Northampton General Hospital NHS
NHS Trust

| AGENDA AND PAPERS | |
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| **Meeting** | **Public Trust Board** |
| **Date** | **Thursday 29 May 2014** |
| **Time** | **09:30** |
| **Venue** | **Boardroom, NGH** |

Northampton General Hospital NHS
NHS Trust

**AGENDA**

# TRUST BOARD MEETING HELD IN PUBLIC

**Thursday 29 May 2014**
**09:30, Boardroom, NGH**

| Time | | | Action | Lead | Enclosure |
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| **09.30** | **INTRODUCTORY ITEMS** | | | | |
| | **1.** | Introduction and Apologies | Note | Mr P Farenden | **Verbal** |
| | **2.** | Declarations of Interest in the Proceedings | Note | Mr P Farenden | **Verbal** |
| | **3.** | Minutes of the 24 April 2014 Board meeting | Decision | Mr P Farenden | **A.** |
| | **4.** | Matters arising from the 24 April 2014 | Note | Mr P Farenden | **B.** |
| | **5.** | Patient Story | Receive | Dr M Wilkinson | **Verbal** |
| | **6.** | Chief Executive's Report | Note | Mr C Abolins | **C.** |
| **09.50** | **CLINICAL QUALITY AND SAFETY** | | | | |
| | **7.** | CQC Action Plan | Assurance | Mr C Abolins | **D.** |
| | **8.** | Medical Director's Quality Report | Assurance | Dr M Wilkinson | **E.** |
| | **9.** | Hard Truth Commitments regarding the Publishing of Staffing Data | Assurance | Mrs J Bradley | **F.** |
| | **10.** | Patient Experience Report | Assurance | Mrs J Bradley | **G.** |
| | **11.** | Infection prevention Performance Report | Assurance | Mrs J Bradley | **H.** |
| | **12.** | Same Sex Accommodation Audit and Update | Assurance | Mrs R Brown | **I.** |
| **10.20** | **OPERATIONAL ASSURANCE** | | | | |
| | **13.** | Operational Performance Report | Assurance | Mrs R Brown | **J.** |
| | **14.** | Urgent Care Report | Assurance | Mrs R Brown | **K.** |
| | **15.** | Finance Report | Assurance | Mr S Lazarus | **L.** |
| | **16.** | Workforce Report | Assurance | Mrs J Brennan | **M.** |
| | **17.** | Improving Quality and Efficiency Report | Assurance | Mrs J Brennan | **N.** |
| **11.30** | **GOVERNANCE** | | | | |
| | **18.** | Approval of the 2013/14 Annual Report and Accounts and Quality Account | Decision | Mr S Lazarus | **O.** |
| | **19.** | TDA Accountability Framework | Assurance | Mrs K Spellman | **P.** |
| | **20.** | Developing a 5-Year Plan | Assurance | Mrs K Spellman | **Q.** |

| Time | | | Action | Lead | Enclosure |
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| | **21.** | Corporate Objectives – 2013/14 Report | Assurance | Mrs K Spellman | **R.** |
| | **22.** | TDA Self-Certification | Decision | Mrs K Spellman | **S.** |
| **12.00** | **23.** | **ANY OTHER BUSINESS** | | Mr P Farenden | **Verbal** |
| | **24.** | **DATE OF NEXT MEETING**<br>26 June 2014, 09:30 Boardroom, NGH | Note | Mr P Farenden | **Verbal** |

**RESOLUTION – CONFIDENTIAL ISSUES:**

The Trust Board is invited to adopt the following:

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

Northampton General Hospital NHS
NHS Trust

**Minutes of the Trust Board Meeting held in public on**

**Thursday 24 April 2014 at 9.30 am at the Boardroom, NGH**

**Present:**

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| Mr P Farenden (Chair) | Chairman |
| Mrs J Bradley | Interim Director of Nursing, Midwifery and Patient Services |
| Mrs J Brennan | Director of Workforce and Transformation |
| 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 |
| Mr N Robertson | Non-Executive Director |
| Mrs E Searle | Non-Executive Director |
| Dr S Swart | Chief Executive Officer |
| Dr M Wilkinson | Acting Medical Director |
| Mr P Zeidler | Non-Executive Director – Vice Chair |

**In Attendance:**

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| Mr C Sharples | Head of Corporate Affairs |

**Apologies:**

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| Mr C Abolins | Director of Facilities & Capital Development |

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| | **Welcome and Introductions**<br>Mr Farenden welcomed and introduced Mrs Bradley, Interim Director of Nursing, Midwifery and Patient Services to the Board. |
| **TB 13/14 194** | **Declarations of Interest in the Proceedings** |
| | No further interests or additions to the Register of Interests were declared. |
| **TB 13/14 195** | **Minutes of the meeting held on 27 March 2014** |
| | The minutes of the meeting of the 27 March 2014 Board meeting were presented for approval.<br><br>Subject a number of typographical amendments, the Board resolved to **APPROVE** the minutes of the 27 March 2014 as a true and accurate record of proceedings. |
| **TB 13/14 196** | **Action Log and matters arising from the 27 March 2014 Board Meeting** |
| | The Board considered the action log.<br><br>The Board **NOTED** the Action Log and Matters Arising from the 27 March 2014. |
| **TB 13/14 197** | **Patient Story** |
| | Dr Swart presented a letter to the Board from the wife of a patient that had passed away. The patient had been looked after for several months at NGH and had developed pressure ulcers. The outcome of a serious incident investigation reported to the family generated the letter. SS had written a thank you to all staff involved in treatment and this had been recorded alongside the investigation report. |

| TB 13/14 198 | **Chief Executive's Report** |
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| | Dr Swart presented the Chief Executive's Report to the Board.<br><br>The Board were informed that NGH management and staff side representatives had signed a Partnership Agreement. Dr Swart emphasised the importance of collaborative working as it had the potential to produce some important benefits to all parties.<br><br>Dr Swart reported that NGH had submitted a planning application to Northampton Borough Council for a proposed extension to the A&E Department. The extension would house a 'navigation nurse' who would assess patients and guide them to the appropriate place for treatment. The extension would also increase resuscitation facilities and provide office space within A&E. The redevelopment work should be expected to be completed by March 2015.<br><br>Dr Swart reported that the Care Quality Commission published the results of the 2013 survey of adult inpatients discharged during June 2013. NGH achieved a rating of 'about the same' as all other NHS trusts in England in 58 scores and a 'worse' rating in just two. Importantly, eight of the scores showed a statistically significant improvement on the last survey.<br><br>Dr Swart informed members that the Friends of NGH volunteers celebrated 25 years as a registered charity within Northampton General Hospital in 2014. To mark the occasion they were donating £25,000 to benefit patients of the hospital.<br><br>Dr Swart informed members that NGH has passed stage two of the prestigious UNICEF Baby Friendly Initiative accreditation. The initiative works with the NHS to ensure a high standard of care for pregnant women and breastfeeding mothers and babies.<br><br>Dr Swart advised the Board of the first ever Strictly NGH on Saturday 14th June at The Deco Theatre in Northampton. Participants from NGH have agreed to raise a minimum of £250 sponsorship for our Charitable Fund. Funds which will be for the chemotherapy appeal, department funds or the general charity.<br><br>The Board **NOTED** the Chief Executives Report. |
| **TB 13/14 199** | **CQC Action Plan** |
| | Dr Swart presented the CQC Action Plan and provided a detailed overview of the content.<br><br>The Care Quality Commission Report into services at Northampton General Hospital NHS Trust was published on 27 March 2014 following the Chief Inspector of Hospital visit in January this year.<br><br>The CQC report gave the hospital a rating of 'requires improvement' although the report recognised that staff at NGH are caring. The report noted that services in the main were providing safe and effective care; it also identified a number of areas where improvement was required. The report highlighted significant strategic issues in relation to urgent care, governance and leadership, as well identifying tactical issues in the form of compliance actions.<br><br>This summary treatment plan presented significant recommendations made |

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| | by the CQC, and the trusts immediate response to these. This plan purposely focused on short term improvements on immediate issues. Once those actions had been implemented, the trust would define a longer term plan. This would be aligned with the outcomes of ongoing governance work to ensure the impact from the actions is sustained and the Board, its committees and management remain sighted on progress.<br><br>With regard to the three strategic issues articulated in the CQC report, the trust has committed to a programme of improvement which accelerated and augmented existing programmes of work that had been in place over recent months covering urgent care, governance and organisational and leadership development.<br><br>Dr Swart commented that End of life care and Stroke pathway would be considered in the more detail at the Integrated Healthcare Governance Committee. Additionally, the first meeting with the TDA will take place next week with the first oversight meeting the following week.<br><br>Dr Swart reported that the CQC Action plan would be reported to the Trust Board on a monthly basis.<br><br>The Board **NOTED** the CQC Action Plan |
| **TB 13/14 200** | **Quality Report** |
| | Dr Wilkinson presented the Quality Report and provided a detailed overview of the content.<br><br>Dr Wilkinson reported that there had been sustained improvement in HSMR and SHMI 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 planned to start during the next three months to enable improved local ownership of performance data. Dr Swart informed the Board that that the latest SHMI was now within expected limits at 110, and as such the trust would no longer be under quality surveillance from the NHS TDA and the CQC for mortality.<br><br>Dr Wilkinson informed the members that 12 new serious incidents were reported during March 2014 of which 11 were submitted to the CCG. He advised that for each serious incident, there was an action plan developed, the progress of which was reviewed and monitored at the Serious Incident Group.<br><br>Dr Wilkinson presented the exception scorecard and advised that the metrics on the dashboard were under review. Dr Wilkinson highlighted the stroke pathway and advised that patients on the stroke unit should be 81% for March. Mrs Needham confirmed that acute stroke beds had now been ring-fenced.<br><br>Mr Farenden commented that the members should acknowledge significant improvement in reducing mortality indicators and offered thanks to all involved.<br><br>The Board **NOTED** the Quality Report. |

| TB 13/14 201 | **Patient Experience Report** |
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| | Mrs Bradley presented the Patient Experience Report to the Board.<br><br>In summarising the report, Mrs Bradley reported that the National Inpatient Survey was an annual national requirement set out by CQC and carried out within every acute hospital in England and that overall the trust performed as 'about the same' in every section of the survey. Two questions were identified as being as within the 'Worse' category when the trusts results were compared nationally. However, the Trust performed statistically and significantly better in 8 questions.<br><br>Mrs Bradley reported that the two issues identified as within the 'worse' category were related to noise and night and discharge delays. It was noted that there had been increased levels of engagement from wards in addressing those issues and improvements were expected.<br><br>It was reported that the Friends and Family Test response rate in A&E was the lowest it had been since the summer of 2013 at 7.02%. This was due in the main to a technical issue. Mrs Bradley informed the members that the main issue had been due to the availability of technology to enable the patient to respond had not been resolved. It should be noted that the feedback was higher than the national average.<br><br>Despite the low response rate in A&E, the trust met its CQUIN target for 2013/14. It was noted that the Net Promoter score in A&E had also significantly reduced, a likely outcome of the pressures in the department. Three ward areas had been highlighted as receiving low Net Promoter scores; Allebone, Abington and Cedar.<br><br>Triangulation of the Friends and Families test with complaints, incidents and PALs data had identified three consistent themes; clinical care, discharge and communication. Mrs Bradley advised that patient experience would now be approached corporately in a multi-facetted approach with complaints, PALs and experience working closely together.<br><br>The Board **NOTED** the Patient Experience Report. |
| **TB 13/14 202** | **Operational Performance Report** |
| | Mrs Needham presented the Operational Performance Report.<br><br>It was reported that the trust had achieved the 18 week RTT across all specialities, with T&O achieving 97.8% for admitted patients against the standard of 95%. The number of patients waiting over 26 weeks from referral had reduced from 37 in March to seven as of today's date. The number of cancelled operations that had not been re-booked within the required timeframe was one patient, which was due to the lack of HDU bed capacity at that time. Mrs Needham advised that that patient had since received undergone their operation.<br><br>With regard to performance against the A&E 4 hour transit time target, the trust achieved 90.4% in March, which was an improvement on previous performance.<br><br>Mrs Needham reported that performance with cancer targets was still below that required. Two week wait performance was at 91% whilst 62 day waits was at 80 %. Mr Farenden questioned when the Trust would achieve the standards. Mr Pallot responded that the issue relate to diagnostics and staff |

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| | constraints in oncology. However every effort will be made to achieve compliance by the end of June.<br><br>The Board **NOTED** the Operational Performance Report. |
| **TB 13/14 203** | **Urgent Care Report** |
| | Mrs Needham presented the Urgent Care Report to the Board.<br><br>It was noted that in March 2014, NGH commissioned McKinsey & Company to provide acceleration and realignment of the internal Urgent Care Programme. The cumulative work would lead to a 'Breaking the Cycle' week starting on the 28 April, where all new processes and treatments would be fully implemented, creating a 'new and sustainable normal' for the entire Trust.<br><br>Over the past four weeks, the Trust and McKinsey had been building on the existing Urgent Care structure, realigning and adding to what exists and identifying the most urgent 'treatments' to be addressed within each work stream. Performance metrics had also been reviewed following the McKinsey recommendation of less but most relevant data.<br><br>The Urgent Care report detailed the work streams and subsequent treatments as slides. The slides have been used at each Urgent Care Board. In addition, a slide had been created to show the progress being made within the 7 day services work stream which is ongoing and will be fully incorporated into the Urgent Care Programme once McKinsey support was complete.<br><br>Mrs Needham informed the members that weekly urgent care programme meetings continued. Delayed transfers of care were still presenting challenges although increased engagement from partners should start to make a difference.<br><br>Dr Swart commented that there was still no agreement from social care regarding the numbers of patients delayed, which was still a risk to the Trust. Mr Farenden commented that he had increased confidence in internal processes but not the same level of confidence in partner engagement and commitment.<br><br>Mr Robertson commented that March increase in attendance was unprecedented and welcomed the work to unblock and improve efficiency. He asked how the trust could ensure that staff did not become disengaged due to unimproved performance from partners. Mrs. Needham informed that twice weekly briefings with staff to keep them informed were taking place. The Trust has seen more engagement with partners in social care and acceptance of the data at a local level.<br><br>The Board **NOTED** the Urgent Care Report. |
| **TB 13/14 204** | **Finance Report** |
| | Mr Lazarus presented the Finance Report to the Board.<br><br>Mr Lazarus advised that report set out the financial position for year ended March 2014.<br><br>The year-end I&E position was a normalised surplus of £197k. This position included the £4.5m of non-recurrent support from the TDA and a range of |

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| | expenditure control measures set out in the financial recovery plan. Mr Lazarus reported that the position for 2014/15 presented an underlying deficit of £7.9m.<br>The financial position had been prepared based on the latest information available however it was noted that final agreement was subject to the validation and finalisation of a range of expenditure estimates which would be agreed during the next week.<br><br>Changes to the financial position were not expected to be material.<br><br>Mr Lazarus reported that the cash position for 2014/15 presented a risk to the trust. Mr Lazarus had engaged with thee TDA to discuss potential support mechanisms to mitigate the risk.<br><br>Mr Farenden requested that congratulations were passed on to Mr Foster and his team.<br><br>The Board **NOTED** the Finance Report. |
| **TB 13/14 205** | **Workforce Report** |
| | Mrs Brennan presented the Workforce Report to the Board.<br><br>Mrs Brennan reported that Mandatory Training compliance in March was 75.51% and achieved the Trust target of 75%. In view of the fact that the Trust target set at IHGC in October 2013 had now been achieved it was therefore proposed that a new target should be set of 80% to be achieved by October 2014 and 85% in March 2015 which reflected the Quality Schedule imposed by the CCG.<br><br>She confirmed that Role Specific Essential Training (RSET) had been defined as training that was previously mandatory in the first instance. The reporting, monitoring and assurance of RSET had been aligned to that of Mandatory Training using the Mandatory Training and Role Specific Essential Training Performance Wave. The current level of compliance for that training was 64.54%. A target of 75% to be achieved was set for August 2014 and 85% was set for March 2015 in accordance with the Contract Quality Schedule.<br><br>Mrs Brennan reported that the appraisal process, linked to incremental pay progression, commenced on January 1st 2014 was currently being embedded within the Trust. A monthly audit on the quality of appraisals undertaken would commence in May 2014. As a result of the CQC findings regarding appraisal rates, an audit was underway to determine the level of in-date appraisals there were across the Trust. Compliance to date stood at 40%/. Managers had been advised that an appraisal must take place in April if staff do not have an up-to-date appraisal. If this date was not align to their incremental date then a further review must take place at the point in the year when their appraisal was due.<br><br>Mrs Brennan report that the Trust had received responses from 351 staff members surveyed in the 2013 National NHS Staff Survey cycle, which constituted a 42.4% response rate. Of the 28 key findings the Trust had none in the top 20% when compared to other Acute Trusts. Staff responses showed the Trust as better than average for 2 of the key findings and average for a further 2. The Trust was worse than average for 4 of the key findings and in the bottom 20% of Acute Trusts for 20 key findings. This is an improvement on the 2012 survey whereby we had 24 key findings in the |

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| | worst 20% of Acute Trusts. The Trust had two statistically significant improvements since 2012. There were no statistically significant deteriorations since 2012.<br>Mr Zeidler commented that he staff survey results were unacceptable and should be acknowledged that the Trust was one of the worst in the country. Dr Swart responded that the root cause of underlying concern would be looked into and that it was important to recognise positives whilst acknowledging poor results.<br><br>The Board **NOTED** the Workforce Report. |
| **TB 13/14 206** | **Improving Quality and Efficiency Report** |
| | Mrs Brennan presented the Improving Quality and Efficiency Report to the Board.<br><br>It was reported that the transformation programme delivered £11.45m against the required plan of £13m in 2014/15. Medicine Care Group and Corporate CIPs overachieved however the Surgical Care Group did not achieve their plan. At the end of month 12 a £1.3m year on year reduction in nursing bank and agency expenditure had been achieved. The agency spend had increased during the past 2 months due to running at higher staffing levels.<br><br>Mrs Brennan felt it important to note that the Trust had delivered CIP and transformation savings of over £40m over that last three years.<br><br>The Trust submitted a deficit plan for 2014/15 of £7.8m to the TDA which left the Trust with a CIP requirement of £12.7m for 2014/15. A number of high priority next steps have been identified in order to rapidly progress the programme to address the challenge, the details of which were being presented to the Finance Committee.<br><br>The Board **NOTED** the Improving Quality and Efficiency Report. |
| **TB 13/14 207** | **TDA Self-Certification Report** |
| | Mr Pallot presented the self-certification report to the Board for approval.<br><br>In accordance with the Accountability Framework, the Trust was 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 March 2014 were discussed and approved.<br><br>The Board **APPROVED** the TDA Self-Certifications |
| **TB 13/14 208** | **Register of Sealings 2013/14** |
| | Mr Sharples presented the Register of Sealings 2013/14 report<br><br>This paper was presented to inform the Board of the documents executed under seal during the year in accordance with the Board's annual cycle of governance reporting.<br><br>Mr Sharples reported that in the period 1 April 2013 to 31 March 2014 the Trust Seal was applied to four documents in the presence of the Head of Corporate Affairs, who has custody of the Trust Seal.<br><br>The Board **NOTED** the Register of Sealings for 2013/4 |

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| **TB 13/14 209** | **Any Other Business** |
| | Mr Pallot informed the Board that the potential partnership working with Leicester regarding cancer services was progressing and now the trusts, alongside Kettering General Hospital, were entering into early discussions regarding potential partnership working with other specialist services. The aim of the discussions was to ensure specialised services could be delivered sustainably across Leicestershire, Northampton and Rutland, however as discussions remained in their infancy it was still too early to provide anything formal to the Board. |
| **TB 13/14 210** | Mr Farenden called the meeting to a close.<br><br>Date of next meeting: 9.30am, Thursday 29 May 2014, Boardroom, NGH.<br><br>The Board of Directors RESOLVED to exclude press and public from the remainder of the meeting as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted |

**Actions from Trust Board**

**Last update** 19/05/2014

| Ref | Meeting date | Minute Number | Paper | Action Required | Responsible | Due date | Status | Review of Completion/Reason for Slippage |
|---|---|---|---|---|---|---|---|---|
| 27 | 27/03/2014 | TB 13/14 188 | Workforce Report | It was requested that outcome measures for appraisal compliance be reported to the Board monthly from June 2014. | Mrs J Brennan | 26/06/2014 | On Track | |

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

# REPORT TO: TRUST BOARD
# 29 MAY 2014

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| **Title** | Chief Executive's Report |
| **Agenda item** | 6 |
| **Sponsoring Director** | Dr Sonia Swart, Chief Executive Officer |
| **Author(s)** | Dr Sonia Swart, Chief Executive Officer |
| **Purpose** | Information and Assurance |
| **Executive summary**<br><br>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)<br><br>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**<br><br>The Board is asked to note the content of the report. | |

Enclosure C

# Trust Board
# 29 May 2014

## Chief Executive's Report

**NGH safety education initiative shortlisted for national award**
A training course designed to help the doctors of tomorrow become more safety aware has been shortlisted for a national award. Developed by NGH consultant anaesthetist, intensivist and patient safety lead, Dr Jonny Wilkinson, 'Aspiring to Excellence' has been designed as a modular course, with a multidisciplinary learning format including DVD, safety events programme and simulation scenarios. It guides final year medical students through a stimulating, interactive, consultant-led programme which focuses on many patient safety issues.

The popular and successful programme enters its fifth year in 2014. It is very much in demand at Leicester medical school and is over-subscribed each year. Feedback shows that students feel empowered to bring about change, particularly when sharing their experiences and results with senior clinicians and managers in the final week of the course. Many safety improvements have been introduced as a result of the students' involvement. Following their work on sepsis the hospital's septicaemia mortality rates fell markedly to half the previous levels. Care of pneumonia patients has been greatly improved, as has intravenous fluid management, the surgery checklist process, medical record keeping and documented medical planning of an inpatient stay. The programme is a key component of our drive to put patient safety above all else and provide the best possible care to our patients.

The NGH team have been invited to attend the awards ceremony in London on 15th July, when the winners will be announced. Whether or not their entry picks up the award, the team are confident the course can be readily developed as a teaching package for other trusts and medical schools, bringing it to a wider population of our doctors of tomorrow.

This programme has been recognised by the University of Leicester who have funded a Senior Lecturer post in Quality Improvement and Acute Medicine and an appointment to this role has now been made. This post will link the various safety initiatives in education to the Trust quality improvement programmes. We have successfully applied for senior medical trainee fellowship posts to augment this work. In addition Health Education England have funded a range of simulation equipment which has now arrived on site. This includes simulation equipment to teach teams to improve their skills in advanced laparoscopic surgery and cardiac, abdominal and gynaecologic ultrasound.

**Friends of NGH £25,000 funding**
Thanks must go to the Friends of NGH who invited NGH departments and services to bid for a proportion of £25,000 funding made available to the Trust in celebration of the Friends' 25th anniversary. Following careful consideration of the bids submitted for the funding, the Friends of NGH have confirmed that three departments will benefit. They are:

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| Cardiology investigations team | £12,000 |
| Surgical services | £10,000 |
| Child physiotherapy | £ 3,000 |

The funds were presented to representatives from the departments at the Friends Annual General Meeting on Thursday 22nd May.

**Willow Tree Garden**
The regeneration of the Willow Tree Garden has now been completed. The garden was looked after by volunteers, but since their retirement it had become rather neglected and the existing planting was looking very 'tired'.

Clare Topping our Energy and Sustainability Manager stepped in to manage this project and with the help of a local landscape designer Mike Greaves, the Charity Committee who provided funding for the plants and the Estates department, the area has been transformed.

The 750 new plants have been carefully selected to provide scent, year round interest, movement and colour as well as being attractive to nature.

It's important to have good accessible outdoor spaces particularly in a healthcare setting to enhance the healing environment for our patients and provide a relaxing area for staff.
A formal opening will be arranged in the next few weeks.

**Accident and Emergency Improvements - Progress Report**

**Accident & Emergency**
At the last Board meeting, I informed you of the planning application to improve the layout of the Accident and Emergency Department. This work has progressed and has been split into two main phases.

Phase 1 involves the construction of an extension housing the new GP Unit and consultants offices and the conversion of current Fracture Clinic into a new Resuscitation Unit to create 8 additional cubicles. This phase of work is currently out to tender, with works anticipated to commence in late June lasting until Christmas.

Phase 2 involves creating an Emergency Observation Unit and a new Ambulatory Care Unit. This work will follow on immediately from Phase 1. Careful planning will be essential to ensure disruption to the normal delivery of clinical services in this very busy area is minimised.

**Paediatric area A&E**
Following the CQC inspection the work to improve facilities for children and their families in A&E has been accelerated and been brought forward ahead of the main schemes of work. The work is currently out to tender and will be completed at the end of June.

**Governance and Organisational Development**
In February 2014 the Trust undertook a programme of work to strengthen its governance processes. Since then, we have been working on the organisational structures, committee structures, reporting frameworks and dashboards with support from Deloitte. The aim of the work was to have a clearer management and committee structure in place that reduced repetition across meetings and better decision making frameworks and increased accountability. This would then help us to provide assurance to the Board more effectively and will also help us manage and lead the hospital more effectively. The scoping phase of this work has now concluded which has delivered a formal report from Deloitte providing a list of findings and potential solutions which was presented to the Board for consideration at its last development away day.

The report from Deloitte confirmed my view that there is much to do internally to improve corporate management, leadership and governance and the Board has approved an outline approach to this. This approach is now being developed in much more detail and an implementation plan will be presented to the Board in the near future.

**Chemotherapy Suite Fundraising Appeal**

The Oncology Centre treats around 450-500 patients as Chemotherapy Day Cases every month (through 16 chairs). The Outpatient facility located in the same Centre treats around 800 patients per week. This means that in any given week there are around 1300 patient visits to Oncology Centre, which is the "Front door" for the service as a whole. Recent work with our patient representatives has consistently shown that the Oncology Centre is one area of significant focus for us with poor scores particularly on the environment and patient dignity.

To improve the experience for patients, the NGH Charity is about to launch the appeal with the Northampton Chronicle & Echo to raise £350,000 for the Chemotherapy Suite Refurbishment. The refurbishment will: improve treatment areas by providing a calming and welcoming environment; provide space to give patients some privacy when speaking to their nurse or loved ones; expand and update the clinical preparation areas.

The appeal is due to be launched imminently and there are a number of ways that people can donate. For further details, contact the NGH Charity on 01604545091.

Northampton General Hospital NHS
NHS Trust

# REPORT TO: TRUST BOARD
# 29 May 2014

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| **Title** | CQC Action Plan |
| **Agenda item** | 7 |
| **Sponsoring Director** | Charles Abolins, Director of Facilities and Capital Development |
| **Author(s)** | Dr Sonia Swart, Chief Executive<br>Craig Sharples, Head of Corporate Affairs |
| **Purpose** | Information and Assurance |

**Executive summary**

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

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

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

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| **Related strategic aim and corporate objective** | All |
| **Risk and assurance** | Risk to the trusts registration with the CQC |
| **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)<br><br>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 the CQC standards. |

**Actions required by the Trust Board**

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

# Trust Board
# 29 May 2014

# CQC Action Plan

## 1. Introduction

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

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

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

## 2. Report Findings

The report highlighted significant strategic issues in relation to urgent care, governance and leadership, as well identifying operational issues in the form of compliance actions.

The CQC reported that during their inspection, the trust appeared to be very clean throughout. In a national survey the trust was noted to have been performing well in relation to infection prevention and control.

The CQC reported that the Trust had a recent history of poor staffing levels on some wards. During their inspection, the CQC noted that action had begun to address staffing issues and that staff had commented that improvements in staffing levels were already having a positive impact on services. The CQC inspection felt that there was also experiencing a shortfall in consultant cover in the Accident and Emergency (A&E) department and the maternity labour ward. This was known by the trust and action had been taken in A&E. The trust had also responded to recent concerns around staffing and care on two medical wards and had taken action by increasing the staffing establishment to address those concerns.

The CQC reported that at the time of the inspection, many of the executive post holders were either new to post or in interim positions. This had an impact on the trust's leadership as staff reported that senior leaders, with the exception of the chief executive, were rarely visible on wards. Staff were unaware of the positions and responsibilities of most executive post holders. There have been significant changes at the executive level of the trust for some time, and the chief executive was aware of the need for stability among this group in order to address the leadership concerns across the trust. A substantive post of director of finance and chief operating officer had since been appointed the medical director post is being actively recruited to.

The report cited areas of poor governance, specifically in relation to the management and maintenance of equipment, and to the dispensing of medications to patients on discharge, were identified during our inspection. Both areas were taken up by the trust and addressed immediately.

Finally, the CQC inspection revealed that leadership of end of life care was an area where the trust required more focus and commitment to improve.

The overall rating for the hospital was as follows:

| Overall rating for this hospital | Requires Improvement |
|---|---|
| Accident and emergency | Requires Improvement |
| Medical care | Requires Improvement |
| Surgery | Requires Improvement |
| Intensive/critical care | Good |
| Maternity and family planning | Requires Improvement |
| Services for children & young people | Good |
| End of life care | Inadequate |
| Outpatients | Requires Improvement |

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

With regard to the three strategic issues articulated in the CQC report; Urgent Care, Governance and Leadership, the trust has committed to a programme of improvement which accelerates and augments existing programmes of work that have been in place over recent months. The summary treatment plan – Appendix 1 - presents the significant recommendations made by the CQC, and the trusts immediate response to these. This plan purposely focuses on short term improvements on immediate issues.

To underpin the strategic plan, a more detailed action plan has been developed – Appendix 2. This plan includes compliance actions and more detailed operational matters identified by the CQC as requiring improvement alongside the agreed actions being taken by NGH to address the issues, the sources of evidence to demonstrate their implementation and the intended outcomes to measure effectives.

The third action plan is the most detailed and presents the Board with a snapshot of the detail management actions that are ongoing. This plan remains dynamic, changing on a daily basis as actions progress, and is managed by the Governance Team. The plan can be found at Appendix 3 of this report.

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

**4. Exceptions**

Of the 8 highly significant points issued by the CQC a total 30 individual actions have been put in place to ensure compliance.

Of these 30 individual actions:

- 11 are green,
- 12 are amber,
- 7 are red.

| Point | Green Actions | Amber Actions | Red Actions | Total |
|---|---|---|---|---|
| 4 – TTO's | 3 | 3 | 0 | 6 |
| 5- Mandatory training | 4 | 4 | 0 | 8 |
| 6-Transfers at night | 2 | 1 | 2 | 5 |
| 7-Stroke imaging pathway | 1 | 0 | 2 | 3 |
| 8 –ITU Core Standards | 0 | 0 | 1 | 1 |
| 9- Emergency Care (ECIST) | 0 | 2 | 0 | 2 |
| 10-Action Plans | 1 | 2 | 1 | 4 |
| 11-Appraisals | 0 | 0 | 1 | 1 |
| **TOTAL** | **11** | **12** | **7** | **30** |

In regards to the outstanding actions the collation of evidence is on-going with a number of reports being submitted to IHGC in May 2014 which will address a number of the amber and red actions.

In addition there are some specific actions where currently there are gaps :

- Implementation of the patient leaflet relating to patient "moves"
- Continued use of the risk assessment for patient "moves "and the monitoring, tracking and reporting of these "moves"
- The trial of using patients own medication to expedite the availability of take home medication ready for discharge
- Communication of stroke imaging pathway to all relevant staff and agreeing a process for ongoing monitoring and reporting
- Completed action plans for sign off at Serious Incident Group. The first completed SI action plans are scheduled to be received at the SIG meeting on 27th May 2014, with evidence that the actions have been implemented.

Good progress has been made towards addressing the points raised by the CQC however to ensure that the evidence supports and reflects the actions that have been taken ,on 22nd May the Governance team are scrutinising the evidence which has been submitted to date.

After this the Trust will have assurance that the actions that have been completed have robust supporting evidence available and the gaps in evidence identified will be escalated and addressed.

There will then need to be a comprehensive strategic approach to ensure that all of the actions that have been taken, have been communicated throughout the Trust especially to all ward and departmental staff.

**5. Oversight Meeting**

Following the Quality Summit, the CQC and the NHS Trust Development Authority (TDA) agreed that an oversight forum should be established to oversee the trust's response to the CQC Report. The Oversight Group is made up of colleagues from the TDA, commissioners and Healthwatch. Its first meeting took place on the 7 May where the trust's overall response to the CQC report and the hierarchy of action plans were scrutinised in detail. The outcome of the meeting was that group felt the trust was demonstrating a good progress in addressing the findings of the CQC report, although it was acknowledged there remained a significant amount of work to do.

**6. Recommendations**

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

**Appendix 1**
**CQC Report – Strategic Treatment Plan and Progress**

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

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

| KEY FINDINGS | WHAT WE HAVE AGREED AND WHY | TIMESCALE | EXTERNAL SUPPORT IDENTIFIED | PROGRESS |
|---|---|---|---|---|
| **We must put processes in place to ensure that medication is dispensed to patients before they have left hospital** | **We will**<br>• Cease the practice of discharging patients home without their prescribed medication<br>• Trial using patient own medication to expedite the availability of to take home medicines ready for discharge<br>• Update existing policy and guidance and make available to all staff<br>• Establish safety huddles to identify potential delays in the availability of to take home medication on discharge<br>**Why?**<br>To ensure we identify and mitigate risks to patients, learn from experience, in line with our value of 'putting patient safety above all else'. | **Completed** | | **DELIVERED** |
| **We must strengthen the leadership of End of Life Care and ensure that there are robust mechanisms in place to inform the palliative care team of those patients who require specialist support at the end of life** | **We will**<br>• Ensure there is a named consultant for the service<br>• Introduce the communication of patients at the end of life to the daily safety huddles<br>• Additional actions to match the action plan to indicate this has not been delivered<br>**Why?**<br>To improve end of life care across the Trust by ensuring patients are cared for in line with our value of 'putting patient safety above all else' | **Completed** | | **DELIVERED** |
| **We must improve arrangements for children's care in the A&E department** | **We will**<br>• Ensure 24 hour access to an RSCN for A&E<br>• Designated an area within the A&E department for use solely by children<br>• Ensure children are appropriately prioritised in A&E<br>• Ensure appropriate training for our A&E staff<br>**Why?**<br>To improve patient experience and outcomes for children and their families when they attend A&E by ensuring the environment is appropriate to their needs and appropriate trained staff are available.<br>This supports the trusts values of 'we put patient safety above all else'. | **September 2014** | | **ON TRACK** |

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

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

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

Appendix 2

Northampton General Hospital NHS
NHS Trust

# CQC Inspection – Summary Action Plan May 2014



Incorporating High level Compliance Notice actions identified by the CQC on their inspection of the 16 & 17 January 2014

Enclosure D

**1. TTO's and Taxis**

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

**NGH action plan no W1.3**

**Outcome: SAFE-** Medication will not be sent home in Taxi's and this is underpinned by policy (outcome 9)

| Ref | Agreed Actions | Progress | Owner(s) | Timescales | Sources of Evidence | Assurance Committee | Proposed indicator / outcome |
|---|---|---|---|---|---|---|---|
| 1.1 | Cease the practice of sending take home medication to patients via taxi | Risk mitigated | Chief Operating Officer | January 2014 | E-mail stipulating taxis not to be used | Medicines Management Committee | **SAFE** TTO's are no longer transported via taxi's |
| 1.2 | Compliance with request to cease practice of send take home medication to patients via taxi | Audit provided however some transfer of medication by Taxi to other hospitals still continues | Chief Operating Officer | April 2014 | Audit to be undertaken to gain assurance the practice has ceased | Medicines Management Committee | **SAFE** 100% compliance |
| 1.3 | Ensure overarching Medicines Management (NGH-PO-249) is in date and available on the intranet. | Medicines Management Policy is due for review November 2014 | Chief Operating Officer | February 2014 | Policy available on the intranet | Procedural Document Group | **SAFE** Revised Policy is ratified and uploaded |

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|---|---|---|---|---|---|---|---|
| 1.4 | Ensure all guidance for staff regarding discharge medicine for exceptional circumstances is available on the Trusts intranet | Medicines Management Committee to review Policy and appendices to ensure all guidance relevant to discharge medication is available on the intranet | Chief Operating Officer | May 2014 | Guidance for Obtaining Medicines Out of Hours (TTO's) available on the intranet | Medicines Management Committee | **SAFE**<br>Staff have access to up to date policy and guidance<br>(outcome 9d) |
| 1.5 | Trial using patient own medication to expedite the availability of take home medication ready for discharge | The arrangements for the trail need to be taken through the medicines management committee and agreed. | Chief Operating Officer | May 2014 | Use of POM included in Appendix 3 of Medicines Management Policy | Medicines Management Committee | **SAFE**<br>Outcome of Trial to be shared widely |
| 1.6 | Establish safety huddles to identify potential delays in the availability of take home medication on discharge | Email from DoN 9 April 2014 to Ward Sisters, Modern Matrons, Site Managers announcing the commencement of Safety Huddles<br>Email with further update to Ward Sisters, Modern Matron 10 April 2014<br>Further email 12 April 2014 containing more update information to cascade to weekend staff<br>Further email 22 April 2014 giving further feedback regarding changes to form | Director of Nursing, Midwifery and Patient Services | April 2014 | Emails<br>Minutes of Safety Huddle<br>Template of Safety Huddle Report<br>Hyperlink to Safety Huddle Folder - daily reports | Nursing and Midwifery Board | **SAFE**<br>No delay of discharge due to medication unavailable |

**2. Mandatory Training**

**Key Issue:** The actions taken to manage the risks are inadequate and there remains a significant number of staff who have not received the relevant mandatory training

**NGH action plan no W7.1 &W7.2**

**Outcome: WELL-LED** -People who use services are safe and their health and welfare needs are met by competent staff and ensure that staff are properly trained, supervised and appraised. (outcome 14)

| Ref | Agreed Actions | Progress | Owner(s) | Timescales | Sources of Evidence | Assurance Committee | Proposed indicator / outcome |
|---|---|---|---|---|---|---|---|
| 2.1 | Provide a variety of options to ensure that staff are able to access mandatory training. | 4 options for mandatory training currently available since Autumn 2013:<br>1) Classroom<br>2)E-Learning<br>3) Workbook<br>4) RoK (Review of Knowledge)<br>All options are available on the intranet.<br>Updated TNA & Course outline (planned for May 2014) | Director of Workforce and Transformation | April 2014 | Snapshot Intranet pages<br>Examples of emails sent to Managers advising dates of training | Clinical Quality and Effectiveness Group | **WELL-LED**<br>Staff are aware of the various options to undertake mandatory training & compliance levels increase |
| 2.2 | Mandate that all A&C staff complete Mandatory Training as e-learning programmes. | Email to Managers been circulated - various managers email dated 8.4.2014, Discussed at CQEG April 2014 - awaiting minutes | Director of Workforce and Transformation | May 2014 | Emails to managers<br>Minutes of IHGC / CQEG Papers April 2014 | Clinical Quality and Effectiveness Group | **WELL-LED**<br>Improve numbers of A&C staff |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 2.3 | Implement a "Mandatory Training wave approach" to forecasting compliance and performance management | Report to CQEG / IHGC April 2014 states that a 'mandatory and role specific essential training performance wave has been produced and is being shared with Ward Sisters and Managers.<br>Email 8.4.2014 of the new Performance wave approach from T&D to all managers | Director of Workforce and Transformation | May 2014 | Compliance Reports demonstrating improvement in compliance.<br>Email with roll out timetable | Clinical Quality and Effectiveness Group | **WELL-LED** |
| 2.4 | Seek advice / support from other Trusts that have robust systems in place and are willing to share good practice. | Contacted Derby Hospital; Nottingham University Hospital; Royal Berkshire Hospitals | Director of Workforce and Transformation | April 2014 | Example of contact with Nottingham inc email and letter and link to the film for Nottingham https://www.nuh.nhs.uk/welcome-to-NUH | Clinical Quality and Effectiveness Group | **WELL-LED** |
| 2.5 | Agree & implement performance management dates when the trust target will be met | Workforce discussed at IHGC & Trust Board monthly | Director of Workforce and Transformation | May 2014 | Workforce reports to IHGC and Trust Board | IHGC | **WELL-LED**<br>Managers<br>are aware of compliance levels against Trust target & take action |
| 2.6 | Ensure accuracy of data including minutes | Email & CQEG Paper March and April 2014 reflecting issues and progress<br>Directorates are asked to review their compliance information and challenge any inaccuracies to help address the issues | Director of Workforce and Transformation | May 2014 | External review of OLM/ESR data (McKesson)<br>Reports to CQEG | Clinical Quality and Effectiveness Group | **WELL-LED** |

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|---|---|---|---|---|---|---|---|
| 2.7 | Scope out what is deemed to be role specific training in each area and staff group | The Role specific course outline includes both Mandatory and Role specific training and can be accessed from the intranet.<br>An update of the Training including outlining which is Role specific and which is Mandatory is being addressed by T&D in May 2014 | Director of Workforce and Transformation | June 2014 | Up to date information regarding role specific training requirements needs to be available to all staff | Clinical Quality and Effectiveness Group | **WELL-LED**<br>Patients are protected from risk of harm |
| 2.8 | Ensure correct information regarding role specific training is available on the intranet | Ongoing | Director of Workforce and Transformation | June 2014 | Up to date information regarding role specific training requirements needs to be available to all staff | Clinical Quality and Effectiveness Group | **WELL-LED**<br>Patients are protected from risk of harm |
| 2.9 | Provide monthly reports of compliance | Reporting to Board, IHGC and CQEG commenced. | Director of Workforce and Transformation | April 2014 | CQEG minutes / reports<br>IHGC minutes / reports<br>Trust Board minutes / reports | IHGC | **WELL-LED** |

**3. Patient Moves at Night**

**Key Issue: NGH had no effective system to identify, assess and manage the risks to the health and welfare of patients who were moved at night**

**NGH action plan no W1.1**

**Outcome: SAFE - Identify**, monitor and manage risks to people who use, work in or visit the service. (outcome 16)

| Ref | Agreed Actions | Progress | Owner(s) | Timescales | Sources of Evidence | Assurance Committee | Proposed indicator / outcome |
|---|---|---|---|---|---|---|---|
| 3.1 | Patient Risk Assessment to be developed (which includes national criteria / local standards e.g. end of life patients / Dementia patients not to be moved after an agreed time etc. | Patient risk assessment developed | Chief Operating Officer | March 2014 | Patient risk assessment<br>Evidence of roll out | IHGC | **SAFE**<br>People who are moved at night are not put at risk |
| 3.2 | Ward Transfer Records to include the time of transfer | This is included in the Nurse Handover Safety Checklist | Chief Operating Officer | March 2014 | Transfer Records and monitoring | IHGC | **SAFE**<br>The number of patient moves reduces |
| 3.3 | System to be established to identify the number of patients moved / at night | Monitoring process needs to be agreed | Chief Operating Officer | March 2014 | Description of process<br>Evidence of roll out | IHGC | **SAFE**<br>The Trust is aware of the volume of pt. moves and takes action to identify risks and areas for improvement |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3.4 | Report the number of patient transfers to IHGC commencing May 2014 | Report to go to IHGC on 22nd May 2014 | Chief Operating Officer | May 2014 | Reports to IHGC and subsequent actions | IHGC | **SAFE** The Trust is aware of the volume of pt. moves and takes action to identify risks and areas for improvement |
| 3.5 | Development of a patient leaflet informing patients that they may on occasion be moved at night | Leaflet has been drafted and has been sent out for consultation. Expected to be submitted to the Patient Information Group w/c 5th May 2014 | Director of Nursing, Midwifery and Patient Services | June 2014 | Draft of Patient leaflet Consultation emails | IHGC | **SAFE** |

**4. Stroke Imaging Pathway**

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

**NGH action plan no W3.3**

**Outcome: SAFE** - planning and delivering care, treatment and support so that people are safe, their welfare is protected and their needs are met (Outcome 4)

| Ref | Agreed Actions | Progress | Owner(s) | Timescales | Sources of Evidence | Assurance Committee | Proposed indicator / outcome |
|---|---|---|---|---|---|---|---|
| 4.1 | Develop the pathway with agreed roles and responsibilities | Complete | Medical Director | April 2014 | Copy of pathway | IHGC | **SAFE** A robust pathway available patients scans are not delayed |

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|---|---|---|---|---|---|---|---|
| 4.2 | Ensure communication of pathway to all staff | Complete | Medical Director | April 2014 | Evidence required for: dissemination of the pathway. meeting minutes that record discussion including Radiology to confirm that the pathway is now in place and working | IHGC | **SAFE** Appropriate staff are aware and utilised the correct pathway |
| 4.3 | Agree process for ongoing monitoring and reporting | Complete | Medical Director | April 2014 | Evidence required for: monitoring of pathway e.g. how many specialist Nurse requested CT's have taken place. Outcome of SSNAP audits to ensure trust maintain above National average compliance | IHGC | **SAFE** The Trust will maintain consistent achievement above the National average (SSNAP audit) |

**5. Intensive Care Society Core Standards for intensive care units**

**Key Issue:** CQC reviewed the analysis which identified gaps against the standards including a medical consultant not being immediately available 24 hours a day and consultant work patterns to deliver continuity of care not being in place. CQC did not see evidence of what actions had been identified to address the gaps and comply with the standards. The analysis was therefore not robust as there was no evidence as to how the compliance would be achieved.

**NGH action plan no W9.5**

**Outcome: SAFE -** Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety. (outcome 16)

| Ref | Agreed Actions | Progress | Owner(s) | Timescales | Sources of Evidence | Assurance Committee | Proposed indicator / outcome |
|---|---|---|---|---|---|---|---|
| 5.1 | Report to be presented to IHGC in May 2014 | A summary report on the findings, actions and progress to be presented to the IHGC in May 2014. | Medical Director | May 2014 | Consultant Rota<br>Gap analysis<br>Actions to address deficits identified and discussed<br>Business Case<br>Minutes of meetings | Strategic Management Board | **SAFE** Reduction in compliance gaps |

**6. Emergency Care Intensive Supportive Team Report**

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

**NGH action plan no W2.1**

**Outcome: SAFE -** Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety. (outcome 16)

| Ref | Agreed Actions | Progress | Owner(s) | Timescales | Sources of Evidence | Assurance Committee | Proposed indicator / outcome |
|---|---|---|---|---|---|---|---|
| 6.1 | Review October 2013 report and identify any additional actions | Complete | Chief Operating Officer | May 2014 | Gap analysis and action plan | IHGC | **SAFE** |
| 6.2 | Resultant action plan to be uploaded to HealthAssure and evidence of completion linked | Monitor the progress through Health Assure | Chief Operating Officer | May 2014 | Report to IHGC | IHGC | **SAFE** |

**7. Follow-Up of Action Plans**

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

**NGH action plan no W5.1**

**Outcome: SAFE -** Improve the service by learning from adverse events, incidents, errors and near misses that happen. (outcome 16)

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

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| 7.2 | Progress of all action plans monitored on HealthAssure | Reports on performance against the revised Serious Incident process will be presented to CQEG, IHGC and the Trust Board on a monthly basis to ensure effectiveness.<br>The Governance Facilitators are reviewing all action plans from Q3 to ensure evidence is available to demonstrate completion. This will be presented to the SIAM meeting with the CCG on 16th May 2014. Q4 onwards action plans are being monitored via HealthAssure and a quarterly compliance report will be submitted to SIG | Medical Director | May 2014 | Reports on compliance<br>Review of Quarter 3 action plans with RAG rated progress<br>Meeting minutes<br>HealthAssure Reports | Clinical Quality and Effectiveness Group | **SAFE**<br>Action plans are monitored to ensure actions are taken and improvements made. |
| 7.3 | Any meeting where concerns are raised in relation to completion of actions the minutes should include mitigating actions and follow up by the group | A draft email has been prepared and will be signed off by SIG on 12th May 2014 for distribution | Medical Director | May 2014 | Email to minute takers of Groups / Committees where action plans are discussed to raise awareness of the need for mitigating actions / follow up actions to be minuted | Clinical Quality and Effectiveness Group | **SAFE** |

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| 7.4 | Ensure all action plans are signed off by the accountable committee in a timely manner | As from Feb 2014 submitted Serious Incident reports and action plans are reviewed by SIG at the next meeting to ensure that contributory factors have been fully explored and that actions are aligned with the root cause of the incidents to reduce the likelihood of recurrence.<br><br>All action plans for Quarter 4 are now on HealthAssure and the Care Group Governance Managers will complete quarterly status updates - Status updates for Quarter 4 are in the process of being completed.<br><br>Action plans are then monitored by the Directorate/Care Groups until completion. Completed action plans will be presented to SIG with the evidence to ensure all actions have been completed. The first action plans are expected to be presented to SIG in May 2014 | Medical Director | May 2014 | SIG Minutes<br>Directorate Governance Meetings<br>CQEG Directorate Governance Reports<br>HealthAssure Reports | Clinical Quality and Effectiveness Group | **SAFE**<br>Information about the quality and safety is gathered and consistently monitored to identify risks and areas for improvement |

**8. Staff Appraisal**

**Key Issue:** Suitable arrangements were not in place for ensuring the number of staff without a performance development plan were robustly managed

**NGH action plan no W7.3**

**Outcome: WELL-LED** - Enable staff to acquire further skills and qualifications that are relevant to the work they undertake. (outcome 14)

| Ref | Agreed Actions | Progress | Owner(s) | Timescales | Sources of Evidence | Assurance Committee | Proposed indicator / outcome |
|---|---|---|---|---|---|---|---|
| 8.1 | An audit will be undertaken on all areas where there is no up-to-date information on staff appraisals. This will require managers to provide appropriate evidence to the HR & L&D teams that staff have had an appraisal via one of the processes. | Completed. At 30 April 2014, compliance rate was 71% | Director of Workforce and Transformation | May 2014 | Results of audit and gap analysis and follow up<br>Example of monthly report | IHGC | **WELL-LED**<br>The organisation are aware of appraisal gaps & appropriate action is taken |

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| 8.2 | Where appraisals have not been undertaken within the last year, managers will be required to provide a plan of how this will be achieved within a given time frame. If this is not aligned to staff increments managers will be required to do an appraisal; however a further review will be required to provide assurance to payroll and L&D that staff can incrementally progress | A detailed action plan has been developed for Appraisals and Training and this is discussed at Trust Board | Director of Workforce and Transformation | May 2014 | Papers & Minutes IHGC<br>Papers of Trust Board & Minutes Trust Board | IHGC | **WELL-LED**<br>There is robust monitoring in place for the staff appraisals and Managers and Trust are aware of compliance levels against Trust target |
| 8.3 | Agree and implement performance management dates when the trust target will be met | Agreed. | Director of Workforce and Transformation | April 2014 | Review Trust target (May) - 85% - Report to IHGC in May 2014 (minutes from March 2014 do not specify the %) | IHGC | **WELL-LED**<br>At least 85% of staff will have had an appraisal by March 2015 |

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| 8.4 | Continue to embed the new appraisal process aligned to incremental progression | Ongoing | Director of Workforce and Transformation | March 2015 | Ongoing compliance reporting | IHGC | **WELL-LED** |

**9. Do Not Attempt CPR Paperwork**

**Key Issue:** The do not attempt cardio pulmonary resuscitation (DNACPR) paperwork was misleading and being incorrectly completed and used

**CQC Must Point 1 : NGH action plan no CM3.1**

**Outcome: SAFE -** planning and delivering care, treatment and support so that people are safe, their welfare is protected and their needs are met (Outcome 4)

| Ref | Agreed Actions | Progress | Owner(s) | Timescales | Sources of Evidence | Assurance Committee | Proposed indicator / outcome |
|---|---|---|---|---|---|---|---|
| 9.1 | Withdraw existing documentation | Friday 17th January 2014 1900hrs onwards - All forms were removed and replaced with copies of the DNACPR form only. This was verbally handed over to the Nurse in charge in all in patient areas, A&E, operating theatres and escalation areas. An accompanying memo to explain the rationale for change and completion process was also provided with mobile contact number for 24/7 advice or support if required during the pending weekend. | Director of Nursing, Midwifery and Patient Services | January 2014 | Documentation withdrawn from all areas<br>Emails<br>Screensavers | Clinical Quality and Efficiency Group | **SAFE:**<br>Removal of documentation |

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

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

**10. Safety Testing of Medical Equipment**

**Key Issue:** Equipment was not being adequately tested or maintained

**CQC Must Point 2 : NGH action plan no CM4.1**

**Outcome: SAFE-** People who use services and people who work in or visit the premises are not at risk of harm from unsafe or unsuitable equipment (outcome11)

| Ref | Agreed Actions | Progress | Owner(s) | Timescales | Sources of Evidence | Assurance Committee | Proposed indicator / outcome |
|---|---|---|---|---|---|---|---|
| 10.1 | Review planned preventative maintenance register of equipment ensuring all medical equipment is listed | Immediately after the concerns raised by CQC, TBS engineers were called in to inspect and action the maintenance of equipment in the following areas: Main Theatres, Manfield Theatres; Gynae Theatres; Day Surgery Unit; ITU and Paediatrics.<br>Subsequently TBS were asked to go to all areas and carry out planned maintenance<br>TBS produced the following KPI's on February 2014 as a progress update:<br>• Planned Maintenance: 86% instead of 90%<br>• Performance Verification Testing: 54% instead of 60%<br>TBS currently on track to meet Trust standards of planned maintenance KPI's by end of March 2014<br>TBS to produce a Trust wide planned maintenance plan for the next 12 months by end of March 2014 | Director of Facilities | March 2014 | Progress report<br>Minutes of meetings where discussed | Medical Equipment Group | **SAFE**<br>Properly maintained and safe for use |

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| 10.2 | Identify any medical equipment which has not been tested and carry out risk assessment for inclusion on Risk Register | A gap analysis to be completed by 31st May 2014 | Director of Facilities | May 2014 | For inclusion in compliance report to CQEG<br><br>Minutes and report to Risk Group | Medical Equipment Group | **SAFE**<br>Trust are aware of which equipment has not been tested and plans are in place to rectify and omit the risk |

**11. Capnography Machines**

**Key Issue:** Ensure adequate supply and use of capnography machines in theatres

**CQC Must Point 3 : NGH action plan no CM4.2**

**Outcome : SAFE -** There are sufficient capnography to meet the service needs within the Trust **(outcome 11)**

| Ref | Agreed Actions | Progress | Owner(s) | Timescales | Sources of Evidence | Assurance Committee | Proposed indicator / outcome |
|---|---|---|---|---|---|---|---|
| 11.1 | Review availability of capnography machines and identify shortfall | Business Case developed showing sufficient capnographs in the system | Director of Facilities | May 2014 | Business Case | Medical Equipment Group | **SAFE**<br>Trust are aware that sufficient equipment is in place to rectify and omit the risk |
| 11.2 | Where a shortfall is identified, carry out a risk assessment for inclusion on Risk Register | Business Case developed showing sufficient capnographs in the system | | May 2014 | Business Case | Medical Equipment Group | SAFE |

**12. Dispensing Medication after Patients are Discharged**

**Key Issue:** Medication is being dispensed after patients have left hospital, it is being delivered by a taxi and no risk assessment of the medication, the delay and the impact and risk of this action is taking place

**CQC Must Point 4 : NGH action plan no CM1.4**

**Outcome: SAFE- Medication will not be sent home in Taxi's and this is underpinned by policy (outcome 9)**

| Ref | Agreed Actions | Progress | Owner(s) | Timescales | Sources of Evidence | Assurance Committee | Proposed indicator / outcome |
|---|---|---|---|---|---|---|---|
| 12.1 | Cease the practice of sending take home medication to patients via taxi | Practice has been stopped | Chief Operating Officer | January 2014 | Practice has been stopped<br>Documentation available on Wards<br>Policy amendment | Medicines Management Committee | **SAFE** |

**13. Off-site Pharmacy Support**
**Key Issue:** Address the lack of pharmacists allocated to the off NGH site ward to review and advise on medication arrangements
**CQC Must Point 5 : NGH action plan no CM3.2**
**Outcome: SAFE** (outcome 9)

| Ref | Agreed Actions | Progress | Owner(s) | Timescales | Sources of Evidence | Assurance Committee | Proposed indicator / outcome |
|---|---|---|---|---|---|---|---|
| 13.1 | Review the requirement for pharmacy support for off-site ward areas | For CCH and Isebrook the arrangements were that pharmacy needs were to continue to be supported contractually by KGH upon transfer of the clinical areas to NGH which ensured supply of stock and non-stock medication as well as TTO's.<br>This also included a visit every 3 months to the ward to ensure the checking of Controlled Drugs. This was changed to every 6 months by KGH.<br>The substantive pharmacy support from Provider services for Corby and Hazelwood did not transfer when areas transferred to management of NGH.<br>There was ad hoc support from the part time pharmacist at Danetre to review the stock levels at Corby and Hazelwood wards and to remove the controlled drugs when required.<br>Danetre was previously covered with locum support 2 days per week, this transferred as well when service came under NGH: This post was then re-evaluated and notice given to enable a substantive post to be recruited across all 3 community hospital sites; however recruitment was then put on hold when decision made for NGH to de-invest into the community hospital beds. | Chief Operating Officer | March 2014 | As part of the transformation of this service NHFT has been copied into the CQC report and action plan relating to community wards. This action has been handed over to NHFT | Medicines Management Committee | **SAFE**<br>This action has been handed over to NHFT |

| 14. Children and A&E<br>**Key Issue:** Children are being treated in an adult A&E department. There are very limited dedicated facilities or specialist staff to care for children<br>**CQC Must Point 6 : NGH action plan no CM2.2**<br>**Outcome: SAFE** - planning and delivering care, treatment and support so that people are safe, their welfare is protected and their needs are met including making reasonable adjustments to reflect children's needs. (Outcome 4) | | | | | | | |
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| **Ref** | **Agreed Actions** | **Progress** | **Owner(s)** | **Timescales** | **Sources of Evidence** | **Assurance Committee** | **Proposed indicator / outcome** |
| 14.1 | Formal review of the NSF for children required to ensure that there is a gap analysis with clear articulation of the issues and actions that are planned to address this. | Issue is being progressed at joint paediatric/A&E meeting. Group consists of Consultants, Service managers and Matrons from each area | Director of Nursing, Midwifery and Patient Services | June 2014 | Formal review of the NSF for children to ensure that there is a gap analysis with clear articulation of the issues and actions that are planned to address this.<br>Minutes of the meeting and resulting plans | Strategic Management Board | **SAFE**<br>Children are cared for in a safe and appropriate environment in accordance with NSF for children |

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| 14.2 | RSCN to be rostered providing 24 hour access for children attending A & E | There are currently 5.06wte paediatric trained nurses available for A&E (5.68wte being required to provide 1 nurse per shift) - this leaves a vacancy of 0.62wte and the posts are currently advertised on NHS Jobs. We plan to over recruit to our nursing posts<br>Shortlisting for both adult and children's nurses have taken place and interviews are planned for 9th and 13th May 2014.<br>A separate roster for paediatric nurse cover has been added to the main A&E roster template to be able to clearly identify this. | Director of Nursing, Midwifery and Patient Services | June 2014 | Copy of advert<br>Copy of job description<br>VCP confirmation<br>Copy of roster | Nursing and Midwifery Board | **SAFE**<br>Children are cared for by appropriately trained staff |
| 14.3 | Identify a designated area within A & E for sole use by children and their families | The separation of the play area and paediatric cubicle will be completed before the end of June.<br>To ensure the environment is appropriate for children a meeting to sign off the design is planned between Matron A & E; Matron Children's and Estates. Appropriate decoration will also be discussed | Director of Facilities | June 2014 | Plans for A & E rebuild programme<br>Revised timetable | Strategic Management Board | **SAFE**<br>Provision of an appropriate and suitable area for children and their families within the A&E department |

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| 14.4 | Full review & itinery of the availability of toys for various age groups. There should also be a plan for regular inspection to ensure fit for purpose, not damaged, cleaned regularly and be EU marked for safety | It was initially agreed that this point would be completed by the play specialists. Given current vacancies within that team the Matron A & E has allocated time on Tuesday 6th May to review all toys within the play area and will discuss further requirements with the play specialist. Once this has been completed the Matron A & E will develop the protocol for cleaning etc. | Director of Nursing, Midwifery and Patient Services | June 2014 | Protocol | Strategic Management Board | **SAFE** Provision for suitable toys for children of all ages within the A&E department |
| 14.5 | Review the requirement for a dedicated or decorated room for minor injuries | This area has since been closed as the department is having a rebuild. There are toys available in the main A&E children's waiting area. | Director of Nursing, Midwifery and Patient Services | June 2014 | Minutes of meetings | Strategic Management Board | **SAFE** Provision of an appropriate and suitable area for children within the A&E department |

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

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

**15. Patient Moves around the Hospital**

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

**CQC Must Point 7 : NGH action plan no CM1.5**

**Outcome: CARING**:- Robust clinical governance process supporting patients moves around the hospital (outcome 16)

| Ref | Agreed Actions | Progress | Owner(s) | Timescales | Sources of Evidence | Assurance Committee | Proposed indicator / outcome |
|---|---|---|---|---|---|---|---|
| 15.1 | Patient Risk Assessment to be developed | Patient risk assessment developed | Chief Operating Officer | May 2014 | Risk Assessment and monitoring tool for assessing the impact of moves on a patient's treatment, length of stay and experience<br>Minutes of meetings<br>Evidence of roll out | Clinical Quality and Effectiveness Group | **CARING**<br>All patients who are moved have a robust risk assessment completed prior to move |
| 15.2 | Ward Transfer Records to include the time of transfer | This is included in the Nurse Handover Safety Checklist | Chief Operating Officer | May 2014 | Minutes of meetings | Clinical Quality and Effectiveness Group | **CARING**<br>Times of patient transfers are reported & number of moves are reduced |
| 15.3 | System to be established to identify the number of patients moved | Monitoring process needs to be agreed | Chief Operating Officer | May 2014 | Minutes of meetings | Clinical Quality and Effectiveness Group | **CARING** |

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| 15.4 | Report the number of patient transfers to IHGC commencing May 2014 | Report to go to IHGC on 22nd May 2014 | Chief Operating Officer | May 2014 | Evidence in report detailing the impact on patient | Clinical Quality and Effectiveness Group | **CARING** Information about the number of transfers safety is gathered and consistently monitored |
| 15.5 | Development of a patient leaflet informing patients of why they may be moved. Leaflet to include details of how patient can report if they are unhappy about being moved which will enable this data to be captured | Leaflet has been drafted and has been sent out for consultation<br>Patients asked to contact PALS if they have concerns about being moved - PALS will then log this information as a 'patient who has been moved'<br>Expected to be submitted to the Patient Information Group w/c 5th May 2014 | Director of Nursing, Midwifery and Patient Services | May 2014 | Draft of Patient leaflet<br>Consultation emails | Clinical Quality and Effectiveness Group | **CARING** |

**16. Maternity Labour Ward Entrance**

**Key Issue:** The door leading in to the maternity labour ward could be left open and posed a risk of unauthorised access to this high risk area

**CQC Must Point 8 : NGH action plan no CM3.6**

**Outcome: SAFE -**The environment is safe and fit for purpose (outcome 10)

| Ref | Agreed Actions | Progress | Owner(s) | Timescales | Sources of Evidence | Assurance Committee | Proposed indicator / outcome |
|---|---|---|---|---|---|---|---|
| 16.1 | Spot checks to be carried out to ensure the door is closed | Spot checks carried out 3 times a day to ensure door closed.<br>Raised staff awareness of need to keep door closed and audited (3x daily spot checks documented). 100% compliance mid-April 2014Compliance with audit to be reported to Governance Group<br>Note: the outer door of labour ward allows access to lobby area only. Two further security doors are used to gain access to the labour ward and MOW. The reception desk has barrier glass to ensure safety of receptionist. No access to clinical area by this single outside door. | Director of Nursing, Midwifery and Patient Services | March 2014 | Spot checks to be carried out to ensure the door is closed | Strategic Management Board | **SAFE** |

**17. Management of Serious Incidents**

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

**CQC should Point 1 : NGH action plan no CS5.2**

**Outcome: SAFE -** Improve the service by learning from adverse events, incidents, errors and near misses that happen. (outcome 16)

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

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| 17.2 | Provision of training for staff in root cause analysis | External training provider being sourced - planned for July 2014. Consultant Governance Leads and Band 8a and above identified to attend<br>Risk Manager and Senior Quality, Risk & Litigation Manager provide support for SI leads and quality assure all serious incident investigation reports prior to submission | Medical Director | July 2014 | Training programme<br>Attendance log | Clinical Quality and Effectiveness Group | **SAFE**<br>Identified staff will receive RCA training |
| 17.3 | Develop a clear pathway which demonstrates the dissemination of lessons learnt at individual directorate, department, care group, trust wide and the wider health economy | A clear pathway has been developed to demonstrate the dissemination of lessons learnt at individual; Directorate/Department; Care Group; Trust wide and the wider health economy levels (see attached). The pathway commenced roll out in February 2014. | Medical Director | February 2014 | Revised pathway demonstrating process<br>Trust Board Report / Minutes<br>CQEG Report / Minutes<br>IHGC Report / Minutes<br>Care Group Governance Minutes<br>Directorate Minutes | Clinical Quality and Effectiveness Group | **SAFE**<br>Lessons learnt are evaluated to see if risks are addressed and improvements made. |
| 17.4 | Serious Incident Group Liaise with Patient Safety Academy to implement simulation training based on learning from serious incidents | The Governance Team are working with the Patient Safety Academy to implement Simulation Training Sessions based on learning from Serious Incidents | Medical Director | May 2014 | Simulation training plan<br>Attendance logs | Clinical Quality and Effectiveness Group | **SAFE** |

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| 17.5 | Development of quarterly staff newsletter 'Quality Street' to include lessons learnt | All Trust Governance leads and managers have been emailed to request submission of articles<br>The Governance Team have written articles on Datix upgrade; Duty of Candour; lessons learnt from incidents, serious incidents<br>Photographs of team taken by Medical Illustrations to improve profile of Governance Team<br>Medical Illustrations to publish first publication end of April / first week in May | Medical Director | May 2014 | Copies of Quality Street | Clinical Quality and Effectiveness Group | **SAFE** |
| 17.6 | Development of a Standard Operating Procedure to ensure lessons learnt are disseminated to ward level | This is included in the Nursing & Midwifery Quality Agenda and the development of Standard Operating Procedures (SOP). A standard template was developed by the Head Nursing & Midwifery, Professional, Practice Development. | Medical Director | May 2014 | Copy of SOP<br>Ward minutes to demonstrate discussion | Clinical Quality and Effectiveness Group | **SAFE** |

**18. Emergency Call Alarms**

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

**CQC Should Point 2 : NGH action plan no CS4.3**

**Outcome: SAFE -** Improve the service by learning from adverse events, incidents, errors and near misses that happen. (outcome 10)

| Ref | Agreed Actions | Progress | Owner(s) | Timescales | Sources of Evidence | Assurance Committee | Proposed indicator / outcome |
|---|---|---|---|---|---|---|---|
| 18.1 | Undertake survey work to determine requirements. | This has been recognised as an issue and work is currently underway within the capital programme. To date anaesthetic rooms and PAR in Main, Manfield and Gynae theatres have had alarms installed and survey work is being undertaken in the remaining theatre areas to determine requirements. | Director of Facilities | June 2014 | Completed action plan | Strategic Management Board | **SAFE** Gaps are known & addressed |

**19. Complaints**

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

**CQC Should Point 3 : NGH action plan no CS5.4**

**Outcome : CARING-** Learning and improvements in care have occurred as a result of answering complaints - (outcome 17)

| Ref | Agreed Actions | Progress | Owner(s) | Timescales | Sources of Evidence | Assurance Committee | Proposed indicator / outcome |
|---|---|---|---|---|---|---|---|
| 19.1 | Develop a robust process for the review and follow up of action plans | The Governance IT Facilitator and Complaints Manager have met to discuss the process. Agreed to adopt the same process as Serious Incident Action plans<br><br>SI Action Plan assurance pathway to be adapted and distributed to care Groups/Directorates<br><br>All Complaints action plans from 1st April 2014 in the process of being uploaded to HealthAssure<br><br>Q1 data to be presented to CQEG / Care Groups / Directorates - July 2014 | Director of Nursing, Midwifery and Patient Services | May 2014 | HealthAssure process plan<br><br>Dissemination to Care Groups/Directorates<br><br>CQEG reports<br><br>Directorate Governance Reports | Clinical Quality and Effectiveness Group | **CARING**<br>Learning and improvements in care have occurred as a result of answering complaints |
| 19.2 | Progress of all action plans monitored on HealthAssure | | Director of Nursing, Midwifery and Patient Services | May 2014 | | Clinical Quality and Effectiveness Group | **CARING**<br><br>Action plans are evaluated to see if risks are addressed and improvements made. |
| 19.3 | Ensure all action plans are signed off by the accountable committee in a timely manner | | Director of Nursing, Midwifery and Patient Services | June 2014 | | Clinical Quality and Effectiveness Group | **CARING** |

| 20. Records<br>**Key Issue:** Records were not available when required and were not always accurately completed with information regarding patients specific needs<br>**CQC Should Point 4 : NGH action plan no CS8.1**<br>**Outcome: SAFE** - Store records in a secure, accessible way that allows them to be located quickly. (outcome 21) | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Ref** | **Agreed Actions** | **Progress** | **Owner(s)** | **Timescales** | **Sources of Evidence** | **Assurance Committee** | **Proposed indicator / outcome** |
| 20.1 | Print off the batch lists for all records sent to specific outpatient clinics. | Spreadsheet documenting number of records requested for clinic and number available. Ongoing data collection from within medical records using batch list and clinic lists. 1.5.14 Meeting with IT to review what data fields needs to be accessible through the patient document tracking universe to improve the data available for checking availability | Director of Strategy and Partnerships | April 2014 | Gap analysis | Medical Records Group | **SAFE**<br>Notes are available in a timely manner |
| 20.2 | Audit list against clinic list tracked to the department / outpatient clinic | This is now completed and presented at Medical Records Group monthly from May 2014 | Director of Strategy and Partnerships | April 2014 | Audit results<br>Minutes of meetings where results are discussed | Medical Records Group | **SAFE**<br>Action plans are monitored to ensure actions are implemented |

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| 20.3 | Print off batch list for all medical records sent to a clinic including the 7 & 2 day changes. Audit those records that were requested from other departments / offices for availability at the clinic | Work is taking place with IT to establish a detailed report that can be monitored monthly by both Medical Record Group and the Service Managers | Director of Strategy and Partnerships | April 2014 | Copy of audit results as evidence<br>Monitoring | Medical Records Group | **SAFE**<br>Notes are available in a timely manner |
| 20.4 | Book OPAs prior to the 2 day cut-off within medical records. Review utilising Infoview report | Work is taking place with IT to establish a detailed report that can be monitored monthly by both Medical Record Group and the Service Managers | Director of Strategy and Partnerships | April 2014 | Exception report | Medical Records Group | **SAFE** |
| 20.5 | Ensure all departments email additions to the medical records clerks to enable pulling to be completed in a timely manner | Development of the Web page and also further publicity of the process for requesting notes required in short timescales | Director of Strategy and Partnerships | April 2014 | Exception report | Medical Records Group | **SAFE** |

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|---|---|---|---|---|---|---|---|
| 20.6 | Training staff who require access to medical records to ensure they understand how to track records in and out of areas | Development of the Web page and also further publicity of the process of training. Link with T&D about making tracking of notes a role specific for Admin & Clerical staff. | Director of Strategy and Partnerships | April 2014 | Training records and attendance logs | Medical Records Group | **SAFE** |
| 20.7 | Improve portering and filing services to ensure more records are held within the library rather than in offices / storage areas in clinics | A risk assessment is being carried out on the lack of porters for the tasks to ensure timely collection of notes. | Director of Strategy and Partnerships | April 2014 | Monitoring Evidence | Medical Records Group | **SAFE** |
| 20.8 | Stronger monitoring of Datix's by undertaking RCA's and reporting back to all concerned | This is now monitored on a monthly basis and outcomes monitored to establish what the root cause of the unavailability of notes is. | Director of Strategy and Partnerships | April 2014 | Process for Medical Records to monitor Datix<br>Reports / Minutes | Medical Records Group | **SAFE** |
| 20.9 | Patient assessments were not comprehensively documented within the notes. | Examples of completed assessment forms are disseminated and the process of completion demonstrated which is then disseminated through the ward teams at handover.<br>The effectiveness is reviewed by the Quest process and dashboard. | Director of Nursing | April 2014 | New nursing documentation has been introduced.<br>The PD Team then follow this up with the wards on a regular basis and can be called upon for updates. | Nursing & Midwifery Board | **SAFE** |

| 21. Nutritional Supplements<br>**Key Issue:** The CQC found food supplements and nutritional drinks were not monitored to ensure consumption within expiry dates.<br>**CQC Should Point 5 : NGH action plan no CS3.4**<br>**OUTCOME: SAFE** - Identify, monitor and manage risks to people who use, work in or visit the service. (outcome 16) | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Ref** | **Agreed Actions** | **Progress** | **Owner(s)** | **Timescales** | **Sources of Evidence** | **Assurance Committee** | **Proposed indicator / outcome** |
| 21.1 | Matrons must check the stock in their areas to ensure it is in date | This is now addressed by the implementation of stock rotation | Director of Nursing, Midwifery and Patient Services | April 2014 | Matrons checklist<br>Exception reports | Nursing & Midwifery Board | **SAFE**<br>A process for stock control is established |
| 21.2 | Ensure nurses responsible for administering these are aware of the need to fully check the labelling including the expiry date before administering to patients. | This is now addressed by the implementation of stock rotation | Director of Nursing, Midwifery and Patient Services | April 2014 | Evidence of discussions at meetings | Nursing & Midwifery Board | **SAFE**<br>A process for stock control is established |
| 21.3 | Ensure stock rotation and stock management is appropriate | This is now addressed by the implementation of stock rotation | Director of Nursing, Midwifery and Patient Services | April 2014 | Audit of supplements to ensure that these are stock rotated and as with any medication/ product expiry date checked. | Nursing & Midwifery Board | **SAFE**<br>A process for stock control is established |

**22. BMI Calculations**

**Key Issue:** The CQC found evidence that Body Mass Index (BMI) calculations were being guessed

**CQC Should Point 5 : NGH action plan no CS3.5**

**OUTCOME: CARING -** Patients Care and treatment is delivered in accordance with the care plan to ensure healthy living choices (outcome 4)

| Ref | Agreed Actions | Progress | Owner(s) | Timescales | Sources of Evidence | Assurance Committee | Proposed indicator / outcome |
|---|---|---|---|---|---|---|---|
| 22.1 | Implementation of the nationally recognised MUST nutrition assessment tool in nursing documentation | This is now within the new Nursing documentation and is now reflected in the Quest Nursing Dashboard. | Director of Nursing, Midwifery and Patient Services | May 2014 | Weigh Day Wednesday<br>Audit as part of Matrons Check<br>QuEST | Nursing & Midwifery Board | **CARING** |
| 22.2 | Provision of extensive training by the practice development team for the whole Admissions & Discharge documentation | The role out of the new documentation has now taken place and training is being offered. | Director of Nursing, Midwifery and Patient Services | May 2014 | Training programme<br>Attendance at training records | Nursing & Midwifery Board | **CARING** |

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|---|---|---|---|---|---|---|---|
| 22.3 | Monitoring of compliance via monthly QuEST audits | The Practice Development Team disseminated the reviewed nursing documentation on 25th April to all the adult inpatient wards. Prior to this the ward sisters were sent details of the reviewed documents and copies to share with their staff during daily huddles and ward meetings in preparation. The on call sisters and night practitioners were requested to speak to staff and raise any issues with the PD team – none received.<br>The PD team are keeping a log of staff who have been spoken to in respect of the revised documentation. Details of contact numbers were left with the wards if they had any concerns of questions<br>The PD Team went out again on the 30th April to all the wards to speak with staff. | Director of Nursing, Midwifery and Patient Services | May 2014 | QuEST audits | Nursing & Midwifery Board | **CARING** |

**23. Care Record Templates and Audits**

**Key Issue:** Care record templates and audits were based on an acute hospital setting and not necessarily appropriate for a community hospital service

**CQC Should Point 4 : NGH action plan no CS8.2**

**Outcome: SAFE**- (outcome 21)

| Ref | Agreed Actions | Progress | Owner(s) | Timescales | Sources of Evidence | Assurance Committee | Proposed indicator / outcome |
|---|---|---|---|---|---|---|---|
| 23.1 | As part of the transformation of this service NHFT has been copied into the CQC report and action plan relating to community wards. This action has been handed over to NHFT Completed | Complete | Director of Nursing, Midwifery and Patient Services | April 2014 | Transfer Documentation | | **SAFE** This action has been handed over to NHFT Completed |

**24. Dissemination of Learning from Incidents**

**Key Issue:** Staff reported that learning from incidents and feedback when they reported incidents was not always given

**CQC Should Point 2 : NGH action plan no CS5.3**

**OUTCOME: SAFE -** Improve the service by learning from adverse events, incidents, errors and near misses that happen. (outcome 16)

| Ref | Agreed Actions | Progress | Owner(s) | Timescales | Sources of Evidence | Assurance Committee | Proposed indicator / outcome |
|---|---|---|---|---|---|---|---|
| 24.1 | Upgrade Datix reporting system to ensure full feedback capability of system. Development of a user guide to ensure staff are aware of whose responsibility it is to feedback to the reporter of the incident | Upgrade of Datix completed by Company March 2014.<br>Gap analysis and redesigning of incident report forms by Governance team has taken place.<br>Discussed at Governance meeting on 25 April 2014 and redesigned form agreed - minutes of meetings awaited<br>User guide in process of development<br>Roll out end May 2014 | Director of Nursing, Midwifery and Patient Services<br><br>Medical Director | May 2014 | User guide<br>Evidence of roll out / dissemination<br>Ward Minutes<br>Directorate Governance Group Minutes<br>Care Group Governance Minutes<br>Trust Board Minutes | Clinical Quality and Effectiveness Group | **SAFE** |
| 24.2 | A standard operating procedure for ward meetings has been launched which includes standing agenda items these include the months incidents | The Ward Meeting SOP was developed by a ward sister and shared with their peers. It sets out a standard of each ward holding monthly ward meetings with a set agenda template that includes sharing of a patient story and learning from complaints and incidents. | Director of Nursing, Midwifery and Patient Services<br><br>Medical Director | May 2014 | Standard Operating Procedure<br>Minutes of meetings | Clinical Quality and Effectiveness Group | **SAFE** |

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|---|---|---|---|---|---|---|---|
| 24.3 | Minutes of the ward meeting will be generated and a sign off sheet to say staff have read them if they were not present at the meeting Evidence of standard agenda's for ward/ dept. meetings, minutes from meetings to demonstrate discussions / feedback &copy of the SOP required. | The SOP also includes a standard template for the minutes and a sign off form providing evidence that staff have read the minutes. It is monitored through the Nursing & Midwifery Quality Dashboard and QuEST. We are reviewing the performance criteria of this SOP to reflect completion of the standard templates. | Director of Nursing, Midwifery and Patient Services<br><br>Medical Director | May 2014 | Minutes of meetings<br>Sign off sheet | Clinical Quality and Effectiveness Group | **SAFE** |

| 25. Multi-Faith Spiritual Support<br>Key Issue: There are no formal arrangements in place to provide multi faith spiritual support, even in areas where end of life care is given<br>OUTCOME: SAFE - (outcome 1) | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Ref** | **Agreed Actions** | **Progress** | **Owner(s)** | **Timescales** | **Sources of Evidence** | **Assurance Committee** | **Proposed indicator / outcome** |
| 25.1 | This finding was associated with the assessment of care at Danetre Hospital.<br><br>Formal arrangements are in place in the Acute Care Trust | As part of the transformation of this service NHFT has been copied into the CQC report and action plan relating to community wards. This action has been handed over to NHFT | Director of Nursing, Midwifery and Patient Services | March 2014 | Information for provision of multi faith spiritual support is available on the intranet | Clinical Quality and Effectiveness Group | **SAFE**<br>This action has been handed over to NHFT |

| 26. Urgent Care and Bed Flow Management<br>Key Issue: Non elective activity levels exceeding plan leading to inability to safely manage urgent care patients, urgent care standards and achieve 95% of patients seen within 4 hours.<br>CQC Should Point<br>OUTCOME: CARING- Delivery of care is safe, effective, appropriate and flexible enough to meet individual needs. (outcome 4) | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Ref** | **Agreed Actions** | **Progress** | **Owner(s)** | **Timescales** | **Sources of Evidence** | **Assurance Committee** | **Proposed indicator / outcome** |
| 26.1 | Review the emergency care flow issues and improve all processes from admission through to discharge<br>Understand all blocks in the system<br>Better understand our demand and effectively plan capacity<br>Work in partnership with the health and social care economy on system redevelopment | In March 14, NGH employed McKinsey & Company to support this work providing realignment of the internal Urgent Care Programme. Working with NGH, the team have evaluated and realigned the existing work streams<br>The cumulative work led to a 'Breaking the Cycle' week where all new processes and treatments were implemented, creating a 'new and sustainable normal' for the entire Trust. | Chief Operating Officer | July 2014 | 'One version of the truth'<br>Sustained delivery of the 4 hour transit time target<br>Reduced number of patient moves | Trust Board | **CARING**<br>Consistent achievement of the 4 hour target to measure effective flow |

**27. End of Life Care**

**Key Issue: The Trust must strengthen the leadership of End of Life Care and ensure that there are robust mechanisms in place to inform the palliative care team of those patients who require specialist support at the end of life**

**CQC : NGH action plan no C6.1-6.8**

**OUTCOME: CARING-** Delivery of care is safe, effective, appropriate and flexible enough to meet individual needs. (outcome 4)

| Ref | Agreed Actions | Progress | Owner(s) | Timescales | Sources of Evidence | Assurance Committee | Proposed indicator / outcome |
|---|---|---|---|---|---|---|---|
| 27.1 | To increase visibility on the wards enabling clinicians to provide high quality End of Life Care incorporating the five key enablers outlined in the National End of Life Transformation programme. | The Lead attends Regional and County Wide Steering Group meetings and will disseminate best practice. | Director of Strategy and Partnerships | May 2014 | Audit of records | IHGC | **CARING** Improvement in the care of patients at the end of life |
| 27.2 | To lead the implementation of the National Principles replacing the Liverpool Care Pathway. | Clarification awaited around Liverpool Care Pathway or the National Principles | Director of Strategy and Partnerships | June 2014 | | IHGC | **CARING** Staff are aware of the correct end of life pathway and evidence of its use. |

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| 27.3 | Promote best practice and support to clinicians to enable them to identify patients approaching the End of Life ensuring a patient centred plan of care is put in place and reviewed regularly. | End of Life Care questions: Named Consultant / Senior Nurse Huddle is to be rolled out in May 2014 | Director of Strategy and Partnerships | June 2014 | | IHGC | **CARING** |
| 27.4 | Provide ward based education in relation to DNAR and TEP with respect to End of Life care planning. | Development of initial training compliance by ward | Director of Strategy and Partnerships | June 2014 | | IHGC | **CARING** |
| 27.5 | Support clinicians to identify patients with unmet needs, ensuring they are referred to the Specialist Palliative Care Team. | Further training available to staff | Director of Strategy and Partnerships | June 2014 | | IHGC | **CARING** |

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|---|---|---|---|---|---|---|---|
| 27.6 | Identify funding for a full time consultant in Palliative Medicine who will act at the End of Life Care Lead for the Trust. | Dr David Riley, Consultant in Palliative Medicine provides 3.5 clinical PA's to the Trust and acts as the named Consultant for the Specialist Palliative Care Team.<br><br>Dr Christine Elwell, Consultant Clinical Oncologist acts as the Trust End of Life Care Lead and will be part of the Operational Group delivering the CQC action plan. | Director of Strategy and Partnerships | December 2014 | Job description and Job Plan | IHGC | **CARING** |
| 27.7 | To lead the development and support the implementation and assessment of competencies across the Trust. | Prioritise training needs as a result of the heat map demonstrating end of life care activity across the Trust.<br>Including educational training strategy and end of life training register | Director of Strategy and Partnerships | June 2014 | Competencies in providing high quality End of Life Care will be assessed during the appraisal process. | IHGC | **CARING** |
| 27.8 | Identify a specific team of individuals whose responsibility it is for delivering EoLC leadership. | Business case being developed for a dedicated team | Director of Strategy and Partnerships | June 2014 | | Clinical Quality and Effectiveness Group | **CARING** |
| 27.9 | Liaise with the Countywide group to develop guidelines based on the National Principles for End of Life Care | County wide guidelines for Care of the Dying | Director of Strategy and Partnerships | July 2014 | | Clinical Quality and Effectiveness Group | **CARING** |

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| 27.10 | Communicate the End of Life Care principles across the Trust | Increase in the use of the LCP in May and June | Director of Strategy and Partnerships | July 2014 | | Clinical Quality and Effectiveness Group | **CARING** |
| 27.11 | Embed the principles into Clinical Practice through the End of Life Care team. | Audit of End of Life care built into the clinical audit programme across the Trust | Director of Strategy and Partnerships | July 2014 | | Clinical Quality and Effectiveness Group | **CARING** |
| 27.12 | Liaise with the Service Manager at CSH to formalise an SLA to provide out of hours telephone support until the full complement of the Palliative Care Team is established. | SLA agreement with NHFT hospice to provide out of hours telephone advice to clinical team in line with National Directive. | Director of Strategy and Partnerships | July 2014 | Written Agreement<br>Process for communicating advice back to the Specialist Palliative Care Team at NGH | Clinical Quality and Effectiveness Group | **CARING** |
| 27.13 | Incorporate the identification of End of Life patients onto the "Ward Work Space" | Development of an electronic system to alert the End of Life Care team about patients approaching the End of Life using ICE | Director of Strategy and Partnerships | January 2015 | Audit of identification of End of Life patients built into the clinical audit programme across the Trust | Clinical Quality and Effectiveness Group | **CARING** |

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| 27.14 | To provide 7 days per week face to face specialists palliative care CNS contact in line with National Directives | Business case for additional CNS resource to implement Sunday working | Director of Strategy and Partnerships | June 2014 | Rota demonstrating a Saturday specialist palliative care service | End of Life Care Strategy Group | **CARING** |

**Appendix 3.**
**1. Patient Flow**

| NGH Priority | Recommendations | Actions Required | Executive Owner | Action Owner | Governance Support | Assurance / Evidence | Target Date end of month | Progress/Milestones | Action Status | Hyperlink | Overarching outcome | outcome or anticipated outcome | Accountable committee |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| W1.1 | The CQC found that NGH had no effective system to identify, assess and manage the risks to the health and welfare of patients who were moved at night | Patient Risk Assessment to be developed (which includes national criteria / local standards e.g. end of life patients / Dementia patients not to be moved after an agreed time etc. | COO | Andy Daly / Bill Wood | Simon Hawes | Patient risk assessment<br><br>Evidence of roll out | Mar-14 | Patient risk assessment being developed (and will need to be shown to be rolled out across the Trust) | | 1. Patient Flow\W1.1\Risk assessment completed.pdf | SAFE - Identify, monitor and manage risks to people who use, work in or visit the service. (outcome 16) | People who are moved at night are not put at risk | CQEG / IHGC |
| | | | | | | | | | | 1. Patient Flow\W1.1\Risk assessment completed.pdf | | | |
| | | Ward Transfer Records to include the time of transfer - This is included in the Nurse Handover Safety Checklist | | Bill Wood | | Transfer Records and monitoring | Mar-14 | | | 1. Patient Flow\W1.1\W1.1.2 Nurse Handover Safety Checklist for Ward Transfers sheet BW LB March 2014 v4.docx | | Decision making procedures and lines of accountability for patient moves are clear | |
| | | System to be established to identify the number of patients moved / at night | | Andy Daly | | Description of process<br><br>Evidence of roll out | Mar-14 | | | Empty | | Information about the quality and safety is gathered and consistently monitored to identify risks and areas for improvement | |
| | | Report the number of patient transfers to IHGC commencing May 2014 | | Andy Daly | | Reports to IHGC and subsequent actions | May-14 | | | Empty | | Information about the quality and safety is gathered and consistently monitored to identify risks and areas for improvement | IHGC |
| | | Development of a patient leaflet informing patients that they may on occasion be moved at night | DoN | Natalie Green / Bill Wood | Chris Ainsworth | Draft of Patient leaflet Consultation emails | Jun-14 | Leaflet has been drafted and has been sent out for consultation. Comments received and leaflet updated. Expected to be submitted to the Patient Information Group - June 2014 | | 1. Patient Flow\W1.1\W1.1.5 Patient Move Leaflet Drafts and Consultation | | | |
| C1.2 | Review patient flows to ensure:<br>• Achieve 4 hour target<br>• Optimise patient flow through A&E<br>• Bed capacity is optimised<br>• Discharges are safe and timely<br>• Pre-empt and flex capacity based on expected demand<br>• Direct admission to Benham and EAU | Establish 'one version of the truth' | COO | | Simon Hawes | | | | | 1. Patient Flow\C1.2\C1.2.1 Critical Care 2 by 1200.msg | | | |
| | | | | | | | | | | 1. Patient Flow\C1.2\C1.2.1 2 by 1200 v2 as at 31.3.2014.docx | | | |
| | | | | | | | | | | 1. Patient Flow\C1.2\C1.2.1 Ward Handover Sheet BW LB March 2014 v4.docx | | | |
| | | Implement 'Breaking the cycle' | | | | | | | | 1. Patient Flow\C1.2\C1.2.2 Breaking the cycle information\C1.2.2 20140321 Breaking the cycle working group kick off deck v5.pptx | | | |
| | | | | | | | | | | 1. Patient Flow\C1.2\C1.2.2 Breaking the cycle information | | | |
| | | Drive sustained performance through transparent reporting | | | | | | | | empty | | | |
| W1.3 | The CQC found that NGH had not regularly assessed and monitored the quality of the provision of discharge medication to service users or assessed and managed the risk of using taxis and its potential impact upon the health and welfare of the people using services | Cease the practice of sending take home medication to patients via taxi | COO | Paul Rowbotham | Simon Hawes | E-mail stipulating taxis not to be used | Jan-14 | Risk removed | | 1. Patient Flow\W1.3\W1.3.1.CQC Inspection - Immediate actions required.msg | SAFE Medication will not be sent home in Taxi's and this is underpinned by policy (outcome 9) | TTOs are no longer transported via taxi's | Medicines Management Committee |
| | | Compliance with request to cease practice of send take home medication to patients via taxi` | COO | Tim Mead | | Audit to be undertaken to gain assurance the practice has ceased | Feb-14 | Audit provided however some transfer of medication by Taxi to other hospitals still continues | | 1. Patient Flow\W1.3\W1.3.2 Audit of Taxis | | 100% compliance | |
| | | Ensure overarching Medicines Management (NGH-PO-249) is in date and available on the intranet. | COO | Paul Rowbotham | | Policy available on the intranet | Feb-14 | Medicines Management Policy is due for review November 2014 | | 1. Patient Flow\W1.3\W1.3.3 Medicines Mangement NGH-PO-249 Nov 2014.pdf | | Revised Policy is ratified and uploaded | Procedural Document Group |
| | | Ensure all guidance for staff regarding discharge medicine for exceptional circumstances is available on the Trusts intranet | COO | Paul Rowbotham | | Guidance for Obtaining Medicines Out of Hours (TTOs) available on the intranet | May-14 | Medicines Management Committee to review Policy and appendices to ensure all guidance relevant to discharge medication is available on the intranet | | Empty | | Staff have access to up to date policy and gu | Medicines Management Committee |
| | | Trial using patient own medication to expedite the availability of take home medication ready for discharge | COO | Bill Wood / Natalie Green | | Use of POM included in Appendix 3 of Medicines Management Policy | May-14 | | | Empty | | Outcome of Trial to be shared | |
| | | Establish safety huddles to identify potential delays in the availability of take home medication on discharge | DoN | Jane Bradley | Chris Ainsworth | Emails<br><br>Minutes of Safety Huddle<br><br>Template of Safety Huddle Report<br><br>Hyperlink to Safety Huddle Folder - daily report | Apr-14 | Email from DoN 9 April 2014 to Ward Sisters, Modern Matrons, Site Managers announcing the commencement of Safety Huddles<br>Email with further update to Ward Sisters, Modern Matron 10 April 2014<br>Further email 12 April 2014 containing more update information to cascade to weekend staff<br>Further email 22 April 2014 giving further feedback regarding changes to form | | 1. Patient Flow\W1.3\W1.3.1 Safety Huddles information same as W1.1.1 | | No delay of discharge due to medication | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CM1.4 | Medication is being dispensed after patients have left hospital, it is being delivered by a taxi and no risk assessment of the medication, the delay and the impact and risk of this action is taking place | Cease the practice of sending take home medication to patients via taxi | COO | Paul Rowbotham | Simon Hawes | Practice has been stopped<br><br>Documentation available on wards<br><br>Policy amendment | Jan-14 | Practice has been stopped | | Empty | Outcome: SAFE<br>Medication will not be sent home in Taxi's and this is underpinned by policy (outcome 9) | | Medicines Management Committee |
| CM1.5 | Patients are being regularly moved around the hospital and there is no system in place to monitor this and the impact it is having on patients and their treatment, their length of stay and their experience | Patient Risk Assessment to be developed | COO | Andy Daly / Bill Wood | Simon Hawes | Risk Assessment and monitoring tool for assessing the impact of moves on a patient's treatment, length of stay and experience<br><br>Minutes of meetings | May-14 | | | 1. Patient Flow\CM1.5\Risk assessment blank.pdf | CARING: Robust clinical governance process supporting patients moves around the hospital (outcome 16) | CARING<br>All patients who are moved around the hospital will have a robust risk assessment completed prior to move | CQEG |
| | | Ward Transfer Records to include the time of transfer | | Bill Wood | | Minutes of meetings | May-14 | | | 1. Patient Flow\CM1.5\CM1.5.2 Ward Handover Sheet BW LB March 2014 v4.docx | | | |
| | | System to be established to identify the number of patients moved | | Andy Daly | | Minutes of meetings | May-14 | | | Empty | | | |
| | | Report the number of patient transfers to IHGC commencing May 2014 | | Andy Daly | | Evidence in report detailing the impact on patient | May-14 | | | Empty | | CARING Information about the number of transfers safety is gathered and consistently monitored | |
| | | Develop a method of capturing patient experience | | Andy Daly / Rachel Lovesy | | Process for capturing patient experience following ward moves | Jun-14 | | | Empty | | | |
| | | Development of a patient leaflet informing patients of why they may be moved. Leaflet to include details of how patient can report if they are unhappy about being moved which will enable this data to be captured | DoN | Natalie Green / Bill Wood | | Draft of Patient leaflet<br><br>Consultation emails | May-14 | Leaflet has been drafted and has been sent out for consultation<br><br>Patients asked to contact PALS if they have concerns about being moved - PALS will then log this information as a 'patient who has been moved'<br><br>Expected to be submitted to the Patient Information Group w/c 5th May 2014 | | 1. Patient Flow\CM1.5\CM1.5.6 Patient Move Leaflet Drafts and Consultation | | | |
| W9.5 | Intensive Care Society Core Standards for intensive care units. CQC reviewed the analysis which identified gaps against the standards including a medical consultant not being immediately available 24 hours a day and consultant work patterns to deliver continuity of care not being in place. CQC did not see evidence of what actions had been identified to address the gaps and comply with the standards. The analysis was therefore not robust as there was not evidence as to how the compliance would be achieved. | Report to be presented to IHGC in May 2014 | MD | Chris Leng | Caroline Corkerry | Consultant Rota<br><br>Gap analysis<br><br>Actions to address deficits identified and discussed<br><br>Business Case<br><br>Minutes of meetings | May-14 | A summary report on the findings, actions and progress to be presented to the IHGC in May 2014. | | 9. Workforce. Leadership\W9.5\C9.5.1 Gap Analysis Core Standards for Intensive Care Units 1.docx | SAFE - Benefit t from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety. (outcome 16) | | Strategic Management Board |
| | | | | | | | | | | 9. Workforce. Leadership\W9.5\C9.5.2 Critical Care Buisness Case 24 10 13 Version 7.pdf | | | |
| | | | | | | | | | | 9. Workforce. Leadership\W9.5\W9.5.3 ITU Consultant cover Jan - Apr 2014.pdf | | | |
| | | | | | | | | | | Empty | | | |

**2. Urgent Care**

| NGH Priority | Recommendations | Actions Required | Executive Owner | Action Owner | Governance Support | Assurance / Evidence | Target Date end of month | Progress/Milestones | Action Status | Hyperlink | Overarching outcome | outcome or anticipated outcome | Accountable committee |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| W2.1 | During September and October 2013 the trust commissioned a review of the Accident & Emergency service, including the Emergency Care Pathway by the Emergency Care Intensive Support Team which provided recommendations for the improvement of the A&E service. There was no evidence that conclusions from this local review of the A&E service had resulted in changes to treatment or care provided to people using services at Northampton General Hospital . | Review October 2013 report and identify any additional actions | COO | | Simon Hawes | Gap analysis and action plan | | | | 2. Urgent Care\W2.1\W2.1.1 ECIST - CQC Update.docx | SAFE - Benefit t from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety. (outcome 16) | | Strategic Management Board |
| | | Resultant action plan to be uploaded to HealthAssure and evidence of completion linked | | | | Report to IHGC | | | | 2. Urgent Care\W2.1\W2.1.2 report to Board Urgent Care Report 31 Oct 2013.pdf | | | |
| | | | | | | | | | | 2. Urgent Care\W2.1\W2.1.2 Urgent care Truist Board Approved Public Minutes 28.11.13.docx | | | |
| CM2.2 | Children are being treated in an adult A&E department. There are very limited dedicated facilities or specialist staff to care for children | Formal review of the NSF for children required to ensure that there is a gap analysis with clear articulation of the issues and actions that are planned to address this. | DoN | Matt Tucker / Fiona Lennon | Chris Ainsworth | Formal review of the NSF for children to ensure that there is a gap analysis with clear articulation of the issues and actions that are planned to address this.<br><br>Minutes of the meeting and resulting plans | Jun-14 | Issue will be taken forward at joint paediatric/A&E meeting. Inaugural meeting 15/4/14. Group consists of Consultants, Service managers and Matrons from each area | | 2. Urgent Care\C2.2\minutes from meeting 15th April 2014.doc | SAFE - planning and delivering care, treatment and support so that people are safe, their welfare is protected and their needs are met including making reasonable adjustments to reflect children's needs. (Outcome 4) | SAFE<br>Children are cared for in a safe and appropriate environment in accordance with NSF for children | Strategic Management Board |
| | | RSCN to be rostered providing 24 hour access for children attending A & E | | Matt Tucker / Fiona Lennon | | Copy of advert<br><br>Copy of job description<br><br>VCP confirmation<br><br>Copy of roster | Jul-14 | There are currently 5.06wte paediatric trained nurses available for A&E (5.68wte being required to provide 1 nurse per shift) - this leaves a vacancy of 0.62wte and the posts are currently advertised on NHS Jobs. We plan to over recruit to our nursing posts<br>Shortlisting for both adult and children's nurses have taken place and interviews are planned for 9th and 13th May 2014.<br>A separate roster for paediatric nurse cover has been added to the main A&E roster template to be able to clearly identify this. | | 2. Urgent Care\C2.2\ AE VCP band 5.msg<br>2. Urgent Care\C2.2\Trust Job Description band 5 child A&E.doc<br>2. Urgent Care\C2.2\20140430123355197.pdf<br>2. Urgent Care\C2.2\A&E Trust Job Description band 5 2011.doc | | SAFE<br>Children are cared for by appropriately trained staff | Nursing & Midwifery Board |
| | | Identify a designated area within A & E for sole use by children and their families | DoE&F | Matt Tucker / Fiona Lennon | Caroline Corkerry | Plans for A & E rebuild programme<br><br>Revised timetable | Jun-14 | The separation of the play area and paediatric cubicle will be completed before the end of June.<br><br>To ensure the environment is appropriate for children a meeting to sign off the design is planned between Matron A & E; Matron Children's and Estates. Appropriate decoration will also be discussed | | 2. Urgent Care\C2.2\A&E plan with notes.pdf | | SAFE<br>Provision of an appropriate and suitable area for children and their families within the A&E department | Strategic Management Board |
| | | Full review & itinery of the availability of toys for various age groups. There should also be a plan for regular inspection to ensure fit for purpose, not damaged, cleaned regularly and be EU marked for safety | DoN | Fiona Lennon | Chris Ainsworth | Full review & itinery of the availability for toys for various age groups.<br>these should also have a plan for regular inspection to ensure fit for purpose, not damaged, cleaned and must all be EU marked for safety - protocol required as evidence | Jun-14 | It was initially agreed that this point would be completed by the play specialists. Given current vacancies within that team the Matron A & E has allocated time on Tuesday 6th May to review all toys within the play area and will discuss further requirements with the play specialist. Once this has been completed the Matron A & E will develop the protocol for cleaning etc. | | empty | | SAFE<br>Provision of an appropriate and suitable area for children and their families within the A&E department | Strategic Management Board |
| | | Review the requirement for a dedicated or decorated room for minor injuries | | Fiona Lennon | | This area has since been closed as the department is having a rebuild. There are toys available in the main A&E children's waiting area.<br><br>Minutes of meetings | Jun-14 | As part of the A&E plan is a separate A&E minor injury & waiting area planned that can be decorated specifically for children? | | 2. Urgent Care\C2.2\A&E plan with notes.pdf | | SAFE<br>Children are appropriately priorities and treated | Strategic Management Board |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| C2.3 | | Review triage process to ensure children attending A & E are appropriately prioritised | MD | Fiona Lennon / Dr Udi Shmueli | Chris Ainsworth | Minutes from meeting<br><br>Audit against "recognised standards" | Jun-14 | Issues discussed at joint paediatric/A&E meeting. Group consists of Consultants, Service managers and Matrons from each area.<br><br>Agreed - 2 nurses in triage – one of which will be assigned to fast track children and young persons through the triage process as soon as they have registered their attendance. C&YP will then be directed to paediatric area once works completed.<br><br>A streaming process is to be introduced by a nurse to determine appropriateness for A&E attendance. Matron A & E to implement fast track and Consultant A & E to liaise with working group to ascertain what provision will be introduced for children and young people. | | 2. Urgent Care\C2.2\minutes from meeting 15th April 2014.doc | | SAFE<br>Children are appropriately priorities and treated | CQEG |
| C2.4 | | There needs to be a consultant nominated as the lead for children's care in A & E | MD | Fiona Lennon | Chris Ainsworth | Dr Julia Weatherill is lead A&E Consultant for Children - minutes of joint paediatric / A & E meeting to confirm<br><br>Photo poster displayed in A & E | Jun-14 | Julia Weatherill is the consultant lead for children's and Lisa Barnes and Vicky Write are the Sisters responsible for children's. Matron - A & E has sent a memo to all staff informing them of above.<br><br>A photo poster is being developed which will be displayed jointly next to the safeguarding teams within the department | | Nominated Lead for Children and Young People in A&E is Dr J. Weatherall | | SAFE<br>All A&E staff are aware of who the nominated consultant is for children's care | Strategic Management Board |
| C2.5 | | Use the same audit tools as the children's ward when auditing children's care in A & E | | Matt Tucker / Fiona Lennon | Chris Ainsworth | Completed audits | Jun-14 | The Matrons from A & E and Children's have reviewed the QUEST audit that is completed in paediatrics. They have agreed which questions from the Paediatric QUEST audit should be incorporated into the A & E monthly QUEST to provide consistency. The Matron A & E is meeting with the Apps team on 6th May to review and update the monthly QUEST audit tool | | empty | | SAFE<br>Consistent process for monitoring the children's care throughout the Trust | Nursing & Midwifery Board |
| C2.6 | Ensure resuscitation trolley is not blocked by other trolleys or equipment | Comment will be added to the Senior Nurse shift leader checklist in A&E to confirm that access to resuscitation equipment is maintained at all times | COO | | Simon Hawes | | | | | empty | | | Nursing & Midwifery Board |
| C2.7 | Improve compliance with Level 3 Safeguarding children for staff in A&E | Continue with planned sessions of bespoke training [low level training had been previously identified]; in order to increase current training compliance. | DoN | | Chris Ainsworth | Training records | 30.4.14 | The safeguarding children training for staff in A & E is currently 80%, which is 5% above the Trust target of 75%<br>Further work continues to increase and maintain compliance | | 2. Urgent Care\C2.7\FW CQC actions.msg | | | |
| | | Review Training compliance level following completion of planned sessions and develop further actions as needed. | | | | | 31.5.14 | | | empty | | | |

**3. Responsiveness - Safety**

| NGH Priority | Recommendations | Actions Required | Executive Owner | Action Owner | Governance Support | Assurance / Evidence | Target Date end of month | Progress/Milestones | Action Status | Hyperlink | Overarching outcome | outcome or anticipated outcome | Accountable committee |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CM3.1 | The do not attempt cardio pulmonary resuscitation (DNACPR) paperwork was misleading and being incorrectly completed and used | Withdraw existing documentation | DoN | Celia Warlow | Chris Ainsworth | Documentation withdrawn from all areas<br><br>Emails<br><br>Screensavers | Jan-14 | Friday 17th January 2014 1900hrs onwards - All forms were removed and replaced with copies of the DNACPR form only. This was verbally handed over to the Nurse in charge in all in patient areas, A&E, operating theatres and escalation areas. An accompanying memo to explain the rationale for change and completion process was also provided with mobile contact number for 24/7 advice or support if required during the pending weekend. | | 3. Responsiveness to Care\W3.1\CQC Inspection - Immediate actions required email 17.1.2014.msg | SAFE - planning and delivering care, treatment and support so that people are safe, their welfare is protected and their needs are met (Outcome 4) | Removal of documentation | CQEG |
| | | | | | | | | | | 3. Responsiveness to Care\W3.1\Screensaver - DNACPR Interim Forms CQC.pptx | | | |
| | | | | | | | | | | 3. Responsiveness to Care\W3.1\Report DNACPR CQC January 2014 v3.doc | | | |
| | | Redesign and implement revised documentation | | | | Copy of revised DNACPR form<br><br>Revised DNARCPR form included in Resuscitation Policy | Jan-14 | Monday 20th – The Resuscitation team visited all in patient areas with further hard copies of the carbonated versions of the DNACPR to resume the required audit trail.<br>The resuscitation team followed up all patients who had a DNACPR decision made since Friday evening and copies were taken for audit purposes.<br>Monday 20th January 0830hrs – Consultation with Doctors of all grades (including the 2222 emergency team) to capitalize on gaining further feedback regarding refinement and potential improvements for the form.<br>Ford redesigned to align the process. New artwork was produced with the assistance of NGH Medical Illustration with two forms produced which sat on one A3 backboard, thus allowing for the TEP form to be used independently or in | | 3. Responsiveness to Care\W3.1\DNACPR Jan 2014.pdf | | Revised DNAR is available in all areas and staff are utilising this appropriately | |
| | | | | | | | | | | 3. Responsiveness to Care\W3.1\Screensaver - Launch of new | | | |
| | | | | | | | | | | 3. Responsiveness to Care\W3.1\TEP Jan 2014.pdf | | | |
| | | | | | | | | | | http://srv-wap-001/IG_DocControl/HG_ViewDoc.aspx?HG_DocID=0655408e-1a5b-4189-b4de-973764471778 | | | |
| | | Support the implementation of the revised documentation with a programme of training, support and audit | | | | Training programme<br><br>Audit results<br><br>Evidence of distribution (i.e. meeting minutes etc.) | Feb-14 | All resuscitation sessions and courses include appropriate training on DNACPR<br><br>DNACPR compliance with correct completion of forms has risen from 54% (Dec) to 87% (March)<br><br>Monthly audits continue | | 3. Responsiveness to Care\W3.1\Resuscitation Training Current levles for Doctors.xlsx | | Information about the quality and safety is gathered and consistently monitored | |
| | | | | | | | | | | 3. Responsiveness to Care\W3.1\Cardiac Arrest Prevention & BLS Staff Training Current Figures.xlsx | | | |
| | | | | | | | | | | 3. Responsiveness to Care\W3.1\DNACPR Compliance Evidence 2013 - 2014.xlsx | | | |
| | | | | | | | | | | 3. Responsiveness to Care\W3.1\Report DNACPR CQC January 2014 v3.doc | | | |
| | | | | | | | | | | to discuss the new re-designed DNAR Form and TEPP Management Plan, in use throughout the Trust, | | | |
| | | | | | | | | | | 3. Responsiveness to Care\W3.1\CQC Feedback for TEP and DNACPR.msg | | | |
| CM3.2 | Address the lack of pharmacists allocated to the off NGH site ward to review and advise on medication arrangements | Review the requirement for pharmacy support for off-site ward areas | DoS&P | Rita Reeves | Sue Cross | n/a as NHFT site now | Mar-14 | For CCH and Isebrook the arrangements were that pharmacy needs were to continue to be supported contractually by KGH upon transfer of the clinical areas to NGH which ensured supply of stock and non-stock medication as well as TTOs.<br>This also included a visit every 3 months to the ward to ensure the checking of Controlled Drugs. This was changed to every 6 months by KGH.<br>The substantive pharmacy support from Provider services for Corby and Hazelwood did not transfer when areas transferred to management of NGH.<br>There was ad hoc support from the part time pharmacist at Danetre to review the stock levels at Corby and Hazelwood wards and to remove the controlled drugs when required.<br>Danetre was previously covered with locum support 2 days per week, this transferred as well when service came under NGH:<br>This post was then re-evaluated and notice given to enable a substantive post to be recruited across all 3 community hospital sites; how-ever recruitment was then put on hold when decision made for NGH to de-invest into the community hospital beds.<br>As part of the transformation of this service NHFT has been copied into the CQC report and action plan relating to community wards. This action has been handed over to NHFT and is completed | | n/a as NHFT site now | SAFE (outcome 9) | | n/a |
| | Whilst the risk posed to the health and welfare of patients admitted with a stroke had been identified and assessed they had not been effectively managed (Concerns | Develop the pathway with agreed roles and responsibilities | | | | Copy of pathway | Apr-14 | Ratified protocol | | 3. Responsiveness to Care\C3.3\Protocol for Acute Stroke Nurses to request CT Head scans for suspected acute stroke patients.pdf | | A robust pathway that does not delay | CQEG / IHGC |

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| W3.3 | were raised to the CQC inspection team regarding understanding of the stroke imaging pathway and confusion between the radiology and medical departments.) | | MD | Lyndsey Brawn / Richard Jones | Caroline Corkerry | | | | 3. Responsiveness to Care\C3.3\Protocol Ratification Form.pdf | Outcome: SAFE - planning and delivering care, treatment and support so that people are safe, their welfare is protected and their needs are met (Outcome 4) | patients scans | |
| | | Ensure communication of pathway to all staff | | | | Evidence required for: dissemination of the pathway. meeting minutes that record discussion including Radiology to confirm that the pathway is | Apr-14 | | empty | | Appropriate staff are aware and utilised the correct pathway | |
| | | Agree process for ongoing monitoring and reporting | | | | Evidence required for: monitoring of pathway e.g. how many specialist Nurse requested CT's have taken place . Outcome of SSNAP audits to ensure trust | Apr-14 | | empty | | The Trust will achieve consistent compliance against the SSNAP audit | |
| CS3.4 | The CQC found food supplements and nutritional drinks were not monitored to ensure consumption within expiry dates. | Matrons must check the stock in their areas to ensure it is in date | DoN | Bill Wood / Natalie Green | Chris Ainsworth | Matrons checklist<br><br>Exception reports | Apr-14 | The checking of expiry dates will take place through 2 avenues once a month – the pharmacy technicians and on the environment audit undertaken through Infection Prevention. | 3. Responsiveness to Care\C3.4\RE Stock Rot | SAFE - Identify, monitor and manage risks to people who use, work in or visit the service. (outcome 16) | A process for stock control is established | Nursing & Midwifery Board |
| | | Ensure nurses responsible for administering these are aware of the need to fully check the labelling including the expiry date before administering to patients. | | | | Evidence of discussions at meetings | Apr-14 | | empty | | | |
| | | Ensure stock rotation and stock management is appropriate | | | | Audit of supplements to ensure that these are stock rotated and as with any medication/ product expiry date checked. | Apr-14 | The principles of good practice will be cascaded through the ward huddlesand a quick check will be performed through 2 routes – a question through the walk round to random staff regarding how they put stock away and on the 'Beat the Bug, Stop the Clock' again a verbal check with staff plus a check of the stock in the cupboards/fridge etc of the front and back with any variance on dates ie soonest at the front. | 3. Responsiveness to Care\C3.4\Key Informa | | | |
| CS3.5 | The CQC found evidence that Body Mass Index (BMI) calculations were being guessed | Implementation of the nationally recognised MUST nutrition assessment tool in nursing documentation | DoN | Bill Wood / Natalie Green | Chris Ainsworth | Weigh Day Wednesday<br><br>Audit as part of Matrons Check<br><br>QuEST | May-14 | | empty | CARING - Patients Care and treatment is delivered in accordance with the care plan to ensure healthy living choices (outcome 4) | | Nursing & Midwifery Board |
| | | Provision of extensive training by the practice development team for the whole Admissions & Discharge documentation | | Bill Wood / Natalie Green | | Training programme<br><br>Attendance at training records | May-14 | The Practice Development Team disseminated the reviewed nursing documentation on 25th April to all the adult inpatient wards. Prior to this the ward sisters were sent details of the reviewed documents and copies to share with their staff during daily huddles and ward meetings in preparation. The on call sisters and night practitioners were requested to speak to staff and raise any issues with the PD team – none received.<br><br>The PD team are keeping a log of staff who have been spoken to in respect of the revised documentation. Details of contact numbers were left with the wards if they had any concerns of questions<br><br>The PD Team went out again on the 30th April to all the wards to speak with staff. | 3. Responsiveness to Care\C3.5\Evidence regards new nursing documentation (3).docx | | | |
| | | Monitoring of compliance via monthly QuEST audits | | Bill Wood / Natalie Green | | | May-14 | | empty | | | |

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| CM3.6 | The door leading in to the maternity labour ward could be left open and posed a risk of unauthorised access to this high risk area | Spot checks to be carried out to ensure the door is closed | DoN | Anne Thomas | Chris Ainsworth | Audit results<br><br>Minutes of meetings where results are discussed | Mar-14 | Spot checks carried out 3 times a day to ensure door closed.<br>Raised staff awareness of need to keep door closed and audited (3x daily spot checks documented). 100% compliance mid April 2014 and 100% compliant end of April 2014<br><br>Compliance with audit has been reported to Governance Group (awaiting minutes of meeting for evidence of completion)<br><br>Note: the outer door of labour ward allows access to lobby area only. Two further security doors are used to gain access to the labour ward and MOW. The reception desk has barrier glass to ensure safety of receptionist. No access to clinical area by this single outside door. | | 3. Responsiveness to Care\C3.6\Checks for status of front door to labour ward.pdf | SAFE The environment is safe and fit for purpose (outcome 10) | SAFE | Strategic Management Board |
| C3.7 | Ensure all forms for pathways available in clinical areas are relevant to that area and are completed appropriately | • Falls<br>• Nursing Assessment Form | DoN | | Chris Ainsworth | | | | | empty | | | Nursing & Midwifery Board |
| CS3.8 | There are no formal arrangements in place to provide multi faith spiritual support, even in areas where end of life care is given | This finding was associated with the assessment of care at Danetre Hospital. Formal arrangements are in place in the Acute Care Trust | DoN | Eileen Ingram | Chris Ainsworth | Information for provision of multi faith spiritual support is available on the intranet | n/a | As part of the transformation of this service NHFT has been copied into the CQC report and action plan relating to community wards. This action has been handed over to NHFT | | n/a | n/a | | n/a |

**4. Medical Equipment**

| NGH Priority | Recommendations | Actions Required | Executive Owner | Action Owner | Governance Support | Assurance / Evidence | Target Date end of month | Progress/Milestones | Action Status | Hyperlink | Overarching outcome | outcome or anticipated outcome |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CM4.1 | Equipment was not being adequately tested or maintained | Review planned preventative maintenance register of equipment ensuring all medical equipment is listed | DoE&F | Hassan Aghourime | Caroline Corkerry | Progress Report<br><br>Minutes of meetings where discussed | Mar-14 | Maintenance **Prior to the CQC visit:**<br>A comprehensive review of both internal and external maintenance carried out. Last KPIs reported in September 2013 shows: • Planned Maintenance: 78.6% instead of 90% • Performance Verification Testing: 54.5% instead of 60%<br>Gaps identified including backlog of planned maintenance and potential non-compliance with CQC requirements. Risk assessment carried out and risk register updated.<br>Maintenance centralisation and consolidation strategy approved.<br>Maintenance of medical equipment tendered<br>TBS GB awarded the contract to provide comprehensive equipment maintenance.<br>TBS started new service mid October 2013.<br>Agreed with TBS a plan of action to achieve compliance by end of March 2104<br>**After CQC visit:**<br>Immediately after the concerns raised by CQC, TBS engineers were called in to inspect and action the maintenance of equipment in the following areas: Main Theatres, Manfield Theatres; Gynae Theatres; Day Surgery Unit; ITU and Paediatrics.<br>Subsequently TBS were asked to go to all areas and carry out planned maintenance<br>TBS produced the following KPIs on February 2014 as a progress update:<br>• Planned Maintenance: 86% instead of 90%<br>• Performance Verification Testing: 54% instead of 60%<br>TBS currently on track to meet Trust standards of planned maintenance KPIs by end of March 2014<br>TBS to produce a Trust wide planned maintenance plan for the next 12 months by end of March 2014 | | 4. Medical Equipment\W4.1\NORTHAMPTON GENERAL HOSPITAL MEDICAL DEVICE MAINTENANCE KEY PERFORMANCE INDICATORS.pdf<br><br>4. Medical Equipment\W4.1\Document 4 - Context of Medical Equipment Maintenance.docx | SAFE People who use services and people who work in or visit the premises are not at risk of harm from unsafe or unsuitable equipment (outcome 11) | Properly maintained and safe for use |
| | | Identify any medical equipment which has not been tested and carry out risk assessment for inclusion on Risk Register | | | | For inclusion in compliance report to CQEG<br><br>Minutes and report to Risk Group | Mar-14 | The Risk register is currently being reviewed | | 4. Medical Equipment\W4.1\Document 6 - Datix re equipment.pdf<br><br>4. Medical Equipment\W4.1\Document 7- Datix re equipment.pdf | | Trust are aware of which equipment has not been tested and plans are in place to rectify and omit the risk |
| CM4.2 | Ensure adequate supply and use of capnography machines in theatres | Review availability of capnography machines and identify shortfall | DoE&F | Hassan Aghourime | Sue Cross | | May-14 | | | | SAFE There are sufficient capnography to meet the service needs within the Trust (outcome 11) | Trust are aware that sufficient equipment is in place to rectify and omit the risk |
| | | Where a shortfall is identified, carry out a risk assessment for inclusion on Risk Register | | | | | May-14 | | | | | |
| CS4.3 | Access to equipment is an issue within the Trust (there were no emergency call alarms in the anaesthetic rooms or operating theatres in the main theatres suite which does not comply with the NHS Estate Health Building Note 26 (HBN 26) | Undertake survey work to determine requirements. | DoE&F | | Caroline Corkerry | Action plan completed | Jun-14 | This has been recognised as an issue and work is currently underway within the capital programme. To date aesthetic rooms and PAR in Main, Manfield and Gynae theatres have had alarms installed and survey work is being undertaken in the remaining theatre areas to determine requirements. | | | SAFE - Improve the service by learning from adverse events, incidents, errors and near misses that happen. (outcome 10) | Gaps are known & addressed |

**5. Governance**

| NGH Priority | Recommendations | Actions Required | Executive Owner | Action Owner | Governance Support | Assurance / Evidence | Target Date end of month | Progress/Milestones | Action Status | Hyperlink | Overarching outcome | outcome or anticipated outcome | Accountable committee |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| W.5.1 | The follow up of action plans was identified as a concern in the minutes of the Trust Board meeting. However, there was no record of how the Trust was going to address the issue and there was no evidence that the associated risks to the health, welfare and safety of people using services at NGH had been identified, assessed and managed | Develop a robust process for the review and follow up of action plans | MD | Chris Ainsworth | Caroline Corkerry | Revised pathway demonstrating process<br><br>CQEG Report<br><br>Trust Board Report | Feb-14 | The Serious Incident Group has devised and implemented a more robust process for the management of Serious Incident action plans. The process has been included in the revised Serious Incident Policy and has been reported to CQEG, IHGC and the Trust Board.<br>Reports on performance against the revised Serious Incident process will continue to be presented to CQEG, IHGC and the Trust Board on a monthly basis to ensure effectiveness. | | 5. Governance\W5.1\Action Plan Assurance Process.docx<br><br>5. Governance\W5.1\CQEG Feb 2014 (for Jan 2014.doc<br><br>5. Governance\W5.1\Trust Board SI for Feb2014.doc | Outcome : SAFE - Improve the service by learning from adverse events, incidents, errors and near misses that happen. (outcome 16) | Action plans are evaluated to see if risks are addressed and improvements made. | CQEG |
| | | Progress of all action plans monitored on HealthAssure | | | | Reports on compliance<br><br>Review of Quarter 3 action plans with RAG rated progress<br><br>Meeting minutes<br><br>HealthAssure Reports | May-14 | Reports on performance against the revised Serious Incident process will be presented to CQEG, IHGC and the Trust Board on a monthly basis to ensure effectiveness.<br>The Governance Facilitators are reviewing all action plans from Q3 to ensure evidence is available to demonstrate completion. This will be presented to the SIAM meeting with the CCG on 16th May 2014. Q4 onwards action plans are being monitored via HealthAssure and a quarterly compliance report will be submitted to SIG | | 5. Governance\W5.1 | | Action plans are evaluated to see if risks are addressed and improvements made. | |
| | | Any meeting where concerns are raised in relation to completion of actions the minutes should include mitigating actions and follow up by the group | | | | Email to minute takers of Groups / Committees where action plans are discussed to raise awareness of the need for mitigating actions / follow up actions to be minuted | May-14 | | | empty | | | |
| | | Ensure all action plans are signed off by the accountable committee in a timely manner | | | | SIG Minutes<br><br>Directorate Governance Meetings<br><br>CQEG Directorate Governance Reports<br><br>HealthAssure Reports | May-14 | As from Feb 2014 submitted Serious Incident reports and action plans are reviewed by SIG at the next meeting to ensure that contributory factors have been fully explored and that actions are aligned with the root cause of the incidents to reduce the likelihood of recurrence.<br><br>All action plans for Quarter 4 are now on HealthAssure and the Care Group Governance Managers will complete quarterly status updates - Status updates for Quarter 4 are in the process of being completed.<br><br>Action plans are then monitored by the Directorate/Care Groups until completion. Completed action plans will be presented to SIG with the evidence to ensure all actions have been completed. The first action plans are expected to be presented to SIG in May 2014 | | 5. Governance\W5.1 | | Information about the quality and safety is gathered and consistently monitored to identify risks and areas for improvement | |
| CS5.2 | The management of serious incidents within the trust is not robust; the process of reporting is delayed, training in report writing is absent, monitoring of action plans is not consistent or timely. Organisational learning is limited if not absent. However there was evidence of learning in the area where the incident occurred. | Ensure incidents which fulfil the criteria of a serious incident are reported as per the national framework timescales | MD | Chris Ainsworth | Caroline Corkerry | Process for identification of incidents which fulfil the classification of an SI<br><br>Quarterly report to IHGC demonstrating compliance with the National Framework for Reporting & Investigating Serious Incidents | Apr-14 | The Serious Incident Group now meet weekly to expedite the agreement & external notification of Serious Incidents (SI).<br><br>A process flow chart has been developed to support identification, confirmation and external reporting of Serious Incidents in a timely manner to meet external reporting requirements<br><br>Compliance with timescales is reported quarterly to CQEG and IHGC | | 5. Governance\C5.2\Incident Approval Process.docx<br><br>5. Governance\C5.2\IHGC_SI_April2014.doc | SAFE - Improve the service by learning from adverse events, incidents, errors and near misses that happen. (outcome 16) | SI process meets the National Guidance | CQEG |
| | | Provision of training for staff in root cause analysis | | | | Training programme<br><br>Attendance log | Jul-14 | External training provider being sourced - planned for July 2014. Consultant Governance Leads and Band 8a and above identified to attend<br>Risk Manager and Senior Quality, Risk & Litigation Manager provide support for SI leads and quality assure all serious incident investigation reports prior to submission | | 5. Governance\C5.2\SI Investigator training.msg<br><br>5. Governance\C5.2\Trust Board SI for March2014.doc | | Identified staff will receive RCA training | |
| | | Develop a clear pathway which demonstrates the dissemination of lessons learnt at individual directorate, department, care group, trust wide and the wider health economy | | | | Revised pathway demonstrating process<br><br>Trust Board Report / Minutes<br><br>CQEG Report / Minutes<br><br>IHGC Report / Minutes<br><br>Care Group Governance Minutes<br><br>Directorate Minutes | Feb-14 | A clear pathway has been developed to demonstrate the dissemination of lessons learnt at individual; Directorate/Department; Care Group; Trust wide and the wider health economy levels (see attached). The pathway commenced roll out in February 2014. | | 5. Governance\C5.2\SI flowchart_lessons learnt.docx | | | |

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| | | Serious Incident Group Liaise with Patient Safety Academy to implement simulation training based on learning from serious incidents | | | | Simulation training plan<br><br>Attendance logs | May-14 | The Governance Team are working with the Patient Safety Academy to implement Simulation Training Sessions based on learning from Serious Incidents | | empty | | | |
| | | Development of quarterly staff newsletter 'Quality Street' to include lessons learnt | | | | Copies of Quality Street | May-14 | All Trust Governance leads and managers have been emailed to request submission of articles<br>The Governance Team have written articles on Datix upgrade; Duty of Candour; lessons learnt from incidents, serious incidents<br>Photographs of team taken by Medical Illustrations to improve profile of Governance Team<br>Medical Illustrations to publish first publication end of April / first week in May | | empty | | | |
| | | Development of a Standard Operating Procedure to ensure lessons learnt are disseminated to ward level | DoN | Bill Wood / Natalie Green / Anne Thomas | Chris Ainsworth | Copy of SOP<br><br>Ward minutes to demonstrate discussion | May-14 | This is included in the Nursing & Midwifery Quality Agenda and the development of Standard Operating Procedures (SOP). A standard template was developed by the Head Nursing & Midwifery, Professional, Practice Development. | | 5. Governance\C5.2\SOP - 10 Standing Agenda.doc | | | |
| CS5.3 | Staff reported that learning from incidents and feedback when they reported incidents was not always given | Upgrade Datix reporting system to ensure full feedback capability of system.<br>Development of a user guide to ensure staff are aware of whose responsibility it is to feedback to the reporter of the incident | MD & DoN | Chris Ainsworth | Caroline Corkerry / Chris Ainsworth | User guide<br><br>Evidence of roll out / dissemination<br><br>Ward Minutes<br><br>Directorate Governance Group Minutes | May-14 | Upgrade of Datix completed by Company March 2014.<br>Gap analysis and redesigning of incident report forms by Governance team has taken place.<br><br>Discussed at Governance meeting on 25 April 2014 and redesigned form agreed - minutes of meetings awaited<br><br>User guide in process of development | | 5. Governance\C5.3\Screensaver - 14th April 2014.pdf<br><br>5. Governance\C5.3\April 2014 Away Day Agenda.docx | SAFE - Improve the service by learning from adverse events, incidents, errors and near misses that happen. (outcome 16) | | Nursing & Midwifery Board |
| | | A standard operating procedure for ward meetings has been launched which includes standing agenda items these include the months incidents | | Bill Wood / Natalie Green / Anne Thomas | | Standard Operating Procedure<br><br>Minutes of meetings | May-14 | The Ward Meeting SOP was developed by a ward sister and shared with their peers. It sets out a standard of each ward holding monthly ward meetings with a set agenda template that includes sharing of a patient story and learning from complaints and incidents. | | 5. Governance\C5.2\SOP - 10 Ward Meetings.doc | | | |
| | | Minutes of the ward meeting will be generated and a sign off sheet to say staff have read them if they were not present at the meeting Evidence of standard agenda's for ward/ dept meetings , minutes from meetings to demonstrate discussions / feedback &copy of the SOP required. | | Bill Wood / Natalie Green / Anne Thomas | | Minutes of meetings<br><br>Sign off sheet | May-14 | The SOP also includes a standard template for the minutes and a sign off form providing evidence that staff have read the minutes. It is monitored through the Nursing & Midwifery Quality Dashboard and QuEST. We are reviewing the performance criteria of this SOP to reflect completion of the standard templates. | | 5. Governance\C5.2\Ward Meeting Sign sheet.docx | | | |
| CS5.4 | Actions following a complaint are realised and logged. However there are considerable delays in initiating actions; some action from complaints remain outstanding after three months after the action shave been agreed and the complaint has been responded to. | Develop a robust process for the review and follow up of action plans<br><br>Progress of all action plans monitored on HealthAssure<br><br>Ensure all action plans are signed off by the accountable committee in a timely manner | DoN | Lisa Cooper | Chris Ainsworth | HealthAssure process plan<br><br>Dissemination to Care Groups / Directorates<br><br>CQEG reports<br><br>Directorate Governance Reports | May-14 | The Governance IT Facilitator and Complaints Manager have met to discuss the process. Agreed to adopt the same process as Serious Incident Action plans<br><br>SI Action Plan assurance pathway to be adapted and distributed to care Groups/Directorates<br><br>All Complaints action plans from 1st April 2014 in the process of being uploaded to HealthAssure | | empty | CARING- Learning and improvements in care have occurred as a result of answering complaints - (outcome 17) | Learning and improvements in care have occurred as a result of answering complaints<br><br>Action plans are evaluated to see if risks are addressed and improvements made. | CQEG |

**6. End of Life Care**

| NGH Priority | Observation | Actions Required | Executive Owner | Action Owner | Governance Support | Assurance / Evidence | Target Date end of month | Progress/Milestones | Action Status | Hyperlink | outcome or anticipated outcome | Accountable committee | TO HIDE<br>Questions for Sue to follow up with Team |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| C6.1 | Four patient records reviewed with regard to the care plan relating to end of life needs found that the completion of the records was not consistent and that there were gaps in all four of the records that we looked at. For example, there were gaps in the daily charts which recorded the repositioning of patients at high risk of pressure ulcers and their daily nutrition and fluid intake for two of the patients and one patient had not had a pain assessment completed. In addition to this, one patient did not have a care plan for their end of life care at all. | To increase visibility on the wards enabling clinicians to provide high quality End of Life Care incorporating the five key enablers outlined in the National End of Life Transformation programme.<br><br>To lead the implementation of the National Principles replacing the Liverpool Care Pathway.<br><br>Promote best practice and support to clinicians to enable them to identify patients approaching the End of Life ensuring a patient centred plan of care is put in place and reviewed regularly.<br><br>Provide ward based education in relation to DNAR and TEP with respect to End of Life care planning.<br><br>Support clinicians to identify patients with unmet needs, ensuring they are referred to the Specialist Palliative Care Team. | DoS&P | Liz Summers | Sue Cross | Audit of records<br><br>Clarification around Liverpool Care Pathway or the National Principles | May-14 | End of life opiate audit is being undertaken by Karin Start | | 6. End of Life\C6.1\6.1.1 Audit of records | | End of life Strategy Group / IHCG | |
| | | | | | | | Jun-14 | End of Life Care questions: Named Consultant / Senior Nurse Huddle is to be rolled out in May 2014 | | 6. End of Life\C6.1\6.1.2 Ward Huddle EOL questions | | | |
| | | | | | | | Jun-14 | Development of initial training compliance by ward | | 6. End of Life\C6.1\6.1.3 Training compliance | | | |
| | | | | | | | | Additional training available to staff | | 6. End of Life\C6.1\6.1.3 Training compliance\6.1.3 Palliative and End of Life Care Training Prospectus 2014.doc | | | |
| | | | | | | | | | | 6. End of Life\C6.1\6.1.3 Training compliance\EOL Strat Groop 6th May 2014.docx | | | |
| | | Increased visibility on the wards of the End of Life Care Facilitator | | | | End of Life Care Facilitator role reviewed to include daily visits to the ward where End of Life care patients have been identified to ensure an End of Life care | June 2014 | End of Life Care Facilitator attending daily "huddle" meeting, in her absence a member if the SPCT. | | 6. End of Life\C6.1\6.1.4 Clinical saftey huddles | | | How else could we demonstrate visbaility |
| C6.2 | The lack of a named consultant for palliative care within the trust meant that there was a lack of overall co-ordination and governance of this care pathway | Identify funding for a full time consultant in Palliative Medicine who will act at the End of Life Care Lead for the Trust. | MD | Liz Summers | Caroline Corkerry | Job description and Job Plan | Dec-14 | Dr David Riley, Consultant in Palliative Medicine provides 3.5 clinical PAs to the Trust and acts as the named Consultant for the Specialist Palliative Care Team.<br><br>Dr Christine Elwell, Consultant Clinical Oncologist acts as the Trust End of Life Care Lead and will be part of the Operational Group delivering the CQC action plan.<br><br>Business Case submitted to CCG for identification of funding | | 6. End of Life\C6.2\6.2.2 EOL Strat Groop 6th May 2014.docx | | End of life Strategy Group / IHCG | Get copy of buisness case as mentioned in workplan |
| | | Actions to address gap at present needs to be added | | | | | | Annual Work programme has been shared | | 6. End of Life\C6.2\6.2.1 EOL Annual Work Programme 2014-15.doc | | | |
| C6.3 | Ensure provision of training for staff regarding end of life care | Identify a specific team of individual whose responsibility it is for delivering EoLC leadership. This could fall within existing senior nurse roles or be a dedicated team (which would require 3 additional WTE Band 7 SPC Nurse Specialists)<br><br>To enable seven day a week face to face contact in line with National Directives.<br><br>To provide out of hours telephone advice to clinical teams in line with National Directives.<br><br>Respond to End of Life patients identified with unmet needs.<br><br>Facilitate education and training related to Palliative and End of Life care.<br><br>To lead the implementation of QELCA across the Trust.<br><br>To develop a robust link nurse system | DoS&P | Liz Summers | Sue Cross | Business case | Jun-14 | To produce a business case for funding for additional Band 7 WTE Specialist Palliative Care Nurses to comply with the National Standards relating to Specialist Palliative Care | | 6. End of Life\C6.2\6.2.2 EOL Strat Groop 6th May 2014.docx | | End of life Strategy Group / IHCG | Get copy of buisness case as mentioned in workplan |
| | | | | | | Job plan and description for Speculative Palliative Care Nurse<br>Appraisal documentation | | | | empty | | | |
| | | | | | | Time table of audits built in to the clinical audit programme across the Trust | | | | empty | | | |
| | | | | | | Minutes of meetings where this has been discussed | | | | empty | | | |
| C6.4 | Ensure the Trust has clear leadership with regard to the provision of end of life care. | To redefine the End of Life Care Strategy Group ensuring TOR is updated to reflect core membership and clarification of roles and responsibilities | DoS&P | Wendy Smith | Sue Cross | Terms of Reference | Apr-14 | TOR developed | | 6. End of Life\C6.4\C6.4.1 EOL Strategy TOR | | End of life Strategy Group / IHCG | |
| | | Provide a formal report to Strategic Management Board / CQEG | | | | Minutes of meetings where this has been discussed | | | | empty | | | |

**6. End of Life Care**

TO HIDE
Questions for Sue to follow up with Team

| NGH Priority | Observation | Actions Required | Executive Owner | Action Owner | Governance Support | Assurance / Evidence | Target Date end of month | Progress/Milestones | Action Status | Hyperlink | outcome or anticipated outcome | Accountable committee |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Develop annual plan | | | | Work Programme | | Annual Work plan developed and will be monitored at End of Life Strategy group in line with the End of Life Strategy. Draft end of Life Strategy been circulated for consultation April 2014 | | 6. End of Life\C6.4\C6.4.3 EOL Annual Work plan | | |
| C6.5 | Ensure there is clear guidance for staff regarding the pathway for end of life care | Liaise with the Countywide group to develop guidelines based on the National Principles for End of Life Care | DoS&P | Liz Summers | Sue Cross | Increase in the use of the LCP in May and June | Jul-14 | | | empty | | End of life Strategy Group / IHCG |
| | | Communicate the End of Life Care principles across the Trust | | | | County wide guidelines for Care of the Dying | Jul-14 | reflection around the Trust | | empty | | |
| | | Embed the principles into Clinical Practice through the End of Life Care team. | | | | Audit of End of Life care built into the clinical audit programme across the Trust | Sep-14 | | | empty | | |
| | | Review Trust policy to ensure it reflects current practice | | | | Six monthly real time audit built into the Clinical Audit Programme across the Trust | Sep-14 | | | empty | | |
| C6.6 | Discuss the provision of formalised arrangement for out of hours telephone support to clinical teams as per peer review requirement. | Liaise with the Service Manager at CSH to formalise an SLA to provide out of hours telephone support until the full complement of the Palliative Care Team is established. | DoS&P | Liz Summers | Sue Cross | Written Agreement | Jun-14 | | | empty | | End of life Strategy Group / IHCG |
| | | | | | | Process for communicating advice back to the Specialist Palliative Care Team at NGH | Jun-14 | | | empty | | |
| C6.7 | Ensure there is a robust process whereby staff on the wards and in the palliative care team are able to articulate how many patients there are who are receiving end of life care. | Incorporate the identification of End of Life patients onto the "Ward Work Space" | DoS&P | Liz Summers | Sue Cross | Register of end of life patients by wards | May-14 | A weekly register is now collated | | 6. End of Life\C6.7\C6.7 End of Life Patient Register Deaths & Discharges | | End of life Strategy Group / IHCG |
| | | | | | | Audit of identification of End of Life patients built into the clinical audit programme across the Trust | Jan-15 | | | empty | | |
| | | Develop an electronic system to alert the End of Life Care team about patients approaching the End of Life using ICE | | | | Monitor the movement of patients approaching End of Life | Jan-15 | | | empty | | |
| | | Prevent the movement of patients at End of Life unless in their best interest | | | | | | | | empty | | |
| C6.8 | Patients on the end of life pathway should have palliative opioids prescribed and all doses should be administered within the two hour 'window' as advised by National guidance | Development and ratification of Palliative opioid administration guidance | DoS&P | Liz Summers | Sue Cross | Six monthly real time audit built into the Clinical Audit Programme across the Trust | Jan-15 | Guidance has been reviewed and minuted at NMB 29..1.2014 | | 6. End of Life\C6.8\C6.8.1 Adult Acute Chronic Surg and Non Surg Pain Mgt Guideline | | End of life Strategy Group / IHCG |
| | | Dissemination of initiation and prescription guidance | | | | | | Karin Start (Pharmacy) is the key contact information still to be provided - WS is chasing Karin currently. A discussion has taken place at NMB | | 6. End of Life\C6.8\C6.8.2 Dissemination of initiation and prescription guidance | | |
| | | Develop Opioid Leaflet for palliative patients | | | | | | | | empty | | |
| | | Palliative opioid management to be incorporated into medicine administration assessments | | | | | | | | empty | | |
| | | Review the possibility of incorporating strong opioids on the critical medicine list in the Medicines Management Policy and recorded on the drug chart | | | | | | | | empty | | |

**7. Mandatory Training & Appraisal**

| NGH Priority | Recommendations | Actions Required | Executive Owner | Action Owner | Governance Support | Assurance / Evidence | Target Date end of month | Progress/Milestones | Action Status | Hyperlink | Overarching outcome | outcome or anticipated outcome | Accountable committee |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| W7.1 | Mandatory Training. The actions taken to manage the risks are inadequate and there remains a significant number of staff who have not received the relevant mandatory training | Provide a variety of options to ensure that staff are able to access mandatory training. | DoW&T | Sandra Wright | Sue Cross | Snapshot Intranet pages<br><br>Examples of emails sent to Managers advising dates of training | Apr-14 | 4 options for mandatory training currently available since Autumn 2013:<br>1) Classroom<br>2)E-Learning<br>3) Workbook<br>4) RoK (Review of Knowledge)<br><br>All options are available on the intranet.<br><br>Updated TNA & Course outline (planned for May 2014) | | 7. Mandatory Training & Appraisal\7.1\Cluster-Day-Programme-April-to-Dec-FINAL2014.docx | WELL-LED People who use services are safe and their health and welfare needs are met by competent staff and ensure that staff are properly trained, supervised and appraised. (outcome 14) | Information to be available to all staff | CQEG |
| | | | | | | | | | | 7. Mandatory Training & Appraisal\7.1\e-learning-Jan-2014.doc | | | |
| | | | | | | | | | | 7. Mandatory Training & Appraisal\7.1\RoK-information-to-staff-v2.docx | | | |
| | | | | | | | | | | 7. Mandatory Training & Appraisal\7.1\Mandatory Training information inc ROK email for weeks | | | |
| | | | | | | | | | | 7. Mandatory Training & Appraisal\7.1\Mandatory Training NGH-PO-306.pdf | | | |
| | | | | | | | | | | 7. Mandatory Training & Appraisal\7.1\W7.1 review of TNC on the street.msg | | | |
| | | Mandate that all A&C staff complete Mandatory Training as e-learning programmes. | | | | Emails to managers<br><br>Minutes of IHGC / CQEG Papers April 2014 | May-14 | Email to Managers been circulated - various managers email dated 8.4.2014, Discussed at CQEG April 2014 - awaiting minutes | | 7. Mandatory Training & Appraisal\7.1\Email to GMs re compliance of Mandatory and Role Spec FW Overall % | | Improve numbers of A&C staff | CQEG |
| | | | | | | | | | | 7. Mandatory Training & Appraisal\7.1\evidence FW re.msg; Mandatory Training for AC staff email 8.4.2014.msg | | | |
| | | Implement a "Mandatory Training wave approach" to forecasting compliance and performance management | | | | Compliance Reports demonstrating improvement in compliance.<br><br>Email with roll out timetable | May-14 | Report to CQEG / IHGC April 2014 states that a 'mandatory and role specific essential training performance wave has been produced and is being shared with Ward Sisters and Managers. Email 8.4.2014 of the new Performance wave approach from T&D to all managers | | 7. Mandatory Training & Appraisal\7.1\CQEG End 3 Mandatory Training April 2014 Paper.pdf | | | CQEG |
| | | | | | | | | | | 7. Mandatory Training & Appraisal\7.1\Example of Pathology Mandatory Role specific compliance email 9.4.2014 FW Overall % Report - March 2014.msg | | | |
| | | | | | | | | | | 7. Mandatory Training & Appraisal\7.1\Email Re Wave roll out.msg | | | |
| | | | | | | | | | | 7. Mandatory Training & Appraisal\7.1\Performance Wave report sent to Directorates email 8.4.2014 FW Monthly Directorate Mandatory Training | | | |
| | | | | | | | | | | 7. Mandatory Training & Appraisal\7.1\7.1 MT performance wave flowchart RSETWave v2.pptx | | | |
| | | | | | | | | | | 7. Mandatory Training & Appraisal\7.1\W7.1.4 Performance wave role out of info | | | |
| | | Seek advice / support from other Trusts that have robust systems in place and are willing to share good practice. | | | | Contacted Derby Hospital; Nottingham University Hospital; Royal Berkshire Hospitals | Apr-14 | Example of contact with Nottingham inc email and letter and link to the film for Nottingham https://www.nuh.nhs.uk/welcome-to-NUH. NGH have also sinitiated a countywide steering group and the next meeting is 25th June 2014. Horizon scanning is a regular activity of the team and areas are adopted that are suitable | | 7. Mandatory Training & Appraisal\7.1\Communication with other Trusts\email FW Meeting up! NHFT KGH 19.2.2014 next mtg 25.6.2014.msg | | | |
| | | | | | | | | | | 7. Mandatory Training & Appraisal\7.1\Communication with other Trusts | | | CQEG |
| | | Agree & implement performance management dates when the trust target will be met (DN/RB) - 01.05.14 | | | | Workforce reports to IHGC and Trust Board | May-14 | Workforce discussed at IHGC & Trust Board monthly | | 7. Mandatory Training & Appraisal\7.1\IHGC Papers | | Managers and Trust are aware of compliance levels against Trust target | CQEG |
| | | | | | | | | | | 7. Mandatory Training & Appraisal\7.1\Trust Board Papers | | | |
| | | Ensure accuracy of data | | | | External review of OLM/ESR data (McKesson)<br>Reports to CQEG | May-14 | Email & CQEG Paper March and April 2014 reflecting issues and progress<br>Directorates are asked to review their compliance information and challenge any inaccuracies to help address the issues | | 7. Mandatory Training & Appraisal\7.1\Email Northampton General - OLM Resolutions 16.4.2014 Data Accuracy.msg | | | CQEG |
| | | | | | | | | | | 7. Mandatory Training & Appraisal\7.1\CQEG papers | | | |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| W7.2 | Clarification and roll out of role specific training | Scope out what is deemed to be role specific training in each area and staff group<br><br>Ensure correct information regarding role specific training is available on the intranet | DoW&T | Sandra Wright | Sue Cross | Up to date information regarding role specific training requirements needs to be available to all staff | Jan-14 | The Role specific course outline includes both Mandatory and Role specific training and can be accessed from the intranet. An update of the Training including outlining which is Role specific and which is Mandatory is being addressed by T&D in May 2014 | | http://thestreet/CorporateInformation/Departments/TrainingandDevelopment/Downloads/Mandatory-Training-Roles-Specific-checklists-version-8-Sept-2012.doc | | Patients are protected from risk of harm | CQEG |
| | | | | | | | | The T&D department are working on specific spocing for specific job roles which will take a while to address. Emails have now been circulated and directorates are being asked to review and define the role specific aspects | | 7. Mandatory Training & Appraisal\7.2\Role specific scoping with email 19.5.2014 eg Copy of Oncology Positions Apr 2014.xlsx | | | |
| | | Provide monthly reports of compliance | | | | CQEG minutes / reports<br>IHGC minutes / reports<br>Trust Board minutes / reports | Apr-14 | Trust Board minutes / reports inc Role specific information<br><br>IHCG minutes / reports inc Role specific information<br><br>CQEG minutes / reports inc Role specific information appendix 1 for role specific | | 7. Mandatory Training & Appraisal\7.1\Trust Board Papers<br>7. Mandatory Training & Appraisal\7.1\IHGC Papers\9.1 Workforce Report.pdf<br>7. Mandatory Training & Appraisal\7.1\CQEG papers | | | CQEG |
| W7.3 | Suitable arrangements were not in place for ensuring the number of staff without a performance development plan were robustly managed | An audit will be undertaken on all areas where there is no up-to-date information on staff appraisals. This will require managers to provide appropriate evidence to the HR & L&D teams that staff have had an appraisal via one of the processes.<br>2. Where appraisals have not been undertaken within the last year, managers will be required to provide a plan of how this will be achieved within a given time frame. If this is not aligned to staff increments managers will be required to do an appraisal; however a further review will be required to provide assurance to payroll and L&D that staff can incrementally progress<br>3. Agree and implement performance management dates when the trust target will be met (DN/RB)<br>4. Continue to embed the new appraisal process aligned to incremental progression | DoW&T | | Sue Cross | Results of audit and gap analysis and follow up Example of monthly report<br><br>Papers & Minutes IHGC<br><br>Papers of Trust Board & Minutes Trust Board<br><br>Review Trust target (May) - 85% - Report to IHGC in May 2014 | Apr-14 | An increased level of appraisal compliance – aiming for 75% by the end of April 2014; incrementally progressing to 85% by March 2015.<br>An action plan has been developed for Appraisals and Training and this is discussed at Trust Board<br><br>performance management process | | 7. Mandatory Training & Appraisal\7.3\Appraisals audit - message sent on behalf of Dr Sonia Swart CEO.msg<br>7. Mandatory Training & Appraisal\7.3\Screensaver - 14th April 2014.pdf<br>7. Mandatory Training & Appraisal\7.3\Trust Board Papers<br>Dr Swart requested that outcome measures for appraisal compliance be reported to the Board monthly from June 2014.<br>7. Mandatory Training & Appraisal\7.3\IHGC Papers\1.0 DRAFT IHGC Minutes - 20th March 2014.pdf | WELL-LED - Enable staff to acquire further skills and qualifications that are relevant to the work they undertake. (outcome 14) | The organisation are aware of which staff have had not had appraisals<br>There is robust monitoring in place for the staff appraisals and Managers and Trust are aware of compliance levels against Trust target<br>At least 85% of staff will have had an appraisal by March 2015 | CQEG |

**8. Record Keeping and Mgmt**

| NGH Priority | Recommendations | Actions Required | Executive Owner | Governance Support | Governance Support | Assurance / Evidence | Target Date end of month | Progress/Milestones | Action Status | Hyperlink | Overarching outcome | outcome or anticipated outcome | Accountable committee |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CS8.1 | Records were not available when required and were not always accurately completed with information regarding patients specific needs | Print off the batch lists for all records sent to specific outpatient clinics. | DoS&P | Tracey Harris | Sue Cross | Gap analysis | Apr-14 | Spreadsheet documenting number of records requested for clinic and number available. Ongoing data collection from within medical records using batch list and clinic lists. 1.5.14 Meeting with IT to review what data fields needs to be accessible through the patient document tracking universe to improve the data available for checking availability. Appendix 2 | | 8. Record Keeping and Mgmt\CS8.1\CS8.1.1 Examples of Printed off Batch Lists | SAFE - Store records in a secure, accessible way that allows them to be located quickly. (outcome 21) | SAFE<br>Notes are available in a timely manner | Health Records Committee |
| | | Audit list against clinic list tracked to the department / outpatient clinic | | Tracey Harris | | Audit results<br><br>Minutes of meetings where results are discussed | Apr-14 | | | 8. Record Keeping and Mgmt\CS8.1\CS8.1.2 example of tracking report | | SAFE<br>Action plans are monitored to ensure actions are implemented | Health Records Committee |
| | | Print off batch list for all medical records sent to a clinic including the 7 & 2 day changes. Audit those records that were requested from other departments / offices for availability at the clinic | | Tracey Harris | | Copy of audit results as evidence<br><br>Monitoring | May-14 | Ongoing data collection from within medical records using batch list and clinic lists. The audit is now taking place and the information is to be provided as evidence.<br>Discussions are taking place with IT to get some smarter reports to address this in a more roust manner. 1.5.14 Meeting with IT to review what data fields needs to be accessible through the patient document tracking universe to improve the data available for checking availability. Appendix 2 | | 8. Record Keeping and Mgmt\CS8.1\CS8.1.3 2 day notice audit | | SAFE<br>Notes are available in a timely manner | Health Records Committee |
| | | Book OPAs prior to the 2 day cut-off within medical records. Review utilising Info view report | | Tracey Harris | | Exception report | Aug-14 | Data/Graphs on number of records tracked out of medical records and into a specified clinic. Appendix 2 & 4 provide evidence of numbers tracked out of medical records, the tracking in clinics and availability. Further evidence will be captured through improvements in the patient document tracking universe. (review booked 2 days; on day and after clinic information)<br>OPA booking will be discussed at the Health Records Group (HRG) and data sent out to service managers to action. | | empty | | | Health Records Committee |
| | | Ensure all departments email additions to the medical records clerks to enable pulling to be completed in a timely manner | | Tracey Harris | | Exception report | May-14 | This process already takes place however a more robust process is being looked into currently. Provide a report on a monthly basis to the Service Managers review the reports and issues are discussed at Governance and or operational meetings | | empty | | | Health Records Committee |
| | | Training staff who require access to medical records to ensure they understand how to track records in and out of areas | | Tracey Harris | | Training records and attendance logs | Sep-14 | Examples of training logs are provided. Discussions are to take place with T&D & IT to review the training including looking at the possibility of making tracking notes a role specific training requirement for A&C staff.<br>Increase profile of tracking etc. - Screensavers to be created to remind people that training is provided.<br>Email has been sent to all admin managers to request all relevant staff have tracking training<br>Email to T&D has been insitagated | | 8. Record Keeping and Mgmt\CS8.1\CS8.1.6 Tracking training log\CS8.1.6 Tracking Training email 19.5.2014.msg | | | |
| | | | | | | | | | | 8. Record Keeping and Mgmt\CS8.1\CS8.1.6 Tracking training log\CS 8.1.6 T&D training role specific 19.5.2014.msg | | | |
| | | | | | | | | | | 8. Record Keeping and Mgmt\CS8.1\CS8.1.6 Tracking training log\CS8.1.6 Appendix 1 Training Log.tif | | | Health Records Committee |
| | | Improve portering and filing services to ensure more records are held within the library rather than in offices / storage areas in clinics | | Tracey Harris | | Monitoring Evidence | Jul-14 | Reduced number of records awaiting collection in departments. Proposal to be developed and submitted to the HRG for approval<br>Update intranet page to give help on how to track, other user information and how to access the training. PR campaign on reminder for tracking notes. | | empty | | | Health Records Committee |
| | | Stronger monitoring of Datixs by undertaking RCAs and reporting back to all concerned | | Tracey Harris | | Process for Medical Records to monitor Datix<br><br>Reports / Minutes | Apr-14 | Datix's are now monitored and a log is available for review. The process is discussed at the Health records Group meetings and is also followed up with the specific department at the time. Some further challenge is required where secretaries and other departments have the notes where the tracking has not taken place | | 8. Record Keeping and Mgmt\CS8.1\CS8.1.8 HR Datix tracking | | | Health Records Committee |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CS8.2 | Care record templates and audits were based on an acute hospital setting and not necessarily appropriate for a community hospital service | As part of the transformation of this service NHFT has been copied into the CQC report and action plan relating to community wards. This action has been handed over to NHFT Completed | n/a | n/a | n/a | n/a | n/a | Handed to NHFT | | n/a Handed to NHFT | Outcome: SAFE- (outcome 21) | | n/a |

**REPORT TO: TRUST BOARD**
**29 May 2014**

| | |
|---|---|
| **Title** | Medical Director's Quality Report |
| **Agenda item** | 8 |
| **Sponsoring Director** | Dr Mike Wilkinson, Interim Medical Director |
| **Author(s)** | Natasha Robinson, Associate Medical Director<br>Christine Ainsworth, Senior Quality, Risk & Litigation Manager |
| **Purpose** | This report updates the Committee on the Mortality & Serious incidents reported, the current status of open investigations and details of incidents closed during the reporting period |

**Executive summary:**

- Sustained improvement in HSMR at 88
- SHMI no longer outwith the expected range
- Recent review of 50 deaths completed and to be distributed to directorates and CCG.
- Next review to commence in next few months
- 12 new Serious Incidents were reported & 10 Serious Incidents were submitted for closure
- 60% of Serious Incidents this month were reported on STEIS within 2 working days; compared to 0% in October, November, December 2013
- There were no requests for extensions and all Serious Incident reports were submitted within the 45 day timeframe
- NRLS Data published April 2014:
    - NGH is just below the top quartile of reporters with a reporting rate of 8.27 per 100 admissions compared to the median reporting rate for medium acute organisations of 7.23 per 100 admissions.
    - 0.5% of incidents reported by NGH resulted in severe harm or death compared to just under 1% nationally.
    - This represents a positive risk profile with a high number of patient safety incidents being reported and a low number of severe harm incidents.

- All action plans produced during the reporting period have been reviewed by the Serious Incident Group and uploaded to HealthAssure. Actions are being monitored by the Care Group Governance Managers

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

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| | |
|---|---|
| **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**<br><br>Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? **N** |
| **Legal implications / regulatory requirements** | Compliance with CQC regulations (Patient safety) and commissioner requirements through mandatory contract. |

**Actions required by the Trust Board**

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

**Trust Board**
**29 May 2014**

# Medical Director's Quality Report

**Review of current mortality and safety data provided by Dr Foster**

## 1. Introduction

This paper provides a brief summary of mortality and safety information provided by Dr Foster Intelligence to end February 2014 and SHMI (to September 2013). Overall improvement is sustained and there have been no new areas of significant concern to investigate. A programme to roll out specialty specific dashboards for use by clinicians and managers in each directorate is underway to enable improved local ownership of performance data.

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

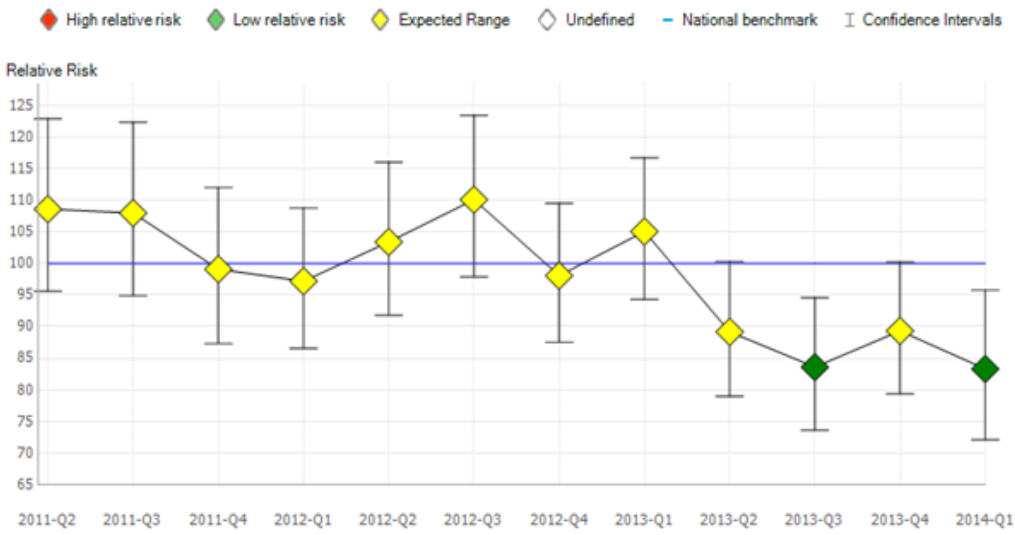
HSMR was developed as a tool to assist hospitals in monitoring mortality, and debate as to its appropriate use continues. It is based on mortality in 56 CCS (Clinical Classification Software) groups. These diagnosis groups account for 80% of hospital mortality and are recognised as having reliable predictive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

At NGH there is a detailed monitoring process which tracks HSMR and investigates individual diagnoses whose SMR (standardised mortality ratio) is persistently adverse. Where the term HSMR is used this refers to the previously defined group. Where all groups are included, the term HSMR 100 is used. The Trust systematically investigates all such areas of concern for both clinical care and data quality (including clinical coding). Where adverse performance is persistent detailed reviews of the information and individual cases are presented and discussed at Mortality & Coding Review Group, a multidisciplinary group chaired by the MD and to be attended by a representative from CCG.

The Board should note that the expected mortality for any given condition cannot take into account the severity of that condition in an individual patient at presentation, but is based on the diagnosis, age, presence of other conditions (comorbidities) and any surgical procedures carried out. Hospital mortality rates are also known to reflect local community and primary care provision. A high standard of care in the community may have a confounding effect on admissions, reducing numbers such that only the highest risk cases are admitted to hospital. Equally, lack of access to primary care may also mean that patients present late to hospital in a more serious condition. This is of particular relevance when considering differential survival rates in those admitted during the week and at weekends [see later]

The model relies on accuracy of clinical coding, and as it is comparative, local performance may also reflect variation in coding practice in other organisations. Northampton General Hospital Trust has previously included 3 community sites until March 2014. Current data reflects this position, and historical data will continue to do so. However from July 2014 data will be released reflecting activity from April 2014 on NGH site only. It is possible to monitor HSMR performance for each site, and is helpful to be able to monitor historical performance on the acute site without any confounding impact from the community wards.

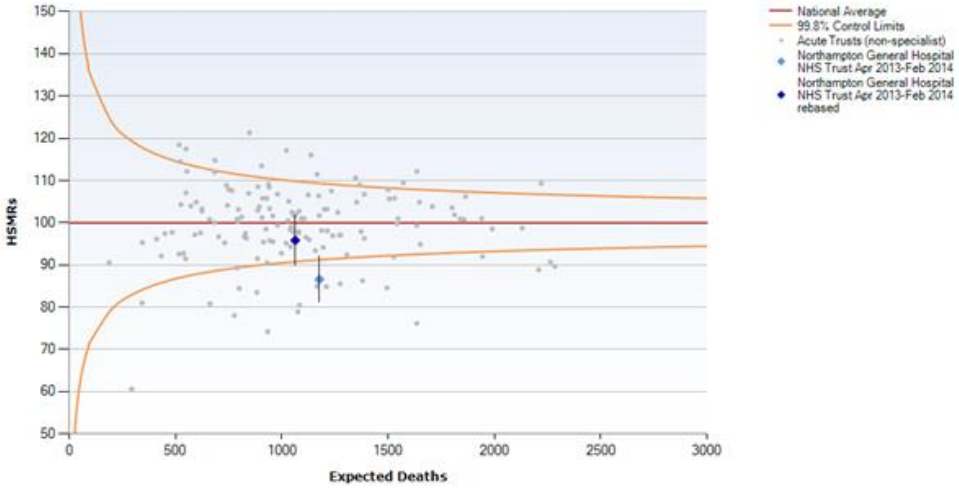
The following graph shows the sustained improvement in HSMR by quarter since 2011:




### 3. HSMR Comparison

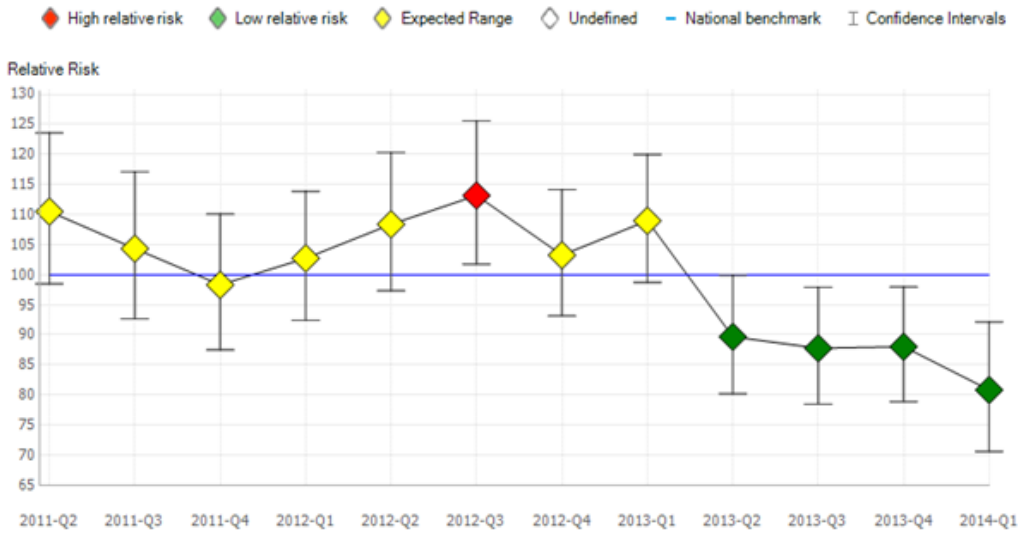
The purpose of the HSMR comparison report is to enable acute Trusts to monitor their HSMR throughout the year and compare against the changing national picture. This is especially important when death rates are falling nationally and the benchmark is continuously falling, as is currently the case. Dr Foster currently re-benchmarks annually in arrears, but will shortly change to real-time rebenchmarking.

The light blue diamond reflects our current position, the dark blue our projected end of year position once rebased to reflect overall England performance in 2013-4. There has already been a substantial countrywide fall in mortality of 9 points since 2012-3, following a winter of unexplained high mortality in 2012-3. NGH HSMR for the rolling year to date is **88** and for 2013-4 is **87** (**96** when rebased). Crude mortality for 2013-4 is currently 3.6%, showing sustained improvement as compared to 2012-3 (4.2%) and one of the 3 lowest in East Midlands. The current average for Trusts in East Midlands is 3.8% (range 3.2% - 4.8%)



**4. Standardised Hospital Mortality Indicator (SHMI)**
There has been a further SHMI data release since the last report to Board. The most recent data release (to end September 2013) shows SHMI for the rolling year to be at **110,** a noticeable fall from the previous **112.9** and no longer outwith the 'expected' range. Due to public concerns surrounding the use of care data, the HSCIC is not releasing the raw data behind this figure, and so neither the quarterly value for Q2 2013-14 nor the trend graph [supplied by Dr Foster] is available. It is hoped that this position will change over the next month.

HSMR for the same period was **95 .** The marked divergence between the 2 remains of concern particularly because SHMI data is not easily available for further analysis to identify areas of poor performance. As later described, it is likely that the some of the discrepancy can be attributed to the lack of allowance in SHMI for palliative care for the hospice admissions to the community wards, and the less discriminating methodology used by SHMI which includes all CCS groups. For this reason SHMI more closely tracks HSMR 100, and so is expected to continue to show very marked improvement over the next 2 quarters. The graphs below shows HSMR 100 to end February 2014, which suggests that SHMI for 2013 will fall further and thus remain within 'expected' limits and become close to average by the end of 2013-2014.

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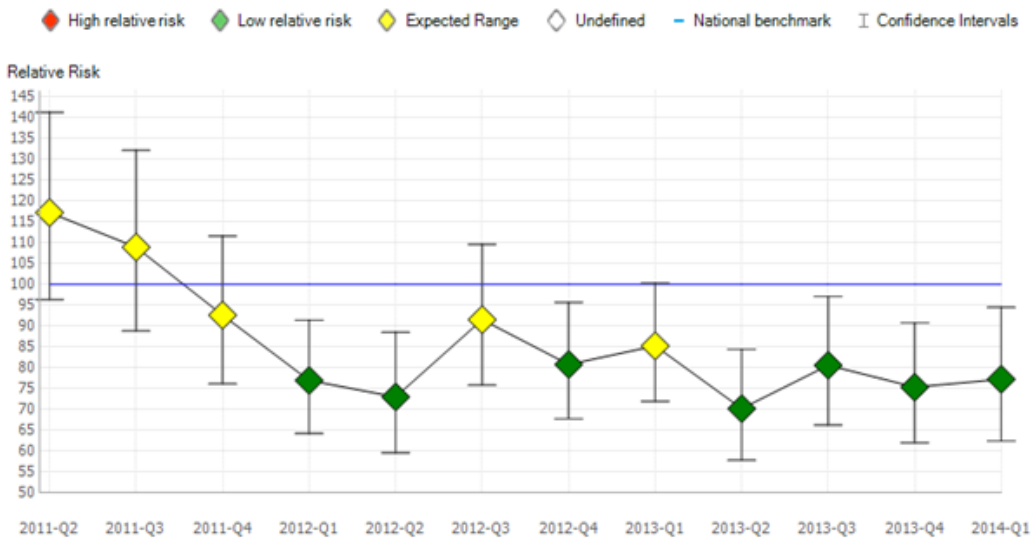
**5. Patient Safety Indicators**

| Indicator | Volume | Observed | Expected | Observed Rate/K | Expected Rate/K | Relative Risk |
|---|---|---|---|---|---|---|
| Deaths in low-risk diagnosis groups * | 38,265 | 26 | 30.2 | 0.7 | 0.8 | 86 |
| Decubitus Ulcer | 9,599 | 299 | 323.0 | 31.1 | 33.7 | 93 |
| Deaths after Surgery | 368 | 47 | 46.1 | 127.7 | 125.3 | 102 |
| Infections associated with central line * | 15,930 | 1 | 1.1 | 0.1 | 0.1 | 94 |
| Postoperative hip fracture * | 24,960 | 4 | 1.5 | 0.2 | 0.1 | 258 |
| Postoperative Haemorrhage or Haematoma | 23,571 | 12 | 14.1 | 0.5 | 0.6 | 85 |
| Postoperative Physiologic and Metabolic Derangement * | 19,846 | 4 | 1.6 | 0.2 | 0.1 | 249 |
| Postoperative respiratory failure | 18,010 | 24 | 16.4 | 1.3 | 0.9 | 146 |
| Postoperative pulmonary embolism or deep vein thrombosis | 23,754 | 29 | 45.4 | 1.2 | 1.9 | 64 |
| Postoperative sepsis | 562 | 3 | 3.9 | 5.3 | 6.9 | 77 |
| Postoperative wound dehiscence * | 988 | 0 | 1.4 | 0.0 | 1.5 | 0 |
| Accidental puncture or laceration | 66,333 | 49 | 76.2 | 0.7 | 1.1 | 64 |
| Obstetric trauma - vaginal delivery with instrument * | 450 | 36 | 37.2 | 80.0 | 82.7 | 97 |
| Obstetric trauma - vaginal delivery without instrument * | 2,513 | 103 | 96.4 | 41.0 | 38.4 | 107 |
| Obstetric trauma - caesarean delivery * | 1,158 | 0 | 4.3 | 0.0 | 3.7 | 0 |

There are no significantly adverse patient safety indicators for the rolling year to date.

**6. Reports on key areas for action or of importance**

Aggregate mortality resulting from the 5 high risk diagnosis groups (acute myocardial infarction, stroke, fractured neck of femur, pneumonia and heart failure) is better than expected for 2013-4 at **76**.




**7. Possible areas for concern under investigation**

There have been no further alerts requiring investigation.

The following areas are included in the Trust Dashboard and some additional detail is provided:

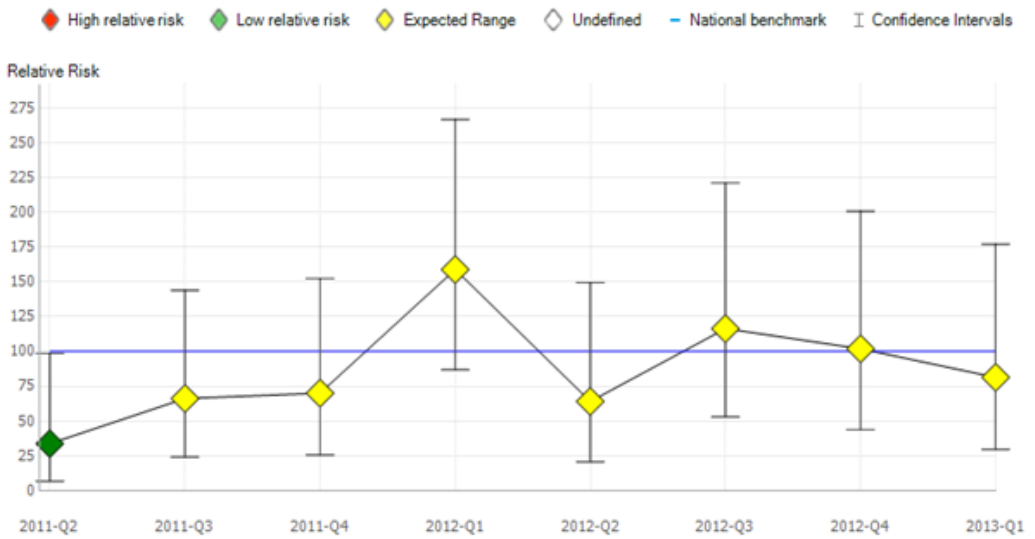
**8. Weekend vs weekday mortality**

There is a national focus on variation in survival in patients admitted as an emergency during the week and over the weekend. NGH data is complex to understand as there appear to be both fewer emergency admissions and fewer deaths in patients admitted at the weekend, suggesting that any adverse effect on survival is potentially more attributable to access to care than to care provided by the hospital. The data for the rolling year to February 2014 is as follows:

| Emergency admission day | HSMR | Crude mortality % | Deaths/day of admission |
|---|---|---|---|
| Weekday | **88** | 7.0 | 165 |
| Weekend | **88** | 7.7 | 148 |

**9. Deaths in low risk conditions**

'Low risk conditions' are defined as those with an overall expected mortality of <1%. However for the individual patient this this may be substantially higher due to comorbidities and extreme age. SMR for the rolling year to February 2014 is **86,** and the trend is shown below:




**10. Readmissions within 28 days of discharge**

This metric measures emergency readmissions following any discharge, and for whatever diagnosis. Data is available from Dr Foster only until November 2013. SRA is currently **104**, showing a distinctly different pattern in adults and children [December 2012- November 2013]

| | Discharges | Readmissions | Expected | Relative Risk |
|---|---|---|---|---|
| Adults | 80740 | 1670 | 1309 | **98** |
| Children | 14808 | 5369 | 5472 | **128** |

**11. Areas of general relevance with respect to overall Trust performance**

**Palliative Care**

Provision of care by a specialist palliative care team on or during admission has improved both at NGH and elsewhere in England over the last year. There has been a simultaneous improvement in the coding for these episodes. A significant casemix adjustment is made when a palliative care code is applied, which takes into account the increased likelihood of death for that patient. This is only true for HSMR and not SHMI, and is one of several significant differences between the 2 metrics. The use of case-mix adjustment for palliative care is currently under review by Dr Foster and it is possible that it will be amended or discontinued, which may impact on HSMR at NGH in the future. There will also be a separate change in data from April 2014 onwards due to the loss of designated palliative care beds at Danetre Hospital, and the overall effect on the future HSMR is difficult to predict accurately.

**12. Crude Mortality**

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

**13. Further actions in place or planned**

The final report following the Trustwide notes review (50 sets) is with the Medical Director and will be made available to the Board in due course. It will be distributed in summary to the directorate mortality review groups and CCG, and will be used to inform the programme of work of the Patient Safety Teams for 2014-2015. The next review [50 deaths in December 2013] is due to start shortly and will include senior nurses and >20 consultant volunteers across all specialties.

**14. Data Quality**

The Data Quality Group met on 12 May 2014. The Quality Dashboard [attached] is being refined for accuracy and relevance. Coding department are running regular reports to identify common coding errors for amendment before submission of SUS data**.** These audits will be available for this report in future.

The monthly distribution of mortality information to consultants is resulting in increasing involvement by clinicians in correcting perceived data quality concerns.

**15. Learning form Serious Incidents**

**Serious incidents reported**

- Within the reporting period 01 – 30 April 2014, 12 new Serious Incidents have been reported.
- The following table illustrates the Serious Incidents by Datix category:

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

Enclosure E

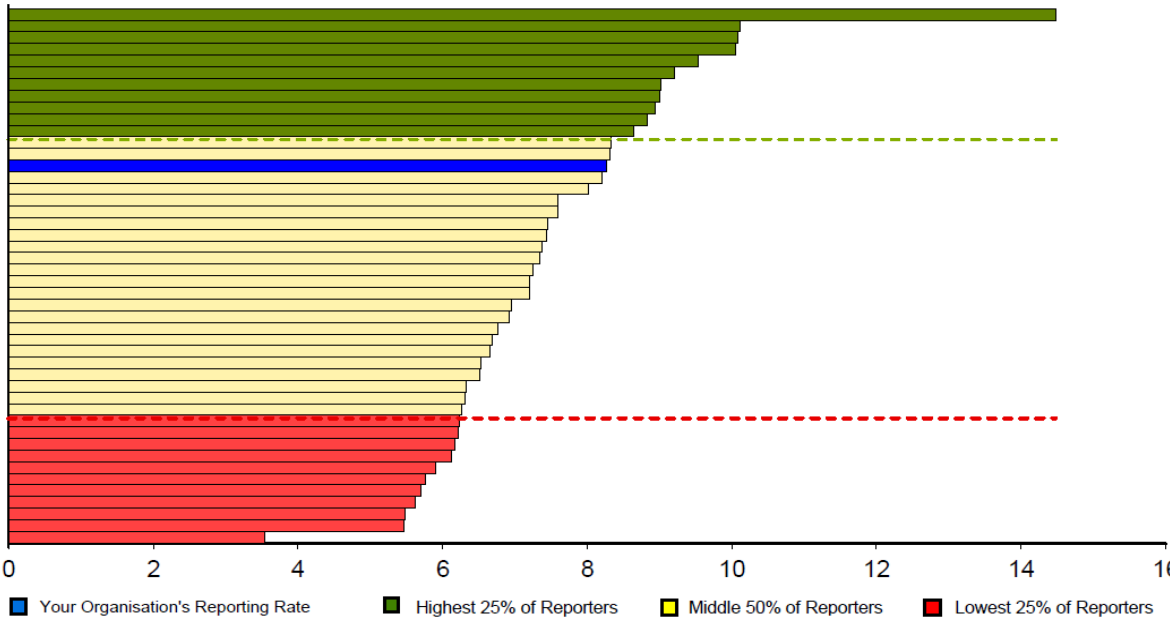
**Closed Serious Incidents**
During the reporting period at total of 10 incidents were submitted to Nene and Corby Clinical Commissioning Group (CCG) for closure as follows:

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

**NRLS Data: 1 April 2013 – 30 September 2013**
The National Reporting & Learning Service (NRLS) have just published the latest 6 month data for incidents which were reported between 1 April 2013 and 30 September 2013.

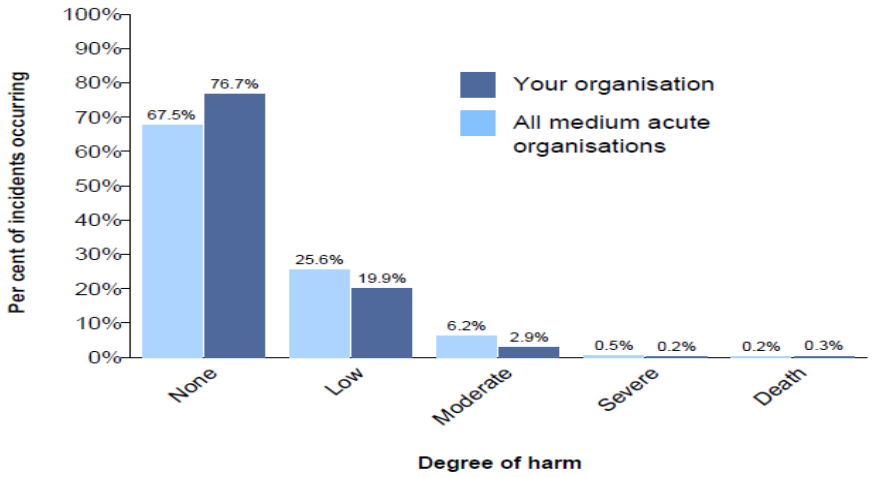
The comparative reporting rate summary below provides an overview of incidents reported by NGH compared to 45 other medium acute organisations. Figure 1 demonstrates that NGH is just below the top quartile of reporters with a reporting rate of 8.27 per 100 admissions compared to the median reporting rate for this cluster of 7.23 per 100 admissions. The NRLS report states that an organisation that reports more incidents usually has a better and more effective safety culture. The Governance team will continue to promote the reporting of all incidents and 'near misses' in order to maximize the opportunities for learning.

**Figure 1: Comparative reporting rate, per 100 admissions, for 46 medium acute organisations.**




Nationally, 68% of incidents are reported as no harm and less than 1% as severe harm or death. The table below illustrates the number of incidents reported by NGH to the NRLS by degree of harm. 0.5% of incidents reported by NGH resulted in severe harm or death. This represents a positive risk profile with a high number of patient safety incidents being reported and a low number of severe harm incidents.

**Figure 3: Incidents reported by degree of harm for medium acute organisations**




| Your figures: | None | Low | Moderate | Severe | Death |
|---|---|---|---|---|---|
| | 3,053 | 790 | 115 | 9 | 13 |

The concern that the Serious Incident reporting rate may pose a potential reputational risk to the Trust when the national data is published by the NRLS in September 2014 is no longer considered a risk. It has been confirmed that although pressure damage (Grade 3 and 4) incidents are reported as Serious Incidents they are not classified as severe harm incidents by the NRLS and therefore are not included in the nationally reported data.

Enclosure E

# Trust Board
# 29 May 2014

## Trust Board Quality Scorecard

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

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



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

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

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

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

# Northampton General Hospital NHS Trust Quality Scorecard 2014-15

## Caring

| Indicator | Target | Trend | Feb-14 | Mar-14 | Apr-14 |
|---|---|---|---|---|---|
| Complaints rate per bed days | None | ⇔ | 0.2% | 0.2% | 0.2% |
| Complaints responded to within agreed timescales | 100% | ↓ | 89% | 93% | 76% |
| Friends & Family Test: Inpatient score | None | ⇔ | 71 | 74 | 71 |
| Friends & Family Test: A&E score | None | ⇩ | 74 | 63 | 57 |
| Friends & Family Test: Maternity score | None | ⇧ | 71 | 76 | 80 |
| Mixed Sex Accommodation | 0 | ⇔ | 0 | 0 | 0 |
| Patients in last days of life with a care plan in place | None | | Available from May -14 | | |
| Transfers: All patients moved / transfered out of hours | None | ⇔ | N/Avail | | 116 |
| Transfers: Patients moved ward to ward out of hours | None | ⇔ | N/Avail | | 15 |
| Transfers: Patients moved with a risk assessment completed | None | ⇔ | N/Avail | | 15 |

## Effective

| Indicator | Target | Trend | Feb-14 | Mar-14 | Apr-14 |
|---|---|---|---|---|---|
| Emergency re-admissions within 30 days (adult elective) | None | ⇔ | 3.6% | 4.9% | 4.2% |
| Emergency re-admissions within 30 days (adult non - elective) | None | ⇩ | 7.9% | 8.3% | 9.2% |
| Length of stay - All | None | ⇔ | | | 4.78 |
| Length of stay - Elective | None | ⇔ | | | 2.77 |
| Length of stay - Non Elective | None | ⇔ | | | 5.11 |
| Maternity: C Section Rates - Total | <25% | ⇧ | 24.4% | 29.2% | 27.3% |
| Maternity: C Section Rates - Emergency | <14% | ↓ | 11.4% | 16.8% | 16.4% |
| Maternity: C Section Rates - Elective | <10% | ⇧ | 12.9% | 12.4% | 10.9% |
| Mortality: SHMI* | Within expected range | ⇧ | | | 109.8 |
| Mortality: HSMR** | | ⇔ | | 89 | 88 |
| Mortality: HSMR - Weekend** | | ⇔ | | | 88 |
| Mortality: HSMR - Week day** | | ⇔ | | | 89 |
| Mortality: Low risk conditions** | | ⇔ | | | 86 |
| Mortality: Maternal Deaths | 0 | ⇔ | 0 | 0 | 0 |
| NICE compliance | 80% | ⇧ | 81.6% | 81.1% | 96.5% |
| Number of patients cared for in an escalation area | None | ⇧ | 109 | 115 | 148 |
| # NoF 36 hours | 100% | ⇧ | 75.0% | 85.7% | N/A |
| Percentage of patients cared for outside of specialty | None | ⇔ | 12.4% | 11.6% | 12.2% |
| Stroke patients spending at least 90% of their time on the stroke unit | 80% | ⇧ | 82.0% | 63.0% | 88.4% |
| Suspected stroke patients given a CT within 1 hour of arrival | 50% | ⇧ | 43% | 49% | 62% |

## Safe

| Indicator | Target | Trend | Feb-14 | Mar-14 | Apr-14 |
|---|---|---|---|---|---|
| C-Diff | Max 2.9 p/mth | ⇔ | 1 | 2 | 1 |
| Dementia: Case finding | 90% | ⇔ | 91.1% | 90.7% | 90.7% |
| Dementia: Initial diagnostic assessment | 90% | ⇔ | 100.0% | 95.5% | 100.0% |
| Dementia: Referral for specialist diagnosis/Follow-up | 90% | ⇔ | 90.5% | 95.0% | 95.2% |
| Falls per 1,000 occupied bed days | None | ⇔ | 5.5 | 5.9 | 5.4 |
| Harm Free Care (Safety Thermometer) | 93% | ⇩ | 91.1% | 91.6% | 90.4% |
| Medical Notes: Availability for clinics*** | 99% | | 99.1% | N/A | N/A |
| Medical notes: Documentation - Doctors | 95% | | | | 64.0% |
| Medical notes: Documentation - Nurses | 95% | | | | 57.4% |
| Medical notes: Documentation - Allied Health | 95% | | | | 71.5% |
| Medication errors causing serious harm | None | ⇔ | | | 26 |
| MRSA | 0 | ⇧ | 1 | 0 | 0 |
| Never event incidence | 0 | ⇔ | 0 | 0 | 0 |
| Pressure Ulcers: Total grade 3 & 4 (incidence) | None | ⇩ | 6 | 8 | 11 |
| Pressure Ulcers: Avoidable grade 3 & 4 (incidence) | None | ⇩ | 3 | 7 | 6 |
| Pressure Ulcers: Unavoidable grade 3 & 4 (incidence) | None | ⇩ | 3 | 1 | 5 |
| Open Serious Incidents Requiring Investigation (SIRI) | None | ⇔ | 9 | 12 | 12 |
| Open CAS alerts | 0 | ⇔ | 0 | 0 | 0 |
| TTO's sent by taxi | 0 | ⇔ | 0 | 0 | 0 |
| UTI with Catherters (Safety Thermometer-Percentage new) | 0.4% | ⇧ | 0.9% | 0.6% | 0.3% |
| VTE Risk Assessment | 95% | ⇔ | 97.7% | 97.2% | 97.4% |

## Responsive

| Indicator | Target | Trend | Feb-14 | Mar-14 | Apr-14 |
|---|---|---|---|---|---|
| A&E: Proportion of patients spending more than 4 hours in A&E | 95% | ⇧ | 81.2% | 90.4% | 92.3% |
| A&E: 12 hour trolley waits | 0 | ⇔ | 0 | 0 | 0 |
| Diagnostics: Number of patients waiting more than 6 weeks for a diagnostic test | 0 | ⇔ | 0 | 0 | 0 |
| Discharge: Number of medically fit patients awaiting discharge | None | ⇧ | | 320 | 317 |
| Cancer: Percentage of 2 week GP referral to 1st outpatient appointment | 93% | ↓ | 93.4% | 90.9% | 92.5% |
| Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms | 93% | ⇧ | 58.5% | 86.0% | 94.1% |
| Cancer: Percentage of patients treated within 62 days of referral from screening | 90% | ⇧ | 95.7% | 94.4% | 100.0% |
| Cancer: Percentage of patients treated within 62 days of referral from hospital specialist | 80% | ⇔ | 90.0% | 92.9% | 89.5% |
| Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers | 85% | ⇧ | 75.3% | 79.2% | 79.5% |
| Cancer: Percentage of patients treated within 31 days | 96% | ⇔ | 88.1% | 93.2% | 92.5% |
| Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery | 94% | ⇧ | 86.2% | 100.0% | 96.0% |
| Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug | 98% | ⇧ | 98.4% | 100.0% | 100.0% |
| Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy | 94% | ⇔ | 98.1% | 96.2% | 96.0% |
| Operations: Urgent Operations cancelled for a second time | 0 | ⇧ | 1 | 0 | 0 |
| Operations: Percentage of patients not treated within 28 days of last minute cancellations - non clinical reasons | 0 | ⇔ | 0 | 1 | 1 |
| RTT for admitted pathways: Percentage within 18 weeks | 90% | ⇔ | 93.8% | 95.2% | 94.1% |
| RTT for non- admitted pathways: Percentage within 18 weeks | 95% | ⇔ | 98.3% | 98.6% | 98.6% |
| RTT waiting times incomplete pathways | 92% | ⇔ | 96.5% | 97.1% | 97.3% |
| RTT over 52 weeks | 0 | ⇔ | 0 | 0 | 0 |

## Well Led

| Indicator | Target | Trend | Feb-14 | Mar-14 | Apr-14 |
|---|---|---|---|---|---|
| Friends & Family: NHS England Inpatient response rate | 25% | ⇧ | 40.9% | 47.8% | 33.3% |
| Friends & Family: NHS England A&E response rate | 15% | ↓ | 15.4% | 11.6% | 16.6% |
| Friends & Family: NHS England Maternity response rate | None | ⇩ | 45.1% | 39.9% | 36.6% |
| Data quality of Trust returns to HSCIC (SUS) | None | ⇔ | 89% | 89% | 89% |
| Staff: Percentage of staff that would recommend the trust as a place of work (national) | 59? | ⇔ | | 53 | |
| Staff: Trust turnover rate | 8% | ↓ | 8.9% | 11.8% | 11.5% |
| Staff: Trust level sickness rate | 3.8% | ↓ | 4.2% | 4.2% | 4.3% |
| Staff: Trust level vacancy rate - Doctors | | | | | 6.1% |
| Staff: Trust level vacancy rate - Nurses | | | | | 9.3% |
| Staff: Trust level vacancy rate - Other | | | | | 12.5% |
| Staff: Temporary costs & overtime as a % of total pay bill | None | ⇔ | 10.6% | 9.9% | 12.3% |
| Staff: Percentage of staff with annual appraisal | 85% | ⇧ | 34.5% | 41.7% | 62.8% |
| Staff: Percentage of all trust staff with mandatory training compliance | 85% | ⇧ | 74.7% | 75.5% | 76.9% |
| Staff: Percentage of all trust staff with role specific training compliance | 85% | ⇔ | | | 63.7% |

| Section | Red Rated | Amber Rated | Green Rated | None | Total |
|---|---|---|---|---|---|
| Caring | 1 | 0 | 1 | 8 | 10 |
| Effective | 1 | 1 | 9 | 8 | 19 |
| Safe | 3 | 1 | 12 | 7 | 23 |
| Responsive | 5 | 0 | 13 | 1 | 19 |
| Well-Led | 5 | 1 | 3 | 5 | 14 |
| Total | 15 | 3 | 38 | 29 | 85 |

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

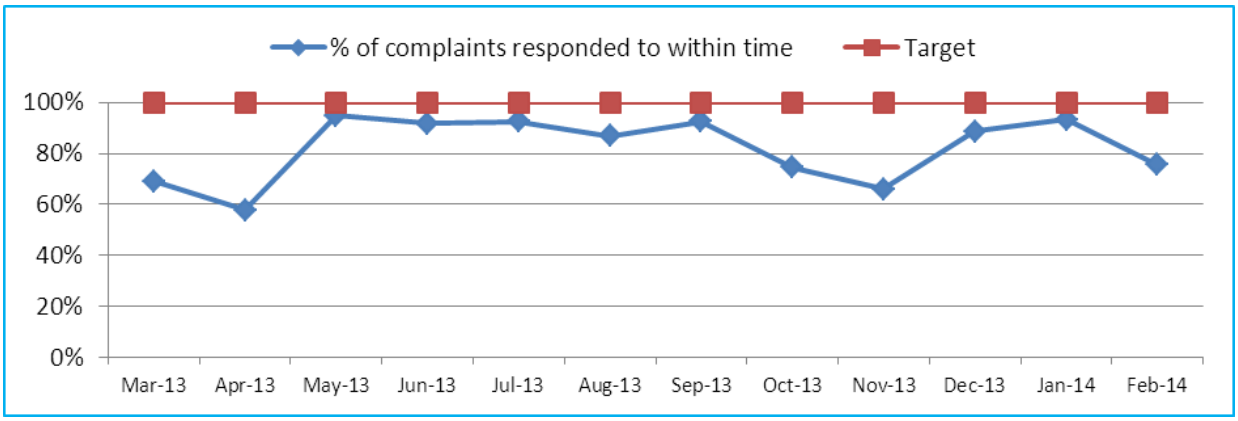
* SHMI October 2012 to September 2013 (published April 2014)
** HSMR Rolling year March 2013 to February 2014
***Currently a manual audit until central reporting is in place - June 2014

# Trust Board Quality Scorecard
# Exception Report

| Target underperformed: | Complaints response rate | Target: | 100% | Report period: | April-14 |
|---|---|---|---|---|---|
| Achieved: | 76% (February 2014 – 40 day response rate) | | | | |

| Driver for underperformance: | Actions to address the underperformance: |
|---|---|
| -A key member of staff left the Trust in early November 2013. The person was replaced but the new person has required training and has understandably worked at a slower pace.<br><br>-As soon as the temporary person left the backlog built up again as the workload cannot be sustained by 2 members of staff.<br><br>-The workload continues to grow due to the ever increasing complexity of complaints, which we report on yearly in the annual complaints report | -Temporary person was employed for 6 weeks to clear the backlog, which was complete<br><br>-Additional 20 hour band 5 recruited – awaiting HR clearances etc…<br><br>-Introduction of 'quiet' days when the complaints officers focus solely on responses without interruption (in place for 1 week at the time of reporting but has worked well to date) |
| **Forecast date (month) for meeting the standard** | **Forecast performance for next reporting period:** |
| July-14 | Most likely the same |
| **Lead for recovery:** | **Lead Director:** |
| Lisa Cooper, Head of Complaints | Jane Bradley, Interim DoN |

## Historical Target Performance




Enclosure E

# Trust Board Quality Scorecard
# Exception Report

| Target underperformed: | Friends & Family Test: A&E score | Report period: | April 2014 |
|---|---|---|---|

| Driver for underperformance: | Actions to address the underperformance: |
|---|---|
| A&E April (without amb care and Eye Casualty) – 48<br><br>A&E March (without amb care and Eye Casualty) - 57<br><br>A&E February (without amb care and Eye Casualty) - 73<br><br>The decline in the FFT score for A&E accumulated (inc ambulatory care and eye casualty) can be largely attributed to the fall in the NPS for A&E.<br><br>It is likely that the score has been largely attributed to the pressures seen within the department.<br><br>There have also been some issues with the response rates with the IPads used to collect data breaking in the month of march meaning the data gained may not be representative of the population. | • Information regarding trends are sent out daily by Matrons and Sisters/NiC for action<br>• Targets are being set daily by the Matron to address the issues with the response rates<br>• Currently reviewing data collection methods to ensure the sample collected is representative<br>• Currently creating a SOP for Matrons and Sisters/NiC to report on any changes which they are making as a result of negative feedback |
| **Forecast date (month) for meeting the standard** | **Forecast performance for next reporting period:** |
| N/A | June 2014 |
| **Lead for recovery:** | **Lead Director:** |
| Rachel Lovesy, Patient Experience Lead | Jane Bradley, Interim Director of Patient & Nursing Services |

## Historical Target Performance

| Indicator | Target | Trend | Feb-14 | Mar-14 | Apr-14 |
|---|---|---|---|---|---|
| Friends & Family Test: A&E score | **None** | ⇩ | **74** | **63** | **57** |

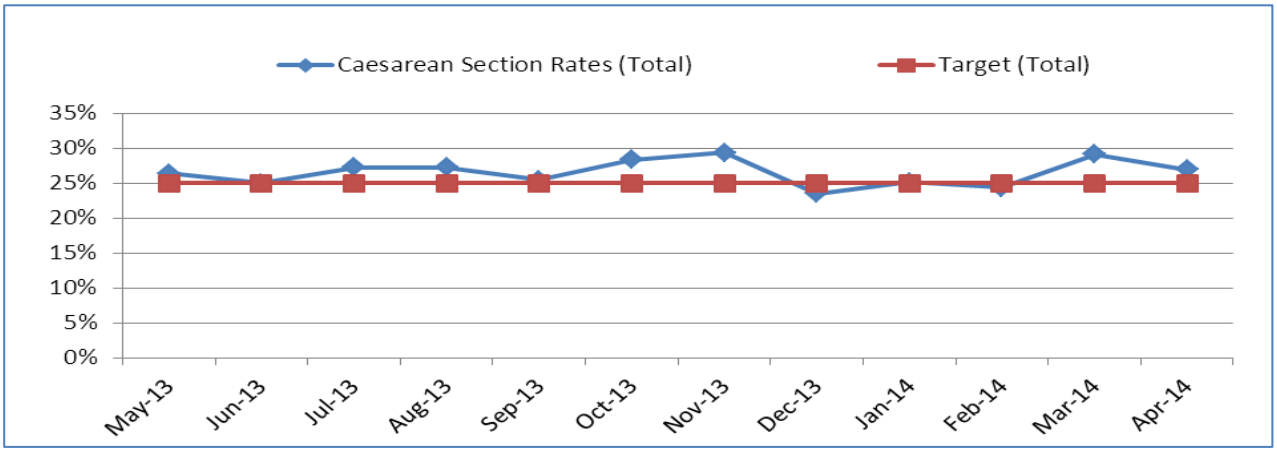
# Trust Board Quality Scorecard

| Target underperformed: | Caesarean Section Rates | Target: | Total <25%, Elective <14%, Non Elective <10% | Report period: | April-14 |
|---|---|---|---|---|---|
| Achieved: | C-Section rates: Total 27.3%, Elective: 16.4%, Non Elective:10.9% | | | | |

| Driver for underperformance: | Actions to address the underperformance: |
|---|---|
| Unexpected increase of emergency caesareans over the past two months. | All caesarean sections are monitored via the maternity dash board and discussed at the monthly obstetric governance meetings.<br><br>The birth after caesarean (BAC) clinic is well established and embedded as usual practice.<br><br>The quarterly audit report continues to demonstrate compliance against NICE guidelines.<br><br>The Barratt Birth Centre opened in December 2013, to encourage and support normal birth. The normal birth rate has increased and sustained over recent months; 63% in April 2014<br><br>The emergency caesareans are being reviewed by the senior obstetric team each morning at the ward round. Compliance report will be reviewed at June governance meeting. |
| Forecast date (month) for meeting the standard | Forecast performance for next reporting period: |
| October 2014 | 27.0% (27.3% this month) |
| Lead for recovery: | Lead Director: |
| Clemens von Widekind | Debbie Needham |

## Exception Report

## Historical Target Performance




Enclosure E

# Trust Board Quality Scorecard
# Exception Report

| Target underperformed: | Pressure Ulcers | Report period: | April 2014 |
|---|---|---|---|

| Driver for underperformance: | Actions to address the underperformance: |
|---|---|
| Documentation-<br>• Lack of pressure ulcer re-assessments in timely manner<br>• Lack of repeated skin assessments.<br>• Lack of evidence of care delivered/implemented.<br>• Transfer information<br><br>High Risk Vulnerable areas – lack of evidence that all areas checked.<br><br>Increasing reporting of device related pressure damage including damage caused by oxygen delivery devices.<br>April<br>• 3 grade 2 PU<br>• 1 Grade 3 PU<br><br>Knowledge –<br>• Identification of at risk patients<br>• Skills to stage/grade pressure damage<br>• Knowledge in risk factors | Documentation –<br>• Redesigning documentation, including plan of care which will encompass daily evaluation of SSKIN bundle.<br><br>Skin inspections-<br>• Stickers designed as short term solution to ensure Skin assessments all patients with Risk score of 15+ are performed at least once per shift. These will discontinue once new documentation rolled out across trust.<br><br>Device related damage-<br>• Introduction of pressure redistribution Pads (Aderma) across trust.<br>• Evaluation of new oxygen delivery devices.<br><br>Knowledge-<br>• Multiple class room based training<br>• 1:1, bedside training<br>• Each ward now has identified TV Buddy, for ward based training, RCA guidance, facilitate with ward action plan on pressure ulcer reduction, attendance of ward meetings/safety huddles. |
| **Forecast date (month) for meeting the standard** | **Forecast performance for next reporting period:** |
| | |
| **Lead for recovery:** | **Lead Director:** |
| Fiona Barnes, Deputy Director of Patient & Nursing Services | Jane Bradley, Interim Director of Patient & Nursing Services |

## Historical Target Performance

| Indicator | Target | Trend | Feb-14 | Mar-14 | Apr-14 |
|---|---|---|---|---|---|
| Pressure Ulcers: Total grade 3 & 4 | None | ⇩ | 6 | 8 | 11 |
| Pressure Ulcers: Avoidable grade 3 & 4 | None | ⇩ | 3 | 7 | 6 |
| Pressure Ulcers: Unavoidable grade 3 & 4 | None | ⇩ | 3 | 1 | 5 |

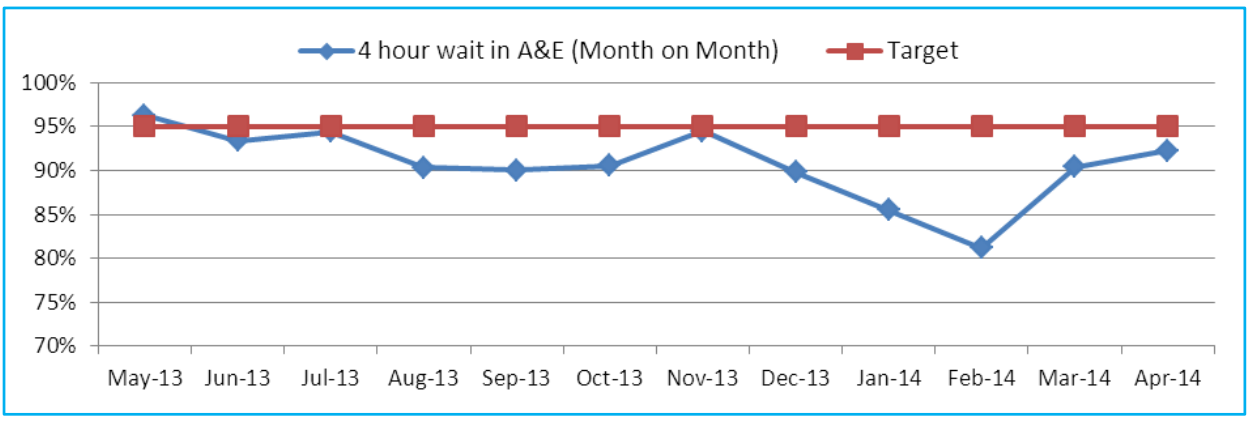
# Trust Board Quality Scorecard
# Exception Report

| Target underperformed: | A&E 4 hours | Target | 95% | Report period: | April-14 |
|---|---|---|---|---|---|
| Achieved | 92.3% | | | | |

| Driver for underperformance: | Actions to address the underperformance: |
|---|---|
| 1. Volume of patients attending ED and subsequent quantity of admissions<br>2. Delays discharging patients with complex needs<br>3. Lack of flow throughout the Trust | • Working with Urgent Care Working Group South on admission avoidance to reduce ED pressures.<br>• Introduction of IC24 in ED – streaming nurse and GP at front door<br>• Implemented FIT (fast intervention) into ED<br>• Improved speciality referral response processes<br>• Daily Discharge to Assess meetings<br>• Daily Delayed Transfer of Care meetings<br>• Daily Community MDT meetings<br>• Twice daily Clinical Safety Huddle<br>• Improved structure of the Urgent Care Programme |
| Forecast date (month) for meeting the standard | Forecast performance for next reporting period: |
| June 2014 | 94.30% |
| Lead for recovery: | Lead Director: |
| Urgent Care Programme Leads | Deborah Needham |

Enclosure E

## Historical Target Performance

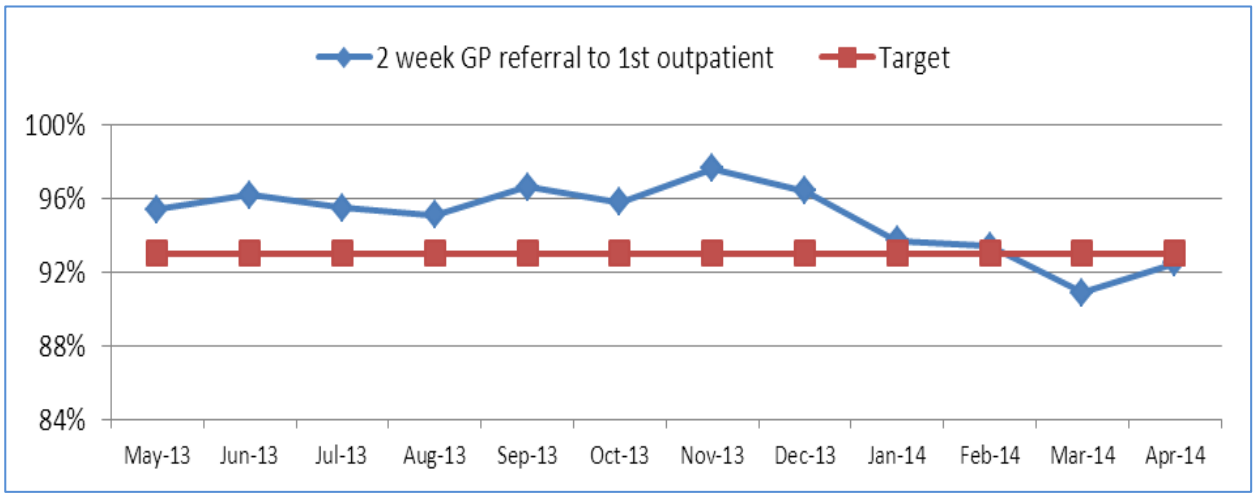


# The Overall Trust Board Quality Scorecard
# Exception Report

| Target underperformed: | Cancer Waiting Times 2 week wait | Target: | 93% | Report period: | April-14 |
|---|---|---|---|---|---|
| Achieved | **92.5%** | | | | |

| Driver for underperformance: | Actions to address the underperformance: |
|---|---|
| • Capacity Issues<br>• Patient availability for appointments | The 2ww referral breaches have been reviewed and the breach reasons identified.<br><br>A communication was sent out to the CCG requesting that they ensured patients were available not only for the 2ww appointment but also the 62 day pathway.<br><br>All internal clinic capacity concerns are being escalated to the teams and service managers where more slots are required than the allocated number for 2ww patients. |
| **Forecast date (month) for meeting the standard** | **Forecast performance for next reporting period:** |
| May-2014 | 93% |
| **Lead for recovery:** | **Lead Director:** |
| Tracey Harris | Chris Pallot |

## Historical Target Performance

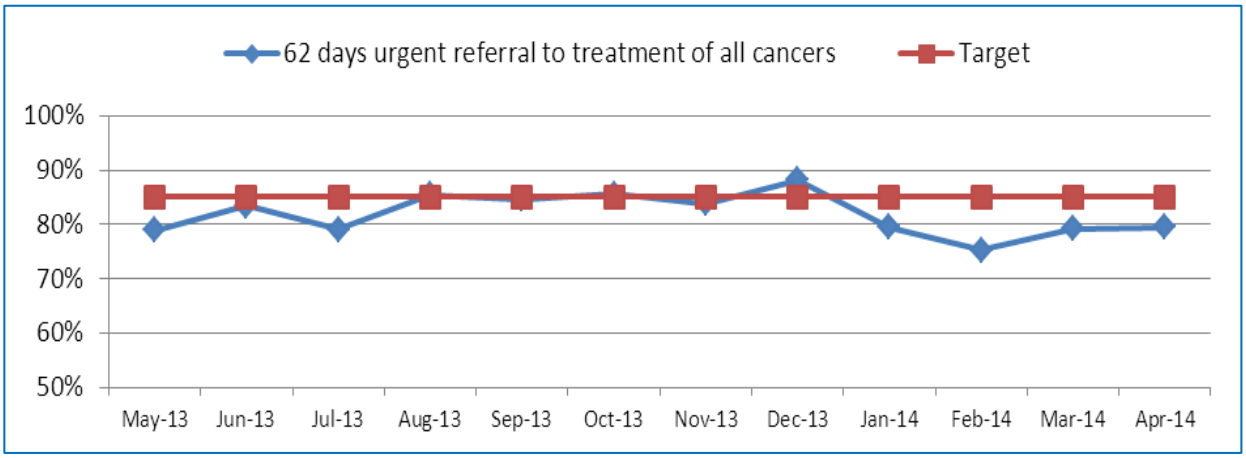


# Trust Board Quality Scorecard
# Exception Report

| Target underperformed: | Cancer Waiting Times 62 day | Target: | 85% | Report period: | April-14 |
|---|---|---|---|---|---|
| Achieved: | **79.5%** | | | | |

| Driver for underperformance: | Actions to address the underperformance: |
|---|---|
| • Reallocation policy not agreed with KGH<br>• Recruitment to oncology positions<br>• Need to agree pre-biopsy MRI pathway for more patients<br>• Joint Clinic for prostate patients<br>• H&N posts based solely at NGH for H&N cancer<br>• Offer MRI/CT within 7 days of referral<br>• Upper GI patients with a suspected cancer on OGD to have a CT on the same day | • Meeting between Chief Operating Officers<br>• Locum and permanent positions being advertised / recruited to.<br>• Urology pathway to be reviewed again as part of the cancer board.<br>• Review job plan of oncologist<br>• Rebecca Brown to lead on H&N surgical review<br>• Review of radiology capacity<br>• Request meeting with radiology to discuss how to implement this. |
| **Forecast date (month) for meeting the standard** | **Forecast performance for next reporting period:** |
| June 2014 | 85% |
| **Lead for recovery:** | **Lead Director:** |
| Tracey Harris | Chris Pallot |

## Historical Target Performance



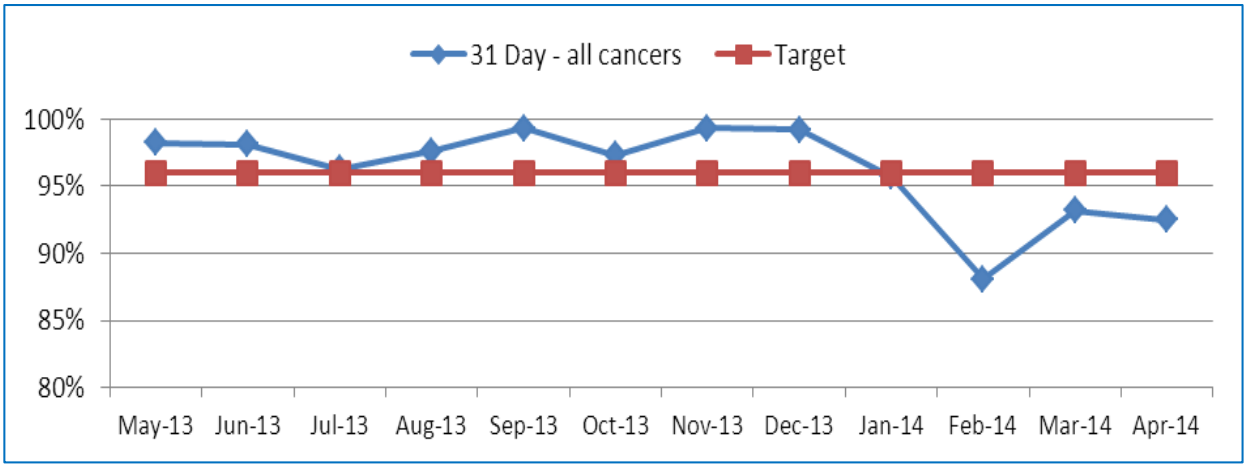

Enclosure E

# Trust Board Quality Scorecard
# Exception Report

| Target underperformed: | Cancer Waiting Times 31 Day | Target: | 96% | Report period: | April-14 |
|---|---|---|---|---|---|
| Cancer: 31 Day: achieved – **92.5%** | | | | | |

| Driver for underperformance: | Actions to address the underperformance: |
|---|---|
| • Administrative error for skin tumour site<br>• Capacity issues | The Trust had 9 breaches on a standard that can only tolerate 6.<br><br>Six of the breaches were from the skin tumour site. Two of these patients had surgery prior to their 62 day target date but were not booked within the 31 day date.<br><br>Communication has been sent out to the dermatology team, skin MDT Coordinator / tracker and plastics team to ensure patients with an SCC are booked in within 31 days of the decision to treat date. |
| **Forecast date (month) for meeting the standard** | **Forecast performance for next reporting period:** |
| June 2014 | 96% |
| **Lead for recovery:** | **Lead Director:** |
| Tracey Harris | Chris Pallot |

## Historical Target Performance



# Trust Board Quality Scorecard
# Exception Report

| Target underperformed: | Data quality of Trust returns to HSCIC (SUS) | Report period: | April 2014 |
|---|---|---|---|

| Driver for underperformance: | Actions to address the underperformance: |
|---|---|
| This is a new measure and is currently based on the National SUS Quality dashboard with the scoring based on matching the national average.<br><br>Clarity is required as to why some areas are not being adequately recorded.<br><br>A key area identified is the capture of patient information in A&E relating to NHS number and GP. | A suite of reports are currently being developed to flag records with key fields not recorded, including, NHS number, GP and consultant.<br><br>The results of these reports will be added to the data quality dashboard and reported monthly at the Data Quality Steering Group.<br><br>Actions will be identified and monitored by this group with specific action groups established as necessary via the Data Quality Working Group. |
| **Forecast date (month) for meeting the standard** | **Forecast performance for next reporting period:** |
| N/A | 90% |
| **Lead for recovery:** | **Lead Director:** |
| Sean McGarvey | Chris Pallot |

Enclosure E

# The Overall Trust Board Quality Scorecard
# Exception Report

| Target underperformed: | Trust turnover rate | Target | <8% | Report period: | April-14 |
|---|---|---|---|---|---|
| Achieved | 11.5% | | | | |

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

# The Overall Trust Board Quality Scorecard
# Exception Report

| Target underperformed: | Trust sickness rate | Target | <3.8 | Report period: | April-14 |
|---|---|---|---|---|---|
| Achieved | 4.3% | | | | |

| Driver for underperformance: | Actions to address the underperformance: |
|---|---|
| The total sickness absence rate within Facilities increased in April to 5.29%.<br><br>An increase in short term sickness in the Porters Department is being addressed by management with HR support.<br><br>Medical Records continues to have a high sickness rate at 8.84%, much of this in April being caused by a high incidence of short term sickness; 18 employees were off, 7 of which had gastro-intestinal problems.<br><br>Medical & Dental staff sickness absence increased slightly by 0.05% to 1.65% in April 2014 | All employees hitting sickness absence trigger points are being actively managed in line with trust policy. |
| **Forecast date (month) for meeting the standard** | **Forecast performance for next reporting period:** |
| | |
| **Lead for recovery:** | **Lead Director:** |
| Andrea Chown | Janine Brennan |

Enclosure E

# The Overall Trust Board Quality Scorecard
# Exception Report

| Target underperformed: | Appraisals | Target | 85% | Report period: | April 2014 |
|---|---|---|---|---|---|
| Performance: Trust compliance with exception of Medical Staff – 62.81% | | | | | |

| Driver for underperformance: | Actions to address the underperformance: |
|---|---|
| Different appraisal processes in recent years have led to limited information being provided to the L&D Department on in-date appraisals. | On-going Appraisal audit, where evidence of in-date appraisals is seen and entered onto ESR<br><br>All staff should have an in-date appraisal and will need to have a further review aligned to incremental dates as per the new appraisal process. |
| **Forecast date (month) for meeting the standard** | **Forecast performance for next reporting period:** |
| August 2014 | 66% |
| **Lead for recovery:** | **Lead Director:** |
| Sandra Wright | Janine Brennan |

# The Overall Trust Board Quality Scorecard
# Exception Report

| Target underperformed: | Mandatory Training | Target | 80% | Report period: | April 2014 |
|---|---|---|---|---|---|
| Achieved: | Doctors 53.8% Nursing & other clinical 80.2% Admin & Support 78.5% | | | | |

| 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.<br><br>Mandatory Training Review in 2013 reduced subjects and proposed target of compliance to be 75% which was achieved in March 2014 therefore target was increased to 80% to be achieved by October 2014 and 85% in March 2015 as per the Quality Schedule | New Appraisal process will encourage uptake of Mandatory training by requiring staff to have in-date training in order to incrementally progress.<br><br>All subjects to have workbook, e-learning, face-to-face and RoK sessions, thereby providing sufficient capacity.<br><br>Encourage A&C roles to access e-learning or workbook. |
| **Forecast date (month) for meeting the standard** | **Forecast performance for next reporting period:** |
| October 2014 | 77.4% (76.9% in April) |
| **Lead for recovery:** | **Lead Director:** |
| Sandra Wright | Janine Brennan |

Enclosure E

# The Overall Trust Board Quality Scorecard
# Exception Report

| Target underperformed: | Mandatory Role Specific Training | Target | 75% | Report period: | April 2014 |
|---|---|---|---|---|---|
| Performance: Doctors | 47.1% | Nursing & other clinical | 68.4% | Admin & Support | 51.5% |

| Driver for underperformance: | Actions to address the underperformance: |
|---|---|
| Proposed target of compliance agreed as 75% by August 2014 and 85% in March 2015 as per the Quality Schedule<br><br>Scoping exercise incomplete on which roles need to do which training therefore limited assurance about the reports.<br><br>Inaccuracies with data which is input into OLM and then not reported upon by ESR. | Scoping and amending OLM and ESR to ensure that reports are generated to reflect who needs to<br><br>Continued dialogue with ESR and McKesson and increased scrutiny of reports, escalating issues where found.<br><br>Mandatory & Role Specific Essential Performance Wave – providing assurance to senior managers when staff will achieve the required compliance levels |
| **Forecast date (month) for meeting the standard** | **Forecast performance for next reporting period:** |
| August 2014 | Trust overall percentage 66.5% (63.7% April) |
| **Lead for recovery:** | **Lead Director:** |
| Sandra Wright | Janine Brennan |

Northampton General Hospital NHS
NHS Trust

**REPORT TO: TRUST BOARD**
**29 May 2014**

| | |
|---|---|
| **Title** | Hard Truth Commitments regarding the Publishing of Staffing Data |
| **Agenda item** | 9 |
| **Sponsoring Director** | Mrs Jane Bradley, Interim Director of Nursing, Midwifery & Patient Services |
| **Author(s)** | Mrs Jane Bradley, Interim Director of Nursing, Midwifery & Patient Services |
| **Purpose** | To inform the Board of the implementation and requirements set out by the National Quality Board (NQB) of the Hard Truths Commitments. |

**Executive summary**

The National Quality Board published a document in November 2013, which outlined 10 expectations in relation to nursing and midwifery staffing (How to ensure the right people, with the right skills, are in the right place at the right time). The following mile stones for the above expectations have been achieved**:**

- Capability is reviewed and reported to board six monthly using an evidence based tool.
- Staffing deployed for each shift compared to what has been planned is displayed at ward level and is visible by patients and carers.

As of July 2014 a monthly report containing details of planned and actual staffing on a shift by shift basis at ward level for the previous month will be presented to board – Hard Truths Commitments.

The monthly report will also be published on the Trust website this report will also be uploaded and be available on the trusts webpage for NHS choices.

The CQC already incorporates information on staffing in its intelligent monitoring system and will consider how the national staffing indicator might be incorporated in due course.

| | |
|---|---|
| **Related strategic aim and corporate objective** | Strategic Aim 1: Focus on Quality and Safety.<br>To be an organisation focussed on quality outcomes, effectiveness and safety |
| **Risk and assurance** | Does the content of the report present any risks to the Trust or consequently provide assurances on risks -<br>**YES, reputational risk** |
| **Related Board Assurance Framework entries** | BAF 4 and 6 |
| **Equality Impact Assessment** | Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (Y/N)<br>**NO**<br>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)<br>**NO** |

Enclosure F

| | |
|---|---|
| **Legal implications / regulatory requirements** | Are there any legal/regulatory implications of the paper<br>**NO** |

**Actions required by the Trust Board**

The Board is asked to:

- Note the pending change in reporting staffing data to the board
- Approve the proposed format and information that will be will be published to Support the Hard truths Commitments
- Support the Hard Truth report to be written in an accessible and understandable format for patients and the public and for this report to be available on the Trust website and NHS choices website
- Support recruitment and deployment of staffing capability and capacity required for safe patient care.

Northampton General Hospital NHS
NHS Trust

# Trust Board
# 29 May 2014

## Hard Truth Commitments regarding the Publishing of Staffing Data

**1. Introduction**

Following the Report of the Francis Inquiry and the Berwick Review into Patient Safety, NICE has been asked by the Department of Health and NHS England to produce guidelines on safe staffing capacity and capability in the NHS. The National Quality Board (NQB) has set out the immediate expectations of NHS providers in providing safe staffing levels.

Research demonstrates that staffing levels are linked to the safety of care and that staff shortfalls increase the risk of patient harm and poor quality care. The "Hard Truths Commitments" regarding the publishing of staffing data is one of the government's commitments to make staff capacity and capability on a ward by ward, shift by shift basis more publicly available and clearly displayed at ward level.

Boards must, at any point in time be able to demonstrate to their patients, carers and families, and Commissioners, that robust systems and processes are in place to assure themselves that the nursing, midwifery and care staffing capacity and capability in their organisation is sufficient to deliver safe and effective care.

**2. Body of Report**

With effect from July 2014 the Board will receive a monthly report on staffing capability and capacity that will include the number of actual staff on duty during the previous month compared to the planned staffing levels, the reason for any gaps and the actions being taken to mitigate risks and address ongoing issues will also be provided.

The Board will also receive a six monthly review on staffing capacity and capability which has involved the use of an evidenced based tool and will include:

- The difference between current establishment and recommendations following the use of an evidenced based tool
- The skill mix ratio before the review, and recommendations for after the review
- The difference between the current staffing post and current establishment and details of how this gap is being covered and resourced
- Details of any element of supervisory allowance that is included in the establishment for the ward sisters /charge nurse or equivalent
- Details of work force metrics – for example data on vacancies (short and long term)
- Staff absence, staff turnover or the use of temporary staffing solutions split by bank, agency extra hours and overtime
- Information against key quality and outcome measures will be triangulated with staffing capacity and capability, for example data from the Safety Thermometer, Serious Incidents, Health Care Associated Infections (HCAIs), this will be work in progress.

Enclosure F

A copy of the “Hard Truths” Board Report will also be published on the Trust website and will have a relevant link for the report to be updated on to NHS Choices.
Data alone cannot assure anyone that safe care is being delivered however, research demonstrates that staffing levels are linked to the safety of care and that fewer staff increases the risks of patient safety incidents occurring. Patients and the public will be able to view how the hospitals they are paying for are being run. This information will also inform hospital inspections.

There is no single ratio or formula that can calculate what the defined staffing ratio should be for any clinical area. The objective is to have the right staff, with the right skills, in the right place at the right time. This requires openness and transparency, within organisations and with public and patients.

The staffing data that will be published on the Trust website will be written in a format that is accessible and understandable to patients and public.

Trust boards take full responsibility for the quality of care provided to patients and, as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability.

**3. Recommendations/Resolutions Required**

The Board is asked to:

- Note the pending change in reporting staffing data to the board
- Approve the proposed format and information that will be will be published to Support the Hard truths Commitments
- Support the Hard Truth report to be written in an accessible and understandable format for patients and the public and for this report to be available on the Trust website and NHS choices website
- Support recruitment and deployment of staffing capability and capacity required for safe patient care.

**Jane Bradley**
**Interim Director of Nursing & Midwifery**
**May 2014**

Northampton General Hospital NHS
NHS Trust

# REPORT TO: TRUST BOARD
# 29 May 2014

| | |
|---|---|
| **Title** | Patient Experience Report |
| **Agenda item** | 10 |
| **Sponsoring Director** | Jane Bradley, Interim Director of Nursing, Midwifery and Patient Services |
| **Author(s)** | Rachel Lovesy, Patient Experience Lead |
| **Purpose** | This report is being presented to The Board for Assurance and Information |

**Executive summary**

- No FFT data is contained within this report as data will now be reported one month retrospectively. Aprils data will be contained within Junes report.
- An overview of the changes taking place with Patient and Public Involvement (PPI) and the move to Patient and Public Engagement (PPE) are detailed within the paper
- In addition to this, an overview of the Patient and Public Engagement Network (PPEN) is included.
- The Committee is provided with an update of the Patient Experience and Engagement Strategy
- An overview of the improvement work taking place is included giving an overview of the work streams and the current focus of Noise at Night (N@N)
- A number of national patient experience surveys are taking place within NGH and an update of progress is provided within this paper.

| | |
|---|---|
| **Related strategic aim and corporate objective** | Be a Provider of Quality Care for All our Patients |
| **Risk and assurance** | *Does the content of the report present any risks to the Trust or consequently provide assurances on risks*<br><br>Yes – failure of FFT CQUIN and loss of income |
| **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? (Y/**N**)*<br><br>*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* - **NO** |

**Actions required by the Trust Board**

The Board is asked to:

- Discuss and challenge the content of the report
- Note the changes to the structure of the Patient and Public Engagement (PPE) within the organisation

# Trust Board
# May 2014

# Patient Experience Report

## 1. Overview

The purpose of this report is to update The Board on any Patient Experience related activities being undertaken within the Trust, providing a comprehensive overview of how our patients are experiencing our hospital and any measures being taken to improve, where satisfaction levels are not meeting the Trusts own high standards.

## 2. Friends and Family Test (FFT)

### *2.1 Background*

The Friends and Family Test is currently active in a number of areas within the Trust. The organisation has a national requirement to ask patients to complete the test within A&E, Inpatients and Maternity. The organisation is assessed against a response rate target, for this quarter A&E are required to obtain a response rate of 15% and Inpatient areas 25%. From the responses a Net Promoter Score (NPS) is calculated and reported nationally. The free text comments received are analysed internally for positive, negatives and themes.

### *2.2 The Issue(s)*

*2.2.1 Reporting of data to Trust Board*

Previously, data from the FFT has been reported to IHGC and the Trust Board each month for the previous month. Providing this data has become more challenging as the level of analysis has deepened, particularly with the free text analysis. For this reason the decision has been made to begin reporting the data to IHGC and Trust Board one month behind. Therefore, April's data will be reported in June. This will allow for a higher level of analysis to be undertaken, and where necessary, changes which have been made as a result of the data can be displayed in direct reference to the month in which it was obtained.

## 3. Patient and Public Involvement (PPI) organisational review

### *3.1 Background*

Active and well supported Patient and Public Involvement (PPI) is key to healthcare reform and to achieving a 'patient led NHS'. Over the past 8 years, the Trust has supported the implementation of patient and public involvement with varying degrees of success. Due to a number of developments within the Trust over the past year, for example the acquisition of a substantive Patient Experience Lead, it has been identified as an ideal time to review and evaluate the current approach to PPI and move forward in ensuring there is true patient engagement within the organisation.

### *3.2 The Issue(s)*

- The decision has been made to change the name from PPI to the all-encompassing term Patient and Public Engagement (PPE).
- The aim of the organisation is to align PPE to the 10 key components of good engagement as identified by the NHS confederation (Appendix 1)
- The previous 'Patient and Public Involvement Steering Group' will be disbanded.
- It will be replaced with a Patient and Public Engagement Network (PPEN) (Appendix 1) which will consist of patients, carers, public, members, volunteers and governors, and will act as a 'pool' of representatives that can become engaged in various activities throughout the organisation.
- Projects involving PPEN members will report directly to the Council of Governors (if a Governor is involved) and to the Patient Experience Board, to ensure there is a clear reporting structure and links between experience and engagement.
- Tasks that PPEN members are to engage with are likely to be audits, service developments and improvement working groups. Although this list is not exclusive and as

knowledge of PPEN grows within the organisation it is expected that the work they are engaged in will become more varied.

- A structured mode of feedback to the PPEN will be established as previously concerns have been raised by PPI members of not being informed of actions and progress from the work they have undertaken. The Trust wants the network to feel valued and this is a key part of this.
- Trust Forums and Groups, i.e. the Northamptonshire Cancer Partnership will also report into the PEB to ensure all patient experience and engagement activities are pulled together into the hub of patient experience.
- All of these changes have been reviewed and agreed within the Patient Experience Board in May and are represented within the Patient Experience and Engagement Strategy.

**4. Patient and Public Engagement Strategy**

***4.1 Background***

A number of significant developments have taken place over the past 8 months with regards to patient experience, including the conducting of a comprehensive Thematic Analysis of all patient experience work carried out the 18 months previous to September 2013. This has led to the need for a review of the Patient Experience Strategy, including Patient and Public Involvement (PPI) (as discussed above) and the Implementation Plan which accompanies it.

***4.2 The Issues***

- The revised strategy has been renamed the Patient Experience and Engagement Strategy
- The previous PPI strategy will be disbanded and the aims of the organisation with regards to engagement will be represented within the new strategy
- In addition to the strategy, a set of smart objectives will be created to ensure successful implementation, each of which will be reviewed within the Patient Experience Board (PEB).
- The Strategy has been approved by the PEB, however due to the recent changes with the new Director of Nursing the strategy will be reviewed again to ensure it is aligned with the wider Trust objectives and direction.

***5.*** **Improvement Work - Themes**

***5.1 Background***

A number of areas in which improvements are required have been identified by reviewing patient experience related data, including the Friends and Family Test, the Inpatient Survey and the Thematic Analysis. These were identified as:

1. Noise at Night
2. Discharge
3. Communication
4. Pain Management
5. Mealtime Experience

***5.2 The Issues***

- Each of these separate issue areas have been established into a work streams
- Discharge and Pain Management are being managed within separate work streams which are already in existence within the organisation and regular reports of progress will be received to Patient Experience Board.
- In addition to the reports of progress being received into PEB, information related to the work streams identified through the patient experience metrics will be reported back to the groups to monitor progress.
- Due to the magnitude of the work required to make improvements within these areas the decision has been made to focus on **Noise at Night** (N@N), before moving on to other areas. Noise at Night has been an issue within the organisation for a number of years and was recently highlighted by CQC when they visited the Trust in January. The aim is to significantly improve the score received within the Inpatient Survey.

- A Patient Experience Questionnaire is being undertaken by volunteers in May focussing on 3 key issue areas;

1. Noise at Night
2. Mealtime Experience
3. Information

The aim is to gather feedback from patients on what we as an organisation could do to improve the issue areas within the Trust. The results from this will be reported to IHGC and The Board once collation and analysis has taken place.

- Future reports will break each different area down and report directly on the progress made within each.

***6.*** **National Surveys - Update**

***6.1 Background***

There are a number of national surveys active and planned for 2014/2015, some of which are mandatory and others which have been commissioned or agreed to participate in, by the organisation.

Mandatory;
National Inpatient Survey
National A&E Survey
National Cancer Patient Experience Survey

Paediatric Inpatient Survey

Commissioned;
Neonatal Survey
Outpatients Survey

Participating in;
Pilot Inpatient Survey – new methods (Picker Institute)

***6.2 The Issues***

- The A&E Survey is currently in sample phase with the sample being collated by the information team. The first questionnaires will be issued on the 22nd of May.
- The pilot inpatient survey has sent their final reminder in April and NGH currently have a response rate of 39%.
- The response rate for NGH as of the 25th April was 59% for the National Cancer patient experience Survey. All reminders have now been issued.
- The sample for the Neonatal Survey is currently being compiled by the Information Team with surveys expected to be begin in May.

***7.*** **Summary**

Although no FFT is presented within this paper, there is still a considerable amount of patient experience related activity taking place within the organisation, with all activities falling into 3 of the key areas needed for ensuring the organisation continuously collects, interprets and improves patients experience. The development of the Patient and Public Engagement Network and revised Patient Experience and Engagement Strategy are significant steps towards ensuring the Trust actively listens and proactively responds to the needs of our patients. The Board is asked to support the ongoing work.

# Review of Patient and Public Involvement (PPI) within NGH
# Proposal - April 2014

Fiona Barnes, Deputy Director of Nursing
&
Rachel Lovesy, Patient Experience Lead

# Review of Patient and Public Involvement (PPI) within NGH
# Proposal - February 2014

## 1. Introduction

Active and well supported Patient and Public Involvement (PPI) is key to healthcare reform and to achieving a 'patient led NHS'. Over the past 8 years, the Trust has supported the implementation of patient and public involvement with varying degrees of success. Due to a number of developments within the Trust over the past year, for example the acquisition of a substantive Patient Experience Lead, it has been identified as an ideal time to review and evaluate the current approach to PPI and move forward into our next phase of ensuring the patients voice is heard throughout all levels of the decision making structure within the organisation.

## 2. Background

The Trust has involved patients, public, governors, members and volunteers in a wide variety of Trust projects, service delivery forums, focus groups and task & finish groups. In Sept 2012, the Patient and Public Involvement strategy was approved by the Patient Experience Board as an outline of the direction PPI would take. The strategy highlighted four key areas in which to engage PPI focus groups; Hotel Services, Infection Prevention, Trauma & Orthopaedics and Pain management. These were all identified by the Director of Nursing at the time as key issue areas within the hospital. Each of these individual 'focus groups' compromised of around 5 members were required to report in to the overarching PPI Steering Group. The Steering Group was chaired by a Governor and contained PPI members that were engaged at a more strategic level, often taking a leadership role within the focus groups. The PPI Steering Group was then required to report in to the Patient Experience Board, through the Chair, on a quarterly basis to show progress and report developments in the work they were undertaking.

In July 2013 the strategy was again updated to reflect the progress made to date. The PPI Strategy Group and members have continued to show their support for the ongoing work of the Trust which is greatly appreciated

## 3. Challenges and justification for review

The initial focus groups that were set up have had varying degrees of engagement, support and progress. Alongside the 'main' focus groups there has been extensive work undertaken within the Medical & Surgical care groups working with staff to undertake 'Noise at Night' audits and 'Protected Meal time' audits. However, it has been identified that often this work was being 'lost' due to the process of reporting being late in being established. This has caused some frustration with members of the focus groups who were keen to hear of developments made from the work they had undertaken.

Through a scoping exercise undertaken in Sept 2013, it became apparent that there are many more forums where patients and the public attend/participate such as the Northamptonshire Cancer Partnership. The NCP was established in the 1990's and represents an ideal model of engagement with patients and carers working as active partners in all aspects of service evaluation and delivery.

These groups are undertaking activities in silo's and it has been identified the need to gain feedback from these groups in a more structured way.

PPI representatives within the different forums may be Governors, members, volunteers; may have been patients or a mix of the above. With people taking on a number of different roles it has become apparent the need to define them as separate entities. For this reason a review is currently being undertaken of the role of the Governor, and this paper will go on to discuss in more detail the role of an active PPE member.

With the commencement of the Trust Patient Experience Lead and the development of the Patient Experience Board there is a requirement to re-align our PPI activity and approach to representative engagement.

Due to the many variables discussed, it is believed that some of the groups have struggled and not had a focus for their work and the Trust are not supporting or maximising the benefit from our PPI representatives.

**4. Proposal**

The aim is to move away from the use of the term Patient and Public Involvement and move on to the all-encompassing term Patient and Public Engagement (PPE). The NHS Confederation identifies 10 key components which make up good engagement, and it is these components that we propose NGH strive to achieve with their own engagement activities.

The overall aim is to ensure that the Patients voice is heard throughout all levels of the organisation, such as:

- Collecting and representing patient feedback
- Evaluating services
- Service design/transformation
- Recruitment of staff

**Good Engagement is:**

- Focused on culture rather than structures or techniques
- Integral to all activity
- Strategic, clear and coordinated
- Open and transparent
- Well-resourced and supported
- Inclusive and representative
- Flexible
- Collaborative and builds partnerships
- Sustained
- Outcomes base and focused on improvement

**NHS Confederation, The heart of the matter: patient and public engagement in today's NHS**

This list is by no means exhaustive and it is likely that as the culture of engagement builds throughout the organisation further levels of engagement will be identified.

As mentioned previously the role of the Governor is currently under review. Governors are likely to play an important role in PPE as advocates and leaders for the patient voice.

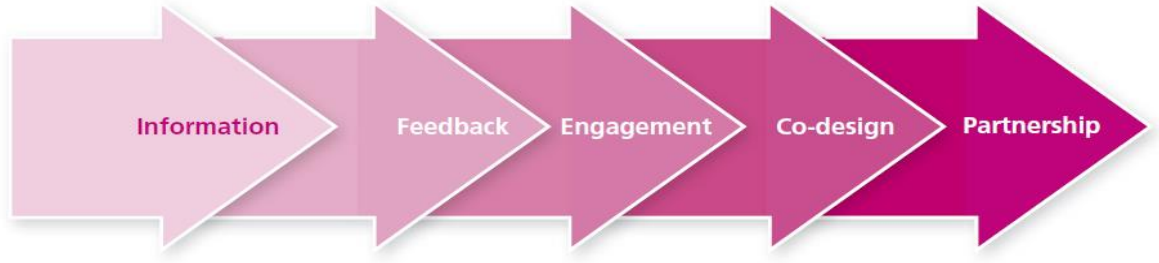
Therefore, the proposal is to disband the current PPI steering group and focus groups and develop a Patient Engagement Network (PEN) that will provide a pool of representatives who can support the Trust in a number of activities. New live members will be recruited through Governors, members and volunteers (Friends of NGH or WRVS).

It is also proposed that a more structured line of feedback is established for the many groups that are running throughout the Trust to ensure their successes are celebrated and their issues are shared.

In addition to the support received through individuals in the community it has also been acknowledged the need to actively engage Stakeholders such as HealthWatch, Deaf Connect, The National Association for the Blind, MIND and the Alzheimer's Society. It is considered that greater engagement with our stakeholders will again assist the organisation in collaboratively working towards improving the patient experience.

**5. Patient Experience and Engagement**

A key aspect of patient engagement is around patient experience and indeed, the two should not be considered in isolation. The NHS Institute for Innovation outlined engagement and experience within the same continuum, and it is from this standpoint that we precede into this next phase of engagement:




A fundamental component of the new role of the PEN will be engagement with the Working Groups which will be set up from the issues identified within the thematic review carried out by the P.E. Lead, and the initial 2013 In Patient survey results. It is considered that involving PEN within the overarching Working Groups, as opposed to running separate PPI groups, will ensure we have true collaborative and partnership working with our patients and public and that work carried out will go on to have a direct impact on service delivery and in turn, the patient experience.

**6. Participation of PEN members**

As previously mentioned participation will encompass a number of different roles, however below are some of the more clearly identifiable ones:

- Lead projects or Working Groups
- Facilitate Focus Groups ('One Offs') or Task & Finish Groups (2-3 meetings)
- Participate in all of the above &
- Undertake audits:
    - Observational
    - QuEST

**7. Accountability & Responsibility for PEN members**

Outputs from the PEN will be accountable to the Patient Experience Board and to the Council of Governors. This will be conducted through the leads of the groups which have active PEN involvement.

PEN members will be accountable to the leads of the groups in which they are working. For example, if they join a Working Group then their accountability will be with whoever is leading that group. For those that are taking part in an audit, their accountability will be with the audit lead. If PEN

members are leading a group/audit/ project then they will be responsible for reporting this to the Patient Experience Board and the Council of Governors.

**8. Training for PEN members**

Consideration needs to be given to the amount of training we offer to PEN members. The main reason for this is to ensure they remain 'lay members' and indeed that they are not given so much training they become like members of staff. Their status as people that are 'looking in' to the organisation is crucial and to remain our 'critical friend'.

A programme has been identified to support the Governors and consideration needs to be given as to whether PEN members are also invited to attend these sessions:

- Finance within the NHS,
- Performance and how it is measured and against what (national standards, CCG requirements etc)
- Patient safety,
- Governance within the NHS
- Quality priorities
- Patient experience and the measuring of data collected

**9. Reporting Mechanisms**

As mentioned previously, the Trust has an established Patient Experience Board and is proposing a Governors Council. It is through these two mechanisms that the reporting of patient experience will be shared. It is therefore recommended that the current PPI Steering Group is disbanded to prevent duplication.

It is also through the Patient Experience Board that Stakeholder engagement will be undertaken. With representatives from external groups invited to attend the Patient Experience Board to share their experiences and become engaged with the key topics within the organisation.

The same is applicable for the current groups which are running in the organisation such as the Cancer Partnership Group, Dementia Group and Black and Minority Ethnic Groups. A structure will be developed to enable them to regularly report and feed back into the Patient Experience Board. Appendix 1 contains a flow chart which details the structure and reporting mechanism for Patient Engagement.

**10. 2014/15 Key Areas for Improvement:**

Through the extensive thematic review undertaken by the Patient Exercise Lead, FFT outcomes and the preliminary Inpatient Survey there are some key areas for the Patient Experience Network to focus upon. With the support of the PEN the following topics will form part of the 'Programme of work':

| Trust wide Projects | Regular Audits |
|---|---|
| - Communication<br>- Discharge<br>- Noise at Night<br>- Pain management<br>- Mealtime Experience<br>- Service Developments | - QuEST<br>- Noise at Night<br>- Protected Mealtimes |

**11. Programme of Work for PEN members**

The Programme of work (appendix 2) is a draft proposal for the engagement of all Patient Experience representatives. Each project, audit schedule, Focus group will require different levels of engagement, commitment and representation. This will be finalised following consideration & input from our current PPI team.

**12. Summary**

The Trust recognises the enormous commitment that the Governors, members, volunteers and members of the PPI group have for the organisation. It is hoped that with a more structured and defined 'Programme of Work' that the newly formed Patient Engagement Network can support the Trust to improve the Patient Experience in partnership.

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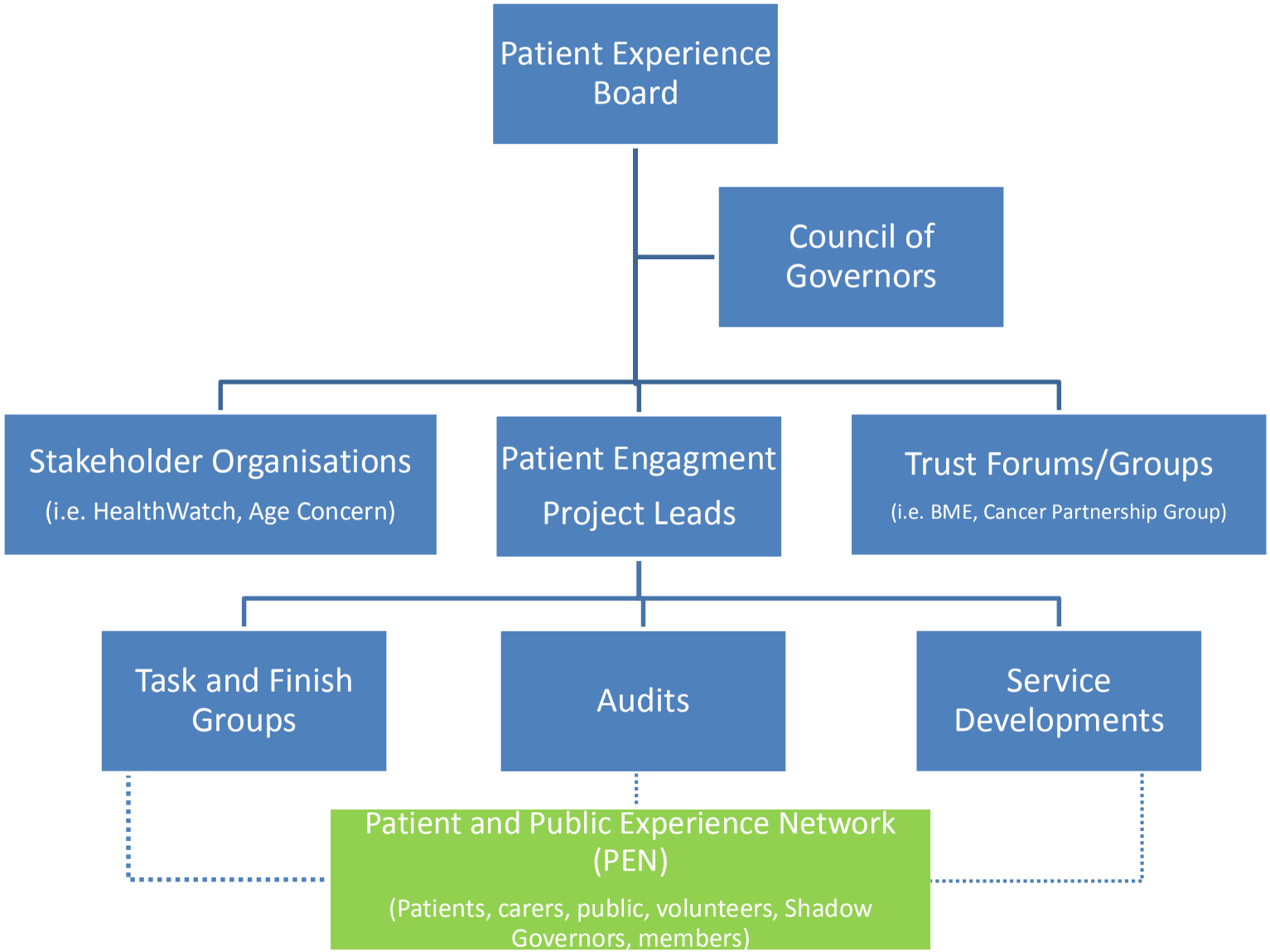
**Appendix 1: Patient Engagement Flow Chart**



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**Appendix 2: Programme of Work – 2014/15** ***EXAMPLE***

## Programme of Work 2014/15 Timetable

| Project/Audit/ Task & Finish Group | Lead | Timeframe | Reporting | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 | Jan-15 | Feb-15 | Mar-15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Quarterly QuEST Audits | NGH Clinical Staff | 3-4 hour Audit 3 months | N&M Board I.H.G.C. | | | | | | | | | | | | |
| Effective Patient Discharge Urgent Care Prog. | NGH Staff | 2 hours / monthly | Urgent Care Board | | | | | | | | | | | | |
| Communication Work stream<br>• What do Patients want to know when they come into hospital?<br>• What do patients want to know when they go home? | MMV | One-off Audit 2 – 3 hours | Patient Experience Board | | | | | | | | | | | | |
| Patient Mealtime Experience<br>• Protected Mealtimes<br>• Quality of food | FE/BW/FB | 2 Monthly Audits | | | | | | | | | | | | | |
| Reducing Noise at Night – Observational Audit during the day to determine patient issues | P.E.N. | On-going | | | | | | | | | | | | | |
| Pressure Ulcer – Leaflet | Sylvia Woods (Lead TVN) | 2 hours | Patient Experience Board | | | | | | | | | | | | |
| Service Developments / Transformation Projects | | | | | | | | | | | | | | | |

Northampton General Hospital NHS
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# REPORT TO: TRUST BOARD
# 29 May 2014

| | |
|---|---|
| **Title** | Monthly Infection Prevention Performance Report |
| **Agenda item** | 11 |
| **Sponsoring Director** | Jane Bradley, Interim Director of Nursing, Midwifery, Patient Services/DIPC |
| **Author(s)** | Pat Wadsworth, Lead Infection Prevention Nurse |
| **Purpose** | To update the Board on Infection, Prevention and Control within the hospital for the month of March and April 2014 |

**Executive summary**

A monthly update on reportable Healthcare associated infections (HCAIs) and review of incidents and trend analysis of HCAIs is paramount to improving learning, patient safety and quality of care and also impacts on staff safety and wellbeing.

Main issues to highlight:

- The total C diff ceiling for 2013/14 was **26**, bringing the Trust under trajectory as the annual target was **29**. The annual ceiling for 2014/15 for the Trust Cdiff is **35** with an internal ceiling of **24**. For April we had 1 post Cdiff.
- Unfortunately we had a MRSA bacteraemia for 2013/14
- National Guidance has been published on the management of carbapenemase-producing Enterobacteriaceae (CPE). This report outlines how this will be managed at NGH.
- The Care Quality Commission (CQC) report highlighted that the hospital environment was clean and infection prevention was good.
- **No** wards on special measures for March and April
- **0** post MSSA bacteraemia for March or April
- **1** post E coli bacteraemia for April
- **1** post colonisation MRSA for March and **0** for April

| | |
|---|---|
| **Related strategic aim and corporate objective** | Be a provider of quality care for all our patients /provide appropriate care for our patients in the most effective way<br><br>Patient safety there will be no avoidable harm to patients from the healthcare they receive. |
| **Risk and assurance** | The Trust has an annual target for 2014/15 of 35 *C.diff* cases. If we exceed this total we will have a financial penalty of £10,000 for every post Cdiff. |
| **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**<br>Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? **No** |

Enclosure H

| | |
|---|---|
| **Legal implications / regulatory requirements** | The Health and Social Care Act 2008 Code of Practice for the Prevention and Control of Health Care Associated Infections. (DH 2008) |

**Actions required by the Trust Board**

- The Board has a statutory obligation to ensure appropriate infection prevention and control mechanisms are in place.
- Failure to review infection prevention and control would be considered to be high risk.
- The Board is asked to discuss and where appropriate challenge the content of this report.

Northampton General Hospital NHS
NHS Trust

# Trust Board
# 29 May 2014

## Infection Prevention & Control Report
## March and April 2014

### 1. Introduction
The Board is aware of its duty to ensure appropriate infection prevention and control mechanisms are in place to promote patient safety and quality of care. This report provides the assurance required by the Board to satisfy its statutory requirements by providing an update as to the current situation in relation to Healthcare Associated Infections (HCAIs) within the Trust.

### 2. Report
In this report, the results for the alert organisms, Surgical Site Infections and Hand Hygiene audits for March and April 2014, have been summarised into the tables below.

A further detailed report is in Appendix 1.

**2.1 MRSA / MSSA bacteraemia**

| | MRSA bacteraemia | MRSA colonisation | Elective screening | Emergency screening | Special Measures | MSSA bacteraemia |
|---|---|---|---|---|---|---|
| March 2014 | 0 | 1 | 99.8% | 96.5% | 0 | 0 |
| April 2014 | 0 | 0 | 99.93% | 97% | 0 | 0 |

**2.2 *Clostridium difficile***

| | >3 day case of *C.diff* | *Total to date* |
|---|---|---|
| March | 2 | 26 |
| April | 1 | 1 |

The CDI objective for 2013/14 was **29**.The Trust achieved **26** and we achieved this objective with no penalties.

**2.3 *Escherichia coli* (*E.coli)* bacteraemia**

| | *>48 hrs E.coli* | *Total of mean of four >48 hrs E.coli a month* |
|---|---|---|
| March | 6 | 4 |
| April | 1 | 4 |

The CDI objective for 2014/15 for NGH is **35.** An internal stretch objective of **24** is to be set as unfortunately the April IPC was cancelled and could not be tabled. This will be discussed and finalised at the May IPC meeting.

**2.4 The management of carbapenemase-producing Enterobacteriaceae (CPE)**
Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals. However these organisms are also some of the most common causes of urinary tract, intra-abdominal and bloodstream infections**.**

National guidance has just been published around this issue and in response to this; a plan is being produced for the early detection, management and control of CPE. This plan will be presented at the May Infection Prevention Committee for approval and implementation.

Enclosure H

### 3. Surgical Site Infection Surveillance (SSIS) Scheme

The trust takes part in the national surgical site surveillance scheme of over 150 hospitals in England so that it can measure the rates of surgical site wound infection and be sure that patients are given the highest possible standard of care. The national programme is coordinated by Public Health England (PHE). The patient is monitored from operation until discharge and then followed up 30 days after the operation to determine if they sustained a surgical site infection.

When submitting the results to the board, it should be noted that surveillance is still on-going as surgical site infections can develop and be reported up to 30 days post operatively for general surgery and Obs & Gynae patients and up to a year post-operatively for T&O patients (due to an implant being inserted). Therefore these monthly results are classified as interim results and are subject to change. The infection prevention team have explored how surgical site infections may be reported in a more robust fashion in the future.

Please note that:

- Surveillance for the March large bowel and the April spinal data is still on-going as surgical site infections can develop and be reported up to 30 days post operatively for general surgery and obstetrics & gynae patients.
- T&O results are subject to change; however no T&O SSIs have been identified this month.

| **Quarter 4 - 2013/2014** | **Large bowel** | **SSI** | **Fractured neck of femur (T&O)** | **SSI** | **Total hip replacement (T&O)** | **SSI** | **Total knee replacement (T&O)** | **SSI** |
|---|---|---|---|---|---|---|---|---|
| **Jan** | 14 | **1** | 39 | 0 | 40 | **1** | 32 | 0 |
| **Feb** | 13 | **1** | 22 | 0 | 18 | 0 | 21 | **1** |
| **March** | 10 | 0 | 22 | 0 | 19 | 0 | 21 | 0 |
| **Total** | 37 | **2** | 83 | 0 | 77 | **1** | 74 | **1** |

**April results**

| **Quarter 1 2014/15** | **Total** | **Presumptive Infection** |
|---|---|---|
| #Neck of Femurs | 11 | 0 |
| Total Hip Replacement (THR) | 25 | 0 |
| Total Knee Replacement (TKR) | 15 | 0 |
| Limb amputation | 9 | 0 |
| Spinal | 2 | 0 |

### 5. Hand Hygiene Audit

Information from the Hand Hygiene Observational Tool (HHOT) data for March and April 2014

| **Month** | **Percentage** | **Areas that did not submit and reason** |
|---|---|---|
| March | Overall score was 89.3%<br><br>Ward compliance was 98.8% | Danetre OP is now covered by community. The ward manager was new to Balmoral and has now been shown how to input. Pain clinic and EAU was sent late, diabetes centre not submit due to work pressure, Heart centre and Rheumatology not submitted due to annual leave, Abington and Gynae DSU had a changeover of staff. |

| Month | Percentage | Areas that did not submit and reason |
|---|---|---|
| April | Overall score was 91.1%<br><br>Ward compliance was 95.5% | Seven areas did not comply, Diabetes Centre, Abington, Gosset, Balmoral, Gyn DSU, Uro Gyna, and Matrnitiy Observation ward. A mixture of staff sickness, holidays and input error were to blame for non compliance. All Matrons are aware and these are being actioned. |

**6. Update on Beat the Bug, Save the Skin, Stop the Clot: Board Quality Visit**
March and April Beat the Bug, Stop the Clot, Save the Skin; found that staff were welcoming and supportive. There was a good atmosphere and effective hand hygiene was observed. They displayed a good knowledge of SSKIN, Saving Lives and when to send a faecal sample. Effective hand hygiene and good use of PPE was observed. However, there was still dust found across the organisation and the monitoring of daily fridge temperatures is not always being undertaken. During March commodes were not always found to be clean, however this improved in April. Store cupboards require de-cluttering and require being kept clean and staff were reminded to keep stock off of the floor. These findings are fed back to the ward co-ordinator and the staff promptly following the review. A report is also sent to the areas Matron and the ward Sister to action. Many of these findings are actioned immediately. A sixth monthly review of Beat the Bug, Stop the Clot, Save the Skin was presented at April's 2014 Trust board development day. A standard operations procedure (SOP) was also presented and discussion regarding the continuing of these valuable quality visits.

**7. Education and Training**
March and April mandatory training percentage was March 62.3% and April 64.1%. Additional measures are continually being put in place to help meet the monthly targets including a different approach to the teaching sessions have been introduced that have a less formal session with greater learner participation.

**8. Assessment of Risk**
The Trust needs to report surgical site infections in a more appropriate way in future, taking into consideration that patients may only start to show signs of deep infection up to a year after the operation.

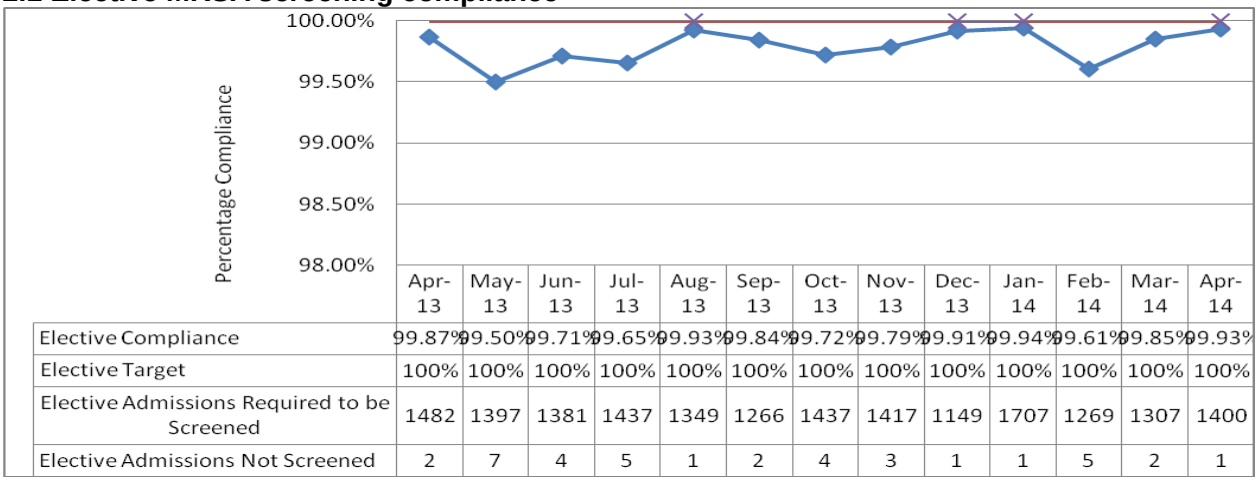
**9. Recommendations/Resolutions Required**
The Board is asked to discuss and where appropriate challenge the content of this report.

**10. Next Steps**
The Infection Prevention Team is continuing to work collaboratively across the Trust to keep levels of infection to a minimum, whilst focusing on ensuring that appropriate *C.diff* sampling is undertaken.

**Appendix 1**

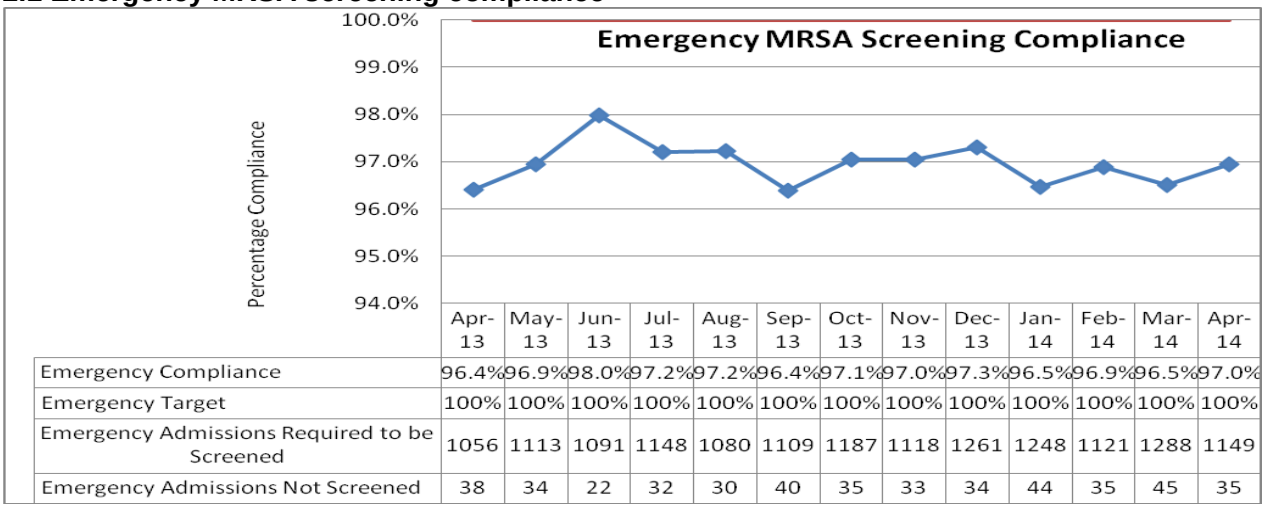
**Elective and Emergency MRSA Screening Compliance**

**2.1 Elective MRSA screening compliance**




| | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 | Apr-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Elective Compliance | 99.87% | 99.50% | 99.71% | 99.65% | 99.93% | 99.84% | 99.72% | 99.79% | 99.91% | 99.94% | 99.61% | 99.85% | 99.93% |
| Elective Target | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Elective Admissions Required to be Screened | 1482 | 1397 | 1381 | 1437 | 1349 | 1266 | 1437 | 1417 | 1149 | 1707 | 1269 | 1307 | 1400 |
| Elective Admissions Not Screened | 2 | 7 | 4 | 5 | 1 | 2 | 4 | 3 | 1 | 1 | 5 | 2 | 1 |

**2.1 Emergency MRSA screening compliance**




| | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 | Apr-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Emergency Compliance | 96.4% | 96.9% | 98.0% | 97.2% | 97.2% | 96.4% | 97.1% | 97.0% | 97.3% | 96.5% | 96.9% | 96.5% | 97.0% |
| Emergency Target | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Emergency Admissions Required to be Screened | 1056 | 1113 | 1091 | 1148 | 1080 | 1109 | 1187 | 1118 | 1261 | 1248 | 1121 | 1288 | 1149 |
| Emergency Admissions Not Screened | 38 | 34 | 22 | 32 | 30 | 40 | 35 | 33 | 34 | 44 | 35 | 45 | 35 |

**2.1 MSSA Bacteraemia (Meticillin Sensitive *Staphylococcus aureus*)**
During March 2014 there were 4 <48hrs and **0 >48hrs** MSSA bacteraemia cases.
During April 2014 there were 5 <48hrs and **0 >48hrs** MSSA bacteraemia cases.

**2.2 *Clostridium difficile***
The Trust has an annual target of 29 *C.diff* cases or less for the financial year 2013/14.
During March **2>3 day case of *C.diff*** were identified against a monthly target of 4 post three day cases, which remains at a total of 26 for the year, putting the trust below CDAD trajectory.

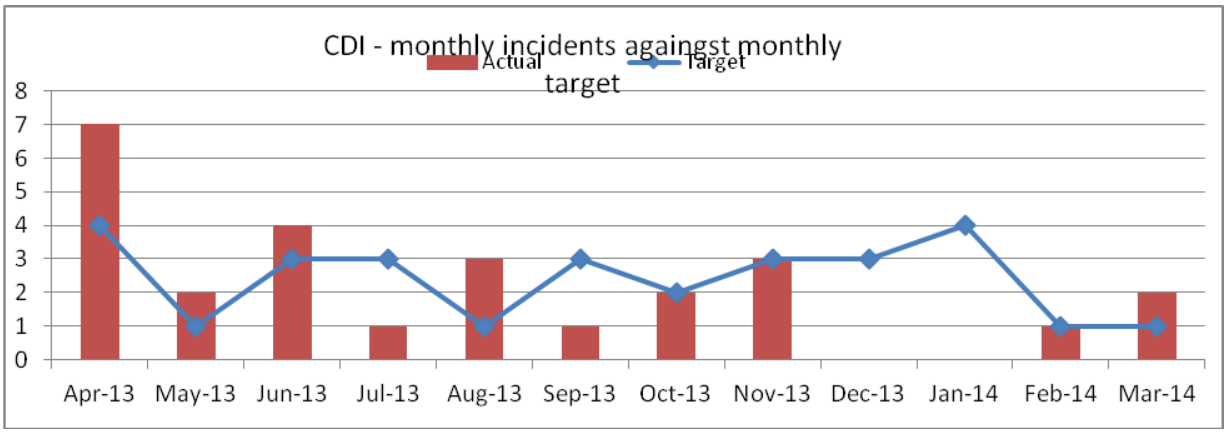
The RCA meetings have not been undertaken and will be fed back at the next month's board report. Case one was on Finedon ward, the patient was admitted with abdominal pain caused by encapsulating peritoneal sclerosis (EPS). The patient did not have diarrhoea on admission and the faecal (stool) sample was an appropriate sample. However, there was a delay in finding the patient a side room due to the availability of an unoccupied side room. This is documented in the patient's notes.

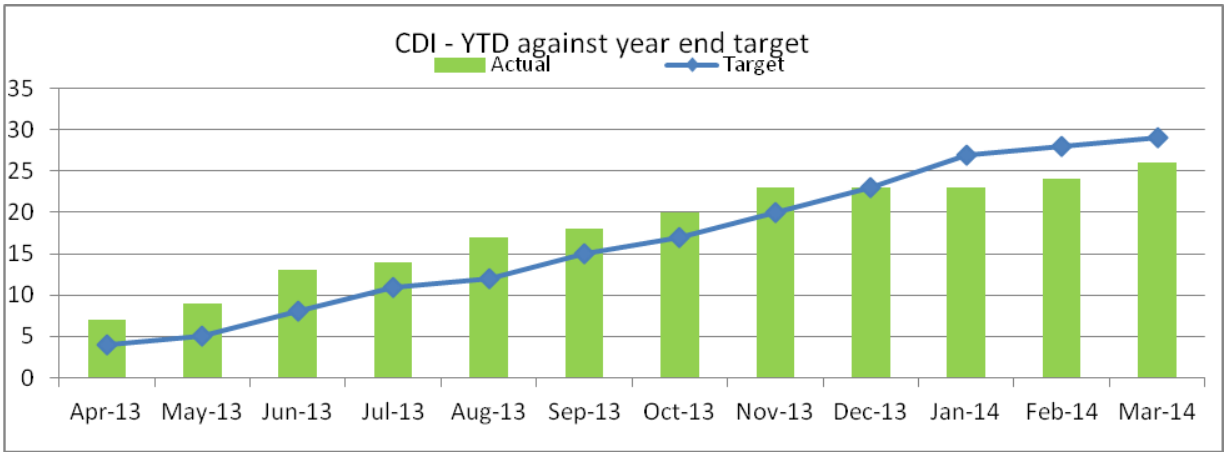
Case number 2 was on Becket ward and this was **not** an appropriate sample. The faecal sample was taken whilst the patient was receiving Laxido and Senna. As part of the action plan following the ward RCA, ward huddles were arranged, to explain appropriate sampling and the C.diff policy displayed in the wards staff room. The stool chart was also not completed accurately and further education and training was given by IPT.

The Trust has an annual target of 35 *C.diff* cases or less for this financial year 2014/15.
During April **1>3 day case of *C.diff*** were identified against a monthly target of 2 post three day cases.

The RCA meeting is to be undertaken and a report will be feedback in the next Board report.

The graphs below show the monthly incidents of *Clostridum difficile* infection against the Trusts monthly target and the incidents of *Clostridium difficile* infection against the year-end target for CDAD for 2014/15.




| Month | Inappropriate Sample | Appropriate Sample |
|---|---|---|
| April 2013 | 0 | 1 |
| **Total** | | **1** |

To maintain the focus on diarrhoea the IPT have continued to facilitate training initially on the areas that sent inappropriate specimens (this is improving) and have widened the training to incorporate the majority of areas.

***2.3 Escherichia coli* (*E.coli*) bacteraemia**
The **1 >48 hrs** bacteraemia for April was on Collingtree ward. Feedback will be given in the next month's board report after the RCA meeting in May.

Northampton General Hospital NHS
NHS Trust

# REPORT TO: TRUST BOARD
# 29 May 2014

| | |
|---|---|
| **Title** | Same Sex Accommodation Audit & Update |
| **Agenda item** | 12 |
| **Sponsoring Director** | Deborah Needham, Chief Operating Officer |
| **Author(s)** | Belinda Wood, Lead Nurse |
| **Purpose** | For information |
| **Executive summary**<br><br>This report provides an update audit on the provision of Same Sex Accommodation by the Trust in April 2014. | |
| **Related strategic aim and corporate objective** | Focus on Quality |
| **Risk and assurance** | No |
| **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)<br><br>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**<br><br>The Board is asked to note the contents of this report. An update will be brought back to Board in 12 months' time. | |

Enclosure I

# Trust Board
# 29 May 2014

## Same Sex Accommodation Audit & Update

### 1. Introduction
The report provides an update audit on the provision of Same Sex Accommodation by the Trust in April 2014.

### 2. Main Report
Same sex-accommodation means:
1. A ward for same sex patients only
2. A bed area (bay) within the main ward will only have patients of the same sex as you
3. Toilet and bathroom facilities will be just a specific gender, and will be close to patient's bed areas.

It is possible that there will be both male and female patients on the ward, but they will not share sleeping areas. Patients may have to cross a ward corridor to reach bathroom facilities but not pass through the sleeping area of the opposite sex patients.

This applies to all areas of hospitals including admission wards and critical care areas. In exceptional circumstances it may be necessary to accommodate men and women together where the need for highly specialised or urgent care takes clinical priority. In these circumstances staff must act in the interests of all the patients involved and patients should be moved to same sex accommodation as soon as possible. Until this can happen staff must take steps to protect all patients' privacy.

Northampton General Hospital underwent significant redevelopment in 2010 to ensure that Same Sex Accommodation could be provided in clinical areas. There was also additional reorganisation in 2011/12 within the admission wards to ensure they could provide the same. The Trust now has separate male and female admission area for urgent care.

Within 2013/14 there were 3 reported occasions when same sex accommodation within critical care could not be maintained. However this was due to the clinical needs of the patients and as such is an accepted criteria. Therefore upon validation these patients were not classified as having experienced a Same Sex Accommodation breach.

Due to the challenges of the urgent care pathway during the last year escalation areas have been opened with every care taken to ensure Same Sex Accommodation breaches do not occur. If this is required due to clinical need only, a datix report is submitted and a root cause investigation undertaken to be able to confirm the reason. The Trust is committed to ensuring the breach occurs for the shortest time possible allocating the patient to a Same Sex area as soon as their clinical condition enables this.

### 3. Assessment of Risk
Due to the validation process it can be confirmed that there were no risks associated with Same Sex Accommodation in 2014.

### 4. Recommendations/Resolution Required
The Trust Board is asked to note the Same Sex Accommodation audit results for April 2014 and agree the declaration which can be found in appendix 1.

### 5. Next Steps
A further audit will be repeated in 12 months' time and reported to the Trust Board.

Northampton General Hospital NHS
NHS Trust

# Same sex accommodation compliance audit April 2014

**C = Compliant**

**NC = Not compliant**

| Ward | Single sleeping arrangements or same sex wards | Single toilets/washing | Passing through bay to access facilities |
|---|---|---|---|
| **Abington** | **C** | **C** | **C** |
| **Allebone** | **C** | **C** | **C** |
| **Becket** | **C** | **C** | **C** |
| **Benham** | **C** | **C** | **C** |
| **Brampton** | **C** | **C** | **C** |
| **Cedar** | **C** | **C** | **C** |
| **Compton** | **C** | **C** | **C** |
| **Creaton** | **C** | **C** | **C** |
| **Collingtree** | **C** | **C** | **C** |
| **Dryden** | **C** | **C** | **C** |
| **Eleanor** | **C** | **C** | **C** |
| **EAU** | **C** | **C** | **C** |
| **Finedon** | **C** | **C** | **C** |
| **Hawthorn** | **C** | **C** | **C** |
| **Head & Neck** | **C** | **C** | **C** |
| **Holcot** | **C** | **C** | **C** |
| **Knightley** | **C** | **C** | **C** |
| **Rowan** | **C** | **C** | **C** |
| **Spencer** | **C** | **C** | **C** |
| **Talbot Butler** | **C** | **C** | **C** |
| **Willow** | **C** | **C** | **C** |
| **Victoria** | **C** | **C** | **C** |
| **Northampton Heart Centre** | **C** | **C** | **C** |

- Same-sex wards (i.e. the whole ward is occupied by either men or women but not both)
- single (bed)rooms with adjacent same-sex toilet and washing facilities (preferably en-suite)
- same-sex bed bays or (bed)rooms, with designated same-sex toilet and washing facilities, preferably within or adjacent to the bay or room.

Service users should not need to pass through accommodation or toilet/washing facilities used by the opposite sex to gain access to their own facilities.

Enclosure I

Northampton General Hospital NHS
NHS Trust

# Delivering Same-Sex Accommodation
# Declaration of compliance – May 2014

We are proud to confirm that mixed sex accommodation has been eliminated in Northampton General Hospital

**Delivering same sex accommodation**
Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. Northampton General Hospital is committed to providing every patient with same sex accommodation, because it helps to safeguard their privacy and dignity when they are often at their most vulnerable.

We are proud to confirm that mixed sex accommodation has been eliminated in our trust. Patients who are admitted will only share their bed area with members of the same sex, and same sex toilets and bathrooms will be close to their bed area.

Sharing with members of the opposite sex will only happen by exception based on clinical need for example where patients need specialist equipment or care such as in ITU or CCU or when patients choose to share.

**What does this mean for patients?**
Other than in the circumstances set out above, patients admitted to Northampton General Hospital can expect to find the following

**Same sex-accommodation means:**

- Your bed area (bay) within the main ward will only have patients of the same sex as you
- Your **toilet and bathroom** will be just for your gender, and will be close to your bed area

It is possible that there will be both men and women patients on the ward, but they will not share your sleeping area. You may have to cross a ward corridor to reach your bathroom, but you will not have to walk through opposite-sex areas.

You may share some communal space, such as day rooms or dining rooms, and it is very likely that you will see both men and women patients as you move around the hospital (eg on your way to X-ray or the operating theatre).

It is probable that visitors of the opposite gender will come into the room where your bed is, and this may include patients visiting each other.

It is almost certain that both male and female nurses, doctors and other staff will come into your bed area.

If you need additional help to use the toilet or take a bath (eg you need a hoist or special bath) then you may be taken to a “unisex” bathroom used by both men and women, but a member of staff will be with you, and other patients will not be in the bathroom at the same time.

**The NHS will not turn patients away just because a “right-sex” bed is not immediately available**

same-sex accommodation:
your privacy, our responsibility

DH Department of Health

Enclosure I

**What are our plans for the future?**

In any new developments we will be ensuring facilities are planned to promote same sex accommodation.
We have a Privacy & Dignity Forum which meets quarterly and is attended by Dignity Champions from every ward.

**How will we measure success?**

We are currently using a variety of patient feedback mechanisms which include patient advice and liaison service (PALS) and the Friends & Family test in all areas, the results of which are fed back to every ward and department to ensure standards are maintained.

All exceptions of same sex accommodation are escalated for approval by a director of the trust; these exceptions are then recorded by directorates and reported to the trust board.

**What do I do if I think I am in mixed sex accommodation?**

We want to know about your experiences. Please contact the nurse in charge or ward/unit manager in the first instance or contact PALS on 01604 545784 if you have any comments, concerns or compliments.

Northampton General Hospital NHS
NHS Trust

# REPORT TO: TRUST BOARD
# 29 May 2014

| | |
|---|---|
| **Title** | Operational Performance Report |
| **Agenda item** | 13 |
| **Sponsoring Director** | Deborah Needham, Chief Operating Officer |
| **Author(s)** | Matt Tucker, General Manager and Tracey Harris, Cancer Manager |
| **Purpose** | The paper is presented for discussion and assurance |

**Executive summary**

**The Trust has not achieved the following standards during April 2014:**
- Urgent Care 4 hour standard - significant improvement has been demonstrated this month.
- Cancelled Operations rebooked within 28 days - this equated to one case.
- The number of patients waiting over 26 weeks without initiation of treatment and not on a waiting list for a procedure remains at 49, no patients have waited over 52 weeks.
- 62 day cancer standard and two other cancer standards; 2ww referral and 31 day first treatment.

**The Trust achieved in April 2014:**
- 18 week RTT across all specialties.
- all diagnostic procedures being undertaken in less than 6 weeks
- all Stroke targets

| | |
|---|---|
| **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 17 |
| **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)<br><br>Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(Y/N) |
| **Legal implications / regulatory requirements** | Are there any legal/regulatory implications of the paper |

**Actions required by the Trust Board**

The Board is asked to note the report

# Access Rating - Summary

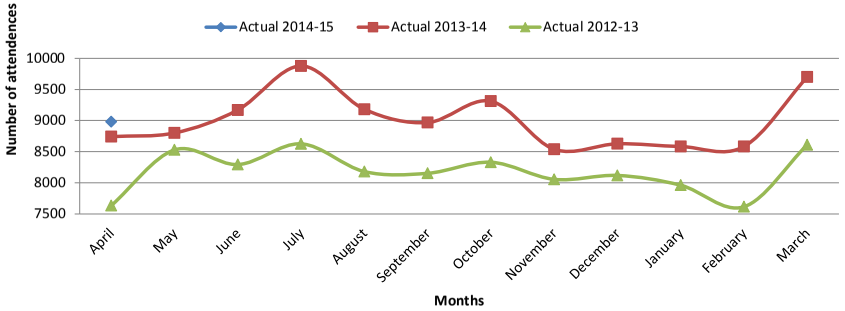
| Access Summary Target or Indicator | Monitoring Regime | Target / Benchmark | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 | Apr-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RTT waiting times – admitted patients treated within 18 weeks | CCG & TDA | 90% | 95.02% | 96.16% | 95.79% | 95.75% | 97.38% | 95.00% | 92.50% | 92.06% | 93.94% | 91.72% | 93.78% | 94.57% | 94.10% |
| RTT waiting times – non-admitted treated within 18 weeks | CCG & TDA | 95% | 97.87% | 98.02% | 97.99% | 98.99% | 98.44% | 98.34% | 98.58% | 98.88% | 99.00% | 98.45% | 98.32% | 98.57% | 98.56% |
| RTT waiting times – Patients on incomplete pathways with a current wait time < 18 weeks | CCG & TDA | 92% | 96.36% | 96.46% | 96.67% | 96.30% | 96.85% | 97.32% | 97.12% | 97.14% | 96.95% | 96.90% | 95.87% | 97.10% | 97.30% |
| RTT waiting times - ongoing >26 weeks | | | 63 | 46 | 63 | 40 | 35 | 31 | 19 | 30 | 47 | 45 | 55 | 49 | 49 |
| RTT waiting times - ongoing >52 weeks | CCG & TDA | 0 | 0 | 0 | 2 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| RTT T&O Admitted | CCG & TDA | 90% | 91% | 90% | 91% | 90% | 90% | 90% | 62% | 64% | 77% | 71% | 87% | 98% | 91% |
| RTT T&O Non-Admitted | CCG & TDA | 95% | 95% | 95% | 95% | 98% | 95% | 95% | 93% | 96% | 96% | 96% | 96% | 96% | 95% |
| RTT ENT Admitted | CCG & TDA | 90% | 93% | 95% | 92% | 97% | 96% | 95% | 93% | 92% | 95% | 87% | 90% | 94% | 91% |
| RTT ENT Non-Admitted | CCG & TDA | 95% | 97% | 98% | 96% | 99% | 98% | 98% | 98% | 98% | 99% | 97% | 96% | 98% | 98% |
| Diagnostic waiting times (number of patients waiting > 6weeks) | CCG & TDA | 99% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Cancelled Operations rebooked within 28 days (as per SITREP definitions) | CCG & TDA | 100% | 98% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 98% | 97% |
| Cancelled Urgent Operations 2nd time | CCG & TDA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 |
| *A&E: Total time in A&E (Calendar month) | CCG & TDA | 95% | 87.89% | 96.28% | 93.42% | 94.43% | 90.35% | 90.02% | 90.56% | 94.53% | 89.82% | 85.49% | 81.16% | 90.43% | 92.29% |
| A&E: Total time in A&E (cumulative) | CCG & TDA | 95% | 87.89% | 92.10% | 92.55% | 93.06% | 92.52% | 92.11% | 91.88% | 92.20% | 91.94% | 91.33% | 90.47% | 90.47% | 92.30% |
| Cancer: 2 week GP referral to 1st outpatient | CCG & TDA | 93% | 96.00% | 95.40% | 96.20% | 95.50% | 95.10% | 96.60% | 95.80% | 97.60% | 96.30% | 93.70% | 93.40% | 90.90% | 92.49% |
| Cancer: 2 week GP referral to 1st outpatient - breast symptoms | CCG & TDA | 93% | 100.00% | 100.00% | 100.00% | 98.90% | 100.00% | 100.00% | 99.65% | 100.00% | 98.60% | 100.00% | 58.50% | 86.00% | 94.12% |
| Cancer: 31 Day | CCG & TDA | 96% | 98.00% | 98.20% | 98.10% | 96.30% | 97.60% | 99.30% | 97.30% | 99.30% | 99.20% | 95.70% | 86.30% | 93.20% | 92.48% |
| Cancer: 31 day second or subsequent treatment - surgery | CCG & TDA | 94% | 100.00% | 100.00% | 95.50% | 100.00% | 100.00% | 94.10% | 100.00% | 100.00% | 100.00% | 82.80% | 78.60% | 100.00% | 96.00% |
| Cancer: 31 day second or subsequent treatment - drug | CCG & TDA | 98% | 100.00% | 98.40% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 95.20% | 96.60% | 100.00% | 100.00% |
| Cancer: 31 day second or subsequent treatment - radiotherapy | CCG & TDA | 94% | 98.32% | 98.60% | 95.80% | 96.50% | 97.40% | 96.50% | 97.80% | 95.80% | 95.70% | 99.20% | 93.80% | 96.20% | 96.00% |
| Cancer: 62 day referral to treatment from screening | CCG & TDA | 90% | 87.88% | 100.00% | 95.20% | 100.00% | 95.20% | 100.00% | 100.00% | 96.30% | 100.00% | 100.00% | 95.70% | 94.40% | 100.00% |
| Cancer: 62 days urgent referral to treatment of all cancers | CCG & TDA | 85% | 85.20% | 79.00% | 83.40% | 79.10% | 85.40% | 84.70% | 85.60% | 83.90% | 86.60% | 79.50% | 73.80% | 79.20% | 79.51% |
| Proportion of people who have a TIA who are scanned and treated within 24 hours | CCG & TDA | 60% | 72.73% | 68.00% | 69.57% | 83.87% | 73.33% | 82.61% | 74.00% | 80.00% | 84.00% | 92.00% | 82.00% | | 86.00% |
| Proportion of people who spend at least 90% of their time on a stroke unit | CCG & TDA | 80% | 80.00% | 88.71% | 98.18% | 89.83% | 87.14% | 86.96% | 92.73% | 82.22% | 96.67% | 91.00% | 90.00% | 89.09% | 88.37% |
| Trolley Waits waiting > 12hours | CCG | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Ambulance Handover Times (with number of patients over 15 minutes) | CCG | 15 mins | 612 | 452 | 500 | 446 | 476 | 1263 | 1656 | 1485 | 988 | 901 | 1021 | 1165 | 929 |
| Ambulance Handover Times (with number of patients between 30 minutes and 60 minutes) | CCG | 30 mins | 196 | 160 | 193 | 125 | 112 | 206 | 346 | 298 | 283 | 316 | 372 | 410 | 288 |
| Ambulance Handover Times (with number of patients over 60 minutes) | CCG | 60 mins | 68 | 3 | 29 | 7 | 31 | 15 | 62 | 53 | 75 | 93 | 144 | 90 | 32 |

* A&E data is calendar month.

**The Trust has not achieved the following standards during April 2014:**
- Urgent Care 4 hour standard - whilst significant improvement has been demonstrated this month
- Cancelled Operations rebooked within 28 days - this equated to one case.
- The number of patients waiting over 26 weeks without initiation of treatment and not on a waiting list for a procedure remains at 49, no patient s have waited over 52 weeks.
- 62 day cancer standard and 2 other cancer standards; 2ww referral and 31 day first treatment.

**The Trust achieved in April 2014:**
-18 week RTT across all specialties
- all diagnostic procedures being undertaken in less than 6 weeks
-all Stroke targets
- 2nd cancellations of urgent operations

# A&E Quality Indicators




April 2014 attendances and more significantly admissions have been greater than the same period in 2013, however both were less than we experienced in previous month of March.

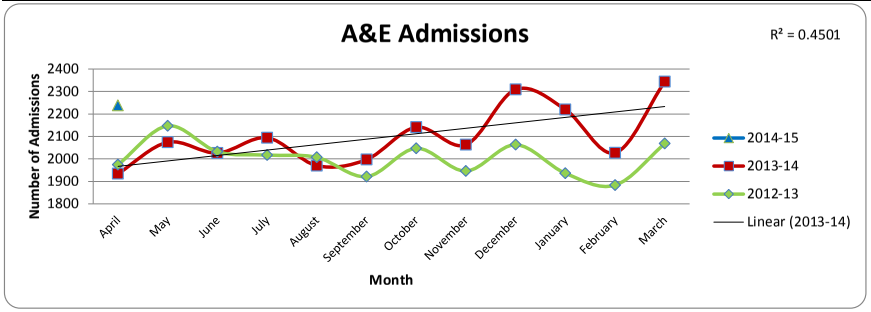
This, combined with the completion of the 'Breaking the Cycle' week (week of 28 th April) resulted in an improvement in the performance of the transit time target.

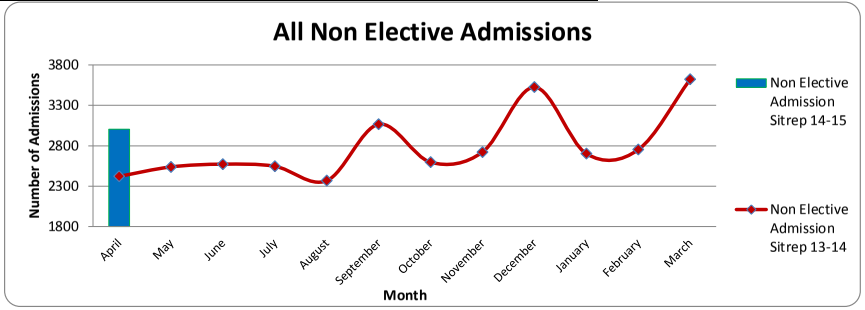
For the first week of May we were the 22nd best performing acute trust in the country.

However since the bank hoilday we have experienced peaks of demand ton a number of days hat have put the system under significant pressure and resulted in days of poor transit time performance. This shows there is more work to do to sustain the changes initiated by the 'Breaking the Cycle' work.

* Note A&E All Attendances from the Symphony system

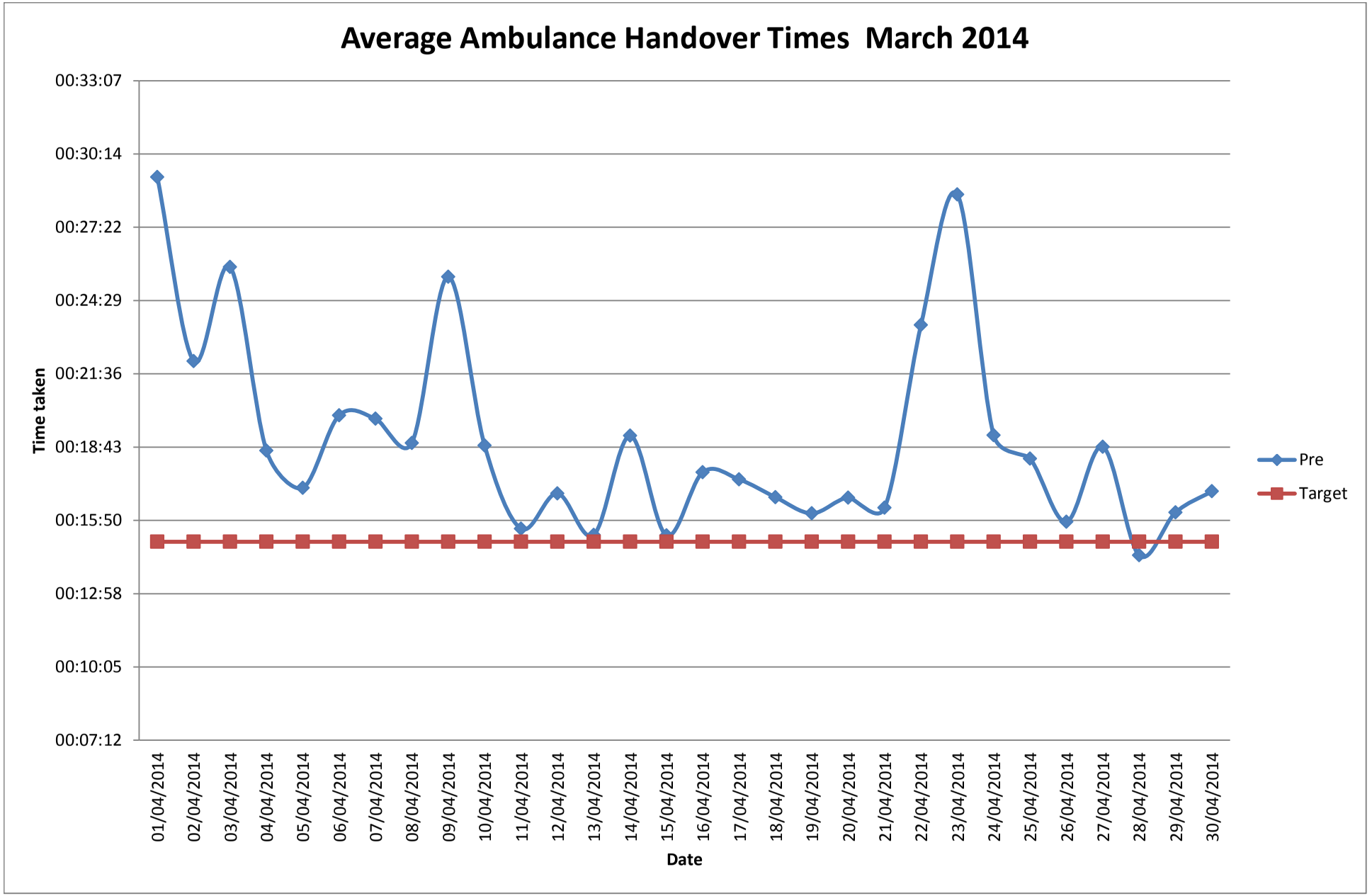
| A&E Targets | Target | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 | Apr-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A&E: Total time in A&E (monthly) | 95% | 87.9% | 96.3% | 93.4% | 94.4% | 90.4% | 90.0% | 90.6% | 94.5% | 89.8% | 85.5% | 81.2% | 90.4% | 92.3% |
| A&E: Total time in A&E (cumulative) | 95% | 87.9% | 92.1% | 92.6% | 93.1% | 92.5% | 92.1% | 91.9% | 92.2% | 91.9% | 91.3% | 90.5% | 90.5% | 92.3% |




* Note: Total A&E Admissions from the Symphony system

*Note: All Non Elective Admissions from the iPM system that are inpatients includes all wards EAU, Benham, etc


Average Ambulance Handover Times March 2014
Time taken
00:33:07
00:30:14
00:27:22
00:24:29
00:21:36
00:18:43
00:15:50
00:12:58
00:10:05
00:07:12
01/04/2014
02/04/2014
03/04/2014
04/04/2014
05/04/2014
06/04/2014
07/04/2014
08/04/2014
09/04/2014
10/04/2014
11/04/2014
12/04/2014
13/04/2014
14/04/2014
15/04/2014
16/04/2014
17/04/2014
18/04/2014
19/04/2014
20/04/2014
21/04/2014
22/04/2014
23/04/2014
24/04/2014
25/04/2014
26/04/2014
27/04/2014
28/04/2014
29/04/2014
30/04/2014
Date
Pre
Target

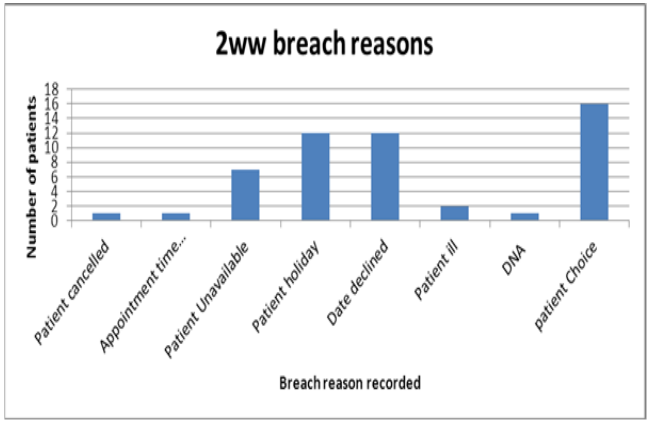
# Cancer

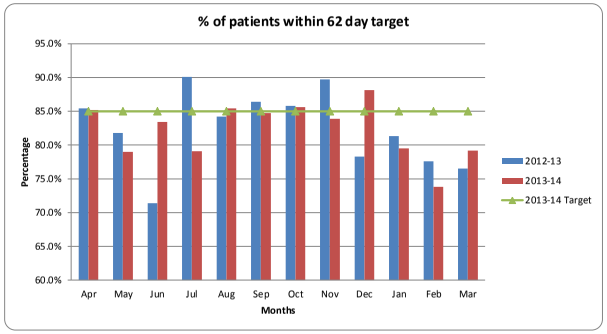
| Access Summary Target or Indicator | Target / Benchmark | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 | Apr-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cancer: 2 week GP referral to 1st outpatient | 93% | 96.00% | 95.40% | 96.20% | 95.50% | 95.10% | 96.60% | 95.80% | 97.60% | 96.30% | 93.70% | 93.40% | 90.90% | 92.49% |
| Cancer: 2 week GP referral to 1st outpatient - breast symptoms | 93% | 100.00% | 100.00% | 100.00% | 98.90% | 100.00% | 100.00% | 99.65% | 100.00% | 98.60% | 100.00% | 58.50% | 86.00% | 94.12% |
| Cancer: 31 Day | 96% | 98.00% | 98.20% | 98.10% | 96.30% | 97.60% | 99.30% | 97.30% | 99.30% | 99.20% | 95.70% | 86.30% | 93.20% | 92.48% |
| Cancer: 31 day second or subsequent treatment - surgery | 94% | 100.00% | 100.00% | 95.50% | 100.00% | 100.00% | 94.10% | 100.00% | 100.00% | 100.00% | 82.80% | 78.60% | 100.00% | 96.00% |
| Cancer: 31 day second or subsequent treatment - drug | 98% | 100.00% | 98.40% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 95.20% | 96.60% | 100.00% | 100.00% |
| Cancer: 31 day second or subsequent treatment - radiotherapy | 94% | 98.32% | 98.60% | 95.80% | 96.50% | 97.40% | 96.50% | 97.80% | 95.80% | 95.70% | 99.20% | 93.80% | 96.20% | 96.00% |
| Cancer: 62 day referral to treatment from screening | 90% | 87.88% | 100.00% | 95.20% | 100.00% | 95.20% | 100.00% | 100.00% | 96.30% | 100.00% | 100.00% | 95.70% | 94.40% | 100.00% |
| Cancer: 62 day referral to treatment from an upgrade by a hospital specialist | 80% | 77.78% | 50.00% | 0.00% | 50.00% | 66.70% | 77.80% | 66.70% | 100.00% | 80.00% | 100.00% | 90.00% | 92.90% | 89.47% |
| Cancer: 62 days urgent referral to treatment of all cancers | 85% | 85.20% | 79.00% | 83.40% | 79.10% | 85.40% | 84.70% | 85.60% | 83.90% | 86.60% | 79.50% | 73.80% | 79.20% | 79.51% |

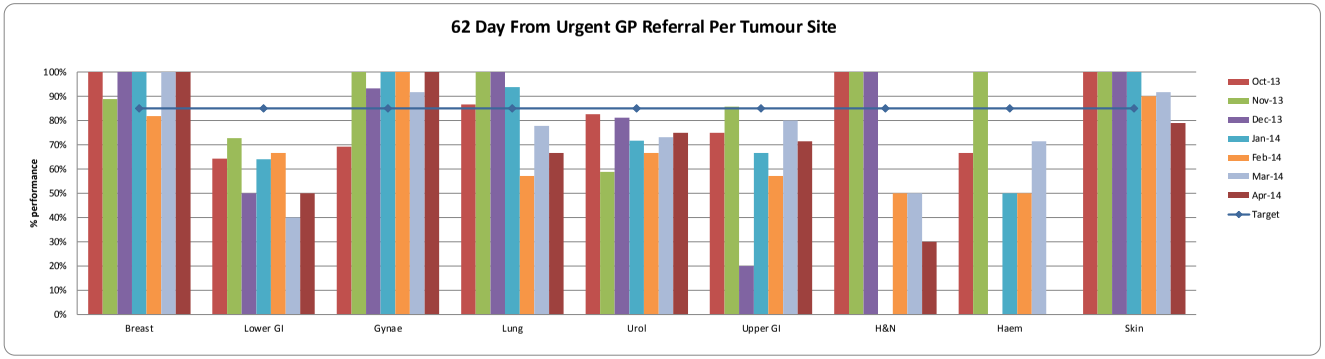
2ww standard
The 2ww referral breaches have been reviewed and the breach reasons are highlighted in the graph below. A communication was sent out to the CCG requesting that they ensured patients were available not only for the 2ww appointment but also the 62 day pathway. All internal clinic capacity concerns are being escalated to the teams and service managers where more slots are required than the allocated number for 2ww patients.

31 day standard
The Trust had 9 breaches on a standard that can only tolerate 6. Six of the breaches were from the skin tumour site. Two of these patients had surgery prior to their 62 day target date but were not booked within the 31 day date. Communication has been sent out to the dermatology team, skin MDT Coordinator / tracker and plastics team to ensure patients with an SCC are booked in within 31 days of the decision to treat date.

62 day standard
Four urology and four Head & Neck patients breached the 62 day target in April. The H&N patient breaches have been investigated and were due to complexity of diagnosing the cancer in 2 cases, a failed feeding tube insertion preventing a patient being treated within target and a KGH referral received on the day of breach. The prostate urology beaches were due to patient indecision about treatment options. These patients had their biopsy prior to the MRI which immediately puts a 4 week delay on the pathway.

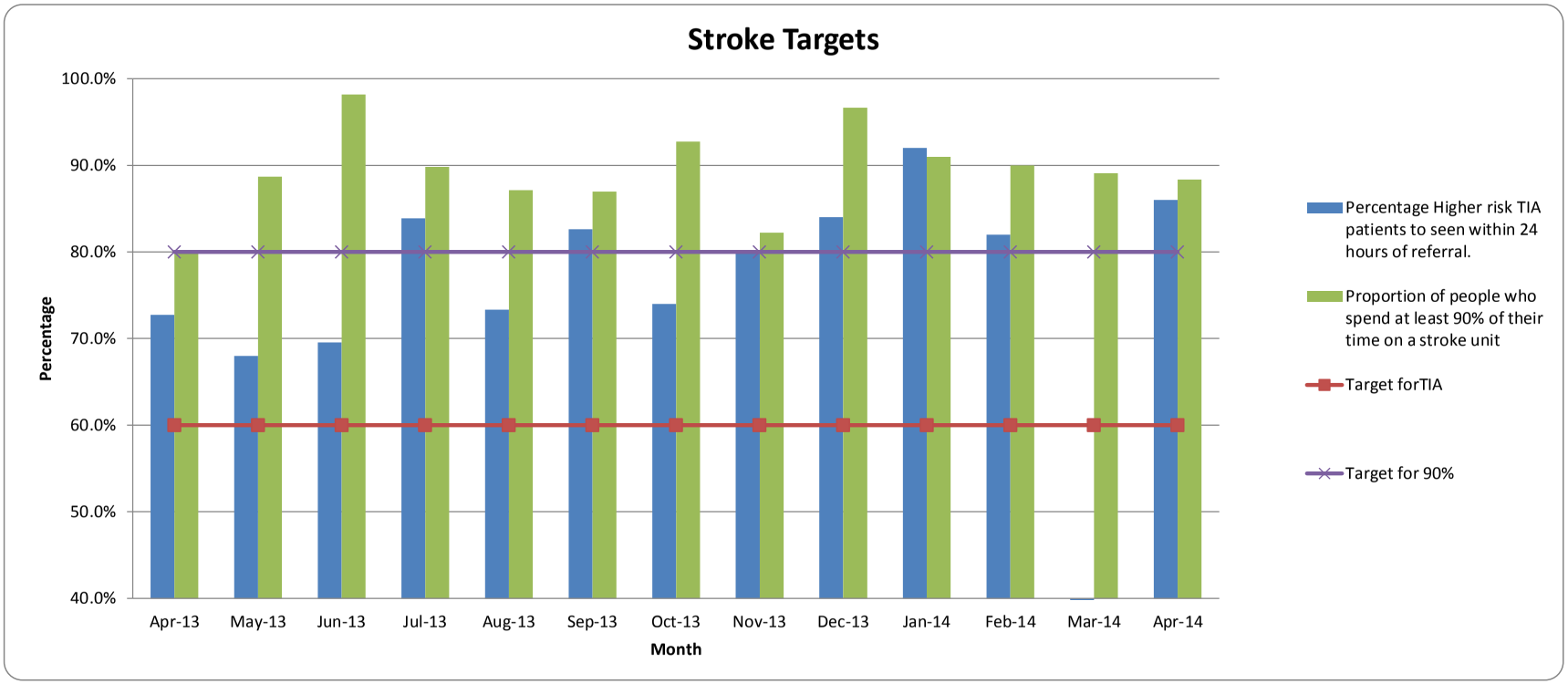


# Stroke

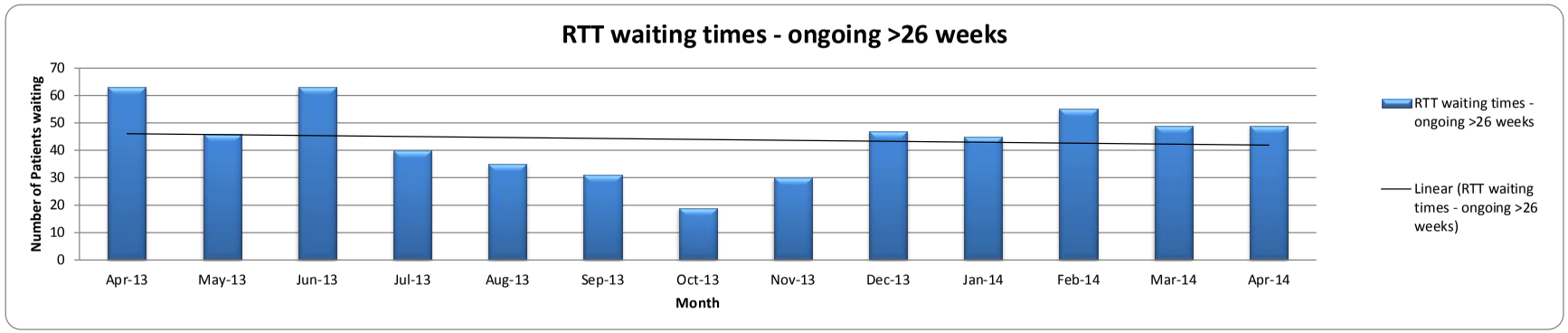
| | Target | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 | Apr-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Percentage Higher risk TIA patients to seen within 24 hours of referral.* | 60.0% | 72.7% | 68.0% | 69.6% | 83.9% | 73.3% | 82.6% | 74.0% | 80.0% | 84.0% | 92.0% | 82.0% | | 86.0% |
| *Proportion of people who spend at least 90% of their time on a stroke unit* | 80.0% | 80.0% | 88.7% | 98.2% | 89.8% | 87.1% | 87.0% | 92.7% | 82.2% | 96.7% | 91.0% | 90.0% | 89.1% | 88.4% |



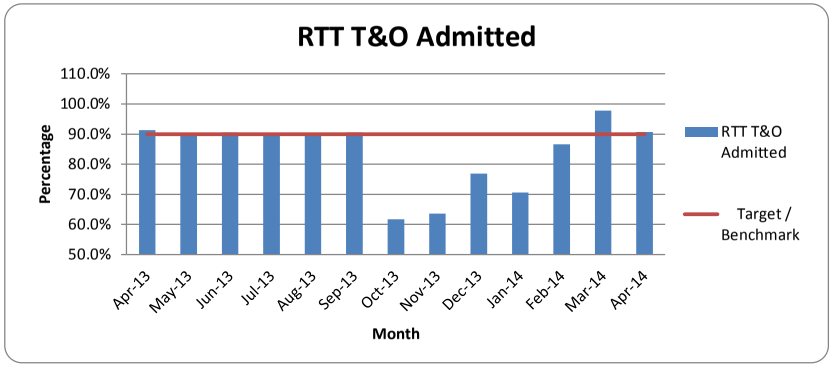

**Key Notes:**

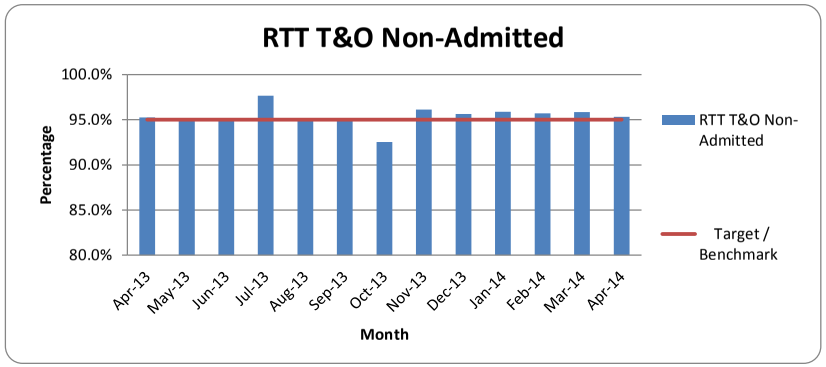
# RTT Waiting Times

| Access Summary Target or Indicator | Monitoring Regime | Target / Benchmark | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 | Apr-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RTT waiting times - ongoing >26 weeks | | 0 | 63 | 46 | 63 | 40 | 35 | 31 | 19 | 30 | 47 | 45 | 55 | 49 | 49 |
| RTT waiting times - ongoing >52 weeks | CCG & TDA | 0 | 0 | 0 | 2 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |




| Access Summary Target or Indicator | Monitoring Regime | Target / Benchmark | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 | Apr-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RTT T&O Admitted | CCG & TDA | **90%** | 91.3% | 90.3% | 90.5% | 90.1% | 90.1% | 90.5% | 61.7% | 63.6% | 76.9% | 70.6% | 86.6% | 97.8% | 90.7% |
| RTT T&O Non-Admitted | CCG & TDA | **95%** | 95.3% | 95.2% | 95.0% | 97.7% | 95.1% | 95.0% | 92.5% | 96.1% | 95.6% | 95.9% | 95.7% | 95.8% | 95.3% |
| RTT ENT Admitted | CCG & TDA | **90%** | 92.9% | 95.5% | 91.9% | 96.5% | 95.7% | 94.7% | 92.9% | 92.0% | 95.5% | 87.1% | 90.5% | 93.8% | 90.7% |
| RTT ENT Non-Admitted | CCG & TDA | **95%** | 96.5% | 98.0% | 96.1% | 99.2% | 98.1% | 97.8% | 98.4% | 98.0% | 98.6% | 97.0% | 95.7% | 97.6% | 98.5% |



Northampton General Hospital NHS
NHS Trust

# REPORT TO: TRUST BOARD
# 29 May 2014

| | |
|---|---|
| **Title** | Urgent Care Report |
| **Agenda item** | 14 |
| **Sponsoring Director** | Deborah Needham, Chief Operating officer |
| **Author(s)** | Richard Wheeler – Urgent Care Programme Manager |
| **Purpose** | The paper is presented for Information and assurance |

**Executive summary**

The Trust has not achieved the Urgent Care 4 hour standard for April 2014 therefore a highlight report was presented to Integrated Healthcare Governance Committee in May 2014.
Significant improvement has been demonstrated throughout May 2014.

The report is attached as an appendix to the overall performance report for information only

Appendix 1 Urgent Care highlight report

| | |
|---|---|
| **Related strategic aim and corporate objective** | Be a provider of quality care for all our patients |
| **Risk and assurance** | Risk of not delivering the 4hr urgent care standard |
| **Related Board Assurance Framework entries** | BAF 17 |
| **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)<br><br>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** | N/A |

**Actions required by the Trust Board**

The Board is asked to note the report

Enclosure K

Northampton General Hospital NHS
NHS Trust

# Trust Board
# 29 May 2014

## Urgent Care Programme Highlight Report

### Breaking the Cycle

In response to the increased demand on front door services, ongoing challenges discharging patients and their combined impact on patient flow, McKinsey & Company were commissioned by the Trust for a 6 week period to work with staff and provide rapid acceleration within the Urgent Care Programme. The collective effort was called 'Breaking the Cycle' and was broken down into 3 categories:

1. **Establishing 'one version of the truth'**
   Throughout the Trust and external agencies there are a multitude of 'issues' which are repeatedly discussed, without confirmation of their reality. 'One version of the Truth' aimed to quash and/or support these myths, so collectively we can tackle and resolve the real issues.

2. '**Breaking the cycle'**
   The Trust had come to accept breaches and red RAG ratings on numerous dashboards. This needed to be stopped and the cycle we had fallen into broken. The Trust implemented a Command and Control approach to operational management which was efficient, however, extremely labour intensive and unsustainable. We needed an effective, long term approach to daily operational management which would create a new normal for the Trust.

3. **Drive sustained performance through transparent reporting**
   NGH is information rich and produces a significant number of dashboards to monitor and manage performance. Nevertheless, this can have an adverse effect and dilute true metrics which should be monitored daily to analyse performance and patient care. These core metrics were identified and circulated at required intervals.

Working with NGH, the McKinsey & Company team evaluated and helped to realign the existing work streams of the Urgent Care Programme to focus on the following areas each area continued to focus around quality and safety:

1. 7 day Services
2. Safe care of patients in ED
3. Safe care of patients in Assessment units and ACC
4. Safe care of patients on the wards
5. Complex Discharges
6. Frail and Elderly pathway
7. Capacity Management

Enclosure K

The cumulative work over the 6 weeks led to ‘Breaking the Cycle’ week where new and sustainable treatments were fully implemented.

Some of the treatments have been reported at previous meetings and include:

Safe care of patients in ED

1. Change in doctor shift hours to start at 7am to match demand
2. Implementation of fast intervention and assessment (FIT)
3. Fit implemented for the last 30 mins of each shift
4. New escalation for speciality referral delays

Safe care of patients in Assessment units and ACC

1. Ring-fenced staffing
2. Different ways of working to track patients

Safe care of patients on the wards

1. Nurse leadership development / back to basics / greater autonomy
2. Marriage agreement for nurses/doctors for each ward
3. Satellite discharge lounges

Complex Discharges

1. Implementation of a daily tracking meeting led by NGH with partners to challenge delays and gain a joint view of responsibility for delayed patients

Frail and Elderly pathway

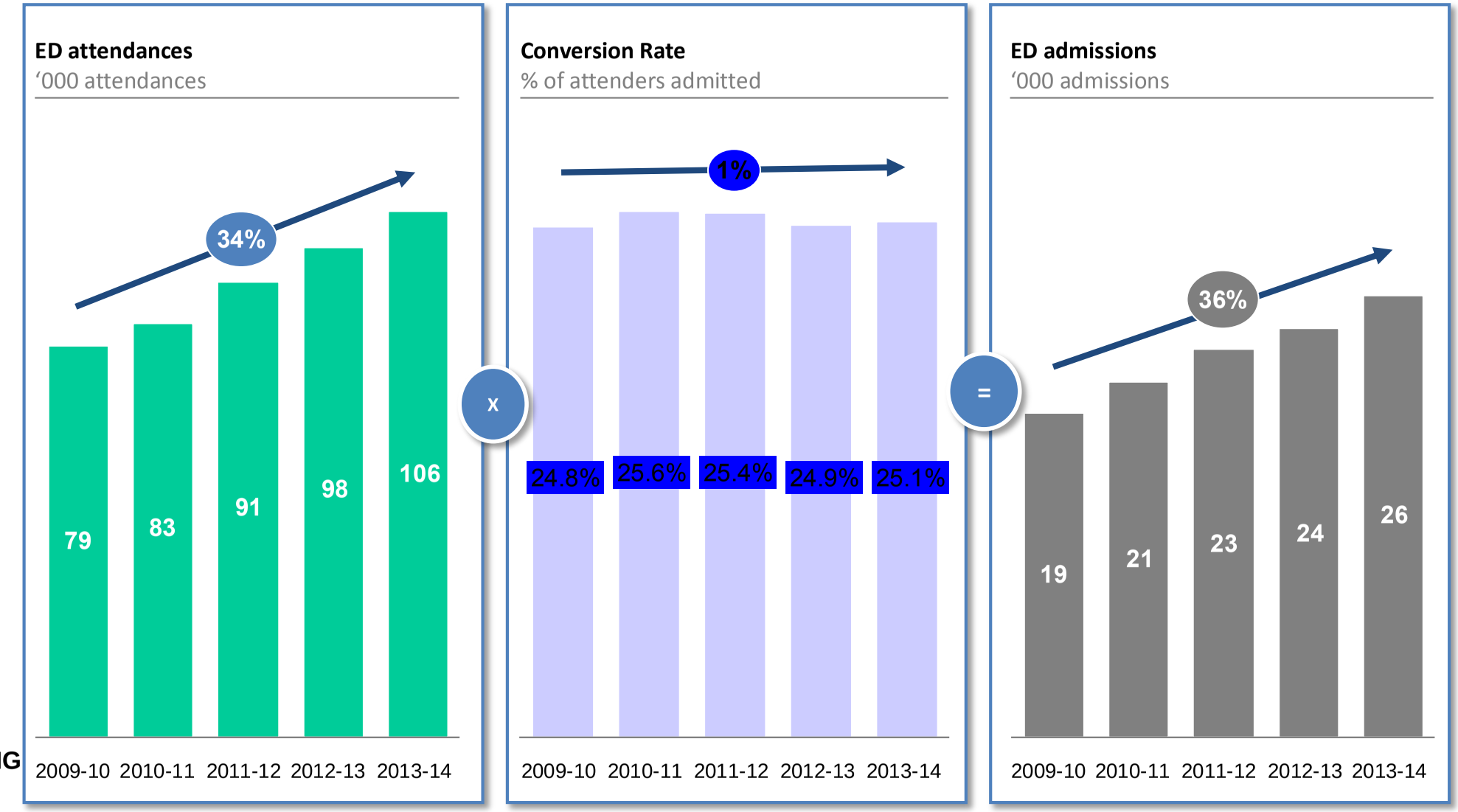
1. Daily MDT on the assessment wards
2. Development of care bundle for falls
3. Introduction of a elderly care nurse to support process and MDT
4. Redefine Creaton ward using same model as Brampton (Crisis hub input)

Capacity Management

1. Twice daily huddles with ward staff
2. Development of daily operational rhythm and refreshed reporting

## ED attendances and subsequent admissions

Over the past 5 years, ED attendances have increased by 34%. With the conversion rate maintaining only a 0.8% variance over the same time, admissions have increased at a similar rate, with a 36% increase, inevitably putting pressure on the urgent care system within the Trust.



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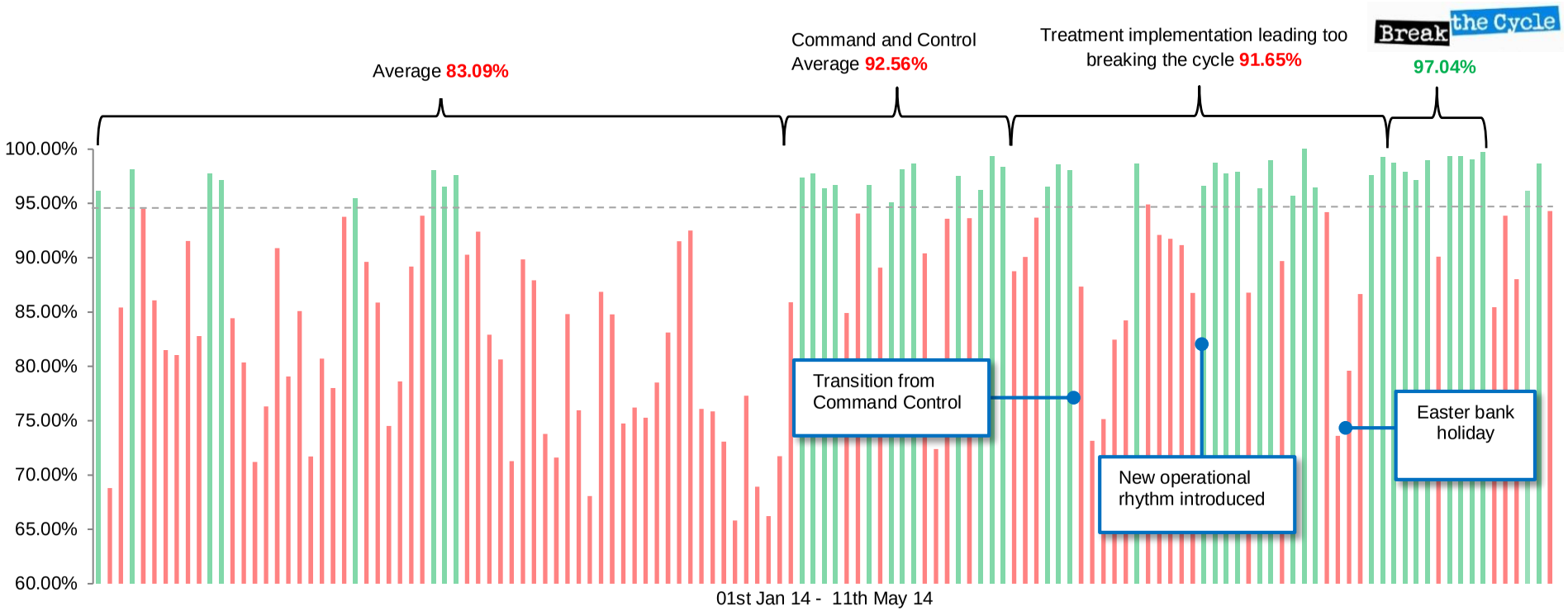
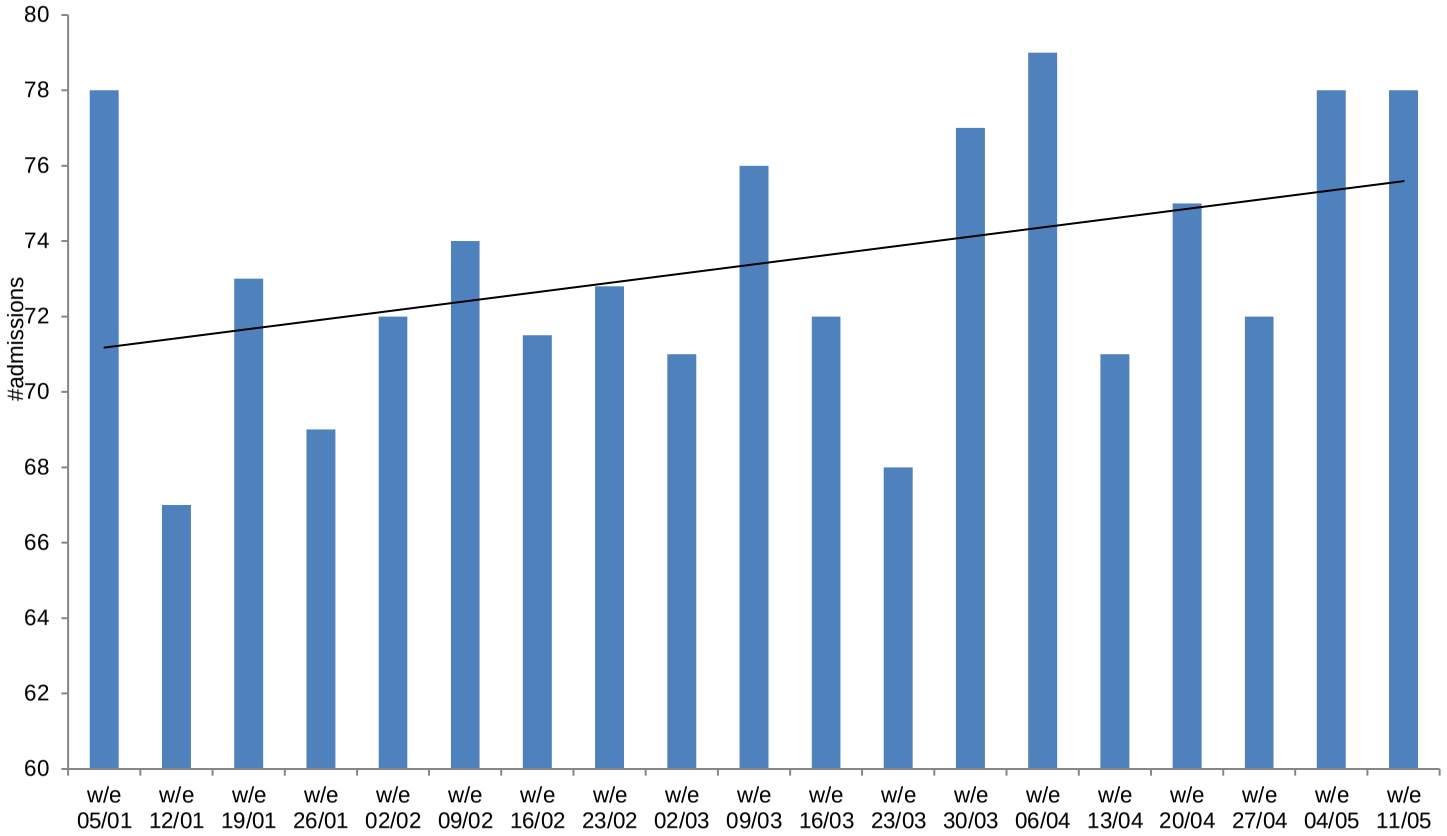
The Graph below shows how the Trusts performance has improved from the introduction of command and control through to breaking the cycle.






The Information for January to March illustrates the level of performance which had become the 'norm', where the Trust failed to achieve the 95% target. From the 3rd March 2014, the Command and Control approach to operational management saw a 9.47% increase in the numbers of patients seen within 4hrs. This increased performance was maintained whilst treatments were implemented with a drop in 1% in average; however, a significant increase occurred following the introduction of 'Clinical Safety Huddles'. Despite a drop over the Easter weekend, the Trust recovered quickly due to the new processes implemented. Unfortunately, the Trust struggled to achieve over 95% following the bank holiday weekend (3/5 – 5/5). This is mainly due to 373 attendances in ED and 110 admissions on the 6/5, but once again the Trust recovered from this position quickly. It is important to note that whilst the weekly admission rate remains variable the trend continues upwards over the same period which supports the effectiveness of the treatments implemented.




Overall, the Trust is performing more effectively due to the treatments implemented and the new' battle rhythm' being adopted.

## ‘One version of the Truth’

As detailed above, McKinsey & Company completed extensive analysis to develop ‘One Version of the Truth’. A full collection of analytics are available at the request to the Urgent Care Programme Manager, Richard Wheeler richard.wheeler@ngh.nhs.uk , however, a Summary of core patient flow areas can be seen below:

1. **Primary Care**

***There is a high number of patients presenting at the NGH ED who could receive care in a lower intensity setting.*** *18% of patients attending the NGH ED have no treatment or investigation carried out – this is high when compared to other hospitals in the region who do not have a dedicated UCC facility, but lower than those with UCC capabilities. An additional 34% of patients attending the ED have low complexity investigations or treatments.*

***NGH should work with primary providers to reduce the demand that this cohort of patients places on the ED.*** *These patients who receive ‘minor’ care from the ED teams are creating pressure in the department both in terms of demand on workforce and occupation of physical space.*

***Options to explore are admission avoidance using primary care channels and improved streaming of patients at the ED front door to manage patients who still present at the ED.*** *The Trust has in place a GP within ED to help alleviate the pressure on the ED service, and plans in place to develop a UCC service.*

***Access and quality of primary care in Nene is below average for the East Midlands region, but there is no evidence to suggest that improving GP coverage would reduce attendances at the ED.*** *Nene has one the lowest number of GPs per head of population in the East Midlands region, and is 21% below the national average. But Nene’s ED attendances per head of population are also lower than average and national data does not suggest there is a link to increasing GP coverage and reducing ED attendances. In addition, only 4% of patients claim to attend ED when they cannot access the GP, almost half that of the East Midlands average of 7%.*

***There is however opportunity to work with specific GP practices to reduce the variation in the proportional volumes of patients attending the ED from their registers.***

2. **Inflows**

***NGH has seen an extreme increase in both attendances and admissions over the past 5 years, higher than any other comparable hospital in the region****. Attendances have risen by 34% in 5 years, however conversion rates have remained relatively flat, leading to*

*an increase in admissions of 36% over the same period. This increase is 3-4 times the increase seen at other consultant-led A&E facilities in the East Midlands region.*

***The Trust has seen a significant increase in elderly patients being brought in by ambulance from within 5 miles, and in walk-in working adults and paediatrics with minor injuries coming from under 5 miles.***

3. **Emergency Department**

***4 hour target breaches in the ED are 40% due to bed unavailability, 25% failures in ED processes, 25% slow specialty response for review and 10% 'others'.***

***Mondays are consistently the worst performing day in the department, and the wider hospital, must develop plans to deal with the expected surge in attendances and admissions.***

***The breaches due to failures in ED processes are primarily due to slow first assessment times****. Most breaches are ambulance patients requiring admission, so focusing on this cohort of patients first for rapid assessment seems sensible, although the process will need to be rolled out in time to cover all major patients. There is also an opportunity to increase productivity through the night shift to ensure the day starts in the best possible position.*

***Most of the breaches are working age adults requiring admission, who are unable to find a bed due to blocked flow through the rest of the hospital.***

4. **Emergency Assessment Unit (EAU)**

***Maintaining flow through EAU is critical to 4hour breach performance in the ED, and in particular NGH should focus on starting the flow out of EAU as early in the day as possible and ensuring patients do not stay overnight in the EAU unnecessarily.*** *There is a 'stepped' profile to the correlation between the number of available beds at midday and the performance for the rest of the day – keeping occupancy below these thresholds is crucial to maintaining flow and performance. There is a linear correlation between the number of available beds at midnight and the following day's performance, therefore moving patients through and keeping beds available is essential for the following day's performance.*

***The current EAU system operates as a short stay ward, rather than a 'true' assessment unit, with the blockage coming from a large volume of elderly patients who stay longer****. 2 in 5 patients stay over 24 hours and 1 in 5 patients stay over 48 hours. 54% of patients on EAU are over 65, and they occupy 63% of available time in beds,*

*averaging 36 hrs on the ward. However the number of elderly patients admitted to EAU from ED is lower than regional and national averages, indicating the issue is not in the volume of patients being admitted, but in the speed at which they can be processed.*

***The problem is systemic, with all consultants averaging over 28hrs ALoS for their patients on the EAU.***

***Timeliness of discharge is also an issue, with low discharges early in the day and at the beginning of the week – the key times when ED needs flow most.*** *Only 54% of discharges occur after 5pm. There are fewer discharges on Monday than any other week day and discharges at the weekend are lower still, despite weekend consultant cover.*

5. **Wards**

***Maintaining flow through the wards, and in particular having capacity available overnight, is critical to achieving good breach performance – however this is something which NGH is unable to do, despite having fewer admissions per bed than peers.***

***This is because NGH has a high non-elective length of stay compared to peers.*** *NGH has a non-elective ALoS of 7.1 days vs. a peer median of 5.9, which is mostly driven by general medicine patients who make up 45% of all non-elective admissions and have an average length of stay of 8.5 days, compared to a peer median of 6.5. Whilst there is a systemic problem, there is scope to reduce the variation between clinicians within specialties.*

***Consequently, bed occupancy on major non-elective wards averages >95%,*** *and there is further work to be done to improve the timeliness of discharge on the wards and to encourage a 'pull' of patients through the system earlier in the day.*

6. **Outflows**

**The lack of flow on the wards is primarily caused by the delays in the discharges of complex patients**

- Analysis suggests that NGH is facing a more severe long-stayer problem than its peers
- Although long stay patients represent only ~20% of non-elective admissions, they occupy ~75% of non-elective bed-days

**To quantify the impact on the Trust of the delays in the flow of patients with complex discharges we have analysed Trust databases and performed audits to verify the results**

- Analysis reveals that most of complex discharges stay 20+ days POST-MDT ALLOCATION in the hospital. In the period of Jan-Mar 2014, “delayed” complex discharges occupied approximately 6,700 bed days, equivalent to ~75 beds
- Audits verify that clinically stable complex patients on average occupy up to 90 beds, ~15 % of the hospital’s total bed base

## Review and update on external reviews

In Q3 13/14, the Trust worked with two external partners and evaluated the Urgent Care Programme and a series of recommendations were provided.

The information below highlights progress against the recommendations:

1. **Mott McDonald**

| Theme | Recommendation | Current position (12/5/14) | RAG rating |
|---|---|---|---|
| Partnership working | Work with CCG and primary care to reduce unnecessary A&E attendance | The Urgent Care Working group meets weekly, with representatives from NGH, CCG, NHFT, GP's, ICT, EMAS and NCC.<br><br>Data is shared discussing ED attendances, GP localities and % of attenders, EMAS conveyance %, care home pathways, public education.<br><br>Joint work continues although there is no impact on reducing attendees | |
| Partnership working | Work to support training of Community provider and Ambulance Trust nursing and paramedic staff so that Ambulance Paramedic Services develop links with Community Nursing teams to provide assessment, see & treat or immediate referral to non-acute setting. | Through the Urgent Care Working Group (UCWG), NGH is kept up-to-date with EMAS pathways, treat on scene, alternative and appropriate treatment locations.<br><br>EMAS Northampton non conveyance is the lowest within the region. EMAS are working to reduce conveyance by a further 1% in 2014/15, the action plan is monitored at the UCWG | |

| Theme | Recommendation | Current position (12/5/14) | RAG rating |
|---|---|---|---|
| Partnership working | Design, agree criteria and implement, with all partners in health and social care, and for all types of bed across the LHSC, a “discharge to assess” model in place of the current “assess to discharge model” supported by a shared electronic single assessment process. | Discharge-to-assess (DTA) is running at NGH with all healthcare partners. The meetings are held daily at 9am to ensure patients are referred to the correct team immediately. All CHC patients are referred and assessed under DTA, the CCG are currently leading a programme to extend DTA to all patients requiring social care via NCC.<br><br>The tracking sheet is used across all teams, administered by the Information Sharing Team. | |
| Partnership working | Undertake a detailed financial review of the cost of alternative care settings compared with the current service provision and develop an implementation plan for resource investment and dis-investment. | In Q1 13/14, a review was undertaken of services provided under winter monies which should be continued, and appropriate business cases were submitted.<br><br>The Trust is continuously looking at alternative options for patients, to ensure they receive the most suitable locations for the care they require. This includes evaluating extending bed base in Cliftonville care home (spencer house), investigating options for ‘Healthcare at Home’ with possible implementation before Winter 2014, and My Care My Home type programmes to ensure self-funding patients requiring further care away from and Acute setting are supported to make decisions and alternative interim locations are made available until final decision is made, ensuring the acute bed is utilised most | |

| Theme | Recommendation | Current position (12/5/14) | RAG rating |
|---|---|---|---|
| | | effectively. | |
| A&E process change | Roll out therapy and social work teams in A&E on 24-hour basis to identify patients immediately suitable to return home, with support or for intermediate care. This will include reduction in known frequent attenders who will have individual care plans. | NGH discharge facilitators work from EAU / Benham to ensure patients' needs are identified and managed from day 1. Patients are discussed at the daily DTA meetings to ensure patients are referred to the correct teams.<br><br>Therapy and social work teams are all included at DTA meetings.<br><br>Therapists are based in and work with A&E (in hours), out of hours the service is provided by ICT. | |
| A&E process change | Compile a directory of LHSC services, relevant to the Urgent Care pathway, for use by all A&E staff. | A Directory of Service (DOS) has been completed and is available for use by A&E and EMAS<br><br>A GP app is also available and contains the DOS | |
| Assessment and admission process | Design and implement a surgical assessment unit. | As part of the urgent care programme, the assessment unit in surgery is being reviewed with a view to refining the processes or joining the medical and surgical units. The SAU (if standalone) will have Symphony implemented, the Clinical IT application used in ED, and assessment units. | |
| Assessment and admission | Embed cross sector discharge planning as part of the admission process so that every patient has an expected | NGH discharge facilitators work from EAU / Benham to ensure patients' needs are identified and managed from | |

| Theme | Recommendation | Current position (12/5/14) | RAG rating |
|---|---|---|---|
| process | LoS and EDD on admission, involving CHC, social care, patients and families in the process from day 1 to reduce the large number of disputes. | day 1. Patients are discussed at the daily DTA meetings to ensure patients are referred to the correct teams. MDTs are organised involving families and patients as necessary.<br><br>DTOC (Delayed Transfer of Care) meetings are also being held daily to actively manage the coordination of health and social partners in addressing delays for discharge.<br><br>Ward Workspace application has been launched and patients EDDs are recorded by the wards after they have been determined by the MDT. This requires some further work. | |
| Assessment and admission process | Design and implement an admission policy that reviews the expected length of stay of the individual and transfers them to an admission unit only if expected LoS is less than 48 hours, otherwise they are admitted directly to a base ward. | Once flow improves through the hospital, the Trusts assessment units will be more able to work as effective assessment units. | |
| Organisation wide UC process - Leadership | Implement a single organisation wide operational role with responsibility for managing the Urgent Care pathway across all departments and beds. | Following the work with McKinsey, The daily responsibility for Urgent Care and flow is delegated from the COO to the care group directors.<br>There is a names clinical lead for urgent care. | |

| Theme | Recommendation | Current position (12/5/14) | RAG rating |
|---|---|---|---|
| Organisation wide UC process - Structure | Decrease the complexity and fragmentation of the management structures for the Urgent Care pathway, unifying into a single forum. | The Urgent Care Programme Structure has been reviewed and expanded meets weekly to monitor performance.<br>Each work stream meets weekly and has a clinical and managerial lead who are responsible for delivery. | |
| Organisation wide UC process - Information | Implement a real time information system, enabling monitoring and management of bed usage and patient flows across the Urgent Care pathway, including Expected and actual discharge date. | Ward Workspace was implemented in Nov 13 and provides the Trust with a bed management application and EPR.<br><br>The application can record EDD, discharge information, medical information, bed status. Further work is required | |
| Discharge planning | Each ward to have a discharge facilitation role per shift to attend ward rounds, undertake or chase follow up actions, and actively manage discharge, such as external liaison, TTOs and transport. | After consideration, it was agreed that this should be the responsibility of the Ward coordinator to complete these tasks with support from the matron and discharge team. | |
| Discharge planning | Review the lessons learnt from others including, for example, the Portsmouth Discharge Policy, with a view to adapting it to meet the needs of NGH. | The Trust reviewed the Portsmouth documentation and incorporated some practice into the admission and discharge policy and escalation plan. | |
| Longer term | Consultant cover is increased, with A&E consultants. To enable a 1 in 8 rota. | The ED departments have additional consultants and can achieve a 1 in 7 rota.<br>Further recruitment is taking place and extended hours will commence when the rota is above 1 in 8 | |

| Theme | Recommendation | Current position (12/5/14) | RAG rating |
|---|---|---|---|
| Longer term | Redesign consultant job plans and medical model so that on-call blocks of days are protected with no other responsibilities with consultant presence for at least 12 hours per day 7 days a week. | On-take rota has been amended, with greater number of days on to ensure continuity of care for patients.<br>An escalation policy has been agreed to ensure waits for speciality review are minimal. Further work is required. | |

**2. ECIST – Emergency Care Intensive Support Team**

| ECIST item | Comments | RAG rating |
|---|---|---|
| Recommend that a model is developed to meet increased demand in ED while trying to assess reason for Significant Growth | Staffing levels now match ED demand profile.<br><br>Rapid Assessment Model (FIT) is implemented between 1100 – 1700.<br><br>Urgent Care Working Group South meets weekly. Data is shared discussing ED attendances, GP localities and % of attenders, EMAS conveyance %, care home pathways, public education.<br><br>One version of the truth work has now been shared and adopted across the county | |
| Early Senior Assessment in ED | 2 hourly safety rounds by senior staff<br><br>Rapid Assessment Model (FIT) now in place between 1100 – 1700. | |
| Streaming to decongest ED | Streaming Nurse in place. Will direct patients away, to GP in ED, patients | |

| ECIST item | Comments | RAG rating |
|---|---|---|
| | own GP or to ED department. Ongoing refinement. (New model in place from 1st May)<br><br>Ambulatory Care Centre opened in September 2013. Ongoing development of unit to maximise potential | |
| GP referral Pathway | GP's are now in ED. Service provided: 11:00 – 17:00 Weekdays / 09:00 – 18:00 Weekends<br>GP referral into specialities has been defined and is well documented | |
| Potential high impact change is to develop front door/assessment model for frail older people – most effective will be multi-disciplinary team approach with cross-over of roles (reduces reliance on Consultants who will be difficult to recruit) | ICT are now on the shop floor in ED / Assessment units.<br>NGH discharge facilitators work from EAU / Benham to ensure patients' needs are identified and managed from day 1. Patients are discussed at the daily DTA meetings to ensure patients are referred to the correct teams.<br>Urgent Care Programme extended to cover frail elderly to ensure cohort of patients are seen by most appropriate clinician and ensure MDT's happen.<br>Daily 12md MDT being undertaken on EAU by elderly care physicians | |
| Urgently need to reduce number of patients over 7 days LOS | The entire Urgent Care Programme is focused on improving processes which in turn will reduce patients LOS<br>A daily tracking meeting led by NGH is in place where all complex discharges are discussed in a confirm and challenge meeting with health and social care partners | |
| Reducing duplication of assessments | Ongoing refinement of processes to reduce duplication. Integrated discharge team now in place early indication is that the new collective working has had positive impact but requires further development | |
| Consider trusted assessment process | As above | |

| ECIST item | Comments | RAG rating |
|---|---|---|
| | | |
| Discharge planning from Admission (Clinical criteria for discharge and IPS) | Change to on take rota to ensure Consultant continuity<br>Implementation and further development of Ward Workspace application, helping to monitor a patient's status and capture complex discharge requirements during admission.<br><br>NGH Discharge Facilitators now working in Assessment Units to capture patients discharge requirements from day 1. | |

## The future for the Urgent Care Programme

The Urgent Care Programme will continue to gain pace and hold project groups to account. The focus will now be to ensure that the treatments implemented are sustained, and the highest level of patient care, safety and performance are maintained.
Once performance is maintained, additional treatments must be identified and rolled out to ensure continuous improvement.

## Conclusion

NGH will continue to provide focus and momentum on the Urgent Care Programme to build on the positive progress made.
ECIST will be invited back into the Trust to further review the urgent care programme and offer recommendations for further improvement.

## Recommendation

The Board is asked to note the report and seek areas of clarification.

**REPORT TO: TRUST BOARD**
**29 May 2014**

| | |
|---|---|
| **Title** | Finance Report Month 1 (April 2014-15) |
| **Agenda item** | 15 |
| **Sponsoring Director** | Simon Lazarus, Director of Finance |
| **Author(s)** | Andrew Foster, Director of Finance |
| **Purpose** | To report the financial position for the period ended April 2014. |

**Executive summary**

**This report sets out the financial position for the period ended April 2014.**

- The position for M1 is a £2.2m deficit giving rise to early concern in relation to achievement of the TDA plan for 14-15.
- The M1 position includes a number of one-off significant expenditure items which should not arise again in future months.
- In April elective and outpatient activity was below plan across most points of delivery.
- Non Elective activity has performed above plan in April giving rise to increased exposure to the associated MRET penalty.
- There is slippage evident in the IQE programme delivery in month 1.
- The cashflow position has remained positive although action needs to be taken to ensure loan applications are progressed in June.

| | |
|---|---|
| **Related strategic aim and corporate objective** | Develop IBP which meets financial and operational targets. |
| **Risk and assurance** | There are a range of financial risks which pose a direct risk to delivery of the financial plan for 2013-14. |
| **Related Board Assurance Framework entries** | BAF 17, 18,19 |
| **Equality Impact Assessment** | N/A |
| **Legal implications / regulatory requirements** | NHS Statutory Financial Duties |

Enclosure L

**Actions required by the Trust Board**

The Board is asked to note the recommendations and actions contained in the report.

Northampton General Hospital NHS
NHS Trust

# Financial Position
# Month 1  2014/15

Report to
Trust Board
May 2014



Enclosure L

# 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 | -£2,242 | -£1,137 | £ 1,105 Adv | -£7,829 | -£7,829 | - |
| Achieving EFL (£000's) | | | | £16,337 | £16,337 | £0 |
| Achieving the Capital Resource Limit (£000's) | £265 | £874 | £ 609 Fav | £21,401 | £21,401 | £0 |
| **Better Payment Practice Code:** | | | | | | |
| Volume of Invoices | 91.98% | 95.00% | 3.02% Adv | 93.00% | 95.00% | 2.00% Adv |
| Value of Invoices | 94.26% | 95.00% | 0.74% Adv | 94.50% | 95.00% | 0.50% Adv |

## Financial Performance

- Financial performance for the period ended April 2014 is a normalised deficit of £2.2m.
- This position remains subject to full validation of case mix and coding for discharges during April.
- The position as set out in his report was submitted to the TDA on Friday 16th May in accordance with the national reporting timetable.
- The Trust is forecasting delivery of the plan as submitted to the TDA in April.

## Capital Expenditure

- The full year planned capital expenditure is £21.5m and includes the replacement Radiology and Radiotherapy equipment schemes.
- YTD expenditure of £0.3m has been recorded for the period with 8% of the full year plan committed to date.
- Delivery of the full plan is contingent on the Trust making a successful application to the Independent Trust Financing Facility (ITFF) for £9m of new PDC loans.

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

- The EFL for 14/15 stands at £16.4m(+ve) reflecting the planned new PDC loans required to fund the Radiology and Radiotherapy capital scheme.
- The Trust continues to improve performance against the BPPC target although fell short of the 95% target to pay suppliers within 30 days in April.

## Key issues

- The position for M1 is a £2.2m deficit giving rise to early concern in relation to achievement of the TDA plan for 14-15.
- The M1 position includes a number of one-off significant expenditure items which should not arise again in future months.
- In April elective and outpatient activity was below plan across most points of delivery.
- NEL activity has performed above plan in April giving rise to a potential increased exposure to the 70% MRET penalty.
- There is slippage evident in the IQE programme delivery in month 1.
- The cashflow position has remained positive although action needs to be taken to ensure loan applications are progressed in June.

## Actions

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

- CIP delivery
- Outsourced activity
- Increased MRET penalty and fines
- CQUIN
- Significant expenditure and agency costs
- PDC loans.

# 2.Financial Performance Dashboard

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

## Key issues

### KPIs

- Shadow Continuity of Service Rating (CSR) of 3 supported by cash balance of £4.3m.

### I&E Position

- I&E position adverse to plan by £1.1m.
- Current forecast aims to deliver plan submitted to TDA in April.
- Formal TDA agreement of plan awaited.
- Pay / Income ratio increased to 70% in April.

### Cost Improvement Programme

- CIP programme delivery is £0.4m, £0.1m adverse to plan in April.

### Capital

- Full year capital expenditure plan stands at £21.5m (includes £100k assumption for donated assets).

### Cash

- Liquidity has been maintained over the financial year end with only £100k reduction in cash balances month on month.
- Loan applications required to secure temporary borrowing and capital PDC funding.
- BPPC performance 92% by volume.

# 3.Income and Expenditure Position

| I&E Summary | Annual Plan 2014/2015 | YTD Actual | YTD Plan | Variance to Plan | Full Year Forecast |
|---|---|---|---|---|---|
| | £000's | £000's | £000's | £000's | £000's |
| SLA Clinical Income | 237,701 | 19,194 | 19,387 | (194) | 237,701 |
| Other Clinical Income | 2,690 | 92 | 224 | (132) | 2,690 |
| Other Income | 24,056 | 1,695 | 1,999 | (304) | 24,056 |
| Total Income | 264,446 | 20,981 | 21,611 | (630) | 264,446 |
| | | | | | 0 |
| Pay Costs | (175,834) | (14,829) | (14,679) | (150) | (175,834) |
| Non-Pay Costs | (77,985) | (7,091) | (6,846) | (245) | (77,985) |
| CIPs | 0 | 0 | 0 | (0) | 0 |
| Reserves/ Non-Rec | (2,250) | 0 | 79 | (79) | (2,250) |
| Total Costs | (256,069) | (21,920) | (21,446) | (474) | (256,069) |
| | | | | | 0 |
| EBITDA | 8,377 | (939) | 165 | (1,104) | 8,377 |
| | | | | | 0 |
| Depreciation | (12,268) | (982) | (982) | (0) | (12,268) |
| Amortisation | (10) | (1) | (1) | 0 | (10) |
| Impairments | 0 | 0 | 0 | 0 | 0 |
| Net Interest | 29 | 2 | 2 | (1) | 29 |
| Dividend | (4,409) | (367) | (367) | (0) | (4,409) |
| | | | | | 0 |
| Surplus / (Deficit) | (8,281) | (2,288) | (1,183) | (1,105) | (8,281) |
| Normalised Postion: | | | | | |
| Donated Assets | 452 | 46 | 46 | 0 | 452 |
| Impairments | 0 | 0 | 0 | 0 | 0 |
| I&E Position | (7,829) | (2,242) | (1,137) | (1,105) | (7,829) |

## I&E Performance

- Financial performance for the period ended March 2014 is a normalised deficit of £2.2m, compared to a planned deficit of £1.1m giving rise to an adverse variance of £1.1m for the month of April.
- Income is £0.6m adverse to plan.
- Pay expenditure is £0.15m adverse to plan.
- Non-Pay expenditure is £0.245m adverse to plan.
- Forecast is for delivery of the I&E plan as submitted to the TDA in April.

## Key issues

**SLA Income**

- Underling overperformance offset by requirement to make provision for potential fines and penalties.
- NEL activity above plan in April giving rise to increased MRET exposure.
- Daycase, elective and outpatients below plan.

**Other Income**

- Private Patient income £71k adverse to plan.
- RTA income £61k adverse to plan.
- Income Generation £292k adverse to plan.

**Pay**

- Pay expenditure £0.15m adverse to plan.
- Nursing pay expenditure £92k adverse to plan including Bank costs of £428k and Agency costs £415k. Increase temporary staffing costs despite loss of Community wards in April.
- Temporary management and administration cost increasing, £112k for month of April.

**Non-Pay**

- Non-Pay expenditure £0.245m adverse to plan.
- Consultancy Fees £182k adverse to plan.
- Nurse Recruitment £66k adverse to plan.

**CIPs**

- CIP targets fully allocated to directorates. Targets for month 1:
  - Income £256k
  - Pay £199k
  - Non-Pay £89k.

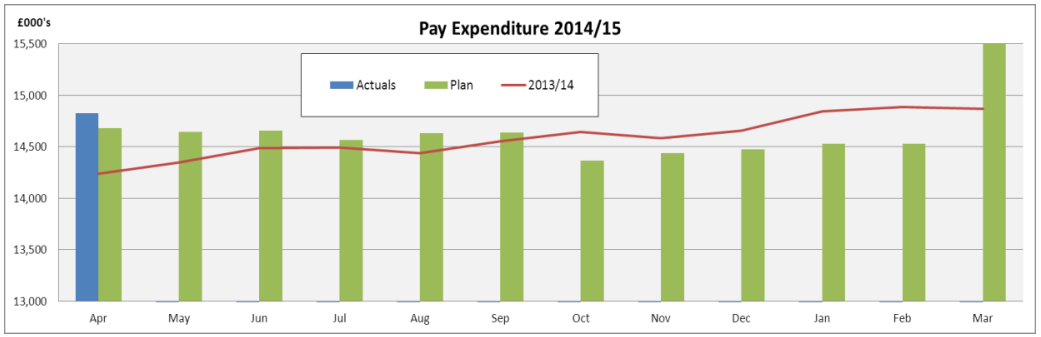
# 3.1 Pay Expenditure

## Highlights

- Overall pay expenditure is £150k adverse in the month 1.
- This is mainly due to nursing temporary staffing costs which remain high despite losing the Community wards which had historically high reliance on temporary staffing (c. £100k pcm).
- CIP tracker highlights under-achievement of pay CIPs.
- All other staff categories are broadly in line with plan in month 1.
- Temporary staffing costs represent **12%** of total Trust pay cost in month 1.
- There is a current gap of 92.4 nursing WTE between budgeted and worked nursing staff (includes all nursing areas).
- Managerial temporary agency costs have increased month on month.
- **Note** – staff numbers & pay exclude the community wards (Danetre, Isebrook and Corby) from 1st April 2014.
- National agenda for change pay award for 2014-15 accrued pending implementation through payroll.

## Actions

- Bank and agency usage controls need to be put in place.
- Pay CIPs - further actions covered in the Transformation report.




| | Staff Numbers (WTE) Analysis | | | | | Permanent Staff Worked Trend | | | Temporary Staff Worked Trend | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Budget Month 1 | Contracted Staff | Permanent Staff worked Month 1 | Temporary Staff worked Month 1 | Variance | February 2013/14 | March 2013/14 | April 2014/15 | February 2013/14 | March 2013/14 | April 2014/15 |
| | WTE | WTE | WTE | WTE | WTE | WTE | WTE | WTE | WTE | WTE | WTE |
| Medical Staff | 515.56 | 484.2 | 460.80 | 33.69 | (21.07) | 459.63 | 459.51 | 460.80 | 26.54 | 31.55 | 33.69 |
| Nursing Staff | 1932.39 | 1753.52 | 1650.43 | 189.43 | (92.53) | 1739.46 | 1740.43 | 1650.43 | 225.05 | 234.95 | 189.43 |
| Managerial and Administration | 967.77 | 850.47 | 846.33 | 105.97 | (15.47) | 831.49 | 846.23 | 846.33 | 141.02 | 98.32 | 105.97 |
| Other Clinical Staff | 307.37 | 277.92 | 266.74 | 7.76 | (32.87) | 284.39 | 283.21 | 266.74 | 7.10 | 9.60 | 7.76 |
| Scientific and Technical Staff | 396.95 | 355.23 | 349.04 | 4.74 | (43.17) | 346.63 | 345.23 | 349.04 | 5.87 | 12.75 | 4.74 |
| Estates Staff | 30.22 | 22 | 25.51 | 1.00 | (3.71) | 25.10 | 26.68 | 25.51 | 1.00 | 1.00 | 1.00 |
| All other Staff | 405.18 | 337.39 | 372.77 | 56.09 | 23.68 | 360.87 | 370.19 | 372.77 | 52.77 | 56.10 | 56.09 |
| Cost Challenges | - | - | - | - | - | - | - | - | - | - | - |
| Total WTE | 4,555 | 4,081 | 3,972 | 399 | -185 | 4,048 | 4,071 | 3,972 | 459 | 444 | 399 |

Nursing - 189 temporary WTE (11.5% of the substantive nursing workforce)

| | Pay Costs Analysis (Month 1) | | | | | Permanent Staff Pay Costs | | | Temporary Staff Pay Costs | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Budget Month 1 | Total Pay Costs Month 1 | Permanent Staff worked Month 1 | Temporary Staff worked Month 1 | Variance | February 2013/14 | March 2013/14 | April 2014/15 | February 2013/14 | March 2013/14 | April 2014/15 |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Medical Staff | 4,068 | 3,957 | 3,611 | 345 | (111) | 3,593 | 3,765 | 3,611 | 479 | 436 | 345 |
| Nursing Staff | 5,604 | 5,704 | 4,860 | 844 | 99 | 5,079 | 4,958 | 4,860 | 709 | 756 | 844 |
| Managerial and Administration | 2,326 | 2,306 | 2,061 | 245 | (20) | 2,003 | 1,904 | 2,061 | 232 | 231 | 245 |
| Other Clinical Staff | 974 | 986 | 861 | 124 | 12 | 904 | 913 | 861 | 53 | 72 | 124 |
| Scientific and Technical Staff | 1,177 | 1,068 | 1,065 | 3 | (108) | 1,038 | 1,047 | 1,065 | 22 | (13) | 3 |
| Estates Staff | 81 | 65 | 63 | 2 | (16) | 63 | 67 | 63 | 9 | 19 | 2 |
| All other Staff | 636 | 744 | 596 | 148 | 108 | 583 | 578 | 596 | 124 | 133 | 148 |
| Cost Challenges | (186) | - | - | - | 186 | - | - | - | - | - | - |
| Total Pay Cost | 14,679 | 14,829 | 13,118 | 1,711 | 150 | 13,263 | 13,233 | 13,118 | 1,627 | 1,634 | 1,711 |

Nursing B&A costs increasing in April despite loss of community wards

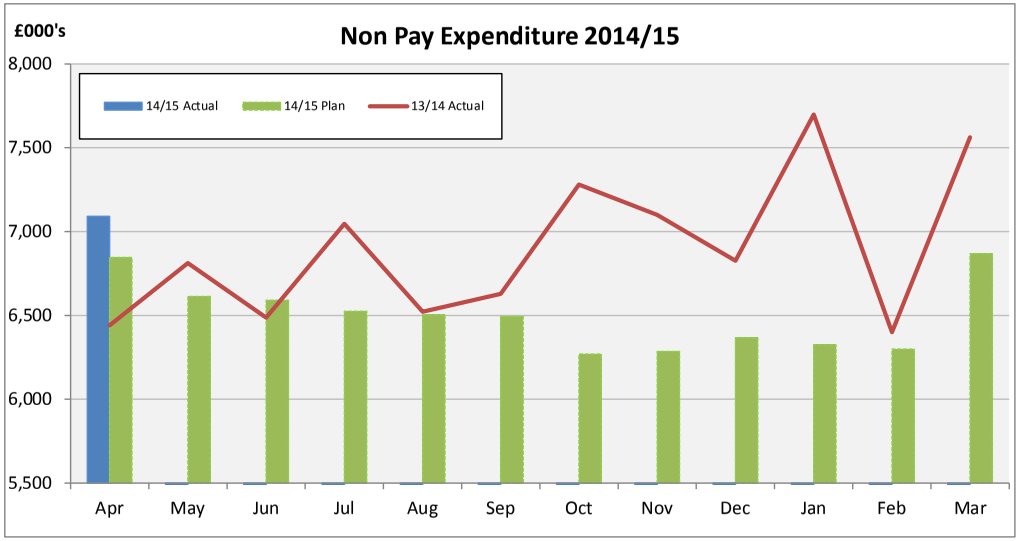
# 3.2 Non Pay Expenditure

## Highlights

- Non-Pay expenditure £0.245m adverse to plan in April.

- **Non-Clinical expenditure £195k adverse to plan.**
- Expenditure of £449k in month for Consultancy fees (of which £220k Clinical Strategy / Governance and £176k Breaking the Cycle).
- £129k costs of RTT outsourcing (T&O £110k , Ophthalmology £19k) giving rise to £65k adverse variance in month.
- £63k international nurse recruitment costs incurred in April.

- **Clinical non-pay £46k adverse to plan (1%)**.
- Medicines £55k adverse to plan.
- Patients appliances £81k adverse to plan.



# 4.SLA Income

| Point of Delivery | Activity | | | Finance £000's | | |
|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Plan | Actual | Variance |
| Elective Daycase | 3,080 | 3,021 | (59) | 1,881 | 1,844 | (37) |
| Elective Inpatients | 576 | 546 | (30) | 1,504 | 1,407 | (98) |
| Elective Excess Bed Days | 237 | 230 | (7) | 57 | 53 | (4) |
| Non Elective | 2,763 | 3,444 | 681 | 4,913 | 5,785 | 872 |
| Non Elective Excess Bed Days | 2,607 | 2,851 | 244 | 603 | 663 | 60 |
| New Outpatients | 5,174 | 4,696 | (478) | 786 | 716 | (71) |
| Follow Up Outpatients | 10,043 | 9,118 | (925) | 891 | 817 | (74) |
| Non Cons Led Outpatients New | 2,237 | 2,037 | (200) | 197 | 180 | (17) |
| Non Cons Led Outpatients Follow Up | 5,265 | 5,187 | (78) | 249 | 241 | (8) |
| Outpatient Procedures | 4,993 | 4,814 | (179) | 831 | 842 | 10 |
| CQUIN | | 1 | 1 | 435 | 370 | (65) |
| Block Contracts - Fixed | | | | 1,678 | 1,678 | |
| Cost Per Case | 212,873 | 215,649 | 2,776 | 3,254 | 3,224 | (30) |
| A&E | 8,562 | 8,527 | (35) | 851 | 865 | 14 |
| Excluded Medicines | | | | 1,209 | 1,250 | 41 |
| Excluded Devices | | 83 | 83 | 123 | 56 | (66) |
| Contract Challenges | | 37 | 37 | | (419) | (419) |
| Readmissions | | | | (199) | (209) | (9) |
| MRET | | | | (270) | (586) | (316) |
| Other Central SLA Income | | 2 | 2 | 198 | 417 | 219 |
| Productivity CIPs | | | | 196 | | (196) |
| **Total SLA Income** | | | | **19,387** | **19,194** | **(193)** |

## Key issues

**Underlying Overperformance**

Month 1 position showing underperformance of £193k. The main driver is £872k over performance in non elective activity, offset by provisions for fines and CCG challenges. Underperformance in outpatient and elective activity.

**Non Elective**

The main drivers of the Non Elective overperformance are: General Medicine (£479k) - Cardiac, Respiratory, Peripheral Nerve Disorders. A&E (£190k) - Mental Health Primary Diagnosis, Cardiac Conditions, General Abdominal Disorders. T&O (£107k) - Hip Procedures.

**CCG Prior Approval Policy**

There has been a significant change in the number of procedures that require prior approval which mainly impact on Hip and Knee procedures in the T&O directorate. Activity in this area will be subject to the CCG's rigorous challenge process, and the Trust needs to respond timely and with well documented evidence.

**Opportunities**

There are outline plans to bid for Specialised Commissioner reinvestment of MRET / Readmissions of £400k which are currently being worked through and will be submitted on 21st May. Schemes relate to End of Life and Stroke pathways.

**Fines & Penalties**

An assessment of potential fines and penalties has been deducted from the M1 income estimate. This estimate has been based on experience and known performance issues.

**QIPPs**

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

**Risks**

The overpeformance on non elective activity poses a risk to the Trust's financial position as this exceeds 13-14 outturn and incurs additional MRET penalty. MKCCG proposing additional £84k of QiPP and post contract changes (£200k). The M1 position is subject to case mix and the formal M1 reconciliation process with CCGs. NENE CCG “Phase 2” QiPPs expected in Q2.

# 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 | | | 269 | 269 | (180) | (180) |
| In year movements | | | 267 | 267 | 21,501 | 21,501 |
| Less depreciation | | | (982) | (982) | (12,268) | (12,268) |
| **Net Book Value** | 143,694 | 143,694 | 143,248 | (446) | 152,747 | 9,053 |
| **Current Assets** | | | | | | |
| Inventories | 5,136 | 5,136 | 5,318 | 182 | 5,119 | (17) |
| Receivables: | | | | | | |
| NHS Debtors | 6,902 | 6,902 | 8,645 | 1,743 | 7,500 | 598 |
| Other Trade debtors | 1,710 | 1,710 | 1,453 | (257) | 1,800 | 90 |
| Debtor impairments provision | (675) | (675) | (675) | | (700) | (25) |
| Capital receivables | | | | | | |
| Non NHS other debtors | 236 | 236 | 416 | 180 | 250 | 14 |
| Compensation debtors (RTA) | 2,694 | 2,694 | 2,620 | (74) | 2,800 | 106 |
| Other receivables | 1,058 | 1,058 | 771 | (287) | 1,200 | 142 |
| Irrecoverable provision | (548) | (548) | (548) | | (600) | (52) |
| Prepayments & accruals | 1,124 | 1,124 | 1,570 | 446 | 1,100 | (24) |
| | 12,501 | 12,501 | 14,252 | 1,751 | 13,350 | 849 |
| Non Current Assets for sale | | | | | | |
| Cash | 4,445 | 4,445 | 4,345 | (100) | 4,547 | 102 |
| **Net Current Assets** | 22,082 | 22,082 | 23,915 | 1,833 | 23,016 | 934 |
| **Current Liabilities** | | | | | | |
| NHS | 637 | 637 | 1,798 | 1,161 | 650 | 13 |
| Trade Creditors Revenue | 1,302 | 1,302 | 4,409 | 3,107 | 2,900 | 1,598 |
| Trade Creditors Fixed Assets | 3,261 | 3,261 | 1,132 | (2,129) | 5,000 | 1,739 |
| Tax and NI owed | 3,433 | 3,433 | 3,534 | 101 | 3,500 | 67 |
| NHS Pensions agency | 2,201 | 2,201 | 2,222 | 21 | 2,500 | 299 |
| Other creditors | 374 | 374 | 390 | 16 | 500 | 126 |
| Short term loans | 626 | 626 | 626 | | 450 | (176) |
| Accruals and deferred income | 7,193 | 7,193 | 8,517 | 1,324 | 7,000 | (193) |
| PCD Dividend due | | | 345 | 345 | | |
| Staff benefits accrual | 811 | 811 | 712 | (99) | 750 | (61) |
| Provisions < 1 yr | 2,338 | 2,338 | 1,897 | (441) | 366 | (1,972) |
| Provisions > 1 yr | 1,384 | 1,384 | 1,384 | | 1,384 | |
| **Net Current Liabilities** | 23,560 | 23,560 | 26,966 | 3,406 | 25,000 | 1,440 |
| **Total Net Assets** | 142,216 | 142,216 | 140,197 | (2,019) | 150,763 | 8,547 |
| **Financed by:** | | | | | | |
| PDC Capital | 103,611 | 103,611 | 103,611 | | 120,619 | 17,008 |
| Revaluation reserve | 35,727 | 35,727 | 35,996 | 269 | 35,547 | (180) |
| Donated Asset reserve | | | | | | |
| General reserves | 2,878 | 2,878 | 2,878 | | 2,878 | |
| I & E current year | | | (2,288) | (2,288) | (8,281) | (8,281) |
| **Financing Total** | 142,216 | 142,216 | 140,197 | (2,019) | 150,763 | 8,547 |

## Key Movements

**Non Current Assets**

- Decrease in in non current assets of £0.4m due to indexation, additions and depreciation charge in April.

**Net Current assets**

- Inventories increased by £0.18m.
- Increase in NHS Debtors of £1.7m.
- Overall cash balance maintained at £4.3m between March and April.

**Net Current Liabilities**

- Increase in net current liabilities led by NHS and Trade creditors.
- Staff benefits accrual reduced due to TCS community wards transfer and related provision utilised in April.
- PDC dividend accrued – 6 months dividend due for half year payment in September.
- Accruals and deferred income increased by £1.3m

**Financing**

- General reserve movement relates to fixed asset indexation adjustment.

# 6. Capital Expenditure

| Capital Scheme | Plan 2014/15 £000's | M1 Plan £000's | M1 Spend £000's | Under (-) / Over £000's | Plan Achieved % | Actual Committed £000's | Plan Achieved % |
|---|---|---|---|---|---|---|---|
| Linacc corridor | 400 | 0 | 0 | 0 | 0% | 0 | 0% |
| MES Equipment - Do Minimum Option FBC | 8,560 | 344 | 0 | -344 | 0% | 0 | 0% |
| SHSWTF - E Prescribing National Funding | 437 | 0 | 11 | 11 | 3% | 402 | 92% |
| CEF Scheme | 350 | 100 | 0 | -100 | 0% | 302 | 86% |
| A&E / Orthopaedics | 1,681 | 75 | 154 | 79 | 9% | 162 | 10% |
| Annual Strategic Planning Approvals | 1,510 | 125 | 0 | -125 | 0% | 0 | 0% |
| Annual Strategic Planning Approvals - MES | 453 | 0 | 0 | 0 | 0% | 0 | 0% |
| Medical Equipment Sub Commiittee | 1,646 | 70 | 71 | 0 | 4% | 71 | 4% |
| Estates Sub Committee | 4,353 | 120 | 1 | -119 | 0% | 211 | 5% |
| IT Sub Committee | 1,977 | 0 | 29 | 29 | 1% | 557 | 28% |
| Other | 134 | 40 | 0 | -40 | 0% | 4 | 3% |
| **Total - Capital Plan** | **21,501** | **874** | **265** | **-609** | **1%** | **1,709** | **8%** |
| Less Charitable Fund Donations | -100 | 0 | 0 | 0 | 0% | 0 | 0% |
| **Total - CRL** | **21,401** | **874** | **265** | **-609** | **1%** | **1,709** | **8%** |

| **Funding Resources:** | |
|---|---|
| Internally Generated Depreciation - NHS | 11,815 |
| Internally Generated Depreciation - Don | 453 |
| SALIX | 125 |
| SHSWTF - E Prescribing | 448 |
| MES - PDC (subject to ITFF approval) | 8,560 |
| **Total - Available CRL Resource** | **21,401** |
| **Uncommitted Plan** | **0** |

## Key Issues

- Linear Accelerator Corridor is linked to first linear accelerator replacement in MES in existing bunker.
- MES Equipment - Do Minimum FBC option relates to the business case submitted to the TDA, as a capital loan has now to be submitted to the Independent Trust Finance Facility.
- SHSWTF - E-Prescribing National Funding is the second year of approved funding from DH and has been matched by £300k of Trust funds.
- CEF Scheme - this is now due to complete in July.
- There is a current contingency of £1.510 million and a further £0.453 million associated with the proposed MES purchases however this assumes the full year effect as per business case whilst in reality it's likely to be a part year effect.
- Full year depreciation forecast is currently £12.268 million which includes £0.453 million associated with the proposed MES purchases .
- Charitable Donations assumptions for additions in year are assumed £100k.

# 7. Receivables, Payables and BPPC Compliance

| Narrative | Total at April £000's | 0 to 30 Days £000's | 31 to 60 Days £000's | 61 to 90 Days £000's | Over 90 Days £000's |
|---|---|---|---|---|---|
| Receivables Non NHS | 1,452 | 180 | 591 | 81 | 600 |
| Receivables NHS | 6,698 | 5,177 | 994 | 179 | 348 |
| **Total Receivables** | **8,150** | **5,357** | **1,585** | **260** | **948** |
| Payables Non NHS | (3,084) | (2,987) | (89) | (8) | 0 |
| Payables NHS | (468) | (464) | (4) | 0 | 0 |
| **Total Payables** | **(3,552)** | **(3,451)** | **(93)** | **(8)** | **0** |

| Narrative | Total at March £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 | 1,710 | 950 | 120 | 36 | 604 |
| Receivables NHS | 5,026 | 3,736 | 463 | 118 | 709 |
| **Total Receivables** | **6,736** | **4,686** | **583** | **154** | **1,313** |
| Payables Non NHS | (2,900) | (2,778) | (118) | (4) | 0 |
| Payables NHS | (71) | (61) | (9) | 0 | (1) |
| **Total Payables** | **(2,971)** | **(2,839)** | **(127)** | **(4)** | **(1)** |

| Narrative | Number of Invoices | Value of Invoices £000's |
|---|---|---|
| **Creditor Payements Team KPI:** | | |
| Total Paid | 7,097 | 9,378 |
| On Time | 7,087 | 9,366 |
| **Processed by Payments Team*** | **99.86%** | **100%** |
| **Trust Perfromance:** | | |
| Total Paid | 7,097 | 9,378 |
| On Time | 6,528 | 8,840 |
| **Within Target Compliance** | **91.98%** | **94.26%** |
| | | |
| **Paid Late** | **569** | **538** |
| | | |
| **April - Cumulative Position** | **91.98%** | **94.26%** |
| **March - Cumulative Position** | **90.93%** | **93.45%** |
| **Improvement in Month (+)** | **0.47%** | **0.54%** |

***Based on comparing input date to payment date***

## Receivables and Payables

- Continued progress in reducing age profile of non current debt. Focus on NCA debt in March and April.
- MK CCG mandate payment processed incorrectly by NHSBA and not received in April.
- Over 90 day debt of £1.3m in March has fallen by £0.4m in April. Balances includes CRIPPS (£240k), NCA's (£235k) and Overseas Patients debt (£254k) .
- 97% of registered creditors current (due within 30 days).
- Appropriate provision and write off has been made in accordance with the stated DH and local Trust policies.

## BPPC Compliance

- BPPC has continued to improve from last month to (91.98% by volume, 94.26% by value) with the payments team continuing to achieve processing within the targets once approved.
- Volume of temporary staffing invoices causing majority of poor performance trust wide. Work ongoing with bank office to improve invoice processing.

# 8. Cashflow

| MONTHLY CASHFLOW | Annual £000s | ACTUAL APR £000s | MAY £000s | JUN £000s | JUL £000s | AUG £000s | SEP £000s | FORECAST OCT £000s | NOV £000s | DEC £000s | JAN £000s | FEB £000s | MAR £000s |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RECEIPTS | | | | | | | | | | | | | |
| SLA Base Payments | 239,844 | 16,228 | 20,416 | 18,393 | 24,815 | 18,393 | 18,393 | 24,815 | 18,393 | 18,393 | 24,815 | 18,393 | 18,393 |
| SLA Performance/ Other CCG Investment | | | | | | | | | | | | | |
| Health Education Payments (SIFT etc.) | 9,565 | 130 | 1,531 | 775 | 775 | 775 | 798 | 799 | 799 | 799 | 799 | 799 | 786 |
| Other NHS Income | 15,126 | 3,110 | 1,261 | 1,075 | 1,075 | 1,075 | 1,075 | 1,075 | 1,075 | 1,075 | 1,075 | 1,075 | 1,075 |
| PP / Other (Specific > £250k) | 264 | 264 | | | | | | | | | | | |
| PP / Other | 12,836 | 953 | 883 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 | 1,100 |
| Salix Capital Loan | 125 | | | | | | | | 45 | 40 | 40 | | |
| PDC - Capital | 9,008 | | | 1,713 | 70 | 2,035 | 2,000 | 1,419 | 693 | | 413 | | 665 |
| PDC - Revenue | 8,000 | | | | | | 3,000 | | 1,000 | | 1,000 | 1,000 | 2,000 |
| Temporary Borrowing | | | | | | | | | | | | | |
| Interest Receivable | 30 | 3 | 2 | 3 | 2 | 2 | 3 | 2 | 2 | 3 | 2 | 2 | 4 |
| TOTAL RECEIPTS | 294,798 | 20,689 | 24,093 | 23,060 | 27,838 | 23,381 | 26,370 | 29,211 | 23,108 | 21,411 | 29,245 | 22,370 | 24,024 |
| PAYMENTS | | | | | | | | | | | | | |
| Salaries and wages | 169,981 | 14,056 | 14,175 | 14,175 | 14,175 | 14,175 | 14,175 | 14,175 | 14,175 | 14,175 | 14,175 | 14,175 | 14,175 |
| Trade Creditors | 78,250 | 3,909 | 7,162 | 6,134 | 7,435 | 7,539 | 6,712 | 8,002 | 6,064 | 6,509 | 8,682 | 6,000 | 4,102 |
| NHS Creditors | 19,581 | 1,123 | 1,611 | 1,611 | 1,611 | 1,611 | 1,611 | 1,611 | 1,611 | 1,611 | 1,611 | 2,198 | 1,759 |
| Capital Expenditure | 22,135 | 1,749 | 990 | 1,167 | 1,874 | 1,916 | 3,837 | 1,336 | 2,272 | 1,831 | 1,703 | 1,602 | 1,858 |
| PDC Dividend | 4,387 | | | | | | 2,183 | | | | | | 2,205 |
| Repayment of Loans | | | | | | | | | | | | | |
| Repayment of Salix loan | 301 | | | | | | 177 | | | | | | 124 |
| TOTAL PAYMENTS | 294,635 | 20,837 | 23,938 | 23,087 | 25,095 | 25,241 | 28,695 | 25,124 | 24,122 | 24,126 | 26,171 | 23,975 | 24,223 |
| Actual month balance | 163 | -148 | 155 | -27 | 2,743 | -1,860 | -2,325 | 4,086 | -1,015 | -2,716 | 3,073 | -1,605 | -199 |
| Cash in transit & Cash in hand adjustment | -62 | 48 | -109 | | | | | | | | | | |
| Balance brought forward | 4,445 | 4,445 | 4,345 | 4,390 | 4,363 | 7,106 | 5,246 | 2,922 | 7,008 | 5,993 | 3,278 | 6,351 | 4,745 |
| Balance carried forward | 4,547 | 4,345 | 4,390 | 4,363 | 7,106 | 5,246 | 2,922 | 7,008 | 5,993 | 3,278 | 6,351 | 4,745 | 4,547 |

## Key Issues

- April cash balance maintained at £4.3m.
- Cashflow plan includes receipt of temporary borrowing of £8m during the financial year due to planned I&E deficit. Application to access temporary borrowing to be submitted to TDA in June.
- New capital PDC loans of £9m included in plan for year. Application to Independent Trust financing Facility (ITFF) required, supported by TDA. Requirement to update LTFM to support application.
- Capital expenditure profile includes planned phasing of Radiology and Radiotherapy equipment.

# 9. Conclusions and Recommendations

**Conclusion:**

The financial position for April shows a significant deficit and gives rise to concern in relation to achieving the TDA plan for the year. However the position includes a number of one-off expenditure items together with additional unplanned income provisions for fines and penalties which may not arise in future months. Non-elective discharges have exceeded plan in April giving rise to an increase in the potential 70% MRET penalty. There is little indication to date that CCG QiPP schemes have been effective in the first month of the financial year although some downturn in planned activity is evident compared to plan. The Trust continues to outsource T&O and Ophthalmology activity to meet the RTT target. It is clear that the CIP programme has incurred some slippage in the first month of the financial year resulting in a downgrading of the annual forecast savings.

**Recommendations & actions**

- CIP delivery – detailed review of month 1 performance to be undertaken by IQE team.
- Outsourced activity – report to next finance committee on forecast use of outsourced RTT activity, process and income capture.
- Increased MRET penalty – validate MRET calculation in readiness for CCG reconciliation process. Consider approach to obtaining reinvestment of additional penalty.
- Other CCG Fines & Penalties – ensure CCG data challenges are robustly defended and month 1 reconciliation process is successfully concluded.
- 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.
- Agency costs – detailed report to finance committee on use of agency and locum staff and identify associated targets for reduction.
- PDC loans – applications for temporary borrowing and capital PDC to be progressed (target date for submission June).
- Reserves – review allocation and commitments against of revenue reserves to ensure mitigation for month 1 adverse deficit and future commitments (e.g. Avery beds).

Northampton General Hospital NHS
NHS Trust

**REPORT TO: TRUST BOARD**
**29 May 2014**

| | |
|---|---|
| **Title** | Workforce Report |
| **Agenda item** | 16 |
| **Sponsoring Director** | Janine Brennan, Director of Workforce & Transformation |
| **Author(s)** | 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 a decrease in Total Workforce Capacity (excluding Medical Locums) employed by the Trust, and a decrease in sickness absence.
- An overview of the results of the 2013 National NHS Staff Survey

| | |
|---|---|
| **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

# Trust Board
# 29th May 2014

# Workforce Report

## 1. Introduction

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

It also sets out current key workforce updates.

## 2. Workforce Report

### 2.1 Key Workforce Performance Indicators

The key performance indicators show:

**Sickness Absence**

The total sickness absence rate decreased by 0.12% in April to 4.27%, which remains above the Trust target

**Workforce Capacity**

Total workforce capacity (excluding Medical Locums) decreased by 201.12 FTE in April to 4,307.18 FTE. The Trust remains below the budgeted workforce establishment figure of 4,419.85 FTE.

The substantive workforce capacity decreased by 144.94 FTE, due in the main to the TUPE of Community Hospital Staff

The temporary workforce capacity (excluding Medical Locums) decreased by 56.18 FTE to 267.35 FTE.

**Mandatory Training**

Mandatory training stood at 76.91% against the revised target of 80% which is to be achieved by October 2014.

Role Specific Essential Training stood at 63.69% against the target of 70% to be achieved by October 2014.

**Appraisal**

Appraisal rates rose to 62.81% against the trust target of 5% which is to achieved by March 2015.

### 2.2 Workforce Updates

**National NHS Staff Survey**

The Trust received responses from 351 staff members surveyed in the 2013 National NHS Staff Survey cycle, which constitutes a 42.4% response rate. Of the 28 key findings the Trust had none in the top 20% when compared to other Acute Trusts. Staff responses showed us as better than average for 2 of the key findings and average for a further 2. The Trust was worse than average for 4 of the key findings and in the bottom 20% of Acute Trusts for 20 key findings. This is an improvement on the 2012 survey whereby we had 24 key findings in the worst 20% of Acute Trusts. The Trust had two statistically significant improvements since 2012. There were no statistically significant deteriorations since 2012.

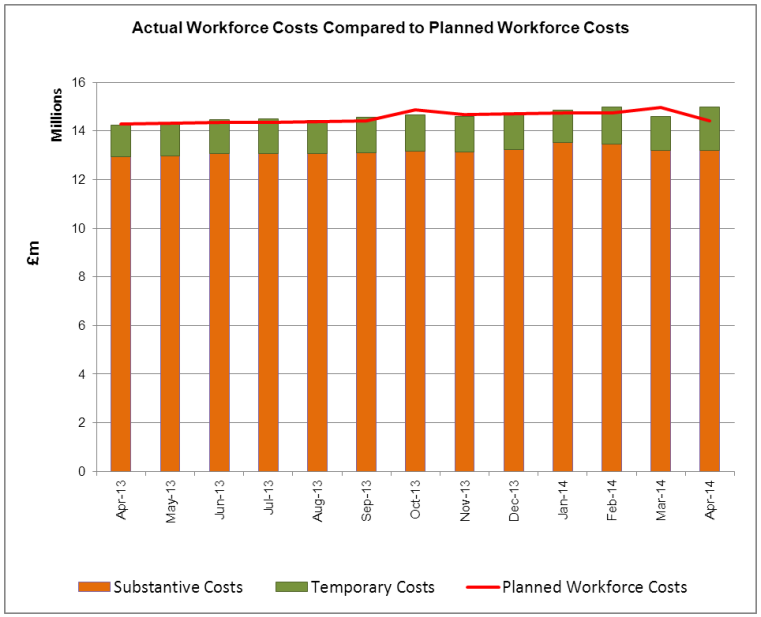
As you will be aware, the response to the Staff Survey is being addressed through the Organisational Effectiveness Strategy: *Connecting for Quality, Committed to Excellence.*

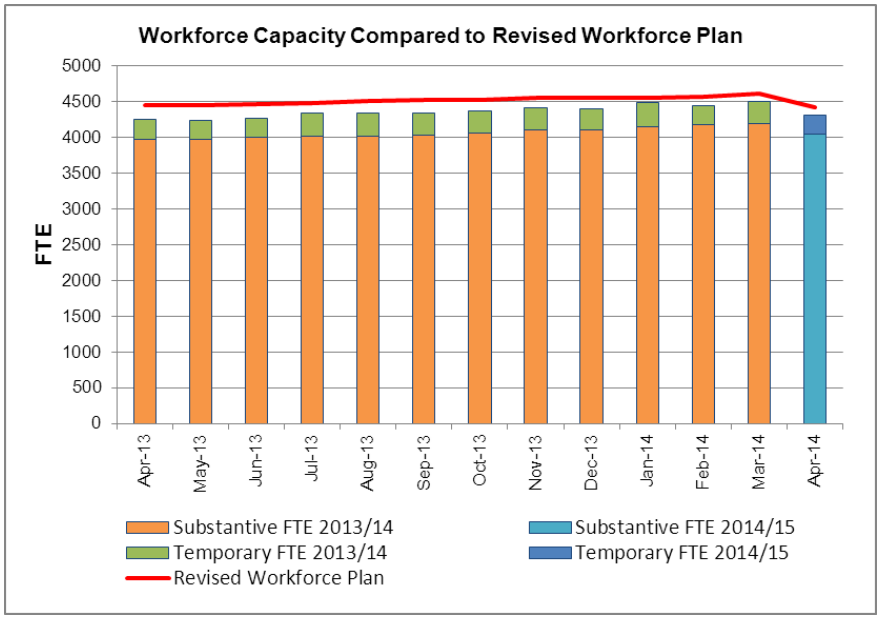
**3. Assessment of Risk**
Managing workforce risk is a key part of the Trust's risk assessment programme.

**4. Recommendation**
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 01




| | 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 | | | | | | | | | | | |
| 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 | | | | | | | | | | | |
| 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 | | | | | | | | | | | |

| | 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 | | | | | | | | | | | |
| Temporary FTE 2013/14 | 266 | 263 | 260 | 329 | 329 | 305 | 316 | 303 | 291 | 334 | 269 | 324 |
| Temporary FTE 2014/15 | 267 | | | | | | | | | | | |
| 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 | | | | | | | | | | | |

## Workforce Expenditure

**Total Workforce Expenditure (all pay elements) increased by £390,178 in April to £14.971m (this is above plan for Month 1).**

**Substantive workforce expenditure increased slightly by £3,806 to £13,197,241.**

**Temporary Workforce Expenditure (including Medical Staff) increased by £386,372 to £1,773,830, equating to 11.85% of the of the total workforce expenditure, the highest rate for more than a year.**

## Workforce Capacity

**Total Workforce Capacity** (including temporary staff but excluding Medical Locums) **decreased by 201.12 FTE in April to 4,307.18 FTE. The Trust remains below the Budgeted Workforce Establishment of 4,419.85 FTE.**

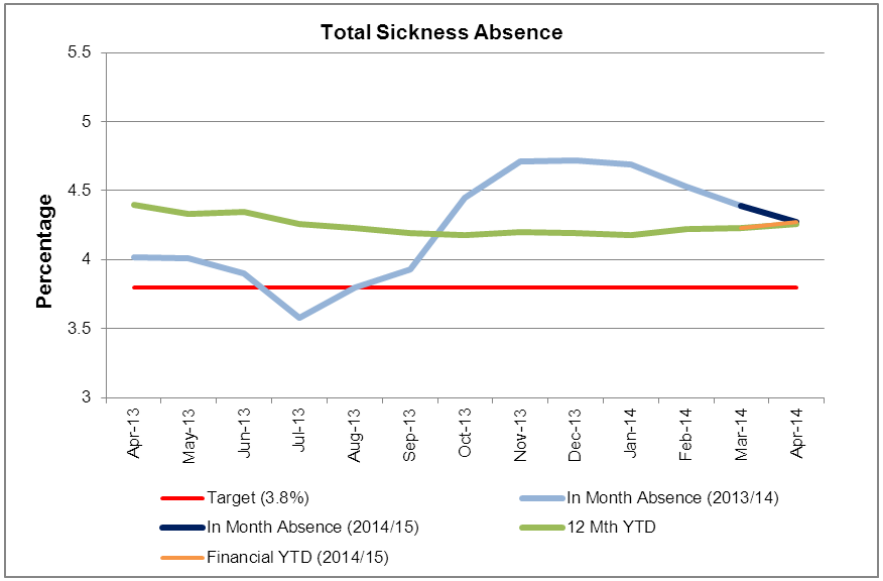
**Substantive workforce capacity decreased by 144.94 FTE to 4,039.83 FTE. This was due mainly to the loss of the Community Beds Service.**

- Overseas recruitment from Spain continues; an additional 9 registered nurses are due to commence in June.

**Temporary workforce capacity** (excluding Medical Locums) **decreased by 56.18 FTE to 267.35 FTE.**

# Human Resources Workforce Performance Indicators 2014/15 Month 01

| | Key Performance Indicators | | | | | |
|---|---|---|---|---|---|---|
| | Threshold | Trust Taraget | Trust Actual | Medicine | Surgery | Support Services |
| Substantive Workforce against Budgeted Establishment (% FTE) | Under 95%<br>Over 97%<br>95 - 97%<br>Over 100% | 95% | 91.40% | 89.82% | **96.05%** | 84.37% |
| Temporary Workforce Capacity (excluding Medical Staffing) | Over 5%<br>4.5 - 5%<br>Under 4.5% | 5% | 6.21% | 8.34% | 4.86% | **3.78%** |
| Total Substantive Workforce plus Temporary Workforce against Budgeted Establishment (% FTE) (excluding Medical Staffing) | Under 95%<br>Over 97%<br>95 - 97%<br>Over 100% | 100% | 97.45% | 97.99% | 100.95% | 87.68% |
| % Staff Turnover (excluding internal transfers) | Under 8%<br>Over 8% | 8% | 11.55% | 15.89% | **7.37%** | 10.69% |




| 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 | | | | | | | | | | | |
| 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 | | | | | | | | | | | |
| Financial YTD (2014/15) | 4.27 | | | | | | | | | | | |

## Workforce Capacity

- **In summary for Nursing,** the total utilisation (Bank & Agency Filled) was 27,668 hours (170.26 FTE), which is a decrease of 7481 hours (46.03 FTE) compared with the previous month.
- **Bank & Agency Fill Rates for Nursing:** Bank fill rate = 44.14% (decrease of 2.90%), Agency fill rate = 25.66% (increase of 2.96%). Total bank & agency fill rate = 69.80% (increase of 0.06% compared with the previous month).
- The control to restrict additional roster duties (implemented April 1st), which are considered to be outside the standard roster demand and therefore covered by bank or agency, has resulted in a reduction of 226 additional duties on the month.

## Sickness Absence

**The new financial year to date starting rate for sickness absence is 4.27%.**

**In month Sickness Absence has decreased by 0.12% to 4.27% which is above the Trust target.**

- Short term sickness absence decreased by 0.07% to 2.31%.
- Long term sickness absence decreased by 0.04% to 1.97% which remains below Trust Target.
- The total calendar days lost to sickness absence decreased by 581 to 6,078 days lost.
- The number of days lost per employee decreased, to 1.28 days.

# Human Resources Workforce Performance Indicators 2014/15 Month 01

| | | Surgery Care Group | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Directorate | | | | | | | |
| | Threshold | Target | Theatres, Anaesthetics & Critical Care | Surgery | Trauma & Orthopaedics | Head & Neck | | Women | Children |
| Short Term Sickness Absence | | 1.60% | 2.54% | 2.14% | 1.82% | 2.90% | | 2.12% | 2.62% |
| Long Term Sickness Absence | | 2.20% | 2.27% | 1.38% | 1.48% | 1.43% | | 2.86% | 1.57% |
| Total Sickness Absence | Over 4.2% | 3.80% | 4.81% | 3.52% | 3.30% | 4.33% | | 4.98% | 4.19% |
| | 3.9-4.2% | | | | | | | | |
| | Under 3.8% | | | | | | | | |

## Surgery Care Group Summary

- The non-medical sickness absence rate for the General Surgery Care Group decreased by 0.53% to 4.23%.

  The highest ward based sickness was on Robert Watson Ward with total sickness absence of 8.61%, mainly due to 2 long term sickness cases, both of which are being managed, with one member of staff returning to work in a redeployed role.

  In Medical Records the total sickness rate in March was slightly decreased at 8.84% but there was an increase in short term sickness to 5.49%, with 18 employees off. Anyone hitting a trigger point is being actively managed in line with trust policy.

| | | Medicine Care Group | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Directorate | | | | | | | |
| | Threshold | Target | Pharmacy | Pathology | Radiology | Therapies | | Oncology & Clinical Haematology | General Medicine & Emergency |
| Short Term Sickness Absence | | 1.60% | 1.35% | 1.96% | 2.03% | 1.75% | | 2.21% | 3.45% |
| Long Term Sickness Absence | | 2.20% | 0.78% | 0.92% | 2.03% | 1.32% | | 2.76% | 3.01% |
| Total Sickness Absence | Over 4.2% | 3.80% | 2.13% | 2.88% | 4.06% | 3.07% | | 4.97% | 6.46% |
| | 3.9-4.2% | | | | | | | | |
| | Under 3.8% | | | | | | | | |

## Medicine Care Group Summary

- The sickness absence rate for the General Medicine Care Group decreased very slightly, to 5.23%, with improvement in the Radiology, Pharmacy, and General Medicine & Emergency Care directorates.
- Becket Ward has sickness of 11.96%; of 4 individuals on long term sickness, one has returned to work and another is due back in May, with the remaining two awaiting medical investigations or surgery. Collingtree Ward has seen an increase in short term sickness, and there are planned meetings in place to manage individual cases. Compton Ward has 3 individuals on long term sickness, of which one is being progressed through ill-health retirement and the remaining two are under Occupational Health with one awaiting a date for surgery.

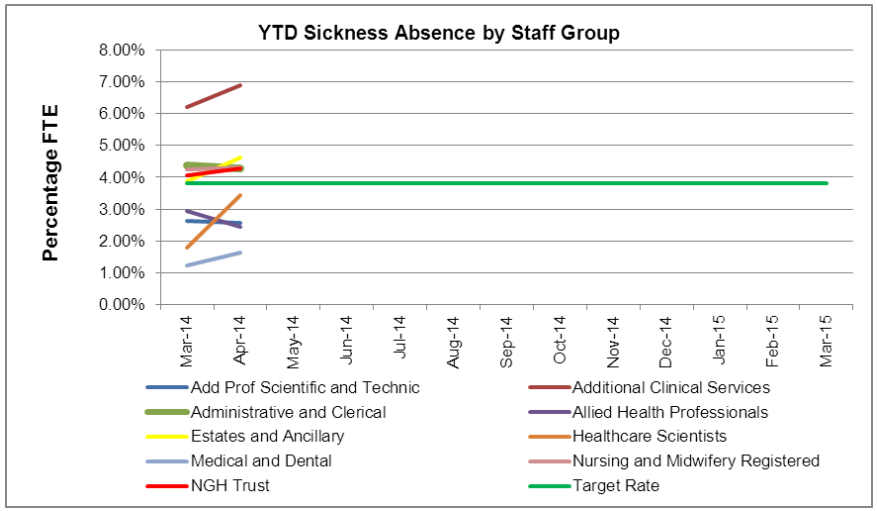
  One member of staff in Radiology on LTS will be managed back to work in the next few months.

| | | Support Services | | | | M&D |
|---|---|---|---|---|---|---|
| | | Directorate | | | | |
| | Threshold | Target | Facilities | Hospital Support | | Medical & Dental |
| Short Term Sickness Absence | | 1.60% | 3.50% | 2.04% | | 0.30% |
| Long Term Sickness Absence | | 2.20% | 1.79% | 1.04% | | 1.35% |
| Total Sickness Absence | Over 4.2% | 3.80% | 5.29% | 3.08% | | 1.65% |
| | 3.9-4.2% | | | | | |
| | Under 3.8% | | | | | |

## Hospital Support and Medical & Dental Summary

- The total sickness absence rate within Facilities increased in April to 5.29%. An increase in short term sickness in the Porters Department is being addressed by management with HR support. An employee within the Café Royale has now left after a period of long term sickness, which should improve the rate in that area.
- Medical & Dental staff sickness absence increased slightly by 0.05% to 1.65% in April 2014.

# Human Resources Workforce Performance Indicators 2014/15 Month 01



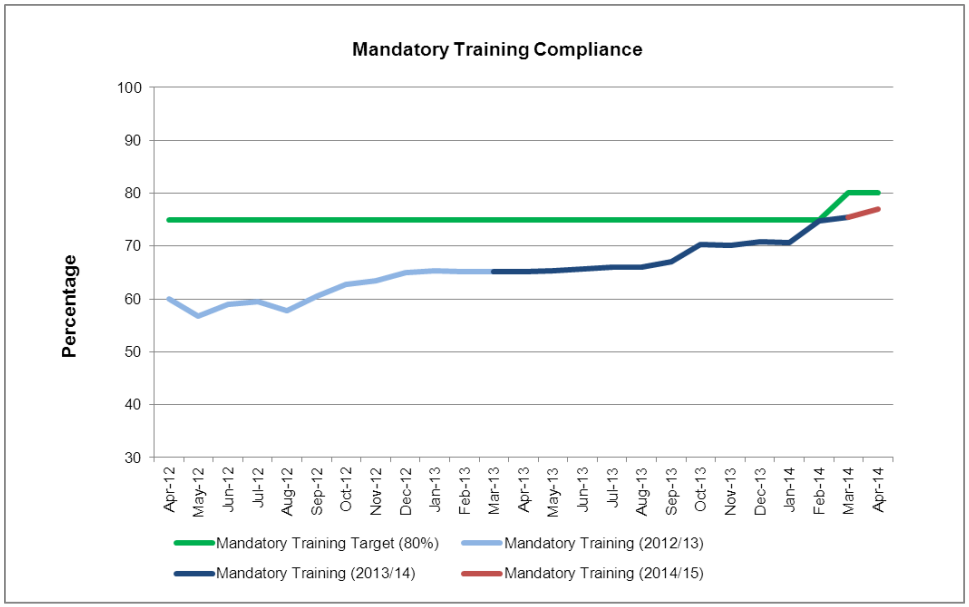

| | Mar-14 | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 | Jan-15 | Feb-15 | Mar-15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Add Prof Scientific and Technic | 2.63% | 2.56% | | | | | | | | | | | |
| Additional Clinical Services | 6.20% | 6.90% | | | | | | | | | | | |
| Administrative and Clerical | 4.36% | 4.27% | | | | | | | | | | | |
| Allied Health Professionals | 2.94% | 2.45% | | | | | | | | | | | |
| Estates and Ancillary | 3.88% | 4.61% | | | | | | | | | | | |
| Healthcare Scientists | 1.79% | 3.44% | | | | | | | | | | | |
| Medical and Dental | 1.23% | 1.64% | | | | | | | | | | | |
| Nursing and Midwifery Registered | 4.26% | 4.31% | | | | | | | | | | | |
| NGH Trust | 4.06% | 4.29% | | | | | | | | | | | |
| Target Rate | 3.80% | 3.80% | 3.80% | 3.80% | 3.80% | 3.80% | 3.80% | 3.80% | 3.80% | 3.80% | 3.80% | 3.80% | 3.80% |

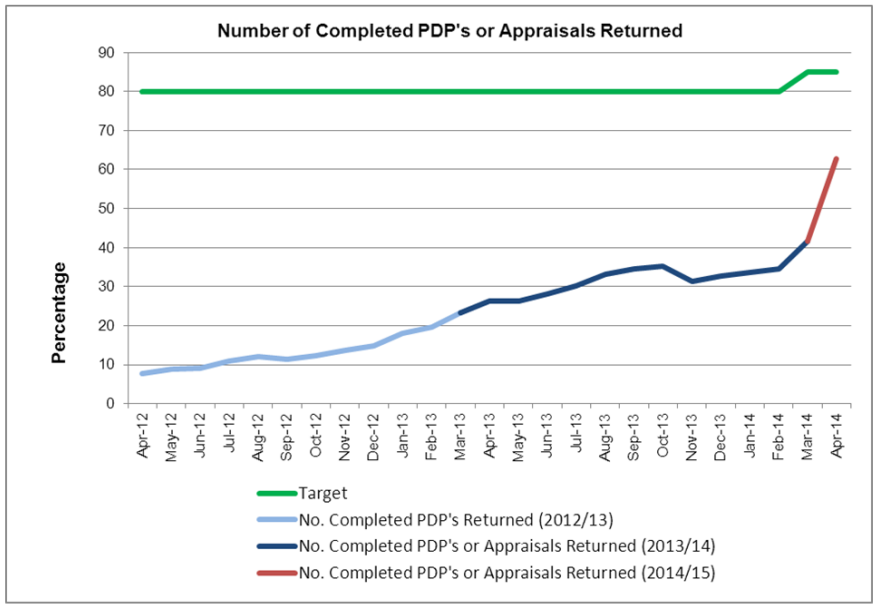
| | Key Performance Indicators | | | | | |
|---|---|---|---|---|---|---|
| | Threshold | Trust Target | Trust Actual | Medicine | Surgery | Support Services |
| Sickness Absence Rate (%) | Over 4.2%<br>3.9-4.2%<br>Under 3.8% | 3.80% | 4.27% | 4.84% | 3.81% | 4.03% |
| No. of completed PDP's returned & completed Appraisals | Under 50%<br>51-84%<br>85% & over | 85% | 62.81% | 60.80% | 63.77% | 67.29% |
| % Statutory & Mandatory Training Compliance | Under 50%<br>51-79%<br>80% & over | 80% | 76.91% | 77.20% | 76.01% | 78.67% |
| % Role Specific Training Compliance | Under 50%<br>51-74%<br>75% & over | 75% | 63.69% | 65.53% | 62.71% | 58.76% |

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

- The current rate of completed PDP's or Appraisals recorded in ESR is 62.81%; an increase of more than 21% since March. This compliance rate will increase further when all records have been updated.
- Mandatory Training compliance has increased again to 76.91%.
- As requested, RSET subjects are now included. Learning & Development are scoping out RSET subjects and a decision will be made on what to report in future, but the rate in April was almost unchanged at 63.69%.

# Human Resources Workforce Performance Indicators 2014/15 Month 01




| 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 | | | | | | | | | | | |

| 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 | | | | | | | | | | | |

# Northampton General Hospital NHST

## Staff Survey Highlights 2013

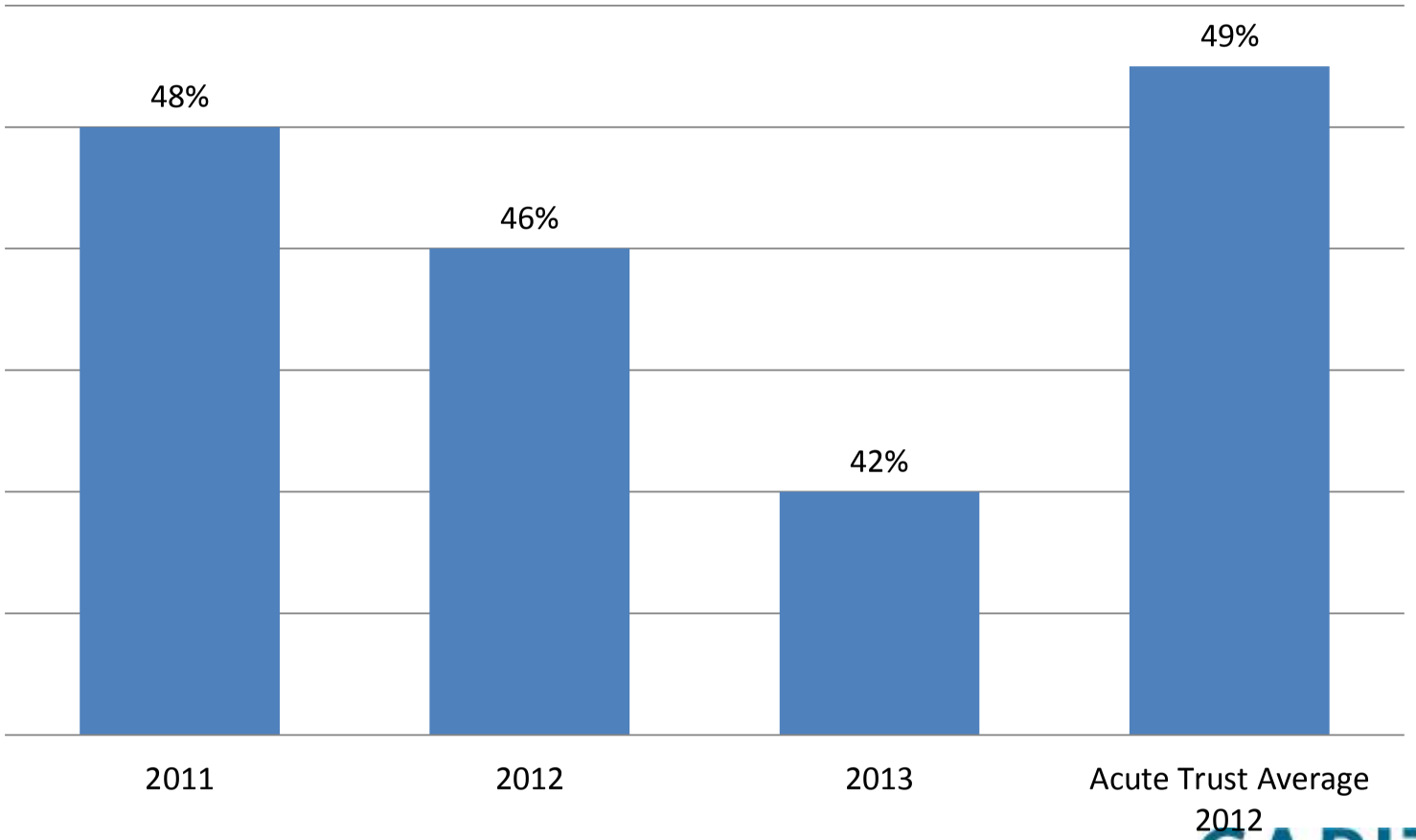
CAPITA

# Introduction

- Background and participation
- Benchmark highlights
- Employee engagement
- Key areas for improvement identified by staff
- [Acute Trust benchmarking in square [] brackets]
- (2012 Trust score in round () brackets)

CAPITA

# Response rates




CAPITA

# Benchmark Highlights

CAPITA

# Your NHS Benchmark Report 2013
# The 28 issues compared with other Acute Trusts

| Position | 2012 | 2013 |
|---|---|---|
| Top 20% | 0 | 0 |
| Better than the average | 1 | 2 |
| Average | 1 | 2 |
| Worse than average | 2 | 4 |
| Bottom 20% | 24 | 20 |
| Statistically significant improvements | 1 | 2 |
| Statistically significant deteriorations | 5 | 0 |

CAPITA

## Key findings where the Trust is above the average for Acute Trusts

1. KF6 - % receiving job-relevant training, learning or development in the last 12 months* (82%) (74%) [81%]

2. KF14 - % reporting errors, near misses or incident witnessed in the last 12 months (91%) (89%) [90%]

CAPITA

## Key findings where the Trust has improved (statistically significantly) since 2012

1. KF6 - % receiving job-relevant training, learning or development in the last 12 months
2. KF24 – Staff recommendation of the Trust as a place to work or receive treatment

CAPITA

## Key findings where the Trust is in the bottom 20% of Acute Trusts (areas for improvement)

1. KF1 - % feeling satisfied with the quality of work and patient care they are able to deliver (70%) (72%) [79%]
2. KF3 – Work pressure felt by staff (3.26) (3.33) [3.06]
3. KF4 – Effective team working (3.60) (3.51) [3.74]
4. KF5 - % working extra hours (75%) (75%) [70%]
5. KF7 - % appraised in the last 12 months (72%) (73%) [84%]
6. KF8 – % having well structured appraisals in the last 12 months (28%) (23%) [38%]
7. KF9 – Support from immediate managers (3.35) (3.27) [3.64]

CAPITA

## Key findings where the Trust is in the bottom 20% of Acute Trusts (areas for improvement)

8. KF10 – % receiving health and safety training in the last 12 months (61%) (63%) [76%]
9. KF11 - % suffering work related stress (40%) (42%) [37%]
10. KF13 - % witnessing potentially harmful errors, near misses or incidents in the last month (42%) (41%) [33%]
11. KF15 – Fairness and effectiveness of incident reporting procedures (3.40) (3.41) [3.51]

CAPITA

## Key findings where the Trust is in the bottom 20% of Acute Trusts (areas for improvement)

12. KF16 – % experiencing physical violence from patients, relatives or the public in the last 12 months (19%) (18%) [15%]
13. KF17 - % experiencing physical violence from staff in the last 12 months (4%) (4%) [2%]
14. KF18 - % experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months (37%) (36%) [29%]
15. KF19 - % experiencing harassment, bullying or abuse from staff in the last 12 months (30%) (29%) [24%]

CAPITA

## Key findings where the Trust is in the bottom 20% of Acute Trusts (areas for improvement)

16. KF20 – % feeling pressure in the last three months to attend work when feeling unwell (39%) (34%) [28%]
17. KF21 - % reporting good communication between senior management and staff (24%) (21%) [29%]
18. KF22 - % able to contribute towards improvements at work (63%) (58%) [68%]
19. KF23 – staff job satisfaction (3.41) (3.40) [3.60]
20. KF28 - % experiencing discrimination at work in the last 12 months (16%) (16%) [11%]

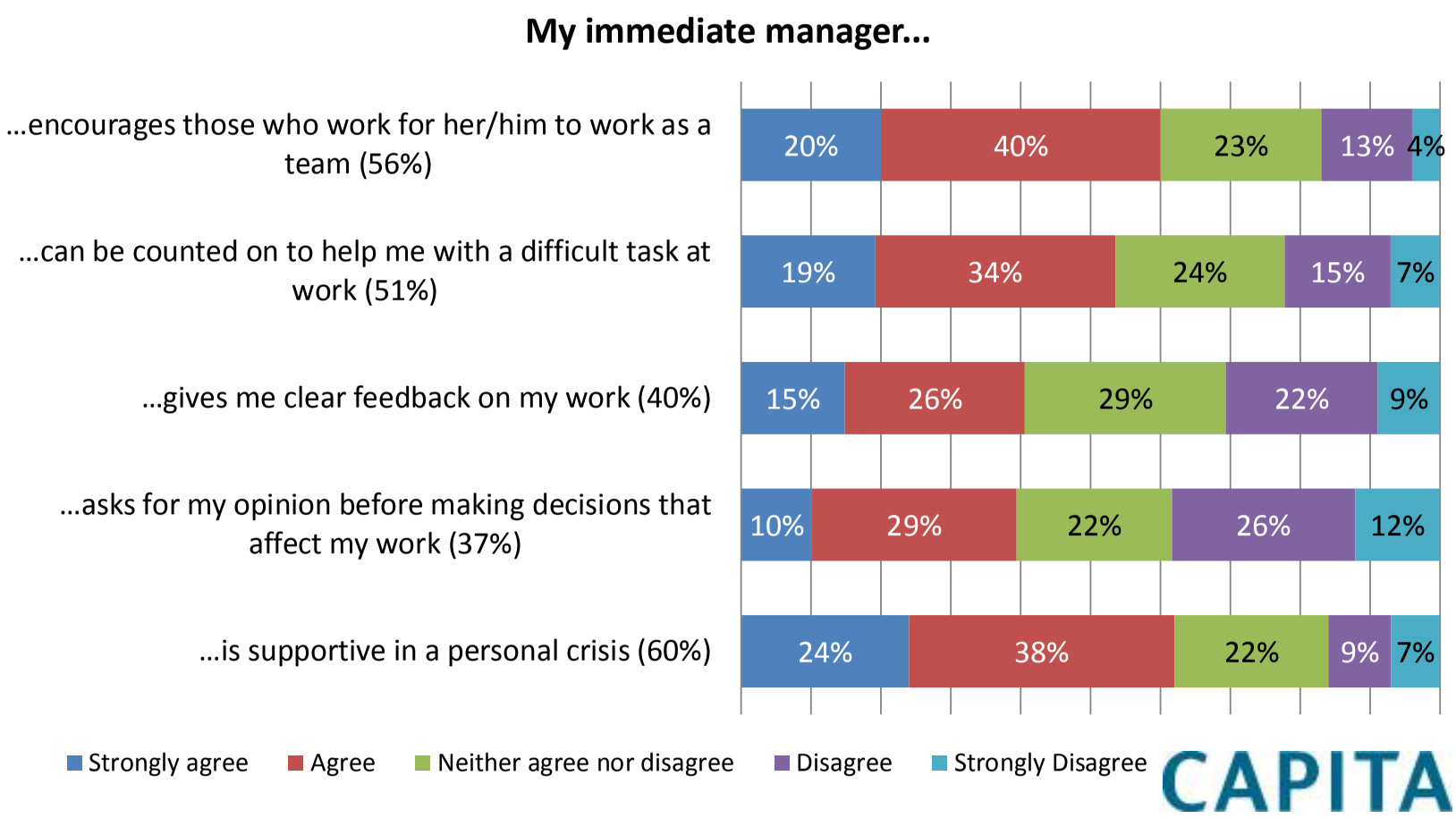
CAPITA

# Key areas for improvement

- Support from immediate managers
- Appraisal
- Health and Safety training
- Work related stress, work pressure and working extra hours
- Effective team working
- Witnessing potentially harmful errors, near misses or incidents
- Fairness and effectiveness of incident reporting procedures
- Feeling pressure to attend work when feeling unwell
- Physical violence & harassment and bullying

CAPITA

# Support from immediate managers



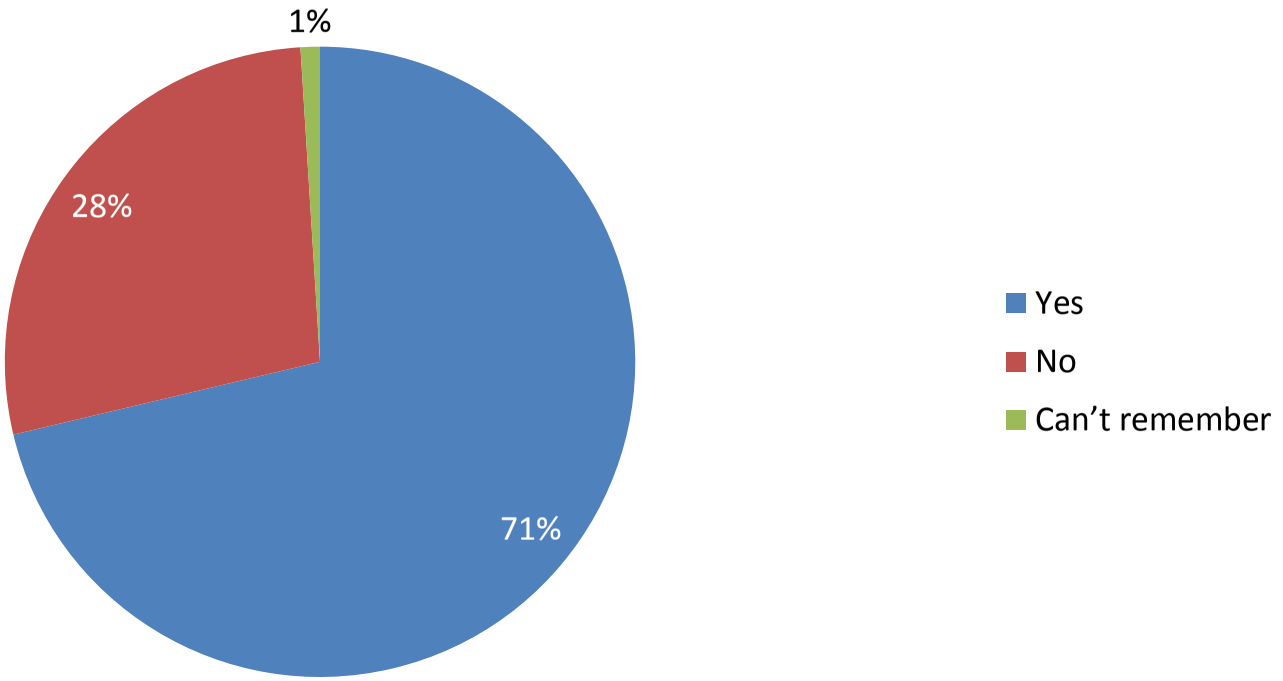

CAPITA

# NGH Additional Manager Questions


CAPITA

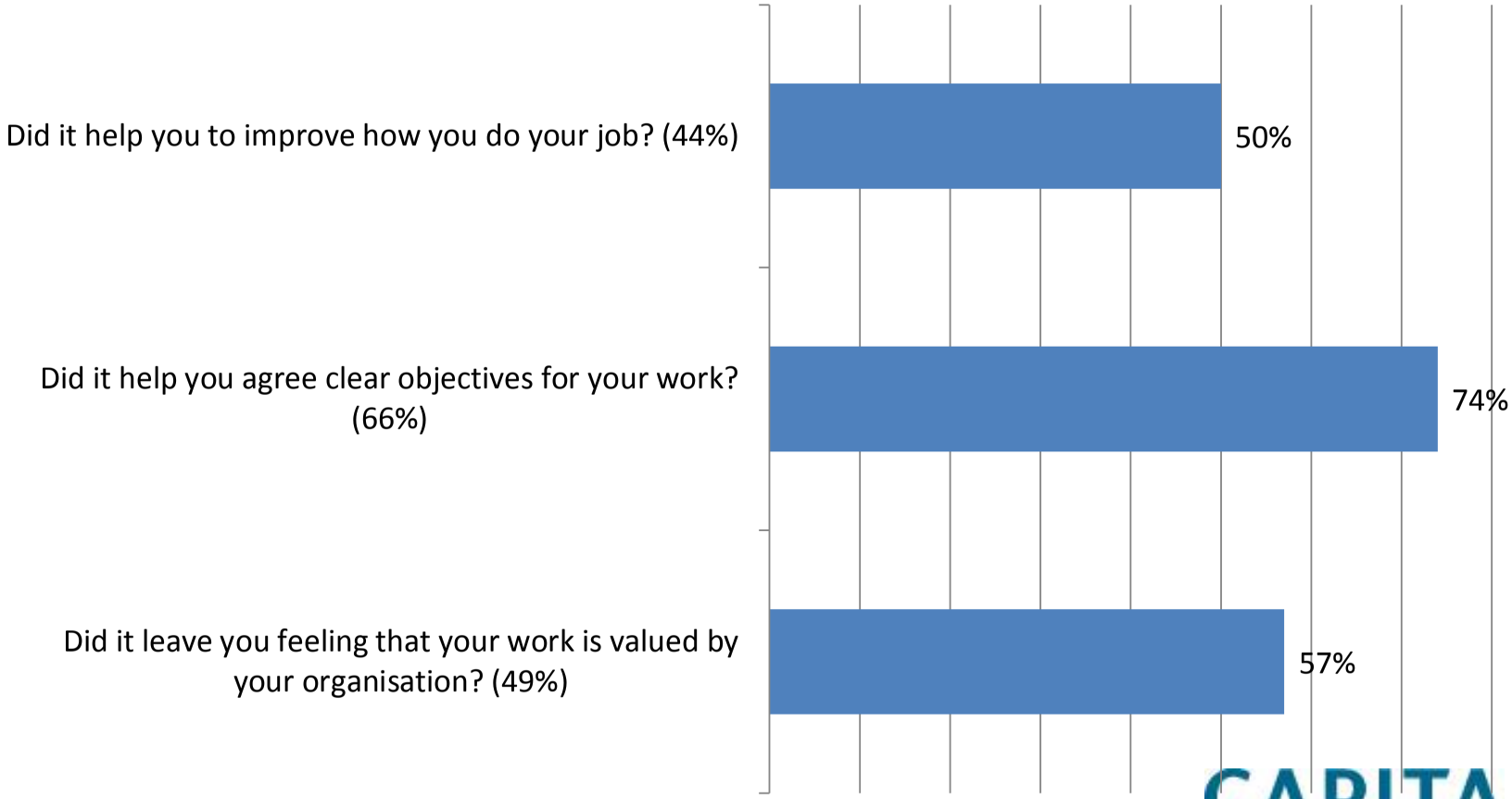
# Appraisal

**In the last 12 months, have you had an appraisal, annual review, development review, or KSF Development review? (70% 2012)**




CAPITA

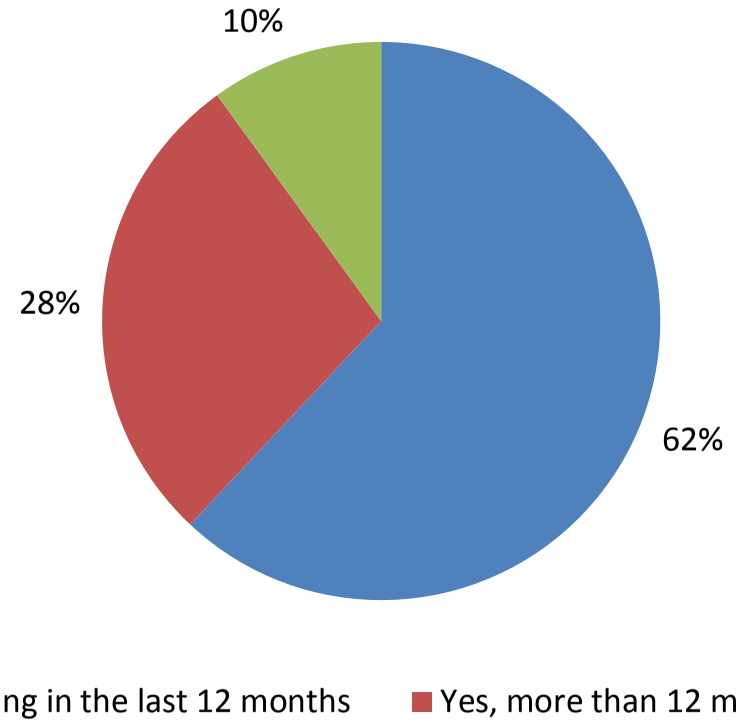
# Appraisal




CAPITA

# Health and Safety training

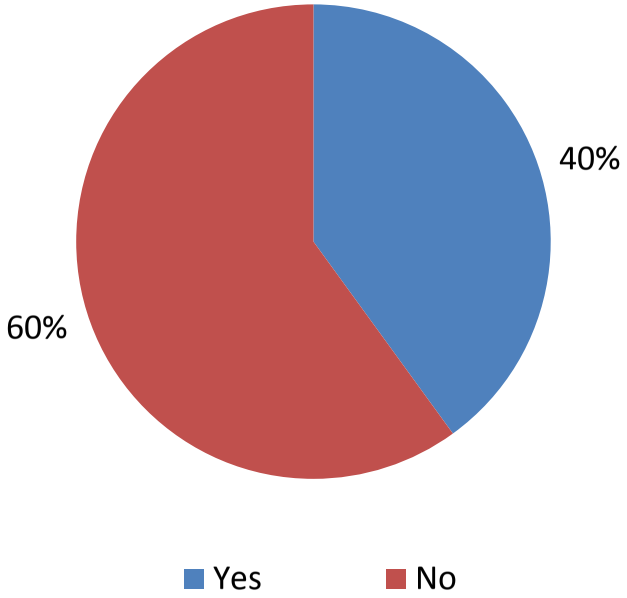
**Have you had any training learning or development? - Health and Safety Training (63% in the last 12 months 2012)**




CAPITA

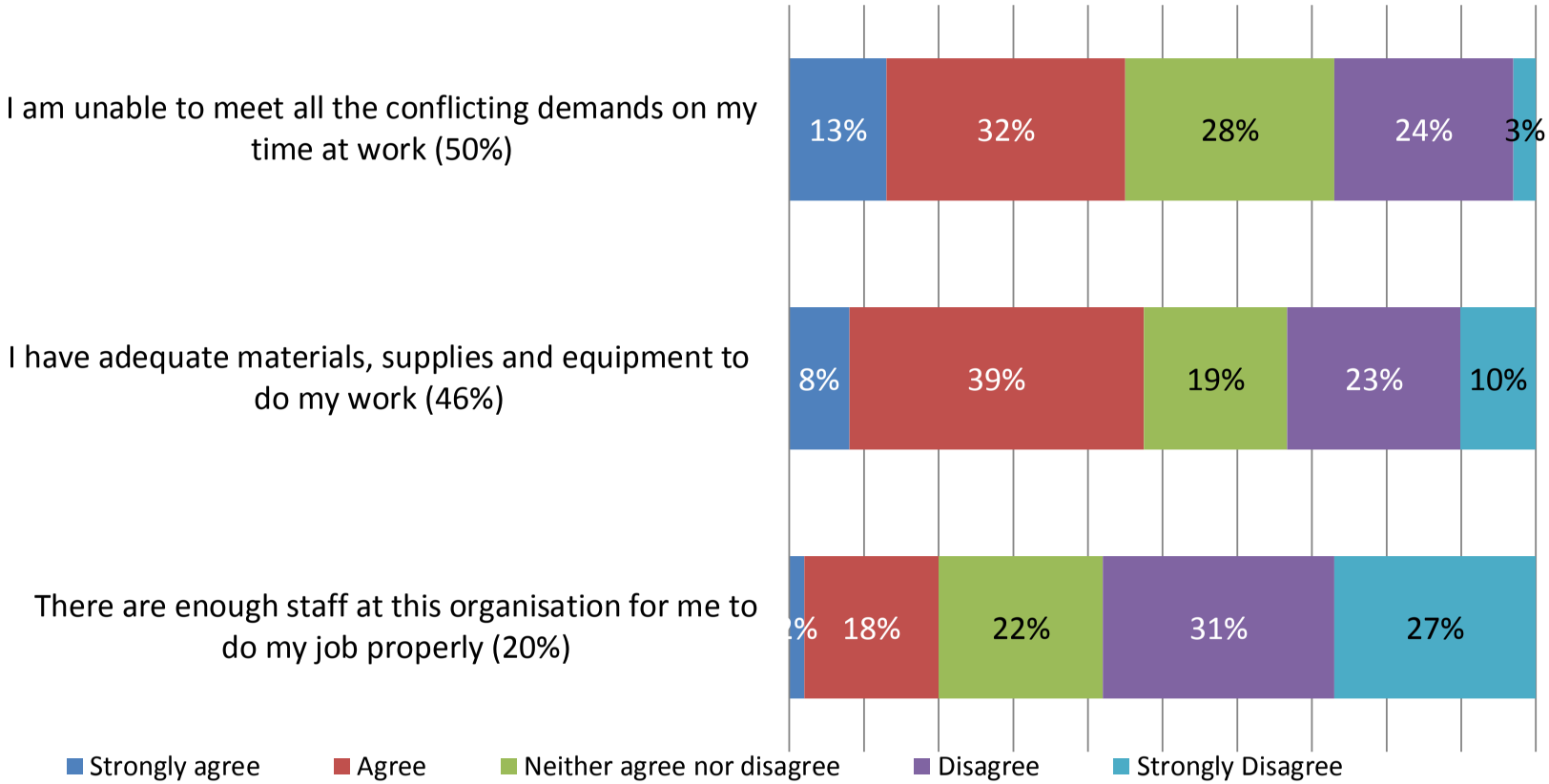
# Work related stress

**During the last 12 months have you felt unwell as a result of work related stress? (43% 2012)**



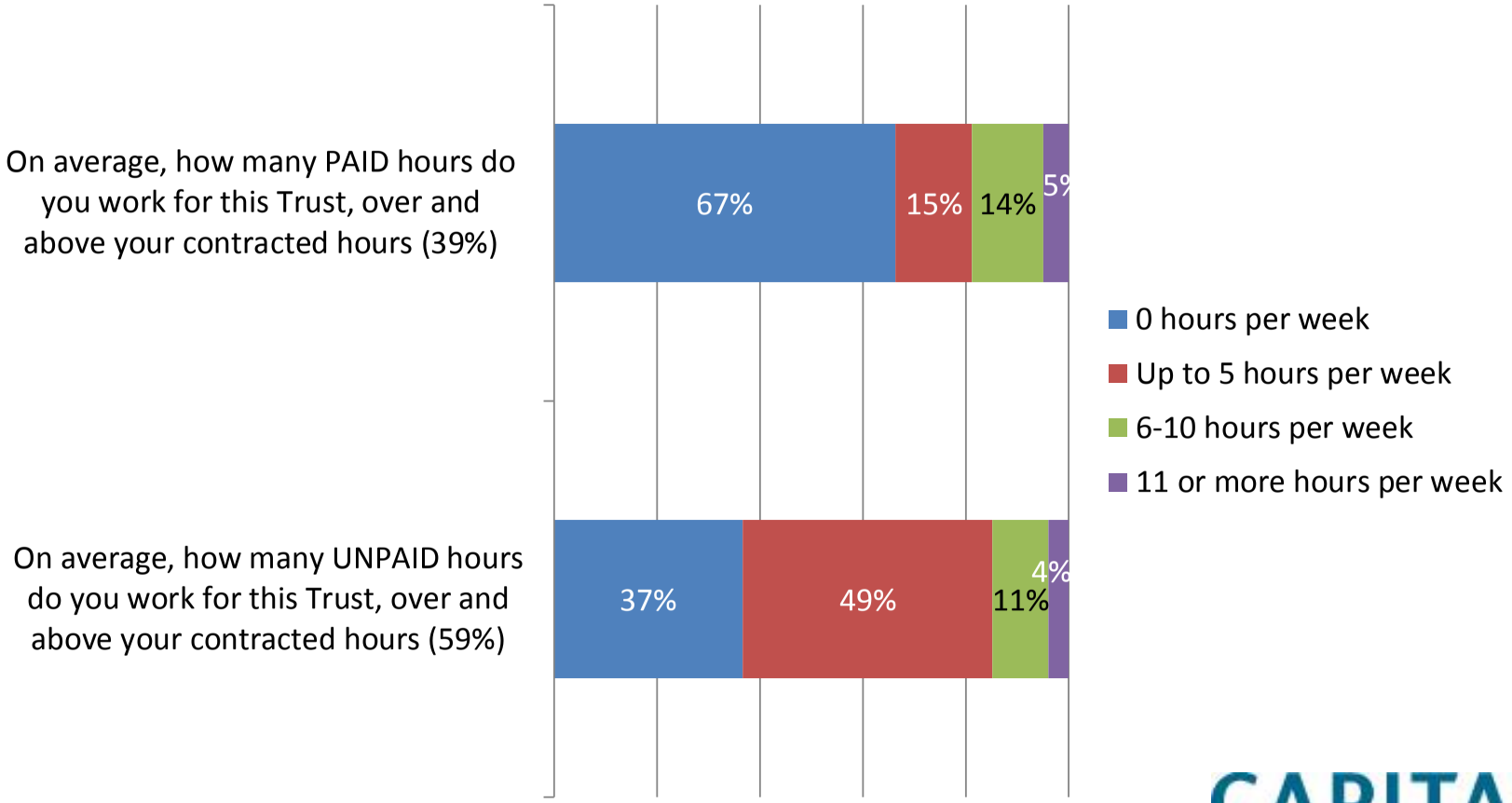

CAPITA

# Work pressure



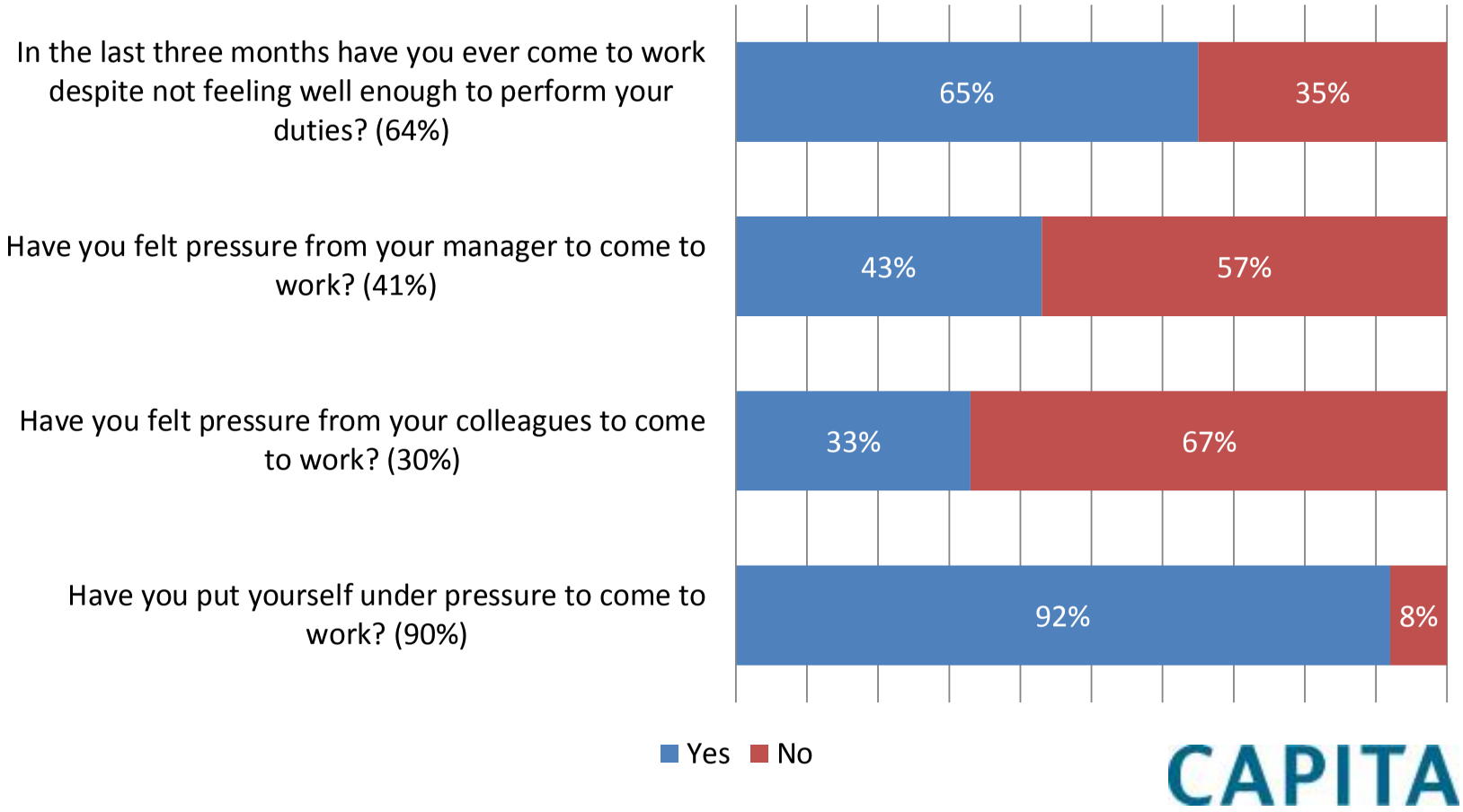

CAPITA

# Working extra hours



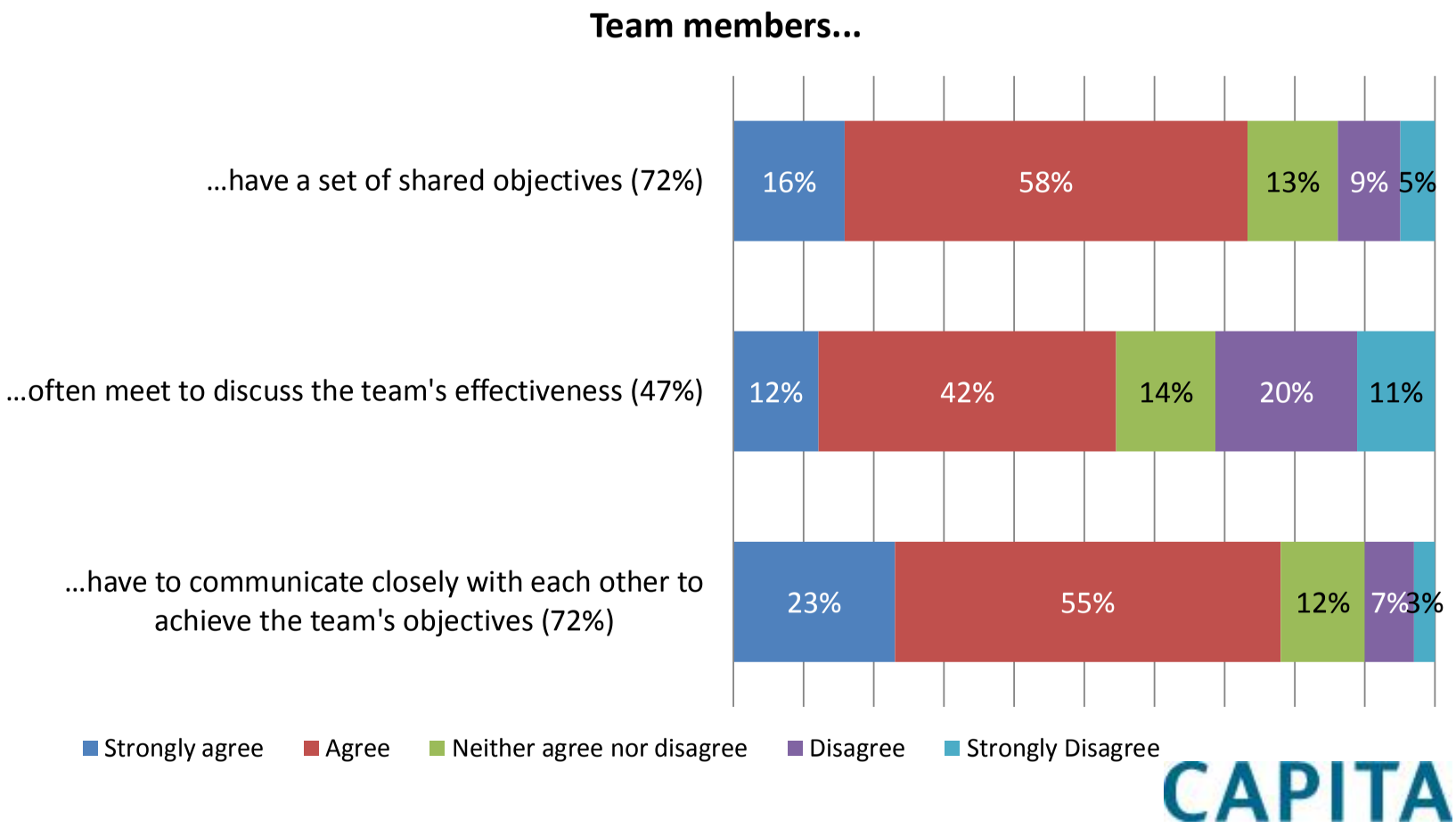

CAPITA

# Feeling pressure to attend work when feeling unwell




CAPITA

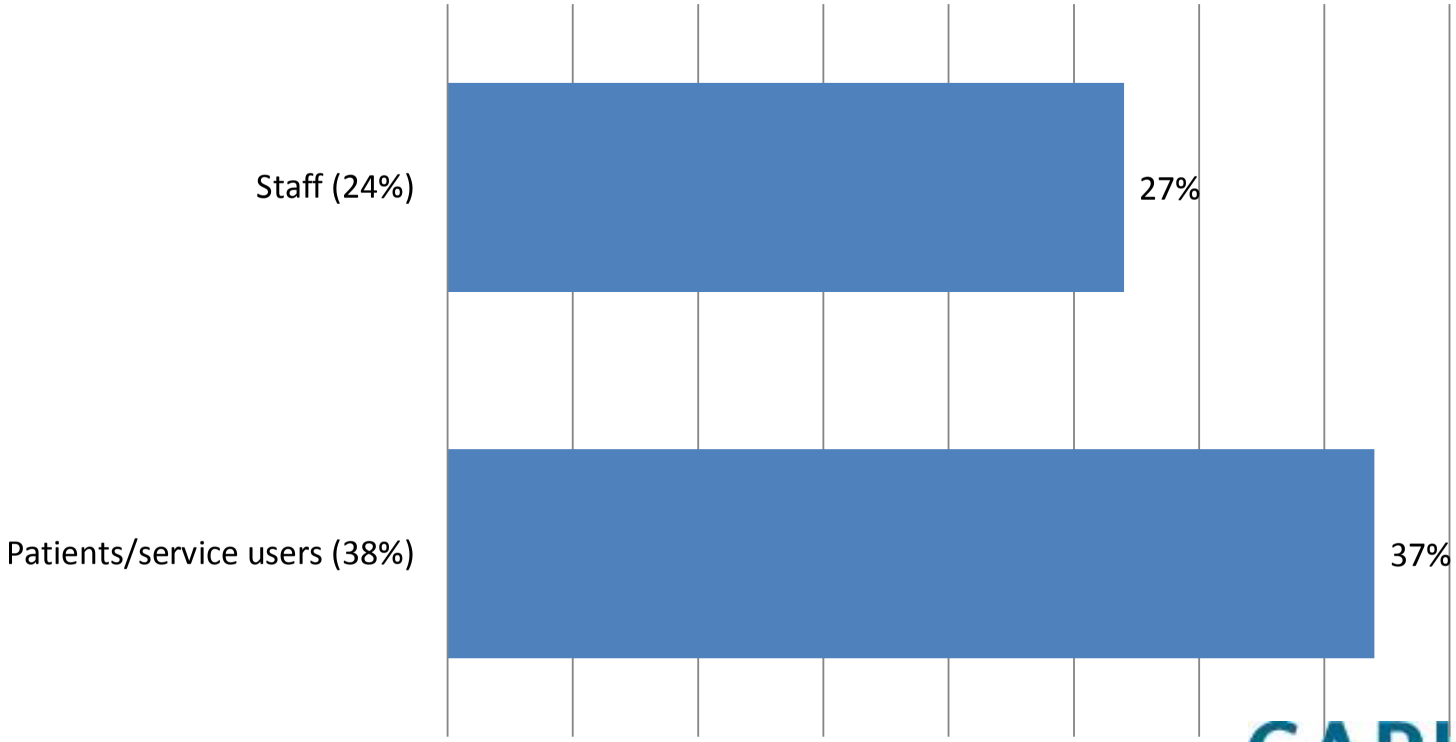
# Effective team working




CAPITA

# Witnessing potentially harmful errors, near misses and incidents

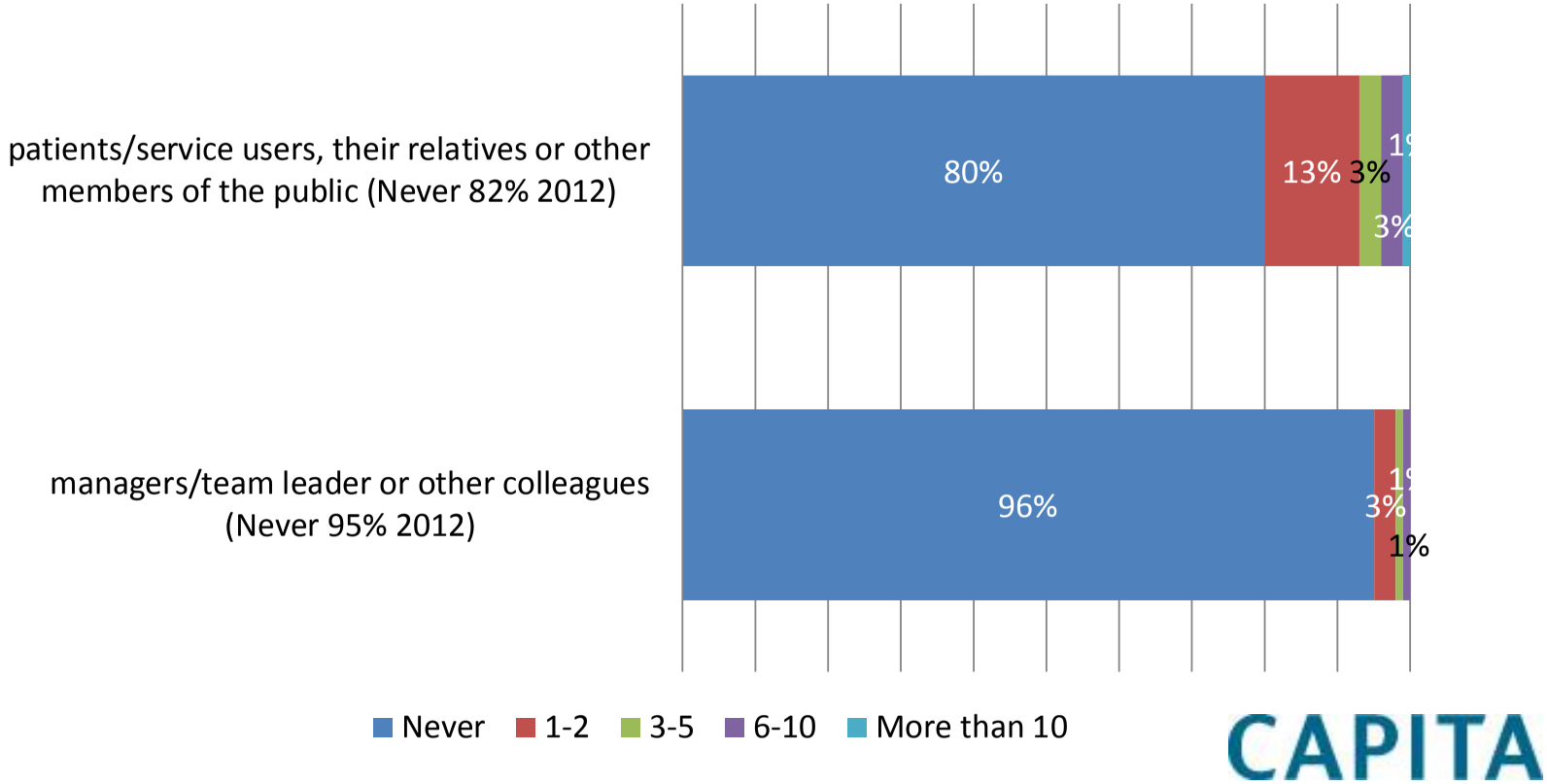
**In the last month have you ever seen any errors, near misses, or incidents that could have hurt...**




CAPITA

# Physical violence

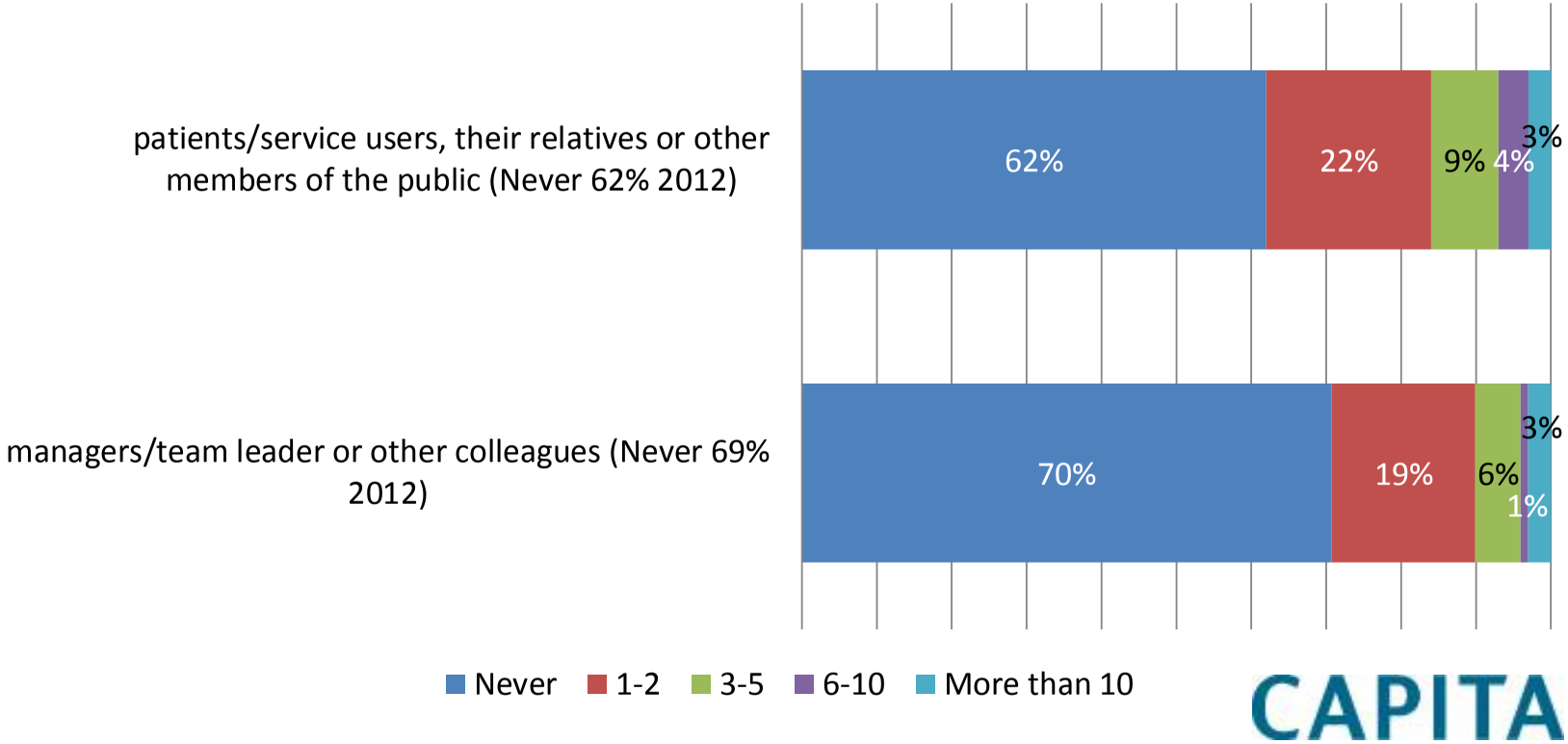
**In the last 12 months how many times have you personally experienced physical violence at work from ..**




CAPITA

# Harassment, bullying or abuse

**In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from..**




CAPITA

# Issues identified by staff

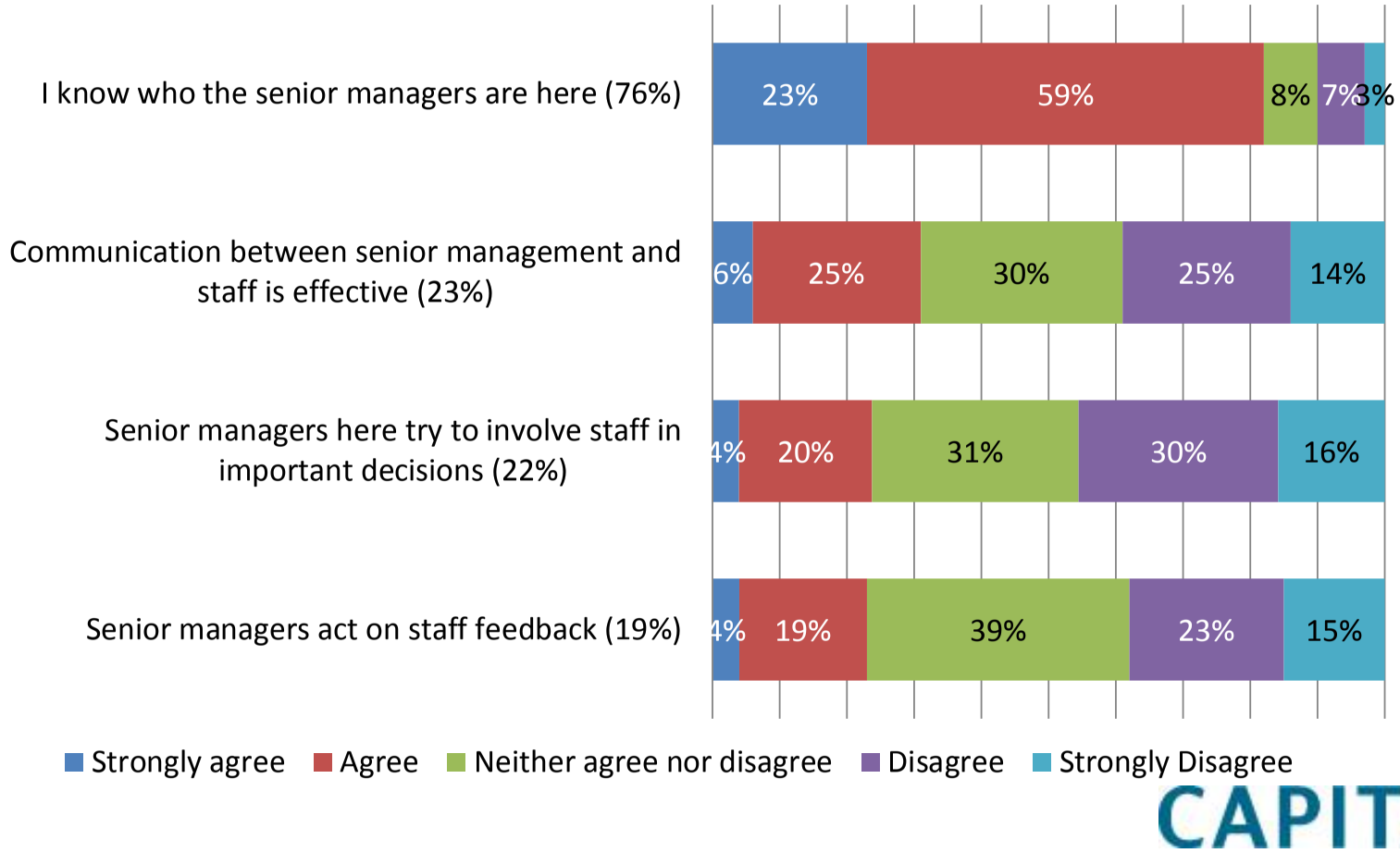
CAPITA

# Issues identified by staff

- Resources (Staffing)
- Staff involvement and Communication
- Pay and feeling valued

CAPITA

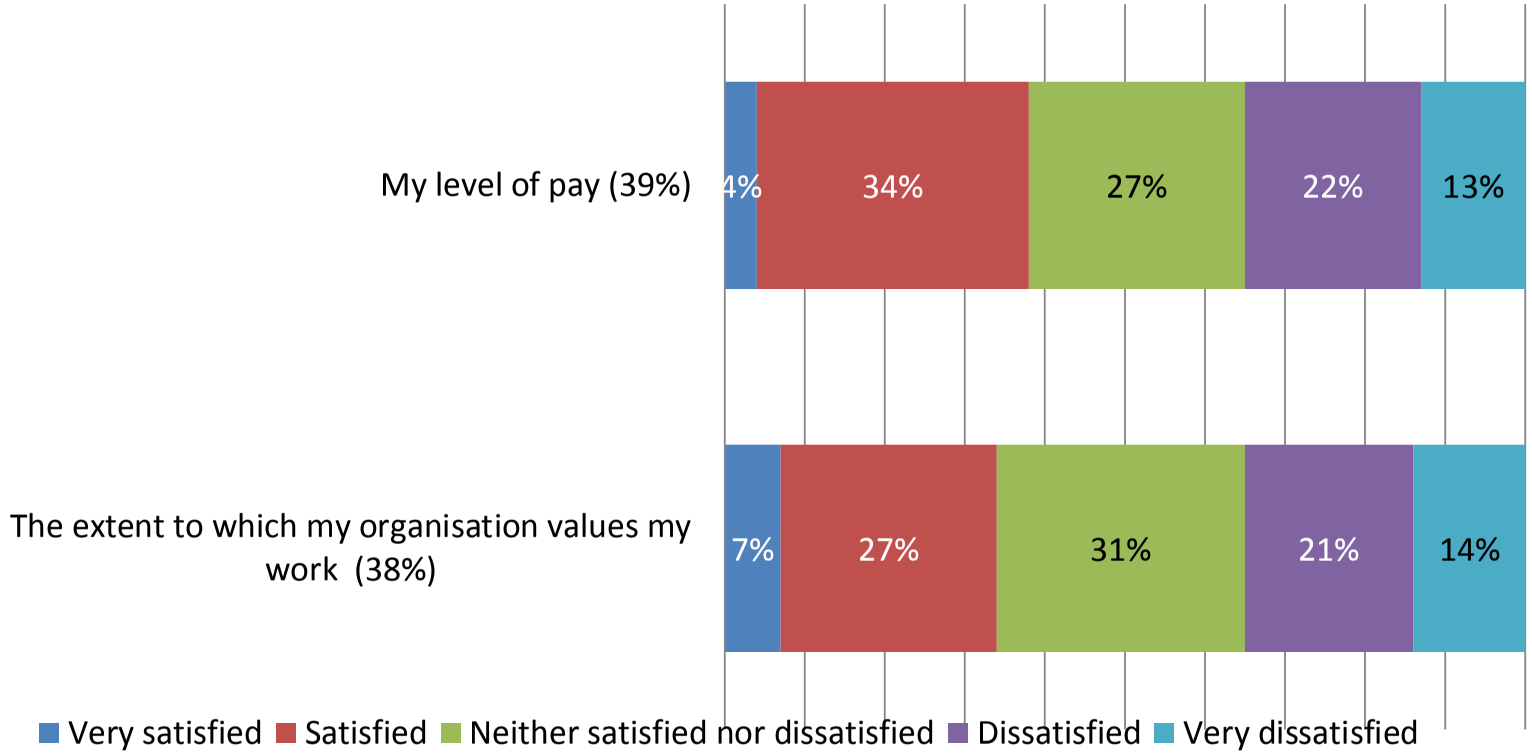
# Staff involvement and communication




CAPITA

# Pay and feeling valued

**How satisfied are you with each of the following aspects of your job?**




CAPITA

# Employee Engagement

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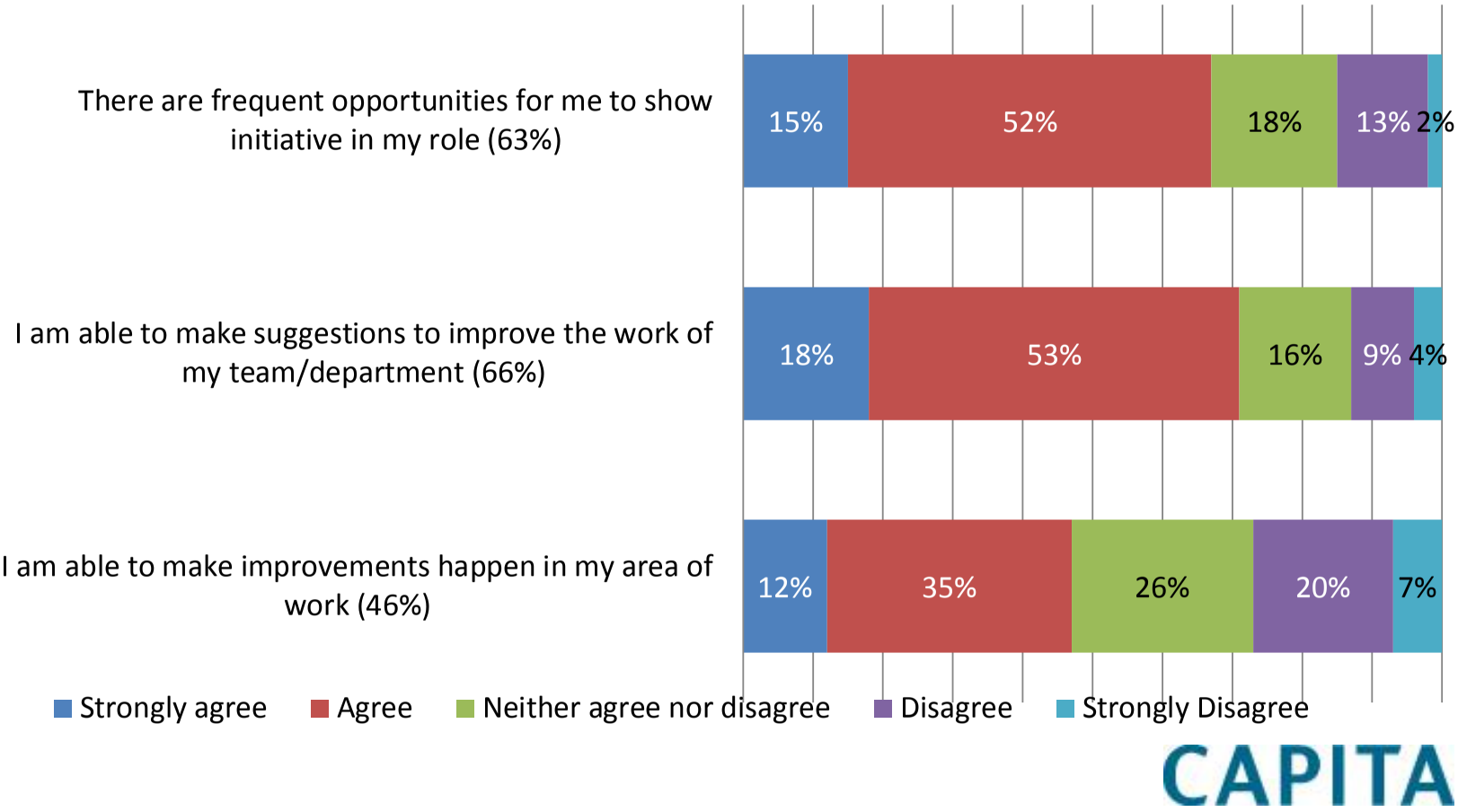
# Employee Engagement

- Overall score 3.62 (3.54) [3.74]
- KF22 – Staff ability to contribute towards improvements at work (63%) (58%) [68%]
- KF24 – Staff recommendation of the Trust as a place to work or receive treatment (3.52) (3.35) [3.68]
- KF25 – Staff motivation at work (3.81) (3.81) [3.86]

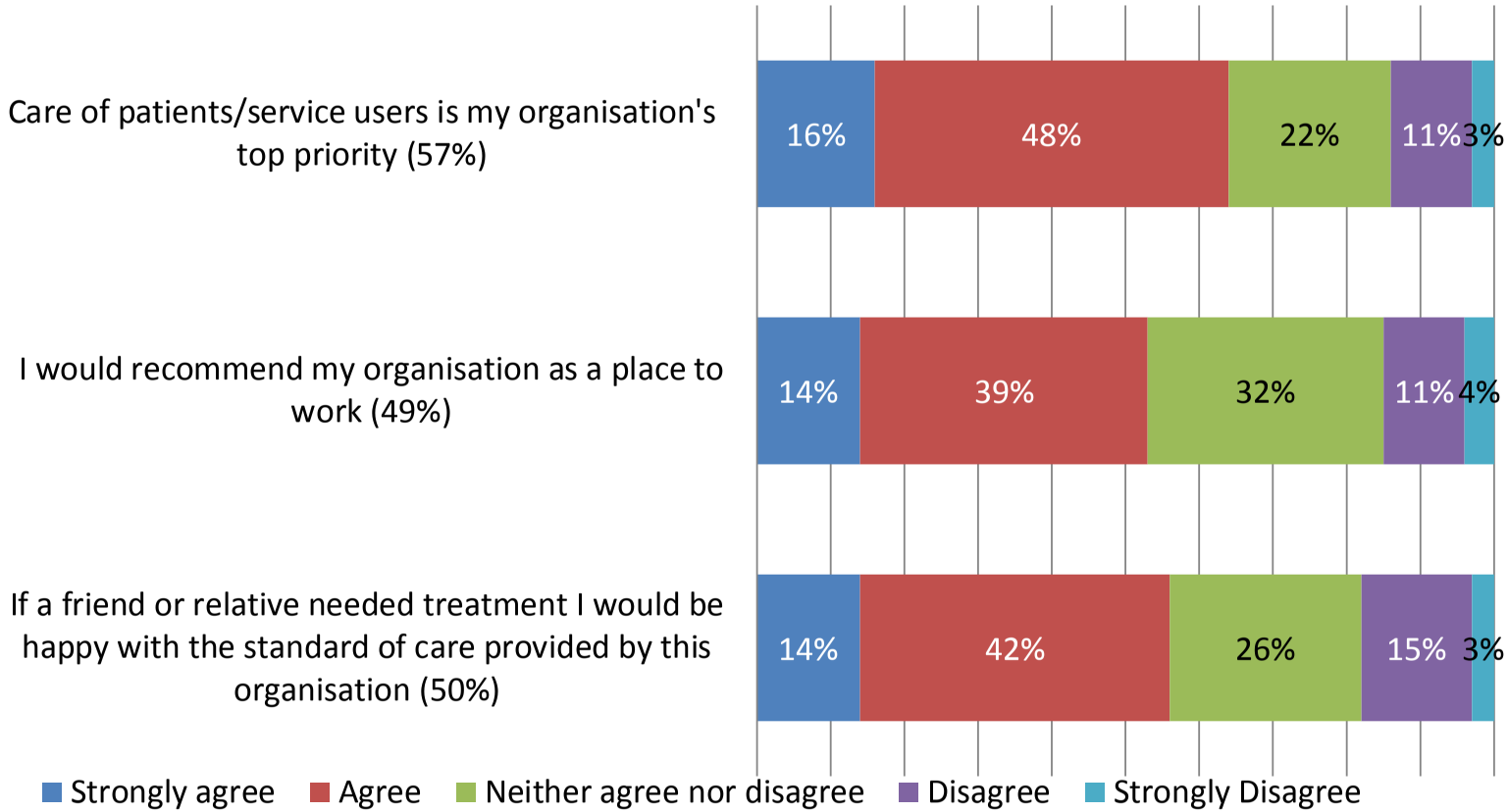
CAPITA

# Staff ability to contribute towards improvement at work



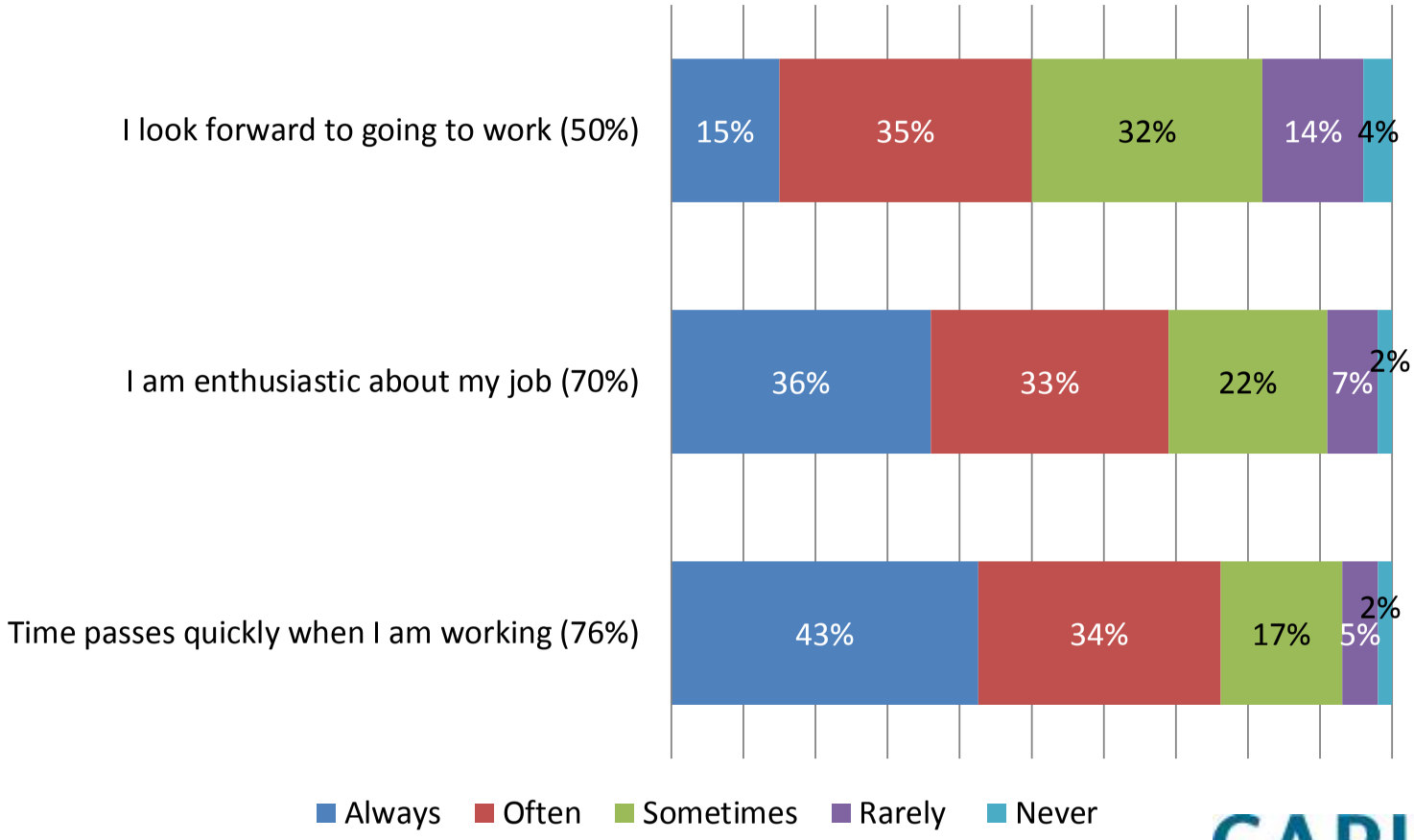

CAPITA

# Staff recommendation of the Trust as a place to work or receive treatment



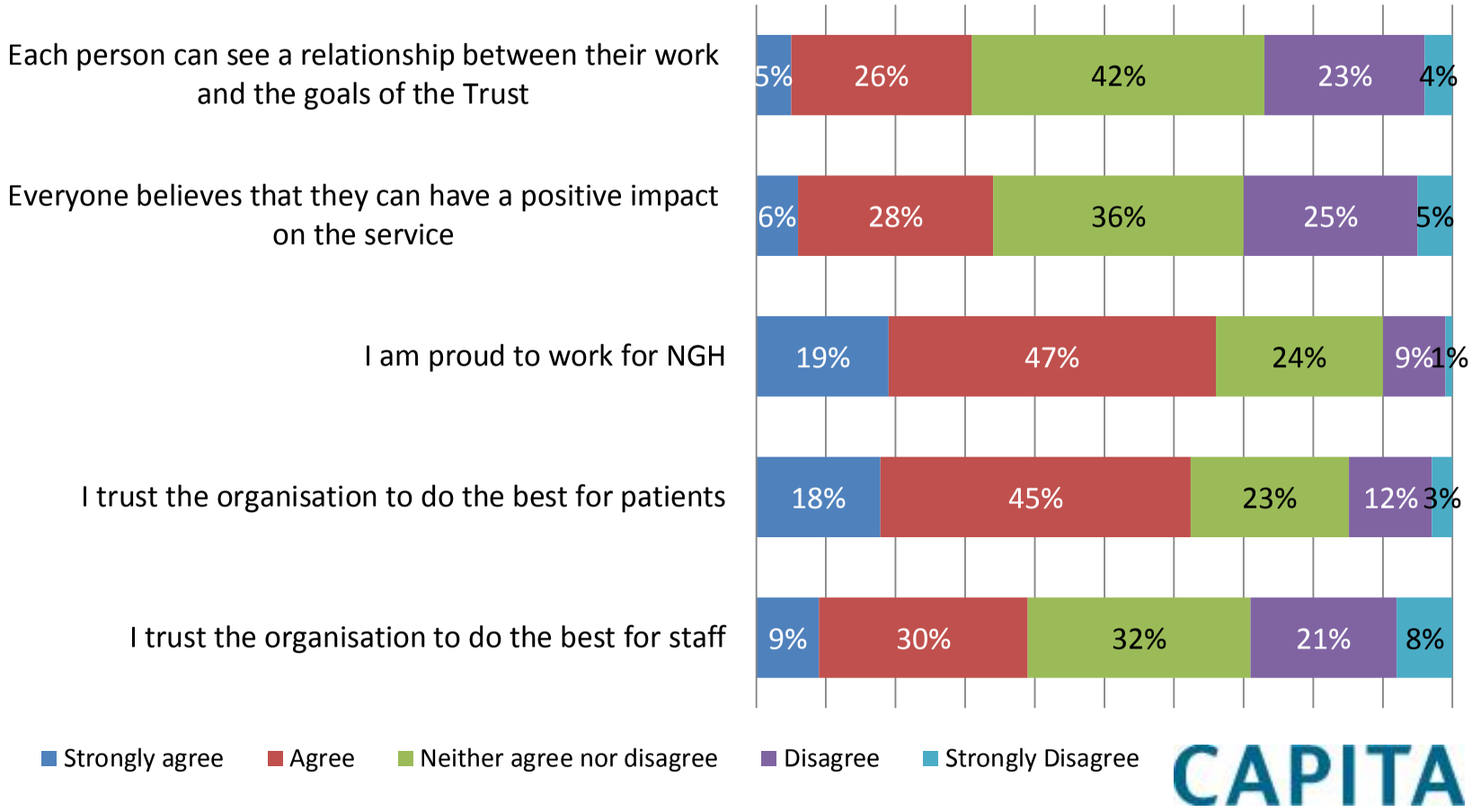

CAPITA

# Staff motivation at work




CAPITA

# NGH Additional Engagement Questions




CAPITA

# Positive perceptions of staff

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# Staff's most positive perceptions

Staff feel

- ..they are trusted to do their job
- ..their role makes a difference to patients/service users
- ..they always know what their work responsibilities are
- ..their organisation does not blame or punish people who are involved in errors, misses or incidents
- ..the Trust encourages them to report errors, near misses and incidents
- ..they know who the senior managers are here
- ..they are satisfied with the quality of care they give to patients/service users
- ..team members have to communicate closely with each other to achieve the team's objectives
- ..they are able to do their job to a standard they are personally pleased with
- ..they have clear, planned goals and objectives for their job

CAPITA

Northampton General Hospital NHS
NHS Trust

# REPORT TO: TRUST BOARD
# 29 May 2014

| | |
|---|---|
| **Title** | Improving Quality and Efficiency Report |
| **Agenda item** | 17 |
| **Sponsoring Director** | Janine Brennan, Director of Workforce & Transformation |
| **Author(s)** | Paul Devlin, Assistant Director Improving Quality and Efficiency |
| **Purpose** | Update to the Committee on the Latest Thinking Financial forecast of the Transformation Programme. |

**Executive summary**

The latest thinking forecast at M1 is £12.136m, against the £12.668m required delivery, off plan by £532k.

The plan submitted to the TDA required delivery of £513k in the first month. Actual delivery is £437k, off plan by £76k.

| | |
|---|---|
| **Related strategic aim and corporate objective** | Strategic Aim 5: To be a financially viable organisation. |
| **Risk and assurance** | The latest thinking forecast is £12.136m against the £12.668m required delivery. |
| **Related Board Assurance Framework entries** | BAF 21 |
| **Equality Impact Assessment** | Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? No<br><br>Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? No |

**Actions required by the Trust Board**

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

Enclosure N

# Northampton General Hospital NHS Trust

Improving Quality & Efficiency Report for Trust Board

MAY 2014

STRICTLY PRIVATE AND CONFIDENTIAL

Enclosure N

# Executive Summary

Northampton General Hospital NHS
NHS Trust

**Transformation Plan for 2014/15**

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

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

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

**The latest thinking forecast for Month 1 April 2014**

The upside latest thinking forecast at M1 is £12.136m, against the £12.668m required delivery, off plan by £532k.

The plan submitted to the TDA required delivery of £513k in the first month. Actual delivery is £437k, off plan by £76k.

**Next Steps**

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

- Completion of QIAs for all identified schemes
- Completion of identification of formally work up all additional schemes including project documentation, valuation and QIA
- Following completion of Clinical Strategy Consultancy, identify any 'quick wins' and include in 2014/15 programme.
- Firm up 2015/16 programme including formal project documentation, valuation and QIA

**Quality Impact Assessments (QIAs)**

The completion of QIAs for all schemes is currently in progress.

Maturity against QIA completion is presented on page 8. The IQE Team have provided significant focus on this aspect over the last month in order to maximise the value of QIA'd Schemes and Themes. We currently have circa £7M worth of plans with completed QIAs.

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

**Risks and Issues**

Given that plans for 2014/15 schemes are still being developed; some of the scheme targets will not be fully achieved in year due to slippage in delivery or risk materialising.

The Trust has mitigated this risk by targeting an additional £2.237m worth of new schemes to supplement its previously reported 2014/15 programme of £12.668m. This has ensured built in contingency against risk of non-delivery; ensuring that the overall target of £12.668m can be delivered. Executive sponsors will be allocated and agree values at the planning phase during May-June 2014.

# 2014/15 Plan in Overview

Northampton General Hospital NHS
NHS Trust

| Efficiencies Summary Information | TDA Plan £000s | % of Total | M1 LTF £000s | % of Total | Variance to TDA Plan £000s |
|---|---|---|---|---|---|
| Identified schemes | 12,005 | 95% | 12,136 | 96% | -131 |
| Shortfall | 663 | 5% | 532 | 4% | 131 |
| **Total Efficiency** | **12,668** | **100%** | **12,668** | **100%** | **0** |
| **CIP delivery vs turnover** | **4.6%** | | **4.7%** | | |

**Identification of the Transformation Programme 2014/15**
The table outlines the current LTF compared to the plan submitted to the TDA in April 2014.
The current LTF of £12.136m if delivered in full would be a 4.7% CIP.

This leaves a shortfall of £532k to be identified.



| Efficiencies Summary Information | Total Efficiency LTF £000s | Proportion of total % |
|---|---|---|
| Recurrent schemes | 11,460 | 90% |
| Non-recurrent schemes | 676 | 5% |
| Total needed to be identified | 532 | 4% |
| **Total Efficiency** | **12,668** | **100%** |

| Efficiencies Summary Information | Total Efficiency LTF £000s | Proportion of total % |
|---|---|---|
| Pay | 4,423 | 46% |
| Non pay | 3,561 | 22% |
| Income | 4,153 | 23% |
| Total needed to be identified | 532 | 9% |
| **Total Efficiency** | **12,668** | **100%** |

Pay schemes account for 46% whereas pay costs are 68% of turnover.

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

# Latest thinking forecast 2014/15

Northampton General Hospital NHS
NHS Trust

| Theme | Year to date | | | Full year 2014/15 | | |
|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Plan | LTF | Variance |
| Workforce | £20,000 | £2,112 | -£17,888 | £489,000 | £421,999 | -£67,001 |
| Back Office | £0 | £0 | £0 | £250,000 | £250,000 | £0 |
| Rightsizing the Organisation | £7,000 | £7,000 | £0 | £85,000 | £85,000 | £0 |
| Individual Driven Themes | £0 | £0 | £0 | £0 | £0 | £0 |
| Urgent Care | £0 | £0 | £0 | £25,000 | £25,000 | £0 |
| Medical Productivity | £25,000 | £12,107 | -£12,893 | £800,000 | £150,000 | -£650,000 |
| Patient Pathways | £0 | £0 | £0 | £287,000 | £436,000 | £149,000 |
| Nursing & Midwifery Productivity | £0 | £0 | £0 | £1,001,000 | £1,166,750 | £165,750 |
| Procurement | £29,000 | £80,683 | £51,683 | £1,249,000 | £979,748 | -£269,252 |
| Directorate CIPs | £377,000 | £303,675 | -£73,325 | £5,669,000 | £6,136,693 | £467,693 |
| 2013/14 FYE | £0 | £31,781 | £31,781 | £0 | £247,851 | £247,851 |
| New Schemes | £0 | £0 | £0 | £2,150,000 | £2,237,000 | £87,000 |
| Unidentified | £55,000 | £0 | -£55,000 | £663,000 | £0 | -£663,000 |
| **Total** | **£513,000** | **£437,358** | **-£75,642** | **£12,668,000** | **£12,136,041** | **-£531,959** |

**Month 1 – Latest Thinking Forecast**

The Transformation Programme is currently projecting a LTF shortfall £532k against the required plan of £12.668m.

Workforce is off plan by £67k due to the removal of the 35 hour scheme and a delay in the reduction of admin bank and agency savings.

Medical Productivity is off plan by £650k due to phasing of job planning, medical recruitment and the locum managed service initiatives.

Patient Pathways are ahead of plan by £149k. This is due to the plan being revised down due to risk, however a stretch plan will be in place.

Nursing & Midwifery Productivity are ahead of plan by £166k . This is due to the plan being revised down due to risk.

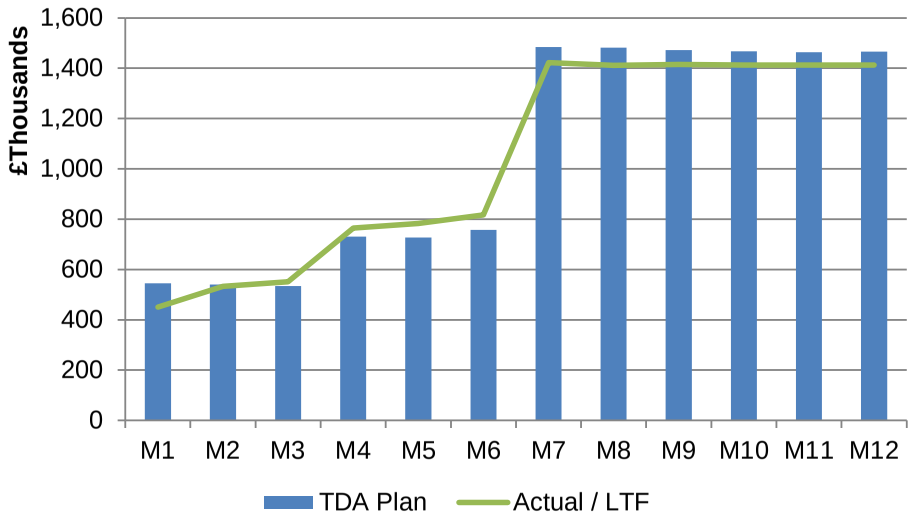
Procurement are behind plan by £269k . This is due to a stretched target.

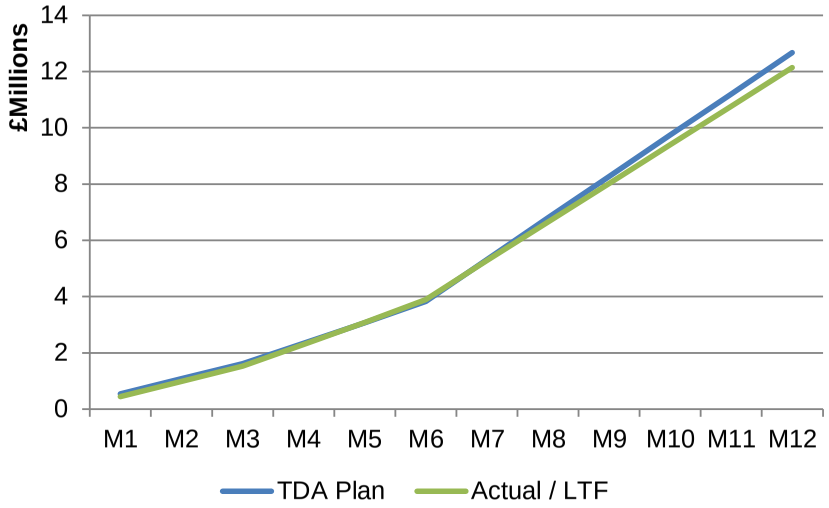
New schemes are presented on page 9. All are currently in the opportunity phase of maturity moving to planning during May and June 2014..

# Delivery and Plan by month

Northampton General Hospital NHS
NHS Trust

**Overall Performance** | **Off trajectory**




Actual delivery in month 1 was £437k against planned delivery of £513k. 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 £532k behind the TDA plan. The plan submitted to the TDA requires savings to accelerate from month 7 onwards.

# Risk Delivery Profile

Northampton General Hospital NHS
NHS Trust

| | LTF £'000s | % of Total target | Most Likely £'000s | Worst Case £'000s |
|---|---|---|---|---|
| Green | 4,561 | 36% | 4,561 | 4,561 |
| Amber | 4,516 | 36% | 3,387 | 3,387 |
| Red | 3,059 | 24% | 1,223 | 0 |
| **Total** | **12,136** | **96%** | **9,172** | **7,948** |
| Gap | 532 | 4% | 3,496 | 4,720 |

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

The latest thinking forecast (£12.136m) has been derived from the current phasing of schemes and assurances on deliverability with scheme owners.

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

The downside case based on current RAG rating would see the programme realise £7.948m.

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.

| Scheme | FY14/15 LTF £'000 R | A | G | Total Identified |
|---|---|---|---|---|
| A1: Site Bed Team | - | - | - | - |
| A2: Surgery | 200 | 89 | 70 | 359 |
| A3: Anaesthetics | - | 112 | 428 | 540 |
| A4: T&O | - | 351 | 6 | 358 |
| A5: Head & Neck | - | 87 | 3 | 90 |
| A6: Child Health | 46 | 195 | 497 | 738 |
| A7: Obs & Gynae | 46 | 540 | 46 | 632 |
| A8: Opthalmology | - | 425 | - | 425 |
| A9: Surgical Care Management | - | - | - | - |
| **SCG sub total** | **292** | **1,799** | **1,050** | **3,141** |
| B1: General Medicine | 150 | - | 891 | 1,041 |
| B2: Pathology | 7 | 358 | 56 | 421 |
| B3: Oncology | 30 | 45 | 34 | 109 |
| B4: Radiology | 7 | 87 | 19 | 113 |
| B5: Research & development | - | - | 10 | 10 |
| B6: Pharmacy | 2 | - | 39 | 41 |
| B7: Therapies | - | - | - | - |
| B8: Medical Care Management | - | - | - | - |
| **MCG sub total** | **196** | **490** | **1,048** | **1,734** |
| C1-C7 Corporate Areas | - | 80 | 254 | 334 |
| C7: Facilities | - | 613 | 315 | 928 |
| **Support sub total** | **-** | **693** | **569** | **1,263** |
| **Care Group & Corporate CIP Total** | **487** | **2,982** | **2,668** | **6,137** |
| Workforce | - | - | 422 | 422 |
| Back Office | 192 | 58 | - | 250 |
| Rightsizing the Organisation | - | 85 | - | 85 |
| Individual Staff Lead Themes | - | - | - | - |
| Urgent Care | 25 | - | - | 25 |
| Medical Productivity | - | - | 150 | 150 |
| Patient Pathways | - | 436 | - | 436 |
| Nursing Productivity | 118 | 955 | 94 | 1,167 |
| Procurement | - | - | 980 | 980 |
| FYE of 13/14 schemes | - | - | 248 | 248 |
| New Schemes | 2,237 | - | - | 2,237 |
| Gap | - | - | - | 532 |
| **Total** | **3,059** | **4,516** | **4,561** | **12,668** |

# Care Group & Corporate CIPs

Northampton General Hospital NHS
NHS Trust

| Directorate | FY14/15 Planned Savings £'000 | FY14/15 Forecast Outturn of Savings (LTF) | Forecast Outturn Variance to plan £'000 | | Year to date £'000 | | | |
|---|---|---|---|---|---|---|---|---|
| | Total | Total | Total | RAG | Planned to date | Actual savings to date | Var | RAG |
| A1: Site Bed Team | - | - | - | | - | - | - | |
| A2: Surgery | 359 | 359 | (0) | | 12 | 12 | (0) | |
| A3: Anaesthetics | 568 | 540 | (28) | | 45 | 17 | (28) | |
| A4: T&O | 431 | 358 | (74) | | 17 | 6 | (11) | |
| A5: Head & Neck | 126 | 90 | (37) | | 6 | 3 | (3) | |
| A6: Child Health | 581 | 738 | 157 | | 52 | 39 | (13) | |
| A7: Obs & Gynae | 669 | 632 | (37) | | 58 | 21 | (37) | |
| A8: Opthalmology | 453 | 425 | (28) | | 34 | - | (34) | |
| A9: Surgical Care Management | - | - | - | | - | - | - | |
| **SCG sub total** | **3,188** | **3,141** | **(47)** | **-** | **225** | **98** | **(127)** | **-** |
| B1: General Medicine | 615 | 1,041 | 426 | | 64 | 106 | 43 | |
| B2: Pathology | 402 | 421 | 19 | | 23 | 27 | 4 | |
| B3: Oncology | 69 | 109 | 40 | | 5 | 15 | 10 | |
| B4: Radiology | 72 | 113 | 41 | | 7 | 18 | 12 | |
| B5: Research & development | 10 | 10 | - | | 1 | 1 | - | |
| B6: Pharmacy | 37 | 41 | 3 | | 3 | 5 | 2 | |
| B7: Therapies | - | - | - | | - | - | - | |
| B8: Medical Care Management | - | - | - | | - | - | - | |
| **MCG sub total** | **1,206** | **1,734** | **528** | **-** | **102** | **172** | **70** | **-** |
| C1: Medical Director | 24 | 24 | - | | 2 | 2 | - | |
| C2: Patient & Nursing Services | 76 | 50 | (26) | | 6 | - | (6) | |
| C3: Strategy & Partnerships | 91 | 95 | 5 | | 8 | 8 | 1 | |
| C4: Corporate Affairs | - | - | - | | - | - | - | |
| C5: Workforce & Transformation | 78 | 72 | (6) | | 7 | 6 | (0) | |
| C6: Finance | 98 | 92 | (6) | | 6 | 2 | (4) | |
| C7: Facilities | 908 | 928 | 21 | | 22 | 15 | (7) | |
| **Support sub total** | **1,275** | **1,263** | **(13)** | **-** | **50** | **33** | **(17)** | **-** |
| **Totals** | **5,669** | **6,137** | **468** | **-** | **377** | **304** | **(74)** | **-** |

At month 1 Care Group & corporate CIPs are £40k behind plan. This is due to a delay in some schemes being started.

This shortfall is expected to be made up and the Directorates over achieve the original plan by £468k this year.

The Surgical Care Group are forecasting a £47k deficit. At month 1 they are behind plan by £127k. This is due to Critical care income , paediatric non elective activity and Obstetrics & Gynaecology maternity pathway income being lower than expected.

The Medical Care Group are forecasting a £528k surplus.
At month 1 they are ahead of plan by £70k.

All Corporate areas are on target to meet the plan, with the exception of Patient & Nursing Services, Workforce & Transformation & Finance.

The Care Group & Corporate CIPs do not take into account any delivery of the Corporate themes. These will be apportioned into each directorate to achieve the 5% target of £12.668m

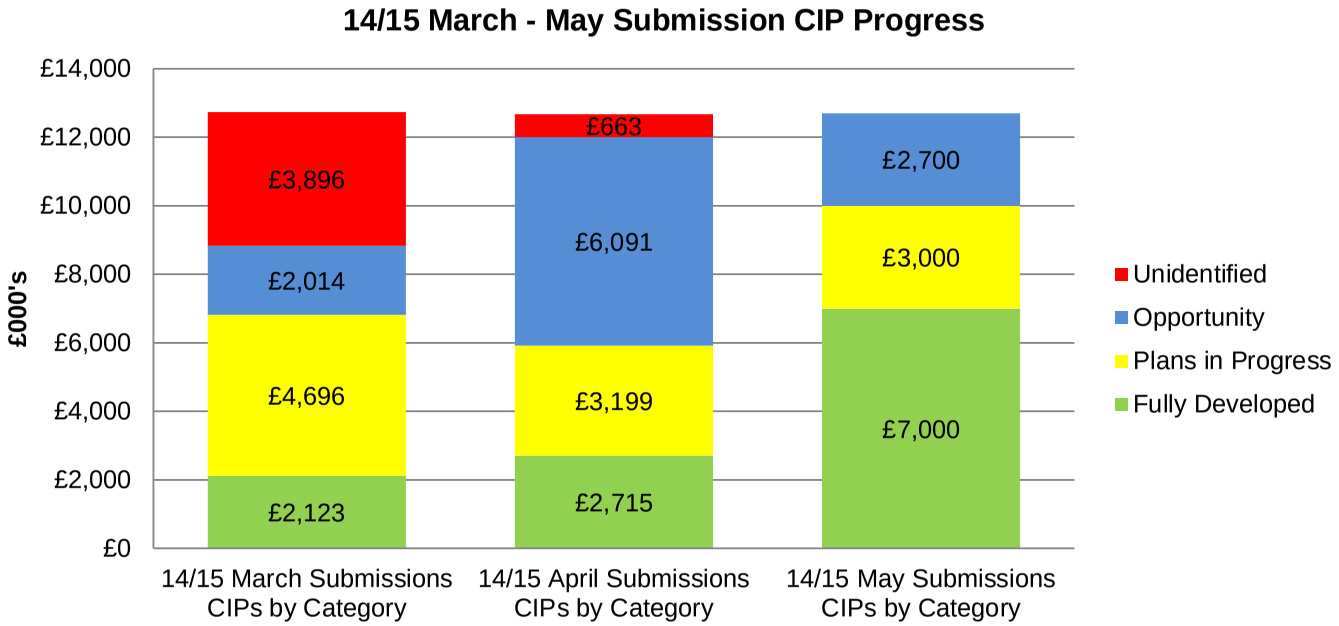
**RAG Key:**

Red = Significantly off plan
Amber = Moderately off plan
Green = On trajectory no negative variance to plan

# QIA Maturity

Northampton General Hospital NHS
NHS Trust

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



# Additional Opportunities CIP Schemes

Northampton General Hospital NHS Trust

New schemes are presented below. All are currently in the opportunity phase of maturity moving to planning during May and June 2014. These are now accounted for in the latest thinking position under new schemes on page 4.

| Additional CIP Scheme Opportunities Supporting Mitigation of 2014-2015 Plan | | | 2014/15 Value | Full Year Value |
|---|---|---|---|---|
| Ser. | Compensatory CIP Scheme | Approach | 4 months | 12 Months |
| 1 | Clinical Excellence Awards | This opportunity represents a designated period where clinical excellence payments would not be paid due to the lag between incurring uplift costs between financial years. | £60 | £181 |
| 2 | Sickness absence management system | This opportunity is based on achieving 0.5% reduction in the sickness absence rate across the Trust and will be adjusted at project level following the identification of enabling costs. | £293 | £880 |
| 3 | Improve theatre efficiency | This is in addition to the £97K already in the pre remedial action plan assessment giving a revised target calculated against all specialties. | £270 | £810 |
| 4 | Discretionary non-pay spend controls | The is a high level assumption which can achieved as a result of targeting printing, travel, taxis, photocopiers, courses and conferences, mobile phones, IT hardware, office equipment, management consultants, off payroll interims and subscriptions. | £134 | £402 |
| 5 | Medicines management | This represents an understated opportunity to optimising medication provisions through the standardisation of products across Directorates and optimisation of highly effective products sourced as efficiently as possible. | £402 | £1,206 |
| 6 | Extension of salary sacrifice scheme | This is an indication of the increased opportunity that could be achieved by expanding the scope of the current salary sacrifice scheme. This is fairly narrow at present and could include white goods and lease cars as well as mobile communications. | £67 | £201 |
| 7 | Pharmacy outsourcing | The Trust is already doing this but the estimated current benefit within pharmacy general efficiency appears to be excessively prudent. This value represents a more realistic achievement going forward. | £67 | £201 |
| 8 | Stretch procurement | Procurement have a good record of delivering about £1m per year without stretch so this additional opportunity that can be realised through broadening the scope of existing work. | £226 | £679 |
| 9 | Junior Doctor travel & relocation | The current practice on travel expenses and relocation expenses for junior doctors appears to be more generous than at other Trusts. This target is based on implementing tried and tested policies utilised within similar Trusts. | £34 | £101 |
| 10 | Diagnostic test rationalisation | This target represents a reduction in the use of diagnostic tests particularly by junior doctors through tighter governance arrangements including senior support at decision making points. | £13 | £40 |
| 11 | Non-elective flow average LOS | This is an indication of the additional potential to reduce average LOS to upper quartile performance through matching capacity with demand and negating the need for incurring the addition costs of opening extra capacity. | £335 | £1,005 |
| 12 | Clinical strategy review (Deloitte) | This potential will be realised by optimising specialist service provision of those services currently being reviewed by Deloitte. This does not include subsequent opportunities within general medicine and gynaecology which will be quantified following an opportunity search in June 2014. | £168 | £503 |
| 13 | Outsourcing review | This indicates the level of opportunity which is achievable as a result of repatriating clinical work such as trauma and orthopaedic operations back into the Trust as opposed to using third party providers. This will be achieved by increasing the efficiency thus creating additional capacity. | £168 | £503 |
| | Total | | £2,237 | £6,711 |

# REPORT TO: TRUST BOARD
# 29 May 2014

| | |
|---|---|
| **Title** | Trust Development Authority Accountability Framework |
| **Agenda item** | 19 |
| **Sponsoring Director** | Chris Pallot, Director of Strategy and Partnerships |
| **Author(s)** | Chris Pallot, Director of Strategy and Partnerships |
| **Purpose** | Information |

**Executive summary**

The Framework articulates how the Trust can expect the Trust Development Authority (TDA) to hold it to account during the course of the year, the processes by which this will happen and the key indicators that must be met.

The indicators are grouped in the following ways:

- Caring
- Well led
- Effective
- Safe
- Responsive
- Finance

The Trust will be managed via the monthly Integrated Delivery Meetings with the TDA which may alter based on any escalation level that is in-place.

The Framework also describes the approval framework for aspiring Foundation Trusts and the process for agreeing significant capital investments in excess of £50m.

| | |
|---|---|
| **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)<br>Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? (N) |

**Actions required by the Trust Board**

The  Board is asked to note the requirements of the Accountability Framework

NHS
Trust Development Authority

# Delivering for Patients:

## the 2014/15 Accountability Framework for NHS trust boards

tda Trust Development Authority
Quality. Delivery. Sustainability.

# Foreword

As we move into 2014/15, the leadership challenge for NHS providers remains very significant indeed. Improving quality for patients at a time of growing financial constraint is an increasingly demanding goal for NHS trusts, one which we must take on at a time when the scrutiny applied to the NHS is rightly very intense. The *Accountability Framework for NHS Trust Boards* sets out how the TDA will work alongside NHS trusts to meet this challenge.

The purpose of the *Accountability Framework* remains a simple one: to articulate in one place all of the key policies and processes which govern the relationship between NHS trusts and the TDA. The Framework sits alongside our planning guidance and covers our approach to measuring and overseeing NHS trusts; to escalation and intervention; to the provision of support for improvement; and to the way we move NHS trusts towards a sustainable future.

The refreshed Framework reflects some of the changes we have seen in the past year, including the development of the new Chief Inspector of Hospitals regime and the "special measures" process. It also reflects out learning from our first year supporting NHS trusts and the feedback we have received on our approach. Our approaches to measurement, intervention and support have all been adapted to reflect these changes.

But while much of the detail has changed, the core principles underpinning our *Accountability Framework* remain consistent. Firstly, the Framework aims to be holistic and integrated, setting out in one place of all our key policies and supporting a single conversation between the TDA and NHS trusts.

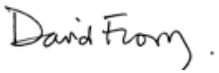
Secondly, our approach is more closely aligned than before with that of our partners, particularly regulators and commissioners. So our oversight metrics are aligned with those used by CQC, while our approvals process has been aligned to clarify the respective of roles of Monitor, CQC and the TDA. And much of our development work will be undertaken in partnership with other bodies. As we come to understand the new system, it is more evident than ever that these partnerships are critical to our success.

Thirdly, our clear focus on quality is stitched throughout the *Accountability Framework*. It sits at the heart of our oversight and approvals models and it is central to our development work.

However, it is important that alongside our focus on quality, a focus on financial discipline and value for money is retained. Improving quality at the same time as maintaining financial control represents a more difficult equation than ever for NHS providers, but it is an equation we must continue to solve.

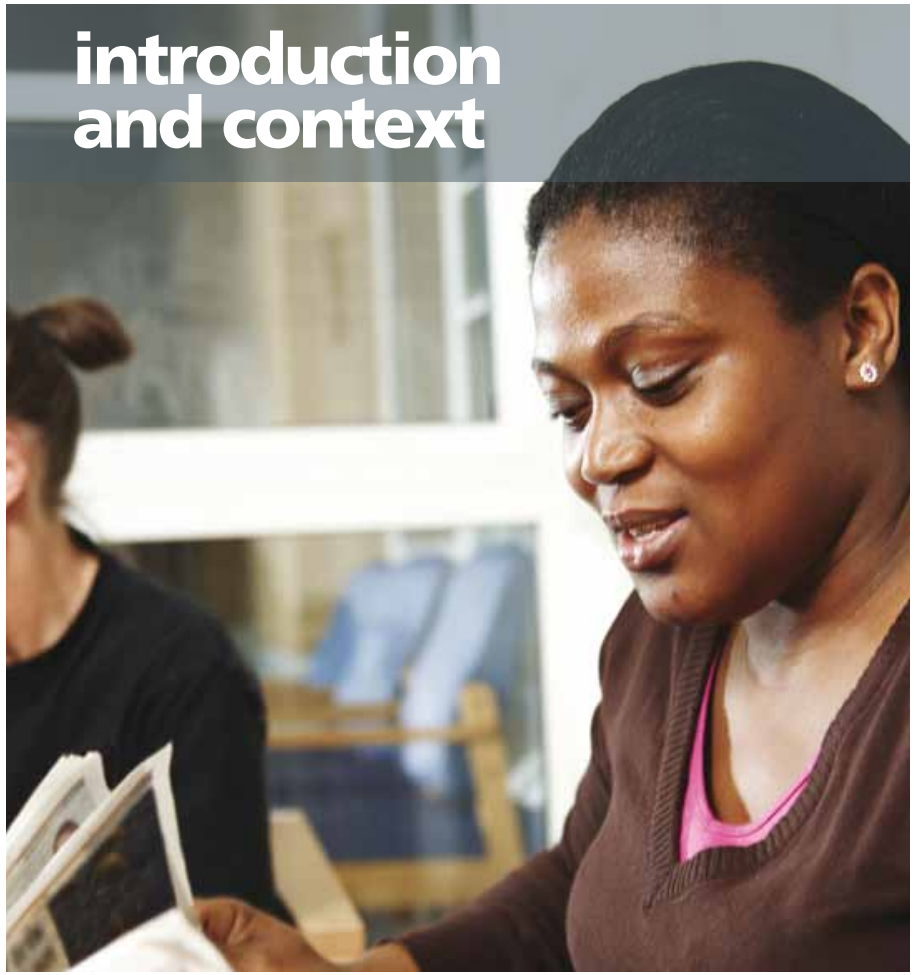
And finally, focussing on developing and supporting our trusts remains a key priority for the TDA. The challenge of moving towards sustainability is not about quick fixes, but rather a long-term process of improvement, based on a deep understanding of organisational needs. So we want more than ever to focus on support and development and on improving culture, leadership and governance in NHS trusts.

I hope this *Accountability Framework* provides a useful guide to the way our organisations work together over the coming year and, as ever, I would welcome feedback so that we can continue to develop and improve.



**David Flory**
Chief Executive

# contents



# introduction and context

## The context for NHS trusts

1.1 The period ahead is likely to prove very challenging for the NHS as a whole, and particularly for provider organisations. The emphasis on providing high quality care for patients has rightly never been greater; the many lessons from the Mid Staffordshire Inquiry and the development of the new regime of the Chief Inspector of Hospitals demonstrate the urgency of the quality agenda. Meanwhile, the financial pressures facing providers are becoming ever more acute, with a 4% annual efficiency requirement likely for the foreseeable future and the introduction of the Better Care Fund from 2015/16. Continuing to deliver high quality care within available resources, to do more and better with less, is therefore an increasing challenge for providers and the boards that oversee them.

1.2 *Securing Sustainability*, the planning guidance for NHS trust boards, was published in December and set out the scale of this challenge and the need for local health systems to work together to deliver effective operational and strategic plans to meet future needs. This refreshed *Accountability Framework* sets out the other key elements of the TDA's relationship with NHS trusts and the approach we will take to our collective business in 2014/15.

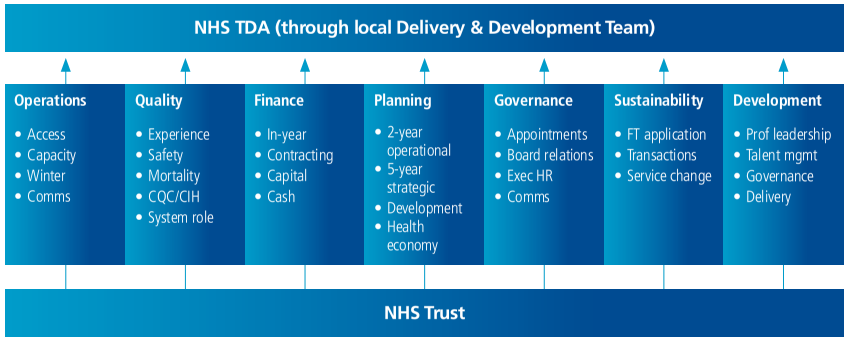
## The role of the NHS TDA

1.3 While the system in which NHS trusts operate is highly complex, the role of the NHS TDA and its relationship with NHS trusts remains a simple one. The TDA oversees NHS trusts and holds them to account across all aspects of their business, while providing them with support to improve services and ultimately achieve a sustainable organisational form. The relationship is holistic and combines a hard edge of accountability with a clear role in providing support and development. Hence the objectives of NHS trusts and the TDA are one and the same, and your success is our success. Figure 1 below captures all of the core elements of the relationship between NHS trusts and the TDA.

1.4 In delivering their responsibilities, both NHS trusts and the TDA work in a much broader environment and interact with a range of other bodies. It is increasingly apparent in the new system that joint working and effective partnerships are critical to all aspects of business, both at local and national level.

1.5 **Commissioners** play a key role across the NHS in setting the shape and pattern of services and overseeing the delivery of services through their contractual relationship with providers. NHS trusts and the NHS TDA therefore work closely with local clinical commissioning groups and with NHS England at regional and national level both on the planning of services and on the day-to-day delivery of contractual requirements. While NHS trusts are responsible to commissioners through their contracts for the service they deliver, their accountability to the NHS TDA is broader and covers all aspects of their business, as shown in Figure 1.

**Figure 1: NHS TDA relationship with NHS trusts**




1.6 **NHS England** has a number of roles in addition to the direct commissioning of certain services. The NHS TDA works with NHS England in its assurance role regarding clinical commissioning groups to provide joint support in resolving issues that span whole health economies or local areas. Our organisations also work together at a national level on key strategic projects to ensure that the system works to provide high quality, sustainable services for patients.

1.7 The **Care Quality Commission** regulates the quality of services provided by NHS trusts and through the Chief Inspector of Hospitals is the ultimate arbiter of the quality of care. The role of the NHS TDA is to support NHS trusts and hold them to account for making improvements to the quality of services, both pro-actively and in response to the findings of the Chief Inspector. So while the Chief Inspector judges the quality of services and identifies where improvement is needed, the role of the NHS TDA is to ensure that NHS trusts fix problems and improve standards.

1.8 **Monitor** licenses existing foundation trusts and makes the final decision on whether applicant NHS trusts meet the standards for FT status. The NHS TDA's role is to support NHS trusts in developing sustainable services and moving through the FT application process by meeting the necessary standards for quality, finance and governance. Monitor also advises the NHS TDA on the impact on choice and competition of transactions involving NHS trusts, and assesses transactions involving NHS foundation trusts.

1.9 The TDA also works with a range of other bodies which interact with NHS trusts, including Health Education England, the General Medical Council, Nursing and Midwifery Council and other professional regulators, NICE, the Health and Social Care Information Centre, the NHS Leadership Academy and the Department of Health. While the number of different bodies which interact with NHS providers is significant, the role of the NHS TDA as the point of accountability for NHS trusts across all aspects of their business provide some clarity in this highly complex environment.

### Developments since the 2013/14 *Accountability Framework*

1.10 The NHS TDA published its first *Accountability Framework* for NHS trust boards at the beginning of April 2013, in line with the TDA taking on its full powers. Since then a number of important developments have taken place which affect the work of NHS trusts and the TDA. First, and most significant, the new health system has been operating for a year and much has been learnt both nationally and locally about roles and responsibilities and dynamics and behaviours within that system. The TDA has also been working alongside NHS trusts and has gathered feedback on its role and processes.

1.11 Secondly, a number of new roles, policies and processes have been introduced since April 2013. Most notably, the first Chief Inspector of Hospitals has been appointed and his work on the programme of new inspections has begun in earnest across all sectors of the NHS. The need for a "Good" or "Outstanding" rating from the Chief Inspector to proceed to foundation trust status has been set out, significantly changing the standards required for moving to FT. And the inspections overseen by Sir Bruce Keogh early in 2013/14 have led to the introduction of the "special measures" process to secure rapid improvement in a small number of provider organisations with significant quality problems.

1.12 Thirdly, the implications of the Mid Staffordshire Inquiry are now clearer than they were a year ago, and a number of related inquiries have been completed, each with significant implications for NHS providers. These include the Keogh review, Professor Don Berwick's review of patient safety, the Cavendish review on healthcare support workers and the Clywd-Hart review into improving the patient complaints procedure. The National Quality Board has also recently published important guidance for providers on maintaining safe staffing levels.

1.13 All of these and many other changes over the past year have had a significant impact on the environment for NHS providers, meaning there is a clear need to refresh and update the different processes within our *Accountability Framework*.

### Approach to the 2014/15 *Accountability Framework*

1.14 Despite these many changes, the purpose and structure of the *Accountability Framework* remain consistent. Put simply, the *Accountability Framework* sets out the key rules, processes and commitments which underpin and define the relationship between NHS trusts and the NHS TDA. The document aims to provide a clear, concise and integrated account of all the key things that NHS trust boards need to be aware of in doing business with the TDA.

1.15 The principles underpinning the *Accountability Framework* remain consistent with those set out last year, highlighting the continuity in the approach taken by the NHS TDA. So the principles which continue to drive our work are:

- **Every interaction we undertake has an impact on the quality of care patients receive** – our focus on quality improvement remains central to the work of the NHS TDA
- **One model, one approach** – the NHS TDA is a national organisation and the approach set out in the *Accountability Framework* will be applied consistently to NHS trusts across England and across all sectors of care
- **Clear local accountability for delivery** – the accountability for all aspects of NHS trust business remains with the board of the trust, held to account and supported by the TDA
- **Openness and transparency** – being open and candid publicly about the quality of care remains central to the TDA's approach
- **Making better care as easy to achieve as possible** – working with partners to create the right environment for change remains a central challenge both locally and nationally
- **Working supportively and respectfully** – the TDA recognises the very significant challenges faced by NHS trust boards and therefore aims to work supportively and respectfully at all times
- **An integrated approach to business** – the TDA remains committed to aligning all the different aspects of its business with NHS trusts through a single set of processes, as set out in this *Accountability Framework*.

1.16 The structure of the *2014/15 Accountability Framework* also remains consistent: the **planning guidance**, already published, sets out the different plans that are required from NHS trusts and how the NHS TDA will assure those plans. 2-year operational plans are due at the beginning of April, 5-year strategic plans by 20 June, and Development Support Plans by the end of September. The planning process provides the foundation for the other aspects of the *Accountability Framework*.

1.17 The **oversight** process (Chapter 2) sets out what we will measure and how we will hold trusts to account for delivering high quality services and effective financial management. For 2014/15, the TDA's quality metrics have been adjusted to improve alignment with the CQC's *Intelligent Monitoring* process. It also sets out how we will score and categorise NHS trusts and a clearer approach to both intervention and support for organisations at different levels of escalation. Finally, the oversight section covers other rules and processes which apply to NHS trusts in areas such as appointments, remuneration, data quality and information governance.

1.18 The **development** section (Chapter 3) describes the TDA's approach to understanding the evolving development needs of NHS trusts, particularly through the production of Development Support Plans to complement trusts' operational and strategic plans. This section also sets out the TDA's approach to development and areas where development support will be targeted during 2014/15. This includes support for challenged health economies to produce effective strategic plans, greater support for boards and leaders across the trust sector, and a refreshed approach to support for aspirant FTs, delivered in partnership with the Foundation Trust Network. The TDA recognises the importance of providing effective support for NHS trusts and will seek to increase the emphasis on this area during 2014/15.

1.19 The **approvals** section (Chapter 4) sets out the TDA's approach to assuring foundation trust applications, transactions proposals and capital schemes. This section clarifies the new role of the Chief Inspector of Hospitals in the FT assessment process, and sets out the ambition for a single framework for assessing provider leadership to increase alignment between current regulatory and assessment processes.

1.20 Each section is underpinned by more detailed guidance and templates where these are needed. Taken together, the different processes brought together in the *Accountability Framework* aim to provide some clarity for NHS trusts in the increasingly complex and demanding environment in which they operate.

# oversight and escalation

## Introduction

2.1 The Oversight model describes how the TDA will work with NHS trusts on a day-to-day basis, within a clear and unambiguous framework. It describes the expectations we have of NHS trusts to deliver high quality services for the communities that they serve. It sets out how we will measure progress, how we will judge performance, how we will intervene where it is necessary to do so, and other rules and policies which will govern our day-to-day relationship with NHS trusts.

2.2 The overall TDA approach to oversight remains consistent for 2014/15, with a clear focus on quality, delivery and sustainability. In holding organisations to account we will act in accordance with the principles set out in the Introduction to this Framework and in particular, we will always seek to be:

- Proportionate and consistent
- Open and transparent
- Respectful and supportive

2.3 For the sake of clarity and consistency, it is critical that we set out the nature of our oversight relationship with trusts. It is important to reiterate that our role in ensuring that patients receive a standard of care consistent with their rights – as set out in the *NHS Constitution* – requires a proactive approach. The TDA will not wait for concerns to become apparent through monthly reporting, but will build effective relationships with trusts to ensure that any issues can be identified and addressed as quickly as possible.

2.4 The key changes to the Oversight model for 2014/15 reflect the changing environment described above and in particular the need to ensure alignment with other national bodies. They reflect the findings of the Mid Staffordshire Public Inquiry and in particular the emergence of the new Chief Inspector of Hospitals' regime.

2.5 The next sections sets out an overview of the Oversight Model for 2014/15, covering:

- Measurement of progress on quality, finance and sustainability
- Escalation and intervention
- Other areas of oversight

## Measurement of progress on quality, finance and sustainability

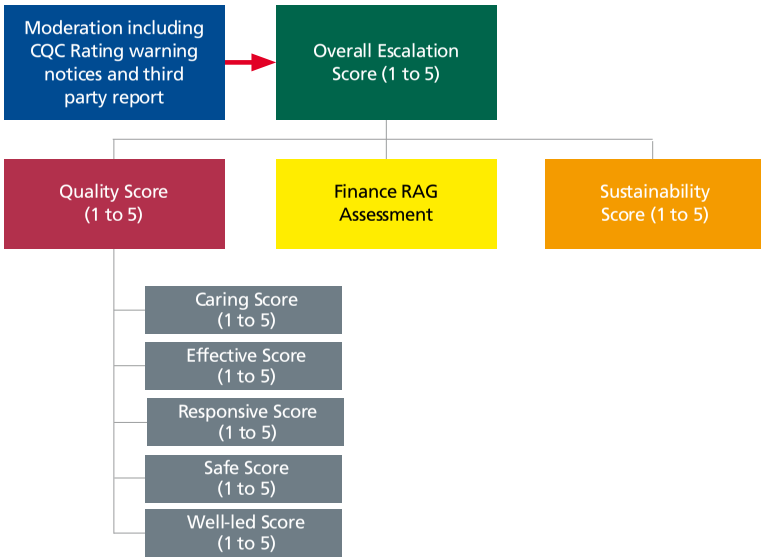
2.6 The overall approach to measuring and tracking NHS trust performance remains consistent with last year's *Accountability Framework*. There are a number of domains each with an associated set of indicators. Performance against these indicators will determine a score for each domain. These domain scores in turn contribute towards an overall Escalation score for each NHS trust.

2.7 Figure 2 sets out an overview of the key elements of the Oversight model.

2.8 For 2014/15, the Quality domain has been aligned with the new CQC regime and the domains of its *Intelligent Monitoring* system. As well as contributing to a consistent assessment of quality nationally, this approach also ensures continued alignment with the *NHS Constitution* and the *NHS Outcomes Framework*.

2.9 There has also been a change to the way the escalation scores will work for next year: for 2014/15 NHS trusts will be scored using escalation levels 1 to 5, as it was last year, but the key change will be that escalation level 1 will now be the highest risk rating with level 5 the lowest. This is to ensure consistency with the CQC's approach to assessing risk through its *Intelligent Monitoring* system.

**Figure 2: Key Elements of the Oversight Model**




2.10 Whilst the Oversight and Escalation model will be closely aligned with the CQC's *Intelligent Monitoring* system, there will remain a number of differences which reflect the different roles of the two organisations. As the regulator and final arbiter of quality, the CQC model is based on a broad and comprehensive set of indicators which are used to highlight where a trust is an outlier compared to its peers. In order to be effective in its oversight and performance management of trusts, the TDA needs a narrower set of metrics, all of which can be updated frequently so that changes in performance can be identified and addressed promptly. The TDA also has a role in ensuring that trusts deliver on commitments made to patients in the *NHS Constitution*, such as maximum waiting times, and must be able to monitor whether trusts are meeting these standards.

2.11 The Quality, Finance and Sustainability scores will primarily be rules-based using a set of thresholds for each indicator. Scores will be aggregated to the overall domain level according to performance against each indicator, individual indicator weightings and where appropriate override rules in extreme cases of poor delivery against key indicators such as mortality. A supporting guidance document will supplement the *Accountability Framework* and will contain all the detailed information about our scoring methodology.

2.12 In addition, and consistent with our current approach, the overall escalation score will be subject to a moderation process led by the directors of delivery and development supported by business and quality directors to determine the level of risk and appropriate level of intervention for each organisation. The results of the rules-based scores will be supplemented with softer intelligence from a range of third party reports including CQC warning notices. Consideration will also be given to any future risks faced by trusts.

2.13 Escalation scores will be refreshed on a monthly basis using only publically available information. This will ensure that all the supporting data and analysis are able to be shared openly, consistent with our commitment to transparency. A timetable setting out the monthly business rhythm for the oversight process is contained within the supporting guidance document.

2.14 The TDA will take a proactive approach to managing the quality of services delivered by trusts. Whilst the oversight model will be based on published data, where there are concerns regarding the performance of a trust, TDA staff may require more frequent information relating to a limited number of key metrics.

2.15 Further detail on the main domain headings of Quality, Finance and Sustainability is set out below.

### *Quality*

2.16 For 2014/15, we will align the domains we use in our assessment of quality with the 5 domains used by CQC in their regime for assessing the quality of services: Caring, Effective, Responsive, Safe and Well-led.

2.17 There is no intention for Oversight to attempt to replicate the CQC risk ratings, rather Oversight will use a sub-set of the indicators used by CQC. In developing this list of indicators we have also taken into consideration:

- *NHS Constitution* standards;
- Measures used by Monitor in their *Risk Assessment Framework*;
- Measures required to be published in NHS trust Quality Accounts, reflecting the *NHS Outcomes Framework* measurements;
- Measures for which data is routinely available;
- Measures which are part of the current Oversight and Escalation and are considered worth retaining.

2.18 Figure 3 details the indicators that will be used in each of the 5 domain areas. An assessment will be made against each indicator, usually on a monthly basis depending on the regularity of information being available. Using thresholds, individual indicator weightings and override rules, an overall domain score will be calculated. These 5 domain scores will then be used to calculate an overall score for Quality.

2.19 Supporting guidance will be available via the TDA website and will provide indicators definitions, data sources and indicator constructions along with detailed scoring rules. It will also set out the indicators which have been added or removed from last year and the rationale behind these decisions.

### *Finance*

2.20 The underpinning business plan that supports an NHS trust's sustainability is as important as the delivery of high quality services as it helps ensure that effective care can be delivered well into the future.

2.21 As in last year, NHS trusts will be monitored against two financial categories:

- In-year financial delivery;
- Monitor *Risk Assessment Framework* – Continuity of Service.

2.22 Delivery against these categories will be RAG rated using agreed thresholds but only the RAG rating for in-year delivery will be used in the assessment of the overall escalation score.

2.23 The indicators that make up the in-year financial delivery domain have been reviewed and a revised set of indicators are included in Figure 3. The thresholds for calculating the overall financial RAG rating have also been updated so that any trust with a forecast deficit or a significant deterioration in surplus will be red rated overall.

2.24 Supporting guidance will be available via the TDA website, including detailed indicator descriptions and clarification of how the individual indicator RAG ratings and overall in-year financial delivery RAG rating is calculated.

### *Sustainability*

2.25 *Securing Sustainability – Planning guidance for trust boards 2014/15 to 2018/19* set out for the first time a framework to enable NHS trusts to look in more depth at how they plan to deliver high quality services in a sustainable way, not just over the coming year but over the next five years.

2.26 The ultimate goal of the NHS TDA is to support organisations to deliver high quality services that are clinically and financially sustainable, and thereby become foundation trusts or implement a suitable alternative solution. The five year plans submitted by trusts are critical to this work.

2.27 In assessing the plans of NHS trusts, the TDA will consider the credibility of the assumptions made by the NHS trusts before determining whether to support their plan. Our assessment of the credibility of plans, will focus on five broad areas of assurance:

- Clinical and workforce strategy
- Financial and business strategy
- Future commissioning and service strategy
- Securing a sustainable organisational form
- Leadership capability and capacity.

2.28 It is the intention that following the assessment of five year plans by the TDA it will be possible to develop a score for the Sustainability domain which will in turn feed through to the overall escalation level for the trust. This will happen later in 2014/15 once the five year plans have been submitted and reviewed by the TDA. Until this approach has been refined, the sustainability of a trust will feed into the escalation scoring system through the moderation process outlined above.

**Figure 3: Proposed indicators for Monthly Oversight and Escalation**

| Caring |
|---|
| Inpatient scores from Friends and Family Test |
| A&E scores from Friends and Family Test |
| Complaints – rate per bed days, MH contacts or calls to ambulance services |
| Inpatient Survey: Q68 Overall I had a very poor/ good experience? |
| Community Mental Health : Q45 Overall, how would you rate the care you have received in the last 12 months? |
| Mixed Sex Accommodation Breaches |

| Well-led |
|---|
| NHS England inpatients response rate from Friends and Family Test |
| NHS England A&E response rate from Friends and Family Test |
| Data Quality of trust returns to the HSCIC |
| NHS Staff Survey: Percentage of staff who would recommend the trust as a place of work |
| NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment |
| Trust turnover rate |
| Trust level total sickness rate |
| Total trust vacancy rate |
| Temporary costs and overtime as % total paybill |
| Percentage of staff with annual appraisal |

| Effective |
|---|
| Summary Hospital Mortality Indicator (HSCIC Published data) |
| Hospital Standardised Mortality Ratio (DFI Quarterly) |
| Hospital Standardised Mortality Ratio – weekend |
| Hospital Standardised Mortality Ratio – weekday |
| Deaths in low risk conditions |
| Emergency re-admissions within 30 days following an elective or emergency spell at the trust |
| IAPT – The proportion of people who complete treatment who are moving to recovery |

| Safe |
|---|
| CDIFF |
| MRSA |
| Never Event incidence |
| Medication errors causing serious harm |
| Percentage of Harm Free Care |
| Maternal deaths |
| Proportion of patients risk assessed for Venous Thromboembolism (VTE) |
| Serious Incidents |
| Proportion of reported patient safety incidents that are harmful |
| CAS alerts |
| Admissions to adult facilities of patients who are under 16 years of age (Number) |

Continued on next page >>

**Figure 3: Proposed indicators for Monthly Oversight and Escalation (continued from previous page)**

| Responsive |
|---|
| Proportion of patients spending more than 4 hours in A&E |
| RTT waiting times for admitted pathways: percentage within 18 weeks |
| RTT waiting times for non-admitted pathways: percentage within 18 weeks |
| RTT waiting times incomplete pathways |
| RTT over 52 week waiters |
| Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test |
| Proportion of patients receiving first definitive treatment for cancer within 62 days of referral from GP |
| Proportion of patients receiving first definitive treatment for cancer within 62 days of referral from screening |
| Proportion of patients receiving first definitive treatment for cancer within 31 days of decision to treat |
| Proportion of patients receiving subsequent treatment within 31 days (Drug) |
| Proportion of patients receiving subsequent treatment within 31 days (Surgery) |
| Proportion of patients receiving subsequent treatment within 31 days (Radiotherapy) |
| Proportion of patients seen within 14 days of urgent GP referral |
| Proportion of patients with breast symptoms seen within 14 days of GP referral |

| Responsive |
|---|
| Urgent operations cancelled for a second time |
| Proportion of patients not treated within 28 days of last minute cancellation due to non-clinical reasons |
| Certification against compliance with requirements regarding access to health care for people with a learning disability |
| The proportion of those on Care Programme Approach(CPA) for at least 12 months<br>**A** Who had a CPA review within the last 12 months<br>**B** Having formal review within 12 months<br>**C** Receiving follow-up contact within 7 days of discharge |
| Admissions to inpatient services who had access to Crisis Resolution/Home Treatment teams |
| Meeting commitment to serve new psychosis cases by early intervention teams (Number) |
| Category A8 Red 1 calls |
| Category A8 Red 2 calls |
| Category A call – ambulance vehicle arrives within 19 minutes |
| 12 hour trolley waits in A&E |
| Mental health delayed transfers of care |

| Finance |
|---|
| Bottom line I&E position – Forecast compared to plan |
| Bottom line I&E position – Year to date actual compared to plan |
| Actual efficiency recurring/non-recurring compared to plan – Year to date actual compared to plan |
| Actual efficiency recurring/non-recurring compared to plan – Forecast compared to plan |
| Forecast underlying surplus/deficit compared to plan |
| Forecast year end charge to capital resource limit |
| Is the Trust forecasting permanent PDC for liquidity purposes? |

## Escalation and intervention

2.29 The measurement and monitoring process described above will continue to place each NHS trust in one of five oversight categories, based on their scoring against the various oversight domains, relevant views of third parties such as the CQC, and the judgement of the TDA. The following table sets out the five escalation levels that will apply, including the characteristics of organisations at each level of escalation, the nature of likely interventions, and the support available to trusts to help them to improve.

2.30 Table 1 below aims to provide more clarity for NHS trusts about what it means to be at each level of escalation, and to ensure greater consistency in our approach to intervening and supporting NHS trusts. The table also clarifies that escalation level 1 and the "special measures" designation are one and the same thing.

2.31 Trust boards should be clear that they at all times remain responsible for ensuring that effective governance and assurance arrangements are in place within their organisations. The purpose of the oversight model is to provide assurance regarding trusts' performance to the TDA and does not affect the overall accountability of trust boards.

2.32 The special measures process will apply to NHS trusts which have serious failures in their quality of care and / or financial performance, along with concerns that the trust's existing leadership cannot make the necessary improvements without intensive oversight and support. Special measures can be triggered by the NHS TDA following a recommendation from the Chief Inspector of Hospitals, or whenever the TDA judges it is necessary. Organisations placed in special measures because of concerns about the quality of care will require a successful re-inspection by the Chief Inspector in order to exit special measures.

2.33 Organisations in special measures will be subject to a set of specific interventions designed to rapidly improve the quality of care. The NHS TDA will intensify its engagement with and oversight of the NHS trust, and trusts will be held to account through regular board-to-board meetings. While the interventions and support brought to bear during the special measures process will reflect the circumstances and needs of the trust, there are a small number of interventions which will apply to every provider placed in special measures. These are:

- The development of a clear, published **Improvement Plan** to address the issues raised, with clear timescales for improvement.
- The appointment of an **improvement director** who will act on behalf of the NHS TDA. They will have a presence on the ground for, on average, two days a week. They will work with NHS trusts and their partners to support improvement and to monitor progress against the action plan.
- The appointment of a **partner organisation** to provide support and expertise in improvement. Partner organisations will be selected on the basis of their strength in relevant areas of weakness in the NHS trust or foundation trust in special measures.
- **The capability of the trust's leadership will be reviewed** and changes to the management of the organisation could be made, if needed, to ensure that the board and executive team is best placed to make the required improvements.

2.34 As the table below sets out, these and other measures can also be used by the TDA for trusts at levels 2 and 3 of escalation. While trusts in special measures will be subject to all of the processes set out above, the deployment of interventions at lower levels of escalation will reflect the particular needs and circumstances of the trust.

2.35 Special measures will be a time-limited period, the expectation being that trusts – with the support of the TDA – will make the necessary improvements within 12 months. From this year, a similar approach will be taken to trusts in escalation levels 2 & 3: trusts will be expected to develop and execute a time-limited improvement plan that will enable them to return to escalation level 4 or 5. Once a trust achieves escalation level 5 it is anticipated that its foundation trust application or transaction will be completed within 12 months.

2.36 At all levels of escalation, the TDA can consider supplementing the interventions below with additional processes, for example reviews of particular services areas or financial systems. In addition, the TDA will explore during 2014/15 a reduction in the autonomy of NHS trusts at high levels of escalation, particularly on financial matters.

2.37 In its approach to escalation and intervention, the TDA will always seek to balance hard-edged intervention with the provision of appropriate support and development. This is clear in the table below and more detail on support available for NHS trusts, including support targeted at challenged organisations, is set out in Chapter 3.

**Table 1: TDA Oversight Categories for 2014/15**

| | Name | Characteristics of a trust in this category | Intervention | Support | Accountability |
|---|---|---|---|---|---|
| 1 | Special Measures | The organisation has significant delivery issues, including clinical and / or financial challenges; the clinical concerns may be serious and / or the in-year financial challenges may be greater than planned; the TDA has limited confidence in the board's current capacity to deliver improvement without additional external support and challenge. | Trust would be subject to all of the following:<br>• Improvement plan;<br>• Capability review;<br>• Board-to-board meetings;<br>• Potential loss of autonomy;<br>• Further reviews as needed. | Support focussed on rapid quality improvement and /or financial turnaround. Support **will** include:<br>• Improvement director;<br>• Partnering with high performer. | Through board-to-board meetings. |
| 2 | Intervention | The organisation has significant delivery issues, including clinical and / or financial challenges; the TDA has concerns about the board's capacity to deliver improvement and is therefore keeping progress under close review, with the potential to deploy external interventions. | Trust required to produce an Improvement Plan and **may** be subject to:<br>• Capability review;<br>• Board-to-board meetings;<br>• Potential loss of autonomy;<br>• Further reviews as needed. | Support focussed on rapid quality improvement and /or financial turnaround. Support **can** include:<br>• Improvement director;<br>• Partnering with high performer. | Through TDA director of delivery and development (with possibility of board-to-board meetings). |
| 3 | Intervention | The organisation has some delivery issues, including clinical and / or financial challenges; the TDA has confidence in the board's capacity to deliver improvement and continue its journey to sustainability. | Interventions likely to be focussed on supporting improvement in particular areas, but broader intervention can be deployed. | Support focussed on improvement on specific issues and early development of foundation trust application. | Through TDA portfolio director. |
| 4 | Standard Oversight | The organisation has limited or no delivery issues; the TDA has confidence in the board's capacity to deliver any improvements needed and make significant progress towards sustainability. | No interventions likely at this level of escalation, but standard TDA oversight processes continue. | Support focussed on movement through the foundation trust application or alternative sustainability plan. | Through TDA Delivery and Development team. |
| 5 | Standard Oversight | The organisation has developed a sound FT application and received a 'Good' or 'Outstanding' rating from the CIH; the TDA has confidence in the board's capacity and expects a sustainable solution to be delivered quickly. | No interventions likely at this level of escalation; standard oversight processes continue but frequency may reduce. | Support focussed on finalising foundation trust application or alternative sustainability plan. | Through TDA Delivery and Development team. |

## Other areas of TDA oversight of NHS Trusts

2.38 In addition to the core measurement, scoring and escalation processes set out above, there are a number of other areas where the NHS TDA has oversight of NHS trusts. For clarity and completeness, these areas are set out below, along with a summary of our expectation of NHS trusts. The key areas are:

- Human resources decisions;
- Workforce assurance mechanisms;
- Data quality;
- Information governance.

### *Human Resources*

2.39 The NHS TDA has an important relationship with trusts in relation to certain workforce and human resources issues.

2.40 The NHS TDA has responsibility on behalf of the Secretary of State for making chair and non-executive appointments to NHS trusts, for ensuring chairs and non-executives have appropriate training and support, and for the suspension and dismissal of chairs and non-executives when this is required. Policies relating to these processes will be available on the TDA website. More detail on support for chairs and non-executives is set out in Chapter 3.

2.41 The TDA also has a key role in oversight of executive appointment, remuneration and severance decisions. The key elements of this are as follows:

- A senior member of TDA staff must be invited to act as an external assessor when NHS trusts make director appointments.
- The NHS TDA will agree annual performance assessments for NHS trust chief executives.
- The NHS TDA has a role in ensuring senior pay levels are proportionate and may from time to time request pay data from trusts in order to respond to DH and wider government pay queries. As part of this, the NHS TDA must agree remuneration rates for senior appointments made by NHS ambulance trusts and community providers.
- The NHS TDA must agree any "off-payroll" senior appointments, including any appointments to roles with significant financial responsibility, whether interim or substantive.
- The NHS TDA must approve proposed severance arrangements for any directors in NHS trusts and for any non-contractual severance arrangements at any grade. Contractual terminations for non-director staff in excess of £100k also require NHS TDA Remuneration Committee approval.

2.42 Details of the NHS TDA's role in appointment, remuneration, performance assessment and severance decisions was set out in writing for NHS trusts in guidance sent out to chairs, CEOs and HRDs in June 2013. This is being updated and will be on the TDA website from April 2014. Further information about the role of the NHS TDA in executive HR decisions by NHS trusts can be found in the supporting guidance published alongside this document.

***Workforce Assurance***

2.43 In light of the increased focus on workforce next year, e.g. through the National Quality Board's *A guide to nursing, midwifery and care staffing capacity and capability* we are taking steps to enhance our oversight of key workforce metrics in 2014/15. As such, trusts will be required to provide more detailed workforce data, including funded workforce establishments, temporary staffing usage and vacancy rates. In recognition of the need for effective triangulation between finance, activity, quality and workforce, we have also continued to develop the national workforce assurance tool.

2.44 All NHS trusts have access to this tool free of charge. It will be the primary method by which the TDA will support and challenge trusts on the triangulation of their plans as part of this year's planning round and on the in-year delivery of workforce and finance metrics (including the delivery of safe staffing) through our core oversight processes.

2.45 For the coming year we are mandating all NHS trusts to actively use the tool to complement existing workforce reporting processes and to inform future planning cycles. Support packages are available to trusts to support them in maximising the benefits of the tool.

2.46 To further evidence application of the NQB guidance NHS trusts will be asked to demonstrate compliance by submitting information about how they have put into practise the nine expectations for provider organisations as set out in the *Guide to nursing, midwifery and care staffing capacity and capability*.

***Data Quality***

2.47 Following the publication of the recent NAO report into elective waiting times in the NHS, it is clear that more robust assurance processes need to be established with respect to the systems that are in place to ensure data quality.

2.48 In line with the recent correspondence with trusts on this matter, NHS trusts should therefore ensure they are undertaking the following best-practice actions:

- Reviewing data quality annually though their internal audit programme;
- Ensuring checks of waiting list management are undertaken through the external audit programme at least every 3 years;
- Deploying Intensive Support Teams where the organisation continues to have difficulty with waiting list management issues and/or where emerging problems are detected;
- Maintaining and publicising a clear patient access policy.

2.49 The NHS TDA will continue to provide support for trusts in this area, in particular working with NHS trusts to understand and implement best practice. If any problems with the data quality of patient access procedures are brought to our attention we will consider commissioning independent reviews. In serious cases, such reviews could inform actions taken in relation to the wider governance of organisations.

***Information Governance***

2.50 Following the Government's response to the Caldicott 2 report, *To Share or not To Share* in September 2013, the NHS TDA requires each NHS trust to provide details of data breaches in both their annual governance statement and in their annual report. NHS trusts are expected to log and summarise any such data security breaches or lapses including the advice of the Caldicott Guardian and any issues that are significant enough to warrant reporting to the Information Commissioner. NHS trusts should also detail how they will manage and mitigate risks in this area and how they measure compliance beyond the requirements of the Information Governance toolkit.

# development and support



## The importance of development for NHS trusts

3.1 NHS trusts provide a wide range of services for patients across England, from the most specialised hospital care to a diverse range of community services. The role of the NHS TDA is to hold NHS trusts to account but at the same time to support them to maximise their potential for delivering high quality sustainable services. Every organisation has development needs, and for NHS trusts the extremely challenging environment that they face means that those development needs are likely to be both far-ranging and critical to the success of the trust.

3.2 Providing support for NHS trusts is part of the core business of the NHS TDA. Much of that support can be provided through our day-to-day interactions, drawing on expertise from within the NHS TDA. In addition, the TDA has sought to provide a range of additional programmes to support priority development areas. To date this has included:

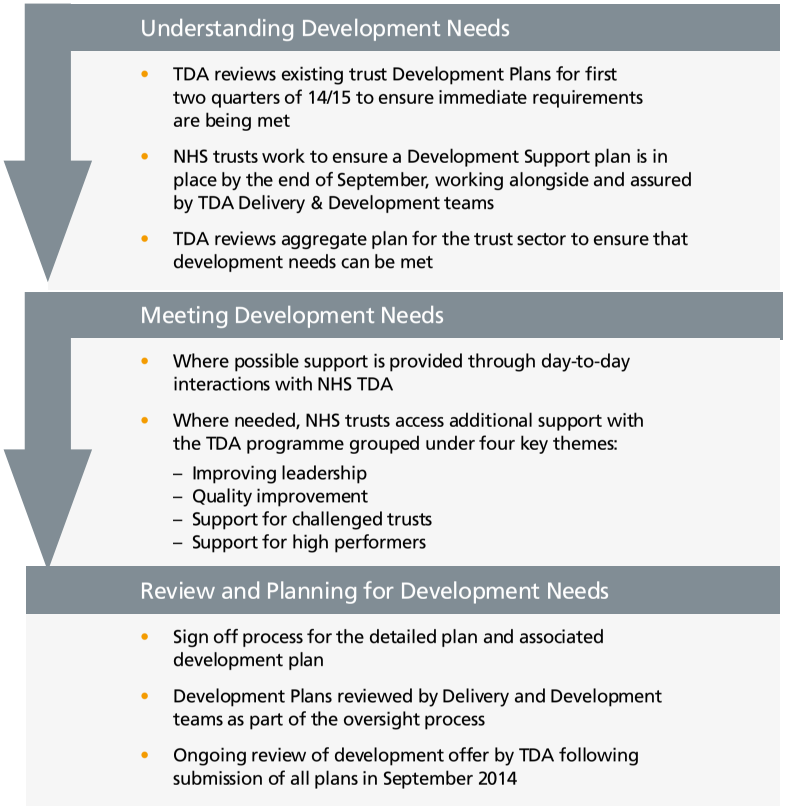
- A tailored programme of support from the NHS Leadership Academy to provide a board assessment and diagnostic process for a group of NHS trusts. This support was delivered to 8 NHS trusts during 2013/14.
- Programmes of support for improvement in a range of high priority areas, including emergency access, elective access and patient experience.
- Support for aspirant foundation trusts to progress through the FT assessment process, provided in partnership with the Foundation Trust Network.
- The pairing of trusts within the special measures framework with high performing organisations to support improvement.

3.3 We recognise, however, that more needs to be done, both to increase the emphasis on development in our core relationship with NHS trusts, and to expand the additional support that can be drawn upon. So for 2014/15 we will build on this initial work in order to establish a broader framework of support for NHS trusts. We will further develop this framework in light of the outcomes of the development planning process which concludes in September 2014.

3.4 It is important to acknowledge that individual NHS trusts are at different points on their journey to sustainability, with some trusts now moving at pace towards FT status whilst others face much more complex challenges. The NHS TDA's approach to development seeks to reflect the range of needs for these organisations.

3.5 Understanding the needs of each of our trusts and how they can best access the various development opportunities is central to our approach. The TDA's local portfolio teams will work with individual trusts focusing on three key steps: understanding development needs; ensuring needs are met; and regular review of development plans. This ongoing process of support is set out in Figure 4 below.

**Figure 4: Overview of the TDA Approach to Development Support for NHS Trusts**




### Understanding development needs

3.6 In 2013/14, we started the process of ensuring that the assessment of development needs for NHS trusts was an on-going, joint process between NHS trusts and the NHS TDA, recognising that development needs will change over a period of time.

3.7 A strong development plan is a critical enabler for the creation a successful organisation. For the planning process in 2014/15 to 2018/19, we have asked that boards of NHS trusts provide a more detailed development plan to be submitted by September 2014. This is so that it can take account of the operational and strategic plans developed by the trust, linking development with core business needs.

3.8 The TDA will work with individual trusts to understand what their development needs are and how they can best be met. Local Delivery and Development teams will lead this process, as part of their core relationship with NHS trusts. Once all plans have been submitted and agreed, the TDA will review the overall development needs of the trust sector and enhance its development offer as required.

3.9 In the period prior to the submission of this year's detailed development plans we will continue to work with trusts building on the existing knowledge we have about their needs.

### Meeting development needs

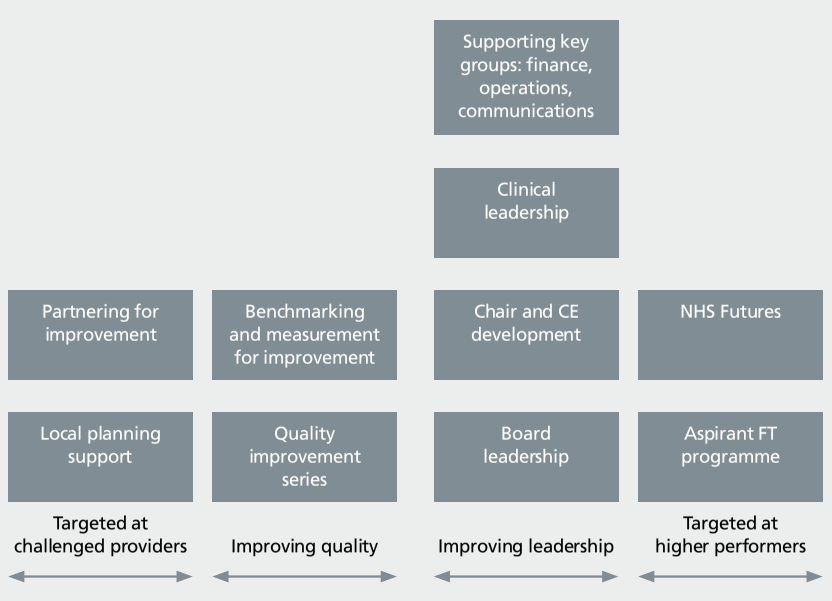
3.10 Some of the support required by NHS trusts can be provided directly by local teams within the NHS TDA; some will be met by drawing on the additional development programmes set out below; and in some cases bespoke further support may need to be commissioned.

3.11 Looking forward, the key elements of the national development offer for NHS trusts in 2014/15 are:

- Improving leadership
- Improving quality
- Support for challenged providers
- Support for high performers

3.12 Figure 5 sets out the key elements of each of these aspects of the development offer:

**Figure 5: Scope of the 2014/15 TDA development offer**




3.13 Below is an outline of the individual programmes sitting beneath each theme.

***Theme one: Improving leadership***

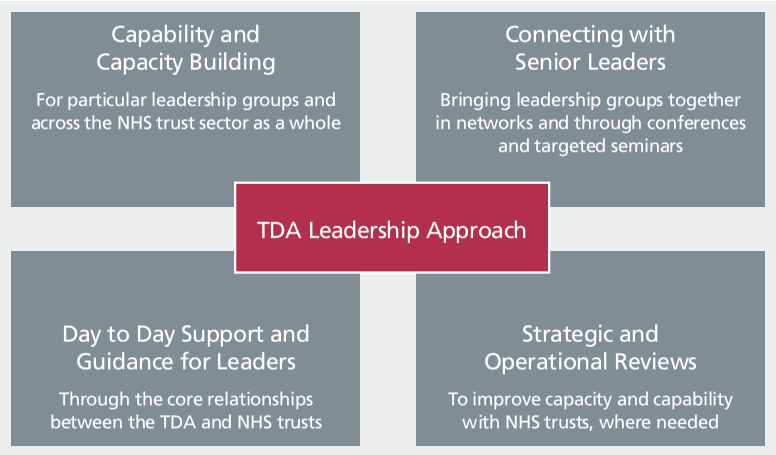
3.14 Strong and effective leadership within organisations from the "board to the ward" is essential to drive improvement, and the delivery of safe and sustainable services. Good leadership leads to a good organisational climate and good organisational climates lead via improved staff satisfaction and loyalty to sustainable high performing organisations.

3.15 Effective governance, culture and leadership are central to the new inspection regime of the Chief Inspector of Hospitals through the "Well-led" domain, as well as Monitor's assessment process for aspirant foundation trusts. Ensuring effective leadership is therefore critical to the success of all NHS trusts.

3.16 The NHS TDA recognises the need for effective support both for boards and for key leadership groups. Alongside the support already available from the NHS Leadership Academy, the TDA will be working during 2014/15 to strengthen its offer to leaders within NHS trusts.

3.17 Figure 6 below outlines the broad approach which will be applied to supporting leaders.

**Figure 6: NHS TDA Approach to Improving Leadership Capacity**




3.18 The NHS TDA will seek to apply this approach across its leadership activities, and will trial the approach in its work to build communications and engagement capacity during 2014/15. The sections below set out the different aspects of our approach to providing support for particular leadership groups within NHS trusts.

### Support for NHS trust boards

3.19 Boards are critical to the success of NHS trusts and developing the capability and capacity of boards is therefore a key priority. Much support for boards can be provided through the core relationship between NHS trusts and the TDA, and many boards will already have development programmes in place. However, the TDA will make the following additional support available for NHS trust boards during the coming period:

- Working with the NHS Leadership Academy, the TDA will seek to continue the successful programme of intensive diagnostic processes for NHS trust boards,
- Working with the Foundation Trust Network, the TDA will pilot a re-focused programme for aspirant foundation trusts with a particular focus on improving board governance,
- Working with CQC and Monitor, the TDA will seek to develop a "well-led framework" for NHS providers, clarifying and aligning the requirements of NHS boards. The framework can then be used to commission specific reviews to test and improve governance.

### Support for chairs and non-executives

3.20 The TDA recognises the critical and very challenging role which chairs and non-executives play in providing leadership for NHS trusts. The role of non-executives is under particular scrutiny following the Mid Staffordshire Inquiry and the Keogh review, and the need to provide appropriate support and development for this group of leaders is therefore pressing.

3.21 The NHS TDA will be facilitating regional networking events for NHS chairs to provide an opportunity to hear from speakers across a range of issues and also meet and network with their peer group. These networks will provide a foundation upon which specific arrangements for supporting and developing the chair community will be built. It is proposed that the first events will take place quarterly, starting in the spring of 2014. We will also look to develop networks for chairs across particular sectors of care (e.g. ambulance or community providers) and for chairs with common interests (e.g. newly appointed chairs).

3.22 In addition, chairs and non-executives have access to a range of support services to ensure they can be effective in their roles as soon as possible. These include an immediate induction programme provided by the HFMA in conjunction with the TDA and other partners. Annual events will be held, mentoring arranged and appraisal programme in place to support the development of individual NEDs.

### Support for chief executives

3.23 The TDA will continue to bring together NHS trust chief executives regularly at regional and national events to network, share intelligence and provide peer support. In addition, the NHS TDA is exploring a series of one day events for chief executives in response to an identified need for focussed events on key topics. These would be co-sponsored by Monitor, and the Foundation Trust Network. Where appropriate, sessions will also be made available to chairs. The programme will consist of a number of sessions across the year using a hybrid of speakers and action learning sets. The first sessions are scheduled for early in 2014/15.

### Support for clinical leaders

3.24 The challenges of being a clinical leader in the environment we face today have never been greater. The clinical directorate of the TDA will continue to engage with and support individual clinical leaders in NHS trusts in a range of ways, including:

- One-to-one support and coaching for individual medical and nursing directors
- Establishing networks and action learning sets with particular groups of directors linking with other organisations where helpful, such as the Faculty of Medical Leadership and Management (FMLM), the Nursing and Midwifery Council (NMC) and others
- Development support for aspiring clinical leaders, building on the success of the TDA's recent programme for aspiring nursing directors, delivered with the support of the NHS Leadership Academy
- Using our national reach to help facilitate specialist advice on key topics and/or peer review
- Thematic events and workshops to support sharing of good practice on particular issues such as those we have held on patient experience and safe staffing.

3.25 We will also continue to support organisations to deliver high quality services, including by providing professional assessment on recruitment panels and advice with preparing job specifications, and by supporting with the planning and delivery of service improvements such as safe staffing reviews and mortality governance.

### Support for finance and business leaders

3.26 The TDA recognises that excellent financial management is key to the provision of sustainable services. The financial challenge is greater than ever before and finance directors and their teams need to support their clinical colleagues to use resources as intelligently as they can to achieve better care for patients.

3.27 To this end, the TDA has joined forces with the 5 other national heads of the NHS finance profession to initiate 'Future Focussed Finance', a vision for the whole of NHS finance to aspire to over the next 5 years. The priority areas for staff development subject to consultation during 2014 are 'Securing Excellence', 'Knowing the Business' and 'Fulfilling Our Potential' and these will be supported by a new Health Business Foundation.

### Support for operational leaders

3.28 The TDA recognises the key role which chief operating officers and their teams play in the success of NHS trusts. As a group, operational leaders have not always received the same support and development as other leaders, despite the critical role that they play. The NHS TDA will therefore be seeking during 2014/15 to develop a package of support for operational leaders to help them to achieve success and to increase capacity in this essential area.

### Support for communications and engagement leaders

3.29 Now more than ever it is crucially important that NHS trusts engage effectively with a range of stakeholders. Good relationships with patients, staff, the public and other stakeholders give organisations the opportunity to understand what is working well, what could be improved and to build trust in their services. Doing this effectively means action can be taken promptly to improve the standard of services or experience offered to patients where it falls short.

3.30 Central to this is ensuring excellent capability of communications teams in all NHS trusts. To support trusts to develop their communications capability the TDA has a development programme focussed on building trust, confidence and respect in the NHS locally and developing better relationships with all stakeholders.

3.31 The development work in this area will act as a pilot for the four-part approach to improving leadership capacity set out at Figure 6. It will include the opportunity for aspiring leaders to work towards an accredited qualification, secondment opportunities, mentoring arrangements and a comprehensive training programme. This all sits alongside the day-to-day support and advice offered to NHS trusts, as well as more tailored, in-depth support offered to overcome specific challenges.

***Theme two: Improving quality***

3.32 Alongside our work to provide support and development for boards and leaders in NHS trusts, we will continue to work with NHS trusts in key areas where there is a particular need or opportunity to drive improvements to services.

**Quality improvement events**

3.33 During 2013/14, the TDA undertook a successful programme of events focussed on improving quality in key areas. The events brought NHS trusts together to learn about and share best practice, to benchmark and compare performance, and to plan for improvement. Our 2013/14 programme focussed on improving emergency access, improving elective access, and improving patient experience.

3.34 Feedback from NHS trusts has indicated that these events have provided a helpful focus for their quality improvement efforts and given valuable access to best practice and comparative data. The TDA will therefore continue this programme during 2014/15 and will be working with NHS trusts to identify suitable themes for future events. To date, the following topics have been agreed for the 2014/15 programme:

- Safe staffing, in light of the National Quality Board's recent guidance on this issue
- Ambulance trust performance, in light of continuing challenges in this area
- Meeting the cancer waiting time standards, supporting delivery in this priority area.

**Broader improvement support**

3.35 In addition to these focused events, the NHS TDA clinical directorate will work with trusts on specific clinical issues. We continue to work with trusts to support improvements in patient experience and have developed a Patient Experience Headlines benchmarking tool. This brings together a range of key patient experience indicators (e.g. national surveys, friends and family test, complaints, CQC ratings) in a single 'at a glance' dashboard to provide trust with rounded view of their performance and the ability to benchmark against others.

3.36 Alongside that, we have developed a Patient Experience Development Framework to support trusts to carry out an organisational diagnostic against a set of criteria that defines those organisations who consistently improve patient experience. Both the Patient Experience Development Framework and the Patient Experience Headlines tool have been co-produced with trusts and they will be available to trusts via a dedicated patient experience page (password protected) on the TDA website.

3.37 The effective management of medicines is a critical part of any organisation's approach to maintaining and improving quality. To support and challenge trusts on this the TDA has developed a framework for medicines optimisation and pharmaceutical services which is based on nationally recognised standards and good practice guidance. The framework not only enables individual organisations to self-assess against areas of good practice, but also facilitates shared learning, co-production of support materials and collaborative improvement.

3.38 NHS trusts have made significant reductions in healthcare associated infections over the last few years but maintaining and building on these improvements remains a real challenge that we are committed to supporting NHS trusts to achieve. To this end, our heads of infection prevention and control in every region work closely with trusts to support and challenge them on delivery of improvements ranging from:

- Providing routine information and advice through day to day interactions and networks such as directors of infection prevention and control (DIPC) forums
- Hands on support through targeted infection and prevention control visits to trusts, working in close collaboration with key partners such as CCGs, NHS England and Public Health England, to support and challenge improvement
- Facilitating peer review of trust approaches to share learning
- Supporting with recruitment and job specifications to support capacity and capability
- Holding workshops for directors of infection prevention and control and other key professionals, often working with partners in the system, to help facilitate sharing of good practice.

### Access to Intensive Support Teams

3.39 In order to support trusts with specific operational challenges the TDA, working with NHS Improving Quality, will provide access to a range of activities that support the delivery of improvement. This includes:

- Bespoke support through the Emergency Support Team (EST). The EST can work with health communities to support changes in practice to deliver best practice emergency pathways and sustainable services.
- Bespoke support through the Elective Intensive Support Team. The team can provide support in relation to elective pathways including cancer services to deliver change in quality of service provision and sustainability. The approach as outlined above.

### Benchmarking and Analysis

3.40 The need for better access to benchmarking data was the most consistent development need identified by NHS trusts during the 2013/14 planning round. To help to address this, the NHS TDA has developed its information provision and performance framework which includes a number of high level dashboards. These dashboards include a range of topic areas such as clinical access performance, quality, ambulance, activity and finance. Workforce dashboards are also being developed in the light of the safe staffing guidance.

3.41 With the move to an Oversight model based on published data it will now be possible to share benchmarked performance against all of the indicators in Oversight which should significantly help organisations to identify where they are outliers and for the TDA to help develop exemplar sites. The aim for the coming year is to introduce a website that will allow easy access for NHS trusts to all of the analytical tools and supporting analysis developed by the TDA, such as the Patient Experience Headlines tool.

3.42 The approach to benchmarking will be based on a number of key principles:

- That no new data collections should be initiated
- That data should be easy to drill down into
- To allow for peer group comparisons
- To include operational as well as financial information wherever possible.

3.43 These principles have informed the development of the Reference Costs Benchmarking Tool, which is currently being piloted. Information collected in the reference cost submission varies according to the type of service so different approaches to benchmarking have been developed for acute, mental health and community services. NHS trusts are encouraged to feed-back to the TDA regarding the existing benchmarking tools. This feedback will be essential in refining these and other benchmarking tools.

***Theme three: Support for challenged organisations***

3.44 Some of the support provided by the NHS TDA will focus in particular on organisations with serious challenges, including those with internal difficulties and those with strategic challenges across their local health economy. During 2014/15 that support will include:

### Partnership for Improvement

3.45 As part of the special measures process, the TDA has put in place arrangements during 2013/14 for some of the most challenged NHS trusts to be paired with high performing NHS organisations to receive improvement advice and support. This development offer has generally been successful in ensuring NHS trusts have access to best practice, advice, support and coaching as they undertake challenging processes of improvement. Support has been targeted at areas of particular need and engagement has been led by the most senior leaders of the high performing trusts.

3.46 The NHS TDA will continue to make this support available during 2014/15 for all NHS trusts in special measures, and will consider developing the partnership approach to support other NHS trusts where this is needed.

### Support for planning in challenged health economies

3.47 The NHS TDA recognises that the requirements of this year's planning process are particularly demanding, notably the requirement for commissioners and providers to produce 5-year strategic plans. Working with NHS England and Monitor, the NHS TDA has therefore commissioned tailored support for 11 of the most challenged health economies. External advisors will be appointed to support the planning process in each of these areas, working alongside local organisations to facilitate the production of effective 5-year plans. The support will be put in place for the period of April to June 2014/15 and will benefit 21 NHS trusts across a number of health economies.

***Theme four: Support for higher performers***

3.48 While many NHS trusts face significant challenges, a number of our organisations are much further on their journey to sustainability and close to achieving foundation trust status. It is important that the NHS TDA provides support for these organisations to achieve their ambitions and improve further. The programme below will be one element of our support for higher performing NHS trusts during 2014/15.

### Aspirant foundation trust programme

3.49 The NHS TDA has been working with the Foundation Trust Network (FTN) during 2013/14 to refresh the long-standing programme of support for aspirant foundation trusts. The TDA and FTN have agreed to pilot a revised approach to providing support for aspirants with a greater focus on tailored and individual support. The revised programme will include:

- Smaller intensive good practice workshops for aspirant FTs, in addition to the existing broader conference and briefing programme
- More one-to-few support for aspirants, in particular from authorised FTs,
- A greater focus on improving quality governance, a key area of focus for Monitor's assessment programme
- A greater focus on improving non-executive capacity to provide effective challenge, another key element of the assessment process

3.50 The revised programme will be piloted during the first part of 2014/15, to coincide with a number of aspirant trusts receiving the outcome of their Chief Inspector of Hospitals visits.

### NHS Futures programme

3.51 Following on from the successful NHS Futures conference last November, the NHS TDA is working alongside NHS England and Monitor to identify high-performing health economies with the potential to achieve rapid transformational change. The proposed change is centred on implementation of the 6 characteristics of future care identified by NHS England. These are:

- Patients empowered in their own care
- Wider primary care, provided at scale
- A modern model of integrated care
- Access to the highest quality urgent and emergency care
- A step-change in the productivity of elective care
- Specialist services concentrated in centres of excellence

3.52 The NHS Futures work will seek to support a small number of health economies in implementing changes in these areas by providing expert advice and access to national and international best practice. The learning will then be spread across the rest of the sector to support improvement across the NHS.

## REVIEWING DEVELOPMENT NEEDS

3.53 This section has set out our broad approach to development and some of our aspirations for providing specific development support during 2014/15. Building the continuing review of development needs into regular interactions between NHS trusts and the NHS TDA will be a core objective during 2014/15. The submission of detailed development plans during 2014/15 requires both proactive review and interaction between Delivery and Development teams with trusts.

3.54 Where a trusts needs cannot be met by the NHS TDA or through the programmes described above, bespoke approaches will be considered to meet the needs of those trusts.

# approvals model

## Context

4.1 The aspiration of the NHS TDA remains a simple one: to support NHS trusts to deliver high quality, sustainable services for the patients and communities they serve. The provision of services that are clinically and financially sustainable remains the basis for becoming a foundation trust or a suitable alternative solution. However, the environment for achieving sustainable solutions has become even more challenging as the Introduction to this document sets out.

4.2 The 5-year plans which NHS trusts are developing for submission in June 2014 will bring into sharp relief the challenges of achieving sustainability in the current environment. However, we also expect this element of the planning process to bring fresh impetus to the pursuit of sustainability by NHS trusts as local health economies agree new and more radical approaches to meeting the challenges ahead.

4.3 It remains vital that as NHS trusts move towards a sustainable form – whether that is through a successful foundation trust application or through a transaction – the TDA has assurance that there is a clear plan in place to maintain the delivery of sustainable, high quality services. This section of the *Accountability Framework* therefore sets out a refreshed approach to approving foundation trust applications and proposed organisational transactions.

4.4 To support trusts on their journey towards sustainability, the NHS TDA will retain its role in relation to capital investments and proposed disposals. Guiding principles and details of the approvals process for capital investments are set out below.

## Changes to the foundation trust assessment process

4.5 With the introduction of the requirement for a full inspection by the Chief Inspector of Hospitals, the number of organisations moving through the FT assessment process slowed significantly during 2013 as the new inspection regime was implemented. However, with the inspection regime now up and running, both acute and non-acute organisations are beginning to move through the process once again. While the hiatus in the approvals process has been regrettable, it was necessary to ensure that the quality of care is truly embedded in the assessment process.

4.6 Over this period we have been working with Monitor and CQC to streamline the assessment process and make more effective the process for developing NHS trusts on their journey to FT status, building on the important lessons from the Mid Staffordshire Public Inquiry about the need for close co-operation between regulators and the need for a consistent focus on the quality of care provided.

4.7 Whilst the fundamental requirements for FT status as set out in Monitor's *Guide for Applicants* remain consistent – centred on high quality services; sound strategic and business planning and strong governance and leadership, we have worked to ensure that the assessment process can, in future, work in a more effective way.

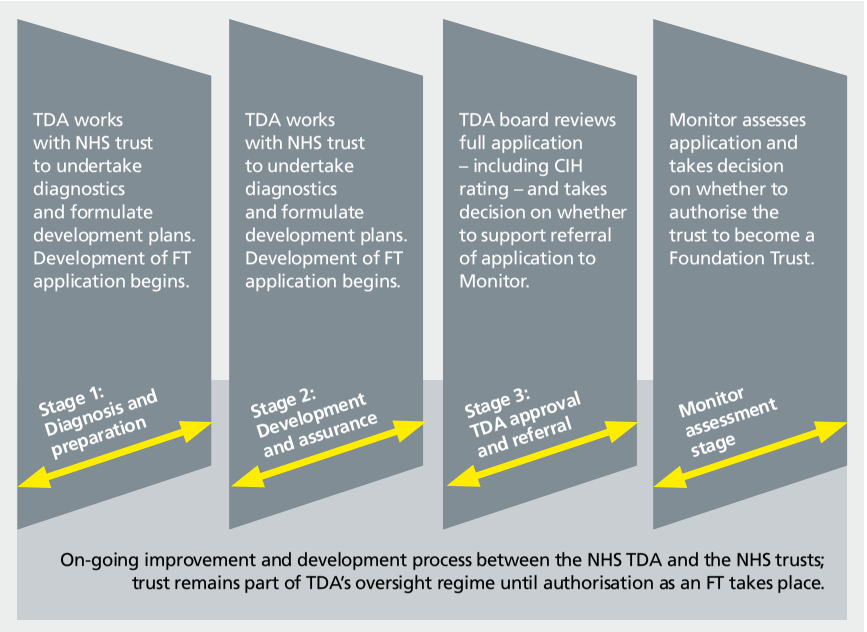
4.8 The approach set out below builds on the existing process, adding further assurances on the quality of services into the approvals process. It also recognises the critical role which partner organisations play in the approvals process and the importance of early and meaningful engagement with partners to ensure sustainability.

4.9 This updated approvals model confirms that:

- **NHS trusts will work with the NHS TDA to ensure they are ready for the assessment process** and are providing high quality services underpinned by a strong business plan. The NHS TDA will provide development and support for NHS trusts, alongside its routine oversight, to help them prepare for the assessment process;
- **A key part of the formal assessment process will be a comprehensive inspection of the trust by the Chief Inspector of Hospitals**. Aspirant trusts will be inspected alongside other organisations as part of the Chief Inspector of Hospital's routine programme. Once the CQC's new ratings system is fully rolled out, an overall rating of 'Good' or 'Outstanding' will be required to pass to the next stage of the assessment process. In the meantime, the Chief Inspector of Hospitals will indicate in the inspection report whether a trust's application should proceed;
- **Trusts that meet the CQC's requirements will quickly move forward in the application process, culminating in consideration by the NHS TDA board**. The board will assess the organisation's overall readiness for FT status, including its business plan, FT application and external quality assurance reports. If the NHS TDA board is satisfied that the trust is ready to proceed then it will offer its support, on behalf of the Secretary of State, for the organisation to move to Monitor for assessment. The NHS TDA will aim to reach a decision on applications as soon as possible after the CQC report is published and will aim to give that approval within six weeks of publication, even where that requires the NHS TDA to hold a special board meeting. Organisations already with Monitor for assessment will receive their CQC inspection during the Monitor phase and will not be required to go back to the NHS TDA for approval;
- **Monitor will then undertake its assessment process as set out in the *Guide for Applicants* to determine whether the organisation should be authorised as a foundation trust**. Monitor has agreed that they will normally aim to reach a decision on an application within four to six months of receiving a referral from the NHS TDA.

4.10 A summary of the revised approach to the approvals process is set out in Figure 7 below:

**Figure 7: Summary of Revised Foundation Trust Approvals Process**



4.11 The work that we have done wih Monitor and CQC has also considered some of the more detailed elements of the assessment in order to streamline and align them as effectively as possible. Changes we have agreed include:

- **Bringing forward Monitor's assessment of quality governance** so that it takes place at an earlier stage in the process. The existing Monitor team will undertake this assessment while the trust is still working with the NHS TDA to develop its application. This will provide Monitor with an earlier insight into aspirant trusts and should help to reduce the number of organisations which struggle to pass Monitor's final assessment due to quality governance concerns. This approach has already been piloted and will be phased in during 2014/15 in line with available capacity;
- **Developing a single well-led framework** to align the different assessments of culture, leadership and governance undertaken by the NHS TDA, Monitor and CQC. This will bring together the current approaches embodied in the *Quality Governance Framework*, the *Board Governance Assurance Framework* and the CQC's new inspection regime to create a single definition of success for NHS trusts. We will develop and test the new framework during 2014/15 but in the meantime assessment undertaken under the existing frameworks will remain valid;
- **Streamlining the different aspects of financial assessment, replacing Historic Due Diligence with an Independent Financial Review.** This will ensure that assessments occur at the most appropriate point in the process, reduce the need for repeat assessments and add as much value as possible. Similarly, the framework will be finalised and tested during 2014/15;
- **Embedding public and patient involvement more thoroughly into the process** by broadening the basis of the public engagement and consultation that trusts undertake. Trusts must demonstrate that they have sought feedback from the public regarding the quality of their services, and that this feedback is being used to make the necessary improvements.

4.12 The core standards required to achieve foundation trust status are not changing but the way in which they are assessed is being streamlined. The NHS TDA will adopt a flexible approach as these new tools are being implemented, so that trusts that have recently carried out assessments using existing tools will be able to continue with their applications, provided that the necessary criteria have been met.

### Overview of the revised foundation trust assessment process

4.13 The model in Figure 8 summarises in more detail the NHS TDA process for the development and assurance of foundation trust applications. It provides NHS trusts and NHS TDA staff with a clear and transparent process that will be used to support NHS trusts to achieve the ambition of becoming foundation trusts.

4.14 The guidance should be read in conjunction with the accompanying TDA supporting guidance and *Applying for NHS Foundation Trust status: Guide for Applicants* which sets out in full the NHS foundation trust application process. In contrast this document sets out the specific steps the NHS TDA will take to gain assurance about the clinical and financial sustainability of applications.

4.15 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. In line with the recommendations of the Francis 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 resources.

4.16 With the Chief Inspector of Hospitals being the arbiter of whether those fundamental standards are being delivered, the role of the NHS TDA in relation to quality has shifted from assessment to development. The approach to development set out in this *Accountability Framework* shows how the NHS TDA will work closely with trusts to support their preparations for inspection and approval. This will help to ensure that not only are services for patients safe, effective, caring, responsive and well-led but also clinically and financially sustainable.

4.17 The NHS TDA will follow a development, application and approval process that involves the following three stages:

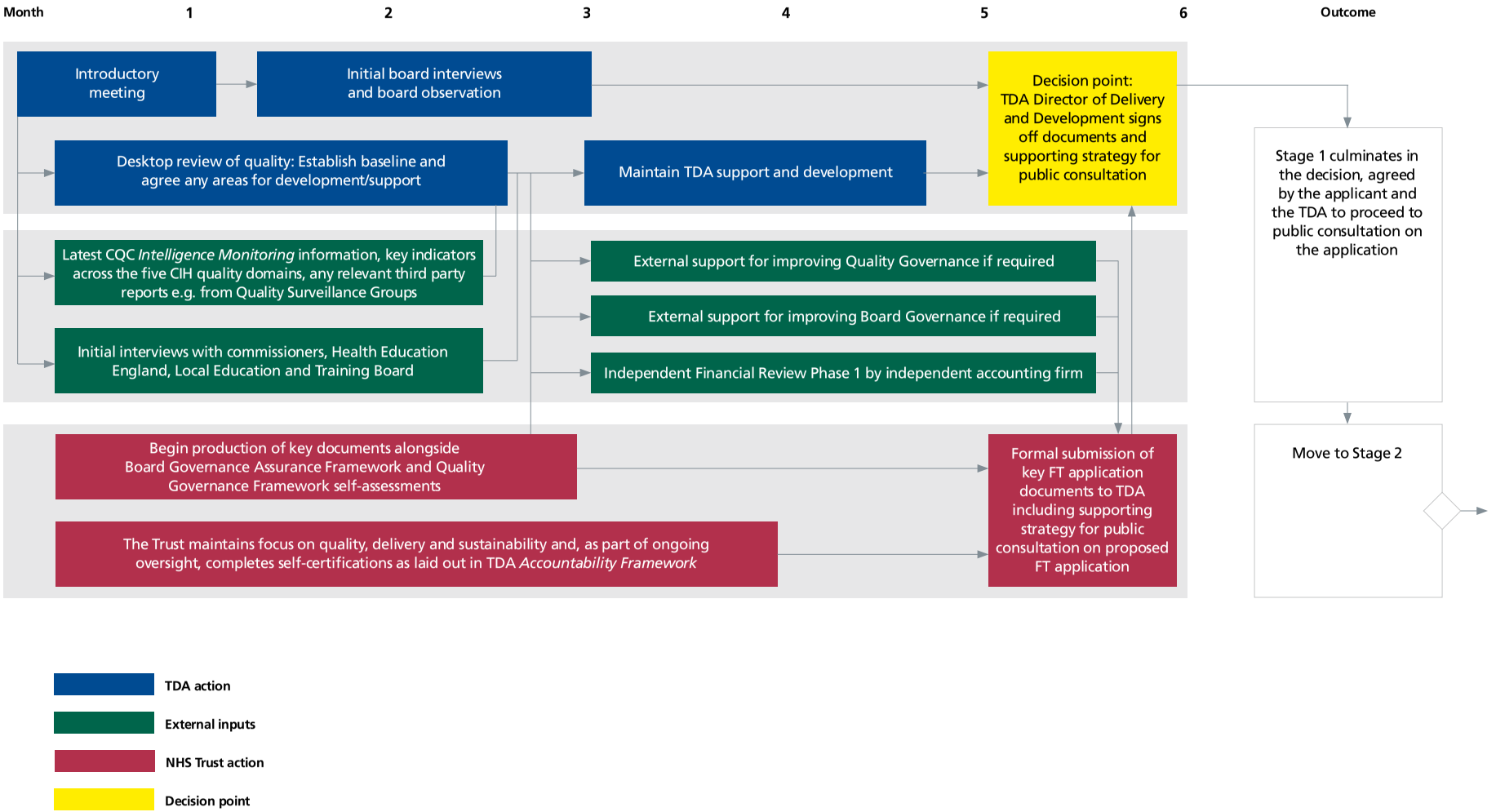
- **Stage 1: Diagnosis and preparation:** This stage involves the trust and the NHS TDA establishing a baseline of the quality, safety and sustainability of the aspirant foundation trust. Baseline performance will be established in relation to quality through a TDA-led desktop review; board and quality governance through trust self-assessments; and finance through phase 1 of the Independent Financial Review. These baseline reviews will inform action and development plans for trusts to support continuous improvement. The preparations for public consultation will need to be strengthened in line with the response to the Francis Inquiry, to ensure that trusts are explicitly asking about the quality of the care they provide. Stage 1 culminates in the decision, agreed by the applicant and the NHS TDA, to proceed to public consultation on the application;
- **Stage 2: Development and assurance:** This stage involves the submission of key documents to the NHS TDA and the testing and scrutiny of trust plans and personnel. It includes a focused period of improvement and support based on the action and development plans produced in Stage 1. Stage 2 currently includes a Monitor assessment of quality governance arrangements and an external assessment against the *Board Governance Assurance Framework*; though over time, these assessments will be made against the new framework for well-led providers. This stage also includes Phase 2 of the Independent Financial Review and, critically, initiating the process that will conclude with a comprehensive inspection by the Chief Inspector of Hospitals. Stage 2 culminates in the decision, following the NHS TDA readiness review, to proceed to consideration for approval by the NHS TDA board;
- **Stage 3: Approval and referral to Monitor:** This stage involves the consideration of the application, including the results of the inspection by the Chief Inspector of Hospitals, at a formal board to board meeting followed by the NHS TDA board. Stage 3 culminates in the decision by the NHS TDA board about whether the trust is ready to undergo a detailed assessment by Monitor.

4.18 NHS TDA Delivery and Development teams will oversee the work on an FT application and ensure that NHS trusts have the support in place to move through the different stages of the processes. The overall model is set out in Figure 8.

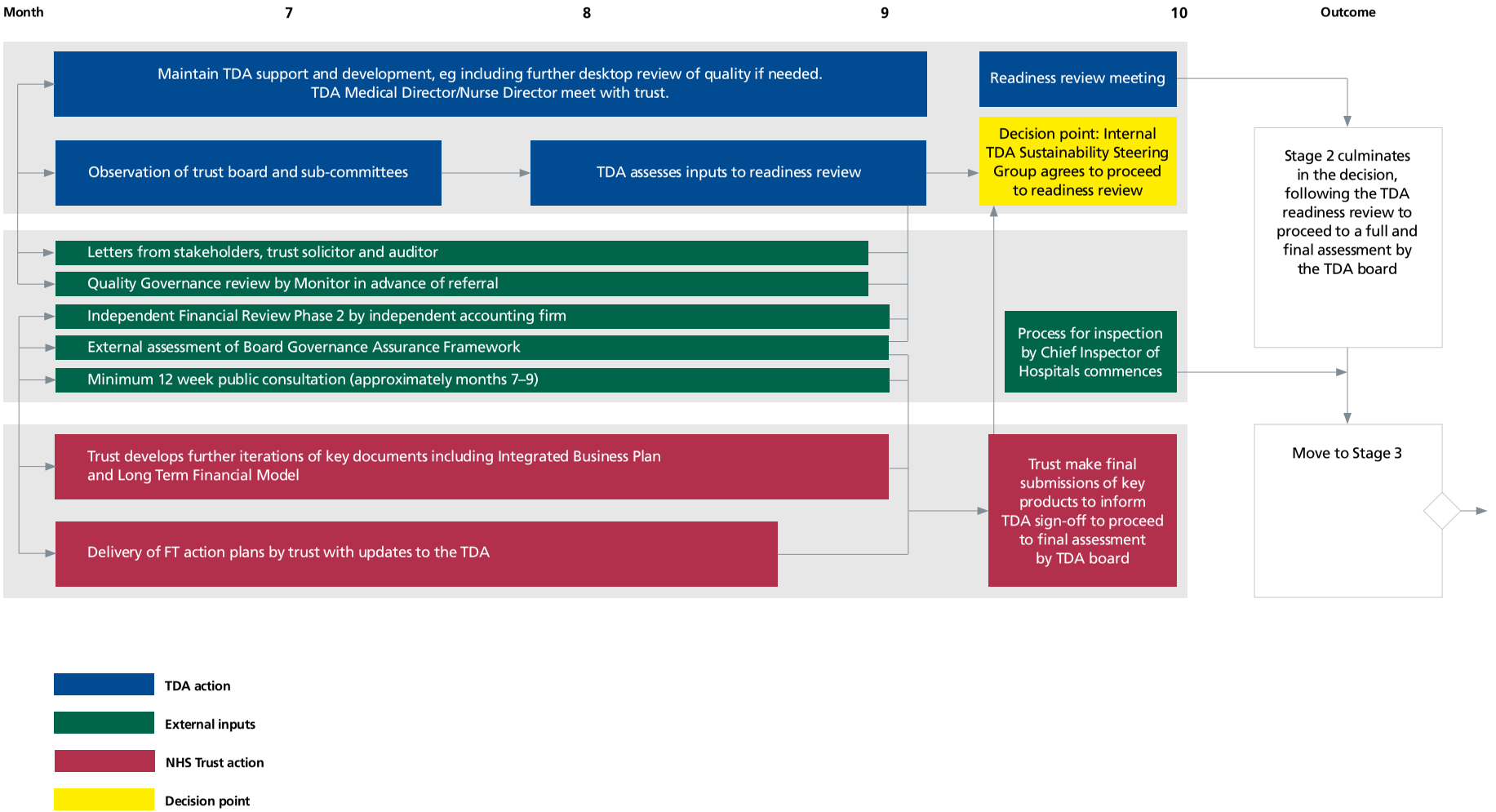
4.19 Further details and templates for the development, application and approval process for FT applications are set out in supporting guidance to accompany the *Accountability Framework*. The supporting guidance and tools will be posted on the NHS TDA website and updated as required to assist in the development of successful applications.

4.20 If NHS trusts encounter difficulties during the application process, an assessment will be made on a case-by-case basis about the elements of the assurance process that will need to be repeated.

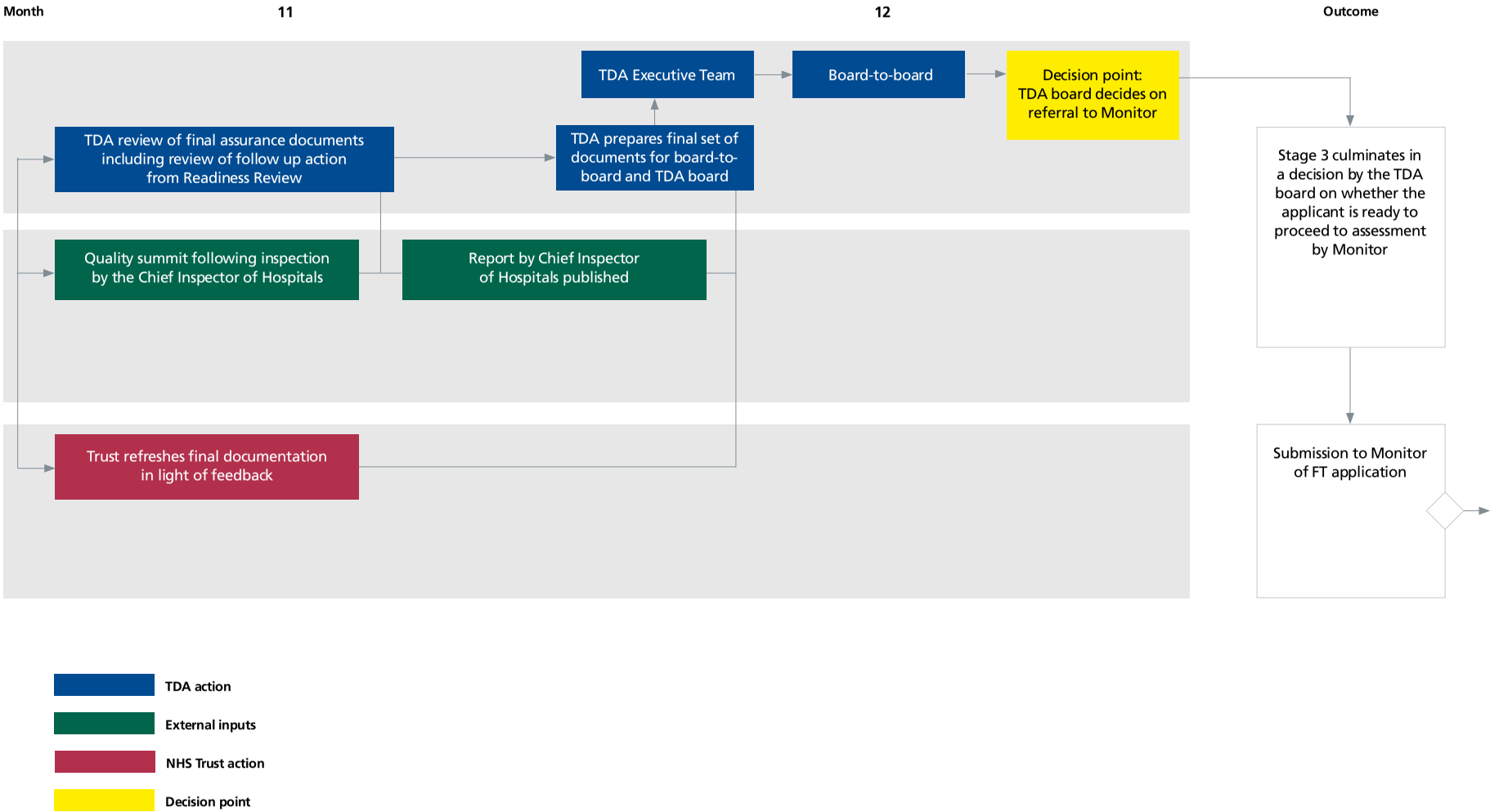
**Figure 8: Stage 1 – Diagnosis and preparation (see Supporting Guidance for detail; time periods are illustrative)**



**Stage 2 – Development and assurance (see Supporting Guidance for detail; time periods are illustrative)**



**Stage 3 – Approval and referral to Monitor (see Supporting Guidance for detail; time periods are illustrative)**



### Taking forward sustainable solutions: the transactions approval process

4.21 The NHS TDA is responsible for ensuring that all NHS trusts achieve a sustainable organisational form. Where a trust cannot achieve sustainability as a foundation trust in its current form, a range of transactions will be considered to achieve sustainability.

4.22 This section summarises the standardised NHS TDA process for the development and assurance of NHS trust plans to achieve high quality, safe, sustainable services through a transaction.

4.23 A transaction may take different forms but always involves a transfer in the ownership of assets and liabilities and/or a business/service from one organisation to another. In the NHS many transactions have taken the form of mergers (e.g. between NHS trusts) or acquisitions (e.g. by an FT of an NHS trust).

4.24 A description of the different forms of transactions is included in the supporting guidance that accompanies this framework. Whilst all transactions are different, in every case where a transaction involves the acquisition of an NHS trust, the NHS TDA is the vendor in the transaction, with responsibility for overseeing and assuring all aspects of the process.

4.25 This *Accountability Framework* confirms the clear set of principles that will be used to assist local teams in following best practice and achieving good value for money in the transfer of an NHS asset/business to a new owner.

4.26 Further work is underway to ensure alignment of the TDA and Monitor assurance process in relation to transactions involving FTs and the results will be incorporated in the accompanying supporting guidance. This is in light of the proposals on which Monitor is currently consulting to increase their involvement at an early stage in transactions involving FTs.

4.27 The transaction process for NHS trusts is structured around the following four gateways, illustrated in Figure 9:

- **Gateway 1 – Entering the transactions pipeline:** This gateway is when the NHS TDA starts the transaction process, because the trust is not able to achievable foundation trust status in its current form. The Gateway 1 review will include consideration of the alternatives to pursuing a transaction within the context of the five year plan for the trust. Trusts unable to demonstrate a viable FT solution to the NHS TDA will enter the 'transactions pipeline'.
- **Gateway 2 – Agreeing the form of procurement:** This gateway is when the NHS TDA takes a decision about the appropriate form of procurement. An option appraisal will be carried out to assess the range of alternative procurement approaches, the transaction types will be evaluated and the strategic marketing approach of the NHS TDA will be considered in order to secure best value from the transaction. This may include issues of timing and commissioner strategy associated with significant service changes that are required.
- **Gateway 3 – The choice of preferred solution:** This gateway is when the decision is made to proceed with a preferred solution following the procurement process. The first step is to gain approval from the TDA board for the preferred solution arising from the procurement. This would be followed by the detailed development of a business case, the clinical and quality strategy, competition assessments, a Long Term Financial Model, letter of commissioner and clinical support, signed Heads of Terms including agreed funding commitments and an outline implementation plan. Once sufficient assurances are in place, the TDA board will be asked to approve the completion of Gateway 3.
- **Gateway 4 – Decision to implement the preferred solution:** After all the due diligence, legal, commercial and external reviews (including Monitor, and the Competition and Markets Authority if necessary) have been concluded, this gateway is the final decision-making step. It includes finalised contract terms or a Transaction Agreement setting out the final arrangements for implementing the transaction. This is equivalent to a 'Full Business Case' described in the DH Transactions Manual and culminates in the NHS TDA's recommendation to the Secretary of State to make the legal changes necessary to finalise the transaction.

4.28 NHS TDA Delivery and Development teams will oversee the transactions process for NHS trusts and ensure that trusts have access to the support needed to move through the different elements of the process. The overall approach is set out in Figure 9.

4.29 As needed during the transaction process, Health Gateway reviews will be commissioned by the NHS TDA, tailored to the specific timetable for each transaction, to gain assurance about the robustness of the project management processes.

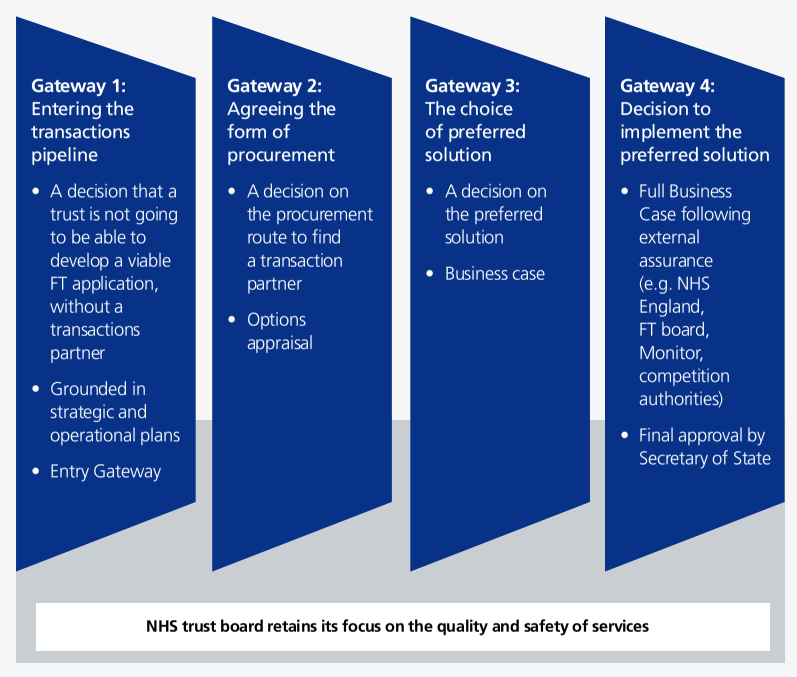
4.30 Further details of the procurement, decision-making and approval process for transactions are set out in the supporting guidance to accompany the *Accountability Framework* which will be posted on the NHS TDA website. The lessons from previous and existing transactions will continue to be used by the NHS TDA to inform and develop its approach as vendor to future transactions.

4.31 The NHS TDA board is clear that a transaction must only be pursued if it can be shown to improve the quality of healthcare available to patients and value for money for the taxpayer. These benefits are likely to be both in terms of improving current standards of care to patients and financial benefits.

4.32 Before embarking on a transaction approach, it is therefore essential that local stakeholders (especially NHS commissioning bodies) and the NHS TDA board have assurance that the transaction is the most beneficial way to improve the quality, delivery and sustainability of services for the local population.

4.33 While a transaction process is underway for the future, it is vital that the NHS trust board retains its focus on present-day delivery. This means driving forward improvements in the quality and safety of services, managing within the resources available and continuing to seek sustainable solutions for services. Whatever the transaction solution in the future, the trust board, staff and stakeholders need to continue to make every effort to resolve the underlying problems that have led to the transaction proposal. This focus on improvement now will also help to ensure the success of the transaction in the future.

**Figure 9: Overview of the Transactions Process – Key Decision Points**



### Sustainable Capital Investments

**Capital Investment: Guiding Principles**

4.34 The NHS TDA requires NHS trusts to adhere to the Department of Health (DH) *Capital Investment Manual* in the production of capital investment business cases. In line with the DH Capital Investment Manual, the TDA requires that all business cases are based upon the five-case model for business case production Each investment proposal must therefore cover the following aspects:

- strategic;
- economic;
- financial;
- commercial;
- management.

4.35 The NHS TDA will require assurance that a capital investment business case has been through an appropriate level of scrutiny and governance within the NHS trusts proposing the investment, before the case is submitted to the NHS TDA.

4.36 Detailed guidance for NHS trusts regarding the NHS capital regime, capital business case approvals and funding application process has been produced and issued to organisations. The detailed operating guidance covers:

- background and details of the NHS capital regime including technical financial guidance;
- delegated limits for NHS trusts for capital investment business case approvals. NHS trusts have the authority to approve capital business cases within agreed thresholds before NHS TDA approval is required;
- a summary of the expected key stage documentation and associated information requirements that NHS trusts must comply with when submitting capital business cases to the NHS TDA for approval. All NHS trusts will be required to submit a business case and a business case checklist in a prescribed format;
- capital planning requirements.

4.37 Recommendations from the directors of delivery and development will be made for capital business case investment proposals put forward by NHS trusts within their portfolio to the NHS TDA approving officer or group in line with the NHS TDA approvals process.

### Capital Investment Approvals

4.38 The NHS TDA has the responsibility for approving all significant capital investments proposed by NHS trusts up to a limit that has been delegated to the NHS TDA by the Department of Health – a key element of helping to ensure NHS trusts are sustainable in the medium-to long term. Capital investment and disposal proposals over a value of £50m will require NHS TDA, Department of Health and HM Treasury approval for all stages of the business case.

4.39 When assessing investment proposals the TDA will consider whether they are consistent with the trust's clinical strategy, and ensure that they clearly demonstrate a high level of engagement with the clinical staff within the organisation and the wider health economy where applicable. We will look closely at the quality, safety, productivity, affordability, value for money and workforce implications associated with any investment proposal, as well as ensuring that any applications help ensure the sustainability of the wider local health economy. Importantly, we will also closely examine whether the NHS trust has the resource and capacity to deliver the investment programme it is proposing within a realistic timescale.

4.40 Capital Investment Loans will be available to NHS trusts to support capital investment. Applications for capital investment loans will need NHS TDA review and approval before they are passed on to the Independent Trust Financing Facility for final approval. Details of the NHS TDA's process for NHS trusts to access capital investment loans is set out in separate NHS TDA financing guidance.

Northampton General Hospital NHS
NHS Trust

# REPORT TO: TRUST BOARD
**29 May 2014**

| | |
|---|---|
| **Title** | Developing a 5-Year Plan |
| **Agenda item** | 20 |
| **Sponsoring Director** | Chris Pallot, Director of Strategy and Partnerships |
| **Author(s)** | Chris Pallot, Director of Strategy and Partnerships<br>Karen Spellman, Deputy Director of Strategy and Partnerships |
| **Purpose** | Information and Assurance |

**Executive summary**

The report describes the process being followed to develop the strategic plan and associated clinical strategy in time for submission to the TDA on 20 June 2014.

| | |
|---|---|
| **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)<br><br>Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(/N) |

**Actions required by the Board**

The Board is asked to endorse the process being followed, and to note the timescales for submission.

# Trust Board
# 29 May 2014

# Developing a 5-Year Plan

## 1.0 Summary

Northamptonshire has seen a number of major change initiatives over the past few years which have been designed to bring clarity to the design of services and organisational form for the future.

The strategies of the NHS organisations in the county have been to align themselves with the programmes of work but there has been a lack of clarity as a result of some changes in direction.

This document describes the process to deliver the Clinical Strategy and the 5-year strategic business plan for Northampton General Hospital as well as describing the recent history with regard to some of these pieces of work.

## 2.0 The History

### 2.1 Healthier Together - 2012

Healthier Together was a Commissioner-led programme across the South East Midlands (Northamptonshire, Buckinghamshire and Bedfordshire) to review secondary care services across:

- Kettering General Hospital NHS Foundation Trust
- Northampton General Hospital NHS Trust
- Milton Keynes Hospital NHS Foundation Trust
- Bedford General Hospital NHS Trust
- Luton and Dunstable NHS Foundation Trust

The aim was to redesign services across the region to minimise duplication, increase quality and reduce cost. This was to deliver a health service that offered the best care and outcomes in the face of increasing demand and finite resources. The desire was to bring care closer to peoples' homes where possible, create centres of excellence for more complex or emergency care, and improve integration of services across Health and Social care. This work subsequently developed along two geographical regions North (Northamptonshire) and South (Buckinghamshire and Bedfordshire).

A summit was held in December 2012 when clinicians across primary and secondary care in Northamptonshire met and expressed their broad support and commitment for the need to consider alternative ways of providing services and working across organisational boundaries. There was a specific challenge to the Boards of the acute trusts to make an explicit statement regarding their future organisational form as this was felt to be a barrier to clinical change at the time.

At this stage the Boards agreed that a programme of work should commence between Kettering and Northampton General Hospitals that would consider all options up to and including merger but which would be based on a clinical strategy that had sustainability at the centre of the proposals. This led to the establishment of Healthier Northamptonshire.

**2.2 Healthier Northamptonshire - 2013**
This programme of work was designed and led by the two Trusts and commenced in April 2013. The aim was to design a proposal for secondary care services across the county, led by clinicians that ensured sustainability for the future. The programme was split into 3 key elements:

- Establishing the case for change – defining the issues facing both Trusts in their standalone form
- Outline Business Case – considering all options for future clinical and structural forms within the county
- Full Business Case – for the preferred option

Early in the programme it became clear that a proposal to alter organisational form would not gain the support of regulators for a number of reasons however the need to collaborate on service delivery was made clear.

Rather than considering provider-led service change the programme became Commissioner led and focussed now on the challenge facing the entire health economy. This resulted in a much wider programme which defined the challenge facing the economy over the subsequent 5-years to be c£275m.

**2.3 Current strategy for Healthier Northamptonshire**
During 2013/14 Healthier Northamptonshire work (led by the CEO of the County Council and comprising of representatives from the whole health and social care economy across Northamptonshire) has continued to develop a strategic plan to bridge the projected 2018/19 funding gap whilst maintaining high quality care.

A programme of work has been developed consisting of 9 workstreams: health and social care integration, frail and elderly, commissioning pathway based care, transformation of general practise, prevention, acute service collaboration, urgent care and service efficiency.

Progress and aspirations include:

1. Urgent care - to develop 2 urgent care centres located at NGH and KGH and to implement primary care streaming in A&E at both sites
2. Collaboration between the 2 acute Trusts – agreement to CCG commissioning of a sole lead provider for stroke, vascular and PCI care and development of plans to do the same for oncology and community paediatrics
3. Prevention - implementing multifactorial assessments of those at risk of falls by GPs with referrals to specialist nurses, increase PPV and flu vaccination rates, risk stratification, optimising outcomes from elective surgery through smoking cessation and weight loss
4. Transformation of General Practice – development of federated practices and minimum standards for general practice
5. Commissioning pathway based care – mobilising task and finish groups to design and implement pathways including asthma and COPD, angina and heart failure, stroke and epilepsy, chronic kidney disease, diabetes as well as other conditions
6. Frail and elderly – rolling out of pilot model of a crisis response hub to which any person over 75 years who has a crisis event is referred for care which is coordinated by multidisciplinary teams, also includes community led discharge to assess and A&E assessments
7. Integration of health and social care – integrated community health and social care teams providing single point of access to health and well-being services, crisis hub (similar to the frail elderly model), reconfiguration of community beds
8. Service efficiency – working with CCGs and providers to look at viability of services, including areas where activity could be reduced without affecting health outcomes, so far focussed on increasing the list of interventions of limited clinical value
9. Finance – developing pooled budgeting to support integration

The programme has a dedicated Programme Management Office but has not yet delivered major service change proposals. The work continues, involving all partners and will be bringing schemes forward for completion in 2014/15.

**3.0 The Current**

**3.1 Intensive Planning Support additional to Healthier Northamptonshire**

Northamptonshire has been identified as 1 of 11 "challenged " health economies (CHE) and as a result has been given an intensive planning support team to work with the Healthier Northamptonshire Board. The aim of the support team is to ensure that options for alternative models of care are developed that are clinically and financially sustainable and that strategic plans across the health economy of Northamptonshire are aligned with each other.

This work is to be completed by 20 June– when all organisations across the health economy have to submit their 5 year plans to the various national bodies (NHS England, Trust Development Authority (TDA), Monitor).

Northamptonshire has been described as a challenged health economy because:

1. There is lack of access to and effectiveness of primary care, particularly with regard to preventing admissions for acute care
2. Acute Trusts are struggling to meet targets
3. There is limited pathway working for high risk complex patients
4. Current models are unaffordable
5. There have been limited results from previous initiatives

The work will not deliver a completed 5-year plan for each organisation, there will still be considerable work at each Trust to deliver its plans. There is an issue with the convergence of dates however:

- 20 June 2014 – Trust to submit 5-year plan and clinical strategy to the TDA
- 30 June 2014 – Challenged Health Economy output received

This may require revision to the plans that are submitted depending on the recommendations made.

**3.2 Development of the Northampton General Hospital Clinical Strategy**

In response to the requirement to produce a revised clinical strategy the Trust agreed to engage external support to assist with generating its clinical strategy. This would have ideally been undertaken in partnership with KGH but due to a requirement from Monitor to produce their own sustainability strategy this isn't possible. However, the outputs will be shared with KGH because irrespective of the outcomes there will undoubtedly be options for strategic service changes between the organisations.

This process to develop the strategy will involve a number of speciality level reviews that will inform the longer term strategy of NGH in relation to sustainability from clinical, operational and financial standpoints.

The reviews will be undertaken in conjunction with the relevant clinical and managerial teams and will inform their individual departmental strategy as well as that of the wider organisation.

This work will evaluate the departments against the various criteria and provide an output based on the range of metrics. These criteria will be summarised in an information pack for each speciality:

- Evaluation of catchment population vs the minimum required to deliver the service both now and into the future
- Local Health Needs analysis (from the Joint Strategic Needs Assessment) and CCG commissioning intentions which are embodied in the Healthier Northamptonshire strategy
- Clinical safety issues
- Minimum volumes per consultant
- Surgical outcomes and medical care using established clinical indicators (e.g. HSMR, infection measures, readmissions) and Royal College or peer review standards where these exist
- Workforce sustainability both currently and in order to deliver 7-day services
- Changes to demand
- Future Quality Premiums

The reviews will also be informed using a suite of information and a range of efficiency metrics.

These metrics include:
- Occupancy rates
- Trend analysis of bed utilisation
- Length of stay by both elective and emergency points of delivery
- Outpatient ratios
- Change in workload

The specialities being reviewed are:
- Orthopaedics
- Urology
- Dermatology
- ENT
- Maxillofacial
- Ophthalmology
- Radiology
- Pathology
- Paediatrics
- Cardiology

The outputs are as follows:
- Directorate information pack for each speciality that includes, as a minimum the metrics listed in above and in the clinical strategy document.
- Development of a balanced scorecard which can be further developed to assess the strategic, operational and financial viability of the services under review.
- Recommendations as to the key actions and findings in relation to improving service viability and profitability, opportunities to collaborate with partners and identification of loss making services.
- Assessment of delivery potential against the efficiency metrics produced as part of the Healthier Northamptonshire programme.
- Directorate specific strategy document and a recommendation on future form as determined by the decision forum for that speciality
- Road-map to implementation signed-off by the Directorate.

This will inform the Trusts strategy for each of the services in terms of ensuring future sustainability.

The remaining specialities will be reviewed through the remainder of the summer and autumn periods to ensure all outputs are ready for the annual contract process.

**3.3 5-Year Integrated Business Plan**
The Trust is expected to produce a five year Integrated Business Plan and Long Term Financial Model (LTFM) by the 20 June 2014. This must be signed-off by the Board and aligned with Commissioners. The plan will cover finance, quality, workforce and delivery, with the first two years being detailed in the two-year plan already submitted in April 2014. Where NHS Trusts have the potential to achieve sustainability, but require a significant change of service patterns to do so, the nature of that change should be clearly set out in their five year plan. The NGH five year plan will detail the Clinical Strategy and Healthier Northamptonshire changes that are agreed as well as proposals for how the plan will be reviewed and developed in line with finalising the Clinical Strategy.

The TDA expects the Board to clearly identify areas where we need further development support. The TDA will work with each organisation to enhance and sign off development plans by the end of September 2014.

**4.0 Summary**
The process to define the Trusts Integrated Business Plan is complex and influenced by many external factors. The approach is to review each clinical service against a range of metrics, including external strategic initiatives to ensure future sustainability.

This approach will result in a number of completed reviews ready for inclusion in the TDA submission on 20 June, but not all will be finalised.

The submission will map the path to completing the reviews which will also enable the Trust to incorporate the outputs of the CHE work.

**Chris Pallot**
**Director of Strategy & Partnerships**

**Karen Spellman**
**Deputy Director of Strategy & Partnerships**

**May 2014**

# REPORT TO: TRUST BOARD
**29 May 2014**

| | |
|---|---|
| **Title** | Corporate Objectives 2013/14 Year-End Update |
| **Agenda item** | 21 |
| **Sponsoring Director** | Chris Pallot, Director of Strategy and Partnerships |
| **Author(s)** | Chris Pallot, Director of Strategy and Partnerships<br>Karen Spellman, Deputy Director of Strategy and Partnerships |
| **Purpose** | Information and Assurance |

**Executive summary**

This paper provides a final update to the Board on progress that was made in relation to the 2013/14 Corporate Objectives.

| | |
|---|---|
| **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)<br><br>Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(/N) |

**Actions required by the Trust Board**

The Board is asked to acknowledge the progress made against the objectives

Enclosure R

# NGH Corporate Objectives 2013/14 - Updated Six Month Review

| Ref No. | Corporate Objective 2013/14 | Outcomes<br>*What is the desired result* | Output Measure<br>*How will the successful implementation of the action be measured* | Planned Completion Date | Owner | 6 Month Progress Review | Year end Progress Review |
|---|---|---|---|---|---|---|---|
| **Strategic Aim 1: Be a provider of quality care for all our patients** | | | | | | | |
| **1** | Invest in enhanced quality including improvements in the environment in which we deliver care | Demonstrated improved clinical effectiveness as demonstrated through NICE compliance and effective use of clinical audit<br><br>Reduction in harm to patients as measured through implementation of the patient safety programme<br><br>Increase nursing establishment through the implementation of the nursing and midwifery staffing strategy | Reduction in SHMI and HSMR<br><br>Improved CQC Scores<br><br>Improvements in results of Patient & Staff Surveys<br><br>Positive PLACE Scores<br><br>Positive performance of Estate KPIs<br><br>Progress on Safety Academy Priorities until 2015<br><br>Achievement of operating Framework standards e.g. RTT, Cancer Waits, 4 hour transit time<br><br>Improvements in Healthcare Acquired Infection KPIs<br><br>Delivery of the Estates Strategy and Capital Programme<br><br>Improvement in pressure ulcer KPIs | Mar-14 | Suzie Loader<br><br>Dr Sonia Swart | At risk of delivery due to; SHMI, HSMR, T&O RTT, Cancer Waits, A&E 4 hour transit time. Full recovery plans in place and presented to sub committees and Board for approval and monitoring. | Improved SHMI and HSMR, achieved Healthcare Acquired infection KPIs. Achieved year end RTT for Trust wide indicators. Achieved upper quartile PLACE scores. Did not achieve year end 62 day cancer waits or Q4 2ww and 31 day standard. |
| **Strategic Aim 2: Enhance our range of hyper acute services and maintain the clinical viability of services for the wider community of Northamptonshire** | | | | | | | |
| **2** | Develop critical clinical care pathways to deliver effective integrated care. | To deliver a safe and sustainable countywide vascular and stroke services<br><br>A strategic review of cancer services undertaken by 31 October 2013<br><br>Urgent Care | Completed strategic reviews undertaken with plans of action developed and signed off at Board. | Mar-14 | Chris Pallot | On track to deliver a review of Cancer services by April 2014. Full plans in place for Urgent Care Board for the Urgent care developments. Improvement plans in place and monitored through operational groups for Stroke and Vascular. | Review of Cancer services underway to develop partnership working with UHL. Revised plans in place for Urgent Care Board for the Urgent care developments. Continued developments and implementation of the Stroke and Vascular services throughout the year. |
| **3** | To develop strategic approaches to stakeholder engagement in order to develop a clinically safe and sustainable organisation. Specifically, develop strategic approaches to relationships with:<br>- Local partners<br>- Commissioners<br>- Local Authorities, Health and Wellbeing Boards<br>- Trust Development Agency<br>- MPs<br>- Regulators | Enhanced clinical links with NHS Nene Commissioning developed<br><br>Closer links with KGHFT through the establishment of a joint Partnership Board<br><br>Clinically viable services developed alongside other healthcare partners | Stakeholder strategy reviewed, approved at Board and implemented.<br><br>PMO appointed to and strategic options developed. | Mar-14 | Chris Pallot | At risk of delivery due to change in focus of Healthier Northamptonshire Proposals for review of the Clinical Strategy to include partnership working agreed at the October Board Development Day | Partially implemented via the new Healthier Northamptonshire arrangements and NGHs approach to defining a new Clinical Strategy. Stakeholder analysis will be developed once the final clinical strategy is approved and moving towards implementation |

# NGH Corporate Objectives 2013/14 - Updated Six Month Review

| Ref No. | Corporate Objective 2013/14 | Outcomes<br>*What is the desired result* | Output Measure<br>*How will the successful implementation of the action be measured* | Planned Completion Date | Owner | 6 Month Progress Review | Year end Progress Review |
|---|---|---|---|---|---|---|---|
| **Strategic Aim 3: Provide appropriate care for our patients in the most effective way** | | | | | | | |
| **4** | Implement the recommendations of the quality strategy | Demonstrable improvement in quality, patient safety, and patient experience<br><br>Wards using bi-monthly governance 'ward pack' for sharing of learning from incidents / complaints and evidence of discussion of this | Reduction in omission of medicines by 50%<br><br>Oxygen correctly prescribed, administered and documented for >90% of patients<br><br>Number of patients that receive sepsis 6 bundle within 1 hour of arrival in A&E.<br>Improvement of 10% on baseline<br><br>Number of deaths in hospital (with the aim of monitoring lives saved over 3 years)<br><br>Number of staff trained in basic human factors in simulation suite<br><br>Number of patients that receive antibiotics within one hour of sepsis being suspected on the ward<br><br>Consultant review within 12hours<br><br>Number of unauthorised EDN's on the ward<br><br>Audit of action plans from 'Never Events'. Number of actions completed / outstanding<br><br>Improvements in the friends and families test -<br><br>• *How likely are you to recommend our Ward to friends and family if they needed similar care treatment?* - 15% response rate per ward, score over 70<br>• *Were you involved as much as you wanted to be in decisions about your treatment or care?* - 50% Response rate, improvement to 50% positive<br>• *Were hospital staff available to talk about any worries or concerns that you had?*<br>50% response rate, improvement to 50% positive<br>• *Did you have enough privacy when discussing your condition or treatment?*<br>50% response rate, improvement to 50% positive<br>• *If you have been prescribed any new medication, have you been informed of any possible medication side effects?* - 50% response rate, improvement to 50% positive<br>• I*f you are ready to be discharged - have you been informed about who to contact if you are worried about your condition after leaving hospital?* - 50% response rate, improvement to 50% positive<br>• *Arrival at hospital to bed / ward – did you feel that you had to wait a long time.*<br>Increase on National Inpatient survey score from 7.4 – 8.0 (previously 7.4)<br>*Overall did you feel that you were treated with privacy and dignity while you were in the hospital?*<br>Increase on National Inpatient survey score from 8.6 – 9.1 (previously 9.0) | Mar-14 | Suzie Loader<br><br>Dr Sonia Swart | At risk of delivery - full oversight and detailed scrutiny at IHGC | 53% reduction in omitted medicines. Since September 2013 oxygen prescription awareness training is included within all resuscitation training sessions. There is significantly better compliance in the care bundle when measured at 2 hours. All staff who attend for any training within the Simulation Suite receive a 20 minute introduction to human factors, the total number attended within the last year is 1639. There is a continued improvement within Medicine for Consultant review within 12-hours, whilst other specialities are work in progress. eDN completion for April 2014 was 83.52%. WHO never event ongoing training & Spot check compliance continues |
| **5** | Further develop service planning through utilisation of business intelligence | Specialty scorecards implemented including service line reporting, quality and activity information<br><br>Clinical acceptance of basis of preparation of service line reporting and confidence to use in decision making<br><br>Service Line Reporting becomes core to delivering enhanced internal and external planning processes | Speciality scorecards in place.<br><br>Corporate assurance reporting and decision making based on service line reporting. | Mar-14 | Chris Pallot<br><br>Andrew Foster | Review of Scorecards underway and process to ease reporting is underway. SLR being developed | Review of score cards carried out. SLR being developed and implemented across specialties |

## NGH Corporate Objectives 2013/14 - Updated Six Month Review

| Ref No. | Corporate Objective 2013/14 | Outcomes<br>*What is the desired result* | Output Measure<br>*How will the successful implementation of the action be measured* | Planned Completion Date | Owner | 6 Month Progress Review | Year end Progress Review |
|---|---|---|---|---|---|---|---|
| **Strategic Aim 4: Foster a culture where staff can give their best and thrive** | | | | | | | |
| **6** | To develop and implement new ways of engaging and supporting staff to enable them to achieve their potential | Improved staff satisfaction,<br>Development of a high performance, patient focussed culture driven by common values, appropriate behaviours and effective teamwork. | Improvements in relevant key findings in the annual staff survey results e.g. staff advocacy rates.<br><br>Optimal staff turnover rates achieved: within 1% tolerance of 8% target,<br><br>Reduction in sickness absence from 4.6% to 3.8%<br><br>Roll out of behavioural framework system and integration with related core systems e.g. appraisal,<br><br>Increase in mandatory training rates,<br><br>Increase in appraisal rates from 73% to 80% or greater (staff survey data) and<br><br>Increase in quality of appraisal ratings from 23% to 35% or greater.<br><br>Successful implementation of the nursing and midwifery strategy | March 2014.<br>Note: this will be part of a 3- 5 year organisational development strategy | Janine Brennan | At risk of delivery. Full details within workforce reports to Board and IHGC | Staff advocacy rate show a statistically significant improvement from 3.37 to 3.53. Staff turnover rates were 11.80% overall but excluding the community beds turnover was 8.84%. Sickness absence reduced from 4.44% in 2012/13 to 4.24% in 2013/14. It was agreed not to implement the behavioural framework but to adopt a new set of values. These were adopted, communicated & integrated with the new appraisal system. Mandatory training compliance rose from |
| **7** | To develop and implement an integrated management and leadership development strategy | Improved Management & and leadership effectiveness, | Improvements in management effectiveness indicator ratings in the annual staff survey, for example staff reporting good communication between senior management and staff increasing from 20% to 30% | March 2014.<br>Note: this will be part of a 3- 5 year organisational development strategy | Janine Brennan | Staff survey results not available until February 2014. Organisation Development strategy being developed. | Support from immediate line manager increased from 23% to 28%. Communication with senior managers increased from 21% to 24% |
| **Strategic Aim 5: To be a financially viable organisation** | | | | | | | |
| **8** | To develop an integrated Business Plan that meets operational and financial targets in the short and medium term | Deliver the Income and Expenditure, Capital Resource Limit and External Finance Limit targets<br><br>Deliver the Transformation programme<br><br>Deliver and implement the financial governance review<br><br>To deliver against the Tripartite Formal Agreement, ensuring NGH becomes a Foundation Trust either in its current or alternative form<br><br>Agreed Long Term Financial Model (LTFM) | Financial targets met<br><br>Board approved Long Term Financial Model in place and endorsed by the Board<br>Milestones achieved | Mar-14 | Andrew Foster | Forecast deficit in line with plan. Increased gap in-year transformation delivery. Scrutiny at Finance Committee. | All statutory financial duties met. Transformation programme partially achieved. No progress made towards financial elements of Foundation Trust application at this time. |

Northampton General Hospital NHS
NHS Trust

**REPORT TO: TRUST BOARD**
**29 May 2014**

| | |
|---|---|
| **Title** | TDA Self-Certification |
| **Agenda item** | 22 |
| **Sponsoring Director** | Karen Spellman, Deputy Director of Strategy and Partnerships |
| **Author(s)** | Craig Sharples, Head of Corporate Affairs |
| **Purpose** | Decision |

**Executive summary**

At the beginning of April 2013, the NHS Trust Development Authority (TDA) published a single set of systems, policies and processes governing all aspects of its interactions with NHS trusts in the form of 'Delivering High Quality Care for Patients: The Accountability Framework for NHS Trust Boards'.

In accordance with the Accountability Framework, the Trust is required to complete two self-certifications in relation to the Foundation Trust application process. Draft copies of these are attached as Appendix A and B 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)<br><br>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 Board**

The Board is asked to approve the Monitor Licensing Requirements and Trust Board Statements self-certifications for April 2014 (attached as Appendix A and Appendix B)

# 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 S

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:

Enclosure S

# 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 S

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:

Enclosure S

**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:

Enclosure S

**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 S

**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 S

Northampton General Hospital NHS
NHS Trust

**AGENDA**

# TRUST BOARD MEETING HELD IN PUBLIC

**Thursday 29 May 2014**
**09:30, Boardroom, NGH**

| Time | | | Action | Lead | Enclosure |
|---|---|---|---|---|---|
| **09.30** | **INTRODUCTORY ITEMS** | | | | |
| | **1.** | Introduction and Apologies | Note | Mr P Farenden | **Verbal** |
| | **2.** | Declarations of Interest in the Proceedings | Note | Mr P Farenden | **Verbal** |
| | **3.** | Minutes of the 24 April 2014 Board meeting | Decision | Mr P Farenden | **A.** |
| | **4.** | Matters arising from the 24 April 2014 | Note | Mr P Farenden | **B.** |
| | **5.** | Patient Story | Receive | Dr M Wilkinson | **Verbal** |
| | **6.** | Chief Executive's Report | Note | Mr C Abolins | **C.** |
| **09.50** | **CLINICAL QUALITY AND SAFETY** | | | | |
| | **7.** | CQC Action Plan | Assurance | Mr C Abolins | **D.** |
| | **8.** | Medical Director's Quality Report | Assurance | Dr M Wilkinson | **E.** |
| | **9.** | Hard Truth Commitments regarding the Publishing of Staffing Data | Assurance | Mrs J Bradley | **F.** |
| | **10.** | Patient Experience Report | Assurance | Mrs J Bradley | **G.** |
| | **11.** | Infection prevention Performance Report | Assurance | Mrs J Bradley | **H.** |
| | **12.** | Same Sex Accommodation Audit and Update | Assurance | Mrs R Brown | **I.** |
| **10.20** | **OPERATIONAL ASSURANCE** | | | | |
| | **13.** | Operational Performance Report | Assurance | Mrs R Brown | **J.** |
| | **14.** | Urgent Care Report | Assurance | Mrs R Brown | **K.** |
| | **15.** | Finance Report | Assurance | Mr S Lazarus | **L.** |
| | **16.** | Workforce Report | Assurance | Mrs J Brennan | **M.** |
| | **17.** | Improving Quality and Efficiency Report | Assurance | Mrs J Brennan | **N.** |
| **11.30** | **GOVERNANCE** | | | | |
| | **18.** | Approval of the 2013/14 Annual Report and Accounts and Quality Account | Decision | Mr S Lazarus | **O.** |
| | **19.** | TDA Accountability Framework | Assurance | Mrs K Spellman | **P.** |
| | **20.** | Developing a 5-Year Plan | Assurance | Mrs K Spellman | **Q.** |

| Time | | | Action | Lead | Enclosure |
|---|---|---|---|---|---|
| | **21.** | Corporate Objectives – 2013/14 Report | Assurance | Mrs K Spellman | **R.** |
| | **22.** | TDA Self-Certification | Decision | Mrs K Spellman | **S.** |
| **12.00** | **23.** | **ANY OTHER BUSINESS** | | Mr P Farenden | **Verbal** |
| | **24.** | **DATE OF NEXT MEETING**<br>26 June 2014, 09:30 Boardroom, NGH | Note | Mr P Farenden | **Verbal** |

**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).