressure Ulcer reports needed to be reviewed and closely monitored to ensure that the report had been received in advance of the external submission date to allow for review and quality assurance checks by the Risk Management team and the Executive Lead. Dr Wilkinson confirmed that the Governance team were currently working on producing an action plan dashboard which would be included in future reports. This would provide the Board with further assurance that recommendations from Serious Incidents were acted upon and monitored until actions were completed.

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

TB 14/15 050 Director of Nursing & Midwifery Care Report

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

Mrs Bradley provided a detailed update on a number of clinical projects and improvement strategies within the Director of Nursing, Midwifery & Patient Services portfolio. A shortened version of this report, which provided an overview of the key quality standards, would be shared on the Trust's website as part of the Open & Honest Care report.

Key points to note were that the N&M Quality Dashboard (QuEST) showed a slight improvement of 79% compliance against last month 77%. Health care associated infections actual to date were at 7. She reported that the Trust had achieved the Friends & Family Test for June and for the first quarter of the year. The Trust had set up a Care for the Dying Steering Group which was a multi-professional group that had developed a detailed action plan to ensure the Trust was prepared for the removal of the Liverpool Care Pathway.

Mrs Needham commented that improved working between Operational and Nursing colleagues had enabled effective and close working. Mr Lazarus also confirmed that joined up working with Finance and Nursing over Bank and Agency staff had been working very well. Mr Farenden acknowledged the positive feedback.

Mrs Searle complimented the team on the End of Life Care Plan.

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

TB 14/15 051 **Hard Truth Commitments and Nurse Staffing Review Update**

Mrs Bradley presented the Hard Truth Commitments and Nurse Staffing Review Update.

Mrs Bradley provided a summary of the Hard Truths data for the month of June that would be prepared for publication on the Trust's website.

To improve the staffing establishment the recruitment of staff, both registered and unregistered, was fundamental to improving the quality of the patients' experience, improving the staffing morale on the wards and to reduce the financial expenditure on the temporary workforce. Mrs Bradley informed the Board that her team had been working closely with the HR and Finance teams, the Bank & Agency group had been working on a Marketing strategy which incorporated the proactive planning of attendance at events, conferences and job fairs, to recruit relevant staff. She advised that development had started with recruitment ownership in that shared working between HR and the Ward Sisters enabled them to be involved and accountable for the staff they recruit.

Mrs Bradley reported that to complement the Hard Truths Commitment, Nurse Staffing Review, and Recruitment Campaign, she had been leading on a number of fundamental changes to workforce development across the nursing & midwifery teams. The Bank & Agency Group which she now leads with support from the Assistant Director of Finance and senior HR leads would concentrate on the recruitment of staff and reduction of the use of temporary staff, in particular Agency staff.

She informed the Board that a 'specials bank' of Healthcare Assistants who have had the relevant training and skills to care for patients who require 1:1 care had been set up. Part of this initiative would include the consideration of using mental health trained staff who may be able to 'special' more than one patient at a time due to their skill set.

Mrs Bradley advised the Board that she had been leading on performance 1:1 meetings with the 15 ward Sisters/Charge Nurses whose current ward expenditure has been over budget. These meetings had been supported by the Finance team. Each Sister/Charge Nurse had been given a financial trajectory to achieve in a given time frame with regular meetings to review progress. All band 7 (Ward Sisters/Charge Nurses) have had to attend a four day development programme focusing on the fundamental aspects of their role. The programme provided clear expectations, roles, responsibilities and accountability of the Sister/Charge Nurse role. Mrs Bradley also informed the Board that Back to Basics Review meetings were taking place to challenge the Sisters & Charge Nurses on Quality Metrics and KPI would be set for the individuals to achieve in a planned timeframe.

Mrs Bradley commented that updates on the progress of these workstreams would be presented as part of her future Board report.

Mrs Bradley advised that when comparing the Trust's ward establishment against the Safer Nursing Care Tool (SNCT) the findings suggested that the Trust had an under establishment in the registered workforce by 19.8 wte, and an over establishment of the unregistered workforce by 33.5 wte. Mrs Wright informed Board that the turnover of nurses was around 8% and that work had been carried out on analysis of retention. Mr Noble asked if detailed analysis about retention could be made available to the Integrated Healthcare Governance Committee.

Action: Mrs Brennan/Mrs Wright

The Board **NOTED** the Hard Truth Commitments and Nurse Staffing Review Update

TB 14/15 052 Integrated Performance Report and Quality Scorecard

Mrs Needham presented the Integrated Performance Report and Quality Scorecard.

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

Mrs Bradley commented that the complaint response rate within agreed timescales was down and this had been due to staff shortage, however an improvement was now showing. She reported that the Friends and Family Test Inpatient score had improved and all areas had been achieved. Mrs Searle suggested that a choice of language on the IPAD would be useful. Mrs Bradley advised that she would take that on board. **Action: Mrs Bradley**

Dr Wilkinson commented that at the Integrated Healthcare Governance Committee he confirmed that he would investigate if the 100% target for Fractured Neck of Femur patients operated on with 36 hours was a nationally set target.

Mrs Wright confirmed that the staff sickness rates had risen and an in depth report on staff sickness would be presented at the next Integrated Healthcare Governance Committee. **Action: Mrs. Brennan**

Mrs Needham informed the Board that a detailed report on Urgent Care and Cancer Performance had been presented to Finance Committee. Mrs Needham reported that the A&E 4 hour target had worsened in May and there had been an increase in non-elective admissions in June by 3%. Mrs Needham advised that once the Emergency Care Intensive Support Team's official report had been published it would be presented to the Finance Committee. Dr Swart commented that the Trust had written an article for the Health Service Journal on how the emergency work undertaken with McKinsey had made an impact on working together.

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

TB 14/15 053 Finance Report Month 3

Mr Lazarus presented the Finance Report Month 3.

Mr Lazarus reported that the Improving Quality and Efficiency position for Q1 showed a £5.8m deficit with the forecast a projected deficit of £14.2m. The Trust had been unable to secure any agreement with Nene CCG in relation to the reinvestment of the excess Marginal Rate Emergency Tariff (MRET) penalty above plan. Non-elective activity had performed above plan in June giving rise to a further increased provision for the associated MRET penalty.

The NHS Trust Development Authority (TDA) had been informed of the increased projected deficit and had offered support in dealing with the excess MRET penalty. The advice given had been to go through the Urgent Care Board. However, the TDA would continue to performance manage the Trust against the £7.8m plan submission.

Mr Lazarus confirmed that the CIP delivery had improved but there remained significant forward risk in the CIP plan. A draft Financial Recovery Plan had been developed to address the projected deficit

The forecast cashflow position had given rise to potential liquidity risk and a temporary borrowing application for £3m had been submitted to DH to cover the period September to November 2014.

Mr Pallot reported that he would be preparing a paper entitled Coding and Counting Letter and Contractual Position which would be presented to the Board at its Private Meeting in September. This would ensure agreement had been reached on the approach to the contract negotiations during the winter period with specific reference to the Trust's position on MRET reinvestment.

Action: Mr Pallot

The Board **NOTED** the Finance Report Month 3.

TB 14/15 054 Improving Quality and Efficiency Report

Mr Lazarus presented the Improving Quality and Efficiency Report.

Mr Lazarus reported that the most likely delivery at M3 was £10.323m, which was up by £1.4m against month 2. This had been off plan by £2.345m against the £12.668m plan prior to mitigation. The plan submitted to the TDA required delivery of £1.6m in the first 3 months and actual delivery was £2.1m, ahead of plan by £449k.

Mr Lazarus reported work was currently underway within Directorates to prepare plans for closing any gaps and these would be presented to Improving Quality and Efficiency Group (IQEG). Mr Lazarus reported that increased governance had been put in place and there had been a lot of good work within the IQE team to improve the position.

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

TB 14/15 055 Workforce Report

Mrs Wright presented the Workforce Report.

Mrs Wright reported that for the financial year to date rate for sickness absence rose slightly to 4.25%. In month sickness absence increased by 0.26% to 4.32% which was above the Trust target.

She reported that the current rate of completed PDPs or Appraisals recorded had been 66.09%; continued improvement had been seen since March. The Mandatory and Role Specific Essential Performance Wave had been refined and simplified so that all managers were aware of what they would receive on a monthly basis and what was required of them to be able to provide assurance. Mrs Wright reported that with effect from 1 August 2014 a new regional agency framework would come into place which would be managed by the East of England Commercial Procurement Hub. The framework would cover community nursing, general nursing, critical nursing, mental health, midwifery and specialist nursing. It would provide a transparent contracting pricing mechanism to realise efficiency savings through negotiated service level agreements.

The Organisational Development (OD) department were progressing with each of the workstreams as identified in the organisational effectiveness strategy. The OD department were currently working on 19 workstreams, one of which included 9 separate departments with specific OD interventions.

The Board **NOTED** the Workforce Report

TB 14/15 056 **Clinical Audit Annual Report**

Dr Wilkinson presented the Clinical Audit Annual Report.

Dr Wilkinson reported that the Audit Forward Plan 2014/15 comprised of both risk and compliance based audits which were aligned with corporate objectives and the Board Assurance Framework. The work of the Department of Clinical Audit, Safety and Effectiveness (DCASE) continued to expand to meet local and national compliance and information requirements.

He informed the Board that the recruitment to the DCASE Lead and the new Senior Clinical Effectiveness and Audit Officer posts had now been completed with the new postholders starting on 1 July 2014. The Department was in the process of recruiting a full-time TARN Coordinator and Governance Facilitator following the retirement of a part-time member of staff (0.6).

Dr Wilkinson advised the Board that the Mortality and Coding Review Group continued its work in monitoring mortality; acting on alerts and engaging clinicians in clinical audits relating to mortality concerns. This group was responsible for the Trustwide casenote mortality review.

In 2014/15 there had been Local CQUIN for Mortality and Morbidity (M&M) meetings at a Trustwide and directorate level. Compliance with Q1 of the local M&M CQUIN was on schedule. The Trust had participated in 100% of national audits and 100% of confidential enquiries on the Quality Account in 2013/14.

The Board **NOTED** the Clinical Audit Annual Report

TB 14/15 057 **Risk Management Annual Report**

Dr Wilkinson presented the Risk Management Annual Report.

Dr Wilkinson reported that this was the first Risk Management Annual Report for Northampton General Hospital NHS Trust. The purpose of the report was to summarise the key activities relating to risk management undertaken between 1 April 2013 and 31 March 2014 and highlight the progress in the ongoing development of the Trust's risk management arrangements and also outlined the risk management objectives for the coming year.

Dr Wilkinson informed the Board that the overall aim was to provide assurance that a programme of work had been put in place to identify, measure and manage risk and the report focused on the key areas such as the Corporate Risk Register, Incident Reporting and Management, Serious Incidents, Central Alert System (CAS) and Claims Management.

Mr Noble asked how the Trust's Clinical Negligence Claims compared to other Trusts and Dr Swart responded that a benchmarking exercise would be carried out.

Action: Dr Wilkinson

The Board **NOTED** the Risk Management Annual Report

TB 14/15 058 Medical Education Annual Report

Dr Wilkinson presented the Medical Education Annual Report.

Dr Wilkinson reported on highlights of current issues with respect to postgraduate medical training at the Trust. Junior doctors were an essential part of the workforce and training was provided largely by consultant medical staff and was reliant on clinical leadership and engagement with changing patterns and demands on training.

Dr Jeffrey confirmed that multi-professional learning and links were increasingly important if the workforce as a whole were to be able to deliver high quality care and staff satisfaction and involvement had increased if high quality learning was provided for doctors and other staff groups.

Dr Wilkinson advised that not all training posts within the hospital were filled despite the Trust receiving good reports from trainees who had worked at the hospital. Starting in September the Trust would have 3 students placed in general medicine. The Trust would be looking to increase the numbers and range of specialty placements available to the Birmingham students in the hope of attracting them to subsequently work at NGH. The University were keen to support this “recruit and train locally to work locally” approach.

Dr Wilkinson reported that the East Midlands had a historically low number of trainees in all specialties for its population size and within the region a very uneven distribution of those that come to the Trust, with the Trust having amongst the smallest number, despite having a history of better training delivery. Large scale re-distribution was unlikely so the size of the benefit to Trust remains unclear. Dr Swart, had been asked to chair the Local Education and Training Board group overseeing this process.

Dr Jeffrey commented that a number of innovative schemes had been developed to fill the gaps in junior rotas. He reiterated that it was important that the Trust needed to continue to recognise training as an essential part of Consultant work.

The Board **NOTED** the Medical Education Annual Report

TB 14/15 059 Medical Revalidation & Appraisal Annual Report

Dr Wilkinson presented the Medical Revalidation & Appraisal Annual Report.

Dr Wilkinson reported that medical revalidation was formally launched by the General Medical Council (GMC) in 2013 and the purpose of medical revalidation had been to strengthen the way doctors were regulated with the aim of improving the quality of care provided to patients, improved patient safety and increased public trust and confidence in medical systems aimed to give extra confidence to patients that their doctor was being regularly checked by the employer and the GMC.

Dr Wilkinson gave an overview of the report and stated that the report provided assurance to the Board that that robust effective local governance systems and processes were in place to support medical appraisal and revalidation and that the Interim Responsible Officer can discharge their statutory duties.

He informed the Board that for the reporting period 1 April 2013 – 31 March 2014 the Trust had 257 doctors with a prescribed connection to the organisation and the Trust had undertaken 208 appraisals. The Trust had 32 Appraisers and that there was a need for further recruitment of Appraisers and to support the managing of the appraisal system.

The Board **NOTED** the Medical Revalidation & Appraisal Annual Report and **APPROVED** that the Statement of Compliance be signed off by the Chairman and Chief Executive.

TB 14/15 060 Equality Delivery Stems 2 (EDS2)

Mrs Wright presented the Equality Delivery Stems 2 (EDS2).

Mrs Wright provided a summary of the consultative process carried out for the EDS2 self-assessment and demonstrated the grades that were awarded for each of the 18 outcomes following consultation with staff side colleagues and representatives from service user groups.

The main purpose of EDS was to help local NHS organisations, in discussion with local partners including local people, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS, NHS organisations can also be helped to deliver on the Public Sector Equality Duty.

EDS2 was made up of 18 outcomes, against which NHS organisations assessed and grade themselves. They were grouped under four goals, Better Health Outcomes, Improved Patient Access and Experience, a Representative and Supported, and Inclusive Leadership Workforce. Of the 18 outcomes the Trust had self-assessed as achieving 3 and developing in 15. The Equality and Human Rights Steering Group would discuss the areas that had been graded as developing at their next meeting in October 2014 to determine which outcomes posed the greatest risk/s and these would form part of the Trust's Four Year Action Plan.

The Board requested that the action plan be presented at the November meeting.

Action: Mrs Brennan/Mrs Wright

The Board **NOTED** the Equality Delivery Stems 2 (EDS2)

TB 14/15 061 TDA Self-Certification Report

Mr Pallot presented the TDA Self-Certification Report.

Mr Pallot reported that in accordance with the Accountability Framework, the Trust had been required to complete two self-certifications in relation to the Foundation Trust application process. Draft copies of Monitor Licensing Requirements and Trust Board Statements self-certifications for June 2014 were discussed and approved subject to the following amendment to Appendix 2 Governance item 10:

The Trust is failing or is at risk of failing the following targets:
- A&E 4 hour transit time
- Cancer 62 Day Wait – timescale for compliance 30/9/2014
Progress against the agreed Improvement Plan for Urgent Care and Cancer is progressing at pace and is reviewed in detail at the Trust Finance Committee. There is an existing risk relating to the recruitment of appropriately skilled medical and nursing staff and a risk regarding the steep rise in attendances at A&E and subsequent admissions and delayed transfers of care in the current year. At present, the Board has insufficient assurance that there are adequate mechanisms in place to reduce or divert demand.

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

TB 14/15 062 **Any Other Business**

There were no items of any other business.

Date of next meeting: Thursday 25 September 2014 at 09:30 in the Board Room at Northampton General Hospital

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 15/09/2014

Ref	Meeting date	Minute Number	Paper	Action Required	Responsible	Due date	Status	Review of Completion/Reason for Slippage
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.	Rebecca Brown/Karen Spellman	Sep-14	On Track	Mrs Spellman has sent a request to the CCG for this information. As at 31 July no response from the CCG. Verbal update at next Board meeting.
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.	Sally-Anne Watts	Sept/October 2014	on Agenda	on Sept Agenda
34	26/06/2014	TB 14/15 028	Patient Story	Mrs Bradley reported that a multidisciplinary team had been set up to look at pain relief and an evaluation report would be available to the Board in September	Jane Bradley	Sep-14	on Agenda	to be included in the Sept Director of Nursing Report
35	26/06/2014	TB 14/15 033	Hard Truths	Mr Farenden requested that an update on agency and locum staff be brought back to the Board in September as much more robust assurance was needed	Jane Bradley	Oct/Nov 2014	On Track	To come to the next Trust Board meeting
36	31/07/2014	TB 14/15 051	Hard Truths	Mrs Wright informed Board that the turnover of nurses was around 8% and that work had been carried out on analysis of retention. Mr Noble asked if detailed analysis about retention could be made available to the Integrated Healthcare Governance Committee.	Janine Brennan/ Sandra Wright	Sep-14	On Track	
37	31/07/2014	TB 14/15 052	Integrated Performance Report and Quality Scorecard	The Friends and Family Test Inpatient score had improved and all areas had been achieved. Mrs Searle suggested that a choice of language on the IPAD would be useful. Mrs Bradley advised that she would take that on board.	Jane Bradley	Sept/October 2014	On Track	
38	31/07/2014	TB 14/15 053	Finance Report Month 3	Mr Pallot reported that he would be preparing a paper entitled Coding and Counting Letter and Contractual Position which would be presented to the Board at its Private Meeting in September	Chris Pallot	Sep-14	on Agenda	On the Private Board Agenda for September meeting
39	31/07/2014	TB 14/15 057	Risk Management Annual Report	Mr Noble asked how the Trust's Clinical Negligence Claims compared to other Trusts and Dr Swart responded that a benchmarking exercise would be carried out	Mike Wilkinson	Sept/October 2014	On Track	In order to carry out the benchmarking exercise, the Senior Quality, Risk & Litigation Manager needs access to the NHS Litigation Authority Extranet. An application for access has been lodged with the NHSLA and this has been authorised by Mr Pallot as the Senior Information Risk Officer (SIRO). When access has been granted the benchmarking exercise will be carried out and a report will be provided to IHGC
40	31/07/2014	TB 14/15 060	Equality Delivery Stems 2 (EDS2).	The Board requested that the action plan be presented at the November meeting.	Janine Brennan	Nov-14	On Track	on November Agenda
41	31/07/2014	TB 14/15 052	Integrated Performance Report and Quality Scorecard	Mrs Wright confirmed that the staff sickness rates had risen and an in depth report on staff sickness would be presented at the next Integrated Healthcare Governance Committee.	Janine Brennan	Aug-14	completed	Report presented at August IHGC

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

Report To	**Public Trust Board**
Date of Meeting	**25 September 2014**

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

Enclosure C

Northampton General Hospital NHS
NHS Trust

Public Trust Board
25 September 2014

Chief Executive's Report

1. **Annual General Meeting**
Our Annual General Meeting (AGM) will be held at 6pm on Monday 29 September in the main Lecture Theatre, Cripps Postgraduate Centre. Our staff, members and Shadow Governors are all invited to attend.

For those who cannot attend the AGM, this year we are doing something different. The majority of the presentation will be included within an interactive film that is currently being produced. The aim is that, following the AGM the film will be available via our website and intranet for our staff and members of the public to watch at a time to suit them.

2. **Building Relationships Across the Local Healthcare Economy**
We have now set up some different style meetings with our Commissioners to include their Contracting and Finance Leads with the aim of improving our discussions about funding.

If we are going to collaborate effectively across the health and social care economy in order to plan for future sustainability, we know that we need to build trusting relationships. Having meaningful discussions with Chief Executives, Finance Directors and Contract Managers from Commissioners and Providers in the room together is a good start.

In the meantime the Chief Executives continue to meet weekly to oversee progress on the health economy collaboration work between Providers and Commissioners of Health and Social Care.

I recently met with the CEO of St Andrew's, who is interested in exploring how we could assist each other in terms of the mental/physical health issues we both face. I also had an interesting meeting with Professor Robert Harris, a former Strategy Director of Monitor who is now a partner in the Corby Lakeside practice. They are interested in developing urgent care centre models that would work alongside A&E departments and assist in the management of a significant number of patients to ensure that admission to hospital is not the default option. It is important for us to explore all options and to work with our Commissioners so that they support the direction of travel.

3. **Aspiring to Excellence**
In mid-August I welcomed our 'Aspiring to Excellence' students who are entering their final year at medical school. This 3-week safety teaching module has been a great success largely due to the energy and enthusiasm of Jane Bradley and will now be run by Celia Warlow, Jonny Wilkinson and others from the Safety Academy. Many of our consultants have also supported this over the years and we are soon to welcome a Senior Lecturer who will join Northampton General Hospital (NGH) and work to develop this for us and the Medical School on a grander scale. Dr Philip Pearson, previously a Consultant Physician at Plymouth, will start in September and will work as a Respiratory/Acute Physician and support quality improvement for our students and doctors in training as part of this Senior Lecturer post shared with Leicester University. Each year the students do a project and trust-wide audit with a safety theme and present their findings to the Board and clinical staff.

4. **Nursing and Midwifery Conference**
We had a very successful day to celebrate achievement in nursing and midwifery on 9 September. The Senior Nursing Team led by Jane Bradley organised some very inspiring presentations which reflected our achievements and aspirations for the future. There was a real appetite for change as well as a realisation that there has been some fantastic work at NGH that should be built on. We were all given a perspective check as we listened to the voluntary work done in Zimbabwe led by one of our midwives and the conference ended with a moving

presentation from one of our nurses who asked us to reflect on the power and value of nursing as he told a very personal story. There was a buzz in the air as we all supported the hope and belief that we can move towards a hospital consistently providing the best possible care supported by a workforce that can be proud of what they do. My favourite phrases from the day were probably 'love what you do' and 'do the right thing'.

5. **Staff Development**
Our programme for development of staff is starting to take shape and updates are being issued to staff. The programme will help us to work with all our staff to ensure everyone understands what is going on in the hospital, and what we all need to do in order to take things forward. We have planned this for a while and although we have not been able to progress this as quickly as we would have liked, I am sure people will start to see and feel a difference as this rolls out.

6. **New X-Ray System for NGH**
NGH is part of a consortium of seven trusts (EMRAD) who have agreed to share the cost of implementing a new x-ray system in the region which will be rolled out over the next 12 months. The new system, which will benefit our patients and our clinicians, will allow our doctors to see images transferred to them straight away and they will be able call in specialist opinions from colleagues at different locations. Up to now, images could be difficult to transfer digitally, or in some cases even mean CD-ROMs physically moved from hospital to hospital.

The seven NHS trusts in the consortium are NGH, Kettering General Hospital, Nottingham University Hospitals, Chesterfield Royal Hospital, Leicester Royal Infirmary, Sherwood Forest Hospitals and United Lincolnshire Hospitals.

Radiology systems have developed hugely in recent years. The ability to review radiology images and reports is now a crucial part of many clinical pathways, and increasingly these pathways involve multiple hospital locations, 24/7.

This is an exciting project for the future of radiology at NGH. We believe that, by joining with our colleagues in Trusts across the East Midlands, we have achieved the best possible outcome for our patients and are now looking forward to getting the new system up and running as soon as possible.

7. **NGH Archive**
We are fortunate to have an active and enthusiastic group of volunteers who help preserve our hospital archive and we are grateful to them for their commitment to bringing the archives to life.

Recently they presented an interesting display in the cyber café to show people how NGH cared for wounded soldiers during World War One. The display was enhanced by Sue Longworth in a nurses' uniform of the time.

Another keen volunteer is Dr Andrew Nason-Williams, Consultant Paediatrician, who is currently working with children from Fairfields School to produce a film depicting the first patient cared for at the Infirmary in George Row when it opened on 29 March 1744, a 13 year old girl called Thomasin Grace.

8. **@SoniaSwartCEO**
I am keen that we use every resource available to us to improve our communication with our staff, patients and the public. With support and encouragement I have recently opened my own Twitter account so that I can let people know about positive things or signpost things of interest. I decided I needed to make more use of social media and we will also be working on this as an organisation. We also have a NGH NHS Twitter account manned by our Communication Department which currently has more than 800 followers.

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**25th September 2014**

Title of the Report	**Medical Director's Report**
Agenda item	**7**
Sponsoring Director	Dr Mike Wilkinson, Interim Medical Director
Author(s) of Report	Dr Natasha Robinson, Associate Medical Director Christine Ainsworth, Senior Quality, Risk & Litigation Manager
Purpose	Assurance

Executive Summary

- Sustained improvement in HSMR at 90.3
- SHMI no longer outwith the expected range
- Recent review of 50 deaths completed and included here. This will to be distributed to directorates and CCG
- Next review to commence in next few months
- 4 new Serious Incidents were reported, all under the category of Grade 3 pressure ulcers
- 30 Grade 3 pressure ulcers have been reported year to date, compared to 13 Grade 3 and 1 Grade 4 in the same period last year
- Grade 3 and 4 pressure ulcers may be removed from the classification of a Serious Incident when the revised National Framework for the Reporting & Learning from Serious Incidents is released later this year. Monitoring would need to continue to ensure the continued emphasis on investigation and improvement to reduce the incident of harm from more severe pressure ulcers
- Year to date, the highest reporting category, excluding pressure ulcers, is Slips/Trips/Falls. This is no change from the same reporting period in 2013/14, although the number of Serious Incidents reported in 2014/15 has increased by 44.4%
- 9 Serious Incidents were submitted for closure. All reports were submitted within the agreed timescale
- Delays in submission of the first draft of the Serious Incident reports – SIG have agreed to pilot a revised process for 6 months. This should allow for greater probity into the investigation
- All action plans produced during the reporting period have been reviewed by the Serious Incident Group and uploaded to HealthAssure. 75% of agreed action plans are either complete or are on target for completion within the timescale. It is envisaged that all historic action plans will be closed by the end of Quarter 2

• Dates for Root Cause Analysis training are currently being circulated. There will be 5 training workshops in October and November, followed by monthly workshops.	
Related strategic aim and corporate objective	Strategic Aim 1: Be a provider of quality care for all our patients Objective No 1 : Invest in enhanced quality including improvements in the environment in which we deliver care
Risk and assurance	Risks to patient safety if the Trust does not robustly investigate root causes identify remedial actions required and ensure cross Trust learning to prevent recurrence of SI.
Related Board Assurance Framework entries	BAF 1
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (**N**) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? (**N**)
Legal implications / regulatory requirements	Compliance with CQC regulations (patient safety) and commissioner requirements through mandatory contracts

Actions required by the Trust Board

The Board is asked to note the content of the report, details of the serious incidents declared and identify any areas for which further asurance is sought.

Public Trust Board
25 September 2014

Medical Director's Report

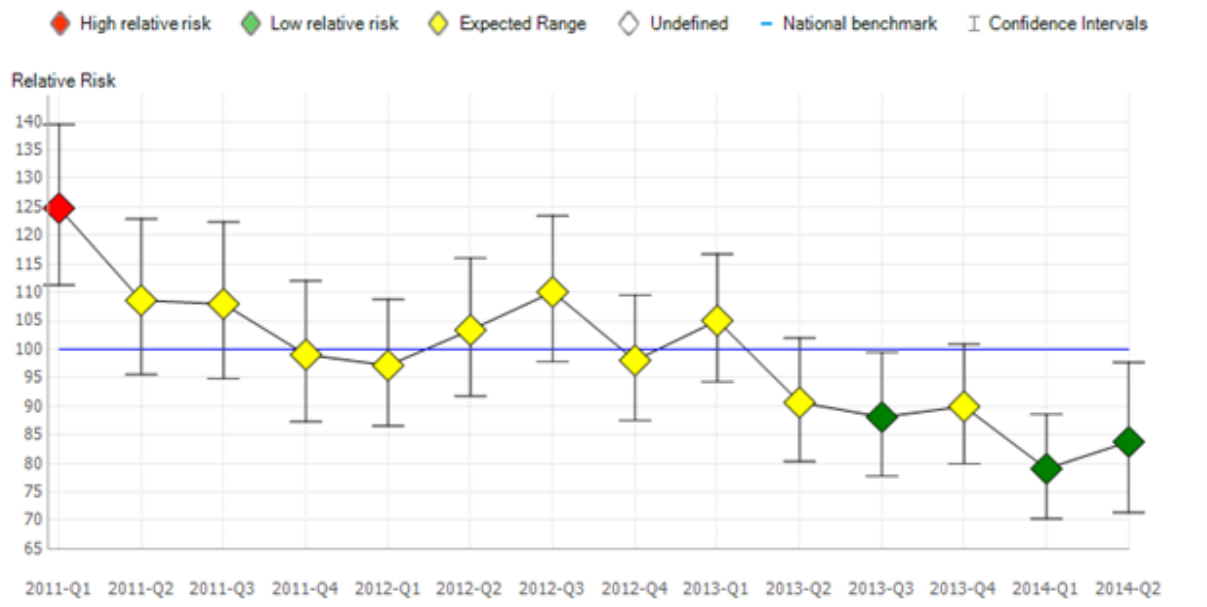
1. Review of current mortality and safety data provided by Dr Foster

This paper provides a brief summary of mortality and safety information provided by Dr Foster Intelligence to end May 2014, and SHMI to end December 2013. This includes the first 2 months of data following the separation of the community hospitals from NGH [April & May 2014]. Hospital mortality has fallen nationwide over the past year, but the improvement at NGH has been more rapid.

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

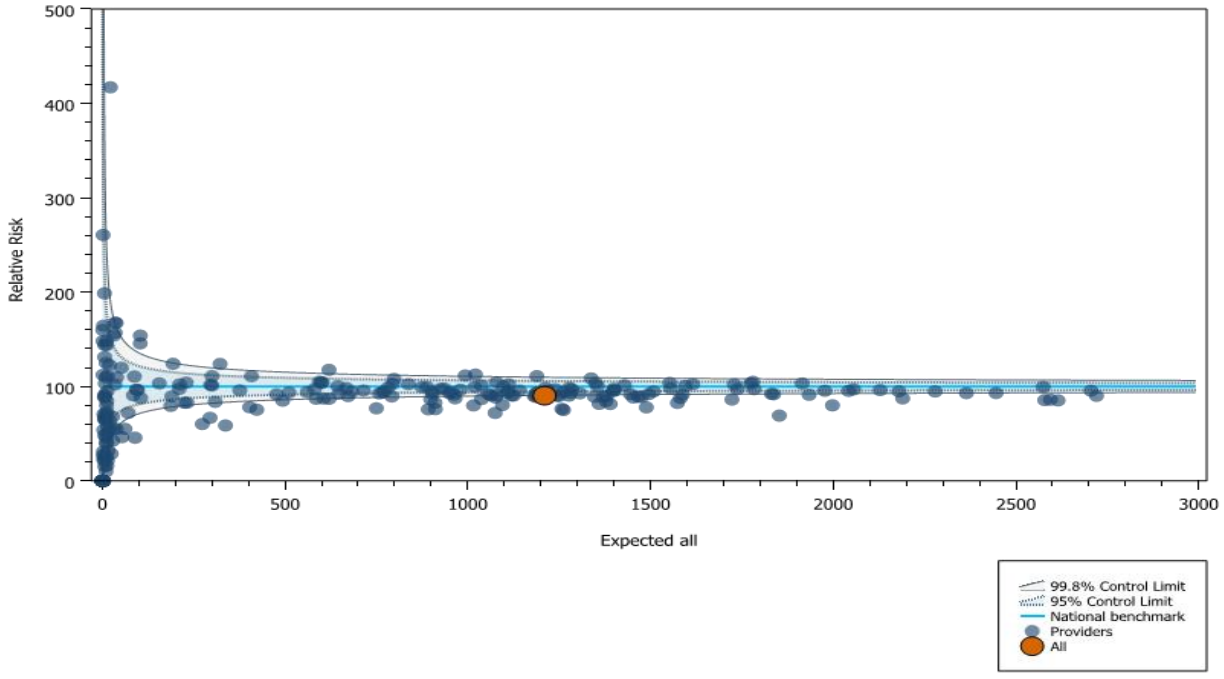
A detailed account of the methodology of HSMR can be found in all recent Board papers for 2014, accompanied by a description of the local process for use, both of which remain unchanged. However as previously explained, the data is now 3 months in arrears, and where numbers <7 ['small numbers'] occur, these are redacted for purposes of patient confidentiality.

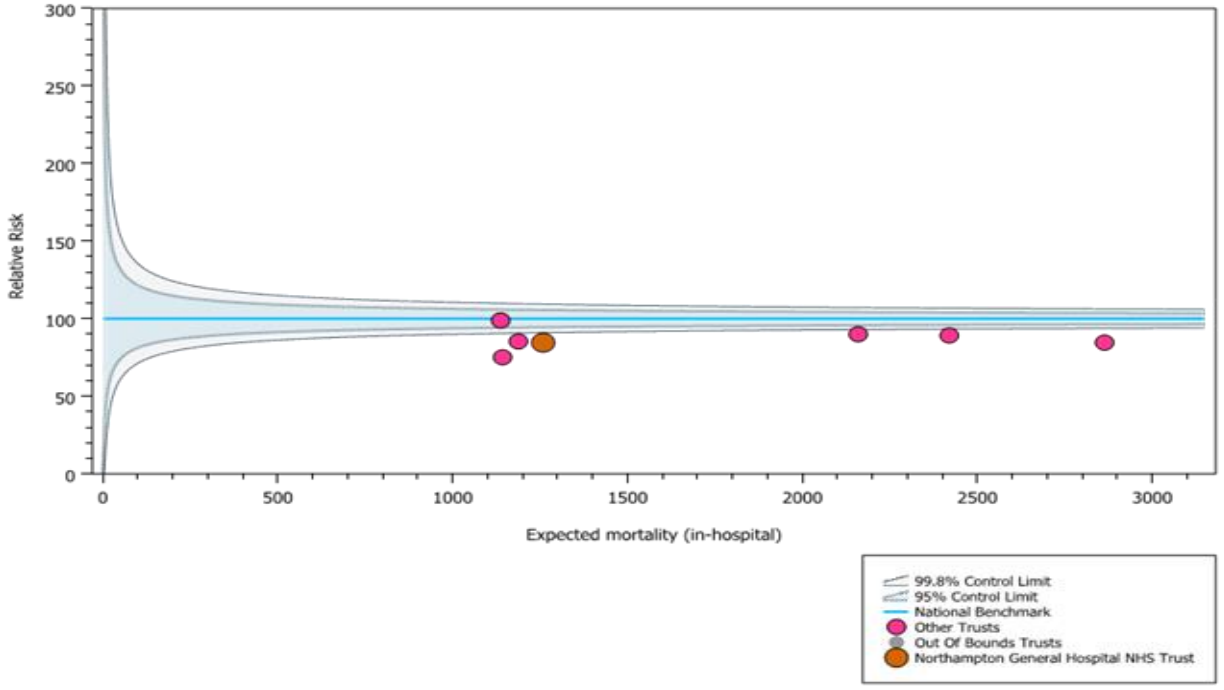
The following graph shows the sustained improvement in HSMR by quarter since 2011:



3. HSMR Comparison

This tool is no longer available from Dr Foster. However the rolling HSMR to end May 2014 has been rebenchmarked [to end 2013] as **90.3,** which is the lowest in 5 years. This is shown on the funnel plots for all of England, and also the East Midlands.. *[Please note the legend on the first graph is incorrect: the orange circle is NGH]*

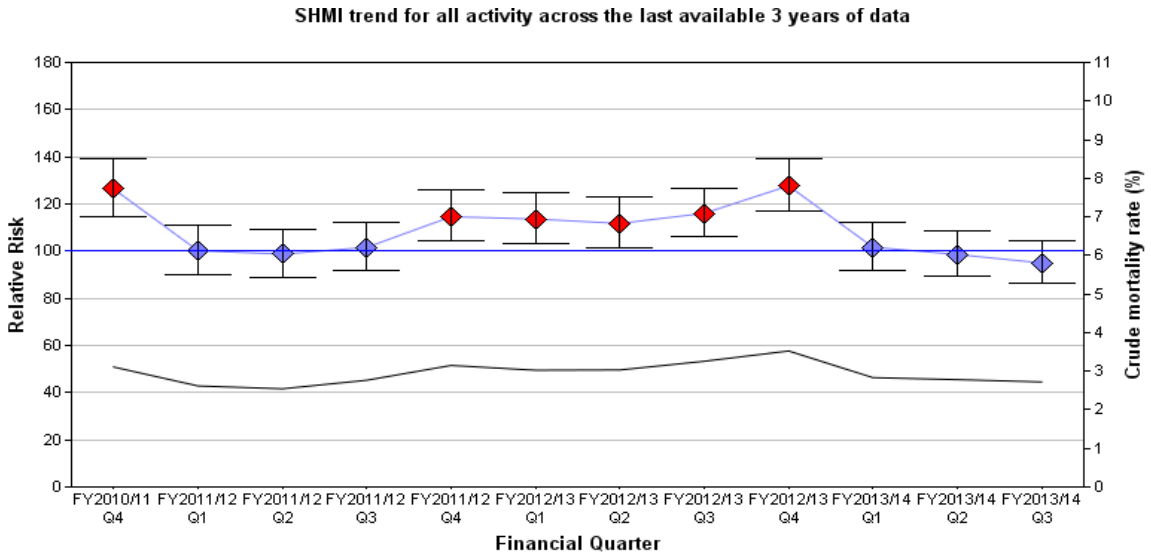




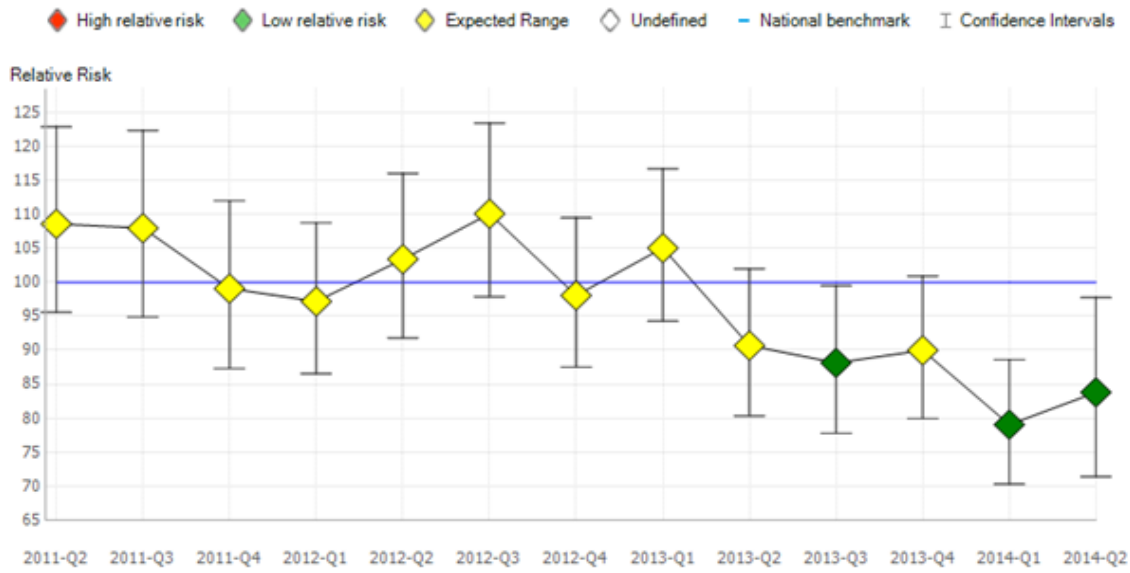
HSMR crude mortality for 2014-15 is now 3%, having been 3.6% in 2013-14. The fall will in part be due to the loss of the community hospitals. However it is the equal lowest in the East Midlands, where the average is 3.7% [3 - 4.6% range]

4. Standardised Hospital Mortality Indicator (SHMI)

The most recent SHMI data to end December 2013 shows continued improvement as expected and is now **105** [within the expected range]. It will fall to below **100** in the next data release [October 2014] as it tracks HSMR 100, currently **80-85**.



HSMR 100 to Q1 2014-15



Palliative care coding accounts for some of the disparity between SHMI and HSMR, as no adjustment is made for palliative care within SHMI calculations. Coding rates for palliative care at NGH have fallen below the national average with the loss of the community hospitals, further suggesting that SHMI will continue to fall in line with HSMR 100.

5. Patient Safety Indicators

Indicator	Volume	Observed	Expected	Observed Rate/K	Expected Rate/K	Relative Risk
Deaths in low-risk diagnosis groups*	38,575	23	30.4	0.6	0.8	76
Decubitus Ulcer	9,734	297	332.2	30.5	34.1	89
Deaths after Surgery	347	40	45.6	115.3	131.4	88
Infections associated with central line*	16,168	****	****	****	****	92
Postoperative hip fracture*	24,908	****	****	****	****	259
Postoperative Haemorrhage or Haematoma	23,515	14	14.2	0.6	0.6	98
Postoperative Physiologic and Metabolic Derangement*	19,787	****	****	****	****	250
Postoperative respiratory failure	18,016	24	17.0	1.3	0.9	141
Postoperative pulmonary embolism or deep vein thrombosis	23,701	29	45.4	1.2	1.9	64
Postoperative sepsis	567	****	****	****	****	76
Postoperative wound dehiscence*	963	0	****	****	****	0
Accidental puncture or laceration	67,817	62	77.3	0.9	1.1	80
Obstetric trauma - vaginal delivery with instrument*	443	44	36.6	99.3	82.7	120
Obstetric trauma - vaginal delivery without instrument*	2,489	110	95.5	44.2	38.4	115
Obstetric trauma - caesarean delivery*	1,180	****	****	****	****	23

**** - cell contains <7

6. Reports on key areas for action or of importance

Aggregate mortality resulting from the 5 high risk diagnosis groups (acute myocardial infarction, stroke, fractured neck of femur, pneumonia and heart failure) is better than expected for the rolling year to date at **76.**

HSMR for patients admitted as an emergency during the week vs weekends continues to show no significant difference, and is <90 for both groups for the year to date when rebenchmarked for 2013.

7. Possible areas for concern under investigation

There have been no new alerts requiring investigation.

8. Crude Mortality

Unadjusted data using the crude numbers of deaths occurring in the Trust provided from internal information sources to the end of August 2014 continues to show that the number of deaths in hospital [90-100/month] remains stable following the separation of the community hospitals.

9. Mortality Case Note Review (Review 4/December 2013)

Background

In 2011, Northampton General Hospital NHS Trust undertook a case note review (Review 1) of the care of 222 patients who died between October 2011 and February 2012. NGH had been an aware of a concern with Hospital Standardised Mortality Ratio (HSMR) since 2008 and this review was one of a number of strands of work that had been undertaken to improve understanding of the issues since 2008. The study was set up to identify avoidable deaths and to examine areas which required most improvement on the basis of analysing themes relating to failures of care at the Trust. Even if the deaths were not avoidable the premise was that there would be useful learning points in terms of targeting improvement activity.

The case note review provided the Trust with objective information relating to patterns of harm and mortality. The overall judgement was that around 6% of deaths may have been avoidable and this information was used to inform improvement work. Whilst it was acknowledged that the review was time consuming, it was also felt that this detailed examination and feedback was very powerful in engaging clinicians across the Trust.

In 2012/13, the review was repeated looking at 50 consecutive deaths occurring in November 2012 (Review 2).

Over the last 18 months, the focus of external regulators such as the Care Quality Commission (CQC) and Trust Development Authority (TDA) has been on strengthening mortality reviews. Therefore the Mortality Case Note Review process was developed further to look at 50 consecutive deaths from 2 selected months each year. The first set of notes to be reviewed (Review 3), was 50 deaths from July 2013 (the notes reviews and challenge meetings were carried out from December 2013 to February 2014). A report was prepared for the Medical Director and a summary of the findings was distributed to M&M leads for feedback and discussion at Directorate M&M meetings. The current report (Review 4) gives details of the results of the second review looking at 50 consecutive deaths from December 2013 (the notes reviews and challenge meetings were carried out from May 2014 to July 2014).

Casenote review is recognised as a valuable tool for understanding and improving standards of care. However the well-recognised inherent subjectivity and inter-rater variability of the method mean that it should not be used in isolation. NGH also uses Dr Foster Intelligence to provide an overview of mortality rates within the Trust, and monitors crude death numbers in real time. Overall mortality at NGH represented by HSMR fell during 2013, (as did the crude number of deaths). The rolling year average HSMR to July 2013 was 99 and to December 2013 was 94. This suggests that mortality in the Trust was now as expected, having been significantly worse than expected in earlier years.

In order to more easily identify the review, each has been allocated a “Review Number” which will be quoted in future (along with the dates to which the reviews relate):

Review 1/ Nov 2011-Jan2012
Review 2/ Nov 2012
Review 3/ July 2013
Review 4/ December 2013

This Trustwide Process runs alongside already well-established directorate mortality and morbidity processes and the work of the Mortality and Coding Review Group. The completion of this Trustwide review and the sharing of identified learning form part of a local M&M CQUIN for 2014/15 (Q2 and Q4). The learning will be shared across NGH NHS Trust and also with colleagues from KGH, NHFT and the CCG. In 2013, the administration of the review passed to the Department of Clinical Audit, Safety and Effectiveness.

Methodology

The process
The Mortality Case Note Review proforma used in the previous review was reused with some minor modification. The December 2013 proforma can be found in Appendix 1 (copies of previous versions are available in the corresponding reports).

Reviewers were recruited more widely for this round, to include doctors in training and nursing members of the governance and patient safety teams. Specific invitations were sent to:

- Those who had been part of the reviewing team on previous occasions
- Directorate Governance Leads
- Care Group Governance Managers

In addition, a general email was circulated to all consultants and SAS grade doctors, explaining the rationale for the review, the process and requesting volunteers. It also requested that consultants discuss the review with their junior staff and invite them to participate.

The above steps resulted in the development of a team of 27 reviewers (15 experienced reviewers and 12 who were new to the team). As previously, the team covered a wide range of disciplines including paediatrics, radiology, general surgery, anaesthetics, trauma and orthopaedics, haematology, oncology and gynaecology and on this occasion there were also reviewers from general medicine, accident and emergency and Head and Neck. Each reviewer was allocated either 1 or 2 sets of notes for review and requested to attend at least 2 challenge meetings. Training and support was available in completing the proforma where requested. The notes were allocated and distributed by the audit department and meetings were held to discuss the findings in detail and challenge the judgements where possible. Presentation slots were allocated for the reviewers at the meetings to ensure an equal workload each week.

Review of clinical coding was undertaken by senior coders before the notes were distributed to clinical reviewers, whereas previously it followed clinical review. Coders attended the meetings and, following discussion with reviewers, further coding amendments were made where appropriate, emphasising the requirement for clear documentation to facilitate accurate clinical coding.

Deaths in A&E were included if the patient had been discharged from NGH within the previous 30 days or they had received treatment in A&E (n=3). The proforma used for this review was modified very slightly from the previous round and can be found in Appendix 2. Deaths in A&E that followed an out of hospital cardiac arrest were excluded from the review process.

Deaths occurring in community hospitals were excluded for Review 4 as at the time the review was carried out, the community hospitals were no longer part of the Trust. Deaths subject to Serious Incident Review [other than those due to occurrence of a pressure ulcer] were also excluded since they have already been scrutinised for learning thus enabling the inclusion of another case (n=1).

Data Collection and Analysis
A clinical summary was presented and discussed for each case at the weekly challenge meetings and a summary sheet was used to document the discussion in brief (appendix 3). This and the completed proforma were then used to enter detailed data into an Excel spread sheet. The notes were available for more detailed analysis as required and results of investigations could be followed up on ICE if necessary. On occasion radiology reports were requested where these had not been provided [due to the patient having died before reporting had been performed].

Results
50 consecutive deaths were identified, reviewed and presented. 47 patients were admitted and died on a hospital ward, the remaining 3 died in A&E (n=50 unless otherwise stated).

9.1 Demographic Measures

- **Distribution by Age**

The ages of the patients at the time of death ranged from 36 to 95 years with a mean age of 77.9 years (median 80 years).

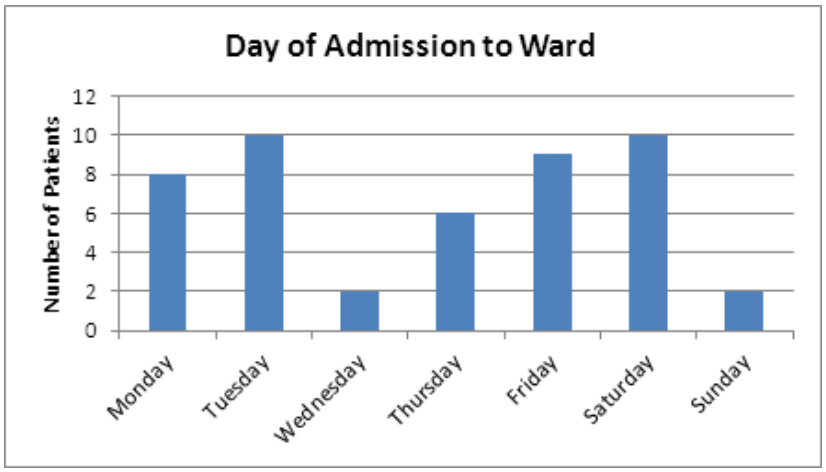
- **Distribution by Gender**

30 (60%) of the patients were male and 20 (40%) were female.

Table 1: Comparison of age and gender for all reviews

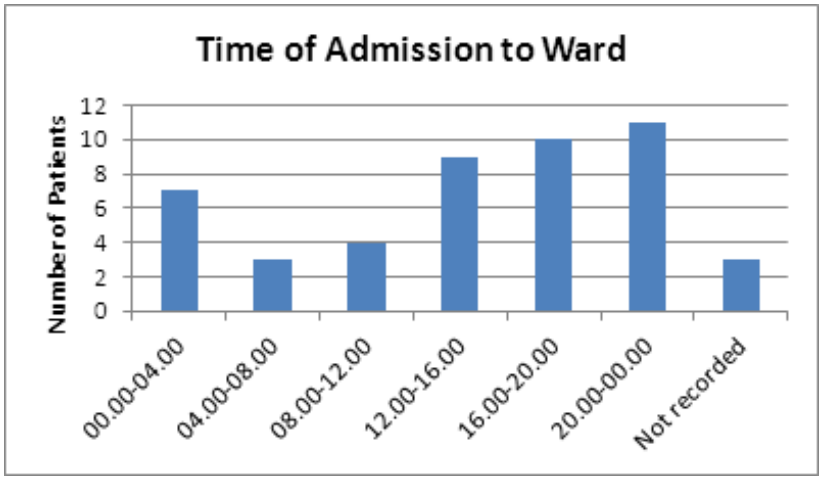
	Review 4 2013 (Dec)	**Review 3 2013 (July)**	**Review 2012 (Nov)**	**Review 2011 (Nov – Jan)**
Number of cases reviewed	50	50	50	222
Age range	36 - 95	31 - 99	39 -98	35 - 99
Median age	80 years	81 years	81 years	84 years
Gender	60% Male: 40%Female	66% Male: 34% Female	54% Male: 46% Female	48% Male: 52%Female

❖ **Distribution by Day of Week of Admission to Ward n=47 (3 patients died in A&E)**

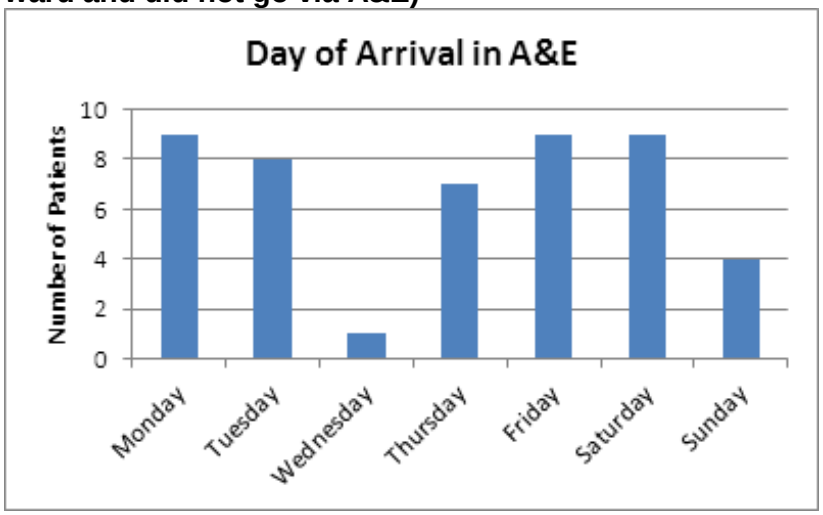


❖ **Distribution by Time of Day of Admission to Ward n=47 (3 patients died in A&E)**

This reflects the pattern of all emergency admissions in the Trust.

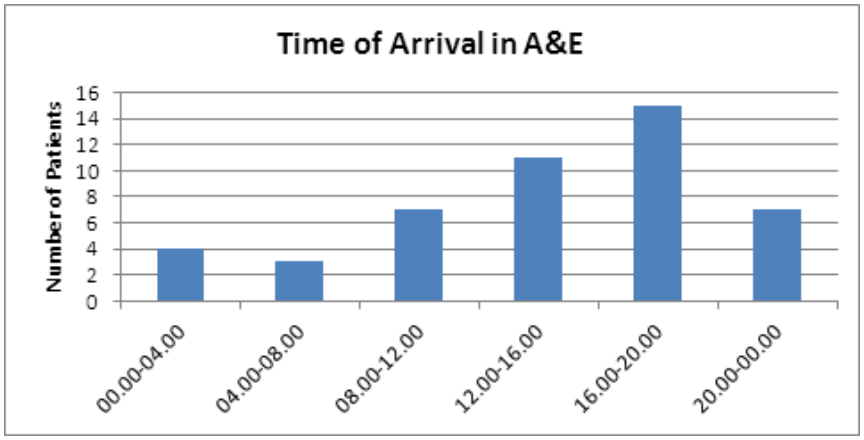


❖ **Distribution by Day of Arrival in A&E n=47 (3 patients were admitted directly to a ward and did not go via A&E)**



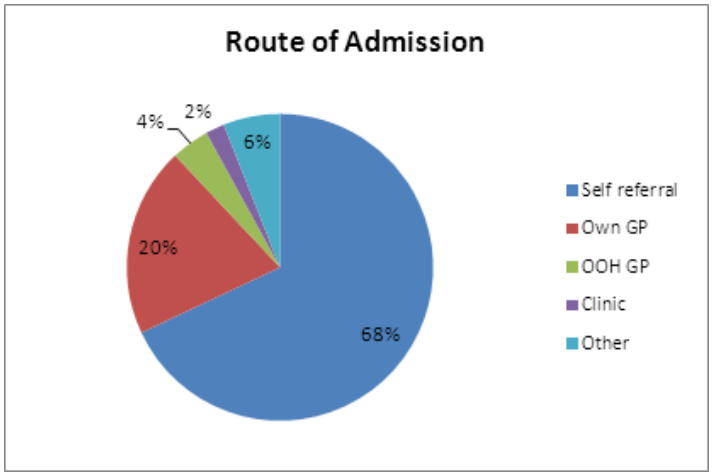
❖ **Distribution by Time of Arrival in A&E n=47 (3 patients were admitted directly to a ward and did not go via A&E)**

This reflects the pattern of all presentations to A&E.



❖ **Distribution by Type of Admission**

All 50 admissions were emergency admissions (there was only one elective death in the Trust in December 2013). The route of admission is shown in the chart below.



❖ **Distribution by Admitting Team n=47 (3 patients died in A&E)**

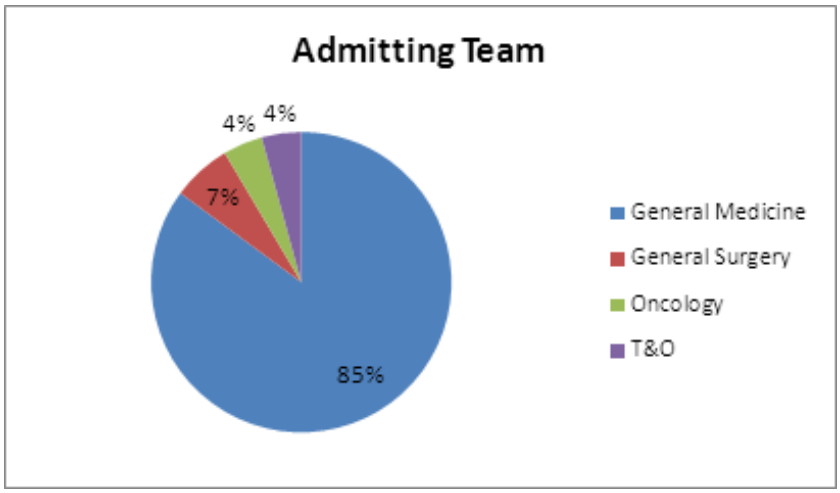


Table 2: Comparison of route of admisison and admitting team for all reviews

	Review 4 2013 (Dec)	Review 3 2013 (July)	Review 2012 (Nov)	Review 2011 (Nov – Jan)
Percentage of patients presenting by self-referral to A&E	68%	68%	58%	-
Percentage of patients admitted under general medicine	85%	64%	76%	76%

❖ **Distribution by Number of Emergency Admissions in Previous 12 months**

28% of patients had been admitted once in the previous 6 months, and 16% had been admitted on 2 or more occasions as an emergency admission. 56% of patients admitted had not been admitted as an emergency to NGH NHS Trust in the previous 6 months.

8 of the admissions in this review were emergency readmissions within 30 days of discharge from NGH NHS Trust.

❖ **Distribution by Previous Residence and Premorbid State**

17 patients were living alone in their own home and 24 were at home with either a spouse/partner or another family member. 2 patients were in residential homes, 3 in care homes and 3 in nursing homes. In 1 case, the usual residence was not recorded.

20 (40%) were documented as living independently and 6 were documented as bed bound (the others were dependent on sticks, Zimmer Frames or wheelchairs for their mobility +/- support from carers). The usual functional status was not recorded in 2 admissions.

Other Demographic Measures

- The incidence of dementia in this population was 24% (comparable with previous review findings)

9.2 Analysis of Failures to Plan, Rescue and Communicate

The notes were reviewed looking for failures to plan, rescue and communicate. Failures to plan were the most common occurring in 40% of patients; failures to rescue occurred in approximately 12% and failures to communicate occurred in 30%. Deciding if care has failed is highly subjective and there is overlap between the three categories and what constitutes failure in each category. Reviewers with previous experience of notes reviews and challenge meetings may be more likely to pick out failures in care and this may in part explain what may appear as an increase in failures of care since 2011.

The numbers of patients included in each review are small and no attempt has been made to attach statistical significance to the variations seen, and therefore the importance of the data is to identify themes of failures in care and areas for learning and improvement that can be shared across the Trust.

❖ Failure to Plan

The following reasons were identified to illustrate failure to plan (20 patients- each individual patient may have had more than 1 of the following reasons for failure to plan).

- Related to initial assessment and plan of care on admission [9]
  - Failure to make a clear diagnosis or consider differential diagnosis
  - Failure to document an adequate examination and assessment
  - Failure to manage pain relief adequately in A&E
  - Failure to do blood cultures on a patient with neutropenic sepsis
- Related to consultant review and request for specialty review [6]
  - Delayed referral to Stroke Team
  - Failure to address issue of consent for endoscopy in a patient with delirium
  - Delayed referral to ITU
  - Infrequent consultant review
  - Delayed initial consultant review
  - Failure to document initial consultant review
- Related to Documentation [6]
  - Failure to review old notes for important comorbidities
  - Poor organisation of notes
  - Poor documentation of handover to another ward
  - Long admission where overall plan was difficult to follow
  - Fluid balance charts not available for review
- Related to end of life care [8]
  - Failure to recognise EOL
  - Failure to consider patient's wishes
  - Confusion over the use of the LCP
  - Failure to stop all monitoring when patient had been designated as End of Life
  - DNAR/TEP form completed too late in the admission
- Related to medication [3]
  - Prescription of diclofenac in a patient with renal impairment
  - Use of Lorazepam/ Zopiclone in patients with agitation and confusion when no clear cause has been established

❖ Failure to Rescue

The following reasons were identified as illustrating failure to rescue (6 patients).

- Failure to perform baseline investigations when patient became confused
- Failure to request senior review when diagnosis was not clear
- Failure to check biochemistry investigation despite request to do so
- Failure to review CXR for 5 days and therefore delayed start of treatment
- Failure to act on ECG findings before transferring patient to the ward

❖ Failure to Communicate

Poor communication was felt to be an issue in each of the following circumstances (12 patients - examples in brackets). A limitation of notes review is that communication may have occurred which was not documented.

- Between wards (failure to hand over appropriately)
- Between ward staff and medical team (failure of escalation process for high EWS or to appropriately reduce monitoring and interventions at end of life)
- Between specialties at NGH (failure to be clear about who was in overall charge or to arrange appropriate consent process for endoscopy)
- Between medical staff and patient (failure to discuss preferences for end of life care)
- Between medical staff and relatives (failure to address concerns of relatives)
- Between NGH and tertiary referral centre (failure to send scans in a timely manner and document discussion)

9.3 Analysis of Triggers for Potential Harm n=47 (this question was not asked for the 3 patients who died in A&E)

18(38%) of patients were identified as having at least 1 trigger for potential harm. Readmission as an emergency within 30 days of discharge is the most common trigger for harm as has been noted previously.

- Emergency readmission [8]
- HCAI [3]
- Fall [3]
- Development or worsening of pressure sores [2]
- Cardiac arrest [3]
- VTE Tests [1]

8 patients were readmitted to NGH having been discharged within the previous 30 days. These cases were further reviewed to look for examples of failure to plan on the initial admission that contributed to the readmission but this was not found. It was generally felt that with better availability of non-acute hospital care, 2 of the re-admissions were potentially avoidable but that nothing could have been done differently to avoid the remainder.

9.4 Analysis of Potentially Avoidable Deaths [n=50]

In 1 case death was felt to have been possibly avoidable had optimal care been given (grade 2). This assessment is very subjective and therefore death may still have been inevitable (further details of this case can be found in appendix 4). There were 4 further cases which have been discussed and followed up in further detail (eg: making sure all investigations were available, requesting that all X-Rays were reported or clarifying the circumstances of a fall or development of a pressure ulcer). Suboptimal care was identified in each of these cases but after full discussion, review and follow up it was felt that the deaths were not avoidable (grade 1). No deaths were felt to be “probably avoidable” (grade 3). Any deaths identified as grade 3 are automatically referred to the Serious Incident Group (SIG).

Table 3: Classification of suboptimal care

Suboptimal Care Question	**Number of patients***	**Percentage**
No suboptimal care (grade 0)	27	**98%**
Suboptimal care identified but death not avoidable (grade 1)	22	
Possibly avoidable death (grade 2)	1	**2%**
Probably avoidable death (grade 3)	0	

Table 4: Identification of possibly or probably avoidable deaths for all reviews

	Review 4 2013 (Dec)	Review 3 2013 (July)	Review 2012 (Nov)	Review 2011 (Nov – Jan)
Deaths identified as possibly or probably avoidable (grade 2 and 3)	1* (2%)	4* (8%)	3* (6%)	13** (5.9%)

*All deaths were grade 2
**12 deaths were grade 2 and 1 death was grade 3

9.5 Analysis of Avoidable Admissions
8 admissions or A&E attendances were felt to have been potentially avoidable with better end of life care planning in the community or more provision of non-acute beds.

Other Quality Indicators

❖ **Notable Care**

Reviewers and the challenge team were asked to comment on notable care. In 58% of admissions, at least one example of notable care was highlighted. Common reasons for the care being noted as very good were:

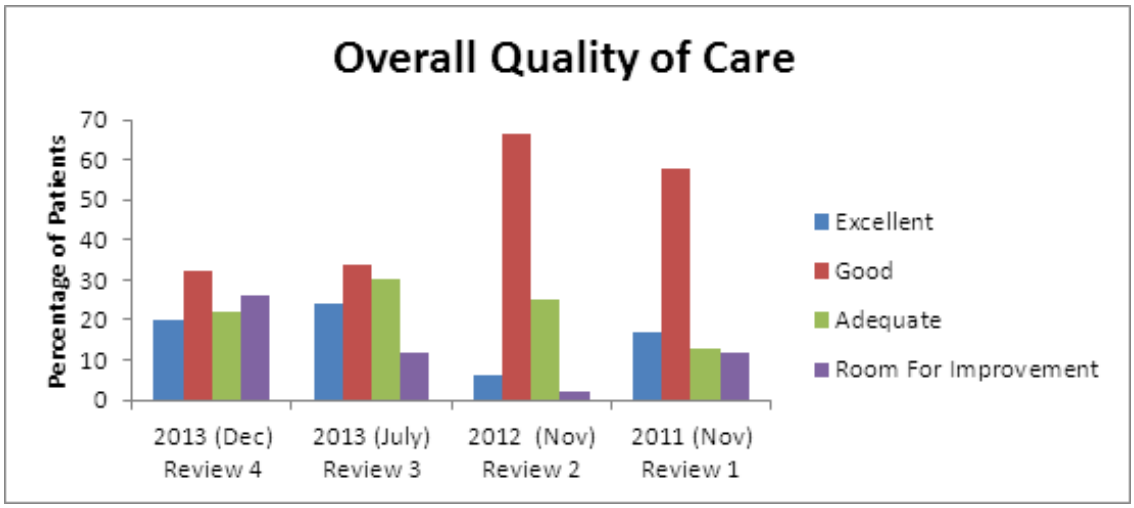
- Good consultant continuity, input or leadership [12]
- Good discussion with the patient and/ or family and carers [7]
- Good Documentation [6]
- Co-ordinated end of life care decisions [5]

❖ **Care Suitable for Reviewers own Family**

Reviewers and the challenge team were asked to comment on whether the care individual patients received would have been suitable for a member of their own family. In 72% of admissions the consensus was that the care was suitable (same as Review 3 July 2013). Reasons for the care being unsuitable can be grouped into 3 areas as follows:

- Recognition and management of end of life care
- Missed diagnosis or failure to make a clear plan for investigation and treatment
- Lack of clear overall responsibility and continuity of care

Overall Quality of Care Measure
Reviewers and the challenge team were asked to rate the overall quality of care taking into account all the contributing factors identified such as triggers for harm, failures of care, delivery of optimal care and notable care and suitability for a family member. It is difficult to know given the changes in makeup and experience of the review group if changes seen in the overall quality of care judgement are genuine or reflect a maturing approach to review.



❖ **Consultant Review Following Admission (n=47)**

The previous standard at NGH for consultant review was that all patients should be reviewed within 12 hours of admission to the ward. This standard has been used for Review 4 but in future reviews the standard for 'time to consultant review' will be determined by NHS England 7 day clinical standards.
In Review 4, 57% of admissions achieved the standard of consultant review within 12 hours of admission to the ward. 10 (24%) patients were seen by a specialty consultant in A&E before admission to the ward. This data is incomplete as for 6 cases, the date or time of the review was not documented and it was not possible to establish from the timeline if the review occurred within the 12 hour period after admission to the ward (although it was evident that a consultant review had occurred and it could have been within the 12 hour period).

Table 5: Consultant review within 12 hours of admission for all reviews

	Review 4 2013 (Dec)	**Review 3 2013 (July)**	**Review 2012 (Nov)**	**Review 2011 (Nov – Jan)**
Consultant Review within 12 hours	57%	60%	70%	67%

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❖ **End of Life Care and Discharge Documentation**

- 40 (80%) patients had an appropriate DNAR/TEP form completed and filed in the notes
- There was evidence of senior involvement in end of life decisions in 45 (90%) cases
- 5 patients were thought to have been subject to futile investigations, monitoring or treatment at the end of life
- The LCP was used for only 12 patients (24%)
- The rate of post mortem examinations remains low at 10% (5 patients). The results of the post mortem examinations were available at the time of this review
- 34 (72%) sets of notes had an EDN (n=47). EDN completion at NGH for patients who have died is approximately 95% therefore this simply reflects the fact that the EDN has not been printed and filed.

Documentation

- **The Admission Proforma n=47**

The Standard Non-Elective Admission Proforma was used for 38 admissions, the stroke proforma was used for 7 admissions and the #NOF proforma was used for 1 admission. On one occasion no proforma was used.

The VTE risk assessment was completed on admission for 38 (81%) cases (this result is for all 47 admissions, not just those where a standard admission proforma was used).

The admission documentation has been analysed in more detail but the pattern of use of the standard proforma has not changed since the first review in 2011:

- Areas that were well completed (>90%) were:
  - Date
  - Presenting complaint
  - History of presenting complaint
  - Past medical history
  - Management plan
- Areas where there is room for improvement (60% to 90%) were:
  - Time
  - Full Name and GMC Number of Doctor
  - Medication Record
  - Allergies
  - Examination
  - Differential Diagnosis
- Areas that were not well completed (<60%) were:
  - Systems enquiry
  - Patients concerns and wishes
  - Family History

- **Continuous Clinical Record n=47**

  - 83% of cases had a daily entry in the notes (n=47) and in 98%, the notes were clear and relevant and told a story (n=50).
  - As has been seen previously, haematology, biochemistry and radiology results were clearly documented in the notes more than 80% of the time however microbiology results are documented less often.

Deaths in A&E

3 cases included in this review were patients who died in A&E. None of the 3 deaths was felt to have been avoidable, however issues surrounding end of life care planning in the community were raised.

Learning Points

Reviewers were asked to identify any learning points for sharing. The main areas highlighted were:

- Review of previous admissions and diagnoses – This is essential to ensure that important pre-existing diagnoses and treatments are not overlooked. Existing medical records should be obtained and reviewed as early as possible and referred to throughout the admission.
- End of Life Care – The lack of provision of end of life care facilities in the community was highlighted again as was the need to reduce admissions from nursing homes

and community hospitals when the patient is clearly at the end of life. It was felt that the new guidance for delivering end of life care at NGH will be very welcome and that communication is essential to ensuring unnecessary investigations, monitoring and treatment are stopped when appropriate.

- Early consultant review, diagnosis and management plan – This is essential to providing high quality care. Less than 60% of patients were seen by a consultant within 12 hours of admission to the ward.
- Investigations – These must be followed up in a timely manner and the results clearly documented including action taken.

Further details of learning points can be found in Appendix 1.

Discussion

This review was carried out as a follow up to similar reviews in 2011, 2012 and 2013. There are important limitations to the methodology which must be considered when interpreting the results.

- ❖ The sample size is small and variation from previous years cannot be considered significant.

- ❖ The reviewing group was a mixture of experienced and new reviewers. Experienced reviewers are more familiar with the process and sources of information; however they may also be less likely to highlight issues they have previously noted even though these remain a problem. New reviewers are less experienced with the sources of information but bring fresh eyes to the process. This leads to variability in the review process.

- ❖ The only information available to the reviewers is information that is documented in the medical record or available electronically.

Areas for discussion raised by this review are as follows:

- All admissions were emergency admissions with the proportion who presented without apparently making contact with primary care in the first instance remaining high at 68%.
- The proportion of emergency general medical patients was very high at 85%.
- There were 8 readmissions in this group and this was the most common trigger for harm.
- An important theme within failure to plan remains the importance of an early consultant review which helps avoid missed or delayed diagnoses and sets out a clear management plan. It was disappointing to find that the number of patients who received consultant review within 12 hours of admission to the ward had not shown improvement despite changes in delivery of on call availability of consultants during the period since the previous review (Review 3).
- The proportion of cases in which the care was judged to be suitable for a member of the reviewers own family remains consistently high at 72%.
- Post mortem rate remains lower than the team felt was desirable as the diagnosis was not always certain.
- 1 death was identified as possibly avoidable (grade 2). There were a further 4 cases where although suboptimal care was identified, it was very difficult to be sure if there was any element of preventability. The cases were reviewed and discussed in detail and followed up with specialty opinions if required. Consideration could be given in future to piloting an alternative scale known as the Hogan Scale which gives 6 different options to choose from and may help reviewers classify these complex cases more easily.

- For this round of the review, there was a much bigger pool of reviewers which had advantages and disadvantages. Each reviewer was only required to review a maximum of 2 sets of notes and attend a minimum of 2 meetings therefore reducing the individual workload. This was also positive in that lots of individuals from a wide variety of backgrounds were engaged with notes reviews and brought their own experience and perspective. More structured coordination of the meetings was required in order to avoid everyone turning up on the same day to present their cases but the advantage of this was that there were always at least 7 or 8 individuals at every meeting and therefore plenty of scope for discussion and challenge. It is hoped that new reviewers to the group will attend a further round and therefore increase their experience and exposure to a variety of different cases and topics.
- Areas for learning were broadly similar to previous reviews. It is likely that this reflects persistent organisational challenges requiring substantial changes in practice that have yet to be fully implemented (eg '7 Day working'). It is also likely that reviewers are becoming more critical as the review process develops.
- The review process needs to be sufficiently detailed to ensure a good understanding of events, but not so burdensome as to discourage participation. With each round, the proforma is adapted and questions removed, changed or added. Similarly the content of the report will be adapted to focus on the opportunities to improve care.
- As with previous rounds, new reviewers who joined the group from a variety of backgrounds commented that they had found the process valuable and educational and would wish to be involved again.
- Specific request for support from the directorate governance leads was well supported and will hopefully have the benefit of improving the flow of skills and learning from the group to the directorates. For future rounds, consideration should be given to inviting directorate M&M leads if they are not already participating as they have a pivotal role in improving the quality of directorate M&M meetings.

Conclusions

Review 4, 50 consecutive deaths from December 2013, was carried out with a large group of engaged reviewers from a variety of specialties and backgrounds including on this occasion both senior nurses and doctors in training. As has been noted previously, one of the most obvious benefits of the review is the experience and skills gained by the reviewers during the process which they then take back into their own practice. It is therefore important that for future rounds, engagement of new reviewers continues to be promoted across the Trust.

Over the period of the 4 reviews HSMR has fallen substantially and continues to do so. It is difficult to identify exactly how the findings of the review programme have contributed to this improvement in terms of changing practice in the Trust. However it is clearly important that the findings are disseminated widely within clinical teams to inform the relevance of their own safety programmes, and also that of the Patient Safety Team.

The current local CQUIN for M&M will support the sharing of learning between the CCG and other local healthcare providers.

Next Steps

1. Discussion of draft Report 4 with MD [04.09.14]
2. Presentation of report to Trust Board (25.09.14)
3. Feedback end of life care issues to End of Life Care Group (KNR)
4. Set dates for next round, Review 5/ Aug 2014(LJ/ KNR)
5. Review and adapt proforma for next round (LJ/ KNR)
6. Prepare a summary for the sharing meeting with the CCG and other local healthcare providers.
7. Distribute summary to directorate M&M leads for discussion.

Appendix 1 – Learning Points

Category	Learning
Documentation	• It is important to seek out old notes and GP referral letters (as soon as they become available). Failure to do so can mean that important diagnoses are overlooked or inappropriate medication prescribed. • The admission clerking and examination is vital both for establishing the diagnosis and also for providing information to the clinical coding team. • Notes must be legible and there should be an entry for every patient contact. • Standard or specialty proforma must be fully completed • Clear documentation of discussion with patients and/ or family members is a very useful source of information for notes review • It can still be difficult to identify which doctor has made a particular entry and GMC stamps should be used. • Documentation of all aspects of ITU care is not always available in the notes (large observation charts are stored elsewhere). • Organisation and general finding of notes is still a problem. • Discussions with tertiary referral centres must be clearly documented.
End of Life Care	• Lack of end of life discussions and planning in the community is still leading to inappropriate admissions, including from community hospitals and nursing homes. • There is insufficient provision of palliative care services in the community and therefore admissions to NGH for end of life care are unavoidable. NGH provides good quality of care to this group of patients when they need it. • Discussion of preferences for end of life care should be undertaken with the patient where appropriate. • The use of the LCP has inevitably declined but it was generally felt that end of life care was better when the pathway was used and therefore further guidance is anticipated. • DNAR/ TEP forms must be completed in good time. • The completion of DNAR/ TEP forms for patients on ITU needs to be reviewed.
Consultant Responsibility	• It is vital to be clear which consultant has overall responsibility for the coordination of a patient‘s care. • Differing management plans can cause confusion and uncoordinated care. • MDT working is very valuable for the care of patients with complex needs eg diabetic foot team. • Clear documentation of the initial consultant review is helpful to clarify differential diagnoses, management plan and support accurate clinical coding.
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. • ICE requests must be double checked to ensure they have been requested for the correct patient.

Following up issues raised regarding quality of care from other providers	• Concern was raised about what to do when care at another healthcare provider was identified as being potentially suboptimal.
Medication	• NSAIDs should be used with caution in patients with renal impairment and renal function should be monitored (ref BNF). • Sedatives must be used with caution, particularly in the elderly. Of particular concern in this round was the use of Zopiclone in patients with new onset confusion where no diagnosis had been made and the use of Lorazepam in a patient with COPD and agitation who subsequently developed respiratory failure. • Medication review should be a standard ward round tool.
Certification of Death	• Completion of death certificates is complex and more education and support for junior doctors is required.
Ward Transfers	• Is there a protocol for moving patients from A&E to a ward if they have a high EWS? • Patients who move from an admission ward to a specialty ward at the weekend must be reviewed.
Miscellaneous	• The post mortem rate remains very low and if the diagnosis is not clear, a PM should be considered. • A patient with suspected sepsis must have blood cultures.

10. Serious Incidents

Introduction

The Trust is committed to identifying, reporting and investigating serious incidents, and ensuring that learning is shared across the organisation and actions taken to reduce the risk of recurrence. The Trust seeks, where at all possible, to prevent the occurrence of serious incidents by taking a proactive approach to the reporting and management of risk to ensure safe care is provided to patients, through the promotion of a positive reporting and investigation culture.

Background

A Serious Incident (SI) is defined as an incident that occurred in relation to NHS-funded services and care resulting in (or could have resulted in) one of the following:

- Unexpected or avoidable death to one or more patients, staff or members of the public
- Serious and or permanent harm to one or more patients, staff or members of the public where the outcome requires life-saving intervention, major surgical/medical intervention or will shorten life expectancy or result in prolonged pain or psychological harm
- The actions of staff providing NHS funded care that are likely to cause significant public concern i.e. serious instances of abuse (physical/sexual/mental).
- An event that prevents or significantly threatens the Trust's ability to deliver healthcare services.
- One of a core set of 'Never Events' as defined and updated annually by the National Patient Safety Agency (NPSA)

The organisation has a responsibility to investigate and where appropriate learn and take corrective action to mitigate the potential for any future incidents and also to report such incidents to the Nene and Corby Clinical Commissioning Group (CCG) and the Strategic Executive Information System (STEIS).

This report is presented to provide assurance that the Trust has robust systems and processes in place to learn from adverse events to minimize or eliminate the risk of recurrence in the interests of patient safety. This report provides a summary of the Trust's performance against key targets for the reporting and management of serious incidents. A thematic analysis and identification of actions taken to reduce risk of recurrence is also included.

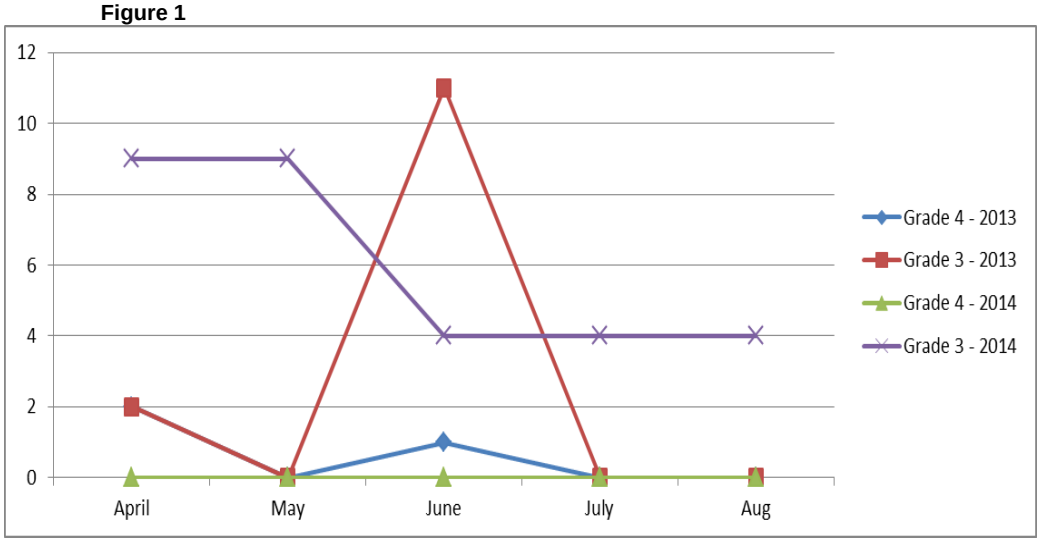
New Serious Incidents

Since the last report to the Committee, and within the reporting period 1 – 31 August 2014, 4 new Serious Incidents have been reported. Serious incidents are graded in accordance with the National Patient Safety Agency (NPSA) Serious Incident Reporting and Learning Framework.

All 4 incidents identified during this reporting period were reported under the category of Grade 3 pressure ulcers.

Category 3 pressure ulcers are subject to Root Cause Analysis investigation led by the responsible Ward Sister and supported by the Tissue Viability Team. Figure 1 illustrates the number of Category 3 / 4 pressure ulcers reported since April 2014 compared to the same period in 2013. It must be noted that pressure ulcer data is shown by number reported on STEIS during the reporting period. This does not necessarily equate to the number of Grade 3 pressure ulcers acquired in each month.

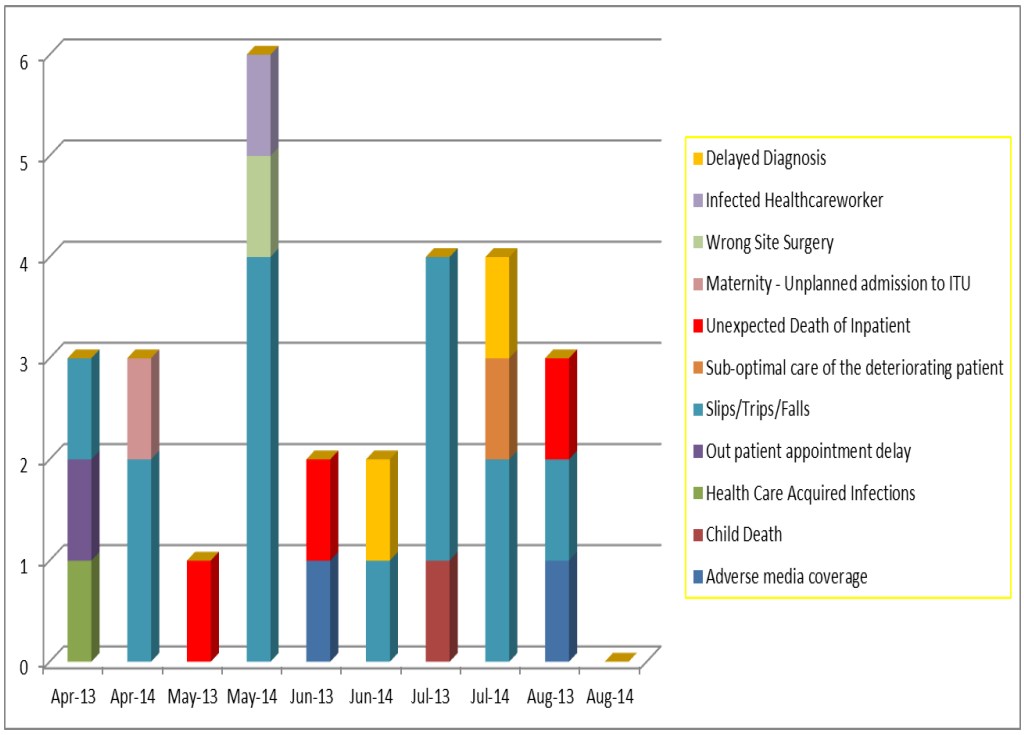
Figure 1



The Trust commenced reporting Grade 3 and 4 pressure ulcers as a Serious Incident in February 2012, as agreed with commissioners and in line with other Trusts. Since this time, there have been ongoing discussions regarding the significant variation in reporting rates and a lack of standardisation across the country, which makes valid comparisons difficult. This has led to discussions as to whether Grade 3 and 4 pressure ulcers will be removed from the classification of a Serious Incident when the revised National Framework for the Reporting & Learning from Serious Incidents is released later this year. If this were to happen, monitoring would need to continue to ensure the continued emphasis on investigation and improvement to reduce the incident of harm from more severe pressure ulcers.

Figure 2 shows the number and category of Serious Incidents (excluding pressure ulcers) from April 2014, compared to the same period in 2013.

Year to date, the highest reporting category, excluding pressure ulcers, is Slips/Trips/Falls. This is no change from the same reporting period in 2013/14, although the number of Serious Incidents reported has increased by 44.4% this year. The Falls Co-ordinator provides a quarterly report on trends to the Serious Incident Group, the next report is due September 2014



Top Categories: April – August 2014/15		Top Categories: April – August 2013/14	
Slips/Trips/Falls	9	Slips/Trips/Falls	5
Delayed Diagnosis	2	Unexpected Death of Inpatient	3
Infected Healthcare Worker	1	Adverse Media Coverage	2
Maternity – Unplanned admission ITU	1	Outpatient Appointment Delay	1
Sub-optimal care of deteriorating patient	1	Child Death	1
Wrong Site Surgery	1	Health Care Acquired Infections	1
Total	15	Total	13

Never Events
"Never events" are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'.

To be a "never event", an incident must fulfil the following criteria;

- The incident has clear potential for or has caused severe harm/death.
- There is evidence of occurrence in the past (i.e. it is a known source of risk).
- There is existing national guidance and/or national safety recommendations on how the event can be prevented and support for implementation.
- The event is largely preventable if the guidance is implemented.
- Occurrence can be easily defined, identified and continually measured.

There were no Never Events reported in August 2014.

April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
0	1	0	0	0							

Serious Incident reporting target (≤ 2 working days of being reported on local system)

STEIS No	Interval	Target Met	Incident Type (STEIS)	Reason for Delay
2014/26870	2 days		Pressure ulcer Grade 3	
2014/26870	11 days		Pressure ulcer Grade 3	Validated by TVN within 3 working days; emailed to Risk Facilitator who was on annual leave
2014/27331	2 days		Pressure ulcer Grade 3	
2014/27308	4 days		Grade 3 Pressure Ulcer	

Key: Green (within timeline) 50% (25% - July; 0% - June; 66% - May)
Amber (breached ≤ 7 days) 25% (37.5% - July; 83.4% - June; 46.7% - May)
Red (breached ≥ 8 days) 25% (37.5% - Aug; 16.6% - June; 13.3% - May)

The Serious Incident Group continue to meet weekly to expedite the agreement & external notification of Serious Incidents (SI)

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

Category of Incident	Number of reports	Comments
Slips/Trips/Falls resulting in fracture	2	The Trust have requested 1 of the incidents to be downgraded as the person affected was not in receipt of NHS funded care
Grade 3 Pressure Ulcer – deemed to be avoidable following investigation	5	
Wrong site surgery	1	
Delayed diagnosis	1	The CCG have recommended downgrading the incident as no care/service delivery problems were identified

Active Serious Incidents
As at 31 August 2014 there were 14 on-going Serious Incidents investigations underway.

STEIS Extension Submission Requests
One extension to the 45 day deadline was requested due to unavailability of medical records as the patient remained in hospital.

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. A section on lessons learnt from Serious Incidents is included in the quarterly Governance newsletter, 'Quality Street'. The next publication of 'Quality Street' has been drafted and is with Medical Illustrations for desk top publishing. Closed Serious Incidents are also discussed at the Patient Safety Learning Forum.

The table below shows the learning/actions identified from the Serious Incidents submitted during the reporting period.

Grade 3 Pressure Ulcers -avoidable (Brampton, Victoria, Rowan x 2, Becket)	
Theme	Learning / Actions
Documentation	Ensure body map completed on ward transfer Daily skin/pressure area check sticker not in use Handover sheet did not reflect current status of patient
Clinical Assessment	Inaccurate risk assessments leading to inappropriate care. Staff failed to thoroughly assess skin integrity on admission and on all shifts Inaccurate Waterlow risk assessments Failure to implement appropriate SSKIN care in relation to risk assessment Inaccurate risk assessment on admission therefore appropriate care plan was not implemented – contributory factor in 2 incidents Independent and mobile patient's skin not checked – contributory factor in 2 incidents Pressure areas to be checked daily by senior staff
Equipment	The Moving and Handling Lead is to scope the availability of suitable equipment for patients with achondroplasia Provide at risk patients on oxygen via nasal cannula a padded cannula.
Training / Education	Staff to attend PUP training

Falls resulting in fracture – Benham; Trust grounds	
Theme	Learning / Actions
Clinical Assessment	Post –fall-Neurological observation not performed in line with trust guidance Junior doctors to be reminded of the importance of carrying out x-rays in a timely manner post fall
Documentation	The inpatient fall medical assessment form was not completed by the doctor Junior doctors to be reminded of the importance of including all information within the clerking documentation Documentation to be reviewed to ensure that confusion is highlighted to receiving ward
Wrong Site Surgery	
Theme	Learning / Actions
Policy / Procedure	All unilateral procedures to have surgical site marked or visual cue for surgeon Review of Surgical Site Marking & Verification Policy to ensure it reflects standardisation in all theatres
Communication	Department to ensure discharge summary is completed and sent to GP
Delayed Diagnosis	
Theme	Learning / Actions
Policy / Procedure	To aim to extend the provision of CT aortography and pulmonary angiography to ensure availability to selected critically ill patients

Action Plan Assurance Process

All 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. Action plans are then uploaded to HealthAssure and are monitored via the Directorate/Care Group Governance Groups until assurance is received for completion of all actions. The action plan and evidence, once completed is then presented to the Serious Incident Group for sign off. Completed action plans remain on HealthAssure until they have been presented at the Serious Incident Assurance Meeting (SIAM) which provides assurance to the CCG that actions have been monitored and completed. Following SIAM, action plans are archived within HealthAssure.

Figure 3 below shows the number of open Serious Incident action plans on HealthAssure.

Red	29
Amber	37
Green	43
Not Applicable	24
Total	133

Key:

Not applicable	Action plan has been discussed at SIG and is awaiting discussion and agreement of actions and timescales at the Directorate / Care Group Governance Groups
Amber	Action plan has been agreed by Directorate / Care Group Governance Group. Actions are in progress and evidence is being collated
Red	An action within the action plan is overdue
Green	All actions are complete and have been signed off by the Directorate / Care Group Governance Group.

The Governance team are continuing to develop the HealthAssure system and monthly action plan progress reports which has resulted in there being a more robust overview of all Serious Incident action plans and progress against actions. During the reporting period action plan progress reports were presented to SIG by the Medicine Care Group and the Surgical Care Group. The Falls Co-ordinator is tabled to present a progress report to SIG in September 2014.

75% of agreed action plans are either complete or are on target for completion within the timescale. The Governance team continue to gather the evidence to close off the 25% overdue action plans which are predominantly historic action plans. Action plans where it is deemed difficult to obtain the evidence have been discussed at SIG and the Group have provided further support and advice on how compliance can be demonstrated. It is envisaged that all historic action plans will be closed by the end of Quarter 2.

Assessment of Risk

Although all SI reports submitted to the CCG this month were within the agreed timescales, there remains an ongoing issue with delays in receiving the draft reports from the investigation leads in a timely manner. It is not unusual for the Risk Management team to have first sight of the draft report on the day it is due to be submitted to the CCG. This does not allow for in depth quality assurance checks by Risk Management or the Executive Lead and there is a risk that all root causes and contributory factors may not be identified.

Recommendations

The Board are requested to note the content of this report and endorse the proposed actions

Next Steps

- The Serious Incident Group continues to meet weekly to expedite the agreement & external notification of Serious Incidents (SI).

- Delays in submission of the first draft of the Serious Incident reports – SIG have agreed to pilot a revised process for 6 months. Investigation leads will be given a deadline of 30 working days to complete the first draft of the investigation report. The first draft will then be circulated to all SIG members for review and comments. This should allow for greater probity into the investigations and sufficient time for further analysis to identify the root cause of these incidents where necessary.

- The delay in the provision of Root Cause Analysis training facilitated by an external provider continues, due to long term sickness of the external facilitator. The Governance Team have therefore put together a training package which will be facilitated in-house. The training will consist of a full day workshop and is aimed at all members of staff at Band 8a or above and Consultants. There will be 5 training workshops in October and November, followed by monthly workshops.

- Once sufficient numbers of staff have attended the RCA training, SIG will implement the revised process for identifying the investigation leads which was detailed in the March 2014 report. The investigation lead will be a manager/member of staff at Band 8a or above. If the incident is clinical, a supporting Matron/Senior Nurse will be nominated. Each investigation (clinical) will then have a sponsoring Consultant to provide the medical input to investigation process.

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**25 September 2014**

Title of the Report	**Director of Nursing and Midwifery Care Report**
Agenda item	**8**
Sponsoring Director	Jane Bradley, Interim Director of Nursing, Midwifery & Patient Services
Author(s) of Report	Senior Nursing & Midwifery Team
Purpose	Assurance & Information

Executive summary

This report provides a detailed update on a number of clinical projects and improvement strategies that the nursing & midwifery Directorate are working on. 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 for August.

Key points from this report:

- N&M Quality Dashboard (QuEST) shows compliance of 82% this month which has reduced due to one wards poor score of 60% (Dryden)
- Hard Truths staffing data has been submitted. This demonstrates the planned versus actual staffing on the wards during August. In summary 27% of our wards were staffed at over 90% for day & night shifts.
- Staffing ratio of the wards (1:8) is presented as part of the second year of the Nurse Staffing Strategy. The current staffing vacancies are also presented with the proposed recruitment plan.
- Safety Thermometer – achieved 88.5 % this month against the national average of 93%. In particular there has been an increase in the prevalence of pressure ulcers which includes those patients that have been in hospital for more than a month.
- There has been a significant increase in the number of new hospital acquired pressure ulcers in August (43) against July (28). The report gives details of the analysis for the month and remedial actions.
- There have been fourteen C. Difficile cases this year; this is above our monthly internal stretch target but within our national annual ceiling of 35
- The Friends & Family Test results for August have remained good however, A&E and Day Case areas are below the response rate.
- The Patient Safety Academy Flagship Ward campaign will be supporting Holcot ward this year.
- The Safeguarding update provides an update on training data for the specialty
- Maternity Update includes a summary of the Maternity Review undertaken by an external assessor

Related strategic aim and corporate objective	To be able to provide a quality care to all our patients

Enclosure E

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.
- support the on-going 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
25 September 2014

Director of Nursing & Midwifery Care Report

1. Introduction
The Director of Nursing & Midwifery Care Report presents highlights from quality and safety initiatives during the month of August. Key quality and safety standards will be drawn from this monthly report to share with the public on our web site as part of an 'Open & Honest' Care report which will include Hard Truths staffing data.

2. Body of Report
2.1 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. An overall score of 82% was achieved for the wards this is a slight decrease from last month (87%) due to a poor score for Dryden Ward. The analysis of Dryden ward demonstrates that the areas of focused support are: Nutritional care, Documentation, Hand Hygiene following the special measures that the ward were placed upon. Actions have been implemented to improve the standards on the ward overseen via the matron.

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

Each month Hard Truths Staffing data will be available on the Trust website & NHS Choices for the public to view. 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.

In summary the results of the monthly data collection exercise illustrated that 27% of wards (7 out of 26) were consistently staffed at or above 90% of their funded establishment for both combined day and night shifts for all registered and support staff groups during August 2014. 54% (14) of the remaining 19 wards were consistently staffed at or above 80% for all shifts / all staff grades, with 9 of those wards showing HCA/support staffing over 100% establishment across shifts.

As experienced in previous months, across inpatient areas there was consistent use of additional Health Care Assistants to fulfil a number of roles including specialling vulnerable patients, escalation area resourcing and supporting increases in patient acuity and dependency, particularly on the night shift.

Early:
RN/RM: 17 wards worked at 90% and above, and 8 wards worked between 80%-90%.
HCA / MSW SUPPORT: Across the month, 58% (15 out of 26 inpatient areas) worked at or above 99%of their established levels on the early shift due to specialling and escalation area deployment.

Enclosure E

Late:
RN / RM: 13 wards worked at 90% or above and 10 wards worked between 80% and 90% of their establishment.
HCA / MSW SUPPORT: Across the month, 62% (16 out of 26 inpatient areas) worked at or above 99% of their established levels on the late shift. 4 wards were staffed at 90%.

Night:
RN / RM: Across the month 20 wards worked at 90% or above of their establishment and the remaining 6 wards were staffed at 80% and above.
HCA / MSW SUPPORT: Across the month, 85% (22 out of 26 inpatient areas) of support staff worked at or above 99% of their established levels on the night shift.

Staffing shortfall has been consistent during August due to unfilled bank/agency requests covering short term sick leave, established vacancies and escalation areas. In some wards maternity leave has not been proactively covered. It should be noted that some wards are working with supernumerary nurses who are not included in the formal staffing count, but offer valuable staffing support to their wards. Furthers details are in Appendix 1.

3.1 Staffing ratio on the General Wards

In March 2014 the Trust Board agreed the second year of the Nurse Staffing Strategy. It was agreed that the implementation of the increased budget would begin in September 2014 along with extensive recruitment. The budgeted 'uplift' will ensure that most of the Trusts wards are at, or above 1 registered nurse **:** 8 patients. Appendix 2

There are a small number of wards are will not be at this national recommendation:

Althorp - 18 bedded elective orthopaedic ward. Night duty – currently the professional view is that this ward is safely managed with the staffing of 2 RN & 1 HCA
Brampton – 27 bedded acute older person's medical ward: Night duty – the ward has had uplift from two RN to three RN on the night shift. However, it is the professional view that this will be reviewed next year as the ward is just short of 1:8. Patient /nurse ratio
Compton – 18 bedded acute older person's medical ward: The ward has received an uplift on the late shift but is below the 1:8 for Nights. However, professional judgement currently believes this is sufficient, but will be reviewed as part of the staffing review in September.
Knightley – 21 bedded acute medical ward/ the ward received an uplift on the late shift this year. The Night shift is still below 1:8 ratios.
Victoria – 18 bedded acute older person's medical ward. The Night shift is below 1:8, currently the professional judgement considers this level of staffing to be adequate. However, there are plans to increase the acuity on the ward which will be considered as part of the staffing review in September.

It is proposed that as part of the budget setting for 2015/16 the Ward Sisters will meet with the Director of Nursing, Director of Finance and Lead Nurses to review their professional judgement, Safer Nursing Care Tool audit (September data) and current year's budgeted establishment to consider appropriate levels of staffing. Part of this process will include the consideration of additional staff to ensure that all wards meet the ratio 1:8 as a minimum.

3.2 Recruitment Plan

The implementation of the increased established budgets for the wards will increase the number of vacancies for both registered and unregistered staff (Appendix 2). Therefore a significant number of initiatives have been taken forward by the Senior Nursing, Midwifery, Finance, Temporary Staffing & Recruitment Team.

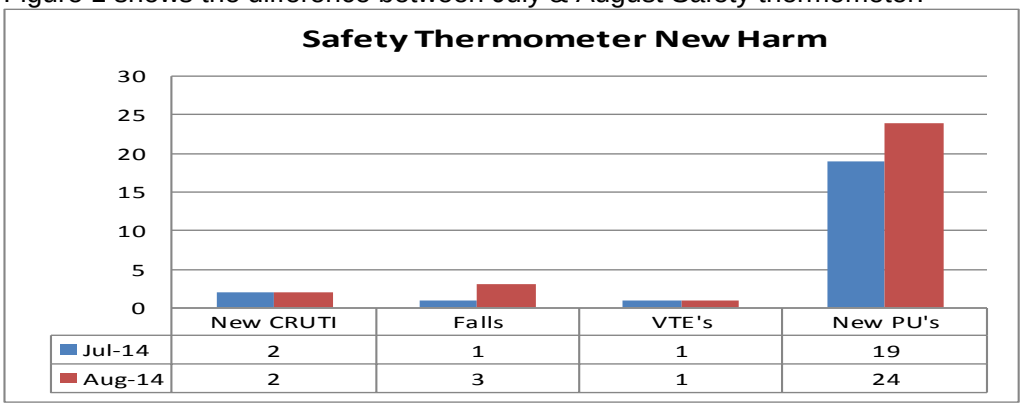
- As part of the ‘Back to Basics’ Development programme for band 7 ward sisters/charge nurses the Ward Sisters have ‘taken’ back the recruitment of their own staff. They are now working in partnership with a designated member of the HR recruitment team to ensure that their own adverts, recruitment plans and interviewing processes are in place. This is giving the ownership and control back to the Ward Sisters.
- From a Trust wide perspective the recruitment, interviewing and training of healthcare Assistances will be led by the Professional Development Nurse (PDN) team from the New Year.
- The Recruitment Team have developed a recruitment plan for Careers events/fairs that are across the country and are now looking at Scotland for future recruitment opportunities.
- Attendance at university Careers Days by the PDN team to promote the Trust as a place to work
- Rolling adverts for general posts for registered staff and HCA workforce
- Specialist adverts for ITU, HDU, Paediatrics, A&E and Theatres.
- Regular recruitment for the Bank Pool, in particular HCA’s to support the current ‘Specialling’
- Development of a Specialist bank for ITU, HDU, Paediatrics, A&E and Theatres to reduce the need for specialist agency staff.
- Improving the ‘turn-around ‘ time for ‘acceptance’ letters & obtaining the references thus facilitating and expediting staff to commence work at the Trust
- Two weekly meeting with the Ward Sisters, Finance, Temporary Staffing , Recruitment and the DoN to review ward expenditure, agency usage, health-roster efficiency and recruitment plans.
- Project group to review the utilisation and role of the ‘Specials’ on the wards thus consider appropriate use of the workforce currently available to use
- Development of a band 1 post to support those patients that require supervision but not complex clinical support
- Weekly discussions at Executive Team and Corporate Nursing & Midwifery Leads Meeting
- Given the Trusts recent experience of overseas recruitment further discussions will need to take place before this option is considered again.
- DoN working in collaboration with neighbouring Trust to scope the opportunities for a shared recruitment and temporary staffing partnership.

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 August 88.5% patients experienced ‘harm free care’ in this Trust which is below the national average of 93%. This is due to the increase in “all harm” which includes those patients which have been in the trust for more than 1 month and are recorded again the second month. In particular there has been an increase in pressure ulcers. Catheter-related urinary tract infections, falls & harm from blood clots, remain at or below the national average.

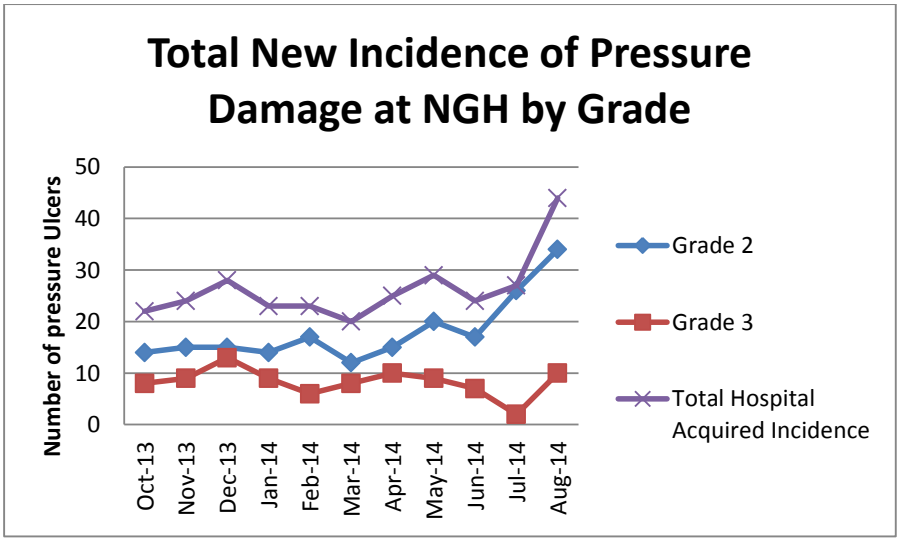
Figure 1 shows the difference between July & August Safety thermometer.



5. Pressure Ulcer Prevention

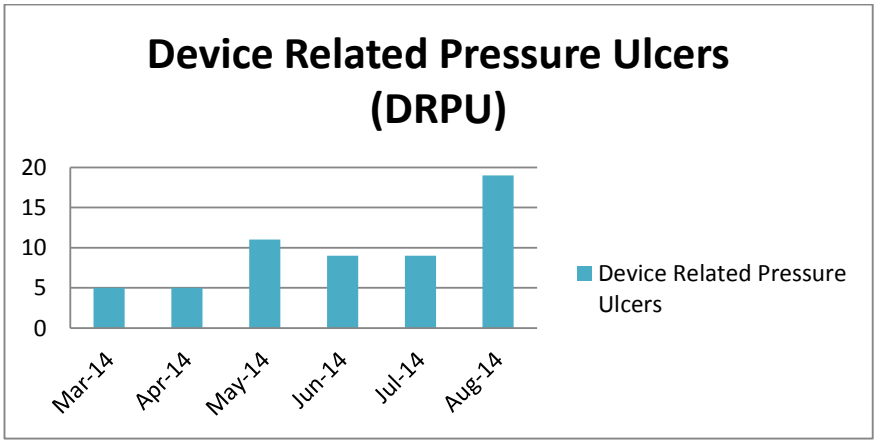
August there was a 34% increase in the number of hospital acquired pressure ulcers from a total of 28 ulcers in July to 43 in August (fig 2). Of these 34 were validated as Grade 2 and 9 Grade 3/Grade 3 unclassified. These pressure ulcers have not been validated to consider whether they are avoidable or unavoidable.

Figure 2



Of the 43 pressure ulcers reported, 19 (43%) have been identified as Device Related Pressure ulcers (DRPU, Fig 3), 8 of which occurred in critical care, reflecting the increased acuity of patients from the wards and in ITU.

Figure 3



The RCA process – Due to the high volume of pressure ulcers in July it was decided (Lead Nurses and TV Lead Nurse) that wards were asked for an action plan to address the deficit in the care that has been identified on completing the paperwork (RCAs). As from 18 September a Back to Basics Quality Assurance meeting chaired by the Director of Nursing will be taking place every two weeks where Grade 3 + ulcers and other Quality and Safety aspects and Avoidable Harm will be discussed directly with ward sisters/charge nurses and matrons.

6. Health Care Associated Infections (HCAIs)

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

	C.difficile	MRSA
Number of infections this month	4	0
Number of infections last month	3	0
Improvement target for year to-date	35	0
Actual to-date	14	0

6.1 Special Measures

Abington ward was put on to Special Measures on 22nd August 2014, due to 2 post 72 hours cases of *Clostridium difficile* within a 28 day period.

Willow Ward was put on to Special Measures on 11/08/2014 due to having two post 48 hours cases of MRSA colonisations within a 28 day period attributed to their ward.

Dryden ward were put onto Special Measures on 27 August 2014 for 2 post MSSA bacteraemias within a 28 day period.

7. Friends & Family Test

Julys FFT data

Response Rates

Of most significance:

- Inpatients achieved a response rate of **33.38%** against a target of 25%
- Maternity services obtained a response rate of **38.78%** against a target of 20%
- A&E were below their response rate target obtaining a response rate of **13.58%** against a target of 15%
- Day case areas obtained a response rate of **22.01%** against a target of 25%
  Paediatrics achieved a response rate of **55.84%** against a target of 25%

A&E has an action plan to improve the current position by focusing on the co-ordinator role, re-positioning the iPad and plan to invite the volunteers to support the service. Interestingly although A&E have not met their trajectory for response rate their Net Promoter Score is 64 against an internal target of 60.

7.1 Technology Solution and FFT expansion

A requirement of the FFT CQUIN for 2014/2015 is the roll out of FFT to all Outpatient and Day Case (OP/DC) areas throughout the hospital. Due to the magnitude of this task and the growing response from other areas in the hospital the decision was made to invest in an external company to provide this level of support. A company has been selected for this and plans are currently in progress to initiate FFT in OP/DC in time to achieve the CQUIN as well

as role out to the rest of the hospital by the end of the year. This is likely to have a hugely positive effect on response rates and the ability of staff to use the information to inform service change.

8. Patient Safety Academy

Flagship Ward

The Academy are delighted to announce that Holcot ward have been successful in their application to be the project Flagship ward. Holcot ward were chosen due to their inspirational team ethos at interview with a range of the whole multidisciplinary team being present, and supplying ideas for some of their problems.

The concept of the Flagship ward is to give focussed support to one ward to create the best possible safe care to the patients by addressing areas such as:

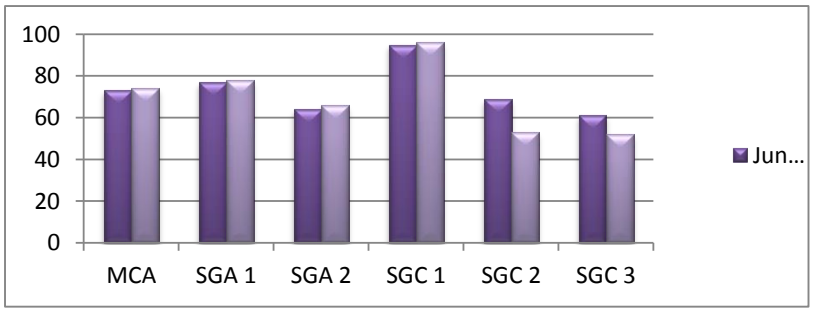
- Ergonomics and environment (including, ward & bay layout, signage, clutter etc.)
- Communication (including white boards, ward rounds, meetings, documentation etc.)
- Nursing care (including, drug rounds, nutrition, fluid balance, pressure prevention)
- Patient experience (including, daily plan, discharge aftercare, patient involvement in the whole project)

Over the next month the Academy leads will individually observe the wards at different times of day and night to assess how the ward currently works. Following this the 'treatment plan' will be jointly formulated by ward staff and the Academy.

9. Safeguarding Update

Training

The current position, in comparison to the previous month, is shown below. Figures remain reasonably static; with a notable exception in safeguarding children levels two and three. The marked drop in the training levels for SGC2 and SGC3 is related to a change in the national parameters for the training competencies; which have now been uploaded into OLM. Whilst there is now an extra shortfall to recover; the position is considerably better than predicted.



In order to support the training moving forward; there will be an enhanced training provision, supporting a number of different methods:

- Face-to-Face
- E-Learning
- Workbook/Self-Directed Study

Allegations relating to NGH

Following learning from a complaint; the safeguarding team have significantly changed the way that Safeguarding Adult Referrals citing NGH as a perpetrator are managed. This is supported by a Standard Operating Procedure and a robust, performance managed timeline. This change began on 1 August 2014 and of the 6 allegations received in the time period following, all have been investigated in detail and managed to time. Of the six, three have been unsubstantiated and one partially substantiated; this latter in the context of

communication and discharge management. Two investigations remain ongoing, however these are currently within timescale and there is no indication that the deadlines will not be met.

Governance
The refreshed safeguarding governance group will meet for its inaugural meeting at the end of September and a further update will be provided following this.

10. Midwifery Update

Maternity Review July 2014
An external review of maternity services was commissioned to investigate allegations made anonymously by a midwife on the 17 January 2014, to the Safeguarding Team (Adult) at Northamptonshire County Council (NCC) Following screening by the NCC it was determined that the notification did not meet the threshold for investigation by them, therefore, they sent it to the Trust for investigation. Terms of reference for the review were formulated by the Trust and agreed by the external reviewer, with the focus on patient safety and working relationships within maternity services. The allegations submitted to the safeguarding website were in relation to two specific areas of maternity. Maternity Observation Ward (MOW) and Community Services.

The external assessor conducted her review on the 22 to 24 July 2014. The report was submitted in August.

Key Points Made
The reviewer considered the maternity service to be safe and there was evidence that risks are well managed. The maternity dash board gave a clear view of activity, workforce, clinical and quality indicators.

Community Services
There was sufficient evidence to show that community caseloads are being effectively managed. The appointment of the new Community Matron was welcomed by the midwifery teams. Compliance was poor in relation to completing weekly activity audit sheets therefore the reviewer could not gain any insight into the recent workload.

Maternity Observation Ward
Care on the Maternity Observation Ward (MOW) of 17 beds was not found to be a high risk area, but often has high dependency women admitted, however the number of midwives trained in high dependency care is sufficient to provide appropriate care 24/7. High levels of activity and acuity are managed appropriately. The reviewer found that peaks of activity and acuity within maternity were strategically managed and there is a robust escalation policy in place which was frequently used.

The midwifery establishment was found to be sufficient to provide a ratio of 1:28.8, although there are a number of vacant posts that are being recruited to, with an uplift of 12 Maternity Support workers (MSW's) which will significantly increase support to midwives. Complaints are low and the Family Friendly Test (FFT) results are a good indicator that the majority of women are satisfied with their care.
There appears to be a particularly high incidence of sickness due to stress in maternity services that warrants further work.

The reviewer found that there is evidence that some midwives feel bullied by the attitude and behaviour of other staff yet the bullying and harassment policy has not been used during the past year.

Labour ward
The reviewer found that based on the midwifery establishment 1:1 care in established labour is achievable

Statutory Supervision of Midwives
The majority of midwives interviewed said that Statutory Supervision is supportive and this was supported by the recent Supervision of Midwives audit by the Local Supervising Authority (LSA) in July.

Recommendations
There were ten recommendations made by the reviewer, these were to help improve communications; working relationships and help staff refocus on the business of providing a quality service.

Open forums both within the hospital and community have been convened by the Head of Midwifery to share and discuss the content of the report and recommendations made.
An action plan has been formulated in collaboration with members of the midwifery teams from the recommendations made and will be monitored by the Maternity Governance Group.

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

Appendix 1

Shift Staffing Levels in August 2014

EARLY	**RN / RM:** In August, 11.5% (3 out 26 inpatient areas including combined Child and Maternity units) of the funded established RN staff levels were at or above 99% of their establishment on the early shift. 14 wards worked at 90% and above, and 8 wards worked between 80%-90% - Abington, Althorp, Becket, Cedar, Child Health combined, Collingtree, Dryden and Maternity. Talbot Butler was staffed at an average of 74% of establishment on the early shift due to short term sickness and vacancies that were covered by their own staff. Staffing shortfall is consistent due to unfilled bank/agency requests covering unpredictable short term sick leave, established vacancies, escalation areas and maternity leave. *Note* that some wards are working with supernumerary nurses who are not included in the formal staffing count, but who offer valuable staffing support to their wards. **HCA / MSW SUPPORT:** Across the month, 58% (15 out of 26 inpatient areas) worked at or above 99%of their established levels on the early shift due to specialling and escalation area deployment. 7 wards worked at or above 90% of establishment, and 2 wards worked between 80% and 90% (ITU and Maternity combined unit). Althorp was staffed at 66% and Child Health combined unit at 78% of establishment. However, both areas closed beds / closed ward during August meaning that fewer staff were actually deployed on these wards against their established numbers.
LATE	**RN / RM:** Across the month, 1 out of the 26 inpatient areas, Knightley, worked at 115% of its establishment on the late shift due to the need for 'specialling' 13 wards worked at 90% or above and 10 wards worked between 80% and 90% of their establishment. There were 2 wards working below 80% on the late shift – Becket (76% fill) due to unfilled vacancies and Cedar (73% fill) due to HR issue. **HCA / MSW SUPPORT:** Across the month, 62% (16 out of 26 inpatient areas) worked at or above 99% of their established levels on the late shift. 4 wards were staffed at 90% and above and 1 ward worked at 83% (Spencer). 3 wards were staffed at 73% (Rowan) and 79% respectively (Maternity and Child Health combined units. Note that Child Health has a small support staff establishment of 1 HCA per ward. Both units move staff to reflect patient numbers and acuity and to ensure consistent cover). The 2 remaining wards worked at 61% establishment (Althorp – however, bed / ward closure meant that fewer staff were actually deployed on the ward) and ITU at 66% (note that ITU works with an establishment of just 1 HCA in ITU and HDU resulting in any absence significantly reducing the fill rate).
NIGHT	**RN / RM:** Across the month, 11.5% (3 out of 26 inpatient areas) of the funded established RN staff levels were either at or above 99% establishment on the night shift. 17 wards worked at 90% or above of their establishment and the remaining 6 wards were staffed at 80% and above. **HCA / MSW SUPPORT:** Across the month, 85% (22 out of 26 inpatient areas) of support staff worked at or above 99% of their established levels on the night shift, with Allebone and Dryden and Victoria staffed above 200% of establishment (both specialling and escalation area cover). Of the remaining 4 wards, 2 were staffed above 97% (Child Health combined unit and Talbot Butler). ITU and Maternity combined unit worked at 68% and 70% of their support staffing establishment (note that ITU works with an establishment of just 1 HCA in ITU and HDU resulting in any absence significantly reducing the fill rate – Maternity move staff to cover acuity and patient numbers which ensures consistent cover even when there are uncovered shifts).

Appendix 2

Nursing Shift Pattern Analysis (General Ward & Specialist Areas only)

Ward	No. of Beds	Current Budgeted Shift Pattern - Fixed						Budgeted Shift Pattern - including 2014/15 uplift						Summary of uplift
		Qualified			Unqualified			Qualified			Unqualified			
		E	L	N	E	L	N	E	L	N	E	L	N	
Abington	28	5	4	3	4	4	3	5	4	4	4	5	3	HCA L x7, RN x7N, RN Lx2 (w/end)
Althorp	18	3	3	2	3	2	1	3	3	2	3	2	1	
Cedar	29	5	4	3	4	3	3	5	4	4	4	4	3	RN Nx7, RN Lx2 (w/end) , HCA Lx7
Hawthorn	30	6	5	3	3	3	3	6	5	4	3	3	3	RN Nx7, RN Ex2 (w/end), RN Lx2 (w/end) HCA Nx2
Head & Neck	14	3	3	2	2	2	1	4	3	2	2	2	1	RN E x7
Rowan	30	6	4	4	3	3	2	6	4	4	4	3	3	HCA E x 7, Nx 7 (previous Business Case)
Spencer	14	3	2	2	3	1	1	3	2	2	3	1	1	
Willow	28	7	6	5	2	3	1	7	6	5	3	3	2	HCA Ex7, HCA N x7
Surgical Group	**191**													
Allebone	28	5	4	4	4	4	2	6	4	5	5	5	3	RN Ex7, HCA Ex7, Lx7, Nx7. RN Nx7, RN Lx2 (w/end) RN Ex2 (w/end)
Becket	26	6	5	4	4	4	2	6	5	4	4	4	2	
Benham	28	5	5	4	2	2	2	5	5	4	2	2	2	
Brampton	27	4	3	2	3	2	3	4	4	3	3	2	3	RN Lx7, RN Nx7, RN Ex2. 0.20 Wd Sr
Collingtree	40	6	6	4	5	4	3	6	6	5	5	4	3	RN Nx7
Compton	18	3	2	2	3	2	1	3	3	2	3	2	1	RN Lx7
Creaton	28	6	4	3	3	4	2	6	4	4	3	4	2	RN Nx7
Dryden	22	5	5	4	2	1	1	6	6	5	2	2	2	RN Ex7, Lx7, Nx7. HCA Lx7, Nx7
EAU	32	6	6	5	3	3	3	6	6	5	3	3	3	
Eleanor	12	4	2	2	2	2	1	4	2	2	2	2	1	
Finedon	18	7	7	3	2	1	1	7	7	3	2	1	1	0.6 Wd Sr
Holcot	27	5	3	3	3	3	2	5	4	4	4	2	2	RN Lx7, Nx7, Lx2 (w/end) Ex2 (w/end). HCA Ex7, L -7
Knightley	21	3	2	2	2	2	2	3	3	2	2	2	2	RN Lx7, RN Lx2 (w/end), RN Ex2 (w/end)
Talbot Butler	30	8	6	3	2	2	2	8	6	4	2	2	2	RN Nx7
Victoria	18	4	3	2	3	3	1	4	3	2	3	3	1	
Medical Group	**375**													
General Wards	**566**													
Critical Care	16	13	13	12	2	2	2	13	13	12	2	2	2	RN 6.84
Paddington	25	7	7	5	1	1	1	7	7	5	1	1	1	
Disney	18	4	4	2	1	1	1	4	4	2	1	1	1	
Gosset	25	8	7	6	1	1	1	8	7	6	1	1	1	
Balmoral (Obs Ward)	17	4	3	3	1	1	1	4	3	3	1	1	1	Midwifery 12.2 MSW
Robert Watson	15	3	3	3	3	3	3	3	3	3	3	3	3	
Sturtridge	8	9	9	10	3	2	2	9	9	10	3	2	2	
A&E		11	13	11	4	5	3	11	13	11	4	5	3	RN 6.26
Specialist Areas														
Grand Total	**566**													

Current vacancies for registered & unregistered staff before the 2014/15 investment and after the investment as whole time equivalent (wte)

	Pre-investment/wte	Post investment/wte
Registered Staff vacancy	97.66	153.83
Unregistered Staff vacancy	16.95	40.68
Total	**114.61**	**194.51**

Enclosure E

Report To	**PUBLIC TUST BOARD**
Date of Meeting	**25 September 2014**

Title of the Report	**Integrated Performance Report and Corporate Scorecard**
Agenda item	**9**
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 Corporate Scorecard provides a holistic and integrated set of metrics closely aligned between the TDA, Monitor and the CQC oversight measures used for identification and intervention.

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

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

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

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

Enclosure F

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.

Northampton General Hospital NHS Trust Corporate Scorecard 2014-15

Caring

Indicator	Target	Trend	Jun-14	Jul-14	Aug-14
Complaints rate per bed days	None	↑	0.21%	0.33%	0.24%
Complaints responded to within agreed timescales	90%	↑	67%	50%	68%
Friends & Family Test: Inpatient score	70	↓	65	63	62
Friends & Family Test: A&E score	60	↑	64	64	68
Friends & Family Test: Maternity score	70	↓	82	90	74
Mixed Sex Accommodation	0	⇔	0	0	0
Patients in last days of life with a care plan in place	None	↑	10.8%	13.5%	35.6%
Transfers: All patients moved / transferred out of hours	None	↓	31	9	36
Transfers: Patients moved with a risk assessment completed	None	↓	23	7	39

Effective

Indicator	Target	Trend	Jun-14	Jul-14	Aug-14
Emergency re-admissions within 30 days (adult elective) *****	None	⇔	1.32%	1.52%	1.44%
Emergency re-admissions within 30 days (adult non - elective) *****	None	↑	1.90%	2.16%	2.60%
Length of stay - All	None	↓	4.59	4.52	4.83
Length of stay - Elective	None	↓	2.8	2.75	3.0
Length of stay - Non Elective	None	↓	4.9	4.8	5.1
Maternity: C Section Rates - Total	<25%	⇔	25.8%	25.4%	25.8%
Maternity: C Section Rates - Emergency	<14%	↓	14.7%	13.9%	15.2%
Maternity: C Section Rates - Elective	<10%	↑	11.6%	11.5%	10.6%
Mortality: SHMI*	Within expected range	⇔	109.8	105.3	105.3
Mortality: HSMR**		↓	86	84.6	90
Mortality: HSMR - Weekend**		⇔	86	86.1	86.8
Mortality: HSMR - Week day**		↑	87	84.2	84.41
Mortality: Low risk conditions**		↑	79	79	75.57
Mortality: Maternal Deaths	0	⇔	0	0	0
NICE compliance	80%	↑	95.9%	95.3%	98.0%
Number of patients cared for in an escalation area	None	⇔	169	93	139
# NoF - Fit patients operated on within 36 hours	100%	↓	81.0%	73.5%	N/Avail
Percentage of patients cared for outside of specialty (General Medicine)	None	↓	10.5%	10.4%	14.2%
Stroke patients spending at least 90% of their time on the stroke unit	80%	↑	89.6%	95.1%	96.2%
Suspected stroke patients given a CT within 1 hour of arrival	50%	↑	61%	76%	83%

Safe

Indicator	Target	Trend	Jun-14	Jul-14	Aug-14
C-Diff	Ave. 3 per mth	↓	1	3	4
Dementia: Case finding	90%	↑	92.5%	90.1%	93.0%
Dementia: Initial diagnostic assessment	90%	↓	100%	96.2%	90.0%
Dementia: Referral for specialist diagnosis/Follow-up	90%	↓	100%	93.3%	91.0%
Falls per 1,000 occupied bed days	5.8	↑	5.49	5.33	4.91
Harm Free Care (Safety Thermometer)	93%	↓	92.9%	91.0%	88.5%
Medical Notes: Availability for clinics***	99%	⇔	99%	97%	98%
Medical notes: Documentation - Doctors	95%	↓	64.5%	68.1%	63.4%
Medical notes: Documentation - Nurses	95%	↓	56.4%	62.7%	60.5%
Medical notes: Documentation - Allied Health	95%	↑	74.2%	74.9%	76.2%
Medication errors (administration)	None	↑	32	21	12
MRSA	0	⇔	0	0	0
Never event incidence	0	⇔	0	0	0
Pressure Ulcers: Total grade 3 & 4 hospital acquired (incidence)	None	↓	1	3	9
Pressure Ulcers: Avoidable grade 3 & 4 (incidence) - verification of current month required prior to publishing	3	↑	7	2	Awaiting verification
Pressure Ulcers: Avoidable grade 2 (incidence) - verification of current month required prior to publishing	7	⇔	13	13	
Open Serious Incidents Requiring Investigation (SIRI)	None	↑	6	8	4
Open CAS alerts	0	⇔	0	0	0
TTO's sent by taxi	0	⇔	0	0	N/Avail
UTI with Catheters (Safety Thermometer-Percentage new)	0.4%	↑	0.48%	0.33%	0.32%
VTE Risk Assessment	95%	↓	97.0%	97.4%	95.9%

Responsive

Indicator	Target	Trend	Jun-14	Jul-14	Aug-14
A&E: Proportion of patients spending more than 4 hours in A&E	95%	↓	92.8%	93.2%	91.3%
A&E: 4hr SitRep reporting	95%	↓	92.3%	93.4%	91.4%
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	1
Discharge: Number of medically fit patients awaiting discharge (average daily)	None	↓	61	69	80
Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	93%	↓	94.3%	89.5%	89.2%
Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	93%	↑	92.5%	73.6%	96.1%
Cancer: Percentage of patients treated within 62 days of referral from screening	90%	↓	95.2%	100%	97.3%
Cancer: Percentage of patients treated within 62 days of referral from hospital specialist	80%	⇔	75.0%	100%	100%
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	85%	↑	72.7%	82.1%	84.5%
Cancer: Percentage of patients treated within 31 days	96%	⇔	93.5%	95.4%	95.1%
Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	94%	↓	100%	95.2%	90.0%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	98%	↓	100%	100%	95.5%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	94%	↓	96.9%	100%	96.7%
Operations: Urgent Operations cancelled for a second time	0	⇔	0	0	0
Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	0	↓	0	0	1
RTT for admitted pathways: Percentage within 18 weeks	90%	↓	94.7%	94.1%	92.3%
RTT for non- admitted pathways: Percentage within 18 weeks	95%	↓	98.4%	98.7%	97.7%
RTT waiting times incomplete pathways	92%	↓	98.0%	97.6%	97.0%
RTT over 52 weeks	0	⇔	0	0	0

Well Led

`	Target	Trend	Jun-14	Jul-14	Aug-14
Friends & Family: NHS England Inpatient response rate	25%	↓	34.3%	33.4%	31.8%
Friends & Family: NHS England A&E response rate	15%	↑	18.5%	13.6%	14.7%
Friends & Family: NHS England Maternity response rate	20%	↓	36.96%	38.78%	30.99%
Friends & Family: Net Promoter Score of staff that would recommend the trust as a place of work ****	None	Not applic.	-11	N/Avail	
Data quality of Trust returns to HSCIC (SUS)	None	⇔	N/Avail	88.9%	N/Avail
Staff: Trust turnover rate	8%	↓	8.7%	9.0%	9.4%
Staff: Trust level sickness rate	3.8%	↓	4.34%	4.38%	N/Avail
Staff: Trust level vacancy rate - Doctors	None	↑	6.7%	6.1%	4.6%
Staff: Trust level vacancy rate - Nurses	None	↓	8.8%	9.5%	10.6%
Staff: Trust level vacancy rate - Other	None	↓	12.4%	11.9%	12.5%
Staff: Temporary costs & overtime as a % of total pay bill	None	↓	11.7%	12.0%	N/Avail
Staff: Percentage of staff with annual appraisal	80%	↑	66.1%	71.8%	72.7%
Staff: Percentage of all trust staff with mandatory training compliance	80%	↓	78.4%	78.7%	78.2%
Staff: Percentage of all trust staff with role specific training compliance	80%	↓	65.4%	63.5%	62.3%

Section	Red Rated	Amber Rated	Green Rated	None	Total
Caring	2	0	3	4	9
Effective	0	3	9	8	20
Safe	4	0	11	6	21
Responsive	9	0	10	1	20
Well-Led	4	1	2	7	14
Total	19	4	35	26	84

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

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

** HSMR Rolling year April 2013 to March 2014

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

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

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

Public Trust Board
25 September 2014

Trust Board Corporate Scorecard

Revised Corporate Scorecard for alignment with the Trust Development Authority's (TDA)

Delivering for patients:
The 2014/2015 Accountability Framework for NHS Trust Boards

This revised corporate 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.

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Complaints response rate – 68% (June 2014)	Report period:	August 2014
Driver for underperformance:		**Actions to address the underperformance:**	
-The workload continues to grow due to the ever increasing complexity of complaints, which we report on yearly in the annual complaints report -The situation has been difficult during August as both experienced complaints officers have been away either sick or on annual leave. Both members of staff are key personnel in the preparation of complaints responses. The new complaints officer (20 hours) is currently ongoing with her training and is progressing very well.		-The additional 20 hour band 5 Complaints Officer commended in post on the 30th June 2014 – training ongoing at present -In August the Head of Complaints was dealing with all new complaints, preparing some responses where possible, reporting, queries and all complainant meetings. Covering both of the absent members of staff plus own workload. -Temporary person in post for 4-6 weeks as of the 7th July 2014 to help to clear the backlog of complaints. Currently this member of staff is the predominant person preparing complaints. Short extension to cover absence of other staff	
Forecast date (month) for meeting the standard		**Forecast performance for next reporting period:**	
October 2014		Most likely the same	
Lead for recovery:		**Lead Director:**	
Lisa Cooper, Head of Complaints		Jane Bradley, Interim DoN	

Historical Target Performance

Indicator	Target	Trend	Jun-14	Jul-14	Aug-14
Complaints responded to within agreed timescales	90%	⇧	67%	50%	68%

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Friends & Family Test: Inpatient score	Report period:	Aug 2014
Driver for underperformance:		**Actions to address the underperformance:**	
The Trust have implemented an in-house target NPS of 70 for Inpatient areas. The NPS dropped in May to 57 and although this has increased to 65 in June it has again fallen to 63 for July and then again to 62 for August.		• Comments have been reviewed and identified particular patient concerns with noise disturbance at night. A campaign to tackle this called the 'Sleep Well' Campaign is currently in process and hopes to address some of these concerns. • Areas that have a low NPS are notified and asked to review comments related to their areas.	
Forecast date (month) for meeting the standard		**Forecast performance for next reporting period:**	
October 2014		No change	
Lead for recovery:		**Lead Director:**	
Rachel Lovesy, Patient Experience Lead		Jane Bradley, Interim Director of Nursing	

Historical Target Performance

Indicator	Target	Trend	Jun-14	Jul-14	Aug-14
Friends & Family Test: Inpatient score	70	⇩	65	63	62

Enclosure F

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Harm Free Care (Safety Thermometer)	Report period:	Aug 2014

Driver for underperformance:	Actions to address the underperformance:
Unfortunately in the month of August we saw a significant increase in 'All Harms' which was predominately pressure ulcers. In particular there was a negative increase in the number of 'all pressure ulcers' prevalence which reflects patients that have been in hospital more than a month which links to the increase in LoS. Falls & VTE have maintained their level below the national average and Catheter related UTI have stayed consistent at 3 (national average).	Ward Sisters to raise each PU SI report findings to their Clinical Huddle and Ward Meetings. Letter of Expectation to be sent by the ward Sister to each member of staff who has been involved in the patients care Any further incidents will be managed through individual performance. PDN team have visited the wards every day for a week in September to understand the common themes (Inaccurate Pt waterlow assessment, poor documentation, poor proactive care) PDN team & TVN team to link and prioritise the key 6 wards where there has been the most PU with training and on-the-ward teaching sessions.
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
End of Q3	89.5% - 90.5%
Lead for recovery:	**Lead Director:**
Sylvia Woods/Fiona Barnes	Jane Bradley

Historical Target Performance

Indicator	Target	Trend	Jun-14	Jul-14	Aug-14
Harm Free Care (Safety Thermometer)	93%	↓	92.9%	91.0%	88.5%

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Pressure Ulcers - (Avoidable)	Report period:	July 2014 (published Aug 14)

Driver for underperformance:	Actions to address the underperformance:
The number of Hospital acquired pressure damage rose again for August, this includes Grade 2 & Grade 3 pressure damage. 44% of which were device related. Compliance to SSKIN care bundle Q1 – 61% of all hospital acquired pressure ulcers were not compliant with SSKIN Care bundle. The Trust is currently negotiating a trajectory for improvement with the CCG. 26 Grade 2 hospital acquired pressure ulcers reported in July of which 50% were considered unavoidable. This is a notable improvement on previous months where between 20-23% of all hospital acquired pressure ulcers were considered unavoidable	Staff checking the vulnerable pressure areas including behind ears. No evidence that advice given to patient (where appropriate) regarding repositioning of oxygen delivery system. Preventative aids to be used prior to damage developing. Trials of other Oxygen delivery devices ongoing, to be rolled out across trust. PDSA 2 Care Round/SSKIN evaluation of care to be trialled on 11 wards for 2/52, then rolled out across trust. Providing evidence of compliance to SSKIN Care bundle
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
End of Q2 For Grade 3's End of Quarter for Grade 2's	Oxygen delivery devices designed to reduce pressure (nasal specs) implemented across trust.
Lead for recovery:	**Lead Director:**
Sylvia Woods / Fiona Barnes	Jane Bradley

Historical Target Performance

Indicator	Target	Trend	Jun-14	Jul-14
Pressure Ulcers: Avoidable grade 2 (incidence) - verification of current month required prior to publishing	7	⇔	13	13

Enclosure F

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Friends & Family: NHS England A&E response rate	Report period:	Aug 2014

Driver for underperformance:	Actions to address the underperformance:
A&E have a national CQUIN target of 15% accumulated across the Quarter. They have struggled within recent months to achieve their national targets and although they showed positive signs of change in June they again fell short of the required target in July obtaining a target of just 13.6%. This has risen for August to 14.7%, however this is still below target. It also means that September's response rate needs to be considerably higher in order to meet the CQUIN target.	• The survey has been changed on the screen to display a more welcoming and appealing message • New posters have been created and displayed around the department, along with the leaflet stands being refilled. • A message is now being displayed on the waiting room television informing patients of the FFT. • One IPad is being moved to a position with better patient footfall • The service manager has access to the online survey and will monitor hours of inactivity for noncompliance and further drive • Volunteers have been enlisted to support patients • An external company has been procured to take on this role in the future
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
November 2014	Above 15%
Lead for recovery:	**Lead Director:**
Rachel Lovesy, Patient Experience Lead	Jane Bradley, Interim Director of Nursing

Historical Target Performance

`	Target	Trend	Jun-14	Jul-14	Aug-14
Friends & Family: NHS England A&E response rate	15%	⇧	18.5%	13.6%	14.7%

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Staff: Trust turnover rate	Report period:	August 2014
Driver for underperformance:		Actions to address the underperformance:	
Staff Turnover has increased within August to 9.4% from 9.0% in July. This is attributed to an increase in leavers within A&C roles and Medical & Dental roles (this does not include junior doctors). Areas that have seen an increased turnover are Child Health, Oncology & Haematology, Pathology and Therapies.		A month on month centralised report will be produced by the Workforce Information team to ascertain the specific reasons why there has been an increase in turnover; in particular in the hot spot areas. This report will include turnover by directorate broken down by department/reasons for leaving, staff group/reasons for leaving. This report will enable identification of actions that need to be taken in the coming months.	
Forecast date (month) for meeting the standard		Forecast performance for next reporting period:	
Not known but monitoring will continue on a monthly basis to identify any downward trend		Above 9.4%	
Lead for recovery:		Lead Director:	
Sandra Wright		Janine Brennan	

Historical Target Performance

`	Target	Trend	Jun-14	Jul-14	Aug-14
Staff: Trust turnover rate	8%	⇩	8.7%	9.0%	9.4%

Enclosure F

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Appraisals	Report period:	August 2014
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.		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. Embedding process into all areas. 1:1 meetings with areas that require additional support in understanding process; paperwork; requirements or queries about the data. Appraisal audit in place to ensure quality of audits.	
Forecast date (month) for meeting the standard		**Forecast performance for next reporting period:**	
March 2015		75.14%	
Lead for recovery:		**Lead Director:**	
Sandra Wright		Janine Brennan	

Historical Target Performance

`	Target	Trend	Jun-14	Jul-14	Aug-14
Staff: Percentage of staff with annual appraisal	80%	⇧	66.1%	71.8%	72.7%

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Role Specific Training Compliance Rates	Report period:	August 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 the number of subjects of which many of those that were originally Mandatory are now Role Specific Essential Training. The target to be achieved by October 2014 is 80% and 85% in March 2015 as per the Quality Schedule Subject Leads have been encouraged to complete Workbooks for some subjects. Due to the completed scoping exercise it has become apparent that for some subjects staff will have accessed training that is not required by their role.	New Appraisal process encouraging uptake of Mandatory training & RSET by requiring staff to have in-date training in order to incrementally progress. Performance Wave refined to produce trajectories to Directors to enable challenge back to Senior Managers on progress against targets. 1:1 sessions & “drop-ins” for Ward Sisters to support understanding of requirements and how to achieve increased compliance. Scoping of RSET against job roles and positions has been completed and uploaded into system to ensure accuracy of reporting however there will continue to be some refinements.
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
March 2015	RSET = 68.2%
Lead for recovery:	**Lead Director:**
Sandra Wright	Janine Brennan

Historical Target Performance

`	Target	Trend	Jun-14	Jul-14	Aug-14
Staff: Percentage of all trust staff with role specific training compliance	80%	⇩	65.4%	63.5%	62.3%

Enclosure F

Trust Board Corporate Scorecard
Exception Report

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

Driver for underperformance:	Actions to address the underperformance:

• Locum Consultants in ED not controlling department as required on night shifts
• High % of breaches due to first assessment
• Continuing high numbers of DTOC's
• Staffing challenges over the month of August
• Periodically, fewer discharges per day than required.
• Reduced flow through the Trust
	• Ongoing Recruitment in ED
	• Operation Kick start every Saturday
	• Discharge teams deployed at weekends
	• Continued greater utilisation and review with primary care of ACC to refine processes
	• Further development and implementation of winter funding business cases to address:
	  ○ Delayed Transfers of Care and all System Delays
	  ○ ED front door
	  ○ Demand Management
	• In depth analysis of time to first assessment in ED to resolve weaknesses and help reduce breaches
	• Ongoing clinical education within ED
	• Go-live for Symphony in SAU scheduled for September
	• Review of Assessment Unit model with clinicians and capacity management teams
	• Ongoing training for ward staff on discharges and ward management
	• 'Ticket Home', 'Moving On', and 'Options' initiative to help with Complex Discharges in development
	• Ward training programme for support in complex discharge paperwork
	• Trusted Assessor paperwork signoff in September to be used across health economy
	• Review and enhancement of predictive planning technology ready for enhanced flow following launch of Integrated Discharge Team
	• Continued development of EAU MDT for early assessment
	• Audit of Falls Care Bundles to refine processes

Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
October 2014	94%
Lead for recovery:	**Lead Director:**
Work stream leads	Deborah Needham

Historical Target Performance

Indicator	Target	Trend	Jun-14	Jul-14	Aug-14
A&E: Proportion of patients spending more than 4 hours in A&E	95%	⇩	92.8%	93.2%	91.3%
A&E: 4hr SitRep reporting	95%	⇩	92.3%	93.4%	91.4%

Trust Board Quality Scorecard
Exception Report

Target underperformed:	Cancer Access Targets:- - *2 week GP referral to outpatient appointment* - *62 days urgent referral to treatment of all cancers* - *31 days* - *Subsequent surgery* - *Subsequent chemo*	Report period:	Aug 2014

Driver for underperformance:	Actions to address the underperformance:
• 2ww Dermatology capacity • Colorectal OPAs being booked nearer to 14 days and increasing the length of time before diagnosis • CT being booked over 14 days • Patient choice to delay treatment	• Increase dermatology slots mapped to 2ww • Locum has ensured slots are now available • Root cause analysis of colorectal pathways and CT timescales
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
The Trust will not meet the 2ww standard for quarter 2 on the number of current breaches and average number of referrals seen. On the present number of breaches it is unlikely that the 31 day first treatment standard will be achieved for quarter 2. The current position for the 62 day standard is higher than the forecast but depends on gaining further treatments for August confirmed by histology.	
Lead for recovery:	**Lead Director:**
Services Managers/Tracey Harris	Chris Pallot

Historical Target Performance

Indicator	Target	Trend	Jun-14	Jul-14	Aug-14
Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	93%	⇩	94.3%	89.5%	89.2%
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	85%	⇧	72.7%	82.1%	84.5%
Cancer: Percentage of patients treated within 31 days	96%	⇔	93.5%	95.4%	95.1%
Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	94%	⇩	100%	95.2%	90.0%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	98%	⇩	100%	100%	95.5%

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Report period:	August 2014

Driver for underperformance:	Actions to address the underperformance:
Patient has complex medical conditions making her a high risk anaesthetic. In addition required isolation owing to infection control issues. Cancelled on the day as out of theatre time (previous case more complex than expected). Required named consultant surgeon – unable to date within 28 days due to isolation and anaesthetic requirements.	Difficult to address in view of specific anaesthetic and infection control requirements. Consider cancelling less complex patient where there are no anaesthetic requirements to consider when rebooking.
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
October 2014	October 2014
Lead for recovery:	**Lead Director:**
Sue McLeod	Rebecca Brown

Historical Target Performance

Indicator	Target	Trend	Jun-14	Jul-14	Aug-14
Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	0	⇩	0	0	1

Trust Board Quality Scorecard
Exception Report

Target underperformed:	Healthcare Records Audit	Report period:	August 2014

Driver for underperformance:	Actions to address the underperformance:
Patient Safety Lead for records audit reviewed categories and relaunched audit in April in an attempt to encourage greater engagement. Result shave not improved. August - Medical Director met with the patient safety leads and head of medical records to establish a new direction for this project as engagement in directorates was poor. Nursing audit performed as part of QuEST visits and reported quarterly. Proving difficult to get engagement at directorate level to establish improvements in medical notes recording. Surgical & medical notes are reviewed every month but actions to improve performance are lacking. Needs to become a priority issue within directorates.	Patient Safety Lead to redefine metrics to more closely reflect key safety issues. Raise the profile within directorates to ensure monthly reporting and encourage challenge for improvement. Medical director has discussed with governance leads in medical & surgical care groups – agenda item at next governance meeting. Medical director to discuss with clinical directors to improve engagement at Consultant level. Encourage patient safety team to develop actions within each directorate to establish improvement.
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
Lead for recovery:	**Lead Director:**
Dr Jonny Wilkinson	Medical Director

Historical Target Performance

Indicator	Target	Trend	Jun-14	Jul-14	Aug-14
Medical notes: Documentation - Doctors	95%	↓	64.5%	68.1%	63.4%
Medical notes: Documentation - Nurses	95%	↓	56.4%	62.7%	60.5%
Medical notes: Documentation - Allied Health	95%	↑	74.2%	74.9%	76.2%

Enclosure F

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**25 September 2014**

Title of the Report	**The Patient-Led Assessment of the Care Environment (PLACE) Programme 2014**
Agenda item	**10**
Sponsoring Director	Charles Abolins, Director of Facilities and Capital Development
Author(s) of Report	Charles Abolins, Director of Facilities and Capital Development
Purpose	Assurance and Information

Executive summary

The aim of PLACE assessments is to provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact in the patient experience of care – Cleanliness; the Condition, Appearance and Maintenance of Healthcare Premises; the extent to which the environment supports the delivery of care with Privacy and Dignity; and the quality and availability of Food and Drink.

It can be seen from the results that NGH has performed above the national average for Cleanliness, Privacy and Dignity and Condition, Appearance and Maintenance, whereas Food is very slightly below the national average (by 0.19%).

Related strategic aim and corporate objective	• Focus on Quality & Safety • Exceed patients expectation
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks (No)
Related Board Assurance Framework entries	BAF – 5
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	PLACE results are used by CQC to inform their assessment of services provided by Trusts

Actions required by the Trust Board

The Board is asked to note the report and the results from this year's PLACE assessments

The Patient-Led Assessments of the Care Environment (PLACE) Programme 2014

1. Introduction

Patient-Led Assessments of the Care Environment (PLACE) are a self-assessment of a range of non-clinical services which contribute to the environment in which healthcare is delivered in both the NHS and independent/private healthcare sector in England. Participation is voluntary. These assessments were introduced in April 2013 to replace the former Patient Environment Action Team (PEAT) assessments which had been undertaken from 2000 – 2012 inclusive. These are the second year results from the revised process.

The PLACE programme aims to promote principles and values of the NHS Constitution by ensuring that the assessment focuses on the areas which patients say matter, and by encouraging and facilitating the involvement of patients, the public and other bodies with an interest in healthcare (e.g. local Healthwatch) in assessing providers in equal partnership with NHS staff to both identify how they are currently performing against a range of criteria and to identify how services may be improved for the future.

2. Principles

The aim of PLACE assessments is to provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact in the patient experience of care – Cleanliness; the Condition, Appearance and Maintenance of Healthcare Premises; the extent to which the environment supports the delivery of care with Privacy and Dignity; and the quality and availability of Food and Drink.

The criteria included in PLACE assessments are not standards, but they do represent both those aspects of care which patients and the public have identified as important, and good practice as identified by professional organisations whose members are responsible for the delivery of these services.

A fundamental part of assessments is the inclusion of lay assessors known generically as Patient Assessors. In this regard there are two specific conditions which organisations are required to ensure:-

- That there are never fewer than two patient assessors in any assessment team (or sub-team where assessment teams are split into more than one e.g. due to the hospital's size;
- That the ratio between staff and patient assessors is never less than 50/50. This ratio can be increased in favour of patient assessors but should not be increased in favour of staff assessors.
- Staff assessors used at NGH come from a range of backgrounds, Nursing, Estates and facilities, Infection Prevention and PALS.

3. Methodology

For each of the areas there are detailed assessment forms comprising multiple choice questions which have to be completed following the physical assessment of an area by the team. The team discuss their findings and comes to a conclusion regarding the score to be awarded against specific criteria in each category. For the food and

hydration part of the assessment a range of patient menu items are sampled by the team in the ward environment and the service and presentation of the food to patients is observed.

Patients are asked for their views regarding the quality, choice and service of meals and beverages. Once the assessments have been completed these are submitted on-line to the Health and Social Care Information Centre (HSCICS), who apply the scoring algorithm and weighting.

The HSCICS undertake this for the whole of the NHS and from this are able to determine the national average for the NHS and compare this with scores from individual organisations. Participating organisations are able to use this information to benchmark their performance.

4. Results

This years results are set out in Appendix 1 which shows the Trust score and the national average. Appendix 1 also shows the comparative data from 2013.

It should be noted however that due to changes in the 2014 methodology the scores for 2013 and 2014 relating to Food and Hydration and Privacy and Dignity are not directly comparable.

It can be seen from the results that NGH has performed above the national average for Cleanliness, Privacy and Dignity and Condition, Appearance and Maintenance, whereas Food is very slightly below the national average (by 0.19%).

5. Conclusion

Overall the results of this year's assessment are encouraging and show the Trust is maintaining environmental standards consistently above the national average.

With regard to Food, each of the assessment teams commented that the standards this year were very good, however this does not come across in the national comparator. The Catering team are reviewing a number of areas of the catering service and changes to menu format etc. are being proposed in order to improve patient satisfaction as well as next year's PLACE results.

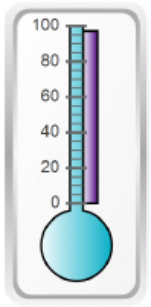
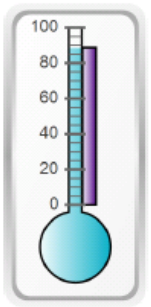
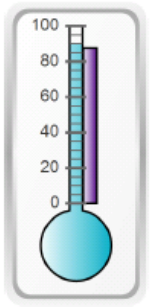
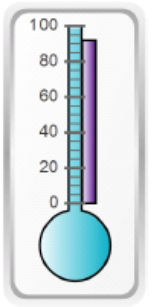
Appendix 1

PLACE
Patient-led assessments of the care environment

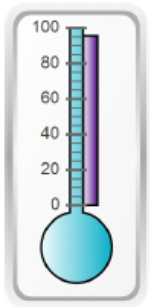
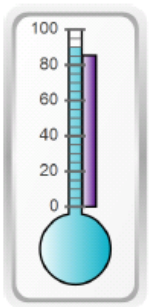
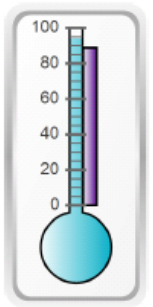
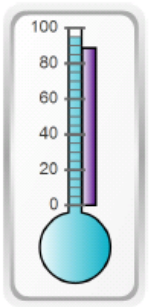
NHS England

NORTHAMPTON GENERAL HOSPITAL

Collection: 2014

Cleanliness	Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance
			
99.39%	88.60%	90.33%	98.71%
97.25%	88.79%	87.73%	91.97%

Collection: 2013

Cleanliness	Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance
			
99.46%	89.63%	94.17%	95.34%
95.75%	85.42%	88.90%	88.78%

Site Score National Average

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**25 September 2014**

Title of the Report	**Financial Position Month 5**
Agenda item	**11**
Sponsoring Director	Simon Lazarus, Director of Finance
Author(s) of Report	Andrew Foster, Director of Finance
Purpose	To report the financial position for the period ended August 2014/15.

Executive summary

- The I&E position for the period ended August is a £10.4m deficit with the forecast position a projected deficit of £14.2m (subject to delivery of a range of recovery actions).
- The TDA have requested the Trust produces a Financial Recovery plan setting out how the I&E position will be managed back to the planned £7.8m deficit set at the start of the financial year. This requirement is set in the context of reports of significant national pressure on NHS finances.
- A range of recovery initiatives are being worked up together with a series of detailed forecasts and action plans at directorate level. At this stage the delivery of a £7.8m deficit would appear to be unachievable without significant external support or additional CCG income.
- The cashflow position at the end of August has significantly reduced to £0.7m.

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

Actions required by the Committee

The Board is asked to consider the recommendations of the report and to consider the approach and key elements required in developing the financial recovery plan. The Board is asked to note the requirements of the NTDA in relation to delivery of the £7.8m deficit plan.

Enclosure H

Northampton General Hospital NHS
NHS Trust

Financial Position
Month 5 2014/15

Report to
Trust Board
September 2014

Enclosure H

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	-£10,437	-£2,803	£ 7,634 Adv	-£7,829	-£7,829	£ 0 Adv
Achieving EFL (£000's)				£18,925	£18,925	£0
Achieving the Capital Resource Limit (£000's)	£2,661	£2,797	£ 136 Fav	£19,545	£19,545	£0
Better Payment Practice Code:						
Volume of Invoices	93.84%	95.00%	1.16% Adv	95.00%	95.00%	-
Value of Invoices	96.35%	95.00%	1.35% Fav	95.00%	95.00%	-

Financial Performance

- Financial performance for the period ended August 2014 is a normalised deficit of £10.4m (July £7.5m).
- The position for August was a deficit of £2.9m led by a reduction in SLA income .
- The forecast I&E position continues to give rise for concern with the most likely deficit of £14.2m, assuming all CIP plans are fully delivered.
- A draft Financial Recovery Plan setting out the forecast position, process and governance arrangements will be presented to Finance Committee in September under separate cover.
- The TDA will conduct a "deep dive" into the Trusts CIP position in September.
- The cashflow position at the end of August has significantly reduced to £0.7m.
- The DH approved the Trust's application for £4m temporary borrowing of which £3m has been drawn down in September primarily to facilitate the half year dividend payment to HMT.

Capital Expenditure

- Delivery of the full plan is contingent on the Trust making a successful application to the Independent Trust Financing Facility (ITFF) for £7.2m of new PDC loans in 14-15.
- An in year review of the current capital plan is underway with a view to creating additional headroom to support cashflow and provide additional contingency.

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

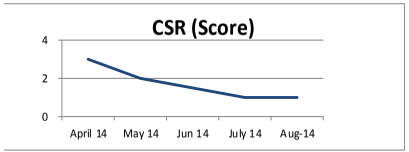
- The EFL for 14/15 has been increased to £18.9m(+ve) reflecting the utilisation of £3.4m internal year end cash balances requested by DH as part of the Q1 FIMS return.
- There has been a reduction in the volume of invoices paid on time in August with 94% of suppliers having been paid within 30 days for the year to date.

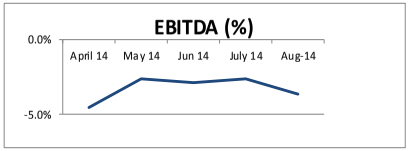
Key issues

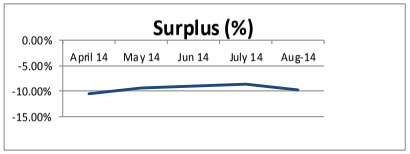
- The I&E position for the period ended August is a £10.4m deficit with the forecast position a projected deficit of £14.2m (subject to delivery of a range of recovery actions).
- The TDA have requested the Trust produces a Financial Recovery plan setting out how the I&E position will be managed back to the planned £7.8m deficit set at the start of the financial year. This requirement is set in the context of reports of significant national pressure on NHS finances.
- A range of recovery initiatives are being worked up together with a series of detailed forecasts and action plans at directorate level. At this stage the delivery of a £7.8m deficit would appear to be unachievable without significant external support or additional CCG income.
- The underlying pay expenditure run rate increased in August largely due to temporary staffing costs which have continued to escalate .
- NEL activity has performed above plan in August giving rise to a further increased provision for the associated MRET penalty.
- The CCG continue to make significant contractual challenges against the Trust and as a result additional provisions have been made in the reported position.
- CIP delivery continues to exceed plan in August. There remains forward risk in the CIP plan with a number of high risk schemes to be delivered together with a further £1.6m still to be identified to meet the plan for the year.
- The final application for longer term revenue and capital cash support was been submitted for TDA review on 22nd August prior to onward submission to the Independent Trust Financing Facility (ITFF) in September. An update on progress of the application is awaited from the TDA .

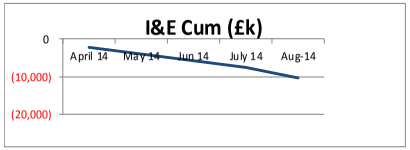
2.0 Financial Performance Dashboard

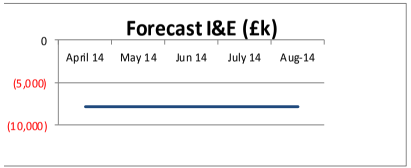
1. Key Metrics

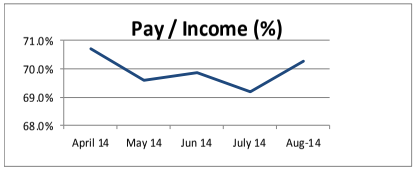




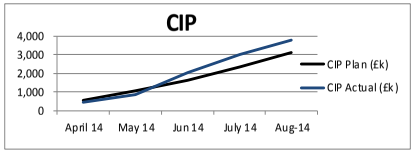


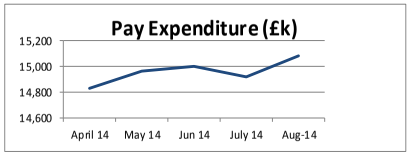


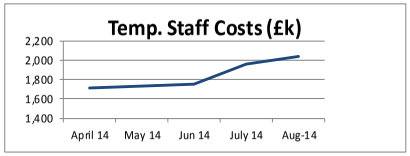


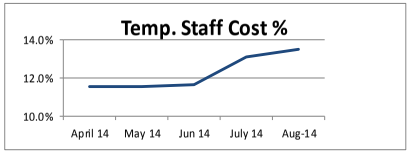


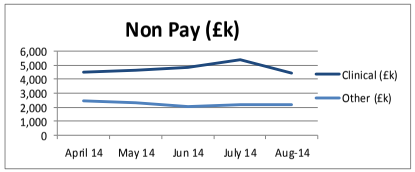
2. I&E Perfromance

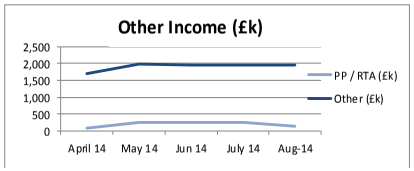




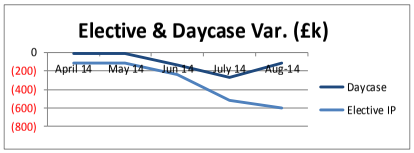


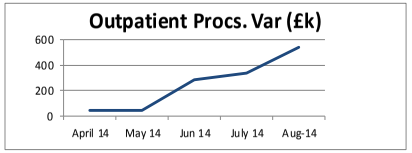


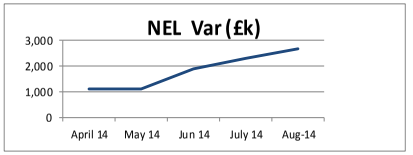


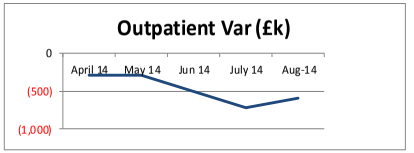


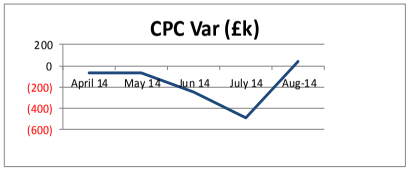
3. SLA Income

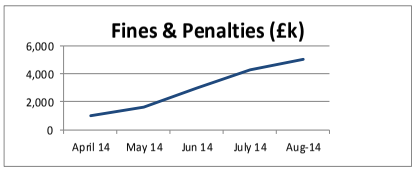




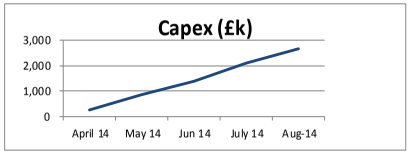


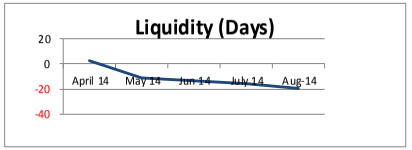


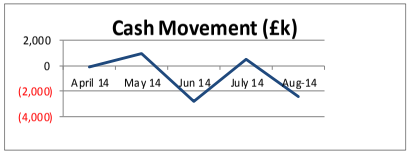


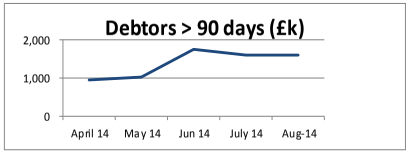


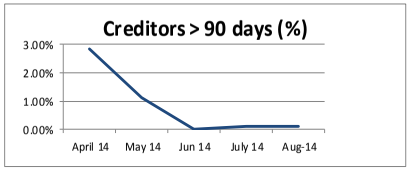
4. Working Capital

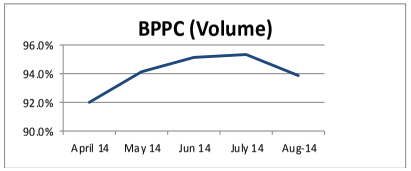












2.1 I&E Summary & Gross Forecast 14-15 (base M5+7)

	Annual Budget 2014/15 £000's	M5+7 Gross Forecast 2014-15	5 YTD Actual £000's	YTG Value £000's	FRP (Most Likely) £000's	EOY Position £000's
SLA Clinical Income	237,701	232,454	95,939	136,516	5,123	237,577
Other Clinical Income	2,690	2,342	1,002	1,340	105	2,447
Other Income	24,056	24,677	9,523	15,154	8,723	33,400
Total Income	264,446	259,474	106,464	153,010	13,951	273,425
Pay Costs	(175,834)	(181,792)	(74,795)	(106,996)	1,213	(180,579)
Non-Pay Costs	(77,985)	(86,534)	(35,552)	(50,982)	1,617	(84,917)
Reserves & Provsions	(2,250)		-	-	1,000	1,000
Total Costs	(256,069)	(268,326)	(110,347)	(157,978)	3,829	(264,496)
EBITDA	8,377	(8,852)	(3,883)	(4,969)	17,780	8,929
Depreciation	(12,268)	(11,708)	(4,708)	(7,000)	503	(11,205)
Amortisation	(10)	(10)	(4)	(6)		(10)
Impairment of Fixed Assets	-	-	-	-		-
Net Interest	29	22	9	14		22
Dividend	(4,409)	(4,491)	(1,871)	(2,621)	50	(4,441)
Gross Surplus / (Deficit)	(8,281)	(25,038)	(10,457)	(14,581)	18,333	(6,705)
Donated Asset adj.	452	242	20	222		242
Surplus / (Deficit)	(7,829)	(24,796)	(10,437)	(14,359)	18,333	(6,463)

- TDA Support	(7,800)
Gross Fcst deficit	(14,263)

Key issues

- Gross forecast allowing for all known cost pressures is for a deficit of £24.7m if no action taken to reduce current run rate.
- Additional costs pressures for A&E expansion, additional bed capacity, MRI and Cardiology equipment expected.
- Assumption the Trust will receive and spend £0.7m of winter funding included in forecast (based on latest CCG resilience plan). Previous assumption £2.1m.
- A draft Financial; Recovery plan with £18.3m of potential actions reduces the forecast position to £14.2m.
- The actions noted above include an assumption that the TDA will provide system support funding of £7.8m in 14-15 (this cannot be guaranteed).
- The TDA have advised the Trust to assume that any MRET above plan (c.£3.4m) is reinvested back to the Trust. Agreement to a local price for A&E EOU activity could reduce the potential exposure by c.£2.6m leaving a further £0.6m for reinvestment against existing Urgent care costs incurred.
- The Trust is targeting receipt of £2.0m of transformation funding from the CCG 2% Strategic Reserve primarily to cover existing costs incurred in the Urgent Care and Clinical Strategy reviews.
- Key to delivery of the forecast is the delivery of the full CIP plan which carries significant risk and is a high priority area within the Financial Recovery Plan.
- Detailed “bottom up” forecast to be prepared based on August (M5+7) results.

3.0 YTD Income and Expenditure Position

I&E Summary	Annual Plan 2014/2015	YTD Actual	YTD Plan	Variance to Plan	Full Year Forecast
	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	237,701	95,938	99,503	(3,565)	242,355
Other Clinical Income	2,690	1,002	1,121	(118)	2,402
Other Income	24,081	9,523	9,935	(412)	24,300
Total Income	264,471	106,463	110,558	(4,095)	269,057
Pay Costs	(175,893)	(74,795)	(73,348)	(1,447)	(178,790)
Non-Pay Costs	(78,002)	(35,552)	(33,295)	(2,258)	(83,645)
CIPs	0	0	0	(0)	
Reserves/ Non-Rec	(2,199)	0	(14)	14	1,000
Total Costs	(256,094)	(110,347)	(106,657)	(3,690)	(261,435)
EBITDA	8,377	(3,884)	3,901	(7,785)	7,622
Depreciation	(12,268)	(4,708)	(5,112)	404	(11,262)
Amortisation	(10)	(4)	(4)	0	(10)
Impairments	0	0	0	0	0
Net Interest	29	9	12	(3)	23
Dividend	(4,409)	(1,871)	(1,837)	(34)	(4,438)
Surplus / (Deficit)	(8,281)	(10,457)	(3,039)	(7,418)	(8,064)
Normalised Postion:					
Donated Asset adj.	452	20	235	(215)	235
Impairments	0	0	0	0	0
I&E Position	(7,829)	(10,437)	(2,804)	(7,633)	(7,829)

I&E Performance

- Financial performance for the period ended August 2014 is a normalised deficit of £10.4m, compared to a planned deficit of £2.8m giving rise to an adverse variance of £7.6m for the year to date.
- Income is £4.1m adverse to plan. (July £2.7m adverse).
- Pay expenditure is £1.45m adverse to plan. (July £1.0m adverse).
- Non-Pay expenditure is £2.2m adverse to plan. (July £2.0m adverse)
- TDA require the Trust to deliver the I&E plan as submitted in April (£7.8m deficit). The year to date position and current run rate clearly highlight the risk of not achieving the planned position of £7.8m for the year.

Key issues

SLA Income

- Underling overperformance offset by requirement to make provision for potential fines and penalties.
- EL IP activity £602k (8%) below plan for year to date.
- Daycase activity £113k (1%) behind plan for the year to date.
- NEL activity 10% above plan for period to date giving rise to increased MRET exposure.
- CCG challenging payment for NEL and A&E observation area activity.

Other Income

- Private Patient income £139k adverse to plan (£87k adv.) RTA income £20k favourable (£52k fav.) to plan.
- Income / Other Generation £412k adverse to plan. (£374k adv.).

Pay

- Pay expenditure £1.4m adverse to plan.
- Locum medical staff and ADH costs £563k (£610k in July).
- Nursing pay expenditure £558k (2.0%) adverse to plan overall.

Non-Pay

- Reduction in overall run rate in August but £0.2m adverse to plan in month.
- Medicines £1,067k adverse to plan of which £917k relates to tariff exclusions.
- Communications £106k adverse to plan
- Consultancy Fees £214k adverse to plan.
- Staff advertising £140k adverse to plan.
- Equipment maintenance £186k adverse to plan.
- Patients appliances £185k adverse to plan.

4.0 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	15,248	14,866	(382)	9,312	9,198	(113)
Elective Inpatients	2,850	2,548	(302)	7,447	6,845	(602)
Elective Excess Bed Days	1,171	866	(305)	281	206	(75)
Non Elective	19,962	22,592	2,630	31,889	35,003	3,114
Non Elective Excess Bed Days	13,386	11,731	(1,655)	3,094	2,675	(419)
New Outpatients	25,653	24,942	(711)	3,879	3,798	(82)
Follow Up Outpatients	56,166	52,740	(3,426)	4,811	4,551	(260)
Non Cons Led Outpatients New	10,485	8,734	(1,751)	937	816	(121)
Non Cons Led Outpatients Follow Up	20,145	16,679	(3,466)	843	711	(132)
Outpatient Procedures	24,716	29,345	4,629	4,330	4,872	542
CQUIN				2,190	1,868	(322)
Block Contracts - Fixed				8,559	8,535	(23)
Cost Per Case	1,053,989	1,038,712	(15,277)	9,145	9,186	41
A&E	43,664	46,429	2,765	4,338	4,747	409
Excluded Medicines				5,984	7,058	1,074
Excluded Devices		635	635	607	743	136
Contract Challenges		31	31	56	(2,469)	(2,526)
Readmissions				(695)	(445)	250
MRET				(648)	(2,020)	(1,372)
Other Central SLA Income	(5,818)	(1,380)	4,438	2,130	59	(2,071)
Productivity CIPs				1,013		(1,013)
Total SLA Income				**99,503**	**95,938**	**(3,565)**

Key issues

Underlying Performance

Month 5 position is for overall under performance of £3.6m (£2.7m July). Expected downturn evident for Daycase, Elective and Outpatient Activity (10% lower in August than average for the year to date). August plan set by Nene CCG was for finances to be c£1m lower than actually achieved . There has been an in-month over achievement to the plan of £1.1m; 50% of this is due to excluded medicines and 20% is due to the new Maternity tariff resulting from refinements to data capture in this area. Non elective activity continues to over perform with evidence to suggest that acuity has increased in August.

Fines & Penalties

An assessment of potential fines and penalties has been deducted from the M5 income estimate (see the table opposite). Reconciliation of the Q1 contractual position remains outstanding and fines and penalties have yet to be deducted in cash terms from the Trust.

Risks

- A range of income CIPs are currently being reviewed and validated to give an accurate indication of achievement to date and likely forecast position.
- The CCG are challenging paying for the non elective overperformance. This has partially been mitigated through an increase in the provisions and discussions are ongoing around negotiating a local price for the A&E EOA eliminating the associated MRET penalty (c. £2.8m pa) if agreed.
- The CCG readmissions calculation is materially different from the NGH position (c£120k per month) and this is currently being validated. There is a partial provision in to cover this, however this is an outstanding item from the M1 reconciliation.
- NENE CCG “Phase 2” QiPPs were expected for delivery in Q2 but so far have not materially impacted activity.

5. Statement of Financial Position

	Balance at 31-Mar-14	Current Month Opening Balance	Current Month Closing Balance	Current Month Movement	Forecast end of year Closing Balance	Forecast end of year 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		247	246	(1)	240	240
In year movements		2,286	2,897	611	19,851	19,851
Less depreciation		(3,740)	(4,708)	(968)	(11,764)	(11,764)
Net Book Value	143,694	142,487	142,129	(358)	152,021	8,327
Current Assets						
Inventories	5,136	5,615	5,739	124	5,300	164
Receivables:						
NHS Debtors	6,902	4,656	6,044	1,388	6,200	(702)
Other Trade debtors	1,710	1,433	1,456	23	1,800	90
Debtor impairments provision	(675)	(675)	(675)		(500)	175
Capital receivables						
Non NHS other debtors	236	502	488	(14)	250	14
Compensation debtors (RTA)	2,694	2,761	2,751	(10)	2,900	206
Other receivables	1,058	973	915	(58)	1,300	242
Irrecoverable provision	(548)	(548)	(548)		(600)	(52)
Prepayments & accruals	1,124	2,722	2,865	143	1,100	(24)
	12,501	11,824	13,296	1,472	12,450	(51)
Non Current Assets for sale						
Cash	4,445	3,092	694	(2,398)	1,000	(3,445)
Total Current Assets	22,082	20,531	19,729	(802)	18,750	(3,332)
Current Liabilities						
NHS	637	1,222	4,229	3,007	637	
Trade Creditors Revenue	1,302	3,012	3,183	171	1,302	
Trade Creditors Fixed Assets	3,261	786	1,088	302	2,545	(716)
Tax and NI owed	3,433	3,294	3,249	(45)	3,500	67
NHS Pensions agency	2,201	2,185	2,199	14	2,300	99
Other creditors	374	397	348	(49)	374	
Short term loans	285	285	285		220	(65)
Accruals	6,658	7,640	7,388	(252)	6,500	(158)
Receipts in advance	535	3,358	1,655	(1,703)	500	(35)
PCD Dividend due		1,475	1,849	374		
Staff benefits accrual	811	712	712		750	(61)
Provisions < 1 yr	2,338	1,934	1,934		857	(1,481)
Total Current Liabilities	21,835	26,300	28,119	1,819	19,485	(2,350)
Net Current Assets	247	(5,769)	(8,390)	(2,621)	(735)	(982)
Non-Curent Assessts +/- Net Current Assets	143,941	136,718	133,739	(2,979)	151,286	7,345
NON CURRENT LIABILITIES						
Short Term Loans > 1 year	341	341	341		230	(111)
Provsions > 1 year	1,384	1,384	1,384		998	(386)
Net Current Liabilities	1,725	1,725	1,725		1,228	(497)
Total Assets Employed	142,216	134,993	132,014	(2,979)	150,058	7,842
Financed by:						
PDC Capital	103,611	103,611	103,611		119,267	15,656
Revaluation Reserve	35,727	35,977	35,977		35,977	250
I & E balance	2,878	2,878	2,878		2,878	
I & E current year		(7,473)	(10,452)	(2,979)	(8,064)	(8,064)
FINANCING TOTAL	142,216	134,993	132,014	(2,979)	150,058	7,842

Key Movements

Non Current Assets

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

Current assets

- Increase in inventories predominantly in pharmacy.
- Increase in NHS receivables of £1.4m.
- Increase in prepayments £0.1m.
- Overall cash balance reduction of £2.4m month on month.

Current Liabilities

- Increase in NHS creditors of £3.0m.
- Increase in trade creditors of £0.2m.
- Increase in fixed asset creditors of £0.3m.
- Decrease in accruals of £0.3m.
- Increase in PDC dividend accrued of £0.4m.
- Decrease in receipts in advance of £1.7m (CCG block contracts paid quarterly).

Non Current Liabilities

- No movement.

Financing

- Deficit in M5 of £2.9m.

N.B. Increase in NHS Creditors includes £2.9m relating to change in balance sheet treatment of CCG MRET & fines & penalties previously netted off in NHS debtors.

6. Capital Expenditure

Capital Scheme	Plan 2014/15 £000's	M5 Plan £000's	M5 Spend £000's	Under (-) / Over £000's	Plan Achieved %	Actual Committed £000's	Plan Achieved %
Linacc corridor	0	0	0	0	0%	0	0%
Replacement Imaging Equipment	7,207	0	0	0	0%	0	0%
SHSWTF - E Prescribing National Funding	738	93	92	-1	13%	564	76%
CEF Scheme	350	75	71	-4	20%	259	74%
A&E / Orthopaedics	2,331	570	570	0	24%	2,428	104%
Annual Strategic Planning Approvals	209	0	0	0	0%	0	0%
Annual Strategic Planning Approvals - MES	0	0	0	0	0%	0	0%
Medical Equipment Sub Committee	1,795	343	305	-38	17%	419	23%
Estates Sub Committee	4,084	607	548	-58	13%	1,267	31%
IT Sub Committee	2,787	1,063	1,061	-1	38%	1,945	70%
Other	349	251	228	-23	65%	252	72%
Total - Capital Plan	**19,850**	**3,001**	**2,875**	**-127**	**14%**	**7,135**	**36%**
Less Charitable Fund Donations	-304	-204	-214	-9	70%	-232	76%
Total - CRL	**19,545**	**2,797**	**2,661**	**-136**	**14%**	**6,903**	**35%**

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

Key Issues

- Original plan included Linear Accelerator Corridor scheme now under review pending replacement of first linear accelerator.
- A capital loan application has now to be submitted to the TDA relating to replacement imaging equipment.
- 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 September.
- There is a current contingency of £0.209 million (no change from M4).
- Full year depreciation forecast is currently £11.764 million (no change from M4) and includes revised phasing associated with the replacement imaging equipment.
- Charitable Donations assumptions for additions in year are assumed £304k (no change from M4).

7. Receivables, Payables and BPPC Compliance

August 2014	Total at August £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	1,455	-67	320	406	796
Receivables NHS	1,677	598	204	66	809
Total Receivables	**3,132**	**531**	**524**	**472**	**1,605**
Payables Non NHS	(4,270)	(4,222)	(12)	(30)	(6)
Payables NHS	(1,328)	(1,327)	(1)		
Total Payables	**(5,598)**	**(5,549)**	**(13)**	**(30)**	**(6)**

Prevoius Month	Total at July £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	1,433	336	143	155	799
Receivables NHS	3,086	1,552	582	137	815
Total Receivables	**4,519**	**1,888**	**725**	**292**	**1,614**
Payables Non NHS	(3,798)	(3,781)	(12)		(5)
Payables NHS	(1,222)	(1,222)			
Total Payables	**(5,020)**	**(5,003)**	**(12)**		**(5)**

Narrative	April 2014	May 2014	June 2014	July 2014	August 2014	Cumulative 2014/15	Cumulative 2013/14
NHS Creditors							
No.of Bills Paid Within Target	165	170	138	177	169	819	473
No.of Bills Paid Within Period	200	180	159	188	177	904	539
Percentage Paid Within Target	**82.50%**	**94.44%**	**86.79%**	**94.15%**	**95.48%**	**90.60%**	**87.76%**
Value of Bills Paid Within Target (£000's)	1,080	1,586	1,729	1,465	1,487	7,347	4,395
Value of Bills Paid Within Period (£000's)	1,164	1,643	1,875	1,566	1,497	7,745	4,682
Percentage Paid Within Target	**92.84%**	**96.53%**	**92.22%**	**93.52%**	**99.29%**	**94.86%**	**93.89%**
Non NHS Creditors							
No.of Bills Paid Within Target	6,363	6,405	6,280	8,057	6,359	33,464	19,048
No.of Bills Paid Within Period	6,897	6,649	6,435	8,418	7,232	35,631	19,981
Percentage Paid Within Target	**92.26%**	**96.33%**	**97.59%**	**95.71%**	**87.93%**	**93.92%**	**95.33%**
Value of Bills Paid Within Target (£000's)	7,759	8,607	7,382	8,796	7,545	40,090	23,749
Value of Bills Paid Within Period (£000's)	8,214	8,667	7,575	9,058	7,975	41,489	24,456
Percentage Paid Within Target	**94.46%**	**99.31%**	**97.46%**	**97.10%**	**94.62%**	**96.63%**	**97.11%**
Total							
No.of Bills Paid Within Target	6,528	6,575	6,418	8,234	6,528	34,283	19,521
No.of Bills Paid Within Period	7,097	6,829	6,594	8,606	7,409	36,535	20,520
Percentage Paid Within Target	**91.98%**	**96.28%**	**97.33%**	**95.68%**	**88.11%**	**93.84%**	**95.13%**
Value of Bills Paid Within Target (£000's)	8,840	10,193	9,111	10,261	9,032	47,437	28,144
Value of Bills Paid Within Period (£000's)	9,378	10,310	9,449	10,625	9,472	49,234	29,137
Percentage Paid Within Target	**94.26%**	**98.87%**	**96.42%**	**96.58%**	**95.35%**	**96.35%**	**96.59%**

Receivables and Payables

- Continued focus on reducing age profile of non current debt.
- 220 accounts (£220k) have now been passed to CCI Legal Ltd to pursue.
- All monthly SLA's (Commissioners) fully paid on time August.
- Little movement in level of over 90 day debt, predominantly relates to agreement of 2013/14 invoice with Herts & South Midlands Area Team. Other significant balances relate to CRIPPS, NCA's and Overseas Patients debt of £0.7m.
- Predominantly all of registered creditors are now 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 deteriorated from last month to (93.84% by volume, 96.35% by value) with the payments team continuing to achieve processing within the targets once approved.

- The volume of temporary staffing invoices continues to be the main area of poor performance trust wide. 31% of all invoices paid late by value and 59% of by number (1.94% value & 3.36% number of all invoices paid). In August 70% by value and 83% by number of all invoices paid late related to the bank office. Work is ongoing with bank office to improve invoice processing.

8. Cashflow

MONTHLY CASHFLOW	Annual £000s	ACTUAL APR £000s	MAY £000s	JUN £000s	JUL £000s	AUG £000s	FORECAST SEP £000s	OCT £000s	NOV £000s	DEC £000s	JAN £000s	FEB £000s	MAR £000s
RECEIPTS													
SLA Base Payments	232,040	16,228	23,419	18,511	21,229	18,365	18,366	21,217	18,372	18,372	21,217	18,372	18,372
SLA Performance/ Other CCG Investment	-5,000	0	0	0	0	0	0	-2,000	-1,000	-1,000	-1,000	0	0
Health Education Payments (SIFT etc)	9,557	130	2,089	218	1,525	20	792	799	799	799	799	799	786
Other NHS Income	16,807	3,110	1,187	675	1,113	1,432	1,696	1,232	1,232	1,232	1,232	1,432	1,232
PP / Other (Specific > £250k)	1,416	264	0	348	418	385	0	0	0	0	0	0	0
PP / Other	12,134	953	941	973	768	800	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	0	45	40	40	0
PDC - Capital	7,655	0	0	0	0	0	0	1,265	4,381	230	359	0	1,420
PDC - Revenue	8,000	0	0	0	0	0	0	0	4,000	4,000	0	0	0
Temporary Borrowing	4,000	0	0	0	0	0	4,000	0	0	0	0	0	0
Interest Receivable	28	3	2	2	2	1	3	2	2	3	2	2	4
TOTAL RECEIPTS	286,762	20,689	27,638	20,727	25,055	21,003	25,957	23,615	28,887	24,782	23,749	21,746	22,915
PAYMENTS													
Salaries and wages	167,703	14,056	14,151	14,043	13,862	13,940	13,950	13,950	13,950	13,950	13,950	13,950	13,950
Trade Creditors	75,177	3,909	9,598	6,905	8,261	7,610	7,250	6,352	6,516	4,125	6,400	5,000	3,251
NHS Creditors	17,088	1,123	1,645	1,874	1,566	1,524	1,511	1,511	1,511	1,511	1,511	900	900
Capital Expenditure	21,408	1,749	1,231	667	828	370	1,057	2,129	2,839	5,204	1,912	1,920	1,503
PDC Dividend	4,468	0	0	0	0	0	2,223	0	0	0	0	0	2,245
Repayment of Loans	4,000	0	0	0	0	0	0	0	4,000	0	0	0	0
Repayment of Salix loan	301	0	0	0	0	0	177	0	0	0	0	0	124
TOTAL PAYMENTS	290,145	20,837	26,625	23,489	24,518	23,444	26,168	23,942	28,816	24,790	23,773	21,770	21,973
Actual month balance	-3,383	-148	1,014	-2,761	537	-2,441	-211	-327	70	-9	-24	-24	942
Cash in transit & Cash in hand adjustment	-62	48	-24	-7	-12	44	-111	0	0	0	0	0	0
Balance brought forward	4,445	4,445	4,345	5,335	2,567	3,092	695	373	45	116	107	83	59
Balance carried forward	1,000	4,345	5,335	2,567	3,092	695	373	45	116	107	83	59	1,000

Key Issues

- August cash balance reduced to £0.7m and the month end balance is now expected to be less than £0.5m to meet the criteria of the temporary borrowing facility agreed by DH.
- £3m of temporary borrowing was approved, with £3m received on 1st and a further £1m due on 22nd September.
- Temporary borrowing to be converted or extended dependent on progress in securing permanent borrowing through ITFF application.
- Any escalation in I&E deficit presents additional cashflow risk.
- Cashflow plan includes £5m reduction to SLA income relating to fines and under performance.
- Revised capital PDC loans of £7.2m included in forecast relating to the replacement Imaging equipment, application to Independent Trust Financing Facility (ITFF) has now been submitted with a decision anticipated in October.
- Capital expenditure profile includes the revised planned phasing of the replacement Imaging equipment.
- As a result of the impact of fines and underperformance, cash availability will impact creditor payments in December. This will have a significant impact on the BPPC performance, as payments are then likely to continue to be delayed to the end of the financial year.
- PDC dividend payment has been amended to reflect the notified collection value by DH in September.
- The EOY closing cash balance has been reduced to £1m to meet the criteria of the ITFF submission and may result in further cash flow issues in the first two weeks of the new financial year.

9. Conclusions and Recommendations

Conclusion:

The financial position for August continues to demonstrate that the current run rate will lead to a significant financial deficit unless remedial action is taken. The TDA now require the Trust to implement a formal Financial Recovery Plan aimed at delivering the planned £7.8m deficit. Current forecast projections indicate that reducing the current deficit to this level may not be achievable without significant additional non-recurrent income. The TDA are aware of the potential risk to the I&E position but require the Trust to maintain focus in delivering the £7.8m deficit plan and have not permitted the Trust to increase the forecast deficit at month 5.

The level of fines and challenges proposed by NENE CCG continue to be excessive with "blanket" challenges being proposed against the Trust for NEL activity although some progress is being made in relation to the negotiations to establish a local price for activity in the A&E Observation Area. Agreement of a local price would negate the associated MRET penalty for this cohort of activity (worth c. £2.6m of the MRET deduction for the year).

The most likely forecast position based on known assumptions is for a deficit in the range of £14.2- £17.7m, an increase of up to £9.9m above the planned I&E position submitted to the TDA in May. Key to delivery of this position is identification and delivery of the CIP plan which includes a significant number of high risk schemes due for delivery in the second half of the financial year. The forecast position includes a range of additional cost pressures in the second half of the financial year together with assumptions about the level of winter funding to be received to offset incremental costs.

Cashflow is now constrained with £0.5m of creditors being disallowed from scheduled payment runs in September. The Trust is waiting on advice from the TDA as to their onward submission of the loan application to the ITFF. The capital element of this loan application is required to support the purchase of imaging equipment and any delay in approval of funding presents a direct clinical risk given the aging profile of several key items of equipment which are now due for replacement.

Recommendations & actions

- Financial Recovery plan to be further developed and process embedded through performance reviews.
- Q1 contract reconciliation to be concluded and robust response to CCG challenges to income position required.
- Agreement of 100% reinvestment of excess MRET above plan to be secured with CCG and Urgent Care Board.
- Prepare for TDA external review of CIP plans including financial projections, project plans and milestones.
- Identification of mitigating actions to eliminate CIP risk and ensure CIP plan for the year can be achieved.
- 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 – work with TDA to secure successful application to ITFF to meet ongoing cashflow and capital expenditure plans.
- Increased controls over agency usage in Nursing and medical staffing required / increased recruitment.
- Review winter funding / resilience plan with CCG and Urgent Care Board.
- Consider recent developments in relation to urgent care tariffs and case for MRET rebasing in 15-16.

Appendix 1: Continuity of Service Risk Rating (CSR)

		M5 ACTUAL	M4 £000's	M3 £000's	M2 £000's	M1 £000's	EOY £000's
LIQUIDITY RATIO (DAYS)		**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Working Capital Balance							
Total - Current Assets	+	19,729	20,531	18,959	20,206	23,757	18,750
Total - Current Liabilities	+	-28,119	-26,300	-23,247	-22,837	-23,334	-19,485
Inventories	-	5,739	5,615	5,543	5,311	4,860	5,300
Non-Current Assets Held for Sale	-	0	0	0	0		
PFI Prepayments - Current Portion	+	0	0	0	0		
Financial Assets Available for Sale	+	0	0	0	0		
Current Assets held for Sale by Charitable Funds	+	0	0	0	0		
Current Liabilities held for Sale by Charitable Funds	+	0	0	0	0		
(1) Working Capital Balalnce		**-14,129**	**-11,384**	**-9,831**	**-7,942**	**-4,437**	**-6,035**
Annual Operating Expenses							
Gross Employee Benefits	+	-76,644	-61,185	-45,895	-30,521	-30,521	-179,314
Other Operating Costs	+	-40,287	-32,587	-23,964	-16,195	-16,195	-92,898
Impairments: IFRIC 12	+	0	0	0	0	0	0
Depreciation	+	4,708	3,740	2,780	2,045	2,045	11,764
Amortisation	+	0	0	0	0	0	0
Stock Write down	+	0	0	0	0	0	0
Impairment of Receivables	+					0	0
(2) Annual Operating Expenses	* -1	**112,223**	**90,032**	**67,078**	**44,672**	**44,672**	**260,448**
Liquidity Ratio Days		**-19**	**-15**	**-13**	**-11**	**-3**	**-8**
(A) LIQUIDITY SCORE		**1**	**1**	**2**	**2**	**3**	**2**
CAPITAL SERVICING CAPACITY							
Revenue Available for Debt Service		-4,110	-2,416	-2,028	-1,249	-938	7,908
Annual Debt Service		1,871	1,497	1,102	735	367	4,815
Capital Servicing Capacity (times)		**-2.2**	**-1.6**	**-1.8**	**-1.7**	**-2.6**	**1.6**
(B) CAPITAL SERVICING CAPACITY SCORE		**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**2.0**
CONTINUITY OF SERVICES RATING		**1.0**	**1.0**	**1.5**	**1.5**	**2.0**	**2.0**

Key issues

CSR

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

Current Score

- Overall score of 1
- Liquidity score of 1
- Debt capacity score of 1 due to in year deficit.

Forecast EOY

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

Monitor Guidance (extract)

Metric	Weight	Definition	Rating categories 1	2	3	4
Liquidity ratio (days)	50%	Working capital balance x 360 / Annual operating expenses	<-14	-14	-7	0
Capital servicing capacity (times)	50%	Revenue available for capital service / Annual debt service	<1.25x	1.25x	1.75x	2.5x

continuity of services risk rating

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**25 September 2014**

Title of the Report	**Improving Quality and Efficiency Report**
Agenda item	**12**
Sponsoring Director	Janine Brennan, Director of Workforce & Transformation
Author(s) of Report	Paul Devlin, Assistant Director IQE Natasha Parkhill, Management Accountant
Purpose	Update to the Committee on the Latest Thinking Financial forecast of the Improving Quality and Efficiency Programme
Executive summary The most likely delivery at M5 is £11.1m, which is up by £81k against month 4. This is off plan by £1.574m against the £12.668m plan prior to further mitigation. The plan required delivery of £3.128m in the first 5 months. Actual delivery is £3.785m, ahead of plan by £657k.	
Related strategic aim and corporate objective	Strategic Aim 5: To be a financially viable organisation.
Risk and assurance	Pace of delivery largely caused by inadequate rigor relating to project and programme management along with a lack of traction from the work stream groups remains a key risk to in year delivery against plan. Our strategy for dealing with this situation remains sound, largely relying on our new standard project management process across the CIP Theme initiatives. Cascading this at pace remains a priority in order to prevent further slippage and maximise delivery of red and amber rated schemes.
Related Board Assurance Framework entries	Link to the Board Assurance Framework
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	There are no legal/regulatory implications of the paper

Actions required by the Trust Board

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

Northampton General Hospital NHS Trust

Improving Quality & Efficiency Report for Trust Board

AUGUST 2014

Executive Summary

The most likely forecast for Month 5 August 2014

The most likely delivery at M5 is £11.1m, which is up by £81k against month 4. This is off plan by £1.574m against the £12.668m plan prior to further mitigation.

The plan required delivery of £3.128m in the first 5 months. Actual delivery is £3.785m, ahead of plan by £657k.

Priorities for August 2014 have included:

- Refining and rolling out the new project documentation across all CIP Themes
- IQE & work stream leads populating the new project documentation
- Project briefs being refreshed to ensure they are fit for purpose
- Master schedules and project highlight reports being rolled out
- Savings strategies appearing as a feature in each project brief
- Developing an online presence for the IQE Team
- Further development of the IQE Theme dashboard
- Amend this report to show total Theme versus total Scheme performance

Priorities for September 2014 will include:

- Preparation for the TDA deep dive CIP visit
- Validate the Deloitte phase 1 clinical strategy assumptions
- Continue with the NGH led clinical strategy review process
- Continue to improve the quality of the new project documentation
- Further development of the Programme Management Office function
- Stock take the income generation CIP initiatives
- Continuing the weekly IQE Team meetings reviewing all master schedules
- Continuing the weekly IQE Team meeting with JB & SL to give assurance

Risks and Issues

Pace of delivery largely caused by inadequate rigor relating to project and programme management along with a lack of traction from the work stream groups remains a key risk to in year delivery against plan.

Our strategy for dealing with this situation remains sound, largely relying on our new standard project management process across the CIP Theme initiatives. Cascading this at pace remains a priority in order to prevent further slippage and maximise delivery of red and amber rated schemes.

Ensuring appropriate levels of engagement for undertaking changes required to net the benefits at Directorate level remains challenging given the operational pressures faced by the Trust and competing priorities. Ensuring strong facilitation from the IQE Team remains key to mitigating this issue.

Work on our mitigation plans continues to focus on validating local efficiencies within services and ensuring that clear plans are in place to deliver sighted benefits. We will continue to use this strategy to address the gap ensuring that the overall target of £12.668m will be delivered.

We will ensure full integration with the work associated with Directorate financial recovery plans in order to avoid double counting of savings coming from work undertaken outside of the IQE Programme.

2014/15 Plan in Overview

Efficiencies Summary Information	Plan £000s	% of Total	M4 Most Likely £000s	M5 Most Likely £000s	% of Total
Identified schemes	12,668	100%	11,014	↑ 11,094	88%
Shortfall	0	0%	1,654	↓ 1,574	12%
Total Efficiency	**12,668**	**100%**	**12,668**	**12,668**	**100%**
CIP delivery vs turnover	**4.9%**		**4.2%**	**4.3%**	

Identification of the Transformation Programme 2014/15
The table outlines the current most likely delivery compared to the plan. The current forecast of £11.094m if delivered in full would be a 4.3% CIP.

This leaves a shortfall of £1.574m to be identified.

Efficiencies Summary Information	Total Efficiency £000s	Proportion of total %
Recurrent schemes	8,131	64%
Non-recurrent schemes	2,963	23%
Total needed to be identified	1,574	12%
Total Efficiency	**12,668**	**100%**

Efficiencies Summary Information	Total Efficiency £000s	Proportion of total %
Pay	5,157	41%
Non pay	2,410	19%
Income	3,527	28%
Total needed to be identified	1,574	12%
Total Efficiency	**12,668**	**100%**

Nearly £3m of schemes are non-recurrent. This poses a risk in 2015/16.

The Directorates will be tasked by IQEG to identify additional recurrent schemes to offset the non-recurrent position.

Efficiencies Summary Information	Total Efficiency £000s	Proportion of total %
CIP Schemes	6,700	53%
Run rate Schemes	4,394	35%
Total needed to be identified	1,574	12%
Total Efficiency	**12,668**	**100%**

Of the £11.094m forecast delivery, £6.7m is a budgetary CIP and £4.4m is a run rate reduction.

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

Most Likely Forecast 2014/15

Theme	Year to date			Full year 2014/15			Full year 2014/15 Most Likely			
	Plan	Actual	Variance	Plan	Most Likely	Variance	M3	M4	M5	MoM
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Workforce	100	228	128	339	436	97	344	391	436	45
Back Office	12	12	0	450	204	-246	174	204	204	0
Rightsizing the Organisation	35	71	36	85	170	85	170	170	170	0
Urgent Care	17	0	-17	25	10	-15	10	10	10	0
Medical Productivity	125	41	-84	1,089	409	-680	436	422	409	-13
Patient Pathways	65	83	18	940	440	-500	468	454	440	-14
Nursing & Midwifery Productivity	129	0	-129	1,001	396	-605	407	404	396	-8
Procurement	407	342	-65	1,249	789	-460	785	789	789	0
Directorate CIPs	1,963	2,902	939	5,669	7,521	1,852	6,811	7,451	7,521	70
2013/14 FYE	0	107	107	0	140	140	140	140	140	0
Sickness absence management system	0	0	0	438	117	-321	117	117	117	0
Medicines management	0	0	0	600	161	-439	161	161	161	0
Pharmacy outsourcing	0	0	0	100	27	-73	27	27	27	0
Diagnostic test rationalisation	0	0	0	20	5	-15	5	5	5	0
Non-elective flow average LOS	0	0	0	0	134	134	134	134	134	0
Repatriation of surgical procedures	0	0	0	0	67	67	67	67	67	0
Clinical Strategy review	0	0	0	0	67	67	67	67	67	0
Undefined Mitigation schemes to be planned	275	0	-275	663	0	-663	0	0	0	0
Total	**3,128**	**3,785**	**657**	**12,668**	**11,094**	**-1,574**	**10,323**	**11,013**	**11,094**	**81**

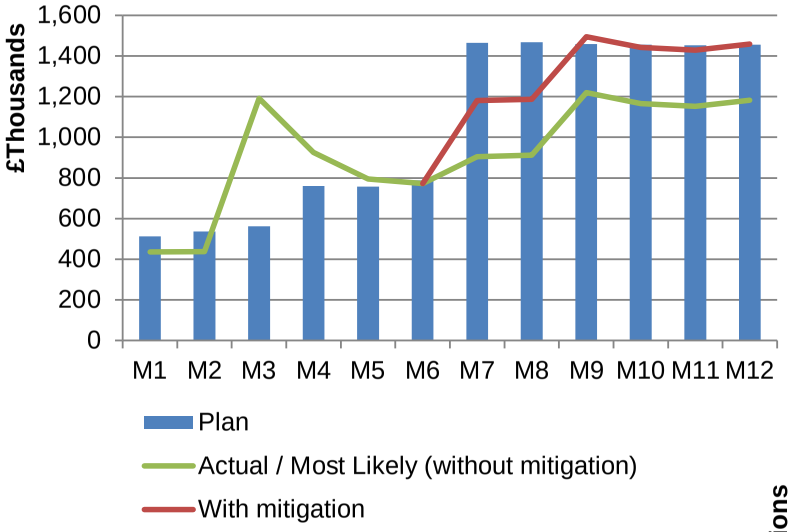
The most likely case of current Themes has been assessed based on 40% of the red rated schemes being achieved, 75% of the amber rated schemes deliver and 100% of the green rated schemes deliver the identified financial benefit.

Mitigations to close the gap include:

- Ensure that we convert the red and amber schemes into full delivery (£3.7m)
- Improvement of performance management processes at Directorate level.
- Improvement of central governance processes through a fully functioning Programme Management Office.
- Following completion of Clinical Strategy Consultancy, implement any 'quick wins' and include in 2014/15 programme.
- Implement quick wins as well as ongoing opportunities from the Making Quality Count Trust wide Service Improvement Programme.
- Maintain the expectation that CIP targets will be achieved by each Directorate & Service area.

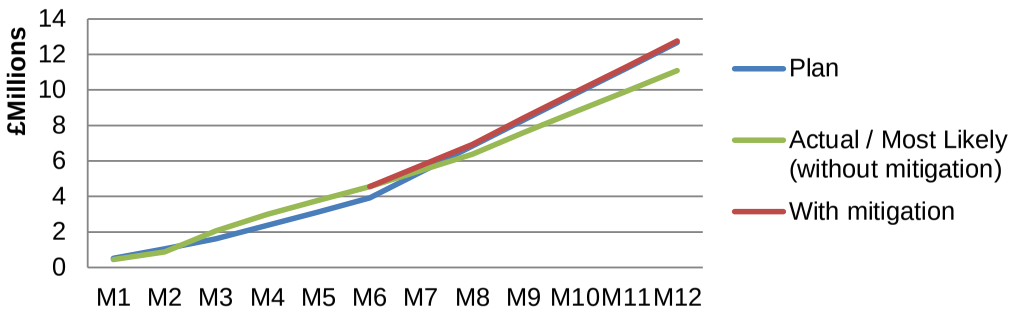
Delivery and Plan by month

Overall Performance | **On trajectory**



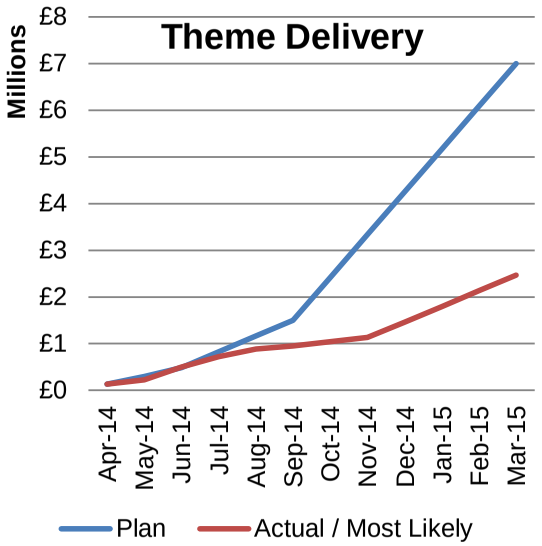
Actual delivery in month 5 was £795k against planned delivery of £757k. This is primarily due to directorate CIPs delivering ahead of plan.
This is down on month 4's delivery.

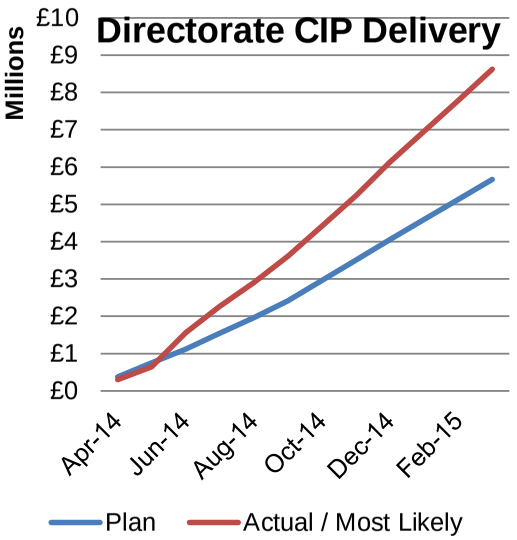
The monthly plan increases significantly from M7 onwards. Development of additional schemes will mitigate the risk of falling off trajectory going forward.



The cumulative delivery of schemes is £657k ahead of plan at month 5. The plan requires savings to accelerate from month 7 onwards.

The graphs below break this down by Theme delivery and Directorate CIP delivery. The Themes are significantly behind plan. This is offset by over-delivery of the Directorate CIPs.





Risk Delivery Profile

Risk Adjusted RAG Status	Most Likely without mitigation £'000s	% of Total target	Most Likely with mitigation £'000s	Worst Case £'000s
Green	7,129	56%	7,129	7,129
Amber	1,914	15%	2,551	1,914
Red	2,052	16%	2,988	0
Total	**11,094**	**88%**	**12,668**	**9,042**
Gap	1,574	12%	0	3,626

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.

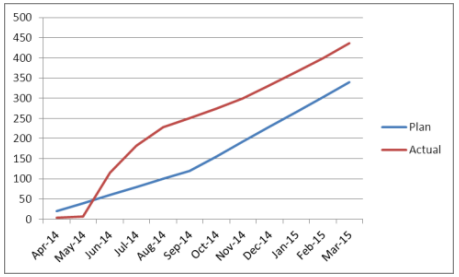
The downside assessment of current schemes has been assessed based on none of the red rated schemes are achieved, 75% of the amber rated schemes deliver and 100% of the green rated schemes deliver the identified financial benefit.

The downside case based on current RAG rating would see the programme realise £9.042m.

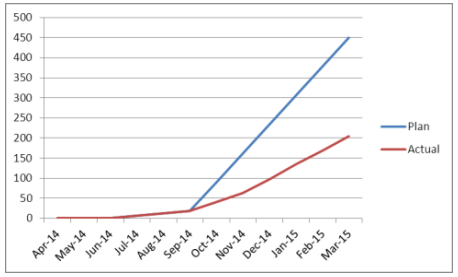
If all schemes fully deliver, with the mitigations, the full £12.668m can be delivered.

	FY14/15 LTF £'000				
	R	A	G	Total Identified	Risk Adjusted 40/75/100
A1: Site Bed Team	-	-	-	-	-
A2: Surgery	-	-	514	514	514
A3: Anaesthetics	-	-	1,034	1,034	1,034
A4: T&O	-	75	96	171	153
A5: Head & Neck	-	39	39	78	68
A6: Child Health	-	283	622	905	834
A7: Obs & Gynae	548	38	91	677	339
A8: Opthalmology	75	174	104	353	264
A9: Surgical Care Management	-	-	48	48	48
SCG sub total	**623**	**610**	**2,548**	**3,780**	**3,254**
B1: General Medicine	150	181	1,249	1,580	1,445
B2: Pathology	-	337	340	678	593
B3: Oncology	64	39	263	366	318
B4: Radiology	16	207	217	439	378
B5: Research & development	-	-	10	10	10
B6: Pharmacy	26	14	168	208	189
B7: Therapies	48	46	112	206	166
B8: Medical Care Management	-	-	-	-	-
MCG sub total	**304**	**823**	**2,360**	**3,487**	**3,099**
C1-C7 Corporate Areas	-	66	318	383	367
C7: Facilities	-	700	276	976	801
Support sub total	**-**	**766**	**594**	**1,360**	**1,168**
Care Group & Corporate CIP Total (pre-risk adjustment)	**926**	**2,199**	**5,501**	**8,627**	**7,521**
Workforce	147	-	377	524	436
Back Office	300	-	84	384	204
Rightsizing the Organisation	-	-	170	170	170
Urgent Care	25	-	-	25	10
Medical Productivity	834	-	76	909	409
Patient Pathways	270	333	83	686	440
Nursing Productivity	955	19	-	974	396
Procurement	226	-	699	925	789
FYE of 13/14 schemes	-	-	140	140	140
Sickness absence management system	293	-	-	293	117
Medicines management	402	-	-	402	161
Pharmacy outsourcing	67	-	-	67	27
Diagnostic test rationalisation	13	-	-	13	5
Non-elective flow average LOS	335	-	-	335	134
Repatriation of surgical procedures	168	-	-	168	67
Clinical Strategy review	168	-	-	168	67
CIP Themes Total (pre-risk adjustment)	**4,203**	**352**	**1,628**	**6,183**	**3,573**
Total (pre-risk adjustment)	**5,129**	**2,551**	**7,129**	**14,809**	
Gap (mitigating actions required)					**1,574**
Total with risk adjustment & mitigation					**12,668**

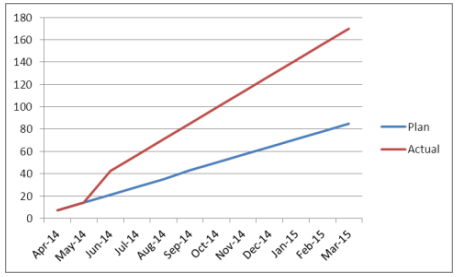
Theme Savings Performance



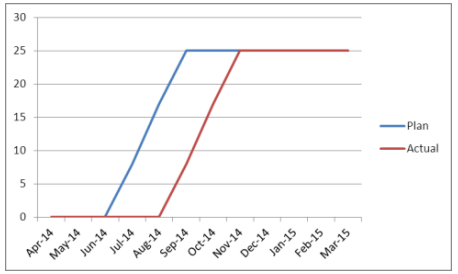
Workforce is ahead of plan by £128k after 5 months due to admin bank & agency costs coming down year on year ahead of plan.



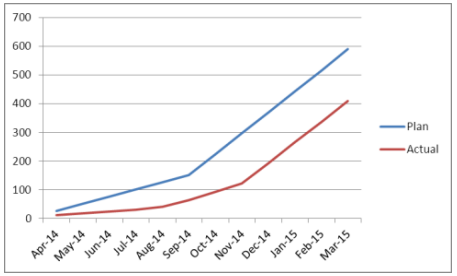
Back Office savings are due to start in the second half of the year. It is not expecting to fully deliver to plan.



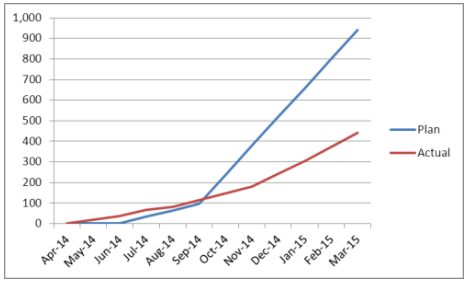
Rightsizing the Organisation are over achieving YTD and will exceed the full year target.



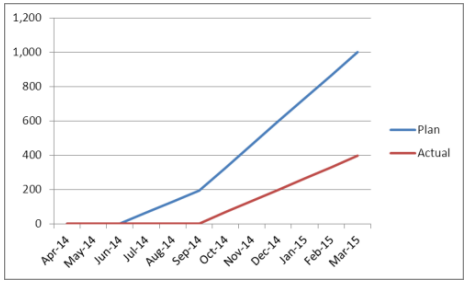
Urgent Care savings have been delayed by a couple of months but are expecting to deliver.



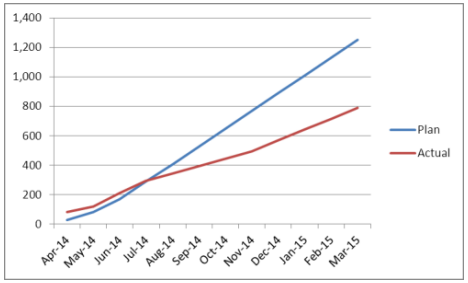
Medical Productivity is off plan by £84k after 5 months and forecasting £180k off plan full year due to phasing of job planning, medical recruitment and the locum managed service initiatives.



Patient Pathways are ahead of plan by £18k after 5 months due to savings starting earlier than expected. It is forecast to be £500k off the annual plan, this is due to the removal of the expected PA efficiencies.



Nursing & Midwifery Productivity are behind plan by £605k . This is due to the savings being revised down due to risk.



Procurement are behind plan by £460k. This is due to a stretched target.

The Improving Quality & Efficiency Themes are currently projecting a shortfall of £2.3m against the required plan of £5.2m.

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**25 September 2014**

Title of the Report	**Workforce Report**
Agenda item	**13**
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 decrease in Total Workforce Capacity (excluding Medical Locums) employed by the Trust, and a decrease in annual average sickness absence
- An update on Mandatory and Role Specific Essential Training, and Appraisals
- An update on Organisational Development activity
- An update on ratification of the Probationary Period Policy

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

Actions required by the Trust Board

The Board is asked to note the report

Northampton General Hospital NHS
NHS Trust

Public Trust Board
25 September 2014

Workforce Report

1. Introduction

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

It also sets out current key workforce updates.

2. Workforce Report

2.1 Key Workforce Performance Indicators

The key performance indicators show:

Sickness Absence
There were technical issues affecting the accuracy of some ESR Sickness Reports, which meant that different methods were used to calculate some figures. These figures may be updated at a future date. The financial year to date rate for sickness absence decreased further to 4.08%, and the annual rolling average fell slightly to 4.32%. In month sickness absence decreased by 0.22% to 3.99% which is above the Trust target.

The non-medical sickness absence rate for the General Surgery Care Group increased to 4.80%. There were improvements in the Surgical Care Management, Trauma & Orthopaedics, and ENT & Maxillofacial Directorates.

The non-medical sickness absence rate for the General Medicine Care Group decreased to 4.59%, and there was improvement in the rates for Pharmacy and Oncology & Haematology.

The sickness absence rate within Facilities decreased in August to 3.85%. Hospital Support also saw an improvement to 3.37%. This meant that the rate for Support Services in total moved below Trust target, to 3.58%.

Medical & Dental staff sickness absence in August was recorded at 0.21%.

Workforce Capacity
Total Workforce Capacity (including temporary staff but excluding Medical Locums) decreased by 76.51 FTE in July to 4,387.91 FTE. The Trust remains below the Budgeted Workforce Establishment of 4,566.65 FTE.

Substantive workforce capacity decreased by 20.81 FTE to 4,075.97 FTE. Temporary workforce capacity (excluding Medical Locums) decreased by 55.70 FTE to 311.94 FTE.

2.2 Workforce Updates

Appraisals
The current rate of completed PDP's or Appraisals recorded is 72.69%; continuing the improvement seen since March.

Mandatory and Role Specific Essential Training
Mandatory Training compliance fell back slightly to 78.20% in July. On-going support is being provided for managers on analysing and interpreting training reports to ensure that they are able to take appropriate action.

RSET compliance also fell back slightly to 62.31%; this is most likely to be due to the scoping project for the Role Specific Essential Training which has identified that some staff that were not required to do the training are now required to and some staff that were not required to do it may already be compliant but not accounted for in the reporting. The mass update of Role Specific Essential Training requirements is almost complete.

A meeting between the Trust and McKesson to review the ongoing data inconsistences between OLM and ESR took place in August and McKesson are continuing to investigate possible system errors, having agreed that correct process was being followed for data input.

2.3 Organisational Development
Staff Family & Friends Test
Quarter two results from the Medicine Care Directorate are now collated and comments being themed and responded to.

Question 1: How likely are you to recommend NGH to a friend or family for treatment?

Likely or extremely likely	74%
Neither likely nor unlikely	19%
Unlikely or extremely unlikely	7%

Question 2: How likely are you to recommend NGH to friends and family as a place to work?

Likely or extremely likely	62%
Neither likely nor unlikely	19%
Unlikely or extremely unlikely	17%
Don't know	2%

Based on the outcomes of the Quarter 2 SFFT return, the OD agenda will focus on:

- Roll out of phase 1 of the NGH Employee Engagement Strategy – to improve staff Interaction using the Rainbow Risk initiative
- Commence a NGH TNA in partnership with L & D
- Develop leadership and management support for operational front line roles.

Organisational Development pages are now live on the intranet. Please see attached appendix for more details on the latest Organisational Development activity.

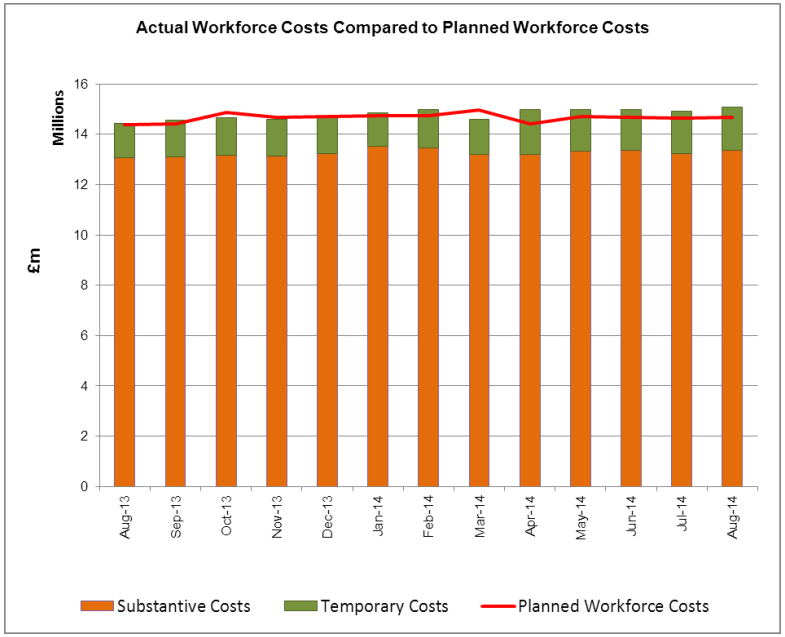
Policy Changes
The Trust Probationary Period Policy has been ratified and uploaded to the intranet.

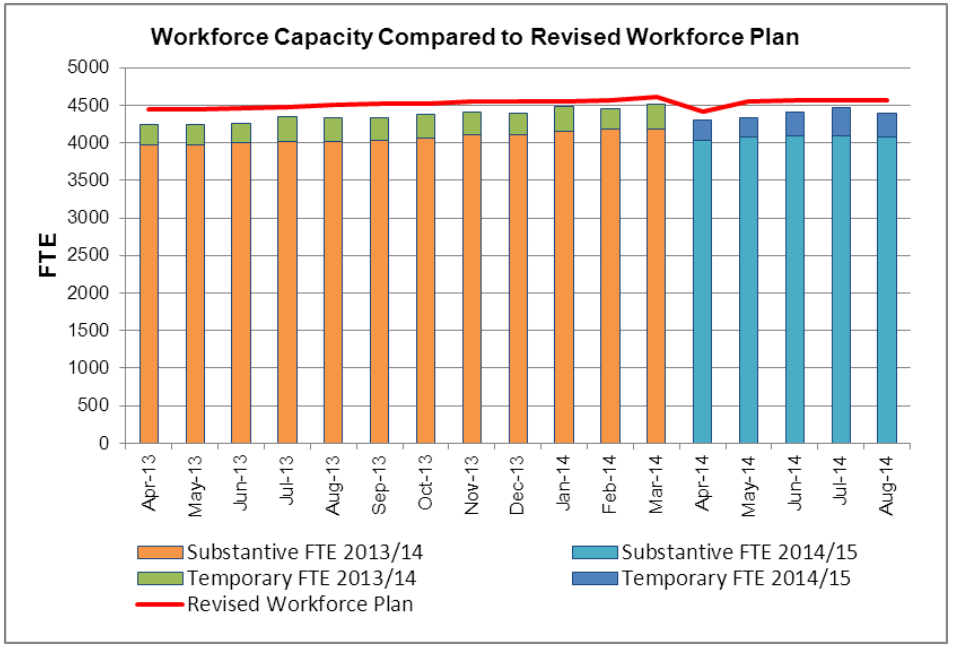
3. Assessment of Risk
Managing workforce risk is a key part of the Trust's risk assessment programme.

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

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

Human Resources Workforce Performance Indicators 2014/15 Month 05





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Substantive Costs 2013/14 (£1,000's)	12927	12979	13057	13056	13070	13111	13153	13148	13238	13521	13470	13193
Substantive Costs 2014/15 (£1,000's)	13197	13317	13353	13235	13349							
Temporary Costs 2013/14 (£1,000's)	1311	1370	1399	1444	1371	1443	1493	1460	1420	1325	1530	1387
Temporary Costs 2014/15 (£1,000's)	1774	1674	1646	1688	1740							
Planned Workforce Costs 2013/14 (£1,000's)	14296	14307	14341	14358	14400	14411	14876	14691	14710	14738	14752	14961
Planned Workforce Costs 2014/15 (£1,000's)	14422	14702	14669	14630	14681							

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Substantive FTE 2013/14	3,976	3,977	4,000	4,016	4,013	4,035	4,059	4,108	4,110	4,149	4,179	4,185
Substantive FTE 2014/15	4,040	4,080	4,090	4,097	4,076							
Temporary FTE 2013/14	266	263	260	329	329	305	316	303	291	334	269	324
Temporary FTE 2014/15	267	250	324	368	312							
Revised Workforce Plan 2013/14	4,452	4,450	4,462	4,476	4,502	4,522	4,522	4,553	4,555	4,558	4,564	4,619
Revised Workforce Plan 2014/15	4,420	4,551	4,561	4,564	4,567							

Workforce Expenditure

Total Workforce Expenditure (all pay elements) increased by £166,458 in August to £15.089m (this is above plan for Month 5).

Substantive workforce expenditure increased by £114,226 to £13,349,213.

Temporary Workforce Expenditure (including Medical Staff) increased by £52,232 to £1,740,043, equating to 11.53% of the total workforce expenditure.

Workforce Capacity

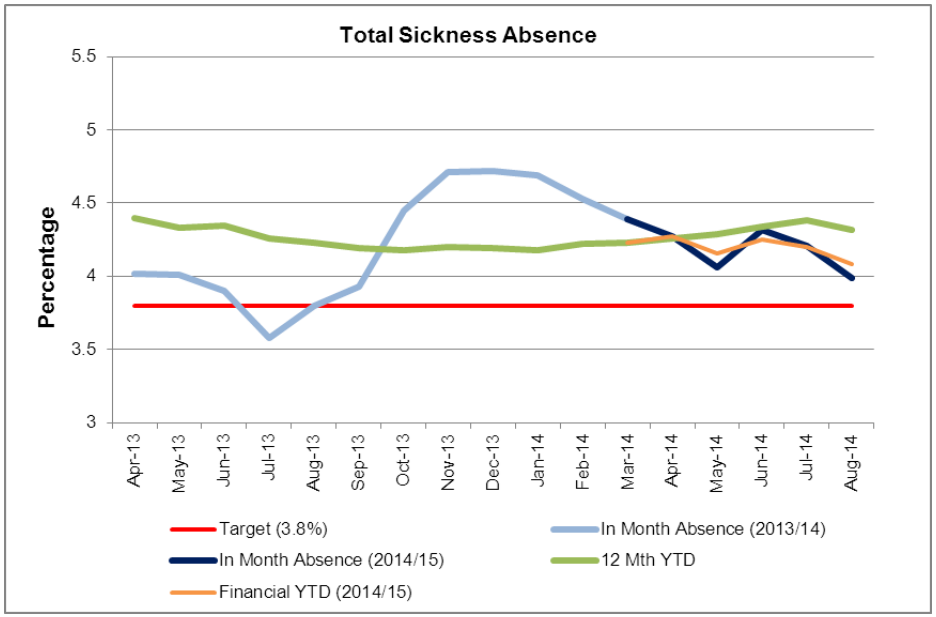
Total Workforce Capacity (including temporary staff but excluding Medical Locums) **decreased by 76.51 FTE in August to 4,387.91 FTE. The Trust remains below the Budgeted Workforce Establishment of 4,566.65 FTE.**

Substantive workforce capacity decreased by 20.81 FTE to 4,075.97 FTE.

Temporary workforce capacity (excluding Medical Locums) **decreased by 55.70 FTE to 311.94 FTE.**

Human Resources Workforce Performance Indicators 2014/15 Month 05

	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%	89.26%	87.91%	92.65%	84.31%
Temporary Workforce Capacity (excluding Medical Staffing)	Over 5% 4.5 -5% Under 4.5%	5%	7.11%	10.30%	5.48%	**2.55%**
Total Substantive Workforce plus Temporary Workforce against Budgeted Establishment (% FTE) (excluding Medical Staffing)	Under 95% Over 97% 95 -97% Over 100%	100%	**96.09%**	**98.00%**	98.02%	86.52%
% Staff Turnover (excluding internal transfers)	Under 8% Over 8%	8%	9.44%	10.67%	**7.96%**	10.12%



Trust Target 3.8%	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
In Month Absence (2013/14)	4.02	4.01	3.90	3.58	3.80	3.93	4.45	4.71	4.72	4.69	4.53	4.39
In Month Absence (2014/15)	4.27	4.06	4.32	4.21	3.99							
12 Month YTD (2013/14)	4.40	4.33	4.35	4.26	4.23	4.19	4.18	4.20	4.19	4.18	4.22	4.23
12 Month YTD (2014/15)	4.26	4.29	4.34	4.38	4.32							
Financial YTD (2014/15)	4.27	4.16	4.25	4.20	4.08							

Workforce Capacity

- In summary for Nursing, the total utilisation (Bank & Agency Filled) was 35,177 hours (203.92 FTE), which is a decrease of 200 hours compared with the previous month.
- Bank & Agency Fill Rates for Nursing: Bank fill rate = 38.86% (decrease of 3.65%), Agency fill rate = 30.16% (decrease of 3.91%). Total bank & agency fill rate = 69.01% (decrease of 6.58% compared with the previous month).

Sickness Absence

There were technical issues affecting the accuracy of some ESR Sickness Reports, which meant that different methods were used to calculate some figures. These figures may be updated at a future date. **The financial year to date rate for sickness absence decreased further to 4.08%, and the annual rolling average fell slightly to 4.32%. In month Sickness Absence decreased by 0.22% to 3.99% which is above the Trust target.**

- Short term sickness absence decreased to 2.34%.
- Long term sickness absence fell to 1.65% which remains below Trust Target.
- The total calendar days lost to sickness absence decreased by 358 to 5995 days lost.
- The number of days lost per employee decreased to 1.27 days.

Human Resources Workforce Performance Indicators 2014/15 Month 05

Surgery Care Group												
Directorate												
	Threshold	Target	Anaesthetics, Critical Care & Theatres	Surgery	Site Bed Team	Surgical Care Management	Trauma & Orthopaedics	Ophthalmology	ENT & Maxillofacial		Women	Children
Short Term Sickness Absence		1.60%	2.99%	4.01%	4.50%	1.85%	2.93%	4.98%	1.32%		2.99%	2.36%
Long Term Sickness Absence		2.20%	2.60%	0.88%	3.14%	0.00%	0.75%	3.34%	0.00%		2.41%	1.20%
Total Sickness Absence	Over 4.2%	3.80%	5.59%	4.89%	7.64%	1.85%	3.68%	8.32%	1.32%		5.40%	3.56%
	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 4.80%. There were improvements in Surgical Care Management, Trauma & Orthopaedics, and ENT & Maxillofacial Directorates.
- The highest ward based sickness was on Singlehurst Ward with 10.64%, with long term absence of 5.11% and short term absence of 5.53%. The highest increase in total sickness was on Willow Ward, moving from 5.14% in July to 10.20% in August.

Medicine Care Group										
Directorate										
	Threshold	Target	Pharmacy	Pathology	Radiology	Therapies		Oncology & Clinical Haematology	Medical Care Management	General Medicine & Emergency
Short Term Sickness Absence		1.60%	0.76%	1.86%	1.98%	1.07%		2.52%	0.00%	2.99%
Long Term Sickness Absence		2.20%	0.00%	2.40%	1.48%	2.35%		2.04%	0.00%	2.42%
Total Sickness Absence	Over 4.2%	3.80%	0.76%	4.26%	3.46%	3.42%		4.56%	0.00%	5.41%
	3.9-4.2%									
	Under 3.8%									

Medicine Care Group Summary

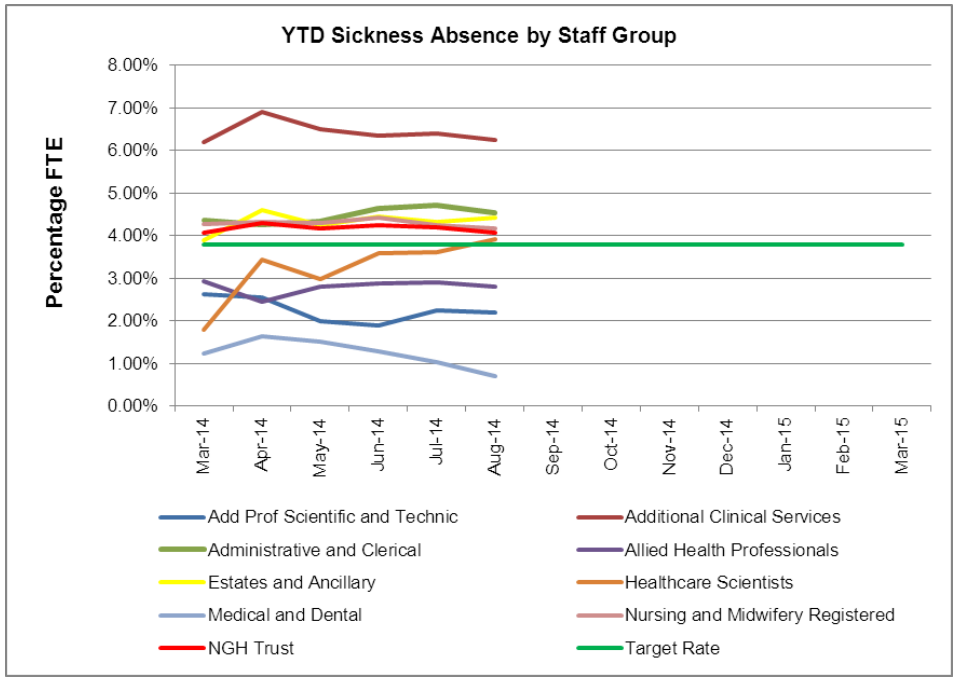
- The non-medical sickness absence rate for the General Medicine Care Group decreased to 4.59%, and there was improvement in the rates for Pharmacy and Oncology & Haematology.
- Compton Ward (sickness rate 14.40%) remains the ward with the highest sickness rate, although the rate has fallen from 16.42% in July; long-term sickness here sits at 12.11%. A big fall in long term sickness on Talbot Butler (from 9.91% to 4.84%) has seen total sickness fall from 11.24% to 8%. Both Knightley & Collingtree Wards have a sickness rate higher than 10%.

Support Services					M&D
Directorate					
	Threshold	Target	Facilities	Hospital Support	Medical & Dental
Short Term Sickness Absence		1.60%	2.59%	1.59%	0.01%
Long Term Sickness Absence		2.20%	1.26%	1.78%	0.21%
Total Sickness Absence	Over 4.2%	3.80%	3.85%	3.37%	0.22%
	3.9-4.2%				
	Under 3.8%				

Hospital Support and Medical & Dental Summary

- The sickness absence rate within Facilities decreased in August to 3.85%. Hospital Support also saw an improvement to 3.37%. This meant that the rate for Support Services in total moved below Trust target, to 3.58%.
- Medical & Dental staff sickness absence in August was recorded at 0.21%.

Human Resources Workforce Performance Indicators 2014/15 Month 05



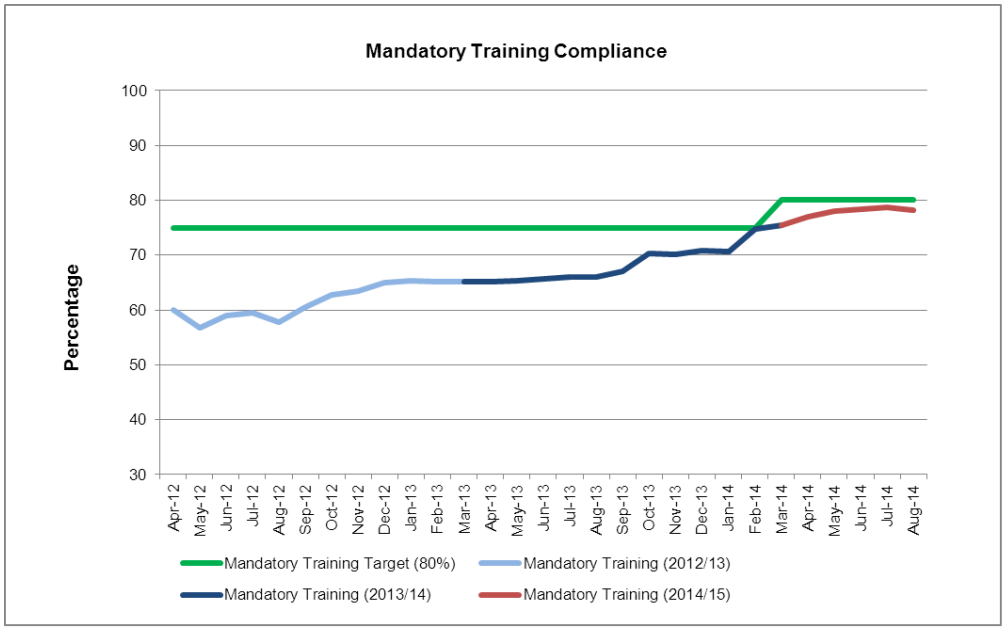
	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Add Prof Scientific and Technic	2.63%	2.56%	1.98%	1.90%	2.23%	2.19%							
Additional Clinical Services	6.20%	6.90%	6.50%	6.36%	6.41%	6.25%							
Administrative and Clerical	4.36%	4.27%	4.34%	4.64%	4.72%	4.55%							
Allied Health Professionals	2.94%	2.45%	2.81%	2.87%	2.90%	2.80%							
Estates and Ancillary	3.88%	4.61%	4.24%	4.44%	4.33%	4.43%							
Healthcare Scientists	1.79%	3.44%	2.99%	3.58%	3.61%	3.91%							
Medical and Dental	1.23%	1.64%	1.50%	1.28%	1.03%	0.70%							
Nursing and Midwifery Registered	4.26%	4.31%	4.30%	4.43%	4.26%	4.18%							
NGH Trust	4.06%	4.29%	4.16%	4.25%	4.20%	4.08%							
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%

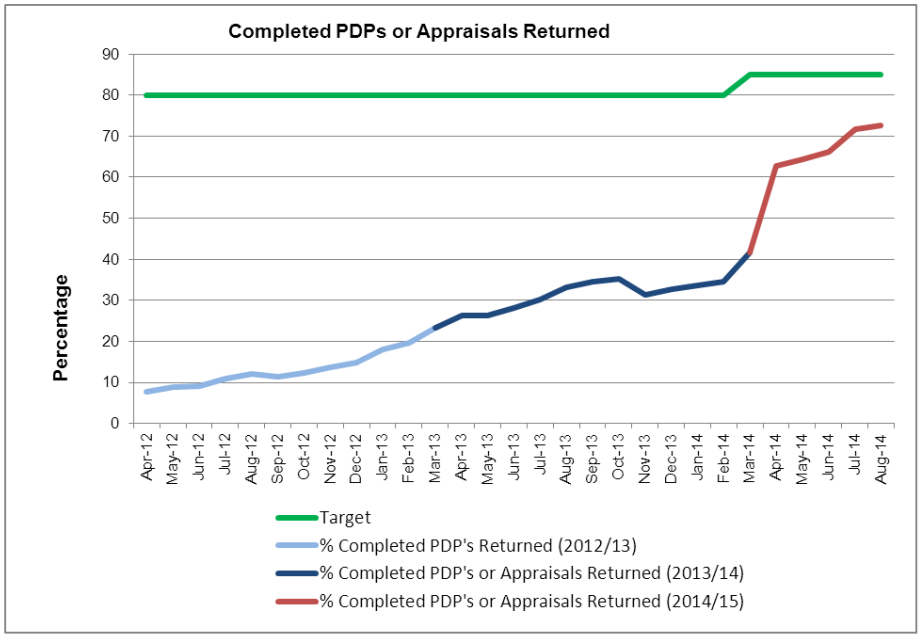
	Threshold	Trust Target	Trust Actual	Medicine	Surgery	Support Services
Sickness Absence Rate (%) - in Month	Over 4.2% 3.9-4.2% Under 3.8%	3.80%	3.99%	4.07%	4.01%	3.70%
No. of completed PDP's returned & completed Appraisals	Under 75% 75 - 79% 80% & over	80% by Oct-14	72.69%	73.99%	71.56%	72.31%
% Statutory & Mandatory Training Compliance	Under 75% 75 - 79% 80% & over	80% by Oct-14	78.20%	78.33%	76.74%	82.03%
% Role Specific Training Compliance	Under 75% 75 - 79% 80% & over	80% by Oct-14	62.31%	62.93%	61.31%	67.85%

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

- The current rate of completed PDP's or Appraisals recorded in ESR is 72.69%, continuing the improvement seen since March.
- Mandatory Training compliance has fallen slightly to 78.20%.
- RSET compliance fell slightly to 62.31%. The initial work to scope RSET requirements and load them into ESR is almost complete. Further validation will take place and then a more accurate picture of the compliance rates will be possible.

Human Resources Workforce Performance Indicators 2014/15 Month 05





Mandatory Training Target 80%	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Mandatory Training (2012/13)	60.09	56.68	59.03	59.42	57.71	60.59	62.68	63.47	64.93	65.31	65.2	65.2
Mandatory Training (2013/14)	65.14	65.4	65.75	65.93	66.09	66.97	70.23	70.20	70.84	N/A	74.68	75.51
Mandatory Training (2014/15)	76.91	78.06	78.42	78.65	78.2							

Completed and Returned PDP Target 85%	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% Completed PDP's Returned (2012/13)	7.83	8.95	9.02	10.93	11.98	11.35	12.24	13.72	14.89	18.07	19.65	23.35
% Completed PDP's Returned (2013/14)	26.28	26.22	28.04	30.12	33.06	34.62	35.17	31.27	32.76	33.58	34.52	41.71
% Completed PDP's Returned (2014/15)	62.81	64.30	66.09	71.75	72.69							

Role-Specific Essential Training

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

Appendix 2

Organisational Development Update

Staff Family & Friends Test

Quarter two results from the Medicine Care Directorate are now collated and comments being themed and responded to

Question 1 – How likely are you to recommend NGH to a friend or family for treatment?

Likely or extremely likely 74%
Neither likely nor unlikely 19%
Unlikely or extremely unlikely 7%

Question 2 How likely are you to recommend NGH to friends and family as a place to work?

Likely or extremely likely 62%
Neither likely nor unlikely 19%
Unlikely or extremely unlikely 17%
Don't know 2%

Based on the outcomes of the Quarter 2 SFFT return, the OD agenda will focus on:

- Roll out of phase 1 of the NGH Employee Engagement Strategy – to improve staff *Interaction* using the *Rainbow Risk* initiative
- Commence a NGH TNA in partnership with L & D
- Develop leadership and management support for operational front line roles.

Activity

Rainbow Risk

Almost 300 staff now completed rainbow risk
10 team sessions booked over next 8 weeks covering approx. 80 people
2 open sessions facilitating possible attendance of up to 50

Top tips for tough talks (handing difficult conversations)

Delivered as part of Band 7 Back to Basics programme to 45 delegates
3 sessions booked for band 6 development

MQC Programme:

45 delegates from programme completed the following modules

- Stakeholder Analysis
- Influence model
- The rainbow risk
- Leading for change
- Introduction to innovation
- Managing emotional impact of change
- Reflecting on practice

Intranet pages

Organisational Development pages now live on intranet. Sections include

- Contact details/about us
- Case studies (live by 15 September)
- Toolkit (live by 11 September)
- Engagement strategy
- Managing for quality opportunities
- Leading for excellence opportunities
- Booking system

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**25 September 2014**

Title of the Report	**Security Management Review 2013/14**
Agenda item	**14**
Sponsoring Director	Charles Abolins, Director of Facilities and Capital Development
Author(s) of Report	Andy Watkins, Local Security Management Specialist (LSMS)
Purpose	Information and assurance

Executive summary

This report sets out the security activity within the Trust for the year 2013/14. The report highlights the reported incidents and trends as well as the improvements made during the year

Related strategic aim and corporate objective	Focus on quality and safety
Risk and assurance	The report highlights the increasing risk to staff of physical assaults from patients with challenging conditions
Related Board Assurance Framework entries	BAF – 5
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	• Police/court action against perpetrators of crime on the hospital site • Potential claims from staff as a result of physical assault

Enclosure K

Actions required by the Trust Board

The Board is asked to note the content of the report, the progress made during the year and support the initiatives proposed for 2014/15.

Public Trust Board
25 September 2014

Security Management Review 2013-2014

1. Executive Summary

The report shows that criminal activity, physical assaults, verbal abuse and disturbances are a daily occurrence. In total there were **442** reported incidents either to security or reported through the Trusts Datix reporting system. This is an increase of **23%** on last year's reported figure of **355**.

There were **18** confirmed reported crimes/thefts: This is a reduction on previous years.

Reported physical assaults via Datix have significantly increased to **206** compared with last year's figure of **134**; this is an increase of **54%.** This is disappointing to report as last year's figure showed a **10%** reduction and had bucked the trend for the two previous years where physical assaults had increased. The type of incidents reported continue to be the same, increasing care of dementia patients, mental health patients and patients going through detox programmes. With the Datix Reporting System it is possible to analyse the data and identify trends and "hot spot wards" that are affected.

Whilst caring for difficult and challenging patients the use of restraint is often a necessary practice. To support staff to perform proportionate restraint to a patient there is a policy available on the Intranet titled "Restrictive Physical Intervention for Adults" (RPI). Within the policy is a training needs analysis which identifies which staff group should attend a 1 day, two day and or four day course.

It was disappointing to note the very poor take up of training which is designed to equip staff to deal with these difficult situations and reduce injury to staff.

Reported verbal, abusive, aggressive and harassment incidents were higher than last year, increasing from **195** to **218**.

It should be noted that all incidents include Trust staff working at other sites that are managed by NGH.

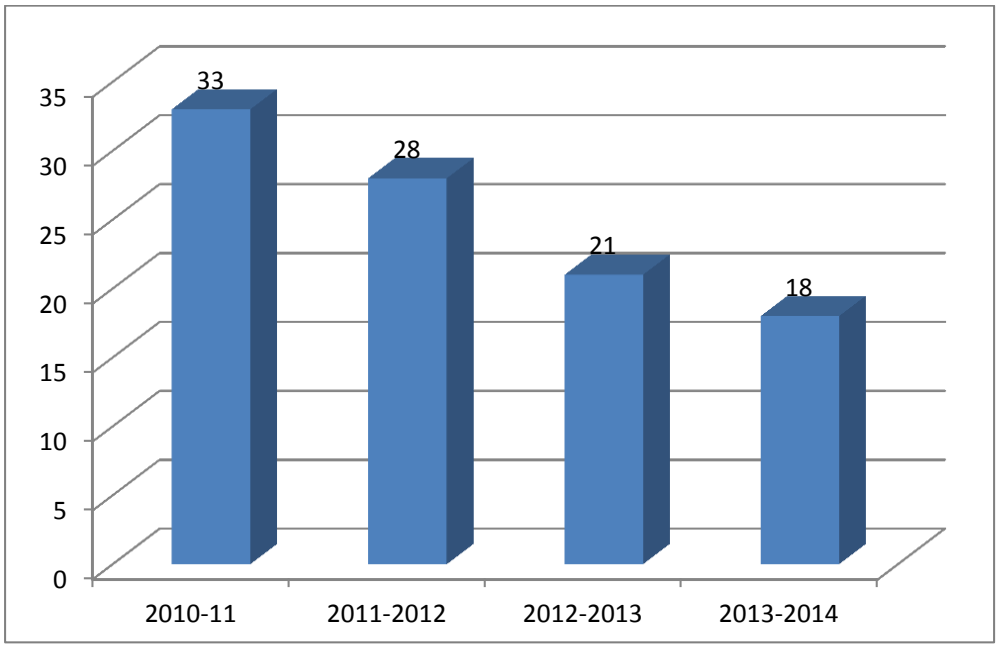
2. Introduction and Background

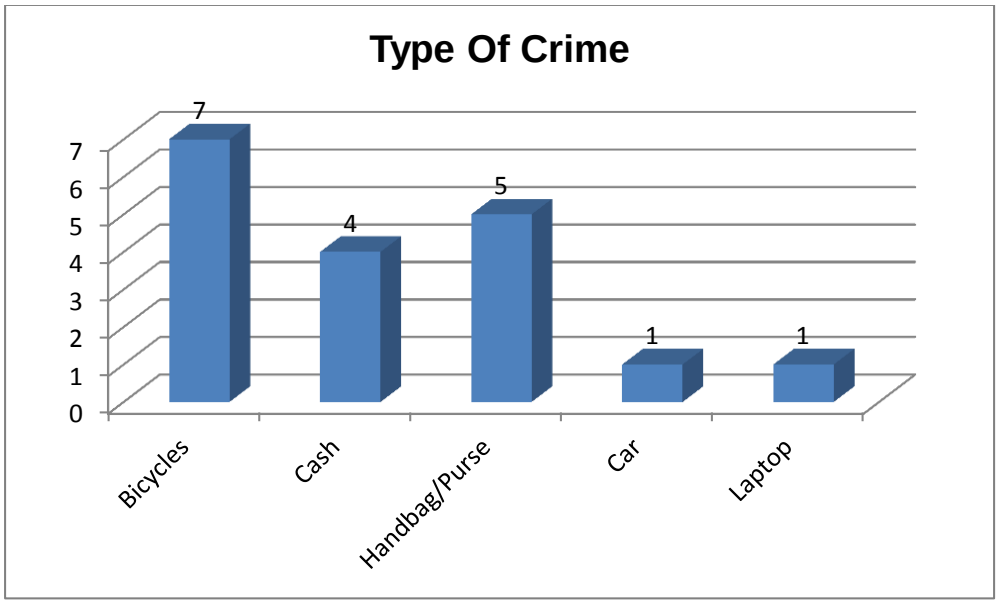
In December 2003 the Secretary of State launched the Security Management Strategy " A Professional Approach to the Management of Security in the NHS" This can be downloaded at www.nhsprotect.nhs.uk

The Facilities Directorate provides an in-house Security team which consists of 10 officers. The Security Department provides services 24/7.

The Security Department manage the Trusts CCTV system of which there are now 107 cameras located within the hospital buildings, grounds and all major car parks. A regular replacement and maintenance programme is in place.

2.1 Reported Crime Incidents 13/14 and Comparative Data





2.2 Data Summary Breakdown

- **18** reported crimes, for the fifth year a decline in reported crime. Crime included the theft of a motor vehicle from Isebrooke Hospital. Through CCTV an individual was seen on site on the day of the theft and images were passed onto the police. The police identified the individual and he was later arrested. The car was recovered.

- **7** bicycle thefts remain the top reported crime on site, an increase of 1 compared with last year's figure of **6**. There was 2 attempted bicycle thefts, one response from security resulted in 2 individuals being caught and handed over to the police. Bicycle thefts remain an ongoing problem around the town. Additional secure bicycle lockers have been purchased for staff use.

- In December 2013 the BBC programme "Fake Britain" visited NGH, interviewed and filmed the hospitals Security Advisor, Portering and Security Manager and a staff victim who was a victim of credit card fraud from the previous year of 2012/13. The episode was aired on May 6th 2014 and

reported how staff at NGH were able to provide good evidence through CCTV to identify the offender leading to their conviction and subsequent imprisonment. The images below are from CCTV and were used as evidence in court and shown on Fake Britain.

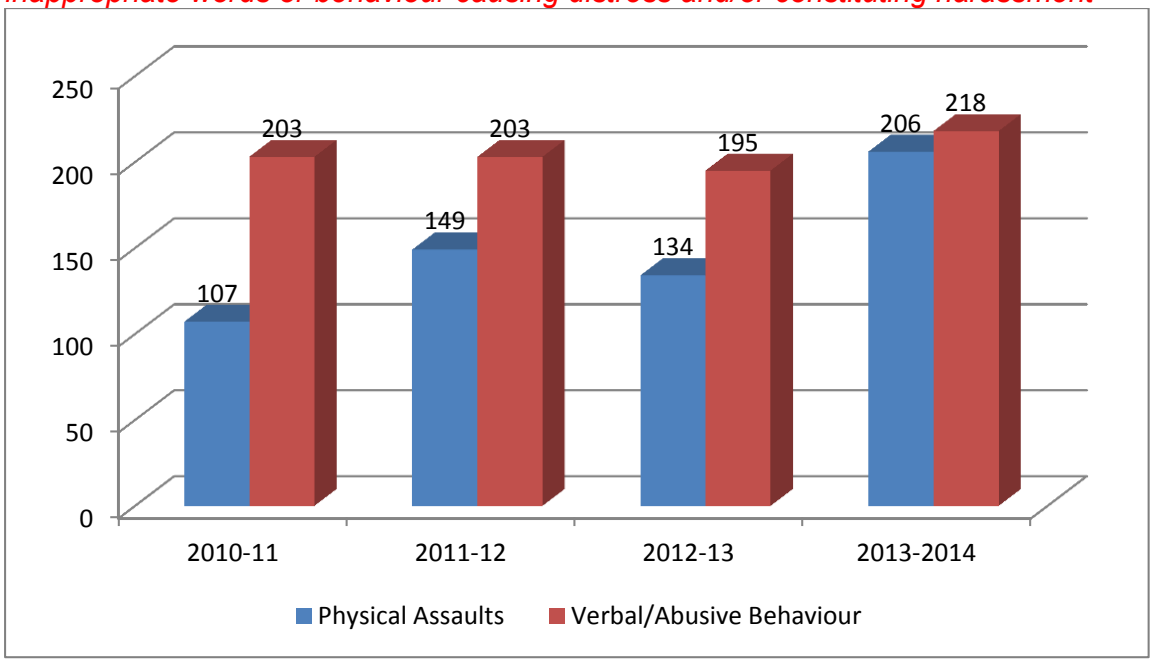
- **4** thefts of cash, one included a break-in to a parking meter. The machine was broken in to and the cash box removed. CCTV identified the break in taking place and CCTV was passed on to the police.

2.3 Physical, Verbal Abuse, Aggressive and Harassment Incident Data

This information is compiled from the Trusts Datix reporting systems

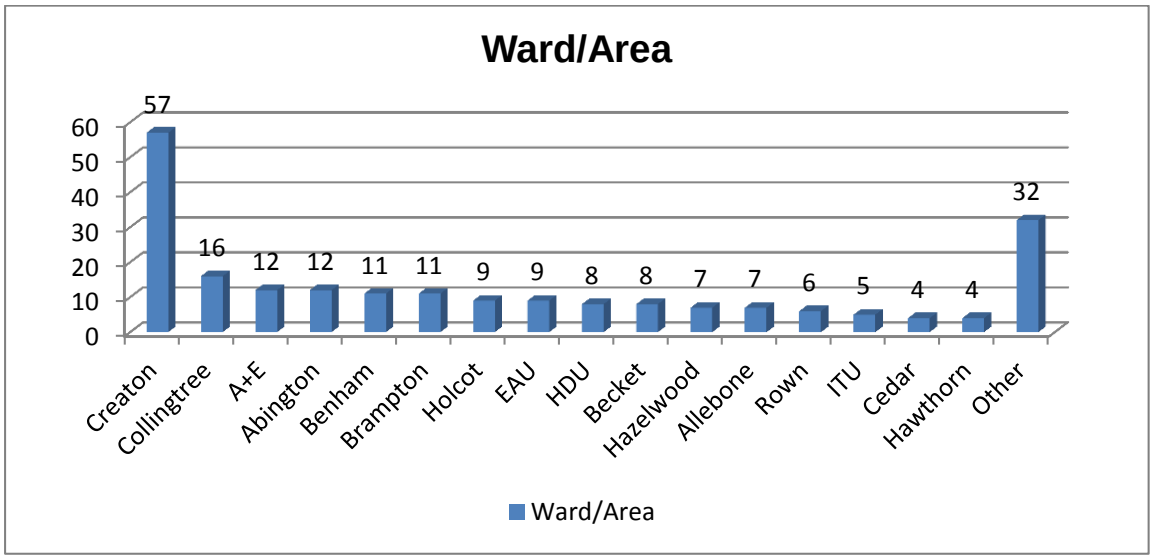
NHS PROTECT definition of physical assault: *"the intentional application of force against the person of another without lawful justification resulting in physical injury or personal discomfort"*

NHS PROTECT definition of verbal abuse, aggression and harassment: *"the use of inappropriate words or behaviour causing distress and/or constituting harassment"*



Enclosure K

2.4 Data Summary Breakdown



- There has been a **54%** increase in reported physical assault incidents during the past year. With the increasing care of dementia, mental health and detox patients, it is inevitable that physical assaults will continue to occur at regular intervals due to the patient's condition. It should be noted that the majority of physical assaults are low level types, where scratching, pinching and flailing arms and legs connecting to staff being the main descriptions used via Datix. Some examples from Datix reports are set out below:

  - *When attending to patient needs the patient grabbed hca hand twisting the thumb and kicking out at other members of staff.*
  - *Very unsettled and intermittent agitation/ aggression. Patient lashed out and kicked staff in the stomach while being assisted into bed.*
  - *patient high risk of falls with dementia trying to climb out of bed and becoming aggressive tried to stop patient from getting out of bed and patient lashed out punching member of staff in the jaw.*
  - *I was trying to stop a patient from throwing his drink when he scratched my face on the left side*
  - *I went to attend to the patient when she grabbed my hair and pulled it*

- The data shows that for the third year Creaton Ward has recorded the most physical assault incidents on staff **(57)** this accounts for **27%** of all recorded physical assaults. It should be noted that Creaton Ward was one of the few areas that sent a significant number of their staff on the one day "Breakaway" training course by staff.

- A+E recorded **12** incidents of physical assault. There was one confirmed arrest and a charge of drunk and disorderly. There were other arrests but difficult to comment on outcomes as when the police remove an offender from site they will either take them to a police cell to cool down or are taken home. More work needs to be done between the Police and NGH in closing the loop on outcomes.

2.5 Restrictive Physical Intervention for Adults Training
In support of the policy and to comply with the requirement to train staff at different levels in accordance with the Training Needs Analysis (TNA) funding was identified and courses were booked. Twenty course dates were arranged allowing for a total of **400** staff to attend. Disappointingly only **73** staff attended leaving **327** spaces not filled. Six courses were cancelled due to insufficient numbers to justify carrying on with the course; fortunately the training company have agreed to move the cancelled courses to this financial year and for which the Trust will not be charged. Currently the Trust is not compliant with the RPI Policy and this has been raised at CQEG as a concern, and the Trusts Health and Safety Committee.

Further courses have been booked to start in September and attendance at these will be promoted through nurse management and regular advertising via e-mail, the intranet and the Bulletin.

3. Achievements during 2013-14

- As part of the ongoing CCTV strategy four digital video recorders have been replaced which increases capacity to provide additional cameras on to the system. There are currently 107 cameras in operation, recording 24/7.

- A Facilities Capital Project identified funding to replace all current swipe card readers and replace them with proximity readers. All Trust users have or are in the process of having their existing card replaced with a smartcard which also acts as their photo ID. Additionally, proximity readers are replacing the card readers on the staff barrier car parks. The smartcard can also provide other services such as cash less vending and can be used for restaurant purchases. These options will be looked at in the future.

  This has been a major exercise however all staff now have photographic ID and access has now been restricted within high risk areas to authorised personnel only.

  As part of the project new proximity readers have been installed at the entrances to the administration corridors, Finance, Pharmacy and external doors off Hospital Street. These installations further strengthen the security of these areas and helps assist in identifying who is using these doors out of hours.

- The Trust's Local Security Management Specialist (LSMS) has been working with NHS Protect, Northamptonshire Police and East Midlands Crown Prosecution Service to produce a document as a "Joint Working Agreement" to tackle violence, other criminal activity and antisocial behaviour in the NHS. The purpose of this agreement is to assist agencies in setting up closer working arrangements. This document is due to be signed off by all shortly.

- In November Security held a "Stop and Check" week whereby security would stop staff and ask to see their photo ID if not clearly visible. During the week 1000 staff were stopped of which 133 did not have photo ID to prove who they were. This was prior to the new ID's being issued and this exercise will be re-run later in the year.

4. Conclusion

It is disappointing to report an increase in reported physical assaults. Better reporting and staff being more confident to use Datix as opposed to verbally informing a colleague or manager has contributed to the increase. It could also be

argued that staff are now treating more patients who have challenging behaviour traits including Alzheimer's which is leading to more assaults on staff.

The poor response to the Breakaway training courses through lack of attendees may also have had a bearing on number of incidents. There are techniques taught that help defuse situations and the signs to look for in a patient who may have the potential to act violently.

It is encouraging however to see reported crime continues on a downward trend and it should be acknowledged that staff are treating their personal possessions more responsibly by either not bringing in personal items or securing them appropriately at work.

5. Key Initiative Planned for 14/15

The Security Department has applied to join the Community Safety Accreditation Scheme (CSAS). The CSAS provides an opportunity for organisations that provide community safety and security services to enter into a formal agreement with their local Chief Police Officer. This will enable security officers to be accredited under the scheme and they may be granted limited powers which will allow them to issue penalty notices for disorder, littering, graffiti and the requirement for a member of the public to give their name and address if an officer believes an offence has been committed. Powers may also include removing alcohol from persons aged under 18 and powers to seize tobacco from a person aged under 16. This accreditation should also assist the Trust in tackling the ongoing issue of smoking on the hospital site.

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**25 September 2014**

Title of the Report	**Health and Safety Annual Report 2013/14**
Agenda item	**15**
Sponsoring Director	Charles Abolins, Director of Facilities and Capital Development
Author(s) of Report	Diana Salvio, Health and Safety Manager
Purpose	Assurance

Executive summary

This report provides an analysis of the Trust's Health and Safety (H&S) performance during the financial year 2013 – 2014 and highlights relevant issues pertaining to the Management of Health and Safety in the Trust.

The report concludes with a forward look, which gives an outline of the key performance Indicators proposed for the financial year 2014/15.

Related strategic aim and corporate objective	• To be a provider of quality care for all patients • Provide appropriate care for our patients in the most effective way • Foster a culture where staff can give their best and thrive
Risk and assurance	Failure to meet statutory Health and Safety obligations and potentially increased costs of litigation
Related Board Assurance Framework entries	BAF- 5
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	Failure to meet statutory obligations under Health and Safety legislation

Enclosure L

Actions required by the Trust Board

The Board is asked to consider the report and note the issues highlighted together with the actions proposed to address the areas of concern.

Northampton General Hospital NHS
NHS Trust

Public Trust Board
25 September 2014

Health & Safety Annual Report 2013/14

1. Introduction

Health and Safety at Work Act 1974 places duties on the Trust, to ensure that the health, safety and welfare of employees and those who are not employed but can be affected such as patients, visitors and contractors is safeguarded. Furthermore a number of other health and safety (H&S) legislations place additional duties on the Trust specifically to ensure H&S risks that can cause harm are identified, assessed, mitigated and managed. The Trust aims to educate, support and enable staff to look after their own safety so far as they reasonably can and to use best practice tools and techniques to help the Trust fulfil its duties and responsibilities. The Trust employs one Health and Safety Manager, Diana Salvio, who commenced on 29 April 2013.

A number of different systems are in place to help ensure effective health and safety management. These include:

- Incident reporting, investigation and data analysis
- Risk Assessment, mitigation and management
- Policies, procedures , safe systems of work, protocols,
- Training, instruction and information
- Communication and Consultation
- H&S Governance Structure
- H&S inspections and audits

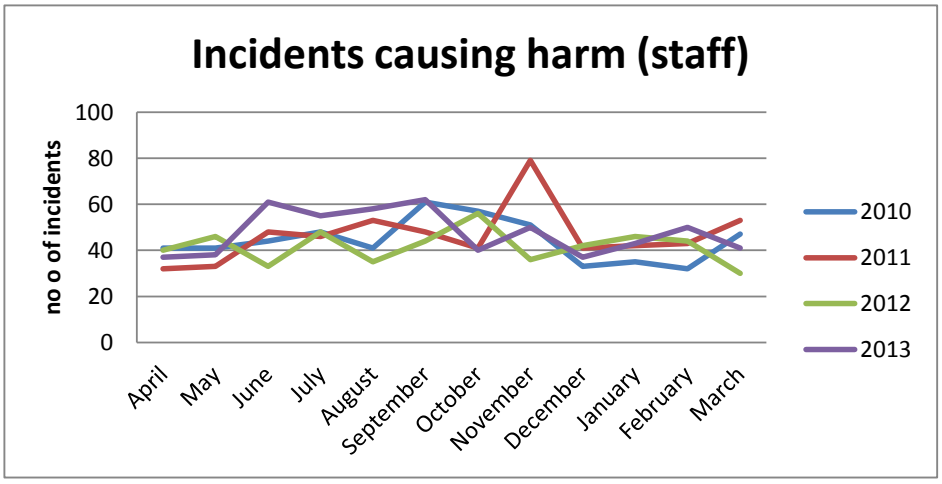
This report provides an analysis of the Trust's Health and Safety (H&S) performance during the financial year 2013 – 2014 and highlights relevant issues pertaining to the Management of Health and Safety in the Trust.

The report concludes with a forward look, which gives an outline of the key performance Indicators proposed for the financial year 2014/15.

2. Incident Analysis

Datix is used within the Trust for reporting of incidents. A total of 1634 incidents affecting staff were reported, out of which 572 were incidents causing harm in 2013/14. There has been a 6% increase in the number of incidents causing harm compared to last year (ref graph 1)

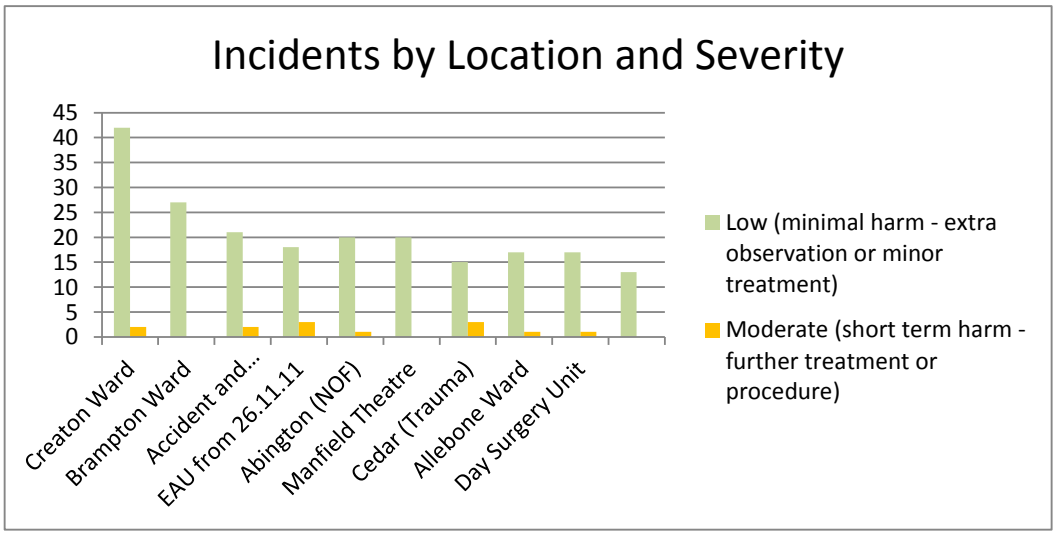
Graph 1



Enclosure L

The breakdown analysis of the incidents causing harm to staff by locations and severity is shown in graph no 2 below.

Graph 2



The top five locations with highest number of incidents with harm to staff are:

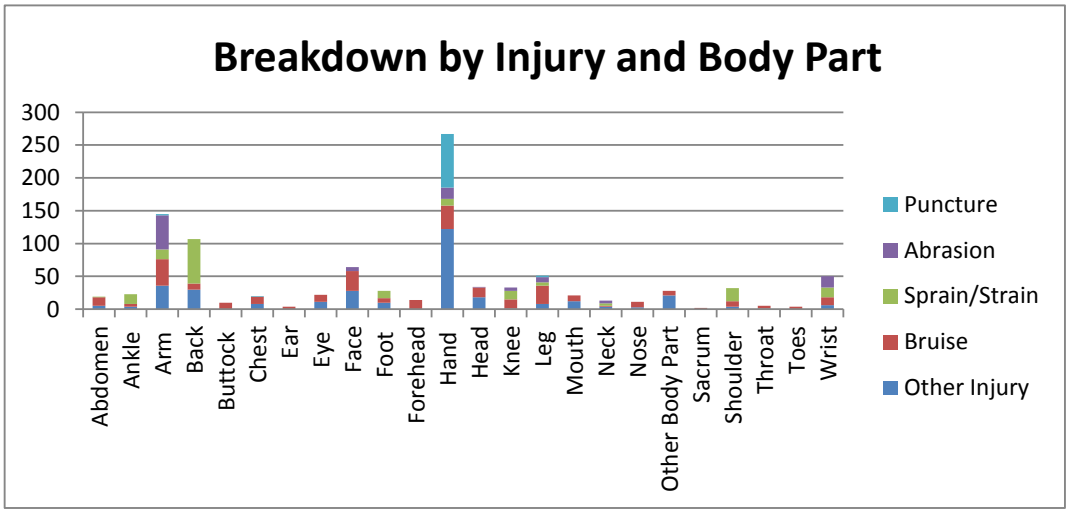
- Creaton ward (46)
- Brampton ward (27)
- A&E (27)
- EAU (21) and Abington ward (21)

The top three locations with the highest severity incidents are:

- EAU and Cedar ward (3 moderate severity incidents each)
- Creaton ward and A&E (2 moderate severity incidents each)
- Abington, Allebone and Day Surgery Unit (1 moderate severity incident each)

Graph 3 below shows the **injury types and the body part affected**. The top 5 most common injuries reported were other injury, bruises, sprains /strains, abrasions and puncture. The top 5 most affected body part include hands, arms, back, face and legs.

Graph 3



The table below shows the **highest type of Adverse Events and the locations** with the highest numbers of these:

Top 5 Adverse events (Datix categories)	Top three Locations with highest numbers
Accident of some other type or cause (141)	Brampton ward (12) Day Surgery Unit and Manfield Theatres (9) Sturtridge ward (6)
Physical abuse, assault or violence (103)	Creaton ward (31) Abington ward (8) A&E (6)
Injury from dirty sharps (95)	Day Surgery Unit (7) Manfield Theatre (6) A&E(5)
Disruptive, aggressive behaviour – other (28)	Creaton ward (7) A&E and EAU(3) HDU and Allebone (2)
Stretching or bending injury, other than lifting (26)	Holcot ward, Main Theatre, Compton, Abington ward (2)

The incidents related to adverse events of abuse, aggressive behaviour are covered in detail in the security report and therefore not covered further in this report.

Sharp Incidents:

95 staff injuries with harm from dirty sharps were reported in 2013/14 which is an increase from last year (72). This increase can be attributed to more incidents being reported via Datix due to raised awareness among staff related to sharps.

A number of actions have been taken in the reporting period to reduce sharp injuries. These include:

- A full **review of the current process** and sharps was undertaken by the safer sharps group and report with recommended actions submitted to CQEG.
- **Staff are trained** on safer sharps and actions to be taken after a sharps injury during training by infection prevention, occupational health and health and safety.
- **New Sharpsmart disposal system** was implemented trustwide. These new sharps bin automatically close once they are filled and prevent overfilling. Their design ensures that hands do not come in contact with sharps within the bins. They come in portable variety so can be taken to the patient's bedside helping staff to dispose sharps at point of use.
- A new **safe management of sharps policy** was developed.
- **Safer sharps awareness leaflets** were also developed and communicated to staff.
- **Safer sharps awareness day** was held where staffs were given opportunity to review and select safer sharp devices for use in their clinical areas.
- **Safer Sharp Devices selected for clinical trials.** Several safer sharp devices are already in use within the trust but need to be uniformly used and all other alternatives removed. Work is planned to clinically trial selected new safer sharp products.

Manual handling Incidents:

26 'Stretching or bending injury, other than lifting' incidents with harm reported in 2013/14 compared to 34 in the previous year.

There has also been a decrease in the overall reported manual handling incidents causing harm to staff in 2013/14 compared to previous year as seen from table below that gives the breakdown of the reported manual handling incidents with harm to staff.

Adverse event	2013/14	2012/13
Stretching or bending injury, other than lifting' incidents	26	34
Lifting in the course of moving loads	2	4
Lifting or moving a patient or other person	19	13
Lifting or moving an object other than a load	1	4
Total	48	55

Mandatory manual handling training is in place and the manual handling team provide the training, expert guidance and specialist advice for all manual handling and ergonomic issues.

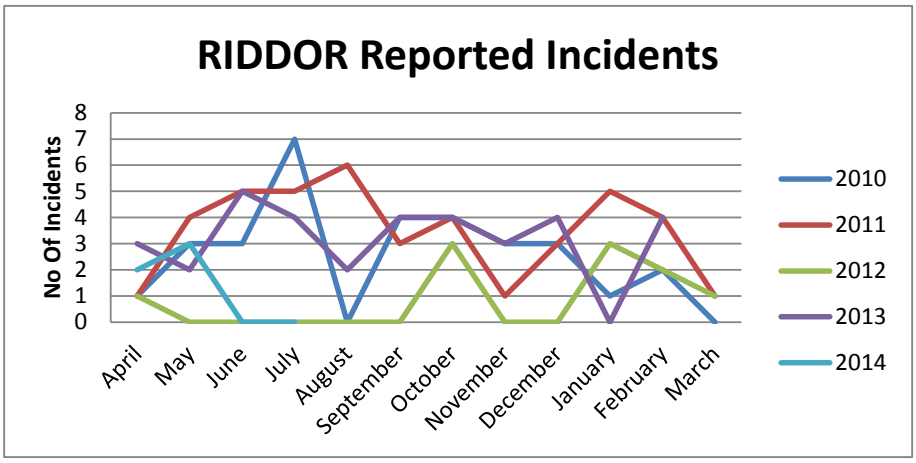
Additionally there are physio services and self-referral systems in place that the employees can use.

The measures in place are clearly having an impact in mitigating the risk as otherwise the numbers would be significantly higher taking into account that significant and continuous manual handling operations are undertaken within the Trust.

2.1 RIDDOR Incidents

There were 39 incidents reported under RIDDOR in this reporting period 2013/14 which is an increase from 10 incidents reported in 2012/13 but similar to the data from 2011/12 and 2010/11 as seen in Graph no 4 below.

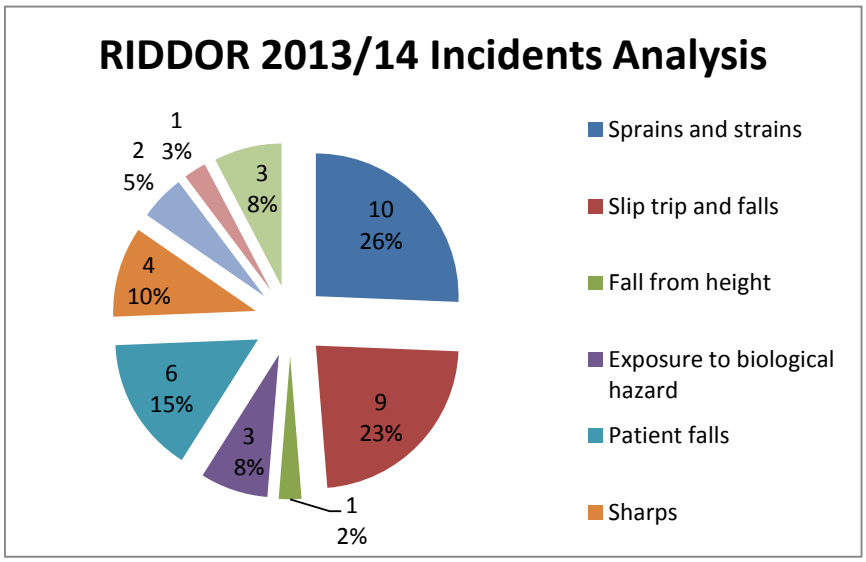
Graph 4



In order to clarify the reporting criteria and timescales of reporting a new RIDDOR procedure was developed and is now available.

Graph no 5 shows the breakdown of the type of incidents that were reported under RIDDOR in 2013/14.

Graph 5



The top five RIDDOR reported Incident types in 2013/14:

Sprains and Strains (10)	Slips trips and falls (9)	Patient falls (6)	Sharps (4)	Exposure to biological hazard (3)	Violence and aggression related (3)

There were 2 pothole related incidents resulting in fracture for a staff and a patient. Estates have since reviewed their process for proactive identification of such potholes. Staff are encouraged to report any potholes spotted to estates for repair.

There were no further trends identified for the incidents reported under RIDDOR

3. Policies

A complete review of all Health and Safety policies was conducted soon after the H&S Manager taking up post. The following policies and procedures were developed and / or updated in the reporting period:

- Lone Working Policy
- Display Screen Equipment (DSE) Policy
- Safe Operation of Electrically Propelled Work Equipment
- Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) Procedure
- Safer Management of Sharps Policy

4. Health and Safety Training

All employees are required to have Health and Safety awareness training and this is part of the Trust mandatory training program. Compliance rate for this was very low and only 32 % in April 2013 (red).

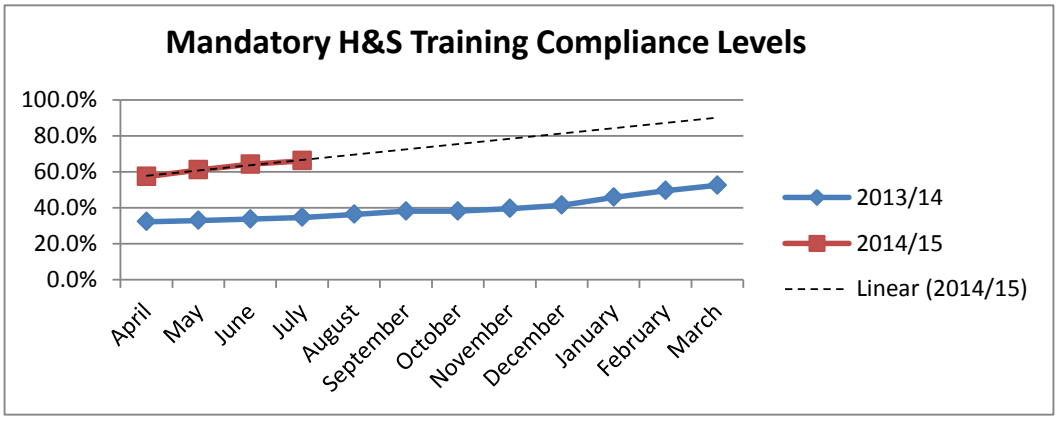
A complete review of the H&S training was completed and number of actions taken which includes:

- Face to face training session's parts of Induction and cluster days.
- Health and Safety Workbook and assessment sheets.
- Review of knowledge (ROK) sessions
- E-learning

Since implementing the above measures, there has been a marked increase in compliance rate. It was at 57.5 % at the end of April 2014 (amber) and has continued to rise.

The trajectory forecasts that we should achieve compliance levels >85 % by end of this year as seen in Graph 6 below.

Graph 6:



Mandatory Health and Safety Training

In addition to mandatory H&S training additional role specific training courses such as risk assessment, COSHH assessment, Incident Investigation were also delivered in the reporting period.

5. Communication

A Health and Safety Webpage has been developed and is now available on intranet. It is an effective tool to communicate and provide easy access to H&S information to all staff. It includes information on latest updates, H&S policies, training, forms, templates, leaflets, posters and contact details.

6. Health and Safety Governance

The Trust H&S Committee structure has also been reviewed and updated to ensure it is an effective communication, consultation forum along with effective decision making and setting strategy for all H&S governance and assurance matters. The current Trust H&S Committee is chaired by the Director of Facilities and has both management and staff H&S representative from the two Care Groups (medicine and surgery), Facilities and Corporate Service areas. These individual areas / Care Groups also have their own Local H&S meetings to ensure governance related to H&S. They are required to provide the Trust H&S Committee with assurance and evidence related to effective H&S management in their areas and also escalate any H&S matter as deemed appropriate for the attention of the Trust H&S committee Additionally the committee is now also receiving assurance reports on request from specialist areas of Manual Handling, Ergonomics, Fire, Security, Occupational Health, Radiation and Laser Protection.

The structure has been revised to ensure effective governance and assurance and will be reviewed again depending on any changes to the organisation structure.
Health and Safety reports are also submitted to CQEG on a quarterly basis.

7. Legal Requirements

The main new regulations that came into force in the reporting period of 2013/14 requiring action are as follows:

Legislation	Implications	Actions
Health and Safety (Sharp Instruments in Healthcare) Regulations 2013	Came into force May 2013. Implements the Sharps Directive (2010/32/EU) concerned with preventing injuries from medical sharps and applies to work in the hospital and healthcare sector.	Compliance with the new regulations is ongoing.
The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013	Came into force in October 2013. The main changes are in the following areas: ➢ The classification of 'major injuries' to workers has been replaced with a shorter list of 'specified injuries' ➢ The existing schedule detailing 47 types of industrial disease replaced with eight categories of reportable work-related illness ➢ Fewer types of 'dangerous occurrence' require reporting	RIDDOR procedure NGH-PC-810 was developed and is available for reference on criteria and timeline for reportable incidents
New Health and Safety Law Poster	Employers have a legal duty under the Health and Safety Information for Employees Regulations to either display the approved law poster in a prominent place or to provide each of their workers with the equivalent leaflet. The new law posters must be displayed by 5 April 2014	New Posters have been displayed at all main entrances to the hospital. Communication to all areas to remove the old posters and and distribute the leaflets (available on intranet) in staff rooms.

8. Health and Safety Audits

An internal health and safety compliance audit process has been implemented to proactively check compliance with legal and other health and safety requirements. Attached below is the summary of the compliance audits conducted in the reporting period of 2013/14:

- **Control of Substances Hazardous to Health (COSHH)** : A number of ward / departments were audited in June – September 2013 to check for compliance to the COSHH Regulations and internal COSHH policy. Significant gaps were found including:
  - × Some areas only had template documents or safety data sheets and had not completed COSHH risk assessments
  - × COSHH risk assessors not available in all areas
  - × Chemical Inventory lists and were not updated
  - × COSHH assessments for exposures such as diathermy plume, surgical smoke, dust / powder etc. have not been considered or completed in many areas.
  - × Local exhaust ventilation (LEV) thorough inspection, maintenance and user check records not available in many areas

  Remedial Actions include:
  - ✓ Risk added to risk register and action plans in place.
  - ✓ A cross functional working group was set up to look into improving COSHH Compliance within the Trust.
  - ✓ List of COSHH assessors was updated.
  - ✓ COSHH assessor training was developed and is available.
  - ✓ Annual support workshop for COSHH assessors has also been scheduled.
  - ✓ A central inventory of chemicals used within the trust was prepared.
  - ✓ Work is in progress to provide a central database of commonly used safety datasheets and example risk assessments.
  - ✓ New format of COSHH risk assessments were developed and trialed.
  - ✓ Looking into feasibility of uploading COSHH risk assessments onto DATIX Risk Registers.
  - ✓ List of LEV present within the trust has been developed and estates are working to arrange thorough inspections.
  - ✓ Further compliance checks planned in 2014.

- **Legionella**: An audit was conducted in October 2013 to check for legionella prevention and control within the trust. The report with findings submitted to estates for action. The main findings were:
  - × Responsible person names need to be updated in the local procedure
  - × Risk assessments for pseudomonas aeruginosa also to be completed in compliance to HTM 04:01 addendum. Look into ensuring Legionella risk assessments also conducted for Cripps if we retain responsibility for maintenance as the landlord.
  - × Whilst water sampling and bacteriological testing is undertaken on a regular basis the points selected for sampling are selected on a random basis. It is advised to have a more structured formal schedule for water testing to ensure each water system is sampled along with sentinel points within required timescales whilst ensuring high risk areas are selected for more frequent/repeated testing. Water sampling and bacteriological testing to also include pseudomonas aeruginosa
  - × Legionella Risk Assessment conducted by independent consultants Empathy Environmental Consultants Ltd. In July 2013, however evidence of progress and completion of actions highlighted in the risk assessment must be in place and readily available for audit purposes.

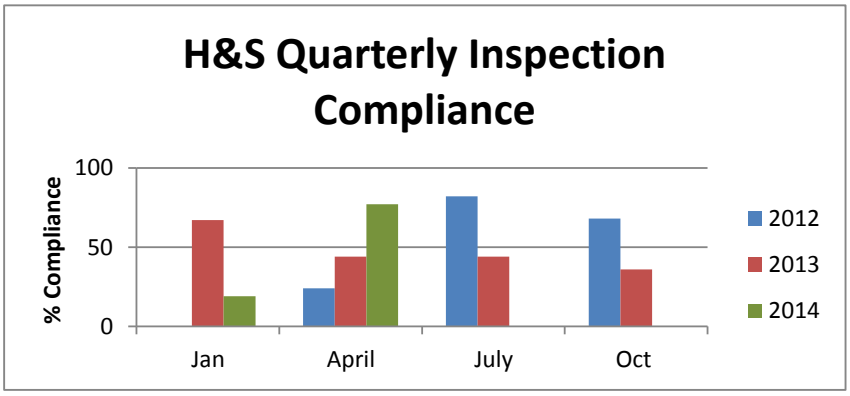
  Progress of the compliance audit action plan was provided by Estates in May 2014 to the Trust H&S Committee Meeting.

- **Asbestos**: Audit was completed in February 2014 to check compliance related to asbestos management and report with findings submitted to estates for action. The key findings were:
  - × Asbestos register needed to be updated and kept current and have version numbers assigned.
  - × Asbestos management plans have to be reviewed and updated.
  - × Systems in place for contractors who would be working near ACMs is to be reviewed and a permit to work system introduced to have assurance that they have checked the asbestos register and are aware of where ACMs may be present.
  - × A formal plan for monitoring arrangements in place to check condition of ACMs to be developed and a written record of monitoring maintained
  - × Ensure brief written records are kept of notifiable non-licensed work including a list of workers on the job, plus the level of likely exposure of those workers to asbestos
  - × Look into feasibility of a trained deputy for the appointed person

  Most actions have been completed the remaining have an action plan in place.

9. **H&S Inspections:** The Trust has a quarterly departmental H&S Inspection process that should be completed in all areas by the local H&S representatives. This process was not being completed in all areas with an average compliance rate of 36% in the reporting period of 2013/14.

Graph 7:



Local Departmental Quarterly H&S Inspection Compliance

The H&S inspection process was reviewed and new inspection template and guidance developed. Compliance rates have seen an improvement in the first quarter of 2014/ 15 with compliance rate of 77 % in April 2014. The compliance rate is monitored and reported to the Trust H&S Committee. Outstanding areas are escalated to the managers for action.

10. Health and Safety Resource

Currently, the Health & Safety Manager is the only Health & Safety resource for the Trust. Additional resource is required to be able to provide the required level of proactive and effective health and safety management within the Trust including proactive internal compliance audits, training, support, competent advice and business continuity. A business case for an additional resource in the form of a Band 5 H&S officer was submitted and was approved. The job description has been prepared and is currently going through the advertising process.

11. Key Performance Indicators (KPIs) for 2014/15

The following KPIs are proposed for the year 2014/15 to evaluate health and safety performance status within the Trust:

	H&S Performance Measure	Linked to NGH Strategic Aim 2014/15
1	10% reduction in staff RIDDOR reportable incidents compared to last year. It includes major injuries, dangerous occurrences, ill health and > 7 day absences.	Strategic Aim 1: To be an organisation focussed on quality outcomes, effectiveness and safety
2	85% staff are up to date with their mandatory health and safety training	Strategic Aim 4: Enabling excellence through our people Develop, support and value our staff
3	At least 2 Compliance Audits Completed	Strategic Aim 1
4	70 % compliance rate achieved for quarterly local departmental H&S inspections	Strategic Aim 1
5	100 % H&S Policies in date (none outstanding out of date)	Strategic Aim 4

12. Next Steps

Continue with the work that has started and ensure actions are completed resulting in improved Health and Safety compliance and performance within the Trust.

Enclosure L

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**25 September 2014**

Title of the Report	**Safeguarding Annual Report 2013/14**
Agenda item	**16**
Sponsoring Director	Jane Bradley, Director of Nursing, Midwifery and Patient Services
Author(s) of Report	Ben Leach, Head of Safeguarding & Dementia, Lorraine Hunt, SOVA Lead, Julie Quincey, Safeguarding Childrens' Lead
Purpose	This report is presented to the Board for scrutiny and assurance
Executive summary This annual report reflects the arrangements to safeguard and promote the welfare of children, young people and vulnerable adults within Northampton General Hospital for the period of April 2013 to March 2014.	
Related strategic aim and corporate objective	To be able to provide a quality care to all our patients
Risk and assurance	N/A
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	Compliance with Statutory Duty under s11 Children Act 2004 and regulation 11 Care Standards Act 2000

Actions required by the Trust Board

Board Members are asked to note the content of this report and assure themselves in relation to activity, compliance and learning.

Northampton General Hospital NHS
NHS Trust

Public Trust Board
25 September 2014

Safeguarding Annual Report 2013/14

1.0 Introduction

1.1 This annual report reflects the arrangements to safeguard and promote the welfare of children, young people and vulnerable adults within Northampton General Hospital for the period of April 2013 to March 2014.

1.2 In order to remain compliant with section 11 Children Act[1] the Trust must ensure that there is the most senior level of commitment, leadership and scrutiny provided to the safeguarding agenda; this annual report provides a part of this. Similar expectations arise from the Care Standards Act[2] regulations; with particular reference to regulation 11.

1.3 It is intended that this formal Board report will be followed by a more public-facing, accessible document with the intention of increasing public engagement with the safeguarding agenda within the Trust.

2.0 National and Local Context

2.1 The national context for safeguarding for 2013/14 was significant. In addition to the responses needed to the Francis, Winterbourne, and similar reports; the impact of the Keogh Mortality reviews and the Jimmy Saville allegations demonstrated that there was no room for Trusts to become complacent. Whilst the Health Service is not a stranger to introspection; the level and depth that has been needed in the past year has been significantly higher than previously.

2.2 Locally; the safeguarding partnerships have faced similar challenges of self-assessment and interagency challenge. The Northamptonshire Improvement Board, established under a Direction Notice, following an “inadequate” Ofsted inspection of multi-agency safeguarding children arrangements, has provided the partnership with rigorous scrutiny and a challenging timetable of work.

2.3 It is unlikely that this national and local landscape will change significantly during 2014/15; with a reasonable expectation that the nature of “confirm and challenge” brought via national recommendations and the local partnerships will increase as the pace of multi-agency work increases.

3.0 Safeguarding Governance

3.1 **Named Safeguarding Roles –** The Trust is statutorily required to maintain certain posts and roles within the organisation in relation to safeguarding; these have been fulfilled and enhanced throughout 2013/14.

[1] Children Act [2004]
[2] Care Standards Act [2000]

3.2 The **Director of Nursing** is the **executive lead** for safeguarding and has represented the Trust at the Northamptonshire Improvement Board [NIB], Local Safeguarding Children Board Northamptonshire [LSCBN] and Safeguarding Vulnerable Adults Board [SOVA]. The executive lead also acts as Named Senior Officer for allegations made against staff.

3.3 In November 2013 the Trust appointed a **Head of Safeguarding and Dementia**; this post provides **strategic direction** for both adults and children's safeguarding and supports the Director of Nursing in the executive role. The role of Named Senior Manager for allegations is fulfilled by the Head of Safeguarding and Dementia.

3.4 The **Named Professionals** provide the organisation with **operationa**l advice, support and input; ensuring the embedding of the strategic priorities and supporting workforce resilience. The Named Professional Team comprises:

- 1.0 WTE Named Nurse [Children]
- 1.0 WTE Named Midwife [Children and Vulnerable Women]
- 1.0 WTE Named Nurse [Adults]
- 2.5 PA/week Named Doctor [Children]

3.5 **Partnership Working –** The Trust is committed to working with partners to improve outcomes for vulnerable adults, young people and children. Part of that commitment takes the form of attendance at, and active participation in, the partnership boards and associated subgroups.

3.6 The table below demonstrates the external Boards and subgroups with which the Trust engages *[relevant subgroups in italics].* Commitment to these subgroups is substantial, not only in terms of attendance, but also with active participation and contribution to work streams:

Meeting	Frequency	Role
Northamptonshire Improvement Board	Monthly	Director of Nursing
Health Strategic Forum	Monthly	Head of Safeguarding
Local Safeguarding Children Board	Quarterly	Director of Nursing / Head of Safeguarding
Child Death Overview Panel	Monthly	Named Doctor [Chair]
Learning and Development Committee	Monthly	Named Nurse Children
Policies and Procedures Committee	Monthly	Named Midwife
Child Sexual Exploitation Committee	Monthly	Named Nurse Children
Quality Assurance Committee	Monthly	Named Doctor
Safeguarding Adults Board	Quarterly	Head of Safeguarding
Training and Development Subgroup	Monthly	Named Nurse Adults
Quality Assurance Subgroup	Monthly	Named Nurse Adults

3.7 **Assurance Mechanisms** – Throughout 2013/14 the internal governance arrangements for safeguarding comprised separate safeguarding adults and safeguarding children governance groups. The minutes of these meetings have been scrutinised via CQEG.

3.8 In addition to the safeguarding groups, the named professionals have provided quarterly [and latterly, monthly] reports to both CQEG and IHGC. The

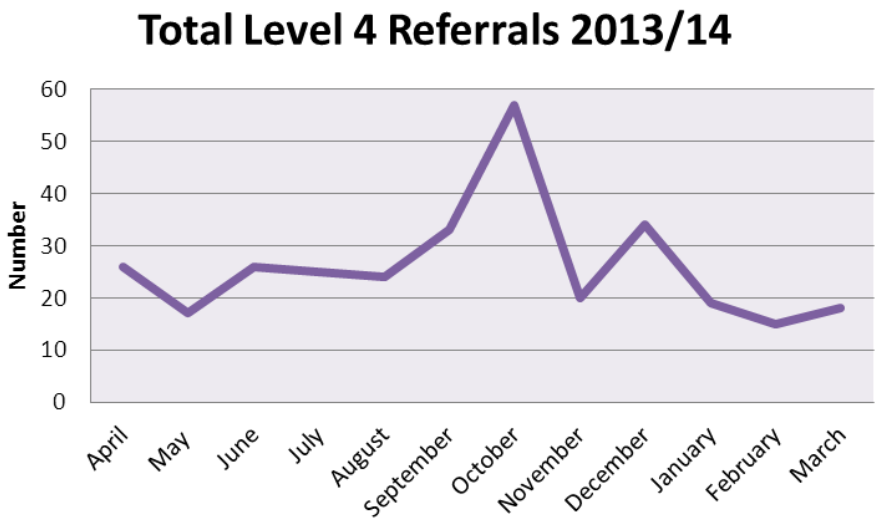
performance and compliance matrices are also reported through the quarterly Patient Safety Clinical Quality Governance report.

3.9 During the latter part of Quarter 4 2013/14; the safeguarding governance arrangements were revised and an integrated safeguarding committee has been established moving forward through 2014/15; in line with the wider review of governance arrangements commenced in the same period.

4.0 Safeguarding Activity

4.1 **Safeguarding Children** – Safeguarding Children 'activity' can be broadly separated into two parts; cases where urgent referral for child in need of protection is required *[level 4 cases]* and cases that do not meet this threshold.

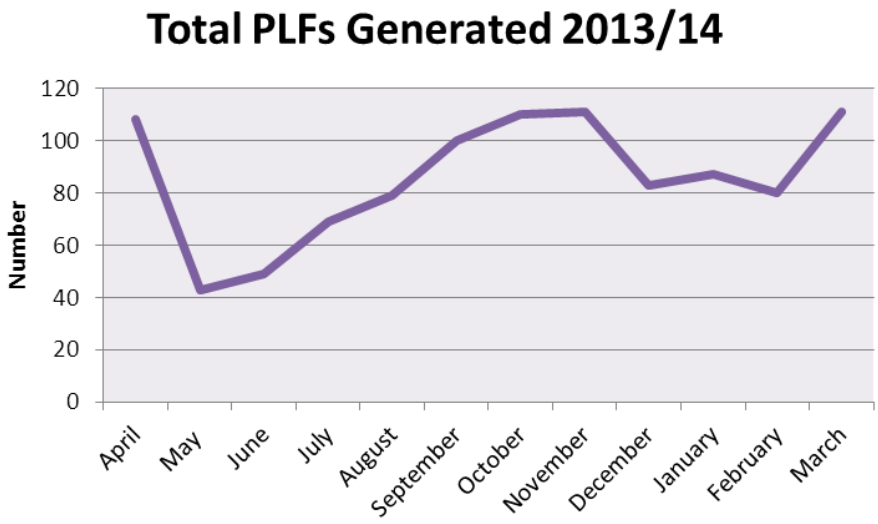
4.2 During 2013/14; the Trust undertook to refer 314 cases to Children's Services at level 4. During quarter three, an audit of referral quality was undertaken, which showed that 74% of these referrals were considered of appropriate quality and met the threshold [based on professional judgement] for level 4 intervention. The referral pattern on a monthly basis is illustrated in the chart below:



4.3 The significant spike in activity in October remains unexplained; however it is possible to align this, speculatively, with the feedback from the Ofsted inspections.

4.4 Where the level of risk posed to children does not, in the practitioners view, meet the level 4 criteria; an alternative process is used to highlight and manage the risk. A number of alternative frameworks are available to support clinicians in this, however regardless of the method used, these cases are all reported internally via the Paediatric Liaison Form *[PLF].*

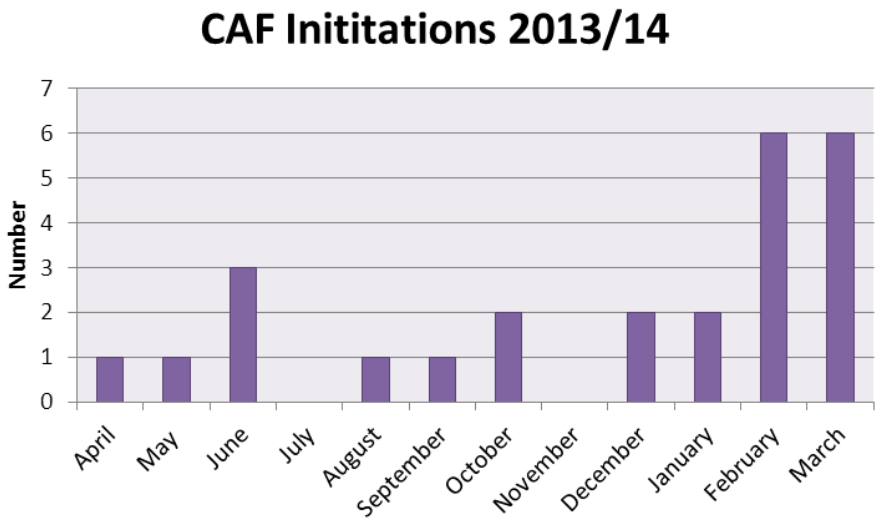
4.5 During 2013/14 the NGH safeguarding children team processed 1030 PLF [and the predecessor form 'SG2']. The monthly activity is reflected below; and a similar October rise can be seen, correlating with the level 4 activity.



4.6 A brief comparison has been undertaken for Qtr 1 2014/15; in which 330 PLFs were generated *[in comparison to 200 for the same period 13/14]*. Therefore we can predict a total number of approximately 1300 PLFs for the coming year. The sustained increase from August 2013 onwards represents the increased understanding of appropriate safeguarding management in the clinical areas; due at least in part, to training, learning and supervision provided by the safeguarding children team.

4.7 One of the most significant frameworks for intervention with families not at level 4 is the Common Assessment Framework, or CAF. The use of CAF within the Partnership is a fundamental driver for the work of the Improvement Board, and from April 2014 has been a performance indicator within the NGH Quality Schedule.

4.8 The chart below demonstrates the improvement in CAF initiation within the Trust during 2013/14; however this remains a comparatively low figure and there must be a drive and focus on increasing this moving forward.



4.9 In addition to the management of the referral and the PLF process, the safeguarding children team at NGH undertake an advice and consultation role for staff in working with vulnerable and complex children. This also includes offering a supervision process, modelled on an 'assertive outreach' process.

4.10 During 2013/14 the safeguarding children's team provided 170 episodes of 'live' safeguarding casework supervision with clincial staff and 30 episodes of planned safeguarding supervision.

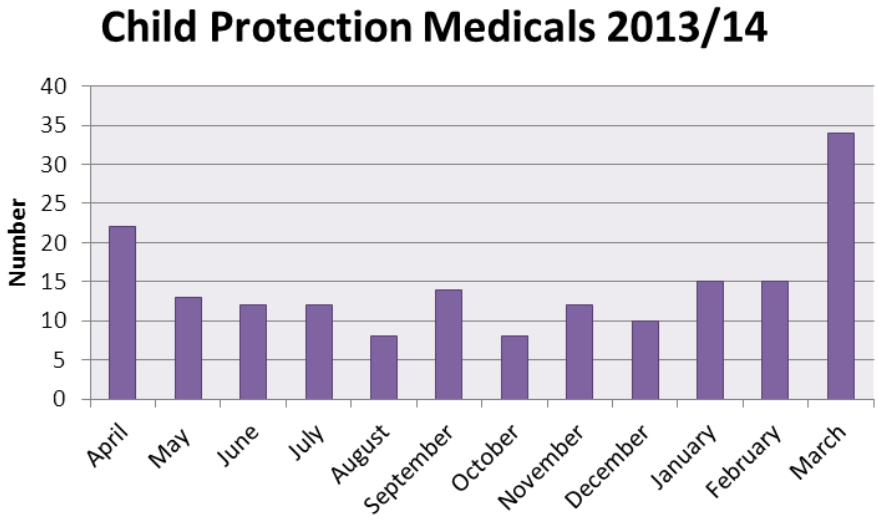
4.11 **Looked After Children [LAC]** – In addition to the broader remit of safeguarding children; the Trust has specific responsibilities in delivering statutory provision to those children who are in the care of the Local Authority, or 'Looked After'.

4.12 There are approximately 90'000[3] children in care at any one time in the UK. This particular group of young people are at a particularly increased risk of poorer health outcomes; due to instability in social circumstances, personal challenges, amongst other reasons.

4.13 The LAC service at NGH is provided by two community paediatricians with designated responsibility. They undertake comprehensive Initial Health Assessments and provide a detailed health care plan to ensure that health and development needs are addressed. Where concerns remain, or are ongoing, supplementatry reviews are provided.

4.14 During 2013/14 the Trust offered 232 clinic appointments for LAC reviews; with a DNA rate of 18%. The attendence rate of those young people in transition [16-18years] is always a particular challenge, however this is improving and the current trend shows a favourable comparision to other areas.

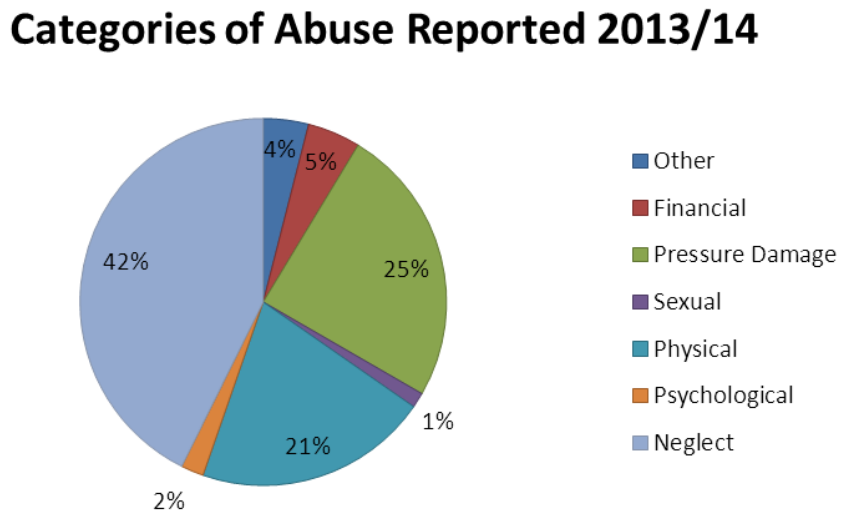
4.15 **Child Protection Medical Service** – Provided by the paediatricians, Child Protection Medicals are delivered to provide medical input to section 47 enquiries. The service is provided during normal working hours by a dedicated paeditrician via a rota system. Whilst contributing to this rota, the paediatricians also provide input into the Sexual Assault Referral Centre; working alongside forensic colleagues in cases of sexual assault in children. The child protection medical service is heavily patronised. The chart below showes the activity for 2013/14.



[3] NSPCC 2014

4.16 **Safeguarding Adults** – Similarly to safeguarding children, the activity in the safeguarding adults arena can be broadly categorised in two ways – although the division itself is somewhat different. Safeguarding adults referrals relating to NGH are either raised by staff at the Trust because they have recognised and responded to potential or actual abuse, or they are raised by other providers or individuals citing abuse on the part of a specific Trust service.

4.17 In 2013/14; the Trust raised 160 alerts with the local authority in relation to safeguarding adults concerns external to the Trust. Of these, 37% were not judged to meet the interagency threshold; the remaining 100 were investigated within the inter-agency safeguarding process.



4.18 The chart above shows the distribution of safeguarding referrals by category. Not surprisingly, the category of 'neglect' is most attributed. Followed by pressure damage.

4.19 The referral rate of 160 in 2013/14 represents a 42% increase on the previous year. A significant increase has also occurred in the number of cases relating to pressure damage; with nearly four times the number reported. This is a clear reflection of the work undertaken by the tissue viability services in increasing awareness and accurate classification of pressure damage and the consequential appropriate reporting of external incidents through the safeguarding processes.

4.20 Reports of abuse are also made to the local authority that cites the Trust as being the 'perpetrator'. During 2013/14 there were 38 such referrals, compared to 35 the previous year. 84% of referrals made against the Trust in 2013/14 related to neglect or acts of omission, in comparison to 66% the previous year.

4.21 The outcomes from these safeguarding alerts are demonstrated in the table below:

Outcome	Number
Closed on Contact	18
Unfounded	10
Partially Substantiated	6
Substantiated	4
	38

4.22 **Deprivation of Liberty Safeguards –** During the reporting period, the Trust applied for standard authorisations under the DOLS legislation to prevent Article Five Human Rights Act breaches on ten occasions. The Trust was granted standard authorisations in three of the ten cases, with the remaining cases determined as, at the point of assessment of Best Interests, not requiring an authorisation as the care and management planning in place was felt not so restrictive as to amount to an Article 5 breach.

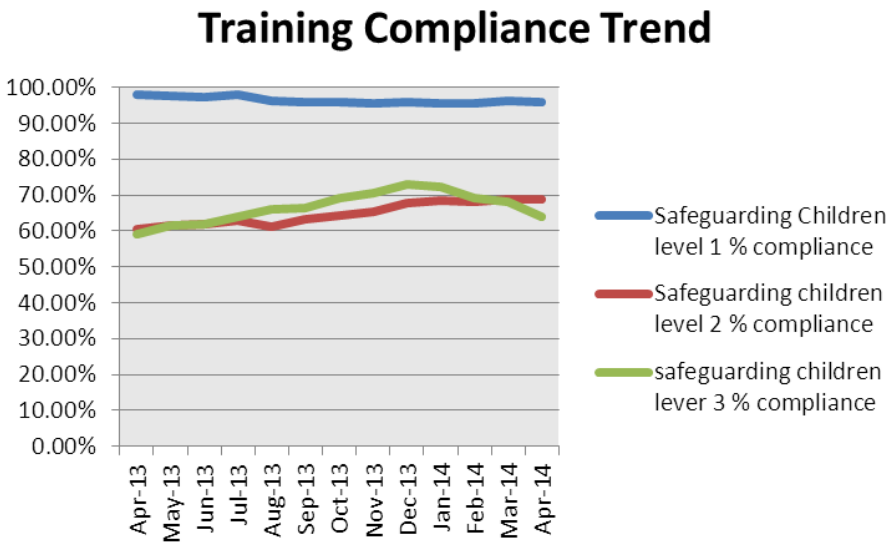
4.23 In the wake of the Supreme Court judgement in *Cheshire West* the requirements surrounding the application of the DOLS framework has changed [from 19th March 2014] and a significantly higher number of DOLS authorisations have been sought and granted into the first quarter of the 2014/15 year. This will be fully reported on in next year's annual report.

5.0 Workforce Compliance

5.1 **Safeguarding Children –** The Trust provides safeguarding children training commensurate with the guidance in *Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff [2010]* at levels 1, 2 and 3.

5.2 The following table and chart represents the percentage compliance at each level at the year end 2013/14, the percentages demonstrate the combined total of face-to-face in house, experiential, e-learning and interagency provision available.

Level	Compliance
Safeguarding Children Level One	96.1%
Safeguarding Children Level Two	68.8%
Safeguarding Children Level Three	68.8%



5.3 Over the year, the safeguarding team have offered face to face training capacity for **4579** staff to receive the appropriate level of training. **26%** [1233] spaces were un-utilised.

5.4 During the year, 3346 people attended face to face training, whilst 174 accessed e-learning and 17 submitted experiential learning. This makes face to face [currently] the most effective training provision.

5.5 **Safeguarding Adults and Mental Capacity Act –** is similarly delivered in tiered training levels:

Level	Compliance
Safeguarding Adults Level One	71%
Safeguarding Adults Level Two	64%
Mental Capacity Act and DOLS	73%

5.6 As part of the safeguarding adults training portfolio, PREVENT training is delivered to relevant staff. Currently, 60% of required staff have completed this Home Office programme of training.

6.0 Learning from Incidents

6.1 In 2013/14 the Local Safeguarding Children Board published two Serious Case Reviews to which the Trust contributed. The pertinent recommendations and the outcomes were:

- *It is recommended that the Chair of LSCBN seeks reassurance from the Clinical Director for Paediatrics at NGH that the safeguarding training for Consultant Paediatricians who are expected to perform the role of Responsible Paediatrician under CDRA protocol has been reviewed in light of this case and is fit for purpose, and that no doctor will be asked to perform that role without such training.* **NGH achieved full compliance with this recommendation.**

- *It is unacceptable that there is no facility within Northampton to carry out a full skeletal survey on children at weekends. It is recommended that the LSCB Chair writes to the Director of Nursing for NHS Northamptonshire asking for reassurance that in the LSCB area, radiology, as a diagnostic tool, would be made available for children whenever it was required.* **This recommendation is being led by the Designated Doctor for the whole Health Economy, supported by the NGH Named Doctor and Clinical Director for Radiography to ensure compliance with the Royal College standards, where applicable.**

- *When children are presented to hospital with suspected non-accidental injuries, the hospital staff should make simultaneous referrals to both social care and police.* **NGH achieved full compliance with this recommendation.**

- *Ensure that safeguarding training is reviewed to enable staff to have a better understanding of the specific vulnerabilities for families in the armed forces.* **NGH achieved full compliance with this recommendation.**

- *Ensure that all staff are aware of when to refer cases for consideration for serious case review.* **NGH achieved full compliance with this recommendation.**

- *Review midwifery specific safeguarding training to ensure that all maternity staff continually assess the family dynamics and the male presence within*

the family. **Midwifery bespoke training has been revisited and now includes packages in relation to domestic violence and abuse and Common Assessment Framework.**

6.2 The Local Safeguarding Adults Board commissioned an historic review into the care and treatment of a patient with learning disabilities during 2011. This had been investigated by the Trust as a Serious Incident and significant learning had already occurred and been taken forward. The impact of this learning will be formally reviewed during 2014/15

6.3 During the year the Trust participate in a statutory Domestic Homicide Review. This report is currently awaiting Home Office approval. The draft recommendations shared with agencies contained no actions for the Trust to progress.

7.0 2014/15

7.1 In many ways, 2014/15 will present a similar landscape in safeguarding to its predecessor year: a focus on early intervention in children, a focus on learning and improvement for adults, a focus on workforce resilience in all areas.

7.2 Conversely, the coming year will also be a preparatory time for the impact of new legislation in January 2015 – Wilful Neglect legislation, primary legislation for safeguarding adults, statutory safeguarding adults boards.

7.3 The Trust safeguarding team will focus on strengthening what is already core business; training and education, quality of intervention, whilst developing other areas; domestic violence and abuse, integrated safeguarding governance.

7.4 Clinical engagement in these areas will be vital, as will the support and engagement, through the Director of Nursing, of the Trust Board, in order to continue to deliver the best possible outcomes for vulnerable children, young people and adults.

8.0 Recommendation

8.1 Board Members are asked to note the content of this report and assure themselves in relation to activity, compliance and learning.

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**25 September 2014**

Title of the Report	**Infection Prevention and Control Annual Report April 2013-March 2014**
Agenda item	**17**
Sponsoring Director	Jane Bradley, Interim Director of Nursing, Midwifery and Patient Services
Author(s) of Report	Patricia Wadsworth, Lead Infection Prevention and Control Nurse
Purpose	This report is being presented to the Board to give information and provide assurance to the Board.
Executive summary The report outlines summary of key infection Prevention and Control initiatives and activities at Northampton General Hospital for the year April 2013 to March 2014.	
Related strategic aim and corporate objective	The Health and Social Care Act 2008 Code of Practice for the Prevention and Control of Health Care Associated Infections. (DH 2008)
Risk and assurance	The report provides assurance on the Infection Prevention and Control Programme.
Related Board Assurance Framework entries	BAF – 22
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	The Health and Social Care Act 2008 Code of Practice for the Prevention and Control of Health Care Associated

Enclosure N

	Infections. (DH 2008)

Actions required by the Trust Board

- The Board has an obligation to ensure appropriate infection prevention and control mechanisms are in place.
- The Board is asked to discuss and where appropriate challenge the content of this annual report.

Northampton General Hospital NHS
NHS Trust

Northampton General Hospital NHS
NHS Trust

Infection Prevention

&

Control

Annual Report

April 2013 to March 2014

Enclosure N

CONTENTS

Enclosure N

1.0 Executive Summary

This report outlines a summary of the key infection prevention and control initiatives and activities of Northampton General Hospital (NGH) for the year April 2013 to March 2014(13/14). It also provides assurance on the Infection Prevention and Control Programme and activity for 2014/15.
All NHS organisations must ensure that they have effective systems in place to control healthcare associated infections. Evolving clinical practice presents new challenges in infection prevention and control, which need continuous review.
The Trust puts infection prevention and control and basic hygiene at their heart of good management and clinical practice, and is committed to ensuring that appropriate resources are allocated for effective protection of patients, their relatives, staff and visiting members of the public. In this regard emphasis is given to the prevention of healthcare associated infection, the reduction of antibiotic resistance and the sustained improvement of cleanliness in the hospital.
Infection prevention and control continues to be a national priority. Public opinion polls year on year demonstrate that cleanliness within healthcare settings and patient safety remain the top concern regarding the NHS from a patient's perspective.

The Director of Infection Prevention and Control (DIPC) is responsible for producing an annual report. The purpose of the report is to inform the Board of Directors of progress in delivering the infection prevention and control programme. This includes providing the Board with assurance that appropriate measures are being taken to maintain the safety of patients and staff and to agree the action plan for sustained reduction and improvements in Healthcare Associated Infections (HCAIs)

There has been continuing focus on reducing both MRSA bacteraemia rates and *Clostridium difficile* rates, monitored by the Health Protection Agency (HPA) now Public Health England (PHE). This report identifies how the Trust has continued to exceed its target reduction in Clostridium *difficile* infection.

The number of post 48hr MRSA bacteraemia infections during 13/14 was 1.

Screening for MRSA has continued within NGH, with elective screening at 97% compliance. Emergency screening during 13/14 and currently stands at 99.8% compliance.

The number of *Clostridium difficile* infections was 26 compared to 30 cases in 12/13. We still remained below the contract ceiling.

The ongoing promotion of 'Ward to Board' and clinical accountability in relation to infection prevention has been further developed and updated with Executive and non executive Directors and the Trust Chairman undertaking 'Beat the Bug, Save the Skin and Stop the Clot' in all ward areas, has truly embedding the ethos that infection prevention is everyone's business.

It has been a challenging and fulfilling year and we face further challenges in the coming year including a new dimension for compliance with CDI objectives, and a move forward with the introduction and implementation of the tool kit for detection and management of carbapenemase resistant Enterobactereciae (CPE) and NICE Quality Standards for reducing HCAI.

2.0 Background

The Infection Prevention and Control Team (IPCT) provide infection prevention and control services for Northampton General NHS Hospital Trust. This report relates to infection prevention and control within the Trust and provides a summary of the work undertaken by the IPCT.

The Trust continues to base its infection prevention and control agenda on the national strategic framework, identified through the following documents

- *The National specifications for cleanliness in the NHS: a framework for setting and measuring performance outcomes (NPSA 2007).*
- *Saving Lives: A delivery programme to reduce healthcare associated infection (HCAI) including MRSA* (DH 2007).
- *The Health and Social Care Act 2008 Code of Practice for the Prevention and Control of Health Care Associated Infections* (DH 2008),
- *Board to ward how to embed a culture of HCAI prevention in acute trusts* (DH 2008)
- *Safe, Clean, Care*:- reducing infections and saving lives(DOH 2008)
- The Operating Framework for 2012/13
- Clostridium difficile infection: How to Deal with the Problem (HPA/DH 2009).
- The Francis Report 2013
- Supporting planning 2013/14 for clinical commissioning group
- DH Planning Guidance-Everyone counts: Planning for patients 2013/14
- Towards High Quality, Sustainable Services: Planning Guidance for the NHS Trust Boards for 2013/14.

The Trust is required to meet the duties of the Hygiene Code, NHS Litigation Authority (NHSLA) and the Care Quality Commission (CQC) standards.

3.0 Infection Prevention and Control Arrangements

The IPCT consists of the following:

- Director of Infection Prevention and Control (DIPC): Director of Nursing, Midwifery and Patient Services
- Deputy Director of Infection prevention and Control (DDIPC) Deputy Director of Nursing
- Consultant Microbiologist
- Lead Infection Prevention Nurse (Band 8A)
- Infection Prevention Nurse (IPC qualified): 2 WTE (Band 7)
- Infection Prevention Nurse: 4 WTE (Band 6)
- Administrative/Surveillance support: 1 WTE (Band 3)

The Infection Prevention and Control Department has a budget to cover all nursing and administrative staff costs.

The Trust has a pro –active infection prevention and control team that is very clear on the actions necessary to deliver and maintain patient safety. Equally, it is recognised that the infection prevention and control is the responsibility of every member of staff and must remain a high priority for all to ensure the best outcome for patients.

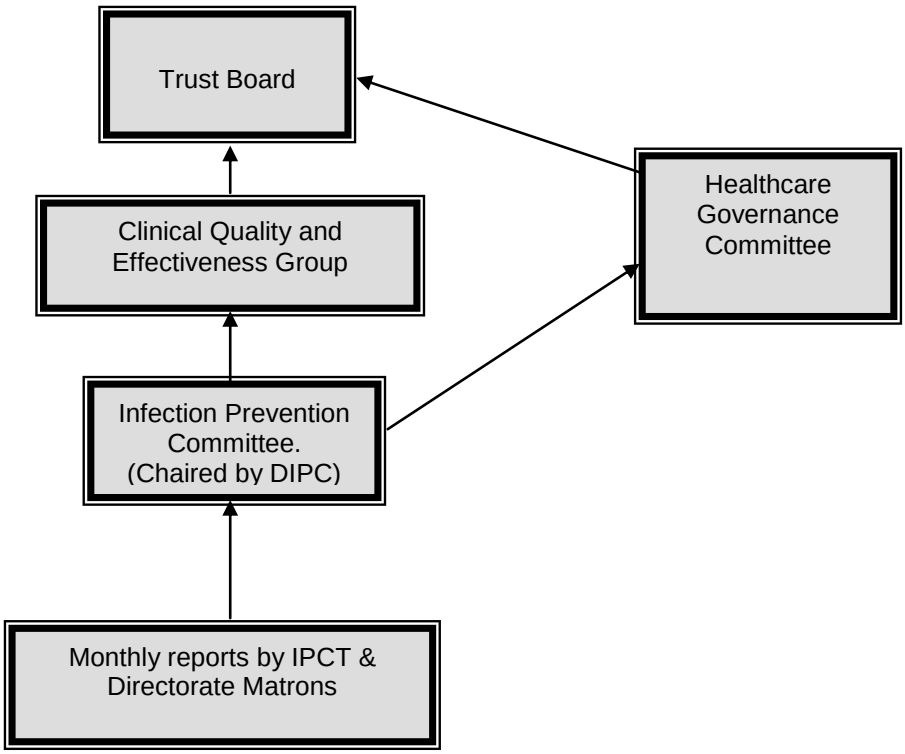
The Infection Prevention and Control Department includes microbiology, virology, wound surveillance, and epidemiology. The IPCT works with pharmacy, facilities, directorate matrons, ward sisters, infection prevention and control link staff and sterile services.

The core service includes an infection prevention and control advisory service, active infection prevention work, education and training throughout the organisation, audit, policy formulation and advice, surveillance, epidemiology, outbreak and control management.

In common with many other trusts, the workload of the core infection prevention and control team continues to increase. Examples of this include the requirement for training of all staff in infection prevention and control and hand hygiene. Another is in the reports (verbal and written) to demonstrate performance and compliance with guidance, standards, targets or reporting frameworks. The addition of a further infection prevention support nurse has greatly supported the team to achieve this workload.

Infection prevention is central to the delivery of safe, cost effective healthcare. It impinges upon all aspects of healthcare delivery, and consequently has a unique place in the Trust. Throughout 2013-14 the Infection Prevention and Control Team (IPCT) were actively involved in managing the risk of infection both to patients and staff. This involved identifying risks of infection and advising of interventions likely to minimise or eliminate those risks. The team has worked with Directorates to ensure that infection prevention and control remains everybody's responsibility and ownership for it can be demonstrated at all levels in the Trust.

Infection Prevention and Control Governance and Reporting Arrangements at NGH



Enclosure N

4.0 Governance

The work undertaken during this period reflected Trust priorities and the Infection Prevention and Control Annual programme and objectives.

4.1 DIPC reporting to the Board –Corporate responsibility

The Director of Nursing, Midwifery and Patient Services is the designated lead; Director of Infection, Prevention and Control (DIPC).She reports directly to the Chief Executive and the Board and she is the chair of the Infection Prevention and Control Committee (IPCC) The DIPC reports to the Trust Board on a monthly basis, including monthly surveillance figures and any matters by exception. The DIPC meets frequently with the Consultant Microbiologist and Lead Infection Prevention Nurse as well as quarterly meeting the IPCT.

The Chief Executive holds the ultimate responsibility for all aspects of the Infection Prevention and Control within the Trust.

The Infection Control Doctor (ICD) is also a consultant microbiologist and is the deputy chair of the IPCC.

The Lead Infection Prevention and Control Nurse is responsible for the operational management of the Infection Prevention and Control Team and for ensuring that the Infection Prevention and Control Plan is embedded.

The Infection Prevention and Control Nurses and support nurses provide clinical infection control advice and support Trust staff in the delivery of the plan.

4.2 Infection Prevention and Control Committee Structure and Accountability

The Infection Prevention and Control Committee is the main forum for discussion concerning changes to policy or practice relating to infection prevention and control. The membership of the Committee is multi-disciplinary and includes all directorates and senior management. The Committee is chaired by the Director of Infection Prevention and Control (DIPC)
Decontamination and sterile services also report through the IPCC.
The DIPC also provides a monthly report to the Trust Board.

4.3 Healthcare Governance Committee (HGC)

The HGC is a subcommittee of the Trust Board and reviews areas of concern arising from the IPCC by exception.

4.4 Links to Clinical Governance and Patient Safety

The Infection Prevention Team reports the Trust position in relation to infection prevention and control to the Clinical Quality and Effectiveness Group (CQEG) on a monthly basis. The Directorates include their monthly infection prevention data within their own quarterly reports to CQEG. Learning from MRSA bacteraemia infections is reported through the Patient Safety Learning Forum to representatives from all Directorates for dissemination to Directorate Governance Groups.

4.5 Northamptonshire Health Economy HCAI Group

The DIPC, Consultant Microbiologist and members of the IPCT are active members of the local health economy group. This group is in existence to drive forward the Northamptonshire approach to infection prevention and control working together to ensure the quality of patient experience throughout the county is of equal good quality.

4.6 Infection Prevention Focus Group

The Infection Prevention Focus group is one of six similar groups first established in August 2010 as part of the Patient and Public Involvement membership strategy at NGH.

The group has continued to meet every two months and has also carried out regular spot checks for visitors hand hygiene against a predetermined schedule of wards. During the year, three new recruits joined the group, which enabled five teams of two to be formed. Evening spot checks were introduced, and as expected more visitors were recorded compared to afternoon sessions.
In May 2013, three wards were selected for a survey on the basis of their particular need for good, effective hand hygiene. In contrast to the majority of wards previously surveyed, the results for these three showed greatly enhanced compliance figures as follows:-

Ward	% Compliance IN	% Compliance OUT	% Compliance IN/OUT
Willow	**76.6**	**56.5**	**70**
Talbot Butler	**94.4**	**91.6**	**93.3**
Finedon	**83.3**	**50.0**	**72.2**
Combined	**81.8**	**65.8**	**67.8**

The combined figure of 67.8% contrasts with a range between 4.5% and 39% for other wards and such a dramatic difference gave rise to much discussion about how the gap might be narrowed. It was decided to give feedback to matrons and other relevant staff, reiterating the importance of the use of hand gels for both staff and visitors through the use of e mails to staff and features in the staff newsletter. It was recognised that were locked doors were in use that visitors and staff should be reminded to gel before entering.

In addition, those matrons attending the monthly IPC were informed of these results with the request that they consider how the gap might be bridged. The response from this initiative was somewhat disappointing with the general view being that those wards with locked doors had a distinct advantage and that in general it would be neither practical nor economically possible to impose a locked door policy on all wards. Other suggestions such as closing doors at visiting times also met with a negative response.

In the meantime, members of the group agreed to publicise Hand Hygiene by manning HH tables at the AGM/ festival in September along with the IP Team. Subsequently they also did this at Integrated Surgery on two occasions using dusting powder and ultra violet light equipment. This initiative too had limited success and revealed a distinct apathy amongst patients who were attending the surgery.

A further attempt to address this issue was made early this year when three wards were selected, and appointments made with the relevant Matrons to discuss how compliance figures might be improved. Unfortunately, these attempts coincided with particularly difficult and busy periods in the hospital generally and it was not always possible to carry out the planned discussions.

Whilst the main focus of the group was on visitors, it became increasingly difficult to convince the team that compliance by staff members was being done to an acceptable standard. This was in spite of evidence that staff were subject to regular audit and observation. It was, however, accepted that staff had access to gel and hand washing facilities which were not always within sight of our audit teams.

More recently, work carried out by the Patient Experience Lead has meant that the function of groups such as this one under the auspices of PPI (Patient and Public Involvement) has been incorporated into PEN (Patient Experience Network) This has led to the disbandment of discrete focus groups and members have been encouraged to sign up to the QUEST programme of quarterly patient and ward surveys.

From the point of view of the IP Focus Group it is probably true to conclude that there is a feeling of a job not satisfactorily completed and that the matter of visitors hand hygiene remains an issue which requires a more satisfactory resolution.

5.0 National and Local Surveillance

The IPCT and Infection Prevention and Control Department undertake the following national and local surveillance:

- National MRSA bacteraemia reporting
- National MSSA bacteraemia reporting
- National E coli bacteraemia reporting.
- National *Clostridium difficile* reporting
- National Glycopeptide Resistant Enterococci reporting
- Surgical site infection reporting
- Local surveillance of all 'Alert' organisms and an extensive surgical site surveillance programme.

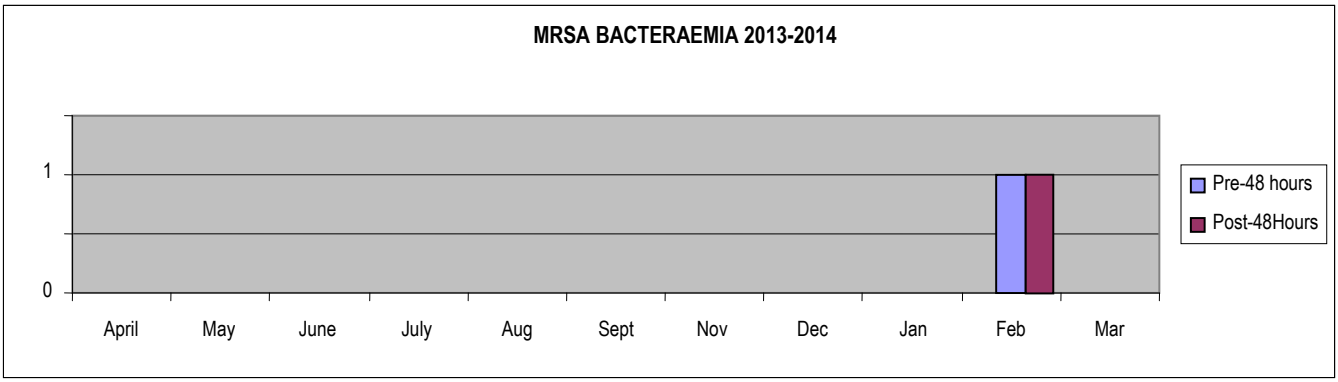
5.1 MRSA bacteraemia

The reporting of MRSA bacteraemia is mandatory for all NHS Trusts. The ceiling for this year was 0 post case. The Trust was attributed 1 post 48 hour cases in total. A root cause analysis (RCA) was carried out. It was reported to the infection prevention committee meeting.

This was attributed to Rowan ward; however this is a whole health economy approach and the community, nutritional services ITU, and Hawthorn ward was involved with the post infection review.

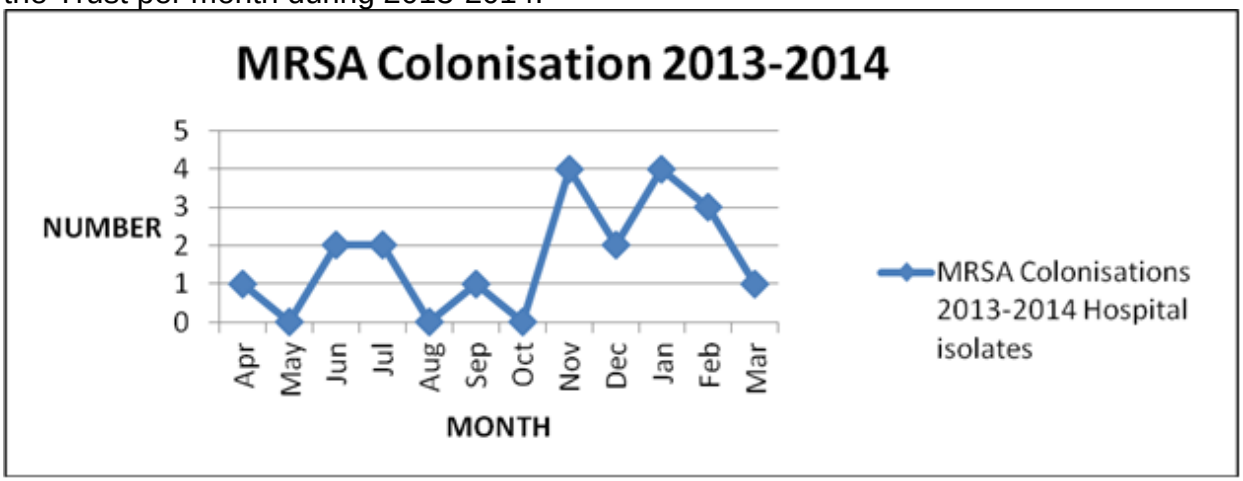
Patient also had a previous history of MRSA from 2009; the community infection prevention team were involved in this review providing a whole health economy approach. The learning from this event was shared at the next CQEG meeting, IPC and the Board meeting.

The patient was a complex patient with Crohn's disease, with multiple surgical interventions inclusive of a stoma, urinary catheter a fistula. There were gaps in screening and decolonisation of a patient with a previous history of MRSA. The medical staff stated that they were not aware to discuss with Consultant microbiologists promptly re appropriate antibiotics for patients with a previous history. This patient had multiple patient moves within the hospital. A comprehensive action plan will be put together for the surgical directorate and this will be shared across the Trust.



MRSA Colonisation

The graph below reflects the number of cases of MRSA colonisations attributed to the Trust per month during 2013-2014.



The Trust continues to work with the Clinical Commissioning Group and the whole health economy in continuing to promote excellent HCAI policy and practice.

Special Measures –MRSA

A period of increased incidence is defined by Public Health England as 2 or more new cases of post admission MRSA colonisation on a ward in a 28-day period. Post admission is defined as any MRSA swab dated over 48 hours after admission.

The IPCT identified a range of 'special measures' which were implemented on any ward that had 2 or more new cases in a 28 day period. Only one ward was on special measures during 2013-2014. The graph below reflects the wards that have been on special measures for MRSA colonisation. The actions from all these special measures are fed back to the board monthly through the board report.

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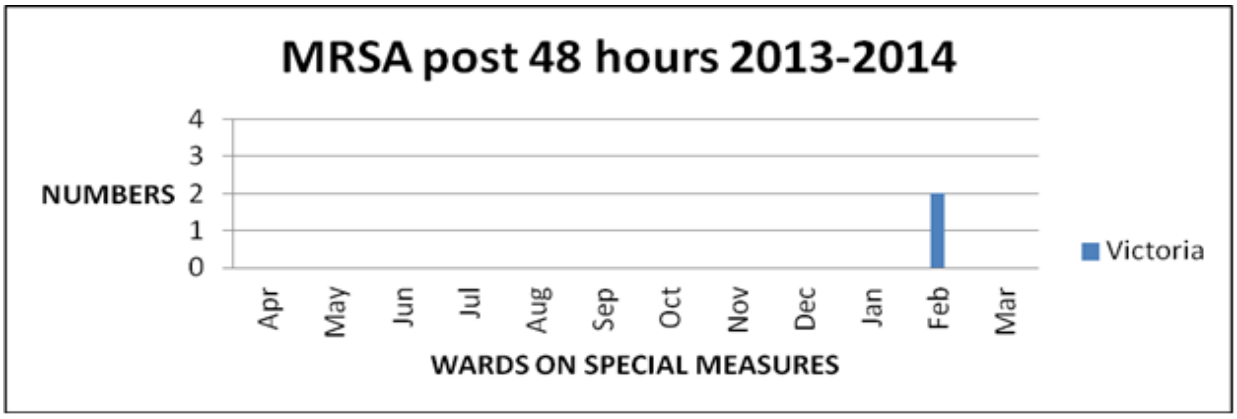
Wards - that have 2 or more incidences of MRSA colonisation



5.2 MRSA Screening

Northampton General Hospital achieved compliance with the requirements for all elective patients to be screened for MRSA colonisation, under the reporting methodology advocated by the DH. The overall compliance for the year for electives was 97% (patient specific verified data) and the overall compliance for non-electives was 99.8%. Efforts continue to achieve greater compliance.

5.3 MSSA bacteraemia

There is a mandatory requirement for all NHS acute trusts to report Meticillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemia from the 1st January 2011.This reflects the zero tolerance approach that the Government has made clear that the NHS should adopt for all Healthcare Associated Infections (HCAIs), while recognising that not all MSSA bacteraemia are HCAIs. Over the past few years, the NHS has made significant progress in reducing MRSA bloodstream and *C. difficile* infections. The availability of a robust and accurate picture of the scale of MSSA infections, nationally and locally, will also support patients in making meaningful choices about their healthcare.

The trust records MSSA bacteraemia cases separately on the web-based system, as they do already for MRSA bacteraemia and the Chief Executive will sign-off on the 15th of the month. The first MSSA Chief Executive sign-off for the January 2011 mandatory data was the 15 February 2011.

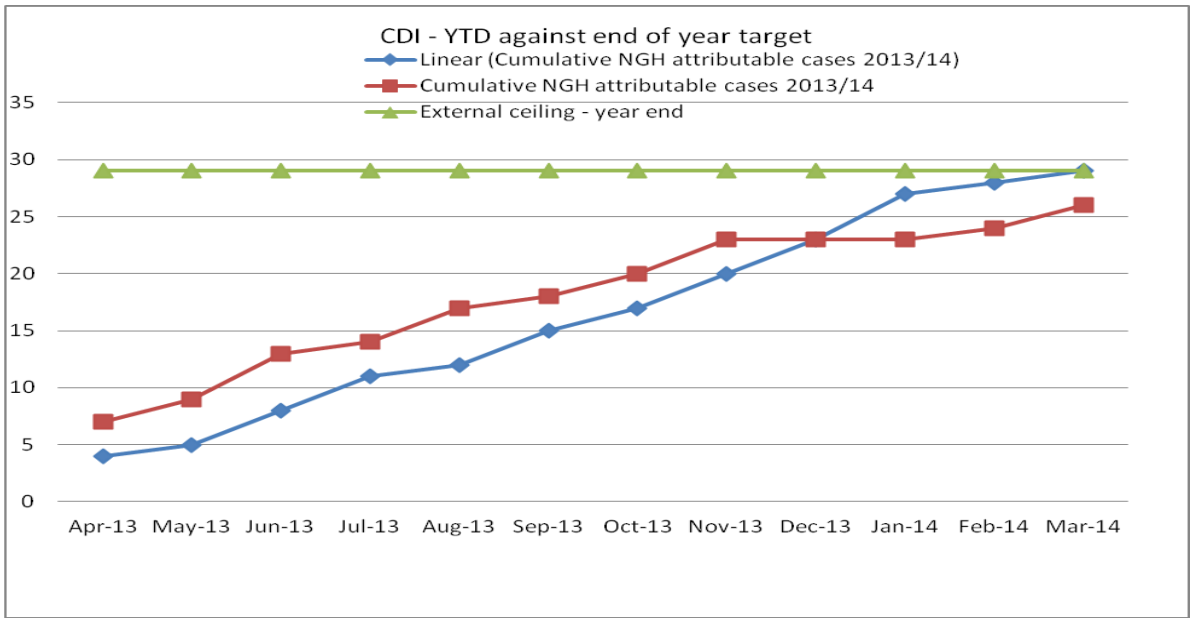
Trusts have not been set a trajectory for MSSA (meticillin-sensitive *Staphylococcus aureus*) bacteraemias. However we have been collecting data for the past 3 years. This year 2013-14 we identified 7 “post-48 hour” hospital-onset cases of MSSA bloodstream infection, a 37% reduction from last year (2012-123)

5.4 Clostridium difficile

The 2012/ 2013 ceiling for cases of *Clostridium difficile* associated diarrhoea (CDAD) was 36 by the PCT contract. The Trust had 30 CDAD cases (post 3 days) attributed to the Trust during 12/13.

Special Measure actions were implemented for wards that have two or more incidences of *Clostridium difficile* in a 28-day period. Creaton ward was the only ward that had been on special measures in this period due to having 2 incidences of CDAD in April.

The graph below is the CDI –YTD against the end of year target.



The weekly CDiff Review Team comprising of a Consultant gastroenterologist, Consultant Microbiologist, a member of the Infection Prevention and Control Team and the Antimicrobial Pharmacist continues. All patients who have *Clostridium difficile* have their antibiotic management proactively reviewed.

Local PHE data April 2013/March 2014 – Number of cases

		Trajectory	
	Bedford Hospital	15	**11**
	East & North Hertfordshire	14	**14**
	Northampton General Hospital	29	**26**
	Luton & Dunstable Hospital	15	**19**
	Milton Keynes Hospital	13	**34**
	Kettering General Hospital	29	**22**
	West Hertfordshire Hospitals	24	**28**
	South Midlands and Hertfordshire	**139**	**154**

While it is a significant achievement to have met the 2012-13 target, the “ambition” set for us for 2013-14 is 35 cases with an internal one set for 24. This will only be met by maintaining the high standards of environmental cleanliness and careful antibiotic prescribing that we have seen this year. Until now we have reported all C.diff toxin positive cases. We must try to ensure that all patients admitted with diarrhoea have a sample sent within the first 3 days post admission to ensure correct case attribution.

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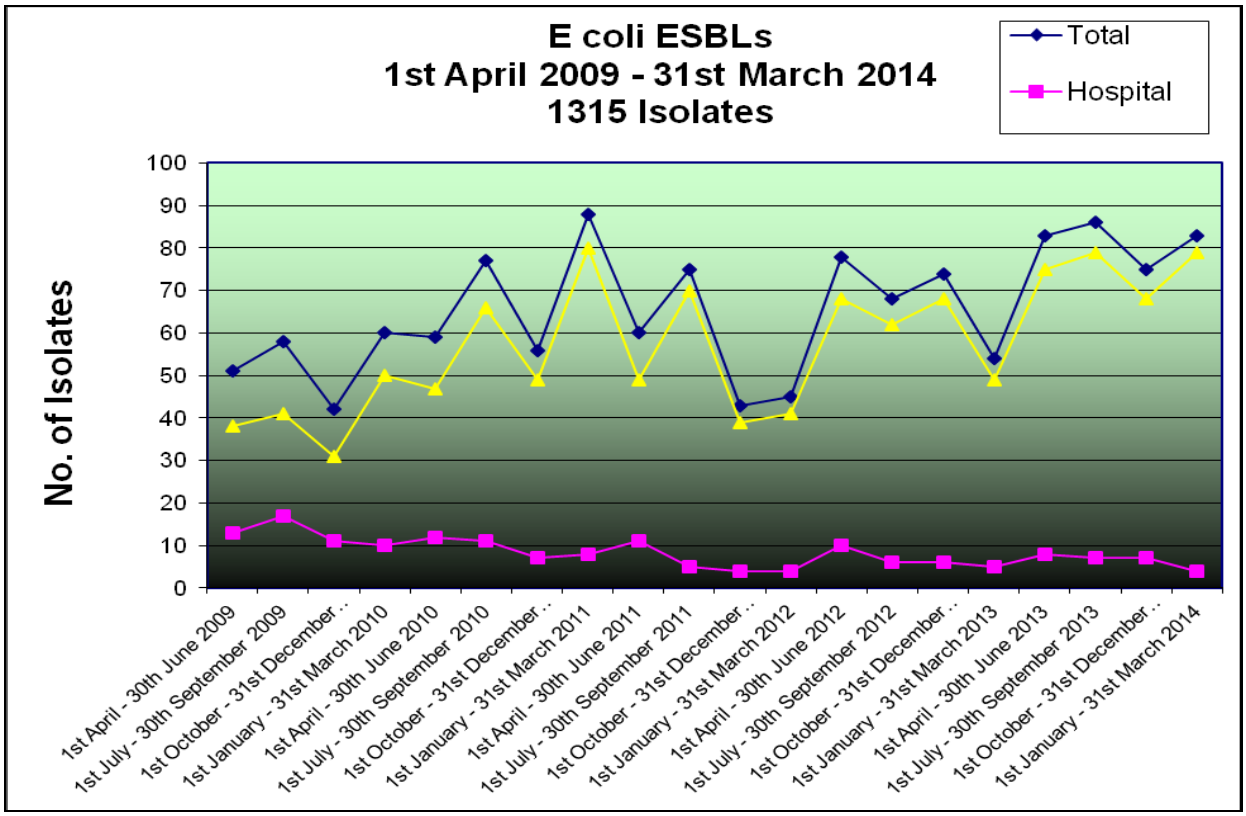
5.5 Local Surveillance of ESBLs

A local surveillance system to monitor the numbers of infections with ESBL (Extended- Spectrum Beta-Lactamase) producing coliform in the south of the country has been established based on reports generated by the laboratory.

ESBL (Extended-Spectrum Beta-Lactamase)-producing *Escherichia. coli* are antibiotic-resistant strains of *E. coli*. *E. coli* are very common bacteria that normally live harmlessly in the gut.

Since 2003 the PHE has been working with NHS hospital microbiologists to ensure they are aware of these infections and are able to advise and provide information to their local GPs and hospitals about their diagnosis and treatment. The PHE has also published information in scientific journals and issued advice directly to GPs via its website and leaflets. It also continues to review the activity of new antibiotics against bacteria with these enzymes.

The IPT continue to collect data for the year on all specimens that are found to be ESBL positive. Clinical specimen positives for example urine, sputum and aspirates are collected from the laboratory. The team report all the community specimens to the community IPT and the internal positive samples are relayed to the ward staff to highlight the result, check that the antibiotic therapy they have been prescribed is effective and to advise on infection prevention and control precautions on an individual basis.



Escherichia Coli (E.coli) bacteraemia

In accordance with the Department of Health Guidelines the IPT commenced mandatory reporting of E coli bacteraemia in June 2011. National data is collated to include all positive results, they are not attributed to either acute of community responsibility.

All ESBL post 48 hour positive blood cultures have detailed data collated and an internal RCA is conducted to highlight any common trends and learn from this analysis. Currently NGH considers all episodes diagnosed after 48 hours as hospital attributed.

On review of the clinical specimen's themes and trends, urosepsis and recurrent UTIs still continue to rank as the highest cause. As the ever increasing drug resistance continues to be seen in all aspects of healthcare the collection of the ESBL data remains of paramount importance for the team to be able to review trends in causes or cases as seen.

6.0 Outbreaks

During 2013/14 we had no outbreaks.

7.0 Antimicrobial Stewardship

7.1 Compliance to Trust antibiotic policy

The point prevalence audits were performed by Clinical Pharmacists at the Trust over a one day period (16th April and 23rd October 2013). The aim was to audit antimicrobial prescribing at the Trust and compliance to the Trusts Antibiotic Policy. This is in response to the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance. Criteria 9 of which states that procedures should be in place to ensure prudent prescribing and antimicrobial stewardship, there should be an ongoing programme of audit, revision and update.

April 2013:

Descriptor	Number	Proportion	Comments
Total number of patients seen	**576**		
Number of patients on antibiotics	**200**	**34.7%**	This is higher than October 2012 when 28.9% of patients were prescribed antibiotics but comparable to March 2012 when it was 35.96%.
Total number of antibiotics prescribed	**264**	**1.32 per patient**	
Number adhered to the policy	**213** **244 (including**	**80.7%** **92.4% (including**	Valid reasons for non-compliance; • Micro approved = 15 (5.7%)

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Descriptor	Number	Proportion	Comments	
	valid reasons for non-compliance)	**valid reasons for non-compliance)**	• Based on culture and sensitivities = 4 (1.5%) • No guidelines for infection = 12 (4.5%) (see below for a list of infections) 20 prescriptions (7.6%) did not comply with NGH antimicrobial guidelines (see below for a list of infections).	
Number of intravenous (IV) prescriptions	**125**	**47.3%**	This is lower than previous audits, October 2012 (57%) and March 2012 (57.9%).	
Number of oral prescriptions	**139**	**52.7%**	This is higher than previous audits, October 2012 (43%) and March 2012 (42%). 30 prescriptions had been switched from IV treatment	
Average duration of IV antibiotics	**4.1 days**	[redacted]	This is similar to the average of 4.3 days in October 2012.	As this is a point prevalence audit data is not available for the total course lengths actually given to each individual patient.
Average duration of oral antibiotics	**3.8 days**		This is lower than the average of 5.4 days in October 2012.	
Duration of antibiotic administration stated on prescription chart	**122**	**46.2%**	This has increased from 31.9% in March 2012 and 44% in October 2012. More work needs to be done to ensure reviews are taking place and that all course lengths are documented. The new chart which has a prompt box for antimicrobial course length was launched in	

Descriptor	Number	Proportion	Comments
			May 2012.
Number of antimicrobial prescriptions with one or more omitted dose	**27**	**10.2%**	This is a new standard added to the audit in April 2013. It is worrying that 10.2% of antibiotic courses have one or more dose omitted. Antibiotics are critical medicines and no doses should be omitted or delayed. The Medication Safety Group is working with all the wards to reduce omitted doses. The data collected for this standard will be looked at in more detail.

October 2013:

Descriptor	Number	Proportion	Comments
Total number of patients seen	**560**		
Number of patients on antibiotics	**184**	**33%**	This is higher than October 2012 when 28.9% of patients were prescribed antibiotics but comparable to April 2013 when it was 34.7%.
Total number of antibiotics prescribed	**238**	**1.3 per patient**	
Number adhered to the policy	**176** **220 (including valid reasons for non-compliance)**	**74%** **92% (including valid reasons for non-compliance)**	Valid reasons for non-compliance; • Micro approved = 24 (10%) • Based on culture and sensitivities = 4 (1.7%) • No guidelines for infection = 16 (6.7%) (see below for a list of infections) 18 prescriptions (8%) did not comply with NGH antimicrobial guidelines (see below for a list of infections).
Number of intravenous (IV) prescriptions	**147**	**62%**	This is higher than previous audits, April 2013 (47.3%) and October 2012 (57%).

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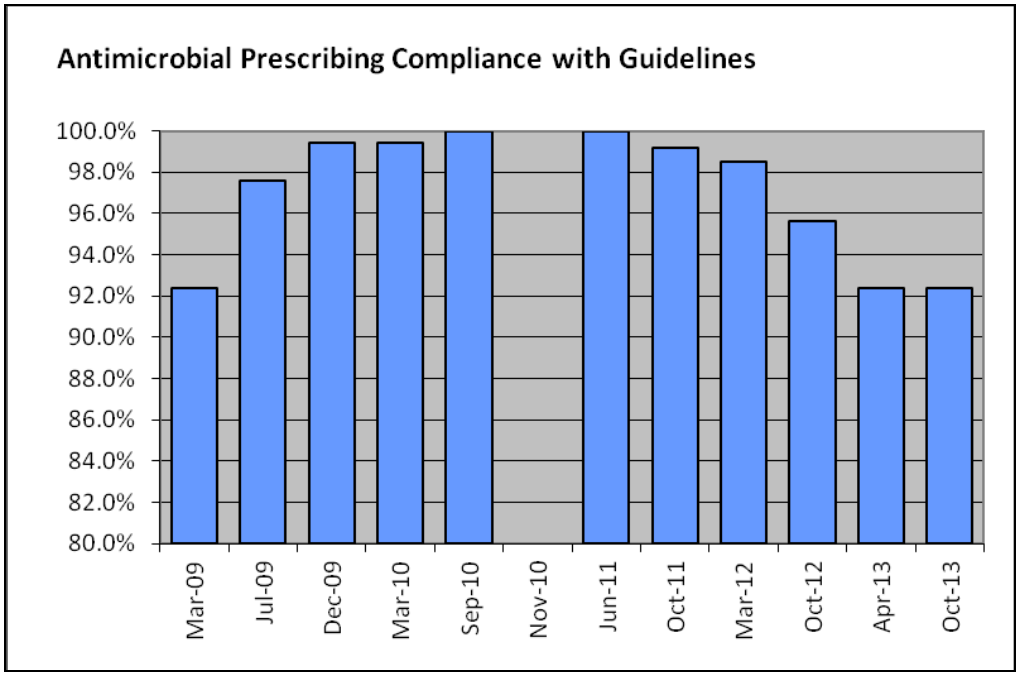
Number of oral prescriptions	**91**	**38%**	This is lower than previous audits, October 2012 (43%) and April 2013 (52.7%). 24 prescriptions had been switched from IV treatment	
Average duration of IV antibiotics	**3.6 days**	[redacted]	This is lower than the average of 4.1 days in April 2013.	As this is a point prevalence audit data is not available for the total course lengths actually given to each individual patient.
Average duration of oral antibiotics	**2.9 days**		This is lower than the average of 3.8 days in April 2013.	
Duration of antibiotic administration stated on prescription chart	**87**	**36.5%**	This has decreased from 46.2% in April 2013 and 44% in October 2012. More work needs to be done to ensure reviews are taking place and that all course lengths are documented. The new chart which has a prompt box for antimicrobial course length was launched in May 2012.	
Number of antimicrobial prescriptions with one or more omitted dose	**19**	**8%**	This is a new standard added to the audit in April 2013. It is worrying that 8% of antibiotic courses have one or more dose omitted. Antibiotics are critical medicines and no doses should be omitted or delayed. The Medication Safety Group is working with all the wards to reduce omitted doses. The data collected for this standard will be looked at in more detail.	



These biannual audits will be repeated and are scheduled for April 2014 (this was conducted and results are being analysed) and October 2014.
If poor compliance is noted then this is followed up immediately, for example each report comments on the very low numbers of prescribing deviations. The Antimicrobial Stewardship Group discusses action planning which needs to be integrated with other performance management processes [Medication Safety Group and Head Nurse Indicators etc].

7.2 Training initiatives

Junior Doctors training was delivered on 10th April 2014.
Pharmacist's training was delivered and facilitated (using Centre of Postgraduate Pharmacy Education Antimicrobial Learning@Lunch training package) on 26th November 2013.

7.3 Antibiotic campaigns

European Antibiotic Awareness Day provides a platform to support and promote national campaigns about prudent antibiotic use in the community and in hospitals. On November 18th 2013 awareness was raised via a presentation on the Trusts corporate screensaver focusing on the Department of Health's Antimicrobial Stewardship Start Smart – Then Focus campaign.

7.4 Antimicrobial Stewardship Group

An Antimicrobial Stewardship Group was set up in 2012. The remit of this group is to develop and implement the organisation's antimicrobials programme for all adults and children admitted to hospital. There were three meetings between April 2013 and March 2014. Developments in the last year have included:

- Ratification of Adult Antibiotic guidelines
- Development and launch of the antibiotic guidelines via the Smartphone App.
- Various PGD reviews and ratification.

- Bi-annual Antimicrobial Point Prevalence audit
- Meropenem point prevalence audit – results of this showed that the two main reasons for its use were the interpretation of the ‘Sepsis 6 pathway’ and documentation of penicillin allergy.
- Communication with the Intermediate Care Team to investigate areas for any improvement and to discuss positive aspects of the service.

8.0 Saving Lives

The Trust has taken significant steps in embedding the Saving Lives programme into daily activities of clinical care. The overall aim of Saving Lives is to ensure that all staff recognise how they can contribute to reducing infection rates and adopt best practice to achieve this. High impact interventions are used to reduce the risk of healthcare associated infection. Each of these interventions has a simple evidence based tool that reinforces the actions that clinical staff must undertake ‘every time’ for key procedures in order to significantly reduce infection. The aim is to increase the reliability of clinical processes and reduce unwarranted variation in care delivery. The compliance ranges from 80% to 100% each month and is RAG rated accordingly.

8.1 Matrons Dashboard

The Matrons are required to populate an Infection Prevention compliance chart each month with the percentages from the high impact interventions within the Saving Lives. The results are RAG rated and fedback at the IPCC, receiving constructive challenge from the DIPC. Areas that are non compliant are raised by exception to the Healthcare Governance Committee (HGC) to report actions being undertaken to resolve any issues.

9.0 The Health Assure formally the Performance Accelerator

The Trust is registered with the Care Quality Commission (CQC) under the Health and Social Care Act 2008, and as a legal requirement must protect patients, staff and others from acquiring health care associated infections by compliance with the Hygiene Code.

The Hygiene Code evidence has been loaded onto the Health Assure platform which is on-line corporate software that provides boards and management teams with assurance and information needed to plan, manage and report on key performance indicators.

All the evidence has been uploaded and there is one area that is partially compliant (amber).This is criteria 9 which is to have and adhere to policies, designed for the individuals care and provider organisations that will help to prevent and control infections.

There is one policy from the facilities department which is the Decontamination Policy which is being updated.

10.0 Infection Prevention Study Day

In October 2013 the Infection Prevention Team celebrated their fourth annual study day where 50 members of nursing, HCA, therapies and domestic staff came together from across the trust to learn more about different aspects of infection prevention and control. The event was sponsored by five companies whose infection prevention products we use.

Suzie Loader, the Director of Nursing, Midwifery & Patient Services and the Director of Infection Prevention and Control gave a very motivating welcome address. She discussed the Trust MRSA and *C.diff* ceilings for 2013-14 and how staff can help achieve this through checking that stool samples are appropriate before we collect them.

We then concentrated on the role that good care of invasive devices play in preventing harm and infection to patients. We listened to a presentation on PICCs (peripherally inserted central catheters) by Carol Lowe a PICC clinical specialist and then peripheral cannulation by a group of our Preceptorship nurses, Chris Kean, Ashley Gaton, Kat Ellis, Annemarie McKeegans, Emma Cuthbert and Charlotte Lane. Their videos highlighted good and bad practice and were very educational.
We wished to focus on *E.coli* as a pathogen because it is recognised nationally that bacteraemia with this organism is becoming more frequent. The talk provided background information on the range of disease processes that *E.coli* is associated with and how these relate to the differences in certain key components of this bacterium. Information on local *E.coli* bacteraemias was presented particularly that concerned the source of infection, its relationship to underlying diseases such as cancer and urinary tract infection and the problem of increasing antibiotic resistance.
Brenda King, Nurse Consultant Tissue Viability, who taught us how to identify bacteria in wounds, through looking at the odour and appearance before sending a wound swab and showed us pictures of infected wounds. Clare Topping, Energy and Sustainability Manager, then discussed new sharps bins that have recently been trialled and will roll out trust wide in November. She then showed us audit findings of inappropriate items in sharps bins including sandwiches, unused cannulas, resheathed needles and paper.

Finally a synopsis of the scaled skin outbreak in Maternity Services at the beginning of the year, where Anne Thomas, Head of Midwifery & Gynaecology, explained how the outbreak was managed and the lessons learnt.

Feedback from the delegates was very positive; staff found it very educational, motivating and enjoyable and are very much looking forward to next year's study day!

11.0 Beat the Bug, Save the Skin, Stop the Clot: Board Quality Visit

To support the on-going HCAI agenda across the Trust all Executive and Non Executive Directors and the Trust Chairman participate in a 'Board Quality Visit' on a monthly basis. This 'inspection', facilitated by the IPCT involves visiting clinical areas with a similar inspection programme to the CQC visit. Each of the Executive Directors visits 2/3 areas and audits the clinical area against set criteria. Data from the visits is collated by the IPCT for the monthly IPCC to review.

The reviews are still being seen as very positive by staff on the wards, and the output from the reviews is beneficial, therefore it is important to maintain regular visits.

12.0 The 2013/14 IPCT Annual Plan

The IPCT Annual Plan (Appendix 1) provides an overview of the commitment to prevention and control of infection by the IPCT within the clinical directorates. The Infection Prevention and Control audit is a vital component of robust infection prevention and control service. The objectives of the audits are to inform the Trust of their level of compliance to national IPC standards, local policies and procedures and allow improvements to be made based upon findings. It also identifies target areas for training.

Review of Annual Plan

The annual plan was achieved except for one area regarding the further development of an ESBL database. The department was not successful with the anticipated web based surveillance application, ICNet. However a business case is currently being undertaken to be put forward in October 2014.

The following audits were undertaken during the year:

Infection Prevention Audits April 2013- March 2014

Audit	Overall Hospital Score
Sharps	**96%**
Environment	**93%**
Linen	**96%**
Isolation	**100%**
Waste	**95%**
ANTT	94%
Blood Cultures	92%
PVC	85%
Total Hospital Compliance	**94%**

13.0 Training and Education

Infection prevention and control training is maintained monthly at the Trust's Induction programme and at the clinical and non-clinical refresher programmes The IPC team have also carried out various education sessions to other staff groups including Healthcare Assistants, Housekeepers, NICU, Paediatric, Maternity staff, Overseas nurses, Trainee Assistant Practitioners, voluntary workers and newly qualified nurses ranging from extended inductions, yearly refresher, formal sessions and training within clinical settings.

- The IPC Team have presented at a number of academic half-day sessions for medical, surgical and orthopaedic staff, featuring presentation on incidence, transmission, prevention and control of HCAI.
- Training and education has been delivered by IPT on the use of the Isolation/ stool chart for patients with diarrhoea and education sessions around *Clostridium difficile.*
- The Infection Control Web page is updated regularly and is accessible to all staff. Monthly 'Bug Bulletins' continue to be sent out to all areas to update staff on issues that the team has identified during the previous weeks.
- Ad hoc sessions as requested on current IPC practices for example Pathology staff.
-

Development opportunities for the members of the infection prevention and control team are agreed at annual appraisal.

14.0 Infection Prevention Annual Programme For Surgical Site Surveillance 2013/14 (Appendix 2)

Since 2004, all NHS hospitals where orthopaedic procedures are performed are required to carry out a minimum of three months surveillance of surgical site infections. This information is reported to the Health Protection Agency who analyse the data and provide reports for local hospitals and produce a national report.
The collaboration with T&O with the continuous surveillance of fractured neck of femur (NOF) is proving very successful. It has extended to fractured knees and hips.

15.0 Hospital cleaning

The first Patient-Led Assessments of the Care Environment (PLACE) took place this year. This is the new system for assessing the quality of the patient environment. The aim of PLACE assessments (which took over from the long established PEAT programme) is to provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the patient experience of care, cleanliness, the condition, appearance and maintenance of healthcare premises. The extent to which the environment supports the delivery of care with privacy and dignity, and the quality and availability of food and drink.

The IPCT is always present at these assessments and we continue to achieve acceptable scores in the majority of the assessment process. The assessment which is carried out mainly by patient representatives took place in April 2014.The results were

- Cleanliness **99.46 %**(95.75%)
- Condition appearance and maintenance **89.6%(**88.7)
- Privacy, dignity and well being **94.17 %(** 88.9%)
- Food and hydration **89.63 %**(85.41%)

The figures in brackets are the national average scores.
Whilst this was a snapshot in time it is nevertheless a very good result and is used as evidence by the CQC in their reviews.

Monthly cleaning audits are performed in all directorates with the table below providing a monthly average and overall average at the end of the year.

2013/2014

Month	%
April	97
May	97
June	97
July	97
August	97
September	97
October	97
November	96
December	96
January	96
February	97
March	96

Average	97

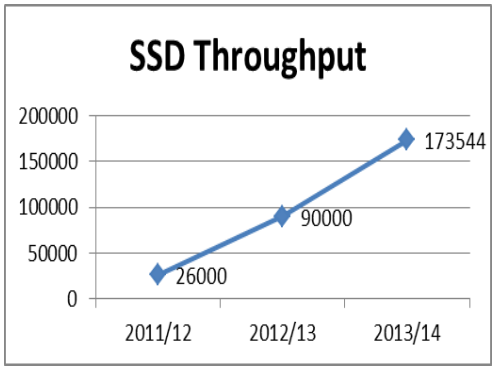
16.0 Decontamination Arrangements

Sterile Services Department

During the past twelve months there have been significant challenges for Sterile Services with the departure of a Manager and Decontamination Lead, Deputy Manager and three Supervisory staff within a few months of each other. A new Decontamination Lead was appointed at the end of November 2013 and was made substantive in June 2014.

The Sterile Services department processed 173,544 packs from April 2013 to March 2014 including Instrument Trays, Procedure Packs and Individual medical devices with a non-conformance rating of under 0.3%.

The throughput of the department has increased year upon year to what is now almost 7 times greater than the throughput was in 2011/12.



The department successfully demonstrated compliance against International, European and British Standards for Decontamination and Quality Systems during a two day external audit and have maintained its accreditation to BS EN ISO 9001 and BS EN ISO 13485.

Unfortunately no students passed the "Institute of Decontamination Sciences Technical Certificate" examination in 2013. However changes in training arrangements have progressed well with one member of staff passing the examination in March 2014. There are now 4 students studying for this qualification with more expected to come on board.

The application of a capital bid for the replacement of washers was not realised in 2013. A bid will be drawn up for their replacement in the next round of bids.

Guidance Documents

After withdrawing the old Health Technical memorandum documents HTM2010 (Sterilizers) and HTM2030 (Washer-Disinfectors) a new document was issued in the form on HTM-01-01. For reasons that are not clear, the Department of Health decided to withdraw this document within the first year of its' publication and replaced with Choice Framework documents.

The adoption of the Department of Heaths' Choice Framework for Policies and Procedures CFPP-01-01 has led to further tests being required to provide sterility assurance when performing yearly tests on sterilizers. These changes include presenting a biological challenge at the end of a very fine long tube to ensure air removal and steam penetration is achieved in a challenging device. A further test is to place 8.6 Kg load of metal to measure the level of condensate (water) produced by a normal sterilization cycle when hot steam hits cold metal with this load configuration. This test is aimed at reducing the risk of water remaining within wrapped loads after sterilization.

During the transition period between HTM-01-01, HTM 2010 and HTM2030 being withdrawn and CFPP or BS EN ISO standards being adopted there will be a period of time when external test reports are quoted with the old references. It is anticipated this will be corrected by the next Annual Report as UKAS testing laboratories come on board with the new standards when they are audited by their Notified Body.

Medical Equipment Library

An additional full-time substantive member of staff was added to the Medical Equipment library team in February 2014. The Trust has moved away from rental arrangements for pressure relieving mattresses and now has its' own supply. An agreement with Arjo Huntleigh to maintain the mattresses whilst under warranty is in place. Continuing arrangements for maintenance will be dealt with by the Medical Electronics contractor (TBS).

Development of the ICE system to requisition mattresses and cushions has continued and this is now rolled out Trust wide. Enhancements to the system have been installed to allow better reporting to be realised.

Increased storage areas have been identified for Mattresses out of hours. Additional shelving is to be purchased to enable the new pumps to be stacked safely. It is not possible to stack the new pumps on top of each other because of their design.

Endoscopy

The department continues to operate with effective Automated Endoscope Reprocessors (AER) and Drying/Storage cabinets.

The department is at full capacity with little room to expand the size of the unit given its current footprint and configuration within the Integrated Surgery area.

A substantive test person has been appointed within the department which has realised more consistency with daily and weekly testing.

Endoscopy services at Danetre hospital have been withdrawn due to the inadequate facilities provided within this hospital. The existing AER is being decommissioned and will be stored at NGH for the foreseeable future.

The vacuum scope transportation system is now in use for scopes that are needed outside of the Endoscopy Department (e.g. ITU, Theatres).

Trust Wide

Compliance with the Decontamination of Medical Devices Policy is reasonably high. There are areas that do still need some work (Gynaecology) where TV Probes are still be reprocessed.

The Decontamination Policy has been updated to include these areas, and encouragement to change practice will be ongoing until full compliance is realised. Audits will continue to ensure compliance with the policy.

Forward Plan 2014 – 2015

A review and business case for a Capital Bid is being developed to replace the existing washer-disinfectors in Sterile Services which are 10 years old. The current capacity of the machines is only 9-12 baskets per cycle. New machines are designed to accommodate 12-15 baskets per cycle, which will give the department greater capacity for turnaround times.

Pressures on the Endoscopy service are growing with more patients being screened thus pushing up the throughput of the unit. Considerations are being given to how the unit can expand given its current footprint.

Conclusion

The Decontamination Lead and the Infection Prevention and Control Team work very closely together. They are working with many disciplines throughout the organisation to provide support and guidance on issues as they arise.

Conclusion for the Report

The improved performance in relation to infection prevention and control within the Trust is no reason for complacency. The Infection Prevention and Control Team will continue to raise awareness of specific issues surrounding HCAIs with both our staff and local population, and to promote and monitor clinical practice to minimise the risk of HCAIs for patients who have their care at NGH.

Appendix 1

Infection Prevention and Control Team Annual Programme of Work April 2014 – March 2015

This document aims to detail the Northampton General Hospital NHS Trust-wide programme for infection prevention and control (IPC). It incorporates the requirements for the revised Health and Social Care Act 2008 - Code of Practice for health and adult social care on the prevention and control of Infections and related guidance. Hereafter referred to as 'The Health Act 2008'.

From April 2009, all NHS providers were required to be registered with the Care Quality Commission. This registration legally requires the Trust to protect its service users, staff and others from the risks of acquiring an infection and to be compliant with the code of practice as far as is reasonably practicable. The Care Quality Commission enforcement powers include imposing, varying or removing the conditions of registration, including the power to impose financial sanctions on non-compliant trusts.

This Trust has declared compliance with the Code and therefore robust systems must be in place. The Code incorporates 10 criterions.

The programme will identify the Infection Prevention Control (IPC) activities that the Trust will focus on for the coming year. All areas are expected to follow existing IPC activities, policies, procedures and guidelines and to be aware of updates and revisions as they occur. The main focus for this year will be:

- Promoting the importance of effective hand hygiene
- Ensuring that staff are knowledgeable in the principles of infection prevention and control
- Engaging management teams in the infection prevention and control agenda
- Monitoring the rates of infections both for national and local reporting requirements.
- Monitoring practices and processes through audit
- Involving staff, service users, carers and visitors in the infection prevention and control process.

2. Summary

A written monthly report is to be submitted to the Trust Board to monitor progression of the infection control programme for 2014-2015, and therefore the Trust's adherence to The Health Act 2008. The report is to cover infectious incidents within the Trust, actions taken and outcomes, if known, to provide reassurance that the Trust is taking the appropriate actions in relation to infection prevention and control. The design of this programme is to ensure the Trust Board has clarity on the requirements and the progress of the programme throughout the year.

Hygiene Code	Action point	Lead/ Responsible person(s)	Implementation Programme	Evidence Required	Current RAG	Review/ Monitor	Review Monitor date
1-Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them **3**- Provide suitable accurate information on infections to service users and their visitors	• Board level agreement regarding responsibility for minimising HCAI • Surveillance of "alert organisms" & Surgical Site Infections • Infection Prevention and control Annual plan, incorporating annual plan of work	DIPC, Lead IPN, Director of Nursing and Midwifery	• Daily Surveillance of alert organisms • Daily surveillance of previous MRSA positive inpatient's. • Mandatory surveillance MRSA/MSSA /E coli Bacteraemia and C-diff in collaboration with Public Health England , Other alert organisms i.e. PVL,CPE • Surveillance of previous MRSA positives. • Maintenance of IPCT data bases • Develop the annual audit plan to include	• Advice to wards/clinical areas via daily ward visits, telephone enquiries and advice on treatment management • Face to face discussions with ward staff on identification of positive Alert Organism • Monthly graphs/charts/figures to Information and Contracting. • Monthly reports Heads of Nursing,		Daily Monthly Monthly Monthly	Monthly IPC

5- Ensure that people who have or develop an infection are identified promptly and receive appropriate treatment and care to reduce the risk of passing the infection to other people **6** Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infections **7 -**Provide or secure adequate isolation facilities **8 -** Secure adequate access to laboratory support as appropriate	• Provide suitable and sufficient assessment risks to patients within healthcare settings • Surgical Site Surveillance		audit of specific IPC policies • Specific IPC documentation for in-patient areas include actions and risk assessments • Monitor elective/emergency screening compliance • Maintenance of MRSA screening compliance. • Report SI's and provide support for directorates to investigate with Root Cause Analysis • RCA all MRSA bacteraemia <48hrs for Trust learning • RCA all MSSA bacteraemia <48hrs for Trust learning • RCA all Ecoli bacteraemia <48hrs for Trust learning • Maintenance of compliance with patients checklist and audit 2 monthly • Mandatory SSIS hips fractured NOFs &	Clinical leads, Monthly reports to HMB, CQEG and Trust Board via IPCC and IHGC minutes. • Achieving of Trust National and locally agreed targets for MRSA/MSSA bacteraemia and *Clostridium difficile* • Feedback from Region via quarterly reports • Feedback to directorate Leads via Surveillance nurse as reports received from HPA		Quarterly Monthly Daily	

			knees undertaken by Orthopaedic teams with support from IPCT. • To maintain SSSI via a rolling programme via HPA Colindale – Vascular, Large Bowel. Hysterectomy Caesarean section and breasts. • Surveillance and management of outbreaks of Infection, e.g. Clusters of MRSA colonisation or clinical specimens, *Clostridium difficile,* Norovirus outbreaks requiring closure of wards and impacting on Trust business • Facilitates the SI report of outbreaks with risk management	• Daily meetings, as required, during outbreaks of infection, reporting to CE, Director of Nursing, CCG and TDA. • Advice to medical staff re: antibiotic treatment via Microbiologists • Advice to wards regarding appropriate isolation and nursing practice • Advice to Heads of Nursing/Matrons, on-call managers and Site Management Team as appropriate as per Policy for Outbreaks of Infection			
2- *Provide and maintain a clean and appropriate environment in*		DIPC, Lead IPCN, Director of Nursing	***Programme of Audit*** Environmental Use of IPS/DH Audit tool	• Feed back to Head of Nursing and ward managers via IPCC • Provide infection prevention and		Monthly, Quarterly, six monthly and annually	Monthly IPC

managed premises that facilitates the prevention and control of infections Towards Cleaner Hospitals **6 -**Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infections **9 -**Have and adhere to policies, designed for the individuals care and provider organisations, that will help and control infections		Midwifery, Lead for Facilities, Lead for Estates	to develop database, maintain safe environment. Collaborative working with Facilities to deliver a robust audit programme to monitor and maintain compliance with national Cleaning standards ***Practice*** • Point Prevalence- Urinary catheters - 6 monthly • **MRSA IPCP audit – compliance with Policy** • MRSA screening Point prevalence monitoring of compliance in admission and high risk areas • **Isolation- Compliance with Policy** • Monthly Time to isolation audit • Hand hygiene monthly by each ward within Saving Lives audit programme • Special measures	control advice • Ensure support of Ward managers and more involvement of link nurses • Plan audits in advance to ensure link nurse availability • Emphasise realistic action plans. • Re-audit within a realistic time-frame • Review of audit tool and care plan • From clinical areas and Leads – use findings to direct education • Further Audits will be added as required.			

			• Ad hoc following outbreaks of clusters of infection • Monthly Saving Lives audit *Clostridium Difficile* • On-going audit of TB precautions and management. • Monthly Safety Thermometer validation of CAUTIs • Six monthly commode audit.				
4 – Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion **5-** Ensure that people who have or develop an infection are identified promptly and receive		DIPC, Lead IPN, Director of Nursing	***Clostridium Difficile Associated Diarrhoea)*** **–** • *Daily Laboratory based surveillance* • Mandatory reporting of all CDT on HPA HCAI web based surveillance system • Reporting of CDT deaths or SI's on STEIS • Identification of Hotspots (2 or more positives in one ward	• Achieving of trust and nationally decided target • Advice to wards regarding appropriate management including isolation and nursing practice • Advice to medical staff re: antibiotic treatment via Microbiologists • Monthly graphs to HN and ward		Monthly Monthly	Monthly ICC

appropriate treatment and care to reduce the risk of passing the infection to other people **6-** Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infections **7-** Provide or secure adequate isolation facilities			area within 28 days) • RCA all positive Cdiff specs >3 days • Maintain Antigen positive surveillance.	Managers • Monthly reports Heads of Nursing, Directorate leads, Monthly reports to HMB and Trust Board via IPCC • Discharge letter to GPs on all positive Clostridium difficle positives.		Monthly Ongoing	
9- Have and adhere to policies, designed for the individuals care and provider organisations, that will help and control infections		DIPC, Lead IPCN, Director of Nursing Midwifery	• Review and update policies in line with National Guidance Review. All policies updated and endorsed by Infection Prevention and Control Committee • Review each policy as necessary • Collaboration with other specialists e.g.	All new and updated policies will be ratified by Infection Prevention and Control Committee prior to Trust ratification at the Quality Governance Board		Monthly	Monthly IPCC

			Occupational Health Department, Site Management, Facilities and Estates Leads • Policies available on Intranet Web Page **Provision of policies for individual organisms will include** • MRSA/MSSA • *Clostridium Difficile* • GRE • Gram Negative infections including ESBLs and Acinetobacter • Tuberculosis • Meningococcal infections • Viral Haemorrhagic Fever • CJD				
10 -Ensure, so far as is reasonably practicable, that care workers are free of and protected from exposure to infections that can be caught at work		DIPC, Lead IPCN, Director of Nursing Midwifery and Quality	**Provision of Education for all staff** **Mandatory** Monthly induction Monthly refresher (x2) Monthly ROK **Infection Prevention and Control Link**	• Monitoring of attendance at mandatory sessions by Staff Development via OLM • Monitor ad hoc attendance by IPCT • Audit practice to			Monthly ICC

and that all staff are suitable educated in the prevention and control of infection associated with the provision of health and Social care			**nurses** 6 meetings - Feb – April - June – August –October –December. **As requested** Housekeepers, Porters, Radiographers, Physiotherapists, Phlebotomists Occupational Therapists, Estates Staff, Hospital Volunteers Teach on the IV study days, Ward Sisters / HCA's/ANTT technique **Monthly** Obstetrics NICU Paediatrics **Night Staff sessions** 1night shift every 6 months. **Hand Hygiene** Ad hoc by directorate IPCT leads and following hot spots or outbreaks of Infection Cascade hand hygiene trainers	evaluate learning and application • Education and Feedback of Practice Audits to address issues/ review guidelines. Inform and participate in establishing evidence to support good Infection Control Practice trust wide. • Liaise with Directorate Practice Development Nurses. Training and Development Department, and Clinical Development Nurse • Continue liaison with University College			

			Target Medical Staff **<u>Alert Organisms</u>** Ad hoc by IPCT leads, cascade trainers and following special measures or outbreaks of Infection Target Medical Staff **Nursing and Midwifery Students** As requested from University Northampton First year students and return to practice allocated one day with infection prevention.	Northampton			
6- Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infections		DIPC, Lead IPCN, Director of Nursing Midwifery and Director of HR, Lead for Facilities and Estates.	Collaborative working with other Departments within the Trust and External to the Trust Involving attendance at Trust wide and External meetings • 6 weekly meetings with estates and IPT • Regular meetings with OH working together on common policies, discuss staff and infection	• Raise awareness with Directorate Managers and Clinical Directors • Raise awareness via Link Nurses, Ward Managers and Directorate Head Nurses		Monthly via Infection Prevention and Control Committee.	Monthly ICC

			prevention policies. • IPCT nominated representative to attend directorate governance meeting. • Whole Health Economy HCAI Group, Led by CCG • Cdiff Task and Finish Group • Practice Development Forum • Estates issues – collaboration with Preventative Maintenance Programme, Advice re future builds/improvements • Procurement Group working with the Materials management and Supplies Department. Participation in product reviews • Decontamination group • Water management Group • Audit and assurance Group – re Cleaning Specifications and	• Raise awareness of purchasing issues with wards • Liaise with wards via housekeepers • Feedback of PEAT assessment to wards, etc • Monitoring process changes following RCA on a county wide basis			

			Standards lead Facilities • Participation in PEAT self-assessment. • Health and Safety Group • Northamptonshire Clinical Investigatory Group • CQEG				

This programme of work will be significantly influenced and added to by tasks assigned to Infection Prevention and Control Team as situations arise.

Audit of this programme is ongoing by the IPCT.

This programme to be reviewed annually or as indicated from feedback.

Appendix 2

Northampton General Hospital NHS
NHS Trust

Surgical Site Infection Surveillance Annual Plan & Report, 2013-14

2013-2014	Category of operation under surveillance	Number of operations	Number of surgical site infections	Final surgical site infection rate after 30 days post-op follow up	Quarterly national average surgical site infection rate from Public Health England
Q1 Total	Abdominal Hysterectomy # Neck of femur	45 76	1 0	2.2% 0%	Abdominal Hysterectomies 1.4% - Repeated in Q2 # Neck of femur 1.5%
Q2 Total	Abdominal Hysterectomy # Neck of femur	61 74	1 2	1.6% 2.7%	Abdominal Hysterectomies 1.4% # Neck of femur 1.5%
Q3 Total	Caesarean section # Neck of femur Total hip replacement Total knee replacement	309 95 72 52	1 1 0 0	1.6% 1.1% 0% 0%	Caesarean sections 4.1% # Neck of femurs 1.7% Total hip replacements 0.8% Total knee replacements 0.7%
Q4 Total	Large bowel # Neck of femur Total hip replacement Total knee replacement	37 86 77 74	2 0 1 1	5% 0% 1.3% 1%	Large bowel 11.5% # Neck of femurs 1.7% Total hip replacements 0.8% Total knee replacements 0.7%

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**25 September 2014**

Title of the Report	**End Of Life Care Strategy for Adults 2014-2016**
Agenda item	**18**
Sponsoring Director	Chris Pallot, Director of Strategy and Partnerships
Author(s) of Report	Wendy Smith, End of Life Care Facilitator Dolly Barron, Specialist Palliative Care CNS (Team Leader)
Purpose	For Approval and Ratification

Executive summary

The strategy outlines the Trusts plan to improve the quality and experience of care for patients over the age of 18 and living within the last year of life and their families. It provides a framework for the implementation of national directives at local level. It also outlines how the Trust will support and educate staff so they can provide timely, compassionate care to patients at the end of life.

This includes developing a culture of continuous quality improvement by supporting the sustained use of existing good practice models (for example Primecare Rapid End of Life Discharge) as well as embracing new innovations (such as the AMBER care bundle for patients whose recovery is uncertain) together with ward based quality improvement initiatives (such as the Quality End of Life Care for All (QELCA) ward manager education programme).

Related strategic aim and corporate objective	Focus on Quality and Safety
Risk and assurance	No risks are identified
Related Board Assurance Framework entries	BAF – 1
Equality Impact Assessment	This Strategy will assert the equality for all adult patients who are within the last 12 months of life, receiving care at NGH Trust, providing a framework that promotes high standards of End of Life Care in line with national policy that can be used across the organisation

	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:

- To endorse and ratify The End of Life Care Strategy for Adults (2014-2015)

Public Trust Board
25 September 2014

End of Life Care (EOLC) Strategy for Adults 2014-2016

1. Introduction

People requiring end of life care represent a significant proportion of the patient population As an acute Trust for it is likely that a quarter of all patients in our hospital are in the last year of life (REF). '*Transforming End of Life Care in the Acute Setting"* offers an improved model of acute care which will yield positive results (both in the quality of patient experience and staff satisfaction) together with effective resource management (such as reducing inappropriate treatments / clinical interventions; fewer crisis admissions; and reduced length of stay). The strategy outlines how The Trust will implement this model of care, and other national directives, offering the best chance for patients at the end of life to be supported to live as well as they can, for as long as they can, and to be discharged or die in their preferred place.

2. Body of Report

From what is known about people's preferences people generally would like to die at home, though most deaths in the UK still occur in hospital (53.3%). The EOLC strategy recognises that the Trust needs to work differently if unnecessary hospital admissions are to be avoided and more people supported to die at home. The Trust also needs to recognise and value the needs of those patients who will die in our care, and this poses significant organisational and cultural challenges. Hospitals will continue to be major providers of care at the end of life in the forthcoming years therefore end of life care (including care of the dying) must be recognised as part of our core business.

If we are to honour the Trust's aim of providing 'the very best care for all our patients' (REF) we must strive to create an environment in which all levels of our staff both recognise (and feel able to provide) competent end of life care. Staff must also be able to access specialist advice and support when needed from the Specialist Palliative Care Team.

This strategy outlines how the Trust will support and educate staff so they can provide timely, compassionate care to patients at the end of life. This includes developing a culture of continuous quality improvement by supporting the sustained use of existing good practice models (for example Primecare Rapid End of Life Discharge) as well as embracing new innovations (such as the AMBER care bundle for patients whose recovery is uncertain) together with ward based quality improvement initiatives (such as the Quality End of Life Care for All (QELCA) ward manager education programme).This will give us the best foundation for supporting patients to receive appropriate treatment in hospital (where necessary) but also to be discharged and remain out of hospital (and die at home) whenever possible.

The Trusts staff will be supported to:

- Recognise the individual needs of patients as they approach death
- Support patients and significant others to anticipate and plan for their end of life care
- Initiate timely and sensitive discussions regarding options, wishes and preferences at appropriate stages of treatment
- Recognise and effectively manage pain and other symptoms
- Recognise and meet patients practical care needs
- Respond sensitively and timely to patients psychological and spiritual needs
- Access specialist support (including Specialist palliative care and Primecare end of

Life Care service) when required
- Recognise and respond to urgent circumstances in a timely fashion (for example Rapid 'home to die' discharges)
- Provide compassionate and dignified care for those dying in NGH
- Provide compassionate care to the bereaved

There are no 'second chances' once the person has died, and poor care and communication can have a significant and life-long impact upon the health and well-being of remaining family and friends.

References

National End of Life Care Programme (2012) TRANSFORMING END OF LIFE CARE IN ACUTE HOSPITALS. THE ROUTE TO SUCCESS "HOW TO" GUIDE. National End of Life Care Programme:

National End of Life Care Intelligence Council (2012) WHAT DO WE KNOW NOW THAT WE DIDN'T KNOW A YEAR AGO? NEW INTELLIGENCE ON END OF LIFE CARE IN ENGLAND. National End of Life Care Intelligence Council

3. Assessment of Risk

No risks are identified

4. Recommendations

The Board is asked to approve and ratify the End of Life Care Strategy for Adults 2014 – 2016.

5. Next Steps

Once ratified, it is important that the Trust as a whole engages in the principles set out within this strategy. To enable this to happen, the End of Life and Specialist Palliative Care Team will endeavour to take opportunities to engage with the clinical care groups, promoting the principles of The Transform Programme and also the Strategy itself.

The Strategy sets out six objectives with key outcomes attached for the next 2 years. A progress report will be submitted by the End of Life / Specialist Palliative Care Team to the End of Life Care Strategy Group on a quarterly basis demonstrating the progress of achieving the key outcomes and reporting any perceived difficulties in moving forward so that this can be reported to CQEG.

Northampton General Hospital NHS
NHS Trust

End of Life Care Strategy For Adults

NGH-SY-

2014 – 2016

Ratified By:	Trust Board
Date Ratified:	
Version No:	Version Five
Supersedes Document No:	No previous documents
Previous versions ratified by (group & date) (please list all dates)	End of Life Care Strategy Group- Friday 25th Oct 2013, 21st January 2014
Date(s) Reviewed:	October 2013, January 2014, February 2014, May 2015
Next Review Date:	October 2016
Responsibility for Review:	End of Life Care Lead
Contributors:	End of Life Care Facilitator Team Leader, Specialist Palliative Care End of Life Care Strategy Group

Enclosure O

CONTENTS

Version Control Summary

Version	Date	Author	Status	Comment
One	Oct 13	DB/WS	Review	Reviewed following feedback from the End of Life Care Strategy Group
Two	Jan 14	DB/WS	Review	Final consultation period for the End of Life Care Strategy Group ending 21st Jan
Three	February 14	DB/WS	Review	Alterations following consultation period (as above)
Four	April 14	WS	Review	Alterations following wider consultation
Five	May 14	WS	Review	Alterations to reflect the CQC Action Plan

STATEMENT OF INTENT

This is the Trusts first End of Life Care Strategy. It sets The Trusts plan to support the provision of effective, timely and compassionate care for patients judged to be in the last months of life, including those who die here at NGH. It describes how we intend to implement and sustain key elements from the national '*Transform*' programme 'Improving End of Life Care in Acute Hospitals' (including AMBER Care Bundle, Rapid Discharge Pathway and individual Care Plans for the Dying) which, combined with other related training and development, will prepare NGH staff to become both competent and confident to care for patients (and their families) facing life-limiting illness.

People requiring end of life care represent a significant proportion of the patient population as an acute Trust for it is likely that a quarter of all patients in our hospital are in the last year of life (REF). '*Transform*' offers an improved model of acute care which will yield positive results (both in the quality of patient experience and staff satisfaction) together with effective resource management (such as reducing inappropriate treatments / clinical interventions; fewer crisis admissions; and reduced length of stay). The strategy outlines how The Trust will implement this model of care, offering the best chance for patients at the end of life to be supported to live as well as they can, for as long as they can, and to be discharged or die in their preferred place.

INTRODUCTION

In the UK death usually follows a period of chronic illness, associated with multiple and often complex health problems. End of Life Care (EOLC) refers to care in the last year of life. Estimates suggest that a quarter of all patients in the acute setting are likely to be in their last twelve months of life (REF). From what is known about people's preferences people generally would like to die at home, though most deaths in the UK still occur in hospital (58%). A 'good death' (such as being cared for in familiar surroundings in the company of family and friends) is more likely when plans are discussed early on, but in Britain 'death and dying' is often not discussed before a crisis. Government policy however recognises the importance of anticipating and planning for end of life care and recommends (wherever possible) that people should be supported to spend their last days in a place of their choosing. This suggests that we need to re-think the way we approach care and look after people at life's end.

The EOLC strategy recognises that The Trust need to work differently if unnecessary admissions are to be avoided, and more people supported to die at home. The Trust also needs to recognise and value the needs of those patients who will die in our care, and this poses significant organisational and cultural challenges. For example, studies show that more than three-quarters of people will be admitted to hospital at least once in their last year of life (REF), with each acute stay estimated to cost £2300 - £3800 (REF). For deaths occurring locally (i.e. people dying at NGH and Kettering General Hospital) nine out of ten followed emergency admission, and half involved a hospital stay of 8 days or longer (REF). There is also a significant group of patients who are admitted on multiple occasions

(sometimes with ten admissions or more) in the last 12 months of life (REF). So even with initiatives intended to reduce unnecessary admissions, hospitals will continue to be major providers of care at the end of life. End of life care (including care of the dying) must be recognised as part of our core business.

The strategy outlines The Trusts plan to improve the quality and experience of care for patients and their families. There are no 'second chances' once the person has died, and poor care and communication can have a significant and life-long impact upon the health and well-being of remaining family and friends.

The Trust will focus on skills-based education for all levels of front-line staff. It also underlines the need for timely referral to The Specialist Palliative Care (and other targeted end of life services) for those patients with complex and urgent needs whose support may not be fully addressed by non-specialist staff. The Trust look to address the environmental factors, clinical and personal skills required to deliver compassionate care, and how systems and structured education (both formal and self-directed) will support high-quality care. In particular the plan outlines how The Trust intend to implement the *'Transform'* programme which has been developed by acute trusts (supported by the National End of Life Care Programme) as a model of best practice.

1. Our Vision

Our vision is that NGH will be recognised as a provider of high quality end of life care. If we are to honour the Trust aim of providing 'the very best care for all our patients' (REF) we must strive to create an environment in which all levels of our staff both recognise (and feel able to provide) competent end of life care. Staff must also be able to access specialist advice and support when needed from the Specialist Palliative Care Team. This strategy outlines how The Trust will support and educate staff so they can provide timely, compassionate care to patients at the end of life.

This includes developing a culture of continuous quality improvement by supporting the sustained use of existing good practice models (for example Primecare Rapid End of Life Discharge) as well as embracing new innovations (such as the AMBER care bundle for patients whose recovery is uncertain) together with ward based quality improvement initiatives (such as the Quality End of Life Care for All (QELCA) ward manager education programme).This will give us the best foundation for supporting patients to receive appropriate treatment in hospital (where necessary) but also to be discharged and remain out of hospital (and die at home) whenever possible.

2. Scope

This strategy applies to **adult patient services** provided by Northampton General Hospital. End of Life care (EOLC) encompasses those with:

- Advanced progressive life-limiting illnesses with no prospect of cure
- General frailty and co-existing conditions where life expectancy is less than 12 months
- Existing conditions where there is a risk of dying from an acute crisis/event
- Life-threatening acute conditions caused by sudden catastrophic events
- People whose death is imminent (i.e. expected within a few hours or days)

3. Compliance Statements

Equality & Diversity

This document has been designed to support the Trust's effort to promote Equality and Human Rights in the work place and has been assessed for any adverse impact using the Trust's Equality Impact Assessment tool as required by the Trust's Equality and Human Rights Strategy. It is considered to be compliant with current equality legislation and to uphold the implementation of Equality and Human Rights in practice.

NHS Constitution

The contents of this document incorporates the NHS Constitution and sets out the rights, to which, where applicable, patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with the responsibilities which, where applicable, public, patients and staff owe to one another. The foundation of this document is based on the Principals and Values of the NHS along with the Vision and Values of Northampton General Hospital NHS Trust.

4. Definitions

Advance Care Plan ACP	Document developed to allow individuals to consider and make a record of their preferences for future care
***AMBER* care bundle**	A tool for clinicians which allows active treatment to continue alongside palliative care. AMBER guides care planning, decision-making and communication with patients (judged to be in the last eight weeks of life) whose condition is unstable and recovery uncertain.
Disease trajectory	Progressive illnesses are generally marked by a predictable pattern of progression and decline This can provide a broad time-frame within which to target health and social care provision (see also GSF Prognostic Indicator Framework).
DNA-CPR	Do Not Attempt Cardiopulmonary Resuscitation
End of Life Care EOLC	EOLC refers to the care of people thought to be in the last twelve months of life
EPaCCS	Electronic Palliative Care Coordination Systems (also known as end of life patient locality register). IT system which allows both primary and secondary care to identify and track end of life patients
Gold standards prognostic indicator framework	Supports early recognition of patients nearing the end of life, so that needs can be better predicted, and the right level of care provided before crisis events. Seeks to predict patient need rather than provide a defined estimate of survival.
Holistic Needs assessment	Comprehensive assessment usually triggered at key point in illness or treatment (such as first diagnosis, relapse or end of life). Will usually include: symptom control; psychological and spiritual needs; Practical / family support needs; Treatment related issues; hopes and expectations for future care. Can be compiled by anyone involved in patient's care, but usually completed by Key Worker / Specialist Nurse
Liverpool Care Pathway for the Dying patient (LCP)	The LCP was the trust chosen model for patients in the last hours of life. Following a national review it is to be replaced in 2014 with an (as yet unspecified) individual 'Care Plan for the Dying Patient'
Palliative care	The goal of palliative care is to achieve the best possible quality of life for patients and families. It is an active approach aimed to support people who have advanced and progressive illness. It includes control of pain (and other symptoms) and the provision of psychological, social and spiritual support. The trust aims for all staff to use the palliative approach when supporting patients (and their families) who are facing the

	uncertainty of advanced, possibly incurable illness.
Preferred place of Care PPC	Discussion to explore a patient's preferences for care (i.e. do they want to remain at home?) Helps influence decision-making and reduces risk of unnecessary or unwanted hospital admission.
Preferred place of death PPD	More specific discussion to explore a patient's preferences for care (for example some people want the support to return home for as long as possible, but for personal or family reasons they do not want to die there). Fear of a home death can be very severe. It is unlikely that discharge from hospital would be appropriate in such circumstances
Primary Care End of Life Link Nurse service	Based within NGH. Responsible for assessing and coordinating discharge plans for patients (judged to be in the last 8 weeks of life) who want to leave hospital
Rapid Discharge Home to Die pathway	Process (supported by the Primary Care Link Nurse and the Specialist Palliative Care Team) to ensure urgent discharge for dying patients. The aim is to get people home (with necessary end of life symptom control drugs and community support) within 24 hours (Mon-Friday) but this will depend upon individual patient / family circumstances and availability of package of care
Special Patient Note (SPN) formerly called the shared care form	Document used in primary care to record special aspects of care (such as PPC or other end of life preferences)
Specialist Palliative Care	Specialist palliative care is provided as an additional service where there are multiple or complex needs (for example severe and unrelenting symptoms; prolonged family distress; help for future care planning). Specialist palliative care is provided by clinicians (nurses and doctors) who are skilled in advanced communication skills and experts in pain and other symptom control
***Transform* programme**	Developed by acute hospital trusts (and the Modernisation Initiative) to achieve quality in end of life care in acute hospitals. Adopting tried and tested approaches *Transform* aims to accelerate organisational success. It includes Five key enablers for change: 1. ACP Advance Care Planning 2. EPaCCS Electronic Palliative Care Coordination Systems 3. Rapid Discharge Home to Die 4. AMBER care bundle 5. Care Plan for the Dying Patient (previously called the LCP)
Treatment Escalation Plan TEP	Document to record treatment plan, ceiling of care and resuscitation decision-making for all patients admitted to the trust

5. Roles and responsibilities

5.1 Roles and Responsibilities of Individuals

The following individuals have responsibilities as summarised below:

Chief Executive	Accountable Officer for Northampton General Hospital NHS Trust, which includes signing the Statement of Internal Control but has delegated the roles as listed below.
End of Life Care Clinical lead	Represent the Trust and responsible for ensuring progress of the "Transform" programme, ensuring that clinicians are committed to the implementation, sustainability and evaluation of each of the key enablers.
Director of Nursing	Represents the Trust and responsible for ensuring progress of the '*Transform*' programme Will feed back to both the Trust Board and National Programme leads regarding the *Transform* programme
Care Group Lead Nurses	Influence and monitor the implementation of *Transform* and other end of life care initiatives within their care group
End of Life Care Strategy group	Promote high quality end of life care by integrating national and local initiatives and guiding and monitoring service provision and development
Consultants	Responsible for: clinical management of patients under their care, including the identification of patients approaching the end of life initiating end of life discussions (with patients and families) and directing their care accordingly Contribute to the implementation and evaluation of the Transform programme (including AMBER care bundle)
PALS / Complaints Service	To manage both formal and informal complaints relating to end of life care a. The governance reporting for complaints & PALS is on a quarterly basis and monthly trend analysis data on a directorate specific basis. This process prompts action planning for quality improvement at directorate level.
IT Dept	Technical support for the introduction of EPaCCS within the hospital sites.
Critical Care Outreach	To be part of the MDT at ward level when discussing patients whose recovery is uncertain and would benefit from the AMBER Care Bundle

Non-Executive Trust Board Member	A core member of the End of Life Care Strategy Group, representing The Trust Board and is directly responsible for End of Life Care within Northampton General Hospital Trust.
Training & Development /Practice Development	To support the Specialist Palliative Care Team in ensuring that staff working for NGH Trust have the right skills at the right level in respect of their role so that they are competent and confident to do so with reference to The Trust Training Needs Analysis for End of Life Care Support with input and analysis of data from OLM to ensure the development of the workforce in caring for patients who are at End of Life.
Specialist Nurses	To undertake holistic assessments and effective care planning to meet the needs of individuals and their families To initiate discussions about end of life preferences and support patients and families to explore and articulate their end of life care needs To actively support the *Transform* programme
Specialist Palliative Care Team (including End of Life Care Facilitator)	To actively support the *Transform* programme To contribute to the collection of baseline data and monitor the impact and implementation of the key enablers within the *Transform* programme To work to ensure that end of life care frameworks and processes are embedded into practice To provide advice, support and act as expert role models to staff To contribute to both formal and informal education and training programmes To undertake holistic assessments and effective care planning to meet the needs of individuals and their families referred to the service To initiate discussions about end of life preferences and support patients and families to explore and articulate their end of life care needs
Palliative and End of Life Link Nurses	To act as a resource and conduit for information related to end of life care To attend link nurse meetings and contribute to the development and implementation of innovations and the *Transform* programme
Primary Care EOL	To be aware of the services available to support patients at the

Link nurse	end of life To explore end of life preferences and support patients and families to achieve preferred place of care and preferred place of death wherever possible To coordinate the appropriate discharge processes for end of life care
Matrons	To influence and monitor the implementation of *Transform* and other end of life care initiatives within their ward areas To recognise and champion high quality end of life care To monitor outcomes and complaints relating to EOLC and care of dying
Ward managers	To lead on the provision of high quality care for patients and families Lead on the provision of a ward environment that is conducive to the privacy and dignity of patients at the end of life To encourage and support their staff to identify and meet end of life training / education needs as part of the IPR process Contribute to the implementation and evaluation of trust strategies for end of life care
All clinical staff	Are responsible for ensuring that patient experience and quality is at the heart of whatever they do All clinical staff are responsible for their own personal development and learning in relation to palliative and end of life care

5.2 **Roles and Responsibilities of Committees/ Sub-Committees**

The following committees have responsibilities as summarised below:

AMBER Care Bundle Steering Group	To ensure that there is a strategic approach to the implementation of the AMBER Care Bundle. To support the AMBER Care lead clinician To provide data analysis on the effect of AMBER Care Bundle has on quality improvement and patient experience as they approach end of life.
End of Life Care Strategy Group	To support the "Transform Programme" and provide a forum for points for agreement and for reporting End of Life Care issues to Trust Board level.
QELCA Steering Group	To work with NHFT (Cynthia Spencer Hospice) in strategically planning a process whereby the principles of QELCA are applied to enable the successful training of influential senior nurses. The steering group will provide a report for The Trust on how QELCA has influenced patient care within the Trust.

6. STRATEGIC OBJECTIVES

The aim is for The Trust to be a provider of quality end of life care, and will use the *Transform* programme to accelerate its success. The main objective is to implement the five key enablers:

1. AMBER care bundle
2. Care Plan for the Dying Patient (previously called the LCP)
3. ACP Advance Care Planning
4. EPaCCS (Electronic Palliative Care Coordination Systems)
5. Rapid Discharge Home to Die Pathway

The Trusts staff will be supported to:

- Recognise the individual needs of patients as they approach death
- Support patients and significant others to anticipate and plan for their end of life care
- Initiate timely and sensitive discussions regarding options, wishes and preferences at appropriate stages of treatment
- Recognise and effectively manage pain and other symptoms
- Recognise and meet patients practical care needs
- Respond sensitively and timely to patients psychological and spiritual needs
- Access specialist support (including Specialist palliative care and Primecare end of Life Care service) when required
- Recognise and respond to urgent circumstances in a timely fashion (for example Rapid 'home to die' discharges)
- Provide compassionate and dignified care for those dying in NGH
- Provide compassionate care to the bereaved

6. 1 End of Life Care Pathway

The national End of Life Strategy (2008) was published by the Department of Health to provide guidelines for all services, both social and health, to raise standards of End of Life Care towards that of Hospice Care. It recommends 6 key elements in an end of life pathway, which we have used when identifying strategic outcomes:

Objective One:	**Discussions as end of life approaches (see appendix 2)**
Key Outcomes:	**By 2015:** • 'Advance Care Plan' (ACP) training available for all trained clinicians working in inpatient/outpatient depts. so that the tool can be either initiated in hospital or an existing ACP can be reviewed with both in/out patients • Designated physician to support AMBER care bundle (including implementation, evaluation and sustainability) • Amber Care Bundle implemented on one medical ward with definite plans in place for implementation onto a second medical ward Care Groups (via matrons and ward sisters) will actively encourage: • Communication skills training for staff (using local universities & other providers) • Use of The Trust EOLC workbooks and competencies (for both existing and newly recruited staff) • RGNs and HCAs to access the End of Life Care education study days provided by The Trust The Specialist Palliative Care Team will work with ward managers and matrons to: • Assess each ward / patient area to see if a conveniently located area for private discussion /family meetings has been made available

	By 2016 • End of life training records (including communications skills training) will be maintained via Oracle Learning Management (OLM) to monitor and evaluate workforce competencies • The AMBER care bundle will be embedded into practice on at least two medical wards and definite plans to implement the bundle onto a third and fourth • Prognostic indicator training (such as 'Gold Standards Framework') will be recommended within clinical/medical IPR outlines
Benefits of these developments:	• The Trust workforce will comprise of clinicians who are competent to identify patients who are at end of life • Clinicians will be competent (and confident) to initiate end of life care discussions which are sensitive to the patients individual needs and circumstances • Patients will be better prepared and supported in EOLC planning and have their needs and preferences discussed in a timely manner • Care planning will anticipate patient need rather than having to react to crisis events • There will be a reduction in unplanned or inappropriate hospital admissions and reduction in length of stay in this group of patients • EOLC patients will experience open, honest and compassionate care
Risk if not addressed:	• Delay in identifying a person at end of life may result in poorly co-ordinated care, avoidable hospital admissions and patients unable to express their wishes and preferences • The Trust may receive complaints (and loss of reputation) regarding communication and patient experience • There would be financial implications if complaints are upheld • Staff lack sensitivity and competence to communicate and support patients • Staff avoid their responsibilities toward care of the dying, and fail to engage with patients and families

Objective Two	**Assessment, Care-planning & review (see appendix three)**
Key outcomes:	**By 2015:** • Patients who are identified at the End of Life (within the last 12 months of life) will have the opportunity to develop, document, review and update a personalised palliative care plan either in the form of an Advance Care Plan or other documented plan • Patients Preferred Place of Care (PPC) or Preferred Place of Death (PPD) should be identified where appropriate and documented • The Trust will engage with other local end of life care organisations such as Northamptonshire Healthcare Foundation Trust and Primecare for example, to promote the commissioning of a county wide EPaCCS locality register **By 2016:** • There will be evidence that The Trust has maintained strategic links with local care commissioning groups and social care on work-streams related to the county wide e-register EPaCCS • There will be a process for reviewing reasons behind failure to achieve patients PPC, and actions / quality improvement work fed-back to End of Life Strategy Group and Trust Board. • AMBER Care bundle will be embedded across The Trust (and effectiveness and impact monitored within care groups and at organisational level) • ACP and End of Life Care Planning is embedded across The Trust as demonstrated by data accessed by INFOVIEW
Benefits of these outcomes:	• Patients at identified at the end of life will have an individualised care plan which reflects their current needs, and is reviewed on a regular basis • Where possible patients preferred place of care (and preferred place of death) will be documented in a timely way, allowing for provision of appropriate care that is proactive (rather than reactive) • Patients will receive coordinated care that is centred on their choices. • Relevant healthcare professionals will have access to up to date

	information regarding end of life plans (including PPC) • Avoidance of clinically inappropriate admissions • Improved discharge co-ordination (and reduced length of stay) • More patients will be cared for in the place of their choice • NGH will have a work-force which is continually developing its competencies (and confidence) in end of life care • The End of Life Care provided by NGH Trust would have a senior lead, influential in improving patient experience and lead on End of Life Quality improvement tools. • Cross-boundary communication (e.g. EPaCCS) will allow patient's care to be better co-ordinated • Patients, carers and relatives will have their needs met during their hospital stay and after discharge
Risk Identified if development not addressed:	• Patients may not receive care that is individual to their needs • Patients may be given treatment and investigations which are unnecessary (with financial and personal costs) • Patients may receive treatment which (given the choice) they would not want (with financial and personal costs) • Patients may not be cared for (or die) in the place of their choice • Percentage of hospital deaths may not be reduced • Patients care may be disjointed leading to multiple and inappropriate hospital admissions • Carers and relatives needs are not met (leading to reduced satisfaction and potential for crisis admissions) • Assessments and care planning may be carried out by untrained staff resulting in poor patient outcomes (leading to reduced patient confidence and satisfaction) and potential for crisis admissions

Objective Three:	**Coordination of individual patient care (see appendix four)**
Key Outcomes:	**By 2015** • The Trust will engage with other county end of life care organisations through strategy groups to push for a locality-wide e-register EPaCCS • The Trust have a process in place to enable rapid discharge planning for patients who are thought to be in their last eight weeks of life • The Specialist Palliative Care Team service is reviewed to ensure that it is adequate enough to support and enable trained and untrained staff to provide ward based palliative care • Those patients who are dying should have an identified consultant who is ultimately responsible for their care and local governance arrangements are explicit about the delegation arrangements when the consultant is not on duty. **By 2016** • The Trust will monitor end of life care planning using AMBER quality metrics • The Trust will monitor discharge preferences / PPC discussions using AMBER quality metrics • The Trust will monitor patient /family experience (through Views of Informal Carers- Evaluation of Services (VOICES) project or similar local mechanism) and demonstrate quality improvement by developing an action plan
Benefits of these outcomes:	• Patients will receive coordinated care that is centred on their choices. • Relevant healthcare professionals will have access to up to date information regarding end of life plans (including PPC) • Avoidance of clinically inappropriate admissions • Improved discharge co-ordination (and reduced length of stay) • More patients will be cared for in the place of their choice

Risks if not addressed:	• Poorly coordinated care • Ineffective use of services and resources. • Patients will be admitted to hospital inappropriately • Patients will receive costly and inappropriate treatment and investigations

Objective Four:	**Delivery of high quality care in an acute hospital (see appendix five)**
Key Outcomes	**By 2015:** • Redefine the Trust End of Life Care Strategy Group, demonstrating clear leadership in the provision of End of Life Care, Governance arrangements and reporting structure • The End of Life Care Strategy Group will have at least one member at Trust Board level • The End of Life Care Strategy Group will have representation from CCG • The Trust will be engaged in phase 2 of the "Transform" programme and will demonstrate service improvement via monthly audit submitted nationally to The End of Life National Intelligence for the following enablers: 1: EPaCCS locality wide EOLC patient register 2: AMBER Care Bundle 3: Individualised care plan for the dying patient (replacement for LCP) 4:Rapid discharge pathway for patients at the end of life 5:Advance care planning ACP • To develop an End of Life Care Education and Training Strategy for The Trust • An annual in-house training programme for End of Life Care will be available for RGNs and HCAs to access. • Training records will be monitored via OLM and demonstrate that clinical staff (bands 2-7) have completed competencies in EOLC • The Trust will have designated 'End of Life / Palliative Care link nurses, meeting quarterly with the Specialist Palliative Care Team for targeted training and development • All trained nurses will have access to the End of Life e-learning facility to enhance their knowledge and skills in end of life care. • A Business case for full-time Specialist Palliative Care Consultant submitted to the Trust • Service review to identify priorities for development of the Specialist Palliative Care nursing team, proposing a business case for funding for additional Band 7 WTE SPC Nurses to comply with the National Standards relating to SPC and a seven day service • To produce a proposal for how the Trust will support the End of Life Care Facilitator in providing leadership in the provision of high quality care at End of Life and increase visibility of the SPCT

	• For the Trust to access Quality Education for All (QELCA) training for band 6&7 facilitated by the local NHFT Hospice • Service Level Agreement with NHFT Hospice to provide out of hours telephone advice in line with National Directives
Benefits of these outcomes:	• The Trust will be an exemplar hospital for End of Life Care • Patients will have their needs addressed, enhancing their own experience (and that of their family / significant others) • The Trust workforce will be confident (and competent) to provide high standards of EOLC • Patients will receive care which reflects their wishes and beliefs, • Patients who die whilst under our care will receive treatment that reflects their wishes and promotes dignity and respect • Clinical staff within The Trust will have access to (and be supported by) a multi-disciplinary Specialist Palliative Care Team with skills and capacity to promote high standards of care. • EOLC will be evidence based, using tools and promoting practices consistent with national policy.
Risks if not addressed	• EOLC within The Trust may be sub-standard • Poor patient (and family) experience may result in complaints • Potential clinical incidents may occur around EOLC care. • De-motivated and unconfident workforce • Non compliance with compassion and dignity agenda
Objective Five:	**Care in the last days of life (see appendix six)**
Key Outcomes	**By 2015** • Dying patients in The Trust will be recognised in a timely way and have an patient/family led individualised plan of care consistent with present national guidance of care of the dying • Patients who are dying will be acknowledged at The Trust safety huddle to allow a member of the SPCT attending, to maintain a local register.

	• Patients who are recognised as dying at the safety huddle will be screened by The SPCT, to ascertain whether ward based palliative care is appropriate or a SPCT referral is required. A special note will be placed on IPM advising that the patient is not to be moved unless it is in their best interest. • The Trust will continue to use the Liverpool Care Pathway for care of the dying patient until alternative guidelines are in place • The Trust will have a strategic plan to manage the transition from care using the Liverpool Care Pathway as guidance to the new guidelines developed by the Leadership Alliance for Care of the Dying with patient safety as paramount. • The Trust will use the report provided by the Royal College of Physicians based on the findings of the National Care of the Dying Audit (round 4) to formulate an action place for service improvement. • Care of the Dying training will be part of The Trust preceptorship and HCA training (for nursing and support staff) and the junior doctor FY1 and FY2 training sessions. • A rolling programme of training ('End of Life Care' and 'Care of the Dying') will be schedule every month (for bands 2 – 7) to support staff to achieve trust EOLC competencies (as defined within role specific IPR outlines) • The Trust will support members of the Specialist Palliative Care Team to attend (and /or present at) National conferences related to End of Life Care and Care of the Dying to ensure that National directives are embedded in local policy and service design
The benefits of this development	• Patients will receive evidence based care and patient safety maintained during transition from the use of the LCP document and the new guidelines for care of the dying. • Those in the last days of life have a plan that is patient centered, holistic, evidence based and meets their needs to allow them to die comfortably, being cared for with dignity and respect • Healthcare professionals will be trained in the principles of care of the dying.
Risks if not addressed	• Patients may not receive holistic care during their last days of life • Unnecessary treatments may still be prescribed or carried out (with personal and financial cost implications) • The LCP may still be used ineffectively leading to poor care and

	communication • Patients may be subject to resuscitation attempts inappropriately or receive other unnecessary or burdensome treatments
Objective Six	**Care after death (see appendix seven)**
Key Outcomes	**By 2016** NGH Trust will provide mortuary facilities that are show dignity and respect after the patient has died. NGH Trust will have viewing arrangements that are sensitive to different needs, cultures and faiths. Bereavement officers, Porters and Mortuary staff will be given the opportunity to attend End of Life Care Training in house which meets the learning needs required for their role in care of the patients after death and care of the bereaved relatives. • Last Offices will be included within the 'End of Life care' training provided by the SPCT for RGNs and HCAs • End of life training records will be monitored via Oracle Learning Management (OLM) • A plan in place to complete a bereavement survey (VOICES) and use the data to provide feedback to frontline staff for continual improvement.
The benefits of this development	• The Trust will provide high quality care to patients after death and their relatives • The Trust will have the appropriate facilities to provide care to relatives and friends after somebody has died in environments that is private and sensitive during this time . • The Trust workforce will be competent in end of life care and care after death thus improving the patient's and their significant others end of life care experience.
Risks if not addressed	• Bereaved relatives may experience complicated grief with

	associated negative impact upon their health and wellbeing • Staff may not feel confident or competent to provide high standards of end of life care

7. IMPLEMENTATION & TRAINING

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8. MONITORING & REVIEW

Strategic Standard	Source of Assurance/ Timescale	Responsibility

9. REFERENCES & ASSOCIATED DOCUMENTATION

National End of Life Care Programme (2012) TRANSFORMING END OF LIFE CARE IN ACUTE HOSPITALS. THE ROUTE TO SUCCESS "HOW TO" GUIDE. National End of Life Care Programme:

Department of Health (2008) END OF LIFE CARE STRATEGY. PROMOTING HIGH QUALITY CARE FOR ALL ADULTS AT THE END OF LIFE. Crown Copyright: London

National End of Life Care Intelligence Council (2012) WHAT DO WE KNOW NOW THAT WE DIDN'T KNOW A YEAR AGO? NEW INTELLIGENCE ON END OF LIFE CARE IN ENGLAND. National End of Life Care Intelligence Council

www.endoflifecare-intelligence.org.uk

National Institute for Health and Clinical Excellence (2011) QUALITY STANDARDS FOR END OF LIFE CARE FOR ADULTS. National Institute for Health and Clinical Excellence: Manchester

www.ncpc.org.uk

Department of Health (2012) LIBERATING THE NHS. NO DECISION ABOUT ME WITHOUT ME. FURTHER CONSULTATION ON PROPOSALS TO SECURE SHARED DECISION- MAKING. Department of Health: London

Include references to ensure a clear evidence base and cross-reference to associated trust policies, procedures etc.

Format of this section should follow **Harvard referencing format** – see page 5 of Guide to References:
http://www.library.northants.nhs.uk/Content/Publications/User_Guides/References.pdf

APPENDICES

The National Council for Palliative Care defines end of life care as: ‘care that helps those with advanced, progressive illness to live as well as possible until they die.’ It recognises the needs of both patient and family, and includes management of pain and other symptoms, and the provision of psychological, social, spiritual and practical support (NCPC 2006).The identification of someone approaching the end of life (and supporting them and their relatives) can be hard to do. It can also be difficult to plan, contract and monitor services that involve a wide range of conditions and care settings.

It is important to recognise that death does not always represent a failure of care. Where advanced illness no-longer responds to maximal treatment (or the patient has declined further intervention) the focus of care must change to palliation. Good symptom control and enabling people to die as well as possible can be rewarding in itself. Good palliative and end of life care should be a core principle of the service we provide.

APPENDIX ONE- The End of life Pathway

The national End of Life Strategy (2008) recommends 6 key elements in an end of life pathway

- Step 1 Discussion as the end of life approaches
- Step 2 Assessment, care-planning and review
- Step 3 Co-ordination of care for individual patients
- Step 4 Delivery of high quality services in different settings
- Step 5 Care in the last days of life
- Step 6 Care after death

In malignant illness disease progression can often be predicted, but the disease trajectory in other long term conditions is much more variable. Some may enjoy reasonable health then experience a sudden, steep decline; for others there is a gradual decline with episodes of acute illness. A third group is frail for months followed by a steady and progressive deterioration. There is therefore no single disease trajectory, or clear point marking where an End of Life Care pathway might begin.

Depending upon circumstance, the trigger for uncertain recovery / end of life may be recognised by the ill person, their family or the health or social professional responsible for care. This recognition triggers the need for comprehensive assessment of supportive and palliative care needs by competent and confident staff.

APPENDIX TWO - STEP ONE: Discussions as the end of life approaches

It is important that needs and preferences of a patient are known to the team responsible for care. Good end of life care planning requires a competent and compassionate work force comprised of staff who accept that EOLC is a legitimate part of the care our hospital provides. Early discussions allow patients to exercise greater control over their treatment and options for care. Identifying the right time and place for this requires staff with the insight to recognise when a person might be entering the end of life phase, married with the skill, confidence and sensitivity to initiate sometimes difficult conversations.

The Trust has a responsibility to provide an appropriate clinical environment. Where possible, accommodation will be made available near ward and clinic areas which for private discussions between staff and patients / families. The need for privacy will be recognised when wards and services are moved or facilities are reconfigured.

The Trust recognises that EOLC awareness / training is necessary for everyone involved in the patient's journey, and staff should be encouraged to develop competencies tailored to their roles within the Trust (See appendix A for workforce categories).

NGH Trust will ensure that all staff can access the right training and support. A variety of resources will be provided to meet different learning needs. These will range from peer support and mentoring, self-directed and e-learning work towards EOLC competencies (for use within IPR and preceptorship) as well as formal teaching. Training will encompass

communication skills, symptom control and illness trajectory (e.g. Gold Standards prognostic indicator framework).

The trust will continue its links with the local universities and others for the provision of accredited communication skills training (for nursing and medical staff) and modular study related to symptom control and other EOLC topics. Education will also be provided in-house for topics such as advance care planning.

APPENDIX THREE - STEP TWO: Assessment, care planning and review

The Trust supports shared decision making between patient and clinician. Patients at NGH should (wherever possible) be involved in decisions about their treatment. This includes decisions to decline treatment if they so wish.

Patients judged as approaching the end of life will have their **holistic needs assessed**. This is recognised as a process (not a single event) and demands communication that is open, honest and fluid. Assessment will include physical, psychological, social, spiritual and practical needs. Personal preferences as to place and priorities of care will be identified and discussed (where appropriate) and clearly documented in patients notes.

Do Not Resuscitate (DNA-CPR) orders will be completed where appropriate and made accessible to all clinicians involved in the care of the patient. In line with Royal College guidelines the need for discussion with the patient and/or relative is at the discretion of the senior clinician. It is stressed that whilst the overall aims of care should be discussed wherever possible, it is not always appropriate to discuss DNA-CPR explicitly with patients who are very close to death (refer to joint college advice). Inept discussions can cause significant and unnecessary distress.

NGH Trust recognises the county **Advance Care Planning** document developed to allow individuals to consider decisions about their future care. Patients with life limiting disease will be supported by trained, competent staff to develop an Advance Care Plan if they wish.

The **AMBER care bundle** has been developed to guide care planning for patients (judged to be in the last eight weeks of life) whose condition is unstable and recovery uncertain. It is our vision that all patients whose recovery is uncertain will have their care supported by the AMBER Care bundle. AMBER is part of the 'Transform' programme. An action plan has been developed, and the project will be audited and results communicated at all levels within the organisation.

The trust supports the commissioning of an electronic locality register **(EPaCCS)** to improve the co-ordination of care for patients with EOLC needs. We will continue to lobby commissioners via the county End of Life Care strategy group to promote this key enabler for improving End of Life Care at NGH Trust.

For those with advanced progressive illness there is the Primecare EOL Link Nurse service. This provides a **Rapid Discharge pathway** for those judged to be in the last eight weeks of life. This includes timely assessment and care planning to support rapid discharge where possible.

Our commitment also extends to involved carers and relatives. Family needs will be assessed during the time a patient is in hospital. This assessment and planning should be integrated in the care of the patient

NGH Trust is committed to having a robust multi-disciplinary **Specialist Palliative Care service** for those whose symptoms are complex or who have other specialist needs. The Specialist palliative care team will have the highest level of knowledge, skills and understanding attained through specialist training in communication skills, assessment, advance care planning and symptom management. Their competence and development needs will be monitored through IPR, continual professional development processes. A business case will be developed to support the appointment of a full-time palliative medicine consultant.

APPENDIX FOUR - STEP THREE- Co-ordination of individual patient care

Some people approaching the end of life will require numerous services in various settings during their disease trajectory. Coordination of service provision is essential so that people are able to be cared for and die in their preferred place of care. When it is identified that a patient is in the last year of life, the best practice is for a key worker will be allocated to them whose responsibility it will be to promote patient centred coordination of care. This is a countywide project and asserts the need for thetrust to have continued representation at county strategic end of life care meetings to takethe key worker project forward.

NGH Trust will promote individualized and coordinated care through ward rounds and MDT meetings together with trust electronic data bases. It is envisaged that coordination across organisational boundaries will be achieved by imputing and accessing data on locality-wide electronic data base EPaCCS. In the interim we will also explore whether the SPCT and site-specific specialist nurses can be given access to the primary care System One.

APPENDIX FIVE - STEP FOUR - High quality care in an acute setting

Patients should receive high quality care regardless of the setting. The environment that someone is cared for in can have a direct impact on the patients experience and of those significant others left behind after death.The national strategy aims to enable a person to die in their preferred place however it is recognized that hospitals will continue to be the most common place for death for the foreseeable future. It is important therefore that all staff of NGH Trust see end of life care as priority.

Communication to the trust board on key developments in *Transform* programme is important, and formal methods of communication will be employed including annual reports and audit results relating to patient experience. The SPCT will monitor and report on the progress towards developing a workforce that is competent to provide high standard end of life care. All wards within the hospital will have a link nurse for end of life care to champion high standards and cascade information and developments to ward level. A named member of the SPCT, together with the EOLC Facilitator will be responsible for facilitating the link nurse programme.

The EOLC operational policy will be updated as per national and regional directives to manage End of Life care. The trust End of Life Care services (including SPCT) will link in with other patient experience and quality forums (such as the Dignity Forum, Compassion in Practice) liaising with fellow champions regarding improving patient care.

APPENDIX SIX - STEP FIVE – Care in the last days of life

NGH wants to train staff so that patient's needs are recognised and addressed during the dying phase. Whenever possible patients (and their relatives) will be involved in discussions about the nature and intensity of treatments, the ceiling of care and the withdrawal or withholding of treatment. Decision should be recorded using the **Treatment Escalation Plan TEP**.

Do Not Resuscitate (DNA-CPR) orders will be completed where appropriate and be accessible to all clinicians involved in the care of the patient. Timely decision making avoids unnecessary cardiac arrest calls.In line with Royal College guidelines the need for discussion with the patient and/or relative is at the discretion of the senior clinician. It is stressed that whilst the overall aims of care should be discussed wherever possible, it is not always appropriate to discuss DNA-CPR explicitly with patients who are very close to death (refer to joint college advice). Inept discussions can cause significant and unnecessary distress. If the patient or relatives wish for the patient to be discharged home (or to another place of care) they should be urgently referred to the **Primary Care End of Life Link Nurse** service.

It is important to recognise that death does not always represent a failure of care. Where advanced illness no-longer responds to maximal treatment (or the patient has declined further intervention) the focus of care must change to palliation. Good symptom control and enabling people to die as well as possible can be rewarding in itself. Good palliative and end of life care should be a core principle of the service we provide. If the patient has been assessed by the Senior responsible clinician and is thought to be in the last days or hours

of life, the use of the Liverpool Care Pathway (or other individual care plan for a dying patient) should be commenced.

The principles of end of life care for the patient should be the main structure of the discussion with the patient and/or significant other with reference to the Liverpool Care Pathway as a guide to support this. Discussion should be open, honest and fluid by a health care professional trained in the use of the LCP with a high standard of communication skills in an area that promotes privacy and dignity.

The Trust has taken part in the National Audit for Care of the Dying, Round 4 to underpin the provision of care for dying patients. This will include both a clinical and organizational audit and independent from the Liverpool Care Pathway.

The data collected from the national audit will enable The Trust to identify any areas of improvement and allow for action planning. Whilst waiting for the new guidelines for care of the dying, the Matrons for all inpatient wards [excluding maternity and paediatrics] will be asked to visit all their wards on a specified day each week and collect information on any patient who is expected to die within the next 72 hours. This will enable the Matrons to deal with any issues at ward level in real time and also the data can be used to analysis any trends.

For patients whose symptoms are complex, NGH Trust is committed to providing a Specialist Palliative Care service consisting in highly qualified doctors and nurses who trained in end of life care. This is a six day service, Monday to Saturday 09.00 – 17.00. The Trust will continue to review the service to meet the needs of the patient population.

NGH Trust has a responsibility to provide an environment that is peaceful and promotes dignity and respect for the patient who is dying. Supporting patients through their last days of life also requires that we recognise the contribution of family and friends. Open visiting times will be available to relatives of patients who are receiving care in the last days/hours of their life.

NGH Trust provides a chaplaincy service offered to patients and their families. The Chaplains are part of the end of life care multi-disciplinary team for patients and their

significant others which continues after a person dies. Patients and relatives may want there own faith group representatives and NGH Trust will endeavor to support this.

APPENDIX SEVEN - STEP 6- Care after death

NGH Trust is responsible for providing high standards of care after death both of the patient and the significant others he/she has left. A timely verification and certification is important when a patient dies and the Trust will endeavor to facilitate this, especially during “out of hours”. Once a patient’s death has been verified, the body of the deceased needs to handled and laid out in keeping with the patients/family expressed wishes either culturally, religiously or spiritually. NGH Trust has guidelines on the Intranet to support nurses in this based on National Care after Death Guidelines (2009).

Care of significant others after a person has died is an important aspect of care at NGH Trust. Families will respond in numerous ways to the death of a loved on and clinicians need to be skilled to assess and respond to needs accordingly. The Trust recognises that some friends/relatives may want to visit their loved ones after death and facilities within the mortuary services will allow this.

The Evelyn Centre, The NGH Trust bereavement suite is a calm and peaceful place for families to come and collect the death certificate. This is in line with the national directive to have a central point for relatives to collect the death certificate and ask any questions they may have regarding processes and services once a person has died.

The NGH Trust will provide information to friends and family on appropriate bereavement and support services available for adults and children verbally and reinforced by The Trust information booklet.

Training Needs Analysis for End of Life Care Training

Northampton General Hospital NHS
NHS Trust

Workforce groups at NGH Trust

Group Definition	Minimum levels of skills and knowledge
Group A – Staff working in specialist palliative care and roles that essentially spend the whole of their working lives dealing with End of Life Care. Physicians in Specialists Palliative Care. Specialist Palliative Care Nurses Allied Health Professionals working in Oncology Macmillian Social Worker End of Life Care Facilitator. Bereavement Officer.	Staff will have a highest level of knowledge, skills and understanding of End of Life and Specialist Palliative Care evidenced through accredited training and/or continuing professional development.
Group B – Staff who frequently deal with End of Life Care as part of their role. Care staff working on medical wards. Care staff working in Oncology. Hospital Chaplains. Specialist Nurses in long term conditions. Hospital Pharmacists. Care staff on some general surgical wards. Care staff working in EAU and A&E.	Staff will be supported to enable them to develop or apply existing skills and knowledge to ward based Palliative Care and End of Life Care, accessing formal or informal study days within the Trust, accredited training facilitated by the local university and resources available within the Trust to enable independent learning.

[1] Training Needs Analysis for End of Life Care – Version 1 – 26.04.2013

Group C – Staff working as specialists or generalists areas who infrequently have to deal with End of Life Care Other professionals working in the acute setting who could be involved in end of life care but on a less frequent basis.	Staff will have a basic knowledge and principles of End of Life Care and the services available

Training for Group A

All staff should have the highest levels of knowledge, skills and understanding accessed through specialist training in End of Life Care.

Skills should include:

- Communication skills
- Assessment
- Advance Care Planning
- Symptom management
- Teaching skills
- Strategic Planning

Education and support links:

- Northamptonshire Health Foundation Trust Palliative Care services. Cransley and Cynthia Spencer Hospice
- University of Northampton
- National Council for Palliative Care
- East Midlands Cancer Network
- Other universities providing accredited courses in End of Life Care
- Peer support/ learning

Staff included in this group:

Specialists Palliative Care physicians
Specialist Palliative Care Nurses
Allied Health Professionals working in Oncology
Macmillian Social Worker

End of Life Care Facilitator.
Bereavement Officer

Training Needs for Group B

This workforce group regularly care for patients at End of Life. Annual training is recommended to maintain the standards required to deliver current, high quality End of Life Care in the acute setting.

Skills should include:

Communication skills
Assessment
Advanced Care Planning
Symptom Management
Coordinating care/discharge planning
Care of the dying patient
Delivery of care after death
Competency to use End of Life Care tools

A full extent of skills required is listed on the End of Life Competencies forms for nurses, Band 2, 5, 6 and 7 (available on the Intranet).

NGH Trust staff included:

Nurses and Doctors working in medicine, respiratory medicine, care of the elderly, cardiology, oncology, renal medicine, long term neurological conditions, accident and emergency, emergency assessment unit and intensive care.
Heart centre staff
Hospital chaplains
Head and neck ward
Specialist care nurse in heart failure
Site Specific Cancer Nurse Specialists
Pharmacist

Education links and support:

Internal teaching sessions from Specialist Palliative Care team and End of Life Care facilitator
Local universities delivering accredited courses

Training Needs for Group C

This refers to NGH staff working in specialist or generalist areas who infrequently deal with End of Life Care. It is known that 75% of patients living the last year of life are likely to access the services of The NGH Trust; therefore most staff members will have some influence in a patient's End of Life Care

For some roles, contact with patients living the end of their life is minimal and less interactive and therefore an understanding of the principles of delivering End of Life Care and the Trusts vision in standards for this patient group is important.

For other roles in The Trust, training needs to enable a good basic understanding of the principles and practice of delivering End of Life Care. Staff may need to access specialist palliative care service and/or The End of Life Care Facilitator for training, patient input and support. It is also encouraged that nurses will work towards the End of Life Care Competencies and supporting workbook towards their ongoing Continuing Professional Development.

Staff included in this:

Nurses and Doctors working on some surgical wards, outpatient clinics, radiology,
Porters
Hotel services staff
Ward Clerks
Administration staff

Skills included:

Communication skills (tailored to individual role)
Knowledge of specialist and support services

Skills that maybe included:

Assessment and care planning
Competency to use End of Life Care tools

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**25 September 2014**

Title of the Report	**Stakeholder Engagement Strategy 2014-2017**
Agenda item	**19**
Sponsoring Director	Chris Pallot, Director of Strategy and Partnerships
Author(s) of Report	Sally-Anne Watts, Head of Communications
Purpose	Presented to the board for approval

Executive summary

Northampton General Hospital (NGH) is committed to providing the best possible care. We aim to achieve this by working in partnership with our stakeholders and by listening and acting upon what our staff, patients, families and carers, other care providers, stakeholders and the local community tell us we could improve. The success of the Trust is dependent on its stakeholders and strengthening our engagement with them is critical for the Trust's future, for accountability, trust, confidence, reputation and organisational culture. It is also a contributory factor for improving quality of care and patient outcomes.

This strategy builds on previous developments in our stakeholder engagement and uses feedback from our external stakeholder survey, insight and best practice to take forward our approach to stakeholder engagement.

Related strategic aim and corporate objective	All
Risk and assurance	No
Related Board Assurance Framework entries	BAF 10
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

Actions required by the Trust Board

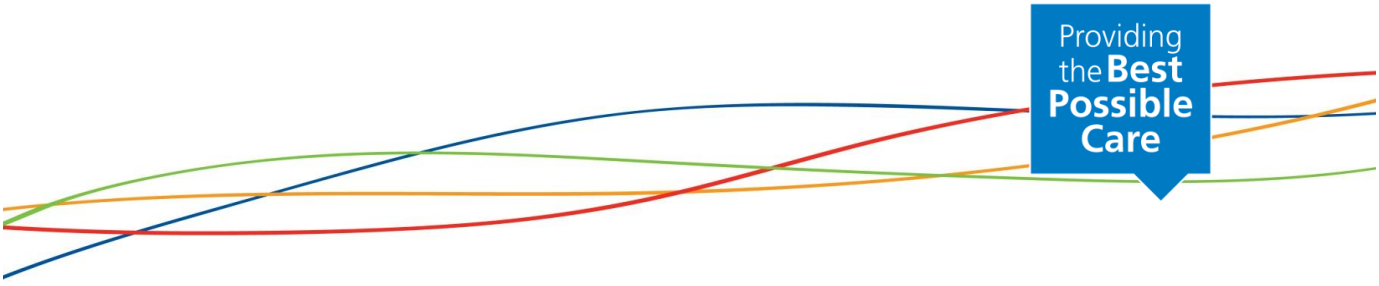
The Board is asked to approve the Strategy and, where appropriate, support implementation.

Northampton General Hospital NHS
NHS Trust

Enclosure P

Stakeholder engagement strategy 2014 – 2017

September 2014



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STAKEHOLDER ENGAGEMENT STRATEGY 2014 – 2017

1. INTRODUCTION

Northampton General Hospital is committed to providing the best possible care. We aim to achieve this by working in partnership with our stakeholders and by listening and acting upon what our staff, patients, families and carers, other care providers, stakeholders and the local community tell us we could improve. The success of the trust is dependent on its stakeholders and strengthening our engagement with them is critical for the trust's future, for accountability, trust, confidence, reputation and organisational culture. It is also a contributory factor for improving quality of care and patient outcomes.

Many stakeholders play a critical role – most notably our patients (who can exercise choice), our staff (who are integral to our performance), our shadow governors and members (our accountability to the local community), commissioners/GPs who purchase and refer to our services, MPs, councillors, local authorities and other bodies who monitor and scrutinise our services and the local media and wider community who are able to report and comment on our services.

This strategy builds on previous developments in our stakeholder engagement and uses feedback from our external stakeholder survey, insight and best practice to take forward our approach to stakeholder engagement.

2. DRIVERS FOR CHANGE

2.1 National context

During recent years the importance of stakeholder engagement has been raised in a number of key papers setting out the NHS agenda.

Research by the King's Fund in 2012 found that the more positive the experiences of staff within an NHS trust, the better the outcomes. The study found that engagement had significant associations with patient satisfaction, patient mortality and infection rates. Positive two-way engagement is essential to ensuring our staff understand, are motivated and feel above to make a positive contribution.

The Francis Report (2013) identified key lessons for the NHS. A central theme was that of cultural change, with all NHS organisations striving to have an embedded culture of caring that fosters openness, transparency and candour to ensure patients are always put first and foremost in all we do. There should be clear standards that are understood and complied with by all. And the culture should be supported by strong clinical and managerial leadership that values and invests in its workforce to ensure staff receiving the ongoing training and development they need.

Ambition three in the Keogh Report (2013) recommended that patients, carers and members of the public should feel they are vital and equal partners who feel confident that their feedback is listened to and evidenced so they can see the impact it has on their care and that

of others. Ambition eight recommended that all NHS organisations should acknowledge and understand the positive impact that happy and engaged staff have on patient outcomes and a positive patient experience. It also states that a high quality patient experience can be achieved by an organisation if it provides evidence that patient feedback is being used proactively, has strong governance systems in place to ensure safety and clinical/operational effectiveness and that it has strong leaders who effectively engage with their workforce.

The Berwick report on safety *A promise to learn – a commitment to act: Improving the safety of patients in England* (2013) includes the following two (of four) guiding principles:

- Engage, empower and hear patients and carers throughout the entire system, and at all times
- Foster whole-heartedly the growth and development of all staff, including their ability and support to improve the processes in which they work

Among the ten recommendations it states that patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of trusts and that all organisations should seek out the patient voice as an essential asset in monitoring the safety and quality of care. As part of its recommended shift in leadership behaviour, it stresses that the patient voice must be heard even when it's a whisper and calls on leaders to seek out and listen to colleagues and staff.

The latest planning guidance from NHS England *Planning for patients 2014/15 to 2018/19* on driving continuous improvement and making its vision a reality includes among its values: 'we prioritise patients in every decision we take and we listen and learn'.

2.2 Legal context

All NHS trusts have a legal duty under section 242 of the NHS Act 2006 to involve stakeholders in healthcare developments. This places a duty to involve the users of health services and the public, whether directly or through representatives, in the planning of services, the development of proposals for change in the way services are provided and in decisions to be made affecting the organisation of services.

The NHS Act also identifies a requirement to consult Health, Community and Care Overview and Scrutiny Committees (HCCOSC) where there is any proposal for substantial change or development of health services in the areas of the local authority or for substantial variation in how that service is provided.

2.3 Local context

Northampton General Hospital faces one of the most challenging times as it strives to improve the quality and safety of services improve performance, achieve financial balance and maintain its reputation.

The trust will need to have an ongoing dialogue with all key stakeholders as it seeks to increase productivity and efficiency, improve outcomes and review its clinical strategy as an active participant in Healthier Northamptonshire in order to meet and address the challenges faced by the local healthcare economy.

Our vision is to provide the best possible care for all our patients.

Our values are the behaviours against which we will be judged as we deliver our vision:

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

Our five strategic aims to achieve the vision are:

1. Be an organisation focussed on quality outcomes, effectiveness and safety
2. Continuously improve our patient experience and satisfaction by delivering personalised care which is valued by patients
3. Provide a sustainable range of services delivered locally
4. Develop, support and value our staff
5. Provide effective and commercially viable services for our patients ensuring a sustainable future for NGH

Providing a high standard of compassionate care that focusses on the needs of our patients and the community we serve, and which is sustainable and deliverable over the coming years, is critical to the trust achieving its vision of providing the best possible care.

The trust remains committed to achieving NHS foundation trust (FT) status and is working with partners in the local healthcare community to deliver sustainable services that focus on both clinical and operational excellence. We will only achieve this through the continued and increased involvement of our patients, staff, members, commissioners and other partners. By delivering our vision, we aim to secure FT status in the future.

3. STAKEHOLDER ENGAGEMENT

A stakeholder can be defined as a person who has something to gain or lose through the outcomes of a planning process, programme or project (Dialogue by Design 2008). Stakeholder engagement is at the heart of a patient-led NHS. It is how we as an organisation involve, learn and understand the view of people who may be affected by our decisions or can influence the implementation of our decisions. Their views help us shape any service changes we plan to make.

Passive or tokenistic engagement is not what we are aiming for. We are striving to develop a culture of partnership with patients, our staff and the community; for our patients to be involved in their care and for our staff to be involved with what we as an organisation want to achieve. Our aim is for there to be ongoing listening and learning so that everyone can work together in the design and delivery of high quality services that safe, effective, sustainable and meet or exceed expectations.

Who are our stakeholders?
NGH has a range of stakeholders:

Stakeholder group	Description
Patients and people using our services	Our patients, users of our services and their family/carers are central to all we do. Although on the whole they have no direct financial arrangement with us, we should consider them as our customers. Patient engagement is a key strand of this strategy.
Staff	Our staff are key stakeholders and our relationship with them, and staffside representatives through our partnership forum, is critical to the success of the organisation. Staff engagement forms part of this strategy.
Shadow governors and members	Our shadow governors and members act as ambassadors for the organisation and it is essential that they feel involved and aware of developments at the trust.
Commissioners	Our commissioners purchase the services we provide and we have formal agreements with them. These include NHS Nene and NHS Corby CCG and NHS England who purchase specialised care.
Healthcare partners	Our relationships with our healthcare partners (GPs, local authorities, other local providers and third sector providers) are key to ensuring sustainability of services and providing better co-ordinated care for patients across primary, secondary and social care.
Community groups	NGH is at the heart of the community. Relationships with all our community groups, especially those who have a close interest in our services, are important to the trust. Our services need to reflect our community's needs and aspirations for local healthcare. These groups include Friends of NGH, HealthWatch, Northamptonshire Carers, Northamptonshire Rights and Equality Council, and Voluntary Impact Northamptonshire.
Elected representatives	Key influencers and representatives of the local community are our MPs, and our councillors (including health and wellbeing boards and members of health and social care scrutiny committees).
Regulators	Our regulators monitor the quality of care we provide and include the NHS Trust Development Authority (TDA), Care Quality Commission (CQC) and NHS England.
The media	The local media is an influential opinion-former. We have developed strong relationships with the local media and it is essential that these are maintained.

4. OBJECTIVES

The purpose of this strategy is to describe our commitment to engagement with all our key stakeholders. The objectives are:

Patient engagement

- Build a culture that puts our patients and those who use our services at the heart of all we do
- Ensure our patients and their carers are involved at all levels across the organisation
- Listen, learn, respond to and act on patient feedback to drive continuous improvement
- Enable confidence in our services through an effective and responsive complaints process

Staff engagement

- Support the development of an environment for a healthy culture with values that are shared throughout the trust
- Enable the view of our staff to be heard, seeking their feedback, listening, empowering and responding to make a difference to their working life
- Ensure our staff are aware of the vision and direction of the trust and enable them to understand how their role plays a part in our success
- Ensure our managers invest, empower, recognise, value and reward staff

Engagement with the community and other key stakeholders

- Engage more effectively with our community through an ongoing dialogue to ensure their views are listened to and reflected in improved services, including their development, future plans and any redesign
- Have an ongoing relationship with our stakeholders so they feel involved, considered and can make a difference
- Work towards an increased and more interactive trust membership which reflects the community we serve, provides opportunities to be involved in trust activities and supports them to live healthier lives

4.1 Patient engagement

> *'We know we're going to need patients and carers to help redesign care and that an NHS with a 'like it or lump it' attitude will simply not survive'.*
>
> **Simon Stevens**
> **Chief Executive of the NHS**

Listening to our patients and users of our services is a key way for us to keep a check and improve. Monitoring, responding to and analysing the feedback we receive from our patients helps us identify where we need to improve and also find better ways of delivering services. We encourage our local community to provide feedback on our services and our future direction.

Objective 1: Build a culture that puts our patients and those who use our services at the heart of all we do

Our vision is to provide the best possible care for all our patients. We know those who use our services are the reason we are here.

- We will ensure that all our staff are caring and compassionate, treat our patients with dignity and respect and involve them as an equal partner in their care

Objective 2: Ensure our patients and their carers are involved at all levels across the organisation

A strategic aim of the trust is to continuously improve our patient experience and satisfaction by delivering personalised care which is valued by patients.

- We are committed to ensuring our patients and their carers are involved in their treatment and care. This includes being invited to plan and care treatment with professionals, providing opportunities to offer feedback through a variety of channels and to be involved in the development and improvement of new and existing services.

Objective 3: Listen, learn, respond to and act on patient feedback to drive continuous improvement

NGH is committed to creating a culture whereby we listen to patient feedback via a variety of channels, including national and local surveys, the Friends and Family Test, comments provided through NHS Choices and Patient Opinion, focus groups and forums and by providing a robust and responsive and PALS and complaints service.

- We will celebrate and extend good practice identified through the compliments and positive feedback we receive from our patients. Where areas for improvement have been identified we will take action and embed change to benefit the ongoing experience of patients. We recognise the importance of sharing these changes with

all our stakeholders to demonstrate our responsiveness and commitment, and encourage further feedback. We will continue to develop mechanisms to share the actions we have taken to improve services.

Objective 4: Enable confidence in our services through an effective and responsive complaints process

We are committed to making our PALs and complaints services accessible. We will ensure that every person making a complaint is taken seriously and involved throughout the process to ensure they receive a timely and robust response that addresses concerns raised, actions taken, areas for improvement and apologises when we have made mistakes.

Patients and carers will be encouraged to provide feedback on their experience of the complaints process to enable us to continue to improve the service we provide.

4.2 Staff engagement

> *'It's the experiences of healthcare staff that shape patients' experiences of care, for good or ill, not the other way round.'*
>
> **Dr Jocelyn Cornwell**
> **Director, The Point of Care Foundation**

Strengthening engagement is critical to the trust's future and is a core component of our organisational development strategy, *Connecting for Quality, Committed to Excellence'.* Kings Fund research in 2012 found that the more positive the experiences of staff within an NHS trust, the better the outcomes for that trust. The study found that engagement had significant associations with patient satisfaction patient mortality and infection rates.

Objective 1: Support the development of an environment for a healthy culture with values that are shared throughout the trust

Connecting for Quality, Committed to Excellence sets out the trust's aim to have a workforce that shares the trust's values and we think and act like one organisation where our staff feel engaged and part of the trust.

The trust's culture is reflected in our vision and values, which were developed with the active involvement of our staff.

- We will work to embed our shared values within the trust. They will define the quality of care Northampton General Hospital expects and staff will be encouraged to put them at the heart of everything they do.

Objective 2: Enable the view of our staff to be heard, seeking their feedback, listening, empowering and responding to make a difference to their working life

There is an increased focus in the trust to develop our staff across the organisation to support sustained high performance.

In April 2014 we launched our first friends and family test for staff. The first quarter concentrated on staff in non-clinical areas and during the second quarter staff in the medicine care group are being asked the same questions. We will continue to roll out the staff friends and family test until all areas of the organisation have been covered. The feedback gathered will inform the work needed to improve engagement and support our staff, and also provide a valuable benchmark against which we can measure our improvement.

- We will continue to give our employees a voice and act on their feedback through the national NHS staff surveys, regular trust surveys and the staff friends and family test.
- The trust will aim to raise the engagement score year on year, in line with benchmark organisations. Progress will be monitored by the executive committee and reports to the trust board.

Objective 3: Ensure our staff are aware of the vision and direction of the trust and enable them to understand how their role plays a part in our success

In 2009 the MacLeod report, *Engaging for success: enhancing performance through employee engagement,* states that a key driver for employee engagement is for leadership to provide a strong strategic narrative which described an organisation's story, its purpose and vision in a way that enables employees to understand how their role and the work they do fits in and makes a positive contribution.

- We will develop 'our story' – the narrative around our vision and strategy. And continue to ensure our staff are aware of our aims and direction from the moment they start working for the trust and throughout their employment.

Objective 4: Ensure our managers invest, empower, recognise, value and reward staff

Another key theme from the MacLeod report was the role of 'engaging managers' in successful staff engagement. These managers are people who appreciate their team's efforts, treat people as individuals, and organise work efficiently, resulting in team members feeling valued and supported in their jobs. The value of recognition and reward in motivating staff is recognised by the trust in a number of ways, including our Best Possible Care Awards.

- We will continue to support our managers to become 'engaging managers' through our organisational development programme which will include good leadership and management training.
- We will ensure staff are taught the skills to effectively coach and mentor their teams.
- We will continue to ensure awards and exceptional achievement receive a high profile and recognition across the organisation.

4.3 Engagement with the community and other key stakeholders

Objective 1: ***Engage more effectively with our community through an ongoing dialogue to ensure their views are listened to and reflected in improved services, including their development, future plans and any redesign***

The importance of engaging effectively with the community and other key stakeholders was reinforced for the trust before, during and after the Care Quality Commission inspection of our services in January 2014, and again during recent industrial action by pathology staff.

The NHS is important to everyone and is of interest to many. The challenges faced by the NHS, both locally and nationally, with people living longer, rising demand, advancements in drugs and care and budget constraints, mean that changes are inevitable.

- We are committed to making stakeholder engagement part of our everyday business to improve care for patients
- We will invest time in developing strong relationships with key stakeholders through a number of ways, including:
  - One to one conversations – to build relationships with representatives of groups or individual stakeholders
  - Regular conversations – as organised conversations, eg scheduled in an annual calendar of events or at stakeholder meetings, or as part of a particular project, eg preparation of the quality account, AGM
  - Specific conversations, eg over proposed service change, which would involve discussion at an early stage of a project and throughout
  - We will continue to pursue different types of conversations and approaches to engagement to meet the needs of our stakeholders
- In carrying out the above activities we will meet our obligations under Section 242 of the NHS Act 2006 to engage our stakeholders in the planning, development and operation of our services
- We will ensure the reasons for, scope and potential impact of any change are clearly outlined
- We will work closely with our partners to ensure as wide engagement as possible
- We will seek out vulnerable groups to identify their needs, concerns and any potential barriers

Objective 2: ***Have an ongoing relationship with our stakeholders so they feel involved, considered and can make a difference***

Effective stakeholder engagement is about building sustainable relationships with our stakeholders.

- We will work to build strong relationships with our stakeholders through listening and being open and honest, so we can understand their agendas and improve mutual understanding and trust
- We will regularly communicate and share our vision, our goals and the work we do in plain English through a number of channels

- We will try to avoid any surprises, informing as far as possible any issues that are emerging
- We will give timely feedback on progress, outlining the options available before a solution is agreed and the impact our stakeholder views have made on services
- We will support people to provide feedback on our services

Objective 3: ***Work towards an increased and more interactive trust membership which reflects the community we serve, provides opportunities to be involved in trust activities and supports them to live healthier lives***

As an NHS trust that is aspiring to achieve foundation trust status, we have a shadow council of governors in place and more than 8,000 members (4,000 public and 4,500 staff).

- We are committed to strengthening our relationship with our membership to build ownership in NGH through regular updates on the trust and on health issues, and by putting on activities and events that are relevant to the trust and our members
- We will recruit and work to increase and sustain our membership base and ensure it is representative of the diverse nature of our local community

5. DELIVERING THE STRATEGY

Responsibility for delivering patient engagement is described in our patient and public involvement strategy. Every member of staff is responsible for providing the best possible care, ensuring a positive patient experience, demonstrating the trust's values and learning from patient feedback. Our wards, services and departments are responsible for ensuring the patient experience is central to their agenda and to incorporating feedback into their plans. The patient experience lead and patient and public engagement network are responsible for promoting the patient engagement element of this strategy, supporting managers and developing initiatives that facilitate patient feedback and involvement.

Our organisational development team is responsible for promoting and supporting staff engagement and implementing the organisational development strategy, providing the mechanisms at a corporate level for gathering the views of our staff and ensuring a process is in place for it to be acted upon and reported to the trust board. Individual services and managers are responsible for listening to their staff and developing their own action plans. The trust executive team and senior management group in conjunction with the communications team are responsible for informing staff of the organisation's vision. The OD team, working with our training and development team, is responsible for developing and providing staff development programmes. All managers are responsible for investing in their staff and recognising the work of their teams.

The responsibility for engagement with the community and other key stakeholders rests at all levels across the organisation. Each service is responsible for approaching and listening to the stakeholders relevant to their area. Each service is responsible for ensuring their annual business plans and planning processes take account of stakeholder engagement. Advice and support will be given from the patient experience lead and communications team. Community engagement on corporate plans is the responsibility of the executive team in conjunction with the communications team. Membership engagement is the responsibility of the trust secretary and communications lead.

6. MONITORING, MEASUREMENT AND CONSULTATION

Patient engagement is included as part of the monthly patient experience reports to the trust board. An annual summary is included within the trust's quality account and annual report. The trust board will be informed of progress on patient engagement through the patient experience lead and an annual report to the board on stakeholder engagement.

Progress on implementing the staff and community engagement components of the strategy will be reported to the trust board

Measures exist for staff and patient engagement activities, for example staff and patient surveys. The trust will explore different ways to measure the success of engagement with the community and other key stakeholders, including introducing regular trust surveys to gauge stakeholder opinion, stakeholder mapping, participating at trust events, membership numbers and level of engagement, media monitoring and social media analysis. The trust will develop joint engagement plans where appropriate with the wider healthcare community, for instance when working on Healthier Northamptonshire.

7. NEXT STEPS

The strategy outlines a framework for more effective stakeholder engagement across three key areas: patients, staff and community and other key stakeholders. However, it is essential that these three aspects are not considered in isolation so that the intelligence and learning obtained from our engagement activity can be shared with the wider organisation and prevent duplication of effort and enquiry.

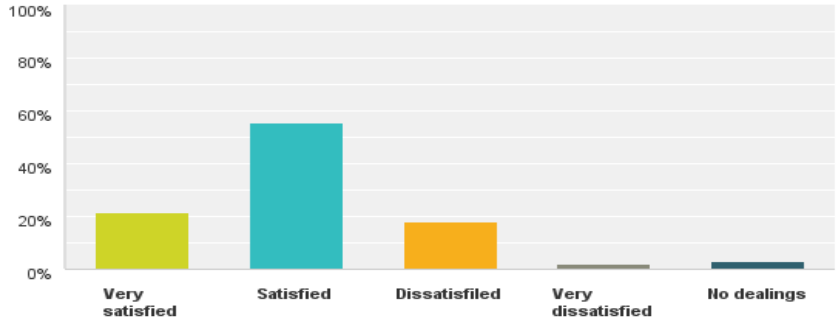
APPENDIX 1 – RESULTS OF MARCH 2014 EXTERNAL STAKEHOLDER SURVEY

Introduction

In March 2014 we undertook our first ever external stakeholder survey in order to assess perceptions of the trust among our key stakeholders. The survey, which ran for four weeks, was disseminated to voluntary and public sector partner organisations through patient and public networks, the trust's membership and to the wider public via the trust's social media accounts.

Key findings

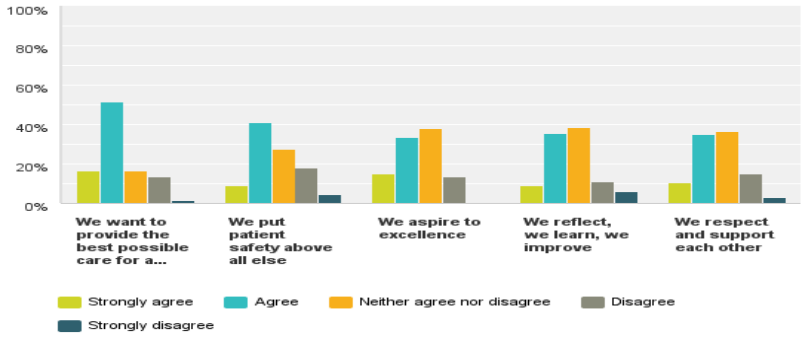
- The majority of responses (62%) were received from staff members in other NHS trusts and those working in GP practices. Public (including members) and voluntary sector bodies comprised approximately 25% of respondents.
- Almost two thirds of respondents had regular contact with the trust, ranging from daily to monthly.
- 76% of respondents we either satisfied (55%) or very satisfied with the dealings they had with staff from NGH.



Areas of dissatisfaction related to poor communication and difficulty in making contact with staff.

Our values

When considering the trust's vision and values, 68% of respondents either agreed or strongly agreed that we want to provide the best possible care for all our patients. 50% agreed or strongly agreed that we put patient safety above all else. 48% agreed or strongly agreed that we aspire to excellence. 44% agreed or strongly agreed that we reflect, we learn, we improve and 45% agreed or strongly agreed that we respect and support each other.



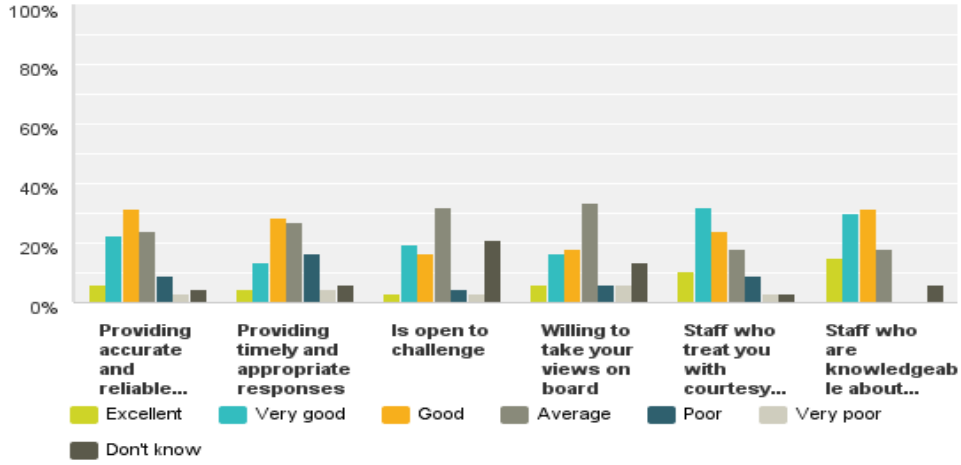
Based on the feedback from respondents there is clearly more work to do to if we are to demonstrate that our values are reflected in our practice and subsequently in our stakeholders' opinions and perceptions of the organisation.

Stakeholder/partnership working

We asked respondents about their day to day interactions with the trust and the attributes they think are important to good stakeholder relations and partnership working. Respondents were asked to rate their experience when considering these.

The results show that our staff's knowledge about their area of work was deemed to be our strongest attribute. This statement elicited a very positive response, with 76% of responses being in the positive spectrum (excellent, very good or good). 20% of responses rated our staff as average, and the remainder said they didn't know. There were no negative responses.

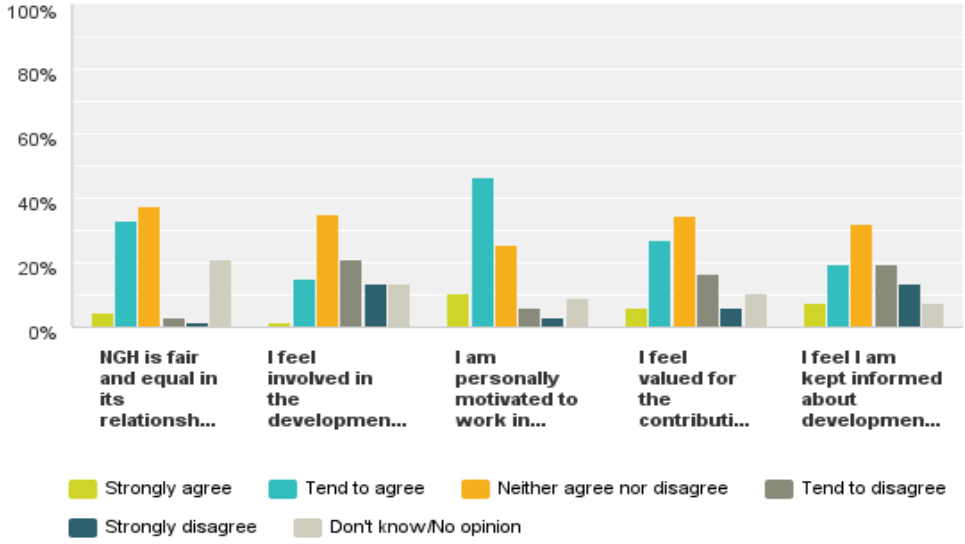
The lowest scoring attributes related to providing timely and appropriate responses, with 21% of respondents recording a response of poor or very poor in this area.



Working with our stakeholders

Responses to the questions in this area are more reflective of the quality of our working relationships than that of our service delivery. The highest level of satisfaction came in response to the statement 'I am personally motivated to work in partnership with NGH to achieve its vision'. This elicited a positive response from the majority of respondents, with 58% expressing a personal desire to work in partnership with us.

By contrast, the least positive statements were 'I feel involved in the development of NGH's policy and services' and 'I feel I am kept informed about developments at NGH'. A third of respondents did not agree with these statements and a third were neutral.



Reputation
The highest scoring statement in this section related to the politeness and courtesy of our staff. 88% of our stakeholders recorded a positive response to this question.

When asked if the trust was easy to do business with, less than 50% of respondents (42%) provided a response in the positive spectrum. 44% provided neutral responses and just over 13% disagreed or disagreed strongly. Given the opportunity to comment, respondents noted that some departments are better than others.

When asked to think about the trust's reputation locally, 28% either agreed or agreed strongly that our reputation was good/positive. However, almost 37% disagreed or strongly disagreed with this statement.

Reflecting on the trust's reputation outside of the county, 11% of respondents agreed that the trust's reputation is good. Just over 45% neither agreed nor disagreed and 13% disagreed or strongly disagreed. 31% of respondents said they didn't know.

The final question in this section asked how respondents would assess the reputation of NGH within their own organisation. 43% of responses were positive, 30% were average, 22% were either below average or poor and 5% felt they couldn't comment.

Improving our stakeholder engagement
We asked respondents to suggest some ways in which we would improve our engagement. The top five were:

- 55% said we should have a better understanding/knowledge of other organisations
- 53% said we should listen to other organisations and stakeholders
- 40% said we should speed up our response
- 38% said we should be more open and transparent
- 37% said we should keep stakeholders better informed

Almost a third of respondents said we should be more proactive; have dedicated staff to manage relationships with partners and engage in earlier/more strategic dialogue.

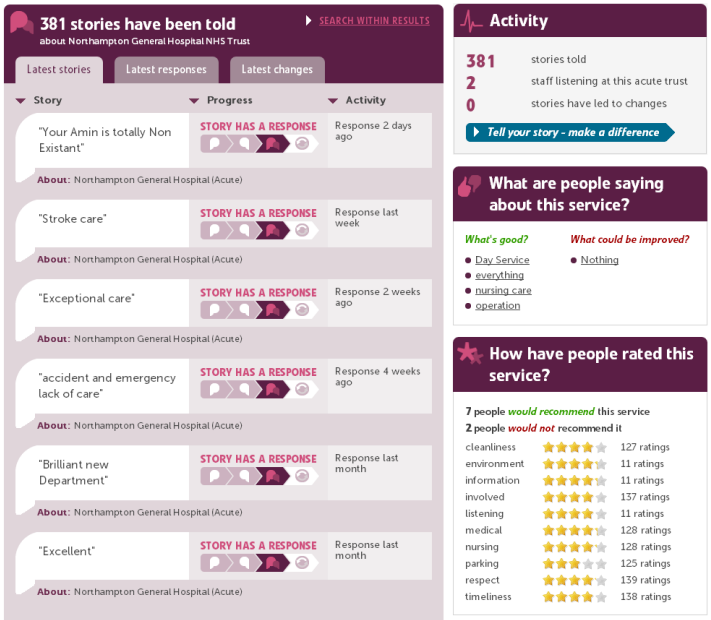
Communication
The survey concluded with a reflection on communication with and by NGH. The results will inform our future communication strategies. We asked:

- Excluding personal correspondence, how often do you hear from NGH?
- Would you like to hear more from NGH?
- What is your preferred way for us to communicate with you?

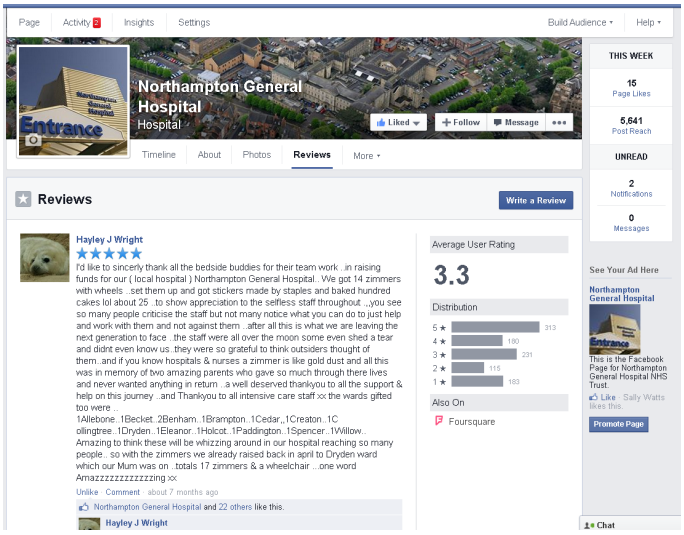
Taking the first two questions together, almost 45% of respondents heard regularly from the trust (more than once a month). However, 37% said they heard from us less than twice a year. 20% said they would like to hear more and 20% said they would not. 50% said they would like to hear more only when it was appropriate.

The majority of respondents (78%) said they would prefer to receive email correspondence. Other preferences ranged from face to face meetings, conferences, correspondence, conferences, social media and our website.

NHS Choices ratings – August 2014
In addition to the trust's reputation survey, ratings and reviews are gathered by the NHS Choices website. The data is split by hospital site and records service user ratings, staff recommendations, data on response to safety alerts, mortality rate and performance against CQC standards. Comments/reviews on the NHS Choices are regularly monitored and moderated by the communications team, as are the comments posted on the Patient Opinion website (see below).



We also have ratings/recommendations on the trust's Facebook page – see below. These are also monitored and moderated by the communications team.



Conclusion

This was the first time the trust has undertaken a reputation survey that sought the views of such a wide range of stakeholders. Overall the survey provides a benchmark and has produced some positive results, but there are also clear areas identified where we need to improve, particularly in relation to transforming our values into a reality for our stakeholders and our response times. While many of our stakeholders are personally motivated to work with the trust, in a significant number of cases the survey suggested that they do not always feel as involved, informed, listened to or valued as they might be.

In general the survey reveals a number of positive experiences of the trust and attitudes towards it. However, this does not necessarily translate to a good reputation. When asked about the trust's reputation across the local area, less than 50% of respondents felt we were easy to do business with. Whilst 43% of respondents said the trust had a positive reputation within their own organisation, 37% of respondents did not feel that our local reputation was good/positive.

The survey was disseminated to a wide range of community and voluntary sector groups, NHS partner organisations and healthcare providers as well as our members and members of the public. However, we did not apply equality monitoring to responses received. As such, on this occasion, it has not been possible to split the results by, for example, gender, ethnicity or disability. This is a learning point for future surveys and we will work with the clinical audit team to explore how best to achieve this level of monitoring in future surveys.

The survey will be repeated in March 2014, with the results compared to the 2013 survey.

APPENDIX 2 – PROGRESS AGAINST 2013 COMMUNICATIONS AND STAKEHOLDER ENGAGEMENT STRATEGY

Objective	Task	Timescale	Responsibility	Indicators	Progress
1. Create a dynamic culture of staff engagement supported by two way effective communications at care group/directorate/ department level and horizontally across the Trust	Strengthen the core brief cascade to ensure effective information flows	July 2013	Communications	Number of staff briefed and feedback received	• Core brief format revised. • Guidance for managers issued and training/advice available.
	Develop communication and engagement champions to be effective communicators of key messages and information	March 2014	Communications with HR	Champions identified Training delivered	Revision of approach going forward in line with OD strategy and revised structures
	Provide training for all line managers so they are able to provide effective briefing for their staff	September 2013	Communications with HR and OD	Training delivered; number of staff briefed/feedback	• Core brief guidance distributed. • Training offered to all responsible for team briefing
2. Ensure all staff are fully engaged in the Trust's commitment to deliver high quality, safe care by keeping them informed about what is changing, why change is needed and, most importantly, involving them in the decisions that affect them	Roll out the Trust's vision and values so staff understand how they relate to their everyday work and how they demonstrate them (or don't)	September 2013	HR supported by Communications	Internal communications survey	• Internal communications survey undertaken June 2013. Results informed development of core brief and will form baseline of internal communications measurement going forward. • Vision and values re-launched December 2013. Refreshed branding April 2014.
	Refresh the Trust's e-communications (including the intranet and bulletins) to make it easier for staff to find and share information.	November 2013	Communications supported by IT	Comms bulletin launched Intranet refreshed	• CEO weekly blog from July 2013 • Weekly bulletin launched August 2013
	Ensure staff are kept informed of progress with Healthier Northamptonshire	Ongoing	Communications with support from Healthier Northamptonshire	Intranet content area Bulletins/briefings/ pod casts	Briefings/updates provided as appropriate as part of core brief and CEO blog.

Objective	Task	Timescale	Responsibility	Indicators	Progress
3. Ensure patients are well informed about the quality, safety and availability of services delivered by NGH so they are empowered to make an informed choice about who provides their treatment/care	Work with departments/services to ensure information about services is up to date and relevant	October 2013	Service managers with web co-ordinators and communications	Patients and local communities have clear, accessible information in appropriate formats	• Web developer now in post. • Work underway to confirm web co-ordinators, address gaps and provide training where needed • Web and intranet content reviewed pre CQC inspection
	Ensure the online directory of services, aligned to NHS Choices information, is updated to provide comprehensive, relevant information	Ongoing	Service managers supported by contracts and IT		
	Develop an online patient information library to provide information in different formats, including downloadable information	March 2015	Patient Information Group with IT and patient experience lead supported by communications	Patients have clear, accessible information about their condition in an appropriate format	Patient information library now under development. To form part of wider website redevelopment in 2014-15
	Support services in identifying opportunities to raise the profile of their service via the local and regional media	Ongoing	Service managers; supported by communications	Articles published	Communications team working with departments to understand and identify opportunities
4. Ensure GPs, commissioners and regulators are well informed about the services delivered by NGH and that the Trust is clearly aware of the priorities and requirements of those who refer to, purchase or regulate acute care	Ensure the online directory of services, aligned to NHS Choices information, is updated to provide comprehensive, relevant information	Ongoing	Contracts manager; IT; service managers; supported by communications	GPs and commissioners are aware of the services we provide	Business development manager in post from mid-Sept 2013.
	To build on the previous GP engagement strategy by developing and delivering a programme of stakeholder engagement activity with GPs and CCGs to promote NGH as the provider of choice	December 2013	Communications with clinical and service leads	% increased recognition and understanding from stakeholders	GP News relaunched. Challenges in getting on the agenda of practice PLT events may be resolved with improved forward planning.

Objective	Task	Timescale	Responsibility	Indicators	Progress
5. Nurture new and existing relationships to enable partners to be engaged and involved in transforming services, delivering care and shaping future developments, particularly in relation to Healthier Northamptonshire	Ensure communities are involved in service change and the 'four tests' of service reconfiguration are met when considering service change	Ongoing	Communications supported by senior managers and Healthier Northamptonshire	Stakeholder engagement has influenced service redesign	NGH active partner in Healthier Northamptonshire.
	Introduce effective feedback mechanisms on our external website to ensure our stakeholders have the opportunity to have their say on our services	December 2013	Patient experience lead supported by IT and communications	Mechanisms in place and feedback received	Feedback received via social media, NHS Choices and Patient Opinion. Survey Monkey already in use for some services. Friends and Family test in use. Patient experience lead in post.
	Work with the voluntary and community sector, local forums and networks in order to engage with specific groups, including older people, younger people, black and ethnic minority groups and other hard to reach groups	Ongoing	Communications	Meetings/briefings held	Activity scheduled to take place as and when appropriate
6. Build trust in the organisation through reputation management	Strengthen relationships with local media to ensure messages are widely promoted	Ongoing	Communications with executive team	% increased positive media coverage	Core messages refreshed to ensure they incorporate/reflect NGH vision and values Media briefings introduced for CQC inspection Weekly catch-up calls made if no contact
	Develop and deliver a programme of stakeholder engagement including GPs, CCGs, MPs, partner organisations and patient groups	March 2014 and ongoing	Communications with executive team and non-executives	% increased recognition and understanding from stakeholders	Briefings issued and meetings arranged

Objective	Task	Timescale	Responsibility	Indicators	Progress
/continued	Work with health and social care partners to identify joint engagement and involvement opportunities	Ongoing		Voluntary and community sector report improved joint working	As part of Healthier Northamptonshire
	Continue to build good working relationship with Northamptonshire Healthwatch	Ongoing	Executive team	Northamptonshire Healthwatch feel informed and involved	NGH represented on Healthwatch Media releases shared pre-publication
7. Retain a vibrant and active membership for the Trust	Ensure members are kept informed of developments through briefings and events	Ongoing	Membership manager with shadow governors supported by communications	Briefings issued and events held	AGM & NGH Festival well attended.
	Identify opportunities for members to become involved in Trust activities	Ongoing		Number of members involved/Feedback	Approach being developed by patient experience lead Members have been involved in noise at night audits, cancer partnership and T&O department. Also involved in QuEST reviews.

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**25 September 2014**

Title of the Report	**Communications Strategy 2014-2017**
Agenda item	**20**
Sponsoring Director	Chris Pallot, Director of Strategy and Partnerships
Author(s) of Report	Sally-Anne Watts, Head of Communications
Purpose	Presented for approval

Executive summary

This Strategy sits alongside our Stakeholder Engagement Strategy and sets out our plans in relation to communications activity over the coming three years. It uses feedback from our external stakeholder survey, staff survey and best practice to develop and strengthen our communications activities.

The Strategy stets out a number of actions needed if we are to deliver and achieve our aspiration for strengthened communications and support our stakeholder engagement. Progress will be monitored through the Trust's governance processes.

Related strategic aim and corporate objective	All
Risk and assurance	No
Related Board Assurance Framework entries	BAF 1, 10 and 14
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	No

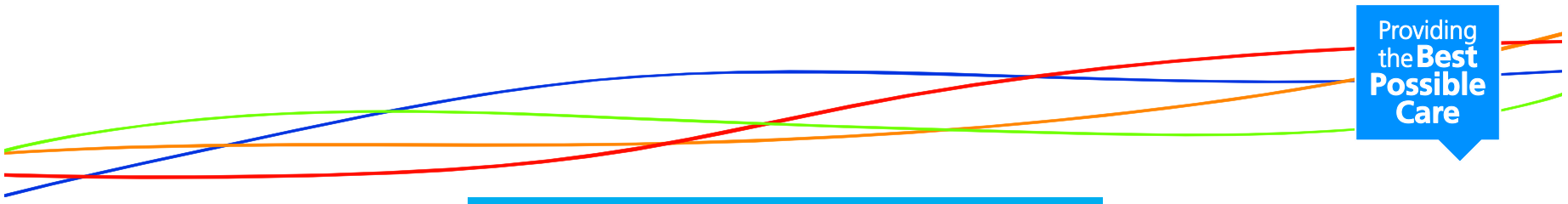
Enclosure Q

Actions required by the Trust Board

The Board is asked to approve the strategy and, where appropriate, support implementation.

Northampton General Hospital NHS
NHS Trust

Communications Strategy
2014 - 2017



Enclosure Q

Contents

Introduction

This strategy sits alongside our stakeholder engagement strategy and sets out our plans in relation to our communications activity during the coming three years. It uses feedback from our external stakeholder survey and staff survey and best practice to develop and strengthen our communications activities.

Effective communication is vital to the trust, both from an external and internal perspective so that we can share information about our services, share good news, explain bad news and encourage our stakeholders to engage in and promote improvements to our services.

Open and regular communication with staff is essential if we are to help our workforce understand how what they do contributes to the overall trust vision, how NGH is performing and helping to celebrate their success.

Stakeholders

We know that NGH has a broad range of internal and external stakeholders, each with their own needs, interests and views on local and specialist healthcare provision. Each of our stakeholder groups is broadly represented in one or more of the following categories:

- Staff
- Patients, their families and carers
- Health and academic partners
- Commissioners
- Community groups, and our members
- Influencers, overseers and scrutineers

Throughout our communication activities we will make sure that each of our target audiences is communicated with appropriately.

Implementation

This strategy sets out a number of actions needed if we are to deliver and achieve our aspiration for strengthened communications and support our stakeholder engagement. Progress will be monitored through the trust's governance processes.

The drivers for change

There are a number of drivers for change, some are internal and others are external.

1. The trust strategy and supporting strategies

We have developed a refreshed vision and values for our organisation and confirmed our strategic aims (set out opposite). The purpose of the communications strategy is to support effective implementation of the trust's strategic aims so that they become a reality.

Our vision, the strategies and programmes of work required to deliver the vision will provide opportunities for generating good news stories to strengthen and promote the reputation of the trust. The challenge is to provide an infrastructure and mechanism to communicate those strategies, explain them to staff and the public and to celebrate our achievement of them.

In all our communications we aim to demonstrate how we live by our values and embed them within our organisational culture. Our communications activities will help staff and stakeholders understand the vision and see its implementation.

NGH faces a challenging time as it strives to improve the quality and safety of services, improve performance, achieve financial balance and maintain its reputation.

We will need to work closely with our stakeholders and our engagement activity must be underpinned by effective communications.

The trust's vision, values and strategic aims

Our vision	**Vision** To provide the best possible care for all our patients
Our values The behaviours against which we will be judged as we deliver our vision	**Values** • We put patient safety above all else • We aspire to excellence • We reflect, we learn, we improve • We respect and support each other
Our strategic aims	**Aims** • Focus on quality and safety • Exceed patient expectations • Strengthen our local services • Enable excellence through our people • Ensure a sustainable future

The drivers for change

The trust's strategic aims and corporate objective (2014-2015) are set out below, with a summary of the role that the communications strategy could play in their successful implementation.

Strategic Aim	Corporate Objectives (2014-2015)	Role of communications
Focus on quality and safety	• Improve our core clinical standards • Provide a high quality environment for our patients	Effective promotion of the trust as a provider of high quality, safe care will contribute to patients choosing to use our services, support the recruitment of staff wishing to work at NGH and enhance our reputation. EXAMPLE: Work with the patient safety academy to ensure develop its profile throughout the organisation, share learning and proactively publicise the work they do. EXAMPLE: Develop and implement long-term communications and publicity campaigns for key services.
Exceed patient expectations	• Integrate under one framework our patient engagement and involvement strategies • Implement new ways of learning from patient experience so we learn lessons more quickly and more effectively • Involve patients in everything we do	Patient experience, reputation and awareness are important factors in what people say about us and where patients choose to receive their healthcare. Systematically building the profile of our patient engagement and involvement activity will help demonstrate our commitment to listening and learning from our patients' experience. EXAMPLE: Strategically support patient engagement and involvement activity to ensure its profile is raised. EXAMPLE: Publicise changes made as a direct result of patient feedback

The drivers for change

The trust's strategic aims and corporate objective (2014-2015) are set out below, with a summary of the role that the communications strategy could play in their successful implementation.

Strategic Aim	Corporate Objectives (2014-2015)	Role of communications
Provide a range of sustainable range of services delivered locally	• Develop partnerships to support redesign of services around the needs of patients through Healthier Northamptonshire • Continue to develop excellence in our existing services	Effective communications with staff, public and partners is key to supporting service redesign and improvement. Proactive provision of clear, transparent information is essential to obtain staff and public buy-in and commitment. EXAMPLE: Develop and implement a joint communications strategy as part of Healthier Northamptonshire EXAMPLE: Develop and implement long-term communications and publicity campaigns for key services.
Develop, support and value our staff	Design and commence implementation of the *Connecting for Quality, Committed to Excellence* strategy to include: staff engagement, improving quality and efficiency programme, leadership and management development and review of trust values	Communications that support engagement activities will help make staff feel more part of the trust and enhance performance. Effective internal communications will support cultural change and increase pride in the organisation and commitment. Continued promotion of the trust's reputation will help attract the very best staff to work for the trust. EXAMPLE: Work closely with the OD team to develop communications that support staff engagement EXAMPLE: Embed the trust values throughout our communications activities EXAMPLE: Revitalise communications around our staff awards, increasing awareness and enhancing award prestige

The drivers for change

The trust's strategic aims and corporate objective (2014-2015) are set out below, with a summary of the role that the communications strategy could play in their successful implementation.

Strategic Aim	Corporate Objectives (2014-2015)	Role of communications
Provide effective and commercially viable services for our patients, ensuring a sustainable future for NGH	Develop an agreed framework so that finance can be used as an enabler to quality and efficiency	Effective communications will enable staff, patients, the public and partners understand how we improve efficiency to make best use of our resources. Effective reputation management, marketing and brand promotion will contribute to patients and commissioners choosing the trust as their provider of choice, which will help secure our financial position. EXAMPLE: Promote and publicise developments EXAMPLE: Work with IQEG to champion innovation and ensure experience and learning of quality and efficiency programmes is shared internally and externally

The drivers for change

2. Rising expectations for openness, transparency and involvement

A central theme of the Francis Report (2013) is for all NHS organisations to have an embedded culture of caring that fosters openness, transparency and candour to ensure patients are always put first and foremost in all we do. These principles and also reflected in the Keogh Report (2013), the Berwick Report (2013) and the latest planning guidance from NHS England *Planning for Patients 2014/15 to 2018/19*.

We need to ensure our communications reflect the reality of our services and the experience of our staff and patients.

3. New ways of communicating

The trust must review and refresh existing communication techniques and embrace modern technologies that offer new and different ways of reaching all our audiences. The growing popularity and mainstreaming of 'e' communication through social networking, podcasts, blogs, etc, offers new ways for our patients, staff and partners to access information, form opinion, have conversations about us and for us to gauge and influence them. For many sections of the community, and our staff, 'e' communication is now the communications medium of choice.

4. The challenge to improve quality and safety at the same time as achieving financial balance

The trust will need to have an ongoing dialogue, supported by effective communication, with all key stakeholders as it seeks to increase productivity and efficiency, improve outcomes and review its clinical strategy as an active participant in Healthier Northamptonshire in order to meet and address the challenges faced by the local healthcare economy.

We will need to ensure there are consistent messages from all partners. Effective communication will be a key component of the underpinning engagement activity required to ensure stakeholder buy-in and commitment to service developments.

Communications in the future

The tables below summarise our communications now and how we would like them to be by 2017.

Now	2017
• Reactive communications • Unsystematic and mostly one-way staff communications throughout the organisation • Weak brand and corporate image • Publication of outcomes and performance data not easily accessible/understood • Some patient and public engagement/ involvement in service improvement and development • Variable relationships with stakeholders • Limited involvement in public health messaging • Unsystematic involvement with key stakeholders • Limited campaign planning	• Proactive, planned communications activity • Robust, systematic and effective two-way staff communication • Strong brand and corporate image • Transparency regarding all clinical outcomes which are published in a way that is easily understood • Robust patient and public involvement/ engagement in service improvement and development • Strong and effective relationships with stakeholders • Proactive role in public health messaging • Planned, targeted communications campaigns with measurable outcomes

Components of the communications strategy

The vision of the communications strategy is: **'Effective communication at the heart of all we do'**

There are six key components to the communications strategy.

1. Develop the trust brand

A major strength of the trust is its brand and reputation.

Northampton General Hospital provides general acute services for a population of 380,000 people living in Northampton and South Northamptonshire, and specialist stroke, vascular and renal services to the whole of the county, a population of 684,000. NGH is also a cancer centre delivering cancer services to a wider population of 880,000 living in Northamptonshire and parts of Leicestershire and Buckinghamshire.

The hospital also has facilities for providing inpatient renal services, interventional cardiology services and interventional radiology. NGH has received national, regional and local recognition for its services, including awards for cleanliness and catering services, national nursing awards, regional awards for promoting inclusion and good practice, development of new and changing roles and inter-professional learning, plus national awards for excellence in communications.

NGH has a high profile locally and there are opportunities to further develop the image and reputation of the trust as an historic and modern healthcare institution, providing high quality, safe care that is well regarded by our patients. Our marketing communications will be aimed at providing service information to existing and potential referrers and service users. We will also develop communication plans designed to increase the profile of specific services.

The aim must be to develop the brand and reputation of the trust and to promote that brand through proactive and reactive media management, high quality patient information and effective communication so that our staff, members and patients can share positive messages about the organisation. We should always eek to promote and celebrate successes locally and nationally, and seize opportunities to promote the trust as a provider of choice because of its high quality care and excellent outcomes.

We will do this by:

- **Developing a core script for the organisation to enable consistent use of key messages for all audiences**
- **Developing and promoting a 'house style' for the trust**
- **Developing a plan to maximise our reputation, making us the hospital of choice**
- **Developing a plan to ensure our audiences understand our role as a provider of specialist services**
- **Developing a plan to increase the profile of specific services**

1. Develop the trust brand

Strategic objective	Tactics
Develop and manage a core script for the organisation to enable consistent use of key messages for all audiences	• Agree key messages which describe the organisation and its recent achievements • Revise quarterly • Make available to staff via trust intranet
Develop a consistent house style for corporate communications which projects professionalism and a clear visual identity	• Agree and implement a consistent identify for the organisation, including design of templates for corporate communications
Develop a plan to maximise our reputation, making us the hospital of choice	• Develop an ongoing campaign for sourcing good news stories that focus on our services and patient outcomes • Ensure that comprehensive, up-to-date information about our services is available on our website
Develop a plan to ensure our audiences understand our role as a provider of specialist services	• Develop an ongoing campaigns for sourcing good news stories, focusing on specialist services, by engaging through the clinical teams • Support clinical teams with engagement and educational events by providing a toolkit for consistent messaging and presentation
Develop a plan to increase the profile of specific services	• Develop service level communications plans to enhance the image and profile of services • Support clinical teams with engagement and educational events by providing a toolkit for consistent messaging and presentation

2. Promote ownership and understanding of the trust's vision, values and strategy

The vision of the trust is to provide the best possible care for all our patients.

Communication plays an important role in ensuring that all stakeholders, our patients, staff, partners, stakeholders, members, shadow governors and the public, understand this vision and the part they can/need to play in helping us achieve it.

Communication also has an important role to play in helping us report our progress in achieving our vision.

Understanding the vision and strategy
We will communicate the vision and values and strategic aims/objectives through regular communications with our staff and stakeholders, and through media briefings.

Informing patients
We aim to ensure our patients are well informed about the quality, safety and availability of clinical services provided by the trust so that they are able to make an informed choice about what treatment/care they chose to have and who they want to provide it.

Reporting achievements
We aim to ensure that our stakeholders are kept informed of our progress, celebrate achievements and promote those clinical services that are important to our strategy.

2. Promote ownership and understanding of the trust's vision, values and strategy

Strategic objective	Tactics
Consistently communicate the vision, values and strategic aims/objectives through communications with staff, stakeholders and the media	• Produce a summary of the trust strategy and ensure that this, along with the full trust strategy, is widely distributed • Develop key messages around our strategic objectives and include these in a core script for the trust's corporate communications activity • Link communications activity and trust achievements back to trust values and strategy to bring them to life • Regularly review the trust strategy with staff and stakeholders to ensure that it is fit for purpose • Proactively inform staff, patients and stakeholders of our progress
Ensure easy to access to quality, safety and performance information to support informed patient choice	• Produce the trust's annual report • Produce the trust's quality account • Develop availability of performance metrics and inspection reports available via the trust website • Produce a plan to use wards, clinics and the wider trust site to promote performance • Introduce patient case studies to the trust website
Widely celebrate success to increase the positive profile of individuals, departments and the trust as a whole	• Publish annual objectives in relation to the trust strategy and report progress against these • As key milestones are reached, publish good news stories • Develop an ongoing campaign for sourcing good news stories through the clinical teams and corporate directorates • Develop a communications strategy to support the trust's improvement programme to demonstrate innovation and best practice

3. Strengthen staff communication

We want to provide the best possible care to all our patients and believe that a highly skilled, motivated and engaged workforce is essential to achieving this.

We want a workforce that:

- Is fully engaged and committed to working according to the trust's values
- Is motivated and inspired to continuously improve the care they provide
- Is fully engaged in shaping the future of the trust
- Is proud to work for the trust, and is proud of the high quality care they provide

Our staff survey results consistently tell us that we need to improve our communications with staff. We also know that some staff groups are difficult to recruit, so we must make the trust an attractive option for prospective employees.

Communications will play a large part in supporting engagement and implementation of the trust's organisational development strategy, *Connecting for Quality, Committed to Excellence.*

Trust values

All the work we do is underpinned by our values and we should look to communicate the importance of these values at every opportunity. We aim to demonstrate that our values are being led form the board to the ward by raising the profile of the board, showing how board members live by the trust values

Staff communications

We aim to review our existing methods of staff communication and develop a framework for staff communications to create a dynamic culture of effective, two-way communication from ward to board.
We aim to promote and reinforce our vision and values and strategic aims/objectives in all communications to help ensure staff ownership of our shared goals.

Celebrating success

Our staff are our greatest asset and it is important that we recognise their achievements and contribution to patient care, so that we develop an organisation where staff take pride in their work and are recognised for what they do.
Our aim, therefore, is to be more proactive in sourcing news stories from across the organisation that demonstrate the achievements of our staff and celebrate their success.

Strengthen staff communication

3. Strengthen staff communication

Strategic objective	Tactics
Be proactive in sourcing and sharing good news stores from across the organisation that demonstrate the achievements of our staff	• Develop an ongoing campaign for sourcing good news stories regarding staff achievements across the trust, focusing on strategically significant services • The weekly bulletin to contain at least one staff story
Review existing methods of staff communication, including their purpose and effectiveness, and develop an overall framework for staff communication, including an effective team briefing system with feedback mechanisms	• Review existing methods of staff communication (staff forums, briefing systems and publications) to assess their purpose and effectiveness • Develop an overall framework to include the various methods of communication available to the trust and engagement activities undertaken as part of the OD strategy • A clear structure and framework for the effective implementation of the core/team brief
To promote and reinforce our vision and values and strategic aims/objectives in all communications to ensure staff ownership of our shared goals	• Features about staff achievements should include reference to living the trust values or supporting the trust strategy • Each staff achievement story to be linked with one or more of the trust values
Show support for cultural behaviours from the top by increasing the profile of senior staff living the trust values	• Create proposals for regular opportunities to demonstrate how senior staff live the trust values • Create opportunities to raise the profile of the board with front line staff • The bulletin, Insight, website and intranet to feature senior managers – 'How do you live the values?'

4. Improve our communication with patients and the public

The present Government's intention is to create an NHS that is much more responsive to patients and achieves better outcomes, with increase autonomy and clear accountability at every level. It is believed that a strong local voice for patients through local democratic representation is critical to creating a more responsive NHS. Individuals should have a greater say in decisions that affect their health and the care, and have a clear route to influence the services they receive.

When the trust becomes a foundation trust it will adopt a governance model that includes public membership and governors. For the past seven years the trust has recruited a membership that is representative of the community we serve and it is important that we continue to communicate with them. We have also an elected council of shadow governors.

The trust has a patient and public engagement strategy and there are methods for involving our members, patients and the public in the work of the trust. However, we can do more to ensure that we communicate these opportunities for engagement, act on feedback and ensure they are kept aware of what is happening – so our communication is based on the principle of *'You said, we did'*

The trust recognises the importance of ensuring that patients are represented in the trust. We are working with our members, shadow governors and members of Healthwatch to develop a more powerful and stable local infrastructure to support patient and public involvement.

We will therefore aim to:

- Develop a communications plan that supports our patient and public engagement activity
- Promote opportunities for involvement
- Recruit and maintain a vibrant and engaged membership

Improve our communication with patients and the public

4. Improve our communication with patients and the public

Strategic objective	Tactics
Promote and reinforce the value the trust places on patient and public engagement and communications	• Develop and implement a communications campaign to support patient and public engagement activity • Features about changes made to services as a result of patient/ public feedback to be provide to the media and published in Insight and on our website • Monthly summaries of board papers on the website
Recruit and maintain a vibrant and engaged membership	• Develop a communications framework between our shadow governors and the membership • Run a minimum of three high quality engagement events exclusively for members each year • Review existing methods of communicating with members • Introduce monthly email bulletin updates

5. Improve our communication with external stakeholders

Good stakeholder relations can keep the wolf from the door when things go wrong. Looking after stakeholders better also makes advocates of them and gives them more confidence in the things we are doing. Helping people to better understand the things the trust is doing and why is important, and taking on board the view of stakeholders will bring legitimacy to the decisions the trust makes.

The trust must ensure it plays an active part in the community, leading debate about the healthcare it provides, the strategy for healthcare in the county, health promotion and illness prevention. Recent changes in the healthcare environment means there are new groups of stakeholders and the trust must nurture these as well as existing relationships to enable effective engagement and communication with partners in transforming services, delivering care and shaping future developments.

Where joint areas of interest exist we should work to ensure that there is a consistent approach to communications across organisations and that NGH retains a suitable profile within those areas of interest.

We have a number of strategic partnerships which are important to the future of healthcare across the county and developing and maintaining these relationships is of vital importance to the trust in achieving our vision. For example:

- The trust's partnership with the Healthier Together programme
- The trust's partnership with the University of Northampton
- The trust's partnership with the
- The trust's partnership with the NGH Charitable Fund and other charities will be important in supporting the improvement of the environment in which we provide our services, such as our chemotherapy service

We also have a number of other stakeholders with whom we must continue to develop and improve our communication and relationships, including:

- MPs – we must review our current ways of communicating with MPs and ensure they are effective
- GPs and commissioners – we must ensure that GPs and commissioners are kept informed about the services we provide and that the trust is clearly aware of the priorities and requirements of those who refer to, purchase or regulate acute care
- Regulators and scrutineers – we must continue to develop and maintain our relationships with our regulators and scrutineers

Improve our communication with external stakeholders

5. Improve our communication with external stakeholders

Strategic objective	Tactics
Develop effective relationships with key influences, overseers and scrutineers, providing them with key points of contact and a formal briefing system	• Review and implement a revised MP/stakeholder briefing • Support trust staff responsible for marketing to develop a strategy for GP engagement • Proactively brief key stakeholders in anticipation of negative publicity
Support partnership working	• Support communications and engagement activity around Healthier Northamptonshire • Work with communications teams in other organisations to identify opportunities for shared messages
Develop the ability to segment and target key stakeholders and record correspondence	• Introduce stakeholder management database to bring structure to stakeholder management and record communications activity/impact

6. Develop our communications infrastructure and tools/techniques

In order to support the achievement of these aims, we must strengthen our communication vehicles and infrastructure to ensure that our messaging is targeted, relevant, accessible, accurate, meaningful and understood. At the same time we must also provide the tools and support our managers and staff need to enable them to communicate.

Advances in technology mean that different methods of communication are available to us that we should embrace. Social media provides an increasingly important vehicle for reaching out and engaging with all our stakeholders. The communications team currently uses social media to communicate good news stories about the trust, raise awareness of events and fundraising activities and gauge valuable feedback about services. Currently the trust has more than 4,200 fans on Facebook, 30% of whom are aged 25-34 (a traditionally hard to reach group). 40% of fans are aged 35 or over. We have more than 800 followers on Twitter.

Our staff intranet, public website and estate need to developed to maximise their potential as effective communication vehicles. Our website received around 500k hits in 2013 and, therefore, is an important part of our communication toolkit. However, it must be refreshed and the content reviewed to ensure we provide the information our users need and that we want to portray.

Investment in technology will also provide financial benefits as well as seizing the opportunities available through the development and marketing of apps and website advertising.

Better media relationships will give us greater opportunity to publicise positive news and be able to respond when negative stories emerge.

We will:

- **Develop and disseminate a toolkit of branded documentation templates and advice for staff to use in developing their own communications, and roll out media training to senior clinicians**
- **Continue development that has already begun in using social media and explore further opportunities to sue social media to enhance our communications and the patient experience**
- **Redevelop the trust website and intranet and to better use our estate for communication**
- **Develop closer relations with the media and with communication functions within the local healthcare community so that we can better reflect the trust's views, as well as raise the profile of the trust**

6. Develop our communications infrastructure and tools/techniques

Strategic objective	Tactics
Redevelop the trust website and to better use the trust's estate for communication	• Review website design to ensure consistency with revised brand • Review content • Develop rolling programme to ensure regular updating • Work with IT to ensure we achieve maximum benefits from the content management system • Develop a cycle of audit of web content • Review/refresh trust welcome/information board at main entrances • Work with Estates to identify appropriate areas for promotion and publicity
Explore opportunities to use social media to enhance the patient experience	• Identify further opportunities to use smartphone apps
Develop closer relations with the media and with central government communications functions	• Establish a link with DH briefings unit • Strategically consider filming and photography requests in light of publicity value and resource implications
Develop staff toolkits for communications and engagement	• Provide appropriate tools and training to key staff, i.e. media training, core brief • Refresh existing communications handbook/toolkit and promote trust-wide • Work with OD team to identify communications gaps

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**25 September 2014**

Title of the Report	**TDA Self-Certification**
Agenda item	**21**
Sponsoring Director	Chris Pallot, Director of Strategy and Partnerships
Author(s) of Report	Karen Spellman, Deputy Director of Strategy and Partnerships
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

Actions required by the Trust Board

The Trust Board is asked to:

- approve the Monitor Licensing Requirements and Trust Board Statements self-certifications for August 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 R

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 R

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 R

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 R

A G E N D A

PUBLIC TRUST BOARD

Thursday 25 September 2014
09:30 in the Board Room at Northampton General Hospital

Time		Agenda Item	Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2.	Declarations of Interest	Note	Mr P Farenden	**Verbal**
	3.	Minutes of meeting 31 July 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.**
09:50	**CLINICAL QUALITY AND SAFETY**				
	7.	Medical Director's Report	Assurance	Dr M Wilkinson	**D.**
	8.	Director of Nursing & Midwifery Care Report	Assurance	Mrs J Bradley	**E.**
10:15	**OPERATIONAL ASSURANCE**				
	9.	Integrated Performance Report and Corporate Scorecard	Assurance	Mrs D Needham	**F.**
	10.	The Patient-Led Assessment of the Care Environment (PLACE) Programme 2014	Assurance	Mr C Abolins	**G.**
	11.	Finance Report	Assurance	Mr S Lazarus	**H.**
	12.	Improving Quality and Efficiency Report	Assurance	Mrs J Brennan	**I.**
	13.	Workforce Report	Assurance	Mrs J Brennan	**J.**
11.05	**ANNUAL REPORTS**				
	14.	Security Management Review 2013-2014	Assurance	Mr C Abolins	**K.**
	15.	Health and Safety Annual Report	Assurance	Mr C Abolins	**L.**
	16.	Safeguarding Vulnerable Adults and Children Annual Report	Assurance	Mrs J Bradley	**M.**
	17.	Infection Prevention Annual Report	Assurance	Mrs J Bradley	**N.**

Time		Agenda Item	Action	Presented by	Enclosure
11:45	**STRATEGY**				
	18.	End of Life Strategy	Decision	Mr C Pallot	**O.**
	19.	Stakeholder Engagement Strategy	Decision	Mr C Pallot	**P.**
	20.	Communications Strategy	Decision	Mr C Pallot	**Q.**
12:15	**GOVERNANCE**				
	21.	TDA Self-Certification	Decision	Mr C Pallot	**R.**
	22.	Report from the Finance Committee	Assurance	Mr P Zeidler	**Verbal**
	23.	Report from the Audit Committee	Assurance	Mr N Robertson	**Verbal**
	24.	Report from the Integrated Healthcare Governance Committee	Assurance	Mr G Kershaw	**Verbal**
12:35	**25.**	**ANY OTHER BUSINESS**		Mr P Farenden	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Trust Board will be held at 09:30 on Thursday 27 November 2014 in the Board Room at Northampton General Hospital

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

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

***The Themes for discussion in the closed agenda are strategy for oncology service, HR issues and forthcoming contractual matters*.**