### AGENDA

<table>
<thead>
<tr>
<th>Item no.</th>
<th>Agenda Item Title</th>
<th>Lead</th>
<th>Timings</th>
<th>Enclosure No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>APOLOGIES, DECLARATIONS OF INTEREST &amp; QUORACY (1/3&lt;sup&gt;rd&lt;/sup&gt; of Board members)</td>
<td>GT</td>
<td>1.00</td>
<td>Verbal</td>
</tr>
<tr>
<td>2.</td>
<td>MINUTES OF THE LAST MEETINGS</td>
<td>GT</td>
<td>1.05</td>
<td>Enc 1</td>
</tr>
<tr>
<td>3.</td>
<td>MATTERS ARISING AND ACTION PLAN</td>
<td>GT</td>
<td>1.10</td>
<td>Enc 2</td>
</tr>
<tr>
<td>4.</td>
<td>RAPID PROGRESS IMPROVEMENT WORKSHOP: LARCH A/B</td>
<td></td>
<td>1.15</td>
<td>Presentation</td>
</tr>
<tr>
<td>5.</td>
<td>CHIEF EXECUTIVE’S REPORT:</td>
<td>SE</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>▪ Update on Strategic Direction/STP</td>
<td></td>
<td></td>
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<td></td>
<td>o STP Ratings</td>
<td></td>
<td></td>
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<td></td>
<td>o Capital Funding for Health and Care Services</td>
<td></td>
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<td>6.</td>
<td>SAFETY AND QUALITY</td>
<td></td>
<td></td>
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<tr>
<td>6.1</td>
<td>Safety &amp; Quality Report Q1</td>
<td>MC</td>
<td></td>
<td>Enc 3</td>
</tr>
<tr>
<td>6.2</td>
<td>Quality Improvement Report Q1</td>
<td>MC</td>
<td></td>
<td>Enc 3a</td>
</tr>
<tr>
<td>6.3</td>
<td>Nurse Staffing Assurance</td>
<td>MC</td>
<td></td>
<td>Enc 4</td>
</tr>
<tr>
<td>6.4</td>
<td>Medical Director’s Report</td>
<td>RH</td>
<td></td>
<td>Verbal</td>
</tr>
<tr>
<td>6.5</td>
<td>Board Assurance Framework and Corporate Risk Register</td>
<td>MC</td>
<td></td>
<td>Enc 5</td>
</tr>
<tr>
<td>6.6</td>
<td>Patient Experience Q1</td>
<td>MC</td>
<td></td>
<td>Enc 6</td>
</tr>
<tr>
<td>6.7</td>
<td>Fire Safety</td>
<td>SH</td>
<td></td>
<td>Enc 7</td>
</tr>
<tr>
<td>6.8</td>
<td>Nasogastric Tube – Delivery Update – Q1 2017/18</td>
<td>RH</td>
<td></td>
<td>Enc 8</td>
</tr>
<tr>
<td>6.9</td>
<td>Learning from Deaths</td>
<td>RH</td>
<td>Enc 9</td>
<td></td>
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<td>6.10</td>
<td>Governance Framework</td>
<td>MC</td>
<td>Enc 10</td>
<td></td>
</tr>
</tbody>
</table>

**7. STRATEGY**

No items for discussion

**8. DELIVERY**

<table>
<thead>
<tr>
<th>8.1</th>
<th>Integrated Performance Report &amp; Recovery Plans</th>
<th>HR/MC/KG/CB</th>
<th>Enc 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.2</td>
<td>Winter Plan</td>
<td>HR</td>
<td>Verbal</td>
</tr>
</tbody>
</table>

**9. REGULATORY**

<table>
<thead>
<tr>
<th>9.1</th>
<th>Annual Organisational Audit on Medical Appraisal</th>
<th>RH</th>
<th>Enc 13</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.2</td>
<td>SAS Charter</td>
<td>RH</td>
<td>Enc 14</td>
</tr>
<tr>
<td>9.3</td>
<td>Sustainability Annual Report 2016/17</td>
<td>SH</td>
<td>Enc 15</td>
</tr>
<tr>
<td>9.4</td>
<td>SIRO/Caldicott Guardian Annual Report 2016/17</td>
<td>RH</td>
<td>Enc 16</td>
</tr>
<tr>
<td>9.5</td>
<td>Research &amp; Development Annual Report 2016/17</td>
<td>RH</td>
<td>Enc 17</td>
</tr>
<tr>
<td>9.6</td>
<td>Declarations of Interest</td>
<td>GT</td>
<td>Enc 18</td>
</tr>
</tbody>
</table>

**10. BOARD SUB-COMMITTEES**

<table>
<thead>
<tr>
<th>10.1</th>
<th>Safety &amp; Quality Committee – June 2017</th>
<th>LR</th>
<th>Enc 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.2</td>
<td>Matters Raised to the Board by Sub-Committee Chairs: No items raised this month</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**11. ANY OTHER BUSINESS**

**12. DATE, TIME AND LOCATION OF NEXT MEETING:**
Tuesday, 26 September 2017 at 1pm in the Board Room, West Cumberland Hospital, Whitehaven

*Members of the public attending the meeting will be allowed to ask agenda related questions at the end of the Board meeting held in public*
MINUTES OF A TRUST BOARD MEETING
HELD IN PUBLIC ON
TUESDAY, 23 MAY 2017 AT 1.00PM IN THE
BOARDROOM, WEST CUMBERLAND HOSPITAL

Present: Ms G Tiller, Chair
Ms L Robson, Non Executive Director
Mr M Cook, Non Executive Director
Mr G Liston, Non Executive Director
Dr D Kennedy, Non Executive Director
Mr S Eames, Chief Executive
Mrs H Ray, Chief Operating Officer
Dr R Harpin, Medical Director
Ms M Cushlow, Director of Nursing & Midwifery
Mr M Brearley, Interim Director of Finance

In Attendance: Dr D Thomson, Associate Medical Director
Dr C Graham, Associate Medical Director
Ms C Brereton, Director of HR & OD
Mrs J Stockdale, Company Secretary
Ms R Jamieson, Senior Executive Assistant

TB22/17 APOLOGIES AND DECLARATIONS OF INTEREST AND QUORACY

Apologies for absence were received from Mr D Rawsthorn, Non-
Executive Director

Declarations of interest were declared by Dr D Thomson as a secondee
from Northumbria Healthcare and Mr Eames as a secondee from Mid
Yorks NHS Trust. Dr Harpin made a declaration regarding a family
member being employed by Capstick, who were providing support to the
Success Regime.

The meeting of the Trust Board was quorate with one third attendance of
board members.

TB23/17 MINUTES OF THE LAST MEETING

The minutes of the meeting held on 25 April 2017 were APPROVED by
the Board.

TB24/17 MATTERS ARISING AND ACTION PLAN

The following matters arising were discussed:
Cancer patient survey action plan:
Mrs Ray presented the annual National Cancer Patient Experience Survey (NCPES) reviewing the care received by patients under the NHS in England which was published in July 2015.

The following results were NOTED:
- The Trust scored above the national expected range in 1 out of 49 questions
- The Trust scored within the national expected range in 35 out of 49 questions
- The Trust scored less than the national expected range in 13 out of 49 questions

Mrs Ray reported following the published results, the need for improved communication with patients and greater patient engagement was required. An action plan was developed to address the 13 questions where the findings were less than the national expected range. It was reported significant progress has been made with respect to addressing those key areas.

In response to a query it was confirmed the results of the 2016 NCPES will be available in July 2017 and that a year on year comparison is not possible due to the changes in study design.

The report was NOTED.

Paediatric liaison service and safeguarding training levels for 2016/17:
Following concerns raised by the Trust Board, Ms Cushlow confirmed she had verbally raised the concerns with the Local Safeguarding Board. In response North Cumbria Clinical Commissioning Group (CCG) was arranging a meeting with partner organisations to review and mitigate the risks.

The update was NOTED.

Time for Freedom to Speak up Guardian role:
Ms Brereton confirmed Richard Heaton, Head of Nursing for Surgery and Medicine, will dedicate a day a fortnight to the Freedom to Speak Up Guardian role. It was confirmed Mr Heaton will be attending Board and apologies were noted for the meeting today due to training.

The update was NOTED.

The action plan was APPROVED, as follows:

TB7b/17 Medical Workforce Strategy Update: Update reports to be presented to the Board in May. Action Complete
TB7d/17 Workforce and Organisational Development Strategy Update: Update report to be presented to the Board in May. **Action Complete**

TB17c/17 Nurse Staffing Assurance: Sickness update on the May agenda. **Action Complete**

TB17g/17 Safeguarding Report Q2/Q3: Ms Cushlow presented an update to the Board in May. **Action Complete**

TB17h/17 Freedom to Speak up Guardian: Ms Brereton presented an update at the Board in May. **Action Complete**

**TB25/17 RAPID PROGRESS IMPROVEMENT WORKSHOP: LARCH A/B**

Following the cyber-attack the Chair postponed the presentation to the July Trust Board.

**TB26/17 CHIEF EXECUTIVE’S REPORT**

Mr Eames gave a verbal update in relation to the key issues facing the Trust at the present time.

The following points were **NOTED**:

- Mrs Ray was confirmed as the Strategic Transformation Partnership (STP) responsible officer for the acute aspects of implementation following the result of the Success Regime consultation.
- Formal closure of the Success Regime will be communicated in June; progress will have concluded moving responsibility to the STP.

Mr Eames formally thanked Mrs Ray for leading the gold command for the recovery of the cyber-attack for the Trust. Mr Eames praised the staff for going over and above the call of duty to keep the services running during the recovery period.

Mrs Ray verbally updated on the cyber attacked. It was outlined a number of PCs were affected by the ransomware resulting in immediate action by the Trust IT department to close down the network for PCs and medical equipment to protect further equipment being affected. Departments implemented contingencies plans with immediate effect resulting in services being paper and telephone based. The attack specific affected machines running on XP and the built up recovery on the PC network was quickly implemented early into the following week leaving only equipment still running on XP switched off.
Mrs Ray reported engagement with suppliers companies to get patches to fix the systems was challenging and the Trust had to run some services un-networked for urgent appointments only for one week. It was confirmed the Ultrasound equipment, supplied by Toshiba was un-networked and work was on going with the IT Department and supplier to fix. In response to a query it was confirmed there was no operational concerns for the Trust.

It was confirmed cyber-attack was declared as a national major incident across the NHS. Mrs Ray personally thanked those who worked tirelessly to bring services back on line.

The update was NOTED.

TB27/17  SAFETY & QUALITY

a) Safety & Quality Report – Q4

Ms Cushlow presented the Safety and Quality report for quarter four outlining the Trust’s performance against the national safety and quality standards.

The following performance measure was NOTED:

- The Trust achieved a performance of 92.53% against a standard of 90% for the safety thermometer harm free. Mr Eames noted the performance as an on-going improvement since he had been in post and congratulated the teams on their on-going work.
- Work continues to reduce hospital acquired pressure ulcers, learning and actions from Rapid Process Improvement Workshop (RPIW) carried out on Ward 4 at WCH will be implemented across all wards at WCH over the summer of 2017.
- An audit has been completed to show where and why urinary catheters are being used in the Trust. This data will inform where improvement will be targeted to reduce the use of urinary catheters.
- During March 2017, the trust reported 7 patients with a new pressure ulcer within 72 hours of admission. This is an improvement on the last month by a reduction of 5. Overall there has been a 38% reduction in pressure ulcers over 2016/17 compared to 2015/16 data.
- Work is progressing with identifying the standard improvement measures to track performance improvement in key quality priorities, namely reducing harm from theatre related incidents and never events, reducing falls and hospital acquired pressure ulcers and reducing harm from the management of the deteriorating patient and sepsis.
- Progress continues to be made with demonstrating full compliance with the Duty of Candour Regulation and has been sustained at 100% for initial notifications for the Q4 period.
• During Q4 the Trust declared 16 serious incidents.

The report was NOTED.

b) **Better Births**

Ms Cushlow presented the report to the Trust Board outlining an update on progress pertaining to the implementation of the recommendations of the National Maternity Review, Better Births – Improving outcomes of Maternity Services in England and the establishment of our Local Maternity System (LMS) within the WNE STP in response to the work undertaken locally in 2015 by Healthwatch and the Maternity Services Liaison Committees (MSLCs), to gauge the views of women across the maternity pathway.

It was reported that the additional challenges that have been identified are:

- Translating the requirements of Local Maternity Systems, some of which are designed for large geographical footprints with large numbers of births, into our reality.
- There is a need for a significant cultural change as we move to a more woman / community centred model.

It was confirmed Eleanor Hodgson, Director for Children and Families, North Cumbria Clinical Commissioning Group, is the lead for the Better Births Programme.

Ms Cushlow confirmed a bi-annual report will be presented to the Trust Board to update on the progress and actions taken supporting the better births programme. It was stated the actions taken will align to the consultation outcomes from the Success Regime.

Discussion took place regarding the Midwifery Lead Unit (MLU) progress within the Trust. It was confirmed the Trust has two MLU beds and work is on-going to review the work at Penrith Hospital and transfer the learning to the West Cumberland (WCH) and Cumberland Infirmary (CIC) site. It was confirmed patients appropriate for MLU care at 30 weeks are being identified at WCH currently.

The progress against the programme was NOTED.

c) **Nurse Staffing Assurance**

Ms Cushlow presented the bi-monthly assurance report to the Trust Board outlining the ward staffing data for February and March 2017 as a whole and analysed at ward level. The report also provides the committee with the Care Hours per Patient Day (CHPPD) and the trend from month to month.
Ms Cushlow confirmed staffing on the wards was a continuing concern and the Trust is continuing to use agency staffing to reduce rota gaps. In response to a query it was confirmed the agency cap has been overridden in some cases due to patient safety. Staffing is a challenge and the senior nursing team was reviewing daily. It was highlighted there was a vacancy rate of just below 90 whole time equivalent (WTE), the senior team was reviewing the vacancies and how long they have been vacant for.

Discussion took place regarding the actions being taken to improve the staffing level within nursing. The following actions were noted:

- Support from the human resources (HR) department to implement international recruitment
- Reviewing the nursing leadership on the wards
- Support from the HR department to review short term sickness
- Embedment of the E Roster system across all wards
- Review of flexible working patterns to retain staffing

Ms Cushlow raised concerns following the closure of community beds. It was stated the Trust was reviewing the position with Clare Parker, Director of Nursing, Cumbria Partnership NHS Foundation Trust (CPFT) to collectively review the issues within the acute and community setting and outline actions which can be supported through the A&E Delivery Board.

In response to a query it was stated Richard Heaton was carrying out a review to identify the specialist nurses across the Trust and the clinical time which can be factored in. It was confirmed the process was in place for new roles and work was on-going to implement for current staff.

It was reported following a Rapid Progress Improvement Workshop (RPIW) feedback has encouraged ward managers and their team to review their structure and release capacity.

The report was NOTED.

d) **Medical Director’s Report**

Dr Harpin presented the report highlighting the following areas which are the main focus:

- An improving appraisal rate in response to improvement measures, action plan will be presented alongside the national audit in July to Trust Board
- Medical Education update which highlights excellent feedback from the Annual Joint Quality Visit from the Northern Foundation School and Newcastle Medical School in January 2017 as well as the Annual Dean’s quality visit
- An explanation of the Weekend HSMR and its significance
- A further update on nasogastric feeding tube safety based on a letter from NHSE.
Mr Eames confirmed France May, Associate Medical Director will lead on Medical Education.

Dr Harpin reported weekend mortality figure continued to be a measure influenced by a number of factors both internally and externally to the Trust. It was stated reporting may demonstrate a system issue not just a Trust issue for weekend mortality (HSMR). It was confirmed actions were being taken to mitigate and review.

It was confirmed the Trust has presented a clear checklist to provide assurance to the Trust Board regarding NG Tube Safety. The checklist was supported by NHS England (NHSE) and a further progress report will be provided in July.

**ACTION:**
Progress report to the July Trust Board against the Trust's performance for the NG Tube checklist.

The report was NOTED.

e) **Board Assurance Framework and Corporate Risk Register**

Ms Cushlow presented the Board Assurance Framework and Corporate Risk Register highlighting the following amendments:

- Updated to reflect the 2017/18 strategic priorities
- Removed the risk relating to special measures.
- The strategic risk relating to staff experience (Ref: 3.1) has been increased from a score of 8 to 12.
- The strategic risk relating to board to ward governance and well led (Ref: 4.3) has been increased from an 8 to 15 given the additional assurance required in medicine and maternity following the CQC inspection in December 2016.
- No new strategic risks have been added to the BAF for this reporting period.
- Risk updates have been provided on key areas, which are summarised in this report.
- Additional risk following the cyber-attack has been included to the risk register.

The report was NOTED.

f) **Safeguarding Report – Q4**

Ms Cushlow confirmed the report would be reviewed to ensure the report provides the appropriate level of assurance required to the Trust Board.
Ms Cushlow presented the report to provide assurance that the Trust is meeting the standards relating to safeguarding children and the unborn child, vulnerable adults, learning disabilities, mental health capacity and deprivation of liberty. It was highlighted the report reflects progress, details the challenges with all aspects of safeguarding and highlights that safeguarding remains a key priority for the Trust. The paper includes detail of safeguarding referrals, training levels and areas of concern.

The following points were NOTED:

- Attendance at formal safeguarding training remains below the Trust mandated 95% for practitioners; 52% (children level 3 core) 55% (children level 3 specialist), 35% (adults level 2). The significant drop in Adult Safeguarding training figures is being explored as the safeguarding adult training courses have been full to capacity and are delivered twice per month.
- Withdrawal of routine school nursing services by Cumbria County Council have resulted in only information pertaining to safeguarding concerns being shared if the child or young person attending NCUH is school age, routine attendances are no longer shared. If there are concerns the acute staff will contact the appropriate GP to share the information.
- The future model of paediatric liaison service is yet to be determined.
- An Internal Audit report (December 2016) identified the lack of an audit trail from Adult Social Care when the Trust raises an adult safeguarding concern with them. A risk register entry has been created; this identifies the issue as being outside the Trusts control. The Trust keeps a log of all contacts with ASC.
- Lead Midwife Safeguarding has been recruited into post with identical hours (15hrs per week), terms and conditions on a temporary contract. A business case is expected to be completed by July 2017 to increase the hours to full time.
- The Named Nurse has requested a care review of one child cared for by multiagency team including NCUHT

Mr Eames raised concerns regarding the performance of those who have completed the Safeguarding Children Level 1 training. It was confirmed a review was being carried out to ensure the essential staff members that are required to carry out the training are aware and completing. Ms Cushlow confirmed discussions were on going with the LSCB chair regarding the level of training and who requires the training.

The report was NOTED.

g) Freedom to Speak up Guardian

Ms Brereton presented the report outlining the role and responsibility of the Freedom to Speak up Guardian (FTSUG) and provides assurance that whistle blowing concerns are managed in line with the best practice
recommendations outlined by The National Guardian's office on behalf of Mr Heaton.

It was reported there was 22 contacts to the FTSUG. The issues discussed have been resolved locally either by directing to an appropriate department or manager, wider concerns have been raised were appropriate.

The update was NOTED.

h) Guardian of Safe Working

Mr Andrew Robson, Guardian of Safe Working/ENT Consultant joined the Board to present the report outlining the progress of engagement within the Guardian of Safe Working.

It was reported that all 35 F1s have been on the terms and conditions (TCS) since December 2016 which have been presented widely to groups of staff to engage them in the aims and logistics of implementing the new TCS.

Ms Brereton confirmed the management of the consultant rotas will be centralised from 1 August 2017. It was highlighted there was an agency team in place within the Trust to review agency staff. The centralisation of the rotas will allow the Trust to have access to all gaps across the board and information will be shared more easily. In response to a query it was confirmed the HR department are developing an internal bank for staff.

The report was NOTED.

TB28/17 STRATEGY

a) West, North & East Allied Health Professionals Strategy 2017/18

Ms Cushlow presented the report on behalf of Helen McGahon, Head of Physiotherapy following the launch of the West, North and East (WNE) Cumbria Allied Health Professionals (AHP) Strategy on 29 March 2017.

It was stated AHPs have knowledge and skills to lead, support and influence areas of work in the WNE Cumbria STP delivery plan which has national been recognised. The AHP leads will present at the Kings Fund event ‘Harnessing the Value of Allied Health Professionals on 6 September 2017.

In response to a query it was confirmed the CPFT AHP engage with the Trust through the Nursing and Midwifery AHP Board with the Trust.

The Trust Board formally thanked Helen McGahon for her on going dedication and hard work to support the development of the strategy.
The report was NOTED.

b) **Workforce and OD Strategy and Objectives for 2017/18**

Ms Brereton presented the report outlining the proposed workforce and OD Strategy for North Cumbria University Hospital Trust for 2017/2018.

The following key themes were NOTED:

- **Recruitment and Retention** – To attract, recruit and retain highly skilled and capable medical and professional staff across the Trust.
- **Staff Engagement** – To listen, engage and interact with staff at all levels recognising and rewarding their contribution to the Trust.
- **Health and Wellbeing** – To create a positive and healthy working environment for our staff resulting in excellent and high quality patient care.
- **Staff and Organisational Development** – To create a flexible learning organisation that continually grows and develops its staff in order to respond to the demands and challenges of our services.

The Board support the content of the report outlining the direction of travel. It was noted that the report should be shared widely throughout the Trust.

The report was NOTED.

**TB29/17 DELIVERY**

a) **Integrated Performance Report & Recovery Plans**

Mrs Ray presented the Integrated Performance Report which identifies and assesses the Trust’s performance against the key Trust measures and nationally mandated performance. It was confirmed the report was not present to the Finance, Investment and Performance Committee as a result of the cyber-attack.

It was reported the following measures and amendments have been added to the report:

- Maternity FFT scores
- Weekend HSM
- Measures that are supplementary or supporting measures now sit in the appendix 4
- FFT response rates and serious incidents numbers have been removed.
- Measures which have no refreshed data have not been included in the report such as annual staff survey information. They will be added when the data is refreshed
- There is no appraisal data because the trajectory target doesn’t apply to April because all staff are set back to not having had an appraisal at the start of the year
Mrs Ray reported the following highlights to be NOTED:

- Eight measures that were off target in the April-17 report are now on target in this May-17 report. These are:
  - Inpatient FFT: % positive scores
  - VTE risk assessments
  - AE 4 hour waits
  - RTT % incomplete <18 weeks
  - Cancer: 62 day All cancers
  - Mandatory Training

- The following measures have moved from being on target in the April-17 report to being off target in the May-17 report:
  - Diagnostics: % waiting <6 wks
  - NHS Safety Thermometer: new harm (%)

- The key measures with nationally agreed trajectories and/or national constitutional standards for the month of May 2017:
  - Cancer 62 days, RTT are meeting both the national standard and the nationally agreed NCUH trajectory. Linked to gastro, 1 substantive WTE currently absent due to sick leave, leaving the service fragile, back up contingency up as of Saturday should see recovery, gastro is a national shortage.
  - A&E 4hr wait measures did not meet the constitutional standard but is on trajectory for April-17
  - Diagnostics waits within 6 weeks is marginally off national standard at 98.9% against a standard of 99%

Mr Andrews presented the financial update reporting there was a concern with the CIP performance and pressures on the capital funding. It was reported the Trust is on plan at Month 1 and is forecasting to meet its Control Total for the year and at Month 1 the Trust is in line with the overall I&E deficit plan, though is behind plan for Operating Deficit and EBITDA.

In response to a query it was confirmed the Trust has identified a CIP opportunity of £10.6million against the Trust target of £16.3m. It was stated £2.99m of this was supported by validated financials and a phased plan for delivery. The Board agreed a further update was required outlining the mitigations to improve the delivery.

**ACTION:**
1. Progress report to the July Trust Board against the Trusts CIP performance.

**TB30/17 REGULATORY**

a) **Standing Orders Update**
Following a review of the Trust’s Standing Orders, Standing Financial Instructions, Reservation and Delegation of Powers in December 2016, the Board is requested to approve some additional amendments to the Standing Orders. The Trust Board **APPROVED** the following amendments; **Section 4: Appointment of Committees and Sub-Committees:**

- **4.8.1** – Risk and Audit Committee – the Emergency Preparedness Committee to report to the Risk and Audit Committee (Page 23)
- **4.8.7** – addition of a new section to include a new sub-committee of the Board – Joint Group Board (Page 25)

b) **Staff Sickness Annual report 2016/17**

Ms Brereton presented the report outlining the annual sickness absence performance for the Trust in 2016/17. It was reported the Trust performance was 5.11% against the set 4% target. The rolling sickness absence rate was recorded as 4.75% at April 2016 and rose throughout the financial year ending at March 2017 at 5.11%. The highest absence rate of 5.87% was recorded in January 2017. The target rate of 4% had not been achieved in any month in the reporting period.

It was reported the cost of sick pay was estimated to be £5.15m year with a loss of 62,543 wte days (this is based on actual salary of the absent employee and does not include cover arrangements.)

An action plan to reduce sickness absence was put in place in January 2017 in an effort to reduce absenteeism. The following actions which have been undertaken were **NOTED:**

- Staff who have breached the short term absence benchmarks have been identified and targeted for formal action as appropriate
- Staff that have shown patterns of sickness around holiday periods have been identified and targeted for formal action as appropriate.
- All long term absence cases have been reviewed
- Sickness absence reporting for junior doctors has been centralised within the HR team
- HR staff have been focussed on reducing sickness absence with managers in their areas.
- A new sickness absence policy has been drafted and has been discussed with the Trust Partnership Forum (TPF) and it is hoped that this will be agreed by end of May. Training for all managers will then be rolled out from June to ensure that managers with HR support are effectively and robustly managing both short and long term absence. The new policy now includes trigger points which will ensure that staff with unacceptable levels of short term absence are formally reviewed.

The report was **NOTED.**
c) **Health and Wellbeing Annual Report 2016/17**

Ms Brereton presented the report outlining the Health and Wellbeing achievements against the Trust plan and CQUIN targets for 2016/17. It was reported there had been extensive activity against the plan which is governed by our Health and Wellbeing Group, which is well attended. This has included the development and implementation of our H&W Plan, the recruitment of a health and wellbeing co-ordinator, introduction of an Employee Assistance Programme (EAP) and the development of an in-house physiotherapy service for our staff.

Through the results of the staff survey it was reported staff didn’t feel the Trust were focusing on the improvements, it was confirmed the 2017/18 priority was to embed and focus staff on the work on going.

The Trust Board formally thanked the Health and Wellbeing Team for their dedication and hard work to drive the delivery of the Health and Wellbeing plan.

The update was **NOTED**.

d) **Director of Infection Prevention and Control Annual Report 2016/17**

Mr Graham presented the report outlining the Trusts performance against the measures for infection prevention and control. The key points were **NOTED**:

- There has been a slight increase in the number of apportioned Clostridium difficile cases with 26 cases compared to a trajectory of 25 cases (23 cases in 2015/16). Of these 26, 21 cases were on the Cumberland Infirmary site, an increase of 5 from last year.

- For the second year running there has been no MRSA bacteraemias but apportioned MSSA bacteraemias have increased to 15 from 7 last year although we believe we are still around the national average.

- There were a significant number of influenza and norovirus cases over the winter with norovirus causing a number of ward closures. Better availability of Infection Prevention staff through 7 day working, laboratory testing and cohort nursing helped contain the virus better than when we last had significant number of cases (2014-15). Although we still had cases on Willow C (where we had invested in bay doors) it did allow us to re-open the ward bay by bay and we believe reduced the risk of transmission across the pavilion. We had one ward closed due to transmission of influenza.

- The number of orthopaedic surgical site infections is lower than last year but we should strive to reduce this further and expand the SSI surveillance beyond orthopaedics.
In response to a query it was confirmed the bay doors which have been installed within Willow C helped to control the influenza virus spreading. It was agreed the Trust would be required to review where is more appropriate to install bay doors throughout the hospital building to support the control of infection.

The report was NOTED.

e) Patient Experience and Complaints Annual Report 2016/17

Ms Cushlow presented the report outlining an overview of the Trust's Patient Experience data for 2016/17 which covers all aspects measured for Patient Experience including PALS, Complaints, Friends and Family Test, Two minutes of your Time and Real time surveys. It also includes Patient Perspective Data which provides an indication of how the Trust is performing against the National Inpatient and Outpatient survey questions.

The following points were NOTED:

- PALS activity has increased in 16/17 with 189 more contacts that in 15/16. Having two PALS officers in the Trust, one on each site has made it easier for patients and relatives to make contact and have any queries dealt with quickly. There were only 19 PALS issues that were converted into formal complaints from the 2071 contacts received.

- Complaints in 2016/17 decreased by 9% with 285 new complaints made. The 30 response rate has been maintained at 100% since its introduction in September 2016 which is an excellent sustained improvement.

- At the end of 2016/17 The Cumberland Infirmary has a rating of 4 stars (from the last 157 comments) and West Cumberland Hospital has a rating of 4.5 stars (from the last 91 comments). West Cumberland Hospital has maintained 4.5 stars throughout the year and the Cumberland Infirmary has improved from 3.5 stars in quarter 1 to 4 stars for the remainder of the year.

- FFT scores for the Trust are comparative with other Trusts with recommendations scores averaging 96.8% for inpatients and day case, 85.6% for A&E, 97.5% for outpatients and 97% for Maternity (postnatal). When compiling the report for Q4 it was noticed that there had been an error on the way the data was being collated and a cumulative figure for responses was used in some of the calculations rather than the actual quarterly figure. The data has been checked and amended meaning that the response rates are lower than previously reported in quarters 2 and 3 and the recommendation rate has improved (smaller denominator). The response rate remains a challenge particularly in A&E and outpatients and actions have been identified in both of these areas to try and improve response rates. In A&E we are hoping to pilot SMS (text messages) for feedback and to do some work with the
reception staff in outpatients about handing out the 2 minutes of your time cards.

- In the Patient Perspective Survey the Trust is in the top 20% of all Trusts on 9 of the 19 most important questions to patients. On the remaining questions, the Trust is around average. The overall score for the Trust on the key 19 questions is 82.7%, just below the threshold for the top 20% of 83.4%. Overall, 81% of patients would recommend the Trust and 94% of patients rated their care as excellent, very good or good.

- The Patient Experience team have carried out 3948 face to face interviews of patients whilst they were in hospital. The responses are reported in ten domains with nine out of the ten domains scoring above 9 (the Trust minimum expected standard). The domain scoring below nine was Medicines and this scored 8.84. Pharmacy are implementing a medication information system called MaPPS2 which will provide patients with specific information about any new medications when they are discharged and will hopefully aid the understanding of the patients of their medications.

- Children and Young People Surveys have increased this year from 1,263 in 15/16 to 2,128 in 16/17. From 781 comments, 105 were negative and a large proportion of these commented on lack of Wi-Fi. Scores in the feedback from 12-18 year olds are the lowest in this section and relate to these young people being seen alone, being advised about confidentiality and being advised about keeping themselves safe. This is an area for the staff in children’s services to look at in the coming year.

- Butterfly surveys, which get feedback from relatives of patients with dementia, showed that 79% of carers felt well supported by staff and 4 of the six domains scoring under 9. Positive comments were received about sensitive patient care and this is something that will be built upon in the coming year.

f) **Clinical Audit Annual Report 2016/17**

Dr Harpin presented the annual report outlining a summary of clinical audit activity from April 2016 to March 2017 reporting the outcomes of the National audits reported during the year. The Trust participated in 38/40 (95%) National clinical audits and 5/5 National Confidential Enquiries into Patient Outcome and Death (NCEPOD’s). It was reported that the Trust has made progress during the year in the systematic review of progress against delivery of the clinical audit plans, which has been achieved by monthly review of the governance dashboard presented to the Safety and Quality Committee.

Discussion took place regarding the support required to deliver the data to support the clinical audits. It was confirmed once the data is simplified it will allow more information to be collected improving the quality of the data audits.
Dr Thomson stated the remarkable progress for the Trust reporting against NICE guidance. It was confirmed an improvement trajectory will be outlined following a discussion with the Governance Team to continue to improve the performance against NICE guidance.

The report was **NOTED**.

g) **Trust Seal Annual Report 2016/17**

The Trust Seal Annual report was presented in line with Section 8 of the Trust’s Standing Orders, the common seal of the Trust is kept by the Company Secretary and a record kept of the sealing of every document.

It was reported from 1 April 2016 to 31 March 2017; the following documents were signed and sealed:
1. Lease for the kiosk at WCH between WH Smith Ltd and NCUH.
2. Lease of the Unit 10/12, Port Road Business Park, Carlisle.
3. Extension of timescales by one quarter for HMC regarding the Interim Settlement Agreement between HMC and NCUH.
4. Second supplemental Interim Settlement Agreement between HMC and NCUH.
5. Third supplemental Interim Settlement Agreement between HMC and NCUH.

The Trust Board **APPROVED** the Trust Seal Annual Report.

**TB31/17 BOARD SUB-COMMITTEES**

a) **Safety & Quality Committee – April 2017**

The minutes of the Safety and Quality Committee meeting held in April 2017 were **NOTED**.

b) **Charitable Funds Committee – April 2017**

The minutes of the Charitable Funds Committee meeting held in April 2017 were **NOTED**.

c) **Matters Raised to the Board by Committee Chairs**

The Committee Chairs reported there were no items to be raised from the sub committees of the Trust Board.

**TB32/17 ANY OTHER BUSINESS**

There were no further items of business.

**TB33/17 QUESTIONS FROM THE PUBLIC GALLERY**

There were no questions from the public gallery.
TB34/17  DATE, TIME AND VENUE OF NEXT MEETING

Tuesday, 25 July 2017 at 1pm in the Board Room, Cumberland Infirmary.

Signed: .................................................................

Chair

Dated: .................................................................
MINUTES OF A TRUST BOARD MEETING
HELD IN PUBLIC ON
THURSDAY, 25 MAY 2017 AT 3.00PM IN
THE BOARDROOM, CUMBERLAND
INFIRMARY, CARLISLE

Present:  Mr M Cook, Vice Chair
Ms L Robson, Non Executive Director
Mr G Liston, Non Executive Director
Mr D Rawsthorn, Non Executive Director
Mr S Eames, Chief Executive
Mrs H Ray, Chief Operating Officer
Ms M Cushlow, Director of Nursing & Midwifery
Mr R Andrews, Interim Director of Finance
Dr R Harpin, Medical Director

In Attendance:  Ms C Brereton, Director of HR & OD
Mrs J Stockdale, Company Secretary
Mrs H McDonnell, Assistant Director of Finance

TB35/17  APOLOGIES, DECLARATIONS OF INTEREST AND QUORACY

Apologies for absence were received from Ms G Tiller and Dr D Kennedy.

Declarations of interest were declared by Mr Eames as a secondee from Mid Yorks NHS Trust. Dr Harpin declared as interest as a family member worked for Capsticks, who provided services to North Cumbria.

The meeting was quorate.

TB36/17  ANNUAL REPORT AND ACCOUNTS 2016/17

Mr Andrews presented the Annual Report and Accounts for 2016/17 to the Board.

At a meeting of the Audit & Risk Committee earlier that day, the Committee had received feedback from the External Auditors, Grant Thornton. The auditors had undertaken a full review of the report and accounts and had confirmed their assurance. The Auditors had commented to the Committee that their audit had been a very positive experience this year and that it had been the Trust’s best audit yet and had gone very smoothly and with an outcome of ‘nearly perfect’.
On behalf of the Audit and Risk Committee, Mr Rawsthorn recommended the Annual Report and Accounts 2016/17 to the Board for approval.

The Trust Board formally APPROVED the Annual Report and Accounts 2016/17.

**TB37/17 ANNUAL GOVERNANCE STATEMENT 2016/17**

Ms Cushlow presented the Annual Governance Statement 2016/17 to the Board.

At a meeting of the Audit & Risk Committee earlier in the day, the Annual Governance Statement had been presented and discussed. Grant Thornton, the Trust’s External Auditors, commented that the Statement was an excellent improvement on the previous year and that they were assured by its content.

On behalf of the Audit and Risk Committee, Mr Rawsthorn recommended the Annual Governance Statement 2016/17 to the Board for approval.

The Trust Board formally APPROVED the Annual Governance Statement 2016/17.

**TB38/17 ANNUAL QUALITY ACCOUNT 2016/17**

Ms Cushlow presented the Annual Quality Account 2016/17 to the Board.

At a meeting of the Audit & Risk Committee earlier in the day, the Quality Account had been presented and discussed. Grant Thornton, the Trust’s External Auditors, commented that there remained a few items to be updated and suggested that the Trust Board be requested to delegate responsibility to the Audit & Risk Chair to sign off these further changes.

On behalf of the Audit and Risk Committee, Mr Rawsthorn recommended the Annual Quality Account 2016/17 to the Board for approval and requested approval to receive delegated responsibility for further amendments to the Account.

The Trust Board formally APPROVED the Annual Quality Account 2016/17 and AGREED to give Mr Rawsthorn, as the Audit & Risk Chair, delegated responsibility for further amendments to the Quality Account.

No further business was discussed and the meeting was concluded.
<table>
<thead>
<tr>
<th>Minute Point Reference</th>
<th>Details of Action Agreed</th>
<th>Action by Whom</th>
<th>Timescale</th>
<th>Progress and Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB17f/17</td>
<td><strong>Improving Naso-gastric Tube Care:</strong> Task and Finish Group to report to the Board on a quarterly basis.</td>
<td>Rod Harpin</td>
<td>25/07/2017</td>
<td>Report to be presented at the July meeting. <strong>Action Complete</strong></td>
</tr>
<tr>
<td>TB27/17</td>
<td><strong>Safety and Quality:</strong> Progress report to the July Trust Board against the Trusts performance for the NG Tube checklist.</td>
<td>Ramona Duguid</td>
<td>25/07/2017</td>
<td>To be discussed at July meeting. <strong>Action Complete</strong></td>
</tr>
<tr>
<td>TB29a/17</td>
<td><strong>Integrated Performance Report &amp; Recovery Plans:</strong> Progress report to the July Trust Board against the Trusts CIP performance.</td>
<td>Robin Andrews</td>
<td>25/07/2017</td>
<td>To be discussed at July meeting. <strong>Action Complete</strong></td>
</tr>
</tbody>
</table>
Date of Meeting: 25 July 2017
Enclosure Number: 3
Title of Report: Safety and Quality Report Quarter One 2017/18
Author: Ramona Duguid, Associate Director of Risk and Quality Governance
Mike Stacey, Information Analyst Manager, Governance Department
Executive Lead: Maurya Cushlow, Executive Director of Nursing / Rod Harpin, Executive Medical Director
Responsible Sub-Committee (if appropriate) Safety & Quality Committee

Executive Summary:
• The Safety Thermometer data for quarter 1 2017/18 indicates that the Trust achieved a performance above 90% in each month against a standard of 90% for the safety thermometer harm free care.
• During the first quarter the Trust reported 7 patients with a new pressure ulcer which had developed within 72 hours of admission, this is an improvement on the last quarter of 2016/17 by a reduction of 20 from 27.
• A target of a 30% reduction in falls has been set for 2017/18 compared to 2016/17 data. The preliminary data for Quarter 1 shows a 19.79% reduction from 384 to 308 inpatient falls.
• NCUH has a higher than national average number of in-patients who have a urinary catheter (short and long term) in situ at 21% (national average is 14%). A catheter insertion reduction plan has been developed with the support of the urology nurse specialists, which includes collaboration with colleagues in CPFT.
• Performance on Duty of Candour continues to be positive, extended monitoring has been introduced on the written notifications element which has identified areas for improvement, which is being addressed with the Divisions.
• 19 serious incidents have been declared during Quarter 1.
• There has been six cases of C-Difficile so far this financial year, our trajectory for the year is 25 cases or less.
• There have been no apportioned MRSA bacteraemia in 2017-18; it is over two years since our last apportioned MRSA bacteraemia.
• The Trust maintained a 100% performance for responding to complaints in 30 working days in Quarter One.
• The learning from deaths dashboard is included in this report for Q1.
• Two CAS Alerts are open beyond their deadline which are included in this report.
<table>
<thead>
<tr>
<th>Strategic Priority and BAF Link:</th>
<th>Strategic Priority:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>List below the associated risk in relation to the Strategic Priority</td>
</tr>
<tr>
<td>1. Strategy &amp; System</td>
<td></td>
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<tr>
<td>2. Operational Flow and Delivery</td>
<td></td>
</tr>
<tr>
<td>3. Patient &amp; Staff Experience</td>
<td></td>
</tr>
<tr>
<td>4. Workforce and Leadership</td>
<td>4.3 Trust fails to develop and embed the well led principles from ward to board resulting in poor governance.</td>
</tr>
<tr>
<td>5. Safety &amp; Quality</td>
<td>5.1 The Trust fails to learn lessons from serious incidents.</td>
</tr>
</tbody>
</table>

Financial Implications:

**Actions Required by the Board:**

- **To approve:** Discussion and decision
- **To note:** Where the Board is made aware of key points but no decision is required
- **For information:** For reading and consideration and for discussion by exception only

The Board is requested to APPROVE the Safety & Quality Report for Q1 2017/18

<table>
<thead>
<tr>
<th>Data Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Source:</strong></td>
</tr>
<tr>
<td><strong>Validated by:</strong></td>
</tr>
<tr>
<td><strong>Date:</strong></td>
</tr>
</tbody>
</table>
Harm Free Care

Developed by the NHS as a point of care survey instrument, the Safety Thermometer data for quarter 1 2017/18 indicates that the Trust achieved a performance above 90% in each month against a standard of 90% for the safety thermometer harm free care. 100% of eligible patients were included in the survey each month. Following admission in June 93% of patients were harm free, whilst 97% of patients were new harm free. This score includes patients who have been admitted to hospital with a pressure ulcer, a fall in a care setting in the previous 72 hours and patients who have had a catheter inserted in any setting in the previous 72 hours and have developed a UTI. Actions/mitigations in place to improve performance: Work continues to reduce hospital acquired pressure ulcers, with the tissue viability team supporting all areas to implement actions from the pressure ulcer collaborative and the improvement work carried out on Ward 4 at WCH. Learning from the falls collaborative and improvement work on EAU at WCH and Elm floor at CIC is being embedded and sharing improvement has started with Larch AB. A catheter reduction improvement plan has been developed with the support of the urology specialist nursing team, which includes working with colleagues in CPFT, to reduce urinary catheter insertion.

Pressure Ulcers

The pressure ulcer data demonstrates point prevalence for new ulcers (Pressure ulcers developed within 72 hours of admission).

During the first quarter the Trust reported 7 patients with a new pressure ulcer which had developed within 72 hours of admission, this is an improvement on the last quarter of 2016/17 by a reduction of 20 from 27. Whilst, patients admitted with an old pressure sore (developed prior to admission or within 72 hours of admission) in the first quarter had reduced to 60 from 74 in quarter 4 of 2016/17.

Overall there has been a 47.41% reduction in pressure ulcers over 2016/17 compared to 2015/16 data.
The ability to achieve a sustained reduction in falls continues to be a challenge for the trust.

A target of a 30% reduction in falls has been set for 2017/18 compared to 2016/17 data. The preliminary data for Quarter 1 shows a 19.79% reduction from 384 to 308 inpatient falls.

NCUH has contributed in May 2017 to the RCPs National audit for Inpatient falls to provide our position nationally in performance in reducing inpatient falls. MDT areas for improvement from this audit have been identified internally and will be included in the action plan established to roll out learning following the Trusts successful involvement in the NHSI 90 day falls collaborative in quarter 4 of 2016/17.

A request for financial support from the divisions has been made to establish a falls lead post to support the Head of Nursing Clinical Standards with the review of the current falls pathway, support wards with the implementation of improved practice and ensure lessons learnt are disseminated across the Trust.
Use of Urinary Catheters

NCUH has a higher than national average number of in-patients who have a urinary catheter (short and long term) in situ at 21% (national average is 14%). This is not however, reflected in the average number of patients who are recorded as having a new patient harm from a catheter associated UTI which is 2% (national average 1%).

Mitigating actions to deliver improvement include:

- A catheter insertion reduction plan has been developed with the support of the urology nurse specialists, which includes collaboration with colleagues in CPFT, areas of improvement on the plan include;
  - Convene application training
  - Training for all staff who insert urinary catheters
  - Teaching to empower nurses to lead on catheter review and removal
  - Raising awareness with medical staff of the reasons for catheter insertion and removal
  - Training to improve the accuracy of fluid balance recording.

VTE (Venous Thrombo-Embolism) Risk Assessment

The Trust is performing significantly better than the National Median for both the Assessment of VTE and Prophylaxis, as well as the provision of information.

Work is required to understand how we are doing with regard to the reassessments of VTE after 24 hours.
The three months of the quarter have all shown reporting rates below the potential National Median for this period, and below last year’s levels.

The departments with the highest level of reporting are, at CIC: Larch AB, A&E, Elm B, Elm C & Theatres. At WCH: EAU, A&E, Ward 4, Ward 1 and Delivery Suite. This group of wards are similar to those for Quarter Four.

The main themes for incidents received in the Quarter are related to Slips, Trips & Falls (particularly found on the floor and on the same level). Incidents also relating to Treatment & Patient Care (mainly treatment/care delays) and Documentation (mainly missing casenotes) were common themes. Pressure Ulcers & Moisture Lesions developed particularly pre-admission were also reported in significant numbers.

The number of severe harm Incidents in the quarter were 8, one more than in Quarter Four and lower than the 13 for Quarter Three.

Reducing harm & tracking our improvements

The key priority areas for improvement (below) link directly to the Quality Improvement Plan for 2017/18, which has been finalised during Q1.

- Reducing harm from management of the deteriorating patient, including sepsis.
- Reducing harm from falls and hospital acquired pressure ulcers.

Reducing harm from theatre related incidents, including never events remain in place through the Perioperative Improvement Plan.
Duty of Candour is applicable to any patient safety incident which has resulted in a moderate or above level of harm. The CQC Regulation sets out the specific requirements for complying with this Regulation. In summary, there are stages which should be complied with. Stage one is the initial notification where a patient and or family member is initially notified in person that they have been involved in a patient safety incident. This is then followed up in writing, which should include a written explanation, apology and clarify how it will be investigated. Performance monitoring on initial notifications is in place and has reached a sustained period of performance. This has now been extended to include the additional performance measure of the written notifications. This has identified areas for improvement and recovery plans have been put in place during June to address any areas of non compliance. This will now be reported as a standard measure on Duty of Candour compliance.
The number of Serious Incidents being declared in Quarter One was 19 and is significantly below the number declared in the previous two quarters. The Patient Safety Panel meet weekly to review the serious incidents across the Trust, including the review of serious incident investigations. The outputs from the safety panels are reported formally on a monthly basis to the Safety & Quality Committee.

A key area of focus is the improvement required to the management of the deteriorating patient, which is identified in the Quality Improvement Plan 2017/18.
HAIs & Infection Prevention

Responsible for the increase terms of preventable factors the main issue appears to be cannula care (predominantly peripheral venous cannula). A task and finish group have been convened to identify the actions required to reduce the number of infections, proposed initiatives to date include:

- Promotion of the use of ACT ON by medical staff to promote regular checking of cannulas (if required or not)
- A rapid improvement cycle (to improve VIP recording)
- Involvement of those responsible for Junior Doctor training to ensure adequate training and awareness in place
- Ensure all MSSA bacteraemias are reported through Ulysses and Duty of Candour applied where indicated
- Review duration cannula are kept in for

Outbreaks / Incidents

There has been a Period of Increased Incidence (PII) declared on Willow A ward.

External Assessments

The Clostridium difficile data for 2016-17 has been independently audited and no issues identified.

Service Developments

Hand Hygiene and Infection Prevention & Control training figures are showing that we have fallen below our 95% target, but since the last report the situation has improved and at the end of May we are at 90%.

Service Improvements

The IP service improvement plan 2017/18 has been agreed, main outstanding issues include cleaning with the cleaning policy still with IFM, ANTT training in orthopaedics, theatre scrub/uniform policy and the need to reduce E.coli bacteraemias across the Health Economy which dovetails with the need to improve catheter care.

C.diff Summary:

In total there have been six cases so far this financial year our trajectory for the year is 25 cases or less. We have note yet met with the CCG to determine which cases were unavoidable.

MRSA Summary:

There have been no apportioned MRSA bacteraemia in 2017-18; it is over two years since our last apportioned MRSA bacteraemia.

MSSA Summary:

There has been six apportioned MSSA bacteraemias in 2017-18, this number of infections is significantly greater than we experienced last year when we had fifteen cases in total. There does not appear to be a single ward location responsible for the increase of preventable factors the main issue appears to be cannula care (predominantly peripheral venous cannula).
The Trust maintained a 100% performance for responding to complaints in 30 working days in Quarter One. The quarter has also seen a continued reduction in the number of complaints received, but the complexity of these complaints has increased over the period. The main types of new complaint cases were for Treatment and Care in Inpatients and Outpatients. It is to be noted the Treatment and Care categories cover all aspects of patient care and therefore are the most common categories throughout all quarters. An increase of complaints received in June is with regard to Attitude of Staff.

The highest number of complaints received under the Treatment and Care categories for the Quarter One period (Inpatients and Outpatients) across both sites, were noted as follows:

Outcome of Treatment & Care, which included Discharge Concerns/Issues. The areas involved include Orthopaedics, Obstetrics, Gynaecology, Urology, Elderly Care and Emergency Care.
SHMI and Mortality Review

Mortality

Mortality Data

HSMR and SHMI data up until the end of December 2016 are within expected limits. The main diagnostic group with higher than expected number of deaths is Pneumonia, we are analysing the mortality reviews which have been done on that diagnostic group to identify any key issues; Sepsis deaths are now less than expected. Weekend mortality rates are less than previously reported.

Analysis of raw data indicate a higher number of Hogan 5 scores than expected but on further assessment these are being downgraded mainly due to poor prognosis of the patient’s primary condition, the one Hogan 5 that has been confirmed has been escalated to an SI.

The key risks identified are:-

- Ensuring our Hogan assessments are performed in line with other organisations and we have a robust process
- Ensuring we improve the care quality issues identified in particular NEWS and the management of the deteriorating patient
- Ensure we have a new Mortality Policy in place by September 2017.
Mortality

North Cumbria University Hospitals NHS Trust: Learning from Deaths Dashboard - June 2017-18

Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

<table>
<thead>
<tr>
<th>Time Series</th>
<th>Total Number of Deaths in Scope</th>
<th>Total Deaths Reviewed</th>
<th>Total Number of deaths considered to have been potentially avoidable (RCP&lt;=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>This Month</td>
<td>Last Month</td>
<td>This Month</td>
</tr>
<tr>
<td>This Month</td>
<td>58</td>
<td>82</td>
<td>8</td>
</tr>
<tr>
<td>This Quarter (QTD)</td>
<td>273</td>
<td>0</td>
<td>162</td>
</tr>
<tr>
<td>This Year (YTD)</td>
<td>273</td>
<td>0</td>
<td>162</td>
</tr>
</tbody>
</table>

Time Series:  
Start date 2017-18 Q1  End date 2018-19 Q2

Mortality over time, total deaths reviewed and deaths considered to have been potentially avoidable.  
(Note: Changes in recording or review practice may make comparisons over time invalid)

Total deceased
Deaths reviewed
Deaths considered likely to have been avoidable

Total Deaths Reviewed by RCP Methodology Score

<table>
<thead>
<tr>
<th>Score 1</th>
<th>Definitely avoidable</th>
<th>Score 2</th>
<th>Strong evidence of avoidability</th>
<th>Score 3</th>
<th>Probably avoidable (more than 80-90%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>This Month</td>
<td>0</td>
<td>0.0%</td>
<td>This Month</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>This Quarter (QTD)</td>
<td>0</td>
<td>0.0%</td>
<td>This Quarter (QTD)</td>
<td>1</td>
<td>0.6%</td>
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<tr>
<td>This Year (YTD)</td>
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<td>0.0%</td>
<td>This Year (YTD)</td>
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<td>0.6%</td>
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<table>
<thead>
<tr>
<th>Score 4</th>
<th>Probably avoidable but not very likely</th>
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<tbody>
<tr>
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<td>This Quarter (QTD)</td>
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<tr>
<td>This Year (YTD)</td>
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<table>
<thead>
<tr>
<th>Score 5</th>
<th>Slight evidence of avoidability</th>
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<tr>
<td>This Month</td>
<td>3</td>
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<tr>
<td>This Quarter (QTD)</td>
<td>57</td>
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<td>This Year (YTD)</td>
<td>57</td>
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</table>

<table>
<thead>
<tr>
<th>Score 6</th>
<th>Definitely not avoidable</th>
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<tbody>
<tr>
<td>This Month</td>
<td>5</td>
</tr>
<tr>
<td>This Quarter (QTD)</td>
<td>83</td>
</tr>
<tr>
<td>This Year (YTD)</td>
<td>83</td>
</tr>
</tbody>
</table>

Summary of total number of learning disabilities and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

<table>
<thead>
<tr>
<th>Time Series</th>
<th>Total Number of Deaths in Scope</th>
<th>Total Deaths Reviewed</th>
<th>Total Number of deaths considered to have been potentially avoidable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>This Month</td>
<td>Last Month</td>
<td>This Month</td>
</tr>
<tr>
<td>This Month</td>
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<tr>
<td>This Quarter (QTD)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>This Year (YTD)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Incidents and Serious Incidents:

During Q1, 8 new claims were the subject of incidents reported against them before a claim was received. Five incidents were for CIC and three were for WCH. The incidents were: 5 for the Surgical Business Unit; 1 for the Medical Business Unit, 1 for the Corporate Function and one for Estates.

Of the new claims received, 4 are the subject of a Serious Incident (SI) Investigation and 3 fall under the Surgical Business Unit with the remaining one falling under the Medical Business Unit. Three new matters are the subject of a complaint and they fall under the surgical business unit.

Trends:

The number of new claims received during Q1 (19) is slightly higher than the claims received in Q1 for 2016/2017 (15)

The majority of the new claims relate to the Surgical Business Unit, so this will continue to be monitored to see if this trend continues in future. However you are asked to note that the years that the incident took place varies from 2010 - 2017 so this does make it difficult to assess whether there is in fact a trend emerging.

Significant Claims Received:

The Trust received 4 significant claims during Quarter Four.

Significant Claims Closed:

The Trust had 9 significant claims conclude during Quarter Four.
**National Audits—Exceptions Q1 2017/18**

There are 45 National audits relevant to NCUHT and the Trust is participating in 43. The Medical Division is not participating in:– Inflammatory Bowel Disease Registry and National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Secondary Care, due to service capacity issues.

<table>
<thead>
<tr>
<th>Title of Audit</th>
<th>Business Unit</th>
<th>June 2017 Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>IBD Registry</td>
<td>Medical</td>
<td>National continuous data entry to IBD Registry from February 2016. NCUH transition to IBD Registry not achieved.</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD) - Secondary Care</td>
<td>Medical</td>
<td>NCUH not registered. National continuous data collection commenced February 2017 – no plans in place for NCUH data collection.</td>
</tr>
<tr>
<td>National Vascular Registry (NVR) (Project 6284)</td>
<td>Surgical</td>
<td>Data co-ordinator left the post. Vascular nurses are covering the tasks of collecting and entering the data.</td>
</tr>
<tr>
<td>National Ophthalmology Database Audit (NOD) (Projects 6022)</td>
<td>Surgical</td>
<td>Participation from the nursing staff remains low.</td>
</tr>
<tr>
<td>National Bowel Cancer Audit (NBOCA) (Project 6282)</td>
<td>Surgical</td>
<td>The national data set has been extended and this has caused issues with the NCUH data collection process.</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA) 3rd Round (Project 6275)</td>
<td>Surgical</td>
<td>Data entry progress is slow.</td>
</tr>
<tr>
<td>National Audit of Breast Cancer in Older Patients (NABCOP) 2017 (Project 6281)</td>
<td>Surgical</td>
<td>Due to staff on leave and database malfunction, the data entry backlog is running at nine and half months behind.</td>
</tr>
<tr>
<td>National Prostate Cancer Audit (NPCA) (Project 6278)</td>
<td>Surgical</td>
<td>Issues with data collection</td>
</tr>
<tr>
<td>BAUS Urology Audits: Nephrectomy Audit. (Project 6286)</td>
<td>Surgical</td>
<td>Data entry delayed due to backlog.</td>
</tr>
</tbody>
</table>
Clinical Audit—NICE

NICE Guidance

The National Institute for Health and Care Excellence (NICE) produces a range of evidence based guidelines and quality standards, with the aim of improving standards of care for people using health and social care services.

New guidance is released on a monthly basis and is reviewed by the CD for Clinical Audit and distributed by the Clinical Audit Team to the relevant speciality for comment as to the relevance to the services provided by NCUHT.

The Trust is compliant with (72%) 378/526

Clinical Audit Plans 17/18 and NICE

The Medical and Surgical Divisional Clinical Audit Plans contain specific planned audits against NICE guidance. This table reflects those NICE audit exceptions on CAP 2017/18.

The summary form has been reviewed and is being redesigned to support the clinical teams complete the audit cycle.

The ‘abandoned’ audit is identified as an audit that was originally registered but was not started, the relevant doctor has left the Trust and there is currently a lack of capacity to undertake the audit.

<table>
<thead>
<tr>
<th>Guidance type</th>
<th>No. Published &amp; Current</th>
<th>No. Awaiting Response re Applicability</th>
<th>No. Applicable to Trust</th>
<th>% that are Fully Compliant</th>
<th>% that have been audited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Guidelines</td>
<td>157</td>
<td>17</td>
<td>95</td>
<td>(68) 72%</td>
<td>(60) 63%</td>
</tr>
<tr>
<td>Diagnostic Guidance</td>
<td>28</td>
<td>3</td>
<td>10</td>
<td>(7) 70%</td>
<td>(1) 10%</td>
</tr>
<tr>
<td>Highly Specialised Technology</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>(1) 100%</td>
<td>(1) 100%</td>
</tr>
<tr>
<td>Interventional Procedures</td>
<td>495</td>
<td>7</td>
<td>62</td>
<td>(49) 79%</td>
<td>(12) 19%</td>
</tr>
<tr>
<td>Medical Technologies</td>
<td>33</td>
<td>2</td>
<td>5</td>
<td>(4) 80%</td>
<td>(0) 0%</td>
</tr>
<tr>
<td>NICE Guidance</td>
<td>68</td>
<td>18</td>
<td>34</td>
<td>(10) 29%</td>
<td>(12) 35%</td>
</tr>
<tr>
<td>Public Health</td>
<td>55</td>
<td>1</td>
<td>14</td>
<td>(6) 43%</td>
<td>(2) 14%</td>
</tr>
<tr>
<td>Social Care</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Technology Appraisals</td>
<td>324</td>
<td>35</td>
<td>216</td>
<td>(199) 92%</td>
<td>(31) 14%</td>
</tr>
<tr>
<td>Quality Standards</td>
<td>147</td>
<td>21</td>
<td>89</td>
<td>(34) 38%</td>
<td>(43) 48%</td>
</tr>
<tr>
<td>Totals</td>
<td>1312</td>
<td>104</td>
<td>526</td>
<td>(378) 72%</td>
<td>(162) 31%</td>
</tr>
</tbody>
</table>

NICE Guidance

CG35 Parkinson’s Care Homes Study

CG74 Surgical Site Infection in NoF Patients

CG83 Compliance with rehabilitation After Critical Illness Practice on ITU WCH

CG188 Bile duct culture and sensitivity during ERCP

CG32 National Audit of Small Bowel Obstruction
CAS Alerts

### Health & Safety

#### Quarter One (April to June) Performance Summary

<table>
<thead>
<tr>
<th></th>
<th>MDA</th>
<th>ESTATES</th>
<th>ESTATES</th>
<th>DH</th>
<th>NHS PSA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Alerts Issued</td>
<td>14</td>
<td>18</td>
<td>0</td>
<td>1</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>Alerts closed within deadline</td>
<td>12</td>
<td>18</td>
<td>0</td>
<td>0</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Alerts closed beyond deadline</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

**Ongoing (previously issued)**

| Alerts open from previous quarters and within deadline | 0 | 0 | 0 | 0 | 2 | 2 |
| Alerts open from previous quarters and beyond deadline | 0 | 0 | 0 | 0 | 2 | 2 |

### Alerts OPEN and beyond deadline as at the end of Q1:

- **NHS/PSA/RE/2015/008**—Supporting the Introduction of the National Safety Standards for Invasive Procedures (NatSIPPs) This alert was issued in September 2015 and required actions to be completed by September 2016. A separate report has been provided to the Trust Board on progress with implementing this alert and the status of this being open has been approved by NHS Improvement. A monthly steering group is in place overseeing this alert.

- **NHS/PSA/2016/008** - Restricted use of open systems for injectable medication. This alert was issued in September 2016 and required actions to be completed by June 2017. Further work in radiology and endoscopy is required in relation to ‘open systems’ which are in use and potential changes to practice are being discussed with the clinical teams. A report was presented to the Safety & Quality Committee in July on this alert.
Policy Implementation

Policies

At April, May and June 2017 TPG meetings there were a total of 12 documents presented for approval:

- 4 priority 1 (P1) policies, 3 were approved and 1 was rejected
- 3 priority 2 (P2) policies, 3 were approved.
- 4 new policies, 4 were approved

There are currently 7 P1 policies and 36 P2 policies that have passed their review date. The policy register review by category continues and in this quarter a review of the nursing documents within the clinical governance section has been completed. A total of 7 of the 54 documents within this category have been proposed removal from the register.

Progress on the Policy Improvement Plan includes visits to 2 external organisations to Salford Royal in Manchester and the RVI in Newcastle. A further visit will take place with CPFT later in July. The purpose of these visits is to compare policy register and processes with a view to capturing strengths and weakness and improve our own systems. Once a full analysis has taken place, recommendations for changes will be proposed for approval by the Safety & Quality Committee.

<table>
<thead>
<tr>
<th>Policy Title</th>
<th>Exec Lead</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge and Transfer Supplement for NCUHT</td>
<td>DoN</td>
<td>04/04/2017 - The final draft of the Discharge Policy and Standard Operating Procedures have been approved at the A&amp;E Delivery Board and was presented to April TPG meeting. Requires further amendments which are awaited.</td>
</tr>
<tr>
<td>Transfer of Patients Policy (including intra and inter Transfer)</td>
<td>MD</td>
<td>19/06/2017 - Dr Barberis has issued the reviewed document to stakeholders and expects to discuss at an appropriate meeting on 11 July.</td>
</tr>
<tr>
<td>Venous Thromboembolism (VTE) Prevention and Management Policy and Procedure</td>
<td>MD</td>
<td>01/06/2017 - Dr Graham confirmed that he will be working with the Pharmacy Education &amp; Training Manager/Medication Safety Officer to re-write the document and split into policy and procedures.</td>
</tr>
<tr>
<td>Fire Safety Policy</td>
<td>DOF</td>
<td>03/07/2016 - Fire Safety Officer has confirmed that the policy document will be discussed by the Fire Safety Committee on 20 July and if the committee agree that the document is current it will be forwarded to the CEO for sign off as the interim document.</td>
</tr>
<tr>
<td>Safe identification of patients using identity bands</td>
<td>DON</td>
<td>14/06/2017 – To be removed from the register following approval at the Safety &amp; Quality Committee in July, as agreed by DON as it is a national standard and therefore is not required as a Trust policy</td>
</tr>
<tr>
<td>Health &amp; Safety Policy</td>
<td>DOF</td>
<td>08/06/2017 - Author contacted to establish timeframe for review</td>
</tr>
<tr>
<td>MRSA Prevention &amp; Management Policy</td>
<td>DIPC</td>
<td>15/06/2017 - Document is being combined with the MRSA Screening policy, draft policy has been issued to stakeholders for comment. Presentation is expected at TPG in August</td>
</tr>
</tbody>
</table>
The Trust is required to have in place a Quality Improvement Plan which sets out the priorities for the year ahead and how they will be delivered. There are principal drivers behind the QIP – namely:

- CQC findings – must do’s
- Addressing the themes arising from safety issues
- Improving patient and staff experience
- Delivering national standards

During May & June 2017 updates to content as well as Q1 delivery have been updated by Executive Directors and delivery leads. The delivery of the QIP forms a fundamental component of the ‘Trust undertakings’ issued by NHS Improvement. In addition, it will be formally reviewed by the CQC at the regular engagement meetings which will shape the CQC inspection plan for the Trust.

The QIP has five main sections, this report summarises the delivery highlights and key exceptions for the quarter across each of these areas.

- Patient Safety & Quality
- Operational Delivery & Flow
- Patient & Staff Experience
- Strategy & System
- Workforce Leadership

The Safety & Quality Committee and Clinical Executive Group have reviewed the draft Q1 delivery position during July 2017.

<table>
<thead>
<tr>
<th>Strategic Priority and BAF Link</th>
<th>Strategic Priority:</th>
<th>List below the associated risk in relation to the Strategic Priority:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Strategy and System</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Operational Flow and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Patient and Staff Experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Workforce and Leadership</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Patient Safety and Quality</td>
<td></td>
<td>This report links directly to delivering the outcomes from the CQC inspection December 2016.</td>
</tr>
</tbody>
</table>

Financial implications: None.
### Actions required by the Board:

<table>
<thead>
<tr>
<th>To approve:</th>
<th>Discussion and decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>To note:</td>
<td>Where the Board is made aware of key points but no decision required</td>
</tr>
<tr>
<td>For information:</td>
<td>For reading and consideration and for discussion by exception only</td>
</tr>
</tbody>
</table>

### Recommendation:

The Board APPROVES the Quality Improvement Plan 2017/18 - Quarter 1 delivery position.

### Data quality:

<table>
<thead>
<tr>
<th>Source:</th>
<th>Executive Directors.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Validated by:</td>
<td>N/A</td>
</tr>
<tr>
<td>Date:</td>
<td>N/A</td>
</tr>
</tbody>
</table>
1. INTRODUCTION

The Trust is required to have in place a Quality Improvement Plan which sets out the priorities for the year ahead and how they will be delivered. There are principal drivers behind the QIP – namely:

- CQC findings – must do’s
- Addressing the themes arising from safety issues
- Improving patient and staff experience
- Delivering national standards

During May & June 2017 updates to content as well as Q1 delivery have been updated by Executive Directors and delivery leads. The delivery of the QIP forms a fundamental component of the ‘Trust undertakings’ issued by NHS Improvement. In addition, it will be formally reviewed by the CQC at the regular engagement meetings which will shape the CQC inspection plan for the Trust.

The QIP has five main sections:

- Patient Safety & Quality
- Operational Delivery & Flow
- Patient & Staff Experience
- Strategy & System
- Workforce Leadership

The current position of the QIP is attached at Appendix 1. This report summarises the key exceptions for the quarter against the five work streams.
2. PATIENT SAFETY & QUALITY

2.1 Delivery highlights for quarter

- Progress continues to be made with reducing harm from pressures sores with the target being met for the quarter.
- Significant work has continued with improving DNACPR compliance which is monitored monthly. This includes the development of a dedicated ‘capacity and consent’ training module for clinical staff which will be launched in Q2.
- Progress has been made on implementation of the Nasogastric Tube Action Plan and a separate delivery report for the quarter has been produced.
- The baseline measures for sepsis have been agreed and plans are in place to support achievement.
- Significant work has also been achieved with the re-launch of NEWS across the trust. This includes a targeted campaign focused on ‘RoaRRRR’ and the five R’s (recognise, react, respond, record & reflect) which will be launched week commencing 24 July 2017. The concept of this week will be reviewed with a view to have 2/3 RoaRRRR weeks during the year dedicated to specific safety topics.
- The improvement plan to reduce harm from patient falls is in place although the targets set for reducing falls have not been achieved significant work is taking place on this across the Trust.
- The safety culture audit tool was reviewed by the Community Leadership Forum in July prior to roll out across the core services as outline in the QIP.

2.2 Items off track / further work required on detail

- Further clarity is required in quarter 2 on the deliverables for human factors this year.
- Urinary catheters has not achieved the required target for the quarter however an improvement plan is in place.
- The targets for improving De-brief compliance with the WHO checklist require clarification from the surgical division.
3. OPERATIONAL DELIVERY & FLOW

3.1 Delivery highlights for quarter

- The Trust has met its trajectory for both the A&E and 18 weeks RTT standard for the Quarter.
- Cancer performance on track for Q1, with the exception of the 62 day standard. Progress continues with the delivery of the financial plan and the control total.

3.2 Items off track / further work required on detail

- Work to clarify and improve the CIP position for the quarter has taken place, which will be progressed in Q2.

4. PATIENT AND STAFF EXPERIENCE

4.1 Delivery highlights for quarter

- Sustained performance has been demonstrated for the quarter in relation to complaints responded to within 30 days.
- Standard objectives are now included in all staff appraisals. A sample of appraisals completing in Q1 will be selected to obtain feedback from staff on their individual experiences. This will help inform further work and improvements required in Q2,3 and 4.
- Reward and recognition scheme has been launched during Q1.
- Staff engagement strategy and action plan will be launched at the Community Leadership Forum in July 2017.

4.2 Items off track / further work required on detail

- Patient cancellations not seen within 28 days has not been achieved for the quarter. The Clinical Executive Group have requested further detail on patient cancellations for both inpatients and outpatients as this links directly to a CQC must do.
- The Clinical Executive Group have requested further data analysis on patient moves after 10pm as this links directly to a CQC must do.
• The workplan for dementia has been developed and will be finalised by the end of July 2017.
• End of year performance targets for manager appraisal training and quarter 1 position to be confirmed and added to the plan by the end of July (3.2.2).
• Local FFT indicators on staff experience to be confirmed and added to the plan by the end of July 2017 (3.2.8 and 3.2.9).
• Milestones within the action plans for staff survey results referred to in 3.2.4 and 3.2.5 to be added for clarity on the specific ‘how’ and tracking delivery over the quarters.

5. STRATEGY & SYSTEM

5.1 Delivery highlights for quarter

• STP Programme Director Role in place to support delivery across the system.
• Work progressed with the SRO workstream leads.
• Shadow / joint arrangements across North, East and West Cumbria progressing.

5.2 Items off track / further work required

• Further clarity on the capability to deliver major change to be added to the QIP in Q2.

6. WORKFORCE AND LEADERSHIP

6.1 Delivery highlights for quarter

• Communication has commenced with regards to raising the profile of the health and well being strategy, the new Facebook page has been launched, with further promotion in development.
• The areas of high turnover / retention difficulties have been identified so that targeted actions can be focused in these areas.
• Overall sickness absence rate is declining.

6.2 Items off track / further work required

• Clarification on actual reduction in locum agency spends and progress on improvement of substantive recruitment to be confirmed in quarter 2.
7. **RECOMMENDATION**

The Board APPROVES the Quality Improvement Plan 2017/18 - Quarter 1 delivery position.

*Appendix 1 – QIP*
<table>
<thead>
<tr>
<th>Section</th>
<th>Priorities</th>
<th>Sub Section</th>
<th>Measures for success</th>
<th>How</th>
<th>Exec Lead</th>
<th>Delivery Lead</th>
<th>Associate Lead</th>
<th>Start Date</th>
<th>End Date</th>
<th>Status</th>
<th>Q1 RAG</th>
<th>Q2 RAG</th>
<th>Q3 RAG</th>
<th>Q4 RAG</th>
<th>End of year target (where appropriate)</th>
<th>Current Quarter Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Rod Harpin</td>
<td>Christine</td>
<td>Business Unit Directors</td>
<td>Apr 2017</td>
<td>Mar 2018</td>
<td>In progress</td>
<td>22%</td>
<td>&lt;20%</td>
<td></td>
<td></td>
<td></td>
<td>Current priorities identified for medical staff recruitment for paediatrics and recruitment is underway (July). Further work is needed to track vacancies with agency spend so that this can be reported to CEG as part of the monthly workforce data.</td>
</tr>
<tr>
<td>5.1.1</td>
<td></td>
<td></td>
<td>Reduce medical staffing vacancy rate to 22%</td>
<td>A recruitment strategy &quot;across system&quot; is being produced this will focus on hard to fill to post and concentrate on the outcomes of the public consultation exercise. Targeted action plan identifying all medical vacancies within the business units will be produced. Vacancies will be tracked monthly to ensure that vacancies are being advertised. Monthly figures to be produced to track progress</td>
<td>Rod Harpin</td>
<td>Christine</td>
<td>Business Unit Directors</td>
<td>Apr 2017</td>
<td>Mar 2018</td>
<td>In progress</td>
<td>22%</td>
<td>&lt;20%</td>
<td></td>
<td></td>
<td></td>
<td>Nursing vacancies out to advert. Attendance at a number of job fairs in Cardiff, Cork and Edinburgh have taken place. Currently considering targeted reward and recognition schemes to encourage nurses to join the trust. Interest has been registered for attendance at international job fairs.</td>
</tr>
<tr>
<td>5.1.3</td>
<td></td>
<td></td>
<td>Reduce nursing vacancy rate to 5% or lower</td>
<td>Development of a nursing recruitment plan to include local, regional, national and international recruitment campaigns. Work across &quot;the system&quot; to identify opportunities for career pathways and to pool resources. Targeted attraction strategy which includes job fairs and advertising and nursing recruitment days.</td>
<td>Maurya Cushlow</td>
<td>Christine</td>
<td>Anna Stabler</td>
<td>Apr 2017</td>
<td>Mar 2018</td>
<td>In progress</td>
<td>13%</td>
<td>&lt;5%</td>
<td></td>
<td></td>
<td></td>
<td>Some evidence (via exit questionnaire and staff survey) that nurses want to work more flexible (especially if close to retirement age) as hours are incompatible with family life and so flexibility of hours may assist with the retention drive of this staff group. Further targeted work needs to be undertaken.</td>
</tr>
<tr>
<td>5.1.3</td>
<td></td>
<td></td>
<td>Identify areas of high turnover / retention difficulties and where necessary, implement solutions to help retain staff.</td>
<td>Recruitment Strategy is being produced. This will focus on identifying high levels of turnover so that specific and targeted actions can be put in place.</td>
<td>Christine</td>
<td>Jason Emerson</td>
<td>Business Unit Directors / Richard Heaton</td>
<td>Apr 2017</td>
<td>Mar 2018</td>
<td>In progress</td>
<td>N/A</td>
<td></td>
<td>A Gap analysis has been undertaken to all wards which has identified hotspot areas as follow: Medical Division: EAU CIC Beech B Elm A Elm B Elm C Willow B Willow C / CCIU Ward 3 Surgical Division: Aspen Maple C Maple B/D</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section</td>
<td>Priorities</td>
<td>Sub Section</td>
<td>Measures for success</td>
<td>How</td>
<td>Exec Lead</td>
<td>Delivery Lead</td>
<td>Associate Lead</td>
<td>Start Date</td>
<td>End Date</td>
<td>Status</td>
<td>Q1 RAG</td>
<td>Q2 RAG</td>
<td>Q3 RAG</td>
<td>Q4 RAG</td>
<td>End of year target (where appropriate)</td>
<td>Current Quarter Exceptions</td>
</tr>
<tr>
<td>---------</td>
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<td>----------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>5.1.4</td>
<td></td>
<td></td>
<td>Reduce locum reliance and financial spend against 2016/17 baseline</td>
<td>Continue to work against the Trust plan to reduce overall agency spend against the 2016/2017 baseline to support the Trust’s CIP programme, reduce agency spend and improve substantive recruitment. Track progress of agency usage against advertising vacancies via monthly scrutiny at CEG.</td>
<td>Rod Harpin</td>
<td>Christine Brereton</td>
<td>Amanda Dunkley</td>
<td>Apr 2017</td>
<td>Mar 2018</td>
<td>In progress</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>To be added in Q2</td>
<td>Central agency team now fully established. KPI in place. Recruitment activity will be aligned against locum use and will be monitored monthly at CEG. New processes and systems are embedded and the Trust receives best VFM available through component break down of rates and commissions through negotiation. The next stage of savings in this area will need to be generated from tackling agency over-reliance, lack of traction on substantive recruitment and inefficient rota. The Agency Team is linking locum use to NHS recruitment activity (or lack of) and highlighting this to departments. In addition a new direct engagement provider is being tendered with the anticipation that further savings can be generated by negotiating a better commercial deal. A medical staffing bank is also being scoped.</td>
</tr>
<tr>
<td>5.2</td>
<td></td>
<td></td>
<td>Develop clinical leadership</td>
<td>Undertake a baseline assessment</td>
<td>Rod Harpin</td>
<td>Jayne Edwards</td>
<td>Sep 2017</td>
<td>Dec 2017</td>
<td>Not started</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Paper to be scoped out and then considered by CEG in August, for roll out from September if approved.</td>
<td></td>
</tr>
<tr>
<td>5.3</td>
<td></td>
<td></td>
<td>Develop middle manager skills</td>
<td>Development of a training package for middle managers on key role competencies such as governance; people; finance and leadership.</td>
<td>Christine Brereton</td>
<td>Jason Emerson</td>
<td>Jayne Edwards</td>
<td>Jean Hill</td>
<td>Sep 2017</td>
<td>Mar 2018</td>
<td>Not started</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>5.4.1</td>
<td></td>
<td></td>
<td>Reduce overall sickness absence to 4%</td>
<td>Sickness absence plan in place targeted at long and short term. This will be monitored on a monthly basis at senior management team. A new sickness policy has now been approved and training will be rolled out in June. Sickness performance to be monitored monthly via CEG and the Board.</td>
<td>Christine Brereton</td>
<td>Jason Emerson</td>
<td>Christine Lightfoot / Isla Edgar</td>
<td>Apr 2017</td>
<td>Mar 2018</td>
<td>In progress</td>
<td>4.89%</td>
<td>&lt;4%</td>
<td>&lt;4%</td>
<td>&lt;4%</td>
<td>N/A</td>
<td>Sickness has declined from January 2017. Sickness Absence policy now approved and training is underway. This has received good feedback. Sickness absence performance has been monitored monthly at CEG and Board</td>
</tr>
<tr>
<td>5.4.2</td>
<td></td>
<td></td>
<td>Reduce short term sickness rate to 1.5%</td>
<td>Sickness absence plan in place targeted at long and short term. This will be monitored on a monthly basis at senior management team. A new sickness policy has now been approved and training will be rolled out in June. Sickness performance to be monitored monthly via CEG and the Board.</td>
<td>Christine Brereton</td>
<td>Jason Emerson</td>
<td>Christine Lightfoot / Isla Edgar</td>
<td>Apr 2017</td>
<td>Mar 2018</td>
<td>In progress</td>
<td>1.41%</td>
<td>&lt;1.5%</td>
<td>&lt;1.5%</td>
<td>&lt;1.5%</td>
<td>N/A</td>
<td>Sickness has declined from January 2017. Sickness Absence policy now approved and training is underway. This has received good feedback. Sickness absence performance has been monitored monthly at CEG and Board</td>
</tr>
<tr>
<td>5.4.3</td>
<td></td>
<td></td>
<td>Achieve flu vaccinations for 2017</td>
<td>Flu Startegy in place for 2017/18 campaign - COUN target of 70% frontline staff vaccinated by the end of December 2017. Plan includes - Communication. Training, Delivery of Vaccination. Staff incentives. Auditing of figures.</td>
<td>Christine Brereton</td>
<td>Pauline Speight</td>
<td>Sep 2017</td>
<td>Dec 2017</td>
<td>In progress</td>
<td>70%</td>
<td>70%</td>
<td>70%</td>
<td>70%</td>
<td>N/A</td>
<td>Vaccines ordered. Appropriate training identified. Flu incentives agreed. Promotional material ordered. Clinic calender agreed. Comms plan to be further developed in time for roll out.</td>
<td></td>
</tr>
</tbody>
</table>
### Section 5.3: Health and Wellbeing

#### Sub Section 5.4.4: Raise the profile of the health and wellbeing strategy through management and leadership teams

<table>
<thead>
<tr>
<th>How</th>
<th>Exec Lead</th>
<th>Delivery Lead</th>
<th>Associate Lead</th>
<th>Start Date</th>
<th>End Date</th>
<th>Status</th>
<th>Q1 RAG</th>
<th>Q2 RAG</th>
<th>Q3 RAG</th>
<th>Q4 RAG</th>
<th>End of year target (where appropriate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Wellbeing Strategy and Plan 2017/2018 to be produced in line with staff survey 2016 outcomes and CQUINN requirements. Specific actions to include: • Initiate a series of communications with staff linked to the results of the staff 2016 staff survey • Attendance at divisional meetings • Development of a health and wellbeing (H&amp;W) social media page • Utilise the CEO's blog to raise the profile of the Trust's H&amp;W initiatives • Development of the Trust's H&amp;W intranet page to include information on topics identified as part of the health needs assessment for the 'Better Health at Work Award'.</td>
<td>Christine Brereton</td>
<td>Pauline Speight</td>
<td>Health and Wellbeing Co-ordinator</td>
<td>Apr 2017</td>
<td>Mar 2018</td>
<td>In progress</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

- "New Facebook page launched – information and link in newsletter. A communications plan to support all health campaigns and promotion of them is currently being finalised (end July 2017)."
- Staff health event planning underway for September dates on campaign log.
- Identifying areas of collaborative working with CPFT. Health Check promotion via Executive team commenced.
Report to a Meeting of the Trust Board of Directors held in Public

<table>
<thead>
<tr>
<th>Date of Meeting:</th>
<th>25 July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enclosure Number:</td>
<td>4</td>
</tr>
<tr>
<td>Title of Report:</td>
<td>Nurse Staffing Assurance</td>
</tr>
<tr>
<td>Author:</td>
<td>Anna Stabler, Deputy Director Nursing, Midwifery &amp; AHP</td>
</tr>
<tr>
<td>Executive Lead:</td>
<td>Maurya Cushlow, Executive Director of Nursing</td>
</tr>
<tr>
<td>Responsible Sub-Committee (if appropriate):</td>
<td>Safety &amp; Quality Committee (paper received on 11/7/2017)</td>
</tr>
<tr>
<td>Executive Summary:</td>
<td>This regular bi-monthly assurance report to the Trust Board and presents staffing data for April and May 2017 as a whole, and analysed to individual ward level. The report also provides the Board with the Care Hours per Patient Day (CHPPD) and the trend from month to month. The data for CHPPD can be found as part of the Dashboards in Appendix 1 and 2 of this report. The report adheres to the recommendations set out by the National Quality Board (NQB): How to ensure the right people, with the right skills, are in the right place at the right time. It provides a bi-monthly detailed retrospective data analysis on a shift by shift basis of the planned and actual staffing levels across our inpatient wards within North Cumbria University Hospital Trust, and is inclusive of Registered Nurses (RN) and Health Care Assistants (HCA). North Cumbria University Hospital Trust is committed to developing a nursing workforce which is efficient and sufficiently resilient to deliver high quality, safe and effective care. This report as with previous reports includes data for patient harms taken from the overarching Heat Map and data from the monthly collection of patient harms as part of the Safety Thermometer. Staffing our wards safely has continued to be challenging and is achieved in no small part due to the efforts of the nursing teams and the matrons who proactively monitor, respond and manage risk on a daily basis. The table below denotes the wards were the qualified nurse staff fill rate was at 80% or below.</td>
</tr>
<tr>
<td>Strategic Priority and BAF Link:</td>
<td>Strategic Priority:</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td></td>
<td>List below the associated risk in relation to the Strategic Priority:</td>
</tr>
<tr>
<td></td>
<td>1. Building a Platform for Better care</td>
</tr>
<tr>
<td></td>
<td>2. Meet all Standards</td>
</tr>
<tr>
<td></td>
<td>3. Create a Good Workforce</td>
</tr>
<tr>
<td></td>
<td>3.2 The Trust is unable to recruit and retain nursing staff in order to ensure safe staffing levels are consistently achieved across all wards and departments.</td>
</tr>
<tr>
<td></td>
<td>4. Achieve Financial Stability</td>
</tr>
<tr>
<td></td>
<td>5. Improve Safety &amp; Quality</td>
</tr>
<tr>
<td>Financial implications:</td>
<td>Yes – Increased costs for staff overtime and bank to cover rotas. Agency nursing which is frequently now being presented above cap when all other avenues have been explored and exhausted</td>
</tr>
<tr>
<td>Actions required by the COMITTEE:</td>
<td>To approve: Discussion and decision</td>
</tr>
<tr>
<td></td>
<td>To note: Where the Board is made aware of key points but no decision required</td>
</tr>
<tr>
<td></td>
<td>For information: For reading and consideration and for discussion by exception only</td>
</tr>
<tr>
<td></td>
<td>The board are requested to RECEIVE the Nurse Staffing Assurance report to note and consider the level of assurance and mitigation to discuss, confirm and clarify what additional assurance may be required by the Board to provide assurance.</td>
</tr>
<tr>
<td>Data quality:</td>
<td>Source: Arthur Lamb, Information Administrator Mike Stacy, Clinical Governance</td>
</tr>
<tr>
<td></td>
<td>Validated by: Anna Stabler, Deputy Director of Nursing, Midwifery &amp; AHP</td>
</tr>
<tr>
<td></td>
<td>Date: 1/7/2017</td>
</tr>
</tbody>
</table>
1. BACKGROUND

1.1 The report adheres to the recommendations set out by the National Quality Board (NQB): How to ensure the right people, with the right skills, are in the right place at the right time. It provides a bi-monthly detailed retrospective data analysis on a shift by shift basis of the planned and actual staffing levels across all inpatient wards within North Cumbria University Hospital Trust, is inclusive of Registered Nurses (RN) and Health Care Assistants (HCA). In addition the report also provides the board with the Care Hours per Patient Day (CHPPD) this is to provide a single consistent way of recording of reporting the deployment of staff working across our wards as required by Lord Card Cole from May 2016. The data for CHPPD can be found as part of the Dashboards in Appendix 1 and 2 of this report.

1.2 North Cumbria University Hospital Trust is committed to developing a nursing workforce which is efficient and sufficiently resilient to deliver high quality, safe and effective care. This report as with previous reports includes data for patient harms taken from the overarching Heat Map and data from the monthly collection of patient harms as part of the Safety Thermometer.

2. OVERALL STAFFING FILL RATES

2.1 The purpose of the Safe Staffing report is to provide a summary at a glance; a rag rated staffing analysis with associated quality indicators. The staffing data provides an overview of planned hours, actual hours by grade throughout April 2017 (Appendix 1) and May 2017 (Appendix 2) and the % fill rate (as per national staffing return).

2.2 The wards highlighted Green, are within agreed tolerances of 80% and above.

2.3 Overall key concerns are areas where the fill rate has fallen below 80% (highlighted red on the report) and understanding the impact on patient care.

2.4 Please note that all the pressure ulcers included within the report are hospital acquired pressure ulcers.
2.5 During the months of April and May 2017 significant challenges in delivering and maintaining safe staffing across all our wards and departments has continued, due to vacancies, sickness and maternity leave. In addition there has continued to be significant pressure across the health economy with an increased demand for hospital beds. This has resulted in the requirement to open additional beds to increase capacity, putting further pressure on nurse staffing. In April 2017 across the Trust a total of 346 escalation beds were open (283 CIC & 63 WCH), in May 341 escalation beds were opened (213 CIC & 128 WCH); full details by ward can be found in Appendix 3.

2.6 The overall Trust staffing fill rates per site for April / May 2017 are presented in Table 1 below:

Table 1: Whole Trust Ward Staffing

<table>
<thead>
<tr>
<th>Day</th>
<th>Day</th>
<th>Night</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average fill rate – registered nurses/midwives (%)</td>
<td>Average fill rate – care staff (%)</td>
<td>Average fill rate – registered nurses/midwives (%)</td>
<td>Average fill rate – care staff (%)</td>
</tr>
<tr>
<td>April</td>
<td>May</td>
<td>April</td>
<td>May</td>
</tr>
<tr>
<td>85.95</td>
<td>88.8</td>
<td>102.35</td>
<td>99.2</td>
</tr>
</tbody>
</table>

2.7 The Trust Staffing fill rates masks some variation across wards; table 2 below denotes the wards were there have been significant challenges and that have an overall fill rate below the 80% Trust threshold.

3 APRIL / MAY EXCEPTIONS

3.1 There continues to be significant challenges to deliver and maintain a registered nurse fill rate of above 80% across some wards. Detailed below are the wards that are have been closely monitored by the senior nursing leadership team where the fill rate has not been achieved; mitigating actions are detailed in section 3.2. The monitoring process has and continues to involve daily oversight of staffing by the Matrons and escalation as per the policy. Significant areas of staffing concern are discussed at the weekly Senior Nurse Meeting.

Table 2: Wards with Registered Nurse fill rates less than 80%

<table>
<thead>
<tr>
<th>CIC</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Beech B</td>
<td>Beech B</td>
<td></td>
</tr>
<tr>
<td>Elm A, B, C</td>
<td>Larch A,B</td>
<td></td>
</tr>
<tr>
<td>Maple A</td>
<td>Elm A, B, C</td>
<td></td>
</tr>
<tr>
<td>Maple B, C, D</td>
<td>Maple A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maple B, C, D</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WCH</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CCU</td>
<td>CCU</td>
</tr>
</tbody>
</table>
The vacancy, sickness and maternity absence rates all impact on a ward’s / Service ability to deliver fill rates greater than 80%. Vacancies are noted to be high across the medical business unit and Maple floor.

4 Utilisation of Safe Care Acuity data & Care Hours Per Patient Day (CHPPD)

4.1 The Matrons have started using the data provided through the SAFE Care Nursing Tool (SCNT) data (a module of eRoster which gives wards the ability to enter the acuity data and dependency of each of their patients at 7am and 7pm) when determining staff moves to support safe staffing. Initially the data is reviewed at the Morning huddle and revisited throughout the day by the allocated Matron as staffing challenges arise, to inform the movement of both registered and support workers. Although this information is not required as part of the CHPPD data set, it provides important patient acuity detail to the information to determine whether or not there are enough CHPPD and registered: non-registered skill mix to meet the needs of patients on each ward and on each shift.

4.2 Full details of CHPPD by ward across both CIC and WCH for October and November can be found in Appendix 1 and 2 within the dashboard.

4.3 Detailed below are the CHPPD graphs for the wards noted in Table 2 where fill rates are reported below 80%. The graphs details:

- Demand; i.e. staffing planned in the budget by hours in any 24 hour period (Green Line)
- Required based on acuity and dependency entered twice per day (Blue Line)
- Actual i.e. what was actually worked (Green / yellow/ red columns)

Where the staffing levels fall below what is required based upon the actual staffing and patient acuity, matrons review and move staff to ensure patient safety; more detailed mitigating action are in section 5 of the report.

4.5 The time frame detailed in the graphs covers the period of the 1st April - 31st May 2017 or the individual month where the ward has fallen below the agreed tolerance.
Beech B is reported as an area of exception for April and May as the fill rate on duty for registered nurses is between 65-67% on days and nights which is below the 80% threshold. The graph of CHPPD for the similar timeframe demonstrates that during the period the required CHPPD was below both the planned level and that the ward required.

Elm A is reported as an area of exception for April and May as the fill rate on duty for registered nurses on both days and nights is between 58-78% which is below the 80% threshold. The graph of CHPPD for the similar timeframe demonstrates that during the period the required CHPPD was below both the planned level and that required, on 18 days when patient acuity was considered however there were 7 occasions where staffing was deemed to be over what was required for based upon patient acuity.
ELM B

Elm B is reported as an area of exception for April and May as the fill rate on duty for registered nurses is between 49-65% on both days and nights which is below the 80% threshold. The graph of CHPPD for the similar timeframe demonstrates that during the period the required CHPPD was below both the planned level and that required, on 41 days when patient acuity was considered however there were 7 occasions were staffing was deemed to be over what was required for based upon patient acuity.

Elm C

Elm C is reported as an area of exception for April and May as the fill rate on duty for registered nurses was 71% on both days and nights which is below the 80% threshold. The graph of CHPPD for the similar timeframe demonstrates that during the period the required CHPPD was below both
the planned level and that required, on all but 1 days when patient acuity was considered.

**Larch AB**

Larch AB is reported as an area of exception for May as the fill rate on duty for registered nurses was 79% on days which is below the 80% threshold. The graph of CHPPD for the similar timeframe demonstrates that during the period the required CHPPD was below both the planned level and that required, on all but 4 days when patient acuity was considered.

**Maple A**

Maple A is reported as an area of exception for April and May as the fill rate on duty for registered nurses is between 69-76% on day shift which is below the 80% threshold. In addition on nights in April the qualified nurse staffing is 126% this accounts for the additional nursing resource deployed to open escalation beds. The graph of CHPPD for the similar timeframe
demonstrates that during the period the required CHPPD was below both the planned level and that required, with the exception of 9 days when patient acuity was considered.

**Maple B/C/D**

Maple B,C,D is reported as an area of exception for April and May as the fill rate on duty for registered nurses is between 66-69% on day shift which is below the 80% threshold. The graph of CHPPD for the similar timeframe demonstrates that during the period the required CHPPD was below both the planned level and that required, when patient acuity was considered with the exception of 4 days in the month.

**WCH CCU**

WCH CCU is reported as an area of exception for April and May as the fill rate on duty for registered nurses is between 77-79% which is below the 80% threshold. The graph of CHPPD for the similar timeframe
demonstrates that during the period the required CHPPD was below the planned level on 28 days, when patient acuity was considered.

**WCH ICU**

![Graph of CHPPD for WCH ICU]

WCH ICU is reported as an area of exception for April and May as the fill rate on duty for registered nurses on both days and nights is between 66-77% which is below the 80% threshold. The graph of CHPPD for the similar timeframe demonstrates that during the period the required CHPPD was below the planned level but met the levels that were required, when patient acuity was considered.

**WCH EAU**

![Graph of CHPPD for WCH EAU]

WCH EAU is reported as an area of exception for April and May as the fill rate on duty for registered nurses is between 63-77% on night shift which is below the 80% threshold. The graph of CHPPD for the similar timeframe
demonstrates that during the period the required CHPPD was below both the planned level and that required, when patient acuity was considered with the exception of 16 days. There were days were staff was above the required level based upon patient acuity.

5. **Mitigating Actions**

5.1 To provide continued assurance re safe staffing on our wards, the ward manager submits a weekly staffing report to their Matron; this includes both retrospective and prospective staffing data including nurse sensitive indicators. These reports are reviewed by Chief Matrons and areas of concern are escalated through to the business unit and to the weekly Senior Nurse meeting. In addition within the Business units the Chief Matron and the senior team review vacancies, sickness, maternity leave, red flag shifts, nurse staffing level incident reports and patient safety incidents, investigating incidents and sharing learning across the business unit.

5.2 To mitigate the staffing risks across the Trust the following actions have been instigated:

- Ward areas working as a floor to ensure safe staffing and redeploying staff when necessary. This practice is under review following the concern raised by the CQC following their inspection in December 2016; a paper will be presented to the Clinical Executive group during July on the proposed changes.
- Additional Health Care assistants being utilised where there are registered nurse gaps that cannot be filled.
- Patient acuity has been reviewed by the Matron’s and where appropriate staffing adjusted to support the safe delivery of care. For example Larch D has worked with two qualified nurses rather than 3, due to reduced patient acuity and the redirection of patients to the Chemotherapy day unit in Reiver house. Elm B Stroke and Neuro rehabilitation ward and Maple BCD pavilion have worked as a floor.
- Staff; have been redeployed from areas such as Theatre, ITU, and CCO when the beds and patient acuity permits. Matrons continue to work clinically on the wards.
- Additional Agency Nurses have been employed in the Trust to support the opening of escalation beds on Larch A/B/ D, Maple A, Willow A, Elm B Neuro.
- Agency Operating Department Assistants have been employed to support the delivery of surgery.

6. **NHS PATIENT SAFETY THERMOMETER**

6.1 The NHS Patient Safety Thermometer is used across all relevant acute wards. This tool looks at point prevalence of four key harms (falls, pressure ulcers, urinary tract infections and deep vein thrombosis (DVT) and pulmonary embolism (PE)) in all patients on a specific day in the month.
6.2 The harm-free care score for the Trust in April 90.89% was 92.91%; in May. These scores reflect the inclusion of all patient harms in the hospital, community and the patient’s own home. The Harm Free score that details the score of patients that have received harm free care whilst in hospital was 97% in respectively in April and May.

7 WORKFORCE DEVELOPMENT AND RECRUITMENT UPDATE

7.1 Attendance Recruitment event in Cardiff

The Trust has attended a recruitment event in Cardiff in May; two nurses were recruited to on the day and are now going through the necessary checks. In addition a number of AHP’s also enquired about joining the Trust. All leads have been followed up by HR Recruitment lead Amanda Dunkley. A team will be attending a further day in Cork on 17th June 2017 and will again offer interviews on the day.

7.2 Visit to UHMBT

UHMBT have hosted staff from out Trust at their bespoke nurse recruitment day, where they observed the process on the 26th June. The recruitment and nursing team are looking to replicate this model and deliver a recruitment day on the CIC site July / August.

7.3 Cadet Interviews

The Trust have again this year worked with our local colleges to continue the popular cadet scheme in the Trust, part of the Trusts ambition to grow our own nurse. Twenty one candidates have accepted places with the college in September 2017 and will join the Trust for their clinical experience.

7.4 Pilot to enter patient acuity via Realtime

During April and May the E-Roster team have ran a pilot where nursing staff entered patient acuity via Realtime the electronic patient record. The four wards were Aspen, Willow B, Ward 1 and ward 3. The pilot evaluated well and all areas advised that it was easier to comply with the entry of acuity; the negative was that red flags still needed to be entered via the SafeCare screen. It was agreed at the E-Roster user group that the facility to enter acuity via Realtime would be rolled out to all inpatient areas and training is planned for July and August.

7.5 Recruitment and Leavers

The Trust continues to actively recruit to vacant posts; there is an advert for the medical business unit that runs continually on NHS jobs with Charge Nurse Harrow interviewing applicants as they apply.
During the months of April and May 2017, 9.11 whole time equivalent (wte) new substantive qualified nursing posts have commenced in post. Table 4 below denotes by headcount and WTE band, hospital and business unit where the nurses are now working.

Table 4:

<table>
<thead>
<tr>
<th>RGN Starters - 01/04/2017 to 31/05/2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Band 5 Headcount</td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>Band 5 FTE</td>
</tr>
<tr>
<td>Band 6 Headcount</td>
</tr>
<tr>
<td>Band 6 FTE</td>
</tr>
<tr>
<td>Band 7 Headcount</td>
</tr>
<tr>
<td>Band 7 FTE</td>
</tr>
</tbody>
</table>

Overall Headcount | Overall FTE | 15 | 9.11 |

7.6 In April and May 2017 17.77 wte qualified nurses left the Trust, Table 5 denotes the leavers by headcount and WTE, in addition to band, business unit and hospital where the nurses had worked.

Table 5:

<table>
<thead>
<tr>
<th>RGN LEAVERS - 01/04/2017 to 31/05/2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Band 5 Headcount</td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>Band 5 FTE</td>
</tr>
<tr>
<td>Band 6 Headcount</td>
</tr>
<tr>
<td>Band 6 FTE</td>
</tr>
<tr>
<td>Band 7 Headcount</td>
</tr>
<tr>
<td>Band 7 FTE</td>
</tr>
</tbody>
</table>

Overall Headcount | Overall FTE | 25 | 17.77 |

7.7 The net result of the leavers leaves the trust with a deficit of 6.59 wte qualified nursing posts. The overall vacancy rate on the ledger as at the 31st May was 114.07 wte; when compared to 31st March 2017 where we 46.05 wte vacant posts, the vacancies have increased by 68.02 wte. The majority of the vacancies are across the medical division 88.05wte with only 26.02wte in the Division of Surgery.

7.8 The board is asked to note that the substantial increases in the vacancy figures are directly attributable to the agreement at board in November 2016 to increase the uplift to 22%.

8. AREAS OF RISK

8.1 The areas that are of risk are detailed in Table 2; all are receiving additional support and input from the Matrons and Chief Matrons.

9. CONCLUSION

9.1 During April and May 2017, delivering safe staffing has continued to be challenging due to vacancies, sickness and maternity leave; compounded increased pressure across the health economy. To
support the activity there has been a requirement to open additional beds to meet winter demand. Table 2 details the wards identified as requiring close monitoring by the Chief Matrons and Matrons, to support and help Ward Managers to deliver improvements.

10. RECOMMENDATIONS

10.1 The board are requested to RECEIVE the Nurse Staffing Assurance report to note and consider the level of assurance and mitigation to discuss, confirm and clarify what additional assurance may be required to the Board to provide assurance.

Anna Stabler
Deputy Director of Nursing, Midwifery & AHP

Maurya Cushlow
Executive Director of Nursing & Midwifery
Appendix 1 -

Monthly Safer Staffing Dashboard ‐ April 2017
Site Division

CIC

WCH

Surgical
Medical
Surgical
Surgical
Surgical
Paediatrics
Medical
Medical
Medical
Medical
Surgical
Medical
Medical
Surgical
Surgical
Surgical
Paediatrics
Medical
Medical
Medical
Medical
Paediatrics
Medical
Medical
Surgical
Paediatrics
Surgical
Medical
Medical
Medical

Specialty

Ward

100 ‐ GENERAL SURGERY
301 ‐ GASTROENTEROLOGY
100 ‐ GENERAL SURGERY
100 ‐ GENERAL SURGERY
100 ‐ GENERAL SURGERY
420 ‐ PAEDIATRICS
300 ‐ GENERAL MEDICINE
430 ‐ GERIATRIC MEDICINE
314 ‐ REHABILITATION
320 ‐ CARDIOLOGY
192 ‐ CRITICAL CARE MEDICINE
300 ‐ GENERAL MEDICINE
823 ‐ HAEMATOLOGY
100 ‐ GENERAL SURGERY
110 ‐ T&O
501 ‐ OBSTETRICS
420 ‐ PAEDIATRICS
430 ‐ GERIATRIC MEDICINE
361 ‐ NEPHROLOGY
320 ‐ CARDIOLOGY
320 ‐ CARDIOLOGY
420 ‐ PAEDIATRICS
300 ‐ GENERAL MEDICINE
192 ‐ CRITICAL CARE MEDICINE
501 ‐ OBSTETRICS
420 ‐ PAEDIATRICS
100 ‐ GENERAL SURGERY
300 ‐ GENERAL MEDICINE
314 ‐ REHABILITATION
430 ‐ GERIATRIC MEDICINE

ASPEN
BEECH A
BEECH B
BEECH C
BEECH D
CHILDRENS CIC
ELM A
ELM B
ELM C
HEART CENTRE
ITU CIC
LARCH A/B
LARCH D
MAPLE A
MAPLE B/C/D
MATERNITY CIC
SCBU CIC
WILLOW A
WILLOW B
WILLOW C/CU
CCU WCH
CHILDRENS WCH
EAU WCH
ICU WCH
MATERNITY WCH
SCBU WCH
WARD 1
WARD 2
WARD 3
WARD 4

Day
Planned Actual Planned Actual
Care
Nurse Nurse Care
Staff Worker Worker
staff
854
748
720
811
721
697
735
745
1227
818
1105
1167
1074
1063
554
557
1080
952
932
919
1510
1483
510
507
890
698
719
789
3768
1844 4104
3095
957
678
792
878
1856
1536 1046
387
2984
2692
360
306
1932
1563 1593
1516
1088
984
540
543
1144
793
699
878
3096
2252 2521
2568
2680
2479
739
647
695
887
360
353
1210
1044 1012
1281
1082
962
540
899
2379
2051
720
726
1073
824
540
650
1252
1204
441
404
1799
1558 1605
1644
2160
1599
360
253
2058
2221
792
861
622
828
198
269
1876
1660 1441
1473
1421
1254 1434
1688
750
725
1281
1226
1503
1258 1445
1864

% RN
88%
97%
67%
99%
88%
98%
78%
49%
71%
83%
90%
81%
90%
69%
73%
93%
128%
86%
89%
86%
77%
96%
87%
74%
108%
133%
89%
88%
97%
84%

46738.0 39353.6 29832.3 29898.2 84%

Planned
% CSW Nurse
Staff
113%
708
101%
716
106% 1080
101%
720
99%
720
99%
750
110%
696
75%
2202
111%
720
37%
720
85%
2880
95%
1440
100% 1080
126%
648
102% 2160
88%
2512
98%
681
127%
690
166%
720
101% 2160
120% 1075
92%
561
102% 1590
70%
2124
109% 1800
136%
720
102% 1080
118% 1068
96%
720
129%
720
100%

Actual
Nurse
Staff
720
663
725
720
720
750
508
1234
540
720
2507
1434
902
817
1819
2284
721
702
720
1788
902
612
1226
1508
1750
719
1019
1062
690
736

Night
Planned Actual
Care
Care
Worker Worker
360
336
360
346
360
571
360
360
684
552
360
360
352
316
2225
1770
360
348
0
0
0
48
720
711
360
361
336
337
1788
1747
720
480
0
0
345
553
360
348
360
360
0
114
281
234
720
810
0
170
718
660
0
0
1440
1298
1068
1140
359
366
1080
1091

35460.6 31214.2 16074.5 15782.0

% RN

% CSW

102%
93%
67%
100%
100%
100%
73%
56%
75%
100%
87%
100%
83%
126%
84%
91%
106%
102%
100%
83%
84%
109%
77%
71%
97%
100%
94%
99%
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102%

93%
96%
158%
100%
81%
100%
90%
80%
97%
#DIV/0!
#DIV/0!
99%
100%
100%
98%
67%
#DIV/0!
160%
97%
100%
#DIV/0!
83%
112%
#DIV/0!
92%
#DIV/0!
90%
107%
102%
101%

88%

98%

Care Hours Per Patient Day
Grade 2 Grade 3 Grade 4
Falls
Pressure
Serious Medication Complaints
Registered
Pressure Pressure Pressure
MRSA
(Major
Care
Ulcers
Incidents Errors
Formal
Overall
midwives /
Ulcers Ulcers Ulcers
Falls)
Staff
nurses
3.5
2.7
6.3
0
0
0
0
0
0
0
1
0
3.4
2.7
6.1
0
0
0
0
0
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0
0
0
2.4
2.7
5.1
0
3
2
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1
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3.3
1.7
5.0
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3.0
2.6
5.6
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2
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9.9
3.9
13.8
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3.5
3.2
6.6
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2.7
4.3
7.0
0
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0
1
1
2
0
3.5
3.6
7.1
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2
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2
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7.8
1.3
9.1
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27.4
1.9
29.2
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6.1
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16.5
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6.1
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3.4
5.7
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3
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0
7.4

3.0

10.4

0

28

13

1

0

3

21

8

0

C.diff

Sickness
and
absence

0
0
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1
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1
0
0

16.49%
2.28%
6.71%
6.60%
8.31%
0.31%
8.32%
7.12%
17.75%
0.56%
3.62%
4.36%
5.84%
6.48%
5.31%
4.13%
0.28%
8.16%
3.22%
2.50%
2.74%
1.10%
2.30%
14.76%
4.36%
3.33%
7.27%
11.21%
10.08%
13.29%

2

6.29%

Key
No Care worker Planned
Staffing Below 80%
Staffing >= 80%

15


## Appendix 2

### Monthly Safer Staffing Dashboard - May 2017

<table>
<thead>
<tr>
<th>Site</th>
<th>Division</th>
<th>Specialty</th>
<th>Ward</th>
<th>Planned Nurse staff</th>
<th>Actual Nurse Staff</th>
<th>Planned Care Worker</th>
<th>Actual Care Worker</th>
<th>% RN</th>
<th>% CSS</th>
<th>Planned Nurse staff</th>
<th>Actual Nurse Staff</th>
<th>Planned Care Worker</th>
<th>Actual Care Worker</th>
<th>% RN</th>
<th>% CSS</th>
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<td>Surgical</td>
<td>Gastroenterology</td>
<td>BEECH A</td>
<td>760</td>
<td>737</td>
<td>768</td>
<td>729</td>
<td>94%</td>
<td>95%</td>
<td>760</td>
<td>737</td>
<td>768</td>
<td>729</td>
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<td>95%</td>
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<td>BEECH B</td>
<td>2449</td>
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<td>2</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Key**
- No Care worker
- Planned Staffing Below 80% Staffing <= 80%
## Appendix 3 Escalation Beds in Use by Ward at CIC & WCH in April & May 2017

### April 2017

<table>
<thead>
<tr>
<th>Date</th>
<th>EAU</th>
<th>WA</th>
<th>WB</th>
<th>EB</th>
<th>MA</th>
<th>MB/D</th>
<th>LD</th>
<th>3B</th>
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* denotes cyber attack no data available
# Executive Summary:

This report summarises the current position on strategic risks set out on the Board Assurance Framework (BAF) and highest scoring operational risks as at 19 July 2017. The report also updates the Board on a full review of the Trust wide risk register which has been completed.

**Exceptions to note:**

**BAF:**

- No new risks or changes to scores have been made to the BAF by the Executive Directors.
- Some updates have been made to specific risks which are summarised in section 2.1.5 of this report.

**Corporate Risk Register:**

The Clinical Executive Group (CEG) reviewed the Corporate Risk Register on 19 July 2017; this report includes a summary on the current Corporate Risk profile.

The material updates to the corporate risk profile include:

- **Four risks have been downgraded from the Corporate Risk Register:**
  - **Medicine:** Haemodialysis Capacity (MED1516-08).
  - **Medicine:** Electronic Prescribing System (MMP1415-01).
  - **Estates:** UPS Batteries (EST1617-10).
  - **Surgical:** Urology Consultant Recruitment (SUR1617-17).

- **One risk has been closed on the Corporate Risk Register**
  - **Medicine:** Locum Doctors & IR35 (MED1617-09).

**Review of the Trust wide risk register:**

In September 2017 the regular reporting of the corporate (highest scoring) risk registers to the Clinical Executive Group (CEG) started to be fully embedded. This has continued systematically is a standard monthly item for CEG.
As part of continuing to improve risk management it was agreed to undertake a review of all risks on the Ulysses system – the Trust wide risk register. This review has now been concluded and this report summarises the findings from this review.

<table>
<thead>
<tr>
<th>Strategic Priority and BAF Link:</th>
<th>Strategic Priority:</th>
<th>List below the associated risk in relation to the Strategic Priority:</th>
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<tr>
<td></td>
<td>1. Building a Platform for Better care</td>
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<td>2. Meet all Standards</td>
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<td>3. Create a Good Workforce</td>
<td>BAF ref 3.5 The Trust fails to develop and embed the well led principles from ward to board resulting in poor governance and risk management.</td>
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<td>4. Achieve Financial Stability</td>
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<td></td>
<td>5. Improve Safety &amp; Quality</td>
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**Financial implications:**
This report includes the finance related risks on the corporate risk register.

**Actions required by the Board:**

| To approve: | Discussion and decision |
| To note: | Where the Board is made aware of key points but no decision required |
| For information: | For reading and consideration and for discussion by exception only |

The Board is requested to NOTE the report, DISCUSS and REVIEW any actions.

**Data quality:**

| Source: | Ulysses |
| Validated by | RD &LM |
| Date: | July 2017 |
1. **INTRODUCTION**

This report outlines the strategic risks on the BAF (attached at Appendix 1) and the Corporate Risk Register as at 19/07/2017. The report summarises any changes to the risk position during this reporting period as well as the outcome of the review of the Trust wide risk register.

2. **SUMMARY OF RISKS ON THE BAF**

The BAF has 20 strategic risks identified in total across the five strategic objectives.

**The highest scoring risks (>15) are summarised below:**

**Strategic Objective – Operational Delivery and Flow**

- Ref 2.1: The urgent care system has not delivered the changes required in order to deliver consistent improvements in capacity and patient flow, resulting in the organisation’s ability to consistently achieve the A&E 4 hour standard (Rating: 16).
- Ref 2.6: WCH delays to Phase 2 site redevelopment resulting in continued use of retained estate that requires major upgrade. This potentially has multiple failures of mechanical, general estates and fire safety standards (Rating: 20).

**Strategic Objective – Workforce & Leadership**

- Ref 4.1: The Trust is unable to recruit and retain sufficient permanent and trainee medical staff thus impacting on the Trust’s ability to maintain service provision and provide quality patient care (Rating: 20).

There are five other risks which are rated as 15, these are summarised below:

**Strategic Objective – Operational Delivery and Flow**

- Ref 2.4: The Trust does not have robust governance and monitoring processes in place to manage the PFI contract at CIC, thus impacting on the Trust’s ability to meet key standards, including cleaning.
- Ref 2.5: The Cumberland Infirmary is not compliant with Fire Safety Regulation due to fire compartmentalisation.

**Strategic Objective – Workforce and Leadership**

- Ref: 4.2 The Trust is unable to recruit and retain nursing staff in order to ensure safe staffing levels are consistently achieved across all wards and departments
- Ref: 4.3 The Trust fails to develop and embed the well led principles from ward to board resulting in poor governance and risk management.

**Strategic Objective – Patient Safety & Quality**

- Ref: 5.1 – The Trust fails to learn lessons from serious incidents and harm.
2.1.1 New risks added
No new risks have been added to the BAF for this reporting period.

2.1.2 Risks removed from the BAF
No risks have been removed from the BAF for the reporting period.

2.1.3 Risks increased in score
No risks have decreased in score.

2.1.4 Risks decreased in score
No risks have decreased in score.

2.1.5 Content updates & exceptions
Executive Directors have reviewed the updated BAF. Material points of note have been made on the following risks:

- REF 1.2 The health and social care partnerships and cross organisational working arrangements within North, East and West Cumbria are not clearly defined in order to ensure the STP is delivered, including future organisational form of the Trust & REF 1.3 – Lack of capacity and capability to deliver the Trust objectives alongside the STP and ACO requirements.

The Trust Board have been provided with reports on progress in relation to the STP and system wide integration. Work to ensure capacity and capability is in place across the system to support the programme continues to progress and be discussed with NHS Improvement as part of the delivery of Trust Undertakings.

- Ref: 2.1, 2.2 & 2.3 – The A&E Standard, 18 Week RTT and cancer standards have been updated to reflect the delivery of trajectories at the end of Q1.

- Ref: 4.3 The Trust fails to develop and embed the well led principles from ward to board resulting in poor governance and risk management. The development of the maternity governance improvement plan and update of the governance framework have been added to the controls.

- Ref: 4.4 The Trust does not develop its culture whereby staff can openly challenge and raise concerns. The roll out of the safety culture surveys as part of the QIP has been added to the action being taken.

- Ref: 5.2 The Trust does not have a systematic approach to quality improvement, thus impacting on the prioritisation and delivery of associated quality and safety improvements. The development of the QIP has been added to sources of assurance.

- Ref: 5.3 The Trust fails to implement robust governance processes to demonstrate full compliance with the CQC standards. Monthly review by CEG and the new Divisional Quarterly reviews added to controls.
3. **UPDATES TO THE CORPORATE RISK REGISTER**

3.1 **New risks added to the Corporate Risk Register**

No new risks have been added to the register.

3.2 **Risks Upgraded onto the Corporate Risk Register**

No risks have been upgraded to the register.

3.3 **Risks Downgraded from the Corporate Risk Register**

The following risks have been downgraded from the Corporate Risk Register:

- **Medicine**
  - Haemodialysis Capacity (MED1516-08).
  - Electronic Prescribing System (MMP1415-01).

- **Estates**
  - UPS Batteries (EST1617-10).

- **Surgical**
  - Urology Consultant Recruitment (SUR1617-17).

3.4 **Risks Transferred**

No risks have been transferred.

3.5 **Risks Closed on the Corporate Risk Register**

The following risk has been closed on the Corporate Risk Register:

- **Medicine**
  - Locum Doctors & IR35 (MED1617-09).

A summary of the Corporate Risk Register is outlined on page 6 of this report.
2.6 Summary of the Corporate Risk Profile – 17/07/2017
The illustration below summarises the corporate risk profile, across the clinical business units and corporate functions in relation to the core risk domains of safety and quality, workforce, finance and estates.

Colour Ref:

Medicine
Surgery
Estates
Finance
HR
IM&T
Resilience
Quality & Governance

Critical care capacity (SUR1617-02)
Dermatology services (MED1617-01)
Patient flow A&E standard (MED1213-01)
Obstetric US capacity (MAT1617-01)

Clinical guidelines (GOV1415-01)
52 week performance (SUR1617-21)
Long term resilience of paediatric services (CHC1314-03)

DNACPR compliance (N&Q1718-01)
Management of patients with challenging & aggressive behaviour (EST1415-01)

Evacuation (RES1516-09)
Safety in event of fire (EST1516-08 & EST1415-09)
Medical engineering bleeps (EST1617-01)

Income & expenditure plans (FIN1314-06)
Better payment practice code (FIN1314-10)
CV COIN network migration (IMT1617-01)
Repeat cyberattacks (IM&T1718-02)

Safety and quality
Workforce
Finance & infrastructure
Estates, equipment & environment

Lack of clinicians with advanced neo-natal skills (CHC1415-11 & MAT1415-08)
Emergency response team WCH (HRT1415-01)
Recruitment of permanent medical staff & trainees (HRT1415-04)

Consultant oncologist (CSC1617-09)
Nursing staff extra hours (SUR1617-15)

Consultant oncologist (CSC1617-09)
Nursing staff extra hours (SUR1617-15)
4. **LIVE ASSESSMENT OF RISKS**

In addition to the current position, there are active areas of risk which are being assessed across the Trust and considered at key committees, these include:

- COSHH assessment (Outstanding from Q4 – escalated to Executive Director of Finance)
- Ageing equipment beyond life cycle (Outstanding from Q4 – escalated to Executive Director of Finance)
- Gastroenterology capacity – assessment completed, risk is moderate (not >15).
- Junior doctor cover, specifically obstetrics and general medicine
- NPSA compliance
- Secretarial backlogs (medical & surgical) – report presented to CEG 12/07/2017, further work on solutions required.
- A report on paediatric / neonatal resuscitation has been completed and presented to the Safety & Quality Committee in July 2017 following significant gaps in assurance being identified. An audit is being undertaken and a report to the Trust Board is being prepared.

5. **ANNUAL REVIEW OF TRUST WIDE RISK REGISTER**

In September 2016 the regular reporting of the corporate (highest scoring) risk registers to the Clinical Executive Group started to be fully embedded. This has continued systematically is a standard monthly item for CEG.

As part of continuing to improve risk management it was agreed to undertake a review of all risks on the Ulysses system – the Trust wide risk register. This review has now been concluded and this report summarises the findings from this review.

The review had specific aims:

- Review data quality
- Identify longest open risks
- Review the risk in the context of workforce, safety & quality, estates and finance/infrastructure.

At the time of writing the report there are currently 337 open risks within the Trust. Of the 337 open risks, 28 of these are on the Corporate Risk Register (graded 15 and above).

5.1 **Outcome of the review**

- The review identified that some of the risks have been on the register for some time and therefore require review and updating in order to determine whether the risk is still a live risk to the Trust / service.
- The content in terms of risk description, controls and assurance require strengthening in key areas.

A detailed report has been presented to the Audit and Risk Committee and Clinical Executive Group in July, which outlined recommendations for approval.
The review of the full register will be undertaken again in 6 months’ time in order to be assured on improvement to content across the clinical divisions and corporate functions.

6. **RECOMMENDATION**

The Board is requested to NOTE the report, DISCUSS and REVIEW any actions.

**Ramona Duguid**  
**Associate Director of Governance**

*Appendix 1 – Board Assurance Framework – July 2017*
### SUMMARY OF STRATEGIC RISKS & RATING:

<table>
<thead>
<tr>
<th>STRATEGIC DOMAIN</th>
<th>1.1 The Trust is not able to implement a viable clinical strategy which addresses the clinical fragility of services and sustains acute care longer term across North Cumbria.</th>
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<tr>
<td></td>
<td>1.2 The health and social care partnerships and cross organisational working arrangements within North, East and West Cumbria are not clearly defined in order to ensure the STP is delivered, including future organisational form of the Trust.</td>
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<td></td>
<td>1.3 Lack of capacity and capability to deliver the Trust objectives alongside the STP and ACO requirements.</td>
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<td>STRATEGIC DOMAIN</td>
<td>2.1 The urgent care system has not delivered the changes required in order to deliver consistent improvements in capacity and patient flow, resulting in the organisations ability to consistently achieve the A&amp;E 4 hour standard.</td>
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<td>Operational</td>
<td>2.2 The Trust does not have the required capacity in place to deliver 18 weeks resulting in patients not receiving timely care and loss in income.</td>
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<td>Flow and Delivery</td>
<td>2.3 The trust has low numbers of cancer pathway cases and limited workforce for management of cancer pathways which may result in patients not receiving timely care or treatment and failure of the 62 day cancer pathway.</td>
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<td></td>
<td>2.4 The Trust does not have robust governance and monitoring processes in place to manage the PFI contract at CIC, thus impacting on the Trusts ability to meet key standards, including cleaning.</td>
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<td>2.5 The Cumberland Infirmary is not compliant with Fire Safety Regulation due to fire compartmentalisation.</td>
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<td>2.6 WCH delays to Phase 2 site redevelopment resulting in continued use of retained estate that requires major upgrade. This potentially has multiple failures of mechanical, general estates and fire safety standards.</td>
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<td>2.7 The Cumberland Infirmary does not have critical electrical infrastructure back up relating to single electrical feed from the main substation in Carlisle that was flooded in 2015 resulting in the Trusts ability to maintain service provision and standards of care.</td>
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<td>2.8 The Trust fails to deliver its financial plan due to non-delivery of CIP, increased expenditure on temporary staff and reduce income.</td>
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<td>2.9 Lack of a sustainable capital replacement programme, resulting in capital investment decisions not being taken in accordance with the greatest clinical risk/need.</td>
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<td>STRATEGIC DOMAIN</td>
<td>3.1 The Trust fails to make improvements to the experience of staff, including staff engagement and communication.</td>
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<td>Patient &amp; Staff</td>
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<td>Experience</td>
<td>4.1 The Trust is unable to recruit and retain sufficient permanent and trainee medical staff thus impacting on the Trusts ability to maintain service provision and provide quality patient care.</td>
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<td>4.2 The Trust is unable to recruit and retain nursing staff in order to ensure safe staffing levels are consistently achieved across all wards and departments.</td>
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<td>4.3 The Trust fails to develop and embed the well led principles from ward to board resulting in poor governance and risk management.</td>
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<td>4.4 The Trust does not develop its culture whereby staff can openly challenge and raise concerns.</td>
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<tr>
<th>STRATEGIC DOMAIN</th>
<th>5.1 The Trust fails to learn lessons from serious incidents and harm.</th>
<th>15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5.2 The Trust does not have a systematic approach to quality improvement, thus impacting on the prioritisation and delivery of associated quality and safety improvements.</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>5.3 The trust fails to implement robust governance processes to demonstrate full compliance with the CQC standards.</td>
<td>10</td>
</tr>
</tbody>
</table>
### STRATEGIC OBJECTIVE 1: Strategy & System

#### STRATEGIC RISK:
1.1 The Trust is not able to implement a viable clinical strategy which addresses the clinical fragility of services and sustains acute care longer term across North Cumbria.

<table>
<thead>
<tr>
<th>Controls in place</th>
<th>Gaps in control</th>
<th>Evidence that controls are working</th>
<th>Sources of assurance</th>
<th>Gaps in assurance</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Future of Healthcare consultation document has been published with key supporting evidence underpinning the options appraisal.</td>
<td>Public views may impact on the delivery and implementation of the strategy.</td>
<td>Clinical engagement on development of options for change.</td>
<td>Internal:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Success regime support is supporting transition to STP footprint with clearly defined programmes of work and a clear governance framework.</td>
<td>Negative views from staff on the deliverability of the options for change.</td>
<td></td>
<td>- Reports to CEG weekly.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>System wide working in place with the success regime. Revised governance framework under STP.</td>
<td>Some limited capacity in internal and external programme management support.</td>
<td></td>
<td>- Formal reports to Board on strategy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal transformation team established to support delivery of the options for change.</td>
<td></td>
<td></td>
<td>Independent:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whole system financial plan in place. Whole system approach to workforce in place.</td>
<td></td>
<td></td>
<td>- Scrutiny and oversight by success regime and NHSI.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Action to address any gaps:**
- Contingency plan in place with Trust Board in the event the clinical strategy is not able to be implemented following consultation.
- Workforce planning assumptions in place to support the clinical strategy and any contingency plans.

<table>
<thead>
<tr>
<th>By when</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>In place (Nov 16)</td>
<td>CEO</td>
</tr>
<tr>
<td>In place (Nov 16)</td>
<td>CEO</td>
</tr>
</tbody>
</table>
**STRATEGIC OBJECTIVE 1:** Strategy & System

**STRATEGIC RISK:**
1.2 The health and social care partnerships and cross organisational working arrangements within North, East and West Cumbria are not clearly defined in order to ensure the STP is delivered, including future organisational form of the Trust.

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>Clear transition plan in place with success regime and STP. Governance and leadership arrangements being developed with partners and formally reported to the Board.</td>
<td>None identified.</td>
<td>Milestones for STP delivered to date. Emerging consensus on organisational form to support implementation.</td>
<td>Internal: - Formal reports to Trust Board. Independent: - Success regime oversight.</td>
<td>Pace of change required across historically traditional organisational boundaries in health &amp; social care in Cumbria could impact on delivery of timescales.</td>
<td>CEO</td>
</tr>
</tbody>
</table>

**Action to address any gaps:**
No additional actions identified, controls in place. Assessment of risk in relation to capacity to manage ACO requirements whilst maintaining delivering of organisational objectives and performance continues to be discussed with NHS Improvement as part of the Trust Undertakings.

**By when**
- N/A
- Ongoing

**Lead**
- CEO
- CEO
### STRATEGIC OBJECTIVE 1: Strategy & System

### STRATEGIC RISK:
1.3 Lack of capacity and capability to deliver the Trust objectives alongside the STP and ACO requirements.

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Divisional structures revised and new structure introduced. Transformation lead in post supporting development of implementation plans. PMO lead appointment to support teams with delivery of cost improvement programme. Succession planning vis introduction of deputy BM posts ILM L5 training programme to be offered to key staff. Development of senior leaders through external and internal training programme. STP supporting structure currently being revised with SRO leads. STP Programme Director appointed.</td>
<td>Scale and pace of change is significant in key areas. Operational challenges in managing patient flow. High levels of sickness absence</td>
<td>Objectives and improvement plans being delivered and reported to CEG. AE Delivery Board fully established Programme Group and System Leadership Board in place to enhance cross organisational working Successful recruitment into 3 of 4 nursing posts</td>
<td>Internal: Updated divisional structures October 2016. Alignment to performance management frameworks (internal and external) Full membership of PAG and SLB Workforce reporting and targeted approach for sickness management</td>
<td>Completion/pass rates of ILM internal leadership programmes.</td>
<td>COO</td>
</tr>
</tbody>
</table>

**Action to address any gaps:**
Report on STP infrastructure to be presented to Board

**By when**
July 2017 (Revised to Sept 2017)

**Lead**
CEO
STRATEGIC OBJECTIVE 2: Operational Flow and Delivery

STRATEGIC RISK:
2.1 The urgent care system has not delivered the changes required in order to deliver consistent improvements in capacity and patient flow, resulting in the organisation’s ability to consistently achieve the A&E 4 hour standard.

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Weekly tactical meeting.</td>
<td>Urgent care demand combined with delayed transfers of care may impact on delivery of the trajectory during Q3/4.</td>
<td>Delivery of performance against trajectory Q1</td>
<td>Internal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active breach analysis and escalation in place.</td>
<td>Staffing issues are leading to service gaps in community and adult social care provision.</td>
<td>Reduction in ALOS across frailty unit</td>
<td>- Daily sitreps.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance and Accountability Meetings with Chief Executive.</td>
<td>GP recruitment issues across North Cumbria place additional burden on list sizes.</td>
<td>Increased number of ambulatory pathways</td>
<td>- Weekly CEG update.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A&amp;E Delivery Board established with oversight of all elements of patient flow (pre hospital, hospital and discharge).</td>
<td>Ward and Department Nurse Staffing challenges.</td>
<td>GP satisfaction with surgical screening</td>
<td>- Safer report</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive review of mandated actions.</td>
<td></td>
<td>Improvement in 95% standard performance over 3 years</td>
<td>- Integrated Performance Report</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrated Discharge Team in place – multi agency and multi-disciplinary approach to early discharge and admission avoidance.</td>
<td></td>
<td></td>
<td>- NHSI submission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recovery trajectory in place for 95%. Ambulatory care, medical procedures unit and frailty pathways in place.</td>
<td></td>
<td></td>
<td>- A&amp;E Board Action Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarterly Review Meeting with NHSE/I implemented. Additional Support meetings to be confirmed.</td>
<td></td>
<td></td>
<td>Independent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focussed work on SAFER standards and introduction of central site co-ordination team. Introduction of “full capacity protocol” approach to flow to back of house wards.</td>
<td></td>
<td></td>
<td>- NHSI scrutiny of performance and plans.</td>
<td></td>
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</tr>
</tbody>
</table>

Action to address any gaps:
Full improvement plan in place for the delivery of the A&E standard.

By when
Specific timescales identified for key milestones in plan.

Lead
COO
**Strategic Objective 2:** Operational Flow and Delivery

**Strategic Risk: 2.2** The Trust does not have the required capacity in place to deliver 18 weeks resulting in patients not receiving timely care and loss in income.

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Improvement plan and trajectory in place and agreed with CCG and NHSI.</td>
<td>Management of impact of emergency care demand on bed capacity and patient flow.</td>
<td>Achieved trajectory Q1 17/18 Ring fence Capacity robustly managed.</td>
<td><strong>Internal</strong></td>
<td>Intensive care capacity for complex elective cases.</td>
<td>COO</td>
</tr>
<tr>
<td>Quarterly scrutiny via NHSI.</td>
<td>Inefficiencies in theatre lists/scheduling.</td>
<td></td>
<td>- PAS implementation group - Theatre user group</td>
<td>Pooling of lists to maximise capacity for urgent and long wait cases</td>
<td></td>
</tr>
<tr>
<td>Performance and Accountability meetings with Chief Executive</td>
<td>No centralised management of waiting lists.</td>
<td></td>
<td></td>
<td>High cancellation rates</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maple floor staffing challenges.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outlier numbers impacting elective flow</td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Action to address any gaps:**
Full improvement plan in place for the delivery of the 18 week RTT standard.

**By when:**
Specific timescales identified for key milestones in plan.
**STRATEGIC OBJECTIVE 2:** Operational Flow and Delivery

**STRATEGIC RISK:**
2.3 The trust has low numbers of cancer pathway cases and limited workforce for management of cancer pathways which may result in patients not receiving timely care or treatment and failure of the 62 day cancer pathway.

<table>
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</table>
| Trajectory for recovery agreed with CCG and NHSI Capacity and demand regularly reviewed and adjusted to meet demand. MDT specific performance reviews and management | Management of patient choice and impact on delivery. | Trajectory achieved throughout 2016/17. | **Internal**  
- Daily and Weekly PTL reports.  
- Weekly report to CEG  
- Monthly report to Board via IPR  
**Independent**  
- Sub group of SRG  
- IDM report oversight | 62 day standard not delivered June 2017. | COO |

**Action to address any gaps:**
No additional actions identified, controls in place with supporting trajectory for delivery.

**By when**
Specific timescales identified for key milestones in plan.

**Lead**
COO
## STRATEGIC OBJECTIVE 2: Operational Flow and Delivery

### STRATEGIC RISK:
2.4 The Trust does not have robust governance and monitoring processes in place to manage the PFI contract at CIC, thus impacting on the Trusts ability to meet key standards, including cleaning.

<table>
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</thead>
<tbody>
<tr>
<td>Process in place with estates, finance and legal input which continues to be updated to the Trust Board in relation to the outputs from the external review reports and action required.</td>
<td>Existing PFI Contract has very limited mechanisms to enforce. HMC are not effectively managing their provider IFM. Lifecycle replacement at sole discretion of HMC (PFI Co.). Plans contractually not visible to the Trust.</td>
<td>Progress on cleaning standards achieved in November 2016.</td>
<td><strong>Internal</strong> - Reports to Trust Board. E&amp;F reports SQC. - Cleaning Standards - PPM’s - HMC/Trust Joint risk register <strong>Independent</strong> - Expert external reports - Contract Management report.</td>
<td>Regular contract monitoring reports to be provided by new contract monitoring team to the Board. Cleaning standards consistently raised in 15 steps and mock assessment programme.</td>
<td>DoF</td>
</tr>
<tr>
<td>Trust Monitoring Team in place for both Hard and Soft FM.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HMC/IFM/Trust Operational Meetings in place. PFI Liaison Committee</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HMC/IFM attendance at Infection Prevention, Fire Safety, Ventilation, Medical Gases Committees.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

### Action to address any gaps:

**Contract Management**

a) Carry out external review  
b) Review of Compliance across Hard and Soft FM  
   2. Cleaning – Standards of compliance against contract and versus National Standards  
   3. Hard FM Review of Progress against CAPITEC report  
   4. Internal Audit of Cleaning costs and operations  
   5. Independent Contract Expert – BlueSky to implement robust systems

### By when

- September 2016 – Complete
- August 2016 - Complete
- Complete September 2016 – Letter issued to HMC
- March 2017 Report Received Dec 16 and under review.
- Commenced Dec 16 – By March 17
- Commenced Jan 17 – By March 17

### Lead

DoF
STRATEGIC OBJECTIVE 2: Operational Flow and Delivery

STRATEGIC RISK: 2.5 The Cumberland Infirmary is not compliant with Fire Safety Regulation due to fire compartmentalisation.

CURRENT

| L | S | 15 |

TARGET

| L | S | 5 |

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Cumbria Fire &amp; Rescue continue to monitor progress. Trust Board to Board meetings with HMC. Fire Prevention Measures: 1. Fire prevention and fire evacuation training is on-going, evidence presented via training records. 2. Fire Risk Assessments have been completed by independent fire experts (Arup); risk assessments. 3. Interserve have implemented a Permit to Work System specifically for hot works and alarm testing increasing effectiveness in control of contractors and raised awareness; this includes approval from the Trust to implement the process. 4. A maintenance program is in place 5. Retrofit of Sprinkler Solution controlled via CEG.</td>
<td>Fire Strategy Not Suitable for Purpose. Fire detection system - Cause and effect requires revising in line with Fire Strategy Fire Stopping throughout building not compliant. Length of time to correct fire stopping deficiencies not yet agreed.</td>
<td>Fire Safety Policy revised. Fire Prevention Plan in place. Fire Strategy developed with External Advisors. DH Strategic Oversight Group and emergency evacuation plans in place. Fire Safety Committee. Sprinkler retrofit programme agreed.</td>
<td>Internal - Reports to Trust Board and CEG External - Expert witness reports - Expert Advisor reports</td>
<td>Certified fire stopping works Certified Fire Safety Policy revised Fire detection system - Cause and effect requires revising in line with Fire Strategy Fire Prevention Plan in place. Fire Strategy developed with External Advisors. DH Strategic Oversight Group and emergency evacuation plans in place. Fire Safety Committee. Sprinkler retrofit programme agreed.</td>
<td>DoF</td>
</tr>
</tbody>
</table>

Action to address any gaps:
Complete Fire Stopping and certification Complete Fire Strategy Agree Sprinkler Retrofit Programme Set up Programme Implementation Team – Led by CEG Replace Fire Alarm System Retrofit of Sprinkler System

By when

Lead
DoF
### STRATEGIC OBJECTIVE 2: Operational Flow and Delivery

#### STRATEGIC RISK:

2.6 WCH delays to Phase 2 site redevelopment resulting in continued use of retained estate that requires major upgrade. This potentially has multiple failures of mechanical, general estates and fire safety standards.

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>PPM’s and reactive testing</td>
<td>No detailed Board approved plan for Phase 2. Adverse double running and interim maintenance costs.</td>
<td>No safety incidents, prevention and detection plans in place for water safety and fire. Estates risk register.</td>
<td>Internal: - Reports to Trust Board and CEG. - Reports to water safety group. Independent: - Authorised Engineers - Arup Fire Risk Assessments</td>
<td>Compliance with HTM’s</td>
<td>DoF</td>
</tr>
<tr>
<td>Cumbria Fire &amp; Rescue monitoring Weekly alarm tests Additional Water flushing regime Fire Strategy and Fire Prevention plans in place.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Action to address any gaps:

1. Complete Consolidation of retained estate occupation
2. Demolish Blocks A, C & D
3. Carry out essential upgrades in Blocks H & M as defined in phase 1b
4. Prepare Outline Business Case for Phase 2 following consultation
5. Full Business Case for Phase 2
6. Complete Phase 2

#### By when

- 2017/18
- 2017/18
- 2016/17
- March 2017 - Commence Subject to Consultation outcome
- 2021

#### Lead

- DoF
STRATEGIC OBJECTIVE 2: Operational Flow and Delivery

STRATEGIC RISK:
2.7 The Cumberland Infirmary does not have critical electrical infrastructure back up relating to single electrical feed from the main substation in Carlisle that was flooded in 2015 resulting in the Trusts ability to maintain service provision and standards of care.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>CIC has backup generation to feed essential supplies but it does not cover the Clinical Buildings in the Surgical Centre and Reiver House</td>
<td>Flooding of the substation has occurred on two occasions in the last few years resulting in a prolonged loss of power. Independent feed into the site. Back up generation in Surgical Centre and Reiver House.</td>
<td>2015 flood situation managed effectively with partners to limit impact on services. However a more robust solution for back up generation to cover core areas is required.</td>
<td>Internal Estates Risk identified</td>
<td>Generators are not able to supply the whole site in the event of power failure.</td>
<td>DoF</td>
</tr>
<tr>
<td>Independent feed to the site completed with North West Electricity.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Action to address any gaps:
Back up generators for satellite leased buildings to be agreed with capital planning.

By when: March 2017
Lead: DoF
## STRATEGIC OBJECTIVE 2: Operational Flow and Delivery

### STRATEGIC RISK:
2.8 The Trust fails to deliver its financial plan due to non-delivery of CIP, increased expenditure on temporary staffing and reduced income.

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</thead>
<tbody>
<tr>
<td>Financial plan in place to achieve deficit position.</td>
<td>Temporary staff remains a key challenge and cost pressure.</td>
<td>The Trusts financial position at M6 16/17 is on plan.</td>
<td>Internal:</td>
<td>CIP delivery at the end of Q1.</td>
<td>DoF</td>
</tr>
<tr>
<td>Support funding application for loans/PDC to cover deficit control total.</td>
<td></td>
<td></td>
<td>- Monthly scrutiny at FIP.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CIP PMO in place. Capital planning expenditure scrutiny and controls in place.</td>
<td></td>
<td></td>
<td>- Monthly return to NHSI.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Independent:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- E&amp;Y support to produce system for CIP assurance.</td>
<td></td>
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</tbody>
</table>

**Action to address any gaps:**
CIP plan in place through PMO.

**By when**
Timescales identified for specific milestones

**Lead**
DoF
**STRATEGIC OBJECTIVE 2: Operational Flow and Delivery**

**STRATEGIC RISK:**
2.9 Lack of a sustainable capital replacement programme, resulting in capital investment decisions not being taken in accordance with the greatest clinical risk/need.

<table>
<thead>
<tr>
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<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital planning group established.</td>
<td>Capacity of the management teams to scope out key capital requirements and life cycles.</td>
<td>Priority of decisions in place through a risk based approach.</td>
<td><strong>Internal</strong> Medical Devices Committee and Policies Updated to include risk assessment. Capital Planning Group minutes. Medical Engineering PPM performance. Corporate Asset Verification and age reports. Reports and business cases to CEG &amp; FIP. <strong>Independent</strong> External Maintenance Contracts</td>
<td>Updated age profile plan approved by the Directorates that identifies replacement funding requirements.</td>
<td>DoF</td>
</tr>
<tr>
<td>Group targeting specific areas of work linked to the Corporate Risk Profile. Additional £10m investment in key risk areas made during 14/15 &amp;15/16 in relation to medical equipment.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Risk based process to support capital investment decisions rolled out in 2015/16 through Medical Device Committee and Policy Updated.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Registers identifying failing equipment and PPM.</td>
<td></td>
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</tbody>
</table>

**Action to address any gaps:**
Clinical divisions attend capital planning group & equipment risk assessments carried out and triangulated with clinical divisional risk registers.

**By when**
Ongoing

**Lead**
DoF
### STRATEGIC OBJECTIVE 3: Patient & Staff Experience

#### STRATEGIC RISK:
3.1 The Trust fails to make improvements to the experience of staff, including staff engagement and communication.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Staff survey action plan in place and delivered.</td>
<td>Operational pressures and staff feedback on ‘stress at work’.</td>
<td>Good response rate received from staff to date on full staff survey.</td>
<td><strong>Internal:</strong> Reports to CEG and workforce.</td>
<td>Staff survey results have consistently remained in worst performance in comparison to national benchmarks.</td>
<td>CEO/DHR</td>
</tr>
<tr>
<td>Staff engagement programme in place and led by executive team.</td>
<td></td>
<td></td>
<td><strong>Independent:</strong> Performance against CQIN on well-being initiatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduction of weekly CEO Blog</td>
<td></td>
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</tr>
<tr>
<td>Dedicated resource for staff engagement confirmed.</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Health &amp; Wellbeing survey undertaken.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Appraisal position significantly improved.</td>
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</tr>
</tbody>
</table>

**Action to address any gaps:**
Action plan to be developed following Community Leadership Forum in May 2017 on how to improve staff engagement.

**By when:** 30/06/2017

**Lead:** DoHR
STRATEGIC OBJECTIVE 4: Workforce and Leadership

STRATEGIC RISK:
4.1 The Trust is unable to recruit and retain sufficient permanent and trainee medical staff thus impacting on the Trusts ability to maintain service provision and provide quality patient care.

<table>
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<th>Evidence that controls are working</th>
<th>Sources of assurance</th>
<th>Gaps in assurance</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruitment plan in place.</td>
<td>Medicine – ‘back of house’ at WCH remains fragile with locum medical staff in place. Impact on MDT working within specialties. Some medical staff employed by the Trust on Northumbria contracts of employment.</td>
<td>Successful recruitment made in certain specialties. Nurse practitioner model working well with plans to extend the role.</td>
<td>Internal: Medical staffing reports to Board. Workforce narrative to support medical staffing improvement prepared nov 16. Independent:</td>
<td>Reporting on medical staffing position being refined.</td>
<td>MD</td>
</tr>
</tbody>
</table>

Action to address any gaps:
No additional actions identified, controls in place.

By when: N/A
Lead: N/A
**STRATEGIC OBJECTIVE 4: Workforce and Leadership**

**STRATEGIC RISK:**

4.2 Ongoing challenges with the recruitment and retention of nursing staff in order to ensure safe staffing levels are consistently achieved across all wards and departments.

<table>
<thead>
<tr>
<th>Controls in place</th>
<th>Gaps in control</th>
<th>Evidence that controls are working</th>
<th>Sources of assurance</th>
<th>Gaps in assurance</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing escalation process in place with Director of Nursing weekly review.</td>
<td>Short term sickness impacting on staffing levels.</td>
<td>Overall vacancy rate is 9.23%.</td>
<td>Internal:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Six month acuity review in place.</td>
<td>Long term plan required for SCBU at CIC due to anticipated retirements.</td>
<td>Successful recruitment and development of innovative nursing roles to look creatively at skills mix and staffing challenges.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recruitment to vacant positions achieved in September and October.</td>
<td>Chemotherapy service at CIC currently with significant gaps.</td>
<td></td>
<td>Independent:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe staffing report to Board in place in accordance with NQB requirements.</td>
<td>Pressure to increase demand and staff escalation beds during winter period.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funded establishment review to ensure sickness and maternity uplift adequate in all areas.</td>
<td>Over reliance on existing staff to cover short term gaps.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staff requested to support from other areas at times of increased pressure.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Action to address any gaps:**

- Establishment review work in progress.
- Mitigation plan in place for Reiver House.
- Mitigation plan for SCBU being developed.
- Nursing plan being developed following Board agreement of budget uplift for sickness/maternity leave.

**By when**

- January 2017
- In place

**Lead**

- DoN
STRATEGIC OBJECTIVE 4: Workforce and Leadership

STRATEGIC RISK: 4.3 The Trust fails to develop and embed the well led principles from ward to board resulting in poor governance and risk management.

<table>
<thead>
<tr>
<th>Controls in place</th>
<th>Gaps in control</th>
<th>Evidence that controls are working</th>
<th>Sources of assurance</th>
<th>Gaps in assurance</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear framework from Board to Ward based on triumvirate model (DoN, MD, DoG to clinical divisions ACO, Matron, AMD). Divisional quality and safety meeting in place. Monthly governance dashboards in place and presented to SQC. Clear risk escalation process in place. Supporting Governance policies in place for key areas including risk management and incident management. Mandatory training packages in place for risk management. Well led assessment of Board undertaken October 2016. Governance re-structure proposal completed May 2017. Additional expertise in place for maternity team. Governance Framework updated for Board ratification July 2017. Maternity action plan &amp; scope of work to improve governance and risk management developed.</td>
<td>Capacity within operational teams and wards to dedicate time on their local clinical governance arrangements, particularly ward sister/manager level. Divisional governance capacity and central/corporate team require investment and changes in key areas.</td>
<td>Good evidence on 15 steps and mock inspections of well-led and governance being embedded. Good ratings in some core services for well led.</td>
<td>Internal:  - Risk management report to audit &amp; risk committee.  - CEG review of risk register.  - Divisional dashboards.  - Trust Action Plan for GGI developed. Independent:  - GGI Review June 2016  - Head of Internal Audit Opinion 2014/15  - Annual Governance Statement 2014/15</td>
<td>Board, Risk and Governance Framework requires review, including committee structure. New clinical divisions require time to ensure reporting requirements across specialties are fit for purpose and focussed on relevant clinical outcomes. Maternity services and medicine division require improvements in relation to governance and risk management following CQC inspection December 2016 (well led scores).</td>
<td>DoN</td>
</tr>
</tbody>
</table>

**Action to address any gaps:**
Board Development Programme for 2017/18 being finalised.
Divisional well led reviews part of QIP 2017/18

<table>
<thead>
<tr>
<th>CURRENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>L 3 S 5 15</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>L 1 S 4 4</td>
</tr>
</tbody>
</table>
**STRATEGIC OBJECTIVE 4:**
Workforce and Leadership

**STRATEGIC RISK:**
4.4 The Trust does not develop its culture whereby staff can openly challenge and raise concerns.

<table>
<thead>
<tr>
<th>Controls in place</th>
<th>Gaps in control</th>
<th>Evidence that controls are working</th>
<th>Sources of assurance</th>
<th>Gaps in assurance</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speak up Guardian in place for medical staff. Freedom to speak lead in place for all staff. Health and well-being board in place. Human factors programme in place as part of the perioperative improvement plan. Ward assurance system in place to display quality of care outcomes openly. Stop the Line (STL) programme in place. Individual safety culture surveys being undertaken. Safety huddles being commonly adopted within individual teams and departments. Monthly safety summits commenced.</td>
<td>Some serious incidents continue to include human factors where STL was not carried out within the MDT.</td>
<td>Evidence of STL being enacted.</td>
<td>Internal: - SOP for STL. - PSP review of incidents. Independent: - RCS and Northumbria reports on never events. - CQC unannounced report for surgery &amp; paediatrics.</td>
<td>Latest staff survey results still identify areas for improvement.</td>
<td>CEO</td>
</tr>
</tbody>
</table>

**Action to address any gaps:**
Formal launch of Stop the Line procedure trust wide. Safety culture survey being rolled out across the Trust as part of the QIP 17/18.

<table>
<thead>
<tr>
<th>By when</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec 16 (revised 17/18 priorities) March 18</td>
<td>DoN DoG</td>
</tr>
</tbody>
</table>
### STRATEGIC OBJECTIVE 5: Patient Safety & Quality

#### STRATEGIC RISK:
5.1 The Trust fails to learn lessons from serious incidents (SI) and harm.

<table>
<thead>
<tr>
<th>Controls in place</th>
<th>Gaps in control</th>
<th>Evidence that controls are working</th>
<th>Sources of assurance</th>
<th>Gaps in assurance</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robust incident management policy and process in place. Weekly Patient Safety Panel in place to review SI investigations and formal follow up on the delivery of SI action plans. Safety message of the week in place. Patient safety walk round programme in place with directors. Trustwide safety newsletter and monthly safety summit in place. Information sharing section on intranet updated. Mortality Hogan reviews triangulated with serious incidents. Clinical Directors for Patient Safety in place for medicine and surgery. First cohort of RCA 2 day training completed. Coroners response on Regulation 28 Notice completed and action plan in place. Contributory factors analysis completed for 2016.</td>
<td>Some serious incidents continue to have similar contributory factors in relation to Root Cause.</td>
<td>Good evidence from 15 steps and mock inspection programme on staff response to sharing lessons learned. Clinical Divisions leading local processes to drive improvement and share lessons in medicine and surgery.</td>
<td><strong>Internal:</strong>&lt;br&gt;- Monthly PSP report to SQC.&lt;br&gt;- Monthly report to Board.&lt;br&gt;- Quarterly SQ report to Board&lt;br&gt;- Safety newsletter&lt;br&gt;- Reg 28 Action Plan <strong>Independent:</strong>&lt;br&gt;-</td>
<td>Levels of training on RCA. Reports on safety walkround programmes are not formally reviewed at Board subcommittee level. Coroners Regulation 28 regarding NG Tubes.</td>
<td>MD &amp; DoN</td>
</tr>
</tbody>
</table>

**Action to address any gaps:**
Patient Safety walkround programme to be revised 2017/18.

**By when**

**Lead**
DoG
**STRATEGIC OBJECTIVE 5: Patient Safety & Quality**

**STRATEGIC RISK:**
5.2 The Trust does not have a systematic approach to quality improvement, thus impacting on the prioritisation and delivery of associated quality and safety improvements.

<table>
<thead>
<tr>
<th>Controls in place</th>
<th>Gaps in control</th>
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<th>Gaps in assurance</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Improvement Plan in place. Priority areas for improvement across the Trust actively being supported by core governance team (perioperative plan, Natsipps, Sepsis, managing the deteriorating patient, falls and pressure area care). Ward quality boards in place to drive local improvement. Sign up to Safety Plan done in December 2014. Mortality Surveillance Group in place to monitor and review key safety priorities. Quality Strategy developed 2014/15.</td>
<td>No clear methodology or process in place to manage and support trust wide quality programmes, including associated improvement reports on delivery.</td>
<td>Improvements demonstrated in key areas, including sepsis, pressure area care and management of early warning scores. Improvement plan for perioperative care in place.</td>
<td>Internal: - QIP 2017/18. - QIP Q1 summary. - Quality Strategy. - Delivery of specific priorities reported to Board. - Revised S&amp;Q report to Board. Independent: - GGI Report.</td>
<td>Sign up to Safety plan requires update and review. ‘Change team’ developed leaving a potential gap for systematic review of quality improvement across the Trust. Delivery of the QIP requires updating and formal reporting across the Trust.</td>
<td>MD &amp; DoN</td>
</tr>
</tbody>
</table>

**Action to address any gaps:**
QIP in place for 2017/18.

<table>
<thead>
<tr>
<th>By when</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DoN</td>
</tr>
</tbody>
</table>
**STRATEGIC OBJECTIVE 5:**
Patient Safety & Quality

**STRATEGIC RISK:**
5.3 The trust fails to implement robust governance processes to demonstrate full compliance with the CQC standards.

<table>
<thead>
<tr>
<th>Controls in place</th>
<th>Gaps in control</th>
<th>Evidence that controls are working</th>
<th>Sources of assurance</th>
<th>Gaps in assurance</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 steps assessment programme in place for wards.</td>
<td>Staffing capacity can impact on local delivery of improvements.</td>
<td>Demonstrable evidence in place across five core domains to support compliance. Areas identified for improvement are formally reviewed in relation to immediate action taken.</td>
<td>Internal:</td>
<td>15 steps not yet implemented in non-ward areas.</td>
<td>DoN</td>
</tr>
<tr>
<td>Accountability framework in place for all Regulations.</td>
<td></td>
<td></td>
<td>- 15 steps report to SQC.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mock inspection programme in place.</td>
<td></td>
<td></td>
<td>- Mock inspection outcome report to CEG.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rolling audit programme in place for key regulations.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust wide programmes for improvement in place for quality and safety as part of the QIP.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Robust monitoring of staff appraisal and mandatory training in place.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse staffing capacity oversight from Director of Nursing &amp; Midwifery.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monthly CEG review of CQC Must Do.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Divisional Quarterly reviews established to focus on delivery of quality governance and ‘should do’ requirements.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Action to address any gaps:**
Programme will be extended in 2017 to include non ward areas.
Accountability Framework being refreshed.

**By when**
- 31/03/2017
- Commenced Dec 2016

**Lead**
- DoN
This report presents an overview of Patient Experience data within the Trust for Quarter One 2017/18; it covers all aspects of measurement for Patient Experience and includes Complaints, PALS, Friends & Family Test and Two Minutes of Your Time. The layout of the report has been amended so that it can be populated throughout the year to show trends and themes.

The Board are asked to note the following:

**PALS enquiries**—there were 404 enquiries in the first quarter. The conversion rate 3.5%, (14 out of 404 contacts) demonstrates how timely intervention and responses can really make a difference for patients and families. Further work to identify trends and themes of contacts is planned to identify what actions could be taken to prevent the contacts from happening in the first place.

**Complaints** - The Trust is maintaining compliance with the 95% target for 30 day response times for completion of complaints cases, in fact since September 2016 we have maintained 100%. The main themes for complaints to the Trust were about Treatment and Care. Throughout the year there will be further work to identify the underlying issues of the complaints and identify particular trends and themes. There were 12 re-opened complaints, 6 were unhappy with the initial response, 1 raised new questions and 5 asked for further clarity in issues raised. One case was referred to the Ombudsman this quarter, no further information on this as yet.

**NHS Choices**—The Cumberland Infirmary star rating on NHS choices has remained at 4 in Q41 based on the last 147 responses. West Cumberland Hospital has maintained a 4.5 start rating based on the last 89 responses.

**Patient Perspective** results for inpatients the Trust is in the top 20% of all Trusts on 13 of the 19 questions most important questions for patients and in the middle 60% on the rest. Outpatients’ scores are in the top 20% for 15 of the 19 most important questions to patients, and for all other questions it is in the middle 60%. The results for the Emergency Departments are good—the Trust averages inside the top 20% nationally, and is in the top 20% on 22 of 27 questions. West Cumberland scores higher (84%) than Cumberland Infirmary scores (76%).

**Friends and family Test** (FFT) When these scores are compared to the latest Average England scores on the Patient Experience Headlines tool, (March 2017) the Trust is scoring better in all areas except the response rate for A&E.
Executive Summary:

2 minutes of your time results—Over 1000 comments from patients received on each site, the majority were positive with negative comments accounting for 16% at CIC and 8% at WCH. Negative comments re access, environment etc to be further reviewed to identify where actions could improve the situation.

Real time / face to face aggregate scores. During this quarter there have been some excellent results with some areas achieving maximum scores in many of the domains. Triangulated ward reports will be circulated to all ward areas during July and actions taken following feedback will be given by ward managers about actions taken particularly where scores have not been so good. Medicines management scores low in many areas across the Trust and pharmacy have work underway to implement MaPPs2 medication information system which hopefully will help inform patients about their medications.

Children’s and Young Peoples Survey (CAYPS) recommendation rates are very good for childrens services and lots of comments have been provided to enable staff to review services and systems. Ongoing comments about no Wifi accesss for children spending long oeriods of time at the hospital.

The Butterfly survey, our dementia patient experience survey s provided lots of positive feedback but only 73% of carers felt well supported and work is required to improve this.

Strategic Priority and BAF Link:

<table>
<thead>
<tr>
<th>Strategic Priority:</th>
<th>List below the associated risk in relation to the Strategic Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Building a Platform for Better Care</td>
<td></td>
</tr>
<tr>
<td>2. Meeting All Standards</td>
<td></td>
</tr>
<tr>
<td>3. Create a Good Workforce</td>
<td></td>
</tr>
<tr>
<td>4. Achieve Financial Stability</td>
<td></td>
</tr>
<tr>
<td>5. Improve Safety &amp; Quality</td>
<td></td>
</tr>
</tbody>
</table>

Financial Implications:

Actions Required by the Board:

To approve: Discussion and decision

To note: Where the Board is made aware of key points but no decision is required

For information: For reading and consideration and for discussion by exception only

The Board is requested to note the report

Data Quality

Source: Ulysses, FFT database, Real time, Take Two Minutes, Patient Perspective

Validated by: A Shaw-Daly, M Stacey, S Bossche, K White, G Wright

Date: 10/07/2017
Quarterly Complaints, PALS and Patient Experience Report
Quarter One 2017/18
## PALS Enquiries

<table>
<thead>
<tr>
<th></th>
<th>Cumberland Infirmary</th>
<th>West Cumberland Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Quarter 1</td>
<td>Quarter 2</td>
</tr>
<tr>
<td>Medicine &amp; Emergency Care</td>
<td>77</td>
<td></td>
</tr>
<tr>
<td>Surgery &amp; Critical Care</td>
<td>207</td>
<td></td>
</tr>
<tr>
<td>Corporate Areas</td>
<td>32</td>
<td></td>
</tr>
</tbody>
</table>

### Narrative:

- **PALS conversion to Complaints** - The conversion rate 3.5%, (14 out of 404 contacts) demonstrates how timely intervention and responses can really make a difference for patients and families. Further work to identify trends and themes of contacts is planned to identify what actions could be taken to prevent the contacts from happening in the first place.

- **Complaints conversion to PALS** - 10 initial contacts (8 at CIC and 2 at WCH) to the complaints department were directed to PALS as they were more concerns rather than complaints. They were effectively dealt with by the PALS team and clinical staff and did not require complaints investigation.
## New Complaints

<table>
<thead>
<tr>
<th></th>
<th>Cumberland Infirmary</th>
<th>West Cumberland Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1</td>
<td>Quarter 2</td>
<td>Quarter 3</td>
</tr>
<tr>
<td>Medicine &amp; Emergency Care</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Surgery &amp; Critical Care</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Corporate Areas</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

## Main themes identified

<table>
<thead>
<tr>
<th></th>
<th>Cumberland Infirmary</th>
<th>West Cumberland Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>Theme</td>
<td>Number</td>
</tr>
<tr>
<td>Medicine &amp; Emergency Care</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>Surgery &amp; Critical Care</td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Corporate Areas</td>
<td>4</td>
<td>1 (Trust wide)</td>
</tr>
</tbody>
</table>

## Re-opened Complaints (FLR’s—Further Local Resolution)

<table>
<thead>
<tr>
<th></th>
<th>Cumberland Infirmary</th>
<th>West Cumberland Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1</td>
<td>Quarter 2</td>
<td>Quarter 3</td>
</tr>
<tr>
<td>Medicine &amp; Emergency Care</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Surgery &amp; Critical Care</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Corporate Areas</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

**Narrative**: 100% of complaint investigations were completed within the 30 day response target. The main themes for complaints to the Trust were about Treatment and Care. Throughout the year there will be further work to identify the underlying issues of the complaints and identify particular trends and themes. There were 12 re-opened complaints, 6 were unhappy with the initial response, 1 raised new questions and 5 asked for further clarity in issues raised. One case was referred to the Ombudsman this quarter, no further information on this as yet.
Cumberland Infirmary

Currently rated 4 Stars, based on the last 147 Ratings
(Star ratings based on information available at end of June 2017)

<table>
<thead>
<tr>
<th>Number of Comments</th>
<th>17</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Positive Comments</td>
<td>82% - 14 comments</td>
<td>77% - 10 comments</td>
</tr>
<tr>
<td>% Negative Comments</td>
<td>17% - 3 comments</td>
<td>23% - 3 comments</td>
</tr>
<tr>
<td>Negative Themes</td>
<td>1— Access &amp; Environment 1—Appointment Issues 1—Information &amp; Communication</td>
<td>1—Access &amp; Environment 1—Appointment Issues 1—Treatment/Care Inpatient</td>
</tr>
</tbody>
</table>

West Cumberland Hospital

Currently rated 4.5 Stars, based on the last 89 Ratings
(Star ratings based on information available at end of June 2017)

Narrative: The star ratings have been consistent from last quarter, and negative comments about access, environments and appointments are a recurring theme. Work will be undertaken in 2017/18 to further review the system and process issues and identify actions to resolve some of the issues identified.
Patient Perspective Survey Results

<table>
<thead>
<tr>
<th>IP &amp; DC</th>
<th>Consistency &amp; Coordination of care</th>
<th>Treatment with Respect and Dignity</th>
<th>Involvement</th>
<th>Doctors</th>
<th>Nurses</th>
<th>Cleanliness</th>
<th>Pain Control</th>
<th>Managing medicines</th>
<th>Combined Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>85%</td>
<td>94%</td>
<td>75%</td>
<td>88%</td>
<td>87%</td>
<td>87%</td>
<td>89%</td>
<td>71%</td>
<td>85%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>82%</td>
<td>93%</td>
<td>75%</td>
<td>90%</td>
<td>95%</td>
<td>95%</td>
<td>86%</td>
<td>70%</td>
<td>85%</td>
</tr>
<tr>
<td>Trust Average</td>
<td>84%</td>
<td>94%</td>
<td>76%</td>
<td>89%</td>
<td>90%</td>
<td>90%</td>
<td>88%</td>
<td>71%</td>
<td>85%</td>
</tr>
<tr>
<td>NHS Average</td>
<td>78%</td>
<td>89%</td>
<td>70%</td>
<td>85%</td>
<td>86%</td>
<td>86%</td>
<td>82%</td>
<td>66%</td>
<td>80%</td>
</tr>
<tr>
<td>NHS top 20%</td>
<td>82%</td>
<td>92%</td>
<td>73%</td>
<td>88%</td>
<td>90%</td>
<td>90%</td>
<td>85%</td>
<td>70%</td>
<td>84%</td>
</tr>
<tr>
<td>NHS Best</td>
<td>92%</td>
<td>98%</td>
<td>86%</td>
<td>96%</td>
<td>97%</td>
<td>97%</td>
<td>93%</td>
<td>85%</td>
<td>93%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatients</th>
<th>Dealing with the issue</th>
<th>Information about treatment</th>
<th>Information about discharge</th>
<th>Doctors</th>
<th>Dignity and Respect</th>
<th>Cleanliness</th>
<th>Organisation of Outpatient department</th>
<th>Overall Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>89%</td>
<td>82%</td>
<td>58%</td>
<td>90%</td>
<td>95%</td>
<td>86%</td>
<td>74%</td>
<td>82%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>92%</td>
<td>83%</td>
<td>64%</td>
<td>93%</td>
<td>98%</td>
<td>94%</td>
<td>83%</td>
<td>87%</td>
</tr>
<tr>
<td>Trust Average</td>
<td>91%</td>
<td>83%</td>
<td>61%</td>
<td>92%</td>
<td>97%</td>
<td>90%</td>
<td>79%</td>
<td>85%</td>
</tr>
<tr>
<td>NHS Average</td>
<td>86%</td>
<td>83%</td>
<td>56%</td>
<td>87%</td>
<td>94%</td>
<td>84%</td>
<td>78%</td>
<td>81%</td>
</tr>
<tr>
<td>NHS top 20%</td>
<td>88%</td>
<td>86%</td>
<td>65%</td>
<td>90%</td>
<td>85%</td>
<td>90%</td>
<td>82%</td>
<td>85%</td>
</tr>
<tr>
<td>NHS best Trust</td>
<td>93%</td>
<td>93%</td>
<td>81%</td>
<td>95%</td>
<td>99%</td>
<td>96%</td>
<td>87%</td>
<td>92%</td>
</tr>
</tbody>
</table>

**Narrative:** **Inpatients** The overall score for the Trust in Q1 is 83.4%, which is below the threshold score for the top 20% of Trusts (85%). It is in the top 20% for 11 of the 19 most important questions to patients. For all other questions it is in the middle 60%.

**Outpatients** The overall score for the Trust in Q1 is 83.4%, which is below the threshold score for the top 20% of Trusts (85%). It is in the top 20% for 11 of the 19 most important questions to patients. For all other questions it is in the middle 60%.
# FFT Survey Results

## Trust Scores

<table>
<thead>
<tr>
<th></th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% Response Rate</td>
<td>% Recommended</td>
<td>% Response Rate</td>
<td>% Recommended</td>
</tr>
<tr>
<td>Inpatients/Day case</td>
<td>27.3%</td>
<td>97.00%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatients</td>
<td>4.7%</td>
<td>97.05%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency care</td>
<td>5.0%</td>
<td>91.39%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity</td>
<td>36.7%</td>
<td>98.61%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Narrative:** When these scores are compared to the latest Average England scores on the Patient Experience Headlines tool, (March 2017) the Trust is scoring better in all areas except the response rate for A&E.

Inpatients/Day case average response rate is 25.4% (NCUH 27.3%) and the average recommendation rate is 95.6% (NCUH 97%)

Outpatients no response rate available but the average recommendation rate is 93.2% (NCUH 97.05%)

Emergency care average response rate is 12.9% (NCUH 5%), average recommendation rate is 87.1% (NCUH 91.39%)

Maternity average response rate is 24.4% (NCUH 36.6%) average recommendation rate 96.8% (NCUH 98.61%)

Work is ongoing to try and pilot text messaging service for FFT in A&E to improve the response rate and there is a Rapid Process Improvement Workshop (RPIW) planned for A&E in September 2017.
### Cumberland Infirmary

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Number of Surveys</th>
<th>Respect &amp; Dignity</th>
<th>Involvement</th>
<th>Timely Information</th>
<th>Cleanliness</th>
<th>Kindness &amp; Compassion</th>
<th>Domain Average</th>
<th>% Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarter 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarter 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### West Cumberland

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Number of Surveys</th>
<th>Respect &amp; Dignity</th>
<th>Involvement</th>
<th>Timely Information</th>
<th>Cleanliness</th>
<th>Kindness &amp;</th>
<th>Domain Average</th>
<th>% Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1</td>
<td>1932</td>
<td>9.95</td>
<td>9.75</td>
<td>9.73</td>
<td>9.92</td>
<td>9.95</td>
<td>9.86</td>
<td>99%</td>
</tr>
<tr>
<td>Quarter 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarter 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarter 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Free Text Responses for this Quarter

<table>
<thead>
<tr>
<th>Cumberland Infirmary</th>
<th>West Cumberland Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Cards Returned</td>
<td>1959</td>
</tr>
<tr>
<td>Number of Comments Received</td>
<td>1197</td>
</tr>
<tr>
<td>Positive Comments</td>
<td>1005 (84%)</td>
</tr>
<tr>
<td>Negative Comments</td>
<td>192 (16%)</td>
</tr>
<tr>
<td>Negative Themes</td>
<td>80 (42%) Access &amp; Environment</td>
</tr>
<tr>
<td></td>
<td>13 (7%) Appointment Issues</td>
</tr>
<tr>
<td></td>
<td>13 (7%) Attitude of Staff</td>
</tr>
<tr>
<td></td>
<td>23 (12%) Information &amp; Communication</td>
</tr>
<tr>
<td></td>
<td>3 (2%) Other</td>
</tr>
<tr>
<td></td>
<td>60 (31%) Treatment/Care Inpatient</td>
</tr>
</tbody>
</table>
# Outpatient Results - 2 minutes of your time - Summary

## Cumberland Infirmary

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Number of Surveys</th>
<th>Expectations Met</th>
<th>Courtesy &amp; Respect</th>
<th>Confidence of Trust</th>
<th>Involvement</th>
<th>Concerns Addressed</th>
<th>Domain Average</th>
<th>% Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1</td>
<td>2235</td>
<td>9.55</td>
<td>9.22</td>
<td>9.85</td>
<td>9.61</td>
<td>9.50</td>
<td>9.69</td>
<td>97%</td>
</tr>
<tr>
<td>Quarter 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarter 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarter 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## West Cumberland Hospital

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Number of Surveys</th>
<th>Expectations Met</th>
<th>Courtesy &amp; Respect</th>
<th>Confidence of Trust</th>
<th>Involvement</th>
<th>Concerns Addressed</th>
<th>Domain Average</th>
<th>% Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1</td>
<td>787</td>
<td>9.74</td>
<td>9.94</td>
<td>9.92</td>
<td>9.70</td>
<td>9.55</td>
<td>9.77</td>
<td>96%</td>
</tr>
<tr>
<td>Quarter 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarter 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarter 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Free Text Responses for this Quarter

<table>
<thead>
<tr>
<th>Cumberland Infirmary</th>
<th>West Cumberland Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Cards Returned</td>
<td>2235</td>
</tr>
<tr>
<td>Number of Comments Received</td>
<td>905</td>
</tr>
<tr>
<td>Positive Comments</td>
<td>796 (88%)</td>
</tr>
<tr>
<td>Negative Comments</td>
<td>109 (12%)</td>
</tr>
</tbody>
</table>

### Negative Themes

- **Cumberland Infirmary**
  - 47 (43%) Access & Environment
  - 37 (34%) Appointment Issues
  - 8 (7%) Attitude of Staff
  - 12 (11%) Information & Communication
  - 1 (1%) Other
  - 1 (1%) Transport
  - 3 (3%) Treatment/Care Inpatient

- **West Cumberland Hospital**
  - 4 (17%) Access & Environment
  - 11 (46%) Appointment Issues
  - 6 (25%) Information & Communication
  - 3 (13%) Treatment/Care Inpatient
### Real Time Face to face - Aggregate Scores Summary

<table>
<thead>
<tr>
<th>Domain</th>
<th>Number of Wards</th>
<th>Minimum Score</th>
<th>Mean</th>
<th>Maximum Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consistency &amp; Coordination</td>
<td>33</td>
<td>8.16</td>
<td>9.25</td>
<td>10.00</td>
</tr>
<tr>
<td>Respect &amp; Dignity</td>
<td>33</td>
<td>9.47</td>
<td>9.92</td>
<td>10.00</td>
</tr>
<tr>
<td>Involvement</td>
<td>33</td>
<td>8.83</td>
<td>9.63</td>
<td>10.00</td>
</tr>
<tr>
<td>Doctors</td>
<td>33</td>
<td>9.50</td>
<td>9.86</td>
<td>10.00</td>
</tr>
<tr>
<td>Nurses</td>
<td>33</td>
<td>9.77</td>
<td>9.94</td>
<td>10.00</td>
</tr>
<tr>
<td>Cleanliness</td>
<td>33</td>
<td>8.23</td>
<td>9.29</td>
<td>9.84</td>
</tr>
<tr>
<td>Pain Control</td>
<td>33</td>
<td>9.17</td>
<td>9.76</td>
<td>10.00</td>
</tr>
<tr>
<td>Medicines management</td>
<td>33</td>
<td>6.11</td>
<td>8.60</td>
<td>10.00</td>
</tr>
<tr>
<td>Noise at Night</td>
<td>33</td>
<td>8.48</td>
<td>9.35</td>
<td>10.00</td>
</tr>
<tr>
<td>Kindness &amp; Compassion</td>
<td>33</td>
<td>9.65</td>
<td>9.93</td>
<td>10.00</td>
</tr>
<tr>
<td>Domain Average</td>
<td>33</td>
<td>9.08</td>
<td>9.56</td>
<td>10.00</td>
</tr>
<tr>
<td>Key Promoter Score</td>
<td>33</td>
<td>7.75</td>
<td>9.41</td>
<td>10.00</td>
</tr>
</tbody>
</table>

**Narrative**: Patients were interviewed in 33 areas across the Trust with monthly scores circulated back to the clinical teams. During this quarter there have been some excellent results with some areas achieving maximum scores in many of the domains. Triangulated ward reports will be circulated to all ward areas during July and actions taken following feedback will be given by ward managers about actions taken.

Medicines management scores low in many areas across the Trust and pharmacy have work underway to implement MaPPs2 medication information system which hopefully will help inform patients about their medications.
# Emergency Care

## Cumberland Infirmary vs. West Cumberland Hospital

<table>
<thead>
<tr>
<th></th>
<th>Cumberland Infirmary</th>
<th>West Cumberland Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quarter 1</strong></td>
<td>66</td>
<td>61</td>
</tr>
<tr>
<td><strong>Quarter 2</strong></td>
<td>7.2%</td>
<td>2.1%</td>
</tr>
<tr>
<td><strong>Quarter 3</strong></td>
<td>%91.87%</td>
<td>%91.35%</td>
</tr>
<tr>
<td><strong>Quarter 4</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Free Text Responses for this Quarter

<table>
<thead>
<tr>
<th></th>
<th>Cumberland Infirmary</th>
<th>West Cumberland Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Surveys Returned</strong></td>
<td>621</td>
<td>118</td>
</tr>
<tr>
<td><strong>Number of Comments Received</strong></td>
<td>516</td>
<td>89</td>
</tr>
<tr>
<td><strong>Positive Comments</strong></td>
<td>%454 (88%)</td>
<td>%83 (93%)</td>
</tr>
<tr>
<td><strong>Negative Comments</strong></td>
<td>%62 (12%)</td>
<td>%6 (7%)</td>
</tr>
<tr>
<td><strong>Negative Themes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>14 (23%) Access &amp; Environment</td>
<td>3 (50%) Access &amp; Environment</td>
</tr>
<tr>
<td></td>
<td>16 (26%) Appointment Issues</td>
<td>1 (17%) Appointment Issues</td>
</tr>
<tr>
<td></td>
<td>6 (10%) Attitude of Staff</td>
<td>1 (17%) Attitude of Staff</td>
</tr>
<tr>
<td></td>
<td>9 (15%) Information &amp; Communication</td>
<td>1 (17%) Treatment/Care Inpatient</td>
</tr>
<tr>
<td></td>
<td>1 (2%) Other</td>
<td>1 (17%) Treatment/Care Inpatient</td>
</tr>
<tr>
<td></td>
<td>16 (26%) Treatment/Care Inpatient</td>
<td></td>
</tr>
</tbody>
</table>

### Narrative

Although the recommendation rate is low at %91.87 CIC and %91.35 WCH, it is higher than the average England recommendation rate for A&E when compared to data on NHSI Patient Experience Headlines Tool which was 87.1% (March 2017, last data available).
## Maternity - Community Antenatal and Postnatal Results

<table>
<thead>
<tr>
<th></th>
<th>Antenatal</th>
<th>Postnatal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Quarter 1</td>
<td>Quarter 2</td>
</tr>
<tr>
<td>FFT Score</td>
<td>83</td>
<td></td>
</tr>
<tr>
<td>% Response Rate</td>
<td>37.9%</td>
<td></td>
</tr>
<tr>
<td>% Recommended</td>
<td>96.6%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Antenatal</th>
<th>Postnatal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Cards Returned</td>
<td>117</td>
<td>117</td>
</tr>
<tr>
<td>Number of Comments Received</td>
<td>97</td>
<td>97</td>
</tr>
<tr>
<td>Positive Comments</td>
<td>96 (99%)</td>
<td>96 (99%)</td>
</tr>
<tr>
<td>Negative Comments</td>
<td>2 (2%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Negative Themes</td>
<td>1 (50%) - Attitude of Staff</td>
<td>1 (100%) - Information &amp; Communication</td>
</tr>
<tr>
<td></td>
<td>1 (50%) - Information &amp; Communication</td>
<td></td>
</tr>
</tbody>
</table>

**Narrative:** The response rate and recommendation rate for Maternity services are above the average England scores which were 24.4% response rate and 96.8% recommendation on the last published data. (Patient Experience Headlines Tool, NHSI, latest scores March 2017)
### Children and Young People’s Ward

<table>
<thead>
<tr>
<th></th>
<th>Cumberland Infirmary</th>
<th>West Cumberland Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Quarter 1</td>
<td>Quarter 2</td>
</tr>
<tr>
<td>FFT Score</td>
<td>82</td>
<td></td>
</tr>
<tr>
<td>% Recommended</td>
<td>98.4%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Free Text Responses for this Quarter</th>
<th>Cumberland Infirmary Face to Face Ward Surveys</th>
<th>Cumberland Infirmary Face to Face Ward Surveys</th>
<th>West Cumberland Hospital Face to face Ward Surveys</th>
<th>West Cumberland Hospital Face to face Ward Surveys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Face to Face Surveys or Surveys Returned</td>
<td>24</td>
<td>105</td>
<td>34</td>
<td>31</td>
</tr>
<tr>
<td>Number of Comments Received</td>
<td>23</td>
<td>51</td>
<td>33</td>
<td>22</td>
</tr>
<tr>
<td>Positive Comments</td>
<td>15 (65%)</td>
<td>42 (82%)</td>
<td>24 (73%)</td>
<td>19 (86%)</td>
</tr>
<tr>
<td>Negative Comments</td>
<td>8 (35%)</td>
<td>9 (18%)</td>
<td>9 (27%)</td>
<td>3 (14%)</td>
</tr>
<tr>
<td>Negative Themes</td>
<td>5 -Access &amp; Environment 2 - Info &amp; Communication 1 - Inpatient Treatment and Care</td>
<td>6 -Access &amp; Environment 1 - Appointment Issues 2 - Attitude of Staff</td>
<td>3 -Access &amp; Environment 1 - Appointment Issues, 1 - Info &amp; Communication 4 - Inpatient Treatment and Care</td>
<td>2 - Access &amp; Environment 1 - Info &amp; Communication</td>
</tr>
</tbody>
</table>

**Narrative**: Excellent recommendation rates for the Children and Young People’s Wards. Negative comments about no Wifi is a recurring theme on both sites in the Trust.
Butterfly Scheme - Carers Survey Results

<table>
<thead>
<tr>
<th>Number of surveys Returned</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No of Carers who felt well supported</th>
<th>Cumberland Infirmary</th>
<th>West Cumberland Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 (73%)</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Free Text Responses for this Quarter**

<table>
<thead>
<tr>
<th>Number of Surveys Returned</th>
<th>Cumberland Infirmary</th>
<th>West Cumberland Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>8</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Comments Received</th>
<th>Cumberland Infirmary</th>
<th>West Cumberland Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Positive Comments</th>
<th>Cumberland Infirmary</th>
<th>West Cumberland Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 (92%)</td>
<td>2 (100%)</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Negative Comments</th>
<th>Cumberland Infirmary</th>
<th>West Cumberland Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (8%)</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Negative Themes</th>
<th>Cumberland Infirmary</th>
<th>West Cumberland Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (100%)</td>
<td>Information &amp; Communication</td>
<td></td>
</tr>
</tbody>
</table>

**Narrative**: Whilst the number of surveys returned was low there was lots of positive feedback which is really good. The figure of 73% of carers feeling well supported is low and work is needed to improve this. There was one negative comment returned about information and communication at CIC. It is hoped that the numbers of surveys returned for the Butterfly scheme will increase throughout the year as we do more work around Dementia in the Trust.
**Improvements From Patient Feedback**

**Complaints**

**ISSUE:**
Complainant unhappy with the delay in receiving a copy of the medical records (Access to Records request through Information Governance team). The delay in sending the notes was due to issues regarding the required payment; the complainant had offered payment in cash which was accepted by Trust staff but no system was in place to process cash payments and the payment had been overlooked.

**ACTION:**
The process has been reviewed and amended as a result of the complaint to accept cash payments and record appropriately.

**PALS**

**ISSUE:**
During the Norovirus outbreak, a visitor came to collect a patient’s laundry. A member of the ward team passed the bagged, soiled laundry to the visitor at the entrance to the ward when gowned in protective wear and blue gloves. The visitor opened the bag at home and felt the soiled laundry required disposal. Two days later, the household came down with Norovirus which the visitor links directly to the dirty linen and for which the staff did not give any pre-warning or advice.

**ACTION:**
PALS involved the Infection Prevention Team for advice. It was identified that the laundry bag given was in fact water soluble—this could have simply been placed in the washing machine and washed without opening or risking infection. Staff however were unaware.

The Ward Matron spoke with staff and the IP team ensured staff were aware of the water soluble bags and the need to communicate the potential for infection with visitors taking items home to wash.

PALS reviewed this further with the IP team who have since looked at implementing stickers to go with the bags providing informative information to visitors. It was identified that the water soluble bags we had did come with instructions written on however they were very faint and could easily be missed. The Trust is now in the process of finalising purchasing of new bags with clear, visible instructions which will be roll out across all wards once successfully implemented.
Improvements From Patient Feedback

Service Improvements From Ombudsman Cases

No cases have been closed within the Q1 period.
3 cases from 2016/17 financial year remain open awaiting PHSO outcomes.
1 new PHSO referral was received within the reporting period (Q1) bringing a total of open PHSO cases to 4.

Themes

Emerging themes will be reviewed and reported as the year progresses, monthly meetings have been set up between the Head of Nursing for Patient Experience and the Patient Relations Manager to take this forward.
Report to a Meeting of the Trust Board of Directors held in Public

Date of Meeting: 25 July 2017

Enclosure Number: 7

Title of Report: Fire Safety

Author: Suzanne Halsall, Assistant Director of Estates

Executive Lead: Robin Andrews, Interim Director of Finance

Responsible Sub-Committee (if appropriate): Health & Safety Committee
                                             Fire Safety Committee
                                             Fire Board to Board
                                             PFI Liaison Committee

Executive Summary:

This briefing paper provides an update of the following:

1. **Rectification work** to address serious issues for the Trust in relation to fire safety at The Cumberland Infirmary in Carlisle. Work is progressing to install a sprinkler system and is on plan. The first areas will go live by December 2017 with completion of the hospital by 2020. Passive fire work is nearing completion and a new fire alarm system is currently being installed.

2. **Recent actions regarding cladding** following the tragic fire at Grenfell Tower, the Trust has not been identified as high risk by the NHSI central co-ordination team. The Cumberland Infirmary does not have any cladding issues however Cumbria Fire and Rescue have raised concern regarding a waterproof membrane material within rain screen cladding at The West Cumberland Hospital. The hospital is less than 18 metres high so not determined as high risk and The Trust is now waiting advice from NHSI whether any fire testing is necessary.

3. **An update regarding options** to reconfigure the site during the retrofit of a sprinkler system. This work is complex due to the need to relocate services and a range of options have been developed.

Strategic Priority and BAF Link:

<table>
<thead>
<tr>
<th>Strategic Priority</th>
<th>List below the associated risk in relation to the Strategic Priority:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Building a Platform for Better care</td>
<td>2.6 The Cumberland Infirmary is not compliant with Fire Safety Regulation due to fire compartmentalisation.</td>
</tr>
<tr>
<td>2. Meet all Standards</td>
<td></td>
</tr>
<tr>
<td>3. Create a Good Workforce</td>
<td></td>
</tr>
<tr>
<td>4. Achieve Financial Stability</td>
<td></td>
</tr>
<tr>
<td>5. Improve Safety &amp; Quality</td>
<td></td>
</tr>
</tbody>
</table>
**Financial implications:**

Ongoing Legal and Expert Advisor Costs

**Actions required by the Board:**

<table>
<thead>
<tr>
<th>To approve:</th>
<th>Discussion and decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>To note:</td>
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</tr>
<tr>
<td>For information:</td>
<td>For reading and consideration and for discussion by exception only</td>
</tr>
</tbody>
</table>

The Board is requested to:

1. Approve that assurance is provided as a result of these actions and to note the ongoing and appropriate steps in place to mitigate the risk.
2. Note the ongoing work regarding cladding at The West Cumberland Hospital.

**Data quality:**

<table>
<thead>
<tr>
<th>Source:</th>
<th>Sue Halsall – Assistant Director of Estates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Validated by:</td>
<td>Robin Andrews – Interim Director of Finance</td>
</tr>
<tr>
<td>Date:</td>
<td>15 July 2017</td>
</tr>
</tbody>
</table>
PURPOSE

This briefing paper provides an update of the following:
1. Rectification to address serious issues for the Trust in relation to fire safety at The Cumberland Infirmary in Carlisle.
2. Recent actions regarding cladding following the tragic fire at Grenfell Tower.
3. An update regarding options to reconfigure the site during the retrofit of a sprinkler system.

1. FIRE RECTIFICATION WORKS

There are 5 key steps necessary to enable the rectification of the Cumberland Infirmary to provide a safe building. These are:

a) **The Fire Strategy** for the Site - A final version 1.5 was received on 13\(^{th}\) March 2017.

b) **Disproportionate Collapse** – HMC engaged specialist advisors and a final report was received on 25\(^{th}\) January 2017. The report found that all of the connections inspected do meet the requirements of disproportionate collapse as stated by AECOM (HMC Fire Experts) in the fire strategy.

c) **Completion of known fire compartmentation defects** – All work was due to be complete by April 2017 with the exception of door architraves in hazard rooms where HMC are currently progressing on a risk basis that is not accepted by the Trust fire advisors.

Trust final inspections were carried out by a team from the Trust Fire Experts, Arup that found further defects. HMC were advised and further work has been carried out. The Trust imminently expects a timetable that will set out revised timescales for any remaining work that should be completed in Summer 2017.

d) **HMC ability to fund the work** and Refinancing – HMC continue to fund the work and are in the final stages of concluding a contract with the Sprinkler Supplier – Vipond.
e) A sprinkler retrofit programme that enables decanting over the next estimated 4-5 years – The Options have been and will continue to be developed to meet clinical requirements. The baseline is shown below. Work commenced in the general outpatient area out of hours on 27 February 2017 and the Ground Floor installation is progressing to plan as shaded green in the diagram below.

f) This has provided assurance that work can be carried out without any operational disruption. The external works have also commenced to install water tanks that will be completed by September 2017. The forward six month plan is shown below.

**Update on on-site activities**

- Areas Complete; MPU and Audiology and ENT now complete.
- Working in Ophthalmology (40% of ground floor)
- Discussion with LGF (CSSU, Aseptic and Pathology) on gong.
- Post block 6 – move to undertake A&E (ad hoc) in conjunction with MRI (planned).
Go live of the Sprinklers will be progressive with the first Phase as soon as the external tank installation is completed. The whole ground floor (except for renal) will be live by the end of 2017.

The Inpatient wards will need to be decanted that requires renal dialysis to be relocated to the lower ground floor, therapies relocated to the Sands Centre, and the removal of the hydrotherapy pool. This work is now fully designed and a lease is being finalised with the Council. The Council are planning development of the Sands Centre that will include the re-provision of swimming pools in Carlisle. The Trust is positively working in Partnership with the Council on this scheme to develop a broader “Health and Wellbeing Centre”.

2. RECENT ACTIONS FOLLOWING GRENFELL TOWER

Following the tragic events at Grenfell Tower, NHSI have set up a central co-ordination team. A specific cladding information request was submitted to NHSI in June who have determined the high risk Trusts. North Cumbria is not on this list.

Further information requests will be issued as NHSI progress. A further request has been received that is due to be submitted in July 17.

Cladding itself is not always a risk providing the overall fire safety measures are in place and that the building is constructed in accordance with Building regulations and Fire Safety standards.
The Cumberland Infirmary is well known to Cumbria Fire & Rescue who regularly attend the Trust Fire Safety Committee. No further inspections are deemed necessary given all the work done over the last 3 years. Fire walkers are still in place on site and Fire Prevention measures continue.

Cumbria Fire and Rescue have since visited The West Cumberland Hospital on 10 July 2017 and raised concern regarding a blue coloured membrane within the rain screen cladding on the new build that is potentially flammable. The membrane is sandwiched between concrete and an outer fireproof system. The Trust has now received technical information from Laing O’Rourke and this has been forwarded to the central NHSI team. The new hospital is less than 18 metres high and although not high risk, the Trust may seek fire testing under guidance from NHSI.

The old hospital was already inspected by Arup who have confirmed;

“Old hospital – we observed the wall build up when a hole was cored. No combustible insulation or cladding panels were observed here”.

In the meantime fire prevention measures are in place to ensure that a 2 meter exclusion zone is maintained and no combustible materials are left near the affected areas.

The Trust Fire Prevention Plans were established in 2015 when the Trust was issued with an enforcement notice. These have been shared with NHSI to assist other Trusts who may be facing potential cladding issues at this time.

3. OPTIONS TO RECONFIGURE THE SITE DURING RECTIFICATION WORKS

The Trust is working with HMC to consider the development of a hot floor that would require outpatients to be relocated off site, the movement of endoscopy, and eventual reduction of 5 bed bays to 3 bed bays, once the rectification work is complete.

4. CUMBRIA FIRE AND RESCUE

Cumbria Fire and Rescue continue to attend the Trust Fire Safety Committee to offer advice and monitor progress.
5. **PRIVATE FINANCING UNIT (PFU)**

The Trust continues to keep the Department of Health PFU appraised of progress and any emerging issues. The PFU continues to monitor progress.

6. **NEXT STEPS**

1. Progress review with NHSI regarding rain screen cladding at The West Cumberland Hospital.
2. HMC/IFM to provide revised programme to complete further defects found following inspections of completed work.
3. Cumbria Fire and Rescue Service – continue to ensure that they are fully apprised of our on-going concerns alongside all NHS regulatory bodies.
5. Continue to monitor progress through Board to Board Programme Meetings, Fire Safety Committee and PFI Liaison Meetings.

We will continue to keep the Board appraised on all the above issues as matters arise.

7. **RECOMMENDATION**

The Board is requested to:

- Approve that assurance is provided as a result of these actions and to note the ongoing and appropriate steps in place to mitigate the risk.
- Note the ongoing work regarding cladding at The West Cumberland Hospital.
- Note the ongoing work to reconfigure The Cumberland Infirmary.

Sue Halsall  
**ASSISTANT DIRECTOR OF ESTATES**
### Executive Summary:

In March 2017, the Trust Board approved the action plan in relation to improving nasogastric tube care, following the issuing of a Regulation 28 Notice by H.M Coroner.

A monthly steering group, chaired by the Medical Director has been established to ensure the delivery of the action plan.

This report summarises for the delivery position as at the end of Quarter 1 2017/18.

**Key exceptions to note:**

- The Nasogastric Tube Policy has been updated, consulted on and is in the final stages of approval.
- A clinical reference group has been established to ensure the material decision making points on the clinical aspects of the policy have been thoroughly reviewed and approved.
- The Standard Operating Procedure for the actual insertion of Nasogastric Tubes has been developed in accordance with the updated Policy. This has included the development of the safety critical elements of the checklist/insertion record.
- Progress with clarifying and updating the training and audit requirements has been made in conjunction with development of the policy.
- The CAS Policy has been re-written and is being finalised prior to circulation for consultation, which includes a change in the process and information technology in place to support the CAS process.
- The exception reporting on CAS alerts has been revised and updated.

The Safety & Quality Committee reviewed this delivery report in detail at their meeting in July.

The Committee requested that revised dates were added to the action plan to clarify the actual dates being worked to as some dates had slipped from the original target dates.
One of the key reasons for this has been the need to ensure clinical engagement on the material updates to both the policy and standard operating procedure.

<table>
<thead>
<tr>
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<tbody>
<tr>
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<td>Strategy and System</td>
<td></td>
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<tr>
<td>2.</td>
<td>Operational Flow and Delivery</td>
<td></td>
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<tr>
<td>3.</td>
<td>Patient and Staff Experience</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Workforce and Leadership</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Patient Safety and Quality</td>
<td>This report links directly to learning from serious incidents and patient harm following two never events in 2012 and 2015 involving misplaced nasogastric tubes.</td>
</tr>
</tbody>
</table>

Financial implications: None.

Actions required by the Board:

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</table>

Recommendation:
The Board NOTES the delivery position as at the end of Q1.

Data quality:

<table>
<thead>
<tr>
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<tbody>
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<tr>
<td>Date:</td>
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</tr>
</tbody>
</table>
1. **INTRODUCTION**

In March 2017, the Trust Board approved the action plan in relation to improving nasogastric tube care, following the issuing of a Regulation 28 Notice by H.M Coroner.

A monthly steering group, chaired by the Medical Director has been established to ensure the delivery of the action plan.

This report summarises for the Trust Board the delivery position as at the end of Quarter 1 2017/18.

2. **WORKSTREAM EXCEPTIONS**

The action plan for the Trust has five work streams; progress against overall delivery of the action plan is attached at appendix 1. This report summarises the key exceptions for the quarter against the five work streams.

2.1 **Safety Culture**

The patient safety story was shared with staff during April 2017, whilst the sessions weren’t attended by large staff numbers, the feedback was very positive. These sessions have been added to the Trust Quality Improvement Plan with the aim of delivering four stories this year relating to patient harm / safety. The video to share across the Trust is in progress; this will be launched during quarter 2 and is being led by the Medical Director.

A report on the 18 Never Events the trust has had since 2012 was presented to the Safety & Quality Committee in April 2017. The governance team are completing a final check on any ongoing audit requirements in order to ensure these are fully reflected in the Divisional audit calendars.

In July 2017, the safety culture survey process was launched with the Leadership Community Forum. It has been agreed with the Director of Nursing and Medical Director that each of the CQC defined core services will complete the safety culture survey this year and it has been added to the Quality Improvement Plan, with areas targeted as a priority.

2.2 **Learning & Development**

Work has commenced on upgrading the ESR platform and adding the staff profiles to professional groups/roles. However this is a significant piece of work and will take time to complete. This will be discussed in detail during Q2 in order to be clear on milestones to be achieved.

Significant discussion has taken place at the steering group regarding nasogastric tube training but also the wider issues of clinical skills training for nursing and medical staff. During Q1 the ‘core skills’ mandatory training list was refined in order to reduce the amount of mandatory training required. The same exercise is now required for essential clinical skills training, this will include for example nasogastric tube training, early warning score training and sepsis management. The clinical skills training are those subjects which are crucial to patient safety and quality of care.
A small group has been set up to co-ordinate this work and draft a briefing paper on how this will be delivered, monitored and attached to staff profiles this year for medical, nursing, midwifery and AHP staff.

2.3 Policy and Practice

The existing Priority 1 policy register has been sent to the Director of Nursing and Medical Director for approval. Visits to Salford Royal NHS FT and Newcastle Hospitals NHS FT have taken place during Q1; a paper on comparisons based on strengths and weaknesses is being drafted for discussion. This will need to link to the development and alignment of the policy process across the system.

The Trust induction component for governance in general is being revised, which will include a section on policy compliance and development.

2.4 Clinical practice for nasogastric tube care

A significant amount of work has taken place in this work stream during quarter 1. This has been driven by the need to ensure the updated policy and standard operating procedure for insertion of a nasogastric tube are finalised and fit for purpose. A small clinical reference group has been set up to ensure the material clinical decisions relating to the policy and standard operating procedure have been thoroughly reviewed prior to approval. This includes direct feedback from a senior nurse who inserts and cares for high numbers of patients with nasogastric tubes as well as feedback from ward areas who insert tubes infrequently. The final draft of the policy and standard operating procedure were approved by the clinical reference group on 19/07/2017 and are progressing through the final ratification process.

The training requirements for nursing and medical staff have been made simple yet explicit in the policy.

The audit requirements have also been updated with the questions being refined in line with the launch of the new policy.

Representation from paediatrics and also Cumbria Partnership NHS Foundation Trust on the steering group has also raised some practical queries which are being considered in the final iterations of the policy in order to ensure all pathways of care have been considered.

It is envisaged that the policy and operating procedure will be formally launched across the Trust, with the training packages in place during September at the latest.

2.5 Risk and assurance

The key focus of this workstream during quarter 1 has been re-writing the CAS Policy. This has been completed and prior to circulation for comments, a review of the current manual process / email information system is being undertaken with a view to switching this to the Ulysses system to allow greater resilience and tracking of alerts.

The reports into the Safety & Quality Committee have also been strengthened to provide greater clarity on alerts issued and responded to within the respective quarter.
Independent testing of the procurement process has been undertaken during the quarter in order to provide assurance that the correct tubes and pH testing strips can be ordered. There is now a Trust Agreed Products (TAP) spreadsheet ensuring that no other items can be ordered. This has been confirmed by the Head of Dietetics. Written notification is also being issued to ward managers to remind them of the procurement process and what tubes/pH strips should be purchased. The Procurement Policy is currently under review and will include details of the TAP.

3. **CONCLUSION**

The updated action plan attached at appendix 1 is a live document which is updated after each steering group meeting. The Trust Board will note that the original target dates for some of the items have not been met, however positive assurance should be sought from the thorough process which is being applied to ensuring the policy and procedure are correct and that the training for staff to access is available from the launch of the new policy and procedure.

Progress has been made on the associated areas from improvement in relation to policy development, safety culture and risk management.

The delivery and engagement from members of the steering group is working well and the clinical reference group is providing expert views in order to ensure critical decisions on changes to the policy have been through a robust clinical governance process.

A further update will be provided to the Board at the end of Quarter 2.

4. **RECOMMENDATION**

The Board NOTES the delivery position as at the end of Q1.

*Appendix 1 – NG Action Plan Version 5*
## WORKSTREAM 1: SAFETY CULTURE

### What does success look like?

- We will tell a story to the organisation on the patient harm caused in the three NG Never Events to professional groups.
- We will understand the safety culture of the organisation and where we need to make improvements in teams and as a Trust.
- We will be open and transparent with the public about the improvements we need to make.
- We will proactively assess the safeguards in place for all 14 defined Never Events.
- We will reinforce ‘stop the line’ to all staff in order to empower and encourage safety practice.

### How will this be delivered?

<table>
<thead>
<tr>
<th>Task Description</th>
<th>By Who</th>
<th>By When</th>
<th>RAG</th>
<th>Commentary on items past delivery dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Staff engagement/roadshows will be delivered by MD, DoN, COO in April.</td>
<td>Head of Communications</td>
<td>28/04/2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2 We will record a video to be shared and made available to all staff.</td>
<td>Head of Communications</td>
<td>28/04/2017</td>
<td></td>
<td>Video in progress.</td>
</tr>
<tr>
<td>1.3 A Safety Culture audit will be undertaken across all staff groups.</td>
<td>Medical Director</td>
<td>28/04/2017</td>
<td></td>
<td>Safety culture questionnaire will be completed at LCF July. Plan in place on QIP for all services.</td>
</tr>
<tr>
<td>1.4 We will be report publicly our response to the Coroner and our supporting action plan.</td>
<td>Associate Director of Governance</td>
<td>31/03/2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.5 We will review the procedures and safeguards in place to prevent Never Events occurring across the 14 prescribed national never events.</td>
<td>Associate Director of Governance</td>
<td>31/03/2018</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.6 We will review the embeddedness of the learning and evidence across the 18 Never Events which have occurred since November 2012.</td>
<td>Associate Director of Governance</td>
<td>29/09/2017</td>
<td></td>
<td>Report on learning in place on all 18 never events completed. Ongoing audit requirements to be determined. For full assurance.</td>
</tr>
</tbody>
</table>
## WORKSTREAM 2: LEARNING & DEVELOPMENT

### What does success look like?

- We will implement the next phase of ESR platform to allow easier integration of training profiles and electronic monitoring of mandatory training.
- The induction process will support safe checking of staff to ensure they are competent in accordance with the Trust’s policy to insert and check nasogastric tube placement.
- The mandatory training requirements for all P1 policies will be clear, robust and accessible.
- Calibre of training packages will support best practice guidance in order to ensure competent practice is in place.

### How will this be delivered?

<table>
<thead>
<tr>
<th>Description</th>
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<th>By When?</th>
<th>RAG</th>
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</tr>
</thead>
<tbody>
<tr>
<td>2.1 The next phase of the ESR ‘platform’ will be implemented to allow easier integration of training profiles and monitoring reports with ESR. This will include adding all staff profiles to the new system.</td>
<td>Deputy Director of HR</td>
<td>31/03/2018</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2 The local induction checklists for nursing and medical staff will be reviewed to ensure they support safe working practice checks to be completed, including nasogastric tube training.</td>
<td>Deputy Director of HR</td>
<td>29/09/2017</td>
<td></td>
<td>Learning &amp; development are reviewing the local checklists.</td>
</tr>
<tr>
<td>2.3 All P1 policies will be mapped against statutory and mandatory training profiles to ensure core training is included.</td>
<td>Head of Compliance &amp; Deputy Director of HR</td>
<td>29/09/2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.4 The training packages for NG Tube for nursing (placement) and confirmation (medical) will be reviewed to ensure they reflect and meet national best practice.</td>
<td>Head of Nursing, Clinical Education &amp; Practice Development &amp; Medical Leads – NGT</td>
<td>30/06/2017 29/09/2017</td>
<td></td>
<td>Training requirements have been updated into revised policy and SoP. Plan on delivery as part of launch of new policy &amp; SoP being finalised.</td>
</tr>
</tbody>
</table>
### WORKSTREAM 3: POLICY AND PRACTICE

#### What does success look like?
- We will continue to ensure that the key policies are prioritised and focussed on.
- Policies which directly impact on patient treatment or intervention will be reviewed in relation to LocSSIPs & clinical decision making aids.
- We will ensure that new staff understand where to access and the importance of complying with Trust policies.
- A benchmarking exercise will be undertaken in relation to the policy process and Trust policy register.
- The policy template will be reviewed and consulted on with key clinical and managerial leads.
- We will ensure that the audit requirements of P1 policies are clear, robust and formally reported on in terms of outcome.

#### How will this be delivered?

<table>
<thead>
<tr>
<th></th>
<th>How will this be delivered?</th>
<th>By Who?</th>
<th>By When?</th>
<th>RAG</th>
<th>Commentary on items past delivery dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>We will review the P1 register annually with the Executive Directors.</td>
<td>Associate Director of Governance</td>
<td>31/05/2017</td>
<td></td>
<td>Register issued to MD &amp;DoN 31/05 to approve.</td>
</tr>
<tr>
<td>3.2</td>
<td>The P1 policies which have a clinical procedural component, including interventions, are reviewed in the context of ensuring local safety standards and checks are in place within the clinical teams.</td>
<td>Head of Clinical Standards – governance</td>
<td>31/10/2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.3</td>
<td>The Trust induction programme will include Policy compliance.</td>
<td>Associate Director of Governance</td>
<td>31/10/2017</td>
<td></td>
<td>Wider review of governance aspects of induction programme underway</td>
</tr>
<tr>
<td>3.4</td>
<td>We will compare the policy register and process with external organisations.</td>
<td>Head of Compliance</td>
<td>28/07/2017</td>
<td></td>
<td>Visits to Newcastle &amp; Salford complete. Report on strengths and weaknesses being prepared.</td>
</tr>
<tr>
<td>3.5</td>
<td>The policy template will be reviewed and updated where required.</td>
<td>Head of Compliance</td>
<td>30/06/2017</td>
<td></td>
<td>Updated template in progress. Will be circulated to TPG for comments in July.</td>
</tr>
<tr>
<td>3.6</td>
<td>The audit profiles of P1 policies will be reviewed and formally included in the Trust Clinical and or Internal Audit Plan (this work will be phased).</td>
<td>Head of Compliance &amp; Head of Clinical Standards – governance</td>
<td>31/10/2017</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## WORKSTREAM 4: CLINICAL PRACTICE FOR NASOGASTRIC TUBE CARE

### What does success look like?
- An updated and revised Nasogastric Tube Policy and supporting clinical procedure will be in place.
- We will ensure standardised nursing and medical practice is in place across both hospital sites.
- We will ensure that a robust clinical procedure for paediatrics is in place.
- We will strengthen the current clinical audit reports and monitoring in order to ensure compliance with the Policy.
- We will ensure competent clinical practice is taking place.

### How will this be delivered?

<p>| | | | |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>4.1</strong></td>
<td>We will formally consult and engage staff on the updated policy, improved summary and clinical procedure. This will include representation and input from all specialties.</td>
<td>Medical Director</td>
<td>28/04/2017</td>
</tr>
<tr>
<td><strong>4.2</strong></td>
<td>We will develop the clinical procedure using the LocSSIP methodology in order to ensure that nursing and medical ownership and engagement is in place.</td>
<td>Medical Director</td>
<td>30/06/2017</td>
</tr>
<tr>
<td><strong>4.3</strong></td>
<td>Linked to 2.4 we will ensure that the learning and development requirements for nursing and medical staff have been fully addressed in order to deliver safe clinical practice.</td>
<td>Head of Nursing, Clinical Education &amp; Practice Development &amp; Medical Leads – NGT</td>
<td>30/06/2017 29/09/2017</td>
</tr>
<tr>
<td><strong>4.4</strong></td>
<td>A clinical procedure for paediatrics will be development and implemented.</td>
<td>Chief Matron Paediatrics</td>
<td>30/06/2017 29/09/2017</td>
</tr>
<tr>
<td><strong>4.5</strong></td>
<td>The existing audit and reporting requirements will be reviewed and strengthened where necessary in order to ensure audit activity is supporting improvements in care.</td>
<td>Head of Clinical Standards – nursing</td>
<td>31/05/2017</td>
</tr>
<tr>
<td><strong>4.6</strong></td>
<td>A programme of observational audits and team reflection sessions are in place in order to ensure competent clinical practice is in place.</td>
<td>Head of Clinical Standards – nursing Medical Leads – NGT</td>
<td>29/09/2017</td>
</tr>
<tr>
<td>What does success look like?</td>
<td>How will this be delivered?</td>
<td>By Who?</td>
<td>By When?</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------------------------</td>
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</tr>
</tbody>
</table>
| • We will review the assessment and monitor the controls in place across the medical and surgical divisional registers for NG Tubes.  
• We will ensure that there is clear ward to board reporting on the training performance and compliance with the Trust policy for nasogastric tube care.  
• We will ensure that the central alert system policy and supporting procedure is robust and based on a formal assessment of risk for patient safety alerts.  
• We will update the existing CAS policy to make explicit links to formal risk assessment and escalation from Ward to Board.  
• An independent review on the delivery of this action plan and implementation of any revised policy will be undertaken and reported to the Board.  
• We will revise purchasing policies to ensure that ordering of non-compliant stock is not possible. | 5.1 Updated risk assessments for Nasogastric Tube Care in medicine, surgery and paediatrics will be completed. | Chief Matrons | 28/04/2017 | Green | Central risk updated. |
| | 5.2 We will review the existing assurance reports in place from W2B which confirm who has been trained and what clinical practice, through robust audit is highlighting. | Associate Director of Governance | 30/08/2017 | | |
| | 5.3 The existing CAS Policy will be reviewed and updated with clear communication to nominated leads on roles and responsibilities. The new policy will include clear process for escalation to the Trust Board on outstanding or incomplete alerts. | Associate Director of Governance & Assistant Director of Estates | 28/04/2017 31/08/2017 | Orange | CAS Policy has been re-written, change to Ulysses system pending prior to finalising policy. |
| | 5.4 Independent and or external audit to be undertaken on delivery of this action plan as well as the practical implementation of the new policy. | Chief Executive | 31/03/2018 | | |
| | 5.5 The existing procurement processes and policies will be reviewed and updated as necessary to reduce the likelihood of the availability of non-compliant equipment. | Assistant Director of Estates | 30/04/2017 31/08/2017 | Orange | Independent testing on purchase ordering completed by head of dietetics. Written communication to ward managers to be completed. |


Report to a Meeting of the Trust Board of Directors held in Public

<table>
<thead>
<tr>
<th>Date of Meeting:</th>
<th>25 July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enclosure Number:</td>
<td>9</td>
</tr>
<tr>
<td>Title of Report:</td>
<td>Learning from Deaths</td>
</tr>
<tr>
<td>Author:</td>
<td>Dr Clive Graham</td>
</tr>
<tr>
<td>Executive Lead:</td>
<td>Dr Rod Harpin</td>
</tr>
<tr>
<td>Responsible Sub-Committee (if appropriate):</td>
<td>Mortality Surveillance Group</td>
</tr>
</tbody>
</table>

**Executive Summary:**

HSMR and SHMI data up until the end of December 2016 are within expected limits. The main diagnostic group with higher than expected number of deaths is pneumonia, we are analysing the mortality reviews which have been done on that diagnostic group to identify any key issues; sepsis deaths are now less than expected. Weekend mortality rates are less than previously reported.

During this quarter mortality reviews have identified one patient with a Hogan 5 which has been investigated as a serious untoward incident, four patient with a Hogan 4, one of these has been identified as a serious untoward incident the other have been investigated as moderate incidents. Some cases are downgraded after initial assessment mainly due to poor prognosis of the patient’s primary condition.

The key risks identified are:-

- Ensuring our Hogan assessments are performed in line with other organisations and we have a robust process
- Ensuring we improve the care quality issues identified in particular NEWS and the management of the deteriorating patient
- Ensure we have a new Mortality Policy in place by September 2017 aligned to the National Guidance on Learning from Deaths (NQB March 2017)

<table>
<thead>
<tr>
<th>Strategic Priority and BAF Link:</th>
<th>Strategic Priority:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Building a Platform for Better care</td>
<td></td>
</tr>
<tr>
<td>2. Meet all Standards</td>
<td></td>
</tr>
<tr>
<td>3. Create a Good Workforce</td>
<td></td>
</tr>
<tr>
<td>4. Achieve Financial Stability</td>
<td></td>
</tr>
<tr>
<td>Financial implications:</td>
<td>5. Improve Safety &amp; Quality</td>
</tr>
<tr>
<td>------------------------</td>
<td>----------------------------</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Actions required by the Board:</th>
<th>To approve:</th>
<th>Discussion and decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>To note:</td>
<td>Where the Board is made aware of key points but no decision required</td>
<td></td>
</tr>
<tr>
<td>For information:</td>
<td>For reading and consideration and for discussion by exception only</td>
<td></td>
</tr>
</tbody>
</table>

The Board is requested to note the report.

<table>
<thead>
<tr>
<th>Data quality:</th>
<th>Source:</th>
<th>NEQOS, in house database</th>
</tr>
</thead>
<tbody>
<tr>
<td>Validated by:</td>
<td>Mike Stacey</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td>17th July 2017</td>
<td></td>
</tr>
</tbody>
</table>
1. **INTRODUCTION**

For many people death whilst or following a hospital admission is an inevitable outcome and they experience excellent care from the Trust in the days, months or years leading up to their death. However some patients experience poor quality provision resulting from multiple contributory factors. When mistakes happen, the Trust working with their partners need to do more to understand the causes. The purpose of reviews and investigations of deaths which problems in care might have contributed to is to learn in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon.

The recently published National Guidance on Learning from Deaths requires us to publish an updated policy by September 2017 on how we responds to, and learns from, deaths of patients who die under our management and care.

Furthermore, from April 2017, Trusts will be required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public Board meeting in each quarter to set out the Trust’s policy and approach (by the end of Q2) and publication of the data and learning points (from Q3 onwards). This is the first such report of this type.

2. **MORTALITY DATA**

   a. **SHMI**

   The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths up to 30 days following discharge. The most recent data up until Dec 2016 indicates a ratio lower than National Average, 0.97. The table below also indicates an improved picture both in the short and long term.
b. HSMR

The Hospital Standardised Mortality Ratio (HSMR) is another method of comparing mortality levels, it is similarly adjusted for case mix (age, sex, co-morbidities, socio-economic deprivation) and also if palliative care has been received. It does not include deaths post discharge.

Our HSMR for the calendar year 2016 is 97 significantly better than the ratio in 2015 which was 109. Much of the increase in 2015 was due to a high number of winter deaths in 2014-15; this peak was much less pronounced in the winter of 2015-16.
There does not appear to be any significant differences in weekend mortality on the most recent data available from NEQOS.

<table>
<thead>
<tr>
<th>Trust Name</th>
<th>Number of discharges per day</th>
<th>Number of deaths per day</th>
<th>HSMR</th>
<th>Number of discharges per day</th>
<th>Number of deaths per day</th>
<th>HSMR</th>
<th>Discharges (weekend - weekday)</th>
<th>Deaths (weekend - weekday)</th>
<th>HSMR (weekend - weekday)</th>
<th>Discharges (weekend - weekday)</th>
<th>Deaths (weekend - weekday)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDD</td>
<td>144</td>
<td>5.3</td>
<td>103</td>
<td>77</td>
<td>4.5</td>
<td>104</td>
<td>67</td>
<td>6</td>
<td>0.8</td>
<td>0.53</td>
<td>0.84</td>
</tr>
<tr>
<td>North Tees</td>
<td>122</td>
<td>3.9</td>
<td>104</td>
<td>49</td>
<td>3.2</td>
<td>112</td>
<td>73</td>
<td>3</td>
<td>0.9</td>
<td>0.45</td>
<td>0.85</td>
</tr>
<tr>
<td>South Tees</td>
<td>170</td>
<td>5.0</td>
<td>99</td>
<td>73</td>
<td>4.0</td>
<td>96</td>
<td>97</td>
<td>1</td>
<td>1.0</td>
<td>0.45</td>
<td>0.95</td>
</tr>
<tr>
<td>Gateshead</td>
<td>80</td>
<td>2.6</td>
<td>103</td>
<td>34</td>
<td>2.2</td>
<td>107</td>
<td>53</td>
<td>0</td>
<td>0.4</td>
<td>0.39</td>
<td>0.95</td>
</tr>
<tr>
<td>South Tyneside</td>
<td>40</td>
<td>2.0</td>
<td>112</td>
<td>22</td>
<td>1.7</td>
<td>125</td>
<td>26</td>
<td>0.3</td>
<td>3</td>
<td>0.44</td>
<td>1.06</td>
</tr>
<tr>
<td>Sunderland</td>
<td>117</td>
<td>4.0</td>
<td>110</td>
<td>53</td>
<td>3.3</td>
<td>116</td>
<td>64</td>
<td>0.7</td>
<td>1</td>
<td>0.45</td>
<td>1.06</td>
</tr>
<tr>
<td>Newcastle</td>
<td>238</td>
<td>4.7</td>
<td>102</td>
<td>77</td>
<td>3.6</td>
<td>111</td>
<td>160</td>
<td>0</td>
<td>0.9</td>
<td>0.32</td>
<td>0.89</td>
</tr>
<tr>
<td>Northumbria</td>
<td>141</td>
<td>6.0</td>
<td>100</td>
<td>62</td>
<td>5.0</td>
<td>107</td>
<td>79</td>
<td>1</td>
<td>1</td>
<td>0.44</td>
<td>1.03</td>
</tr>
<tr>
<td>North Cumbria</td>
<td>95</td>
<td>3.4</td>
<td>96</td>
<td>38</td>
<td>2.7</td>
<td>101</td>
<td>57</td>
<td>0.7</td>
<td>5</td>
<td>0.40</td>
<td>1.01</td>
</tr>
<tr>
<td>Total</td>
<td>1104</td>
<td>30.5</td>
<td>105</td>
<td>485</td>
<td>30.4</td>
<td>108</td>
<td>97</td>
<td>0.6</td>
<td>4</td>
<td>0.42</td>
<td>0.83</td>
</tr>
</tbody>
</table>

Table 3. Weekday and weekend mortality (HSMR), 2016

**c. VLAD Reports**

Variable Life Adjusted Display (VLAD) charts are a visual way of monitoring clinical outcomes adjusted for risk. Consecutive cases are plotted within a selected SHMI diagnosis group. Using the observed and expected mortality for individual patients, changes in the pattern of outcomes are detected using statistical control limits that generate alerts these are also produced by NEQOS. They should be used as a trigger for further analysis and/or if issues already identified for action to be taken. An example (for sepsis) is
given below followed by a table summarising the data contained within similar charts followed by an interpretation of these.

<table>
<thead>
<tr>
<th>Diagnosis Groups</th>
<th>Deaths</th>
<th>Cases</th>
<th>% Deaths</th>
<th>SHMI</th>
<th>VLAD Signals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Positive</td>
</tr>
<tr>
<td>Septicemia</td>
<td>59</td>
<td>319</td>
<td>18.5%</td>
<td>95</td>
<td>1</td>
</tr>
<tr>
<td>Lung Cancer</td>
<td>40</td>
<td>125</td>
<td>32.0%</td>
<td>84</td>
<td>0</td>
</tr>
<tr>
<td>Acute MI</td>
<td>54</td>
<td>646</td>
<td>8.4%</td>
<td>103</td>
<td>0</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>93</td>
<td>617</td>
<td>15.1%</td>
<td>105</td>
<td>0</td>
</tr>
<tr>
<td>Stroke</td>
<td>121</td>
<td>740</td>
<td>16.4%</td>
<td>95</td>
<td>0</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>323</td>
<td>1707</td>
<td>18.9%</td>
<td>103</td>
<td>0</td>
</tr>
<tr>
<td>Pneumonia - Cumberland</td>
<td>203</td>
<td>1120</td>
<td>18.1%</td>
<td>97</td>
<td>0</td>
</tr>
<tr>
<td>Pneumonia - West Cumberland</td>
<td>120</td>
<td>587</td>
<td>20.4%</td>
<td>117</td>
<td>0</td>
</tr>
<tr>
<td>Acute Bronchitis</td>
<td>33</td>
<td>1200</td>
<td>2.8%</td>
<td>91</td>
<td>0</td>
</tr>
<tr>
<td>COPD</td>
<td>40</td>
<td>910</td>
<td>4.4%</td>
<td>74</td>
<td>1</td>
</tr>
<tr>
<td>Intestinal Infection</td>
<td>28</td>
<td>715</td>
<td>3.9%</td>
<td>161</td>
<td>0</td>
</tr>
<tr>
<td>Renal</td>
<td>39</td>
<td>317</td>
<td>12.3%</td>
<td>80</td>
<td>0</td>
</tr>
<tr>
<td>UTI</td>
<td>88</td>
<td>1387</td>
<td>6.3%</td>
<td>101</td>
<td>0</td>
</tr>
<tr>
<td>#NOF</td>
<td>42</td>
<td>491</td>
<td>8.6%</td>
<td>98</td>
<td>1</td>
</tr>
</tbody>
</table>

Single alerts for: Acute MI (March 2016) and Intestinal Infection (September 2016), no alerts for the latest quarter.

Pneumonia shows 1 alert for the Cumberland site (April 2016) and 1 at West Cumberland (September 2016).
Trust SHMI is 97 with 2 negative alert shown (was 4), the overall picture is good.

Serious infection
- Pneumonia: improved picture from the last time;
- Septicemia: looks good – positive alert;
- Intestinal Infection: negative alert in September;
- UTI: VLAD hovers around 0.

Site breakdown highlights differences for Pneumonia, particularly in the second half of 2016.

3. MORTALITY REVIEWS

The National Quality Board (NQB) have created a standard dashboard for reporting deaths, information for the first quarter are given below:

![Dashboard Image]

Not all cases reviewed have been entered onto the database but no additional Hogan 4s or above have been identified at the time of writing this report.

A small number of Learning Disability deaths have been reviewed but these relate to deaths in the previous financial year.
We attempt to review all adult deaths and achieve around 80% of deaths being reviewed, various elements are looked at including an assessment of whether the death was avoidable or not using something called the Hogan Score, this is a subjective judgement where the following apply. It should be noted that the RCP numbering is the other way round such that a Hogan 1 is RCP 6 and Hogan 6 is a RCP 1.

Hogan 1 – Definitely not preventable
Hogan 2 – Slight evidence of preventability
Hogan 3 – Possibly preventable but not very likely, less than 50-50 but close call
Hogan 4 – Probably preventable, more than 50-50 but close call
Hogan 5 – Strong evidence of preventability
Hogan 6 – Definitely preventable

There is one Hogan 5 (RCP 2) case, this has been declared as a serious untoward incident and has been investigated, the conclusions indicated that care was sub-standard and a number of recommendations made.

Of the four Hogan 4 (RCP 3) cases, one has been declared as a serious incident (delayed diagnosis of hip fracture), three have undergone investigation as moderate incidents, two have been reviewed by the patient safety panel (one death related to Clostridium difficile infection the other followed an elective procedure), one is yet to be reviewed.

4. CONCLUSIONS

It must be noted that although this report focuses on issues identified there are many examples of high quality care both in the management of the patient who is acutely unwell as well as carefully considered end of life care.

Overall our mortality data is within expected range with improved HSMR and most diagnostic groups within expected range. We are identifying a small number of avoidable deaths and the most serious cases are being escalated and reviewed as Serious Untoward Incidents.

A number of the reviews do not score highly in terms of Hogan Score but there are some key themes that emerge that represent issues with care quality and delivery, these include:-

- Management of the deteriorating patient (use and response to elevated NEWS)
- Fluid Balance – poor recording and response to low urine output
- Use of oxygen in particular saturations that are set lower than one would expect on the basis of Oxygen Policy.
- Missed doses of medication
These issues link with our Quality Improvement Plan particularly with the management of the deteriorating patient and this has been identified as a focus for this financial year. It is reassuring to see that where we have identified issues for example sepsis and undertaken focused pieces of work to improve this has resulted in improved patient outcomes. Finally we need to identify how we better involve families in the mortality review process.

5. **RECOMMENDATIONS**

The Trust Board is asked to note the content of this report.

Dr Clive Graham

**AMD Patient Safety**
# Report to a Meeting of the Trust Board of Directors

<table>
<thead>
<tr>
<th>Date of Meeting:</th>
<th>25 July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enclosure Number:</td>
<td>10</td>
</tr>
<tr>
<td>Title of Report:</td>
<td>Governance Framework and Terms of Reference</td>
</tr>
<tr>
<td>Author:</td>
<td>Ramona Duguid, Associate Director of Risk and Quality Governance</td>
</tr>
<tr>
<td>Executive Lead:</td>
<td>Maurya Cushlow, Executive Director of Nursing</td>
</tr>
<tr>
<td>Responsible Subcommittee (if appropriate):</td>
<td>N/A</td>
</tr>
</tbody>
</table>

## SUMMARY

The Trust is required to have in place an overarching document which sets out how governance works in practice. Historically this has been referred to as the Risk Management Strategy within NHS organisations (as part of the NHS Litigation Authority Assessments).

The Trust last updated this document in detail in 2015 and it was titled the ‘Board, Risk and Assurance Framework’. In January 2016, minor amendments were made to the framework, however material points in the framework were still required to be updated. In late 2016, the Good Governance Institute gave their feedback on the Trust governance review. One of the key areas in this review was the need to review the Safety & Quality Committee terms of reference. This cover report sets out the material updates which have been made to the Governance Framework and terms of reference for this committee.

### Trust Governance Framework Material Updates (Appendix 1)

- The title of this document (previously Board, Risk and Assurance Framework) has been updated to the ‘Governance Framework’. This follows feedback from staff on the potential confusion between this and the Board Assurance Framework.
- The roles and responsibilities sections have been updated.
- A new, more detailed section on ‘governance in practice’ has been added to the framework.
- It is proposed that Quarterly Divisional Reviews are established to allow greater scrutiny on governance in practice as well as delivery of associated quality programmes at divisional level.
- The core sections on risk and incident management have been updated to ensure they reflect the recently updated associated governance policies.
- Initial priorities for 2017/18 have also been included in this framework.
Safety & Quality Committee Terms of Reference Material Updates (Appendix 2) and Workplan (Appendix 3)

- The terms of reference have been reviewed in relation to content of the duties and also membership.
- The duties of the committee have been updated to explicitly reference the key remit of the committee across the core functions of governance.
- The proposed membership has been updated.
- There is a shift from this Board level committee being involved in reviewing divisional/operational detail on a month by month basis (which will be achieved through the Divisional Quarterly Governance reviews).
- The work plan for the committee and the proposed new terms of reference has been updated.
- The quoracy for the committee is proposed to increase from the current position of one Executive Director and one Non-Executive Director to two Non-Executive Directors, one Executive Director (or their nominated deputies) and two other members of the committee.

NEXT STEPS

Whilst governance arrangements are picking up pace and emerging in relation to potential new organisational forms, it is important the current governance structure for the Trust, particularly in relation to Board committees is robust and fit for purpose. The Safety & Quality Committee does require updated terms of reference to be in place. Members of the committee and the Clinical Executive Group will be asked for comments on the proposed changes by Friday 23 June 2017.

<table>
<thead>
<tr>
<th>Strategic Priority and BAF Link:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Priority:</td>
</tr>
<tr>
<td>1. Strategy and System</td>
</tr>
<tr>
<td>2. Operational Flow and Delivery</td>
</tr>
<tr>
<td>3. Patient and Staff Experience</td>
</tr>
<tr>
<td>4. Workforce and Leadership</td>
</tr>
<tr>
<td>5. Patient Safety and Quality</td>
</tr>
</tbody>
</table>

Financial implications:

None identified.
**Recommendation:** The Board is asked to:

a) APPROVE the updated Governance Framework attached in Appendix 1.
b) RATIFY the revised terms of reference for the Safety and Quality Committee attached in Appendix 2.
c) NOTE that further work will be required on the governance framework and committee terms of reference as the development of system wide working and new organisational forms emerge.
TRUST GOVERNANCE FRAMEWORK & PRIORITIES 2017/18

Quality Governance
<table>
<thead>
<tr>
<th>TABLE OF CONTENTS</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PURPOSE</td>
<td>3</td>
</tr>
<tr>
<td>2. VALUES</td>
<td>4</td>
</tr>
<tr>
<td>3. RESPONSIBILITIES</td>
<td>5</td>
</tr>
<tr>
<td>4. QUALITY GOVERNANCE</td>
<td>7</td>
</tr>
<tr>
<td>5. REPORTING AND ASSURANCE</td>
<td>8</td>
</tr>
<tr>
<td>6. GOVERNANCE IN PRACTICE</td>
<td>11</td>
</tr>
<tr>
<td>7. EXTERNAL SCRUTINY &amp; VISITS</td>
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<tr>
<td>8. IMPLEMENTATION &amp; TRAINING</td>
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</tr>
<tr>
<td>9. 2017/18 GOVERNANCE PRIORITIES</td>
<td>21</td>
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</table>
1. PURPOSE OF THIS FRAMEWORK

All staff who work in the NHS have a duty to ensure that they carry out their duties in the safest way possible in order to achieve good quality outcomes for patients, their families and carers.

As an NHS organisation we have a duty to ensure that Quality Governance is in place across all services and departments for the benefit of both our staff and patients.

The purpose of this framework is to ensure that all staff at all levels across the Trust understand how governance works in practice in our organisation.

1.1 What is Quality Governance?

Quality Governance is the combination of structures and processes at and below board level to lead on trust-wide quality performance including:

- Ensuring required standards are achieved
- Investigating and taking action on substandard performance
- Planning and driving continuous improvement
- Identifying, sharing and ensuring delivery of best-practice
- Identifying and managing risks to quality of care
- Ensuring our culture and behaviours support the delivery of safe, effective patient care

1.2 What is Risk Management?

Risk management is the systems and processes we have in place in order to minimise the probability and impact of adverse outcomes and support the achievement of the organisation’s objectives.

Risk management is a continuous process and it aims to influence behaviour and develop an organisational culture within which risks are recognised, escalated and addressed.

1.3 What is Assurance?

Assurance is the evidence in place to confirm the status of a specific objective, delivery of a project or control in place to manage a risk. Assurance can be both positive and negative and it is the difference between guessing and knowing.

1.4 Supporting Policies

All staff should ensure that they comply with Trust policies and procedures. There are key policies which support the implementation of this Governance Framework across the Trust:

- Incident Management Policy
- Risk Management Policy
- Duty of Candour Policy
- Complaints Policy
2. **OUR VALUES**

Our values and behaviours are integral to how well our organisation is governed and the standards we accept as both individuals and as multidisciplinary teams. The day to day decisions we take reflect how quality governance happens in practice.

**Patients First**
- Patient care will be the best we can deliver
- We show compassion, empathy and respect
- We respond to the needs of all patients
- We provide excellent services
- We ensure physical comfort and emotional support
- We provide the right information at the right time for patients and their families

**Safe and High Quality Care**
- Quality and safety is at the heart of everything we do
- We set clear standards and report against them
- We will encourage new ideas and innovation
- We will continuously improve to ensure our standard is the highest it possibly can be

**Responsibility and Accountability**
- We take personal responsibility for our actions
- We actively build relationships within and across teams
- We measure performance and act on facts

**Everyone’s Contribution counts**
- We all have a part to play in delivering excellence
- We encourage education and personal development
- We all take responsibility for developing others

**Respect**
- We lead by example
- We aim to be good role models
- We respect everyone’s contribution
- We support individuals to succeed
3. OUR RESPONSIBILITIES

3.1 Who is responsible for governance?

In very simple terms, governance is **EVERYONE’S** responsibility. All staff must ensure that the policies and procedures in place to deliver safe care are followed in their day to day practice and job role. In addition to this, all staff have a duty to ensure:

- They comply with the ongoing training requirements in order to perform their job to the highest possible standard.
- Report, escalate and investigate poor practice and risks to delivering safe patient care.
- Communicate and engage with their team members.
- Promote openness and transparency in order to prevent and learn from errors and near misses.

Patients, their families and carers rely on our organisation to treat them safely, achieve a good quality outcome and deliver positive patient experience. This is why good quality governance in practice is everyone’s responsibility.

3.2 The Trust Board

3.2.1 The role of the Trust Board & Governance

The Trust Board is responsible and accountable for ensuring that effective clinical and corporate governance and risk management systems are in place to support the safe delivery of care to patients as well as ensuring a safe working environment for all staff.

The Trust Board is responsible for ensuring that effective information and reporting structures exist to ensure scrutiny on key governance and risk issues, which contribute to the standards of safety and quality across the organisation.

The Chief Executive has on behalf of the Trust Board, responsibility for maintaining a sound system of internal control. This requires the organisation to have in place the necessary controls to manage its risk exposure. Through the Trust Board, Audit & Risk Committee, Safety and Quality Committee and Divisional Governance Boards, the Chief Executive is assured that effective leadership for Governance and Risk Management is provided and that the strategic objectives are met.

3.2.2 Executive Directors

Each Executive Director and non-voting Directors are responsible for ensuring that their individual obligations for effective governance and risk management are achieved and implemented within their areas of responsibility. This includes leading the reinforcement of the organisational values and goals that determine our culture.

Each Director has a specific portfolio of duties in relation to delivery of the trusts objectives which includes specific duties in relation to good governance and risk management.
A summary of these in relation to Quality Governance is attached at Appendix 1 of this framework.

### 3.2.3 Divisional Management Team

The divisional management teams are responsible for ensuring that this framework is implemented across all wards, departments and services within their division, this includes ensuring all managers and heads of department are clear on their individual and collective duties in relation to quality governance in practice. This includes:

- Reporting, escalating and investigation incidents and near misses in accordance with the Trust policies and procedures. This includes acting on findings and implementing the learning.
- Being open with patients, their families and carers about any incident which has happened to them whilst in our care.
- Investigating complaints in accordance with the Trust Policies and ensuring associated recommendations and action plans are fully implemented and audited where necessary.
- Identifying and escalating risks in accordance with the Risk Management Policy.
- All risk registers are reviewed, updated and monitored within the agreed timescales. This includes ensuring all areas have access to their risk registers.
- Compliance with key regulatory bodies in relation to their specialty. This includes external visits and inspections.
- Ensure this framework and the core pillars of governance are embraced and developed within their Division.
- Ensure all staff complete the required governance and risk management training.
4. WHAT DOES QUALITY GOVERNANCE LOOK LIKE?

There are various components which make up the overall system of quality governance within the Trust. These are summarised in the illustration below:

Our Organisation has six Core Components of Governance:

![Quality Governance Components](image)

4.1 Compliance and Regulation

This is the conforming to agreed standards through the various regulatory bodies that all NHS organisations have to comply with for example CQC, HSE, CNST, NHSLA. The outcomes from external agency visits as well as meeting the required national and local performance indicators is also included in our compliance with key standards and regulations.
4.2 Standards, Safety & Experience

These are the three core strands for how we measure quality within our organisation:

- The **Standards** of care we set for our patients and staff and how we monitor and benchmark against best practice and other organisations. This includes how our patient outcomes measure against our peer groups.
- The **Safety** of the care we provide to our patients and the Safety of the environment we provide for our staff to work in.
- The **Experience** our patients have from the care we give and the Experience our staff have in their day to day working environment.

4.3 Risk Management

This is the process within the organisation for the management of all clinical and non-clinical risks. This includes the management of incidents, near misses, and ongoing assessment of risks in clinical and non-clinical areas across the organisation.

4.4 Workforce Governance

This is the system to ensure all staff are safe and supported to deliver quality patient care. This includes the collective accountability to ensure fair and effective management arrangements exist for all staff as well as how we develop our staff to meet the objectives of our organisation.

4.5 Information Governance

This ensures necessary safeguards for, and appropriate use of, patient and personal information.

4.6 Financial Governance

This is the process by which the finances and our financial plans for the organisation are monitored and reviewed. A key component of this is ensuring all staff follow the Trust’s Standing Financial Instructions and Scheme of Delegation.

5. REPORTING & ASSURANCE

The Trust has in place a committee structure to ensure that underneath the Trust board there are clear decision making, monitoring and escalation procedures in place to support the organisation in achieving its objectives and delivering safe patient care. The Trust Committee structure is illustrated in Appendix 2 of this framework.

5.1 Audit & Risk Committee

This Committee is a statutory Committee of the Trust Board and has the responsibility for reviewing the establishment and maintenance of an effective system of internal control across the whole organisation’s activities. It is also responsible for ensuring that the system supports the achievement of organisational objectives.
This committee will also ensure that appropriate control and escalation systems are in place for the management of risk across the clinical Business Units and corporate functions. This committee will ensure a ‘live’ connection with the Board Assurance Framework and the Corporate Risk Register. This committee will also ensure the Trust wide Risk Register is fit for purpose through a formal annual review.

The Audit & Risk Committee provides independent scrutiny on the systems and processes the organisation has in place to meet its objectives and ensure a robust system of internal control exists. The Audit & Risk Committee monitors and reviews the actions arising from internal and external audits and ensures an annual audit plan is in place. The committee also reviews the assurance gained from the Trust’s Clinical Audit function. The Emergency Preparedness (including resilience) Committee formally reports to this Committee.

This is a Committee of the Trust Board with the responsibility for gaining assurance that the process for managing risk is effective and fit for purpose. The Audit & Risk Committee reports to the Trust Board through formal minutes of each meeting as well as associated annual reports, including the annual financial accounts.

5.2 Charitable Funds Committee

This Committee is another statutory committee of the Board, which is established in accordance with the Trust’s role as a corporate trustee for funds held in trust, either as charitable or non-charitable funds, the Trust Board will administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission.

5.3 Remuneration Committee

The purpose of the Committee is to advise the Trust Board on appropriate remuneration and terms of service for the Chief Executive, Directors and Very Senior Managers (VSM), including:

- all aspects of salary (including any performance-related elements/bonuses);
- provisions for other benefits, including pensions and cars;
- arrangements for termination of employment and other contractual terms.

5.4 Finance, Investment and Performance Committee

This is a Committee of the Trust Board with the responsibility for reviewing performance against mandatory and contractual targets as well as reviewing investment decisions which require scrutiny due to financial value or strategic impact. There are a number of sub committees and reporting groups which will report to this committee and will escalate any issues of concern

- Financial Sustainability Group
- Workforce Group
- Capital Planning Group
- IM&T Group
- Finance Risk Executive Group
- Information Governance Group
5.5 Safety and Quality Committee

This is a Committee of the Trust Board with the responsibility for gaining assurance in relation to the provision of safe quality care. This includes delivering care to best practice standards and evidencing that the care we give is effective.

This committee is a key part of building our safety culture by ensuring that the clinical Business Units have robust systems in place for clinical governance.

There are a number of sub committees and reporting groups which will report to this committee and will escalate any issues of concern:

- Clinical Guidelines Group
- End of Life and Bereavement Group
- Falls Prevention Group
- Health and Safety Committee
- Healthcare Records Committee
- Infection Prevention Committee
- Medical Devices Committee
- Medicines Management Committee
- Mortality Surveillance Group
- Patient Safety Panel
- Nasogastric Tube Steering Group
- NatSSIPs Steering Group
- Nutrition & Hydration Steering Group
- Nursing, Midwifery and AHP Board
- Patient Acuity Steering Group
- Quality Improvement Board
- Resuscitation Committee
- Safeguarding Board
- Tissue Viability Group
- Trust Policy Group

5.6 Clinical Executive Group

The purpose of the Committee is to manage the business of the Trust within agreed financial limits set by the Trust Board. It provides a formal mechanism for the Executive functions and decision-making associated with delivering the strategic direction, plans and corporate objectives agreed by the Board. It is accountable through the Chief Executive to the Board. It oversees and actively manages the highest scoring risks (through the Corporate risk register) across the Clinical Divisions and Corporate Functions. It has authority for the day-to-day management of the Trusts operations with the exception of those matters reserved for decision making by the Board, or delegated to other Committees/senior officers.

The following committees/groups report into the Clinical Executive Group:

- CCG Contract Management
- Divisional Boards
- IM&T
- Workforce
WCH Project Board  
Medical Education Board  

Terms of reference for all of the above can be obtained from the Company Secretary or staff intranet.

6. GOVERNANCE IN PRACTICE

In addition to the Trust’s committee structure it is important to understand how governance works in practice across the Trust. The Trust operates a Triumvirate model which is a model for bringing together medical, nursing and managerial leadership within specific specialties and teams. Each ward/department/service belongs to a Clinical Division which is again led through the Triumvirate model of an Associate Medical Director, Chief Matron and Associate Chief Operating Officer.

The Clinical Divisions have a dedicated Safety & Quality Board to oversee, monitor, implement and review governance and risk management across all of their specialties and services. The Safety & Quality Boards report to the Divisional Boards. The Divisional Management Teams report formally into the committee structure for the Trust through dedicated reports, escalation of items and performance delivery.

6.1 Quarterly Divisional Quality Governance Reviews

Each quarter the Divisions have a Quality Governance review. The purpose of the review is to ensure appropriate scrutiny is in place from ward to board against governance in practice within the clinical divisions. This will include the delivery of key requirements against the Divisional Quality Improvement Plan and general performance against the core pillars of governance, including:

- Delivery of Quality Improvement Plans  
- Management of Incidents & Duty of Candour  
- Clinical effectiveness & audit delivery  
- Workforce governance metrics & delivery  
- 15 steps assessment & escalation  
- Risk management
Figure 1: Governance in Practice
6.2 The management of risk and escalation

Risk management is a core component of governance across the organisation and is a fundamental step towards continuing to build a ‘Safety Culture’ for the benefit of patients, staff and other stakeholders. The Trust is committed to:

- Providing and safeguarding the highest standards of care for patients.
- Protecting staff, patients, the public, other stakeholders, the organisation’s assets and reputation from the risks arising from its activities.
- Minimising risks associated with new developments and service improvement activities.
- Achieving this by maintaining a process by which there is a continuous and systematic identification, recording and management of risk.
- Ensuring we have a sound system of control in order to ensure the organisations objectives are fully achieved and risks associated with their delivery are mitigated as far as reasonably possible.

The Trust’s risk management policy outlines the process for the assessment, identification and evaluation of risk.

6.2.1 Approach to Risk Management

The Trust sets out five steps of risk management, which is adapted from the British Standard Institute:

- Identify
- Assess
- Respond
- Report
- Review

6.2.2 Risk Identification

The identification of risks within the Trust can be both proactive and reactive:

**Proactive**

The ability to identify risks that could happen or hazards that may stop us achieving what we need to or have the potential to cause harm to patients or staff.

**Reactive**

The ability to identify risks following adverse events, incidents or claims or situations which have already occurred; this is to assess the likelihood and consequences of this happening again.

The identification of risks will include:

- Risks associated with the achievement of the organisations objectives and annual plans
- Risks associated with hazards in the workplace / carrying out a specific work related activity
- Risks arising from a complaint, claim, serious incident or inquest
• Risks from external scrutiny and inspections eg internal/external audit reports, CQC,
• Risks from Business Planning including production of business cases
• Operational assessment of risk at ward and departmental level

6.2.3 Risk Assessment

The Trust uses a 5 x 5 scoring matrix for the assessment of risk, which is attached at Appendix 3. This matrix looks at the core domains of risk, including:

• Patient safety, quality of care and patient experience
• Workforce
• Finance
• Information Governance
• Environment and Business Continuity

The 5 x 5 matrix identifies a risk score by reviewing the likelihood of the risk occurring and the severity this will have as a result.

The Trust has a Risk Assessment Proforma which should be used for the documentation of a risk assessment.

Further guidance on the assessment of risk and the completion of a risk assessment is explained in the mandatory training package for all staff and the Risk Assessment Policy.

6.2.4 Responding to the Risk

Once a risk has been identified and assessed, we need to respond to the assessment that has been made. This will include confirmation on how the risk is currently being managed/controlled. This will usually involve prevention methods, detection strategies or contingency plans:

Prevention: This involves prevention of the risk by having policies, procedures, guidelines, training and checklists in place.

Detection: This involves detection of the risk occurrence through audit, inspection, monitoring and surveys.

Contingency: This involves ensuring contingency plans are in place for example evacuation plans, escalation procedures, back-up generators, insurance, locum/agency staff.

This will also include clarification as to whether the risk requires treatment, transferring, can be tolerated on the issue causing the risk needs to be terminated.

Responding to the risk will also include what the risk score is following the controls you have put in place and identify what the acceptable level/target risk score should be. This is to ensure clarity on the action to be taken to achieve the target risk score.
### 6.2.5 Reporting the Risk

When a risk assessment has been completed the manager has the responsibility to ensure it is added to the relevant **risk register** for the department / service. The Trust has the following registers in place where all risks are added:

**Trust wide Risk Register**
- The Trust wide Risk Register is an **amalgamation** of all the individual **Clinical Divisions and Corporate Function Risk Registers**. This includes individual department/ward risk registers. Each Clinical Division and Corporate Function have their own Risk Register.

**Corporate Risk Register**
- The Corporate Risk Register is all risks from the trust wide risk register which **score greater than 15** in their assessment.

**Board Assurance Framework**
- The Board Assurance Framework contains the **strategic** (principal) **risks** affecting the delivery of the organisation's strategic (principal) objectives.

This ensures that the risk has been added to the correct register for monitoring and regular review.
6.2.6 Reporting and Escalation of Risks in Practice from ‘Ward to Board’

Risks affecting the delivery of the organisations strategic objectives

These risks are identified and reviewed by the Directors

They are added to the Board Assurance Framework (BAF) which is reviewed by the Trust Board monthly

Board Assurance Framework (BAF)

Trust Board

Audit & Risk Committee receive a risk management report

Clinical Executive Group Reviews Corporate Risk Register

Corporate Risk Register

Any risk which scores greater than 15 is added to the Corporate Risk Register

All these risk registers form the total Trust Wide Risk Register

Risk Added to Clinical Business Unit or Corporate Function Risk Register

Risks Assessment completed

Risks identified by wards and departments

Escalation of new risks which impact on the strategic objectives

Medical Divisional Risk Register (urgent and emergency care, medicine, clinical support & cancer services)

Surgical Divisional Risk Register (surgery, trauma and orthopaedics, critical care, outpatients, maternity & paediatrics)

IM&T Risk Register

Estates and Facilities Risk Register

HR Risk Register

Nursing & Quality Risk Register

Finance Department Risk Register
6.2.7 Risk Monitoring & Review

The following groups / committees have specific duties in relation to the monitoring of risks in order to ensure a ward to board approach for the systematic review of risks across the organisation:

<table>
<thead>
<tr>
<th>Group / Committee</th>
<th>Inputs and Purpose</th>
<th>Frequency (minimum)</th>
</tr>
</thead>
</table>
| Trust Board                       | • Review the Board Assurance Framework to ensure strategic risks are being controlled / reaching their target position.  
• Receive a report on the escalation of risks on the Corporate Risk Register. | Monthly             |
| Audit & Risk Committee            | • Receive a risk management report including updates to the BAF and Corporate Risk Register.  
• Review the Trust wide Risk Register.  
• Request for independent audits to be undertaken against specific risks.  
• Escalate items of limited or no assurance to the Executive Management Team for formal consideration of risk exposure. | Bi-monthly  
Annually  
As required |
| Safety and Quality Committee      | • Through reports received on the safety and quality of care provided escalate any items of concern or assurance. | As required |
| Clinical Executive Group          | • Review the Corporate Risk Register and receive reports on specific actions being progressed to mitigate the risks.  
• Escalate items of concern to the Trust Board.  
• Review the Trust wide Risk Register. | Monthly  
Annually |
| Clinical Divisional Boards        | • Review their Divisional Risk Register for all departments and services within their Division | Quarterly |
| Directorate Meetings              | • Review the risks relating to their directorate and escalate any items to the Clinical Divisional Board | Bi-monthly |
| Ward/department level             | • Review the risks relating to their ward / department | Monthly |
| Project and Programme Management Boards | • Specific Projects or Programmes of work may have individual risk registers in place. In such cases these risks registers must report formally into the allocated oversight and monitoring group/committee. | As required. |

6.2.8 Risk Appetite

It is important for all staff involved in the assessment of risk to understand the organisations ‘risk appetite’ in order to prevent erratic or inopportune risk taking which exposes the organisation to a risk it cannot tolerate. Similarly it is important to highlight that an overly cautious approach to risk may stifle growth and development. It is recognised as good practice for organisations to have an agreed statement on risk appetite (British Standards Institute, 2009).

The Trust’s risk appetite statement is ‘The Trust recognises that its fundamental purpose is to ensure patients are treated and cared for safely and that we do not cause any harm to patients whilst in our care. As such, the Trust will not accept risks that impact on its fundamental purpose.'
6.3 Incident management

The Trust is committed to developing a strong safety culture through learning from harm, errors and adverse events. Controlling and minimising risks to patients, staff and visitors is a core component of risk management.

Ensuring we have robust systems to identify, report and review incidents, is an essential component of our risk management arrangements. Accurate and timely reporting of incidents allows the Trust to implement successful solutions for those affected and change systems to prevent a reoccurrence. This results in enhanced patient safety, improvements in future care and contributes to a safer culture for staff to work in and patients to be cared for.

When an adverse event (when something goes wrong) or where there has been a near miss (something nearly went wrong or could of happened without intervention) these events should be reported using the Trusts online reporting tool Ulysses. Incidents can include specific patient safety incidents or incidents which relate to staff accidents.

The Trust has an Incident Management Policy as well as various practical guides available for staff to support the management of an incident, which include ‘Ulysses Reporting Guide’ for all staff and ‘Guide to Incident Management’

Once an incident has been reported, this is reviewed by the line manager, who has the responsibility of confirming the severity of the initial incident reported, the likelihood of this occurring again and the actual impact of harm caused.

The investigation of incidents reported will depend on their final grading of severity, which is summarised in table 1 on the following page.

6.3.1 When an incident becomes serious?

Serious Incidents are those incidents where the severity or level of harm caused is significant (major or catastrophic) and the learning is so great, or consequences to patients, families, carers, staff or organisations is so great that a comprehensive response is warranted. This comprehensive response involves a thorough investigation included a Root Cause Analysis.

There is nationally defined criteria (NHS England, Serious Incident Framework, March 2015) which confirms the circumstances when an incident becomes serious.

The Trust’s Incident Management Policy sets out the serious incident criteria in greater detail as well as the process to be followed for declaring and investigating serious incidents.
Table 1: Severity of Incidents & Levels of Investigation

<table>
<thead>
<tr>
<th>ULYSSES ACTUAL IMPACT</th>
<th>SHORT DESCRIPTION (PEOPLE / RESOURCES)</th>
<th>LEVEL OF INVESTIGATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Injuries</td>
<td>No injuries/harm, without intervention</td>
<td>No damage or loss, no impact on service. Nuisance toxic release.</td>
</tr>
<tr>
<td>Minor</td>
<td>Short-term injury/harm or emotional distress. Includes extra observation.</td>
<td>Minor damage, loss of property/service. Minor on site release contained by organisation.</td>
</tr>
<tr>
<td>Moderate</td>
<td>Semi-permanent physical or emotional injury/trauma/harm.</td>
<td>Moderate damage, loss of property/service. Significant on site release contained by organisation.</td>
</tr>
<tr>
<td>Major</td>
<td>Permanent physical or emotional injury/trauma/harm.</td>
<td>Major damage, loss of property/service. Release affecting off-site area, requiring external assistance.</td>
</tr>
<tr>
<td>Catastrophic</td>
<td>Incident that leads to one or more deaths.</td>
<td>Severe organisation wide damage / loss of service. Toxic release affecting off-site with detrimental effect.</td>
</tr>
<tr>
<td>Near Miss</td>
<td>Injury/harm prevented.</td>
<td>Damage or loss of service prevented. Toxic release prevented.</td>
</tr>
</tbody>
</table>

6.3.2 Patient Safety Panel

The Patient Safety Panel is a sub group of the Safety & Quality Committee and is fundamental part of the incident management assurance process within the Trust. It consists of the Medical Director, Associate Medical Director, Director of Nursing, and Deputy Director of Nursing, Director of Governance and Head of Governance. The safety panel meets weekly and has a set programme of work which is fundamental to clinical governance in practice across the organisation. This includes:

- Declaration & performance management of serious incident investigations
- Following up action plans and sharing key messages in relation to learning and safety
- Outcomes from mortality reviews
- Immediate review of incidents graded moderate and above
The key outputs in relation to serious incidents, complaints, mortality and inquests are reported to the Safety and Quality Committee each month through a formal report.

6.3.3 Being Open and Duty of Candour

The Trust promotes a culture whereby staff are able to acknowledge mistakes, take action to put things right and learn from the event. Staff are encouraged and have a responsibility to report adverse events, near misses, concerns and unexpected outcomes. The Trust promotes a culture of “being open” and “fair blame”.

Being open with patients and their families or carers when they are involved in a patient safety incident which has resulted in moderate, severe or catastrophic harm is a contractual obligation for all NHS providers under the Duty of Candour.

Further guidance is available in the Trusts Incident Management Policy & Duty of Candour Policy.

7. RESPONDING TO EXTERNAL AGENCY VISITS & INSPECTIONS

The Trust is subject to a number of announced and unannounced inspections and accreditation visits or reviews from external agencies. The planning and outcomes from such visits are a core part of the Trust’s governance and assurance arrangements.

A specific policy for the Management of External Agency Visits, Inspections and Accreditations (Assessments) is in place and should be adhered to by all staff. All External Agency visits should be formally notified by the procedure set out in the policy.

The Clinical Divisions should ensure external visits are formally reported through their Divisional Safety & Quality Boards.

8. IMPLEMENTATION AND TRAINING REQUIREMENTS

Effective risk management depends on all staff having a clear understanding of the subject and the contribution they can make to risk control.

The Trust’s Training Needs Analysis sets out the requirements of staff in relation to mandatory training on risk management.

Managers are responsible for ensuring that their staff are able to access and attend training appropriate to their needs including statutory and mandatory training. Individual members of staff also have a responsibility, through their Personal Development Plans, to identify and participate in risk management training. New staff will receive information on risk management as part of the organisation’s general induction arrangements.

The Trust will implement and promote this framework in the following ways:

- All managers will receive a copy of this framework which will be reinforced through the governance related training programmes for managers.
• The framework will be issued to the core leads identified in the ‘Governance Triumvirate’ in the respective divisional teams.
• It will be available on the Trust intranet.
• The Trust will bring this framework and the core pillars of governance to the notice of all new employees at Induction.
• The Trust will promote framework in relevant training.

9. **2017/18 GOVERNANCE PRIORITIES**

The Trust has in place a Quality Improvement Plan for 2017/18 which sets out the priorities for improvement in relation to quality and safety. In addition to this there are governance priorities for 2017/18 which are summarised below. These priorities will support the ongoing development and embedding of this framework across the Trust.

a) Review the governance and risk management mandatory training packages and identify areas for improvement
b) Review and updated the corporate induction material for governance and risk management
c) Re-launch the clinical effectiveness strategy for the Trust
d) Complete Divisional Well-led reviews
e) Establish the Divisional Quarterly Governance review process
## APPENDIX 1 –DIRECTOR RESPONSIBILITIES

| Executive Medical Director (MD) | • Responsibility for ensuring effective systems and processes are in place to support the delivery of safe quality care (jointly with DoN).  
• Responsibility for ensuring that necessary arrangements are in place for the Caldicott Guardian role for the Trust.  
• Responsibility for ensuring the pillars of governance are embraced and implemented across the organisation (jointly with DoN).  
• Ensure that Serious Incidents are managed, investigated and lessons learned where necessary.  
• Advise the Trust Board on any issues relating to clinical governance.  
• Executive Director lead for Medicines Management & Optimisation.  
• Nominated Director for Information Governance and Information management related risks, including Senior Information Risk Owner. |
| Executive Director of Nursing | • Responsibility for ensuring effective systems and processes are in place to support the delivery of safe quality care (jointly with MD).  
• Executive Director Lead for safeguarding.  
• Responsibility for ensuring the pillars of governance are embraced and implemented across the organisation (jointly with MD).  
• Ensure that Serious Incidents are managed, investigated and lessons learned where necessary.  
• Advise the Trust Board on any issues relating to clinical governance. |
| Deputy Chief Executive and Executive Chief Operating Officer | • Ensure that the Divisions have in place effective Governance and Risk Management arrangements in accordance with the framework set out in this framework.  
• Ensure a co-ordinated approach is taken on key compliance and performance returns.  
• Ensure that this framework is embedded within the Divisional Teams.  
• Lead on the emergency planning arrangements for the Trust.  
• Ensure an effective Estates Management Strategy and associated policies and procedures are in place.  
• Ensure that risks regarding the estate or medical equipment are identified and robust mitigation plans put in place to address any gaps in control.  
• Ensure effective monitoring and joint working with PFI partners.  
• Delivery and monitoring of estates and facilities related CQC essential standards.  
• Lead Director for Health and Safety. |
| **Executive Director of Finance** | • To ensure the strategic development and operational management of the Trust’s financial control, and the assurance of that system  
• Ensure that the Trust carries out its business of providing healthcare within sound financial governance arrangements.  
• Ensure that financial governance is controlled and monitored through robust audit and accounting mechanisms that are open to public scrutiny on an annual basis.  
• Ensure that the Trust has an effective internal audit service to support the organisation’s governance and risk management arrangements.  
• Seek the Chief Internal Auditor’s Opinion on the effectiveness of Internal Financial Control.  
• Ensure there is a system for all incidents of physical assault against members of staff are reported to the Counter Fraud and Security Management Service (CFSMS).  
• Ensure the Trust complies with Secretary of State’s Directions relating to counter fraud activity in the NHS. |
| **Director of Human Resources** | • Ensure that effective HR systems and processes are in place to support robust workforce governance, including statutory requirements for example Nursing and Midwifery Council registration.  
• Report on workforce planning and development to the Trust Board.  
• Ensure the provision and implementation of an integrated Education and Training Prospectus, inclusive of Risk Management Education and Training.  
• Delivery and monitoring of workforce related CQC essential standards. |
| **Associate Director of Risk & Quality Governance** | • Ensure that the Board has in place effective systems and processes for governance and risk management; this includes associated reports (jointly with MD and DoN).  
• Oversee the Trust’s governance and risk framework in conjunction with the Medical Director and Director of Nursing.  
• Lead on the establishment and continuous improvement of quality governance arrangements across the organisation, in conjunction with the Medical Director and Director of Nursing and Quality.  
• Lead on the delivery of this framework and associated objectives/work programmes, including the management and leadership of the Trust governance team.  
• Ensure the compliance arrangements for CQC are implemented effectively and reported to the Trust Board.  
• Ensure issues of compliance and regulatory requirements are reported and reviewed by the appropriate subcommittee. |
and Trust Board.

- Seek the Chief Internal Auditor’s Opinion on the effectiveness of the Assurance Framework and the Annual Governance Statement.
- Ensure robust training packages are in place to deliver this framework and associated governance policies.
### APPENDIX 3 – TRUST RISK SCORING MATRIX

#### Risk Assessment Scoring Matrix February 2014

**SEVERITY ASSESSMENT:**

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>1 NEGLIGIBLE</th>
<th>2 MINOR</th>
<th>3 MODERATE</th>
<th>4 MAJOR</th>
<th>5 CATASTROPHIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAFETY EXPERIENCE QUALITY</td>
<td>No injury/harm, no intervention required/near miss.</td>
<td>Short-term injury/harm/accident or emotional distress.</td>
<td>Semi-permanent physical or emotional injury/trauma/harm. Increased length of stay.</td>
<td>Permanent physical or emotional injury/trauma/harm, including mismanagement of patient care with long term effects, including increased length of stay.</td>
<td>Incident that leads to one or more deaths.</td>
</tr>
<tr>
<td></td>
<td>Inpatient patient concern with no harm.</td>
<td>Complaint involving suboptimal treatment with minor impact.</td>
<td>Poor patient experience feedback.</td>
<td>Significant failings in key standards of care.</td>
<td>System or team failures which directly impact on a large number of patients or quality of service provision.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduced performance in meeting key standards.</td>
<td>Complaint involving lack of care and treatment with moderate impact to patient.</td>
<td>Consistent poor patient experience feedback.</td>
<td>Total loss of public confidence.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Repeated failure to meet key standards.</td>
<td>Complaints involving breaches of fundamental standards of care and significant patient safety concerns.</td>
<td>Complaints relating to the death of a patient due to lack of treatment or harm caused.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Non-compliance with core standards.</td>
<td>Breaches of Duty</td>
<td>Gross failure in patient safety or quality standards.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>External validation reports that confirm poor standards or gaps in service provision.</td>
<td>Non-Compliance with core standards which impact on patient care and compliance with statutory duties.</td>
<td>Consistent breaches and non-compliance with core standards or statutory duties with no recovery plan in place.</td>
</tr>
</tbody>
</table>

| WORKFORCE | Short term low staffing levels that reduces quality <1 day with no harm to patients. | Short term low staffing levels that reduces quality <1 week with no harm to patients. | Unsafe staffing levels or competence <1 day with contingency plans in place to maintain service provision. | Delivery of objectives compromised due to lack of capacity. | Non delivery of objectives. |
| | | | Late delivery of objectives due to lack of capacity | Unsafe staffing levels or competence >5 days with no medium term plan in place | Ongoing unsafe staffing levels with no plan to resolve. |
| | | | Poor staff attendance at training. | Limited attendance at staff training in order to maintain key skills. | Loss of several / key staff which compromises service delivery. |
| | | | Low staff morale. | Very low staff morale and dysfunctional teams. | Dysfunctional teams that directly impact on patient care. |
| | | | Accident or injury requiring >3 days off work. | Inability to retain quality staff. | Accident or event which leads to one or more deaths. |

| FINANCE | Loss of or against plan by £<10 | Loss of or against plan by £10 - £10,000 | Loss of or against plan by £10,000 - £100,000 | Loss of or against plan by £100,000 - £1m | Loss of or against plan by £>1m |
| | | | Claims between £10,000 and £100,000 | Claims between £100,000 and £1m | Claims over £1m |
| | | | Claims less than £10,000 | Claims between £100,000 and £1m | Failure to meet statutory financial duties. |
North Cumbria University Hospitals NHS Trust
Governance & Risk Framework
Publication Date: March 2014
Version 6.0
DOCUMENT CONTROL

Author/Contact
- Ramona Duguid (Associate Director of Risk and Quality Governance)
- Jacky Stockdale (Head of Corporate Affairs/Acting Company Secretary)

Version
6.0

Status
FINAL FOR BOARD RATIFICATION JULY 2017

Publication Date
TBC

Review Date
July 2018

Approved by: -
Trust Board: Date:

This document supersedes or replaces the following documents:
- Board, Risk and Assurance Framework 2015/16
- Governance, Risk and Quality Strategy 2011/13
- Risk Management Strategy 2009/11
- Quality Improvement Strategy 2009/10
- Governance Strategy 2008/9

Please note that the Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as “uncontrolled” and as such, may not necessarily contain the latest updates and amendments.

Approved policies related to this policy

Name Policy
Maternity Risk Management Strategy
Risk Management Policy
Management of External Visits Policy
Incident Management Policy
Statement of changes made to date:

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Changes / comments received from</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.1</td>
<td>03/05/2010</td>
<td>Rewritten to combine Risk &amp; Governance Strategies</td>
</tr>
<tr>
<td>0.2</td>
<td>22/06/2010</td>
<td>Comments received from Company Secretary</td>
</tr>
<tr>
<td>0.3</td>
<td>23/06/2010</td>
<td>Comments from Head of Governance &amp; Quality &amp; Co Secretary</td>
</tr>
<tr>
<td>0.4</td>
<td>23/06/2010</td>
<td>Comments from Director of Nursing, Quality &amp; Governance</td>
</tr>
<tr>
<td>0.5</td>
<td>24/06/2010</td>
<td>Formatted by Head of Corporate Affairs</td>
</tr>
<tr>
<td>0.6</td>
<td>29/06/2010</td>
<td>Amended following Trust Board Development Day</td>
</tr>
<tr>
<td>0.7</td>
<td>01/07/2010</td>
<td>Final review and amendments by Company Secretary</td>
</tr>
<tr>
<td>0.8</td>
<td>09/07/2010</td>
<td>Final draft following Board approval on 06/07/2010</td>
</tr>
<tr>
<td>0.9</td>
<td>10/01/2011</td>
<td>Amended to incorporate the new NHSLA Standards 2011/12 and CQC Essential Standards of Safety and Quality</td>
</tr>
<tr>
<td>0.10</td>
<td>01/02/2011</td>
<td>Strategy updated to reflect new risk management process</td>
</tr>
<tr>
<td>Final</td>
<td>08/02/2011</td>
<td>Strategy updated and reviewed as part of annual review of strategy for Governance Committee approval December 2011</td>
</tr>
<tr>
<td>1.0</td>
<td>19/12/2011</td>
<td>Final version for publication APPROVED BY THE TRUST BOARD 08/02/2011</td>
</tr>
<tr>
<td>1.1</td>
<td>09/01/2012</td>
<td>Final strategy updated for Trust Board ratification January 2012</td>
</tr>
<tr>
<td>1.2</td>
<td>18/01/2012</td>
<td>Final proof prior to publication following ratification by Trust Board January 2012</td>
</tr>
<tr>
<td>3.0</td>
<td>01/07/2013</td>
<td>Interim update required to strategy in accordance with impending acquisition. Specifically in relation to key Board committees and the section relating to quality.</td>
</tr>
<tr>
<td>3.1</td>
<td>01/03/2014</td>
<td>Updates to strategy following governance and committee review with Trust Development Authority.</td>
</tr>
<tr>
<td>4.0</td>
<td>17/03/2014</td>
<td>Final version for Trust Board Approval 25/03/2014.</td>
</tr>
<tr>
<td>5.0</td>
<td>18/01/2016</td>
<td>Final version for Trust Board Approval 26/01/2016.</td>
</tr>
<tr>
<td>6.0</td>
<td>17/07/2017</td>
<td>Re-write of framework, material changes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The title of this document (previously Board, Risk and Assurance Framework) has been updated to the ‘Governance Framework’. This follows feedback from staff on the potential confusion between this and the Board Assurance Framework.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The roles and responsibilities sections have been updated.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A new, more detailed section on ‘governance in practice’ has been added to the framework.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• It has been agreed that Quarterly Divisional Reviews are established to allow greater scrutiny on governance in practice as well as delivery of associated quality programmes at divisional level. The first reviews for Quarter 1 take place on 21 July 2017 in ‘shadow form’.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The core sections on risk and incident management have been updated to ensure they reflect the recently updated associated governance policies.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Initial priorities for 2017/18 have also been included in this framework.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The visual reference tool for the core components have been update to reflect interlinking pieces following review by the governance team at their team away day in June 2017.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• S&amp;Q Terms of reference.</td>
</tr>
</tbody>
</table>
1. INTRODUCTION:
The committee will assure the Trust Board that the Trust has in place effective systems and processes in order to ensure the provision of safe, high quality care. This includes the continuous improvement and delivery of the Trust’s safety and quality priorities.

2. ACCOUNTABILITY:
This committee is accountable to the Trust Board. It is authorised to investigate any activities within the scope of this terms of reference and obtain information required to facilitate understanding of the issues.

The committee has delegated authority to make decisions regarding its role, duties and objectives.

It will give assurance that the development of the Trust’s safety and quality priorities are delivered and will ensure that the Trust Board receives regular reliable assurance on safety and quality issues including safety, effectiveness and patient experience.

3. CONNECTIONS
Formal Committees/groups reporting into this committee are:

*note this frequency is the minimum standard, items can be escalated at any time to the committee
**the minutes are for noting by the committee unless the chair of the committee has an item to escalate to the safety & quality committee (this includes the chairs of those groups where minutes are not formally received).

<table>
<thead>
<tr>
<th>Committee / group</th>
<th>How does this group and associated functions report &amp; frequency *</th>
<th>Minutes received for noting? **</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Guidelines Group</td>
<td>Twice Yearly Clinical Guidelines Report (this will include progress with implementation of NatSSIPs)</td>
<td>No</td>
</tr>
<tr>
<td>End of Life and Bereavement Group</td>
<td>Twice yearly report</td>
<td>No</td>
</tr>
<tr>
<td>Falls Prevention Group</td>
<td>Quarterly delivery report update</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety Committee</td>
<td>Quarterly Health &amp; Safety Report (including security) and Quarterly CAS Alert Report</td>
<td>Yes</td>
</tr>
<tr>
<td>Healthcare Records Committee</td>
<td>Twice yearly Healthcare Records Report</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention Committee</td>
<td>Monthly Infection Prevention Report</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical Devices Committee</td>
<td>Twice yearly Medical Devices Report</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management Committee</td>
<td>Quarterly Medication Safety Report</td>
<td>Yes</td>
</tr>
<tr>
<td>Mortality Surveillance Group</td>
<td>Quarterly Mortality Report</td>
<td>No</td>
</tr>
<tr>
<td>Nasogastric Tube Steering Group</td>
<td>Quarterly delivery report update</td>
<td>No</td>
</tr>
<tr>
<td>NatSSIPs Steering Group</td>
<td>Twice Yearly Clinical Guidelines Report (this will include progress with implementation of NatSSIPs)</td>
<td>No</td>
</tr>
<tr>
<td>Nutrition &amp; Hydration Steering Group</td>
<td>Twice yearly patient nutrition and hydration report</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing, Midwifery and AHP Board</td>
<td>Quarterly Nursing Assurance Report and Quarterly Safe Staffing Report</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient Acuity Steering Group</td>
<td>Quarterly QIP update (News &amp; Sepsis).</td>
<td>No</td>
</tr>
</tbody>
</table>
4. REPORTING ARRANGEMENTS:
The committee Chair will report to the Trust Board following each meeting that will include identified risks to patient safety and quality of care.

A copy of the minutes of meetings, identifying key themes, issues and decisions will be submitted to the Trust Board for information.

Any decisions that require higher authority will be presented and discussed at the Trust Board.

5. FREQUENCY OF MEETINGS:
- The Committee will meet on a monthly basis, with the exception of August.
- The Chair may request additional meetings according to business, strategic or operational requirements.

6. ROLE, REMIT AND OBJECTIVES OF COMMITTEE:

Compliance & Regulation
- Receive regular reports in relation to the internal monitoring and compliance with CQC core standards.
- Receive exception reports on external agency visits and inspections.
- Receive and discuss regular updates on nursing/ward accreditation schemes including the '15 steps' ward assessment reports or other associated internal spot checks or inspection reports.
- Review the processes and assurances in place in relation to compliance with Health and Safety legislation and associated standards.

Safety, Standards & Experience
- Review and monitor the delivery of the Trust's Quality Strategy and associated Quality Improvement Plans. This may include specific reports on key areas of work being undertaken across the Trust.
- Ensure corrective action has been initiated, and successfully implemented where gaps in patient safety concerns are identified and to assure the management of such risks on behalf of the Board.
- Oversee the development and promotion of a learning culture (open, transparent, constructive, active).
- Receive a monthly report on the scrutiny and learning from serious incidents.
- Review the implementation and performance in relation to the application of Duty of Candour.
- Review the outcomes and themes from the Trust's mortality review process, including benchmark reports against the Trust's overall mortality rates and indicators.
- Oversee the production of an annual clinical audit plan and review implementation quarterly.
• Oversee the delivery of agreed best practice, as defined in the national clinical audit framework, in the context of the Trust’s services. To include, for example, NICE clinical guidelines and NHS frameworks as well as the guidance that emerges from national confidential enquiries, high-level enquiries and other nationally agreed guidance.
• Oversee and monitor progress with policy and clinical guidelines implementation as part of the Trust’s quality governance arrangements.
• Review the standards and application of clinical research and trials across the organisation.
• Receive a monthly complaints report, including identification of themes and trends in order to provide assurance on effective complaints handling across the Trust.
• Receive and review quarterly reports summarising feedback from patients experience and involvement.
• Receive assurance reports on the patient environment.
• Review the annual reports from Health Watch.
• Review the annual complaints report.
• Receive and review the production of the Trust’s Quality Account.
• Receive an annual report on the Divisional Governance arrangements in place from ward to board; this may require escalation of items for increased reporting or monitoring by the committee.

**Workforce Governance**
• Receive regular reports on compliance with clinical skills training for all medical and nursing staff.
• Receive assurance that the associated governance and risk management training packages are robust and fit for purpose.
• Receive assurance on the implementation of improvements in relation to the experience of staff.

**Risk Management**
• Escalate items formally to the Trust board in relation to risks identified to the provision of safe, high quality care.
• Receive a regular report on the status of the Trust’s risk profile from ward to board.
• Receive a regular report on litigation trends.
• Review the action taken against any Regulation 28 report issued to the Trust.

**Information Governance**
• Review the Trusts position against information governance standards and associated action plans.
• Receive formal reports on notifications to the information Commissioner.
• Receive assurance on the role of the Caldicott guardian within the Trust.
7. MEMBERSHIP AND ADMINISTRATION OF COMMITTEE:

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair</td>
<td>Non Executive Director</td>
</tr>
<tr>
<td>Vice Chair</td>
<td>Non Executive Director</td>
</tr>
<tr>
<td>Management Lead</td>
<td>Director of Nursing &amp; Midwifery (Executive Lead for Governance)</td>
</tr>
<tr>
<td>Secretarial Support</td>
<td>Executive Assistant</td>
</tr>
<tr>
<td>Core members (voting):</td>
<td>Three Non-Executive Directors (including the Chair and Vice Chair)</td>
</tr>
<tr>
<td></td>
<td>Executive Medical Director</td>
</tr>
<tr>
<td></td>
<td>Executive Director of Nursing</td>
</tr>
</tbody>
</table>

Attendees:
- Associate Director of Risk and Quality Governance
- Deputy Director of Nursing
- Director of Infection Prevention and Control
- Associate Medical Director for Patient Safety
- Associate Director of Midwifery
- Chief Pharmacist
- Divisional Clinical Directors for Patient Safety or nominated deputy*

- Members are authorised to appoint deputies to act on their behalf when they are unable to attend meetings of the committee.
- Other Executive Directors, Senior Managers and individuals who are deemed appropriate by the Committee shall be invited to attend meetings or part of meetings as the Chairman of the Committee and Executive Lead for the Committee sees fit.
- The committee will be serviced by the management lead that will prepare the agenda in liaison with the Chair of the committee and maintain a rolling programme of work for the committee.
- Agendas and papers will be circulated five days in advance of the meeting date.
- Minutes of the meeting will be available within one week of the meeting.
- Papers will be circulated to the Divisional Triumvirate Team for information, review and onward circulation as appropriate.

8. QUORACY OF COMMITTEE:

Quoracy will consist of:
- two Non-Executive Directors
- one Executive Director (or their nominated deputies)

9. REVIEW DATES:

- 6 monthly review of committee effectiveness with Chair of the Trust Board for Non Executive chairs and with the CEO for the committee’s management lead.
- These terms of reference will be reviewed annually (one year from issue date). No alteration will be made to them without the approval of the Trust Board.
- Annual review of the Committee’s delivery of objectives (to be included within the Committee’s Business Cycle).

10. ISSUE DATE OF TERMS OF REFERENCE:

FINAL DRAFT VERSION FOR BOARD RATIFICATION
Report to a Meeting of the Trust Board of Directors held in Public

Date of Meeting: 25 July 2017

Enclosure Number: 11

Title of Report: Integrated Performance Report

Author: Tommy Davies, Head of Performance and Contracting

Executive Lead: Helen Ray, Chief Operating Officer

Responsible Sub-Committee (if appropriate): Finance, Investment and Performance Committee

Executive Summary: The Integrated Performance Report identifies and assesses the Trust’s performance against the key Trust measures and nationally mandated performance. Performance is reported using the balance scorecard from CQC and NHSI of the following; safe, caring, effective, responsive, well-led. Finance, CIP and CQUIN are also included within the report. Each indicator is assigned a Red, Amber and Green (RAG) rating based on actual and forecast performance against pre-defined thresholds and by exception with commentary and action plans where necessary if performance is below the planned trajectory or target.

Key highlights from the report:

Performance measures
- The following measures that were off target in the June-17 report are now on target in this July-17 report (see section 2.3):
  - Diagnostics %<6 weeks
  - C Section rates
  - NHS Safety Thermometer % New harm

- The following measures have moved from being on target in the June-17 report to being off target in the July-17 report:
  - Cancer 62 day – all cancers
  - C Difficile rate per 100,000 bed days
  - C Difficile (end of year maximum 25 cases)

- Nine measures are off target out of a total of the 34 measures (see section 2.4). These following nine exception measures have commentary in section 3.2:
  - C Difficile (end of year maximum 25 attributable cases)
  - C Difficile rate per 100,000 bed days
The key measures with nationally agreed trajectories and/or national constitutional standards for the month of June 2017:
- RTT is meeting both the national standard and the nationally agreed NCUH trajectory.
- A&E 4hr wait measures did not meet the constitutional standard but is on trajectory for June-17
- Cancer 62 day is not currently meeting either the trajectory or the constitutional standard.

Finance
- The Trust is on plan at Month 3 and is forecasting to meet its Control Total for the year
- At Month 3 the Trust is in line with the overall I&E deficit plan, though is behind plan for Operating Deficit and EBITDA.

CIP
Following delivery of the 2016/17 CIP of £13.47m, of which £4.4m was non-recurrent, the Trust 2017/18 CIP Target has been set at £16.3m. This is designed to allow the Trust to reach the agreed deficit of £44.22m.

To date, £13.82m of CIP Schemes have been identified, have had PID’s created and are live on the Tracker.

This is under the required £16.3m target and under delivery overall at the end of Quarter 1 is an issue. As a result, to deliver full year effect (i.e. deliver £16.3m savings in the remainder of the financial year) future scheme identification will have to be greater than the original target.

CQUIN
Quarter one 2017/18 CQUIN will be reported in the August 2017 report. The report to date highlights some of the key risks and actions to date, alongside the estimated RAG ratings for each CQUIN against their quarterly targets for 2017/18.
### Financial Implications:

- £2.64m is available for delivery of the CQUIN targets.
- £2.47m of Sustainability and Transformation Funding is available in 17/18 for meeting a range of A&E deliverables including the A&E 4 hour trajectories.
- CIP and Financial control total implications are covered in the other finance papers for this meeting.

### Actions Required by the Board:

- **To approve:**
- **To note:**
- **For information:**

  Document is for reading and consideration and for discussion by exception only.

### Data Quality:

- **Source:** Information Team
- **Validated by:** Lorraine Gray
- **Date:** July 2017
CONTENTS

1.0 Introduction
2.0 Executive Summary
3.0 Balanced Scorecard
3.1 Exception Report
3.2 Trust Board Balanced Scorecard
4.0 Updates on Previously Submitted Recovery Plans
5.0 Finance
5.1 Cost Improvement Plans (CIP)
6.0 Commissioning for Quality and Innovation
7.0 Recommendations
8.0 Appendices
1.0 Introduction

The primary purpose of the NHS is to improve the outcomes of health for all: to deliver care that is safer, more effective, and provides a better experience for patients. North Cumbria University Hospitals NHS Trust (the Trust) is committed to delivering this vision and to driving the improvements in service quality, safety, and performance that are required locally in order to achieve this.

The purpose of the monthly Trust Board Performance Report is to identify and assess the Trust’s performance against the key measures of quality, safety and sustainability mandated nationally. These are indicators identified in the National Standard Contract for 2016/17 through which NHS services are commissioned and by the NHS Trust Development Authority (TDA) in Delivery for Patients: the 2015/16 Accountability Framework for NHS Trust Boards. A small number of selected local indicators are included for information at the request of the Trust Board, in addition to activity and finance against planned.

Performance is reported using a scorecard approach; indicators grouped in to six domains based on finance and the five domains of quality identified by the Care Quality Commission (CQC) and NHSI. Each indicator is assigned a Red, Amber and Green (RAG) rating based on actual and forecast performance against pre-defined thresholds (summary table below) and review on an exception basis where performance below the required standard is identified. If an indicator is rate as red in any given month or amber for two consecutive periods, a recovery plan may be requested from the Responsible Officer by the Trust Board for submission to the following meeting.

<table>
<thead>
<tr>
<th>RAG</th>
<th>Performance Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green</td>
<td><strong>Achieved</strong> – the required standard has been met for this indicator</td>
</tr>
<tr>
<td>Amber</td>
<td><strong>Not Achieved</strong> – the required standard has not been met by a narrow margin and performance is within an agreed tolerance</td>
</tr>
<tr>
<td>Red</td>
<td><strong>Not Achieved</strong> – the required standard has not been met and performance is not within an agreed tolerance</td>
</tr>
</tbody>
</table>

The latest activity data at the time of writing is used in producing this report and may be subject to change through validation prior to the Board meeting. Any significant changes will be brought to the attention of the Board. It should be noted that due to close down of various data sets at different times the most recent available month is presented.
EXECUTIVE SUMMARY

2 Executive Summary

The aim of the Executive Summary is to provide a high-level overview of performance; summarising the information detailed in the balanced scorecards based on the percentage of indicators rated red, amber or green in each of the six domains of performance referred to previously. This section of the report also highlights the performance of the Trust against a small basket of quality indicators considered key to the Trust’s overall performance and fundamental in striving for excellence.

2.1 Key Indicator Summary

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Month Actual</th>
<th>YTD</th>
<th>Trajectory (RAG for month)</th>
<th>National Target (RAG for month)</th>
<th>Activity Volume (month)</th>
<th>Lead Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>AE 4 hour waits (% of trajectory)</td>
<td>92.6%</td>
<td>90.9%</td>
<td>89.6%</td>
<td>95.0%</td>
<td>7,896 HR</td>
<td></td>
</tr>
<tr>
<td>RTT % incomplete &lt;18 weeks (c.f. trajectory)</td>
<td>92.6%</td>
<td>92.6%</td>
<td>92.0%</td>
<td>92.0%</td>
<td>22,949 HR</td>
<td></td>
</tr>
<tr>
<td>Diagnostics: % waiting &lt;6 wks (c.f. trajectory)</td>
<td>99.4%</td>
<td>99.4%</td>
<td>99.0%</td>
<td>99.0%</td>
<td>5,015 HR</td>
<td></td>
</tr>
<tr>
<td>Cancer: 62 day All cancers (c.f. trajectory)</td>
<td>72.3%</td>
<td>81.1%</td>
<td>83.9%</td>
<td>85.0%</td>
<td>77 HR</td>
<td></td>
</tr>
<tr>
<td>Hospital Standardised Mortality Ratio (HSMR)</td>
<td>97</td>
<td>97</td>
<td>110</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes:
The Trajectory figure is the agreed point the Trust needs to reach each month for performance to recover to national targets.
The Overall target figure is the absolute target for this indicator.
RAG scores have been given for month actual performance against both Trajectory and Overall target.
Diagnostics and RTT incomplete are period-end snapshots so there is no cumulative YTD figure.
For the purpose of this summary, YTD is taken to be the same as current month performance for Diagnostics and RTT.
HSMR has not been updated recently (there is a lag in production and publication).

2.2 Trust Balance Scorecard measures RAG

<table>
<thead>
<tr>
<th>Caring</th>
<th>Safe</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Responsive</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Well-led</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
</tr>
</tbody>
</table>

Note:
The graph shows the total number of indicators for each RAG category grouped by thematic headings (as used in the NHSI Single Oversight Framework).
Behind each of the bars is a “shadow” bar illustrating what the position was in the previous report.
This allows a quick assessment of how the proportions of Red, Amber and Green have changed.
### 2.4 Summary of measures; off target or trajectory, improved since last month or deteriorated since last month

<table>
<thead>
<tr>
<th><strong>Notable Changes since June 2017 Report</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Improved:</strong> from red/amber RAG last month to green RAG this month;</td>
</tr>
<tr>
<td>Diagnostics: % waiting &lt;6 wks</td>
</tr>
<tr>
<td>Emergency Section rate</td>
</tr>
</tbody>
</table>

| **Deteriorated** from Green RAG last month to red/amber RAG this month; |
| C. difficile: (end of year max 25 attributable cases) |
| Cancer: 62 day All cancers (c.f. trajectory) |

<table>
<thead>
<tr>
<th><strong>Measures that are not meeting targets (with RAG trend change from last month)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Off Trajectory and national target or off local target:</strong></td>
</tr>
<tr>
<td>C. difficile: (end of year max 25 attributable cases)</td>
</tr>
<tr>
<td>Cancer: 62 day All cancers (c.f. trajectory)</td>
</tr>
<tr>
<td>C. difficile: rate per 100,000 bed days</td>
</tr>
<tr>
<td>Cancer: 62 day Screening</td>
</tr>
<tr>
<td>Appraisals AfC staff</td>
</tr>
<tr>
<td>Cancelled operations: 28 day breaches</td>
</tr>
<tr>
<td>DTOC (% of occupied bed days)</td>
</tr>
<tr>
<td>Appraisals Medical Staff</td>
</tr>
<tr>
<td>Staff sickness long term</td>
</tr>
</tbody>
</table>
2.5 Progress of four key national standards against trajectory

### Progress against Trajectory: RTT

<table>
<thead>
<tr>
<th>Month</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Mar-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trajectory target</td>
<td>91.5%</td>
<td>92.0%</td>
<td>92.0%</td>
<td>92.0%</td>
<td>92.0%</td>
<td>92.0%</td>
<td>92.0%</td>
<td>91.0%</td>
<td>91.0%</td>
<td>92.0%</td>
<td>92.0%</td>
<td>92.0%</td>
</tr>
<tr>
<td>Actual Performance</td>
<td>92.0%</td>
<td>92.4%</td>
<td>92.6%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Progress against Trajectory: Cancer 62 day target

<table>
<thead>
<tr>
<th>Month</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Mar-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trajectory target</td>
<td>80.8%</td>
<td>82.4%</td>
<td>83.9%</td>
<td>85.3%</td>
<td>85.0%</td>
<td>85.0%</td>
<td>85.0%</td>
<td>85.0%</td>
<td>85.0%</td>
<td>85.0%</td>
<td>85.0%</td>
<td>85.0%</td>
</tr>
<tr>
<td>Actual Performance</td>
<td>85.5%</td>
<td>85.3%</td>
<td>72.3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Progress against Trajectory: A&E 4 hour waits

<table>
<thead>
<tr>
<th>Month</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Mar-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trajectory target</td>
<td>88.3%</td>
<td>89.0%</td>
<td>89.6%</td>
<td>90.0%</td>
<td>91.0%</td>
<td>92.0%</td>
<td>93.0%</td>
<td>92.5%</td>
<td>92.0%</td>
<td>93.0%</td>
<td>94.0%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Actual Performance</td>
<td>90.2%</td>
<td>90.3%</td>
<td>92.6%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3.0 Balanced Scorecard

The following narrative and scorecards detail the Trust’s performance against the key measures of performance mandated nationally and those selected local indicators included at the request of the Trust Board. Indicators are grouped into the five domains of quality in a balance scorecard (caring, safe, effective, responsive and well led). Exceptions are then presented with the reasons why they are off target and what actions will be taken to improve the performance. The remaining sections of the report show performance against CQUIN, CIP and the Trust overall financial position.

In line with the Trust’s Performance Framework, the following approach to RAG rating and escalation has been adopted throughout the scorecard and performance management of delivery against the specified targets.

<table>
<thead>
<tr>
<th>RAG Status</th>
<th>Performance Description</th>
<th>Escalation Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green</td>
<td>Achieved – the required standard has been met for this indicator</td>
<td>• No action required</td>
</tr>
</tbody>
</table>
| Amber      | Not Achieved – the required standard has not been met by a narrow margin and performance is within an agreed tolerance | One Amber  
• No action required  
Two Consecutive Ambers  
• Recovery Plan to following Board |
| Red        | Not Achieved – the required standard has not been met and performance is not within an agreed tolerance | • Recovery Plan to following Board |

For the purpose of this report, an amber RAG rating is defined as performance that is below the required standard but is within 1% of the identified target. This is a small number of notable exceptions which are highlighted in Appendix 1 in addition to the parameters for RAG rating of performance against all indicators in the scorecard.
### 3.1 Trust Board Balanced Scorecard

#### Caring

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Year to Date</th>
<th>Performance in last five months</th>
<th>Relative change in performance</th>
<th>Forecast Quarter</th>
<th>Forecast Year</th>
<th>Director responsible</th>
<th>Recovery Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed sex accommodation breaches</td>
<td>Jun-17</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HR</td>
<td>No</td>
</tr>
<tr>
<td>Complaints: rate per 1,000 bed days</td>
<td>Jun-17</td>
<td>*</td>
<td>1.94</td>
<td>1.77</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MC</td>
<td>No</td>
</tr>
<tr>
<td>Inpatient FFT: % positive scores</td>
<td>Jun-17</td>
<td>*</td>
<td>96.0%</td>
<td>96.6%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MC</td>
<td>No</td>
</tr>
<tr>
<td>A&amp;E FFT: % positive scores</td>
<td>Jun-17</td>
<td>*</td>
<td>87.5%</td>
<td>92.8%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MC</td>
<td>No</td>
</tr>
<tr>
<td>Maternity FFT: % positive scores</td>
<td>Jun-17</td>
<td>*</td>
<td>95.0%</td>
<td>97.6%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MC</td>
<td>No</td>
</tr>
</tbody>
</table>

NB: See appendix 2 for key to balance scorecards

#### Effective

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Year to Date</th>
<th>Performance in last five months</th>
<th>Relative change in performance</th>
<th>Forecast Quarter</th>
<th>Forecast Year</th>
<th>Director responsible</th>
<th>Recovery Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality: HSMR</td>
<td>Dec-16</td>
<td>110</td>
<td>97</td>
<td>97</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RH</td>
<td>No</td>
</tr>
<tr>
<td>Mortality: Weekend HSMR</td>
<td>Sep-16</td>
<td>106</td>
<td>101</td>
<td>101</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RH</td>
<td>No</td>
</tr>
<tr>
<td>Mortality: SHMI</td>
<td>Dec-16</td>
<td>1.1</td>
<td>0.97</td>
<td>0.97</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RH</td>
<td>No</td>
</tr>
<tr>
<td>Emergency readmissions: 30 days</td>
<td>Apr-17</td>
<td>&lt;= 9.4%</td>
<td>8.2%</td>
<td>8.2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RH</td>
<td>No</td>
</tr>
</tbody>
</table>

NB: See appendix 2 for key to balance scorecards

(*) target is dynamically linked as weekday HSMR +10
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Year to Date</th>
<th>Performance in last five months</th>
<th>Relative change in performance</th>
<th>Forecast Quarter</th>
<th>Forecast Year</th>
<th>Director responsible</th>
<th>Recovery Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA: cases</td>
<td>Jun-17</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>⬇️</td>
<td>⬇️</td>
<td>⬇️</td>
<td>⬇️</td>
<td>MC</td>
<td>No</td>
</tr>
<tr>
<td>C. difficile: (end of year max 25 attributable cases)</td>
<td>Jun-17</td>
<td>&lt;= 2</td>
<td>4</td>
<td>6</td>
<td>⬇️</td>
<td>⬆️</td>
<td>⬆️</td>
<td>⬆️</td>
<td>MC</td>
<td>No</td>
</tr>
<tr>
<td>C. difficile: rate per 100,000 bed days</td>
<td>Jun-17</td>
<td>&lt;= 15.0</td>
<td>26.8</td>
<td>12.2</td>
<td>⬆️</td>
<td>⬆️</td>
<td>⬆️</td>
<td>⬆️</td>
<td>MC</td>
<td>No</td>
</tr>
<tr>
<td>VTE risk assessments (from quarterly submissions)</td>
<td>Jun-17</td>
<td>95.0%</td>
<td>95.0%</td>
<td>98.0%</td>
<td>⬆️</td>
<td>⬆️</td>
<td>⬆️</td>
<td>⬆️</td>
<td>RH</td>
<td>No</td>
</tr>
<tr>
<td>Never Events: Number in month</td>
<td>Jun-17</td>
<td>*</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>⬆️</td>
<td>⬆️</td>
<td>⬆️</td>
<td>RH</td>
<td>No</td>
</tr>
<tr>
<td>Never Events: rate per 100,000 bed days</td>
<td>Jun-17</td>
<td>*</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>⬆️</td>
<td>⬆️</td>
<td>⬆️</td>
<td>RH</td>
<td>No</td>
</tr>
<tr>
<td>NHS Safety Thermometer: % harm free care</td>
<td>Jun-17</td>
<td>90.0%</td>
<td>93.2%</td>
<td>⬆️</td>
<td>⬆️</td>
<td>⬆️</td>
<td>⬆️</td>
<td>⬆️</td>
<td>MC</td>
<td>No</td>
</tr>
<tr>
<td>NHS Safety Thermometer: new harm (%)</td>
<td>Jun-17</td>
<td>&lt;= 3.5%</td>
<td>3.1%</td>
<td>⬆️</td>
<td>⬆️</td>
<td>⬆️</td>
<td>⬆️</td>
<td>⬆️</td>
<td>MC</td>
<td>No</td>
</tr>
<tr>
<td>Emergency C-section rates (%)</td>
<td>May-17</td>
<td>&lt;= 16.0%</td>
<td>13.4%</td>
<td>15.1%</td>
<td>⬆️</td>
<td>⬆️</td>
<td>⬆️</td>
<td>⬆️</td>
<td>HR</td>
<td>No</td>
</tr>
<tr>
<td>% Serious Harm Incidents</td>
<td>Jun-17</td>
<td>*</td>
<td>&lt;= 0.4%</td>
<td>0.00%</td>
<td>0.29%</td>
<td>⬆️</td>
<td>⬆️</td>
<td>⬆️</td>
<td>MC</td>
<td>No</td>
</tr>
<tr>
<td>CAS alerts: No. outstanding</td>
<td>Jun-17</td>
<td>*</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>⬆️</td>
<td>⬆️</td>
<td>⬆️</td>
<td>MC</td>
<td>No</td>
</tr>
</tbody>
</table>

NB: See appendix 2 for key to balance scorecards
## Trust Board Balanced Scorecard

### Responsive

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Year to Date</th>
<th>Performance in last five months</th>
<th>Relative change in performance</th>
<th>Forecast Quarter</th>
<th>Forecast Year</th>
<th>Director responsible</th>
<th>Recovery Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AE 4 hour waits (% cf trajectory)</strong></td>
<td>Jun-17</td>
<td>*</td>
<td>89.59%</td>
<td>92.58%</td>
<td>90.86%</td>
<td>↑ ↓ ↓ ↑ ↑</td>
<td></td>
<td>HR</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>AE 12 hour Trolley Waits</strong></td>
<td>Jun-17</td>
<td>*</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>→ → → →</td>
<td></td>
<td>HR</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>DTOC (% of occupied bed days)</strong></td>
<td>Jun-17</td>
<td>3.5%</td>
<td>10.7%</td>
<td>10.8%</td>
<td></td>
<td>↑ ↓ ↑ ↑ ↑</td>
<td></td>
<td>HR</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>RTT % incomplete &lt;18 weeks (c.f. trajectory)</strong></td>
<td>Jun-17</td>
<td>*</td>
<td>92.0%</td>
<td>92.6%</td>
<td>92.6%</td>
<td>→ ↑ → ↑</td>
<td></td>
<td>HR</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostics: % waiting &lt;6 wks</strong></td>
<td>Jun-17</td>
<td>*</td>
<td>99.0%</td>
<td>99.4%</td>
<td>99.4%</td>
<td>→ → ↓ ↓ ↑</td>
<td></td>
<td>HR</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Cancer: 2 week All</strong></td>
<td>Jun-17</td>
<td>*</td>
<td>93.0%</td>
<td>94.5%</td>
<td>95.0%</td>
<td>→ ↓ → ↑↓</td>
<td></td>
<td>HR</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Cancer: 31 day All</strong></td>
<td>Jun-17</td>
<td>*</td>
<td>96.0%</td>
<td>97.1%</td>
<td>97.4%</td>
<td>↓ ↑ ↓ ↑ ↓</td>
<td></td>
<td>HR</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Cancer: 62 day All cancers (c.f. trajectory)</strong></td>
<td>Jun-17</td>
<td>*</td>
<td>83.90%</td>
<td>72.31%</td>
<td>81.06%</td>
<td>↓ ↑ ↑ → ↓</td>
<td></td>
<td>HR</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>Cancer: 62 day Screening</strong></td>
<td>Jun-17</td>
<td>*</td>
<td>90.0%</td>
<td>77.8%</td>
<td>78.3%</td>
<td>→ ↑ ↓ ↑ ↓</td>
<td></td>
<td>HR</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Cancelled operations: 28 day breaches</strong></td>
<td>Jun-17</td>
<td>0</td>
<td>5</td>
<td>7</td>
<td>7</td>
<td>↓ ↓ ↑ ↑ ↓</td>
<td></td>
<td>HR</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

NB: See appendix 2 for key to balance scorecards
## Well-led

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Year to Date</th>
<th>Performance in last five months</th>
<th>Relative change in performance</th>
<th>Forecast Quarter</th>
<th>Forecast Year</th>
<th>Director responsible</th>
<th>Recovery Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff turnover rate</strong></td>
<td>Jun-17</td>
<td>&lt;= 12.0%</td>
<td>11.9%</td>
<td>11.9%</td>
<td></td>
<td>↑</td>
<td></td>
<td></td>
<td>CB</td>
<td>No</td>
</tr>
<tr>
<td><strong>Staff sickness rate (Short-term)</strong></td>
<td>Jun-17</td>
<td>&lt;= 1.5%</td>
<td>1.5%</td>
<td>1.5%</td>
<td></td>
<td>↓</td>
<td></td>
<td></td>
<td>CB</td>
<td>No</td>
</tr>
<tr>
<td><strong>Staff sickness rate (Overall)</strong></td>
<td>Jun-17</td>
<td>&lt;= 4.0%</td>
<td>4.7%</td>
<td>4.7%</td>
<td></td>
<td>↑↑</td>
<td></td>
<td></td>
<td>CB</td>
<td>No</td>
</tr>
<tr>
<td><strong>Appraisals: Medical staff</strong></td>
<td>Jun-17</td>
<td>95.0%</td>
<td>94.0%</td>
<td>94.0%</td>
<td></td>
<td>↓↓↑↑↑↑</td>
<td></td>
<td></td>
<td>CB</td>
<td>No</td>
</tr>
<tr>
<td><strong>Appraisals: AfC staff</strong></td>
<td>Jun-17</td>
<td>50.0%</td>
<td>15.7%</td>
<td>15.7%</td>
<td></td>
<td>↑↑↑↑↑↑</td>
<td></td>
<td></td>
<td>CB</td>
<td>No</td>
</tr>
<tr>
<td><strong>Mandatory Training (c.f. trajectory)</strong></td>
<td>Jun-17</td>
<td>50.0%</td>
<td>50.0%</td>
<td>50.0%</td>
<td></td>
<td>↑↑↑↑↑↑</td>
<td></td>
<td></td>
<td>CB</td>
<td>No</td>
</tr>
</tbody>
</table>

**NB:** See appendix 2 for key to balance scorecards
3.2 Exception Reporting

For those indicators against which the required performance was not achieved against target in the latest reporting period; identified by a red or amber RAG status in the Balanced Scorecard further narrative is included on an exception basis below:

### DTOC

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Year to Date</th>
<th>Performance in last five months</th>
<th>Relative change in performance</th>
<th>Forecast Quarter</th>
<th>Forecast Year</th>
<th>Director responsible</th>
<th>Recovery Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTOC (% of occupied bed days)</td>
<td>Jun-17</td>
<td>3.5%</td>
<td>10.7%</td>
<td>10.8%</td>
<td>⬆️ ⬆️ ⬆️ ⬆️ ⬆️</td>
<td>⬆️ ⬆️ ⬆️ ⬆️</td>
<td>⬆️</td>
<td>⬆️</td>
<td>HR</td>
<td>No</td>
</tr>
</tbody>
</table>

**Executive lead:** Helen Ray, Chief Operating Officer

**Management lead:** Fraser Cant, Associate Chief Operating Officer

- **Reason why the measure is off target:**
  - Delays in assessment, particularly DST and Fast track assessments.
  - Lack of capacity in community hospitals.
  - Lack of capacity and delays in provision of intermediate care, particularly care packages in own home and reablement.
  - Lack of EMI nursing beds.

- **Actions/mitigations in place to improve performance:**
  - Acute staff attending ICC MDT meetings to facilitate discharge
  - Reablement team co-located with Integrated Discharge Team in Acute Trust
  - Integrated Discharge Team implementing pro-active discharge planning on day of admission
  - Discharge policy rollout across all partners
  - Discharge Navigators embedded in acute wards
### Appraisals

#### Current Performance:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Year to Date</th>
<th>Performance in last five months</th>
<th>Relative change in performance</th>
<th>Forecast Quarter</th>
<th>Forecast Year</th>
<th>Director responsible</th>
<th>Recovery Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appraisals: Medical staff</td>
<td>Jun-17</td>
<td>95.0%</td>
<td>94.0%</td>
<td>94.0%</td>
<td>✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗</td>
<td>✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗</td>
<td>CB</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appraisals: AfC staff</td>
<td>Jun-17</td>
<td>50.0%</td>
<td>15.7%</td>
<td>15.7%</td>
<td>✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗</td>
<td>✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗ ✗</td>
<td>CB</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Director responsible:** Christine Brereton, Director of Human Resources and Organisational Development

**Reason why the measure is off target:**

The appraisal rates at 10th July were recorded as 18.10%. Within the business units and services the compliance rates were:

- Corporate Services 40.89%
- Medicine 20.22%
- Surgery 11.04%
- Estates and Facilities 8.63%

The Data Management team are receiving calls and emails confirming that appraisals have been undertaken but have not been entered into ESR.

**Actions/mitigations in place to improve performance:**

Appraisal reports are being produced on a weekly basis and are being distributed to line managers from July to manage the gaps. The Data Management team are providing managers with support to ensure that appraisals are being entered into ESR to ensure accurate reporting.
**Staff sickness rate**

### Current Performance:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Year to Date</th>
<th>Performance in last five months</th>
<th>Relative change in performance</th>
<th>Forecast Quarter</th>
<th>Forecast Year</th>
<th>Director responsible</th>
<th>Recovery Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff sickness rate (Overall)</td>
<td>Jun-17</td>
<td>&lt;= 4.0%</td>
<td>4.7%</td>
<td>4.7%</td>
<td></td>
<td>=</td>
<td>=</td>
<td>=</td>
<td>CB</td>
<td>No</td>
</tr>
</tbody>
</table>

**Director responsible:** Christine Brereton, Director of Human Resources and Organisational Development

**Reason why the measure is off target:**
The overall sickness rate is over the target due to long term absences. The majority of long term absences (156 occurrences) are between 28 days and 6 months in length. Long term absences are highest within Estates and Facilities (long term absence rate 4.78%) followed by Surgery (long term absence rate 3.47%). Corporate Services and Medicine are both under 3% with Medicine being close to the target rate with a recorded rate of 2.68% for June. The majority of long term absences relate to anxiety/stress/depression, back and musculoskeletal problems and cancers.

**Actions/mitigations in place to improve performance:**
There has been a reduction in long term absence from 3.62% recorded in May to 3.18% recorded in June; the rate is at its lowest since August 2016. The new Attendance Management Policy has been agreed and the procedures are being embedded within the organisation by providing line managers with training on implementing the policy. The Trust implemented an Employee Assistance Programme at the beginning of the year to provide a confidential helpline for staff including counselling. A physiotherapy service for staff based at the CIC was established in December 2016 for manager and self-referrals.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Year to Date</th>
<th>Performance in last five months</th>
<th>Relative change in performance</th>
<th>Forecast Quarter</th>
<th>Forecast Year</th>
<th>Director responsible</th>
<th>Recovery Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C. difficile:</strong> (end of year max 25 attributable cases)</td>
<td>Jun-17</td>
<td>&lt;= 2</td>
<td>4</td>
<td>6</td>
<td>●●●●●</td>
<td>●</td>
<td>●</td>
<td>MC</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>C. difficile:</strong> rate per 100,000 bed days</td>
<td>Jun-17</td>
<td>&lt;= 15.0</td>
<td>26.8</td>
<td>12.2</td>
<td>●●●●●</td>
<td>●</td>
<td>●</td>
<td>MC</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

**Director responsible:** Maurya Cushlow, Executive Director of Nursing

**Clinical Lead:** Clive Graham, Associate Medical Director

The annual target is 25 or less, therefore the target for each month is 2 or less, so far in April we had 2 cases, no cases in May and 4 cases in June. So we are over for the month of June but not over for the year

**Reason why the measure is off target:**

After a very good start to the year with only 2 cases in April and no cases in May we had four cases in June (all on the CIC site), all 4 cases have undergone a Root Cause analysis, 2 of the cases were linked (same ward – Willow A) and we identified a number of issues when we carried out an Infection Prevention and control audit on that ward. Inappropriate sampling was an issue with one patient, cleaning both domestic and nursing featured in 3 cases.

**Actions/mitigations in place to improve performance:**

The ward with the 2 linked cases has undergone a deep clean, there is an action plan agreed with the ward which will be monitored through the HCAI group. Cleaning standards will be monitored through the monthly cleaning meeting. There is ongoing education of staff regarding appropriate samples.
### Cancelled Operations

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Year to Date</th>
<th>Performance in last five months</th>
<th>Forecast Quarter</th>
<th>Forecast Year</th>
<th>Director responsible</th>
<th>Recovery Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancelled operations: 28 day breaches</td>
<td>Jun-17</td>
<td>0</td>
<td>5</td>
<td>7</td>
<td>⬇️ ⬇️ ⬆️ ⬆️ ⬆️ ⬆️</td>
<td></td>
<td></td>
<td>HR</td>
<td>No</td>
</tr>
</tbody>
</table>

**Director responsible:** Helen Ray, Chief Operating Officer

**Management Lead:** Yvonne Fairbairn, ACOO Surgery

**Reason why the measure is off target:**

Cancellations due to:

- The increase in medical outliers on the surgical wards causing on the day cancellations
- Theatre List overruns

**Actions/mitigations in place to improve performance:**

The following actions have been taken:

- Monitoring weekly at RTT meeting
- Operational teams are managing cancelled patients through the system to ensure they do not breach this standard by
  - ensuring bed available on the day
  - patients are listed first on the theatre list unless clinical needs indicate otherwise
  - confirmation of all pre operation work up have been done

Escalation process in place to General Managers if patients are potentially going to be cancelled again.
Cancer 62 day All cancers and 62 day screening

Current performance

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Year to Date</th>
<th>Performance in last five months</th>
<th>Forecast Quarter</th>
<th>Forecast Year</th>
<th>Director responsible</th>
<th>Recovery Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer: 62 day All cancers (c.f. trajectory)</td>
<td>Jun-17</td>
<td>83.90%</td>
<td>72.31%</td>
<td>81.06%</td>
<td>● ● ● ● ● ● ● ↓ ↑ ↑ → ↓</td>
<td>● ● ● ● ● ● ●</td>
<td>HR Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer: 62 day Screening</td>
<td>Jun-17</td>
<td>90.0%</td>
<td>77.8%</td>
<td>78.3%</td>
<td>● ● ● ● ● ● ● → ↑ ↓ ↑ ↓</td>
<td>● ● ● ● ● ● ●</td>
<td>HR No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The target data for June will not be frozen until August. It may, therefore, change.

**Director responsible:** Helen Ray, Chief Operating Officer  
**Management Lead:** Fraser Cant, ACOO Medicine

**Reason why the measure is off target:**
- Persistent underperformance in certain tumour groups, namely – lung, urology, and lower/upper GI.
- Loss of 2 FTE trackers, in terms of time, due to sickness/annual leave in June resulting in decreased data inputting.
- Loss of Consultant clinics due to sickness/annual leave.
- Lack of timely access to diagnostic tests.

**Actions/mitigations in place to improve performance:**
- Updated Cancer improvement plan to reflect additional work to be undertaken - tumour pathway process improvement work for all groups to identify specific barriers, streamline processes, and enhance team working. Prioritised Urology, Lower/Upper GI. Specifically working alongside the relevant business manager or deputy business manager to ensure ownership of area and delivery of the cancer pathway targets.
- Proposal completed to NHSI for justification for additional revenue to expand current cancer tracking team for a period of 6 months in order to catch-up on current workload and allow Lead Cancer Co-ordinator some capacity to review cancer tracking processes and identify areas for improvement.
- Working with Informatics to identify reports to manage the cancer patient pathway more effectively – currently in scoping phase.
- Working with Infoflex development to identify opportunities to improve software solution to streamline cancer tracking processes – currently in scoping phase.
- Reviewing PTL meeting in order to ensure ownership is with the business units and driven by the business managers in order to create more ‘push’ than ‘pull’ – terms of reference being completed.
4.0 Exception Reporting against Improvement Plans

This section of the report includes exception reporting on improvement plans that are in place to support delivery of the agreed trajectories against the national standards.

<table>
<thead>
<tr>
<th>BUSINESS UNIT LEAD</th>
<th>Divisional Lead: Fraser Cant, Associate Chief Operating Officer – Medicine</th>
</tr>
</thead>
</table>
| EXCEPTION REPORTING | • Updated Cancer improvement plan to reflect additional work to be undertaken - tumour pathway process improvement work for all groups to identify specific barriers, streamline processes, and enhance team working. Prioritised Urology, Lower/Upper GI. Specifically working alongside the relevant business manager or deputy business manager to ensure ownership of area and delivery of the cancer pathway targets.  
• Proposal completed to NHSI for justification for additional revenue to expand current cancer tracking team for a period of 6 months in order to catch-up on current workload and allow Lead Cancer Co-ordinator some capacity to review cancer tracking processes and identify areas for improvement.  
• Working with Informatics to identify reports to help manage the cancer patient pathway more effectively – currently in scoping phase.  
• Working with Infoflex development to identify opportunities to improve software solution to streamline cancer tracking processes – currently in scoping phase.  
• Reviewing PTL meeting in order to ensure ownership is with the business units and driven by the business managers in order to create more ‘push’ than ‘pull’ – terms of reference being completed. |
## 5. Finance

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>RAG Criteria</th>
<th>Unit</th>
<th>Month 3</th>
<th>Year to Date</th>
<th>Outturn Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Finance &amp; Use of Resources Risk Rating</strong></td>
<td>The finance and use of resources risk rating assesses the capital service cover, liquidity, income and expenditure margins, variance from forecast total and agency spend. Each element is scored, and an aggregate overall score given.</td>
<td>Red: 4</td>
<td></td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Amber: 2 or 3</td>
<td></td>
<td>3</td>
<td>(138)</td>
<td>(34,964)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Green: 1</td>
<td></td>
<td>3</td>
<td>(34,964)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Operating Surplus / (Deficit)</strong></td>
<td>Surplus/(Deficit) before finance costs and PDC.</td>
<td>£000s</td>
<td>3,181</td>
<td>(26)</td>
<td>(8,675)</td>
<td>(34,964)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td><strong>EBITDA</strong></td>
<td>Earnings before Interest, Tax, Depreciation and Amortisation.</td>
<td>£000s</td>
<td>2,492</td>
<td>34</td>
<td>(6,287)</td>
<td>(25,876)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td><strong>Adjusted Financial Performance Retained</strong></td>
<td>Surplus/(Deficit) excluding impairments and donated asset adjustments.</td>
<td>£000s</td>
<td>3,940</td>
<td>5</td>
<td>(11,002)</td>
<td>(44,223)</td>
</tr>
<tr>
<td><strong>CIP Programme</strong></td>
<td>The value of cost reduction delivered.</td>
<td>£000s</td>
<td>995</td>
<td>362</td>
<td>2,986</td>
<td>16,265</td>
</tr>
<tr>
<td><strong>Cash and Liquidity</strong></td>
<td>Available cash balances.</td>
<td>£000s</td>
<td>1,400</td>
<td>1,279</td>
<td>2,514</td>
<td>16,265</td>
</tr>
<tr>
<td><strong>Gross Capital Expenditure</strong></td>
<td>Expenditure on capital programme.</td>
<td>£000s</td>
<td>744</td>
<td>454</td>
<td>1,271</td>
<td>10,060</td>
</tr>
<tr>
<td><strong>Agency Ceiling</strong></td>
<td>The maximum the Trust can spend on Agency Staff.</td>
<td>£000s</td>
<td>1,350</td>
<td>1,213</td>
<td>3,627</td>
<td>13,775</td>
</tr>
</tbody>
</table>

> The Trust is on plan at Month 3 and is forecasting to meet its Control Total for the year.
> The Trust’s Risk Rating at Month 3 is 3, in line with plan. The low rating is driven by the Trust’s deficit and liquidity pressures. (Please note the change in rating criteria from last financial year)
> At Month 3 the Trust is in line with the overall I&E deficit plan, though is behind plan for Operating Deficit and EBITDA.
> CIP actual delivery is behind plan at Month 3. The Trust is forecasting to achieve the overall annual CIP target.
> Cash balances are below planned levels at Month 3 as a result of lower VAT recovery from HMRC than can normally be expected.
> Capital Expenditure for Month 3 was lower than plan. At this stage in the financial year the Trust is forecasting to spend £10.06m which is £1m more than the original plan. The increase relates to the A&E Primary Care Streaming monies the Trust has been awarded.
> At Month 3 the Trust is below the agency ceiling set by NHSI.
5.1 Cost Improvement Plans (CIP)

Following delivery of the 2016/17 CIP of £13.47m, of which £4.4m was non-recurrent, the Trust 2017/18 CIP Target has been set at £16.3m. This is designed to allow the Trust to reach the agreed deficit of £44.22m.

To date, £13.82m of CIP Schemes have been identified, have had PID’s created and are live on the Tracker.

This is under the required £16.3m target and under delivery overall at the end of Quarter 1 is an issue. As a result, to deliver full year effect (i.e. deliver £16.3m savings in the remainder of the financial year) future scheme identification will have to be greater than the original target.

Work continues within the Trust to ensure and drive delivery of current schemes and to rapidly identify additional opportunities for the required CIP savings to attain Target. This now has considerable effective Executive level engagement (up to and including the Trust CEO).

The M03 phased plan was to deliver £995K of CIP and following the closure of the financial position, the in month CIP delivery is £1.36m. This is an over delivery of £362K.

This is an improvement on regarding CIP delivery, but is arising from financial validation of a number of schemes already under development. Action is being taken to push schemes through the Gateway process and to identify more opportunities.

As demonstrated in Figure 1 below, whilst there is over delivery in some areas, delivery in other, key, Divisions/Business Areas remains off track and is now receiving significant attention by the respective senior management to bring it into line with target and plan.

£6.63m of the CIP schemes are at Tracker Gateway 1 & 2, £2.17m of schemes are at Gateway 3, £418k at Gateway 4 and £4.61m at Gateway 5.
**RISK ADJUSTED FORECAST**

The full year actioned figure is £6.48m.

<table>
<thead>
<tr>
<th>Division / Area</th>
<th>Target</th>
<th>Identified Plan</th>
<th>Forecast</th>
<th>Variance to Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate</td>
<td>1,579,623</td>
<td>1,088,724</td>
<td>905,822</td>
<td>(673,801)</td>
</tr>
<tr>
<td>Estates &amp; Facilities</td>
<td>1,153,307</td>
<td>492,309</td>
<td>362,936</td>
<td>(790,371)</td>
</tr>
<tr>
<td>Medicine &amp; Emergency Care</td>
<td>6,602,317</td>
<td>3,490,060</td>
<td>2,530,158</td>
<td>(4,072,159)</td>
</tr>
<tr>
<td>Surgery &amp; Critical Care</td>
<td>6,929,753</td>
<td>2,515,741</td>
<td>985,213</td>
<td>(5,944,540)</td>
</tr>
<tr>
<td>Trustwide</td>
<td>0</td>
<td>368,334</td>
<td>1,698,821</td>
<td>1,698,821</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>16,265,000</td>
<td>7,955,168</td>
<td>6,482,950</td>
<td>(9,782,050)</td>
</tr>
</tbody>
</table>

Table 1 – 2017/18 Target, Plan and Forecast by Area

*As discussed at the April 2017 FIP Committee, Targets are not assigned to Trustwide CIP Schemes as the total CIP is found from within Divisional budgets.

**IDENTIFYING THE CIP PLAN & GAP**

As at 13th July 2017, the identified CIP opportunity stands at £13.82m, against a Trust Target of £16.3m, with £7.96m of this supported by validated financials and a phased plan for delivery. The table below shows the Target, Plan and Gap.

<table>
<thead>
<tr>
<th>Division / Area</th>
<th>Target</th>
<th>Phased Plan</th>
<th>Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate</td>
<td>1,579,623</td>
<td>1,088,724</td>
<td>(490,899)</td>
</tr>
<tr>
<td>Estates &amp; Facilities</td>
<td>1,153,307</td>
<td>492,309</td>
<td>(660,998)</td>
</tr>
<tr>
<td>Medicine &amp; Emergency Care</td>
<td>6,602,317</td>
<td>3,490,060</td>
<td>(3,112,257)</td>
</tr>
<tr>
<td>Surgery &amp; Critical Care</td>
<td>6,929,753</td>
<td>2,515,741</td>
<td>(4,414,012)</td>
</tr>
<tr>
<td>Trustwide</td>
<td>0</td>
<td>368,334</td>
<td>368,334</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>16,265,000</td>
<td>7,955,168</td>
<td>(8,309,832)</td>
</tr>
</tbody>
</table>

Table 2 – CIP Plan versus Target
Focus continues on identifying new schemes and validating those put forward, so that the CIP requirement in year will be met. Whilst the Trust is behind plan in terms of scheme identification and delivery, both have picked up considerably over the last month, following sustained Executive pressure.

As at 13th July 2017 M03 delivery was £1.36m, against the target of £995K giving an over performance of £362k. Below is the overall identified value and risk-adjusted plan in terms of gateway progression and value:

Table 3 – Risk Adjusted CIP Plan Value (excludes actual delivery)

The top ten phased schemes listed by value and by Gateway are shown below:
### 2017/18 CIP GOVERNANCE & GUIDANCE

Workshops have been facilitated throughout 2016 and early 2017, which set the scene re the CIP and set it as a business as usual requirement within the Trust.

As a result of last month’s FIP paper, CIP is now a standing item at weekly Executive meetings, at which the Director of Finance reports, supported by the Head of PMO. Individual scheme leads are asked to demonstrate delivery to Plan.

Monthly CEO led meetings with Divisional and Cross Cutting Scheme Leads now take place, with the expectation being that Leads articulate delivery to target, gap and mitigating action being taken. Challenging targets have been set for each area to deliver to on a monthly basis.

As mentioned in the 20th April 2017 FIP report, the Performance Management Group (PMG) meeting structure was amended to the following format;

1. Strategic PMG - The Strategic PMG has met twice, with the next meeting planned for 26th July.
2. Tactical PMG - There have been 3 Tactical PMG, with another in depth look at Estates & Facilities planned for Monday 17th July 2017.

### 2017/18 – RISKS TO DELIVERY OF CIP

The risk to delivery of the CIP for 2017/18 remains high, despite reasonable figures for in month delivery in Month 3. To mitigate and reduce this risk the requirement is as follows;

1. Identification of sufficient schemes, of sufficient value, in all areas of the Trust to meet the CIP delivery Target requirement of £16.3m.
2. Increase pace of moving schemes through the Gateways.
3. Continued Executive engagement to drive activity.
4. Budget realignment exercise on a Trustwide basis.

---

**Table 4 – Top 10 CIP Schemes by Scheme Value**

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Value (£k)</th>
<th>Gateway</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Rates reduction - charitable status</td>
<td>1,790,000</td>
<td>Gateway 1</td>
</tr>
<tr>
<td>Procurement Workplan - Medicine - Trust-led schemes</td>
<td>613,355</td>
<td>Gateway 3</td>
</tr>
<tr>
<td>Finance Interest</td>
<td>590,160</td>
<td>Gateway 5</td>
</tr>
<tr>
<td>WCH Acute Medicine Composite Workforce Model</td>
<td>588,712</td>
<td>Gateway 5</td>
</tr>
<tr>
<td>Admin &amp; Clerical Review</td>
<td>500,000</td>
<td>Gateway 1</td>
</tr>
<tr>
<td>Vacancy control</td>
<td>500,000</td>
<td>Gateway 1</td>
</tr>
<tr>
<td>Reduce all consultants to maximum of 12 PAs</td>
<td>470,000</td>
<td>Gateway 1</td>
</tr>
<tr>
<td>Medical Staff - Medical Productivity</td>
<td>400,000</td>
<td>Gateway 1</td>
</tr>
<tr>
<td>Gastro Vacancies (non recurring savings)</td>
<td>399,872</td>
<td>Gateway 5</td>
</tr>
<tr>
<td>Procurement Workplan - Surgery - Trust-led schemes</td>
<td>390,710</td>
<td>Gateway 3</td>
</tr>
</tbody>
</table>
Trust senior managers in all business areas must continue to identify additional CIP potential, which will be worked up by the PMO and Finance. To date, work has been done on this but more is still required.

Divisions and CIP Scheme Leads must increase their efforts on providing CIP delivery. CIP should be regarded as a priority in all Trust areas and impetus given to move the schemes through the Gateways. The Trust Executive and Senior Managers should continue to stress this until the required targets are met for the year.

For 2017/18 where delivery, in year, is not possible, mitigating schemes/actions must be identified and delivered against. The requirement for mitigation should be raised to and flagged at Tactical & Strategic PMG.

Where the schemes are high value, the risk of non-delivery should be raised to the Trust Executive.

1. RECOMMENDATIONS

The Finance, Investment and Performance Committee are recommended to:

- Acknowledge progress to date
- Approve the governance structure reported on
- Consider risks to delivery
- Note this report
6.0 Commissioning for Quality and Innovation

The 2017-18 CQUIN is under way with the first reporting on progress for quarter one due in the August Integrated Performance Report. Below are some brief updates on progress, estimated RAGs, key actions taken and key risks as at July 2017.

Clinical Commissioning Group CQUINs – estimated progress report

<table>
<thead>
<tr>
<th>2017/18 CQUIN Schemes</th>
<th>Lead responsibility</th>
<th>Year 1 £</th>
<th>Estimated RAGs</th>
<th>Key actions taken as at Jun-17</th>
<th>Brief summary</th>
<th>Key risks as at Jun-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement of health and wellbeing of NHS staff - 5% improvement in 2 out of 3 relevant survey questions</td>
<td>Christine Brereton</td>
<td>£127,000</td>
<td>Q1 Q2 Q3 Q4</td>
<td>Plan is place and actions in progress</td>
<td>High risk that the staff responses don’t all improve by 5% points.</td>
<td></td>
</tr>
<tr>
<td>Healthy food for NHS staff, visitors and patients – healthy options in retail food outlets in hospital</td>
<td>Sue Halsall</td>
<td>£127,000</td>
<td></td>
<td></td>
<td>Plans in progress</td>
<td>Non compliance of external suppliers</td>
</tr>
<tr>
<td>Improving the uptake of flu vaccinations for frontline clinical staff. Targets: 17/18 - 70%, 2018/19 - 75%</td>
<td>Christine Brereton</td>
<td>£127,000</td>
<td></td>
<td>Pre-planning, implementation will start again in Sep-17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90% of eligible patients screened for SEPSIS in inpatients and emergency</td>
<td>Jon Sturman</td>
<td>£96,000</td>
<td></td>
<td>Significant amount of training, data collection, awareness raising by SEPSIS nurses has led to improved performance of these measures.</td>
<td>Achieving 90% is difficult for all trusts. We will get over 50% and receive at least 40% payments. The whole payment at 90% is at high risk of failure</td>
<td></td>
</tr>
<tr>
<td>Sepsis Treatment - 90% of patient screened positive for SEPSIS patients treated within 1 hour in inpatients and emergency.</td>
<td>Jon Sturman</td>
<td>£96,000</td>
<td></td>
<td>Review lead joined the SEPSIS group and is working on a system to deliver this</td>
<td>New measure and so delivery potential is unknown</td>
<td></td>
</tr>
<tr>
<td>Antibiotic review empiric review for SEPSIS improvement to 90%</td>
<td>Bill Glendinning</td>
<td>£96,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibiotic treatment 2% reduction in usage overall</td>
<td>Bill Glendinning</td>
<td>£96,000</td>
<td></td>
<td></td>
<td>Already much better than national average so it will be difficult to improve</td>
<td></td>
</tr>
<tr>
<td>20% reduction in A&amp;E attendances for a selected cohort of frequent attenders with mental health needs</td>
<td>Fraser Cant</td>
<td>£383,000</td>
<td></td>
<td>Regular meetings and good progress with CPT. Cohort identified, plans in place.</td>
<td>There is a risk that the individual plans for the 16 patients are unsuccessful.</td>
<td></td>
</tr>
<tr>
<td>Advice and Guidance delivered in specialties covering 35% of referrals in 17/18, rising to 75% in 18/19</td>
<td>Yvonne Fairbairn</td>
<td>£383,000</td>
<td></td>
<td>Business Case for the UHMB A&amp;G system and plan for delivery complete</td>
<td>Systems lacks ownership in the trust once it is implemented.</td>
<td></td>
</tr>
<tr>
<td>All outpatient appointments managed through E Referral system by March 2018, slot polling ranges matching other methods and appointment slot issues reduce to 4%</td>
<td>Yvonne Fairbairn / Lorraine Gray</td>
<td>£383,000</td>
<td></td>
<td>Planning meetings have started and baselines been produced.</td>
<td>Slot polling ranges / slot errors targets will be challenging</td>
<td></td>
</tr>
<tr>
<td>Improvements to % of inpatients in longer than 72 hours, aged 65+ and discharged to usual place of residence between 3 and 7 days compared to total 3 days and over.</td>
<td>Fraser Cant</td>
<td>£383,000</td>
<td></td>
<td>Regular meetings and good progress with CPT. Planning work ongoing</td>
<td>Social Care availability could affect DTOC and LOS and ability to meet targets</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£2,297,000</td>
<td></td>
</tr>
</tbody>
</table>

Risk that target will not be met
Risk of target of part of target not met
Very likely target will be met
Specialist Commissioning CQUINs – estimated progress report

<table>
<thead>
<tr>
<th>2017/18 CQUIN Schemes</th>
<th>Lead responsibility</th>
<th>Year 1 £</th>
<th>Estimated RAGs</th>
<th>Key actions taken as at Jun-17</th>
<th>Key risks as at Jun-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA2- Chemotherapy Dose banding.</td>
<td>Fraser Cant</td>
<td>£51,755</td>
<td></td>
<td>Should be largely business as usual</td>
<td></td>
</tr>
<tr>
<td>CA3- Optimising Palliative Chemotherapy.</td>
<td>Fraser Cant</td>
<td>£77,663</td>
<td></td>
<td>Work has already commenced</td>
<td></td>
</tr>
<tr>
<td>GE3- Medicines Optimisation.</td>
<td>Bill Glendinning</td>
<td>£77,663</td>
<td></td>
<td>Detailed guidance yet be received from Spec Comm</td>
<td>Lateness of the guidance means impact may be low</td>
</tr>
<tr>
<td>Local- Improving Chemotherapy Pathways.</td>
<td>Fraser Cant</td>
<td>£51,755</td>
<td></td>
<td>Meetings held, work in progress</td>
<td>Difficulty recruiting could cause a problem.</td>
</tr>
<tr>
<td>Dental dashboard and network engagement</td>
<td>Yvonne Fairbairn</td>
<td>£79,647</td>
<td></td>
<td>Meetings held, work in progress</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>£338,483</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Available for CQUIN from quality improvement measures £2,635,483

- Risk that target will not be met
- Risk of target of part of target not met
- Very likely target will be met
7.0 Recommendations

The Board members are asked to:

- Discuss the performance of North Cumbria University Hospitals NHS Trust against the key indicators
- Be assured of progress regarding performance including CQUIN delivery
- Where necessary seek clarification that required actions are being taken.

8.0 Appendices

Appendix 1 – Domains against performance
Appendix 2 – Scorecard Key
Appendix 3 - Glossary
## Targets with trajectories

<table>
<thead>
<tr>
<th>Trajectories</th>
<th>Mandatory Training - overall</th>
<th>Appraisals: (All staff)</th>
<th>AE 4 hour waits</th>
<th>RTT % incomplete pathways &lt;18 weeks</th>
<th>Cancer: 62 day All cancers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-17</td>
<td>20%</td>
<td>20%</td>
<td>88.3%</td>
<td>91.5%</td>
<td>80.8%</td>
</tr>
<tr>
<td>May-17</td>
<td>35%</td>
<td>35%</td>
<td>89.0%</td>
<td>92.0%</td>
<td>82.4%</td>
</tr>
<tr>
<td>Jun-17</td>
<td>50%</td>
<td>50%</td>
<td>89.6%</td>
<td>92.0%</td>
<td>83.9%</td>
</tr>
<tr>
<td>Jul-17</td>
<td>65%</td>
<td>65%</td>
<td>90.0%</td>
<td>92.0%</td>
<td>85.3%</td>
</tr>
<tr>
<td>Aug-17</td>
<td>80%</td>
<td>80%</td>
<td>91.0%</td>
<td>92.0%</td>
<td>85.0%</td>
</tr>
<tr>
<td>Sep-17</td>
<td>95%</td>
<td>95%</td>
<td>92.0%</td>
<td>92.0%</td>
<td>85.0%</td>
</tr>
<tr>
<td>Oct-17</td>
<td>95%</td>
<td>95%</td>
<td>93.0%</td>
<td>92.0%</td>
<td>85.0%</td>
</tr>
<tr>
<td>Nov-17</td>
<td>95%</td>
<td>95%</td>
<td>92.5%</td>
<td>92.0%</td>
<td>85.0%</td>
</tr>
<tr>
<td>Dec-17</td>
<td>95%</td>
<td>95%</td>
<td>92.0%</td>
<td>91.0%</td>
<td>85.0%</td>
</tr>
<tr>
<td>Jan-18</td>
<td>95%</td>
<td>95%</td>
<td>93.0%</td>
<td>91.0%</td>
<td>85.0%</td>
</tr>
<tr>
<td>Feb-18</td>
<td>95%</td>
<td>95%</td>
<td>94.0%</td>
<td>92.0%</td>
<td>85.0%</td>
</tr>
<tr>
<td>Mar-18</td>
<td>95%</td>
<td>95%</td>
<td>95.0%</td>
<td>92.0%</td>
<td>85.0%</td>
</tr>
</tbody>
</table>

### Caring

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Required direction</th>
<th>Target</th>
<th>Amber Threshold</th>
<th>Up Down Tolerance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed sex accommodation breaches</td>
<td>↓</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Complaints: rate per 1,000 bed days</td>
<td>↓</td>
<td>No target set</td>
<td>0.5%</td>
<td></td>
</tr>
<tr>
<td>Staff FFT: % recommending care</td>
<td>↑</td>
<td>70.0%</td>
<td>69.0%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Inpatient FFT: % positive scores</td>
<td>↑</td>
<td>95.0%</td>
<td>90.3%</td>
<td>0.5%</td>
</tr>
<tr>
<td>A&amp;E FFT: % positive scores</td>
<td>↑</td>
<td>87.5%</td>
<td>86.5%</td>
<td>0.5%</td>
</tr>
</tbody>
</table>
### Safe

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Required direction</th>
<th>Target</th>
<th>Amber Threshold</th>
<th>Up Down Tolerance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MRSA</strong>: cases</td>
<td>↓</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>C. difficile</strong>: cases (attributable)</td>
<td>↓</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td><strong>C. difficile</strong>: rate per 100,000 bed days</td>
<td>↓</td>
<td>No target set</td>
<td>0.1%</td>
<td></td>
</tr>
<tr>
<td><strong>VTE risk assessments</strong></td>
<td>↑</td>
<td>95%</td>
<td>94%</td>
<td>0.5%</td>
</tr>
<tr>
<td><strong>Duty of Candour breaches</strong></td>
<td>↓</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Never Events</strong>: Number in month</td>
<td>↓</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Never Events</strong>: rate per 100,000 bed days</td>
<td>↓</td>
<td>No target set</td>
<td>0.5%</td>
<td></td>
</tr>
<tr>
<td><strong>NHS Safety Thermometer</strong>: % harm free care</td>
<td>↑</td>
<td>90%</td>
<td>89%</td>
<td>0.5%</td>
</tr>
<tr>
<td><strong>NHS Safety Thermometer</strong>: new harm (%)</td>
<td>↓</td>
<td>3.50%</td>
<td>3.60%</td>
<td>0.5%</td>
</tr>
<tr>
<td><strong>Emergency C-section rates (%)</strong></td>
<td>↓</td>
<td>16.0%</td>
<td>17.0%</td>
<td>0.5%</td>
</tr>
<tr>
<td><strong>Serious incidents</strong>: No. of new in month</td>
<td>↓</td>
<td>No target set</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Serious incidents</strong>: rate per 1,000 bed days</td>
<td>↓</td>
<td>No target set</td>
<td>0.5%</td>
<td></td>
</tr>
<tr>
<td><strong>Medication errors</strong>: serious harm</td>
<td>↓</td>
<td>No target set</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>% patient safety incidents</strong>: harmful</td>
<td>↓</td>
<td>29%</td>
<td>30%</td>
<td>0.5%</td>
</tr>
<tr>
<td><strong>CAS alerts</strong>: No. outstanding</td>
<td>↓</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

### Effective

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Required direction</th>
<th>Target</th>
<th>Amber Threshold</th>
<th>Up Down Tolerance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mortality: HSMR</strong></td>
<td>=</td>
<td>100</td>
<td>Not set</td>
<td>0.5%</td>
</tr>
<tr>
<td><strong>Mortality: SHMI</strong></td>
<td>=</td>
<td>1</td>
<td>Not set</td>
<td>0.5%</td>
</tr>
<tr>
<td><strong>Emergency readmissions</strong>: 30 days</td>
<td>↓</td>
<td>9.4%</td>
<td>9.50%</td>
<td>0.5%</td>
</tr>
</tbody>
</table>
### Responsive

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Required direction</th>
<th>Target</th>
<th>Amber Threshold</th>
<th>Up Down Tolerance</th>
</tr>
</thead>
<tbody>
<tr>
<td>AE 4 hour waits (% cf trajectory)</td>
<td>↑</td>
<td></td>
<td></td>
<td>0.5%</td>
</tr>
<tr>
<td>AE 12 hour Trolley Waits</td>
<td>↓</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Ambulance handovers &gt; 30 mins: %</td>
<td>↓</td>
<td>9.8%</td>
<td>10.3%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Ambulance handovers &gt; 60 mins: %</td>
<td>↓</td>
<td>2.7%</td>
<td>2.8%</td>
<td>0.5%</td>
</tr>
<tr>
<td>DTOC (% of occupied bed days)</td>
<td>↓</td>
<td>3.5%</td>
<td>3.6%</td>
<td>0.5%</td>
</tr>
<tr>
<td>RTT % incomplete &lt;18 weeks (c.f. trajectory)</td>
<td>↑</td>
<td></td>
<td></td>
<td>0.5%</td>
</tr>
<tr>
<td>RTT &gt;52 week incomplete at month end</td>
<td>↓</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Diagnostics: % waiting &lt;6 wks (c.f. trajectory)</td>
<td>↑</td>
<td></td>
<td></td>
<td>0.5%</td>
</tr>
<tr>
<td>Cancer: 2 week All</td>
<td>↑</td>
<td>93.0%</td>
<td>92.0%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Cancer: 2 week Breast symptomatic</td>
<td>↑</td>
<td>93.0%</td>
<td>92.0%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Cancer: 31 day All</td>
<td>↑</td>
<td>96.0%</td>
<td>95.0%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Cancer: 31 day Surgery</td>
<td>↑</td>
<td>94.0%</td>
<td>93.0%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Cancer: 31 day Chemotherapy</td>
<td>↑</td>
<td>98.0%</td>
<td>97.0%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Cancer: 31 day Radiotherapy</td>
<td>↑</td>
<td>94.0%</td>
<td>93.0%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Cancer: 62 day All cancers (c.f. trajectory)</td>
<td>↑</td>
<td></td>
<td></td>
<td>0.5%</td>
</tr>
<tr>
<td>Cancer: 62 day Screening</td>
<td>↑</td>
<td>90.0%</td>
<td>89.0%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Cancer: 62 day Con. upgrade</td>
<td>↑</td>
<td>90.0%</td>
<td>89.0%</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

### Responsive - continued

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Required direction</th>
<th>Target</th>
<th>Amber Threshold</th>
<th>Up Down Tolerance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancelled (Non-clinical) elective operations</td>
<td>↓</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Cancelled operations: 28 day breaches</td>
<td>↓</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>28 day breaches: % of cancelled</td>
<td>↓</td>
<td>0.0%</td>
<td>0.00%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Urgent operations cancelled for a 2nd time</td>
<td>↓</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>OP &lt;6wk cancellation rate %</td>
<td>↓</td>
<td>8.0%</td>
<td>9.0%</td>
<td>0.5%</td>
</tr>
</tbody>
</table>
### Well-led

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Required direction</th>
<th>Target</th>
<th>Amber Threshold</th>
<th>Up Down Tolerance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Turnover rate</td>
<td>↓</td>
<td>12.0%</td>
<td>13.0%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Staff sickness rate (short term sickness)</td>
<td>↓</td>
<td>1.5%</td>
<td>1.4%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Staff sickness rate (total)</td>
<td>↓</td>
<td>4.0%</td>
<td>3.9%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Staff Survey (KF14) incident reporting</td>
<td>↑</td>
<td>3.53</td>
<td>Not set</td>
<td>Not set</td>
</tr>
<tr>
<td>FFT Response Rate - Inpatients</td>
<td>=</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.5%</td>
</tr>
<tr>
<td>FFT Response Rate - A&amp;E</td>
<td>=</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>FFT Response Rate - Staff</td>
<td>↑</td>
<td>25.0%</td>
<td>24.0%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Staff FFT: recommending as place of work</td>
<td>↑</td>
<td>55.0%</td>
<td>54.0%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Appraisals: (All staff)</td>
<td>↑</td>
<td>See trajectories above</td>
<td>0.5%</td>
<td></td>
</tr>
<tr>
<td>Mandatory Training - overall</td>
<td>↑</td>
<td>See trajectories above</td>
<td>0.5%</td>
<td></td>
</tr>
</tbody>
</table>
## APPENDIX 2 – Key for the balance scorecards

### Trust Board Balanced Scorecard

#### Responsive

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Year to Date</th>
<th>Performance in last five months</th>
<th>Relative change in performance</th>
<th>Forecast Quarter</th>
<th>Forecast Year</th>
<th>Director responsible</th>
<th>Recovery Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>AE 4 hour waits (% performance)</td>
<td>Apr-16</td>
<td>95.00%</td>
<td>88.57%</td>
<td>88.57%</td>
<td>↑↓↑↑↑↑</td>
<td></td>
<td></td>
<td></td>
<td>HR</td>
<td>Yes</td>
</tr>
<tr>
<td>AE 12 hour Trolley Waits</td>
<td>Apr-16</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>↓→↑↑↑↑↑</td>
<td></td>
<td></td>
<td></td>
<td>HR</td>
<td>No</td>
</tr>
</tbody>
</table>

| 1 Dashboard banner: indicates which dashboard is being presented |
| 2 Section banner: thematic grouping of indicators, aligned to the TDA Accountability Framework |
| 3 Column headers |
| 4 Individual indicators |
| 5 Indicator title (full definitions and indicator construction details are documented separately) |
| 6 Period: the month (or occasionally other period) of the data being presented in the “Actual” column |
| 7 Period: Red asterisk denotes provisional data (e.g. the data has been collated but the UNIFY return has not yet been submitted – or local Cancer data) |
| 8 Target: the target (for the reporting period). Where there is recovery trajectory, the monthly trajectory point will be used as the target |
| Where the target is an upper limit, this is indicated by the “<=” symbol |
| 9 Actual: RAG rating for the reporting period |
| 10 Actual: the actual performance in the reporting period |
| 11 Year to date: RAG rating for performance current year to date |
| 12 Year to date: The actual performance current year to date |
| 13 The RAG rating for the sequence results in the last five months |
| 14 The relative change in performance over each of the last five months |
| 15 Forecast Quarter: The RAG rating for the forecast position for the current quarter |
| 16 Forecast Year: The RAG rating for the forecast position for the current year |
| 17 Director responsible: The initials of the Director responsible for the indicator |
| 18 Recovery Plan: whether a recovery (improvement) plan has been initiated for this indicator |
### APPENDIX 3 – Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &amp; E</td>
<td>Accident and Emergency</td>
</tr>
<tr>
<td>ASC</td>
<td>Adult Social Care</td>
</tr>
<tr>
<td>BCP</td>
<td>Business Continuity Plan</td>
</tr>
<tr>
<td>BPT</td>
<td>Best Practice Tariff</td>
</tr>
<tr>
<td>CAS</td>
<td>Central Alert System</td>
</tr>
<tr>
<td>CCG</td>
<td>NHS Cumbria Clinical Commissioning Group</td>
</tr>
<tr>
<td>CIC</td>
<td>Cumberland Infirmary Carlisle</td>
</tr>
<tr>
<td>CIP</td>
<td>Cost Improvement Assessment</td>
</tr>
<tr>
<td>COO</td>
<td>Chief Operating Officer</td>
</tr>
<tr>
<td>CPFT</td>
<td>Cumbria Partnership NHS Foundation Trust</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation</td>
</tr>
<tr>
<td>DTOC</td>
<td>Delayed Transfers of Care</td>
</tr>
<tr>
<td>EMCS</td>
<td>Emergency C-Section</td>
</tr>
<tr>
<td>ESR</td>
<td>Electronic Staff Record</td>
</tr>
<tr>
<td>EY</td>
<td>Ernst &amp; Young</td>
</tr>
<tr>
<td>FFT</td>
<td>Friends and Family Test</td>
</tr>
<tr>
<td>HR</td>
<td>Human Resources</td>
</tr>
<tr>
<td>ICE</td>
<td>Integrated Clinical Environment</td>
</tr>
<tr>
<td>IDT</td>
<td>Integrated Discharge Team</td>
</tr>
<tr>
<td>IOL</td>
<td>Induction of Labour</td>
</tr>
<tr>
<td>KPI</td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td>LDA</td>
<td>Lead Divisional Accountant</td>
</tr>
<tr>
<td>MDT</td>
<td>Multi-Disciplinary Team</td>
</tr>
<tr>
<td>MLU</td>
<td>Midwifery Lead Unit</td>
</tr>
<tr>
<td>NCUH</td>
<td>North Cumbria University Hospitals NHS Trust</td>
</tr>
<tr>
<td>NEWS</td>
<td>North East Ambulance Service</td>
</tr>
<tr>
<td>NHSI</td>
<td>NHS Improvement</td>
</tr>
<tr>
<td>NWAS</td>
<td>North West Ambulance Service</td>
</tr>
<tr>
<td>OD</td>
<td>Organisation Development</td>
</tr>
<tr>
<td>PAS</td>
<td>Patient Administration System</td>
</tr>
<tr>
<td>PBR</td>
<td>Payment by Results</td>
</tr>
<tr>
<td>PTL</td>
<td>Primary Targeting Lost</td>
</tr>
<tr>
<td>QIA</td>
<td>Quality Impact Assessment</td>
</tr>
<tr>
<td>RTT</td>
<td>Referral to Treatment Target</td>
</tr>
<tr>
<td>SAFER</td>
<td>Secure and Fast Encryption Route</td>
</tr>
<tr>
<td>SOP</td>
<td>Standard Operating Procedure</td>
</tr>
<tr>
<td>SRG</td>
<td>System Resilience Group</td>
</tr>
<tr>
<td>TDA</td>
<td>Trust Development Authority</td>
</tr>
<tr>
<td>VBAC</td>
<td>Vaginal Birth After Caesarean Section</td>
</tr>
<tr>
<td>WCH</td>
<td>West Cumberland Hospital</td>
</tr>
</tbody>
</table>
## Trust Board Balanced Scorecard - Additional Measures

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Year to Date</th>
<th>Performance in last five months</th>
<th>Relative change in performance</th>
<th>Forecast Quarter</th>
<th>Forecast Year</th>
<th>Director responsible</th>
<th>Recovery Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Serious incidents</strong>: No. of new in month</td>
<td>Jun-17 *</td>
<td>9</td>
<td>21</td>
<td></td>
<td></td>
<td>↓ ↑ ↓ ↑ ↓</td>
<td></td>
<td></td>
<td>MC</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Serious incidents</strong>: rate per 1,000 bed days</td>
<td>Jun-17 *</td>
<td>0.00</td>
<td>0.60</td>
<td>0.43</td>
<td></td>
<td>↓ ↑ ↓ ↑ ↓</td>
<td></td>
<td></td>
<td>MC</td>
<td>Yes</td>
</tr>
<tr>
<td>Medication errors -&gt; serious harm</td>
<td>Jun-17 *</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>→ ↑ ↑ →</td>
<td></td>
<td></td>
<td>MC</td>
<td>No</td>
</tr>
</tbody>
</table>

NB: See appendix 2 for key to balance scorecards
## Trust Board Balanced Scorecard - Additional Measures

### Responsive

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Year to Date</th>
<th>Performance in last five months</th>
<th>Relative change in performance</th>
<th>Forecast Quarter</th>
<th>Forecast Year</th>
<th>Director responsible</th>
<th>Recovery Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance handovers &gt; 30 mins: %</td>
<td>Jun-17</td>
<td>&lt;= 9.8%</td>
<td>3.9%</td>
<td>9.4%</td>
<td>⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆</td>
<td>↑ → ↑ → →</td>
<td>⬆</td>
<td>⬆</td>
<td>HR</td>
<td>No</td>
</tr>
<tr>
<td>Ambulance handovers &gt; 60 mins: %</td>
<td>Jun-17</td>
<td>&lt;= 2.7%</td>
<td>0.0%</td>
<td>0.8%</td>
<td>⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆</td>
<td>↑ ↓ ↑ ↑ ↓ ↓</td>
<td>⬆</td>
<td>⬆</td>
<td>HR</td>
<td>No</td>
</tr>
<tr>
<td>Cancer: 2 week Breast symptomatic</td>
<td>Jun-17</td>
<td>*</td>
<td>93.0%</td>
<td>69.2%</td>
<td>⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆</td>
<td>↓ ↓ ↑ ↑ ↓ ↓</td>
<td>⬆</td>
<td>⬆</td>
<td>HR</td>
<td>No</td>
</tr>
<tr>
<td>Cancer: 31 day Surgery</td>
<td>Jun-17</td>
<td>*</td>
<td>94.0%</td>
<td>75.0%</td>
<td>⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆</td>
<td>↓ ↑ ↓ ↓ ↓ ↓</td>
<td>⬆</td>
<td>⬆</td>
<td>HR</td>
<td>No</td>
</tr>
<tr>
<td>Cancer: 31 day Chemotherapy</td>
<td>Jun-17</td>
<td>*</td>
<td>98.0%</td>
<td>78.6%</td>
<td>⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆</td>
<td>↓ ↑ ↑ ↓ ↓</td>
<td>⬆</td>
<td>⬆</td>
<td>HR</td>
<td>No</td>
</tr>
<tr>
<td>Cancer: 31 day Radiotherapy</td>
<td>Jun-17</td>
<td>*</td>
<td>94.0%</td>
<td>100.0%</td>
<td>⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆</td>
<td>↑ → → → →</td>
<td>⬆</td>
<td>⬆</td>
<td>HR</td>
<td>No</td>
</tr>
<tr>
<td>Cancer: 62 day Screening</td>
<td>Jun-17</td>
<td>*</td>
<td>90.0%</td>
<td>77.8%</td>
<td>⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆</td>
<td>→ ↑ ↓ ↑ ↓</td>
<td>⬆</td>
<td>⬆</td>
<td>HR</td>
<td>No</td>
</tr>
<tr>
<td>Cancer: 62 day Con. upgrade</td>
<td>Jun-17</td>
<td>*</td>
<td>90.0%</td>
<td>100.0%</td>
<td>⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆</td>
<td>→ → → → →</td>
<td>⬆</td>
<td>⬆</td>
<td>HR</td>
<td>No</td>
</tr>
<tr>
<td>28 day breaches: % of cancelled</td>
<td>Jun-17</td>
<td>0.0%</td>
<td>0.0%</td>
<td>2.0%</td>
<td>⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆</td>
<td>↓ ↓ ↑ ↑ ↑</td>
<td>⬆</td>
<td>⬆</td>
<td>HR</td>
<td>No</td>
</tr>
<tr>
<td>Urgent operations cancelled for a 2nd time</td>
<td>Jun-17</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆</td>
<td>→ → → → →</td>
<td>⬆</td>
<td>⬆</td>
<td>HR</td>
<td>No</td>
</tr>
<tr>
<td>OP &lt;6wk cancellation rate %</td>
<td>Jun-17</td>
<td>8.0%</td>
<td>5.7%</td>
<td>5.0%</td>
<td>⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆ ⬆</td>
<td>↑ → ↑ ↑ ↓</td>
<td>⬆</td>
<td>⬆</td>
<td>HR</td>
<td>No</td>
</tr>
</tbody>
</table>

NB: See appendix 2 for key to balance scorecards
Report to a Meeting of the Trust Board of Directors held in Public

<table>
<thead>
<tr>
<th>Date of Meeting:</th>
<th>25 July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enclosure Number:</td>
<td>13</td>
</tr>
<tr>
<td>Title of Report:</td>
<td>Annual Board Report for Appraisal and Revalidation. A Framework of Quality Assurance for Responsible Officers and Revalidation</td>
</tr>
<tr>
<td>Author:</td>
<td>Dr Chris Flucker, Lead Appraiser</td>
</tr>
<tr>
<td>Executive Lead:</td>
<td>Dr Rod Harpin, Medical Director and Responsible Officer</td>
</tr>
<tr>
<td>Responsible Sub-Committee</td>
<td>N/A</td>
</tr>
<tr>
<td>Executive Summary:</td>
<td>Dr Rod Harpin, Medical Director was appointed as the Responsible Officer for the Trust from 4th January 2017.</td>
</tr>
<tr>
<td></td>
<td>The report highlights the number of doctors with a prescribed connection to this Trust and reports on the number of completed appraisals in the year 2016/17.</td>
</tr>
<tr>
<td></td>
<td>During this period 82% of doctors with a prescribed connection to the Trust had an appraisal, which compares to 93% for 2015/16 and 74% for 2014/15. The Trusts’ Annual Organisational Audit (AOA) for 2016-17 has been sent to the NHS England higher Responsible Officer on time.</td>
</tr>
<tr>
<td></td>
<td>A new appraisal policy which supports positive revalidation recommendations to the GMC came into full force on 1 April 2016 with allocation of appraiser to appraise and the appraisal to occur normally in the appraisee’s birth month.</td>
</tr>
<tr>
<td></td>
<td>Revalidation is now in its second 5 yearly cycle. From 1 April 2016 to 31 March 2017 69 positive recommendations were made to the GMC, and 16 deferrals. There were no non participation recommendations made. Of the deferrals 9 subsequently became positive recommendations before 1 April 2017.</td>
</tr>
<tr>
<td></td>
<td>A second review of the quality of appraisals has taken place which emphasises the need for improvement, particularly around appropriate challenge in the appraisal discussion and for greater evidence of reflection on learning, which are similar findings with the first audit.</td>
</tr>
<tr>
<td></td>
<td>A visit by the HLRO was undertaken to review the Trusts’ historically low appraisal rate. An action plan relating to that visit is in place.</td>
</tr>
</tbody>
</table>
**Strategic Priority and BAF Link:**

<table>
<thead>
<tr>
<th>Strategic Priority:</th>
<th>List below the associated risk in relation to the Strategic Priority:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Strategy and System</td>
<td></td>
</tr>
<tr>
<td>2. Operational Flow and Delivery</td>
<td></td>
</tr>
<tr>
<td>3. Patient and Staff Experience</td>
<td></td>
</tr>
<tr>
<td>4. Workforce and Leadership</td>
<td>A risk that by non-engagement, a practitioner could become unemployable</td>
</tr>
<tr>
<td>5. Patient Safety and Quality</td>
<td></td>
</tr>
</tbody>
</table>

**Financial implications:**

Medium Risk

**Actions required by the Board:**

<table>
<thead>
<tr>
<th>To approve:</th>
<th>Discussion and decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>To note:</td>
<td>Where the Board is made aware of key points but no decision required</td>
</tr>
<tr>
<td>For information:</td>
<td>For reading and consideration and for discussion by exception only</td>
</tr>
</tbody>
</table>

The Board is requested to note this report, which will also be shared with the Higher Level Responsible Officer, and to approve the signing of the ‘statement of compliance’ confirming that the Trust, as a designated body, is in compliance with the regulations (see Annex E – Statement of Compliance).

**Data quality:**

<table>
<thead>
<tr>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Validated by:</td>
</tr>
<tr>
<td>Date:</td>
</tr>
</tbody>
</table>
1. INTRODUCTION

The Trusts’ Responsible Officer is required to report to the Trust Board annually in relation to medical revalidation. The purpose of this report is to summarise the position in relation to appraisals and revalidation for the year 1 April 2016 to 31 March 2017.

2. BACKGROUND

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations and it is expected that executive teams will oversee compliance by:

a. monitoring the frequency and quality of medical appraisals in their organisations;

b. checking there are effective systems in place for monitoring the conduct and performance of their doctors;

c. confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and

d. Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

3. GOVERNANCE ARRANGEMENTS

Dr Gbenga Afolabi was the interim, Responsible Officer for the Trust until 4th January 2017. This was an interim arrangement as part of a buddy agreement with Northumbria.

Dr Rod Harpin, Medical Director was appointed on 4th January 2017 as the Trust’s
Responsible Officer (RO) and has now taken over responsibility for medical appraisals and revalidation.

Dr Hilton Dixon was the Associate Medical Director for Appraisal and Revalidation for North Cumbria from 6 July 2015 until his retirement from this post due to ill health. Dr Chris Flucker was appointed on 21st January 2017 as Lead Appraiser (LA) for the Trust. During this period of transition and ill health appraisals have not been led for a considerable period of time.

Administrative support to the medical appraisal process and revalidation is provided by Human Resources staff and the Medical Director’s Office.

The Trust submits quarterly returns to NHS England who monitor progress in relation to appraisals and revalidation.

The Medical Directorate maintains the list of medical practitioners with whom the Trust has a prescribed connection for medical and revalidation purposes.

The Higher Level Responsible Officer (North) visited the Trust on 24 April 2017 to meet the new team and assure himself that the policy and procedures relating to medical appraisal and revalidation were fit for purpose.

4. POLICY AND GUIDANCE

The Trust’s existing Medical Appraisal Policy has been reviewed and updated in line with NHS England’s Medical Appraisal Policy. The Policy was ratified in December 2015. It is under regular review to see what works well and what improvements are required.

5. MEDICAL APPRAISAL

The Annual Organisational Audit (AOA) questionnaire for 2016-17 medical appraisal has been submitted by the Responsible Officer and is included in Appendix 1.

6. APPRAISAL AND REVALIDATION PERFORMANCE DATA

As at 31 March 2016 the Trust had a prescribed connection with 242 doctors.

An audit of appraisals was carried out for the 2016-2017 year and the number of appraisals carried out including late appraisals is below using the NHS England definitions as follows.

**NHS England’s Framework for Quality Assurance – Appraisal Definitions**

For the annual report, the definitions are reported under one of 4 categories:

- Category 1a completed annual medical appraisal is one where:
  - The appraisal meeting has taken place between 9 and 15 months of the date of the last appraisal.
  - The outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting.
And the entire process occurred between 1 April 2015 and 31 March 2016.

• Category 1b Completed medical appraisal is one where:
  o the appraisal meeting took place in the appraisal year between 1 April 2015 and 31 March 2016.
  o the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the following apply:
    o a period of time of less than 9 months or greater than 15 months from the last appraisal has elapsed
    o the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor between 1 April and 28 April of the following appraisal year;
    o the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor more than 28 days after the appraisal meeting.
  o However, in the judgement of the responsible officer the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.

• Category 2 Approved incomplete or missed appraisal is one where:
  o the appraisal has not been completed according to the parameters of either a Category 1a or 1b completed annual medical appraisal, but the responsible officer has given approval to the postponement or cancellation of the appraisal.

• Category 3 Unapproved incomplete or missed appraisal is one where:
  o the appraisal has not been completed according to the parameters of either a Category 1a or 1b completed annual medical appraisal, and the responsible officer has not given approval to the postponement or cancellation of the appraisal.

AOA as at 31/03/2017

<table>
<thead>
<tr>
<th></th>
<th>Completed Appraisals</th>
<th>Approved incomplete or missed appraisal</th>
<th>Unapproved incomplete or missed appraisals</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants</td>
<td>144</td>
<td>54</td>
<td>27</td>
<td>0</td>
</tr>
<tr>
<td>SAS grades</td>
<td>37</td>
<td>11</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Temporary or short term contract</td>
<td>61</td>
<td>35</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>242</td>
<td>100</td>
<td>43</td>
<td>0</td>
</tr>
</tbody>
</table>
The number of prescribed connections is very similar to the previous year, however the composition of the workforce identified during this period demonstrates many more doctors on temporary and short term contracts. This is most likely due to medical appraisals moving to the HR department who have made great improvements in the accuracy of the staff lists and so this year's workforce breakdown is likely to be the true picture.

There has been a small increase in missed appraisals from 37 to 43 but more concerning, a significant increase in late appraisals from 15 to 100 in both the consultant and temporary groups. The latter is not surprising as these doctors move from post to post whereas the former is disappointing.

The themes for missed appraisals were similar to the previous year:
- New starters during the appraisal year.
- Prolonged absence during the majority of the appraisal year (Maternity leave, sick leave, career break).
- Doctors having left the organisation and not informed the Medical Appraisal Office.
- However the absence of the AMD leading appraisal and sending out reminders has resulted in many doctors falling behind.

There was a significant backlog of doctors who had become out of date for their appraisal when the new team took over. Individuals have been written to, had regular phone calls and some have had interviews with the RO and LA. As of 31 05 2017, only 5 doctors are overdue on the Clarity system.

An appraisal update bulletin has been sent to all doctors and it can also be accessed on the intranet. It sets out the expectation the Trust has for its doctors. Furthermore an “engagement pathway” (Appendix 5) has been circulated which clearly describes the timescale for appraisal, what reminders a doctor can expect and when they are
viewed as not engaged and the risk of disciplinary action that they may face.

7. **APPRAISERS**

**Count of appraisers**

44 Appraisers trained to Revalidation Support Team standards.

**Training**

North Cumbria Appraisal and Revalidation training is a rolling programme which incorporates initial and update national training for appraisal and revalidation, and local standards and skills development. The training is delivered by workshops which are open to all medical appraisers. One session has been delivered in 2017; the next is due in June 2017 with 3 more sessions now fixed. The agenda has been determined by the finding of this year’s audit below.

The Trust also provides group and one to one training sessions to support appraisees and appraisers with the introduction of the on-line appraisal toolkit – Clarity system.

8. **QUALITY ASSURANCE**

The Trust is developing a Quality Assurance process as follows.

**Assurance of the Process**

Assurance of the process is carried out by the Responsible Officer via this report, the content of which will be in line with NHS England guidance.

**Assurance of the Work of Appraisers**

The RO holds statutory responsibility for the appraiser’s outputs and will annually discharge this responsibility and quality assure the outputs by using methods recognised by NHS England.

These will include the following:

- Feedback from appraisees, colleagues, administrative staff who support appraisal.
- Assessment against pre-agreed criteria.

This can include:

- Assessment of 10% of the appraiser’s outputs against NHS England quality standards by clinical appraisal leads.
- Assessment of the appraiser’s review of supporting information against NHS England quality standards by the RO.
- Assessment of the quality of challenge and reflection by the appraiser.
- Collection and review of information relating to appraiser performance e.g. appraisal activity, CPD, attendance at appraiser support group meetings,
response to complaints and SI’s etc.

**Review of appraisal information at appraisers appraisal**

A review of 44 Clarity appraisals for 2016-2017 was undertaken by the **Lead Appraiser** (Appendix 2) based on the Galloway review tool (Appendix 3). The methodology for this audit was different compared to the previous one which only looked at the appraisal summary discussion. This audit looked for evidence across all domains of the Clarity appraisal record.

However, the findings were remarkably similar to the previous year’s audit in that the main areas for improvement are documenting what the appraisee has reflected on and noting any challenge made.

Feedback from both appraisees and appraisers from the 2016-2017 appraisal year is included in Appendix 4. This was generally positive and suggestions of sufficient notice of the appraisal, and appraisal outside specialty are now in place and better links to the job planning process are planned.

9. **ACCESS, SECURITY AND CONFIDENTIALITY**

**Access**

Access to appraisal portfolios on Clarity is available to:

<table>
<thead>
<tr>
<th>Appraisees</th>
<th>Appraisers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible Officer</td>
<td>Clarity Administrator</td>
</tr>
<tr>
<td>Administrator for Education and Training</td>
<td>Lead Appraiser</td>
</tr>
</tbody>
</table>

**Security**

Clarity holds the ISO27001 Information Security Management System (ISMS) Certificate, which is independently audited each year. Clarity also complies with NHS Information Governance Toolkit Level 3.

**Confidentiality**

There have been no information management breaches to date.

10. **CLINICAL GOVERNANCE**

A system using Patient Perspective Sharepoint, is available by named consultant and specialty, to provide data for individual clinician’s appraisals to be revalidation ready, and this information is available on the Trusts’ intranet site. The information is available to each individual consultant and broken down by site, specialty and individual clinician. While this provides quantitative data qualitative data from patient comments is not currently available but work is in progress to try
to capture this in out-patient clinics.

Medical staff are expected to bring to their own appraisal information relating to incidents, complaints, SUI's etc.

11. REVALIDATION RECOMMENDATIONS

69 doctors with whom the Trust has a prescribed connection were recommended positively for revalidation between 1 April 2015 and 31 March 2016.

16 revalidation recommendations were deferred. The main reasons for deferral were inadequate supporting information provided in the appraisal portfolio and long term sickness.

There were no non-engagement notifications.

There were however 2 late recommendations both due to difficulty by the locum getting all of the information together. The RO has to provide a full explanation to NHSE revalidation to account for these late recommendations. All occurred prior to January 2017 and it is likely that the closer alliance of designated body, RO and HR will avoid such delays.

12. RECRUITMENT AND ENGAGEMENT BACKGROUND CHECKS

All medical staff are appointed subject to satisfactory pre-employment checks. The Trust complies with the NHS Employers 6 pack and checks are undertaken in relation to health, ID, right to work, Disclosure & Barring Service, qualifications, references.

Before a start date is arranged with a new doctor each recruitment file is audited to ensure all the correct checks are in place.

Last year, as part of the new RO’s plans and as a response to findings in MHPS investigations it was proposed that as part of future pre-employment checks, information is collected on the doctor’s former Designated Body, their previous Responsible Officer, their revalidation date and the date of their last appraisal to ensure that the NCUH systems are populated promptly to enable effective engagement with the Clarity system and our appraisal processes.

Locums employed via an Agency are engaged using the same standards and their prescribed connection is to the locum agency.

13. MONITORING PERFORMANCE

The monitoring of the performance of doctors, but not the appraisal process, will be a Business Unit responsibility. Any concerns will be escalated to the Medical Director/Responsible Officer, Chief Executive or Director of HR.

14. RESPONDING TO CONCERNS AND REMEDIATION

The Trust has policies in place to deal with:
Responding to concerns raised in relation to the conduct, capability or ill health of doctors

Remediation

Between 1 April 2015 and 31 March 2016 there were no capability concerns which required remediation programmes.

15. RISK AND ISSUES

The Trust now has its own Responsible Officer, Dr Rod Harpin who has appointed a Lead Appraiser (LA) and moved Medical Appraisal into the HR department. This is a new team who are finding their feet and learning what is required. Due to our previous buddy arrangements with Northumbria and historically low appraisal rates, the HLRO has visited and met the team and is happy with the direction of travel (Appendix 6)

Dr Chris Flucker lead appraiser for appraisal and revalidation leads on medical appraisals and the medical appraisal policy which is aligned with NHS England and has been implemented in NCUH.

The Clarity IT system has been a mandatory requirement in NCUH from 1 October 2014. The whole process, including data storage, archives and monitoring functions is now dependent on a 3rd party supplier, Clarity.

There is a risk that by non-engagement, a practitioner could become unemployable. This is a particular risk to service provision in small specialties, of which NCUH has several.

Currently the Trust does not routinely use the MPIT form to request information from the previous RO with respect to performance concerns while employed in that trust. We are routinely requesting information from the previous Medical Director/Responsible Officer for all new recruits using a form which mirrors the MPIT form.

There is a need for continuing development of the appraiser pool and currently we are in the process of recruiting more appraisers.

The Quality Assurance process is undertaken but needs further development.

16. BOARD REFLECTIONS

The Board should reflect on the challenges faced by the new team over the transition period and that the end point aligns appraisal with other HR processes such as MHPS, starters and leavers and job planning. Also to note that for many of our senior medical staff the process of appraisal is not yet sufficiently embedded that allows sustained performance to target.

17. CORRECTIVE ACTIONS, IMPROVEMENT PLAN AND NEXT STEPS

The Trust is currently working to develop plans in relation to:
A peer review process across Trusts in the North East and North Cumbria
Improved Quality Assurance of appraisals
A system to ensure all new consultants and staff grade doctors working in NCUH are included in our system at the commencement of their employment with transfer of appraisal and revalidation administration to HR

Ensuring RO to RO communication system processes are in place for new doctors working in NCUH when required.

A robust contract with locum agencies to make explicit their responsibility in relation to locums engaged to work in NCUH.

18. RECOMMENDATIONS

The Board is asked to note that the Annual Organisational Audit questionnaire (Appendix 1) was submitted to NHS England by the Responsible Officer in May 2017.

The Board is asked to accept this report which will also be shared with the Higher Level Responsible Officer and to approve the ‘statement of compliance’ confirming that the Trust, as a designated body, is in compliance with the regulations (see Annex E – Statement of Compliance). This statement of compliance should be submitted by the 30 September 2017.

Dr Chris Flucker FRCA FFICM
Lead Appraiser
GMC No 3588459
Annex E – Statement of Compliance Designated

Body Statement of Compliance

The board of North Cumbria University Hospitals NHS Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

Yes, Dr Rod Harpin

An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

Yes

There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

Yes

Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

The process for Quality Assurance of appraisal continues to be developed as part of quality improvement of appraisal

All licensed medical practitioners¹ either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

Yes

There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners¹, which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

Yes

There is a process established for responding to concerns about any licensed medical practitioners¹ fitness to practice;

---

¹ Doctors with a prescribed connection to the designated body on the date of reporting.
Yes

There is a process for obtaining and sharing information of note about any licensed medical practitioners’ fitness to practice between this organisation’s responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Yes

The appropriate pre-employment background checks (including pre- engagement for Locums) are carried out to ensure that all licenced medical practitioners\(^2\) have qualifications and experience appropriate to the work performed; and

Yes

A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Yes

Signed on behalf of the designated body

Name: ______________________ Signed: ______________________

[Chief Executive or Chairman a Board member (or Executive if no Board exists)]

Date: ______________________

---

\(^2\) Doctors with a prescribed connection to the designated body on the date of reporting.
Doctors with a prescribed connection to the designated body on the date of reporting.

3

Annual Organisational Audit (AOA)
End of year questionnaire 2016-17

—

3 Doctors with a prescribed connection to the designated body on the date of reporting.
The AOA (Annex C of the Framework for Quality Assurance) is a standardised template for all responsible officers to complete and return to their higher level responsible officer via the Revalidation Management System. AOAs from all designated bodies will be collated to provide an overarching status report of progress across England.

A Framework for Quality Assurance for Responsible Officers & Revalidation April 2014 Gateway ref 01142

2015/16 AOA cleared with Publications Gateway Reference 04543

Lynda Norton
Professional Standards Team
Quarry House
Leeds
LS2 7UE
0113 825 1463

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.
Promoting equality and addressing health inequalities are at the heart of NHS England’s values. Throughout the development of the policies and processes cited in this document, we have:

Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.
Contents

Contents .................................................................................................................... 4
1 Introduction ......................................................................................................... 5
2 Guidance for submission .................................................................................... 7
3 Section 1 – The Designated Body and the Responsible Officer ......................... 8
4 Section 2 – Appraisal ........................................................................................ 15
5 Section 3 – Monitoring Performance and Responding to Concerns ............... 24
6 Section 4 – Recruitment and Engagement ....................................................... 28
7 Section 5 – Comments .....................................................................................30
8 Reference ......................................................................................................... 31
1 Introduction

The Framework of Quality Assurance (FQA) and the monitoring processes within it are designed to support all responsible officers in fulfilling their statutory duty, providing a means by which they can demonstrate the effectiveness of the systems they oversee. It has been carefully crafted to ensure that administrative burden is minimised, whilst still driving learning and sharing of best practice. Each element of the FQA process will feed in to a comprehensive report from the national level responsible officer to Ministers and the public, capturing the state of play in implementing medical revalidation across the country.

The reporting processes are intended to be streamlined, coherent and integrated, ensuring that information is captured to contribute to local processes, whilst simultaneously providing the required assurance. The process will be reviewed and revised on a regular basis.

The AOA (Annex C) is a standardised template for all responsible officers to complete and return to their higher level responsible officer. AOAs from all designated bodies will be collated to provide an overarching status report of implementation across England. Where small designated bodies are concerned, or where types of organisation are small in number, these will be appropriately grouped to ensure that data is not identifiable to the level of the individual.

The AOA is designed to assist NHS England regional teams to assure the appropriate higher level responsible officers that designated bodies have a robust consistent approach to revalidation in place, through assessment of their organisational system and processes in place for undertaking medical revalidation.

Learning from the experience of the Organisational Readiness and Self-Assessment (ORSA) the AOA has a dual purpose to provide the required assurance to higher level responsible officers whilst being of maximum help to responsible officers in fulfilling their obligations.

The aims of the annual organisational audit exercise are to:

- gain an understanding of the progress that organisations have made during 2016/17;
- provide a tool that helps responsible officers assure themselves and their boards/management bodies that the systems underpinning the recommendations they make to the General Medical Council (GMC) on doctors’ fitness to practise, the arrangements for medical appraisal and responding to concerns, are in place;
- provide a mechanism for assuring NHS England and the GMC that systems for evaluating doctors’ fitness to practice are in place, functioning, effective and consistent.

Please do not use this version of the form to submit your response.
This AOA exercise is divided into five sections:

Section 1: The Designated Body and the Responsible Officer
Section 2: Appraisal
Section 3: Monitoring Performance and Responding to Concerns
Section 4: Recruitment and Engagement
Section 5: Additional Comments

The questionnaire should be completed by the responsible officer on behalf of the designated body, though the input of information to the questionnaire may be appropriately delegated. The questionnaire should be completed during April and May 2017 for the year ending 31 March 2017. The deadline for submission will be detailed in an email containing the link to the electronic version of the form, which will be sent after 31 March 2017.

Whilst NHS England is a single designated body, for the purpose of this audit, the national and regional offices of NHS England should answer as a ‘designated body’ in their own right.

Following completion of this AOA exercise, designated bodies should:

- consider using the information gathered to produce a status report and to conduct a review of their organisations’ developmental needs.
- complete a statement of compliance and submit it to NHS England by the 29 September 2017.

The audit process will also enable designated bodies to provide assurance that they are fulfilling their statutory obligations and their systems are sufficiently effective to support the responsible officer’s recommendations.

For further information, references and resources see pages 31-32 and www.england.nhs.uk/revalidation
2 Guidance for submission

Guidance for submission:

- Several questions require a ‘Yes’ or ‘No’ answer. In order to answer ‘Yes’, you must be able to answer ‘Yes’ to all of the statements listed under ‘to answer ‘Yes”
- Please do not use this version of the questionnaire to submit your designated body’s response.
- You will receive an email with an electronic link to a unique version of this form for your designated body.
- You should only use the link received from NHS England by email, as it is unique to your organisation.
- Once the link is opened, you will be presented with two buttons; one to download a blank copy of the AOA for reference, the second button will take you to the electronic form for submission.
- Submissions can only be received electronically via the link. Please do not complete hardcopies or email copies of the document.
- The form must be completed in its entirety prior to submission; it cannot be part- completed and saved for later submission.
- Once the ‘submit’ button has been pressed, the information will be sent to a central database, collated by NHS England.
- A copy of the completed submission will be automatically sent to the responsible officer.
- Please be advised that Questions 1.1-1.3 may have been automatically populated with information previously held on record by NHS England. The submitter has a responsibility to check that the information is correct and should update the information if required, before submitting the form.
3 Section 1 – The Designated Body and the Responsible Officer

<table>
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<th>The Designated Body and the Responsible Officer</th>
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</thead>
<tbody>
<tr>
<td>1.1</td>
<td><strong>Name of designated body:</strong> North Cumbria University Hospitals NHS Trust</td>
</tr>
<tr>
<td></td>
<td>Head Office or Registered Office Address if applicable line 1 Management Suite, Pillars Buliding</td>
</tr>
<tr>
<td></td>
<td>Address line 2 Cumberland Infirmary</td>
</tr>
<tr>
<td></td>
<td>Address line 3 Newtown Road</td>
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<td>Address line 4</td>
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<tr>
<td></td>
<td>CityCarlisle</td>
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<td>CountyCumbria</td>
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<td></td>
<td>Postcode CA2 7HY</td>
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<td></td>
<td><strong>Responsible officer:</strong></td>
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<tr>
<td></td>
<td>Title *****</td>
</tr>
<tr>
<td></td>
<td>GMC registered first name *****</td>
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<td>Special health authorities (NHS Litigation Authority, NHS Improvement, NHS Blood and Transplant, etc)</td>
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<td>Independent / non-NHS sector (tick one)</td>
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<td>Faculty/professional body (FPH, FOM, FPM, IDF, etc)</td>
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<td>Government department, non-departmental public body or executive agency</td>
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<td>Other non-NHS (please enter type)</td>
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<td>1.3</td>
<td><strong>The responsible officer's higher level responsible officer is based at:</strong> [tick one]</td>
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<td>NHS England South</td>
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<td>Department of Health</td>
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<td>Faculty of Medical Leadership and Management - for NHS England (national office) only</td>
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<td>Other (Is a suitable person)</td>
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<thead>
<tr>
<th>1.4</th>
<th><strong>A responsible officer has been nominated/appointed in compliance with the regulations.</strong></th>
</tr>
</thead>
</table>
|     | To answer ‘Yes’:  
|     | • The responsible officer has been a medical practitioner fully registered under the Medical Act 1983 throughout the previous five years and continues to be fully registered whilst undertaking the role of responsible officer.  
|     | • There is evidence of formal nomination/appointment by board or executive of each organisation for which the responsible officer undertakes the role.  | ✔ Yes |
|     |                                                                                         | No  |
1.5 Where a Conflict of Interest or Appearance of Bias has been identified and agreed with the higher level responsible officer; has an alternative responsible officer been appointed?

(Please note that in The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty’s Stationery Office, 2013), an alternative responsible officer is referred to as a second responsible officer)

To answer ‘Yes’:

The designated body has nominated an alternative responsible officer in all cases where there is a conflict of interest or appearance of bias between the responsible officer and a doctor with whom the designated body has a prescribed connection.

To answer ‘No’:

A potential conflict of interest or appearance of bias has been identified, but an alternative responsible officer has not been appointed.

To answer ‘N/a’:

No cases of conflict of interest or appearance of bias have been identified.

Additional guidance

Each designated body will have one responsible officer but the regulations allow for an alternative responsible officer to be nominated or appointed where a conflict of interest or appearance of bias exists between the responsible officer and a doctor with whom the designated body has a prescribed connection. This will cover the uncommon situations where close family or business relationships exist, or where there has been longstanding interpersonal animosity.

In order to ensure consistent thresholds and a common approach to this, potential conflict of interest or appearance of bias should be agreed with the higher level responsible officer. An alternative responsible officer should then be nominated or appointed by the designated body and will require training and support in the same way as the first responsible officer. To ensure there is no conflict of interest or appearance of bias, the alternative responsible officer should be an external appointment and will usually be a current experienced responsible officer from the same region. Further guidance is available in Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer (NHS Revalidation Support Team, 2014).
1.6 | In the opinion of the responsible officer, sufficient funds, capacity and other resources have been provided by the designated body to enable them to carry out the responsibilities of the role.

Each designated body must provide the responsible officer with sufficient funding and other resources necessary to fulfil their statutory responsibilities. This may include sufficient time to perform the role, administrative and management support, information management and training. The responsible officer may wish to delegate some of the duties of the role to an associate or deputy responsible officer. It is important that those people acting on behalf of the responsible officer only act within the scope of their authority. Where some or all of the functions are commissioned externally, the designated body must be satisfied that all statutory responsibilities are fulfilled.

1.7 | The responsible officer is appropriately trained and remains up to date and fit to practise in the role of responsible officer.

To answer ‘Yes’:

- Appropriate recognised introductory training has been undertaken (requirement being NHS England’s face to face responsible officer training & the precursor e-Learning).
- Appropriate ongoing training and development is undertaken in agreement with the responsible officer’s appraiser.
- The responsible officer has made themselves known to the higher level responsible officer.
- The responsible officer is engaged in the regional responsible officer network.
- The responsible officer is actively involved in peer review for the purposes of calibrating their decision-making processes and organisational systems.
- The responsible officer includes relevant supporting information relating to their responsible officer role in their appraisal and revalidation portfolio including the results of the Annual Organisational Audit and the resulting action plan.

Please do not use this version of the form to submit your response.
| 1.8 | The responsible officer ensures that accurate records are kept of all relevant information, actions and decisions relating to the responsible officer role.  
The responsible officer records should include appraisal records, fitness to practise evaluations, investigation and management of concerns, processes relating to 'new starters', etc. | ☑ Yes ☐ No |
| 1.9 | The responsible officer ensures that the designated body's medical revalidation policies and procedures are in accordance with equality and diversity legislation.  
To answer ‘Yes’:  
- An evaluation of the fairness of the organisation's policies has been performed (for example, an equality impact assessment). | ☑ Yes ☐ No |
| 1.10 | The responsible officer makes timely recommendations to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and the GMC Responsible Officer Protocol.  
To answer ‘Yes’:  
- The designated body's board report contains explanations for all missed and late recommendations, and reasons for deferral submissions. | ☑ Yes ☐ No |
| 1.11 | The governance systems (including clinical governance where appropriate) are subject to external or independent review.  
Most designated bodies will be subject to external or independent review by a regulator. Designated bodies which are healthcare providers are subject to review by the national healthcare regulators (the Care Quality Commission, the Human Fertilisation and Embryology Authority or Monitor, now part of NHS Improvement). Where designated bodies will not be regulated or overseen by an external regulator (for example locum agencies and organisations which are not healthcare providers), an alternative external or independent review process should be agreed with the higher level responsible officer. | ☑ Yes ☐ No |
| 1.12 | The designated body has commissioned or undertaken an independent review* of its processes relating to appraisal and revalidation. (*including peer review, internal audit or an externally commissioned assessment) | ✔ Yes | ☐ No |
### 4 Section 2 – Appraisal

<table>
<thead>
<tr>
<th>Section 2</th>
<th>Appraisal</th>
</tr>
</thead>
</table>
| **2.1** IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2017 should be included. Where the answer is ‘nil’ please enter ‘0’. | **1a** 1b **2** **3**
| | Number of Prescribed Connection | Completed Appraisal | Completed Appraisal (1) | Approved incomplete or missed appraisal | Unapproved incomplete or missed appraisal | Total |
| **2.1.1** Consultants (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government/other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work). | 144 | 63 | 54 | 27 | 0 | 144 |
| **2.1.2** Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff). | 37 | 25 | 11 | 1 | 0 | 37 |
| **2.1.3** Doctors on Performers Lists (for NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs). | 0 | 0 | 0 | 0 | 0 | 0 |
| **2.1.4** Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade). | 0 | 0 | 0 | 0 | 0 | 0 |
| **2.1.5** Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc). | 61 | 11 | 35 | 15 | 0 | 61 |
| **2.1.6** Other doctors with a prescribed connection to this designated body (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc). | 0 | 0 | 0 | 0 | 0 | 0 |
| **2.1.7** TOTAL (this cell will sum automatically 2.1.1 – 2.1.6). | 242 | 99 | 100 | 43 | 0 | 242 |

See guidance notes on pages 16-18 for assistance completing this table.

Please do not use this version of the form to submit your response.
Did the doctor have an appraisal meeting between 1st April 2016 and 31st March 2017, for which the appraisals outputs have been signed off? (include if appraisal undertaken with previous organisation)

Yes

Was this in the 3 months preceding the appraisal due date*,

AND

was the appraisal summary signed off within 28 days of the appraisal date,

AND

did the entire process occur between 1 April and 31 March?

No

Was the reason for missing the appraisal agreed by the RO in advance?

No

Unapproved incomplete or missed appraisal (3)

Yes

Approved incomplete or missed appraisal (2)

Completed Appraisal (1a)

Completed Appraisal (1b)

Unapproved incomplete or missed appraisal (3)

Approved incomplete or missed appraisal (2)

Completed Appraisal (1a)

Completed Appraisal (1b)

Please do not use this version of the form to submit your response.
2.1 | **Column - Number of Prescribed Connections:**
Number of doctors with whom the designated body has a prescribed connection as at 31 March 2017

The responsible officer should keep an accurate record of all doctors with whom the designated body has a prescribed connection and must be satisfied that the doctors have correctly identified their prescribed connection. Detailed advice on prescribed connections is contained in the responsible officer regulations and guidance and further advice can be obtained from the GMC and the higher level responsible officer. The categories of doctor relate to current roles and job titles rather than qualifications or previous roles. The number of individual doctors in each category should be entered in this column. Where a doctor has more than one role in the same designated body a decision should be made about which category they belong to, based on the amount of work they do in each role. Each doctor should be included in only one category. For a doctor who has recently completed training, if they have attained CCT, then they should be counted as a prescribed connection. If CCT has not yet been awarded, they should be counted as a prescribed connection within the LETB AOA return.

| Column - Measure 1a Completed medical appraisal: |
A Category 1a completed annual medical appraisal is one where the appraisal meeting has taken place in the three months preceding the agreed appraisal due date, the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting, and the entire process occurred between 1 April and 31 March. For doctors who have recently completed training, it should be noted that their final ACRP equates to an appraisal in this context.

| Column - Measure 1b Completed medical appraisal: |
A Category 1b completed annual medical appraisal is one in which the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the following apply:
- the appraisal did not take place in the window of three months preceding the agreed appraisal due date;
- the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor between 1 April and 28 April of the following appraisal year;
- the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor more than 28 days after the appraisal meeting.
However, in the judgement of the responsible officer the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.
Where the organisational information systems of the designated body do not permit the parameters of a *Category 1a completed annual medical appraisal* to be confirmed with confidence, the appraisal should be counted as a *Category 1b completed annual medical appraisal*.

**Column - Measure 2: Approved incomplete or missed appraisal:**

An *approved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*.

**Column - Measure 3: Unapproved incomplete or missed appraisal:**

An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*.

**Column Total:**

Total of columns 1a+1b+2+3. The total should be equal to that in the first column (Number of Prescribed Connections), the number of doctors with a prescribed connection to the designated body at 31 March 2017.

* Appraisal due date:

A doctor should have a set date by which their appraisal should normally take place every year (the ‘appraisal due date’). The appraisal due date should remain the same each year unless changed by agreement with the doctor’s responsible officer. Where a doctor does not have a clearly established appraisal due date, the next appraisal should take place by the last day of the twelfth month after the preceding appraisal. This should then by default become their appraisal due date from that point on. For a designated body which uses an ‘appraisal month’ for appraisal scheduling, a doctor’s appraisal due date is the last day of their appraisal month. For more detail on setting a doctor’s appraisal due date see the Medical Appraisal Logistics Handbook (NHS England 2015).
2.2 Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded

If all appraisals are in Categories 1a and/or 1b, please answer N/A.

To answer Yes:

- The responsible officer ensures accurate records are kept of all relevant actions and decisions relating to the responsible officer role.
- The designated body’s annual report contains an audit of all missed or incomplete appraisals (approved and unapproved) for the appraisal year 2016/17 including the explanations and agreed postponements.
- Recommendations and improvements from the audit are enacted.

Additional guidance:
A missed or incomplete appraisal, whether approved or unapproved, is an important occurrence which could indicate a problem with the designated body’s appraisal system or non-engagement with appraisal by an individual doctor which will need to be followed up.

Measure 2: Approved incomplete or missed appraisal:
An approved incomplete or missed annual medical appraisal is one where the appraisal has not been completed according to the parameters of either a Category 1a or 1b completed annual medical appraisal, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an Approved incomplete or missed annual medical appraisal.

Measure 3: Unapproved incomplete or missed appraisal:
An Unapproved incomplete or missed annual medical appraisal is one where the appraisal has not been completed according to the parameters of either a Category 1a or 1b completed annual medical appraisal, and the responsible officer has not given approval to the postponement or cancellation of the appraisal.
Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an Unapproved incomplete or missed annual medical appraisal.
There is a medical appraisal policy, with core content which is compliant with national guidance, that has been ratified by the designated body's board (or an equivalent governance or executive group).
To answer ‘Yes’:
- The policy has been ratified by the designated body’s board or an equivalent governance or executive group.

| 2.3 | ✔ Yes | No |

There is a mechanism for quality assuring an appropriate sample of the inputs and outputs of the medical appraisal process to ensure that they comply with GMC requirements and other national guidance, and the outcomes are recorded in the annual report template.
To answer ‘Yes’:
- The appraisal inputs comply with the requirements in *Supporting Information for Appraisal and Revalidation* (GMC, 2012) and *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), which are:
  - Personal information.
  - Scope and nature of work.
  - Supporting information:
    1. Continuing professional development,
    2. Quality improvement activity,
    3. Significant events,
    4. Feedback from colleagues,
    5. Feedback from patients,
    6. Review of complaints and compliments.
  - Review of last year’s PDP.
  - Achievements, challenges and aspirations.
- The appraisal outputs comply with the requirements in the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) which are:
  - Summary of appraisal,
  - Appraiser’s statement,
  - Post-appraisal sign-off by doctor and appraiser.

| 2.4 | ✔ Yes | No |
2.5 There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified.

To answer ‘Yes’:

- There is a written description within the appraisal policy of the process for ensuring that key items of supporting information are included in the doctor’s portfolio and discussed at appraisal.
- There is a process in place to ensure that where a request has been made by the responsible officer to include a key item of supporting information in the appraisal portfolio, the appraisal portfolio and summary are checked after completion to ensure this has happened.

Additional guidance:

It is important that issues and concerns about performance or conduct are addressed at the time they arise. The appraisal meeting is not usually the most appropriate setting for dealing with concerns and in most cases these are dealt with outside the appraisal process in a clinical governance setting. Learning by individuals from such events is an important part of resolving concerns and the appraisal meeting is usually the most appropriate setting to ensure this is planned and prioritised.

In a small proportion of cases, the responsible officer may therefore wish to ensure certain key items of supporting information are included in the doctor’s portfolio and discussed at appraisal so that development needs are identified and addressed. In these circumstances the responsible officer may require the doctor to include certain key items of supporting information in the portfolio for discussion at appraisal and may need to check in the appraisal summary that the discussion has taken place. The method of sharing key items of supporting information should be described in the appraisal policy. It is important that information is shared in compliance with principles of information governance and security. For further detail, see Information Management for Revalidation in England (NHS Revalidation Support Team, 2014).
| 2.6 | The responsible officer ensures that the designated body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection. To answer ‘Yes’:
The responsible officer ensures that:
  - Medical appraisers are recruited and selected in accordance with national guidance.
  - In the opinion of the responsible officer, the number of appropriately trained medical appraisers to doctors being appraised is between 1:5 and 1:20.
  - In the opinion of the responsible officer, the number of trained appraisers is sufficient for the needs of the designated body.

**Additional guidance:**
It is important that the designated body’s appraiser workforce is sufficient to provide the number of appraisals needed each year. This assessment may depend on total number of doctors who have a prescribed connection, geographical spread, speciality spread, conflicts of interest and other factors. Depending on the needs of the designated body, doctors from a variety of backgrounds should be considered for the role of appraiser. This includes locums and salaried general practitioners in primary care settings and staff and associate specialist doctors in secondary care settings. An appropriate specialty mix is important though it is not possible for every doctor to have an appraiser from the same specialty.

Appraisers should participate in an initial training programme before starting to perform appraisals. The training for medical appraisers should include:
  - Core appraisal skills and skills required to promote quality improvement and the professional development of the doctor
  - Skills relating to medical appraisal for revalidation and a clear understanding of how to apply professional judgement in appraisal
  - Skills that enable the doctor to be an effective appraiser in the setting within which they work, including both local context and any specialty specific elements.

Further guidance on the recruitment and training of medical appraisers is available; see *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014). |

☑ Yes
☐ No
| 2.7 | **Medical appraisers are supported in their role to calibrate and quality assure their appraisal practice.**  
To answer ‘Yes’:  
The responsible officer ensures that:  
  • Medical appraisers have completed a suitable training programme, with core content compliant with national guidance (*Quality Assurance of Medical Appraisers*), including equality and diversity and information governance, before starting to perform appraisals.  
  • All appraisers have access to medical leadership and support.  
  • There is a system in place to obtain feedback on the appraisal process from doctors being appraised.  
  • Medical appraisers participate in ongoing performance review and training/development activities, to include peer review and calibration of professional judgements (*Quality Assurance of Medical Appraisers*).  

**Additional guidance:**  
Further guidance on the support for medical appraisers is available in *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014). | ☑ Yes  
☐ No |
## 5 Section 3 – Monitoring Performance and Responding to Concerns

<table>
<thead>
<tr>
<th>Section 3</th>
<th>Monitoring Performance and Responding to Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>There is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection.</td>
</tr>
</tbody>
</table>

To answer ‘Yes’:

- Relevant information (including clinical outcomes, reports of external reviews of service for example Royal College reviews, governance reviews, Care Quality Commission reports, etc.) is collected to monitor the doctor’s fitness to practise and is shared with the doctor for their portfolio.
- Relevant information is shared with other organisations in which a doctor works, where necessary.
- There is a system for linking complaints, significant events/clinical incidents/SUIs to individual doctors.
- Where a doctor is subject to conditions imposed by, or undertakings agreed with the GMC, the responsible officer monitors compliance with those conditions or undertakings.
- The responsible officer identifies any issues arising from this information, such as variations in individual performance, and ensures that the designated body takes steps to address such issues.
- The quality of the data used to monitor individuals and teams is reviewed.
- Advice is taken from GMC employer liaison advisers, National Clinical Assessment Service, local expert resources, specialty and Royal College advisers where appropriate.

Additional guidance:

Where detailed information can be collected which relates to the practice of an individual doctor, it is important to include it in the annual appraisal process. In many situations, due to the nature of the doctor’s work, the collection of detailed information which relates directly to the practice of an individual doctor may not be possible. In these situations, team-based or service-level information should be monitored. The types of information available will be dependent on the setting and the role of the doctor and will include clinical outcome data, audit, complaints, significant events and patient safety issues. An explanation should be sought where an indication of outlying

Please do not use this version of the form to submit your response.
quality or practice is discovered. The information/data used for this purpose should be kept under review so that
the most appropriate information is collected and the quality of the data (for example, coding accuracy) is
improved.
In primary care settings this type of information is not always routinely collected from general practitioners or
practices and new arrangements may need to be put in place to ensure the responsible officer receives relevant
fitness to practise information. In order to monitor the conduct and fitness to practise of trainees, arrangements will
need to be agreed between the local education and training board and the trainee’s clinical attachments to ensure
relevant information is available in both settings.

| 3.2 | The responsible officer ensures that a responding to concerns policy is in place (which includes arrangements for investigation and intervention for capability, conduct, health, and fitness to practise concerns) which is ratified by the designated body's board (or an equivalent governance or executive group).

To answer ‘Yes’:

- A policy for responding to concerns, which complies with the responsible officer regulations, has been ratified by the designated body's board (or an equivalent governance or executive group).

Additional guidance:
It is the responsibility of the responsible officer to respond appropriately when unacceptable variation in individual practice is identified or when concerns exist about the fitness to practise of doctors with whom the designated body has a prescribed connection. The designated body should establish a procedure for initiating and managing investigations.
National guidance is available in the following key documents:

- Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice (NHS Revalidation Support Team, 2013).
- How to Conduct a Local Performance Investigation (National Clinical Assessment Service, 2010).

The responsible officer regulations outline the following responsibilities:

- Ensuring that there are formal procedures in place for colleagues to raise concerns.
- Ensuring there is a process established for initiating and managing investigations of capability, conduct,
health and fitness to practise concerns which complies with national guidance, such as *How to conduct a local performance investigation* (National Clinical Assessment Service, 2010).

- Ensuring investigators are appropriately qualified.
- Ensuring that there is an agreed mechanism for assessing the level of concern that takes into account the risk to patients.
- Ensuring all relevant information is taken into account and that factors relating to capability, conduct, health and fitness to practise are considered.
- Ensuring that there is a mechanism to seek advice from expert resources, including: GMC employer liaison advisers, the National Clinical Assessment Service, specialty and royal college advisers, regional networks, legal advisers, human resources staff and occupational health.
- Taking any steps necessary to protect patients.
- Where appropriate, referring a doctor to the GMC.
- Where necessary, making a recommendation to the designated body that the doctor should be suspended or have conditions or restrictions placed on their practice.
- Sharing relevant information relating to a doctor’s fitness to practise with other parties, in particular the new responsible officer should the doctor change their prescribed connection.
- Ensuring that a doctor who is subject to these procedures is kept informed about progress and that the doctor’s comments are taken into account where appropriate.
- Appropriate records are maintained by the responsible officer of all fitness to practise information.
- Ensuring that appropriate measures are taken to address concerns, including but not limited to:
  - Requiring the doctor to undergo training or retraining,
  - Offering rehabilitation services,
  - Providing opportunities to increase the doctor’s work experience,
  - Addressing any systemic issues within the designated body which may contribute to the concerns identified.
- Ensuring that any necessary further monitoring of the doctor’s conduct, performance or fitness to practise is carried out.

3.3 The board (or an equivalent governance or executive group) receives an annual report detailing the number and type of concerns and their outcome.

[ ] Yes

[ ] No
The designated body has arrangements in place to access sufficient trained case investigators and case managers.

To answer ‘Yes’:
The responsible officer ensures that:

- Case investigators and case managers are recruited and selected in accordance with national guidance *Supporting Doctors to Provide Safer Healthcare, Responding to concerns about a Doctor’s Practice* (NHS Revalidation Support Team, 2013).
- Case investigators and case managers have completed a suitable training programme, with essential core content (see guidance documents above).
- Personnel involved in responding to concerns have sufficient time to undertake their responsibilities.
- Individuals (such as case investigators, case managers) and teams involved in responding to concerns participate in ongoing performance review and training/development activities, to include peer review and calibration (see guidance documents above).

Additional guidance

The standards for training for case investigators and case managers are contained in *Guidance for Recruiting for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014) and *Guidance for Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014). Case investigators or case managers may be within the designated body or commissioned externally.
### 6 Section 4 – Recruitment and Engagement

<table>
<thead>
<tr>
<th>Section 4</th>
<th>Recruitment and Engagement</th>
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</thead>
<tbody>
<tr>
<td>4.1</td>
<td>There is a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors (including locums).</td>
</tr>
</tbody>
</table>

In situations where the doctor has moved to a new designated body without a contract of employment, or for the provision of services (for example, through membership of a faculty) the information needs to be available to the new responsible officer as soon as possible after the prescribed connection commences. This will usually involve a formal request for information from the previous responsible officer.

**Additional guidance**

The regulations give explicit responsibilities to the responsible officer when a designated body enters into a contract of employment or for the provision of services with a doctor. These responsibilities are to ensure the doctor is sufficiently qualified and experienced to carry out the role. All new doctors are covered under this duty even if the doctor’s prescribed connection remains with another designated body. This applies to locum agency contracts and also to the granting of practising privileges by independent health providers.

The prospective responsible officer must:

- Ensure doctors have qualifications and experience appropriate to the work to be performed,
- Ensure that appropriate references are obtained and checked,
- Take any steps necessary to verify the identity of doctors,
- Ensure that doctors have sufficient knowledge of the English language for the work to be performed, and
- For NHS England regional teams, manage admission to the medical performers list in accordance with the regulations.

It is also important that the following information is available:
- GMC information: fitness to practise investigations, conditions or restrictions, revalidation due date,
- Disclosure and Barring Service check (although delays may prevent these being available to the responsible officer before the starting date in every case), and
• Gender and ethnicity data (to monitor fairness and equality; providing this information is not mandatory).
It may be helpful to obtain a structured reference from the current responsible officer which complies with
GMC guidance on writing references and includes relevant factual information relating to:
• The doctor’s competence, performance or conduct,
• Appraisal dates in the current revalidation cycle, and,
• Local fitness to practise investigations, local conditions or restrictions on the doctor’s practice, unresolved
  fitness to practise concerns.
  See Good Medical Practice: Supplementary Guidance: Writing References (GMC, 2007) and paragraph 19
  of Good Medical Practice (GMC, 2013) for further details.

The responsible officer regulations and GMC guidance make it clear that there is an obligation to share information
about a doctor when required to support the responsible officer’s statutory duties, or to maintain patient safety.
Guidance, published in August 2016, on the flow of information to support medical governance and responsible
officer statutory function (2016) therefore aims to promote improvements to these processes:

• setting out the common legitimate channels along which information about a doctor’s medical practice
  should flow, describing the information that might apply and arrangements to support its smooth flow
• providing useful toolkits and examples of good practice

The guidance on information flows to support medical governance and responsible officer statutory functions can
be accessed via the link below.

https://www.england.nhs.uk/revalidation/ro/info-flows/
7 Section 5 – Comments

<table>
<thead>
<tr>
<th>Section 5</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td></td>
</tr>
</tbody>
</table>
8 Reference

Sources used in preparing this document

1. The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty’s Stationery Office, 2013)
2. The Medical Profession (Responsible Officers) (Amendment) Regulations 2013 (Her Majesty’s Stationery Office, 2013)
3. The Medical Act 1983 (Her Majesty’s Stationery Office, 1983)
5. The National Health Service (Performers Lists) (England) Regulations 2013
6. The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance (Department of Health, 2010)
7. Revalidation: A Statement of Intent (GMC and others, 2010)
8. Good Medical Practice (GMC, 2013)
9. Good Medical Practice Framework for Appraisal and Revalidation (GMC, 2013)
10. Good Medical Practice: Supplementary Guidance - Writing References (GMC, 2012)
12. Supporting Information for Appraisal and Revalidation (GMC, 2012)
17. Providing a Professional Appraisal (NHS Revalidation Support Team, 2012)
18. Information Management for Medical Revalidation in England (NHS Revalidation Support Team, 2014)
19. Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor’s Practice (NHS Revalidation Support Team, 2013)
22. Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer (NHS Revalidation Support Team, 2014).


26. How to Conduct a Local Performance Investigation (National Clinical Assessment Service, 2010)

27. Use of NHS Exclusion and Suspension from Work amongst Doctors and Dentists 2011/12 (National Clinical Assessment Service, 2011)

28. Return to Practice Guidance (Academy of Medical Royal Colleges, 2012)

It was decided to conduct a review of the quality of medical appraisals undertaken by the Trust for the 2016-2017 appraisal year.

Forty four Clarity (all sections) appraisals completed by 44 appraisers were reviewed by Dr Chris Flucker LA using the modified Galloway tool (Appendix 3)

The results of this are shown below.

The scope of practice for all doctors was reviewed and declared that it took place and evidenced by answering a mandatory Clarity statement.
Very few subjective statements were noted and even then, more factual statements were recorded with them. This has improved on the previous year most likely because the appraiser was not from the same specialty since they are now being allocated.

“It was noticeable in the review that evidence of documentation of challenge in the appraisal required improvement and was absent in more than half of the summaries reviewed” This is last year's audit observation and it is clear that challenge does not occur appropriately.
This reflects last year’s findings that there needs to be improvement in documenting what learning and reflection has taken place.

It is clear from Clarity what evidence is presented and broadly what it shows has been documented. However, this domain still requires improvement.
This is significantly different to last year’s audit in that there is evidence of reviewing last year’s PDP. This is done ubiquitously in the PDP section and unless further explanation is required does not need to be duplicated in the discussion section.

Although a number of PDPs are recorded there needs to be guidance on what constitutes proper PDP eg mandatory training, or an MSF in my opinion does not. This is a topic at the next development day.
Most appraisals had sufficient evidence, however, where it was identified to be missing there was good documentation of what needed to be done.

The appraisal notes any gaps in the requirements for revalidation and how they will be addressed.

Again, mostly not required but when it was the documentation is good. However, concerns relating to revalidation are encouraged to be raised with the LA and RO.
## Appendix 3

<table>
<thead>
<tr>
<th>Name Appraisee</th>
<th>Appraiser</th>
<th>Appendix 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modified Galloway Summary of Appraisal Rating Tool</td>
<td>Score</td>
<td>Comments</td>
</tr>
<tr>
<td>0 = Absent</td>
<td>1 = Need improvement 2= Good</td>
<td>How can Appraiser improve their appraisal documentation</td>
</tr>
</tbody>
</table>

- The Whole Scope of Practice has been reviewed.
- Has factual statements. No subjective statements.
- There is evidence of challenge within the appraisal.
- Evidence: there is a description of what evidence has been seen including reflection on learning.
- There is a description of what the evidence shows.
- Where evidence is missing or poor there are action points addressing this.
- Charts progress in relation to last year’s PDP.
- PDP is appropriate and actions are specific/SMART and contains at least 3.
- The appraisal notes any gaps in the requirements for revalidation and how they will be addressed.

**Total**

**Overall impression and comments**
General conclusions

There is a need to significantly improve the quality of appraisal summaries. Appraisal is essentially a formative process designed to improve the performance of doctors and the quality of care for patients through supporting reflective practice and challenge.

Limitations

This is a snapshot of a single appraiser's output, however it is clear that when appraisals are reviewed each appraiser has their own style.

Next steps

The findings of the audit which are broadly consistent with the previous year have shaped the agenda for the development days.

All appraisers will be forwarded both the Galloway appraisal review tool upon which their summaries will be assessed as well as a structured template aligned to the 4 domains of good medical practice to enable more consistent summary completion. A further review of the quality of appraisal summaries will be undertaken in 12 months to assess the impact of these improvements.

The Trust has agreed to participate in a peer review process with other Trusts in the North East.
APPENDIX 4

Letter 1
Reminder of Appraisal

56 Days

Appraisal due on last day of your birthday month

Postponement requested prior to appraisal. Application to Lead Appraiser (LA)

Agreed by LA

No application or not agreed by LA

Appraisal date and location agreed. Default appraisee travels to appraiser. Clarity submitted at least 2 weeks before meeting

If Clarity submitted <10 days before agreed meeting, appraiser can cancel. Appraisee responsible for organising new meeting

Appraisal meeting Sign off

Appraisal complete

Reminders and non-engagement pathway

Appraisal must be completed by last day of birthday month

Appraisal not taken place on time or no contact

28 day deadline contact details are checked as correct
Appendix 5

Appraisals Feedback
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST, 2017

<table>
<thead>
<tr>
<th></th>
<th>Questionnaires completed</th>
<th>Time spent (hours)</th>
<th>Average time spent (hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>By Appraisee</td>
<td>186</td>
<td>3,428.1</td>
<td>18.4</td>
</tr>
<tr>
<td>By Appraiser</td>
<td>176</td>
<td>924.0</td>
<td>5.2</td>
</tr>
<tr>
<td>Total</td>
<td>362</td>
<td>4,352.1</td>
<td></td>
</tr>
</tbody>
</table>

Appraisee Feedback

Organisation Systems

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was given adequate notice to allow preparation for my appraisal</td>
<td>7</td>
<td>4</td>
<td>14</td>
<td>88</td>
<td>73</td>
</tr>
<tr>
<td>I received the support and explanation I need to prepare for my appraisal</td>
<td>7</td>
<td>16</td>
<td>33</td>
<td>91</td>
<td>39</td>
</tr>
<tr>
<td>I am happy about the confidentiality of the appraisal process</td>
<td>4</td>
<td>1</td>
<td>10</td>
<td>100</td>
<td>71</td>
</tr>
<tr>
<td>Overall the organisation supported my appraisal</td>
<td>8</td>
<td>8</td>
<td>43</td>
<td>88</td>
<td>39</td>
</tr>
<tr>
<td>The software I used supported my needs to record and manage my portfolio and appraisal</td>
<td>9</td>
<td>6</td>
<td>22</td>
<td>110</td>
<td>39</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>26.1%</td>
<td>13.1%</td>
<td>51.3%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments

"-"

"Given time to fill in Clarity. I did not find it intuitive to use. But only do it once a year."

"Could mandatory training automatically feed/link with appraisal system to prevent duplication?"

"Doctors have to be given time allocation to work on their appraisal instead of just their spare time"

"Lack of private office space ie everyone has shared offices"

"Trust IT systems are slow and therefore the appraisal process is lengthened by waiting for the pages to open."

"appraisal depends on CPD and an external component is important but the study leave process had become too complex for most doctors in the trust. I paid for most of mine myself which I believe is not in the spirit of the modern NHS."

"The trust could do more to ensure accurate collection of data about the work done by SAS doctors and assist in gathering individualised patient feedback for SAS doctors"
"Well organised and feel i would have benefited from summary of areas that are necessary to cover and importance of reflective practice fields."

"The software is cumbersome & hugely repetitive; does not appropriately take account of the fact that many clinicians record CPD through their relevant royal college (which is a much better way of nationally peer reviewing & managing CPD, than isolated records in a portfolio). The sudden change of appraisal arrangements to manage those who have not engaged with appraisal has again seemed to penalise those of us who have followed requirements"

"Other than getting rid of the whole process? No."

"The significant time pressures that consultant staff are working under impacted both on the meeting arrangements and the subsequent documentation and sign off of that appraisal meeting"

"have appraisers from the same area as the appraisee would reduce the burden on both"

"I didn't receive any information on the appraisal process. I didn't receive any training on using the Clarity system. The Clarity system is, however, very straightforward to use and I worked it out myself."

"Stop doing them"

"The categories section for classification of CPD has clearly been lifted from the GP version of clarity and not appropriate to secondary care. A link to the Royal College CPD would be preferable to having to duplicate this or ignore the college system. The trust does not proactively invite clinicians to participate in 360. In my previous organisation OPD surveys were conducted on 50 consecutive patients seen by me. I handed out the forms and these were returned to and collated by the trust. The trust also required that all appraisees completed a 360 from colleagues and provided a system to do this (I am not sure if NCUH has such a system but if so I have not been invited or required to use it)"

"Dr. Flucker(My appraiser) was really helpful and very understanding and took me through every single aspects of the appraisal process. The clarity software needs to be added to the mandatory training(induction process)."

"Mike is an excellent appraiser. Organisation will be benefited from more appraisers like him."

"There was a lack of understanding around the difficulty created by moving the date to six months after a previous event. The lack of understanding and rather aggressive manner in which the medical director chose the address this was unnecessary and unsupportive for a senior doctor who has always produced high quality appraisals. The Trust needs to work in much closer co operation with those on flexible contracts and adopt a listening approach. Ultimately this will benefit the patients we serve and the organisation."

"The job is too busy and does not give adequate time to allow for a satisfactory preparation."

"On the whole the appraisal was carried out very well."

"I strongly feel that the appraisal process needs to be supported, rather than run, by the organisation. I find the current approach stifling, which has led to me disengaging from what has proved (for the first time) a genuinely useful process in the end."

"My appraiser has helped me to have a much clearer understanding of the framework underpinning the appraisal process. This has supported me in finalising my appraisal and looking to the next appraisal period. Going forward, I also feel more informed about which educational activities/CPD events will support my practice. I would have liked more notice/ a staggered approach to changing my appraisal to my birth month (Sept). My appraisal was due 10/12/2016. I received an email on 7/4/16 informing me my appraisal date was brought forward to 30/9/16."
"well done, I had no issues."

"As a new consultant, the clarity software is brand new to me. A brief training session at induction would be very helpful to get the best out of the software."

"Need time released from clinical work to keep on top of appraisal."

"Discussion forum or workshop for Appraisers to discuss their "way" and discuss with others. Even though I was being appraised this time we still discussed the value of such a workshop!"

"I received no previous complete explanations about appraisal process. However, now my appraiser has identified all my queries and solved my questions. He has explained in an easy way how to perform better my appraisal."

"The Clarity software is very nice to use, but the problem is you could go on forever. There are so many places where you can give feedback and needing to upload a lot of documents takes a lot of time. Obviously as this was my first appraisal there was a lot to do. I think my appraiser had thought I had spent too long on my appraisal but I do not like to leave too many empty boxes!"

"Poor software for trainees to record progress"

**Appraiser Skills**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The appraiser adequately reviewed my progress against my PDP and the supporting information for the appraisal</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>77</td>
<td>99</td>
</tr>
<tr>
<td>My appraiser's skill in conducting my appraisal was adequate</td>
<td>5</td>
<td>0</td>
<td>4</td>
<td>70</td>
<td>107</td>
</tr>
<tr>
<td>My appraiser challenged me to help me to review my practice</td>
<td>4</td>
<td>2</td>
<td>21</td>
<td>99</td>
<td>60</td>
</tr>
</tbody>
</table>

Total: 2% 1% 4% 42% 51%

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall my appraiser conducted a successful appraisal</td>
<td>4</td>
<td>0</td>
<td>3</td>
<td>78</td>
<td>101</td>
</tr>
<tr>
<td>I am happy to have the same appraiser again</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>69</td>
<td>107</td>
</tr>
</tbody>
</table>

Total: 2% 1% 4% 42% 51%

**Comments**

"Very supporting"

"Very professional and objective in her appraisal skills. Should keep it up."

"Thorough and thoughtful appraisal. My appraiser had good knowledge of the content of my appraisal documentation prior to our meeting."
"I really appreciated the positive feedback and advice in developing and structuring as well as appropriately uploading the required information for assessment."

"very pleased with the way my appraisal was conducted this year, thank you"

"Supportive and knowledgable about the whole process which made things easier."

"None really. Perfectly happy."

"None- Very precise and well conducted appraisal meeting with the right degree of emphasis on various aspects of the appraisal."

"Mike is an excellent appraiser. He reviewed my appraisal document before the appraisal and was ready with all the relevant points which need to be addressed during the appraisal process. I believe the appraisal process was brilliant. The in depth analysis needed time and we had a longer appraisal than usual. However I felt it was beneficial and I would rather have a longer complete appraisal like this rather than a short one not addressing all the issues."

"It would have been more helpful if my appraiser had read my appraisal before the event and the time together was spent in discussion and personal development. Much of the face to face time was spent reading the document and them filling in the final documents. In all my other appraisals the latter has been done after the event."

"I thought my appraiser found the right mix of challenging me in a supportive way and I could not think of how he could have done that better."

"Overall my appraiser has been fair and honest in his responses and feedback. Thanks"

"One of the best appraisals I've had. Good mix of challenge and feedback."

"I did not feel comfortable throughout the appraisal. My stress level was only picked up at the end. Comments made about support from family or friends, though well meant, only made me feel worse and our approach to difficulties in our work was obviously very different."

"I have been given some pointers for next year"

"Appraiser liked attention to detail and once things were explained, he has accepted the explanations."

"Strongly recommend Dr Flucker as an appraisal to other trainees."

"I would like to extend my gratitude to Ernest for making the time to go through this with me and for his input over the past 2 years"

"Dr Kingsbury is an experienced appraiser and this shows in his appraisals where he understands what both appraisee and the system need from the process, and how to ensure this is achieved."

"At first glance, a surgeon appraising a paediatrician may seem an odd fit, but it is useful to have an external perspective. I particularly value that Mike is not only someone I trust clinically, but whose previous management experience also gives a different angle of view. "
The Appraisal

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The appraisal challenged me to consider new areas for development</td>
<td>6</td>
<td>4</td>
<td>38</td>
<td>105</td>
<td>33</td>
</tr>
<tr>
<td>My PDP for the coming year reflects my main priorities</td>
<td>5</td>
<td>0</td>
<td>7</td>
<td>115</td>
<td>59</td>
</tr>
<tr>
<td>Overall the appraisal was useful in my professional development</td>
<td>6</td>
<td>9</td>
<td>28</td>
<td>94</td>
<td>49</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>Disagree</td>
</tr>
<tr>
<td>Neutral</td>
</tr>
<tr>
<td>Agree</td>
</tr>
<tr>
<td>Strongly Agree</td>
</tr>
</tbody>
</table>

Comments

"Adequate time for preparation and early allocation of an appraisee. Online colleague feedback tool."

"I believe that the strict cut off points (year beginning/year end) are too rigid and do not take full account of the five year revalidation cycle. I believe as was originally intended that the CPD should be planned over a longer period of time and that over the five year period there should be work in all areas but not necessarily everything in every year."

"Provide some evidence that the managers that oversee appraisals actually read the comments and take actions suggested in them, or at least take them seriously and respond, rather than sim"

"The appraiser took time to review all the information to help guide this process. She was very helpful and provided useful insights which will help me in the future I cannot think of any further suggestions."

"The amount of paperwork needed for an appraisal is a total waste of time energy and makes little sense. It is patronising and not fit for purpose"

"Stop doing them"

"Dedicated time is needed"

"My appraiser this year had little understanding of my scope of practice and therefore it was necessary that we spent most of time discussing this rather than having a more in depth discussion about the developmental aspects of the process. However this is as much a reflection on the way the organisation has chosen to appoint appraisers in a random fashion than the individuals who is clearly doing the best they can in the circumstances."

"I was happy with the appraisal process and particularly with the appraisal meeting."

"I have always enjoyed the process of appraisal. However, I have raised issues within my appraisals in the past which remain unresolved. I have lost faith that the trust believe in appraisal for anything other than a "tick box" exercise. If the trust wants engagement from staff, they need to take seriously the issues that are raised."

"Helped me to focus and be able to demonstrate ongoing professional development"

"the job plan should be adjusted to accommodate appraisal process"

"Reduce the time, effort and cost involved in appraisals"
Appraiser Feedback
Organisation Systems

Comments

"The website is cumbersome to use both as an appraise and as an appraiser"

"Clarity is too clunky- too many submenus which complicate and do not add any value SIMPLIFY"

"Improve Study Leave process"

"Lack of private space and facilities to carry out appraisal in confidential and appropriate environment"

"Better training for appraisees in the reflective approach to appraisal. Maybe more recognition of the time it takes to perform an effective appraisal on behalf of the appraisers."

"Give us more SPA Time to do proper Appraisals"

"The software or computers are slow, making the process of reviewing the appraisal before hand laborious."

"I have more faith in the appraisal process"

"There is a significant issue with new consultants/staff grades not being given enough information to prepare themselves for an appraisal a year after starting. This is particularly true for non-UK trained doctors."

"Better appraisal training for appraisees. Formal core data set agreed for specific fields of practice."

"Private office space with computers can be difficult to find."

"Appraisal is very time consuming, so more time needs to be set aside to do it. This is difficult in busy jobs."

"Institutional inhibitors to the process"
I think it would help to have a central record of each college's/ specialty association's CPD requirements that could be used by appraisers as a reference if unfamiliar with the requirements of such an association or college.

The current appraisal policy does not account for junior doctors outwith a training scheme who would be better suited with a Trust ARCP following the guidance and portfolio requirements of those in equivalent posts but on a training scheme. The Clarity documentation does not really support this. Also no training is given to appraisees as to what is expected of them.

Appraiser Skills

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I adequately reviewed the appraisee's progress against their PDP and supporting information for the appraisal</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td>127</td>
<td>40</td>
</tr>
<tr>
<td>I felt this appraisal was difficult to manage</td>
<td>63</td>
<td>75</td>
<td>14</td>
<td>17</td>
<td>7</td>
</tr>
<tr>
<td>Overall I conducted a successful appraisal</td>
<td>2</td>
<td>1</td>
<td>25</td>
<td>127</td>
<td>21</td>
</tr>
<tr>
<td>I am happy to have the same appraisee again</td>
<td>4</td>
<td>0</td>
<td>8</td>
<td>111</td>
<td>53</td>
</tr>
</tbody>
</table>

10% 11% 7% 54% 17%

Comments

Further update on appraisal skills. I continue to find it difficult to address and manage appraisals where written reflection is lacking but appraisee seems to reflect well verbally. It is more difficult to be confident in appraising clinicians from other specialities where my knowledge of their college requirements is lacking.

Appraiser update

I found it difficult to challenge. He is 2 years off retirement and whilst no evidence of lack of engagement in clinical work at all I found trying to get him to make take this as anything more than a box ticking exercise difficult. I failed to motivate him in the process or on linkage and reflection.

I think the Trust's recent policy changes in providing better guidance to appraisees needs to be rolled out in a local training programme. I think it would help me as an appraiser to be party to that teaching. Particularly to better understand how and why some appraisees find it difficult to engage in the package as a whole.

trying to balance the degree of 'challenge' against clear improvement was difficult, make sure clear advice is given at initial meeting to avoid 'ping pong' with the appraisal documents. this hasn't happened this time but sometime hard to know how much more to reasonably push for.
"I think it is currently more about ensuring that the appraisees already have the skills and attitude to proactively contribute to appraisal so that less of the appraisal process is taken up with appraise guidance. This would then allow a more productive use of accrued skills within the appraisal process."

"Time to review appraisal process is not factored in my job plan"

"It would be helpful to have appraiser group sessions to understand how others appraise and how "they do it" as I am sure I have still much to learn!"

"Time to do appraisal in job plan"

"Difficulty with Study Leave applications"

"Attending further development days would be helpful."

"I was appraising a person who is an experienced appraiser - I hope I did justice to the Appraisal process. He did suggest I approached the Appraisal in a manner similar to how he undertakes appraisals. I think I learned much from undertaking this appraisal."

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**The Appraisal**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The appraisal challenged me to consider new areas for my development as an appraiser</td>
<td>2</td>
<td>7</td>
<td>85</td>
<td>72</td>
<td>10</td>
</tr>
</tbody>
</table>

Comments

"Clarity is too clunky- too many submenus which complicate and do not add any value SIMPLIFY"

"Confidential environment"

"This was a fairly straightforward appraisal that was not as challenging as some others and the appraisee was more pro-active in the appraisal process than many. It was also partly helped by sharing the same professional role. Not that I think this is always appropriate."

"Need feedback on how we have performed as appraisers"

"I think there is not enough departmental guidance as to what data is appropriate to include in the evidence log. I would like to see in general the CD being asked if there are any events concerning the appraisee that need to be considered within the appraisal process. (Note this does not reflect in any way this appraisal but just a general comment)."

"Improve Study Leave process and deal with current anomalies"

"I need to be able to find out what the person in each specialty needs to have done in accordance with their college"

"Stop using CLARITY"
"I think I provided the approach to the appraisal process that the appraiser wanted. However I don't think that the trust has formally promoted reflection within the appraisal process (to appraises) for a long enough period for it to be the useful tool it can be."

"Due to the level that this doctor was at a Trust ARCP would have been more appropriate"
Appendix 6

Higher Level Responsible Officer Quality Review (HLROQR) Meeting. Notes and Actions

<table>
<thead>
<tr>
<th>Organisation: North Cumbria University Hospital NHS Trust (NCUH)</th>
<th>Date: 24th April 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Attendees</strong></td>
<td><strong>Meeting Time:</strong> 2pm - 4.30pm</td>
</tr>
<tr>
<td>Paul Twomey (PT - Chair)</td>
<td>Joint Medical Director NHS England-North</td>
</tr>
<tr>
<td>Janet Bell</td>
<td>Project Support Officer</td>
</tr>
<tr>
<td>Rod Harpin (RH)</td>
<td>Medical Director and Responsible Officer</td>
</tr>
<tr>
<td>Chris Flucker (CF)</td>
<td>Appraisal Lead</td>
</tr>
<tr>
<td>Chris Carroll (CC)</td>
<td>Senior Medical Workforce Coordinator</td>
</tr>
<tr>
<td>Dave Steele (DS)</td>
<td>HR Manager, Medical Workforce</td>
</tr>
<tr>
<td>Kay Hewetson (KH)</td>
<td>HR Assistant</td>
</tr>
<tr>
<td><strong>Location:</strong> Medical Directors Office, North Cumbria University Hospital NHS Trust, Cumberland Infirmary, Newtown Road, Carlisle, CA2 7HY</td>
<td></td>
</tr>
</tbody>
</table>

**Notes and Actions**

**Framework of Quality assurance**

The Framework of Quality Assurance (FQA) has been produced to provide assurance and oversight that designated bodies are discharging their statutory duties. It also provides the basis on which Responsible Officers are required to demonstrate that the appropriate resource and systems are in place, that they work effectively and that they meet the agreed national standards.

https://www.england.nhs.uk/revalidation/qa/

The higher level responsible officer quality review (HLROQR) forms part of the FQA and its aim is to:

1. Establish that there are robust systems in place to underpin the statutory responsibilities of the responsible officer,

2. Provide designated bodies with support and guidance as and where appropriate, and

3. Enable discussions to take place between the key members of a designated body (responsible officer plus others) and the regional team representing the higher level responsible officer to consider:

   - compliance with the Responsible Officer Regulations (2010 & 2013)
   - any examples of good practice that have developed in the designated body that could be shared more widely
   - any areas of challenge
   - ways in which the designated body can be supported to further develop their delivery of the RO function
It is also an opportunity an opportunity for the regional team to gain a greater insight into the delivery of the RO function by the designated body and their sector, to inform future network discussions and the considerations by NHS England.

**Rationale for the visit**

The visit was prompted partially at the request of the new RO (RH) and also as a follow up to a quality review visit undertaken on 28th April 2016, at which time the designated body was supported by the RO of Northumbria who acted as the RO for both trusts.

The team were thanked for the timely provision of their documentation and in particular their undertaking of the core standards assessment which was utilised to frame the focus of the subsequent discussions. It was noted that this assessment was perhaps not fully consistent with the population of the 2015/16 AOA or the board report and subsequent compliance statement. This was not intended to be a criticism but rather reflected the strength of the reflection and the opportunities it presents to support our discussions.

**The Designated Body**

- NCUH is now out of special measures.
- Since the last HLROQR visit (April 2016) there have been significant changes in the senior executive team including a new RO (RH), Clinical Appraisal Lead (CF) and management support as per the membership of the meeting. This significant progress was acknowledged.
- There has been a sustained period of transition including the successful move of the Appraisal and Revalidation administration to the HR team.
- An additional band 5 post will be created to support the RO with GMC and MHPS cases and a high grade medical appraisal manager or deputy RO is also required.
- In line with a number of trusts with similar characteristics (the Keogh trusts), recruitment and retention at NCUH is difficult, with an approximate 27% vacancy rate covered by agency locums. There are plans to reduce the reliance on agency staff. These plans include securing more short term contract doctors as currently this is a small percentage of the prescribed connections.
- NCUH has doctors with a prescribed connection to them who work full time for them but who have a contract of employment with and are seconded from Northumbria. PT and RH to discuss this with the GMC ELA (Helen Sinclair). Whilst it is an appropriate solution re good governance and to appropriately support this cohort of doctors, the prescribed connection is normally informed by the employment of the doctor.
- West, North & East Cumbria was selected as one of three health economies in England to be part of the Success Regime programme in September 2015. Since then, the Trust has been working closely with health partners to create a sustainable clinical strategy for the future through a move toward becoming an Accountable Care Organisation. The team agreed to share the emerging medical and clinical governance which will underpin this action.
- The medical appraisal resources are keen to engage with the regional programme of networks for clinical and managerial leads.

**Actions**

1. PT to discuss with GMC ELA (Helen Sinclair) the issue of the full time seconded doctors employed by Northumbria Healthcare NHS Foundation Trust. RH gave permission for the summary notes from today to be shared with Helen.
2. RH to cite the board on the challenges faced by the new team over the transition period.
3. Regional team to ensure the new clinical appraisal and managerial leads within NCUH are informed of all network meetings.
4. RH to share the emerging medical and clinical governance of the ACO.
Appraisal

- Appraisal uptake was 85% for 2016/17.
- Significant data cleansing has now taken place. Appraisers are allocated to the doctors and although NCUH recognises the advantage of keeping March and the latter half of February free to allow for slippage it is reluctant to introduce further change this year, as they have just introduced allocation by birthday month.
- NCUH ensures all new consultants and staff grade doctors working in NCUH are included in the appraisal system shortly after the commencement of their employment. This has been made easier and timelier by closer alignment with HR.
- NCUH have an excellent appraisal policy which is an example of good practice and have implemented a tighter non participation process comprising a series of letters and phone calls culminating in a discussion with CF or RH. It was suggested in general and for specific cases they utilise the relevant Clinical Directors to ensure the doctor's personal and professional circumstances are understood and maximise the effectiveness of the action plan to enable their participation.

Actions

5. For doctors new to the organisation and appraisal (generally doctors from abroad) - introduce a “priming” appraisal which allows for the development of a PDP and a full appraisal 9-12 months later. This “priming” appraisal may be classified as a completed appraisal for the purposes of the AOA.
6. Aim for an appraisal uptake of > 90% for the 2017/18 appraisal year.
7. Produce a robust action plan for the post-AOA Board report to enable their board to provide leadership and support as appropriate.
8. During 2017/18 CF plans to review their medical appraisal policy to ensure it is up to date as part of his leadership role. Suggested to utilize the NHS England version 2 policy as a guide.

Appraisers

- Appraisers are provided with 0.15 SPA time which equates to 4 hours per appraisal.
- Colleague feedback is collated every two years with patient feedback collected once per revalidation cycle. The next revalidation bulletin will recommend ensuring SharePoint feedback appears in the appraisal process.
- Two appraisal training/update sessions were delivered in 2015-16 both well attended with good feedback. It would be appropriate to clarify and formalise the local network meeting arrangements for appraisers to ensure consistency and support the development of appraisers and the quality of the programme.
- The Appraisal Lead (CF) is ensuring that wherever an action plan has been developed after an SI that suggests reflection, the relevant appraisers will be notified and it will be flagged on the “Clarity” IT system that this needs to considered during the appraisal.

Actions

9. Ensure a robust system is in place to feed SIs into the appraisal process and ensure reflection and discussion within the appraisal context.
10. Introduce a programme of appraiser networks as per the ‘blueprint’ within 2017/18.

RTC

- NCAS is providing Case Investigator training onsite. Currently NCUH has 15-20 trained case investigators. RH reports back regularly to the board with regard to the number of doctors involved in MHPS.
- The case manager role is shared with Jeremy Rushmer and Derek Thomson within the
Trust.

- A new remediation policy is being developed over the next 6 months.

Actions

11. NCUH are developing a remediation policy which they will share with the Regional Revalidation Team

Peer Review

- NCUH has a good history of engagement at NHSE RO networks and this is to be extended to include the MA leads network. Some work has taken place re peer review with other organisations in the NE. However due to other challenges this has understandably not progressed as anticipated. RH to link with fellow ROs to look to progress.

Actions

12. To revisit the peer review opportunities with NE trusts.

Quality Assurance

- The Appraisal Lead (CF) since his appointment has looked to review all appraisal outputs but to date has not used one of the tools. Historically QA of appraisal documentation has not been consistent beyond review of the first three for each new appraiser and the review undertaken by Hilton Dixon contained within the 15/16 board report.
- CF is going to further extend the use of the “Galloway” quality assurance tool to build on the excellent baseline work previously done by Hilton Dixon.
- A further example of good practice is the level of feedback achieved for; Doctors providing to their appraiser
  Appraisers providing feedback to the team
  It was confirmed in the subsequent discussion that all significantly –ve feedback is reviewed and appropriate action is taken.

Actions

13. Use an approved Quality Assurance Tool to assess a representative sample of appraisers in addition to quality assuring the first 3 appraisals for any new appraiser. This to be complemented by collating and sharing with all appraisers the summary of their Dr feedback and also a summary of their feedback to the revalidation team.

Useful Links

NHS England Medical Appraisal Policy:
https://www.england.nhs.uk/revalidation/appraisers/app-pol/

Improving the inputs to medical appraisal guidance
https://www.england.nhs.uk/revalidation/appraisers/improving-the-inputs-to-medical-appraisal/

Information flows:
https://www.england.nhs.uk/revalidation/ro/info-flows/

Quality Assurance guidance
https://www.england.nhs.uk/revalidation/qa/
<table>
<thead>
<tr>
<th>Action plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is embedded in the report but also shown below</td>
</tr>
</tbody>
</table>

NCUH Action Plan.doc
Please complete the below action plan and return to:
England.revalidation-north@nhs.net
By: (insert date)

<table>
<thead>
<tr>
<th>Name of designated body</th>
<th>North Cumbria University Hospital Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of responsible officer</td>
<td>Dr Rod Harpin</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Area/concern/issue identified at Review Visit</th>
<th>Action</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Prescribed Connection</td>
<td>PT to discuss with GMC ELA (Helen Sinclair) – Doctors working predominantly for NCUH and have a prescribed connection to them but who are contractually employed by Northumbria.</td>
<td>By 12/05/2017</td>
</tr>
<tr>
<td>2) Board Engagement</td>
<td>RH to cite the board on the challenges faced by the new team over the transition period and share the summary report of Quality Review to ensure they may support as appropriate</td>
<td>By 30/06/17</td>
</tr>
<tr>
<td>3) Communications</td>
<td>Regional team to ensure the new appraisal lead + team within NCUH (CF) is informed of all network meetings.</td>
<td>Complete</td>
</tr>
<tr>
<td>4) Accountable Care Organisation</td>
<td>RH to share the emerging medical and clinical governance of the ACO</td>
<td>As it emerges, suggest first update by 30/9/17</td>
</tr>
<tr>
<td>5) “Priming” Appraisal</td>
<td>For doctors new to the organisation and appraisal - introduce a “priming” appraisal which allows for the development of a PDP and a later full appraisal.</td>
<td>To be implemented within the appraisal year 2017/18</td>
</tr>
<tr>
<td>6) Board Report</td>
<td>Produce a robust action plan for the post-AOA Board report to enable their board to provide leadership and support as appropriate.</td>
<td>31st August 2017</td>
</tr>
<tr>
<td>7) Appraisal uptake</td>
<td>Aim for an appraisal uptake of &gt; 90% for the 2017/18 appraisal year.</td>
<td>By 31/03/2018, as evidenced in Annual Organisational Audit (AOA)</td>
</tr>
<tr>
<td>8) Significant Incidents</td>
<td>Ensure a robust system is in place to feed SIs into the appraisal process and ensure reflection and</td>
<td>For the 2017/18 appraisal year.</td>
</tr>
</tbody>
</table>
9) **Appraisal Policy**

During 2017/18 CF plans to review their medical appraisal policy to ensure it is up to date as part of his leadership role. Suggested to utilise the NHS England version 2 policy as a guide.

By 31/03/2018

10) **Appraiser Training/Updates**

Introduce a programme of appraiser networks as per the 'blueprint' within 2017/18.

Commencing 2017/18 appraisal year

11) **Remediation Policy**

NCUH are developing a remediation policy which they will share with the Regional Revalidation Team

November 2017.

12) **Peer Review**

To revisit the peer review opportunities with NE trusts.

Over the 2017/18 appraisal year. Update by 31/03/2018

13) **Quality Assurance**

Use an approved Quality Assurance Tool to assess a representative sample of appraisers in addition to quality assuring the first 3 appraisals for any new appraiser. This to be complemented by collating and sharing with all appraisers the summary of their Dr feedback and also a summary of their feedback to the revalidation team.

For the 2017/18 appraisal year.

**Follow up meeting / Telecon**

Initial review at the RO + MA leads network in June

**As responsible officer I confirm that the information above has been discussed and agreed with my Board or equivalent**

*Signature & Date*

**Date of Board sign-off**
Appendix 6

AGENDA

<table>
<thead>
<tr>
<th>Item</th>
<th>Issue</th>
<th>Duration</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Welcome and introductions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Review and discussion of pre-visit information, evidence and analysis (see template for completion below)</td>
<td>1hr 45 mins</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Discussion opportunities with equivalent roles (split into two groups)</td>
<td>20 mins</td>
<td></td>
</tr>
</tbody>
</table>

Group 1 – Deputy/Associate Medical Directors
Group 2 – Administrative Leads
<table>
<thead>
<tr>
<th></th>
<th>Break for consideration and summing up key issues</th>
<th>15 mins</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Informal feedback presented to Responsible Officer and team:</td>
<td>15 mins</td>
</tr>
<tr>
<td></td>
<td>Suggested attendees:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Above, plus RO, plus any other relevant, plus Chair of committee that Trust revalidation group reports to e.g. at CHSFT, the Medical Revalidation Sub Group reports to the Governance Committee.</td>
<td></td>
</tr>
</tbody>
</table>

**PAPERS TO BE PROVIDED AND REVIEWED PRE-VISIT**

<table>
<thead>
<tr>
<th></th>
<th>Annual Organisational Audit and Comparative Report (if latter available at time of peer review visit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>NHSE Core Standards Checklist/Action Plan</td>
</tr>
<tr>
<td>3.</td>
<td>Trust Medical Appraisal/Revalidation Annual Report</td>
</tr>
<tr>
<td>4.</td>
<td>Trust Medical Appraisal Policy</td>
</tr>
<tr>
<td>5.</td>
<td>Trust Responding to Concerns/Remediation Policy</td>
</tr>
</tbody>
</table>
## REVIEW FORMAT:

<table>
<thead>
<tr>
<th>THEMES</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Leadership of the Responsible Officer</td>
<td></td>
</tr>
<tr>
<td>RO meetings:</td>
<td></td>
</tr>
<tr>
<td>Access to GMC Connect:</td>
<td></td>
</tr>
<tr>
<td>Revalidation deferral rates:</td>
<td></td>
</tr>
<tr>
<td>2) The process of review of the doctor’s appraisal and revalidation portfolio</td>
<td></td>
</tr>
<tr>
<td>Appraisal database:</td>
<td></td>
</tr>
<tr>
<td>Method of appraisal:</td>
<td></td>
</tr>
<tr>
<td>Current position 2013 – 2016:</td>
<td></td>
</tr>
<tr>
<td>How are appraisal dates/appraisers allocated and how does this work?:</td>
<td></td>
</tr>
<tr>
<td>How are performance issues flagged at appraisal or revalidation?:</td>
<td></td>
</tr>
<tr>
<td>3) Triangulation of information</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quality Assurance process</td>
</tr>
<tr>
<td>---</td>
<td>---------------------------</td>
</tr>
<tr>
<td>5)</td>
<td>Risks and issues</td>
</tr>
<tr>
<td></td>
<td>• General points with regard to the systems and processes</td>
</tr>
</tbody>
</table>
SAS Doctors Charter

Speciality Doctors, Staff Grades and Associate Specialists (SAS) are senior health professionals, a diverse group of experienced clinicians, often in niche roles, undertaking specialised patient care.

- We make significant contributions in the areas of leadership, education, research and governance
- We are committed to providing safe and effective clinical care in accordance with the General Medical Council’s Good Medical Practise and Trust’s values and priorities.

The Trust is committed to acknowledging SAS doctors and their work through treating SAS doctors with respect and by ensuring:

- Contracts of employment are under national terms and conditions.
- Annual job planning and an SAS representative on the job planning consistency panel
- Timely annual appraisals, to promote and nurture personal development in accordance with General Medical Council (GMC) and General Dental Council (GDC) revalidation requirements
- Acknowledging potential ability to work autonomously, as supported by the British Medical Association (BMA) and Association of Royal Medical Colleges (AoRMC)
- Work towards making provision for individual coding and activity data
- Offer representation in all decision-making bodies in the Trust, alongside other senior health professionals, including Joint Local Negotiating Committee (JLNC) representatives
- Support and guidance for all wishing to gain the Certificate of Eligibility for Specialist Registration (CESR)
- Opportunity to attend SAS doctor development days
- Invitation to be involved in the recruitment and retention of permanent medical staff

Dr Laura Hipple
SAS Tutor

Dr Rod Harpin
Medical Director

Stephen Eames
Chief Executive
Report to a Meeting of the Trust Board of Directors held in Public

<table>
<thead>
<tr>
<th>Date of Meeting:</th>
<th>25 July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enclosure Number:</td>
<td>15</td>
</tr>
<tr>
<td>Title of Report:</td>
<td>Sustainability Annual Report 2016/17</td>
</tr>
<tr>
<td>Author:</td>
<td>Suzanne Halsall, Assistant Director of Estates</td>
</tr>
<tr>
<td>Executive Lead:</td>
<td>Robin Andrews, Interim Director of Finance</td>
</tr>
<tr>
<td>Responsible Sub-Committee (if appropriate):</td>
<td>Safety and Quality Committee Estates &amp; Facilities Advisory Group (EFAG)</td>
</tr>
</tbody>
</table>
| Executive Summary:        | The Trust has had a challenging year with trying to improve its carbon footprint and its continuation of sustainable development in 2016/17. The Trust acknowledges its responsibility towards creating a sustainable future and work continues on a range of areas highlighted in the report. The key points to note are:  

- The impact of The West Cumberland redevelopment double running and dual energy centres until Phase 2 is complete.  
- Energy cost savings in gas through new supplier.  
- Sustainability and Environmental Management Group set up with our PFI Partner to develop further opportunities. |

**Strategic Priority and BAF Link:**

<table>
<thead>
<tr>
<th>Strategic Priority:</th>
<th>List below the associated risk in relation to the Strategic Priority:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Building a Platform for Better care</td>
<td></td>
</tr>
<tr>
<td>2. Meet all Standards</td>
<td></td>
</tr>
<tr>
<td>3. Create a Good Workforce</td>
<td></td>
</tr>
<tr>
<td>4. Achieve Financial Stability</td>
<td></td>
</tr>
<tr>
<td>5. Improve Safety &amp; Quality</td>
<td>Carbon Reduction and Sustainability</td>
</tr>
</tbody>
</table>

**Financial implications:**

Double running costs at The West Cumberland Hospital.
<table>
<thead>
<tr>
<th>Actions required by the Board:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>To approve:</td>
<td>Discussion and decision</td>
</tr>
<tr>
<td>To note: ✔</td>
<td>Where the Board is made aware of key points but no decision required</td>
</tr>
<tr>
<td>For information:</td>
<td>For reading and consideration and for discussion by exception only</td>
</tr>
</tbody>
</table>

The Board is requested to note the report.

<table>
<thead>
<tr>
<th>Data quality:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Source:</td>
<td>Louise Wood, Estates Officer, Specialist Services</td>
</tr>
<tr>
<td>Validated by:</td>
<td>Suzanne Halsall, Assistant Director of Estates</td>
</tr>
<tr>
<td>Date:</td>
<td>12/07/2017</td>
</tr>
</tbody>
</table>
1. **INTRODUCTION**

The Trust has had a challenging year with trying to improve its carbon footprint and its continuation of sustainable development in 2016/17. The Trust acknowledges its responsibility towards creating a sustainable future and the tool will continue to be utilised as one of the measures in monitoring the effectiveness of performance. This includes a commitment to further Staff and Patient engagement.

The Trust will continue to concentrate on engaging with its PFI partners (HMC) and with the help of the Sustainability and Environmental Management Group to engage in identifying carbon reduction projects with a robust payback period identified when measured against investment funding.

Sustainability is about solutions, and allows innovative managers and staff to consider how they can improve their service.

**Energy**

North Cumbria University Hospitals NHS Trust has spent £2,670,056 on energy in 2016/17; this reflects additional usage from the new part of the West Cumberland Hospital coming into full operational mode and the running down of the phase 2 building.

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Electricity consumed (kWh)</strong></td>
<td>15,583,814</td>
<td>14,716,080</td>
<td>14,951,681</td>
<td>17,022,825</td>
<td>17,684,585</td>
</tr>
<tr>
<td><strong>Gas consumed (kWh)</strong></td>
<td>27,269,015</td>
<td>19,768,136</td>
<td>20,806,390</td>
<td>20,863,537</td>
<td>28,506,977</td>
</tr>
<tr>
<td><strong>Oil consumed (kWh)</strong></td>
<td>118,623</td>
<td>224,219</td>
<td>309,128</td>
<td>374,482</td>
<td>581,822</td>
</tr>
<tr>
<td><strong>Energy costs (all energy supplies) £</strong></td>
<td>2,006,687</td>
<td>2,087,289</td>
<td>2,144,824</td>
<td>2,744,607</td>
<td>2,670,056</td>
</tr>
</tbody>
</table>

The energy consumption for 2016/17 is higher than previous year as the Trust has the additional effect of running two energy centres on the West Cumberland Hospital site until the second phase of the West Cumberland’s Development is completed. Within the New West Cumberland Hospital the amount of Air Handling Units in operation has significantly increased which has contributed to the rise in energy usage; this however means that the facility is running to the very latest designs giving a better quality environment.
The Trust has engaged a new energy broker for the October 2016/17 round of electrical and gas contracts. With the new partner there is a substantial saving in the gas rate and a smaller saving in the electrical rate.

**Waste**

The Trust continues to make progress in segregating waste streams as indicated by the current legislation, more robust mechanisms will be introduced in 2017. By careful management of Trust resources, the Trust will work towards reducing and re-using waste where possible in the future.

**Water**

WCH consumption has decreased in 2016/17. During the construction of the new build all water outlets were flushed constantly for 24 hours a day. This procedure has now ceased due to the occupation of the building, but due to the old building being partially unoccupied it is necessary to flush the old building system more frequently. This will continue until the completion of Phase 2 of the new West Cumberland Hospital.

**Green Projects**

The Trust continues to run the Bike to Work scheme; with 21 orders being accepted onto the scheme in 2016/17, helping the fitness and wellbeing of staff over both sites.

More teleconferencing facilities have been installed with the opening of the new West Cumberland Hospital which will result in less travelling between sites.

Recycling of various materials still continues to be the main focus of the Trust’s target and to continue to upcycle various pieces of equipment and furnishings. The Trust is currently working in partnership with Interserve to install a paper shredding facility at CIC; all of the paper waste accumulated from all the premises occupied by the Trust will be shredded by Interserve with no cost to the Trust.

Replacement of old calorifier’s at Cumberland Infirmary with new plate heat exchangers which would reduce the heating load, saving utility usage and cost.

Life cycle replacement of lighting in main circulation areas like the atrium Cumberland infirmary creating reduced maintenance and utility costs.

The British native trees planted are continuing to flourish and provide staff and visitors with a small woodland area to access during breaks.
The Electric Vehicle at West Cumberland Hospital has reduced our reliance on a diesel vehicle around site.

Although not a green project, the installation of smart meters throughout the hospitals will highlight the high consumptions areas and help to monitor improvements and the ability to save the Trust energy consumption and money.

At Cumberland Infirmary, working in partnership with the PFI provider, a group was set up to look at some Energy and Carbon Reduction projects for 2017/18.

**Procurement**

The Trust is part of the shared procurement service providing increased availability and opportunity with Northumbria Healthcare and Northumbria Council. This will utilise the use of local companies to compete for Trust contracts and reduce carbon mileage. This will help sustain local economies across the regions.

The Trust is committed to reducing packaging were possible in the contractual conditions of procurement.

Achievements over a range of disciplines and departments have yielded significant carbon reduction in the past few years. There is still much work
to achieve in this area and the next big challenge will be faced as we plan Phase 2 of the Carbon Reduction Strategy. Sustainability and Carbon Reduction is a corporate and workforce responsibility.

It continues to be demonstrated that with good management and the adoption of sustainable driven goals carbon reductions can be achieved, which leads to financial savings and importantly, improved environmental impact and reputational benefit.

Suzanne Halsall
ASSISTANT DIRECTOR OF ESTATES
Report to a Meeting of the Trust Board of Directors held in Public

**Date of Meeting:** 25 July 2017

**Enclosure Number:** 16a

**Title of Report:** Senior Information Risk Owner (SIRO) Annual Report 2016/17

**Author:** Lorraine Gray, Head of Information

**Executive Lead:** Robin Andrews / Rod Harpin

**Responsible Sub-Committee (if appropriate):**

<table>
<thead>
<tr>
<th>Executive Summary:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The final IG toolkit submission at the end of March 2017 was compliant with all requirements achieving level 2 or above. Internal audit in January 2017 of the evidence provided for the annual IGT submission. The final report provided the Trust with substantial assurance that governance, risk management and control arrangements ensure that risks identified are managed effectively.</td>
</tr>
<tr>
<td>2. There was 1 case reported to the ICO at Level 2 and logged on the Trust’s Serious Incident system during 2016/17. This incident was reviewed by the ICO and no further action was required by the Trust.</td>
</tr>
<tr>
<td>3. Freedom of information (FOI) requests and Subject matter requests rates are reported. FOI requests increased by 31% from 2015/2016 and response times improved significantly in Q4. Of the 1392 SARs completed in this period 80% were responded to within the required 40 day timescale.</td>
</tr>
<tr>
<td>4. A key issue for 20172018 and the Trust Board is to consider the implications of the new General Data Protection Regulations (GDPR) which comes into force on the 25 May 2018. GDPR Work streams are being developed in collaboration with colleagues at CPFT and a Data Protection Officer needs to be appointed for the Trust as an early step towards compliance with the regulations. Non- compliance carries a severe financial penalty.</td>
</tr>
<tr>
<td>Strategic Priority and BAF Link:</td>
</tr>
<tr>
<td>---------------------------------</td>
</tr>
<tr>
<td>1. Strategy and System</td>
</tr>
<tr>
<td>2. Operational Flow and Delivery</td>
</tr>
<tr>
<td>3. Patient and Staff Experience</td>
</tr>
<tr>
<td>4. Workforce and Leadership</td>
</tr>
<tr>
<td>5. Patient Safety and Quality</td>
</tr>
</tbody>
</table>

**Financial implications:**

**Actions required by the Board:**

- **To approve:** Discussion and decision
- **To note:** Where the Board is made aware of key points but no decision required
- **For information:** For reading and consideration and for discussion by exception only

The Board is requested to note the assurances provided in this paper and note the proposed information governance objectives for 2017/18.

**Data quality:**

- **Source:**
- **Validated by:**
- **Date:**

---

[2]
Senior Information Risk Owner (SIRO) Annual Report 2016/17

This report is to inform the Board of progress throughout 2016/17 on information assurance and is intended to:

- document compliance with legislative and regulatory requirements relating to handling of information, including compliance with the Data Protection Act (1998) and Freedom of Information Act (2000)
- inform the Board of information security risk assessments and approve identified risk mitigation plans if required
- detail any Serious Incidents requiring Investigation (SIRI) within the preceding twelve months, relating to any losses of personal data or breaches of confidentiality
- compliance with the Information Governance Toolkit 2016/17
- information governance work for 2017/18 and how this aligns with the strategic business goals of the Trust

The Trust recognises the value of the data within its information systems. The Trust also recognises its responsibility to ensure the appropriate use, security, reliability, and integrity of this data; to safeguard it from accidental or unauthorised access, modification, disclosure, use, removal, or destruction; and to comply with relevant legislation.

The Trust is a recognised and registered Data Controller within the Information Commissioner’s Data Protection Register, and has current Data Protection registration. There are no current or historical conditions or cautions against the Trust’s data protection registration.

The Trust’s standard of Information Governance remains at a reasonable level and this is represented in the annual returns. This level of compliance is attributed to the effective management of the IGT requirements.

Due to increased national and international news coverage regarding information security breaches of personal information and cyber security including ransomware attacks, there is a heightened awareness of the requirement for robust information governance and security processes.

The IG framework covers a complex agenda which will continue to gain momentum. Public interest will continue to rise through the media reporting of adverse events and the proactive increase of awareness planned by the Information Commissioners Office (ICO), Data Guardian Report and the new GDPR regulations. Going forward, the Trust will review national guidance issued in support of changes to legislation and monitor how the ICO applies its Regulatory Powers with regards to penalty notices for data loss incidents and where required, continue to apply the learning to ensure risk mitigation within the Trust.

Key responsibilities of the Senior Information Risk Owner
The key responsibilities of the SIRO include:

- oversee the development of the Information Governance Policy;
- ownership of the assessment processes for information risk, including prioritisation of risk and review of the annual information risk assessment to support and inform the Annual Governance Statement;
- ensure the Trust Board is fully informed of key information risks;
- review and agreeing actions in respect of identified information risks;
- ensure the effective implementation of the Information Asset Owner / Information Asset Administrators (IAO / IAA) infrastructure to support the role of the SIRO;
- ensure that identified information threats and vulnerabilities are investigated for risk mitigation, and that all perceived or actual information incidents are managed in accordance with the Trusts Incident Management policy; and
- ensure effective mechanisms are established for the reporting and management of Serious Incidents Requiring Investigation relating to the information of the Trust, maximising the opportunity to ensure learning from incident reporting.

**Information Governance Group**

The Information Governance Group meets bi-monthly and is responsible for the effective management of the Trust's information governance processes, reporting to the IM&T Group about how risks are being managed.

Chaired by the SIRO, the key duties of the group include:

- review and monitoring of the Trust's compliance with the Information Governance Toolkit
- review and monitor the Trust's annual Information Governance Work Plan
- review and monitor any information governance risks, ensuring appropriate escalation to the Board
- review and monitoring of new and changing information assets in compliance with the requirements of the Information Governance Toolkit
- ensure the Trust has an information governance training programme
- review of information governance policies and procedures to take into consideration new legislation and good practice guidance.

The Trusts IG Strategy & Framework describes the Trust’s approach to meeting its statutory duties in relation to information governance, data protection and confidentiality and has been refreshed to take into account new legislation e.g. GDPR

- Patients have the right to privacy and confidentiality, to expect the NHS to keep patient confidential information safe and secure, and to be informed about how their information is used
- For the purpose of direct care relevant personal confidential data should be shared among the registered and regulated health and social care professionals (organisations) who have a legitimate relationship with the individual

**Information Governance Toolkit**

The Information Governance Toolkit is an online tool that enables organisations to measure their performance against a set of information governance requirements, including the following:

- Information Governance Management
- Confidentiality and Data Protection Assurance
- Information Security Performance
- Clinical Information Assurance
- Secondary Users Assurance
- Corporate Information Assurance

There are 3 assessments annually:

- Baseline 31 July
- Performance Update 31 October
- Final Submission 31 March.
The IGTK for 2017/18 has been released as version 14.1 (interim) in preparation for significant changes for 2018/19 which will incorporate a greater emphasis on cyber security.

**Organisational Compliance**

**IG toolkit 2016/17**
The final IG toolkit submission at the end of March 2017 was compliant with all requirements achieving level 2 or above:

<table>
<thead>
<tr>
<th>Level 0</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Total number of Requirements</th>
<th>% score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>19</td>
<td>26</td>
<td>45</td>
<td>85%</td>
</tr>
</tbody>
</table>

**Internal Audit**
An evaluation was carried out by internal audit in January 2017 of the evidence provided for the annual IGT submission. The final report provided the Trust with substantial assurance that governance, risk management and control arrangements ensure that risks identified are managed effectively.

**SIRI Report**
Information governance incidents are reported internally through the web based incident reporting system Ulysses and notified immediately to the Information Governance Officer and the Information Security Officer for logging where appropriate on the Serious Incidents Requiring Investigation section of the Information Governance Toolkit and with the Trust’s Serious Incident Lead where appropriate. Incident data is regularly reported to and monitored by the IGG. There was 1 case reported to the ICO at Level 2 and logged on the Trust’s Serious Incident system during 2016/17. This incident was reviewed by the ICO and no further action was required by the Trust.

**Risk Management**
There are currently 0 Information Governance risks on the risk register.

**Information and Cyber Security**
During the course of the year the Information Governance Group has considered a number of data security/cyber security issues in the light of increased incidents of phishing and spam email. The Group supported the introduction of strengthened password standards and the requirements for staff to change their passwords more frequently communications with staff to raise awareness of cyber security issues.

**Information Sharing**
The Trust recognises it has a responsibility to work with partners to minimise the burden of data collection, and ensure that data is used effectively to support the overall aims of public sector and voluntary organisations, ensuring the delivery of safe, quality, clinical care. The Trust is an active member of the Regional Information Sharing Gateway, which is expanding nationally.

**Freedom of Information Requests**
During 2016/17 the Trust received 656 requests under the provisions of the Freedom of Information Act 2000, which is an increase of 157 (31%) from the 2015/16 figures.

Compared to previous years the nature of requests have been more complex and several required in-depth investigation to find detailed information and subsequently greater review of that information and any exemptions that apply prior to disclosure. There has been an improvement in obtaining information from leads following a temporary investment in staffing, change of process and the direct involvement of CEO’s office.
The table below shows the quarterly breakdown of requests and response times and significant improvement in Q4.
## Subject Access Requests (Data Protection Act 1998)

The Data Protection Act 1998, Section 7, gives individuals the right to find out what personal data the organisation holds about them. Such requests are termed Subject Access Requests (SARs), and have a statutory response time of 40 calendar days from date of receipt. Correct and prompt management of subject access requests increase levels of trust and confidence in the organisation by being open with individuals about the personal information held about them. Of the 1392 SARs completed in this period 80% were responded to within the required 40 day timescale.

## Plans for 2017/18

The following Information Governance objectives are to be considered for 2017/18:

- to continue to achieve minimum Level 2 compliance against the Information Governance Toolkit and review the percentage of requirements achieving Level 3
- to deliver a new training strategy for information governance and cyber security management to incorporate GDPR
- to revise and further embed the Data Protection Impact Assessment process
- to ensure appropriate expertise and staffing levels are in place to meet Trust/STP objectives
- to consider the implications of the new General Data Protection Regulations (GDPR) which comes into force on the 25 May 2018. GDPR Work streams are being developed in collaboration with colleagues in Cumbria Partnership to identify actions, gaps and risks for each organisation.
- to improve health outcomes and the quality of patient care through digital technology and innovation. The NHS will be paperless by 2020 ("Personalised Health and Care 2020"), and the Trust is working with partners across the STP to deliver a “Digital Roadmap
- to improve compliance with IAO/IAA training levels in association with CPFT
- to review cyber security incidents on a monthly basis
- increase the technical measures employed to protect the network and to ensure cyber resilience in the event of a successful compromise.
- to escalate any risks or areas of concern to the IM&T Group and in the case of any significant security incidents to report these directly to Trust Board.

## Recommendations:

The Board is asked to

- note the assurances provided in this paper
- note the proposed information governance objectives for 2017/18
### Executive Summary:

The Caldicott Guardian has a key role in ensuring that the Trust achieves the highest practical standards for handling patient information. This includes representing and championing confidentiality requirements and issues at Board Level, and wherever appropriate within the Trust’s overall governance framework.

The key Caldicott Guardian responsibilities as defined in the Department of Health Caldicott Guardian Manual (2006) are:

1. Strategy and Governance
2. Confidentiality and Data Protection expertise
3. Internal Information Processing
4. Information Sharing

This report is required annually as a summary of the work undertaken in this role.

### Strategic Priority and BAF Link:

<table>
<thead>
<tr>
<th>Strategic Priority and BAF Link</th>
<th>Strategic Priority:</th>
<th>List below the associated risk in relation to the Strategic Priority:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Strategy and System</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Operational Flow and Delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Patient and Staff Experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Workforce and Leadership</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Patient Safety and Quality</td>
<td>To ensure that the Trust achieves the highest practical standards for handling patient information.</td>
<td></td>
</tr>
</tbody>
</table>
### Actions required by the Board:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>To approve:</td>
<td>Discussion and decision</td>
</tr>
<tr>
<td>To note:</td>
<td>Where the Board is made aware of key points but no decision required</td>
</tr>
<tr>
<td>For information:</td>
<td>For reading and consideration and for discussion by exception only</td>
</tr>
</tbody>
</table>

The Board is requested to note the report.

### Data quality:

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source:</td>
<td></td>
</tr>
<tr>
<td>Validated by:</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
</tbody>
</table>
1. **INTRODUCTION**

The Caldicott Guardian has a key role in ensuring that the Trust achieves the highest practical standards for handling patient information. This includes representing and championing confidentiality requirements and issues at Board Level, and wherever appropriate within the Trust’s overall governance framework.

A key role of the Caldicott Guardian is to ensure that the Trust balances the need to protect people’s confidentiality with the need to protect their welfare; by ensuring that information is safely communicated among the various professional teams caring for an individual, sometimes across organisational boundaries.

The key Caldicott Guardian responsibilities as defined in the Department of Health Caldicott Guardian Manual (2010) are:

<table>
<thead>
<tr>
<th>Strategy &amp; Governance</th>
<th>Confidentiality &amp; Data Protection expertise</th>
<th>Internal Information Processing</th>
<th>Information Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Caldicott Guardian should champion confidentiality issues at Board/senior management team level, should sit on an organisation’s Information Governance Board/Group and act as both the ‘conscience’ of the organisation and as an enabler for appropriate information sharing.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Caldicott Guardian should develop a knowledge of confidentiality and data protection matters, drawing upon support staff working within an organisation’s Caldicott function but also on external sources of advice and guidance where available.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Caldicott Guardian should ensure that confidentiality issues are appropriately reflected in organisational strategies, policies and working procedures for staff. The key areas of work that need to be addressed by the organisation’s Caldicott function are detailed in the Information Governance Toolkit.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Caldicott Guardian should oversee all arrangements, protocols and procedures where confidential patient information may be shared with external bodies both within, and outside, the NHS and CSSRs. This includes flows of information to and from partner agencies, sharing through the NHS Care Records Service (NHS CRS) and related new IT systems, disclosure to research interests and disclosure to the police.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
This report is produced annually as a summary of the work undertaken in this role.

2. REPORT ON COMPLIANCE IN 2016/17

1) Strategy and Governance

The Caldicott Guardian chairs the IM&T Group and is Vice Chair of the Information Governance Group.

All reported confidentiality incidents are subject to timely investigation and review of mitigating action at weekly meetings of the Governance Delivery and Scrutiny Groups. Serious Information Risk Incidents (SIRIs) are further reviewed at meetings held between the Caldicott Guardian and Senior Information Risk Owner.

A serious untoward incident was reported to the Information Commissioner’s Office (ICO) in September 2016 (Reference IGI/6175). In September the Trust became aware that a Standard Operating Procedure (SOP) provided in response to a Freedom of Information request, and uploaded to the Trust’s public website (FoI responses section) in February, included an appendix which contained patient information. The Trust immediately removed the document, contacted the patients concerned and notified the Information Commissioner’s Office. The ICO reviewed the Trust’s response to the incident and informed the Trust in November that no further action was required.

2) Confidentiality and Data Protection expertise

The Caldicott Guardian works closely with the Data Protection Officer/Information Governance lead and is supported by the Trust’s Information Governance and Information & Cyber Security Officers.

3) Internal Information Processing

Information Governance and Information Security Policies and Procedures have been updated through 2016/17, and progress reported through the Information Governance Group.

Subject Access Requests under the Data Protection Act 1998 are managed through the Subject Access Team. The Trust aims to complete 85% of all requests within the 40 days target required by the Act. In 2016/17 the average compliance rate was 80%, an improvement on the previous year’s 72%. Changes to Subject Access processes have contributed to the Trust’s progress in this area of compliance.

4) Information Sharing

During 2016/17 the Trust’s Information Sharing Agreements were kept under review and updated as necessary, and reported through the Information Governance Group. In addition, the Trust has joined the Information Sharing
Gateway (ISG) which was developed by a number of organisations in Lancashire and Cumbria to administer and risk assess information sharing in the public sector.

3. PLANS FOR 2017/18

Development priorities for the year ahead relating to the Caldicott role include:

a) General Data Protection Regulation (GDPR)
GDPR comes into force in May 2018. The Information Governance functions in Cumbria Partnership and North Cumbria University Hospitals NHS Trust will develop a work programme to ensure compliance with the requirements of GDPR. Key elements of the programme will be around the following themes:

- Changes to consent
- Right to be “forgotten”
- Data Portability
- Contracts and Purchasing
- Amendments to Subject Access Request processes
- Data Portability

Graham Putnam
CALDICOTT GUARDIAN
APPENDIX A: THE TRUST’S COMMITMENT TO THE CALDICOTT PRINCIPLES

1) **Justify the purpose(s).** Every proposed use or transfer of personal confidential data within or from the Trust will be clearly defined, scrutinised and documented, with continuing uses regularly reviewed, by the Caldicott Guardian.

2) **Don’t use personal confidential data unless it is absolutely necessary.** Personal confidential data items will not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified will be considered at each stage of satisfying the purpose(s).

3) **Use the minimum necessary personal confidential data.** Where use of personal confidential data is considered to be essential, the inclusion of each individual item of data will be considered and justified so that the minimum amount of personal confidential data is transferred or accessible as is necessary for a given function to be carried out.

4) **Access to personal confidential data should be on a strict need-to-know basis.** Only those individuals who need access to personal confidential data will have access to it, and they will only have access to the data items that they need to see.

5) **Everyone with access to personal confidential data should be aware of their responsibilities.** Those handling personal confidential data (both clinical and nonclinical staff) will be made fully aware of their responsibilities and obligations to respect patient confidentiality.

6) **Comply with the law.** Every use of personal confidential data will be lawful. The Caldicott Guardian will be responsible for ensuring that the organisation complies with legal requirements.

7) **The duty to share information can be as important as the duty to protect patient confidentiality.** Health professionals will have the confidence to share information in the best interests of their patients within the framework set out by these principles. They will be supported by the policies of the Trust, regulators and their professional bodies.
APPENDIX B: INFORMATION GOVERNANCE SUMMARY

a) Information Governance Toolkit annual submissions

Information Governance Toolkit 2016/17 (version 14) by initiative

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Score</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Governance Management</td>
<td>93%</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>Confidentiality and Data Protection Assurance</td>
<td>81%</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>Information Security Assurance</td>
<td>75%</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>Clinical Information Assurance</td>
<td>100%</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>Secondary Use Assurance</td>
<td>100%</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>Corporate Information Assurance</td>
<td>77%</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>Overall</td>
<td>85%</td>
<td>Satisfactory</td>
</tr>
</tbody>
</table>

Information Governance Toolkit annual submissions from 2014

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Stage</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version 14 (2016/17)</td>
<td>Published</td>
<td>85%</td>
</tr>
<tr>
<td>Version 13 (2015/16)</td>
<td>Published</td>
<td>85%</td>
</tr>
<tr>
<td>Version 12 (2014/15)</td>
<td>Published</td>
<td>85%</td>
</tr>
<tr>
<td>Version 11 (2013/14)</td>
<td>Published</td>
<td>85%</td>
</tr>
</tbody>
</table>

b) DPA Section 14 issues ("Rectification, blocking, erasure and destruction")

The Trust had one DPA Section 14 issue in 2016/17: A&E clinical information challenged by the patient concerned. Comment was added to the health record.

c) Information Security Incidents relating to patient information:

The IG SIRI categories are determined by the context, scale and sensitivity of the information involved. Level 2 SIRIs involve either large numbers of patients, and /or highly sensitive information which is likely to cause substantial damage or distress to the individuals concerned. Where a similar incident has occurred in the previous 12 months the SIRI level will be higher than it would otherwise.

Table 1: IGSIRI level 2

<table>
<thead>
<tr>
<th>Date of incident (month and year)</th>
<th>IG Incident Reference</th>
<th>Nature of incident</th>
<th>Nature of data involved</th>
<th>Number of data subjects potentially affected</th>
<th>Notification steps</th>
</tr>
</thead>
</table>
August 2016  IGI/6175

Standard Operating Procedures (SOP) provided in response to a Freedom of Information Request was uploaded to the Trust's website in February 2016. Notified by a member of staff on 11/08/2016 that the document's appendix contained patient information (breach of patient confidentiality)

The SOP contained an appendix with a table containing 47 patient's information, comprising the following data items:
• Patient name
• Patient Date of Birth
• Hospital Number
• Imaging Request Date
• Histology request reference
• Tumour Site
• Consultant
• 62 Day target date

ICO notified 14/09/2016. ICO informed the Trust that no further action was required 14/11/2016

Table 2: IG SIRI level 1
IG SIRI level 1 incidents involve small numbers of patients and / or information that is unlikely to identify individuals.

<table>
<thead>
<tr>
<th>Category</th>
<th>Breach Type</th>
<th>2016/17 Total</th>
<th>2015/16 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Corruption or inability to recover electronic data</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>B</td>
<td>Disclosed in Error</td>
<td>48</td>
<td>65</td>
</tr>
<tr>
<td>C</td>
<td>Lost in Transit</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>D</td>
<td>Lost or stolen hardware</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>E</td>
<td>Lost or stolen paperwork</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>F</td>
<td>Non-secure disposal – hardware</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>G</td>
<td>Non-secure disposal – paperwork</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>H</td>
<td>Uploaded to website in error</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>I</td>
<td>Technical security failing (including hacking)</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>J</td>
<td>Unauthorised access / disclosure</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>K</td>
<td>Other</td>
<td>4</td>
<td>13</td>
</tr>
</tbody>
</table>

d) Information Governance (IG) Training 2016/17

IG training is available to staff through an e-learning package and by workbook on staff web. All new staff (with the exception of locums on less than 90 day contract) receive IG training on day one of the Induction programme. The Education Department has a process in place to ensure that short-term locums receive IG training prior to starting work within the Trust.

Induction training involves a 30-minute session which covers staff responsibilities for confidentiality, the Caldicott Principles, and requirements of the Data Protection Act.

Information Governance sessions are provided within the IHRIM Certificate in Technical Competence programme which runs annually.

The Trust's final IG training compliance rate was 94% for 2016/17.
## Executive Summary:

(Key points/main issues, i.e. top 3, key risks and implications)

1. Research activity in 2016/17, as measured by patient recruitment into National Institute for Health Research (NIHR) National Portfolio studies recruited 859 participants against a trust target of 755.

2. The Trust Research & Development (R&D) Committee was formed during the year and held its inaugural meeting on 31\textsuperscript{st} January 2017, giving the Trust governance oversight of research activity.

3. The ability to continue to deliver research activity at current levels and increase activity remains at risk due to high turnover of clinical staff able to take on the role of Principal Investigator for interventional studies.

4. The process to bring together the R&D systems in NCUH and CPFT has begun with the appointment of an interim joint Director of R&D. This offers a significant opportunity to develop a system that reflects the developing structure of services in NWE Cumbria and to raise the profile of R&D as a vehicle for collaboration and innovation within the STP.

### Strategic Priority and BAF Link:

<table>
<thead>
<tr>
<th>Strategic Priority</th>
<th>List below the associated risk in relation to the Strategic Priority:</th>
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<tr>
<td>1. Strategy and System</td>
<td>A strong R&amp;D department is essential to improve the standing of the Trust nationally, to improve consultant recruitment and to improve the quality of care to patients.</td>
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<td>2. Operational Flow and Delivery</td>
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<td>5. Patient Safety and Quality</td>
<td>A strong R&amp;D department is essential to improve the standing of the Trust nationally, to improve consultant recruitment and to improve the quality of care to patients.</td>
</tr>
</tbody>
</table>

**Financial implications:**
The R&D Department is largely self-funding from external sources (predominately the North East and North Cumbria Clinical Research Network and commercial research funding). There is considerable opportunity to use the income from research activity to invest in processes to engage senior clinical staff in research and innovation activity within the trust.

**Actions required by the Board:**

| To approve: | Discussion and decision |
| To note: | Where the Board is made aware of key points but no decision required |
| For information: | For reading and consideration and for discussion by exception only |

The Board is requested to note the report.

**Data quality:**

| Source: | NIHR Open Data Platform (ODP) |
| Validated by: | NIHR Portfolio Management Systems |
| Date: | |

|  |  |
1. INTRODUCTION

Research is essential to generate new knowledge for the benefit of patients, the modernisation and promotion of services in the NHS and the development of evidence-based patient care. There is evidence from a number of sources that engagement by clinicians and healthcare organisations in research improves healthcare performance at various levels (Boaz et al 2015) and that those NHS Trusts which contribute to delivery of clinical research have better mortality outcomes (Bennet et al 2012; Ozdemir et al 2015).

The NHS Constitution, March 2013 sets out principles that guide the NHS in its commitment to the promotion, conduct and use of research to improve the current and future health and care of the population. The Health & Social Care Act, 2012 places a duty on Secretary of State such that in exercising functions in relation to the health service, the Secretary of State must promote research on matters relevant to the health service. Successive NHS Operating Frameworks from 2011/12 set out the importance of research to the NHS, including confirming that the promotion and conduct of research is a core NHS function.

In 2006 the National Institute for Health Research (NIHR) was created under the 2005 Government strategy for health research: Best Research for Best Health. This was largely in response to the Academy of Medical Sciences report that indicated critical challenges to the health research environment in England, including inadequate support and collaboration with the life sciences industry for the benefit of patients and the public. The NIHR became responsible for management of the Department of Health research budget, which is currently distributed to Trusts via 15 Clinical Research Networks (CRNs). Income distribution is based on activity levels in terms of volume and quality of research undertaken.

In 2016/17 external income from both the North East & North Cumbria CRN (NENC CRN) and funded Clinical Trials (both commercial and non-commercial) supported a team of 20 Research nurses, practitioners, administrators, a number of research Programmed Activities (PAs) for research active clinicians, and funding for pharmacy, pathology and radiology support services.
2. PERFORMANCE

Recruitment

In 2016/17 the Trust recruited to 52 (2015/16, 73) research studies that are included in the NIHR Portfolio – this comprises high quality research that is fully funded and has undergone rigorous peer review.

Patient recruitment into NIHR National Portfolio studies reached 859 (2015/16, 1,962) participants against a target of 755. Whilst this was a significant reduction in recruitment from the previous year, there were no single high recruiting study open, although patients recruited to high recruiting studies in previous years required follow-up data collection. The underlying trend, once high recruiting studies is removed is relatively stable:

Throughout the year there has been a focus on closing studies that the Trust has been unable to recruit to, and on only opening new studies with realistic delivery targets, i.e. a shift towards quality from quantity. This is in line with NIHR High Level Objectives to improve performance in relation to recruitment to time and target

The Trust achieved a number of successes during the year, including:

- For the second year in succession, highest recruiting site nationally to CORGI – a genetics study into colorectal tumours.
- Achieved recruitment of 234 against a target of 130 to a commercially sponsored study looking at a test to aid in the diagnosis of bladder cancer
• Overall 4th highest recruiting Trust of 25 recruiting to the ERIC PPCI (Cardiology) trial. Recruitment to date is at 88 participants, against a contracted target of 60.

• NCUH was the second Trust nationally to recruit to Dex Enceph – a study looking at dexamethasone in the treatment of herpes simplex virus encephalitis

• Achieved recruitment target for the following studies that closed during the year:
  
  o MCM5 bladder
  o ROSE ACS
  o EUROPA
  o PAUSE-P
  o After Francis
  o CISKO
  o UK Meningitis
  o EVRA

**HRA Approval**

In line with the introduction of HRA Approval, the new national process for approval of new studies, systems have been put in place locally to enable more accurate assessment of ‘Capability & Capacity’ and more intelligent setting of targets to improve performance at a local level, both in terms of overall recruitment and quality of delivery.

**National Benchmarking**

Since 2014/15 the Trust has been subject to national benchmarking relating to Performance in the Initiation and Delivery of Clinical Trials (PID).

Performance in Initiation by the Trust has improved with new systems in place and research staff being made aware of targets. The table below shows performance against the Initiation target from Q1 2015/16.
NB studies where failure to meet the initiation target is attributable to the sponsor or neither the sponsor nor Trust, are excluded.

Performance against the Delivery target – recruitment to time and target for Commercial sponsored clinical trials, has similarly improved, with performance at 50% at Q3 2016/17 against a national rate of 52.6% as can be seen in the table below:

Finance

In 2016/17 the R&D Department received external income in excess of £800k, made up as follows:

NENC Clinical Research Network (CRN) £690,275
This funding supported 18 research delivery staff, 5.35 Consultant research PAs (split between 14 Consultants) and 2.2WTE support services staff (pharmacy, pathology & radiology).

**Infrastructure**

It was with great sorrow that the R&D Department noted the passing away of Dr Jim George, R&D Director/Clinical Lead, in January 2017.

Professor Janusz Jankowski was appointed Director of R&D in June 2016. However, he left the role, and the employment of the Trust on 31 January 2017. Professor Dave Dagnan was appointed on an interim basis to a new post of joint Director of R&D for NCUH and Cumbria Partnership NHS Foundation Trust from 1 April 2017.

All research studies require a local Principal Investigator who carries responsibility for the conduct of the study at site. For studies falling within the Medicines for Human Use (Clinical Trials) Regulations the Investigator should be medically qualified. The relatively high turnover of substantive and high number of locum consultant posts within the Trust remains a threat to research activity, making it a challenge to grow the portfolio for these studies. This is particularly the case for commercially contracted trials.

Accommodation for R&D activities at both sites remains challenging. The team at Carlisle is spread over 3 different locations. This makes cross-cover for studies and administrative support difficult to deliver. There are also desk shortages when the whole team is on site. In addition, there is no dedicated research clinic space at Carlisle. Dedicated clinic space would allow some patients to be seen for research visits without taking up Out Patient space and time.

At Whitehaven the team remains based in the staff hostel. There is a small dedicated clinic room within this facility that has enabled the team to see patients enrolled on the REVEAL (lipid-modification trial in patients with established vascular disease) outside of the Out Patient Department. This is better for patients and staff and more cost-effective to the Trust.

Discussions have, however, been held with the Estates team and UCLAN to build a new research facility at Whitehaven as part of the Phase 3 development.

**Trust oversight**

A new R&D Committee was formed during the year and held its inaugural meeting on 31st January 2017. This Committee will have oversight of
research activity including performance and safety, as well as be responsible for driving forward the R&D Strategy. Committee members include representation from partner organisations including Cumbria Partnership, the NENC CRN, UCLAN and Cumbria University, as well as representation from research-activity clinical specialties.

3. **COST BENEFITS**

The promotion and conduct of research is a core NHS function.

The Research & Development Department is currently entirely self-funding, and whilst the Trust ‘nominally’ contributes 0.4WTE of the R&D Manager salary, in reality this has been covered by external income generated by the R&D team year on year.

As well as the core team, research active consultants’ time is funded by the NIHR CRN by way of research PAs, and core support functions (pharmacy, pathology & radiology) are also funded direct from the R&D budget.

In addition to income generated, there are further, more hidden, cost benefits to the Trust from supporting research. As well as improved patient experience and mortality rates, there are financial and other benefits to Trust departments. These include training in new techniques and therapies from trial sponsors, equipment donation and financial savings for pharmacy.

4. **FUTURE DIRECTION**

There is now agreement from CPFT, NCUH and the NE and North Cumbria Clinical Research Network (CRN) that the creation of a single R&D structure for NWE Cumbria offers a number of advantages and opportunities. In particular it offers an opportunity to engage patients across the clinical pathways from primary through to specialist secondary care in high quality research projects and to develop significantly collaborative approaches to R&D activity. The CRN is keen to support Cumbria to developing innovative approaches to collaborative R&D activity as it sees NEW Cumbria at the leading edge of new ways of working in this field. Over time, this has the potential to become a unique aspect of services in NWE Cumbria and contribute to recruitment, retention and engagement of clinicians in STP footprint.

A proposal for the new structure and the goals and potential benefits of this approach will be developed for October 2017 with a view to implementation early in 2018.

5. **CONCLUSIONS**

North Cumbria University Hospitals continues to deliver a healthy portfolio of research studies, and continues to be entirely self-funding. A strong R&D
department is essential to improve the standing of the Trust nationally, to improve consultant recruitment and to improve the quality of care to patients.

There is a relatively research naïve population in North Cumbria, providing great scope to grow R&D activity. By working closely with other healthcare providers in the region, in primary and secondary care, there are opportunities to provide cross-service access to research for our patients. This will open up the opportunities for a relatively research naïve patient population to have access to cutting edge care. The first move towards providing an integrated service is the appointment of a joint Director of R&D for NCUH and Cumbria Partnership.

6. RECOMMENDATIONS

The Board is asked to note the report.

7. KEY REFERENCES


Websites:
NIHR CRN North East & North Cumbria, [http://www.crn.nihr.ac.uk/about_us/local_clinical_research_networks/nencumbria](http://www.crn.nihr.ac.uk/about_us/local_clinical_research_networks/nencumbria);
Report to a Meeting of the Trust Board of Directors held in Public

<table>
<thead>
<tr>
<th>Date of Meeting:</th>
<th>25 July 2017</th>
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<tr>
<td>Enclosure Number:</td>
<td>18</td>
</tr>
<tr>
<td>Title of Report:</td>
<td>Declarations of Interest</td>
</tr>
<tr>
<td>Author:</td>
<td>Jacky Stockdale, Company Secretary</td>
</tr>
<tr>
<td>Executive Lead:</td>
<td>Gina Tiller, Chair</td>
</tr>
<tr>
<td>Responsible Sub-Committee (if appropriate):</td>
<td>n/a</td>
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**Executive Summary:**
In accordance with the Standing Orders, the Trust is required to have in place an up to date Register of Interests for Trust Board Directors. This Register is appended to this report.

<table>
<thead>
<tr>
<th>Strategic Priority and BAF Link:</th>
<th>Strategic Priority:</th>
<th>List below the associated risk in relation to the Strategic Priority:</th>
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<tbody>
<tr>
<td>1. Strategy and System</td>
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<td>2. Operational Flow and Delivery</td>
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<td>3. Patient and Staff Experience</td>
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<td>4. Workforce and Leadership</td>
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<td>5. Patient Safety and Quality</td>
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**Financial implications:**

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<th>Discuss and decision</th>
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<tbody>
<tr>
<td>To note:</td>
<td>Where the Board is made aware of key points but no decision required</td>
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<tr>
<td>For information:</td>
<td>For reading and consideration and for discussion by exception only</td>
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The Board is requested to note the Declaration of Interest Register.

**Data quality:**

<table>
<thead>
<tr>
<th>Source:</th>
<th>J Stockdale</th>
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<td>Validated by:</td>
<td>J Stockdale</td>
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<tr>
<td>Date:</td>
<td>17 July 2017</td>
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## TRUST BOARD - DECLARATIONS OF INTEREST REGISTER: JULY 2017

| Name                      | Directorships, including Non-Executive Directorships held in Private Companies or PLcs | Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS | Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS | A position of authority in a charity or voluntary organisation in the field of health and social care | Any connection with a voluntary or other organisation contracting with NHS Services | Research funding/grants that may be received by an individual or their department | Interests in pooled funds that are under separate management | Membership of any public body, organisation, charity or pressure group whose work is related to the business of the Trust | Donations and Sponsorship | Other Interests |
|---------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|
| Gina Tiller (Chair)       | No                                                                                     | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  |
| David Rawsthorne (Non Executive Director) | No                                                                                     | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  |
| Malcolm Cook (Non Executive Director)   | No                                                                                     | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  |
| Louise Robson (Non Executive Director)   | No                                                                                     | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  |
| David Kennedy (Non Executive Director)   | Degree Programme Director for Medicine and Surgery Undergraduate & Deputy Head of School of Medical Education, Newcastle University | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  |
| George Linton (Non Executive Director)   | Member of Scottish Fencing Ltd representing the governing body as President and I Chair the Board. Wife is Corporate Services Director of A Share and Sons Ltd, a major furniture retailer | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  |
| Stephen Eames (Chief Executive)          | No                                                                                     | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  |
| Louise Grieves (Director of Nursing & Midwifery) | No                                                                                     | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  |
| Rod Harper (Medical Director)            | No                                                                                     | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | Yes, daughter a senior lawyer at Capsticks  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | I am employed by Humberside HC FT and seconded to NUCH. STP Lead for West, North & East Cumbria | No                                                                                                                                  |
| Helen May (Chief Operating Officer)       | No                                                                                     | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  |
| Robin Andrews (Director of Finance)       | Yes                                                                                     | Director, own PSC. RKA Contracting Ltd. Likely to wind company up as now on NHS Payroll.                                           | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  |
| Debbie Booth (Director of HR&D) Non-voting Director | No                                                                                     | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  | No                                                                                                                                  |

Enc 18 - Copy of Declarations of Interest Register July 2017.xls

1 of 1
MINUTES OF THE SAFETY AND QUALITY COMMITTEE HELD ON TUESDAY 13 JUNE AT 2PM VIA VC LINK BOARDROOM CIC, BOARDROOM WCH

Present: Laura Robson, Non-executive Director, Chair
        George Liston, Non-executive Director
        David Rawsthorn, Non-executive Director
        David Kennedy, Non-Executive Director
        Ramona Duguid, Director of Governance
        Maurya Cushlow, Executive Director of Nursing
        Dr Rod Harpin, Executive Medical Director
        Bill Glendinning, Chief Pharmacist
        Dr Clive Graham, Associate Medical Director & Director of Infection, Prevention and Control
        Claire Thompson, Governance Facilitator
        Andrea Tomlinson, Chief Matron Surgery
        David Kennedy, Non-Executive Director
        Sara Jones, General Manager
        Donna Beecher, Governance Facilitator
        Liz Klein, Head of Nursing - Clinical Standards
        Yvonne Fairbairn, Associate Chief Operating Officer
        Ajith Wijesiriwardana - Consultant & Clinical Director

Present via VC: Anna Stabler, Deputy Director of Nursing
                 Richard Heaton, Lead Matron, Surgical and Critical Care Division
                 Diane Murchison, Matron Critical Care
                 Christina Cuncarr, Associate Director of Midwifery
                 Linda Bell, Risk Governance Manager, Maternity

In Attendance: Laura Beattie, Executive PA
               Sue Murray, Executive PA
               Sheena Bossche, Patient Relations Manager

S&Q220/17 APOLOGIES AND DECLARATIONS OF INTEREST

Mrs Robson welcomed everyone to the meeting.

Apologies were received from:

Georgia Wright, Head of Nursing for Patient Experience
Jane Taylor, Clinical Governance Facilitator
Lynn Anderson, Lead Matron, Emergency Care and Medicine Division
Claire Moore, Lead Matron, Child Health
Mike Stacey, Information Analyst Manager
S&Q221/17 MINUTES OF THE LAST MEETING

- Minutes of the June meeting were reviewed by Mrs Duguid and changes will be updated along with the action list.

  Action: L Beattie to amend minutes to reflect required corrections.

S&Q222/17 MATTERS ARISING AND ACTION LIST

- The action list was updated and will be circulated with the minutes.

S&Q223/17 GOVERNANCE

Governance Framework & TOR:

- Mrs Duguid gave a detailed summary of the report advising that the last detailed review took place in 2015 with minor updates being done in January of 2016, however the framework still contained inaccuracies which required updating.
- Mrs Duguid stated that a large number of groups report into the Committee and clarity was required as to how these groups report.
- It was noted that it is necessary to make some changes to membership of the Committee.
- Mrs Duguid advised that this should not be an operational meeting and the divisional dashboards should be discussed and owned at the divisional governance boards. The new Divisional Quarterly reviews, which commence from Q1 will assist with the scrutiny and review of governance in practice across the clinical divisions. Mrs Duguid advised she requires any feedback from members around this paper no later than the 23rd of June.
- D Rawsthorn advised that the list of Committee members should be reduced as it is very high when compared with other Committees such as the Audit and Risk Committee. D Rawsthorn also noted that he does not see Executive Directors in attendance as much as he would like to. Mr Liston agreed that there should be two Executive Directors present at each meeting in order to be Quorate and also stated that there seems to be a lack of engagement from Executive Directors.
- A discussion took place around Executive Director’s attendance and Dr Harpin suggested that reducing members to 2 Executive Directors & 3 Non-Executive Directors would create a tighter Committee.

  Action: Committee Members to review the governance framework & TOR and provide any comments to RD by 23rd June.
CQC Monitoring Framework:

- Mrs Duguid summarised the report highlighting significant changes for the Trust and noting that this is the initial draft regarding what is monitored across the Trust in relation to CQC Regulations and outcomes. Mrs Duguid also requested any feedback regarding this paper from the Committee by the end of June.
- Mrs Duguid added that the national changes to the inspection regime and the ongoing monitoring of the Trust meant that clarity on where the CQC standards are monitored and reviewed was important.
- Ms Cushlow suggested that going forward it could be beneficial to select one key line of enquiry each month and perform a deep dive exercise in order to be CQC ready. Mrs Duguid agreed that this could be built into the work plan for the committee during the year.

**Action:** Committee Members to review the CQC Monitoring Framework and provide any comments to RD by end of June 2017.

S&Q224/17 BUSINESS UNIT GOVERNANCE DASHBOARDS

Emergency Surgical & Elective Care:

- A Tomlinson summarised the report advising of a medication error on ward one which has resulted in follow up work taking place. It was also noted that there is currently a VTE compliance issue however A Tomlinson is unsure of figures so is looking further into.
- A Stabler stated that issues are originating from medics recording on infolox as they don’t use realtime – Ms Cushlow stated that issues are both medical and surgical and need to be looked into. Dr Harpin stated that he would take this to the new senior medics meeting and will work on an initial report with Dr Graham.
- D Rawsthorn requested that all dashboards should be consistent and the audit should be reflected on a clinical basis.

**Actions:**

Dr Harpin & Dr Graham to work on initial report regarding issues with VTE recording.

Surgical division to include the clinical audit performance in monthly dashboard.

Maternity:

- C Cuncarr and L Bell summarised the report advising that there had been a new case in June involving the death of a baby.
- It was noted that there are 49 cases in total being reviewed.
- C Cuncarr confirmed hot topics included Labour Ward Forums and an external reviewer working with Maternity.
- C Cuncarr advised she has met with ESR regarding training which she confirmed is currently 48% and on target.
- M Cushlow raised a query regarding benchmarking – L Bell advised they are currently having issues with the system.
- L Robson queried the issues around ultrasound scans – Y Fairbairn stated this is being looked at and a business case is being prepared for CEG which will increase ultrasound capacity.
- Mr Wijesiriwardana advised that Maternity are closing the gap regarding issues with scanning and radiographers are happy to be involved.

**Child Health:**

- S Jones summarised the report advising of three ongoing Serious Incidents and an issue with case conference minutes getting to consultants although confirmed that this is being worked on.
- S Jones noted that the infusion pumps for SCBU are now onsite and have progressed.
- It was noted that two risks relating to resuscitation are being amalgamated to reflect updates and this should be done within the next month or so – Ms Cushlow stated that this seems a long time to update a risk register and requested that S Jones bring this forward to the next meeting regarding these specific risks.
- Mrs Duguid stated that it is important to be clear on how effective controls to mitigate this risk are working in practice and what the gaps actually are.
- Mrs Duguid confirmed that this would be included in the monthly risk report to CEG for escalation.
- D Kennedy queried how we check learning in relation to trends on incidents within the divisions – Mrs Duguid advised that the quarterly and year to date positions would be included in the new data packs for the quarterly divisional reviews.

**Action:** S Jones to bring forward date of completion for amalgamating two risks on the register to the July meeting

**Emergency Care & Medicine:**

- D Murchison summarised the report noting that there had been 10 complaints in April however no themes were present. 59 PALS enquiries had been placed and the main topics on the risk register were dermatology and oncology services, consultant capacity and cancer scripts.
- Ms Cushlow noted that those that have become complaints have been picked up at the patient safety panel.

S&Q225/17 **PATIENT EXPERIENCE**

**Monthly Complaints Performance Report:**

- S Bossche summarised the complaints report and advised that there were currently 26 active complaints within the Trust, 23 new, 3 returned. It was noted that there were no recurring themes or trends and the Trust has achieved 100% compliance regarding turnaround for the ninth consecutive month.
• D Kennedy stated that after reading the report he would find it helpful to see a follow up to illustrate any learning and how the complaint was resolved. S Bossche confirmed she would prepare and action plan to highlight this going forward.
• G Liston queried how we measure learning as a Trust – S Bossche stated that she links directly with the teams and Ms Cushlow stated that Georgia Wright is working with S Bossche with regards to patient experience and how this report can be joined together with the patient experience report to focus on themes and learning.

**National Inpatient Survey 2016 Results**

• Mrs Stabler reported that the Trust has maintained our position on last year and confirmed the same issues have arisen with regard to communications and planning. It was noted that G Wright has set up a patient information group to tackle these issues.
• D Rawsthorn raised a query around the results in section 4.2 of the report with Mrs Stabler advising that the task and finish group will provide the Committee with an action plan to clarify.

**Action:** Mrs Stabler to ensure the task and finish group provide action plan to the Committee for assurance purposes.

**Friends & Family Test Update**

• Mrs Stabler reported that there had been a date error in regards to the friends and family test scores as had been showing a decline. It was noted that the correct figure is actually 96.8%.
• It was reported that there is a reasonable response rate however obtaining figures from A&E can be challenging as most patients are keen to leave. Mrs Stabler advised the Committee that details around moving to the text service will be presented to CEG and implemented across the Trust.

**S&Q226/17 PATIENT SAFETY & QUALITY**

**Patient Safety Panel Report:**

• Dr Harpin summarised report highlighting an insulin incident (4611) which has also been included in B Glendinning’s report. Dr Harpin reported that this has been picked up out with the patient safety panel and work is underway to address via further mandatory training outside core topics. Dr Harpin also discussed incident 5427 around a delay in treatment in relation to a patient suffering from lung cancer advising that this has been picked up and will be reviewed by the Patient Safety Panel in October 2017.

**Infection Control Report:**

• Ms Cushlow provided the Committee with an outline of the full report and confirmed that the MSSA regarding cannulation approach is in line with IPC procedure. Ms Cushlow asked the Committee to note that the NM & AHP Board are working to relieve wards of pressure with regard to compliance. Mr Rawsthorn
queried whether this report was for approval or noting – Ms Cushlow advised just for noting.

- Ms Cushlow and Dr Harpin held a discussion regarding training during which Mrs Stabler stated that ENT should be in place. Ms Cushlow concluded that core medical and nursing training should be the same.
- Mr Liston raised a query around the bay doors – Ms Cushlow confirmed this is being picked up under fire rectification plans.

15 Steps Monthly Update:

- Mrs Klein reported that all key lines of enquiry have improved however there are currently issues around the checking of resus trolley and work is ongoing around cleaning and medication.
- Mrs Klein confirmed that there have been some issues with regard to DNACPR forms however the Trust is in the process of moving to the RESPECT form which Dr Harpin advised needs to be done across the board with a focus on capacity and documentation.
- Ms Cushlow requested for the key lines of enquiry currently facing challenges to be picked out and to be addressed via some targeted work and an update to be given to the Committee at the September meeting.

Action:

Mrs Klein to identify KLOE’s requiring improvement and perform some targeted work to drive improvement.

QIP 2017/18

- Mrs Duguid advised the Committee that this paper was solely to note but she was happy to take any questions – no questions were raised. A detailed report on the Q1 position would be presented at the July meeting.

Q4 Medication Safety Report

- B Glendinning summarised the report and advised the Committee were requested to note the grey areas being due to updates which will be provided when S Murphy returns from annual leave.

- B Glendinning reported that medicines mandatory training is improving now at 84% however concurred with Dr Harpin that following the incident involving insulin further training is required.

- B Glendinning requested the Committee to note that the NPSA Alert relating to open injectable medicines is still being worked on by S Murphy however he stated that he has been made aware that in both endoscopy and radiology there are cases of drugs being mixed in galipots and injected into patients. Dr Harpin stated that if this is in fact happening then full risk assessment must be completed in accordance with this alert and he will pick this up out with the Committee with B Glendinning
• Ms Robson queried where the issue of CAS Alerts sits within the Trust. Mrs Duguid advised that references to strengthening capacity had been made as part of the governance review, however investment was required. In the interim the existing arrangements remain with the CAS alert system being managed by the Health & Safety Team who report to the Assistant Director of Estates.

• Mrs Duguid confirmed that she is directly involved and supporting the health and safety team with the re-write of the CAS Alert Policy which would be circulated for consultation in the next few weeks.

• Mrs Duguid commented she would also review the timeline and process applied for this specific alert relating to open injectable medicines.

**Actions:**

Dr Harpin to liaise with Mr Glendinning in relation to the risk assessment around the issue of drugs being mixed in galipots before being injected into patients.

Mrs Duguid to identify who the CAS Alert around drugs being mixed in galipots was issued to and report back to the Committee in July.

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**S&Q227/17 ANY OTHER BUSINESS**

No other business was raised at the meeting.

**S&Q228/17 NEW RISKS IDENTIFIED/TO BE ESCALATED TO TRUST BOARD**

- Resus trolley issue
- CAS Alerts

**S&Q229/17 DATE, TIME AND LOCATION OF NEXT MEETING**

The next meeting would take place on Tuesday 11 July at 2pm, via VC Link Boardroom CIC/Boardroom WCH.