Keogh Review – Assurance of actions for lifting of Enforcement undertaking – S106

Extract from Monitor Letter, dated 06.08.13, regarding the detail of the Enforcement undertaking:

Monitor has agreed to accept and the Licensee has agreed to give the following undertakings, pursuant to section 106 of the Act:

1. Keogh Review Plan

1.1 The Licensee will implement effectively all of the actions in the action plan it agrees that it will develop and agree with the Keogh Review team to address all the recommendations and associated actions in the Keogh Review ("the Keogh Review Plan") in accordance with timescales specified in the Plan unless otherwise agreed with Monitor

1.2 The Licensee will report to Monitor on the implementation of the Keogh Review Plans as required and in particular monthly unless Monitor stipulates otherwise.

1.3 The Licensee will provide to Monitor, should it so request, assurance on the implementation of the Keogh Review Plan or any part thereof, in such form and at such time as may be specified in the request.

2. General

2.1 The Licensee will implement sufficient programme management and governance arrangements to enable delivery of the recommendations and associated actions in the Keogh Review Plan.

2.2 Such programme management and governance arrangements will enable the Board to:

2.2.1 obtain a clear oversight over the progress in delivering the plans;

2.2.2 obtain an understanding of any risks to the successful achievement of the plans and ensure appropriate mitigation of any such risks; and

2.2.3 hold individuals to account for the delivery of the actions in the plans.

2.3 The Licensee shall attend meetings or, if Monitor stipulates, conference calls, during the currency of the undertakings detailed in this notice to discuss its progress in meeting those undertakings. These meetings shall take place once a month unless Monitor stipulates otherwise at a time and place to be specified by Monitor and with attendees specified by Monitor

Extract from Monitor Letter, dated 07.10.14, regarding issue of compliance certificate

Annex 1: Summary of the process for the Trust to be issued with a compliance certificate with regards to its s106 enforcement undertaking.

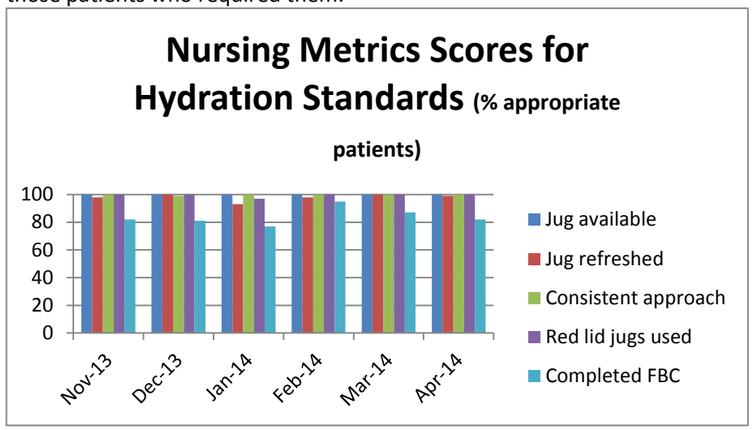
1. The Trust should submit appropriate evidence to Monitor to demonstrate that it is now compliant with its enforcement undertakings.
2. The Trust's relationship team will review the evidence submitted and the Regional Director will then make a recommendation on whether a compliance certificate should be issued to Monitor's relevant decision making committee. The committee will decide whether the Trust is compliant with its enforcement undertakings. This will be done within a month of the Trust submitting its evidence to Monitor.
3. If Monitor decides that the Trust is compliant with its enforcement undertakings, a certificate of compliance will be issued to the Trust and published on Monitor's website.
4. If Monitor decides that the evidence is not sufficient to demonstrate that the Trust is compliant with its enforcement undertakings, Monitor will write to the Trust explaining the reason(s) for this decision or to request further information, as appropriate

Keogh RRR June 2013			**Keogh Assurance Review – December 2013 – Level 3 Assurance**		**Trust Board Report – July update**		**Level of assuranc**	**Sources of Assurance (Positive Assurance) (Negative Assurance)**	**27.10.14**
	Action	**Priority**	**Outcome**	**Comments/ Outstanding issues**	**Exec Owner**	**Trajectory for fully assured (self-assessed)**	**L1 –** e.g. Internally generated reports **L2 –** e.g. Internal Audit, Clinical Audit **L3 –** e.g. External Audit, CQC reports		**TMB Recommendation**
1	**Complaints and Support Staff Levels**	**Urgent**	**Partly Assured**		**S Bowler**	**July 2014**			**Fully assured / Partly assured**
	Director of Nursing to be the Executive clinical lead for Complaints – Completed before risk summit						L1 L1	**Trust Board April 2014 – Quarterly Patient Experience Report** , breaching response targets, lessons learned Trust Board June 2014 – Monthly Quality Report did not include complaints or serious incidents	
	Backlog of complaints to be cleared			Backlog cleared				**Quarterly Patient Experience Report** – breaching response times for Q1	
	Redesign the complaints process including: Involving patients in redesign Appropriate resource for process			Trust recognises the longer-term changes required, including structural changes and further work on ensuring lessons are learned and		**April Update** No backlog- benchmarking with other trust shows us in a strong performance position	L1 L1	**Minutes from July Board** – SL concerned with breaching of 7 complaints **Trust Board September** – Monthly Quality Report showing 100% compliance with response rates **CQC report July 2014** – stated The complaints department has been reorganised	

		Integration of PALS and complaints A revised process that engages consultants Reports on complaints and incidents to the Board should detail themes and actions being taken. Complaints can be triangulated through the use of patient stories at the Board Support staff levels and roles to be reviewed and sustainable plans to be put in place for managing complaints, discharge letters, clinic appointments and radiology reporting.			shared. Complaints policy will be updated once further changes have been made. Trust beginning consultation with staff regarding the future complaints and PALS structure		Weekly monitoring of performance – following legislation Complaints posters and evidence of divisional ownership Implementation of difficult workforce change continues to progress. Key posts will be advertised shortly Director of Nursing and CEO have had a positive meeting with Healthwatch **May 2014 update** Implementation of difficult workforce change continues to progress, consultation ended 21st May 2014. Key posts are to be advertised as soon as consultation completed. Positive informal feedback from CQC inspection will be fully assured in June 2014 **June Update** Interviews for key appointments in the Complaints team are ongoing and expect to be concluded in July. We are awaiting the formal report from CQC after their inspection in April to provide assurance in respect of the Trust complaints process **July Update** Normal processes in place. The workforce restructure has been completed. Training has commenced for the new team, the new patient experience manager will commence on 15th September and the new Datix module for complaints is being implemented which will help with theme and trend analysis	L3	there was a streamlined process to manage complaints. The complaints team liaised with the wards, and met patients on the wards themselves, to resolve complex concerns. There was a computerised system tracking complaints and flagging required timescales for responses. The trust's approach to managing complaints promoted meetings between staff and complainants (local resolution meetings). The CQC team reviewed Q3 and Q4 quarterly patient experience reports and found the trust was breaching its timeframe of 40 days in which to respond to a complaint, and this had increased from 15% in quarter 3 to over 50% in quarter 4. The reports presented sections on 'trends and themes', but these were superficial and did not describe any trends. The report on quarter 4 provided informative examples of learning to date and actions planned. However, these did not relate to the 'main themes' identified. In A & E, Medicine, Maternity there were systems in place to investigate complaints and these were responded to in line with Trust policy. At Newark staff aimed to deal with complaints as they occurred, to prevent them being escalated to a formal complaint. Where formal complaints had been made, the trust had not always responded within their own policy guidelines	
2	**Nursing and medical staffing levels and nurse skill mix**	**Urgent**	**Partly Assured**		**S Bowler**	**March 2014** – for nursing assuming the investment will take 2 years. Monitoring and remedial action undertaken daily			
		Trust to identify acceptable nursing levels for each ward and Director of Nursing to provide immediate assurance that these levels are being met out			The panel recognised good improvement against this action, although there remain real challenges for the Trust to address.		The Trust Board has agreed to an investment of £4million in nursing – plan has commenced – presented to Trust Board, with progress report given. New establishments have been shared with ward sisters and individual plans	L1 L1	**Trust Board April 2014 –** **Quarterly Workforce report**, nursing staff group increased staff in post by 38 wte's **Nurse Staffing report**. - *'How to ensure the right people, with the right skills, are in the right place at the right time'.* analysis of how the Trust perform against the guidance detailing board responsibilities	

		of hours and that there is appropriate supervision in place for untrained staff Nursing staffing and establishment review with recommendations for issues identified. KMH should consider the patients on the wards, benchmarking with other PFI hospitals. Both reviews should account for staff sickness, with particular review at Newark Hospital with the lower levels of staffing there. The review should include understanding of workforce in relation to performance, for example are workforce levels impacting on mortality or patient falls and safety. A workforce strategy should be developed as a result ant this should include policies on appropriate use of agency and locum staff ensuring that they are not putting the hospital at risk. This should also include adequate support for junior staff. The Trust to consider expanding the role of HCA's to train them formally to provide more of a support role to nurses. A review of the nursing skill mix with immediate plans to ensure that the skill mix in place is adequate to provide safe patient care. To utilise national and professional benchmarks to determine appropriate levels, also taking account of the facilities and environment at each hospital.			The Director of Nursing has completed a nursing staffing review and presented the outcomes to TB, actions have not yet been agreed. We raised our concerns with the CEO about the delay in agreeing actions and investment following this review. Ward leaders well engaged. More junior staff do not yet feel fully engaged. Outside of nursing less progress on staffing levels. All staff groups told us they had not seen any change, and felt additional staff needed particularly Healthcare Assistants. Pressure increased on junior doctors due to inexperience, F1's not working out of hours and limited use of ANP's Difficulties in recruiting both medical and nursing staff, shifts often made up with bank, agency and locum staff. Deanery training posts not being filled and covered by locums of variable quality Significant delays in HR process Preceptorship programmes inconsistent across the Trust.		for enacting discussed. The additional Registered nurse on night duty for each ward has been sustained and feedback from ward sisters is that this has made a demonstrable difference to perceptions of safety. In post figures show that we have more nurses than 1 year ago – previous board reports from HR Director Overseas recruitment has been implemented. Daily staffing numbers are on public display through Communication Boards Ward Staffing numbers are collated and responded to (formally) three times a day via email-actions to gaps are recorded and checked at bed meetings	L1 L1 L1 L1	**Trust Board May 2014 – Monthly Workforce report** - Vacancies remain at broadly the same at 221.5 wte with the registered nursing staff group holding a 3% vacancy rate. Recruitment activity remains high with the recruitment team making 129 offers of employment throughout April 2014, compared to an average of 100 per month. The total number of starters in month equated to 39.15 wte with the main staff group being Medical staff totalling 15 wte's, this includes 13 wte rotational Doctors. The number of staff leaving the Trust in April 2014 was 41 wte's, this includes 13wte rotational Doctor turnover. International recruitment continues to be pursued and the Trust has already engaged with 10 nursing students who are due to qualify in September 2014 in order to fill vacant posts. **Trust Board June 2014 – Monthly Workforce report** - Recruitment activity remains high - 55 adverts were placed throughout May 2014, this compared to April where 49 adverts were placed. International recruitment continues with a team visiting Rome in June. 107 posts were offered to candidates throughout May 2014, compared to 129 posts in April **Trust Board July 2014 – Quarterly Workforce report**, At the end of quarter 1 the Trust budgeted establishment stood at 3887.37, the increase in the quarter is due to the Registered Nurse Keogh funding being funded into divisional budgets. It is anticipated that in the next quarter the Registered Nurse staff group will increase when the 13 recently appointed international recruits commence in post and 51 NQN's start in September. The recruitment campaign continues for Registered Nurses **Nurse Staffing report** - In total for June there were 678 enhanced patient observation shifts declared on the current staffing template Ward 25 - The ward is experiencing staffing gaps with HCAs (sick and maternity leave). The ward risk assess where best to place the HCAs they do have available during the next duty rota. The night times tend to be quieter and the ward also reduce capacity by 10 beds. The RN staffing levels are at the planned level for nights to provide adequate RN cover. If the nursing care demands are high, additional hours are requested – these tend to be filled by their own staff, as paediatric experienced HCAs are not commonly available. NICU - The reduction in the fill rate of health care workers on is due to a 1.11 wte vacancy plus annual leave. Support worker shifts are difficult to cover with bank or agency due to the speciality, so they are covered by a RN when required, resulting in an overfill in RN numbers. Beds have been reduced in NICU to ensure the numbers of patients are safely cared for until recruitment is completed. This is being closely monitored by the surgical divisional team, with regular updates to the Executive team Areas which identified a short fall included **Critical Care Unit:** The variation between planned and actual for the Unit was related to acuity and dependency of the patients. At no time was there less than the required number of registered nurses to provide either 1:1 care for ventilated patients or 1:2 care for high dependency patients. **Cardiology ward 23-**variation indicates the planned staffing was not met, however the staffing levels available were appropriate for the demand at that time. This was monitored closely by the Divisional Matron. There is currently an assessment of whether the funded staffing levels exceed the demands of the patients, as cardiology care has become less invasive and intensive. **Maternity Services** – Whilst the actual hours may differ from the plan, this is due to the workforce flexing and relocating as women progress through their pathway of care There were a total of 38 incidents with regards to falls and medication errors	

										reported in June: • There were 26 falls across the areas within this report. Some of these falls occurred when there were shortfalls on the day but when correlated with the timing of the incidents only Ward 23 had a harm incident when there was an actual shortfall in staffing. The majority of falls occurred when there was a full complement of staff. Likewise some wards had falls when there were additional staff present. • There were 4 medication incidents but these predominantly do not appear related to shortfalls in staffing. Sconce ward had a RN shortfall and a medication error related to miss reading a drug administration chart. • There were 8 reported staffing incidents for the wards, most were related to requests for extra support for enhanced patient observation or increase in RN to patient ratio. • There was 1 reported incident in ED and this did not relate to a shortfall of staff and 0 incidents in EAU despite their shift shortfalls **Trust Board September 2014 – Monthly Workforce report**, . Since 1 April 2014 staff in post numbers have increased by 31.7 wte. Registered Nurse staff in post have decreased slightly by 8.9 wte since 1 April 2014 which is disappointing and signals that further focus is required . The nursing workforce holds the highest number of vacancies both in numerical and percentage terms. The unregistered nurse vacancies have resulted from management action in order to accommodate future potential changes in skill mix. The Registered Nurse vacancies remain an area of concern, a number of initiatives continue to be progressed in order to recruit additional nursing numbers **Nurse Staffing report (August)** Whilst the overall average fill rates for RN's and HCA's exceeded the required 90% threshold; it does however illustrate a significant increase in HCA utilisation during night periods. A total of 6 wards / departments failed to achieve the 90% threshold and in the main is attributable to fluctuations in acuity, dependency and activity in month Triangulation of our nurse staffing levels against a number of quality and safety indicators / patient outcomes recorded in our Datix incident reporting system (Falls, nurse staffing levels and medication errors) evidences low levels of harm The design of our wards, increased dependency and acuity of patients, as well as our high occupancy and activity levels are challenging our ability to sustain consistently staffed shifts throughout the Trust, albeit, this mainly relates to individual areas like the Neonatal Unit and EAU **CQC Report July 2014 –** A & E – staffing levels were, at times, below that expected especially at night and in the children's department Medicine – numbers of nursing staff were variable Critical Care – Staffing levels were appropriate for the needs of patients, staffing ratios in the intensive therapy unit were in line with national guidance and staffing was flexible to meet changing demands. Staffing in the critical care outreach team (CCOT) had been increased in response to a rise in the use of the team Maternity – Midwifery and medical staffing levels were appropriate for the numbers of births at the unit C&YP – Staffing levels were adequate, and the directorate was in the process of recruiting additional nursing and medical staff. Outpatients – there were staff shortages which had led to cancelled clinics or lack of chaperones at KMH	L3	

								L1	CQC concern (by letter Oct 2014) regarding staffing levels on EAU and SAU – Comprehensive response from Executive Director of Nursing	
		Intentional rounding to be implemented across the Trust					Care and comfort, accountability and leadership rounds in place across all inpatient areas.	L3	**CQC Report July 2014 –** EOLC – Care and comfort rounds were carried out regularly to ensure patients were well cared for. Outpatients – We observed staff providing care and comfort rounds Outpatients Newark – we observed staff providing care and comfort rounds.	
3	**Fluid Management**	**Urgent**	**Partly Assured**		**S Bowler**	**July 2014 – Partly assured**				
		Actions to improve fluid management to be implemented: Training through induction / development days to strengthen nutrition and hydration Protected mealtimes, red tray and red jug policy to be revised and re-launched Communication campaign on fluid management and red jug scheme Assurance model implemented that is fit for purpose to provide evidence that actions are improving fluid management			Hydration charts and fluid balance charts introduced. Further work to ensure these are being used actively and are embedded. Fluid balance charts do not allow an easy view of a 24 hour period Staff on surgical wards did not feel the charts met their needs and were not using them. We recognise that the charts have only recently been introduced and are to be reviewed; we'd recommend these issues be considered as part of that review		**April Update** All proposed actions implemented. Embedding and sustaining monitored on an ongoing basis A point prevalence audit has been undertaken on 7 wards . The draft report shows significant improvement. Consistency improving but requires further support **May 2014 update** Appointment of 7 practice development matrons. First role is to drive and sustain care and comfort rounds and accountability handover to improve documentation. Increase emphasis on nutrition nursing matrix results at 21st May 2014 meeting **June Update** Workshop with ward leaders and senior nurses 10th June to recognize needs in respect of documentation and prepare action plan. Executive Director of Nursing and Executive Medical Director preparing Trustwide communication regarding accurate completion of documentation and accountability. Documentation has been discussed at the grand round. **July Update** Remains partly assured as a result of CQC feedback which recognised the progress so far but requires more work	L2 L2 L2	**Trust Board April 2014- Quarterly Quality Report** In October 2013 we were pleased to note that 100% of our patients felt that they are able to ask for a drink when required and where appropriate 100% patients had a jug of water near that they could reach. Red-lidded jugs were in use for 100% of those patients who required them.  Trust Board May 2014 – Monthly Quality Report – Feb audit report positive Drill-down into Q5 from the audit in March 2014 showed that while the overall audit results showed that fluid balance charts were an area of concern, when data for individual wards was extrapolated there were six ward areas where urgent remedial action was required, namely ward 11, 22, 24, 31, 36 and 54. All other areas (22 wards) scored 100% compliance on this element of the audit **Trust Board July 2014 – Monthly Quality Report** – monthly hydration audit showing completion of fluid balance charts % and trend analysis 		Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
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Jug Available	100	100	100	100	100	100	100	100
Jug Refreshed	98	100	93	98	100	99	100	100
Consistent approach	100	99	100	100	100	100	100	**100**
Red lid on jugs	100	100	97	100	100	100	100	100
Complete Fluid balance chart	82	81	77	95	87	82	76	90 | |										

							going forwards around accountability, responsibility and ownership of documentation	L2	**Care of the Acutely ill Flash Report October 2014** – Fluid balance was commenced appropriately in 88% of cases. Of those with fluid balance charts only 76% were completed fully. This is being addressed by a practice development nurse	
4	**Strategic Direction**	**Urgent**	**Partly Assured**		**P O'Connor**	**April 2014**				
	Clinical Strategy to be developed and submitted to Monitor based on clear commissioning intentions within the Mid Notts Review agreed framework			The panel felt good progress had been made against this action. While we gave the action urgent priority following our review in June, we recognise that it requires significant work and consultation. Draft clinical strategy submitted to Monitor 31 October. To be shared with clinicians. final version to be completed 31 March		**April update** 'Plan on a Page was approved at the Trust Board meeting in March 2014 and has subsequently been further improved and adapted and is now being used in the *Quality for All* presentations being rolled out across the Trust. The Trust is active on the "Better + Together" Programme Board and full details of the programme and its constituent programmes have been discussed and agreed at a Board to Board meeting between the Trust and its 2 local CCGs. The first 5 projects within the "Better + Together" programme are agreed as: • Integrated Community Teams (PRISM) rollout • Intermediate Care Design • Care Planning in Care Homes • Transfer to Assess • Elective Referral Gateways Final position for Newark Surgery has been agreed and communicated to all staff and stakeholders which has brought the implementation planning phase of the Newark Strategy to completion. Divisions have worked with the Director of Strategic Planning & Commercial Development to articulate a Strategic Direction which has been submitted to Monitor on 4th April. Trust Chief Executive and Director of Strategic Planning & Commercial Development joined with County Council and other partners in a collective visit of the Spanish Integrated Care Model, to further assist "Better + Together" development	L3	**CQC Report July 2014 –** A & E – none of the staff we spoke with in the unit were aware of the 'Quality for All' programme Medicine – The visibility and relationship with the board was less clear for junior staff, not all of whom had been made aware of recent trust-wide initiatives. Maternity – Staff spoke positively about their work and were aware of the trust's overarching vision Outpatients – Staff perception of the leadership was positive, they thought that directors were approachable and listened to their concerns. The vision for the trust had recently been introduced and had not been embedded.	
	Nursing Strategy to be published						L1	**Trust Board December 2013** – Approved Nursing Strategy		
	Supporting strategies to be reviewed and updated to be aligned to the Clinical Strategy. These are to include IT, Estates, Communications,					Supporting strategies approved by Trust Board Quality Strategy phase 1 IT Strategy Estates Strategy Phase 1 Workforce and OD Strategy				

		Research and Innovation, Workforce and Organisational Development Strategies					Patient Experience Strategy Service Improvement Strategy Newark Strategy			
5		**Newark Hospital – Strategy, facilities and governance**	**Urgent**	**Assured**		**J Tufnell**	**Dec 2013**			
		Newark Strategy to be developed through stakeholder event organised for 24 July 2013 involving CCG, local authority, patients and the Trust			We understand that the trust will imminently confirm the surgical procedures that will continue to be undertaken on the Newark site. [NB this action should move to partly assured if list in not confirmed, or is inappropriate/not in line with review recommendations]		Outstanding action is the surgical review implementation. Plan to communicate the decision on 4 April following comprehensive discussions with main GP providers	L1	**Trust Board April 2014 Private session** – Newark Strategy update Minutes – Board agreed to dissolve the Newark Strategy Group, progress would be through exec team via the Newark Hospital Management Board and TMB **CQC Report July 2014 –** CEO felt staff had been kept well informed of proposed change. Staff governors and partner organisations had also been briefed. Staff we spoke to at Newark Hospital were not clear on the future plans. At Newark Hospital none of the staff we spoke with on the wards or in theatres knew what they would be doing next, once surgery no longer took place there.	
		To include communication and engagement strategies						L3		
		Review of staffing arrangements at Newark Hospital including anaesthetists review								
		Cover arrangement implemented to ensure that, even in cases of sickness, there is doctor cover at Newark overnight every night								
		Review of medical arrangements at Newark to consider adequacy. To include review of day and out of hours cover. To include change of consultant round timing to provide consultant rounds five days a week.								
		Review to cover surgery, procedures and MIU								
		Immediate review as to whether the facilities at Newark have detrimentally impacted on patient safety over the last six months. Agreement of required action plan arising from the results of the review with Dr David Levey, NHS England Regional Medical Director								
		Review governance arrangements at Newark Hospital as part of the Trust Govern ace Action Plan to ensure that								

		management arrangements and report structures are robust								
		The choice of surgical procedures being undertaken would be reviewed by an independent surgeon. Panel will ask head of surgery from regional hospital to come and examine the safety of issue around identification of safe surgeries.								
6		**Development of a focus on quality at Board Level**	**Urgent**	**Partly Assured**		**K Rogers**	**September 2014**			
		Comprehensive development programme for the Board			There is evidence of progress on this action; however, the panel felt more pace was needed, particularly on board development The Chair and NEDs are relatively new in post and could benefit from some team and quality focus development sessions. This is a potential barrier to real quality focus at the board level. Trust governance arrangement are not yet fully aligned to the board, and some sub-committee papers are received at board meetings before the sub-committees have had the opportunity to meet and discuss them		**April Update** Board development Programme began on 23rd January, facilitated by Foresight Partnership (authors of the Intelligent Board). Following this event a programme of development time out sessions have been included in the annual meeting scheduler and a proposed Board development timeline is included in the March Chairman's Report. Furthermore, Board are alerted to the information included in the QGF submission in March that articulates further activity of the Board in connection with quality focus enabling a reduction in the self-assessed QGF score from 4.0 to 3.5. **May 2014 Update** Each of the QGF questions have been allocated an exec owner who has developed and agreed actions with a trajectory when a score of 0.0 will be achieved. There will be external evaluation of the Board towards the end of the year. **July Update** Data Quality Masterclass took place in July attended by Board members and senior colleagues Clarity regarding Board Development session in Q3 regarding the link to clinical and quality governance. Further work with Newcastle under the	L1 L3	**Trust Board May 2014** – Chairmans report proposed approach to Board review by Foresight Partnerships **CQC report July 2014** – Collective responsibility for clinical leadership, quality and patient safety shared by the director of nursing and medical director. Both were aware of organisational issues, and clinical concerns across the trust.	
		Quality strategy to be developed including assurance framework and implementation plan			An impressive and measurable patient safety and quality strategy has been developed and was taken to the last board to be signed off.					
		The current focus on mortality to be widened to consider quality and safety			The interim medical director presented recent work on mortality at board level. We were not clear that this was reflected through all the			L3	**CQC Report July 2014** – NEDs had been on formal and informal ward visits over the last few months, with executives. The NEDs told us that their presence ensured the focus of the board was on quality over finance, and gave examples of increasing priorities in certain areas of care.	

					directorate and divisional structures.		buddying arrangements' to support development in the executives thinking regarding focus and presentation of information to Board. Positive commentary concerning the Board and Well led domain captured in the CQC report			
		Sufficient time should continue to be given to quality issues at the Board						L3	**CQC Report July 2014** – We observed NEDs being appropriately challenging in a board meeting, commenting on the levels of data and its analysis, and requesting benchmarks for outcomes and timescales in relation to certain projects. Discussion of the patient experience report did not look at what worked well, in order to learn from it, or to focus on the shortfalls to action improvement	
		Directors responsibilities should be clearly articulated and sufficient time to be given to these								
		The board should hear a patient story at every Board meeting			The board is hearing patient stories, and we heard that the chairman also feeds back to board meetings the comments and stories he hears on walkabouts of the trust.			L1	**Extract from TB minutes Sept 2014** '*SB updated that the story that was told at the Board of Directors meeting in July was presented again at a senior nurse development day and a request was made for the nurses to take the story back to their respective areas and spread the examples of good practice widely. '*	
		Board away day development to develop quality and transformation strategy. Board away day time to review quality governance and align this to annual business planning						L3	**CQC Report July 2014** - NEDs told us recent reconfiguration of the sub-committee would assure quality from on operational focus. A Board development programme started in February 2014.	
		Improvement trajectories need to be set with a range of KPI's and run charts that underpin the overarching strategy for HSMR reduction								
		On a rotation basis, a member of the Executive team should be regularly based at Newark Hospital and Non Executive Directors and Governors should regularly visit that Hospital			The roles of the Board and NEDs have been clarified which include a NED for Newark hospital and plans to link in with Governors as part of this is in place.					
		Every Board meeting to include a public session			Board meetings are being held in public and one board meeting has been held off site.					
7	**Ward performance information and organisational learning**		**Urgent**	**Partly Assured**		**S Bowler**	**March 2014**			
		Ward dashboard to be in place in all wards containing up to date information					Visited Norwich and Norfolk Ward assurance / performance matrix well established and used across the			

		Process for discussion of results with ward staff at all levels for learning to be agreed with NHS England along with timescales			Further evidence will be required over the coming months that the dashboards, and regular discussion of results with ward staff, have become embedded.		Trust Feedback to non execs at confirm and challenge –" one of the best tools to be developed this year" Director of Nursing meets with Matrons for whole day every month to assess each ward performance – supported by specialist nurses to pick up themes and provide support. Used as opportunity for learning and sharing Used the tool to celebrate consistent performance across our wards – celebration certificates being prepared- opportunity for learning and sharing Tool discussed at Clinical Governance Committee and operational governance forums – used as a tool for further deep dives e.g. falls Displayed in all ward sisters offices Divisional and service line governance information greatly improved and strengthened – evidenced through confirm and challenge Patient safety steering group chaired by medical director			
		Review of the Trust decision to remove ward white boards								
		A quality strategy to support the completion of routine triangulated quality reports incorporating patient safety, patient experience and clinical effectiveness			Although the patient safety and quality strategy has been developed, the panel did not feel the patient safety programme was in place as yet.					
		A comprehensive patient safety programme to enable staff to understand how process and outcome measures aid the delivery of an HSMR reduction			The panel heard that mortality reviews are not consistent across directorates					
8	**Concerns over patient locations and high numbers of patient moves**		**Urgent**	**Partly assured**		**J Tufnell**	**July 2014**			
		Bed modelling to ensure correct forecast capacity requirements are identified			The panel felt that further analysis of the bed base was required					
		The Trust will ensure that where a patient move is required that a risk assessment is completed prior to the move taking place			The trust provided a draft policy dated 7 October, which includes requirement for careful consideration of risks prior to making a patient move outside of the primary specialty and a principle commitment to specialty review to the outlying patient. We heard the system		**April 2014** The risk assessment process for patient moves is being regularly audited. A meeting has taken place with Duty Nurse Managers, Ward Leaders and divisional teams to understand and address issues with ensuring this is embedded in our practice. This is now being robustly monitored with relevant actions taking place where practice is falling short of the requirements.			

					does not work as well out of hours. We also heard it could be difficult to ensure consultant cover for outlying on the cardiology ward and from day case as these wards to do not have allocated medical consultant cover. We noted that the outlier risk assessment form was not known by some of the front line staff and did not include the named lead consultant for each patient. We recommend that the trust reviews these issues.		The outlier policy has been reviewed to ensure the definition of an outlier is very clear and consistently understood across the Trust and has been uploaded to the intranet. **May update** A further audit is being undertaken at the end of May to ensure the risk assessment process is embedded and consistently utilised at which point the Quality Improvement Group will assess if this action is now fully assured **June update** Clinical staff are currently auditing the risk assessment process, this will be complete prior to board for verbal update that this action is now fully assured **July update** Improved audit process. Weekly monitoring by DNM's to ensure embedded process. The recent CQC report confirmed the hospital policy was adhered to and the decision tool was completed ensuring no patients transferred after 11pm.			
		Targets to be defined and communicated for ambitions for maximum bed moves and outliers			Trust provided a draft policy dated 7 October which includes requirement for careful consideration of risks prior to making a patient move outside of the primary specialty and principle commitment to specialty review to the outlying patient.					
		Bed meetings to routinely discuss patient safety concerns and identification of outliers and escalation areas.								
9	**Handovers**		**Urgent**	**Partly Assured**		**S Bowler**	**March 2014**			
		Ward handover arrangements to be reviewed as part of the nursing staffing levels and establishment review.					Nurse in charge aware of all patients – clear messages and checked at ward sister forums Handovers reviewed on every ward – some have moved to taped handover and then patient specific handover at the bedside Handover included within Care and Comfort rounds Daily leadership rounds being undertaken on wards			
		As part of immediate review into staffing levels, ensure appropriate handover times and that the ward lead has knowledge of all patients on the ward.			Time allowed for nursing handover has only been increased from 20 minutes to 30 minutes and it was felt that this remained inadequate – suggest 45 minutes Staff find the handover sheets extremely useful					

					for effective communications between shifts, however the patient specific information in not retained in individual patients notes. It is recommended that the trust considers this issue. Roll out of electronic handover process in used in Surgery across Medicine. More staff have been trained on PAS but it remains an issue in different directorates out of hours. No junior staff reported having PAS training.		Accountability handover implemented – standardising process to support embedding Handover times increased within nursing establishment proposal			
10	**Patient Experience**	**Urgent**	**Partly Assured**		**S Bowler**	**March 2014**				
	Patient experience and engagement strategy to be written in partnership with staff, patients, carer's and governors.			There is no patient experience strategy in place as yet. However there is a clearly defined process, which in on track to meet the aim of patient and staff experience strategies going to the trust board in January 2014		Patient experience strategy agreed by board – evidence of wide engagement Launch event with patients 25th March 2014			
	To be proactive in its approach to engaging with patients and their families and carers.			We saw staff are wearing their security badges, but not name badges and it not easy to read the names on the security badges.					
	Staff to wear name badges and clearly communicate to patients who their consultant is. Where consultants are changed, the reasons for the change to be communicated to patients.			We saw staff are wearing their security badges, but not name badges and it not easy to read the names on the security badges.					
	Audit times taken for buzzers to be answered and ensure issues identified are rectified.								

		Review staff uniform policy so that patients and the public can easily recognise staff levels by their uniform								
11	**NEWS roll out**		**Urgent**	**Partly Assured**		**S Bowler**	**March 2014**			
		Revised observation and early warning policy to be published in August 2013 and disseminated to all staff, ensuring that staff at Newark Hospital are also aware of the revised policy			NEWS has been rolled out across the wards. We heard from some staff and wards that it is appreciated. Staff on the surgical wards are less happy with the tool, because it doesn't include fluid management.		NEWS implemented across the whole Trust. Policy updated and implemented Nursing metrics demonstrating high compliance and accuracy with all measures > 90% - reported to Trust Board – undertaken by independent assessors	L2	**Care of the Acutely ill Flash Report (October 2014)** – Compliance with NEWS scoring = 99%, Correctly calculated NEWS = 99%. Of those patients with NEWS trigger only 78% were escalated.	
		Training to support the revised policy to be delivered to all relevant staff, including those at Newark Hospital.			We heard that healthcare support worker training had a significant positive impact on adherence to early stages of NEWS cascade. We felt further support and embedding was needed for the later stages.					
		Audit process implemented to ensure every ward is compliant with the policy			We saw examples in notes of significant NEWS triggers where evidence of the nursing or medical actions taken was not clearly recorded. We felt the audit needed to be extended to include medical actions, including any escalation or resetting of triggers, and night-time activity to be properly comprehensive					
12	**Whistle blowing policy**		**Urgent**	**Assured**		**K Fisher**	**December 2013**			
		The policy has been reviewed and amended to ensure that staff do not perceive that they will be monitored I they blow the whistle. A revised policy will be submitted to the Trust Board for approval at the September meeting			Staff we spoke to in the focus groups and on the wards knew that there was revised guidance in place, but were not all sure what whistleblowing means. Although this suggests further staff engagement may be helpful, the panel was satisfied that the action					

					was completed.					
13	**Supporting structures and services**		**Urgent**	**Partly Assured**		**J Tufnell**	**Radiology – March 2014** **Clinical Typing – Mar 14** **Junior Doctors – Apr 14**			
		Clear the backlog of radiology reporting			Although the trust continues to have a radiology backlog, the backlog is now stable.		The radiology reporting backlog was cleared by 31 July 2013 and reporting has been sustained at a maximum 1 week turnaround since this date. The outsourcing arrangement has been extended to a second provider to provide full business continuity.	L1 L1	**Trust Board April 2014** – Private Session – AOB Radiology Review **Trust Board May 2014** – Private Session Radiology report – Service Review	
		Root cause analysis review to identify the causes of the radiology backlog			The trust is facing some significant challenges with staffing in radiology which impacts on capacity, including to clear the backlog fully, and just under half of consultant radiologists posts are unfilled					
		Review the impact of the radiology backlog on patient care and safety. Terms of reference for the review to be agreed with commissioners.			The trust also has invited an external review to scope the current radiology service and staffing requirements					
		Development of actions to prevent the radiology backlog issue reoccurring. This should include clear and explicit standards against which performance should be measured.			Junior doctors raised concerns with us about attitudes in the radiology department. We recognised that there may need to be some agreement in place to manage referrals while the capacity of the radiology department is under such pressure					
		Similar actions to the radiology reporting to be agreed for letters and clinic appointments.					The clinical typing backlog was cleared by 31 July 2013 and has been sustained at 10 working days since this date			
		Integration of the supporting infrastructure into processes including: • Improved use of IT throughout the trust • Increased clinician engagement in procurement and management of medical equipment across services								

		Review inappropriate pressures on junior doctors and ensure consent is valid and appropriately informed by procedure-competent or procedure-experience clinicians.			Junior doctors continued to report that they are under pressures they acknowledged that an effort had been made to increase staffing and support, but that this has not kept pace with increases in patient numbers and workload.		CEO and Chairman more accessible to Junior doctors, positive LETB visit. There is clear evidence of actions following the LETB and educational visits. Clinical Director for Surgery has spoken to specific specialties in relation to consultant support for juniors. This has been triangulated with the ward confirming more active consultant involvement in Ward Rounds	L3	**CQC Report July 2014** – Junior doctor staffing levels on the wards had improved, but they (junior doctors) felt that staffing levels in general were a risk.	
14	**Anaesthetists**		**High**	**Partly Assured**		**A Haynes**	**May 2014**			
		Review anaesthetists' arrangements to formalise their input into pre-operative assessment at both hospital sites and communicate the arrangements to all staff, including: • A named lead for day surgery • Formal session of time for dedicated preoperative assessment sessions • An acute p ain clinical session • Use of protocols for preoperative management of co-morbidities			There is no named lead for day surgery that could be identified by the senior nurse on the day ward		Project initiated through Elective Programme Board in respect of Pre-operative Assessment, named clinical lead. Current Pre-operative Assessment being reviewed and monitored by Head of Service for Anaesthetics.			
15	**Staff development**			**Assured**		**K Fisher**	**December 2013**			
		Regular appraisals and personal development plans to be provided to all staff and review of achievement of these by the Board	High		We heard in the focus groups that appraisals have been of good quality			L3	**CQC Report July 2014** – Surgery – Staff were not always supported and developed through the appraisal system	
		Trust to introduce staff rotation between KMH and NH	Medium		We did not hear any evidence of staff rotation however; in light of the revised strategy for Newark we did not feel that this action remained relevant.					
16	**Communication with Patients**		**High**	**Partly Assured**		**S Bowler**	**March 2014**			
		Patient communication strategy and processes to			We saw evidence of improved communication			L3	**CQC Report July 2014** – Newark MIU – patients said that communication was good	

		be developed to ensure patients receive proper and timely communications from presenting within the healthcare system with an illness to resolution of their concern			with patients on the wards about the staff caring for them. However there is no strategy in place for patient communications.				Medicine – staff interactions with people were person-centred and unhurried. Surgery – patients said they were informed of any treatment required. Newark Surgery – patients said they were informed of any treatment required. Critical Care – patient and their relatives were involved in decision about their care and treatment.	
17	**Ability to rescue**					**A Haynes**	**April 2014**			
		'Do No Resuscitate' forms should be signed by a consultant. Regular audits to be performed to ensure that this is occurring	High	Assured			The National Early Warning Score (NEWS) was introduced in Feb 2013 as part of a package of measures to improve the monitoring of sick patients. Nursing metrics audits confirm high completion rates for vital signs and NEWS which has resulted in a higher call out for the Critical Cared Outreach Team (CCOT) from an average of 150 calls to over 220 per month. The number of cardiac arrests has significantly reduced and in line with this the rate of cardiac arrest per 1000 bed days which now stands at 1.8 is 53% lower than in 2010. There has been a corresponding reduction in unexpected admission to ITU The CCOT team was expanded in October 2013 and since that point the numbers have consistently been below the mean. The Association of UK University Hospitals (AUKUH) acuity and dependency audit shows that the number of sick patients hence acuity of work has increased over this time period. VitalPac has begun to roll out across the wards and will facilitate patient monitoring and CCOT	L1 L1 L1 L2 L2 L3	**Trust Board April 2014** – Quarterly Quality Report (Q4) ability to rescue and increased calls to CCOT team detailed **Trust Board May 2014** – Update on VitalPac **Trust Board July 2014** – Update on VitalPac **Clinical Audit – (amended 15th Oct 2014)** – shows 'Senior endorsement evident on the form if JD has completed section 8' compliance 57.14% (16/28) 22NA RAG rated red as adherence less than 75% **Care of the Acutely ill Flash Report (Oct 14)** – Total calls to CCOT have increased month on month. Overall trend in cardiac arrest rate remains low **CQC Report July 2014** – There were concerns about the resuscitation boxes and there were plans to replace these with trolleys C&YP – Sealed resuscitation equipment boxes, including adult resuscitation boxes, had been supplied to individual children and young people services wards and clinics by the trust resuscitation team Maternity – appropriate equipment was available to ensure safe care. Sealed resuscitation equipment boxes were supplied to individual wards and clinics by the trust resuscitation team. This meant that the maternity service, along with other trust services, could not ensure that resuscitation equipment boxes were routinely checked to guarantee that all equipment worked safely	
		Review the policy for resuscitation equipment and consider updating to comprehensively equipped trolleys	Medium	Partly Assured	A business case has been prepared for 75-80 trolleys to be presented shortly. The CCOT and the resuscitation officer felt a key strength in the current system was that used boxes are taken away and replaced with new boxes while the contents are refreshed. We heard that the business case is to be presented shortly and would expect it to be considered as part of an options appraisal.					
18	**Maintaining the pace of change**		**High**	**Partly Assured**		**P O'Connor**	**March 2014**			
		Early and effective comprehensive induction of new appointments throughout the Trust, including the new Board members supported by effective Board review			The panel saw some early evidence that the trust is starting to address this action; however, there is a lot still to do. The NED we met advised					

		and development			that there has not been a full induction for new board members. Nursing staff do not always stay for the full 6 week induction programme. Newly qualified staff could not always be released to attend the trust's preceptorship programme				
		Systematic Board Governance Assurance Framework and build in discussion regarding the effectiveness of Board at each meeting including whether any new risks have been identified. To be supported by Board development for the Board as a whole and individual Board members			The trust shared a draft assessment by PwC against the board governance assurance framework. This demonstrated significant improvement form a similar assessment completed in January				
		Board engagement as widely as possible with staff groups to both emphasise and energise the importance of the transformation and to engage staff in the changes.			We heard that board members undertake ward walk arounds and internal assurance visits. Nursing staff reported that the chief executive and chair are visible; however most Junior doctors said they didn't see them and would not recognise them				
		Clear and costed training plan to deliver transformation agenda			We did not receive any evidence of a training plan to deliver the transformation agenda				
19	**Governors**		**High**	**Assured**		**K Rogers**	**December 2013**		
		The Trust to work with Governors to transform their role to enable them to support the Trust more effectively			The chairman is leading this action, and has undertaken a lot of work to support governors in their roles. He has further work and development planned. We heard there has been good progress and considered that this action was completed				
20	**Organisational learning**			**Partly Assured**		**A Haynes**	**September 2014**		

		Systems to ensure organisational learning from good practice, concerns, complaints and incidents lead by an Executive	Urgent		As the complaints section, the trust has made improvement in its process and lessons are being considered in teams and as part of appraisals; this is also the case for incidents. There is further work to do to ensure that processes and systems are embedded and that lessons are shared across the organisation		The Trust has initiated new training programmes for clinicians on quality improvement and patient safety. QI training for clinicians and clinical teams forms a cornerstone of the Trust's Service Improvement Strategy The strategy includes a comprehensive service improvement capability framework and an extensive deployment plan for embedding quality improvement skills within the clinical workforce, as an integral part of delivering QI projects to support achievement of trust objectives.	L1 L1 L3	**Trust Board May 2014 – Monthly Quality Report** – Serious Incidents and lessons learned **Trust Board July 2014 – Quarterly Quality Report** – Serious Incidents and lessons learned. **CQC report July 2014** – Within A & E the report states 'There was no systematic method for capturing and sharing learning across the team or the wider organisation' however in C & YP the CQC team found that learning from incidents were shared with directorate staff and within outpatients there was evidence of changes in practice implemented following incidents.	
		Adaptation of the resuscitation audits into the deteriorating patient work. Consider linking the resuscitation officer to the outreach team, as a minimum the teams should work closely together	High		Trust decision not to formally link the resuscitation officer and CCOT but some training was delivered by them jointly					
		Organisational development programme in quality improvement leadership and skills linked to patient safety programme	High		Staff are listening to patients, including holding focus groups with patients and inviting those patients back in for further feedback.					
21	**A & E**		**High**	**Assured**		**A Haynes**	**December 2013**			
		Review the A & E triage and observation arrangements to ensure appropriate prioritisation of patients and adequate clinical oversight of the A&E waiting area			We saw the system in use across A&E to prioritise patients. Processes and patient flow through the department appeared good, and we found the atmosphere calm					
22	**Medicines Management**		**High**	**Partly Assured**		**A Haynes**	**May 2014**			
		Medication charts should be clearly completed upon admission to detail existing medication for patients. It should be ensured that patients receive the appropriate medication when at the Trust.			We saw medication charts that had not been completed and drugs not prescribed. We heard that TTOs are an issue, and can be delayed. The trust is considering the implementation of e-prescribing		A number of actions are being progressed: • A regular Medicines Safety Bulletin relating themes from incident reporting • "Incident of the Week" presentations at the weekly Grand Round • Better capture of incidents on Datix to give higher quality data • In line with the NHS England Patient Safety Alert on improving Medication Error published last month the trust has a Board level	L1 L3	**Trust Board April 2014 – Quarterly Quality Report (Q4)** identified Medicines management including completed actions for 2013/14 and further actions for 2014/15 **CQC Report July 2014** – stated Medicines reconciliation on admission followed national recommendations by NICE and the National Patient Safety Agency (NPSA). The trust's audit data showed that more than 95% were completed, which is the required standard, but the trust did not meet the 90% target for this to be done within 24 hours. Within critical care, Maternity and C&YP the report states 'there were appropriate procedures to safely manage medicines'	

							director (the medical director) responsible for incident reporting and learning, has an existing Medicines Safety Group which will take local action and is in the process of creating a job description for a Medication Safety Officer to represent it on the new national network • A pilot of missed doses is underway on wards 23 and 24 with a plan to roll out across the trust Medicines Management is a theme of the Patient Safety Steering Group which monitors ongoing projects. This has successfully overseen the implementation of alerting for medication on renal impairment on all wards Mon-Fri 9-5 and 7 days a week on EAU			
23	**Infection Control**	**High**	**Assured**		**A Haynes**	**December 2013**			
	Review of infection control processes including location to hand gel throughout the Trust.			Across the wards, we observed good practice, alcohol gels were visible and staff were using appropriate PPE. We heard that external advice has been sought and no systemic issues or major recommendations were identified.					
	Enforcement of the Hygiene code to be part of routine DIPC reporting			The infection prevention and control team carries out regular and responsive audits and feels sufficiently well-resourced to do so.					

Keogh report presented to Trust Board:

April 2014 – Minutes state – full assurance K4, K13, K17 and moving K3 to May 2014

May 2014 – Minutes state – note progress on K3, K8 ,K14, K22

June 2014 – Minutes state – noted progress on K3, K8, K14, K22

July 2014 – Minutes state noted progress with all the actions and this would be the last report in this format