UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Public Trust Board

Thursday 26 March 2020

09:30

Via Teleconference
Northampton General Hospital

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

A G E N D A

NHS
Northampton General Hospital
NHS Trust

PUBLIC TRUST BOARD

Thursday 26 March 2020
09:30 in the via Video-Conference at Northampton General Hospital

Time	Agenda Item		Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr A Burns	**Verbal**
	2.	Declarations of Interest	Note	Mr A Burns	**Verbal**
	3.	Minutes of meeting 20 January 2020	Decision	Mr A Burns	**A.**
	4.	Matters Arising and Action Log	Note	Mr A Burns	**B.**
	5.	Chairman's Report	Receive	Mr A Burns	**Verbal**
	6.	Chief Executive's Report	Receive	Dr S Swart	**C.**
PERFORMANCE					
	7.	Integrated Performance Report	Assurance	Dr S Swart	**D.**
	8.	Emergency Preparedness Annual Report inc Winter Plan	Information	Mrs D Needham	**E.**
	9.	Covid-19 update	Assurance	Dr S Swart Mrs D Needham	**To follow**
CULTURE					
	10.	Staff Survey Results	Assurance	Mr M Smith	**F.**
STRATEGY					
	11.	NGH Improvement Plan	Assurance	Ms C Campbell	**G.**
	12.	Capital Plan	Assurance	Mr P Bradley	**Verbal.**
ANY OTHER BUSINESS				Mr A Burns	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held at 09:30 on 28 May 2020 in the Board Room at Northampton General Hospital.

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

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

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
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Minutes of the Public Trust Board

Thursday 30th January 2020
09:30 in the Board Room at Northampton General Hospital

Present		
	Mr A Burns	Chairman (Chair)
	Dr S Swart	Chief Executive Officer
	Mrs D Needham	Chief Operating Officer and Deputy CEO
	Mr M Metcalfe	Medical Director
	Ms S Oke	Director of Nursing, Midwifery and Patient Services
	Mr P Bradley	Director of Finance
	Ms J Houghton	Non-Executive Director
	Mr J Archard-Jones	Non-Executive Director
	Ms A Gill	Non-Executive Director
	Mr D Moore	Non-Executive Director
	Prof T Robinson	Non-Executive Director
	Ms R Parker	Non-Executive Director
	Dr E Heap	Associate Non-Executive Director
	Mr T Richard-Noel	Next NED Scheme
In Attendance		
	Mr C Pallot	Director of Strategy and Partnerships
	Ms C Campbell	Director of Corporate Development Governance and Assurance
	Mr S Finn	Director of Facilities and Capital Development
	Mrs B Curtis	Director of HR
	Mrs S Watts	Associate Director of Communications
	Mr A Evans	Agenda Item – Patient Story only
	Mrs A Pardoe	Executive PA to the CEO, Chair and Director of Finance
Apologies		
	Mr M Smith	Chief People Officer

TB 19/20 91 Introductions and Apologies

Mr Burns welcomed those present to the meeting of the Public Trust Board.

Apologies were noted from Mr Smith.

Mr Burns advised we have a new Non-Executive Director in post and asked Ms Parker to introduce herself.

Ms Parker advised she has lived in Moulton for 15 years and has two children. Her background is corporate estates but she is currently working for the DWP in Estates.

Mr Burns also advised Ms Kirkham was in attendance as an observer and will be taking up post as an Associate Non-Executive Director from 1st February 2020.

TB 19/20 92 Declarations of Interest

No new Declarations of Interest were noted.

TB 19/20 93 **Minutes of the Public Trust Board held on 28th November 2019**

The minutes of the Public Trust Board held on 28th November 2019 were presented and **APPROVED** as a true and accurate recording of proceedings with the addition that Mr Richard-Noel be noted as present at the meeting.

TB 19/20 94 **Matters Arising and Action Log Public Trust Board**

The Matters Arising and Action Log were considered and noted.

Ms Campbell advised all actions are now completed and included in the relevant reports.

The Board **NOTED** the Matters Arising and Action Log.

TB 19/20 95 **Patient Story**

Ms Oke introduced Mr Evans who delivered his patient story.

Mr Evans was originally referred to NGH in 2009 with severe back pain, after some discussions with surgery as to whether the issue originated in his back or his legs, he was given a hip replacement following which he was given some physiotherapy but the pain continued. It was then determined the issue was in his back and he was scheduled for a discectomy but sadly he suffered a heart attack before the surgery date which inevitably delayed the surgery.

By the end of 2011 Mr Evans was still in pain despite surgery and more physiotherapy and he was told the position may never improve which he accepted but this was in fact incorrect. There followed a series of visits to other hospitals and a course of pain management and a number of expensive purchases to improve his quality of life whilst coping with severe daily pain.

Mr Evans advised one day he was watching the television programme Supervet and a story about a rabbit with a loose hip joint made him wonder if his problem was similar to this and went back to his GP with this in mind. The GP referred him to Three Shires and the same surgeon who agreed and hip revision surgery was arranged and planned for October 2018; unfortunately this date was postponed as were eight further dates, the last of which was the beginning of January 2020. Mr Evans stressed that he understood the reasons for cancellations and that he is a great admirer of NGH.

Mr Evans talked about some of the knock on effects of surgery being cancelled several times including a reduced range of activities that he can do, not able to enjoy holidays, not being able to play with his grandson properly, his wife having to take time off work every time surgery is scheduled and the costs associated with numerous cancellations.

Mr Burns thanked Mr Evans for sharing his story. Ms Oke commented it was helpful to put a human face to these issues which can easily be seen as numbers. Dr Swart commented Mr Evans first came to see her in October 2019 and thanked him for his patience and good humour. Mr Evans stressed again he understands NGH are taking extra care due to his heart problems and this is commendable. Ms Houghton thanked Mr Evans and asked if he had been given a new date to which he said no. It was asked if there was any learning to be gained from this, Mr Evans commented that Mr Old has advised he has changes his procedures as a result; Mr Metcalfe agreed with Mr Evans and advised any learning should sit with the GP and apologised for the cancellations and their impact. Ms Needham also apologised and advised the ward is still full of emergency patients and we are trying to get it back to being an orthopaedic ward by the end of march and Mr Evans should get a date then. Mr Evans accepted the apologies and Mr Burns advised he is reasonably

confident we will be able to provide a date and offered his apologies also.

TB19/20 96 Chair's Report

Mr Burns began by thanking Dr Swart for the work done on announcing the plans for the group model and for including thanks to the staff for their hard work during a difficult time. Mr Burns felt the meetings had gone well and positive reactions have been received from partners.

Mr Burns asked if a message could be sent to all EU staff in the Trust on 31st January (Brexit day) to reassure them and let them know how welcome and valued they are. This was **AGREED** and Mrs Watts will draft something for Mr Burns' and Dr Swart's approval.

ACTION: Mrs Watts

The Board **NOTED** the Chair's Report.

TB 19/20 097 Chief Executive's Report

Dr Swart presented her report and began by commenting the Trust has been dominated by emergency pressures over the last few weeks and this pressure has a big impact on staff especially when having to work in ways we would prefer not – largely staff are not comfortable with boarding but they are working with it as best they can. Dr Swart noted that patients are still thanking us for the care we provide – as noted by the patient story; however staff feel that service to patients is not as good as we would want to be and working better with the system and our partners should help with this.

There is a lot of work to do with system working alongside the day job and pressure on NHS staff has never been higher which is why she thanked staff during the group model announcement and why there is a need to think about how to motivate staff during difficult times especially as the underlying fact remains that a better offer of care is better for staff and patients. There are plans to improve matters soon but at the moment staff are very stretched. Any Government announcements won't solve everything but we remain hopeful and will make the best of things. Mr Burns also added his thanks to staff.

Mr Moore asked if we were beginning to see the system coming together yet and if there were any extra community beds. Dr Swart explained the first component was a realistic view of the capacity needed in acute hospitals and this is now becoming a national issue. The second component is to take this to the wider health economy – it is not just beds but staff and beds at the right levels to support the right patients and this is being prioritised by the system. Mr Burns added his perspective is that this is starting with discussions about priorities and that recent appointments across the system have been helpful, there have been reasonable conversations about going forward and all sides are working to do better.

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

TB 19/20 098 Integrated Performance Report

Dr Swart introduced the integrated performance report and advised it would be taken as read but asked the Board to consider is it telling us something useful, does it provide a basis for debate, are there items missing and does it include anything we don't need.

Ms Oke highlighted the improvements made for inpatient day cases in the Friends and Family Test, some increases have been seen and the report highlights the actions being taken to ensure we continue to improve.

Ms Needham picked up on the national targets and advised December and January were very challenging in Urgent Care and NGH was no exception to this. Activity remained stable but there were definite peaks in demand in emergency care. Flu cases increased and peaked at 25. Ms Needham summarised that acuity was very high in December and we saw high occupancy in critical care. Ms Needham drew attention to page 37 which showed a significant increase in ambulance handover waits, especially those over 60 minutes. A&E put new actions in place in January which have made a huge improvement and since 11th January 2020 only 2 patients have waited more than 60 minutes which was due to exit blocks from A&E.

Ms Needham advised that in terms of transformation we are focusing on three areas – board rounds, medical rotas and improving complex discharges.

Ms Needham advised cancer 62 day rates went down in November specifically in 5 areas: Head and Neck, Upper GI, Colorectal, Lung and Haematology. There is now new support in place for each pathway with new project managers, so they are not solely reviewed by Ms Needham twice a week, better divisional involvement and more holding to account by Divisions.

Dr Swart commented flu preparations could be used as preparation for Coronavirus as well – there have been no reported cases in the UK yet but use of screening, isolation and tabletop exercises are planned as it could have a big impact and we will need to be prepared.

Ms Houghton asked about the twelve patients who waited over 104 days for treatment and if there were any themes. Ms Needham confirmed all patients over 104 days have an RCA which is presented to the cancer Board which is clinically led and any harm/potential harm is discussed at the point. Mr Metcalfe added there is a monthly review of 104 days+ patients (this is a national measure) with joint scrutiny between the Trust and commissioners and no harm has been identified. Mr Metcalfe explained that some cases will inevitably breach due to uncertain diagnosis (Lung) where the clock keeps ticking even though only 4% cases are cancerous or due to Nene CCG's different interpretation over the rules for watchful waiting (Prostate) which other CGS define as the first treatment so all those cases will breach but remain clinically acceptable. Mr Archard-Jones advised some cancer pathways are outdated and asked if clinicians had accepted the need for change, Ms Needham advised this is difficult to answer as it is an ongoing process and it is hoped the new process will improve matters. Mr Metcalfe advised steps are being taken with those clinicians who are not engaged. Ms Gill asked, as we had been making progress what is the reason for the dip and Ms Needham advised it is largely due to urgent care pressures with meetings being cancelled due to patient safety and the focus not being on cancer as much as it should be. Ms Gill asked how will this be managed if it continues and Ms Needham advised the pressures are continuing but are not as high, PTL meetings are back in place with new action plans and Ms Needham will ensure these are prioritised.

Mr Burns commented the graphs don't tell a good story but we broadly accept the argument; however the SPC shows it has been a long time since we were in green and this is a different problem that needs a different solution. Mr Burns thinks we should challenge the CCG over watchful waiting, Mr Metcalfe advised this has been done and Mr Burns commented more push is needed.

Mr Bradley commented he would discuss year to date and cover year end at a later point in the meeting. In Month 9 we are £1.3m overspent and this is mostly pay from covering vacancies and escalation areas. We are £4.8m away

from plan and have lost £5m of sustainability funding so £9.8m overall. Mr Bradley advised pay costs are one third medical and two thirds nursing; a major cause of this is short notice agency use which incurs high rates and pay premiums. Non pay is also overspent which is unusual but there have been excess costs around drugs, lab costs and blood products which match with the additional pressures we have seen. Mr Bradley commented we are not where we want to be but we can clearly see why.

Ms Curtis commented the high costs are indicative of the pressures and advised HR are doing as much as they can to reduce vacancies and are putting support mechanisms in place however this doesn't get away from the cause which all relates to the pressures and significant demand on staff. Ms Houghton commented it is worth celebrating that we managed to recruit so many overseas nurses. Mr Moore commented the flu jab rates are also a cause for celebration in that we are third highest in the county, Dr Swart advised we are highest in the Midlands and East. Mrs Watts also advised sickness figures in relation to mental health have fallen. Mr Burns advised the best to solve the agency staffing issue is to have more permanent staff, Ms Oke advised 168 offers have been made to registered nurses against 109 registered nurse vacancies and with a 20% to 30% attrition rate Ms Oke is reasonably confident we will have no nurse vacancies this time next year and Ms Gill commented these are excellent numbers.

Mr Metcalfe raised medical vacancy rates and does not wish to provide undue assurance as the medical establishment rate has not been reviewed in terms of demand for a couple of years but work on this has now been commissioned.

Mr Metcalfe also commented he is very proud of how staff have responded to the pressures and acknowledged there was some relaxation of housekeeping in terms of training and renewal of policies to accommodate this and do what we can to mitigate the impact.

Professor Robinson asked for an update on the VTE EPMA issues. Mr Metcalfe advised the recent EPMA update had three purposes, to enforce VTE assessment, increase functionality and support for prescribing and increase speed. The first two have been met but the speed of the upgrade has been very variable and clinically unsustainable so Ms Needham and Mr Metcalfe took the decision to use our Business Continuity Plan, namely paper prescribing until we are fully assured the update is safe, there are regular silver meetings in place chaired by Ms Needham supported by Mr Metcalfe and Ms Oke while the issues are fixed. The next meeting is today so we are not currently in a position to provide detailed assurance on when EPMA can be switched on as we do not want to cause additional disruption if it is not properly fixed. Dr Heap asked about VTE assessment rates and Mr Metcalfe advised these go to QGC and he will share these outside the meeting however there is no trend in assessment increasing events. Ms Gill asked how are we assuring VTE assessments are still being done and Mr Metcalfe advised VitalPac should be used but acknowledged measuring this for January will be tricky.

Ms Houghton commented it is good to see an improvement in job plans and interesting to note the status in HSMR and improvements in other areas. Mr Burns advised he would like a reminder of HSMR shimmies to be added to a future meeting.

ACTION: Mr Metcalfe/Ms Campbell

Mr Archard-Jones asked what other EPMA users are doing for VTE assessments and Mr Metcalfe commented different providers of electronic prescribing have built it in and we are working with the suppliers on this, we are

aware of one other trust with this issue and we are in contact them to understand the impact. Dr Swart advised there would be a full report on the EPMA issues at future meeting due to its importance.

The Board **NOTED** the Performance Report.

TB 19/20 099 End of Year financial position

Mr Bradley presented the End of Year financial position report.

Mr Bradley advised that due to the figures our ability to get back on plan is very unlikely. We can only re-forecast at quarterly points but this has been in discussion for a number of months and we are not alone in doing this now.

The year-end position is being agreed with the CCG and we are working with Divisions to forecast. The deficit has been fixed at £8.5m and we must stick to this, the divisions need to work on it and will be held to account with monthly updates to FPC; this work has involved the STP and the final step was to discuss with the regional team via a phone call with Mark Mansfield where questions were asked and as we have information to hand they were assured we have done everything we can to mitigate; the key point being that not only did we understand the drivers, they have been well understood by the board and we were able to evidence that as a result Mark Mansfield was amenable to us submitting this and the board assurance statement has been submitted. As a consequence of this we need to request extra money from the centre - £19.5m cover the deficit and non-recurrent loss of PSF/RFR funding and Mr Bradley asked for board approval of this. We must not normalise overspending and have to evidence sound clinical grounds. Mr Moore advised it is worth noting we are losing £35m and ask about how this will go forward. Mr Burns asked for the statement to be approved and acknowledged there is work to do and it will be difficult to maintain the £8.5m.

The Board AGREED the statement.

Mr Bradley commented due to previous revenue support loans there is a deficit of £104m on our balance sheet which costs £2m per year in interest; we believe this will be written off but details are not known. This could save £8m but we need more detail. Mr Burns advised the detail should be known next week.

The Board **NOTED** the end of year financial position.

TB 19/20 100 Agency Staff Governance

Ms Curtis presented the Agency Staff Governance report and advised it covers three aspects: the appropriate governance processes for appointing from agencies, are we getting the best rates, and how are we managing it.

Ms Curtis confirmed at present we are not getting the best rates but this is being worked on. Ms Curtis also confirmed we are also not doing enough to ensure all agency appointed staff are still needed but again this is being worked on. The process is there is an agency meeting every fortnight with very senior members of staff, we are beginning to review pay rates and how we can reduce them. Each Division is asked to talk through their most significant and longest standing agency staff to explain if any why they are still needed. Ms Curtis advised we know there will be cases where there is no alternative but to use agency staff but we need to be aware of these.

HCAs are also being looked at as this was an area of concern and a challenge has been agreed with Ms Oke to eliminate HCA agency use by the end of

March 2020. We are also working to confirm the medical establishment but this is not an easy task. Ms Houghton asked if we are working with KGH on this and Ms Curtis confirmed we are and an external review of the additional costs of the medical workforce has also been commissioned, Mr Metcalfe commented there is no medical equivalence to the nursing staffing guidelines. It was felt that given the premium spends we have on medics this review should be very cost effective and Mr Burns commented it is important to get this right going forward for next year.

Professor Robinson asked whose responsibility is it for determining hours of work given what we see in terms of sickness – does it fall to the trust or individuals and Ms Gill commented there is a regular report to Workforce on safe working hours. Dr Swart added this is very difficult as staff can have substantive posts here and bank at other trusts so it is largely individual responsibility but this does need more monitoring. Ms Oke commented we can't manage this when staff also work in other trusts but can cap permitted hours working in this trust. Mr Richard-Noel asked how well we utilise our bank staff, if we can make any improvement to this and how we benchmark agency spend and Mr Bradley advised this is contained within Model Hospital, Ms Curtis advised she will report back to Workforce on this and in terms of control Ms Curtis acknowledged we have more to do in terms of pushing bank over agency and we need to be more pro-active on this and not make agency the better option.

Ms Gill asked about 12 hour shifts and collaboration work and whether it has any impact and it was confirmed this will be piloted.

Ms Houghton commented that self-certification is the only way to address moonlighting and asked if we ensure agency staff are not working alone in any area. Ms Oke confirmed we will never have agency staff only in any one area and robust local induction processes are in place.

Mr Burns asked for an update at a future Board.

ACTION: Ms Oke/Ms Curtis

The Board **NOTED** the Agency Staff Governance Paper.

TB 19/20 101 Board Assurance Framework Q3

Ms Campbell presented the Board Assurance Framework (BAF) for Quarter 3 and advised all risks have been taken through individual committees and discussed fully. Some changes have been made to dates. All corporate risks have been reviewed and updated.

Ms Campbell advised that Risk 1.3 in section 4 has been reduced to 8 due to the year-end agreement with the CCG. Risks 5.1 and 5.2 have increased to 25 for well documented reasons.

Ms Campbell advised the next version will include pledges and links to CQC.

Ms Houghton asked about safeguarding risk and avoidable harm and Ms Campbell advised it has its own risk on the corporate register but the full version is strategic only.

The Board **NOTED** the Board Assurance Framework Q3

TB 19/20 102 EU Exit Operational Readiness

Ms Needham apologised for the wrong paper being circulated.

Ms Needham advised Professor Keith Willett had advised all NHS Trusts to cease all no-deal planning. The UK will formally leave the EU at 11pm on Friday 31st January 2020 and no further details have yet emerged with regards to delivery aspects after 31st January and the implementation period which could be up to the end of 2022.

Internally we were well prepared and whilst we have stepped down planning that can be re-instated at any point using our Trust wide Business Continuity Plans

The Board **NOTED** the EU Exit Operational Readiness report

TB 19/20 103 Standing Orders/SFI and Scheme of Delegation

Mr Archard-Jones advised there is nothing that covers the appointment of group directors and should something be added. Ms Campbell advised that at present we only have joint committees but if this is needed we will think about it and it should be reasonably straightforward. Mr Bradley added joint directors are covered under 118 but not the appointment process. Subject to board approval role specific training will be instigated for managing a group model.

The Board **APPROVED** this report

TB 19/20 104 Maternity Review

Ms Oke presented the report.

Ms Oke advised following the incidents at Shrewsbury and Telford, East Kent and Morecambe Bay Mr Burns had asked how do we know that we are not in the same position and there was a long discussion on this at the December meeting; the report has since been updated and a Board to Ward visit to Maternity is planned for today.

Ms Oke commented that following concerns at Morecambe Bay in 2015 a report was developed which included 44 written recommendations; this was used to form the basis for an NGH Action Plan and as a result of more recent concerns at Shrewsbury and Telford and East Kent Ms Oke committed to reviewing all of these actions to ensure we were still compliant and any concerns are addressed as appropriate. The second review will be completed by 14th February and will come back to the board in due course. The Shrewsbury and Telford report has not been published yet but some details have been leaked.

It was commented that in terms of CNST we need to ensure all mitigation is put in place but it was stressed there are no major concerns. There was a question about maintaining the midwife to birth ratio and Ms Oke advised this was dependant on business case approval but there is mitigation in place daily to ensure staff staffing due to demand; in terms of out of hours staffing we are looking to increase SHO numbers to reduce workload and a business case is in process for this. There was a question about the Saving Babies Lives recommendation to develop a triage area and Ms Oke advised there is an options review ongoing as to where this would be best placed. Ms Oke advised we have been achieving Saving Babies Lives for three years consecutively and in terms of modernising Maternity we are looking to reconfigure the labour wards and review staffing in this area.

Ms Oke was pleased to report from the national maternity survey for 2019 (which was embargoed to 28th January) we have received positive feedback and are better than the national average in 3 areas. We remain average in the

other areas and there are no areas where we are lower than average. Ms Oke is waiting for more granular detail but this is very positive. Ms Oke also commented that the recent Pascal survey has resulted in a number of projects which should help staff. The Values in Practice work is also going well.

Dr Swart commented that safety was covered in the last report and the cultural work is the next step and will need to be strongly supported by the executive team. Ms Needham commented that the Ockenden review recommends an MDT meeting and asked who is leading this and if the operational team could be included which Ms Oke agreed to.

Ms Houghton commented there was a discussion at QGC about Saving Babies Lives where the progress to date had been agreed but there was a question regarding the shortage of scan availability within 72 hours and this has not been mentioned in terms of business plans, Ms Oke advised there would be an update on this after the Board meeting in time for the next QGC. Mr Pallot asked about business cases, are these the only ones or can we change elements of practice as well. Ms Oke confirmed we need to improve the continuity of care which has a lot of external scrutiny and there are aspects of practice we can improve as well.

Ms Needham commented the East Kent report implied money was more important that patient safety, Ms Campbell assure that draft documents have been scrutinised by Governance are all fully evidenced. Mr Bradley advised more money has been spent than was needed for Patient Safety. Ms Houghton remarked the report needs to be signed off externally and engagement with the regional midwife is in place. Ms Gill questioned the dates for actions as these seem quite far out and asked what we are doing now. Ms Oke advised there will be a more detailed report on staff shortly. Mr Metcalfe advised there has been a significant investment to improve safety including three new substantive consultants. Ms Oke also confirmed we are fully engaged with the HCIP independent review of peri-natal harm. Ms Oke commented that many trusts only have maternity governance from within governance but we have been very careful to ensure maternity feeds into oversight from ROHG etc and the results of peri-natal audit are relatively assuring.

Mr Archard-Jones asked why it was taking nine months to implement triage and Mr Finn agreed to review to see if this work could be brought forward but it was stressed that the business case has not been approved yet.

The Board **NOTED** the Maternity Report

TB 19/20 105 NGH Improvement Plan

Ms Campbell presented the improvement plan and advised all actions associated with improvement notices have been completed and we are now working on the should dos.

Ms Campbell advised good progress has been made and commented that in 2.4 a change has been made to the actions as the timelines were not feasible and this was appropriate. In 2.5 the evidence has been provided and this is now complete.

Ms Campbell advised the re-launch of LOCCSIPS is a good example as more detailed work is needed.

Ms Campbell advised our CQC relationship manager has been through the plan in great detail and is assured by what has been provided and the plan

comes to the Board for assurance.

There was a question about the paediatric ED and Mr Finn commented a paper was due to come to the executive team outlining two potential solutions to provide a small extensions but other areas would need to be re-homed. We also have an estimate on a completely new ED and Mr Finn will report back to the executive team next week. Dr Swart added that this had been raised in the House of Commons by Andrew Lewer MP and he is keen to see this delivered, there have been numerous discussions with him about this and it fits with the national directive about right sizing EDs.

The Board were **ASSURED** by the NGH Improvement Plan

TB 19/20 106 Freedom to Speak Up Strategy and Self-Assessment

Ms Campbell presented the Freedom to Speak up Strategy and Self-Assessment back to the board for approval. This was discussed by the board in November 2019 and in workforce committee this month.

Ms Gill commented she had gone through the strategy with Ms Campbell and they had gone through the timeliness of the responses. There have been 26 cases in the last quarter which is encouraging. There is a need to ensure we are capturing themes and feed them through to link with the work done by Ambassadors.

Ms Campbell advised the strategy is now in place and will be tracked regularly. Dr Swart commented there has been a succession of Freedom to Speak Up cases in one particular area which are now going through the normal route which is encouraging to see that people now have the confidence to do this.

The Board **APPROVED** the Freedom to Speak Up Strategy and Self-Assessment

TB 19/20 107 Any Other Business

There were no items of any other business

TB 19/20 108 Resolution

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

The Board **ADOPTED** this resolution.

Date of next meeting: Public Trust Board - Thursday 26 March 2020 at 09:30 in the Board Room at Northampton General Hospital.

Public Trust Board Action Log **Last update** **10/03/2020**

Item No	Month of meeting	Minute Number	Paper	Action Required	Responsible	Due date	Status	Updates
Actions - Slippage								
Actions - Current meeting								
118	Jan-20	TB19/20 96	Chairs Report	Mr Burns asked if a message could be sent to all EU staff in the Trust on 31st January (Brexit day) to reassure them and let them know how welcome and valued they are. This was AGREED and Mrs Watts will draft something for Mr Burns' and Dr Swart's approval.	Mrs Watts	Jan-20	On Agenda	**confirmation given that this was actioned**
119	Jan-20	TB 19/20 098	Integrated Performance Report	Ms Houghton commented it is good to see an improvement in job plans and interesting to note the status in HSMR and improvements in other areas. Mr Burns advised he would like a reminder of HSMR shimmies to be added to a future meeting.	Mr Metcalfe/Ms Campbell	Mar-20	On Agenda	**Update in Matters Arising**
Actions - Future meetings								
120	Jan-20	TB 19/20 100	Agency Staff Governance	Mr Burns asked for an update at a future Board.	Ms Oke/Ms Curtis	TBC	TBC	

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Report To	**Public Trust Board**
Date of Meeting	**26 March 2020**

Title of the Report	**Chief Executive's Report**
Agenda item	**6**
Presenter of Report	Dr S Swart, Chief Executive
Author(s) of Report	Dr S Swart – Chief Executive Mrs S-A Watts – Associate Director of Communications

This paper is for:	
✓ Note	✓ Assurance
For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

Executive summary
The report highlights key business and service issues for Northampton General Hospital NHS Trust in recent weeks.

Related Strategic Pledge	Which strategic pledge does this paper relate to? *ALL*
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks - No
Related Board Assurance Framework entries	BAF – please enter BAF number(s) ALL
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
Financial Implications	None
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper - No

Actions required by the Trust Board

The Board is asked to note the contents of report.

UNIVERSITY OF LEICESTER
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Public Trust Board
26 March 2020

Chief Executive's Report

1. COVID-19 (coronavirus) preparedness

Like other NHS organisations, we have been preparing for the impact of COVID-19 (coronavirus). We initially set up one NHS 111 pod opposite our emergency department in line with national guidelines and within 7 days installed a second pod so that anyone attending the hospital with symptoms could be kept isolated from other patients. Both pods have instructions for people on how to contact NHS 111 for further advice and the action they should take.

We understand that there is concern among our patients, visitors and staff about COVID-19 and it is essential, therefore, that our communications are factually accurate and reassure everyone of our preparedness NHS England/Improvement has been working with social media platforms to combat fake news and improve access to 'verified information.' Our communications team had already ensured all our corporate social media accounts are verified so that people can be sure our accounts provide a trusted source of information.

We are using our website, social media, switchboard, text messaging and hybrid mail to communicate national guidance to our patients and local community.
It is important to remember that everyone can continue to play their part in preventing the spread of infection by taking simple steps such as thorough hand-washing. A local primary school has now produced its own version of our 'Gangnam-style' hand-washing video and we are challenging other local schools to do the same.

Twice daily communications to staff are now in place so that our workforce are feeling as informed as possible

In addition to our own daily meetings within NGH, we are now linked into high level system-wide, regional and national public sector meetings and briefings so that there can be a shared ownership of the key issues in order to ensure that more targeted and rapid actions are possible. For the NHS and for Northamptonshire this current crisis comes on the back of a long-standing difficulty in terms of urgent care capacity. There is now a real appetite to consider how we can do things differently for the greater good both in the short term in response to COVID-19 and leading into the future.

In all the discussions we are ensuring that decongestion of the acute hospitals in the county is at the top of the agenda. In addition, we are following all the latest guidance from Public Health England and involving our clinical teams in the critical planning discussions that are needed to expand our ability to treat seriously ill patients

We have set up a 7-day-a-week incident response team for COVID-19 and are following our own NGH major incident procedures in order to handle the various components of the pandemic as it develops. This is not something any of us have ever experienced. The level of anxiety is high but we have seen a fantastic energy and response from a range of staff across the hospital and empowering our teams to be as agile as possible with decisions. We are also sharing approaches with KGH and will be making sure we align our efforts in this regard, as we increasingly move into conversations with the wider system.

On behalf of the board, I would like to thank all the staff who have been involved to date in developing and implementing our plans. We have had some extremely impressive responses and ideas from a number of teams particularly in the arena of training staff in infection prevention and the use of personal protective equipment and simulating various scenarios. Our intensive care teams who already put in some extraordinary efforts to assist in our fire safety plans are enthusiastically pursuing and sharing their ideas around how best to plan for the need to support large numbers of seriously ill patients with ventilation support. This enthusiasm and willingness to work differently is extending throughout our clinical and managerial teams with a real willingness to go over and beyond to keep patients and colleagues as safe as we can

2. Fire Safety

In January we detected an increased fire risk in our critical care floor. Since that time our fire team, supported by the Fire Service, has worked exceptionally hard to support our clinical teams in fire drills and evacuation plans while our estates teams have pulled together to improve fire safety in as rapid a period as possible .

I have been really impressed by the engagement and involvement of our teams which has been amazing given the operational pressures that have continued during this period. Because of these efforts we now have much better plans in place, a safer top floor and are rapidly progressing plans for a new critical care unit as part of an emergency capital bid.

3. March 2020 Budget

The Budget included a significant package of measures designed to support those affected by COVID-10. The Chancellor also outlined a number of announcements which make good on commitments in the Conservative Party manifesto.

The most significant announcement for the NHS is the Chancellor's announcement of a rise to the annual allowance taper thresholds within the NHS pension. Although there is a restatement of the government's commitment to abolish car-parking charges, there is no mention of how the associated costs will be met. There was also an extra £1bn of capital funding announced for the NHS for this year, with further details to come in the comprehensive spending review later in the year.

4. Staff Survey

The results of the 2019 NHS national staff survey contained some disappointing results particularly relating to staff views about patient care, where we saw a drop in the number of staff who would recommend NGH as a place to receive care. Underpinning this were some specific questions which, for example, showed that staff felt less able to provide the care they aspire to, were less confident safety concerns would be addressed and less able to make improvements at work.

Board members will be aware of increased demand and rising emergency activity, which has undoubtedly had an impact. However, we are aware that there are some key issues which we need to address. A number of the areas of concern identified have already been the focus of specific work as outlined in our People Plan and work that was just beginning at the time the survey was actually done therefore continues.

A key area priority is to create a place to work that staff would recommend to others. Some important actions from this include the revised flexible working policy which is

now in its final stages, the talent management review which has led to trials of a number of new ways of supporting staff to achieve their potential and is now being rolled out and the disability and LGBTQ+ networks that have now been established. We are also determined to achieve improvements in staff recommendation as a place to receive care. The learning from our summer of engagement as well as further listening to staff will inform our efforts to ensure that we continue to keep quality and safety of care at the heart of our efforts and that staff feel empowered to play their part in quality improvement.

As part of our preparations for COVID-19 we have an opportunity to demonstrate how much we value our staff and it is critically important that we emphasise the importance of looking after each other in this most difficult of times. The response of staff so far has been extremely positive and there has been a real sense of collegiate spirit and people pulling together with a very high degree of engagement. Offers of help from the public and from local business have certainly been very well received and we are planning a range of benefits for our workforce as the situation develops.

5. Stakeholder Engagement

In early February I met with Andrew Lewer MP, when we discussed a number of challenges faced by NGH, including demand, capacity and ITU/HDU provision. I was able to show Andrew our existing ITU/HDU facilities and his visit ended with an overview of our ED, when he was able to see for himself the impact of rising demand.

We are planning further meetings with local MPs as part of working together in the context of responding to the challenge of COVID-19 as a united public sector.

Dr Sonia Swart
Chief Executive

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**26 March 2020**

Title of the Report	**Integrated Performance Report**
Agenda item	**7**
Presenter of Report	Dr Sonia Swart - CEO
Author(s) of Report	Mrs D Needham – COO/DCEO Mrs S Oke – Director of Nursing Mr M. Metcalfe – Medical Director Mr P. Bradley – Director of Finance Mr M. Smith – Chief People Officer Mr S. McGarvey – Head of information

This paper is for:

☐ Approve	☐ Receive	☐ Note	x Assurance
To formally receive and discuss a report and approve its recommendations OR a particular course of action	To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it	For the intelligence of the Board without the in-depth discussion as above	To assure the Board that controls and assurances are in place

Executive summary

The paper is presented to provide information and assurance to the board on the key national performance, quality, finance & workforce KPI's

The report now includes SPC charts where there is variation for each indicator.

Each director has the opportunity to comment the KPI's within the summary sections from page 8 onwards.

Related Strategic Pledge	Which strategic pledge does this paper relate to? *All*
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks Assurance only
Related Board Assurance Framework entries	BAF – please enter BAF number(s) All
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? **No** If yes please give details and describe the current or planned activities to address the impact.

	Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? **No** If yes please give details and describe the current or planned activities to address the impact.
Financial Implications	
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper? **No**

Actions required by the Board

The Board is asked to:

1. Note the report
2. Seek clarification on performance & actions being taken to gain assurance

Corporate Scorecard – Integrated performance report

Date: March 2020
Reporting Period: February 2020

Northampton General Hospital NHS
NHS Trust

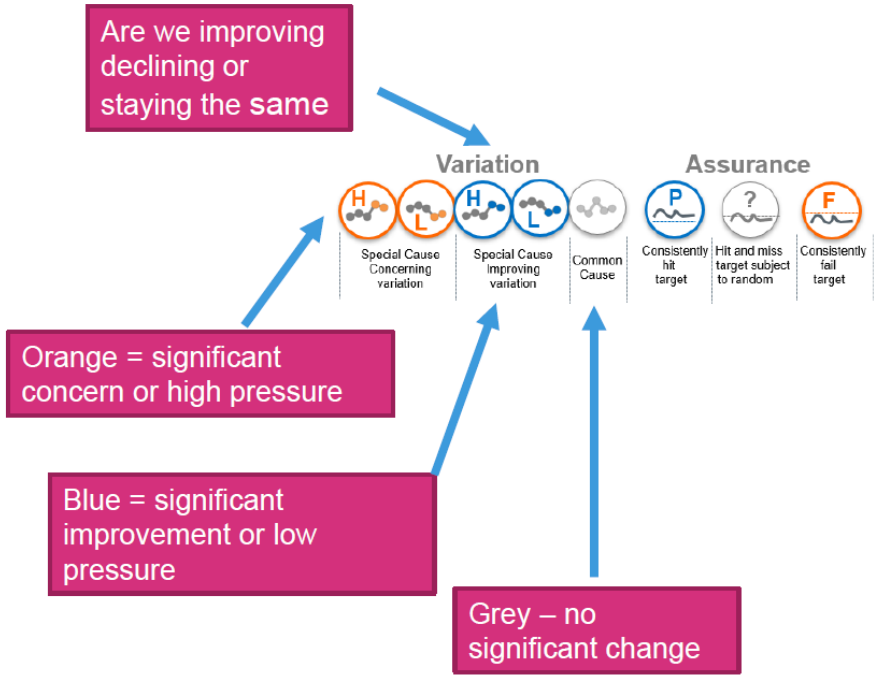
Pilot SPC Charts

Collaboration work with KGH and a wish to move to a common style of Board reporting was agreed by the Collaboration Steering Group in August 2019. Subsequently, an assessment of both Boards' report was completed, leading to eight metrics being agreed for both trusts to report on using SPC. The number of metrics moved to SPC will increase over the next few months, with the format of the Corporate Scorecard changing accordingly.

The reports that follow use the key below. A recap of using these descriptions is also included

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

High level key - variation



High level key - assurance

Domains: Caring, Effective & Safe

Domain	Metric	Target	Variation	Assurance	Chart
Caring	Complaints responded to within agreed timescales	90%			
Caring	Friends & Family Test % of patients who would recommend: A&E	86%		F	Page 8
Caring	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	96%		F	Page 9
Caring	Friends & Family Test % of patients who would recommend: Maternity - Birth	97%			
Caring	Friends & Family Test % of patients who would recommend: Outpatients	94%		F	Page 10
Caring	Mixed Sex Accommodation	0	L		

Caring Domain - Non-SPC Metrics

Section:	Indicator:	Target:	Jan-19	Feb-20	Chart
Caring	Compliments	N/A	4,059	3,278	

Domain	Metric	Target	Variation	Assurance	Chart
Effective	Length of stay - All	4.2			
Effective	Percentage of discharges before midday	25%	L	F	Page 12
Effective	# NoF - Fit patients operated on within 36 hours	80%			
Effective	Maternity: C Section Rates	29%			
Effective	Mortality: HSMR	106			
Effective	Mortality: SHMI	109	Outside Control Limits	P	Page 39
Effective	Stranded Patients (ave.) as % of bed base	40%		F	Page 13
Effective	Super Stranded Long Stay Patients (ave.) as % of bed base	25%			

Effective Domain - Non-SPC Metrics

Section:	Indicator:	Target:	Jan-20	Feb-20	Chart
Effective	Patient Ward Moves Overnight (22:00 - 06:59)	=0	466	384	
Effective	Readmissions within 30 days of previous reporting month	<=12%	13.6%	14.0%	
Effective	% Daycase Rate	>=80%	88%	87%	

Domain	Metric	Target	Variation	Assurance	Chart
Safe	HOHA and COHA (C-Diff > 2 Days)	3	H		
Safe	MSSA > 2 Days	1			
Safe	VTE Risk Assessment	95%	Outside Control Limits	F	Page 40
Safe	Transfers: Patients transferred out of hours (between 10pm and 7am)	60			
Safe	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	98%			

Safe Domain - Non-SPC Metrics

Section:	Indicator:	Target:	Jan-20	Feb-20	Chart
Safe	Never event incidence	0	0	0	
Safe	Number of Serious Incidents (SI's) declared during the period	N/A	1	0	
Safe	MRSA > 2 Days	0	0	0	
Safe	New Harms	<=2%	t	2.8%	
Safe	Appointed Fire Wardens	>=85%	97.8%	100.0%	
Safe	Fire Drill Compliance	>=85%	72.1%	92.0%	
Safe	Fire Evacuation Plan	>=85%	93.4%	100.0%	

Domains: Responsive

Domain	Metric	Target	Variation	Assurance	Chart
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	90%	Outside Control Limits	F	Page 14
Responsive	Average Ambulance handover times	00:15:00	H	F	Page 15
Responsive	Ambulance handovers that waited over 30 mins and less than 60 mins	25	Outside Control Limits	F	Page 16
Responsive	Ambulance handovers that waited over 60 mins	10		F	Page 17
Responsive	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons		L	F	Page 18
Responsive	Delayed transfer of care	23	H	F	Page 19
Responsive	Average Monthly DTOCs	23	H	F	Page 20
Responsive	Average Monthly Health DTOCs	7	H	F	Page 21
Responsive	Cancer: Percentage of patients treated within 31 days	96%		?	

Domain	Metric	Target	Variation	Assurance	Chart
Responsive	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	98%		?	
Responsive	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	94%		?	
Responsive	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	94%		?	
Responsive	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	85%		F	Page 22
Responsive	Cancer: Percentage of patients treated within 62 days of referral from screening	90%		?	
Responsive	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	85%		?	
Responsive	RTT over 52 weeks	0	L	?	
Responsive	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	99%		F	Page 23
Responsive	Stroke patients spending at least 90% of their time on the stroke unit	80%	L	F	Page 24
Responsive	Suspected stroke patients given a CT within 1 hour of arrival	50%		P	

Section:	Indicator:	Target:	Jan-19	Feb-20	Chart
Responsive	RTT Average wait incomplete pathways	<=10.9	9.3	N/A	
Responsive	Unappointed Follow Ups	=0	7095.0	6302.0	
Responsive	Cancer: Faster Diagnosis Standard	>=63%	0.6	N/A	

Domains: Well Led

Domain	Metric	Target	Variation	Assurance	Chart
Well Led	Income YTD (£000's)	0%	H	?	
Well Led	Surplus / Deficit YTD (£000's)	0%	Outside Control Limits	F	Page 26
Well Led	Pay YTD (£000's)	0%	Outside Control Limits	F	Page 27
Well Led	Non Pay YTD (£000's)	0%	Outside Control Limits	F	Page 28
Well Led	Bank & Agency / Pay %	7.5%	Outside Control Limits	F	Page 29
Well Led	CIP Performance YTD (£000's)	0%	Outside Control Limits	?	
Well Led	Sickness Rate	3.8%	H	F	Page 31

Domain	Metric	Target	Variation	Assurance	Chart
Well Led	Staff: Trust level vacancy rate - All	9%		F	Page 32
Well Led	Staff: Trust level vacancy rate - Medical Staff	9%	Outside Control Limits	?	Page 33
Well Led	Staff: Trust level vacancy rate - Registered Nursing Staff	9%		F	Page 34
Well Led	Staff: Trust level vacancy rate - Other Staff	9%	Outside Control Limits	F	Page 35
Well Led	Turnover Rate	10%	H	P	
Well Led	Percentage of all trust staff with mandatory training compliance	85%		P	
Well Led	Percentage of all trust staff with role specific training compliance	85%	Outside Control Limits	F	Page 36
Well Led	Percentage of staff with annual appraisal	85%	L	F	Page 37
Well Led	Job plans progressed to stage 2 sign-off	90%	H	F	Page 41

Section:	Indicator:	Target:	Jan-20	Feb-20	Chart
Well Led	CIP Performance - Recurrent	N/A	38.4%	0.0%	
Well Led	CIP Performance - Non Recurrent	N/A	57.9%	0.0%	
Well Led	Percentage of all trust staff with mandatory refresher fire training compliance	>=85%	82.2%	83.4%	

Directors view – Director of Nursing

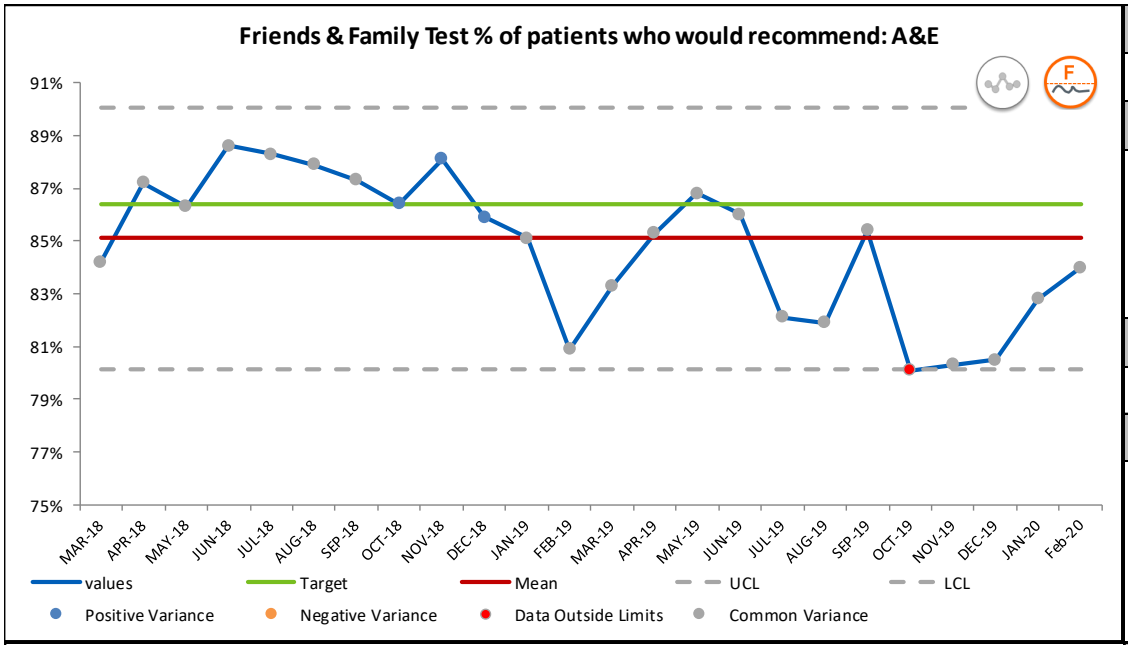
Performance

- Recommendation rates for A&E were 82.8% for February which was 3.6% below the national average.
- The result for Inpatient and Day Case continues to be within normal levels of variation. The Inpatient and Day Case result is 2.0% below the national average for February when compared with 2.7% for January.
- The result for Outpatients continues to be within normal levels of variation for February.

Action taken

- Continue with training and attendance at multidisciplinary meetings to raise awareness of patient experience.
- Medicine and Urgent care held a nursing council in January to identify projects which could be run across the division. This looked at best practice on wards which could be replicated. Projects identified included the use of Sound Ears within high traffic areas to try and reduce noise, reminder stickers used on Esther White to be rolled out in other departments around the explanation of medications, and a review on the placement of patients with dementia and delirium within wards as it is more unsettling for them when they are placed together.
- From the 1st April the FFT is changing. There will be new rebranded FFT postcards and new communications advertisement in the form of posters and banners. Alongside this, patients will be able to give feedback at any point in their journey instead of at the point of discharge. It is expected that this will improve response and recommendation rates.

SPC Charts – Friends & Family Test - % of patients who would recommend A&E



Feb-20
84%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
86%
Target Achievement
Metric is consistently failing the target

Context:

The recommendation rate for A&E (inc Springfield, ambulatory care and eye casualty) was 82.8% which was 3.6% below the national average figure of 86.4%. Recommendation rates have continued to show further signs of recovery with January demonstrating a 2.3% increase from December which was at 80.5% (5.9% below the national average).

Actions Completed:

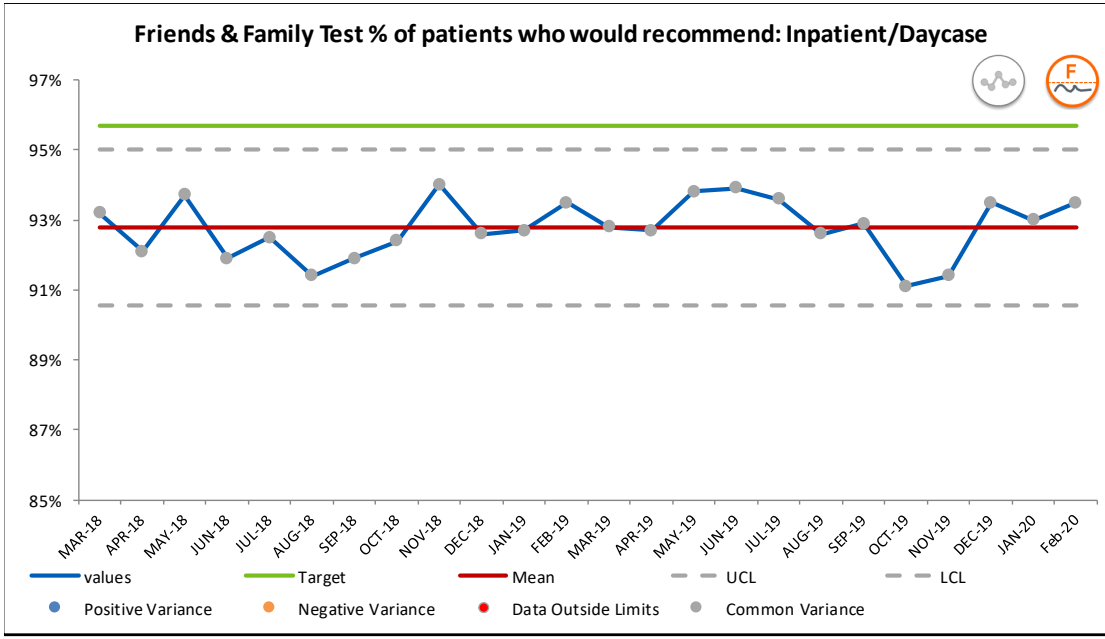
A&E continue with the initiative implemented at the beginning of the year to reduce waiting times for lower priority patients according the emergency needs.

Actions:

Action plans have been put in place in order to help with waiting times, tests and facilities.

- Continue with the Action plans put in place to help with waiting times, tests and facilities, waiting times and information.
- As of the 1st of April 2020, the FFT is changing.
- Bespoke cards for A&E will be available in the A&E Department and on the inpatient wards.
- This is likely to improve response and recommendation rates further.

SPC Charts – Friends & Family Test - % of patients who would recommend Inpatient & Daycase



Feb-20
93.5%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95.7%
Target Achievement
Metric is consistently failing the target

Context:

The result for Inpatient and Day Case continues to be within normal levels of variation. The Inpatient and Day Case result is 2.0% below the national average for February when compared with 2.7% for January. Results per ward continue to vary greatly.

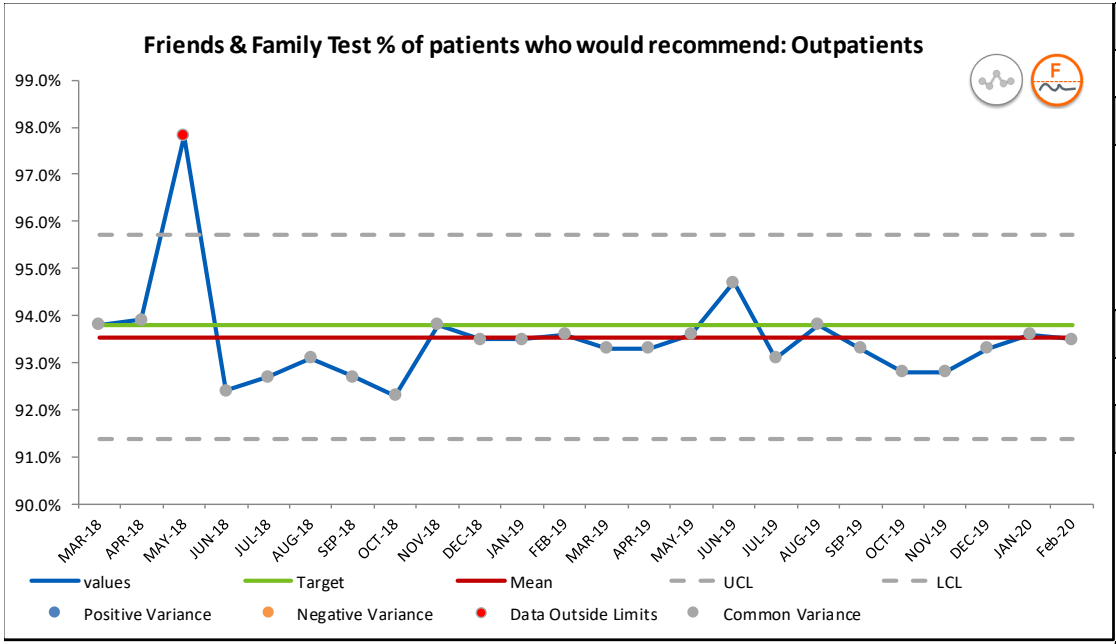
Actions Completed:

Bespoke surveys continue to be carried out which identify specific areas where further improvement is needed. The patient experience team continues to hold multidisciplinary meetings including Right Time forums, Councils and train within the nurse development programmes to raise awareness of patient experience and the common themes.

Actions:

- Continue with training and attendance at multidisciplinary meetings to raise awareness of patient experience.
- Medicine and Urgent care held a nursing council in January to identify projects which could be run across the division.
- This looked at best practice on wards which could be replicated.
- Projects identified included the use of Sound Ears within high traffic areas to try and reduce noise, reminder stickers used on Esther White to be rolled out in other departments around the explanation of medications, and a review on the placement of patients with dementia and delirium within wards as it is more unsettling for them when they are placed together.

SPC Charts – Friends & Family Test - % of patients who would recommend Outpatients



Feb-20
94%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
94%
Target Achievement
Metric is consistently failing the target

Context:

The result for Outpatients continues to be within normal levels of variation for February.

Actions Completed:

The Matron for Outpatients continues to challenge and encourage outpatient departments to give out FFT cards to patients.

Actions:

- From the 1st April the FFT is changing.
- There will be new rebranded FFT postcards and new communications advertisement in the form of posters and banners.
- Alongside this, patients will be able to give feedback at any point in their journey instead of at the point of discharge.
- It is expected that this will improve response and recommendation rates.

Directors view – Chief Operating Officer / DCEO

Performance - A&E 4hrs

- Performance Improved In February
- Emergency activity remained variable with peaks of activity during the evenings
- Numbers of stranded patients increased in month
- 60 minute handovers improved significantly in February
- Average ambulance handover times have increased slightly in month mainly due to the time required to hand over potentially infectious patients

Actions being taken
Winter plan remains in place
Routine elective work has significantly reduced
The transformation programme has now ceased due to the response required for Covid-19

Cancer waiting times

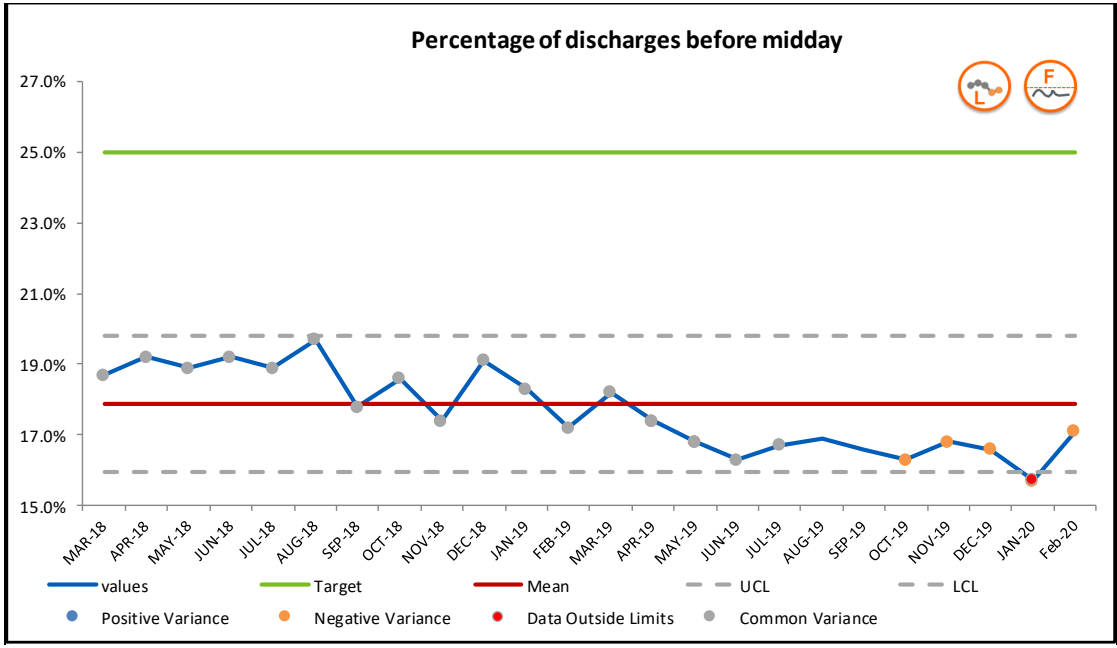
- 62 day performance decreased in month

Actions being taken:
2 x weekly PTL meetings in place, now via telecall
Support from NHS elect has been paused due to the response required for Covid-19

Diagnostics – 6 weeks

- Performance continues to improve

SPC Charts – Discharges by Midday



Feb-20
17%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance below the mean
Target
25%
Target Achievement
Metric is consistently failing the target

Actions:

- Currently exploring a TTO home delivery service with Pharmacy team
- Working on a 'dinner tray liner' that outlines expectations of patients and families around discharge and transport

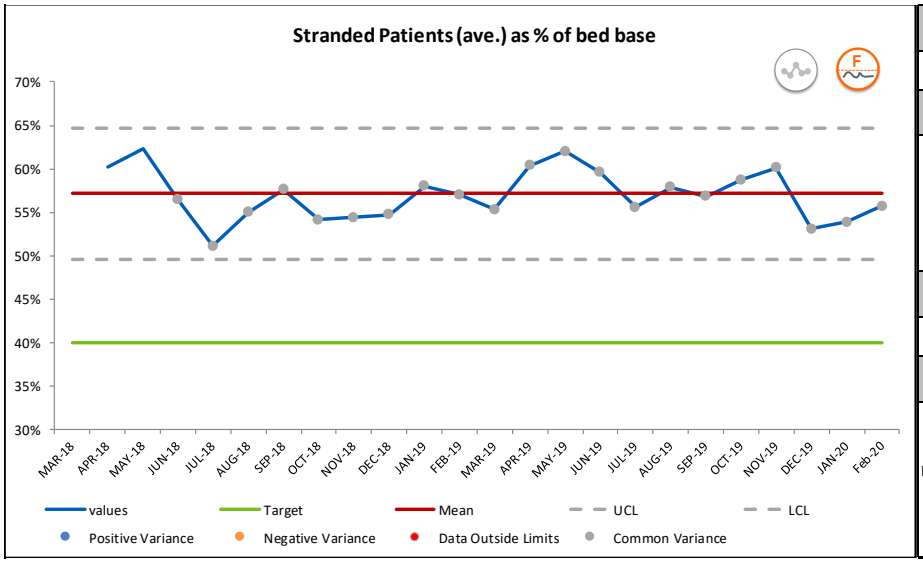
Context:

- Although patients are moved to the Discharge Suite as early discharges to free up the bed, they do not leave the site early due to EDN's and TTO's not completed.
- Patients for packages of care are usually notified on the day that the care is in place so patient needs to be prepared for discharges and EDN's TTO's and transport booked
- Transport can only be booked for patients once their EDN's and TTO's are complete
- Patients waiting for transfer to rehab services are not notified to the trust till late morning by community trust and again patient then needs to be made ready.

Previous Actions:

- 'Early bird' patients identified to the site team at the 4pm bed meeting for the following morning
- Current workstream led by Deputy MD is focussing on improving the EDN and TTO processes with support
- Private transport crews are supporting the service provided by TASL to improve the transport response times.
- NGH volunteers supporting discharge suite by collecting TTO's from Pharmacy for patients
- Discharge team admin staff phoning wards as soon as notified of bed allocation in rehab units
- AGE-UK supporting service by taking patients home and fetching TTO's from Pharmacy

SPC Charts – Stranded patients (avg.) as a % of bed base



Feb-20
55.7%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
40%
Target Achievement
Metric is consistently failing the target

Actions:

- Review of the 'Turnaround Tuesday' and 'Long stay Wednesday' to be undertaken to refresh and strengthen the process
- MADE Event to be planned to run in March to decongest hospital to allow Althorp ward to be returned to Orthopaedics
- Discharge team, SPA and the IDT is a key Exec led workstream for 2020

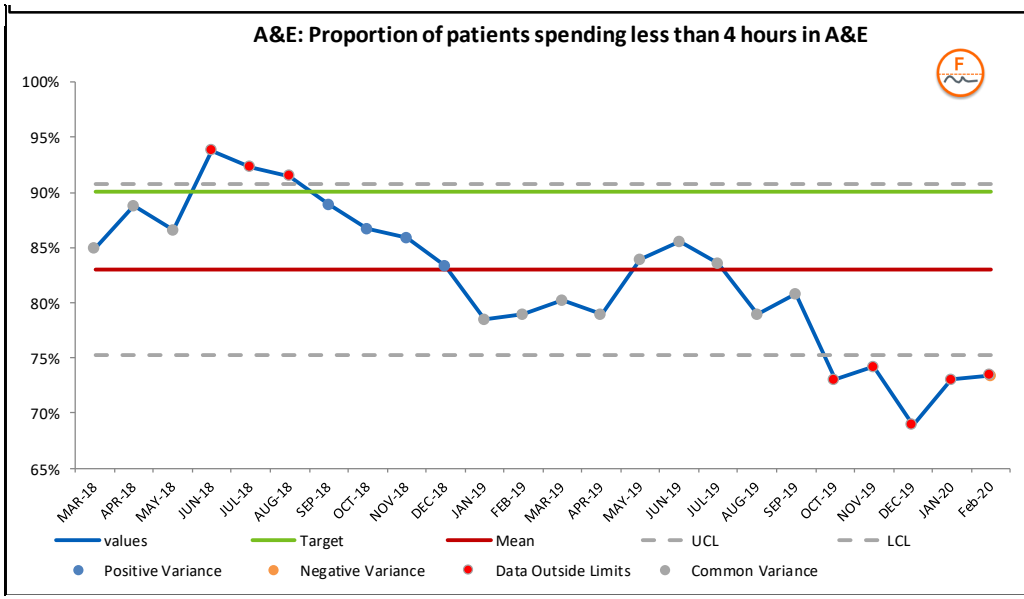
Context:

- Target set by NHSI of 132 patients >21days LOS (40% reduction) from a baseline of 220. Current figures are 163>21 days and 397 >7days this position has deteriorated during January and into February
- 214 PDNA's are live in the system meaning this number of patients need support with care going home with 126 who could leave today if there was care in place
- Increased admissions from Urgent care during winter and acuity increased
- Over prescribing of care 'this patient will not cope at home' but 30% of care packages are cancelled within 72 hours as the patients don't want them.
- Restrictions by providers on acuity of patients they are commissioned to take results in many patients being deemed unsuitable to take out of hospital
- Families objecting and blocking discharges and an aversion of some teams to have those challenging discussions
- Over investigating patients for conditions NOT related to their admission
- Additional beds at Spencer House are now online to support inevitable New Year pressures

Previous Actions:

- Weekly review with every ward of every patient with a LOS> 21days
- 3 times a week tracking meeting face to face with Partners
- Robust use of the Choice Policy
- ICT now on site 3 times a week to assess all NOF patients to pull early into community with only 15 NOFs compared to 28 the previous month
- Winter beds opened on Southfields 14beds and Merryfield 5 beds to help ease pressures over winter
- QI project underway to review the function of the discharge team including external partners to increase supported discharges to 1 per ward per day. This will include new ways of working for both hospital and social care teams.
- Increased consultant support for the wards each day is being mapped over winter to provide that increased challenge and scrutiny to the patients pathway

SPC Charts – A&E: Proportion of patients spending less than 4 hours in A&E



Feb-20
73.4%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
90.1%
Target Achievement
Metric is consistently failing the target

Context:

While there has been some improvement in month, analysis has shown that there has been a significant increase in the time admitted patients are waiting for speciality review and admission to a bed since September 19.
Blocked ED cubicle space then slows internal ED flow which affects non-admitted performance also. ED staffing is below recommended levels for the demand for nursing and medical workforce.

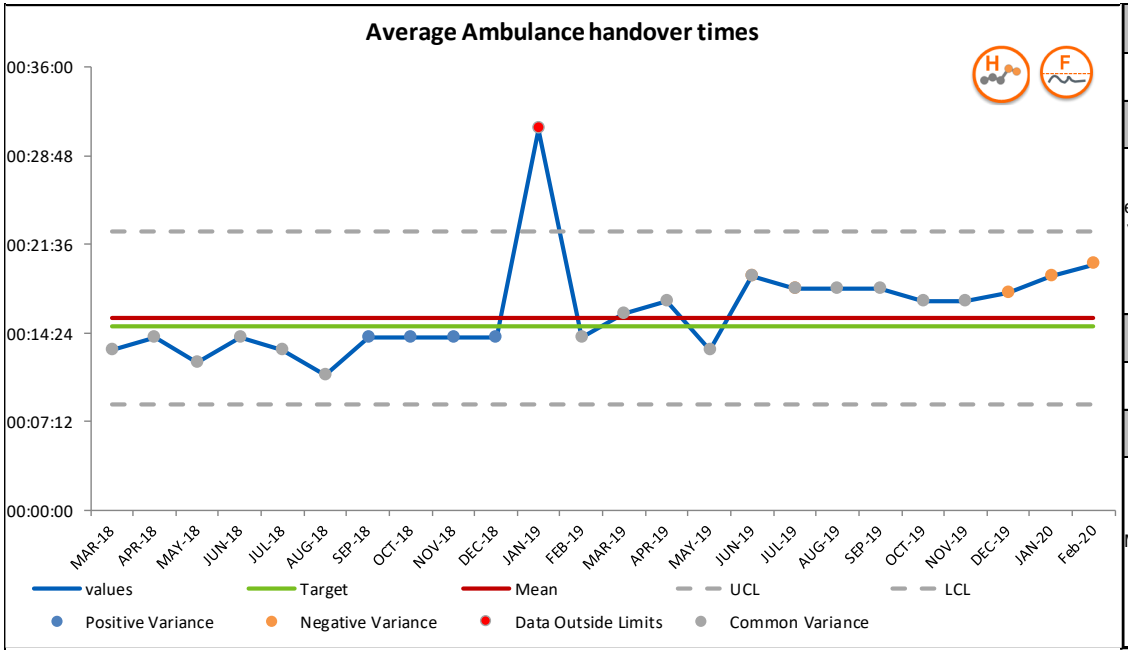
Actions completed:

Improved front door initial assessment processes should assist with non admitted performance improvement in time. New action cards for clinicians and nurses have been drafted for use in April 20.

Actions:

New ED shift performance dashboard has been requested. This is to enable shift leaders to more accurately assess and manage internal processes in real time. Estates review to increase space in Paeds, COA and Majors is ongoing.
The focus within ED now is on non admitted performance, and referring patients effectively to specialities within 2-3 hours.
Transformation programme in place

SPC Charts – Average ambulance handover times



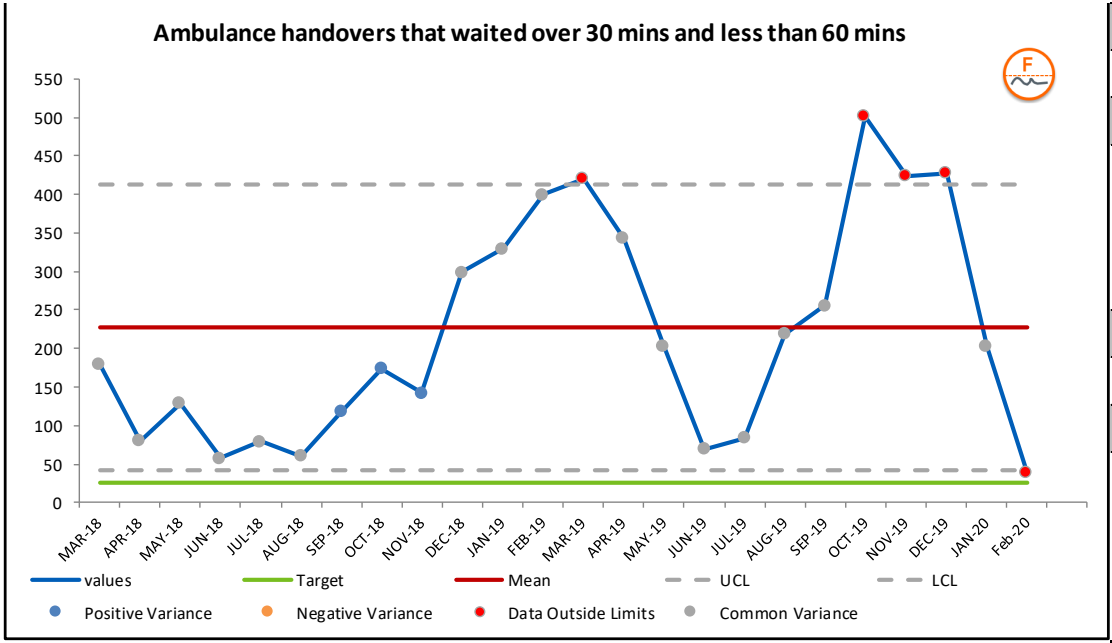
Feb-20
00:20:00
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance above the mean
Target
00:15:00
Target Achievement
Metric is consistently failing the target

Context:
Average ambulance handover times have increased slightly in month due to the requirement to handover potential infectious patients (Covid-19)

Actions Completed:
All actions now in place including a separate AE area for handover for this cohort of patients

Actions:
No further actions required

SPC Charts – Ambulance handovers that waited over 30 minutes and less than 60 minutes



Feb-20
39
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
25
Target Achievement
Metric is consistently failing the target

Context:

Performance has significantly improved since mid Jan 2020, with the best performance in month for 18 months + and favourable across the region. There has also been no 60 minute breach reported in this data set for the first time. Data quality issues with EMAS remains an issue which has been escalated.

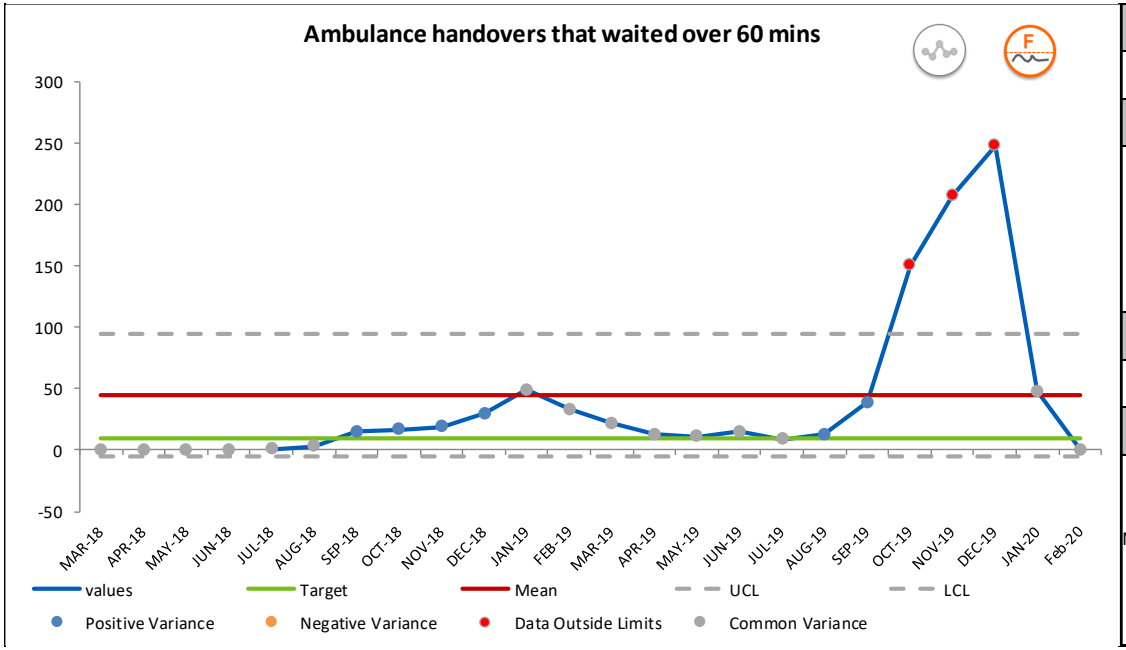
Actions Completed:

Sustainably implemented the changes to the ED front door, with commensurate escalation of exit block delays and use of the corridor for patients with stable DTAs rather than un-assessed EMAS patients.

Actions:

Awaiting improved data dashboard and DQ support to assist in driving down times even further, together with coaching of clinicians in assessment. Outcome of trust wide work to address capacity and flow.

SPC Charts – Ambulance handovers that waited over 60 minutes



Feb-20
0
Variance Type
Metric is currently experiencing Common Cause Variation
Target
10
Target Achievement
Metric is consistently failing the target

Context:

Performance has significantly improved since mid Jan 2020, with the best performance in month (even noting feb is a short month) for 18 months + and favourable across the region. There has also been no 60 minute breach reported in this data set for the first time. Data quality issues with EMAS remains an issue which has been escalated.

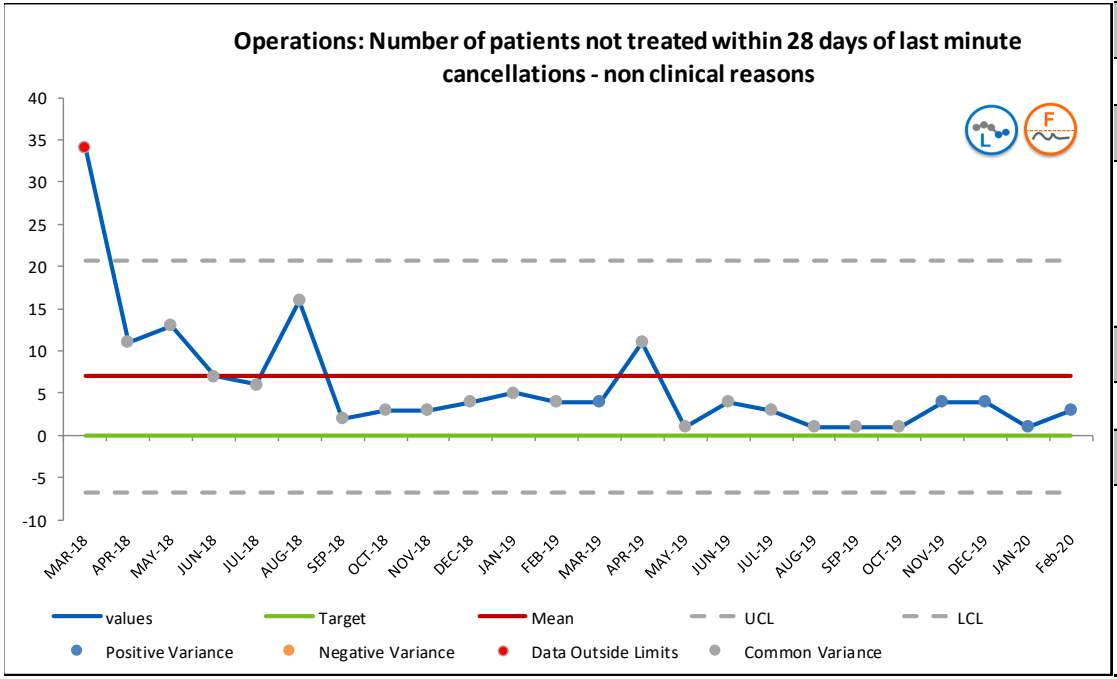
Actions Completed:

Sustainably implemented the changes to the ED front door, with commensurate escalation of exit block delays and use of the corridor for patients with stable DTAs rather than un-assessed EMAS patients.

Actions:

Awaiting improved data dashboard and DQ support to assist in driving down times even further, together with coaching of clinicians in assessment. Outcome of trust wide work to address capacity and flow.

SPC Charts – Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons



Feb-20
3
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a positive performance below the mean
Target
0
Target Achievement
Metric is consistently failing the target

Context:

Due to an electrical generator failure we had a significant cohort (32) of patients whom were cancelled over a 3 day period, all requiring re-scheduling within 28 days. All but 3 were rebooked and had their surgery within the required timescale.

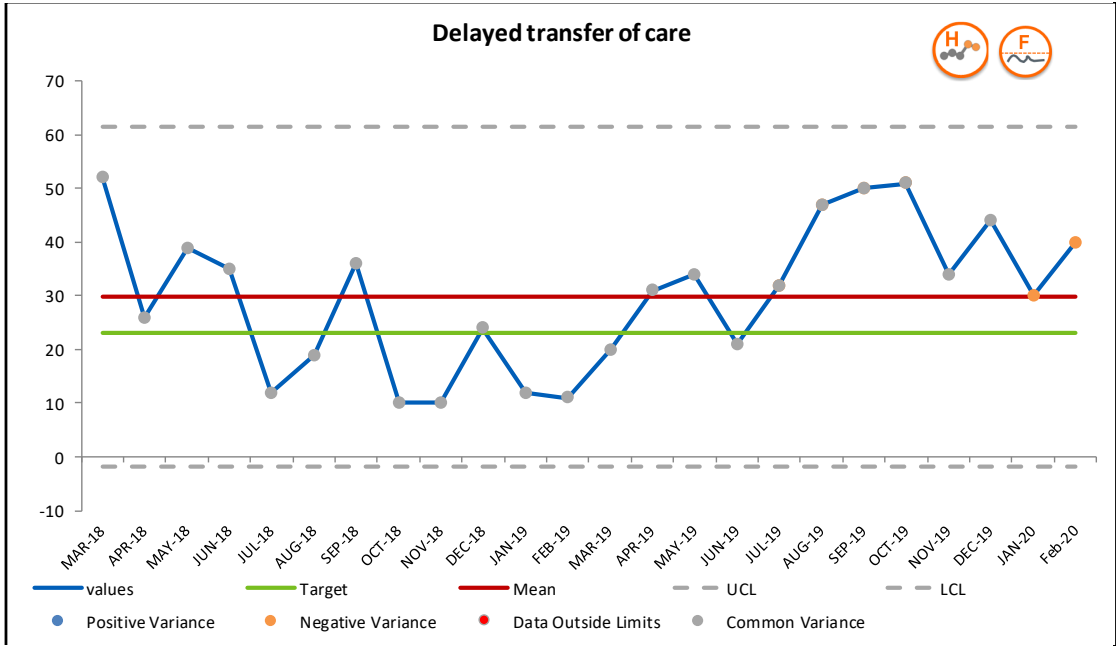
Actions Completed:

The 3 patients whom we were unable to rearrange in time were plastic surgery patients awaiting non-urgent day case treatments.
Due to planned sick leave of 1 (of 2) substantive consultants, the remaining substantive consultant wanted to operate on the patients (rather than locum).

Actions:

- Generators hired to temporarily replace with new equipment ordered to be installed in March 2020

SPC Charts – Delayed transfer of care



Feb-20
40
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance above the mean
Target
23
Target Achievement
Metric is consistently failing the target

Context:

- Slow turn around with Social Brokerage Teams Social assessments are very lengthy
- Delays from SPA not processing in real time Legal constraints in regard to Human Rights and capacity for patients sitting with Social are experiencing very long delays
- Lack of community availability with packages of care, placements and rehab
- Discharge waiting lists are expanding due to poor community resources
- High numbers of complex patients that are hard to place
- Doctors referring to other specialities repeating bloods, xrays that could be seen as OP
- Risk averseness, expecting patients to be at their base line, not accepting patients have a right to make wrong decisions
- Delays with TTO/EDN/Transport
- Not enough Discharge Coordinators to support one on each Ward

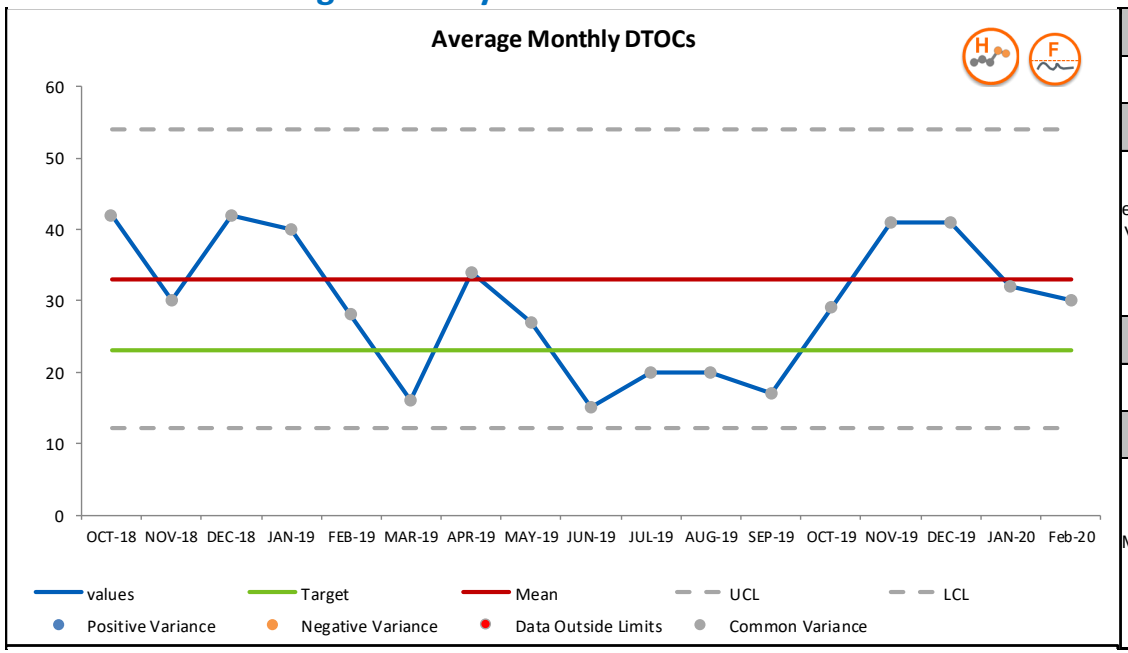
Actions:

- Long Stay Wednesdays being re launched
- Planning a MADE event for March 2020
- Task and Finish group to be set up for IBox to support discharge process
- PDNA to be redesigned

Actions Completed:

- HUB process being reviewed, Extra 10 beds have been spot purchased from Social services
- Extra 10 beds being funded from health to support Social discharges
- Further review of patient s waiting rehab/CRT/ICT to see if family can offer support
- Recruitment of 3 new Coordinators in HR process IBox being developed to provide patient Tracker
- Long Stay Wednesday Reviews on patients with over 7 day LOS

SPC Charts – Average monthly DTOCs



Feb-20
45
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance above the mean
Target
23
Target Achievement
Metric is consistently failing the target

Actions:

- Long Stay Wednesdays being re lunched
- Planning a MADE event for March
- Task and Finish group to be set up for IBox to support discharge process
- PDNA to be redesigned

Context:

- Slow turn around with Social Brokerage Teams Social assessments are very lengthy
- Delays from SPA not processing in real time Legal constraints in regard to Human Rights and capacity for patients sitting with Social are experiencing very long delays
- Lack of community availability with packages of care, placements and rehab
- Discharge waiting lists are expanding due to poor community resources
- High numbers of complex patients that are hard to place
- Doctors referring to other specialities repeating bloods, xrays that could be seen as OP
- Risk averseness, expecting patients to be at their base line, not accepting patients have a right to make wrong decisions
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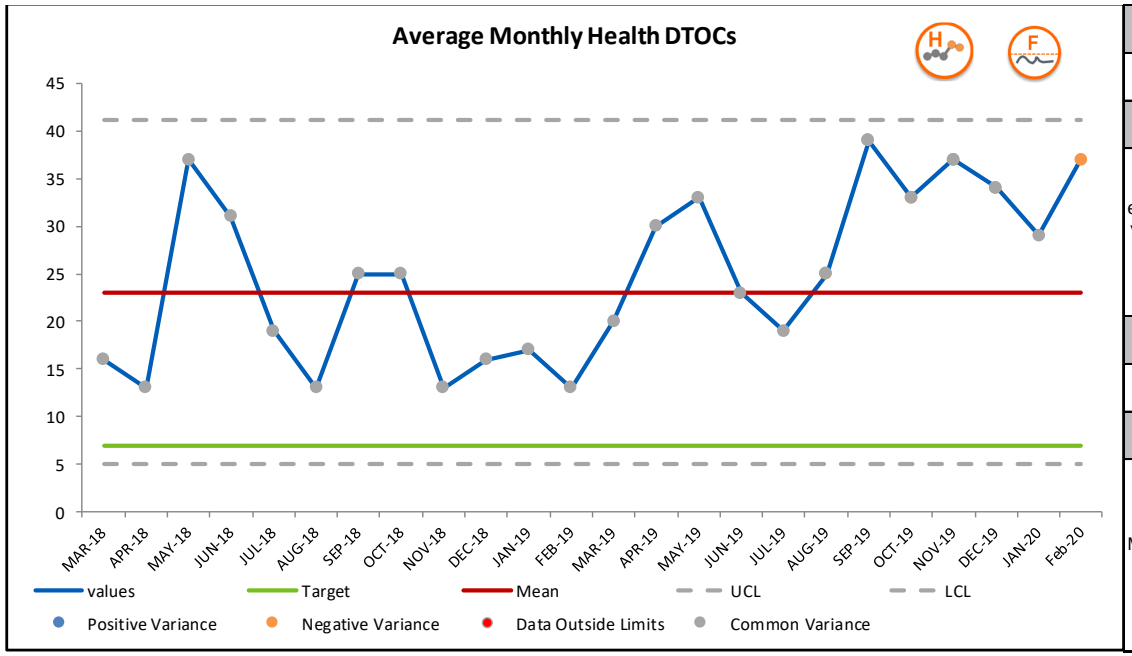
Actions Completed:

- HUB process being reviewed, Extra 10 beds have been spot purchased from Social services
- Extra 10 beds being funded from health to support Social discharges
- Further review of patient s waiting rehab/CRT/ICT to see if family can offer support
- Recruitment of 3 new Coordinators in HR process IBox being developed to provide patient Tracker
- Long Stay Wednesday Reviews on patients with over 7 day LOS

SPC Charts – Average monthly health DTOCs



Feb-20
37
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance above the mean
Target
7
Target Achievement
Metric is consistently failing the target

Context:

- Slow turn around with Social Brokerage Teams Social assessments are very lengthy
- Delays from SPA not processing in real time Legal constraints in regard to Human Rights and capacity for patients sitting with Social are experiencing very long delays
- Lack of community availability with packages of care, placements and rehab
- Discharge waiting lists are expanding due to poor community resources
- High numbers of complex patients that are hard to place
- Doctors referring to other specialities repeating bloods, xrays that could be seen as OP
- Risk averseness, expecting patients to be at their base line, not accepting patients have a right to make wrong decisions
- Delays with TTO/EDN/Transport
- Not enough Discharge Coordinators to support one on each Ward

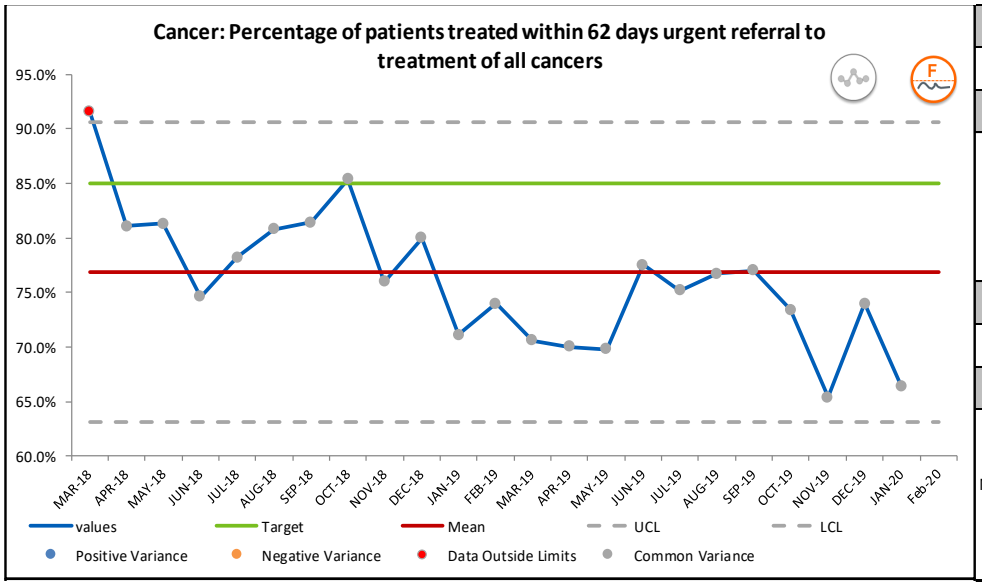
Actions:

- Long Stay Wednesdays being re lunched
- Planning a MADE event for March
- Task and Finish group to be set up for IBox to support discharge process
- PDNA to be redesigned

Actions Completed:

- HUB process being reviewed, Extra 10 beds have been spot purchased from Social services
- Extra 10 beds being funded from health to support Social discharges
- Further review of patient s waiting rehab/CRT/ICT to see if family can offer support
- Recruitment of 3 new Coordinators in HR process IBox being developed to provide patient Tracker
- Long Stay Wednesday Reviews on patients with over 7 day LOS

SPC Charts – Cancer: Percentage of patients treated within 62 days



JAN-20
66.4%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85%
Target Achievement
Metric is consistently failing the target

Context:

The Trust has undertaken in January 95.5 treatments which is a 22% increase on December, however due to the number of breaches, 32 in total performance is 66.5% against the 85% standard, skin is the only site to achieve this month reaching 100%. Colorectal and breast had the most breaches this month. 2019 conversion rates for 2ww are in line with national overall, the Trust has seen an increase in 2ww referrals from 2018 to 2019 of 1610, which equates to 11.3% adding more pressure to the system Patients waiting in excess of 62 days on their 2ww pathway as of the 06/03 is 68 for 2ww. 25 patients have a cancer diagnosis with 43 undiagnosed.
A further 7 screening and 21 consultant upgrades have breached the 62 day standard, in total 96 legacy.
Colorectal, Lung and Skin share 61 of the 96 legacy patients.
Whilst legacy patients remain high the Trusts ability to recover the 62 day standard is compromised, and is a national challenge.

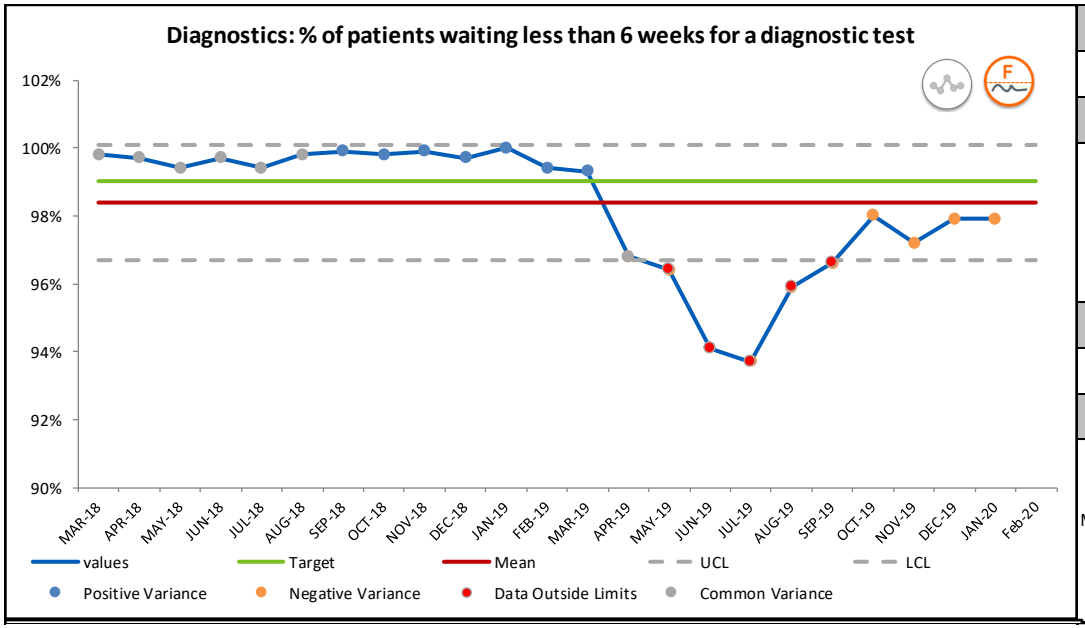
Actions:

- The NHSI intensive support team (IST) have been asked to support us with delivery of the 62 day target.
- Lung and colorectal teams have been identified as the areas which require the most support.
- Their feedback has been very positive stating that we're 'starting from an advanced stage.
- Good PTL meeting with appropriate challenge and staff knowing their patients'. They will be looking to do some detailed demand and capacity work with us, and supporting us with updating our cancer access policy and straight to test processes

Actions completed:

The weekly project meetings for Lung continue to ensure continued impetus towards the changes required to achieve the new pathway. Risk meetings have been held with progress against some of these, however outputs of these mitigations will not be known until early April. Unless these risks are dealt with, NGH is very unlikely to achieve the KPI targets set within the national guidance for the NOLCP. Mitigation for the risk to the radiology department stages of the pathway is being formalised. The department is expecting this risk to be better managed by June 2020 as additional workforce is key to this improvement. KPI measures and how to measure them have been agreed. Project Managers at NGH and KGH have met to begin the process of agreeing one report for both sites for reporting against KPIs this will be tabled at the next countywide lung meeting. Robust methodology and how best to ensure Business as Usual continuation is now being devised. New directorate manager and the Clinical lead for NOLCP at NGH have validated the KPI report. Demand and capacity analysis for the respiratory department, which will give vital information regarding the 2WW clinic capacity, has been completed Clinical Nurse Specialist led clinics trial will run for 3 weeks in March 2020. PDSA cycle to be followed with feedback due end of March RAPID pathway live from 06/01 Straight to test for Lower GI pathway still under development with anticipated "go live" date April 2020

SPC Charts – Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test



JAN-20
97.9%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
99%
Target Achievement
Metric is consistently failing the target

Context:

- Recovery of the diagnostic 6 week wait performance levels from 96% in November to 97.1% in December continues with an unvalidated position for January of 98%.
- There is a full recovery plan in place and we expect to be delivering the target of 99% by next month Endoscopy backlog has almost been cleared completely with single figure breaches
- There have been breaches in Cardiology due to the use of the heart centre over the winter
- As such we have been unable to get patients in within six week for key diagnostics cardiology tests.

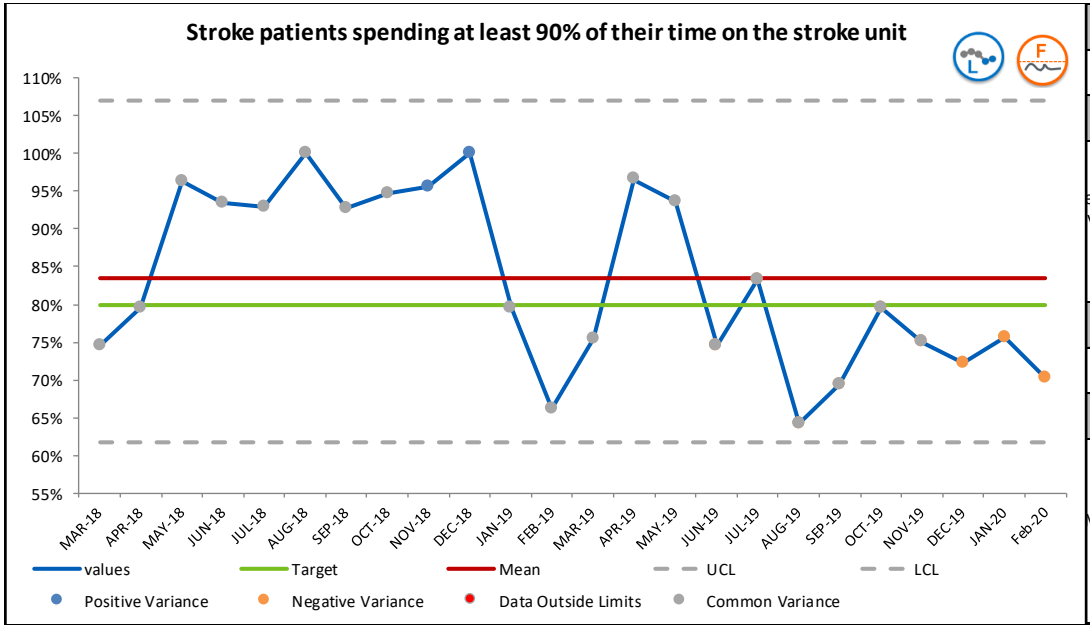
Actions Completed:

- Outsourcing of Endoscopy activity of circa 250 patients to Blakelands to support the capacity gap continues
- Insourcing contract agreed to provide 4 weekend Endoscopy session a week
- Rectification plan for Radiology being developed and action to clear these in 1 month expected
- Additional lists are being provided in house where possible
- Use of Heart Centre running additional diagnostics lists at the weekend
- Full validation of all lists to ensure all breaches are accurate

Actions:

- Action plan on track for delivery

SPC Charts – Stroke patients spending at least 90% of their time on the stroke unit



Feb-20
70%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance below the mean
Target
80%
Target Achievement
Metric is consistently failing the target

Context:

- We continue to have a higher number of admissions/month compared with last year.
- More marked is the increasing number of dependent patients waiting longer for NASS assessments and then availability of packages of care and placement.
- The reduced outflow from Allebone ward has meant that we frequently have 10-14 stroke outliers on many different wards in the Trust and not only are we missing this target but we also failing badly on the % of stroke patients getting to a bed in 4 hours.

Actions Completed:

- See above.

Actions:

- Directorate action plan to assess bed capacity

Directors view – Director of Finance

The Trust's financial position for the month ended 29 February 2020 and shows an in-month adverse variance of £1,152k (pre-PSF/FRF), resulting in a year to date adverse variance of £6,657k against plan. This position is better than forecast, details of which are provided under separate cover.

We have not accounted for PSF/FRF funding of £9,002k (Q3 to date) as the Trust has missed its financial plan, therefore the total year to date adverse variance to plan is £15,659k.

Overall the cost base has been consistent across the recent winter months however we have seen a significant drop in income especially elective, outpatients and daycase activity. However this has been offset by the benefit from the year-end deal with Nene CCG and has helped to keep the Trust performance in line with forecast.

Pay costs remains high, driven by high usage of agency staff to cover urgent care pressures – escalation, increased enhanced care, vacancies as well as backfill for leave.

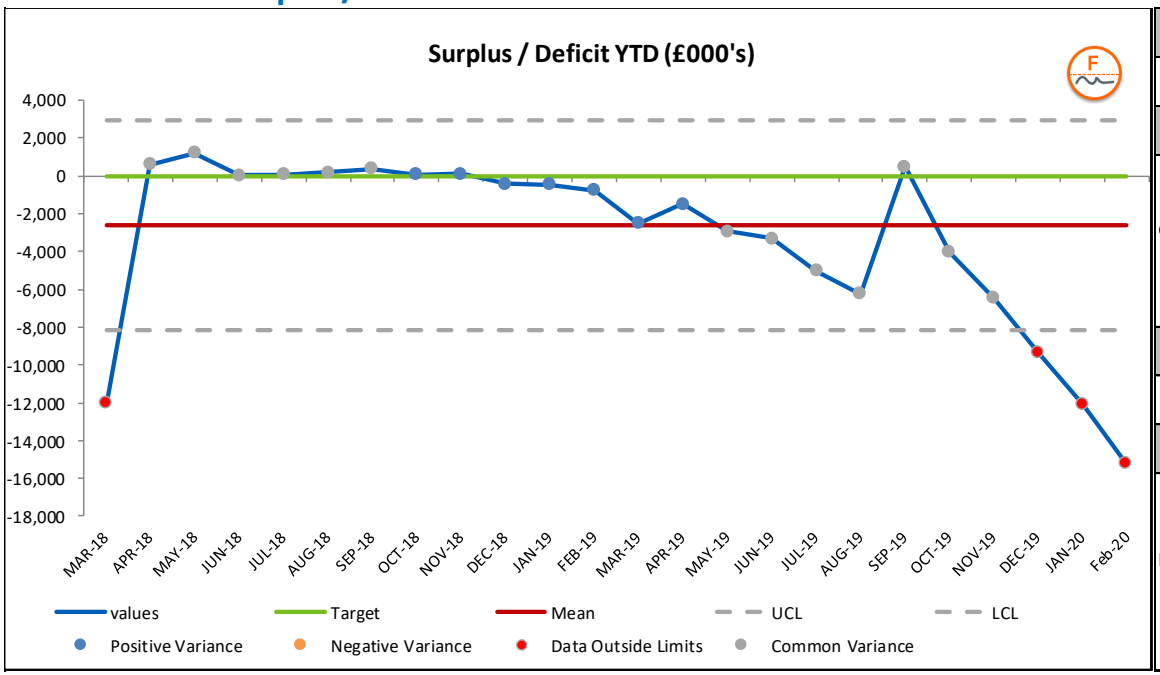
Winter funding of £403k is included in the position and has helped to offset some of the overspends.

The current uncertainty around COVID-19 is likely to impact the Trust finances going forward but we are monitoring this closely to ensure that we maintain adequate financial governance in uncertain times.

Capital spend is £7,260k at the end of the month which is better than plan by £384k. Around 92% of the plan is committed and the overall plan is expected to be met. In addition, emergency capital funding of £1.5m is expected to be approved to deal with urgent electrical and fire works.

Cash balance at the end of the month is £1,682k and we continue to monitor the cash position carefully to ensure that staff and suppliers get paid as and when due.

SPC Charts – Surplus/Deficit YTD



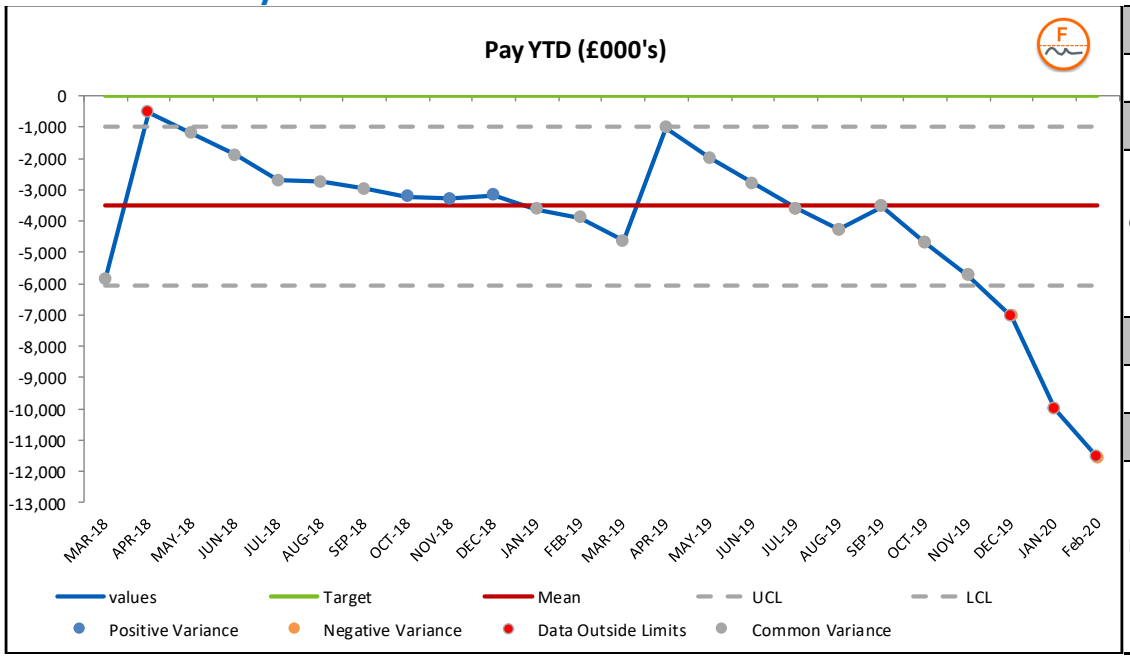
Feb-20
-15,238
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
0
Target Achievement
Metric is consistently failing the target

Context: **The Trust's financial position for the month ended 29 February 2020 and shows an in-month adverse variance of £1,152k (pre-PSF/FRF), resulting in a year to date adverse variance of £6,657k against plan. This position is better than forecast, details of which are provided under separate cover.**

We have not accounted for PSF/FRF funding of £9,002k (Q3 to date) as the Trust has missed its financial plan, therefore the total year to date adverse variance to plan is £15,659k.

Actions:

SPC Charts – Pay YTD



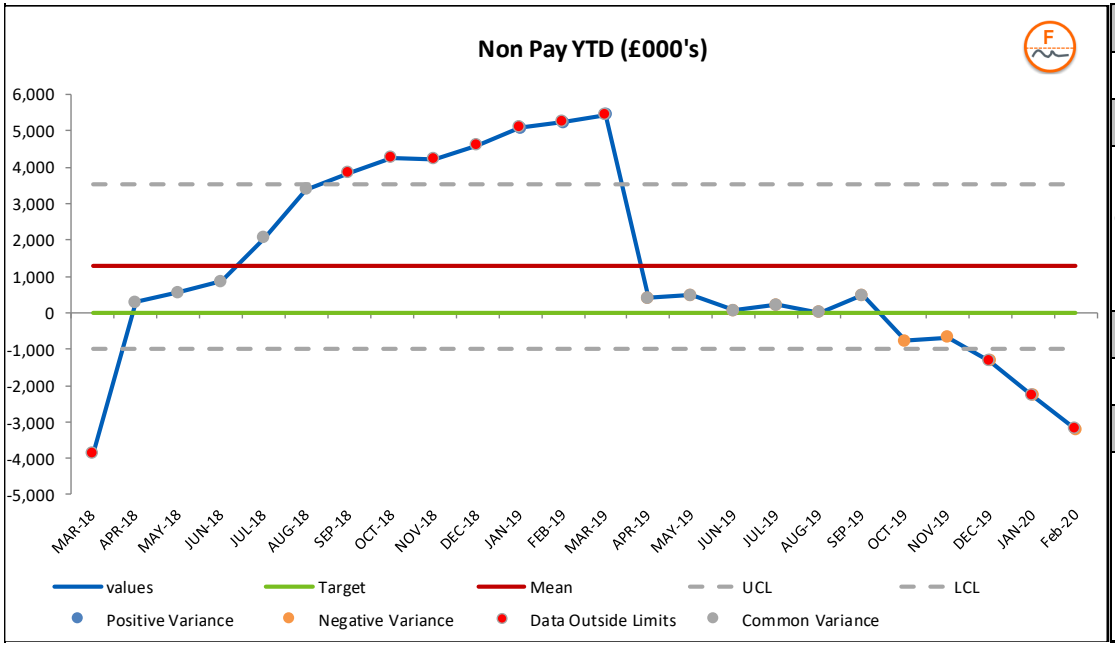
Feb-20
-11,544
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
0
Target Achievement
Metric is consistently failing the target

Actions:

In Month 11 Pay Expenditure was £21.25m against a plan of £19.7m; resulting in a £1.54m adverse variance to plan in month; £11.5m adverse variance year to date.

- The plan figure includes a CIP allocation of £0.49m being the amount of pay underspends across a number of cost centres within the Trust in Month 11. This has been applied as a non-recurrent CIP in month.
- **Nursing staff** pay continues to increase (£609k adverse to plan in Month 11) with temporary staff costs and WTE numbers increasing in February (£135k/20WTE increase from January to February) mainly within temporary HCA staff. Increases in expenditure in areas with increased patient boarding, increased numbers of beds following ward moves and wards with medical outliers (Surgical and Talbot Butler). Increased levels of annual leave and sickness also driving demand for temporary staff.
- **Medical staff** pay remains above budget in month (£593k adverse to plan in month) with increased expenditure on temporary staff again in February with 13.8% of WTE being temporary staff. Overspends against budget continue to occur in Medicine Division due to additional medical staff employed to manage medical outliers on surgical wards and the medical model to support acute medicine.

SPC Charts – Non-Pay YTD



Feb-20
-3,213
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
0%
Target Achievement
Metric is consistently failing the target

Actions:

Non Pay expenditure for month 11 is £0.9m adverse in month, £3.2m adverse year to date.

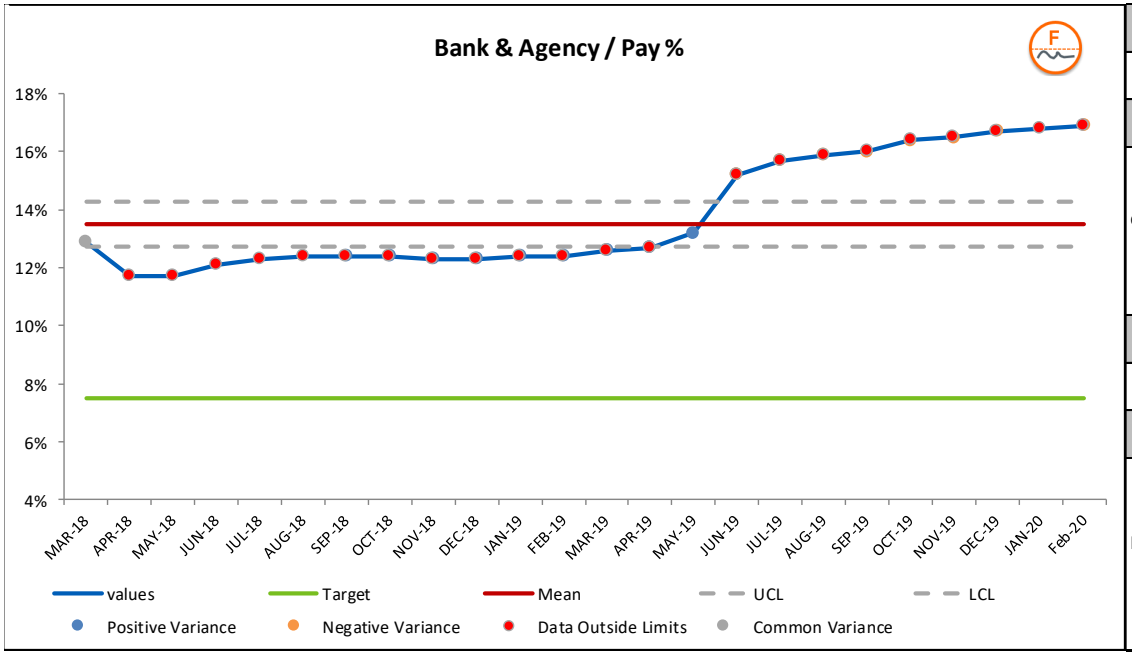
Excluding pass-through drugs and devices costs, the in month non-pay variance is £712k adverse to plan with key variances including:

- £519k Other Fees; a higher month of heavy insourcing (£170k) in Endoscopy, plus the commencing of operations for those orthopaedic patients (£112k) that were passed to the independent sector (Ramsay) at the start of 2020. Also a £300k provision for HR.
- £84k Lab Consumables; includes some increased costs of winter such as mortuary storage, insourced cost of more post-mortems in the last few months, flu testing.
- £73k Medicines; includes £50k of costs for medicines sold on; the remainder being the timing of medicines expenditure reported in Pharmacy stores.
- £64k Equipment Maintenance; a doubling of expenditure for Clinical Engineering in Estates this month.

Favourable variances offsetting above adverse variances in month include:

- £73k Building & Engineering; includes a £125k reduction from capitalising expenditure, from this normally overspending category.
- £58k Prosthesis; due to the continuing winter cessation of inpatient orthopaedics.

SPC Charts – Bank & Agency spend



Feb-20
16.9%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
7.5%
Target Achievement
Metric is consistently failing the target

In Month 11 Temporary Staff expenditure was £3.92m against a plan of £2.0m (original plan of £2.49m less £0.49m unplanned non-recurrent pay CIP savings)

Increase of £195k from previous month's expenditure with increased expenditure on agency across medical and nursing staff (£256k overall increase in agency offset by decreased bank and ADH expenditure in junior medical staff).

Actions:

Directors view – Chief People Officer

Vacancy Rates

For the fifth consecutive month, there was a further decrease in the overall Trust vacancy rate however, the Trust vacancy factor continues to be above the 9% target at 10.13%. There was a further decrease in the vacancy factor for medical staff at 4.33% and an increase in the nursing & midwifery vacancy factor from 9.41% to 9.66% for the month of February 2020. The first cohort of 11 overseas nurses arrived on 5 March 2020 with a further 11 scheduled to arrive on 11 March 2020. Cohorts for the months of April and May 2020 are established with 33 and 30 due to arrive respectively.

HCA recruitment continues to be an area of focus in order to eliminate HCA agency costs. In order to fill the 105 HCA vacancies, 74 Trust wide HCAs are currently in employment clearance, 36 of which have scheduled start dates. A HCA hub comprising of 10 HCAs who can be deployed flexibly across the Trust according to need has also commenced.

The risk of reduced workforce capacity brought about as a result of the Trusts vacancies continues to be mitigated through backfilling vacancies with bank and agency staff. Agency spend continues to be scrutinised and reviewed through fortnightly meetings with Divisional representatives and finance. The recruitment time to hire is as follows:

	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Advertising Start Date to Unconditional Offer (Weeks)	9.6	8.73	9.21	8.57	9.1
Authorisation Granted to Start Date (Weeks)	12.29	10.87	10.55	11.48	12.17

(The current Trust target is 14 weeks with a stretch target of 11 weeks)

Turnover

Turnover marginally decreased since January and remains below the Trust target of 10% across the Trust at 8.5%. Nursing and Midwifery turnover decreased to 6.44% for the month of February 2020 and Medical staff turnover increased to 10.03%.

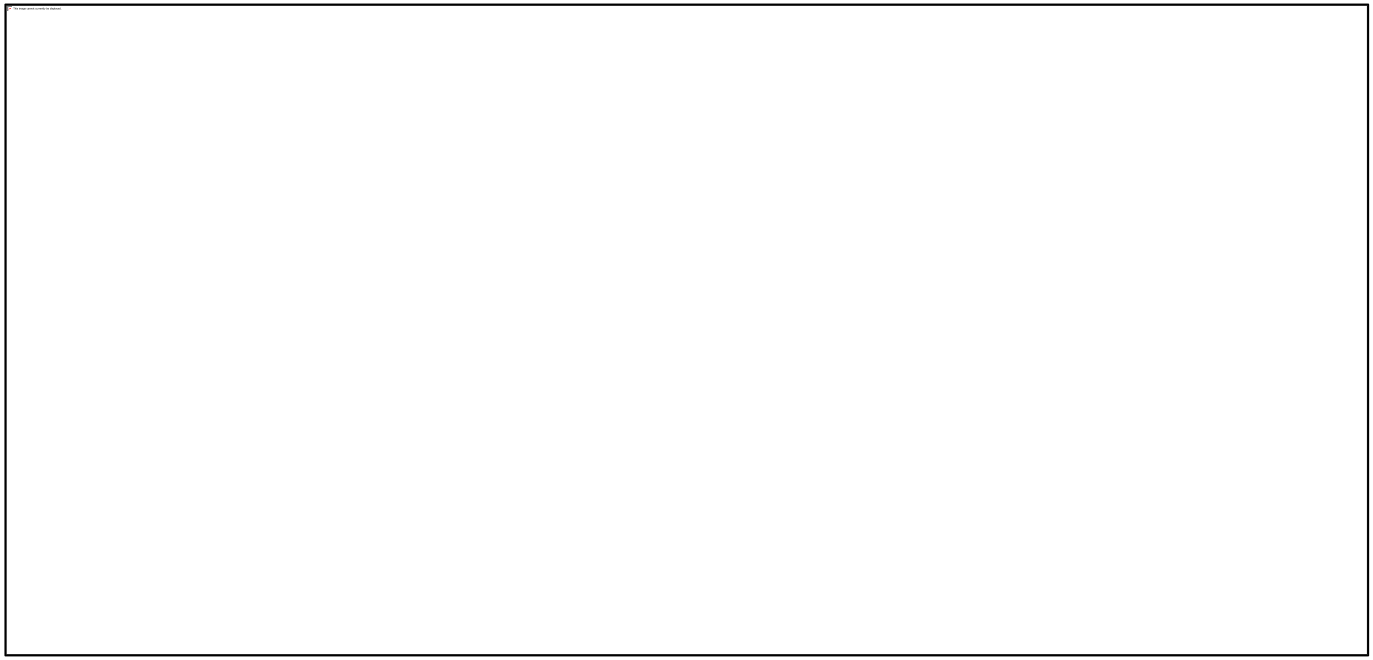
Attendance

The Trusts attendance target is 96.2% (3.8% absence target) and current attendance rates remain below this target despite there being an increase from January 2020 to 95.15%. The management of sickness absence is being supported by HR Business Partners and Occupational Health with preventative measures being taken through the Trusts Health and Wellbeing programme. A system has been put in place to monitor staffing levels on a real time basis through the rostering system during the coronavirus outbreak.

Competency

Compliance with the Trusts mandatory training saw an increase since January 2020 as did Appraisal and RSET compliance. Mandatory training compliance continues to be above Trust target however, Appraisal and RSET compliance continue to be below the Trust target of 85%. A contributory factor to the increase will be the removal of the requirement for a number of roles to undertake VTE training. Work has been undertaken to increase capacity at Trust induction which resulted in 60 places being made available. This has been achieved through reviewing the training undertaken by new starters in their previous positions and where appropriate recognizing the validity of that training as transferable. This has also contributed to an improvement in the mandatory training compliance level.

SPC Charts – Sickness Rate



Context:

- Anxiety and depression plus pregnancy related absences are high.
- There are a high number of bullying and harassment cases across all divisions.
- Staff survey results and reasons for absence data suggest staff are experiencing an increase in MSK problems.

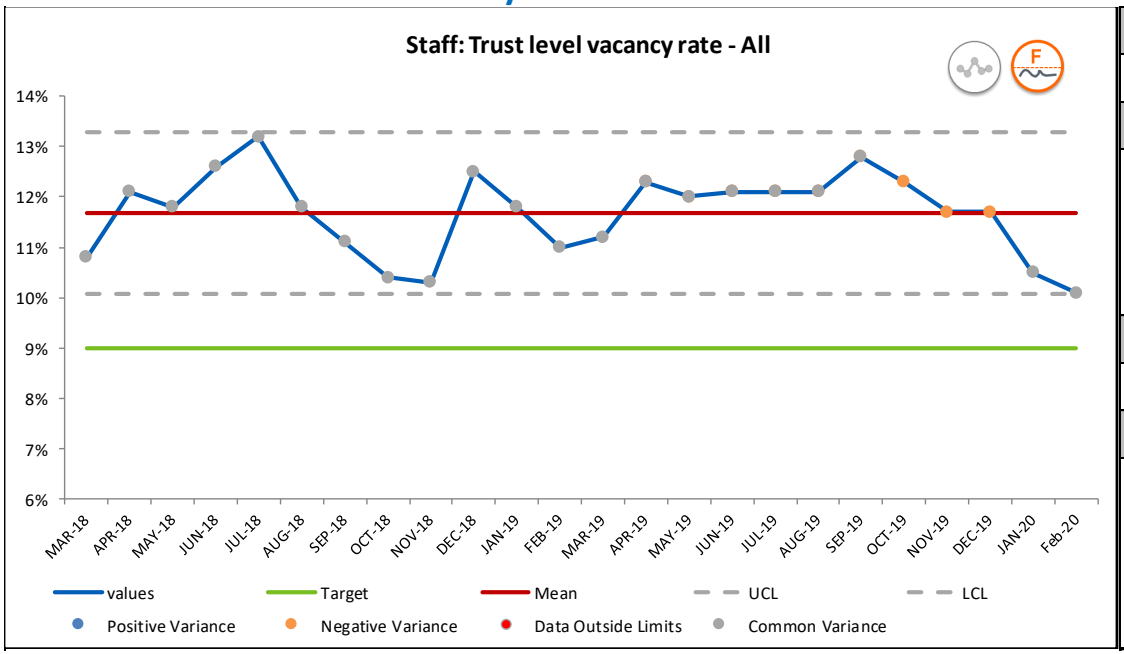
Actions completed:

Robust sickness management continues with support from the HR Business Partners and HR Advisors. (February 2020)

Actions:

- Continue to manage sickness absence across all areas of the Trust. (On-going)
- HR Business Partners to raise sickness as part of the divisional management meetings. (On-going)
- As part of the newly formed people strategy work is under way to try to manage sickness absence in a more preventative way through health and wellbeing initiatives. (March 2020)

SPC Charts – Trust level vacancy rate - all



Feb-20
10.1%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
9.0%
Target Achievement
Metric is consistently failing the target

Context:

There is a national shortage of nursing staff along with a shortage within other professional allied specialities

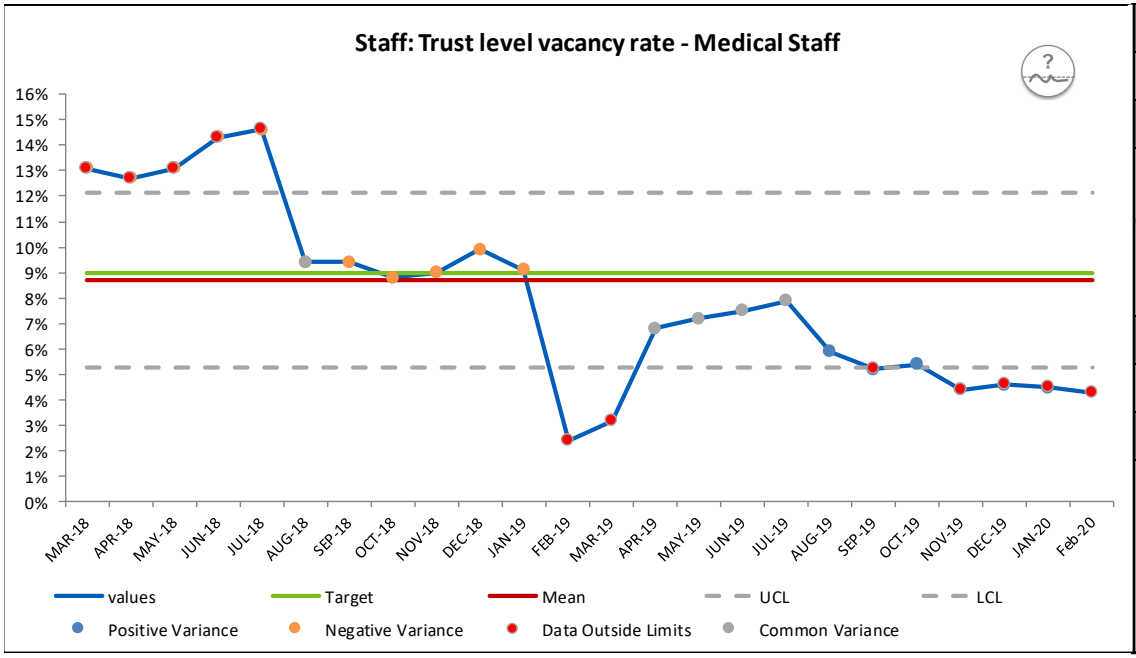
Actions completed:

Local recruitment continues – Feb 2020 Overseas recruitment of 22 commenced in March

Actions:

- On-boarding of overseas nurses has commenced – next cohort of 33 due to arrive April 2020
- Continue sourcing candidates and complete interviews for direct and agency candidates – March 2020

SPC Charts – Trust level vacancy rate – Medical Staff

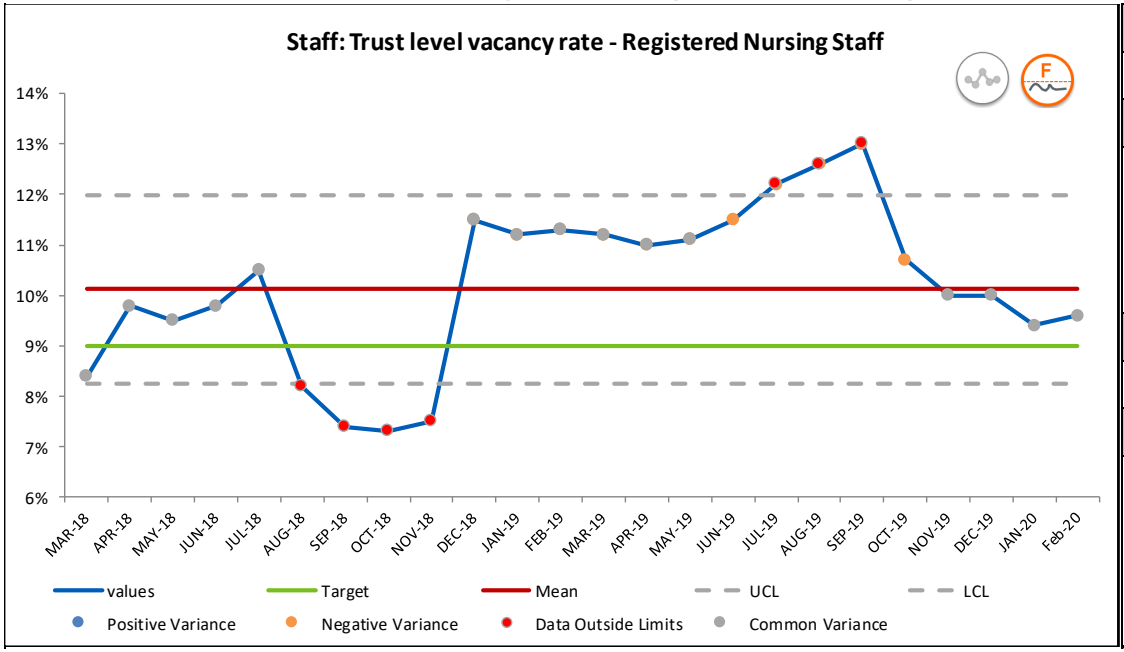


Feb-20
4.3%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
9.0%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Context:
Shown for information as the performance is outside the control limits but representing a positive performance.

Actions:

SPC Charts – Trust level vacancy rate – Registered nursing staff



Feb-20
9.6%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
9.0%
Target Achievement
Metric is consistently failing the target

Context:

There is a national shortage of nursing staff

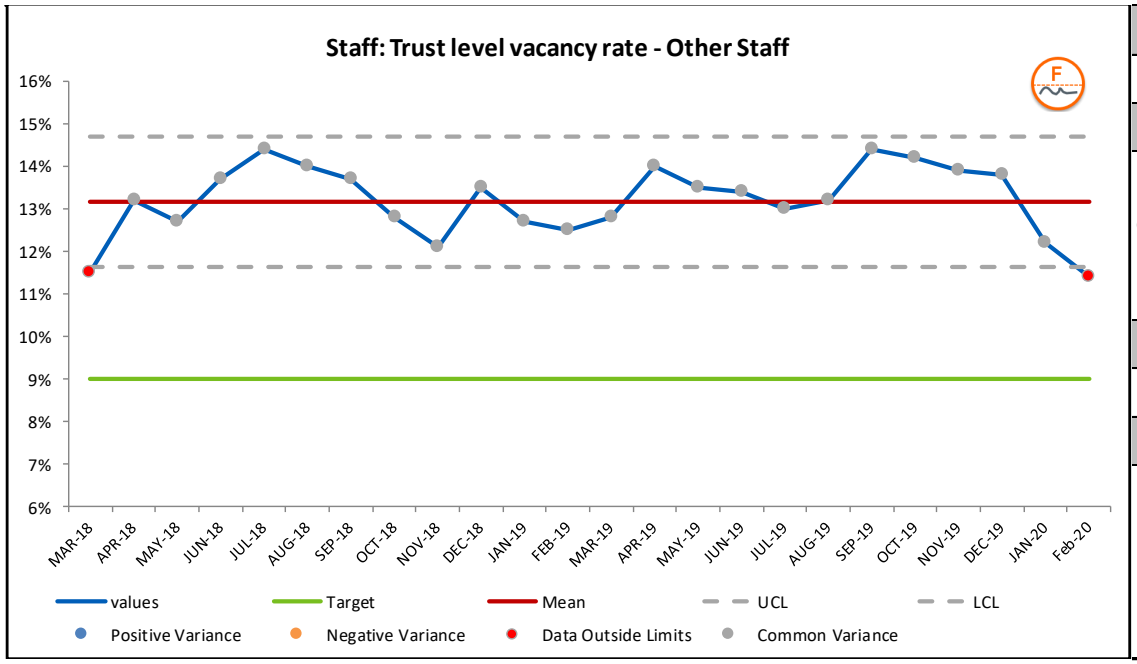
Actions completed:

Local recruitment continues – Jan 2020 Overseas recruitment of 22 commenced in March

Actions:

- On-boarding of overseas nurses has commenced – next cohort of 33 due to arrive April 2020

SPC Charts – Trust level vacancy rate – Other staff



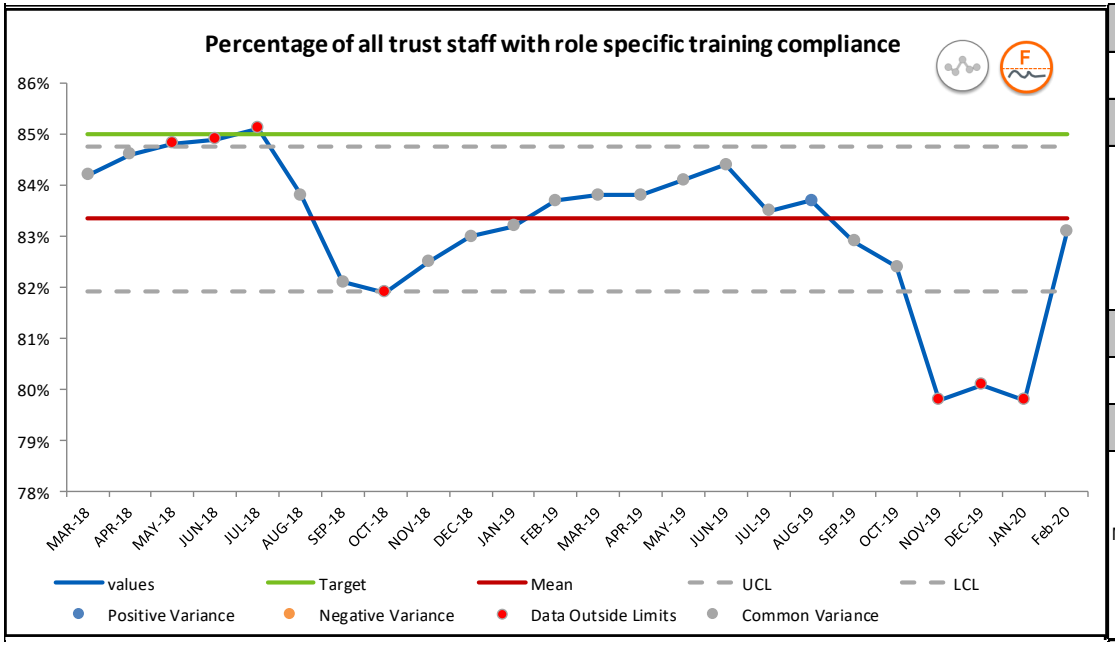
Feb-20
11.4%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
9.0%
Target Achievement
Metric is consistently failing the target

Context:
There is a national shortage within professional allied specialities

Actions completed:
Detailed analysis of hard to recruit hotspots has commenced – Jan 2020

Actions:
Continue sourcing candidates and complete interviews for direct and agency candidates – Feb 2020

SPC Charts – Staff with role specific training compliance



Feb-20
83.1%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85.0%
Target Achievement
Metric is consistently failing the target

Context:

- Some job roles within the Trust are not being aligned to Role Specific Training subjects
- Inflexibility of the national OLM system means that the lowest dominator that training can be aligned to is position level not assignment level.
- There is no ability to change the current system

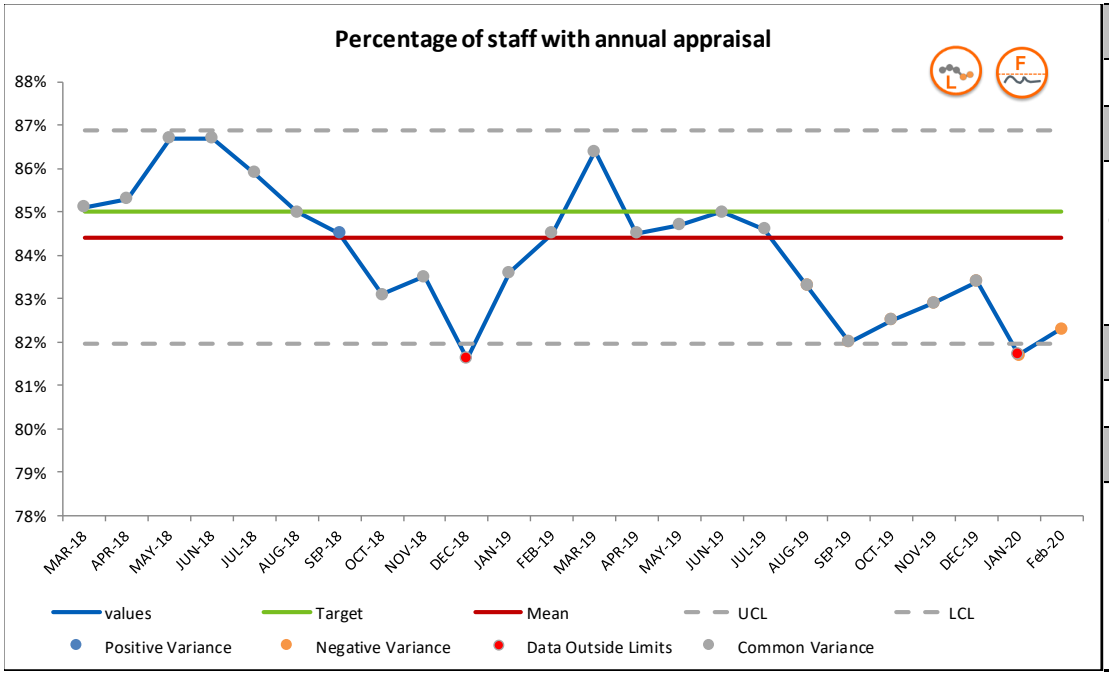
Actions completed:

- Due to the number of positions being created each month, work continues on data cleansing ESR to reduce the number of positions and the number of new position being created – Feb 2020
- Promotion on the importance of RSET is included in the appraisal training – Feb 2020
- Following the VTE review templates have been created but the information has not yet been uploaded by IBM. Therefore this competency was removed from the reports – Feb 2020

Actions:

- HRBP's to raise importance of compliance at the DMT's – On-going Implementation by 2020 of employee self-service – On-going
- Continue to introduce Inter Authority Transfers (IAT), which will transfer training for staff moving from one Trust to another – on-going
- VTE templates to be upload by IBM – March 2020

SPC Charts – Staff with an annual appraisal



Feb-20
82.3%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance below the mean
Target
85.0%
Target Achievement
Metric is consistently failing the target

Context:

- The appraisal spreadsheet covers two months, so some areas have waited until the final cut-off date to notify L&D of the appraisal, even though the appraisal may have occurred during the first month meaning the member of staff is one month out of date.
- Appraisal information is being received after the submission deadline.
- The number of new starters within some depts. has affected the overall % compliance due to timing of start date and appraisal date.

Actions completed:

- Training for managers continues which covers the process of submission of data.
- 1:1's are also being conducted with managers – Feb 2020
- Work continues with appraisal co-ordinators to ensure that information is submitted within timeframes – Feb 2020
- Identifying and contacting areas that have not submitted the appraisal information – Feb 2020

Actions:

- The HRBPs to address with those managers with low compliance and if necessary create action plans – March 2020
- Those managers who have a discrepancy with the % of compliance have been asked to contact the L&D manager so an audit can be carried out – March 2020
- For a trial period appraisal reports will be re-run a week later to see if the compliance increased due to late submission of information – March 2020

Directors view – Medical Director

Overview

As part of Covid-19 preparations, including a medical assessment protocol, remote monitoring of relatively well patients, and expansion of ITU capacity from 8 to 38 ventilated beds many of the BAU items of the medical directors portfolio have been suspended on a 3 or 6 month rolling basis, or slimmed down to business critical “governance light” approaches.

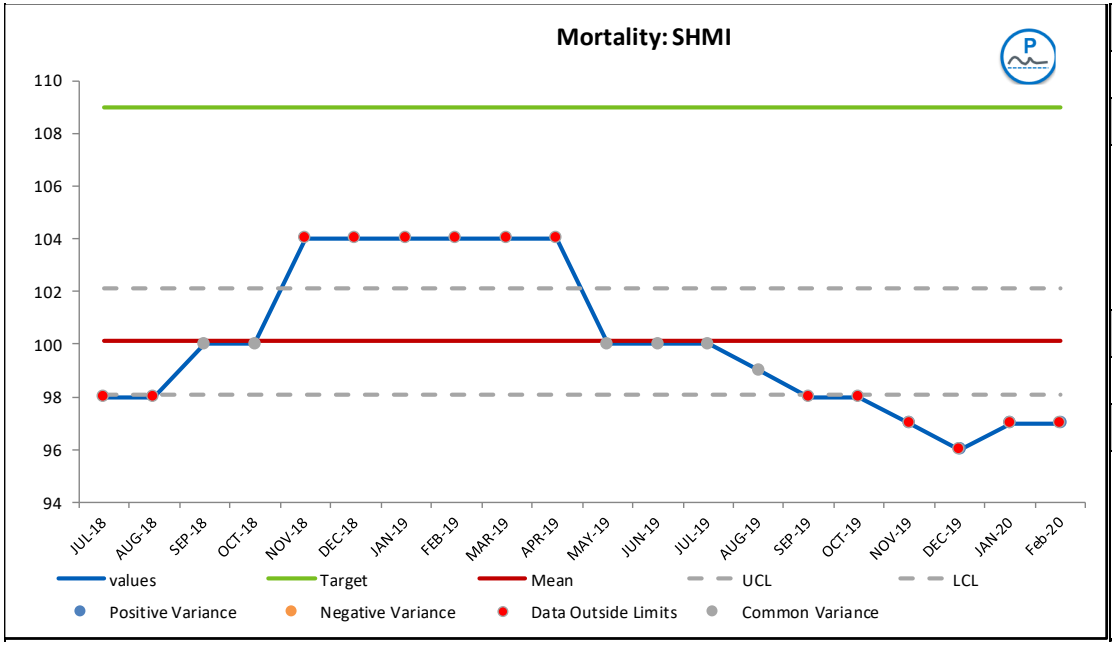
Medical appraisal and revalidation activities have been suspended for at least 6 months, and the GMC have now come into line with this position.

Consultant job plans (recorded) have been rolled over for 12 months, on the understanding that colleagues will be asked to work with agility over coming months.

Doctors from outside the trust and medical students who have been stood down from their studies are volunteering to join our clinical teams, and a programme of training, orientation and deployment is in rapid development.

Governance “light” processes have been approved with the chair of QGC.

SPC Charts – Mortality: SHMI



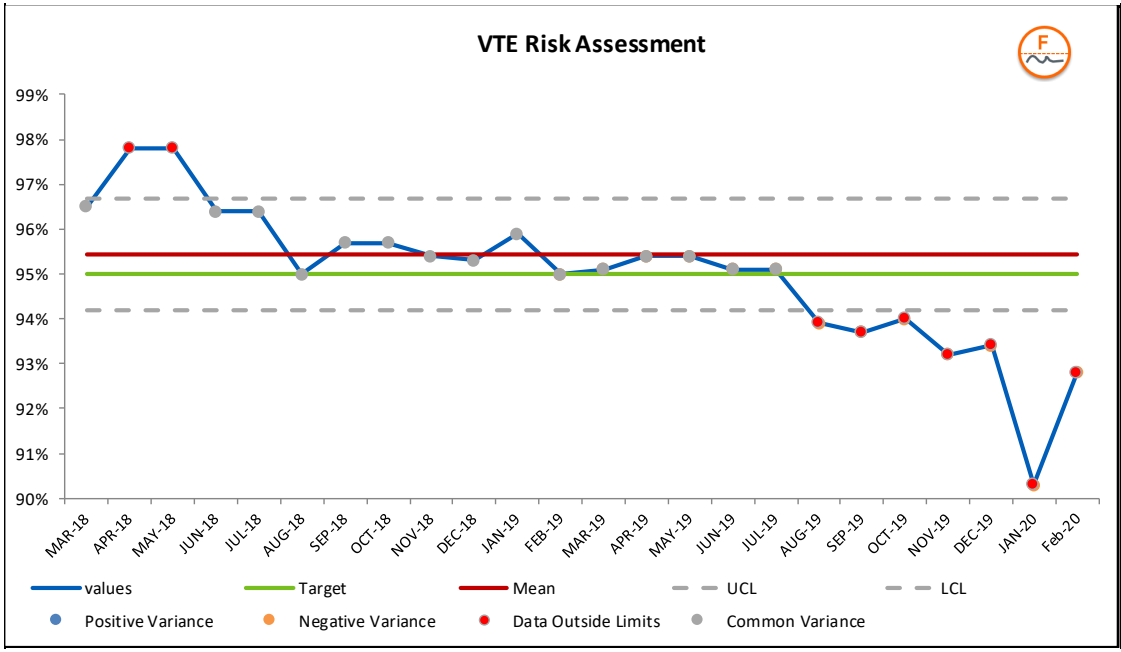
Feb-20
97
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
109
Target Achievement
Metric is consistently achieving the target

Context:

Shown for information as the performance is outside the control limits but representing a positive performance.

It is notable that SHMI has decreased substantially whereas HSMR (within "expected" range on Dr Foster, has been relatively static. A key difference between the 2 metrics is that SHMI incorporates post discharge mortality for up to 30 days.

SPC Charts – VTE Assessment



Feb-20
92.8%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
95%
Target Achievement
Metric is consistently failing the target

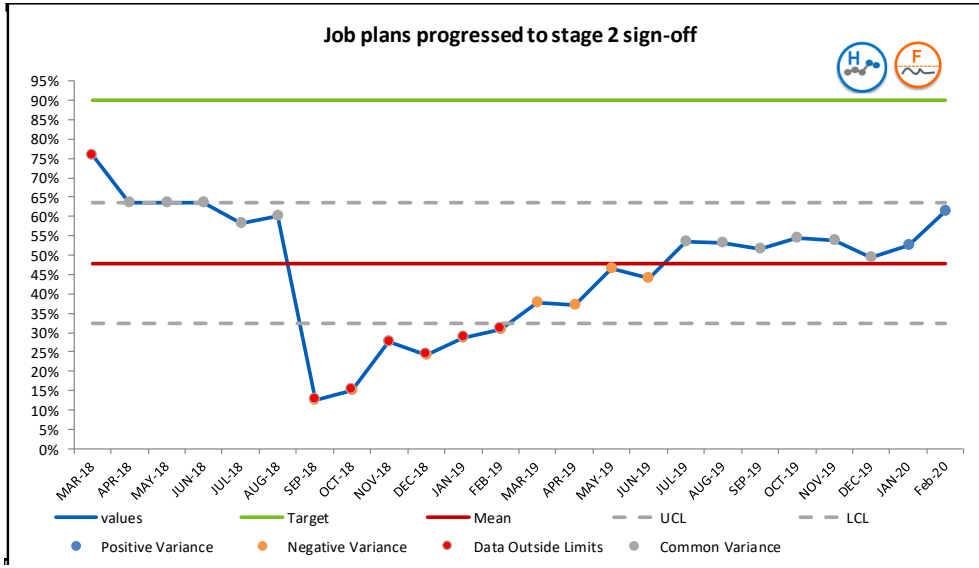
Context:

The metric presented is the capture of VTE 1st assessment at discharge on the eDN (electronic discharge notification). This does not reflect accurately the completion against Nice Guidance and Royal College standards. It remains below target.

Actions:

The ePMA (electronic prescribing) upgrade mandating VTE assessment prior to prescription was installed on the 8th of January. Reporting for subsequent months will be based on ePMA data and therefore be more accurate. Compliance is expected to improve substantially also.

SPC Charts – Job plans progressed to stage 2 sign-off



Feb-20
61.4%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a positive performance above the mean
Target
90.0%
Target Achievement
Metric is consistently failing the target

Actions:

- Changes to Job Plans are reflected in pay and tracked and reported on a monthly basis.
- All job plans awaiting second stage sign off are being notified to the departments to ensure timely progression and expedited to the Medical Director (MD) when necessary.
- Following the February review a further update will shortly be provided to assure the MD that the divisions are progressing.
- Where possible the PM is now integrating outpatient metrics to service plans to assist services to better understand the demand required.
- Consultant rostering solutions are being explored that could see the Trust revolutionise the way we manage and track our senior workforce's performance and could provide succinct reporting aligning with job plans (longer term)

Context:

- Job planning data was rebased during September 2018 with divisions agreeing that for a job plan to be compliant it must have been reviewed within a 12 month period and progressed to second stage sign off – i.e: a job plan that is aligned with the speciality demand and, clinician availability (for the purpose of recording compliance this is the numerator).
- The denominator will continue to be dynamic as this is attributed to the number of all clinicians within the speciality /division, varying as new consultants either join or leave the speciality workforce and is presented as a rolling 12 month period.

Actions completed:

- The recovery of the Trust position has improved significantly and is now 61% signed off.
- It is worth noting that had Women's Directorate not republished plans the position would be 67% the highest point in 2 years.
- During February deep dive reviews and comparisons continue to take place for Inpatients as part of a continuing piece to ensure that efficiency and transparency are delivered through completion of job plans.
- The Executive team meet on March 31st to undertake a full review and consider recommendations.
- The Clinical Director (CD) for Women's Directorate has requested the team republication ahead of schedule, which is very positive, many job plans will remain unchanged but this process ensures compliance.
- A deep dive service review and significant changes to working patterns is expected within the next 6 months as the service recruits 2 WTE colleagues.
- The Project Manager (PM) has been working closely with the CD's and updating the Divisions on progress and signalling areas that require focus.
- The Divisions show ever more commitment to the process and are applying new levels of scrutiny and accuracy to their job plans which is commendable during recent winter strains.

NGH Mortality Dashboard Q2 2019/20

Northampton General Hospital NHS Trust

	Monitoring & Screening			1st and 2nd Stage Review		Consideration for Investigation	
Data for the Rolling Year to September 19	Total number of adult inpatient deaths	Total number of adult deaths in ED	Percentage of all deaths screened by Mortality Screening Team	Number of 1st Structured Judgement Reviews completed in directorate/ specialty morbidity and mortality meetings ot Trust wide reviews	Total number of deaths referred for 2nd stage review at Trust Wide Challenge Meetings	Number of deaths considered more likely than not to be due to a problem in care and referred to Review of Harm Group	Review of Harm Group Decision Serious Incident (SI) Comprehensive Investigation (CI) No Investigation (NI)
Q3 18/19	308	33	92%	68	9	2	1 SI / 1 NI
Q4 18/19	384	37	91%	66	5	2	1 SI / 1 NI
Q1 19/20	350	36	92%	38 of 96	4	0	0
July	125	15	71%	12 of 21	1	0	0
August	107	9	79%	8 of 15	0	0	0
September	107	14	83%	14 of 24	1	0	0
Total Q2 18/19	**339**	**38**	**77%**	**34 of 60**	**2**	**0**	0

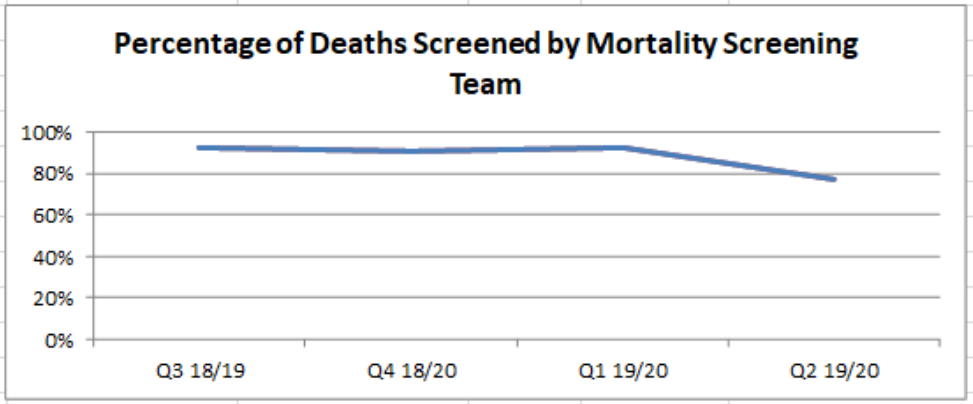
Vulnerable Adults

Patients with a learning disability

In Q2 2019-20 there were no patients with a learning disability who died at the Trust.

Patients with a significant mental health diagnosis

In Q2 2019-20 5 patients with a significant mental health diagnosis died atthe Trust. 4 of the 5 cases have been reviewed at the Vulnerable Adults M&M. One case was judged to have received poor care, 2 were judged to have received good care and 1 patient received adequate care. All the deaths were judged to be definitely unavoidable. Details of the poor care were sent tothe relevant department for local learning. A death from Q1 2019-20 was reviewed and care was thought to be excellent.



NGH Mortality Dashboard Q3 2019/20

Northampton General Hospital NHS Trust

	Monitoring & Screening			1st and 2nd Stage Review		Consideration for Investigation	
Data for the Rolling Year to December 19	Total number of adult inpatient deaths	Total number of adult deaths in ED	Percentage of all deaths screened by Mortality Screening Team	Number of 1st Structured Judgement Reviews completed in directorate/ specialty morbidity and mortality meetings ot Trust wide reviews	Total number of deaths referred for 2nd stage review at Trust Wide Challenge Meetings	Number of deaths considered more likely than not to be due to a problem in care and referred to Review of Harm Group	Review of Harm Group Decision Serious Incident (SI) Comprehensive Investigation (CI) No Investigation (NI)
Q4 18/19	384	37	91%	66	5	2	1 SI / 1 NI
Q1 19/20	350	36	92%	38 of 96	4	0	0
Q2 19/20	339	38	77%	34 of 60	2	0	0
October	123	14	81%	7 of 12	0	0	0
November	129	8	47%	4 of 20	0	0	0
December	182	27	41%	7 of 16	1	0	0
Total Q3 19/20	**434**	**49**	**54%**	**18 of 48**	**1**	**0**	0

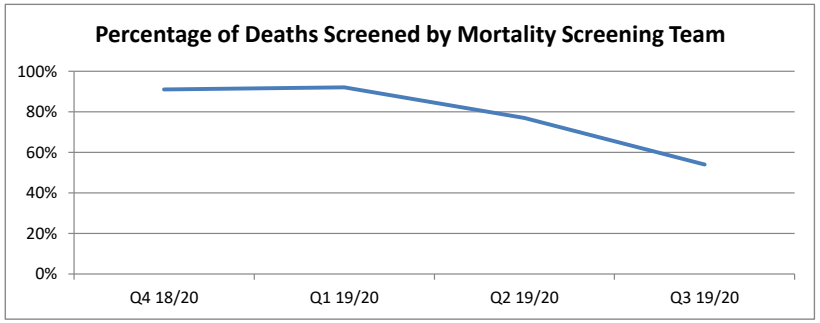
Vulnerable Adults

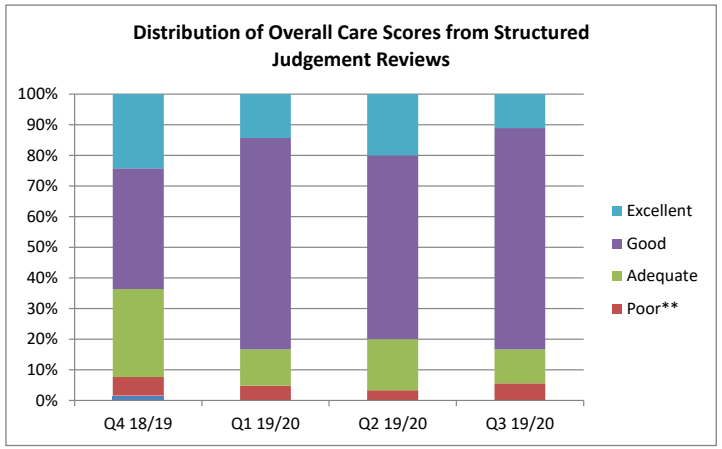
Patients with a learning disability

In Q3 2019/20 there was 1 patient with a learning disability who died at the Trust. This case will be reviewed at the next Vulnerable Adults M&M meeting.

Patients with a significant mental health diagnosis

Two patients with a significant mental health diagnosis died in the Trust in Q3 2019/20. One case has been reviewed by the Vulnerable Adults M&M meeting and care was judged to be good. A review of the second case will be carried out at the next meeting.





**Trigger for 2nd stage review

The Medical Examiner Team started scrutinising deaths on 21/10/2019. Cases reviewed were 19 cases Oct 19, 38 cases Nov 19, 59 cases Dec 19

Mortality Screening Rates have signicficantly declined due to some of the screening team transferring over to the ME Office, retirement and illness. There is one screener left.

An alert for Nervous system congenital anomalies was received in the quarter. All 3 deaths were stillbirths and had a spina bifida diagnosis. These were reviewed as part of the perinatal deaths process and no concerns were found.

Mortality was significantly raised over the rolling year for Diverticulosis and Diverticulitis SJR review s had been carried out by Colorectal Surgery for 2 deaths and no concerns were noted. A further death had been screened with the outcome of no further review. The remaining 4 cases have now been reviewed and the overall care was judged as excellent for 1 patient, good for 2 patients and adequate for 1 patient.

Work is in progress on the implementation of the Mortality Module for the new Datix Cloud System (DCIQ).

Learning from Screening, and Structured Judgement Reviews

Updates to the following workstreams were received during the quarter:

Congestive Heart Failure mortality continued to show a downward trend for the rolling year and has not been significantly raised for 5 months. Work with Primary Care and Kettering General is underway to develop a collaborative heart failure palliative care pathway.

Secondary malignancy mortality continued to be significantly raised in the Dr Foster metric however deaths were below the expected level for the SHMI measure which includes deaths within 30 days. 10 of the 50 deaths were following non-acute transfers to hospices and these are counted as deaths in the community by SHMI.

A **Comorbidity Capture** paper was presented by the Head of Coding at the December meeting of the Mortality Review Group. The group discussed a range of solutions to the problem of all known medical history not being documented for every attendance and therefore not being coded. This has an adverse effect on risk profiling for deceased patients with HSMR and has an impact on the income received for all patients. Further work on electronic clerking would be progressed with IT and the Clinical Senate Group.

Reviews of **cancer alerts** identified that since April 2018 patients transferred to **hospices for palliative care** were included in the total hospital deaths by Dr Foster. These are counted as deaths in the community for the SHMI mortality metric. This has had an adverse effect on a number of diagnoses as the expected deaths remain unaltered.

Dr Foster have investigated and found that data for the Northamptonshire hospices is submitted by Northamptonshire Healthcare NHS Foundation Trust and transfers are treated as if patients are transferred to a community hopsital.

Report To	**TRUST BOARD**
Date of Meeting	**26th March 2020**

Title of the Report	**Emergency Preparedness, Resilience & Response Annual Report**
Agenda item	**8**
Presenter of the Report	Deborah Needham – Chief Operating Officer, Deputy Chief Executive
Author(s) of Report	Jeremy Meadows – Head of Resilience and Business Continuity
Purpose	For assurance/information/awareness.

Executive summary

As an acute provider of NHS Funded Care, the Trust is required to evidence appropriate planning and response mechanisms for a wide range of emergencies and business continuity incidents. These requirements are set out by the Civil Contingencies Act (CCA, 2004) and NHS England's Emergency Preparedness, Resilience and Response (EPRR) Framework 2015.

A robust and stringent process with Executive and Senior Management engagement has been followed to complete a review of the Trust's level of Emergency Preparedness to ensure that the results provide a true reflection of the Trust's overall position against the NHS EPRR Framework.

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? Strategic aim 1 – focus on quality and safety
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks (**Y**)
Related Board Assurance Framework entries	BAF – please enter BAF number(s) BAF 1
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (**N**) Is there potential for or evidence that the proposed decision/policy

	will affect different population groups differently (including possibly discriminating against certain groups)? (**N**)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper (**N**)

Actions required by the Group

The Group is asked to:

- Note the contents of this paper.
- Discuss and appropriately challenge the contents of this report.
- Identify areas where additional assurance is required.

Northampton General Hospital NHS Trust

Emergency Preparedness, Resilience & Response – Annual Report March 2020

1. Introduction

This paper provides a report on the Trust's emergency preparedness in order to meet the requirements of the Civil Contingencies Act (2004) and the NHS England Emergency Preparedness, Resilience and Response Framework 2015.

The Trust has a suite of plans to deal with Major Incidents and Business Continuity issues. These conform to the Civil Contingencies Act (2004) and current NHS-wide guidance. All plans have been developed in consultation with regional stakeholders to ensure cohesion with their plans.

The paper reports on the training and exercising programme, EPRR reporting programme, and details the developments of the emergency planning arrangements and plans. The report gives a summary of instances in which the Trust has had to respond to extraordinary circumstances.

Background

The Civil Contingencies Act (2004) outlines a single framework for civil protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparedness and response at a local level. As a category one responder, the Trust is subject to the following civil protection duties:

- Assess the risk of emergencies occurring and use this to inform contingency planning
- Put in place emergency plans
- Put in place business continuity management arrangements
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other local responders to enhance coordination
- Cooperate with other local responders to enhance coordination and efficiency

2. Overview of EPRR

Risk Assessment

The Civil Contingencies Act (2004) places a legal duty on responders to undertake risk assessments and publish risks in a Community Risk Register. The purpose of the Community Risk Register is to reassure the community that the risk of potential hazards has been assessed, and that preparation arrangements are undertaken and response plans exist. Those risks currently identified on the Northamptonshire Local Resilience Forum Community Risk Register with a rating of high or very high include:

- Mass influx of evacuees
- Influenza type disease
- Fuel shortages
- Countywide loss of electricity
- Severe flooding

- Loss of significant telecommunications infrastructure in a localised incident such as a fire, flood or gas incident
- Major radiological contamination as result of an out of county nuclear reactor accident (inc. overseas)
- Local accident involving transport of hazardous materials

The emergency planning team works closely with other agencies as part of the Northamptonshire Local Resilience Forum to consider these risks to keep the county as safe as possible.

Partnership Working

The Trust works in collaboration with a range of partner agencies through formal standing meetings and ad hoc arrangements. Formal committees of which the Trust is a member include the Northamptonshire Local Health Resilience Partnership and the Northamptonshire Health Resilience Working Group. The Trust is also represented at a number of sub groups of the Northamptonshire Local Resilience Forum. The purpose of these groups is to ensure that effective and coordinated arrangements are in place for NHS emergency preparedness and response in accordance with national policy and direction from NHS England Central Midlands.

Debriefing from Live Events and Exercises

Following live events and exercises, debriefs are undertaken in order to capture learning points. Lessons identified from live events and exercises are subsequently incorporated into major incident and business continuity plans, and are shared with partner organisations.

Communications

Communications is critical in dealing with any adverse incident. The Trust has recently purchased a dedicated web-based system to assist with the notification and call-out process during an incident. As part of the rollout of this system, the resilience team are linking with key areas within the Trust to provide training and ensure ongoing maintenance of contact details. Additionally, work has recently been undertaken to install contingency phones throughout the Trust in order to maintain communication during periods of potential IT/network outage. As part of the Trust's exercise programme, a series of communication cascade exercises will be held throughout the year in order to test the ability of the organisation to contact key staff and other NHS and partner organisations.

3. Governance

Resilience Planning Group

The Trust has a Resilience Planning Group that meets bi-monthly. All standing members of the group are required to attend 4 of the 6 meetings held each financial year and not be absent for two consecutive meetings without the permission of the chair of the group.

The group includes representation from all areas within the Trust and other Directors and Officers of the Trust may be asked to attend at the request of the Chair. External partner agencies will be invited if there are specific agenda items that require multi-health partner involvement.

The group is authorised by the Trust Board to investigate any activity within its terms of reference and to seek any information it requires from any employees and all employees are directed to co-operate with any request made by the Group.

The Group has devolved responsibility from the Chief Operating Officer as the Accountable Emergency Officer for the following elements of the Resilience and Business Continuity workstreams:

- Ensuring that the Trust is compliant with the requirements of the Civil Contingencies Act (2004).
- Ensuring that the Trust can satisfy the requirements of external standards, legislation and statutory requirements.
- Ensuring that the Trust is engaged at a strategic, tactical and operational level with National, Regional and local health and multi-agency resilience agendas specifically: Local Health Resilience Partnership, Northamptonshire Local Resilience Forum and its sub-groups.
- Ensuring appropriate Trust input via Operational and Resilience routes into multi-agency plans, procedures and policies.
- Ensuring that the Trust has a robust and tested Major Incident Plan in place and that staff have been trained in their roles.
- Ensuring that the Trust has a range of emergency plans in place to respond to specific emergency situations such as Pandemic Influenza, Communicable Disease Outbreaks, Mass Casualty and CBRN.
- Ensuring that staff are trained to an appropriate level with respect to role and function in an emergency situation.
- Ensuring that the Trust and all of its Directorates have robust Business Continuity Management plans in place which would enable the continued delivery of key services even whilst responding to an emergency.
- Ensuring that all Divisions are involved in the emergency planning and resilience agenda and that updates, potential risks and new initiatives are shared with respective management teams.
- To provide a forum to exchange information, and promote good practice in emergency planning across the Trust.

Planning Sector Reports

The following sections provide an area-by-area report on developments over the past year and planning for the next 12 months.

Corporate Major Incident Response Plan

This plan details the Trust's actions in the event of a major incident (e.g., a rail crash, floods, or a terrorist attack). Such an event will require the hospital to employ a different method of working in order to manage the situation. The plan contains unit-level plans that details the actions required of individual areas to ensure that a trust-wide response is achieved.

The policy is currently under review to incorporate recent changes within the Trust. Work is currently underway to provide stepdown support to Critical Care.

Business Continuity Management Policy

Business Continuity Management is a management process that helps to manage the risks to the smooth running of the organisation or delivery of a service, ensuring that the Trust can continue in the event of a disruption. These risks can be from an external environment (e.g., power failures or severe weather) or from within the organisation (e.g., system failures or loss of key staff). A

business continuity event is any incident requiring the implementation of special arrangements in order to maintain or restore services.

The policy comprises of a corporate-level policy supported by service-level plans. These service level-plans detail what would be required for the service to continue; which less-critical services or functions could be suspended and for how long in order to maintain critical services; which other services are required for that service to function; and which services rely on that service being operational.

All local plans are currently being reviewed to ensure maintenance of critical services in the preparation of Covid-19.

EU Exit Business Continuity Plan

The EU Exit Business Continuity Plan has recently been developed in consultation with the Brexit Planning Group with the intention of managing the Trust's response to the potential risks associated with the UK's departure from the EU. The UK formally left the EU at 23:00 on the 31st January without any changes to current arrangements; it remains bound to the bloc's rules until the 31st December 2020. The Government is now focussing on the delivery aspects of the current deal, the future relationship negotiations and preparing for the end of the implementation period.

Although it is not known what the end of 2020 will look like, we do know that there will not be a no-deal exit scenario as a structure will be in place. No details regarding how we end up at that point are known at present.

Following the passing of the Brexit bill there will now no longer be a "No Deal" Brexit.

The Resilience Planning Group will continue to monitor the situation.

Adverse Weather Plan

Adverse weather covers conditions such as snow, ice, fog, floods, gales and high winds and heavy storms, which render journeys by road extremely hazardous. The UK Cold Weather alert watch came into operation on 1 November 2019 until 31 March 2020. Throughout this period, senior managers have received alert communications to ensure preparedness across the Trust. This plan details how the Trust would manage an adverse weather event which would result in staff requiring assistance to attend their place of work, and/or requiring overnight accommodation. The resilience team have recently acquired the services of 4x4 Response UK, an organisation who provide 4x4 vehicles, equipment and trained personnel to support the emergency services in adverse weather and poor road conditions where conventional plans cannot cope.

Additionally, the Trust has arrangements with Northampton Leisure Trust who operate the onsite Cripps Recreation Centre and will provide a 'Snow School' play scheme for 5-13 year olds to allow staff, who would otherwise be required to provide childcare, to work in the event of school closures.

No changes from the national plan was required, therefore, the Trust Cold Weather plan remains in place. This is readily available on the Trust Intranet.

Training

A key part of any preparedness arrangements is to ensure that staff are appropriately trained to implement the required response. The Head of Resilience facilitates the delivery of monthly major incident training to staff, in addition to specific sessions as required, and has included;

- Quarterly ED training days which focus on major incident and CBRN responses, including erection of the CBRN decontamination tent and donning the Powered Respiratory Protection suits.
- Emergency Department CBRN Major Incident Study Day: 8th May 2019, 25th September 2019. Major incident response training covering both CBRN and infectious diseases have been held throughout the year. This is specifically aimed at ED staff that are likely to be involved in the initial response following this type of incident. It covers training on how to operate the protective PRPS suits as well as awareness on the process of patient decontamination using the Trust decontamination facility. These sessions continue to be delivered to all new ED starter staff and facilitated by the Trust CBRN nurse lead.
- Loggist training ensures that NGH has sufficiently trained members of staff who can act as loggists during an incident. In addition, sessions have been developed to provide qualified loggists with refresher training in decision logging during a major incident.
  As part of the training, loggists are encouraged to attend some senior meetings in order to practice the logging of key decisions.
- Members of ED and Resilience attended the Critical Care Network mass casualty event which highlighted the impact of recent terror events on the health economy.
- Members of ED attended the Major Incident Surgical Training & Teams (MISTT) Training Course and highlighted the benefit for surgical staff to attend the session focussed on cadaveric procedures for damage control.
- The Head of Resilience and Business Continuity attended a one day structured debrief course on 31st July 2019. This was delivered by Public Health England and the purpose was to enable those involved in emergency planning to gain the skills required to effectively facilitate a structured debrief following an incident or exercise. This is important in identifying lessons learnt and identifying opportunities for improvement.

As required by the EPRR Core Standards, all corporate-level training and exercising is based on and referenced to the National Occupational Standards for Civil Contingencies.

Exercising

The Trust has a rolling programme of live, table-top, command post and communications exercises that are designed to test and develop our plans. The Trust is required to undertake the following:

- Communications exercise – minimum frequency – every six months
- Table top exercise – minimum frequency – every 12 months
- Live exercise – minimum frequency – every three years

If the Trust activates its Incident Control Centre in response to a live incident this replaces the need to run an exercise, providing lessons are identified and logged, and an action plan is developed.

It is vital to ensure that internal exercises are run in a multi-departmental context in order to provide areas of the Trust with an increased understanding of any potential requirements and realistic expectations in the event of an incident.

Whenever possible, the Trust strives to ensure that testing is held in a multi-agency context in order to provide familiarisation with other organisations and to assist with benchmarking our response with our partners. Exercises provide valuable insight into the operationalisation of our plans and important information regarding the areas of the plans that require further development.

The following exercises have taken place over the past 12 months:

- 28th March 2019: Data Security Business Continuity Tabletop took place to test the IT department's response to a data security incident.
- Special Branch Terrorism and Extremism training: 31st May 2019, 11th September 2019, 11th October 2019, 4th November 2019
- On-call Managers Major Incident Tabletop Exercise took place on 17th January 2020.

Tactical command training has been delivered to on-call managers. The aim of the session was to provide managers with an update on EPRR arrangements in being able to respond to a major incident and to build their competence. This also included engagement from clinicians to test ED's response in receiving, triaging and treating causalities involved in a major incident.

- NHS England Communications Exercise Touch Base: 9th July 2019. Regional communications exercise.
- Exercise Eris – 10th October 2019: A one-day discussion-based exercise designed and developed by NHS England and NHS Improvement Midlands with PHE to assess the response, escalation and recovery to a cyber incident that impacts across the whole health economy within the Midlands region.
- Emergency Department Major Incident Tabletop Exercises: 24th May 2019, 19th July 2019, 17th January 2020. These exercises are open to all. The latter exercise was preceded by a call-out system test prior to a table-top exercise.
- On the 11th October 2019, Anaesthetics and Critical Care ran a Major Incident table-top exercise to test the practicalities of collaborative working in the event of an influx of casualties following a major incident. This was well received by all in attendance.
- Northamptonshire Police, Operation Explorer: 26th November 2019. Attended by Head of Resilience, Directorate Managers, ED consultants and on-call executives.
- Northampton Counter Terrorism Consequence Management tabletop exercise VENIPLEX: Thursday 21st November 2019. Included the considerations of: Initial scene containment and investigation, decontamination, casualty clearance, health management, contingency plans, escalation of response, investigation/forensics. This was attended by the Head of Resilience and ED Consultant. Following this exercise Run, Hide, Tell guidance was circulated to staff.
- Pharmacy Major Incident Tabletop Exercise: 4th December 2019.
- IT Business Continuity Tabletop Exercise: 24th January 2020.
- Coronavirus Tabletop Exercise: 7th February 2020.

Staff who have attended table-top exercises have found them to be enjoyable and informative with lots of new useful information discussed.

- Emergency communication tests: Call cascade. The Trust has undertaken a number of communication exercises utilising the electronic call cascade system 'Alert Cascade'. The exercises have identified some learning outcomes which have been actioned. These exercises continue to take place on a quarterly basis.

Live Incidents

During 2019, NGH experienced a number of extraordinary incidents. These are detailed below:

- 23rd February 2019: Power Failure

On the 23rd February 2019 an internal incident was declared due to the loss of electrical power affecting a number of wards and departments.

As a result of the power failure, a decision was taken at 00:55 on the 23rd February 2019 to close the Emergency Department (ED) and the East Midlands Ambulance Service (EMAS) were informed of this and requested to divert all ambulances.

The internal incident was managed in line with Trust Policy and Silver meetings were commenced let by the Chief Operating Officer (COO).

When the Trust's high voltage power supply failed due to an underground fault with the cable, the Trust's generators started but due to two separate issues two of the Trust's generator sets didn't provide power supply to the affected areas, all other generators worked as normal. As a result inpatient wards were affected along with main theatre, pathology, pharmacy and Labour Ward. The Trustwide telephone and paging system was also not working.

Contingency plans were immediately activated which included stocks of blood being sent to the Three Shires Hospital and if any patient required lifesaving surgery then this was to be performed in Main Theatres where emergency lightening had been sourced.

The Silver Meetings continued regularly overnight and all patients remained safe with the contingency plans put in place.

By 07.47 the Trust had re-opened.

Following the incident, it was noted that the initial problem has been caused by a loss in power due to a fault with the high voltage cabling on site.

Those in attendance at the debrief were in agreement that the incident was managed appropriately and patient safety was maintained throughout the incident.

- 4th July 2019: Network Outage

The Trust experienced an unplanned network downtime on 4th July 2019 between the hours of 10:27am and 10:43am (16 minutes)

Whilst in the process of testing network switches to support the rollout of the trust's replacement wireless network, a network switch was connected to one of the two core network switches for testing and this proved successful. The next stage of this test was to connect the network switch to

both of the network core switches. This is a very important step as all network switches need to be connected to both core switches to provide resilience. This means that if one core network switches or one fibre optic connection to the network switch fails there will be no impact to the Trust. This would only cause a resilience issue. When network switch was connected to both network core switches this caused a spike in network traffic and caused two critical fibre optic links to shut down. This made the network unavailable to all users and devices (including desk phones, emergency lift lines and the red phone system).

The switch was removed from the network and all configuration was changed back to its previous state. This resolved the issue and the network came back up into a normal state.

The network was unavailable for 16 minutes.

During the period of outage, Switchboard reverted to their contingency mobile phone in order to allow emergency 2222 bleeps to continue. Mobile phones were requested for each ward. Radios were provided by Estates for the following weekend and an SOP was created and circulated to key areas regarding plans in place for continuing communication in the event of a future outage.

Patient safety was maintained throughout the incident. There was no reported harm as a result of the incident.

- 3rd – 15th October 2019: Electrical Shutdown:

A project was undertaken to provide assure that the generators that support the site in the event of a mains power loss could meet the demand of the site if the power was to be cut during 'primetime' working. As a result a plan was developed to switch off the mains power to areas of the site for a maximum of 15 seconds at pre-determined times.

Given the inevitably that this was likely to cause some disruption, it was crucial that areas did not turn off their equipment in readiness for this powerdown in order to determine the impact of losing power at 'full capacity'. Work was undertaken to ensure patients were not undergoing procedures or in a CT or MRI scanner etc. At the time of the powerdown, however, it was important that equipment was powered up, theatre lights and ventilation was on to truly test the load.

The outage had the same effect as the regular generator tests; the difference was surrounding equipment that isn't in use when these early morning tests are carried out.

These isolations were carried out by Estates who had staff in affected areas to respond to any issues.

This exercise was run as an internal incident and an incident room was in place to pick up any issues that arose when the power was switched back on to ensure any issues were dealt with promptly. Areas used this opportunity to test their departmental Business Continuity Plans. As a result, it has been agreed that this exercise meets the criteria to fulfil our requirement to undertake a three-yearly live exercise.

- December 2019: Mortuary Capacity.

Conerns arose on the 30th December 2019 regarding mortuary capacity over the New Year period. The initial risk was about the capability of storing bodies through the bank holiday period, and then the need to continue the additional storage for the following weeks as the process returned to normal. Multi-agency Strategic Coordination Group meetings took place to secure suitable and

sufficient capacity. Given neighbouring hospitals were unable to support with storage, Northampton County Council led the response which resulted in a temporary solution onsite.

Debriefs were held after the incidents and action plans for plan development were produced. These incidents have helped the Trust and services to develop their plans to manage such incidents should they occur again in the future.

- Covid-19. March 2020.

At time of writing, the number of confirmed cases of Covid-19 is increasing and the UK is currently in the 'contain' period. There have currently been no confirmed cases at NGH.

The Trust has followed instruction from the NHS England incident team to establish a substantial Incident Management Team and Incident Coordination Centre which is operating 7 days a week. Command and Control is in place and Gold and Silver command meetings are taking place. All areas of the Trust are represented in the planning meetings and plans are being drawn up to ensure a scalable response. Work is being undertaken to identify increased ventilation capacity, manage stock levels of key consumables and ensure staff are supported. Areas have been asked to review their business continuity plans to ensure continuity of critical services.

The Trust is engaging in system-wide calls and participating in the weekly National webinar hosted by Professor Keith Willett.

4. EPRR Core Standards Review 2019/20

NHS England requires providers of NHS funded care to provide assurance against the National Core Standards in relation to Emergency Preparedness, Resilience and Response (EPRR). Work to complete the annual EPRR Core Standards self-assessment took place to ensure that the results provide a true reflection of the Trust's overall position against the NHS Core Standard for Emergency Preparedness, Resilience and Response. The Core Standards are subject to annual review. The deep dive element focussed on severe weather and climate adaptation. This was as a result of a request from the Government's Environmental Audit Committee which has responsibility for assessing adaptation to climate related issues. It is deemed that the Trust is fully compliant with the twenty core standards as a result of sustainability initiatives which continue to be guided by a Sustainability Strategy, annual plan, external resource efficiency targets and feedback from our staff.

Table1 below provides an overview of the Trust's position against the Core Standards which is described through a series of 64 criteria.

Table 1: NGH Core Standards Review 2019.

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	14	0	0
Command and control	2	2	0	0
Training and exercising	3	3	0	0
Response	7	7	0	0
Warning and informing	3	3	0	0

Cooperation	4	4	0	0
Business Continuity	9	9	0	0
CBRN	14	14	0	0
Total	64	64	0	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Severe Weather Response	15	15	0	0
Long term adaptation planning	5	5	0	0
Total	20	20	0	0

NHS England and CCG colleagues attended the Trust to undertake a site visit and a review of our policies, procedures and processes. Initial feedback was very complimentary. Following the submission, site visit and attendance at the EPRR assurance panel, NHS England were assured that NGH were, for the fourth year in succession, "fully compliant" with the requirements of the core standards. This included assurance of the programme of work to address any gaps.

The EPRR Core Standards confirmation letter is attached for awareness. **APPENDIX 1**

Priorities for 2020, as identified by the Core Standards review.

- Use Green Log Books, or alternatively consider procuring a binding machine to ensure log books are compliant with security requirements.
- Continue to engage with Northamptonshire County Council with regard to evacuation plans.

5. Recommendations

The Board is asked to receive this report as a statement of assurance of the preparedness of the Trust to provide an effective response to a range of incidents and emergencies.

6. Next steps

The past year has seen good developments in the Trust's resilience arrangements; however ongoing work is required to maintain full resilience. The priorities highlighted above will determine the Emergency Planning and Business Continuity work plan for 2020.

Appendix 1

NGH Core Standards Letter 2019-20_.pdf

NHS
Northampton General Hospital
NHS Trust

2019 National Staff Survey Results

Key Themes and Issues

Mark Smith
Chief People Officer

Providing the Best Possible Care

NHS Staff Survey 2019 headlines

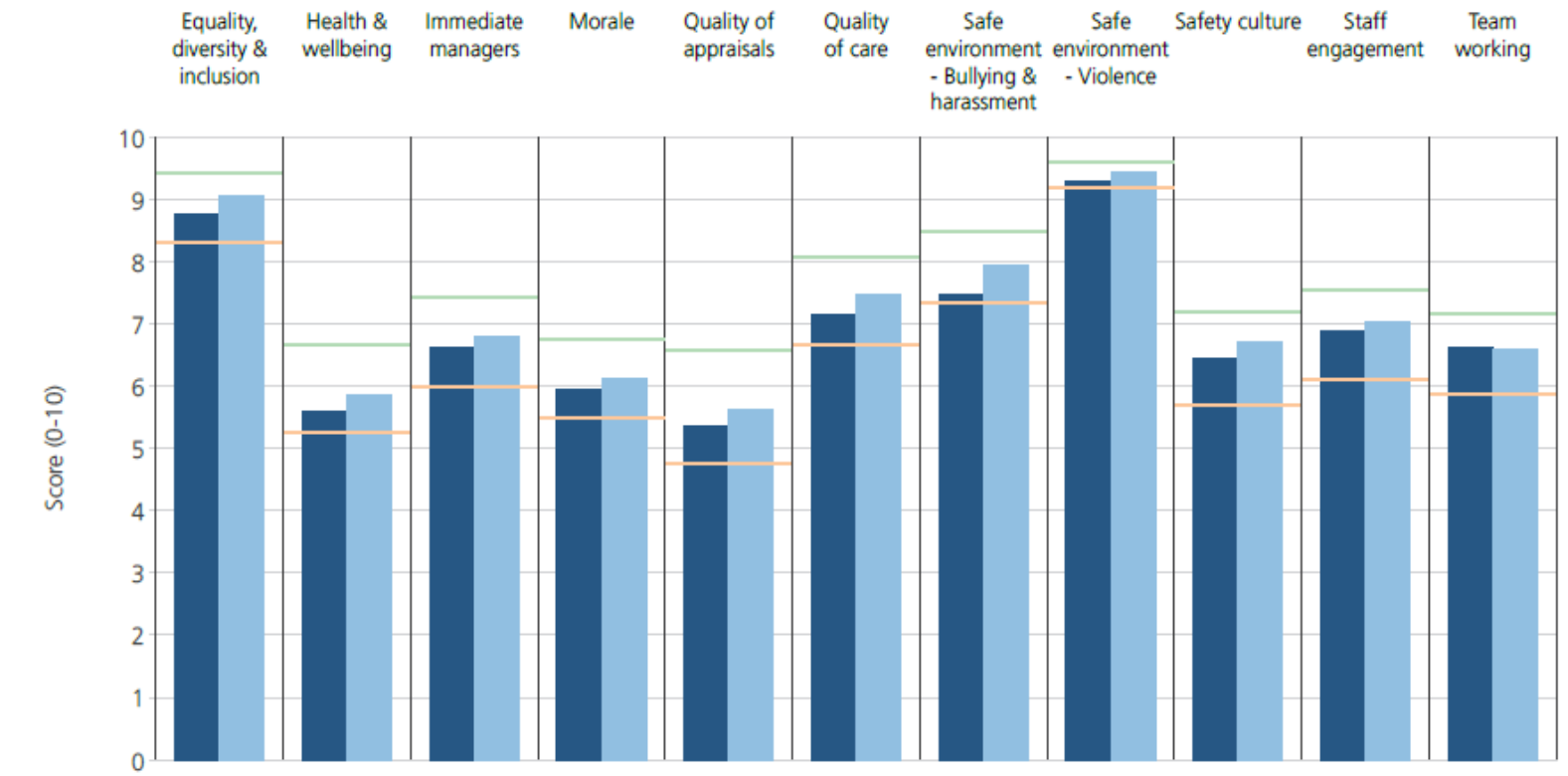
Response rate – 40%

Northampton General Hospital NHS Trust

Survey Coordination Centre

2019 NHS Staff Survey Results > Theme results > Overview

NHS England



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.4	6.7	7.4	6.7	6.6	8.1	8.5	9.6	7.2	7.5	7.2
Your org	8.8	5.6	6.6	6.0	5.3	7.2	7.5	9.3	6.5	6.9	6.6
Average	9.0	5.9	6.8	6.1	5.6	7.5	7.9	9.4	6.7	7.0	6.6
Worst	8.3	5.3	6.0	5.5	4.8	6.7	7.3	9.2	5.7	6.1	5.9
Responses	1,981	1,997	2,008	1,969	1,816	1,772	1,986	1,979	1,984	2,021	1,986

Key themes at a glance

Northampton General Hospital
NHS Trust

Theme	2018 score	2018 respondents	2019 score	2019 respondents	Statistically significant change?
Equality, diversity & inclusion	**8.9**	2058	**8.8**	1981	Not significant
Health & wellbeing	**5.7**	2078	**5.6**	1997	Not significant
Immediate managers	**6.6**	2086	**6.6**	2008	Not significant
Morale	**6.0**	2021	**6.0**	1969	Not significant
Quality of appraisals	**5.5**	1884	**5.3**	1816	Not significant
Quality of care	**7.4**	1867	**7.2**	1772	↓
Safe environment - Bullying & harassment	**7.5**	2052	**7.5**	1986	Not significant
Safe environment - Violence	**9.3**	2048	**9.3**	1979	Not significant
Safety culture	**6.7**	2060	**6.5**	1984	↓
Staff engagement	**7.1**	2123	**6.9**	2021	↓
Team working	**6.7**	2100	**6.6**	1986	Not significant

Themes Trust/Divisions v National Average

Northampton General Hospital NHS Trust

Themes	National Average	Trust Score		Surgical	Medical	Support Services	Clinical Support	W,C & O
Quality of appraisals	5.6	5.3		4.9	5.5	5.5	5.3	5.5
Health & wellbeing	5.9	5.6		5.4	5.0	6.1	5.7	5.8
Morale	6.1	6.0		5.7	5.8	6.0	6.1	6.3
Safety culture	6.7	6.5		6.1	6.3	6.5	6.5	6.9
Immediate managers	6.8	6.6		6.3	6.5	6.5	6.9	6.9
Team Working	6.6	6.6		6.2	6.6	6.4	6.6	7.1
Staff engagement	7.0	6.9		6.6	6.8	6.9	6.9	7.2
Quality of care	7.5	7.2		7.2	7.1	7.2	7.1	7.3
Safe environment – bullying & harassment	7.9	7.5		7.0	6.6	8.4	8.1	7.7
Equality, diversity & inclusion	9.0	8.8		8.4	8.3	9.0	9.2	9.1
Safe environment – violence	9.4	9.3		9.1	8.6	9.6	9.6	9.7

Staff Groups v National Average

Northampton General Hospital NHS Trust

Themes	National Average	Trust Score		Medical & Dental	Others	Nursing & Healthcare Assistants	Wider Healthcare Team	Registered Nurses / Midwives	Allied Health Professionals / Healthcare Scientists / Scientific & Technical
Quality of appraisals	5.6	5.3		3.9	5.3	5.5	5.1	6.0	5.3
Health & wellbeing	5.9	5.6		4.7	5.6	5.4	5.9	5.5	5.8
Morale	6.1	6.0		5.4	5.9	6.1	6.0	5.9	6.1
Safety culture	6.7	6.5		5.9	6.5	6.7	6.3	6.6	6.5
Immediate managers	6.8	6.6		5.6	6.6	6.7	6.4	7.0	6.9
Team Working	6.6	6.6		6.0	6.5	6.6	6.2	7.0	6.9
Staff engagement	7.0	6.9		6.3	7.0	6.9	6.7	7.1	7.0
Quality of care	7.5	7.2		6.6	7.2	7.5	7.3	7.0	7.3
Safe environment – bullying & harassment	7.9	7.5		6.2	8.0	7.1	8.2	6.9	7.9
Equality, diversity & inclusion	9.0	8.8		8.4	8.8	8.2	9.1	8.5	9.1
Safe environment – violence	9.4	9.3		9.7	9.8	8.2	9.7	8.8	9.6

Areas of focus – Staff Engagement

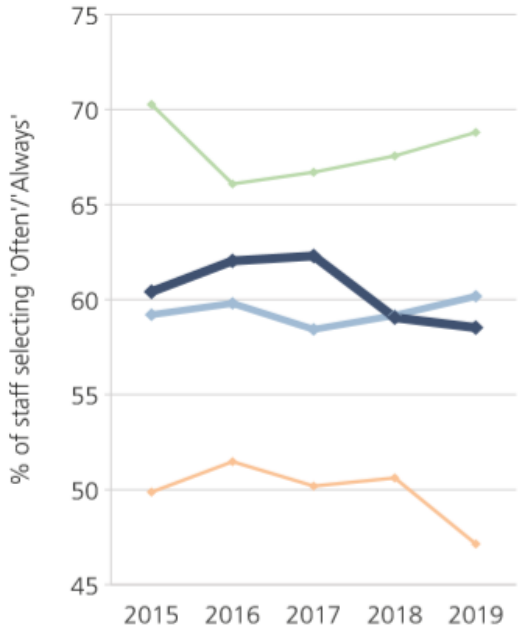
Northampton General Hospital NHS Trust

Survey Coordination Centre

2019 NHS Staff Survey Results > Theme results > Detailed information > Staff engagement – Motivation

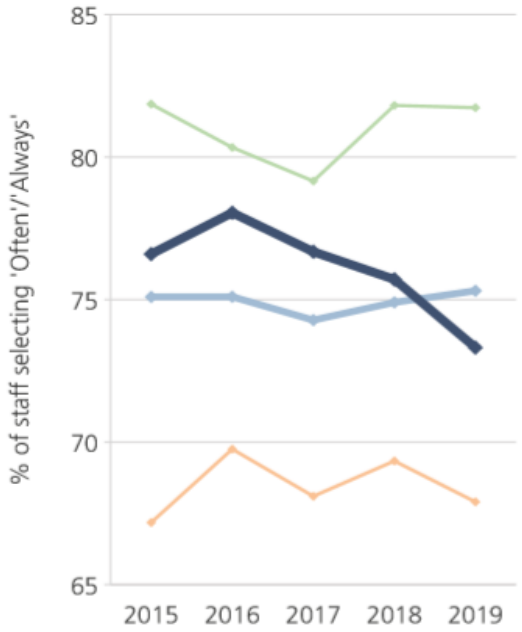
NHS England

Q2a
I look forward to going to work



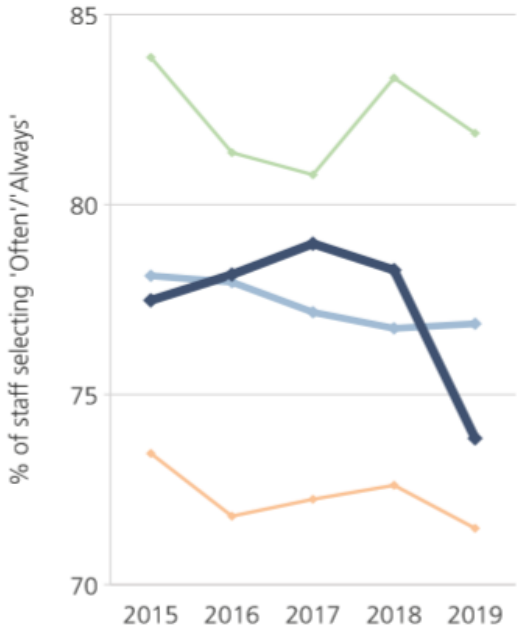
	2015	2016	2017	2018	2019
Best	70.3%	66.1%	66.7%	67.6%	68.8%
Your org	60.4%	62.0%	62.3%	59.1%	58.5%
Average	59.2%	59.8%	58.4%	59.2%	60.2%
Worst	49.9%	51.5%	50.2%	50.6%	47.1%

Q2b
I am enthusiastic about my job



	2015	2016	2017	2018	2019
Best	81.9%	80.3%	79.2%	81.8%	81.7%
Your org	76.6%	78.0%	76.7%	75.7%	73.3%
Average	75.1%	75.1%	74.3%	74.9%	75.3%
Worst	67.2%	69.8%	68.1%	69.3%	67.9%

Q2c
Time passes quickly when I am working



	2015	2016	2017	2018	2019
Best	83.9%	81.4%	80.8%	83.3%	81.9%
Your org	77.5%	78.2%	79.0%	78.3%	73.9%
Average	78.1%	78.0%	77.2%	76.7%	76.9%
Worst	73.5%	71.8%	72.2%	72.6%	71.5%

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Areas of focus – Staff Engagement

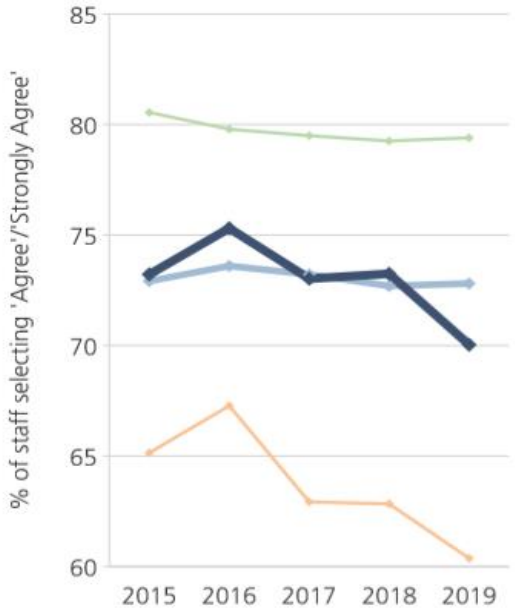
Northampton General Hospital
NHS Trust

Survey Coordination Centre

2019 NHS Staff Survey Results > Theme results > Detailed information > Staff engagement – Ability to contribute to improvements

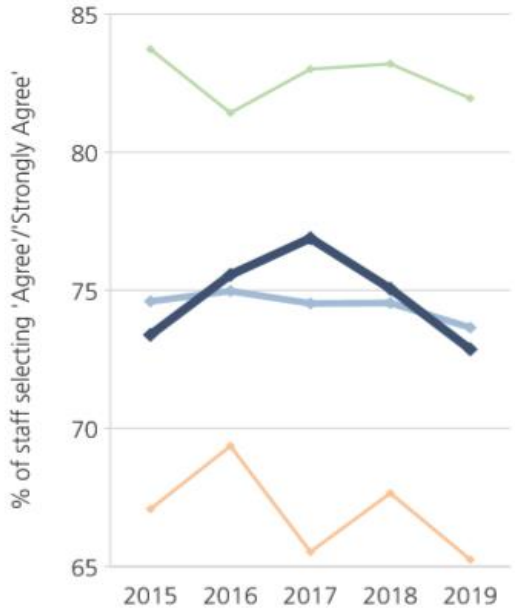
NHS England

Q4a
There are frequent opportunities for me to show initiative in my role



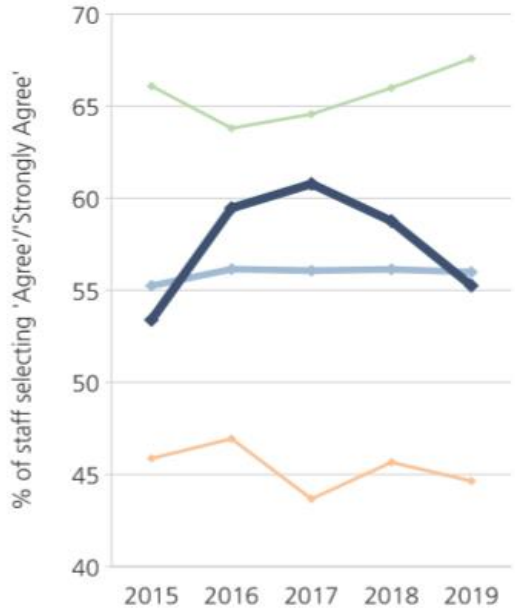
	2015	2016	2017	2018	2019
Best	80.5%	79.8%	79.5%	79.3%	79.4%
Your org	73.2%	75.3%	73.0%	73.2%	70.0%
Average	72.9%	73.6%	73.2%	72.7%	72.8%
Worst	65.1%	67.3%	62.9%	62.8%	60.4%

Q4b
I am able to make suggestions to improve the work of my team / department



	2015	2016	2017	2018	2019
Best	83.7%	81.4%	83.0%	83.2%	81.9%
Your org	73.4%	75.6%	76.9%	75.1%	72.9%
Average	74.6%	75.0%	74.5%	74.5%	73.6%
Worst	67.1%	69.4%	65.5%	67.7%	65.2%

Q4d
I am able to make improvements happen in my area of work



	2015	2016	2017	2018	2019
Best	66.1%	63.8%	64.6%	66.0%	67.6%
Your org	53.4%	59.5%	60.8%	58.8%	55.2%
Average	55.2%	56.1%	56.1%	56.1%	56.0%
Worst	45.9%	46.9%	43.7%	45.7%	44.6%

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Areas of focus – Staff Engagement

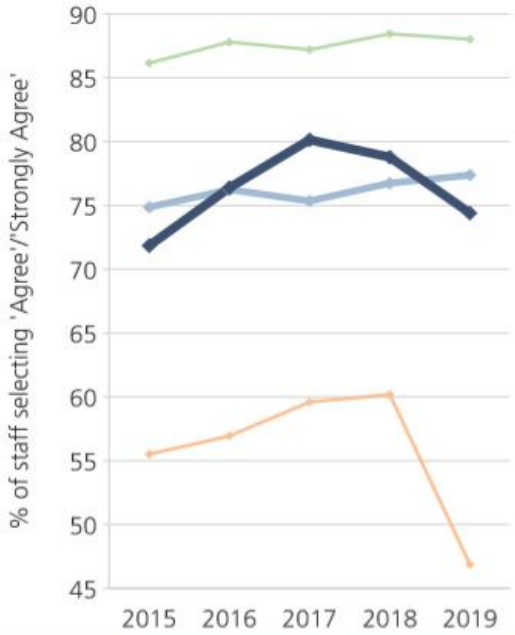
Northampton General Hospital NHS Trust

Survey Coordination Centre

2019 NHS Staff Survey Results > Theme results > Detailed information > Staff engagement – Recommendation of the organisation as a place to work/receive treatment

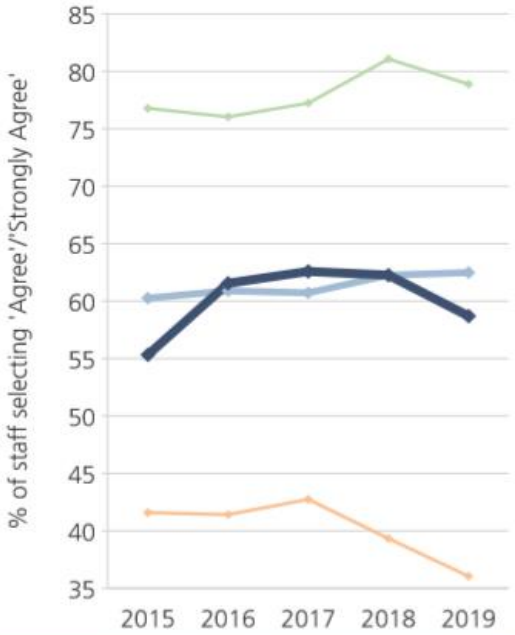
NHS England

Q21a
Care of patients / service users is my organisation's top priority



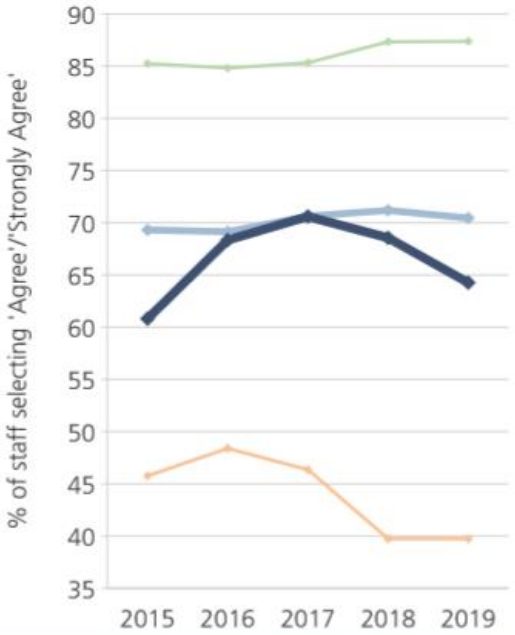
	2015	2016	2017	2018	2019
Best	86.1%	87.8%	87.2%	88.4%	88.0%
Your org	71.8%	76.4%	80.1%	78.8%	74.4%
Average	74.9%	76.2%	75.3%	76.7%	77.4%
Worst	55.5%	56.9%	59.6%	60.2%	46.9%

Q21c
I would recommend my organisation as a place to work



	2015	2016	2017	2018	2019
Best	76.8%	76.0%	77.2%	81.1%	78.9%
Your org	55.3%	61.6%	62.6%	62.3%	58.7%
Average	60.3%	60.9%	60.7%	62.3%	62.5%
Worst	41.6%	41.4%	42.7%	39.3%	36.0%

Q21d
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



	2015	2016	2017	2018	2019
Best	85.3%	84.8%	85.3%	87.3%	87.4%
Your org	60.8%	68.4%	70.6%	68.6%	64.3%
Average	69.3%	69.1%	70.6%	71.2%	70.5%
Worst	45.8%	48.4%	46.4%	39.7%	39.7%

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Staff Engagement Six

Northampton General Hospital NHS Trust

1. **Shared strategic direction – Motivation**

   Do we agree we are working towards a common direction?

   Do colleagues understand the vision and how they contribute to delivery?

   Do we have clear goals to deliver our vision which we monitor?

2. **Collective and distributed leadership – Motivation**

   Do we have a leadership plan?

   Do we empower colleagues in a leadership role?

   Are we absolutely sure staff are able to raise concerns?

3. **Adopt supportive and inclusive leadership styles – Innovation**

   What do we think are the most common leadership styles in the Trust?

   What ROI are we seeing based on recent leadership development?

   How can we be more inclusive?

Staff Engagement Six

Northampton General Hospital NHS Trust

4. Are colleagues able to lead transformation (small or large) – Innovation

Do we have a strategy for continuous learning and improvement – e.g. PFIS

Model – West Sussex, Virginia Mason – Leeds, LiA – Chesterfield, NHSE/I

Leadership and Culture – Salford

Have we invested in innovation?

How much time do we spend listening and educating for innovation?

5. Establish a culture based on integrity and trust

Do we have clear values and behaviours?

What do we do to promote the values and address behaviour inconsistent with them?

6. Place staff engagement firmly on the board agenda

How often do we discuss staff engagement and improvements

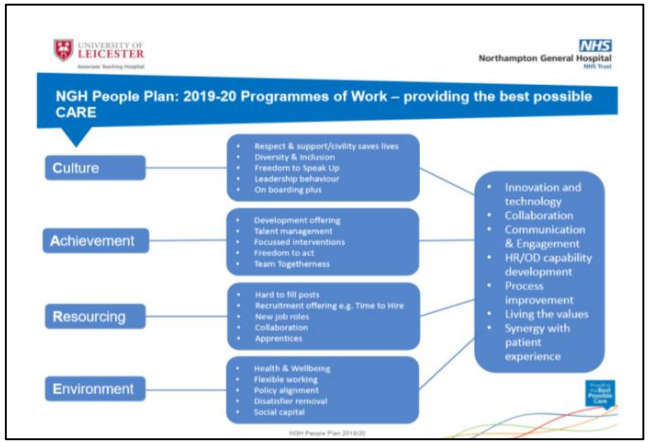
What should we measure, how frequently

Action – so far…

Northampton General Hospital NHS Trust

Summer of engagement in August/September 2019 – over 1000 colleagues contributed stating what would enhance their work experience

A 2020 People Plan was designed to action issues raised as part of the summer of engagement
– endorsed by the Board in November 2019



A number of actions spanning a number of themes have taken place which include:

- Head of Diversity and Inclusion appointed
- D&I networks being established
- Overseas Nursing bite size training
- Introduction of corporate team initiatives re wellbeing e.g. flexible working reviews, monthly gatherings
- Appointment of OH staff to support Mental Health issues
- Talent Management pilot undertaken in Surgical Division
- Hospital @ night service strengthened
- Recruitment to vacancies to reduce staffing challenges progressed

Action – what next…

Northampton General Hospital NHS Trust

As part of the response to the results the Executive team had started to review actions to be taken which included:

- Staffing establishment reviews – to reduce pressure and staff moves
- Communicate Shared Decision Council outcomes
- Review the quality and safety narrative for the Trust
- Enhance Goal Clarity – acknowledging capacity pressure has had a significant impact
- Cultural awareness campaign in facilities
- Review the Trust Awards – inclusive of long service
- Reverse mentoring with those from D&I networks

However the business of the Trust has changed significantly in managing the response to COVID-19, which has led to the Trust operating differently and preparing for the impact of the virus. This has represented an opportunity for the Trust to demonstrate its commitment to staff engagement with a number of colleagues contributing to a number of workstreams through distributed leadership. Staff benefits have and will be enhanced e.g. car parking and there is a strong sense of team and collaboration within the Trust making change happen. Therefore the motivation and innovation aspects of the staff engagement six are being followed.

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Report To	**Trust Board**
Date of Meeting	**20th March 2020**

Title of the Report	**NGH Improvement Plan**
Agenda item	**11**
Presenter of Report	Ms Claire Campbell, Director of Corporate Development, Governance and Assurance
Author(s) of Report	Mrs Sarah Brown, Compliance Governance Manager

This paper is for:

□ Note	□ Assurance	
For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place	

Executive summary

- Further to publication of the final reports, the Trust has developed an improvement plan to address the 'must' and 'should' actions listed in the reports.
- The Trust received three requirements notices. Two in relation to the proper and safe use of medicines (Medicine and Maternity) and one in relation to receiving and acting on complaints (Maternity).
- 6 actions have been closed in month
- All actions have been completed for the three requirement notices and the supporting evidence of completion is in place
- 44 actions are outstanding and remain on track for completion by the deadline date
- 4 actions have had been changed (date for completion)(detail in report)
- 6 actions have been signed off as complete but the evidence of completion is required (detail in the report)

Related strategic pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Create a sustainable future supported by new technology* 4. *Strengthen and integrate local clinical services particularly with Kettering General Hospital* 5. *Create a great place to work, learn and care to enable excellence through our people*
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks: **Yes** Failure to meet statutory requirements can lead to improvement

	notices, and prosecution and in extremes withdrawal of Trust services
Related Board Assurance Framework entries	All
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? **(No)** Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? **(No)**
Financial Implications	Some actions will require additional funds e.g. business cases and capital projects. Failure to meet requirements can lead to fines.
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper: **Yes** **CQC Fundamental Standards** The Trust has been issued with three requirement notice following the CQC inspection. Two in relation to Regulation 12 (2) (g): The proper and safe use of medicines. One in relation to Regulation 16 (2): Receiving and acting on complaints.

Actions required by the Trust Board:

The Committee is asked to:

- Accept this report as part of the assurance process, showing the Trust has and is taking action to address the concerns raised in the CQC reports and undertakings requirements.
- Challenge any areas of concern or where it is felt that progress is not occurring in a timely manner, or evidence of completed action is not forthcoming.

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Quality Governance Committee
20th March 2020
NGH Improvement Plan

1. Introduction

The CQC completed a use of resources, core service and well-led inspection of the Trust on 4th June 2019, 11th -13th June 2019 and 24th -25th July 2019 respectively. Three services were reviewed as part of the core service inspections, Urgent and Emergency Service, Medical Care (including older people's care) and Maternity. This was the first time the Trust has had a use of resources inspection as part of the updated CQC inspection methodology.

The final reports were published on 24th October 2019. Three reports were published:

- Provider report
- Evidence appendix (to support the provider report)
- Use of resources report

The reports are available on the CQC website https://www.cqc.org.uk/provider/RNS/reports

2. Progress against actions

2.1 NGH Improvement Plan (Update)

Following the publication of the reports, the 'must' and 'should' actions from the reports, have been transposed and used to form the detail of the NGH Improvement Plan. The Trust was issued with three requirement notices. The current version of the plan is provided in *Appendix A*. Actions have been provided, to show how the Trust will complete each of the 'must' and 'should' concerns raised in the reports. A deadline date, evidence of completion and a score for the likelihood of completion are also included.

The likelihood score is rated from 1 (rare- not going to happen) to 5 (almost certain) to mirror the likelihood scoring within the Trusts risk assessment processes. Only one action is currently scored as unlikely (15.3) this is due to the lack of available capital funding, to make the necessary changes to the paediatric ED layout.

The improvement plan was approved at Public Trust Board on 28th November 2019. The process for confirming closure of actions , is for the Lead Executive to 'sign off' on receipt of the required evidence and for the Executive team to ratify, prior to the monthly Quality Governance Committee meeting. An update will also be provided to Public Trust Board on a bi-monthly basis.

Report Month	Total actions remaining	Number closed in month	Number outstanding (on track)	Number overdue
November 2019	126	30	96	0
December 2019	96	17	79	0
January 2020	79	24	55	0
February 2020	55	5	50	0
March 2020	50	6	44	0

2.2 List of actions closed in month

Detail is provided in the NGH Improvement Plan (see Appendix A)

2.2.1 March 2020 closures

Action number	Concern	Action/s
9	**The trust should consider an external review of its governance structure and systems**	9.1 Refresh well- led Board knowledge 9.2 Identify basic specification of need
20	**The service should check catering staff are following infection prevention and control protocols**	20.6 A review of catering procedures and working practices will be carried out by Infection control and the Catering management team
21	**The service should keep all confidential patient records securely**	21.5 Assessment & Accreditation will incorporate criteria regarding the safe storage of health records.
22	**The service should introduce local procedures for invasive procedures in non-theatre settings**	22.1 LocSSIP documents reviewed and updated
32	**The service should ensure managers are planning the service for the long term. For example, to enable planning and organisation of services so they met the needs of the local population within the local expected population growth**	32.1 Develop Long Term Plan in conjunction with the Local Maternity System

2.3 Updates on actions which are overdue

None for March 2020

2.4 Changes to actions

Action number	Action	Change to action
5.2	**Training refresh for all ARC members on risk, including mitigation, and controls**	Date for completion changed from 31/03/2020 to 30/04/2020, the training can then include Datix Cloud
18.3	**Review Heat activity Re-define programme**	Date for completion changed from 29/02/2020 to 31/03/2020 so COO can

	Re-launch"	advise on current position
21.5	**Assessment & Accreditation will incorporate criteria regarding the safe storage of health records.**	Wording changed to *Assessment & Accreditation will incorporate criteria regarding the safe storage of health records* (from All areas need to demonstrate compliance as part of the Ward Accreditation Assessment). This is due to inability to achieve current action as A&A timetable is dependent on the outcome of the wards previous assessment, i.e. as ward may not be required to have an assessment for 6 months.
33.2	**Review medical recruitment strategy**	Date for completion changed from 03/04/2020 to 31/05/2020 to progress the medical establishment review

2.5 Evidence
Evidence to close actions will be provided by the action owner to the relevant Executive Lead, they will review prior to sign off of the action. Evidence will be collated by the Compliance Team. The Team will complete a final review of the evidence and raise any concerns with the Executive Lead. If evidence is not sufficient to demonstrate completion, the action will be re-opened. Any gaps in the evidence are included in the table below.

Action number	Action	Gaps in evidence
9.1	**Refresh well- led Board knowledge**	Action signed off as completed. Evidence of completion required.
9.2	**Identify basic specification of need**	Action signed off as completed. Evidence of completion required.
15.4	**Review pathways for use of PAU and increased activity**	Evidence provided. Concerns raised by action owner. With exec lead for review. Due to AL this remains outstanding.
20.6	**A review of catering procedures and working practices will be carried out by Infection control and the Catering management team**	Action signed off as completed. Evidence of completion required. To be provided once member of staff returns from annual leave
22.1	**LocSSIP documents reviewed and updated**	Action signed off as completed. Evidence of completion to be provided once minor amendments made to policy post approval at procedural document group in February 2020
23.1	**Inpatients cared for on outlying wards have a designated medical team to review patients. This is monitored and audited twice weekly by reviewing the medical plans in the patient's medical records**	Completed and in place. Evidence of completion required. (on previous report)

2.6 Updates from external reporting to CQC/ NHSE/I
No updates to report for March 2020 in relation to feedback from CQC or NHSE/I.
The TIAA are currently reviewing the governance arrangements over the monitoring, assessment and evaluation of evidence for the Improvement Plan. They visited the Trust on

5th March 2020 and are arranging a further follow-up visit; so far they have reviewed the evidence relating to the three requirement notices.

3. Assessment of Risk

The Trust has been issued with three requirement notices by CQC. A requirement notice is issued when a service is found to be in breach of one of the fundamental standards of care; the standards below which care must never fall. These fundamental standards are linked to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Trust must be able to demonstrate it has taken action to address these breaches. If not, there is the potential for further enforcement action to be taken against the Trust (warning notice) or prosecution (with qualifications). Please refer to section 2.6 for detail on updates provided to the CQC to show progress with the actions associated with the requirement notices.

The summary detail of the three requirement notices is provided in the table below. Further detail can be found in the improvement plan (appendix A)

Core service	Regulation	Brief detail	Progress update
Medical care (including older people's care)	**Regulation 12 (2) (g): The proper and safe use of medicines**	Staff not always ensuring the proper and safe management of medicines	All actions completed and supporting evidence in place
Maternity	**Regulation 12 (2) (g): The proper and safe use of medicines**	Staff not always following systems and processes when prescribing, administering, recording and storing medicines	All actions completed and supporting evidence in place/
Maternity	**Regulation 16 (2): Receiving and acting on complaints.**	Information on how to make a complaint was not seen at the time of the inspection	All actions completed and supporting evidence in place

4. Agreed governance reporting framework

The Improvement Plan will be presented to Executive meetings and the Quality Governance Committee on a monthly basis. Bi-monthly updates will be presented at Public Trust Board.

The process for confirming closure of actions will be for the Lead Executive to sign off on receipt of the required evidence and for the Executive team to ratify prior to the Quality Governance Committee.

5. Recommendations

The Committee is asked to:

- Accept this report as part of the assurance process, showing the Trust has and is taking action to address the concerns raised in the CQC reports
- Challenge any areas of concern or where it is felt that progress is not occurring in a timely manner, or evidence of completed action is not forthcoming.

NGH Improvement Plan
(Incorporating CQC Inspection Report outcomes published October 2019/ NHSE/I Undertakings actions)

03/03/2020
V6

13/03/2020

No	Concern: Medicine Division Requirement notice	Action	Deadline	Progress/ Comments
1	The trust must ensure the proper and safe management of medicines. Staff must follow current national practice to check patients receive the correct medicines. The service must have systems to ensure staff are aware about safety alerts and incidents. Staff must store and manage all medicines and prescribing documents in line with the provider's policy. (Regulation 12 (2) (g): The proper and safe management of medicines).	1.1 Implementation of Task and Finish Group chaired by Medical Director	01/08/2019	Completed
		1.2 Medicines Optimisation Work plan updated to include CQC recommendations (post inspection)	02/08/2019	12/02/2020 Safety alert issued via NetConsent last week for staff and via weekly staff comms update. 21/12/2019 Update from Chief Pharmacist advise safety alerts already shared across the Trust but exploring the use of Netconsent for this as well. Help raise profile and enable audit of staff accessing documents. Also provide historic reminders of key messages Completed
		1.3 Ongoing enhanced audits monitored through medicines governance structure	31/12/2019	20/12/2019 Update from Chief Pharmacist- Audit form approved August 2019 - changes made after 3 months of use and discussions at MOSG. Completed Audits remain ongoing
		1.4 Safe & Secure Controlled Drug audit carried out on a monthly basis	31/12/2019	20/12/2019 Update from Chief Pharmacist- Audits are completed monthly for areas of poor compliance (normally done quarterly). CD Audit form has been updated. Plan is to combine CD and MM audits, completed jointly by Nursing and Pharmacy from April 2020 Completed Audits remain ongoing

No	Concern: Womens Childrens, Oncology & Haematology and Cancer Services Division Requirement notice	Action	Deadline	Progress/ Comments
2	Staff must follow systems and processes when safely prescribing, administering, recording and storing medicines. The service must ensure medicines are in date and medicine waste and returns are stored securely. Infusions that require protection from light must be stored appropriately. Staff must ensure medicines stored in the medicine trolley are stored in their original boxes to ensure expiry dates and names of medicines are visible. Staff must ensure action is taken to address repeated high room temperature values, where the recommended storage conditions for medicines have been exceeded. (Regulation 12 (2) (g): The proper and safe management of medicines).	2.1 Implementation of Task and Finish Group chaired by Medical Director	01/08/2019	Completed
		2.2 Medicines Optimisation Work plan updated to include CQC recommendations (post inspection)	31/10/2019	Completed
		2.3 Ongoing enhanced audits monitored through medicines governance structure	31/12/2019	20/12/2019 Update from Chief Pharmacist- Audit form approved August 2019 - changes made after 3 months of use and discussions at MOSG. Completed Audits remain ongoing
		2.4 Safe & Secure Controlled Drug audit carried out on a monthly basis	31/12/2019	20/12/2019 Update from Chief Pharmacist- Audits are completed monthly for areas of poor compliance (normally done quarterly). CD Audit form has been updated. Plan is to combine CD and MM audits, completed jointly by Nursing and Pharmacy from April 2020 Completed Audits remain ongoing
		2.5 Approve business case for maternity pharmacist	31/12/2019	20/12/2019 Chief Pharmacist email - confirm Exec team approve business case and recruitment will commence Jan 2020, with view to providing service from April 2020. 18/12/2019 Supporting evidence saved- business case and emails re taking case to Dec 2019 Finance Committee 05/12/2019 Action updated to Approve business case for maternity pharmacist (previous action Appoint maternity pharmacist)
3	The maternity service must ensure information and guidance about how to complain is widely available to everyone who uses the service. (Regulation 16: (2) Receiving and acting on complaints).	3.1 4Cs information leaflets and posters to be displayed in all areas	31/12/2019	06/01/2020 Completed. Audits will remain ongoing. No concerns with compliance. Evidence also included of attendance at Meet the Matrons clinic - 3 months of data. Women are accessing this service to discuss their care 18/12/2019 S.Oke advise spot audits will be available for CQC engagement meeting Jan 2020 05/12/2019 Leaflets and posters on display. Meet the Matron posters are also on display in all areas of maternity. Flyers to support the availability of the above are also now included within the mothers discharge pack
		3.2 'Meet the Matron' posters displayed in all areas- so service users can raise concerns	31/12/2019	06/01/2020 Audits provided which show posters on display and evidence of clinics taking place 05/12/2019 Meet the Matron posters are available in all areas of maternity
		3.3 Use of Big Word translation services	31/12/2019	6/01/2020 Information available in ward areas. Currently included in maternity's 'Stork Talk' newsletter to remind staff. HOM continues to monitor use of interpreters 05/12/2019 Message relayed through safety huddles, information also available in ward areas. Currently included in maternity's 'Stork Talk' newsletter to remind staff. HOM is monitoring use of interpreters
		3.4 Develop poster which contains information in other languages for women and families in whom English is not their first language	31/12/2019	06/01/2020 Poster on display at hospital. Information booklets available in Romanian, Polish, Lithuanian and Bengali (most common languages). Provided to women at booking appointment by Community Midwife. Evidence of completion changed to Copy of poster 05/12/2019 Information also provided by midwives at booking appointment by community midwife. New poster under design to signpost, leaflets being translated into other languages (most commonly used)

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
4	a) The trust should review its board assurance framework to ensure it provides adequate assurance b) he trust should consider tabling the board assurance framework monthly and consider how current gaps in assurance are highlighted. This consideration should inform debate on the sufficiency of the actions taken to close these gaps, and the associated timelines	4.1 BAF to be reviewed by Board- benchmarked against CQC advised exemplar document and revised format to be agreed. This will assist in improving assurance, highlight gaps in assurance and timely actions as a result.	31/12/2019	Completed
		4.2 Board to consider frequency of reporting of BAF.	26/09/2019	20/12/2019 Evidence of completion changed to Board development programme (from Board paper). Frequency of reporting discussed as part of presentation for 4.1 Completed- Board agreed to leave as quarterly reporting in line with other Trusts.
		4.3 BAF content reviewed and links to strategy pledges included	28/11/2019	Completed
		4.4 BAF presented in revised format	28/11/2019	Completed

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
5	The trust should review its risk register so staff can easily track changes to risk or mitigation and improve clarity on how the existing controls relate to the risk as stated in the risk register	5.1 Revised report format for ARC, Board and its committees	31/10/2019	Completed
		5.2 Training refresh for all ARC members on risk, including mitigation, and controls	31/03/2020	09/03/2020 SH confirm with SB that CaC had agreed to change of date (on behalf of CIC). To change date from 31/03/2020 to 30/04/2020. This will enable training to cover Datix Cloud. 12/02/2020 Date for completion changed to 31/03/2020 (from 29/02/2020). For presentation at March 2020 ARC meeting 13/01/2020 Link to training provided. 31/12/2019 Video presentation due at ARC Dec 2019 - lack of presentation software on the day. Expected Jan 2020 or Feb 2020. Date changed to end of Feb 2020 (from 12/12/2019). Link to online training to be provided. 18/12/2019 Email sent to action owner asking if amended date required as training not yet provided at ARC
		5.3 Deep dives into Divisional Risk Registers	31/10/2019	Completed
		5.4 Introduction of Datix Cloud to improve risk management processes	01/04/2020	10/02/2020 Datix Cloud IQ launch planned for April 2020. Training to be provided to staff and ARC members on new risk module once created

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
6	The trust should consider how it could improve the effectiveness of its medicines audit processes	6.1 Action is covered by Medicines Optimisation Action Plan (part of the Medicines Optimisation Strategy 2016-2020). The action plan is monitored through Medicines Optimisation Strategy Group which reports to CQEG	31/12/2019	Completed
		6.2 See also entry and actions for action 1	31/12/2019	Completed

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
		7.1 The Infection Prevention Team carried out a six week audit of all wards, departments, Outpatient areas and Theatres looking in every bin, the results of which were fed back to senior staff	30/09/2019	Completed/Audit results available
		7.2 Focus on findings of these audit results with a view to improving compliance	31/12/2019	Completed. Audit results shared with Ward Manager, Matron and Infection Prevention Steering group & IPC Operational group on a monthly basis

7	The trust should consider its methods of assurance relating to the segregation of clinical waste	7.3 Established a rolling audit programme to carry out a detailed Infection Prevention audit	31/12/2019	Completed. Audit rolling plan developed and implemented
		7.4 A screensaver has been produced and displayed across the Trust	30/09/2019	Completed. Screensaver developed and launched across the Trust
		7.5 Key issues are raised at the Infection Prevention Operational Group, Link Nurse Meetings and Infection prevention Steering Group	31/12/2019	Completed. Minutes available from Infection Prevention Steering Group & IPC Operational Group on a monthly basis
		7.6 Weekly walk arounds with Claire Topping, Sustainability Manager	31/12/2019	Completed. Weekly walk rounds completed by Sustainability Manager & IPC team. Findings shared with Ward Manager and Infection Prevention Steering Group & IPC Operational group on a monthly basis

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
8	a) The trust should review the effectiveness of its audit committee b) The trust should consider the observations in relation to the audit committee to ensure that only realistic and deliverable internal audit recommendations are agreed in future, and that internal audit recommendations, as far as is practicable, are implemented within agreed timescales.	8.1 Agree Committee membership and Lead Executive	24/09/2019	Completed
		8.2 Meeting with Committee Chair and Lead Exec to discuss issues raised in CQC report and Committee effectiveness review	10/10/2019	Completed
		8.3 Revise committee reporting matrix	15/10/2019	Completed
		8.4 Agreed to include committee self-assessment at the end of each meeting	18/12/2019	20/12/2019 Require final version of minutes from Audit meeting (will be available after March 2020 meeting)
		8.5 Agreed to include actions from clinical audit and compliance with Clinical audit bi- annually	15/10/2019	Completed
		8.6 Ensure only realistic and deliverable IA recommendations are agreed in future and monitor delivery against agreed timescale	31/03/2020	12/02/2020 Action remains ongoing as Internal Audit reviews are identified
		8.7 Ensure Audit committee takes a zero tolerance to longstanding issues and seeks resolution	31/03/2020	
		8.8 Closure of salary overpayment issue via audit committee (Cross reference with action no 14.)	18/12/2019	20/12/2019 Exec email- discussed at Audit Committee and Finance and Performance. Require final version of minutes from Audit meeting (will be available after March 2020 meeting)

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
9	The trust should consider an external review of its governance structure and systems	9.1 Refresh well- led Board knowledge	29/02/2020	03/03/2020 Discussed at Board of Directors on 27/02/2020. Evidence of completion required. 12/02/2020 Postponed from January 2020 Board meeting as ran out of time. To now take place in Feb 2020. Date changed from 30/01/2020 to 29/02/2020. All other actions to be moved back one month. 20/12/2019 Exec email- actions relating to 9.1 and 9.2 postponed as Dec 2019 Board overran. To now take place in Jan 2020 (changed from 19/12/2019). All other actions to be moved back one month.
		9.2 Identify basic specification of need	29/02/2020	03/03/2020 Discussed at Board of Directors on 27/02/2020. Evidence of completion required. 12/02/2020 Postponed from January 2020 Board meeting as ran out of time. To now take place in Feb 2020. Date changed from 30/01/2020 to 29/02/2020. All other actions to be moved back one month. 20/12/2019 Exec email- actions relating to 9.1 and 9.2 postponed as Dec 2019 Board overran. To now take place in Jan 2020 (changed from 19/12/2019). All other actions to be moved back one month.
		9.3 Commission external review via competitive quotes	31/03/2020	12/02/2020 See action 9.1- date for completion changed to 31/03/2020 (from 29/02/2020) 20/12/2019 See action 9.1- date for completion changed to 29/02/2020 (from 31/01/2020)
		9.4 Undertake governance review	31/05/2020	12/02/2020 See action 9.1- date for completion changed to 31/05/2020 (from 30/04/2020) 20/12/2020 See action 9.1- date for completion changed to 30/04/2020 (from 31/03/2020)
		9.5 Provide evidence to NHSE/I	31/05/2020	12/02/2020 See action 9.1- date for completion changed to 31/05/2020 (from 30/04/2020) 20/12/2020 See action 9.1- date for completion changed to 30/04/2020 (from 31/03/2020)

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
10	The trust should consider the structure, management and oversight arrangements for its quality improvement function	10.1 Collective transformation resource reviewed	01/04/2020	18/12/2019 Transformation Resource paper to be presented at Finance and Performance meeting 19/12/2019 Completed
		10.2 Recommendations of review to be presented to Trust Board	01/04/2020	13/01/2020 Discussed and recommendations approved at Dec 2019 Finance and Performance meeting (Committee of Board)

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
11	The trust should continue to engage all its partners in operational and strategic decision making	11.1 To publish the new strategy and retain evidence of consultation with partners.	01/11/2019	13/01/2020 Strategy includes how partners were consulted and input used Completed
		11.2 Continue to engage partners in large scale strategic changes	01/11/2019	13/01/2020 Evidence of completion added in- Examples of work with partners Completed and remains ongoing
		11.3 Continue to engage partners in strategic operational issues and decision making	01/11/2019	13/01/2020 Evidence of completion added in- Examples of work with partners Completed and remains ongoing

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
12	The trust should take steps to assure itself that the interventions in progress to address bullying and poor behaviour are having an impact at pace	12.1 Review impact of current programme	31/10/2019	Completed. Feedback responded to from staff in the People's Plan
		12.2 Targeted interventions in 'hotspots'	31/12/2019	06/01/2020 Freedom to Speak Up/HR/OD linkage created. Targeted interventions plans are in place or being progressed for 'hotspot' areas (Oncology, Cardiology and Maternity) Evidence of completion changed from Staff Survey 2020 to Example of targeted intervention work in 'hotspot' area
		12.3 Incorporate 'Civility Saves Lives' into Respect and Support programme	31/03/2020	09/03/2020 Action owner confirm action complete subject to exec sign off next week. To amend deadline from 29/02/2020 to 31/03/2020. Refocus of respect and support approach complete. New programme incorporating Civility Saves Lives, GMC Professional Standards and previous Respect and Support campaign agreed ready for rollout Executive sign off planned for 17/03/20 06/02/2020 Two pilots run in Oncology 06/01/2020 Piloting GMC professional standards in January 2020 to incorporate Civility Saves Lives for roll out from February 2020. Completion date changed from 31/12/2019 to 29/02/2020

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
13	The trust should consider commissioning a more detailed analysis of the drivers of its deficit to inform those elements that are within its gift to be able to address both directly and indirectly	13.1 Work with NHSE/I to agree process to complete this (using their expertise and knowledge)	01/04/2020	04/03/2020 Working with systems colleagues a review into the drivers of the deficit is to be commissioned during march 2020 and completed in May 2020. 12/02/2020 This is superseded by the issued financial improvement trajectories and system working relating to transformation and block contracts. We know that the major cause of our deficit is the underfunding of the tariff.

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
14	The trust has plans to introduce an electronic solution between the human resources function and payroll to seek to address the issue of staff overpayments. The trust should consider requesting an internal audit function review of the planned electronic solution, in order that any control weaknesses can quickly be identified and addressed.	14.1 Request an internal audit review and address weaknesses	01/04/2020	09/03/2020 Remain on track for completion date 13/02/2020 Electronic solution designed and process agreed Await confirmation of functionality before implementation

No	Concern: Urgent and Emergency Services Quality "Should" actions	Action	Deadline	Progress/ Comments
		15.1 Set up working group to establish with Paediatrics and Estates to review the current working practices that our Paediatric area has to meet these standards.	31/03/2020	06/03/2020 The space that had been initially identified has been assessed as unsuitable and therefore other options are now being considered. The space has been identified and plans are being worked up by estates. The urgency of developing these plans has been discussed at the Trust estate meeting which is chaired by the COO. We are expecting plans to be available in the next 4 weeks to enable a further discussion 10/02/2020 – Plans in development. Short term plan - Extension to current ED area by relocating the staff area and one other room & developing 2 additional cubicles in the Childrens waiting area. Longer term plan – develop a Childrens ED which will run alongside the current A&E area and utilise the consultants office space. (long term plan pending funding) 09/01/2020 Update from D.Needham Plans are being drawn up to extend the Children's cubicle area by 2 cubicles. Work will progress in Q4. Change date of completion/ review to 31/03/2020 from 31/12/2019 04/12/2019 Update from S.Finn The group have identified a short term solution to reconfigure and expand the department.

15	The service should continue to re-assess the layout of the paediatric emergency department to ensure it meets the Children and Young People in Emergency Care Settings 2012 standards	15.2 Develop options paper looking at expanding or relocating the department. Seek potential options for capital funding.	31/03/2020	06/03/2020 The space that had been initially identified has been assessed as unsuitable and therefore other options are now being considered. The space has been identified and plans are being worked up by estates. The urgency of developing these plans has been discussed at the Trust estate meeting which is chaired by the COO. We are expecting plans to be available in the next 4 weeks to enable a further discussion 10/02/2020 See action 15.1 09/01/2020 See update for action 15.1. Change of completion/ review date to March 2020 (from 31/12/2019) 04/12/2019 Update from S.Finn Initial long term, high level plans have been produced but funding has not been identified to allow the scheme to progress at this time. A short term solution has been identified and is currently being costed. A paper will be presented to ET for approval in Jan 20
		15.3 Complete works to change the department	31/03/2020	10/02/2020 See action 15.1 09/01/2020 Linked in with action 15.1, Change of completion/ review date to 31/03/2020 from 31/12/2019 Review date of 31/12/2019
		15.4 Review pathways for use of PAU and increased activity	31/12/2019	09/03/2020 Remains outstanding due to annual leave 14/02/2020 SB liaise with DN PA to try and resolve issues around closure of action 29/01/2020 Evidence of compliance provided - concerns raised by TD. SB email DN for confirmation of sign off 09/01/2020 Email from D.Needham. Pathways from A&E to PAU in place. Evidence of completion required
16	The service should make arrangements so patient group directions are regularly checked and updated on the trust internal website	16.1 This action is included within the Medicines Optimisation action plan (part of the Medicines Optimisation Strategy 2016- 2020).	31/12/2019	20/12/2019 Further supporting evidence added in. Action complete 18/12/2019 Supporting evidence added re amendments to PGD process
		16.2 Include process in revised Medicines Management Policy	31/03/2020	07/02/2020 Process for PGDs will be included in review of Medicines Management Policy (due for update March 2020). Once policy approved, Pharmacy will audit against it and will add to 20/21 Medicines Optimisation Plan 18/12/2019 Supporting evidence added re amendments to PGD process 05/12/2019 Action changed to 'Include process in revised Medicines Management Policy'. Date revised to 31/03/2020 (from 31/12/2019) Previous action was 'See also entry for action 1'
17	The service should take action so medical staff are compliant with the trust target for safeguarding children level three training	17.1 Mandatory training compliance of all staff groups is reviewed at every Urgent Care Governance meeting	29/02/2020	12/02/2020 Data is included in monthly governance reports and discussed in more detail where required. Training data is also emailed monthly by Training and Development to key leads in the directorate. 13/01/2020. Compliance Governance Manager review plan. No current update available at time of writing report. Extend date of completion by 1 month to 29/02/2020 (from 31/12/2019). Compliance team will raise at Urgent Care Governance meeting on 16/01/2020 05/12/2019 Exec owner changed from Matthew Metcalfe to Mark Smith
		17.2 Clinical Director for Urgent Care will remind all medical staff of their need to complete the training	29/02/2020	29/01/2020 E-mail from TD confirming medical staff are reminded to complete mandatory training. Action closed. 13/01/2020 Compliance Governance Manager review plan. No current update available at time of writing report. Extend date of completion by 1 month to 29/02/2020 (from 31/12/2019). Compliance team will raise at Urgent Care Governance meeting on 16/01/2020 05/12/2019 Exec owner changed from Matthew Metcalfe to Mark Smith
		17.3 The Safeguarding Team provide regular updates of who needs to completed training and this will be monitored for medical staff who are not completing the training and are repeatedly on the list	01/04/2020	09/03/2020 Plan to achieve by deadline date 13/02/2020 Joint working between QI and L&D to identify non-compliance. Currently working with safeguarding to ensure availability of training 05/12/2019 Exec owner changed from Matthew Metcalfe to Mark Smith
18	The service should take action to improve the median time from arrival to treatment	18.1 Implement winter actions	31/12/2019	01/02/2020 Evidence of completion provided. Action closed down. 29/01/2020 Evidence of completion confirmed as Winter action plan and paper to Board. Winter action plan needed as evidence (will be sent over 30/01/2020 post progress meeting today) 09/01/2020 Email from D. Needham. In progress- ET updated weekly. Evidence of completion required, Action completed
		18.2 Appoint PMO lead for Urgent Care and Winter	12/11/2019	Completed
		18.3 Review Heat activity 18.3 Re-define programme 18.3 Re-launch	31/03/2020	10/03/2020 Dep COO request extension for one month so COO can advise current position. Date for completion changed from 29/02/2020 to 31/03/2020 10/02/2020 New workstreams agreed and being led by COO/MD/DofN 29/01/2020 Evidence of completion confirmed as Agreement of workstreams 09/01/2020 Email from D. Needham. Meeting planned for PMO, DofN, Med Dir and COO to relaunch. Winter actions taken priority. Completion date changed to 29/02/2020 (from 31/12/2019)
		18.4 Rapid improvement project with IDT	09/12/2019 (and ongoing)	05/02/2020 Evidence provided. Time to PDNA currently monitored via SPA. Project in progress to utilise real time data from iBox. Trust has implemented an internal PDNA Hub. 03/02/2020 SB link with relevant leads to source evidence 09/01/2020 Email from D.Needham. Action is completed. Evidence of completion required

No	Concern: Medical Care Quality "Should" actions	Action	Deadline	Progress/ Comments
19	The service should check medical staff are up to date with mandatory, safeguarding and mental capacity training	19.1 Use of Netconsent software to check and force compliance	01/04/2020	09/03/2020 Plan to achieve by deadline date13/02/2020 Netconsent in place
		19.2 Provide additional sessions of 'bundles' of mandatory training for trust grade staff	01/04/2020	09/03/2020 Plan to achieve by deadline date13/02/2020 Additional cluster days available
20	The service should check catering staff are following infection prevention and control protocols	20.1 Induction training for new starters	30/04/2020	23/01/2020 Evidence of completion provided. 06/01/2020 Email from S.Finn. IPC mandatory training and bespoke food hygiene induction training is in place for all new starters and existing staff. Action completed. Evidence of completion required 04/12/2019 Catering and IPC meeting held 29 Nov 19 to discuss and agree actions. Documentation including HASAP (Hazard and Critical Control Process) has been shared with IPC who are reviewing. Next meeting to be arranged in Jan 20
		20.2 Infection Prevention representation at Catering Meetings regarding PPE	30/04/2020	28/01/2020 Evidence of completion provided 06/01/2020 Email from S.Finn PPE is issued to all food handlers/production staff. Ward hostesses uniforms are issued and protective aprons and gloves available. Staff are trained in food hygiene procedures which include PPE. Staff records evidence training and issue of PPE. Action completed. Evidence of completion required. 04/12/2019 As above
		20.3 Infection Prevention Mandatory training - 3 yearly for non-clinical staff	30/04/2020	28/01/2020 Evidence of completion provided 06/01/2020 Email from S.Finn. This has been reviewed by SF and BW and recorded as completed. Evidence of completion required. 04/12/2019 This is in place for all catering staff and monitored via mandatory training results and at appraisals. Every 'food handler' also complete 'Food Hygiene' course
		20.4 Environment audits and Catering audits are carried out when infection is identified	30/04/2020	28/01/2020 Evidence of completion provided 06/01/2020 Email from S.Finn. Audits and inspections are in place and carried out regularly. Post infection audits and inspections are carried out by IPC and include ward kitchens. This has been reviewed by SF and BW and recorded as completed. Evidence of completion required 04/12/2019 IPC have been asked to comment
		20.5 Domestic monthly cleaning audits include host/hostess staff - hand hygiene etc observed	30/04/2020	28/01/2020 Evidence of completion provided 06/01/2020 Email from S.Finn. This has been reviewed by SF and BW and recorded as completed. Evidence of completion required. 04/12/2019 This is in place as part of the cleaning audits. The ward kitchens are scored separately as part of the audit and include the ward host/hostess
		20.6 A review of catering procedures and working practices will be carried out by Infection control and the Catering management team	30/04/2020	10/03/2020 This action has been completed. W. Foster has written to A. Head to confirm that the procedures have been reviewed and are suitable and in place. A. Head will provide copy of the email as evidence on return form leave 16/03/20 23/01/2020 Email from W Foster. Dates being organised between IPC and Hotel Services 06/01/2020 Email from S.Finn. BW arranging follow-up meeting with IPC. 04/12/2019 Catering and IPC meeting held 29 Nov 19 to discuss and agree actions. Documentation including HASAP (Hazard and Critical Control Process) has been shared with IPC who are reviewing. Next meeting to be arranged in Jan 20
		21.1 The Trust have invested in lockable trollies in order to store patient records securely	30/09/2019	Completed
		21.2 Lockable cupboards are available for the safe storage of patient records	30/09/2019	Completed

21	The service should keep all confidential patient records securely	21.3 Annual Information Governance mandatory training for all staff	31/12/2019	13/01/2020 Further email confirmation of the below received 05/12/2019 Completed As part of the Data Security and Protection Tool kit, the trust met the 95% Mandatory Information Governance training requirement for 2019 and are working towards this requirement in time for the March 2020 submission
		21.4 Data Quality, Security and Protection team to complete spot audits of compliance on wards and departments (Oct 2019 and March 2020). Findings to be shared at Assurance, Risk and Compliance meeting)	01/04/2020	09/03/2020 Verbal update from Dep DofN Waiting for outcome of further audit to be completed March 2020 13/02/2020 High level findings from Oct 2019 DSP audit shared at ARC 13/02/2020. A number of screensavers have been issued as result of findings from spot audits. Acceptable Use Policy also being updated and taken to February 2020 PGD meeting. 14/01/2020 Action amended to read Data Quality, Security and Protection team to complete ..... Date of audit completed changed to Oct 2019 Evidence provided for audit completed Oct 2019. Results discussed at Data Governance Group. 05/12/2019 On Track - Spot audits of 12 wards have been carried out so far this financial year. The findings are to be published at the next Data Governance Group Meeting which feeds into the Assurance Risk and Compliance group as appropriate
		21.5 Assessment & Accreditation will incorporate criteria regarding the safe storage of health records.	01/04/2020	09/03/2020 Email from Dep DofN to reword action. Wording changed to Assessment & Accreditation will incorporate criteria regarding the safe storage of health records (from All areas need to demonstrate compliance as part of the Ward Accreditation Assessment). Due to inability to achieve current action as A&A timetable is dependent on the outcome of the wards previous assessment, i.e. as ward may not be required to have an assessment for 6 months. 12/02/2020 All evidence provided waiting confirmation of closure from action owners 07/01/2020 Evidence of related documents used for Assessment and Accreditation provided 05/12/2019 On track, being included in ward Assessment & Accreditation process, not as yet reported owing to timings of Assessments
22	The service should introduce local procedures for invasive procedures in non-theatre settings	22.1 LocSSIP documents reviewed and updated	29/02/2020	03/03/2020 Policy discussed and approved at Feb 2020 PDG meeting. Minor changes needed then will be uploaded to intranet. Final version required for evidence of completion. 05/02/2020 LocSSIPs policy is going to PDG in February 2020. Date for completion changed to 29/02/2020 (from 01/02/2020) 05/12/2019 Date changed from 01/01/2020 to 01/02/2020 due to current progress with workstream
		22.2 Relaunch of LocSSIPs - training and comms	30/06/2020	05/02/2020 Existing LocSSIPs being updated to new Trust format. Education being provided to teams as these are updated 31/12/2019 Email from Ms.Metcalfe. Work programme has increased. New Clinical Lead for this. Plan to revise the template for the Trust and do base line audit of documents in existence and staff awareness. Re-launch planned for June 2020. Completion date changed to 30/06/2020 (from 01/05/2020) 05/12/2019 Date changed from 01/04/2020 to 01/05/2020 due to progress with action 22.2
		22.3 Audit of compliance	31/10/2020	31/12/2019 See comment for 22.2. Completion date changed to 31/10/2020 (from 01/09/2020) 05/12/2019 Date changed from 01/08/2020 to 01/09/2020 due to progress with action 22.1
23	The service should manage medical outliers so they are seen in a timely manner	23.1 Inpatients cared for on outlying wards have a designated medical team to review patients. This is monitored and audited twice weekly by reviewing the medical plans in the patient's medical records	29/02/2020	10/02/2020 Completed and in place. Evidence of completion required.06/01/2020 Email
		23.2 Ward staff escalate any issues regarding medical reviews at the x3 daily Site meetings.	31/10/2019	29/01/2020 D Needham advise evidence of completion can change to What's App messages 23/01/2020 Example Daily Safety Sheet notes provided for Oct 19, Dec 19 and Jan 20. Site Team to provide relevant Whats App messages as well. This is the format of notes from meeting. 13/01/2020 Evidence of completion required Completed and ongoing review quarterly
		23.3 Number of medical outliers to be communicated daily via Sitrep (Whats app)	31/10/2019	23/01/2020 Evidence provided of example x6 daily Trust position- Sitrep. Recent change to now include medical outliers in this as well as info going out via Whats app. Also sample What's app message 13/01/2020 Evidence of completion required Completed and ongoing review quarterly
24	The service should consider how it manages private and NHS patients for cardiology procedures to ensure equity of access	24.1 East Midlands Clinical Senate review completed August 2019- Terms of reference included private practise arrangements	31/08/2019	Completed
		24.2 Action plan developed linking multiple reports/ workstreams in Cardiology	13/03/2020	03/03/2020 Associate medical director request an update on progress. SB will be completed by deadline of 13/03/2020 12/02/2020 Some delays in collating information. Completion date changed to 13/03/2020 (from 16/02/2020) 13/01/2020 Compliance Governance Manager involved in this workstream. Meeting planned for 07/01/2020 (cancel due to Trust pressures) rebooked for 16/01/2020. Progress has also been made with using this approach in Breast- method can now be transferred to Cardiology. Completion date changed from 31/12/2019 to 16/02/2020. 18/12/2019 Action plan in place to address concerns from Senate visit. Meeting held 17/12/2019 to identify relevant reports for Cardiology- further meeting planned 07/01/2020
25	The service should review clinical guidelines to check they are current	25.1 Netconsent to ensure guidelines reviewed in line with policy	01/04/2020	03/03/2020- Process at Document Group make monthly and overdue document list is brought to the meeting to gain support from attendees to address any overdue documents within the sphere of control. Net Consent continues to send reminders to document authors in advance of the expiry date 10/02/2020 Overdue Policies / guidelines continue to be presented at every PDG to gain support from PDG members to address those that are overdue. Reminders are also sent via NetConsent system to the authors ahead of the Policies going out of date for them to take appropriate action to ensure that the Policies/ Guidelines are reviewed in a timely manner. In addition PDG have requested that the amount of notice given to Policy authors via Netconsent is increased to 6 months 18/12/2019 Overdue Policies / guidelines are presented at every PDG to gain support from PDG members to address those that are overdue. Reminders are also sent via NetConsent system.
		25.2 Use of PDG report to show reduction in overdue guidelines	01/04/2020	03/03/2020- PDG continues to submit reports to CQEG in relation to the documents that have been approved and those that are overdue. This is a long term action, including rationalisation of procedural documents. 10/02/2020 Monthly report provided to CQEG which demonstrates the progress in reducing the number of overdue documents. This will be a long term action. 18/12/2019 Monthly report provided to CQEG which demonstrates the reduction in the number of overdue documents. This will be a long term action.
26	The service should consider reviewing storage and security of substances subject to control of substance hazardous to health (COSHH)	26.1 All storage areas reviewed during core service inspection and security risks removed	30/06/2019	08/01/2020 Email from P. Barnes. DofN complete further spot check on door codes before Christmas (late evening and night shift). None found. Completed (spot audit to review ongoing compliance planned late November 2019)
27	The service should consider reviewing environment and facilities for inpatient outliers staying on the Heart Centre	27.1 Complete review of Heart Centre environment and facilities	31/03/2020	29/01/2020 Evidence of completion provided. Escalation documents taken from the Weekend Plan in relation to use of Heart Centre for outliers 09/01/2020 Email from D.Needham. Undertaken as part of escalation areas review previously. Action completed. Evidence of completion required.
28	The service should consider addressing cultural issues across some medical wards	Covered within action 12	31/12/2019	Covered within action 12
29	The stroke services to consider improving compliance with completion of VTE assessments	29.1 To monitor stroke service VTE compliance via thrombosis committee and implement actions if compliance has not improved	31/03/2020	10/02/2020 Action owner confirmed data is captured by ward. Will provide for relevant wards related to stroke service.

No	Concern: Maternity Services Quality "Should" actions	Action	Deadline	Progress/ Comments
30	The service should ensure women can access the service when they need it and receive the right care promptly and that waiting times from referral to treatment and arrangements to admit, treat and discharge women are in line with national standards	30.1 Continue monitoring access to maternity services by 10+0 weeks and 12+6 weeks	31/10/2019	Completed
		30.2 Monitor access to scan appointment within 72 hours for women with reduced/static growth	30/11/2019	Completed Currently monitoring is in place, to be added to dashboard as from December
		30.3 Review midwifery ultrasonography scan clinics to ensure adequate capacity	31/12/2019	06/01/2020 Email from DofN to confirm completed. Evidence provided. 05/12/2019 MDU midwife currently completing QI project reviewing demand to baseline match capacity developing a better triage system
		30.4 MESC bid for ultrasound machine for Labour Ward to prevent overnight referrals to MDU / Midwife Scan clinics	31/03/2020	01/03/2020 Awaiting bid outcome, continue to monitor waiting times and report 72 hour breeches to governance 11/02/2020 Awaiting outcome 08/01/2020 Continue to await feedback on bid 05/12/2019 Bid has been submitted, feedback awaited
		30.5 Seek further funding / training for more midwives to be trained in 3rd Trimester scanning	31/03/2020	06/01/2020 No requirement at present to train additional midwives. As per 30.3 - 2 midwives will complete training in April 2020. Funding currently available via HEE if situation changes - next course September 2020. Action completed. 05/12/2019 Two midwives have to date commenced the training scanning programme. Funding currently available via HEE. Currently exploring how places can be accessed going forward as next programme is Sept 20
		30.6 Monitor Triage waiting times on Maternity Dashboard – monthly report to Directorate / Divisional Governance Group.	31/10/2019	Completed (see evidence for 30.2)

		30.7 Business case to reconfigure Labour Ward which will make a dedicated Triage area and provide easier access to obstetric care. It will also reduce attendances / waiting times on the Maternity Day Unit.	31/03/2020	01/03/2020 Continue to monitor triage waiting times, these are poor, triage on MDU is an issue, 19% had first assessment within 15 mins (Jan' 20) Support for business case will address concern 11/02/2020 Executive Team support case– Options currently being developed by Facilities 05/12/2019 Business case submitted awaiting outcome
31	The service should formally monitor delayed discharges and how frequently induction of labours or elective caesarean sections are delayed (or cancelled) so the service can analyse and monitor trends to inform future plans	31.1 Develop audit proforma for delayed/cancelled IOL and elective caesarean sections	01/04/2020	01/03/2020 Audit proforma is being used, sections are now datixed and are reported on the huddle sheets. Figures to be reported as below 13/02/2020 Cancelled electives being monitored through Datix and IOL though audit . Figures to be included in Risk Management report and Clinical effectiveness report and escalated as appropriate 06/01/2020 Audit proforma developed and circulated to all staff - December 2019 Every induction to be audited as well as cancelled electives, To continue and feedback through Divisional Governance meetings 05/12/2019 Supported by snapshot audit, every induction audited as well as cancelled electives, To continue and feedback through Divisional Governance meetings
		31.2 Reasons for delayed discharges discussed and documented at the Maternity Safety Huddle	01/04/2020	01/03/2020 As per 31.1. Audit proforma being used 13/02/2020 Maternity huddle sheets being used daily and well embedded in service 05/12/2019 This is currently under development and on track to deliver by stated deadline
		31.3 Monthly report to Directorate Governance Group and Divisional Governance Group	01/04/2020	01/03/2020 Results of Feb 2020 audit will be presented at March 2020 Maternity governa
		31.4 Business case for pharmacy support to assist with delayed discharges for take home medications	01/04/2020	01/03/2020 Pharmacy post out to advert 11/02/2020 Please refer to 2.5 06/01/2020 Business case supported and recruitment underway 05/12/2019 Please refer to No.2.5 Business case has been completed and due for submission in Dec 19
32	The service should ensure managers are planning the service for the long term. For example, to enable planning and organisation of services so they met the needs of the local population within the local expected population growth	32.1 Develop Long Term Plan in conjunction with the Local Maternity System	01/04/2020	01/03/2020 Action completed. Discussed at strategy meeting- 5 year LMS plan has been submitted 13/02/2020 Feedback still awaited 06/12/2019 Long Term Plan developed, awaiting feedback
		32. 2 Develop integrated Business Plan for Maternity Services	01/04/2020	06/01/2020 Email from DofN to confirm action completed. 05/12/2019 Plan has been developed and has been presented to the Divisional Team meeting
		32.3 Engagement in East Midlands Clinical Network as well as other Regional / National events and meetings	01/04/2020	01/03/2020 Service attends relevant events. Evidence to follow. 13/02/2020 The service continue to engage and be involved in these events 05/12/2019 Trust team has attended and engaged in events, sharing findings and outcomes with local teams
		32.4 Monthly report to Divisional Management Board on forecasted activity based on bookings	01/04/2020	01/03/2020 Updated evidence provided of meeting reports13/02/2020 Work is ongoing t
		32.5 Business case to be submitted to reconfigure Sturtridge Labour Ward – non clinical rooms changed into clinical rooms, dedicated Triage area consisting of 4 rooms which could be used as further birthing rooms at times of high activity	01/04/2020	01/03/2020 Executive Team support case- options awaited from Facilities 11/2/20 Executive Team support case– Options currently being developed by Facilities 05/12/2019 Business case submitted awaiting outcome
		32.6 Business case to be submitted for midwifery staffing to be submitted to ensure sufficient staff are available for the higher level of activity / acuity forecast.	01/04/2020	01/03/2020 Continue to await outcome for submitted business case 11/02/2020 Business case submitted awaiting outcome 05/12/2019 Safe staffing review using Birthrate plus - Business case submitted awaiting outcome
		32.7 Ensure sufficient midwifery staff in post to meet the Continuity of Carer agenda as per Better Births	01/04/2020	01/03/2020 Linked with action 32.6 11/02/2020 – Discussed at Maternity Safety Champions meeting, minuted. Business case for additional staff submitted awaiting outcome 05/12/2019 Safety champions meetings occur bi monthly, all discussion minuted

No	Concern: Use of resources 'Should' Actions	Action	Deadline	Progress/ Comments
33	The NHS trust should continue working to ensure optimisation of its substantive medical workforce and reduce reliance on agency staff.	33.1 Reinforce medical agency committee	31/12/2019	09/03/2020 Evidence of completion provided 04/03/2020 SB review evidence. Contact LL to see if meeting held- request evidence of completion. 14/01/2020 Email from L.Ludgrove to advise meeting today did not go ahead due to lack of attendance. Reschedule to next week. Agenda and ToR to be provided. 06/01/2020 Monitoring meetings refreshed. New fortnightly meetings to start from 14/01/2020. Attendance to include Execs to support strategic decision making on reducing medical agency spend.
		33.2 Review medical recruitment strategy	31/05/2020	09/03/2020 Project initiated to determine correct medical establishment. Date amended from 03/04/2020 to 31/05/2020 to progress the medical establishment review 13/02/2020 Senior level review meeting in place concerned with agency cost reduction, substantive recruitment and shift to Bank where possible
34	This NHS trust should continue working to achieve further efficiencies from collaborative working with partners in its clinical and support services	34.1 Continue to seek opportunities to collaborate on the delivery of clinical and support services with partners within Northants and Leicestershire	31/10/2019	14/01/2020 See supporting evidence for Action 11 Completed Ongoing through the life of the new strategy and Long Term Plan
		34.2 Continue to pursue opportunities with KGH through the Unified Acute Model workstream of the HCP	31/10/2019	14/01/2020 See supporting evidence for Action 11 Completed Ongoing through the life of the new strategy and Long Term Plan
35	The NHS trust should continue focusing on building internal capacity and capability to deliver trust wide workforce and service productivity improvements	35.1 Support the transformation of the quality function	31/03/2020	09/03/2020 Leadership role assigned and focus of new team agreed Recruitment to vacant posts in progress. No further significant support needed 06/01/2020 Integration on plan for Quarter 1 20/21. HR and OD support in place
		35.2 Integrate productivity improvements in OD interventions	31/03/2020	09/03/2020 Work in progress against key elements of plan with next steps identified 06/01/2020 Oncology plan fully integrated
		35.3 Introduce talent management	31/03/2020	09/03/2020 Rollout to other divisions launched as well as pipeline identification for non clinical areas 06/02/2020 Surgery due for completion February 2020 06/01/2020 Launch Jan 2020 with focus on directorate/divisional management
36	The NHS trust should ensure the improvements that they make in pathways results in achieving better performance against constitutional operational standards	36.1 Cancer recovery plan in place	31/03/2020	10/03/2020 Intensive support team (IST) have been working with us for 3 weeks now with very positive feedback on our cancer board, processes and cancer PTL structure. They are going to support us with some demand and capacity work for our most challenged cancer sites as well as helping to review our cancer access policy and 'straight to test processes' A full action plan will be developed once the IST diagnostic has been completed 10/02/2020 Recovery plans in place for individual tumour sites, support being provided by the IST (NHSI) starting on 14th February 2020 09/01/2020 Email from D.Needham. Recovery plan is in place. Completion date amended to 31/03/2020 (from 31/12/2019). Action not yet signed off Review date (31/12/2019)
		36.1 AE plan in place as per actions 18 and 23	31/03/2020	10/02/2020 New work streams agreed and being led by COO/MD/DoN 09/01/2020 Email from D.Needham. Recovery plan is in place. Completion date amended to 31/03/2020 (from 31/12/2019) Action not yet signed off.
37	The NHS trust should ensure existing cost improvement initiatives achieve the expected reduction of its expenditure run-rate and overall cost base.	37.1 Development of a recurrent savings plan	31/03/2020	04/03/2020 The 2019/20 CIP target should be achieved in its totality, though a large percentage will be non recurrent Part of budget setting for 20/21
38	The NHS trust should develop a plan to return to finance balance on recurrent basis	38.1 Development of System 3 year financial strategy	31/03/2020	04/03/2020 The system finance group will move on to the development of this workstream over the next few months 12/02/2020 This is superseded by the issued financial improvement trajectories and system working relating to transformation and block contracts. We know that the major cause of our deficit is the underfunding of the tariff. (links with action 13.1)
		38.2 Development of a LTFM to see if this is possible	30/06/2020	04/03/2020 The LTFM will be an integral part of 38.1 12/02/2020 This development continues and will involve our system partners
		39.1 Continued recruitment into newly created Estates maintenance posts. Some key roles already filled.	01/06/2020	10/03/2020 Deputy Director of Facilities & Head of Estates interview on 10/03/20 – originally 6 shortlisted for interview but 5 withdrew. An interim has been interviewed and is due to start end of March. Senior Maintenance Manager advert closed and 2 applicants selected for interview end of March. Suitable interims continue to prove difficult to source. 06/01/2020 Further posts have been filled - during Dec 19/Jan 20 (fire officer and mechanical maintenance engineer). Senior maintenance manager & electrical maintenance manager interviews due end of Jan 2020. Deputy director role advert closes end of Jan 2020. Trade staff vacancy interviews due end of Jan 2020 04/12/2019 Recruitment continues to be difficult but remaining posts are being actively managed

39	The NHS trust should progress implementation of its five-year estates maintenance plan.	39.2 Implementation of new CMMS (computer maintenance management system)	01/08/2020	10/03/20 Independent review completed which confirmed existing system is fit for purpose. A number of recommendations were made as part of the report which are being reviewed. 06/01/2020 Independent review starting 7 Jan 20 04/12/2019 An independent review of the existing system has been arranged. This will include recommendations and action plan to implement the system and utilise the reporting function. Date of review TBC
		39.3 Development of key maintenance compliance reports from CMMS to be presented at Facilities Governance committee	01/08/2020	10/03/20 Independent review completed which confirmed existing system is fit for purpose. A number of recommendations which included reporting were made as part of the report which are being reviewed. 06/01/2020 Independent review starting 7 Jan 20 04/12/2019 An independent review of the existing system has been arranged. This will include recommendations and action plan to implement the system and utilise the reporting function. Date of review TBC
		39.4 Put in place a new Facilities Governance committee and structure	30/09/2019	Completed

NGH Improvement Plan
(Incorporating CQC Inspection Report outcomes published October 2019/ NHSE/I Undertakings actions)

03/03/2020
V6

12/03/2020

No	Concern: Medicine Division Requirement notice Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date Completed	Evidence of completion	Likelihood of completion	Progress/ Comments
1	The trust must ensure the proper and safe management of medicines. Staff must follow current national practice to check patients receive the correct medicines. The service must have systems to ensure staff are aware about safety alerts and incidents. Staff must store and manage all medicines and prescribing documents in line with the provider's policy. (Regulation 12 (2) (g): The proper and safe management of medicines).	Matthew Metcalfe	Maxine Foster/ Associate Directors of Nursing/ Midwifery	1.1 Implementation of Task and Finish Group chaired by Medical Director	01/08/2019	01/08/2019	1.1 Updated Medicines Optimisation workstream	5- Almost certain	Completed
		Matthew Metcalfe	Maxine Foster/ Associate Directors of Nursing/ Midwifery	1.2 Medicines Optimisation Work plan updated to include CQC recommendations (post inspection)	02/08/2019	31/10/2019	1.2 Papers of Task and Finish Group- updates provided to CQEG	5- Almost certain	12/02/2020 Safety alert issued via NetConsent last week for staff and via weekly staff comms update. 21/12/2019 Update from Chief Pharmacist advise safety alerts already shared across the Trust but exploring the use of Netconsent for this as well. Help raise profile and enable audit of staff accessing documents. Also provide historic reminders of key messages Completed
		Matthew Metcalfe	Maxine Foster/ Associate Directors of Nursing/ Midwifery	1.3 Ongoing enhanced audits monitored through medicines governance structure	31/12/2019	03/12/2019	1.3 Audit results/ report and meeting minutes	5- Almost certain	20/12/2019 Update from Chief Pharmacist- Audit form approved August 2019 - changes made after 3 months of use and discussions at MOSG. Completed Audits remain ongoing
		Matthew Metcalfe	Maxine Foster/ Associate Directors of Nursing/ Midwifery	1.4 Safe & Secure Controlled Drug audit carried out on a monthly basis	31/12/2019	03/12/2019	1.4 Audit results/ report and meeting minutes	5- Almost certain	20/12/2019 Update from Chief Pharmacist- Audits are completed monthly for areas of poor compliance (normally done quarterly). CD Audit form has been updated. Plan is to combine CD and MM audits, completed jointly by Nursing and Pharmacy from April 2020 Completed Audits remain ongoing

No	Concern: Womens Childrens, Oncology & Haematology and Cancer Services Division Requirement notice Undertakings Section 4 (both action 2 and 3)	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
2	Staff must follow systems and processes when safely prescribing, administering, recording and storing medicines. The service must ensure medicines are in date and medicine waste and returns are stored securely. Infusions that require protection from light must be stored appropriately. Staff must ensure medicines stored in the medicine trolley are stored in their original boxes to ensure expiry dates and names of medicines are visible. Staff must ensure action is taken to address repeated high room temperature values, where the recommended storage conditions for medicines have been exceeded. (Regulation 12 (2) (g): The proper and safe management of medicines).	Matthew Metcalfe	Maxine Foster/ Associate Directors of Nursing/ Midwifery	2.1 Implementation of Task and Finish Group chaired by Medical Director	01/08/2019	01/08/2019	2.1 Updated Medicines Optimisation workstream	5- Almost certain	Completed
		Matthew Metcalfe	Maxine Foster/ Associate Directors of Nursing/ Midwifery	2.2 Medicines Optimisation Work plan updated to include CQC recommendations (post inspection)	31/10/2019	31/10/2019	2.2 Papers of Task and Finish Group- updates provided to CQEG	5- Almost certain	Completed
		Matthew Metcalfe	Maxine Foster/ Associate Directors of Nursing/ Midwifery	2.3 Ongoing enhanced audits monitored through medicines governance structure	31/12/2019	03/12/2019	2.3 Audit results/ report and meeting minutes	5- Almost certain	20/12/2019 Update from Chief Pharmacist- Audit form approved August 2019 - changes made after 3 months of use and discussions at MOSG. Completed Audits remain ongoing
		Matthew Metcalfe	Maxine Foster/ Associate Directors of Nursing/ Midwifery	2.4 Safe & Secure Controlled Drug audit carried out on a monthly basis	31/12/2019	03/12/2019	2.4 Audit results/ report and meeting minutes	5- Almost certain	20/12/2019 Update from Chief Pharmacist- Audits are completed monthly for areas of poor compliance (normally done quarterly). CD Audit form has been updated. Plan is to combine CD and MM audits, completed jointly by Nursing and Pharmacy from April 2020 Completed Audits remain ongoing
		Matthew Metcalfe	Maxine Foster/ Christine Ainsworth	2.5 Approve business case for maternity pharmacist	31/12/2019	20/12/2019	2.5 Submitted business case	4- Likely	20/12/2019 Chief Pharmacist email - confirm Exec team approve business case and recruitment will commence Jan 2020, with view to providing service from April 2020. 18/12/2019 Supporting evidence saved- business case and emails re taking case to Dec 2019 Finance Committee 05/12/2019 Action updated to Approve business case for maternity pharmacist (previous action Appoint maternity pharmacist)

3	The maternity service must ensure information and guidance about how to complain is widely available to everyone who uses the service. (Regulation 16: (2) Receiving and acting on complaints).	Sheran Oke	Christine Ainsworth/Lorraine Ryan	3.1 4Cs information leaflets and posters to be displayed in all areas	31/12/2019	31/12/2019	3.1 Three spot audits to confirm leaflets and posters on display	5- Almost certain	06/01/2020 Completed. Audits will remain ongoing. No concerns with compliance. Evidence also included of attendance at Meet the Matrons clinic - 3 months of data. Women are accessing this service to discuss their care 18/12/2019 S.Oke advise spot audits will be available for CQC engagement meeting Jan 2020 05/12/2019 Leaflets and posters on display. Meet the Matron posters are also on display in all areas of maternity. Flyers to support the availability of the above are also now included within the mothers discharge pack
		Sheran Oke	Christine Ainsworth/Lorraine Ryan	3.2 'Meet the Matron' posters displayed in all areas- so service users can raise concerns	31/12/2019	31/12/2019	3.2 Record of when Senior Midwifery Team walk arounds completed	5- Almost certain	06/01/2020 Audits provided which show posters on display and evidence of clinics taking place 05/12/2019 Meet the Matron posters are available in all areas of maternity
		Sheran Oke	Christine Ainsworth/Lorraine Ryan	3.3 Use of Big Word translation services	31/12/2019	31/12/2019	3.3 Briefing to staff to remind them to use Big Word	5- Almost certain	6/01/2020 Information available in ward areas. Currently included in maternity's 'Stork Talk' newsletter to remind staff. HOM continues to monitor use of interpreters 05/12/2019 Message relayed through safety huddles, information also available in ward areas. Currently included in maternity's 'Stork Talk' newsletter to remind staff. HOM is monitoring use of interpreters
		Sheran Oke	Christine Ainsworth/Lorraine Ryan	3.4 Develop poster which contains information in other languages for women and families in whom English is not their first language	31/12/2019	31/12/2019	3.4 Copy of poster	5- Almost certain	06/01/2020 Poster on display at hospital. Information booklets available in Romanian. Polish, Lithuanian and Bengali (most common languages). Provided to women at booking appointment by Community Midwife. Evidence of completion changed to Copy of poster 05/12/2019 Information also provided by midwives at booking appointment by community midwife. New poster under design to signpost, leaflets being translated into other languages (most commonly used)

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
4	a) The trust should review its board assurance framework to ensure it provides adequate assurance b) The trust should consider tabling the board assurance framework monthly and consider how current gaps in assurance are highlighted. This consideration should inform debate on the sufficiency of the actions taken to close these gaps, and the associated timelines	Claire Campbell	Claire Campbell	4.1 BAF to be reviewed by Board- benchmarked against CQC advised exemplar document and revised format to be agreed. This will assist in improving assurance, highlight gaps in assurance and timely actions as a result.	31/12/2019	26/09/2019	4.1 Board development programme	5- Almost certain	Completed
		Claire Campbell	Claire Campbell	4.2 Board to consider frequency of reporting of BAF.	26/09/2019	26/09/2019	4.2 Board development programme	4- Likely	20/12/2019 Evidence of completion changed to Board development programme (from Board paper). Frequency of reporting discussed as part of presentation for 4.1 Completed- Board agreed to leave as quarterly reporting in line with other Trusts.
		Claire Campbell	Claire Campbell	4.3 BAF content reviewed and links to strategy pledges included	28/11/2019	28/11/2019	4.3 Board paper	4- Likely	Completed
		Claire Campbell	Claire Campbell	4.4 BAF presented in revised format	28/11/2019	28/11/2019	4.4 Board paper	4- Likely	Completed

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
		Claire Campbell	Simon Hawes	5.1 Revised report format for ARC, Board and its committees	31/10/2019	31/10/2019	5.1 Reports to ARC, Board and its committees	4- Likely	Completed

5	The trust should review its risk register so staff can easily track changes to risk or mitigation and improve clarity on how the existing controls relate to the risk as stated in the risk register	Claire Campbell	Simon Hawes	5.2 Training refresh for all ARC members on risk, including mitigation, and controls	31/03/2020		5.2 Training presentation	4- Likely	09/03/2020 SH confirm with SB that CaC had agreed to change of date (on behalf of CIC). To change date from 31/03/2020 to 30/04/2020. This will enable training to cover Datix Cloud. 12/02/2020 Date for completion changed to 31/03/2020 (from 29/02/2020). For presentation at March 2020 ARC meeting 13/01/2020 Link to training provided. 31/12/2019 Video presentation due at ARC Dec 2019 - lack of presentation software on the day. Expected Jan 2020 or Feb 2020. Date changed to end of Feb 2020 (from 12/12/2019). Link to online training to be provided. 18/12/2019 Email sent to action owner asking if amended date required as training not yet provided at ARC
		Claire Campbell	Simon Hawes	5.3 Deep dives into Divisional Risk Registers	31/10/2019	31/10/2019	5.3 ARC minutes	4- Likely	Completed
		Claire Campbell	Simon Hawes	5.4 Introduction of Datix Cloud to improve risk management process	01/04/2020		5.4 Training presentation on new module	4- Likely	10/02/2020 Datix Cloud IQ launch planned for April 2020. Training to be provided to staff and ARC members on new risk module once created

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
6	The trust should consider how it could improve the effectiveness of its medicines audit processes	Matthew Metcalfe	Maxine Foster	6.1 Action is covered by Medicines Optimisation Action Plan (part of the Medicines Optimisation Strategy 2016-2020). The action plan is monitored through Medicines Optimisation Strategy Group which reports to CQEG	31/12/2019	03/12/2019	6.1 Action Plan & most recent report to CQEG	5- Almost certain	Completed
		Matthew Metcalfe	Maxine Foster	6.2 See also entry and actions for action 1	31/12/2019	03/12/2019	6.2 See above - action 1	5- Almost certain	Completed

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
7	The trust should consider its methods of assurance relating to the segregation of clinical waste	Sheran Oke	Wendy Foster/ Claire Topping	7.1 The Infection Prevention Team carried out a six week audit of all wards, departments, Outpatient areas and Theatres looking in every bin, the results of which were fed back to senior staff	30/09/2019	30/09/2019	7.1 Audits completed over 6 weeks	5- Almost certain	Completed Audit results available
		Sheran Oke	Wendy Foster/ Claire Topping	7.2 Focus on findings of these audit results with a view to improving compliance	31/12/2019	05/12/2019	7.2 Action plans from audits/ improvement work	5- Almost certain	Completed. Audit results shared with Ward Manager, Matron and Infection Prevention Steering group & IPC Operational group on a monthly basis
		Sheran Oke	Wendy Foster/ Claire Topping	7.3 Established a rolling audit programme to carry out a detailed Infection Prevention audit	31/12/2019	05/12/2019	7.3 Rolling audit programme	5- Almost certain	Completed. Audit rolling plan developed and implemented
		Sheran Oke	Wendy Foster/ Claire Topping	7.4 A screensaver has been produced and displayed across the Trust	30/09/2019	30/09/2019	7.4 Screensaver	5- Almost certain	Completed. Screensaver developed and launched across the Trust
		Sheran Oke	Wendy Foster/ Claire Topping	7.5 Key issues are raised at the Infection Prevention Operational Group, Link Nurse Meetings and Infection prevention Steering Group	31/12/2019	05/12/2019	7.5 Minutes from IPOG, Link nurse meetings and IPSG	5- Almost certain	Completed. Minutes available from Infection Prevention Steering Group & IPC Operational Group on a monthly bass
		Sheran Oke	Wendy Foster/ Claire Topping	7.6 Weekly walk arounds with Claire Topping, Sustainability Manager	31/12/2019	05/12/2019	7.6 Notes from weekly walk arounds and any actions to be taken	5- Almost certain	Completed. Weekly walk rounds completed by Sustainability Manager & IPC team. Findings shared with Ward Manager and Infection Prevention Steering Group & IPC Operational group on a monthly basis

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
		Claire Campbell	Claire Campbell	8.1 Agree Committee membership and Lead Executive	24/09/2019	24/09/2019	8.1 Named attendees and Lead Exec	5- Almost certain	Completed
		Claire Campbell	Claire Campbell	8.2 Meeting with Committee Chair and Lead Exec to discuss issues raised in CQC report and Committee effectiveness review	10/10/2019	10/10/2019	8.2 Meeting outcomes as agreed below	5- Almost certain	Completed
		Claire Campbell	Claire Campbell	8.3 Revise committee reporting matrix	15/10/2019	15/10/2019	8.3 Revised reporting matrix	5- Almost certain	Completed

8	a) The trust should review the effectiveness of its audit committee b) The trust should consider the observations in relation to the audit committee to ensure that only realistic and deliverable internal audit recommendations are agreed in future, and that internal audit recommendations, as far as is practicable, are implemented within agreed timescales.	Claire Campbell	Claire Campbell	8.4 Agreed to include committee self-assessment at the end of each meeting	18/12/2019	18/12/2019	8.4 Minutes of December 2019 meeting	4- Likely	20/12/2019 Require final version of minutes from Audit meeting (will be available after March 2020 meeting)
		Claire Campbell	Claire Campbell	8.5 Agreed to include actions from clinical audit and compliance with Clinical audit bi- annually	15/10/2019	15/10/2019	8.5 Revised reporting matrix	4- Likely	Completed
		Claire Campbell	Claire Campbell	8.6 Ensure only realistic and deliverable IA recommendations are agreed in future and monitor delivery against agreed timescale	31/03/2020		8.6 TIAA Recommendation tracker	3 - Possible	12/02/2020 Action remains ongoing as Internal Audit reviews are identified
		Claire Campbell	Claire Campbell	8.7 Ensure Audit committee takes a zero tolerance to longstanding issues and seeks resolution	31/03/2020		8.7 Audit Committee minutes	3 - Possible	
		Claire Campbell	Claire Campbell	8.8 Closure of salary overpayment issue via audit committee (Cross reference with action no 14.)	18/12/2019	18/12/2019	8.8 Minutes of December 2019 meeting	3 - Possible	20/12/2019 Exec email- discussed at Audit Committee and Finance and Performance. Require final version of minutes from Audit meeting (will be available after March 2020 meeting)

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
9	The trust should consider an external review of its governance structure and systems	Claire Campbell	Claire Campbell	9.1 Refresh well- led Board knowledge	29/02/2020	27/02/2020	9.1 Presentation	4- Likely	03/03/2020 Discussed at Board of Directors on 27/02/2020. Evidence of completion required. 12/02/2020 Postponed from January 2020 Board meeting as ran out of time. To now take place in Feb 2020. Date changed from 30/01/2020 to 29/02/2020. All other actions to be moved back one month. 20/12/2019 Exec email- actions relating to 9.1 and 9.2 postponed as Dec 2019 Board overran. To now take place in Jan 2020 (changed from 19/12/2019). All other actions to be moved back one month.
		Claire Campbell	Claire Campbell	9.2 Identify basic specification of need	29/02/2020	27/02/2020	9.2 Specification document	4- Likely	03/03/2020 Discussed at Board of Directors on 27/02/2020. Evidence of completion required. 12/02/2020 Postponed from January 2020 Board meeting as ran out of time. To now take place in Feb 2020. Date changed from 30/01/2020 to 29/02/2020. All other actions to be moved back one month. 20/12/2019 Exec email- actions relating to 9.1 and 9.2 postponed as Dec 2019 Board overran. To now take place in Jan 2020 (changed from 19/12/2019). All other actions to be moved back one month.
		Claire Campbell	Claire Campbell	9.3 Commission external review via competitive quotes	31/03/2020		9.3 Supplier engaged	4- Likely	12/02/2020 See action 9.1- date for completion changed to 31/03/2020 (from 29/02/2020) 20/12/2019 See action 9.1- date for completion changed to 29/02/2020 (from 31/01/2020)
		Claire Campbell	Claire Campbell	9.4 Undertake governance review	31/05/2020		9.4 Governance review completed	4- Likely	12/02/2020 See action 9.1- date for completion changed to 31/05/2020 (from 30/04/2020) 20/12/2020 See action 9.1- date for completion changed to 30/04/2020 (from 31/03/2020)
		Claire Campbell	Claire Campbell	9.5 Provide evidence to NHSE/I	31/05/2020		9.5 Outcome evidence	4- Likely	12/02/2020 See action 9.1- date for completion changed to 31/05/2020 (from 30/04/2020) 20/12/2020 See action 9.1- date for completion changed to 30/04/2020 (from 31/03/2020)

No	Concern: Trustwide Quality "Should" actions Undertakings Section 5	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
10	The trust should consider the structure, management and oversight arrangements for its quality improvement function	Matthew Metcalfe	Phil Bradley	10.1 Collective transformation resource reviewed	01/04/2020	03/12/2019	10.1 Completed review 10.1 New organogram for QI resource	4- Likely	18/12/2019 Transformation Resource paper to be presented at Finance and Performance meeting 19/12/2019 Completed
		Matthew Metcalfe	Phil Bradley	10.2 Recommendations of review to be presented to Trust Board	01/04/2020	19/12/2019	10.2 Completed review	4- Likely	13/01/2020 Discussed and recommendations approved at Dec 2019 Finance and Performance meeting (Committee of Board)

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments

11	The trust should continue to engage all its partners in operational and strategic decision making	Chris Pallot	Chris Pallot	11.1 To publish the new strategy and retain evidence of consultation with partners.	01/11/2019	01/11/2019	11.1 New strategy 11.1 Responses from partners	5- Almost certain	13/01/2020 Strategy includes how partners were consulted and input used Completed
		Chris Pallot	Chris Pallot	11.2 Continue to engage partners in large scale strategic changes	01/11/2019	01/11/2019	11.2 Examples of work with partners	5- Almost certain	13/01/2020 Evidence of completion added in- Examples of work with partners Completed and remains ongoing
		Chris Pallot	Chris Pallot	11.3 Continue to engage partners in strategic operational issues and decision making	01/11/2019	01/11/2019	11.3 Examples of work with partners	5- Almost certain	13/01/2020 Evidence of completion added in- Examples of work with partners Completed and remains ongoing

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
12	The trust should take steps to assure itself that the interventions in progress to address bullying and poor behaviour are having an impact at pace	Mark Smith	Bronwen Curtis	12.1 Review impact of current programme	31/10/2019	31/10/2019	12.1 Summer of engagement feedback	5 - Almost certain	Completed. Feedback responded to from staff in the People's Plan
		Mark Smith	Bronwen Curtis	12.2 Targeted interventions in 'hotspots'	31/12/2019	31/12/2019	12.2 Example of targeted intervention work in 'hotspot' area	4 - Likely	06/01/2020 Freedom to Speak Up/HR/OD linkage created. Targeted interventions plans are in place or being progressed for 'hotspot' areas (Oncology, Cardiology and Maternity) Evidence of completion changed from Staff Survey 2020 to Example of targeted intervention work in 'hotspot' area
		Mark Smith	Bronwen Curtis	12.3 Incorporate 'Civility Saves Lives' into Respect and Support programme	31/03/2020		12.3 Staff survey 2020	4 - Likely	09/03/2020 Action owner confirm action complete subject to exec sign off next week. To amend deadline from 29/02/2020 to 31/03/2020. Refocus of respect and support approach complete. New programme incorporating Civility Saves Lives, GMC Professional Standards and previous Respect and Support campaign agreed ready for rollout Executive sign off planned for 17/03/20 06/02/2020 Two pilots run in Oncology 06/01/2020 Piloting GMC professional standards in January 2020 to incorporate Civility Saves Lives for roll out from February 2020. Completion date changed from 31/12/2019 to 29/02/2020

No	Concern: Trustwide Quality "Should" actions Undertakings Section 2	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
13	The trust should consider commissioning a more detailed analysis of the drivers of its deficit to inform those elements that are within its gift to be able to address both directly and indirectly	Phil Bradley	Bola Agboola	13.1 Work with NHSE/I to agree process to complete this (using their expertise and knowledge)	01/04/2020		13.1 Copy of agreed process	3 - Possible	04/03/2020 Working with systems colleagues a review into the drivers of the deficit is to be commissioned during march 2020 and completed in May 2020. 12/02/2020 This is superseded by the issued financial improvement trajectories and system working relating to transformation and block contracts. We know that the major cause of our deficit is the underfunding of the tariff.

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
14	The trust has plans to introduce an electronic solution between the human resources function and payroll to seek to address the issue of staff overpayments. The trust should consider requesting an internal audit function review of the planned electronic solution, in order that any control weaknesses can quickly be identified and addressed.	Mark Smith	Adam Cragg	14.1 Request an internal audit review and address weaknesses	01/04/2020		14.1 Internal audit report and action plan	4 - Likely	09/03/2020 Remain on track for completion date 13/02/2020 Electronic solution designed and process agreed Await confirmation of functionality before implementation

No	Concern: Urgent and Emergency Services Quality "Should" actions	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments

15	**Undertakings Section 4** The service should continue to re-assess the layout of the paediatric emergency department to ensure it meets the Children and Young People in Emergency Care Settings 2012 standards	Deborah Needham	Tristan Dyer/ Head of Estates	15.1 Set up working group to establish with Paediatrics and Estates to review the current working practices that our Paediatric area has to meet these standards.	31/03/2020		15.1 Minutes from Working Group	5- Almost certain	06/03/2020 The space that had been initially identified has been assessed as unsuitable and therefore other options are now being considered. The space has been identified and plans are being worked up by estates. The urgency of developing these plans has been discussed at the Trust estate meeting which is chaired by the COO. We are expecting plans to be available in the next 4 weeks to enable a further discussion 10/02/2020 – Plans in development. Short term plan - Extension to current ED area by relocating the staff area and one other room & developing 2 additional cubicles in the Childrens waiting area. Longer term plan – develop a Childrens ED which will run alongside the current A&E area and utilise the consultants office space. (long term plan pending funding) 09/01/2020 Update from D.Needham Plans are being drawn up to extend the Children's cubicle area by 2 cubicles. Work will progress in Q4. Change date of completion/ review to 31/03/2020 from 31/12/2019 04/12/2019 Update from S.Finn The group have identified a short term solution to reconfigure and expand the department.
		Deborah Needham	Tristan Dyer/ Head of Estates	15.2 Develop options paper looking at expanding or relocating the department. Seek potential options for capital funding.	31/03/2020		15.2 Options paper	5- Almost certain	06/03/2020 The space that had been initially identified has been assessed as unsuitable and therefore other options are now being considered. The space has been identified and plans are being worked up by estates. The urgency of developing these plans has been discussed at the Trust estate meeting which is chaired by the COO. We are expecting plans to be available in the next 4 weeks to enable a further discussion 10/02/2020 See action 15.1 09/01/2020 See update for action 15.1. Change of completion/ review date to March 2020 (from 31/12/2019) 04/12/2019 Update from S.Finn Initial long term, high level plans have been produced but funding has not been identified to allow the scheme to progress at this time. A short term solution has been identified and is currently being costed. A paper will be presented to ET for approval in Jan 20
		Deborah Needham	Tristan Dyer/ Head of Estates	15.3 Complete works to change the department	31/03/2020		15.3 Completion of works	2 - Unlikely	10/02/2020 See action 15.1 09/01/2020 Linked in with action 15.1, Change of completion/ review date to 31/03/2020 from 31/12/2019 Review date of 31/12/2019
		Deborah Needham	Tristan Dyer/ Owen Cooper	15.4 Review pathways for use of PAU and increased activity	31/12/2019	31/12/2019	15.4 Increase referrals to PAU from A&E	4- Likely	09/03/2020 Remains outstanding due to annual leave 14/02/2020 SB liaise with DN PA to try and resolve issues around closure of action 29/01/2020 Evidence of compliance provided - concerns raised by TD. SB email DN for confirmation of sign off 09/01/2020 Email from D.Needham. Pathways from A&E to PAU in place. Evidence of completion required
16	**Undertakings Section 4** The service should make arrangements so patient group directions are regularly checked and updated on the trust internal website	Matthew Metcalfe	Maxine Foster	16.1 This action is included within the Medicines Optimisation action plan (part of the Medicines Optimisation Strategy 2016-2020).	31/12/2019	20/12/2019	16.1 Action plan 16.2 Most recent report taken to CQEG	4- Likely	20/12/2019 Further supporting evidence added in. Action complete 18/12/2019 Supporting evidence added re amendments to PGD process
		Matthew Metcalfe	Maxine Foster	16.2 Include process in revised Medicines Management Policy	31/03/2020		16.2 Revised Medicines Management Policy	5- Almost certain	07/02/2020 Process for PGDs will be included in review of Medicines Management Policy (due for update March 2020). Once policy approved, Pharmacy will audit against it and will add to 20/21 Medicines Optimisation Plan 18/12/2019 Supporting evidence added re amendments to PGD process 05/12/2019 Action changed to 'Include process in revised Medicines Management Policy'. Date revised to 31/03/2020 (from 31/12/2019) Previous action was 'See also entry for action 1
17	**Undertakings Section 4** The service should take action so medical staff are compliant with the trust target for safeguarding children level three training	Mark Smith	Tristan Dyer	17.1 Mandatory training compliance of all staff groups is reviewed at every Urgent Care Governance meeting	29/02/2020	12/02/2020	17.1 Governance report and governance meeting minutes	4 - Likely	12/02/2020 Data is included in monthly governance reports and discussed in more detail where required. Training data is also emailed monthly by Training and Development to key leads in the directorate. 13/01/2020 Compliance Governance Manager review plan. No current update available at time of writing report. Extend date of completion by 1 month to 29/02/2020 (from 31/12/2019). Compliance team will raise at Urgent Care Governance meeting on 16/01/2020 05/12/2019 Exec owner changed from Matthew Metcalfe to Mark Smith
		Mark Smith	Tristan Dyer	17.2 Clinical Director for Urgent Care will remind all medical staff of their need to complete the training	29/02/2020	29/01/2020	17.2 Email sent to medical staff	4 - Likely	29/01/2020 E-mail from TD confirming medical staff are reminded to complete mandatory training. Action closed. 13/01/2020 Compliance Governance Manager review plan. No current update available at time of writing report. Extend date of completion by 1 month to 29/02/2020 (from 31/12/2019). Compliance team will raise at Urgent Care Governance meeting on 16/01/2020 05/12/2019 Exec owner changed from Matthew Metcalfe to Mark Smith

		Mark Smith	Tristan Dyer	17.3 The Safeguarding Team provide regular updates of who needs to completed training and this will be monitored for medical staff who are not completing the training and are repeatedly on the list	01/04/2020		17.3 Training information over 3 months and identification of medical staff on the list more than once	4 - Likely	09/03/2020 Plan to achieve by deadline date 13/02/2020 Joint working between QI and L&D to identify non-compliance. Currently working with safeguarding to ensure availability of training 05/12/2019 Exec owner changed from Matthew Metcalfe to Mark Smith
18	Undertakings Section 1 The service should take action to improve the median time from arrival to treatment	Deborah Needham	Claire Dannatt	18.1 Implement winter actions	31/12/2019	31/12/2019	18.1 Winter action plan 18.1 Board paper in relation to winter plan	5- Almost certain	01/02/2020 Evidence of completion provided. Action closed down. 28/01/2020 Evidence of completion confirmed as Winter action plan and paper to Board. Winter action plan needed as evidence (will be sent over 30/01/2020 post progress meeting today) 09/01/2020 Email from D. Needham. In progress- ET updated weekly. Evidence of completion required, Action completed
		Deborah Needham	Deborah Needham	18.2 Appoint PMO lead for Urgent Care and Winter	12/11/2019	12/11/2019	18.2 PMO lead identified and commenced	5- Almost certain	Completed
		Deborah Needham	Deborah Needham	18.3 Review Heat activity 18.3 Re-define programme 18.3 Re-launch	31/03/2020		18.3 Agreement of workstreams	5- Almost certain	10/03/2020 Dep COO request extension for one month so COO can advise current position. Date for completion changed from 29/02/2020 to 31/03/2020 10/02/2020 New workstreams agreed and being led by COO/MD/DofN 29/01/2020 Evidence of completion confirmed as Agreement of workstreams 09/01/2020 Email from D. Needham. Meeting planned for PMO, DofN, Med Dir and COO to relaunch. Winter actions taken priority. Completion date changed to 29/02/2020 (from 31/12/2019)
		Deborah Needham	Deborah Needham	18.4 Rapid improvement project with IDT	09/12/2019 (and ongoing)	09/12/2019	18.4 Time to PDNA reduced	4 - Likely	05/02/2020 Evidence provided. Time to PDNA currently monitored via SPA. Project in progress to utilise real time data from iBox. Trust has implemented an internal PDNA Hub. 03/02/2020 SB link with relevant leads to source evidence 09/01/2020 Email from D.Needham. Action is completed. Evidence of completion required

No	Concern: Medical Care Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
19	The service should check medical staff are up to date with mandatory, safeguarding and mental capacity training	Mark Smith	Sally Shocklidge/ Becky Samson	19.1 Use of Netconsent software to check and force compliance	01/04/2020		19.1 Information provided on Netconsent	4 - Likely	09/03/2020 Plan to achieve by deadline date 13/02/2020 Netconsent in place
		Mark Smith	Sally Shocklidge/ Becky Samson	19.2 Provide additional sessions of 'bundles' of mandatory training for trust grade staff	01/04/2020		19.2 Dates training bundle provided and attendance records	4 - Likely	09/03/2020 Plan to achieve by deadline date 13/02/2020 Additional cluster days available. Attendance records updated accordingly
		Stuart Finn	Wendy Foster/ Brian Willet	20.1 Induction training for new starters	30/04/2020	06//01/2020	20.1 Induction training	5- Almost certain	23/01/2020 Evidence of completion provided. 06/01/2020 Email from S.Finn. IPC mandatory training and bespoke food hygiene induction training is in place for all new starters and existing staff. Action completed. Evidence of completion required 04/12/2019 Catering and IPC meeting held 29 Nov 19 to discuss and agree actions. Documentation including HASAP (Hazard and Critical Control Process) has been shared with IPC who are reviewing. Next meeting to be arranged in Jan 20
		Stuart Finn	Wendy Foster/ Brian Willet	20.2 Infection Prevention representation at Catering Meetings regarding PPE	30/04/2020	06/01/2020	20.2 Meeting minutes	5- Almost certain	28/01/2020 Evidence of completion provided 06/01/2020 Email from S.Finn PPE is issued to all food handlers/production staff. Ward hostesses uniforms are issued and protective aprons and gloves available. Staff are trained in food hygiene procedures which include PPE. Staff records evidence training and issue of PPE. Action completed. Evidence of completion required. 04/12/2019 As above

20	The service should check catering staff are following infection prevention and control protocols	Stuart Finn	Wendy Foster/ Brian Willet	20.3 Infection Prevention Mandatory training - 3 yearly for non-clinical staff	30/04/2020	06/01/2020	20.3 See 20.1	5- Almost certain	28/01/2020 Evidence of completion provided 06/01/2020 Email from S.Finn. This has been reviewed by SF and BW and recorded as completed. Evidence of completion required. 04/12/2019 This is in place for all catering staff and monitored via mandatory training results and at appraisals. Every "food handler" also complete 'Food Hygiene' course
		Stuart Finn	Wendy Foster/ Brian Willet	20.4 Environment audits and Catering audits are carried out when infection is identified	30/04/2020	06/01/2020	20.4 Audits/ report and meeting minutes where presented	5- Almost certain	28/01/2020 Evidence of completion provided 06/01/2020 Email from S.Finn. Audits and inspections are in place and carried out regularly. Post infection audits and inspections are carried out by IPC and include ward kitchens. This has been reviewed by SF and BW and recorded as completed. Evidence of completion required 04/12/2019 IPC have been asked to comment
		Stuart Finn	Wendy Foster/ Brian Willet	20.5 Domestic monthly cleaning audits include host/hostess staff - hand hygiene etc observed	30/04/2020	06/01/2020	20.5 Audits/ report and meeting minutes where presented	5- Almost certain	28/01/2020 Evidence of completion provided 06/01/2020 Email from S.Finn. This has been reviewed by SF and BW and recorded as completed. Evidence of completion required. 04/12/2019 This is in place as part of the cleaning audits. The ward kitchens are scored separately as part of the audit and include the ward host/hostess
		Stuart Finn	Wendy Foster/ Brian Willet	20.6 A review of catering procedures and working practices will be carried out by Infection control and the Catering management team	30/04/2020	10/03/2020	20.6 Completed review	5- Almost certain	10/03/2020 This action has been completed. W. Foster has written to A. Head to confirm that the procedures have been reviewed and are suitable and in place. A. Head will provide copy of the email as evidence on return form leave 16/03/20 23/01/2020 Email from W Foster. Dates being organised between IPC and Hotel Services 06/01/2020 Email from S.Finn. BW arranging follow-up meeting with IPC. 04/12/2019 Catering and IPC meeting held 29 Nov 19 to discuss and agree actions. Documentation including HASAP (Hazard and Critical Control Process) has been shared with IPC who are reviewing. Next meeting to be arranged in Jan 20
21	The service should keep all confidential patient records securely	Sheran Oke	Fiona Barnes/ Sally Shocklidge	21.1 The Trust have invested in lockable trollies in order to store patient records securely	30/09/2019	30/09/2019	21.1 Confirmation email from Senior member of Nursing team	5- Almost certain	Completed
		Sheran Oke	Fiona Barnes/ Sally Shocklidge	21.2 Lockable cupboards are available for the safe storage of patient records	30/09/2019	30/09/2019	21.2 Confirmation email from Senior member of Nursing team	5- Almost certain	Completed
		Sheran Oke	Fiona Barnes/ Sally Shocklidge	21.3 Annual Information Governance mandatory training for all staff	31/12/2019	05/12/2019	21.3 Relevant section from Data Protection Toolkit submission	5- Almost certain	13/01/2020 Further email confirmation of the below received 05/12/2019 Completed As part of the Data Security and Protection Tool kit, the trust met the 95% Mandatory Information Governance training requirement for 2019 and are working towards this requirement in time for the March 2020 submission
		Sheran Oke	Fiona Barnes/ Sally Shocklidge	21.4 Data Quality, Security and Protection team to complete spot audits of compliance on wards and departments (Oct 2019 and March 2020). Findings to be shared at Assurance, Risk and Compliance meeting)	01/04/2020		21.4 Data Protection Audit results	5- Almost certain	09/03/2020 Verbal update from Dep DofN Waiting for outcome of further audit to be completed March 2020 13/02/2020 High level findings from Oct 2019 DSP audit shared at ARC 13/02/2020. A number of screensavers have been issued as result of findings from spot audits. Acceptable Use Policy also being updated and taken to February 2020 PGD meeting. 14/01/2020 Action amended to read Data Quality, Security and Protection team to complete ..... Date of audit completed changed to Oct 2019 Evidence provided for audit completed Oct 2019. Results discussed at Data Governance Group. 05/12/2019 On Track - Spot audits of 12 wards have been carried out so far this financial year. The findings are to be published at the next Data Governance Group Meeting which feeds into the Assurance Risk and Compliance group as appropriate

		Sheran Oke	Fiona Barnes/ Sally Shocklidge	21.5 Assessment & Accreditation will incorporate criteria regarding the safe storage of health records.	01/04/2020	09/03/2020	21.5 Relevant Assessment and Accreditation document	5- Almost certain	09/03/2020 Email from Dep DofN to reword action. Wording changed to Assessment & Accreditation will incorporate criteria regarding the safe storage of health records (from All areas need to demonstrate compliance as part of the Ward Accreditation Assessment). Due to inability to achieve current action as A&A timetable is dependent on the outcome of the wards previous assessment, i.e. as ward may not be required to have an assessment for 6 months. 12/02/2020 All evidence provided waiting confirmation of closure from action owners 07/01/2020 Evidence of related documents used for Assessment and Accreditation provided 05/12/2019 On track, being included in ward Assessment & Accreditation process, not as yet reported owing to timings of Assessments
22	The service should introduce local procedures for invasive procedures in non-theatre settings	Matthew Metcalfe	Michelle Metcalfe	22.1 LocSSIP documents reviewed and updated	29/02/2020	18/02/2020	22.1 Completed documents	5- Almost certain	03/03/2020 Policy discussed and approved at Feb 2020 PDG meeting. Minor changes needed then will be uploaded to intranet. Final version required for evidence of completion. 05/02/2020 LocSSIPs policy is going to PDG in February 2020. Date for completion changed to 29/02/2020 (from 01/02/2020) 05/12/2019 Date changed from 01/01/2020 to 01/02/2020 due to current progress with workstream
		Matthew Metcalfe	Michelle Metcalfe	22.2 Relaunch of LocSSIPs - training and comms	30/06/2020		22.2 Education/ Comms provided and timelines	4 - Likely	05/02/2020 Existing LocSSIPs being updated to new Trust format. Education being provided to teams as these are updated 31/12/2019 Email from Mi.Metcalfe. Work programme has increased. New Clinical Lead for this. Plan to revise the template for the Trust and do base line audit of documents in existence and staff awareness. Re-launch planned for June 2020. Completion date changed to 30/06/2020 (from 01/05/2020) 05/12/2019 Date changed from 01/04/2020 to 01/05/2020 due to progress with action 22.2
		Matthew Metcalfe	Michelle Metcalfe	22.3 Audit of compliance	31/10/2020		22.3 Audit forward programme and outcome of audit	4 - Likely	31/12/2019 See comment for 22.2. Completion date changed to 31/10/2020 (from 01/09/2020) 05/12/2019 Date changed from 01/08/2020 to 01/09/2020 due to progress with action 22.1
23	The service should manage medical outliers so they are seen in a timely manner	Deborah Needham	Divisional Director for Medicine	23.1 Inpatients cared for on outlying wards have a designated medical team to review patients. This is monitored and audited twice weekly by reviewing the medical plans in the patient's medical records	29/02/2020	10/02/2020	23.1 Twice weekly audits	5- Almost certain	10/02/2020 Completed and in place. Evidence of completion required. 06/01/2020 Email from D. Needham. Each outlying ward has nominated consultant. Audits completed within the division by the management team. Date of completion amended to 29/02/2020 (from 31/12/2019). Not yet signed off by exec lead. 31/12/2019 Review date of 31/12/2019
		Deborah Needham	Divisional Director for Medicine	23.2 Ward staff escalate any issues regarding medical reviews at the x3 daily Site meetings.	31/10/2019	31/10/2019	23.2 What's app messages	5- Almost certain	28/01/2020 D Needham advise evidence of completion can change to What's App messages 23/01/2020 Example Daily Safety Sheet notes provided for Oct 19, Dec 19 and Jan 20. Site Team to provide relevant Whats App messages as well. This is the format of notes from meeting. 13/01/2020 Evidence of completion required Completed and ongoing review quarterly .
		Deborah Needham	Divisional Director for Medicine	23.3 Number of medical outliers to be communicated daily via Sitrep (Whats app)	31/10/2019	31/10/2019	23.3 Examples of Sitrep communications	5- Almost certain	23/01/2020 Evidence provided of example x6 daily Trust position- Sitrep. Recent change to now include medical outliers in this as well as info going out via Whats app. Also sample What's app message 13/01/2020 Evidence of completion required Completed and ongoing review quarterly
		Matthew Metcalfe	Fay Gordon	24.1 East Midlands Clinical Senate review completed August 2019- Terms of reference included private practise arrangements	31/08/2019	31/08/2019	24.1 Completed report	5- Almost certain	Completed

24	The service should consider how it manages private and NHS patients for cardiology procedures to ensure equity of access	Matthew Metcalfe	Fay Gordon	24.2 Action plan developed linking multiple reports/ workstreams in Cardiology	13/03/2020		24.2 Action plan	5- Almost certain	03/03/2020 Associate medical director request an update on progress. SB will be completed by deadline of 13/03/2020 12/02/2020 Some delays in collating information. Completion date changed to 13/03/2020 (from 16/02/2020) 13/01/2020 Compliance Governance Manager involved in this workstream. Meeting planned for 07/01/2020 (cancel due to Trust pressures) rebooked for 16/01/2020. Progress has also been made with using this approach in Breast- method can now be transferred to Cardiology. Completion date changed from 31/12/2019 to 16/02/2020. 18/12/2019 Action plan in place to address concerns from Senate visit. Meeting held 17/12/2019 to identify relevant reports for Cardiology- further meeting planned 07/01/2020
25	The service should review clinical guidelines to check they are current	Matthew Metcalfe	Caroline Corkerry	25.1 Netconsent to ensure guidelines reviewed in line with policy	01/04/2020		25.1 Sample of reminders sent out using Netconsent	3 - Possible	03/03/2020- Procedural Document Group meet monthly and overdue document list is brought to the meeting to gain support from attendees to address any overdue documents within the sphere of control. Net Consent continues to send reminders to document authors in advance of the expiry date 10/02/2020 Overdue Policies / guidelines continue to be presented at every PDG to gain support from PDG members to address those that are overdue. Reminders are also sent via NetConsent system to the authors ahead of the Policies going out of date for them to take appropriate action to ensure that the Policies/ Guidelines are reviewed in a timely manner. In addition PDG have requested that the amount of notice given to Policy authors via Netconsent is increased to 6 months 18/12/2019 Overdue Policies / guidelines are presented at every PDG to gain support from PDG members to address those that are overdue. Reminders are also sent via NetConsent system.
		Matthew Metcalfe	Caroline Corkerry	25.2 Use of PDG report to show reduction in overdue guidelines	01/04/2020		25.2 PDG reports	4- Likely	03/03/2020- PDG continues to submit reports to CQEG in relation to the documents that have been approved and those that are overdue. This is a long term action, including rationalisation of procedural documents. 10/02/2020 Monthly report provided to CQEG which demonstrates the progress in reducing the number of overdue documents. This will be a long term action. 18/12/2019 Monthly report provided to CQEG which demonstrates the reduction in the number of overdue documents. This will be a long term action.
26	The service should consider reviewing storage and security of substances subject to control of substance hazardous to health (COSHH)	Sheran Oke	Fiona Barnes	26.1 All storage areas reviewed during core service inspection and security risks removed	30/06/2019	30/06/2019	26.1 Senior staff visited areas and ensured door codes removed 26.1 Spot audit of compliance to be completed by Health and Safety team late November 2019	5- Almost certain	08/01/2020 Email from F. Barnes. DofN complete further spot check on door codes before Christmas (late evening and night shift). None found. Completed (spot audit to review ongoing compliance planned late November 2019)
27	The service should consider reviewing environment and facilities for inpatient outliers staying on the Heart Centre	Debbie Needham	Fay Gordon	27.1 Complete review of Heart Centre environment and facilities	31/03/2020	09/01/2020	27.1 Completed review	4- Likely	29/01/2020 Evidence of completion provided. Escalation documents taken from the Weekend Plan in relation to use of Heart Centre for outliers 09/01/2020 Email from D.Needham. Undertaken as part of escalation areas review previously. Action completed. Evidence of completion required.
28	The service should consider addressing cultural issues across some medical wards	Mark Smith	Bronwen Curtis	Covered within action 12	31/12/2019	31/12/2019	See action 12	See action 12	Covered within action 12
29	The stroke services to consider improving compliance with completion of VTE assessments	Matthew Metcalfe	Amanda Bisset	29.1 To monitor stroke service VTE compliance via thrombosis committee and implement actions if compliance has not improved	31/03/2020		29.1 Copy of meeting minutes and associated actions (if relevant)	4- Likely	10/02/2020 Action owner confirmed data is captured by ward. Will provide for relevant wards related to stroke service.

No	Concern: Maternity Services Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
		Sheran Oke	Christine Ainsworth/Sue Lloyd	30.1 Continue monitoring access to maternity services by 10+0 weeks and 12+6 weeks	31/10/2019	31/10/2019	30.1 Maternity Dashboard 30.1 Minutes of Directorate Governance Meetings	5- Almost certain	Completed
		Sheran Oke	Christine Ainsworth/Sue Lloyd	30.2 Monitor access to scan appointment within 72 hours for women with reduced/static growth	30/11/2019	30/11/2019	30.2 Datix Incidents / Trends 30.2 Minutes of Maternity Risk Group Meeting / Directorate Governance Group Meeting	5- Almost certain	Completed Currently monitoring is in place, to be added to dashboard as from December
		Sheran Oke	Christine Ainsworth/Sue Lloyd	30.3 Review midwifery ultrasonography scan clinics to ensure adequate capacity	31/12/2019	31/12/2019	30.3 Service review presented to the Directorate Management Board	5- Almost certain	06/01/2020 Email from DofN to confirm completed. Evidence provided. 05/12/2019 MDU midwife currently completing QI project reviewing demand to baseline match capacity developing a better triage system

30	The service should ensure women can access the service when they need it and receive the right care promptly and that waiting times from referral to treatment and arrangements to admit, treat and discharge women are in line with national standards	Sheran Oke	Christine Ainsworth/Sue Lloyd	30.4 MESC bid for ultrasound machine for Labour Ward to prevent overnight referrals to MDU / Midwife Scan clinics	31/03/2020		30.4 Completed bid.	4- Likely	01/03/2020 Awaiting bid outcome, continue to monitor waiting times and report 72 hour breeches to governance 11/02/2020 Awaiting outcome 08/01/2020 Continue to await feedback on bid 05/12/2019 Bid has been submitted, feedback awaited
		Sheran Oke	Christine Ainsworth/Sue Lloyd	30.5 Seek further funding / training for more midwives to be trained in 3rd Trimester scanning	31/03/2020	06/01/2020	30.5 Additional training places available for midwives	4- Likely	06/01/2020 No requirement at present to train additional midwives. As per 30.3 - 2 midwives will complete training in April 2020. Funding currently available via HEE if situation changes - next course September 2020. Action completed. 05/12/2019 Two midwives have to date commenced the training scanning programme. Funding currently available via HEE. Currently exploring how places can be accessed going forward as next programme is Sept 20
		Sheran Oke	Christine Ainsworth/Sue Lloyd	30.6 Monitor Triage waiting times on Maternity Dashboard – monthly report to Directorate / Divisional Governance Group.	31/10/2019	31/10/2019	30.6 Maternity Dashboard 30.6 Minutes of Directorate/Divisional Governance Group	5- Almost certain	Completed (see evidence for 30.2)
		Sheran Oke	Christine Ainsworth/Sue Lloyd	30.7 Business case to reconfigure Labour Ward which will make a dedicated Triage area and provide easier access to obstetric care. It will also reduce attendances / waiting times on the Maternity Day Unit.	31/03/2020		30.7 Completed business case	3 - Possible	01/03/2020 Continue to monitor triage waiting times, these are poor, triage on MDU is an issue, 19% had first assessment within 15 mins (Jan' 20) Support for business case will address concern 1 1/02/2020 Executive Team support case– Options currently being developed by Facilities 05/12/2019 Business case submitted awaiting outcome
31	The service should formally monitor delayed discharges and how frequently induction of labours or elective caesarean sections are delayed (or cancelled) so the service can analyse and monitor trends to inform future plans	Sheran Oke	Christine Ainsworth	31.1 Develop audit proforma for delayed/cancelled IOL and elective caesarean sections	01/04/2020		31.1 Audit proforma	5- Almost certain	01/03/2020 Audit proforma is being used, sections are now datixed and are reported on the huddle sheets. Figures to be reported as below 13/02/2020 Cancelled electives being monitored through Datix and IOL though audit . Figures to be included in Risk Management report and Clinical effectiveness report and escalated as appropriate 06/01/2020 Audit proforma developed and circulated to all staff - December 2019 Every induction to be audited as well as cancelled electives, To continue and feedback through Divisional Governance meetings 05/12/2019 Supported by snapshot audit, every induction audited as well as cancelled electives, To continue and feedback through Divisional Governance meetings
		Sheran Oke	Christine Ainsworth	31.2 Reasons for delayed discharges discussed and documented at the Maternity Safety Huddle	01/04/2020		31.2 Maternity Safety Huddle sheets	5- Almost certain	01/03/2020 As per 31.1. Audit proforma being used 13/02/2020 Maternity huddle sheets being used daily and well embedded in service 05/12/2019 This is currently under development and on track to deliver by stated deadline
		Sheran Oke	Christine Ainsworth	31.3 Monthly report to Directorate Governance Group and Divisional Governance Group	01/04/2020		31.3 Monthly reports / Minutes of Directorate / Divisional Governance Group	5- Almost certain	01/03/2020 Results of Feb 2020 audit will be presented at March 2020 Maternity governance meeting 13/02/2020 Monitoring and reporting as outlined and concerns escalated as needed 05/12/2019 To commence Feb 2020
		Sheran Oke	Christine Ainsworth	31.4 Business case for pharmacy support to assist with delayed discharges for take home medications	01/04/2020		31.4 Approved business case	3 - Possible	01/03/2020 Pharmacy post out to advert 11/02/2020 Please refer to 2.5 06/01/2020 Business case supported and recruitment underway 05/12/2019 Please refer to No.2.5 Business case has been completed and due for submission in Dec 19
32	The service should ensure managers are planning the service for the long term. For example, to enable planning and organisation of services so they met the needs of the local population within the local expected	Sheran Oke	Sue Lloyd	32.1 Develop Long Term Plan in conjunction with the Local Maternity System	01/04/2020	01/03/2020	32.1 Long Term Plan submitted to NHSE/I	5- Almost certain	01/03/2020 Action completed. Discussed at strategy meeting- 5 year LMS plan has been submitted 13/02/2020 Feedback still awaited 05/12/2019 Long Term Plan developed, awaiting feedback
		Sheran Oke	Sue Lloyd	32. 2 Develop integrated Business Plan for Maternity Services	01/04/2020	06/01/2020	32.2 Integrated Business Plan	5- Almost certain	06/01/2020 Email from DofN to confirm action completed. 05/12/2019 Plan has been developed and has been presented to the Divisional Team meeting
		Sheran Oke	Sue Lloyd	32.3 Engagement in East Midlands Clinical Network as well as other Regional / National events and meetings	01/04/2020		32.3 Minutes from Network meetings	5- Almost certain	01/03/2020 Service attends relevant events. Evidence to follow. 13/02/2020 The service continue to engage and be involved in these events 05/12/2019 Trust team has attended and engaged in events, sharing findings and outcomes with local teams
		Sheran Oke	Sue Lloyd	32.4 Monthly report to Divisional Management Board on forecasted activity based on bookings	01/04/2020		32.4 Reports and minutes of Divisional Management Board meetings	5- Almost certain	01/03/2020 Updated evidence provided of meeting reports 13/02/2020 Work is ongoing 05/12/2019 Commenced

	population growth	Sheran Oke	Sue Lloyd	32.5 Business case to be submitted to reconfigure Sturtridge Labour Ward – non clinical rooms changed into clinical rooms, dedicated Triage area consisting of 4 rooms which could be used as further birthing rooms at times of high activity	01/04/2020		32.5 Business Case submitted in line with trust process	3/4 (outcome dependent)	01/03/2020 Executive Team support case- options awaited from Facilities 11/2/20 Executive Team support case– Options currently being developed by Facilities 05/12/2019 Business case submitted awaiting outcome
		Sheran Oke	Sue Lloyd	32.6 Business case to be submitted for midwifery staffing to be submitted to ensure sufficient staff are available for the higher level of activity / acuity forecast.	01/04/2020		32.6 Business case submitted in line with trust process	5 (outcome dependent 4)	01/03/2020 Continue to await outcome for submitted business case 11/02/2020 Business case submitted awaiting outcome 05/12/2019 Safe staffing review using Birthrate plus - Business case submitted awaiting outcome
		Sheran Oke	Sue Lloyd	32.7 Ensure sufficient midwifery staff in post to meet the Continuity of Carer agenda as per Better Births	01/04/2020		32.7 Minutes of the Maternity Safety Champions Meetings	5- Almost certain	01/03/2020 Linked with action 32.6 11/02/2020 – Discussed at Maternity Safety Champions meeting, minuted. Business case for additional staff submitted awaiting outcome 05/12/2019 Safety champions meetings occur bi monthly, all discussion minuted

No	Concern: Use of resources 'Should' Actions	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
33	**Undertakings Section 4** The NHS trust should continue working to ensure optimisation of its substantive medical workforce and reduce reliance on agency staff.	Mark Smith	Louise Ludgrove	33.1 Reinforce medical agency committee	31/12/2019	12/12/2019	33.1 Minutes of meeting	4 - Likely	09/03/2020 Evidence of completion provided 04/03/2020 SB review evidence. Contact LL to see if meeting held- request evidence of completion. 14/01/2020 Email from L.Ludgrove to advise meeting today did not go ahead due to lack of attendance. Reschedule to next week. Agenda and ToR to be provided. 08/01/2020 Monitoring meetings refreshed. New fortnightly meetings to start from 14/01/2020. Attendance to include Execs to support strategic decision making on reducing medical agency spend.
		Mark Smith	Louise Ludgrove	33.2 Review medical recruitment strategy	31/05/2020		33.2 Strategy in place	4 - Likely	09/03/2020 Project initiated to determine correct medical establishment. Date amended from 03/04/2020 to 31/05/2020 to progress the medical establishment review 13/02/2020 Senior level review meeting in place concerned with agency cost reduction, substantive recruitment and shift to Bank where possible
34	**Undertakings Section 2** This NHS trust should continue working to achieve further efficiencies from collaborative working with partners in its clinical and support services	Chris Pallot	Chris Pallot	34.1 Continue to seek opportunities to collaborate on the delivery of clinical and support services with partners within Northants and Leicestershire	31/10/2019	31/10/2019	34.1 Evidence of collaboration work with relevant groups- e.g emails/ proposals for joint working	4 - Likely	14/01/2020 See supporting evidence for Action 11 Completed Ongoing through the life of the new strategy and Long Term Plan
		Chris Pallot	Chris Pallot	34.2 Continue to pursue opportunities with KGH through the Unified Acute Model workstream of the HCP	31/10/2019	31/10/2019	34.2 Workstream model 34.2 Business cases e.g MSk and Stroke	4 - Likely	14/01/2020 See supporting evidence for Action 11 Completed Ongoing through the life of the new strategy and Long Term Plan
35	**Undertakings Section 4** The NHS trust should continue focusing on building internal capacity and capability to deliver trust wide workforce and service productivity improvements	Mark Smith	Bronwen Curtis	35.1 Support the transformation of the quality function	31/03/2020		35.1 HR/ OD support plan	3 - Possible	09/03/2020 Leadership role assigned and focus of new team agreed Recruitment to vacant posts in progress. No further significant support needed 06/01/2020 Integration on plan for Quarter 1 20/21. HR and OD support in place
		Mark Smith	Bronwen Curtis	35.2 Integrate productivity improvements in OD interventions	31/03/2020		35.2 Oncology Intervention plan	3 - Possible	09/03/2020 Work in progress against key elements of plan with next steps identified 06/01/2020 Oncology plan fully integrated
		Mark Smith	Bronwen Curtis	35.3 Introduce talent management	31/03/2020		35.3 Talent Management rollout plan	4 - Likely	09/03/2020 Rollout to other divisions launched as well as pipeline identification for non clinical areas 06/02/2020 Surgery due for completion February 2020 06/01/2020 Launch Jan 2020 with focus on directorate/divisional management
36	**Undertakings Section 1** The NHS trust should ensure the improvements that they make in pathways results in achieving better performance against constitutional operational standards	Debbie Needham	Owen Cooper	36.1 Cancer recovery plan in place	31/03/2020		36.1 Most recent version of recovery plan	3- Possible	10/03/2020 Intensive support team (IST) have been working with us for 3 weeks now with very positive feedback on our cancer board, processes and cancer PTL structure. They are going to support us with some demand and capacity work for our most challenged cancer sites as well as helping to review our cancer access policy and 'straight to test processes' A full action plan will be developed once the IST diagnostic has been completed 10/02/2020 Recovery plans in place for individual tumour sites, support being provided by the IST (NHSI) starting on 14th February 2020 09/01/2020 Email from D.Needham. Recovery plan is in place. Completion date amended to 31/03/2020 (from 31/12/2019). Action not yet signed off Review date (31/12/2019)

		Debbie Needham	Debbie Needham Sheran Oke Matthew Metcalfe	36.1 AE plan in place as per actions 18 and 23	31/03/2020		36.2 AE plan	3- Possible	10/02/2020 New work streams agreed and being led by COO/MD/DoN 09/01/2020 Email from D.Needham. Recovery plan is in place. Completion date amended to 31/03/2020 (from 31/12/2019) Action not yet signed off.
37	**Undertakings Section 2** The NHS trust should ensure existing cost improvement initiatives achieve the expected reduction of its expenditure run-rate and overall cost base.	Phil Bradley	Robert Mayes	37.1 Development of a recurrent savings plan	31/03/2020		37.1 Savings plan	5- Almost certain	04/03/2020 The 2019/20 CIP target should be achieved in its totality, though a large percentage will be non recurrent Part of budget setting for 20/21
38	**Undertakings Section 2** The NHS trust should develop a plan to return to finance balance on recurrent basis	Phil Bradley	Phil Bradley	38.1 Development of System 3 year financial strategy	31/03/2020		38.1 STP financial strategy	3- Possible	04/03/2020 The system finance group will move on to the development of this workstream over the next few months 12/02/2020 This is superseded by the issued financial improvement trajectories and system working relating to transformation and block contracts. We know that the major cause of our deficit is the underfunding of the tariff. (links with action 13.1)
		Phil Bradley	Phil Bradley	38.2 Development of a LTFM to see if this is possible	30/06/2020		38.2 LTFM	3 - Possible	04/03/2020 The LTFM will be an integral part of 38.1 12/02/2020 This development continues and will involve our system partners
39	**Undertakings Section 4** The NHS trust should progress implementation of its five-year estates maintenance plan.	Stuart Finn	James Stewart	39.1 Continued recruitment into newly created Estates maintenance posts. Some key roles already filled.	01/06/2020		39.1 Recruitment plan and updates as posts are filled	5- Almost certain	10/03/2020 Deputy Director of Facilities & Head of Estates interview on 10/03/20 – originally 6 shortlisted for interview but 5 withdrew. An interim has been interviewed and is due to start end of March. Senior Maintenance Manager advert closed and 2 applicants selected for interview end of March. Suitable interims continue to prove difficult to source. 06/01/2020 Further posts have been filled - during Dec 19/Jan 20 (fire officer and mechanical maintenance engineer). Senior maintenance manager & electrical maintenance manager interviews due end of Jan 2020. Deputy director role advert closes end of Jan 2020. Trade staff vacancy interviews due end of Jan 2020 04/12/2019 Recruitment continues to be difficult but remaining posts are being actively managed
		Stuart Finn	James Stewart	39.2 Implementation of new CMMS (computer maintenance management system)	01/08/2020		39.2 Confirmation email new CMMS in place and in use	5- Almost certain	10/03/20 Independent review completed which confirmed existing system is fit for purpose. A number of recommendations were made as part of the report which are being reviewed. 06/01/2020 Independent review starting 7 Jan 20 04/12/2019 An independent review of the existing system has been arranged. This will include recommendations and action plan to implement the system and utilise the reporting function. Date of review TBC
		Stuart Finn	James Stewart	39.3 Development of key maintenance compliance reports from CMMS to be presented at Facilities Governance committee	01/08/2020		39.3 Maintenance compliance reports and copy of meeting minutes	5- Almost certain	10/03/20 Independent review completed which confirmed existing system is fit for purpose. A number of recommendations which included reporting were made as part of the report which are being reviewed. 06/01/2020 Independent review starting 7 Jan 20 04/12/2019 An independent review of the existing system has been arranged. This will include recommendations and action plan to implement the system and utilise the reporting function. Date of review TBC
		Stuart Finn	James Stewart	39.4 Put in place a new Facilities Governance committee and structure	30/09/2019	30/09/2019	39.4 Governance structure and terms of reference for meetings	5- Almost certain	22/01/2020 Evidence of completion provided 06/01/2020 Review meeting arranged for 9 Jan 2020 This action can be closed as committee and structure is in place Evidence of completion required 04/12/2019 Facilities Governance structure is in place. Trust Governance team have been asked to review the structure to ensure it is sufficient. Date for review TBC Completed (since initial version of action plan- update provided as above)

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

A G E N D A

NHS
Northampton General Hospital
NHS Trust

PUBLIC TRUST BOARD

Thursday 26 March 2020
09:30 in the via Video-Conference at Northampton General Hospital

Time		Agenda Item	Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr A Burns	**Verbal**
	2.	Declarations of Interest	Note	Mr A Burns	**Verbal**
	3.	Minutes of meeting 20 January 2020	Decision	Mr A Burns	**A.**
	4.	Matters Arising and Action Log	Note	Mr A Burns	**B.**
	5.	Chairman's Report	Receive	Mr A Burns	**Verbal**
	6.	Chief Executive's Report	Receive	Dr S Swart	**C.**
PERFORMANCE					
	7.	Integrated Performance Report	Assurance	Dr S Swart	**D.**
	8.	Emergency Preparedness Annual Report inc Winter Plan	Information	Mrs D Needham	**E.**
	9.	Covid-19 update	Assurance	Dr S Swart Mrs D Needham	**To follow**
CULTURE					
	10.	Staff Survey Results	Assurance	Mr M Smith	**F.**
STRATEGY					
	11.	NGH Improvement Plan	Assurance	Ms C Campbell	**G.**
	12.	Capital Plan	Assurance	Mr P Bradley	**Verbal.**
ANY OTHER BUSINESS				Mr A Burns	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held at 09:30 on 28 May 2020 in the Board Room at Northampton General Hospital.

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

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