Northampton General Hospital NHS
NHS Trust

Public Trust Board

Thursday 27 November 2014

09:30

Board Room
Northampton General Hospital

Northampton General Hospital NHS
NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 27 November 2014
09:30 in the Board Room at Northampton General Hospital

Time		Agenda Item	Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2.	Declarations of Interest	Note	Mr P Farenden	**Verbal**
	3.	Minutes of meeting 25 September 2014	Decision	Mr P Farenden	**A.**
	4.	Matters Arising and Action Log	Note	Mr P Farenden	**B.**
	5.	Patient Story	Receive	Dr S Swart	**Verbal**
	6.	Chairman's Report	Receive	Mr P Farenden	**Verbal**
	7.	Chief Executive's Report	Receive	Dr S Swart	**C.**
10:00	**CLINICAL QUALITY AND SAFETY**				
	8.	Sign up to Safety	Decision	Mrs J Bradley	**D.**
	9.	Nurse Staffing Report	Assurance	Mrs J Bradley	**E.**
	10.	Director of Nursing and Midwifery Report	Assurance	Mrs J Bradley	**F.**
	11.	Medical Director's Report	Assurance	Dr M Cusack	**G.**
10:40	**OPERATIONAL ASSURANCE**				
	12.	Integrated Performance Report and Corporate Scorecard	Assurance	Mrs D Needham	**H.**
	13.	Finance Report	Assurance	Mr S Lazarus	**I.**
	14.	Workforce Report	Assurance	Mrs J Brennan	**J.**
11:15	**ANNUAL REPORTS**				
	15.	Fire Safety Annual Report	Assurance	Mr C Abolins	**K.**
	16.	Complaints Annual Report	Assurance	Mrs J Bradley	**L.**
	17.	Emergency Preparedness Annual Report	Assurance	Mrs D Needham	**M.**
11:45	**GOVERNANCE**				
	18.	Revised Terms of Reference for: • Audit Committee • Quality Governance Committee • Finance Investment and Performance Committee • Remuneration Committee • Trust Board	Decision	Mr P Farenden	**N.**

Time		Agenda Item	Action	Presented by	Enclosure
	19.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler	**O.**
	20.	Highlight Report from Quality Governance Committee	Assurance	Mrs L Searle	**P.**
	21.	TDA Self-Certification	Decision	Mr C Pallot	**Q.**
12:00	**22.**	**ANY OTHER BUSINESS**		Mr P Farenden	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Trust Board will be held at 09:30 on Thursday 29 January 2015 in the Board Room at Northampton General Hospital

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

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

The Themes for discussion in the closed agenda are: Contractual matters and Clinical Strategy

Northampton General Hospital NHS
NHS Trust

Minutes of the Public Trust Board

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

Present		
	Mr P Farenden	Chairman (Chair)
	Mrs J Bradley	Interim Director of Nursing, Midwifery & Patient Services
	Mr G Kershaw	Non-Executive Director
	Mr S Lazarus	Director of Finance
	Mrs D Needham	Chief Operating Officer
	Mr N Robertson	Non-Executive Director
	Mrs L Searle	Non-Executive Director
	Dr S Swart	Chief Executive Officer
	Dr M Wilkinson	Interim Medical Director
In Attendance		
	Mr C Abolins	Director of Facilities and Capital Development
	Mrs J Brennan	Director of Workforce and Transformation
	Mrs S McKenzie	Committee Secretary
	Mr C Pallot	Director of Strategy and Partnerships
	Mrs Sally-Anne Watts	Head of Communications (Agenda Items 19 and 20)
Apologies		
	Mr D Noble	Non-Executive Director
	Mr P Zeidler	Non-Executive Director (Vice Chair)

TB 14/15 063 Introductions and Apologies

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

Apologies for absence were recorded from Mr Noble and Mr Zeidler.

TB 14/15 064 Declarations of Interest

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

TB 14/15 065 Minutes of the meeting 31 July 2014

The minutes of the Trust Board meeting held on 31 July 2014 were presented for approval.

The Board resolved to **APPROVE** the minutes of the 31 July 2014 as a true and accurate record of proceedings.

TB 14/15 066 Matters Arising and Action Log 31 July 2014

The Matters Arising and Action Log from the 31 July 2014 were considered.

TB 14/15 011 Same Sex Accommodation Audit and Update

Mr Pallot advised that he would circulate detailed information with regard to the benchmarking information requested but confirmed that the Trust compared favourably. **Action: Mr Pallot**

The Board **NOTED** the Action Log and Matters Arising from the 31 July 2014.

TB 14/15 067 Patient Story

Dr Swart presented the Patient Story.

Dr Swart reported that complimentary messages received from patients were now being tracked. Staff who were complimented were passed on the message and also sent a thank you card.

Dr Swart informed the Board that with support and encouragement she had recently opened her own Twitter account @SoniaSwartCEO. Dr Swart commented that she was keen to use every resource available to improve communications with staff, patients and the public in order to let people know about positive comments or signpost things of interest. Dr Swart gave the Board a variety of examples of tweets she had made and compliments that had been received. Mr Farenden commented that it was nice to have a positive balance.

The Board **NOTED** the Patient Story

TB 14/15 068 **Chief Executive's Report**

Dr Swart presented the Chief Executive's Report.

Dr Swart informed the Board that on Wednesday 24 September at 5:45am five inspectors from the Care Quality Commission (CQC) arrived on site. They spent the whole day at the hospital and visited many wards and areas and examined a large number of documents. Their main purpose was to determine whether the Trust had addressed the issues they had raised in a series of warning notices from their visit earlier in the year.

Dr Swart reported that although the CQC had not yet issued the Trust with a formal report following their unannounced visit, the initial feedback from them was largely positive and they had not felt it necessary to arrange further visits in the immediate future. They acknowledged the huge amount of work that had been done since their visit in January and made a number of favourable comments in relation to the improvement that they saw. They had taken away a large amount of documentation to scrutinise further and would issue a report within the next 2 weeks.

The CQC inspectors raised one area of significant concern in relation to the Trust's policy for the use of bumpers and crash mats which related to vulnerable patients where cot sides or low beds were used for patients who were at risk of falling. Immediate action was requested and taken to correct this and confirmation sent in writing to the CQC. Mr Kershaw asked if this was a new action and Dr Swart commented that it was picked up on the visit and was policy related. Mrs Bradley confirmed that the risk assessment was a national one and it was now embedded in the policy.

Mrs Searle commented that it was good to hear a positive response from the CQC and that they had recognised the work that had been undertaken. Mrs Searle asked that congratulations be passed on to Mrs Corkerry and her team as a lot of work had gone into the Risk Register and Action Log. Mr Kershaw also offered congratulations to Dr Swart and her Executive Team.

Dr Swart informed the Board that the Annual General Meeting (AGM) would be held at 6pm on Monday 29 September in the main Lecture Theatre, Cripps Postgraduate Centre and that this year the AGM would have a different format in that the majority of the presentation would be included within an interactive film. The aim was that, following the AGM the film would be available via the Trust's website and intranet for staff and members of the public to watch at a time to suit them.

The Board were informed that meetings with a different style had been set up with the Commissioners to include their Contracting and Finance Leads with the aim of improving discussions about funding. It was essential to collaborate effectively across the health and social care economy in order to plan for future sustainability and having meaningful discussions with Chief Executives, Finance Directors and Contract Managers from Commissioners and Providers in the room together was a good start.

Dr Swart reported that Chief Executives (CEOs) continued to meet weekly to oversee progress on the health economy collaboration work between Providers and Commissioners of Health and Social Care. Yesterday the CEOs jointly presented proposals to the regulators on their collaborative work with Kettering on clinical collaboration and other projects related to Healthier Northamptonshire. The regulators supported that the process should continue with the collaborative approach. Dr Swart mentioned that Mr Pallot had done a lot of collaborative work with Kettering General Hospital (KGH) on the clinical strategy.

The Nursing and Midwifery Conference on 9 September had proved to be a very successful day. The Senior Nursing Team led by Jane Bradley organised some very inspiring presentations which reflected the Trust's achievements and aspirations for the future. There was a real appetite for change as well as a realisation that there had been some fantastic work at Northampton General Hospital (NGH) that should be built on. The audience were given a perspective check as they listened to the voluntary work done in Zimbabwe led by one of the Trust's midwives and the conference ended with a moving presentation from one of its nurses who asked for reflection on the power and value of nursing as he told a very personal story.

Dr Swart commented that the programme for development of staff had started to take shape and updates were being issued to staff. The programme would help staff work with all staff to ensure everyone understood what was going on in the hospital, and what was needed to be done in order to take things forward.

Dr Swart informed the Board that the Trust was now part of a consortium of seven trusts the East Midlands Radiology (EMRAD) who had agreed to share the cost of implementing a new x-ray system in the region which would be rolled out over the next 12 months.

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

TB 14/15 069 **Medical Director's Report**

Dr Wilkinson presented the Medical Director's Report.

Dr Wilkinson provided a detailed overview of the Mortality Case Note Review and informed the Board that there had been a scaling reduction in mortality figures and therefore the Mortality Case Note Review process had been developed further to look at 50 consecutive deaths from 2 selected months each year. In 2012/13, the review was repeated looking at 50 consecutive deaths occurring in November 2012. The 50 consecutive deaths review was carried out in December 2013 with a large group of engaged reviewers from a variety of specialties and backgrounds including on this occasion both senior nurses and doctors in training. As has been noted previously, one of the most obvious benefits of the review was the experience and skills gained by the reviewers during the process which they then took back into their own practice. It was therefore important that for future rounds, engagement of new reviewers continued to be promoted across the Trust.

Dr Wilkinson commented that it was clearly important that the findings were disseminated widely within clinical teams to inform the relevance of their own safety programmes, and also that of the Patient Safety Team. Dr Wilkinson commented that it was hoped that junior doctors would have a VitalPac device and Dr Swart responded that the project was being supported by IT with a clinical lead.

He informed the Board that Grade 3 and 4 pressure ulcers could be removed from the classification of a Serious Incident when the revised National Framework for the Reporting & Learning from Serious Incidents was released later this year. However, monitoring would still need to be continued to ensure the emphasis on investigation

and improvement to reduce the incident of harm from more severe pressure ulcers. The reporting would now come through the Director of Nursing and Midwifery. He advised that 4 new Serious Incidents had been reported, all under the category of Grade 3 pressure ulcers and 30 Grade 3 pressure ulcers had been reported year to date, compared to 13 Grade 3 and 1 Grade 4 in the same period last year. Mr Farenden commented that this was a difficult issue and that the Trust needed to maintain focus.

Dr Wilkinson advised that the Governance team continued to develop the HealthAssure system and monthly action plan progress reports which had resulted in there being a more robust overview of all Serious Incident action plans and progress against actions. Although all Serious Incident reports submitted to the Clinical Commissioning Group (CCG) this month were within the agreed timescales, there remained an ongoing issue with delays in receiving the draft reports from the investigation leads in a timely manner. It was not unusual for the Risk Management team to have first sight of the draft report on the day it was due to be submitted to the CCG. This did not allow for in depth quality assurance checks by Risk Management or the Executive Lead and there was a risk that all root causes and contributory factors may not be identified.

He reported that the Serious Incident Group (SIG) agreed to pilot a revised process for 6 months. Investigation leads would be given a deadline of 30 working days to complete the first draft of the investigation report. The first draft would then be circulated to all SIG members for review and comments. This should allow for greater probity into the investigations and sufficient time for further analysis to identify the root cause of these incidents where necessary.

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

TB 14/15 070 **Director of Nursing & Midwifery Care Report**

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

Mrs Bradley informed the Board that she had presented a detailed report to the Integrated Healthcare Governance Committee (IHGC) this month. The N&M Quality Dashboard presented findings from the monthly QuEST audit and an overall score of 82% was achieved for the wards which was a slight decrease from last month (87%) due to a poor score for Dryden Ward. The analysis of Dryden Ward demonstrated that the areas of focused support were; Nutritional Care, Documentation, Hand Hygiene. Following the special measures that the ward had been placed upon actions had been implemented to improve the standards on the ward overseen via the matron.

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

Mrs Bradley informed the Committee that there had been a significant increase in the number of new hospital acquired pressure ulcers in August (43) against July (28) which was very disappointing. Of the 43 pressure ulcers, 34 were grade 2 and 9 were grade 3. The 'Back to Basics back rounds had been introduced to ensure patients received regular assessments and this would be trialled on 6 wards. As from 18 September a Back to Basics Quality Assurance meeting chaired by the Director of Nursing would take place every two weeks, where Grade 3 + ulcers and other quality and safety aspects and avoidable harm would be discussed directly with ward sisters/charge nurses and matrons.

Mrs Searle commented that pressure ulcers had been discussed in detail at IHGC and acknowledged that the openness and transparency was commended. She also commented that it was important to ensure compliance to the SSKIN care bundle.

Mrs Bradley reported that there had been 14 C.Difficile cases this year and that this was above the monthly internal stretch target but within the national annual ceiling of 35.

The Friends & Family Test results for August had remained good however, A&E and Day Case areas were below the response rate. A&E had an action plan to improve the current position by focusing on the co-ordinator role, re-positioning the iPad and plans to invite the volunteers to support the service. Although A&E had not met their trajectory for response rate their Net Promoter Score was 64 against an internal target of 60.

Mrs Bradley informed the Board that the number of moderate falls this month had been 2 which was a positive decrease on previous months.

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

TB 14/15 071 **Integrated Performance Report and Corporate Scorecard**

Mrs Needham presented the Integrated Performance Report and Corporate Scorecard.

Mrs Needham introduced the Integrated Performance Report and Corporate Scorecard and informed the Board that all areas had been covered in detail at IHGC and Finance Committee.

Mrs Bradley commented that the Complaints team of 4 were on track to reach the October target and that implementation of the Datix complaint module would improve the process. Dr Swart commented that the Medical Director and Director of Nursing were signing complaint letters as well as herself and that it was important that teams looked at the issues.

Mrs Brennan commented that Staff Turnover had increased within August to 9.4% from 9.0% in July. This was attributed to an increase in leavers within Admin & Clerical roles and Medical roles, which did not include junior doctors. A month on month centralised report would be produced by the Workforce Information team to ascertain the specific reasons why there had been an increase in turnover; in particular in the hot spot areas. Areas that had seen an increased turnover were Child Health, Oncology & Haematology, Pathology and Therapies.

Dr Wilkinson drew the Committee's attention to the Healthcare Records Audit and stated that it had been proving difficult to get engagement at directorate level to establish improvements in the recording of medical notes. Surgical and medical notes were reviewed every month but actions to improve performance were lacking. The profile within directorates would be raised to ensure monthly reporting and encouraged challenge for improvement. Dr Wilkinson would be having discussions with Clinical Directors on how to improve engagement at consultant level. Mr Robertson commented that there was no target date for meeting the standard and that this should be high on the agenda for the new Medical Director.

Mrs Needham reported that the A&E 4 hour target had not been achieved during August and had seen performance against the 95% target unfortunately drop which had been caused by a number of issues.

An Integrated Discharge Team had been developed as part of winter funding which would develop enhanced processes, but would also provide additional domiciliary care. This would facilitate the immediate discharge of Delayed Transfer of Care (DTOC) patients which, if the figures presented were realised, would reduce the number of patients to around 20 within NGH. Coupled with the NGH Urgent Care Programme work improvement on internal processes surrounding complex discharges should be reduced further. Over the next month, the 'System Resilience Group', formally known as the 'Urgent Care Working Group' would work through each of the successful winter funding schemes to ensure they started on time and achieved the impact. Over the next few months, a more long term strategic view of Urgent Care would be established incorporating winter fining schemes and all actions found in the Emergency Care Intensive Support Team (ECIST) report. Dr Swart commented that discharge to assess and primary care streaming were discussed at a meeting with the Trust Development Authority (TDA), CCG and Social Care and that there was a great desire to work together. The Trust had now received the ECIST report following their visit in June and all actions would be incorporated into the appropriate work streams.

Mrs Needham informed the Committee that as part of the restructure the Cancer Management Team had moved from the Strategy and Partnerships Directorate to Operations. 62 day cancer standard and 5 other cancer standards for August had not been achieved. The Cancer Management Team would be developing an action plan to reflect the recommendations of the Intensive Support Teams visit. Mr Farenden commented that a robust plan for cancer was needed as quickly as possible. Dr Swart informed the Board that members of the Cancer Team would be presenting the Intensive Support Team Report and Action Plan to the October Board of Directors meeting in order for the Board to have full in depth discussion and understanding.

The Board **NOTED** the Integrated Performance Report and Corporate Scorecard.

TB 14/15 072 **The Patient-Led Assessment of the Care Environment (PLACE) Programme 2014**

Mr Abolins presented the Patient-Led Assessment of the Care Environment (PLACE) Programme 2014.

Mr Abolins reported that the Patient-Led Assessments of the Care Environment (PLACE) were a self-assessment of a range of non-clinical services which contribute to the environment in which healthcare was delivered in both the NHS and independent/private healthcare sector in England and that participation was voluntary. These assessments were introduced in April 2013 to replace the former Patient Environment Action Team (PEAT) assessments. The aim of PLACE assessments was to provide a snapshot of how an organisation had performed against a range of non-clinical activities which impacted on the patient experience of care – Cleanliness; the Condition, Appearance and Maintenance of Healthcare Premises; the extent to which the environment supports the delivery of care with Privacy and Dignity; and the quality and availability of Food and Drink.

Mr Abolins informed the Board that the criteria included in PLACE assessments were not standards, but they had represented both those aspects of care which patients and the public had identified as important, and good practice as identified by professional organisations whose members were responsible for the delivery of those services.

A fundamental part of assessments was the inclusion of lay assessors known generically as Patient Assessors. NGH had performed above the national average for Cleanliness, Privacy and Dignity and Condition, Appearance and Maintenance,

whereas Food was very slightly below the national average by 0.19%. Overall the results of this year's assessment were encouraging and showed the Trust was maintaining environmental standards consistently above the national average.

Mr Abolins commented that with regard to Food, each of the Assessment Teams commented that the standards this year were very good, however this had not come across in the national comparator. The Catering Team were reviewing a number of areas of the catering service and changes to menu format had been proposed in order to improve patient satisfaction as well as next year's PLACE results.

The Board **NOTED** Patient-Led Assessment of the Care Environment (PLACE) Programme 2014

TB 14/15 073 **Finance Report**

Mr Lazarus presented the Finance Report.

Mr Lazarus reported that the I&E position for the period ended August was a £10.4m deficit with the forecast position a projected deficit of £14.2m, subject to delivery of a range of recovery actions. The TDA had requested the Trust produced a Financial Recovery plan setting out how the I&E position would be managed back to the planned £7.8m deficit set at the start of the financial year. This requirement was set in the context of reports of significant national pressure on NHS finances. A range of recovery initiatives were being worked up together with a series of detailed forecasts and action plans at directorate level. At this stage the delivery of a £7.8m deficit would appear to be unachievable without significant external support or additional CCG income. He commented that the cashflow position at the end of August had significantly reduced to £0.7m. Dr Swart advised that a more detailed discussion would be had later on at the Private Board meeting.

The Board **NOTED** the Finance Report

TB 14/15 074 **Improving Quality and Efficiency Report**

Mrs Brennan presented the Improving Quality and Efficiency Report.

Mrs Brennan informed the Committee that the most likely delivery at Month 5 would be £11.1m, which was up by £81k against Month 4. This was off plan by £1.574m against the £12.668m plan prior to further mitigation. The plan required delivery of £3.128m in the first 5 months. Actual delivery was £3.785m, ahead of plan by £657k.

She confirmed that priorities for September would include preparation for the TDA deep dive CIP visit in October, validation of the Deloitte phase 1 clinical strategy assumption and further development of the Programme Management Office function.

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

TB 14/15 075 **Workforce Report**

Mrs Brennan presented the Workforce Report.

Mrs Brennan reported that the financial year to date rate for sickness absence decreased further to 4.08%, and the annual rolling average fell slightly to 4.32%. In month sickness absence decreased by 0.22% to 3.99% which was above the Trust target. She informed the Board that the Flu campaign would commence on the 6 October for 4 weeks and 'Flu Central' would be based on Hospital Street.

She informed the Board that the current rate of completed PDPs or Appraisals recorded was 72.69% which showed a continued improvement since March. Mrs Needham commented that a plan had been reviewed for the Divisions in order that they achieved the target. Mandatory Training compliance fell back slightly to 78.20% in July. On-going support had been provided for managers on analysing and interpreting training reports to ensure that they were able to take appropriate action. Role Specific Essential Training (RSET) compliance also fell back slightly to 62.31% this was most likely due to the scoping project for the RSET which had identified that some staff who were not required to do the training were now required to and some staff that were not required to do it may already be compliant but not accounted for in the reporting. The mass update of RSET requirements had been completed. A meeting between the Trust and McKesson to review the ongoing data inconsistences between OLM and ESR took place in August and McKesson contiued to investigate possible system errors, but had agreed that correct process had been followed for data input.

Mrs Brennan commented that with regard to the Staff Family and Friends Test question on 'how likely would you recommend NGH to a friends and family as a place to work' received '62% likely or extremely likely' which was disappointing and would have to be tracked in order to understand the response. Free text comments were being reviewed to establish reasons behind this score.

Mrs Brennan commented that the process for recruitment of nurses had changed and monitoring would take place at the Workforce Committee. Dr Swart commented that the Workforce Committee had been set up because workforce was valued.

The Board **NOTED** the Workforce Report

TB 14/15 076 Security Management Review 2013-14

Mr Abolins presented the Security Management Review 2013-14

Mr Abolins provided an overview of the report which showed that criminal activity, physical assaults, verbal abuse and disturbances were a daily occurrence. In total there were 442 reported incidents either to security or reported through the Trust's Datix reporting system. This had been an increase of 23% on last year's reported figure of 355. There had been 18 confirmed reported crimes/thefts which was a reduction on previous years.

In order to support staff to perform proportionate restraint to a patient there was a policy available on the Intranet titled "Restrictive Physical Intervention for Adults" (RPI). Included in the policy was a training needs analysis which identified which staff group should attend a 1 day, two day and or four day course. Mr Abolins commented that it was disappointing to note the very poor up take of the training which had been designed to equip staff to deal with those difficult situations and reduce injury to staff. Mr Pallot commented that it was important to attend the training as it was useful in all walks of life. Reported verbal, abusive, aggressive and harassment incidents were higher than last year, increasing from 195 to 218.

Mr Abolins commented that, according to the data, for the third year Creaton Ward had recorded the most physical assault incidents on staff (57) this accounted for 27% of all recorded physical assaults. It should be noted that Creaton Ward was one of the few areas that sent a significant number of their staff on the one day "Breakaway" training course by staff. A&E recorded 12 incidents of physical assault. There had been one confirmed arrest and a charge of drunk and disorderly. There had been other arrests but it was difficult to comment on outcomes because when the police removed an offender from site they would either take them to a police cell to cool down or they were taken home. It was recognised that more work was needed to be

done between the Police and NGH in closing the loop on outcomes.

Mr Abolins advised that a Facilities Capital Project had identified funding in order to replace all current swipe card readers and replace them with proximity readers. All Trust users had or were in the process of having their existing card replaced with a smartcard which also acted as their photo ID. Additionally, proximity readers were replacing the card readers on the staff barrier car parks. The smartcard could also provide other services such as cashless vending and can be used for restaurant purchases. These options would be looked at in the future. He commented that this had been a major exercise however all staff now had photographic ID and access had now been restricted within high risk areas to authorised personnel only.

He informed the Board that the Security Department had applied to join the Community Safety Accreditation Scheme (CSAS). The CSAS provided an opportunity for organisations that provided community safety and security services to enter into a formal agreement with their local Chief Police Officer.

The Board **NOTED** the Security Management Review 2013-14

TB 14/15 077 **Health and Safety Annual Report**

Mr Abolins presented the Health and Safety Annual Report.

Mr Abolins informed the Board that this report provided an analysis of the Trust's Health and Safety (H&S) performance during the financial year 2013 – 2014 and highlighted relevant issues pertaining to the Management of Health and Safety in the Trust.

He drew the Board's attention to the fact that Sharps incidents continued to give concern, even though focus had been increased 95 staff injuries with harm from dirty Sharps had been reported in 2013/14 which was an increase from last year (72). This increase could be attributed to more incidents being reported via Datix due to raised awareness among staff related to sharps.

A new Sharpsmart disposal system had been implemented throughout the Trust and the new Sharps bins automatically closed once they were filled which prevented overfilling. The design ensured that hands would not come in contact with Sharps within the bins. The Sharps bins came in a portable variety and could therefore be taken to the patient's bedside which enabled staff to dispose of Sharps at point of use. A new Safe Management of Sharps Policy had also been developed along with Safer Sharps Awareness leaflets and an Awareness Day had been held where staff were given the opportunity to review and select safer Sharps devices for use in their clinical areas.

Mrs Searle commented that the increase in incidents was disappointing but hoped the new equipment would see an improvement. Dr Wilkinson confirmed that the new equipment was much improved.

Mr Abolins reported that there had been 26 stretching or bending injury, other than lifting' incidents with harm reported in 2013/14 compared to 34 in the previous year and there had also been a decrease in the overall reported manual handling incidents causing harm to staff in 2013/14 compared to previous year. There were 39 incidents reported under RIDDOR in 2013/14 which was an increase from 10 incidents reported in 2012/13 but similar to the data from 2011/12 and 2010/11.

All employees were required to have Health and Safety awareness training and this was part of the Trust mandatory training programme. Compliance rate for this had been very low with only 32% in April 2013. A complete review of the H&S training

had been completed and a number of actions taken. Since implementing the measures, there had been a marked increase in compliance rate. It was at 57.5 % at the end of April 2014 and had continued to rise.

Mr Farenden commented that his was a very helpful and comprehensive report.

The Board **NOTED** the Health and Safety Annual Report

TB 14/15 078 **Safeguarding Vulnerable Adults and Children Annual Report**

Mrs Bradley presented the Safeguarding Vulnerable Adults and Children Annual Report

Mrs Bradley gave a brief overview of the report which reflected the arrangements to safeguard and promoted the welfare of children, young people and vulnerable adults within NGH for the period of April 2013 to March 2014. The Trust was committed to working with partners to improve outcomes for vulnerable adults, young people and children. Part of that commitment took the form of attendance at, and active participation in, the Partnership Boards and associated subgroups. The Safeguarding Governance Committee had been established and Mrs Searle would be the Non-Executive Director attending the inaugural meeting.

Mrs Searle commented that it was a very helpful report.

The Board **NOTED** the Safeguarding Vulnerable Adults and Children Annual Report

TB 14/15 079 **Infection Prevention Annual Report**

Mrs Bradley presented Infection Prevention Annual Report

Mrs Bradley reported that the improved performance in relation to infection prevention and control within the Trust was no reason for complacency. The Infection Prevention and Control Team continued to raise awareness of specific issues surrounding Healthcare Acquired Infections (HCAIs) with both staff and local population and promoted and monitored clinical practice to minimise the risk of HCAIs for patients who have their care at NGH.

Mrs Bradley commented that this was a very positive report which indicated that there were no areas of concern.

The Board **NOTED** the Infection Prevention Annual Report

TB 14/15 080 **End of Life Strategy**

Mr Pallot presented the End of Life Strategy

Mr Pallot gave an overview on the strategy which outlined the Trust's plan to improve the quality and experience of care for patients over the age of 18 and living within the last year of life and their families. It provided a framework for the implementation of national directives at local level. It also outlined how the Trust would support and educate staff so they could provide timely, compassionate care to patients at the end of life. This included the development of a culture of continuous quality improvement by supporting the sustained use of existing good practice models, for example Primecare Rapid End of Life Discharge, as well as embracing new innovations such as the AMBER care bundle for patients whose recovery was uncertain together with ward based quality improvement initiatives such as the Quality End of Life Care for All (QELCA) ward manager education programme.

Mr Pallot commented that once ratified, it was important that the Trust as a whole engaged in the principles set out within this strategy and to enable this to happen, the End of Life and Specialist Palliative Care Team would endeavour to take

opportunities to engage with the clinical care groups, promoting the principles of The Transform Programme and also the Strategy itself. The Strategy set out six objectives with key outcomes attached for the next 2 years. A progress report would be submitted by the End of Life/ Specialist Palliative Care Team to the End of Life Care Strategy Group on a quarterly basis demonstrating the progress of achieving the key outcomes and reporting any perceived difficulties in moving forward so that this could be reported to the Clinical, Quality and Effectiveness Group.

Mrs Searle commented that this was a very good strategy however the challenge would be in monitoring it. Mr Pallot responded that the End of Life Group would have a reporting structure within the governance system.

The Board **ENDORSED AND RATIFIED** the End of Life Strategy

TB 14/15 081 **Stakeholder Engagement Strategy**

Mrs Sally-Anne Watts presented the Stakeholder Engagement Strategy.

Mrs Watts informed the Board that this was the first time that Stakeholder Engagement and Communications had been separated into 2 strategies and gave an overview of the strategy document.

Mrs Watts reported that the Trust was committed to providing the best possible care and to achieved this by working in partnership with its stakeholders and by listening and acting upon feedback ,on how improvement could be made, from its staff, patients, families and carers, other care providers, stakeholders and the local community. The success of the Trust was dependent on its stakeholders and strengthening engagement with them was critical for the Trust's future, for accountability, trust, confidence, reputation and organisational culture. It was also a contributory factor for improving quality of care and patient outcomes.

In March 2014 the Trust undertook its first ever external stakeholder survey in order to assess perceptions of the Trust among our key stakeholders. 76% of respondents were either satisfied (55%) or very satisfied with the dealings they had with staff from NGH. Mrs Watts advised that this strategy had been built on previous developments in stakeholder engagement and used feedback from external stakeholder survey, insight and best practice to take forward an approach to stakeholder engagement.

Mrs Searle commented that under the table of 'who are our stakeholders' the 'public' had not been identified. Dr Swart advised that getting the message out to the public would be addressed in the Communications Strategy.

Dr Swart commented that social media had been very effective and Twitter was gaining momentum. Mr Pallot comment that this was hugely positive and that it was important to build and develop relationships with key stakeholders.

The Board **APPROVED** the Stakeholder Engagement Strategy

TB 14/15 082 **Communications Strategy**

Mrs Sally-Anne Watts presented the Communications Strategy

Mrs Watts gave a detailed overview of the strategy and informed the Board that this strategy sat alongside the Stakeholder Engagement Strategy and set out the Trust's plans in relation to communications activity over the coming three years. It used feedback from the external stakeholder survey, staff survey and best practice to develop and strengthen communications activities. The Strategy set out a number of actions needed if the Trust were to deliver and achieve its aspiration for strengthened communications and support its stakeholder engagement.

She advised that social media provided an increasingly important vehicle for reaching out and engaging with all our stakeholders. The Communications Team currently used social media to communicate good news stories about the Trust, raised awareness of events and fundraising activities and gauged valuable feedback about services. The Trust also had a number of other stakeholders, including MPs, GPs and Commissioners of which it was important that development and improvement of communication continued. Dr Swart commented that more links would be made with stakeholders to ensure good communications.

Mr Farenden commented that this was a very good document.

The Board **APPROVED** the Communications Strategy

TB 14/15 083 **TDA Self-Certification Report**

Mr Pallot presented the TDA Self-Certification Report.

Mr Pallot reported that in accordance with the Accountability Framework, the Trust had been required to complete two self-certifications in relation to the Foundation Trust application process. Draft copies of Monitor Licensing Requirements and Trust Board Statements self-certifications for August 2014 were discussed and approved.

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

TB 14/15 084 **Report from the Finance Committee**

Mr Farenden presented the Report from the Finance Committee

Mr Farenden gave a highlight report of key items discussed on 17 September 2014 Finance Committee which included the continuing significant challenges in achieving the financial plan for 2014/15. A paper outlining the structure of a Recovery Plan designed to give appropriate focus from the Executive on steering the financial result for the year back towards a £14m deficit. The TDA had also formally requested a recovery plan be drawn up. The Finance Committee supported the proposals around structure and reporting, and it was agreed that the actions to deliver the Recovery Plan would be brought to the September Private Board meeting for discussion. The Committee requested from the relevant Executives a clear joined up action plan to solve the challenge of the shortage of substantive nursing staff as the Trust continued to significantly overspend on Bank and Agency staff.

Mr Farenden reported that the Director of Finance confirmed to the Committee that the Trust had submitted its application for longer term Revenue and Capital finance to the TDA, which was key both to support cashflow and to permit the necessary investment in medical equipment, which, should it be delayed, increased the clinical risks of delivering a safe service.

He confirmed that the Department of Health had approved the £4m temporary borrowing facility to support the short term cashflow required. Mr Farenden informed the Board that the Committee had an update regarding the historical debt owed to the Trust by Cripps of c £300k, and the recommendation was given that there was no realistic prospect of the debt being recovered, the Trust should write it off. After due consideration the Finance Committee duly recommended to the Trust Board that the debt was written off. Dr Swart commented that it was important from a health and wellbeing perspective for staff to have a facility like the CRIPPS centre.

The Board **NOTED** the Report from the Finance Committee

TB 14/15 085 **Report from the Audit Committee**

Mr Robertson presented the Report from the Audit Committee.

Mr Robertson reported that the Audit Committee met on the 17 September 2014 and that the External Auditors (KPMG) were mandated to give an opinion on the Trust's Quality Accounts for 2013/14. In their Audit letter they had highlighted specific issues in respect of the lack of an audit trail on the indicators for C Diff and FFT. Whilst there had been no reason to doubt that the numbers for these quoted in the Quality Account were an accurate reflection of the underlying performance, their opinion would be formally qualified in this respect. The processes for reporting these indicators were the subject of a full internal review.

The Audit Committee were presented with a review of waivers which indicated that in too many cases Standing Financial Instructions (SFIs) were not being followed. This had been an increasing issue over the past year. Suppliers had been written to and informed that formal purchase orders were required before supplying the Trust and further training was taking place. The Committee would keep this under close review.

Mr Robertson informed the Board the that the Committee reviewed the Purchasing and Supply Strategy, updated Standing Orders, SFIs, and the Scheme of Delegation and the revised versions would be presented to the Board shortly for formal adoption.

Mr Robertson reported that the Committee reviewed the 'Supporting Staff to raise concerns at Work' (Whistleblowing). The Committee also reviewed the Business Assurance Framework and the Corporate Risk Register. He noted that much work had been done in this area and the documents were now to a good standard and an appropriate vehicle to allow informed discussion at the Board and the joint meeting of the assurance committees in December.

The Committee noted that there was considerable work still to be done to ensure that the Standards of Business Conduct Policy was widely understood and appropriate declarations made throughout the Trust. This would be reviewed in March 2015.

Mr Robertson advised the Board that following the reissue of the NHS Audit Handbook, a revised Terms of Reference for the Committee had been reviewed. They would be presented to the Board along with the Terms of Reference for the other sub-committees in the new structure.

The Board **NOTED** the Report from the Audit Committee

TB 14/15 086 **Report from the Integrated Healthcare Governance Committee**

Mr Kershaw presented the Report from the Integrated Healthcare Governance Committee.

Mr Kershaw informed the Board that the Integrated Healthcare Governance Committee (IHGC) met on the 19 September 2014 and Mr McMullan, Consultant Ophthalmologist and Mrs McLeod, General Manager Surgery, gave a detailed update on the Ophthalmology service which gave the Committee assurance over the delivery of the service recovery plan. The Committee recognised the tremendous work the staff had undertaken in clearing the backlog. The Committee noted that the Ophthalmology department had identified ways to increase capacity and was developing a business plan to support this.

The Committee approved the future Terms of Reference and noted that the Committee would be renamed from IHGC to Quality Governance Committee. The Terms of Reference would be submitted to the Trust Board in November for formal

ratification. Terms of Reference for the Workforce Committee were noted by the IHGC Committee as the 'workforce' agenda would become the responsibility of the new committee for Workforce. The specific actions in respect to workforce were agreed by IHGC to be transferred to the responsibility of the Workforce Committee and these actions would be picked up at the inaugural meeting in October.

Mr Kershaw reported that IHGC had not received complete assurance that the target for staff having an annual appraisal would be achieved. IHGC requested a focussed piece of work and this action to be transferred to the Workforce Committee as IHGC members felt that there was still a lot of work to do.

IHGC recognised that evidence was being continually updated on the CQC action plan and also recognised that staff had worked hard in closing down actions - there were 52 actions which are were green, 24 amber actions, no reds. The Compliance Action Plan addressed the recommendations within the CQC Action Plan. However the Committee noted that there had been delays with some of the actions on the Compliance Action Plan which resulted in an extension of the timescales being required. These included; provision of Route Cause Analysis training that was due to commence in September but had now been arranged to commence in October therefore a change in target date was required. Complaints action plans had been put onto the Healthassure system for monitoring however the Complaints Manager had stated that they would not be in a position to monitor the follow up of action plans until the Datix module for complaints had been updated in December 2014. Great progress had been made with capturing data on patient moves however additional assurance was required in capturing patient experience following patient moves which currently triangulating PALS contacts, complaints & incident reports. A more proactive approach was now needed to be considered to measure the impact on patients involved.

Mr Kershaw advised that mandatory training and appraisal compliance target for October was 80% and had been set at 85% for March 2015. Again great progress had been made. The Committee commented that it was important to ensure that plans were in place and continued to be driven to achieve the targets set.

A Review Sections 4-6 of the Patient Safety, Clinical Quality and Governance Progress Report (Quarter 1) was covered in detail by the Committee and IHGC noted particular concerns in respect to and requested urgent attention to ensure improved standards on DNARCPR Audit of the notes; Sepsis; and restocking of Resuscitation Trollies. The Committee received assurance on how the Trust would respond to a potential EBOLA victim and were assured over the decision algorithm to be used in such circumstances and the Trust response.

The Board **NOTED** the Report from the Integrated Healthcare Governance Committee

TB 14/15 087 **Any Other Business**

On behalf of members of the Board, Mr Farenden extended his thanks to Dr Wilkinson for all his efforts during his time as Interim Medical Director.

Mr Farenden passed a motion that with immediate effect the Trust Board would move to meet on a bi-monthly basis and on the months where a Trust Board meeting was not held, a meeting of the Board of Directors would take place.

Dr Swart informed the Board that she would be meeting with the Non-Executive Directors on the 9 October 2014 for a Board Development Day looking at the workings of the Board of Director meetings.

Dr Swart informed the Board that detailed Highlight Reports from all the Board Sub-Committees would be presented to the Trust Board therefore enabling only items by exception to be presented to the Board.

Date of next meeting: Thursday 27 November 2014 at 09:30 in the Board Room at Northampton General Hospital

Mr Farenden called the meeting to a close at 11:45

The Board of Directors RESOLVED to exclude press and public from the remainder of the meeting as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted

Public Trust Board Action Log

Last update 20/11/2014

Ref	Month of meeting	Minute Number	Paper	Action Required	Responsible	Due date	Status	Review of Completion/Reason for Slippage
30	29/05/2014	TB 14/15 011	Same Sex Accommodation Audit and Update	Mr Noble asked how the Trust compared against other Trusts and Mrs Brown advised that a benchmarking exercise would be undertaken.	Rebecca Brown/Karen Spellman	Sep-14	Completed	Mrs Spellman has sent a request to the CCG for this information. As at 31 July no response from the CCG. Verbal update at next Board meeting. **Update 25 September 2014** Mr Pallot advised that he would circulate detailed information with regard to the benchmarking information requested but confirmed that the Trust compared favourably.
35	26/06/2014	TB 14/15 033	Hard Truths	Mr Farenden requested that an update on agency and locum staff be brought back to the Board in September as much more robust assurance was needed	Jane Bradley	Sep-14	On Agenda	
36	31/07/2014	TB 14/15 051	Hard Truths	Mrs Wright informed Board that the turnover of nurses was around 8% and that work had been carried out on analysis of retention. Mr Noble asked if detailed analysis about retention could be made available to the Integrated Healthcare Governance Committee.	Janine Brennan/ Sandra Wright	Dec-14	Moved	Transferred to Workforce Action Log
39	31/07/2014	TB 14/15 057	Risk Management Annual Report	Mr Noble asked how the Trust's Clinical Negligence Claims compared to other Trusts and Dr Swart responded that a benchmarking exercise would be carried out	Medical Director	Oct/Nov 14	Moved	Transferred to Quality Governance Action Log In order to carry out the benchmarking exercise, the Senior Quality, Risk & Litigation Manager needs access to the NHS Litigation Authority Extranet. An application for access has been lodged with the NHSLA and this has been authorised by Mr Pallot as the Senior Information Risk Officer (SIRO). When access has been granted the benchmarking exercise will be carried out and a report will be provided to IHGC
40	31/07/2014	TB 14/15 060	Equality Delivery Stems 2 (EDS2).	The Board requested that the action plan be presented at the November meeting.	Janine Brennan	Nov-14	Slippage	Moved - to be presented to March 2015 meeting as work will not be completed until early in the new year.

KEY

- Completed or on Agenda
- On Track
- Slippage - to be updated at the Meeting
- Significant Slippage
- moved to another committee
- Closed/Presented

Report To	**Public Trust Board**
Date of Meeting	**27 November 2014**

Title of the Report	**Chief Executive's Report**
Agenda item	7
Sponsoring Director	Dr Sonia Swart, Chief Executive
Author(s) of Report	Dr Sonia Swart, Chief Executive
Purpose	For information and assurance
Executive summary The report highlights key business and service developments for Northampton General Hospital NHS Trust in recent weeks.	
Related strategic aim and corporate objective	N/A
Risk and assurance	N/A
Related Board Assurance Framework entries	N/A
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?/N)
Legal implications / regulatory requirements	None

Enclosure C

Actions required by the Trust Board

The Board is asked to note content of the report.

Northampton General Hospital NHS
NHS Trust

Public Trust Board
27 November 2014

Chief Executive's Report

1. New organisational structure

Board members will be aware that reviews of the way the hospital is managed and governed have indicated that changes were needed to ensure that we become more effective and efficient. We have also recognised the need to improve board assurance, accountability, responsibility and decision-making. We therefore agreed the need to move from the existing care group structure to a clinically managed and led, divisional structur. We are convinced that this will allow better involvement of clinical staff and improved managerial support for key decisions.

Consultation on the proposed new structure has ended and feedback provided to affected staff. During the consultation we received feedback, comments and questions from individuals, staff side representatives and groups of staff, as well as from the Royal College of Nursing. All views were considered and taken into account and some changes were made, such as changing the directorate/division in which some services/departments sit, job titles and ensuring each directorate within the medicine, surgery and women's, children's, oncology and haematology divisions will have at least one dedicated directorate matron. We have also created two new associate director of nursing posts as well as an associate director of midwifery as part of our quality assurance and improvement team.

We have communicated the changes and the reasons for them to all our staff.

We are now moving towards implementation of the new structure, which was revised following feedback received during consultation, from 6 January 2015.

2. Discharge lounge

We have been successful in obtaining additional winter pressures funding which will allow us to develop a much improved discharge lounge which will be created within the space that is currently occupied by our clinical coding team. The new discharge lounge will have capacity for beds and 15 chairs, together with associated facilities. The new location has good ambulance and vehicle access and altogether this will provide a much improved 'departure' experience for our patients, as well as helping with flow through the hospital.

The work is currently out to tender and we anticipate completion by the end of January 2015. The clinical coding team will be relocating to the Naseby corridor.

3. Endoscopy

We recently had an excellent JAG accreditation visit, when we were awarded unconditional accreditation. Only 10% of units across the country have achieved this. The team in endoscopy are to be congratulated for the considerable effort they put into achieving this level of accreditation and their commitment to providing the best possible care for our patients.

4. Sustainability

NGH has achieved the top level 'Green Award' accreditation in recognition of our efforts to reduce our impact on the environment and support sustainability. Our sustainability lead, Clare Topping, has implemented a broad range of actions to help reduce the trust's environmental impact as well as ensuring our staff and the local community are engaged with our plans.

5. Making quality count

I have now been able to give feedback to the first of our 'Making Quality Count' teams. There has generally been good engagement with the process and some good ideas have emerged. It is important that we support this and ensure that projects move from concept to implementation with some pace and grip. I hope that by next year all services will have a quality improvement project as part of their performance scorecard.

6. Staff engagement

At NGH - as in the NHS generally - there is an increasing realisation that engagement of the workforce is becoming increasingly critical as the pressures mount in the face of salary restrictions. For this reason we are working to agree our staff engagement strategy which will include a number of strands. In essence this is about helping to develop and support staff to give of their best, feel valued and connected to their job, their team and our hospital. The overall aim will be to ensure that we are all proud to work here and would want our family to be treated here and really feel that 'we are NGH'. We will also develop an overall recruitment and retention of staff strategy to consider key issues.

Our staff have worked particularly hard this year in a number of areas and the fruits of this are starting to pay dividends in terms of some improvement in quality of care and urgent care flow. This has been teamwork at its best and I hope that this in itself will motivate everyone to continue their excellent work.

7. NGH in the media

The Chronicle and Echo portrayed our financial issues in a reasonably balanced way with an emphasis on the Board's decision not to make cuts that would result in a significant fall in quality.

I was delighted to meet and welcome Tom, our part-time worker with a learning disability, to the Trust a few weeks ago. The work Tom does, with his support worker, is ably led by Debbie Wigley, who has transformed the approach to learning disability at NGH. I am sure that Tom and his family are rightly proud of this first step into the world of work and enjoyed hearing Tom talk about his experience of working at NGH during an interview with Tom Percival on BBC Radio Northampton.

8. Healthier Northamptonshire

A key outcome from our meeting with the regulators was the production of a high level implementation plan with key milestones against which progress will be measured. Work is ongoing in each of three portfolios: clinical collaboration, collaborative resource management and integrated care closer to home, to achieve this. An update was provided to the Health, Adult Care and Wellbeing scrutiny committee in early November.

The expectation is that the resource required to take the work forward will primarily be identified from within the local health and social care system. However, there will also be a requirement for external support in key areas and funding options are being explored.

Work in relation to clinical collaboration between ourselves and Kettering General Hospital will be continued in respect of the four specialty areas covered in the Proof of Concept exercise – rheumatology, ophthalmology, orthopaedics and radiology. There will also be further consideration of more strategic aspects with active commissioner involvement.

9. Stakeholder engagement

As part of our wider stakeholder engagement strategy I have arranged some meetings with our local MPs to give them some understanding our key issues. It is clear that our MPs are supportive of our plans and recognise the challenges we face. At the same time, however, they are mindful of the impact that any service change may have for their constituents. The thorny issue of car parking came up again and we do need to improve this if we can – I think this is an issue all over the country but that should not stop us trying to think of ways of resolving it as far as we are able.

10. National strategy – five year forward view

The 5 year Forward View for the NHS has been published. It was produced by NHS England but draws in views from all the regulators and from the CQC and Health Education England. The essence of the document is a call for cross-system leadership and a vision to unite the NHS by insisting that things will have to be done differently – meaning new models of care and more prevention. It also speaks of letting go of the command and control from the centre and argues for additional investment in the NHS – for the first time formally articulating that more and more cost cutting alone will not get us where we need to be.

The Five Year Forward View describes how action needs to be taken on four fronts:

- Doing more to tackle the root causes of ill health. The Forward View backs hard-hitting action on obesity, alcohol and other major health risks.
- Committing to giving patients more control of their own care, including the option of combining health and social care, and new support for carers and volunteers
- Changing to meet the needs of a population that lives longer; for the millions of people with long-term conditions and for those who want person-centred care. The Forward View sets out new models of care built around patients' needs rather than historical or professional divides.
- Developing and delivering new models of care, local flexibility and more investment in our workforce, technology and innovation.

Overall the messages are aligned with the approach we are trying to support at NGH and in Northamptonshire.

Local health economies have been tasked with getting on and delivering change in an evolutionary way with some pace. At the same time we must also deliver operational discipline, manage the money and indeed balance quality and money, reduce unacceptable variation in standards, adopt best practice standards and develop resilience for our systems.

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Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**27 November 2014**

Title of the Report	**NHS England 'Sign up to Safety' Campaign (2014)**
Agenda item	**8**
Sponsoring Director	Jane Bradley, Interim Director of Nursing
Author(s) of Report	Celia Warlow, Patient Safety Academy & Resuscitation Services Manager
Purpose	Decision
Executive summary 'Sign up to Safety aims to deliver harm free care for every patient, every time, everywhere. It champions openness and honesty and supports everyone to improve the safety of patients.' The Board is asked to consider and decide if the Trust should join the campaign.	
Related strategic aim and corporate objective	Patient Safety
Risk and assurance	There has been a marked increase in the focus on quality and safety at all levels internal and external to the Trust. To sustain the positive improvements achieved, the continued engagement from staff to support the improvement projects is essential. This will help to improve the safety culture and reduce avoidable harm at NGH.
Related Board Assurance Framework entries	BAF – 1
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? N Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? N
Legal implications / regulatory requirements	Regulators will consider safety and quality indicators and will take action where appropriate. Assurance for regulators can be provided through the demonstration that the analysis of issues is combined with the necessary quality and safety improvement work

Actions required by the Trust Board

The Board is asked to consider the safety pledges and decide if the Trust should join the NHS England 'Sign up to Safety' Campaign

Northampton General Hospital NHS
NHS Trust

Public Trust Board
27 November 2014

NHS England 'Sign up to Safety' Campaign (2014)

1. Introduction

'Sign up to Safety aims to deliver harm free care for every patient, every time, everywhere. It champions openness and honesty and supports everyone to improve the safety of patients.'

The Board is asked to consider and decide if the Trust should join the campaign.

2. Body of Report

NHS England launched the Sign up to Safety Campaign in June 2014, and states the following:

'This campaign and its mission are bigger and much more important than our individual organisations programmes or activities. We want to establish and deliver a single vision for the whole NHS to become the safest healthcare system in the world. This means taking all activities and programmes that each of our organisations currently own and aligning them with this single common purpose. Organisations who Sign up to Safety commit to strengthen patient safety by:

- *Setting out the actions they will undertake in response to the five Sign up to Safety Pledges and agree to publish this on their website for staff, patients and the public to see.*
- *Committing to turn their actions into a safety improvement plan which will show how organisations intend to save lives and reduce harm for patients over the next 3 years.*

How the campaign is is organised and supported?

A National Co-coordinating and Support Group has been established, chaired by **Sir David Dalton** who is supported by **Dr Suzette Woodward** as Campaign Director.

The following national organizations have committed to system wide support of Sign up to Safety:

- NHS England will provide expert clinical patient safety input to the development of improvement plans and framework for plan assessment. They will also play a key leadership role in the campaign and will ensure all their programmes of work described above are actively working to support the campaign.
- Monitor and the NHS Trust Development Authority will offer leadership and advice to trusts and foundation trusts who participate in Sign up to Safety and who will develop and own locally their improvement plans. They will also sign post to partner organisations for specific expertise where required.
- NHS Litigation Authority which indemnifies NHS organisations against the cost of claims, will review trusts' plans and if the plans are robust and will reduce claims, they will receive a financial incentive to support implementation of the plan. Any savings made in this way will be redirected into frontline care. This is just one way that we can tackle some of the financial costs of poor care. Any savings made in this way will be redirected into frontline care.
- The Care Quality Commission will support trusts signed up by reviewing their improvement plans for safety as part of its inspection programme. CQC will not offer a judgment on the plans themselves but consider them as a key source of evidence for Trusts to demonstrate how they are meeting the expectations of the five domains of safety and quality.

- The Department of Health will provide Government-level support to the campaign and work with the Sign up to Safety partners to ensure that the policy framework does all it can to support the campaign and the development of a culture of safer care.

The five Sign up to Safety Campaign Pledges:

1. ***Put safety first.*** *Commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally.*
2. ***Continually learn****. Make their organizations more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe their services are.*
3. ***Honesty****. Be transparent with people about their progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.*
4. ***Collaborate****. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.*
5. ***Support****. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress*

Proposed NGH Pledges:

1. **Put Safety First.** Commit to reduce avoidable harm in the NGH by half and make public our goals and plans developed locally.

   We will:

   - Continue to develop our Safety Huddles, making safety the new 'normal'
   - Publicise and promote our Safety Strategy and our ambitions for patient safety, and continue to build on our existing safety improvement work streams.
   - Engage with our patients by the use of a daily patient plan. This will encourage patients to ask about their care and treatment whilst in Hospital and whether they feel safe.
   - Continue to develop our safety culture of Safety Champions throughout the Trust, ensuring the concept of 'eyes & ears' of patient safety in clinical and non-clinical areas.
   - Continue to focus on reducing avoidable harm
   - Continue to develop our internal safety inspections (QuEST – Quality, Effectiveness and Safety Team)

   - We put patient safety above all else
   - We aspire to excellence
   - We reflect, we learn, we improve
   - We respect and support each another

2. **Continually learn.** Make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are.

   We will:

   - Continue to promote the use of our patient safety leaflets and video to educate patients to help manage their own safety whilst in our care
   - Continue to develop our Patient Safety Learning Forum to ensure we continually learn new ways to extract the learning from incidents and good practice which can flow throughout the organisation.
   - Develop and support our Ward Mangers to enable them to run 'Flagship' wards.
   - Continue to use our Aspiring to Excellence Programme for Medical students to be the spring board for patient safety concepts. Topics are approached from a systems perspective and embedded into wider clinical systems. This is then incorporated into the improvement and risk

   - We put patient safety above all else
   - We aspire to excellence
   - We reflect, we learn, we improve
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management framework and shared with senior colleagues and Safety Champions.

- Ensure that the Executive team through Board to Ward visits continue to monitor safety and promote an open and honest culture for reporting concerns.
- Monitor staff's perceptions through a twice yearly Safety Culture questionnaire.
- Proactively seek feedback from and with our patients and public and use their valuable experience to shape improvement work to the direct benefit of our patients.
- Provide support for Doctors in training to learn about safety and improvement.

3. **Honesty.** Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

We will:

- Display data at ward level on Patient Safety & Quality Boards with regards to days since last; Falls, Avoidable Pressure Ulcers, MRSA & Cdfiff, and Cardiac Arrests. Monthly data in relation to; Hand Hygiene, Omitted Medicines, VTE Prophylaxis, and Escalation of Deteriorating Patients.
- Encourage Safety Champions to utilise 'drop in' sessions to discuss local issues and improvement ideas.
- Start each Patient Safety Learning Forum and Patient Safety Board with a patient story.
- Fully implement the new Duty of Candour and review practice to ensure the Trusts systems and processes support a culture of transparency, openness and honesty.

- We put patient safety above all else
- We aspire to excellence
- We reflect, we learn, we improve
- We respect and support each another

4. **Collaborate.** Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

We will:

- Promote all Trust Patient Safety events with GP's and continue to monitor GP concerns and represent the Trust at primary care Protected Learning Time (PLT) meetings to ensure Primary and Secondary care learning is developed.
- Link with the East Midlands Patient Safety Collaborative to share good practice and Improvement work
- Utilise Safety Champions across the Trust to assist with dissemination of Safety information and key messages within their work areas.
- Develop a Safety & Quality master class for the 'Connecting for Quality, Committed to Excellence' internal Management and Leadership Programme.

- We put patient safety above all else
- We aspire to excellence
- We reflect, we learn, we improve
- We respect and support each another

5. **Support.** Help People understand why error occurs and help them understand how to reduce the risk of it happening again. Support staff to review this process and celebrate success.

We will:

- Continue to support teams to undertake PDSA cycles of change and how to monitor sustainability
- The Safety Academy will work on a campaign to support and develop a Flagship ward. This will include working with Academy leads and other specialists looking at working differently to achieve a safer environment for patients and better outcomes. This model would then form a platform for roll out to other clinical areas in the Trust.
- Continue to celebrate success by awarding individuals and teams who have made significant contributions to patient safety.
- Support Patient Safety Champions to attend educational safety events. This will promote the patient safety ideals.
- Continue to develop the patient safety intranet site to be a conduit of inform all staff.

- We put patient safety above all else
- We aspire to excellence
- We reflect, we learn, we improve
- We respect and support each another

- Support staff to attend specific training within our Simulation Centre.

3. Assessment of Risk

The Sign up to Safety pledges align with the Hospitals values as indicated within each pledge.

4. Recommendations

The Board is asked to endorse the campaign pledges and approve the launch for January 2015.

5. Next Steps

The launch date co-insides with the refreshed Patient Safety Strategy. The launch will be led by the Safety Academy Leads and supported by Communications.

Northampton General Hospital NHS
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**27 November 2014**

Title of the Report	**Hard Truths Staffing Report**
Agenda item	**9**
Sponsoring Director	Jane Bradley, Interim Director of Nursing and Midwifery
Author(s) of Report	Jane Bradley, Interim Director of Nursing and Midwifery
Purpose	Information and Assurance

Executive summary

- In 2012 the Trust agreed the Nurse Staffing Strategy, which is a four year strategy, to improve the nurse staffing levels across the Trust. This has equated to £1.9m investment in year 1 - 2012/13 and £1.4m has been allocated for investment in year 2 - 2014/15.
- Recruitment for trained nursing staff continues to be a significant challenge nationally and for the Trust.
- Trained nurse vacancy as of month 7 (October 2014) is 105.49 wte for general wards including A&E. This increases to 127.20wte when specialist areas are included.
- All Nursing as a whole is £282k favourable to the YTD FRP position.
- To complement the Hard Truths Commitment, Nurse Staffing Review, and nurse recruitment and retention the Director of Nursing is leading a number of fundamental changes to nursing workforce development across the nursing & midwifery teams

Related strategic aim and corporate objective	To be able to provide safe quality care to all our patients
Risk and assurance	The report aims to identify the current staffing position and assurance with regard to the progress and action taken to date.
Related Board Assurance Framework entries	BAF – 1
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? **NO** Is there potential for or evidence that the proposed decision/policy

Enclosure E

	will affect different population groups differently (including possibly discriminating against certain groups)? **NO**
Legal implications / regulatory requirements	Boards take full responsibility for the quality of care provided to patients and as a key determinant of quality, take collective responsibility for nursing, midwifery and care staffing capacity and capability.

Actions required by the Trust Board

The Board is asked to:

- Note the staffing information provided and acknowledge that safe care continues to be delivered.
- Note the analysis of the shift by shift staffing numbers, the vacancy factor, and active recruitment initiatives in place
- Support the recruitment and retention initiatives to sustain and maintain a flexible and resilient nursing and midwifery workforce.

Northampton General Hospital NHS
NHS Trust

Public Trust Board
27 November 2014

Hard Truths Staffing Report

1. Introduction

The focus on nursing, midwifery and healthcare staffing as a key determinant of the quality of care experienced by patients has become increasingly heightened during recent months. Recent reports including Robert Francis report into the events at Mid Staffordshire Hospital, Professor Sir Bruce Keogh's review into hospitals with elevated mortality rates and Professor Don Berwick's report into Patient Safety all highlighted the importance of ensuring appropriate nurse staffing capacity and capability.

The National Quality Board (NQB) issued guidance in November 2013 to optimise nursing, midwifery and care staffing capacity and capability and provide transparency for patients and the public with regard to the publication of staffing data. This is one of a number of government made commitments known as "Hard Truths".

Research demonstrates that staffing levels are linked to the safety of care and that staff shortfalls increase the risks of patient harm and poor quality care. In June 2014 all Trusts with inpatient beds were required to publish their staffing fill rates (actual vs planned) in hours worked. The data on staffing fill rates for nurses, midwives and care staff was made available on the NHS Choices website to facilitate patients and the public to view hospital staffing as an indicator in an easy and accessible way. This data also sits alongside a range of other key performance quality indicators which are also updated monthly.

Recruitment for trained nursing staff continues to be a significant challenge nationally and for the Trust. The reduction in the number of student nurses being trained, combined with an ageing workforce, and high numbers of staff leaving the profession coupled with the demand and opportunity for staff to work for staffing agencies who offer enhanced payment has created a "national workforce crisis".

Safe staffing has to take account of multiple factors. It must be matched to patient needs and is about skill mix as well as numbers, and includes many other health professionals as well as nurses; however this paper will focus on nurse staffing, trained nurse vacancies, Hard Truths staffing data and initiatives that have been implemented since April 2014 to improve the nursing establishments on in patient ward areas and A&E which support ward sisters and charge nurses to lead on recruitment initiatives and exercise more robust overt budgetary control for their individual ward areas.

The nursing recruitment, retention and work force forecast will not be discussed in detail within this paper and is planned to be presented as a separate paper to the Board via the Director of HR and workforce.

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Methodology used to develop nursing rotas
In 2012 the Trust agreed the Nurse Staffing Strategy, which is a four year strategy, to improve the nurse staffing levels across the Trust. This equates to £1.9m investment in year 1 - 2012/13 and £1.4m has been allocated for investment in year 2 - 2014/15.

As part of that strategy, and in line with national guidance, a bi-annual review of the nursing skill mix using an appropriate methodology and tool is recommended to be undertaken.

The methodology used to determine the appropriate safe staffing levels for each of the clinical areas, which relates specifically to registered nurses is based upon guidance on Safe Nursing Staffing Levels in the UK (RCN 2012), and the "Safe Staffing for Nursing in Adult Patient Wards in Acute Hospitals, NICE Safe Staffing Guidelines draft for consultation (NICE 2014).

The professional judgement of the senior nursing team is also used as this is based on an in-depth knowledge of the acuity, dependency and activity requirements of each clinical speciality. This concept is advocated by NICE (2014, page 15) when formulating nursing establishments. It is acknowledged that there is no single nursing staff to patient ratio that can be applied across a wide range of wards to safely or adequately meet the nursing needs of patients. NICE therefore recommends the factors that need to be systematically assessed at ward level when determining nursing staff requirements with the nursing care needs of individual patients being the main drive.

A nursing skill mix review was completed in May of 2014 and repeated in October 2014. This included a skill mix review across the general wards using the Safer Nursing Care Tool (SNCT). The findings from the October 2014 review will include a Confirm & Challenge meeting with the Director of Nursing, Director of Finance, Ward Sister, Matron and Lead Nurse to review the findings from the SNCT. Part of this meeting will also include the professional judgement of the Ward Sister which collectively will form part of the Budget setting process for 2015/16.

Trained Nurse Vacancies month 7 position
The trained nurse vacancy as of month 7 (October 2014) is 105.49 wte for general wards including A&E. This increases to 127.20wte when specialist areas are included.

The above excludes trained members of staff on long-term sick leave, maternity leave and staff suspended from duty. This cohort of absent workforce equates to an additional 29wte ward based staff members.

Hard Truths Ward Staffing Levels in Inpatient Areas October 2014 – overview by Early, Late & Night Shift
Results of the monthly data collection exercise illustrated that 35% of wards (9 out of 26) were staffed at over 99% of their funded establishment which is planned combined day *and* night shifts for both registered and support staff groups which includes temporary staff during October 2014. It must be noted that the use of temporary staffing (bank and agency) and extra hours worked were required to achieve the above compliance.

Of more concern is the 11 wards 42% (11 of 26) reported in October that were below the 80% threshold for planned staff versus actual staff worked, the number of wards below the threshold has increased when compared to September 2014 (4 wards 15%).

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

Staffing shortfalls were a consequence of outstanding established vacancies, maternity / other long term leave plus unpredictable short term sickness which could not be filled with temporary staff. In these instances, safe staffing levels are reviewed frequently, then maintained by internal staff movements from other ward areas. Staffing concerns are discussed and remedial action agreed at the twice daily corporate safety huddles, night team handover and supported by the senior nursing team.

Trained supernumerary staff (i.e. Nurses recruited from Spain / others awaiting PIN registration etc.) worked across the Trust during the month, this group is not accounted for in the actual staffing figures, but supports established registered and unregistered staff on the ward.

Wards vacancies (from staffing returns via Care Group) are as follows:

SCG:

- Abington has 5 wte RN and 0 wte HCA vacancies with 1 wte RN and 1 wte HCA on long term sick leave.
- Cedar has 4 wte RN and 3 wte HCA vacancies and 1wte RN and 1 wte HCA on long term sick leave.
- Child Health Combined has14 wte RN and 3 wte HCA vacancies with 3 wte RN on maternity leave and 2 wte RN on long term sick leave.
- Hawthorn has 3 wte RN vacancies and 2 wte HCA vacancies and 1 wte RN on long term sick leave.
- ITU/HDU has 8 wte RN and 2 wte HCA vacancies with 3 wte RN on maternity leave.
- Head & Neck show 1 wte RN and 2 wte HCA vacancies.
- Rowan has 0 wte vacancies and 2 wte HCA vacancies with 2 wte RN on maternity leave.
- Spencer has 1 wte RN vacancy and 1 wte RN on long term sick leave.
- Willow has 6 wte RN and 2 wte HCA vacancies with 2 wte RN on maternity leave and 2 wte on long term sick leave.

MCG:

- Allebone has 4.83 wte RN and 1 wte HCA vacancies.
- Brampton has6 wte RN and 0.39 HCA vacancies.
- Becket has 6.27 wte RN and 0.37 wte HCA vacancies with 1 wte RN on maternity leave and 1 wte on long term sick leave.
- Benham has 0.57 wte RN and 0 wte HCA vacancies with 2 wte RN on maternity leave and 1 wte RN on long germ sick leave.
- Compton has 0.91 wte RN and 0.37 wte HCA vacancies.
- Creaton has 6.62 wte RN and 0.85 wte HCA vacancies with 1 wte RN on maternity leave.
- Dryden has 2.17 wte RN and 0 wte HCA vacancies with 3 wte RNs on maternity leave.
- Collingtree has 4 wte RN and 0 HCA vacancies.
- EAU has 2.07 wte RN and 0.26 wte HCA vacancies with 2 wte RN and 1 wte HCA on maternity leave.
- Eleanor has 2.23 wte RN and 0 wte HCA vacancies.
- Finedon has 3 wte RN and 0 wte HCA vacancies.
- Holcot has 4.72 wte RN and 0 wte HCA vacancies.
- Knightley has 4.74 wte RN and 0.85 wte HCA vacancies.
- Talbot Butler has 4.49 wte RN and 0 wte HCA vacancies.

Shift Staffing in October – Overview

EARLY	RN: In October, 15% (4 out 26 inpatient areas including combined Child and Maternity units) of the funded established RN staff levels were either achieved or above establishment (i.e. >99% + of planned staffing) on the early shift. 77% (20 out of 26 inpatient areas) wards worked between 80% and 99%; HCA / MSW SUPPORT: Across the month, 58% (15 out of 26 inpatient areas) of support staff established levels were either achieved or above establishment i.e. (i.e. >99% + of planned staffing), on the early shift to include specialling and escalation deployment. 312% (8 out of 26 inpatient areas) wards worked between 80% and 99%; Staffing shortfalls were a consequence of outstanding established vacancies,

	maternity / other long term leave plus unpredictable short term sickness which could not be filled with temporary staff.
LATE	RN: For the month, 8% (2 out 26 inpatient areas including combined Child and Maternity units) of the funded established RN staff levels were either achieved or above establishment (i.e. >99% + of planned staffing) on the late shift. 65% (17 out of 26 inpatient areas) wards worked between 80% and 99%; HCA / MSW SUPPORT: Across the month, 58% (15 out of 26 inpatient areas) of support staff established levels were either achieved or above (i.e. >99% + of planned staffing), to include specialling and escalation deployment. 31% (8out of 26 inpatient areas) wards worked between 80% and 99%; Staffing shortfalls were a consequence of outstanding established vacancies, maternity / other long term leave plus unpredictable short term sickness which could not be filled with temporary staff.
NIGHT	RN: For the month, 62% (16 out 26 inpatient areas including combined Child and Maternity units) of the funded established RN staff levels were either achieved or above establishment (i.e. >99% + of planned staffing) on the night shift. 35% (9 out of 26 inpatient areas) wards worked between 80% and 99%; HCA / MSW SUPPORT: Across the month, 81% (21 out of 26 inpatient areas) of support staff established levels were either achieved or above establishment (i.e. >99% + of planned staffing), on the night shift to include specialling and escalation deployment. 12% (3 out of 26 inpatient areas) wards worked between 80% and 99%; Staffing shortfalls were a consequence of outstanding established vacancies, maternity / other long term leave plus unpredictable short term sickness which could not be filled with temporary staff.
SCG Summary	**Abington** increase in staff due to complex patients with increased dependency and additional specials Decrease due to 1 HCA suspended **Althorp** increase in staff due to clinical needs / cognitive impairment with increased dependency and additional specials HCA short term sickness has impacted on the ability to cover the ward. **Cedar** increase in staff due to complex patients with increased dependency and additional specials Decrease due to 1 HCA suspended **Child Health Combined** increase in staff due to complex patients with increased dependency and additional specials Decrease due to 1 RN suspended **HDU / ITU** decrease due to unpredictable short term sickness - could not be covered by bank/agency at short notice **Rowan** Decrease in patients' clinical needs /dependency/acuity, requiring fewer specials / trained on some shifts Staff re-assigned to another ward on request, as skill mix vs acuity/numbers considered safe **Willow** increase in staff due to complex patients with increased dependency and additional specials Unpredictable short term sickness - could not be covered by bank/agency at short notice
MCG Summary	**Allebone** increase in staff due to complex patients with increased dependency and additional specials **Becket** staff moved from ward to cover shortfalls on other wards Decrease due to 1 member of staff suspended **Compton** Decrease due to 1 member of staff suspended **Collingtree** staff moved from ward to cover shortfalls on other wards **Creaton** increase in staff due to complex patients with increased dependency and additional specials

	Dryden Decrease due to 1 member of staff suspended **Eleanor** increase in staff due to complex patients with increased dependency and additional specials **Holcot** decrease due to 1 member of staff suspended **Victoria** increase in staff due to complex patients with increased dependency and additional specials.

Bank & Agency Usage (Nursing) WC 03.11.14

In summary:
The total utilisation (Bank & Agency Filled) was 7,658 hours (204 WTE), **a decrease of 1,000 hours compared with the previous week.** The total number of hours requested (10,129) **decreased by 1,587.**

Agency hours filled decreased by 870. Bank hours filled decreased by 131 hours.

Bank fill rate = 46.16% **(increase of 4.32%),** Agency fill rate = 29.82% **(decrease of 2.69%).** Total bank & agency fill rate = 75.98% **(increase of 1.63%).**

As of **month 7 the cumulative spend** for **Trained Agency Nursing** is **£2.3m** this includes an estimated £966k of agency premium.
The **Total spend** for the Temporary Nursing Workforce **as of month 7 is £5.8m**.
All **Nursing** as a whole **is £282k favourable to the YTD FRP position**.

	Week Commencing 27/10/2014		Week Commencing 03/11/2014		Change in Hours
Booking Reason (Total Hours Req	Hours	WTE	Hours	WTE	Requested
Approved Unavailability	786.45	20.97	633.00	16.88	-153.45
Domestic Leave Cover	0.00	0.00	0.00	0.00	0.00
Escalation Areas	535.83	14.29	557.75	14.87	21.92
Estab Vacancies	4804.48	128.12	3771.33	100.57	-1033.15
High Acuity	0.00	0.00	0.00	0.00	0.00
Increased Workload	0.00	0.00	0.00	0.00	0.00
Invoicing	104.25	2.78	162.50	4.33	58.25
Maternity	856.50	22.84	921.90	24.58	65.40
Phased Return	132.75	3.54	206.00	5.49	73.25
Prof Development or Training	17.00	0.45	32.00	0.85	15.00
Project Work	0.00	0.00	13.50	0.36	13.50
Sickness - Long Term	676.98	18.05	404.48	10.79	-272.50
Sickness - Short Term	1310.05	34.93	973.70	25.97	-336.35
Specialling	2422.35	64.60	2407.08	64.19	-15.27
Staff Moved to Another Ward	10.50	0.28	0.00	0.00	-10.50
Unauthorised Booking	0.00	0.00	0.00	0.00	0.00
Unauthorised Absence	59.50	1.59	46.00	1.23	-13.50
Grand Total	**11716.65**	**312.44**	**10129.25**	**270.11**	**-1587.40**
Bank Filled	**4810.22**	**128.27**	**4679.65**	**124.79**	**-130.57**
Agency Filled	**3848.55**	**102.63**	**2978.67**	**79.43**	**-869.88**
Total Utilisation	**8658.77**	**230.90**	**7658.32**	**204.22**	**-1000.45**

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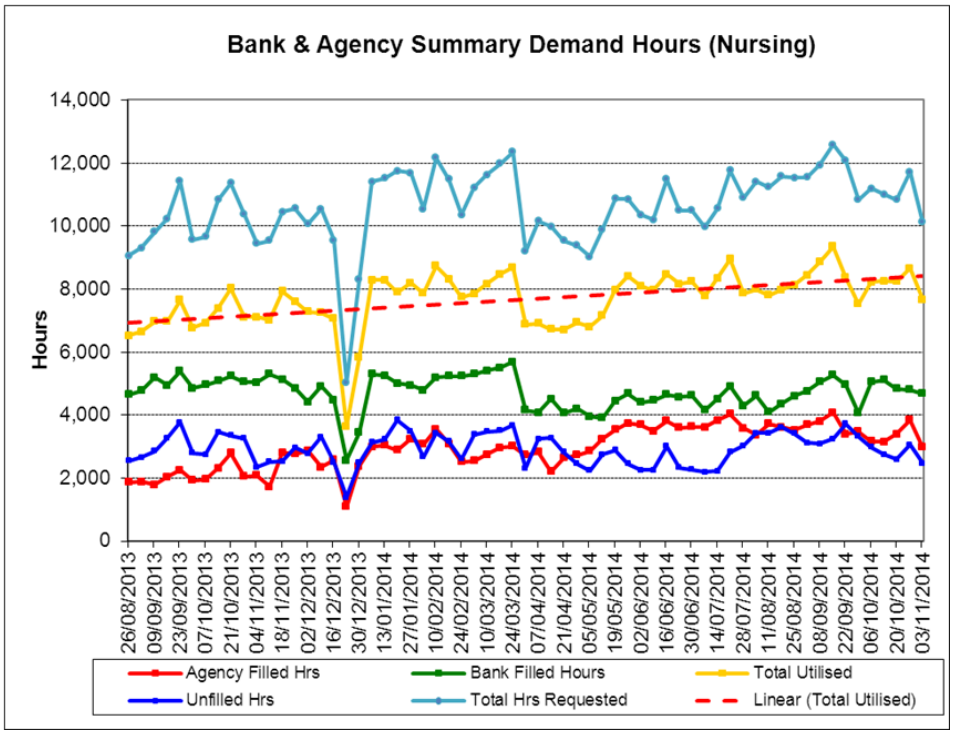
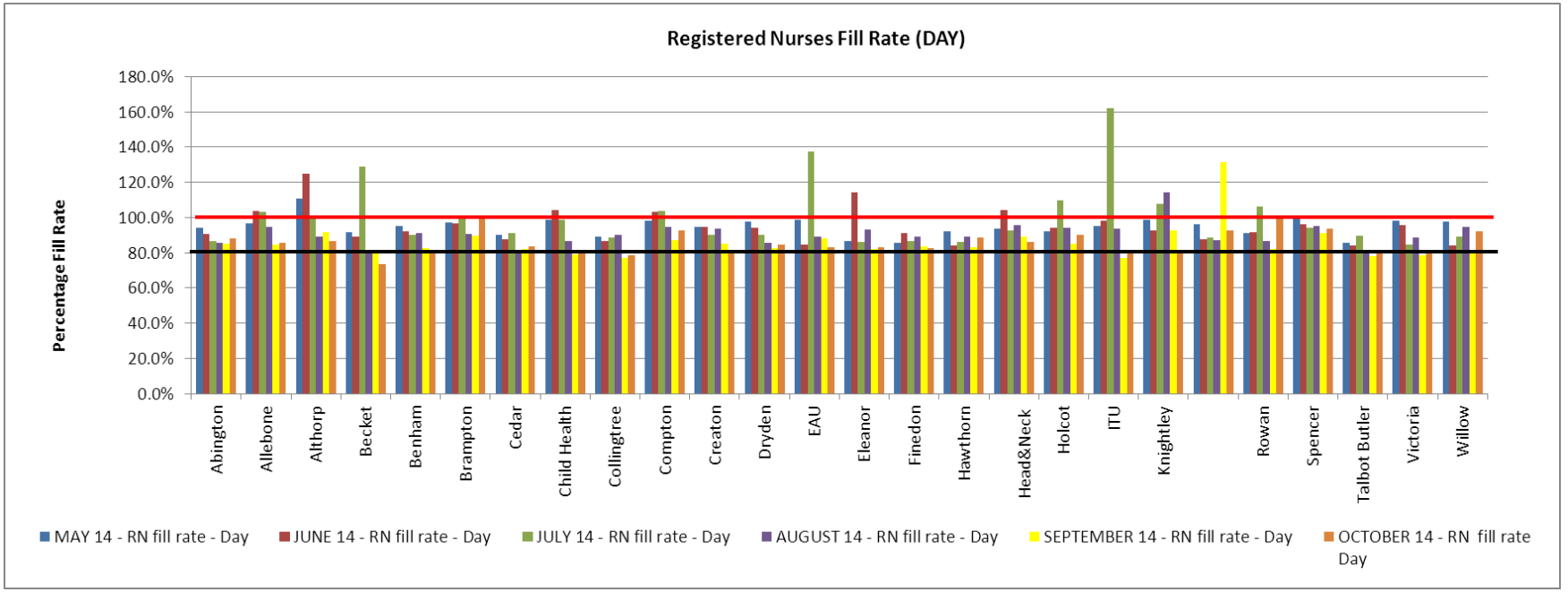

Bank & Agency Summary Demand Hours (Nursing)
Hours
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
26/08/2013
09/09/2013
23/09/2013
07/10/2013
21/10/2013
04/11/2013
18/11/2013
02/12/2013
16/12/2013
30/12/2013
13/01/2014
27/01/2014
10/02/2014
24/02/2014
10/03/2014
24/03/2014
07/04/2014
21/04/2014
05/05/2014
19/05/2014
02/06/2014
16/06/2014
30/06/2014
14/07/2014
28/07/2014
11/08/2014
25/08/2014
08/09/2014
22/09/2014
06/10/2014
20/10/2014
03/11/2014
Agency Filled Hrs
Bank Filled Hours
Total Utilised
Unfilled Hrs
Total Hrs Requested
Linear (Total Utilised)

NGH WARD STAFFING % FILL RATES: DAY SHIFTS May – October 2014

Note: red horizontal line = 100% staff fill (establishment) & lower black line = 80% Fill Rate Target. Supernumerary staff not included. Escalation area resourcing managed by Althorp, Dryden, Spencer Wards



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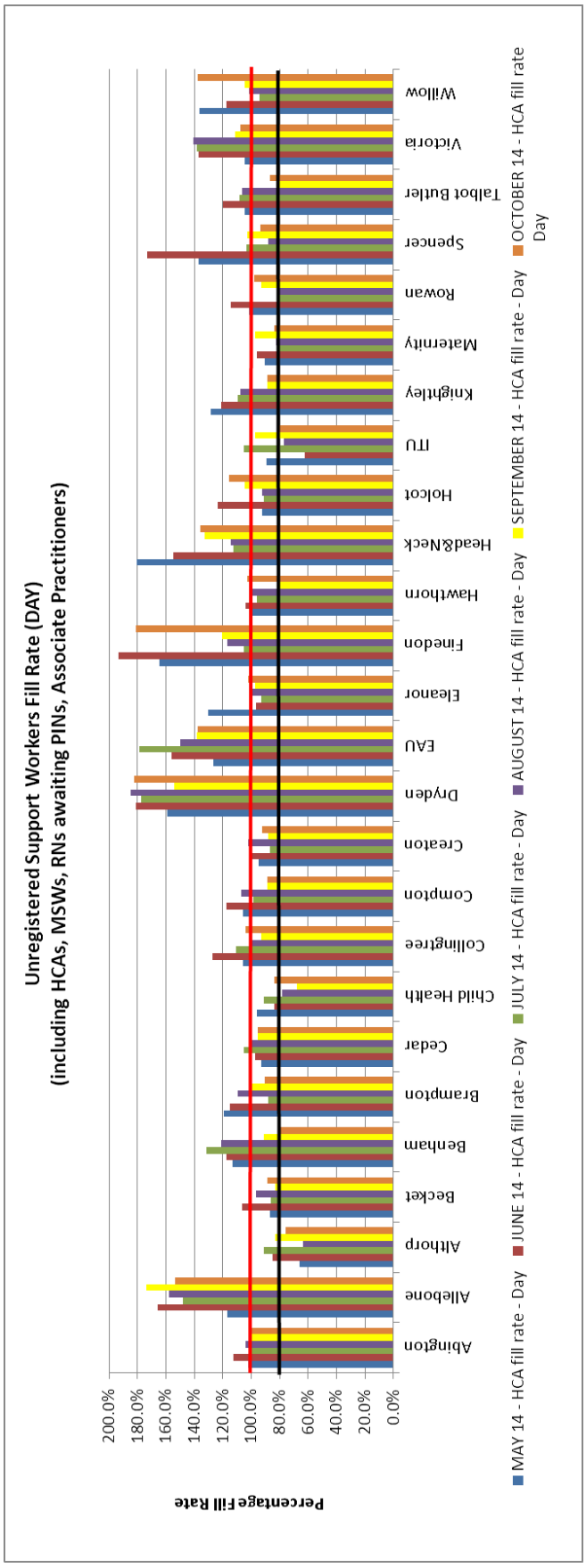
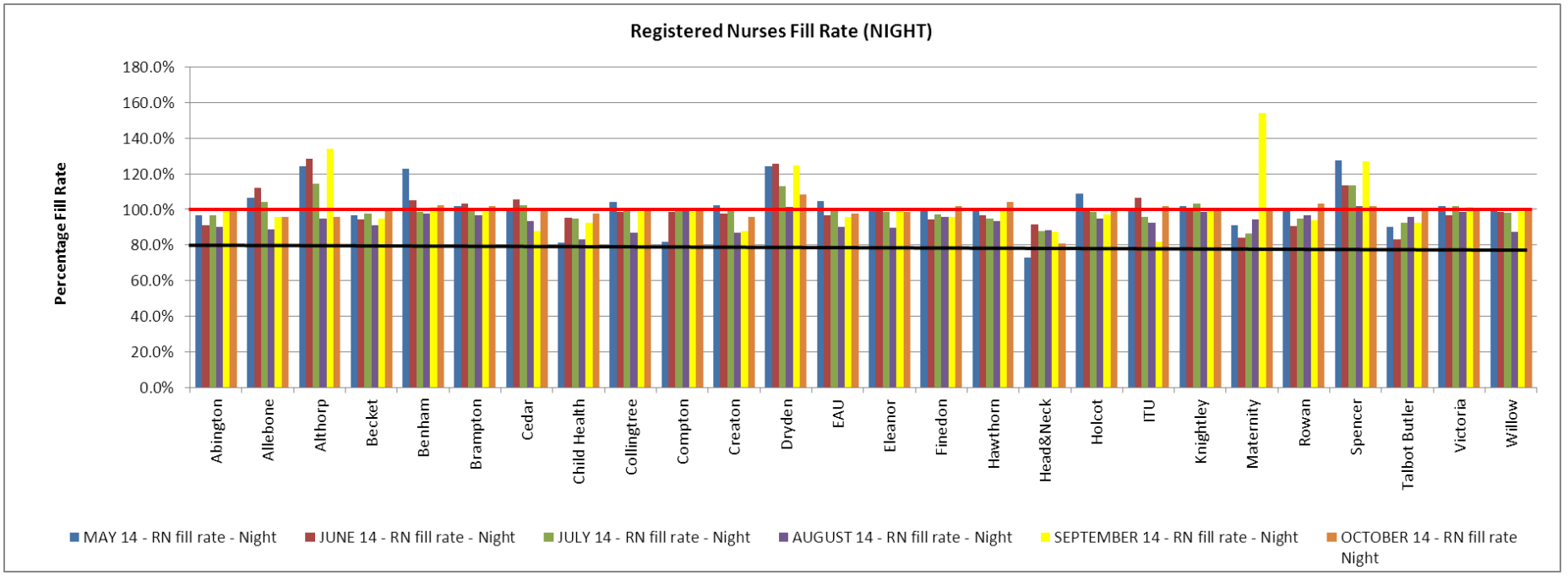
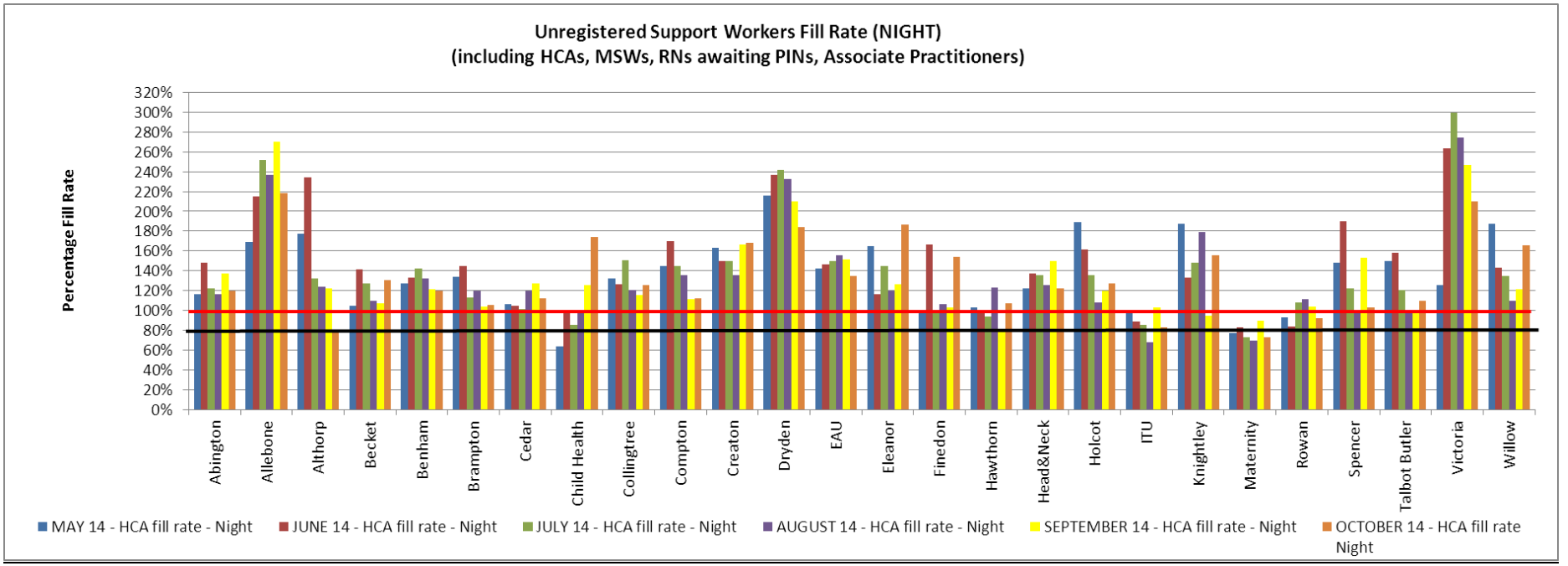

Unregistered Support Workers Fill Rate (DAY)
(including HCAs, MSWs, RNs awaiting PINs, Associate Practitioners)
Percentage Fill Rate
200.0%
180.0%
160.0%
140.0%
120.0%
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
Abington
Allebone
Althorp
Beckel
Benham
Brampton
Cedar
Child Health
Collingtree
Compton
Creaton
Dryden
EAU
Eleanor
Finedon
Hawthorn
Head&Neck
Holcot
ITU
Knightley
Maternity
Rowan
Spencer
Talbot Butler
Victoria
Willow
MAY 14 - HCA fill rate - Day
JUNE 14 - HCA fill rate - Day
JULY 14 - HCA fill rate - Day
AUGUST 14 - HCA fill rate - Day
SEPTEMBER 14 - HCA fill rate - Day
OCTOBER 14 - HCA fill rate - Day


Registered Nurses Fill Rate (NIGHT)
Percentage Fill Rate
180.0%
160.0%
140.0%
120.0%
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
Abington
Allebone
Althorp
Becket
Benham
Brampton
Cedar
Child Health
Collingtree
Compton
Creaton
Dryden
EAU
Eleanor
Finedon
Hawthorn
Head&Neck
Holcot
ITU
Knightley
Maternity
Rowan
Spencer
Talbot Butler
Victoria
Willow
MAY 14 - RN fill rate - Night
JUNE 14 - RN fill rate - Night
JULY 14 - RN fill rate - Night
AUGUST 14 - RN fill rate - Night
SEPTEMBER 14 - RN fill rate - Night
OCTOBER 14 - RN fill rate Night

Enclosure E


Unregistered Support Workers Fill Rate (NIGHT)
(including HCAs, MSWs, RNs awaiting PINs, Associate Practitioners)
Percentage Fill Rate
320%
300%
280%
260%
240%
220%
200%
180%
160%
140%
120%
100%
80%
60%
40%
20%
0%
Abington
Allebone
Althorp
Becket
Benham
Brampton
Cedar
Child Health
Collingtree
Compton
Creaton
Dryden
EAU
Eleanor
Finedon
Hawthorn
Head&Neck
Holcot
ITU
Knightley
Maternity
Rowan
Spencer
Talbot Butler
Victoria
Willow
MAY 14 - HCA fill rate - Night
JUNE 14 - HCA fill rate - Night
JULY 14 - HCA fill rate - Night
AUGUST 14 - HCA fill rate - Night
SEPTEMBER 14 - HCA fill rate - Night
OCTOBER 14 - HCA fill rate Night

Initiatives in place to enhance Ward recruitment and retention
To complement the Hard Truths Commitment, Nurse Staffing Review, and Recruitment Campaign the Director of Nursing is leading a number of fundamental changes to further develop resilience of the nursing and midwifery workforce.

- Bank & Agency Group – this is now lead by the Director of Nursing with support from Assistant Director of Finance, Head of Nurse Informatics and Senior HR recruitment lead. The group is focussed on the recruitment of staff and reducing the use of temporary staff, in particular Agency staff.
- Set up a 'Specials' bank of HCA's who have the relevant training and skills to care for those patients who require 1:1 care. Part of this initiative will include the consideration of using mental health trained staff who may be able to 'special' more than one patient at a time due to their skill set and bolster the trained nurse workforce.
- Performance Meetings – the Director of Nursing is leading 1:1 meetings with the 15 ward Sisters/Charge nurses whose current ward expenditure is over budget. The bi-weekly meetings are supported by the team. Each Sister/Charge Nurse has been allocated an improvement plan and/or a financial trajectory to achieve in a given time frame with regular meetings to review progress. All wards sisters/charge nurses meet with the Director of Nursing and support team regardless of budgetary position. This is to provide assurance that the a plan is in place at ward level for active recruitment and retention for ward staff and ward budgets and ward rotas are clearly compatible and understood.
- Back to Basics – Band 7 Development programme. All band 7 (47 Ward Sisters/Charge Nurses) have attend a four day development programme focusing on the fundamental aspects of their role. The programme provided clear expectations, roles, responsibilities and accountability of the Sister/Charge Nurse role, which includes ward budgetary management, recruitment and retention of staff and the financial and quality impact of a temporary workforce. The second programme is in development.
- Back to Basics Review Meetings – the Director of Nursing with the Deputy Director of Nursing hold bi-weekly meetings to challenge the Sisters & Charge Nurses on Quality Metrics, supporting the reduction and sharing best practice and lessons learnt from all Avoidable Harms.
- Nurse informatics are working directly with wards to reduce unused hours making rotas more efficient and effective. Part of this ward based work includes "good rota housekeeping", for accurate, timely data entry in Healthroster (Workforce)
- Completed pilot project for electronic Safe Care staffing
- Bi weekly Review Workforce plans and ward managers recruiting and managing ward vacancies with support of a designated recruitment advisor
- Implemented an English language course for all Spanish speaking nurses at NGH.
- Implemented new cost centres for escalation areas to identify nurse overspend with the providing further clarity for ward budgets
- Identified escalated and reduced the number of staff suspended and the associated financial cost
- Provided comparison financials for Bank and Agency for previous year to demonstrate a reduction in actual bank and agency WTE`s.
- Streamlined and removed the opportunities to book extra shifts, bank and agency via Healthroster
- Disbanded the bank agency monthly meeting introduced weekly targeted meetings for ward managers with support team in attendance
- Identified a time lag and delay form appointed staff to start dates
- Introduced active monthly recruitment events and internal specialty recruitment days
- Revised the NOC process to more efficient and align nominal role with Pay role.
- Nurse informatics currently refining presentations of all staffing data for ease of use for ward managers.

2. Next steps

- Continue with initiatives in place that are continuing to have a positive impact on nurse staffing and KPI`s.
- Continue bi weekly confirm and challenge meetings for wards who are challenged with recruitment issues or/and have a high reliance on a temporary workforce.
- Continue Back to Basics bi weekly Review Meetings for KPI`s
- Recruitment and retention strategy, plans are in development with the Director of Nursing, the Director of HR and the Finance Director to recruit nationally and internationally for trained nurses, the scoping of appropriate agencies has commenced

3. Recommendations

The Trust Board are asked to:

- Note the staffing information provided and acknowledge that safe care continues to be delivered.
- Note the analysis of the shift by shift staffing numbers, the vacancy factor, and active recruitment initiatives in place
- Support the continued reporting of the Hard Truths data on the Trust website & NHS Choices website
- Note that the Director of Nursing and senior team have reviewed the SNCT findings and will review the use of 'Specials' as part of the overall 'Temporary Staffing Review'
- Note that a further SNCT audit in October has been completed which will include the Confirm & Challenge meeting with the Ward Sisters, Director of Nursing & Director of Finance ready for 2015/16 budget setting.
- Support the on-going recruitment of the increased establishment that the Trust Board supported in April 2014.
- Support the work streams lead by the Director of Nursing.

The Trust Board are requested to advise on further assurances required in relation to staffing capability and capacity and the content of future Board reports required regarding staffing data.

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**27 November 2014**

Title of the Report	**Director of Nursing and Midwifery Report**
Agenda item	**10**
Sponsoring Director	Jane Bradley, Interim Director of Nursing, Midwifery & Patient Services
Author(s) of Report	Senior Nursing & Midwifery Team
Purpose	Assurance & Information

Executive summary

This report provides an update and progress to date on a number of clinical projects and improvement strategies that the Nursing & Midwifery senior team are working on. A shortened version of this report, providing an overview of the key quality standards, will be available on the Trusts website as part of the Open & Honest Care Report.

Key points from this report:

- N&M Quality Dashboard (QuEST) shows compliance of 82%, with a number of wards improving their month on month position
- Safety Thermometer – achieved 92.6 % this month against a ceiling of 93%. This is a slight improvement from last month (92%). CRUTI has remained consistent, with falls & harm from blood clots being below national average.
- The number of reported pressure ulcers for October has remained static however, there has been a 48% reduction on the number of grade 3 pressure ulcers reported in quarter 2 compared with quarter 1 in which 25 grade 3 pressure ulcers were reported.
- There have been 3 C. Difficile cases this month; this is above our monthly internal stretch target but within our national annual ceiling of 35, the total for the year is currently 18 cases.
- For the second consecutive month there have been no moderate or harmful falls.
- The Friends & Family Test results for October have remained positive:
    - Inpatients achieved a response rate of **29.78%**
    - Maternity services obtained a response rate of **38.27%**
    - A&E were below their response rate target obtaining a response rate of **14.75%,** it should be noted that the CQUIN for A&E's performance is dependent upon reaching 15% in Q1 and 20% in Q4. There is no reporting within Q2 and Q3.
    - Day case areas obtained a response rate of **27.41%**
    - Paediatrics achieved a response rate of **68.15%**
- In October we successfully launched the roll-out of the FFT to Outpatients and Day case areas across the trust.
- The Safeguarding report provides an update on the specialist services and improved training figures
- The Patient Safety Academy summary provides an update on the Flagship
- The Midwifery report provides an update on the external Supervisors of Midwives audit from July.

Enclosure F

Related strategic aim and corporate objective	To be able to provide a quality care to all our patients
Risk and assurance	The report aims to provide assurance to the Trust regarding the quality of nursing and midwifery care being delivered
Related Board Assurance Framework entries	BAF – 1
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? No Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?No
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper - No

Actions required by the Board

The Board is asked to discuss and where appropriate challenge the content of this report and to support the work moving forward.

The Board is asked to support the on-going publication of the Open & Honest Care Report on to the Trust's website which will include safety, staffing and improvement data.

Public Trust Board
27 November 2014

Director of Nursing Midwifery Report

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

2. Nursing & Midwifery Quality Dashboard
The N&M Quality Dashboard presents the findings from the monthly QuEST audit. The QuEST data is 'aggregated' onto the Dashboard, which is triangulated with a wealth of information from other data sets and audits.

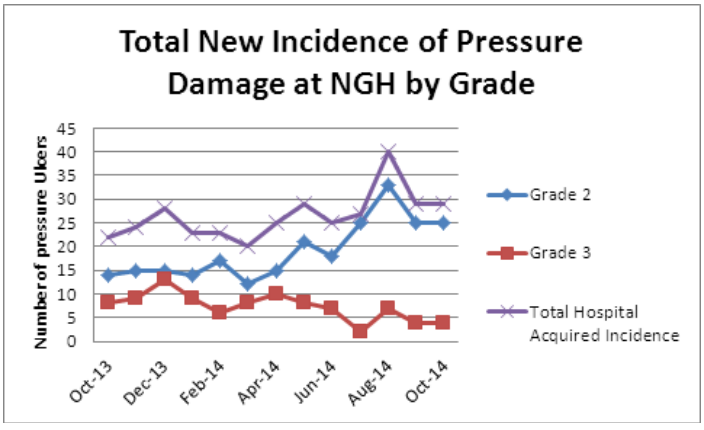
In October the wards achieved an overall score of 82% compliance which is the same as last month. Allebone has decreased this month from 83% in September to 76% in October. The Ward Sister is working with the Practice Development Team to focus on documentation, complaints and FFT results. After a number of months in 'amber' Collingtree has achieved 82% this month and Dryden has increased for the second consecutive month to 82%. Willow Ward has decreased this month from 79% to 71% compliance; the ward already has an improvement plan in place that the Matron is supporting. Cedar Ward has improved significantly for the second month from 80% to 88% in October.

3. Safety Thermometer
In October 92.6% patients experienced 'harm free care' in this Trust which is just below the national average of 93%. This has slightly improved from last month (92%), which is due to the reduction in the prevalence of pressure ulcers. Catheter-related urinary tract infections, falls & harm from blood clots, remain at or below the national average.

4. Pressure Ulcer Incidence
There was 29 hospital acquired pressure ulcers reported in October. Of these 25 were validated as Grade 2 and 4 validated as Grade 3. These pressure ulcers have not been confirmed to consider whether they are avoidable or unavoidable.

From the September pressure ulcers we have had fifteen grade 2 avoidable pressure ulcers, one grade 3 avoidable pressure ulcer, ten grade 2 unavoidable pressure ulcers. There are still three grade 3 pressure ulcers that have not been confirmed avoidable or unavoidable.

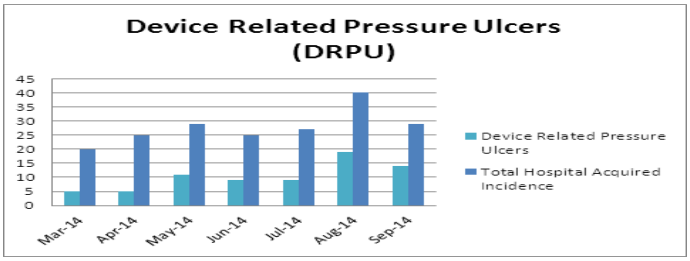
Figure 1



Enclosure F

Of the 29 pressure ulcers in September 48% (14) were device related, Figure 2 demonstrates the anatomical sites of the damage occurred, with the ears remaining the most common site.

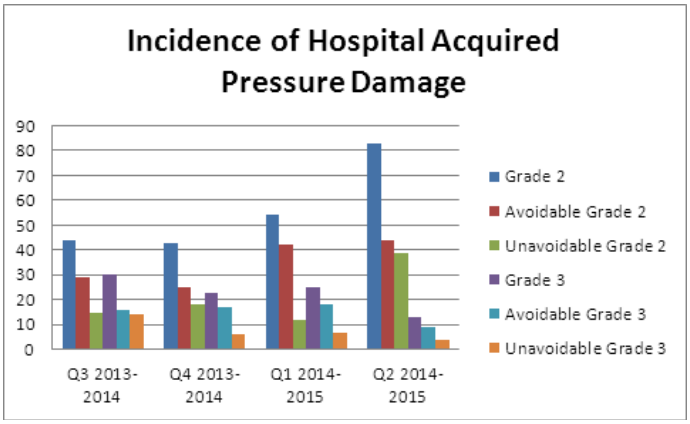
Figure 2



CQUIN

It should be noted that in Q2 the number of HAPU Grade 2 validated by the CCG as unavoidable has also increased considerably. Figure 1 also acknowledges the acuity and dependency of inpatients noted in August. The Board are asked to note that this data does not include validated outcomes (September's Data) by the CCG at the time of writing this report.

Figure 3



The Trust has reported 13 grade 3 pressure ulcers in Q2, this is a 48% reduction on the previous quarter where 25 Grade 3 ulcers were reported of which 18 were considered (by the CCG) to be avoidable. It is anticipated that 9 of the 13 will be validated as avoidable by CCG. The CQUIN threshold for 2014-2015 is a reduction of 35% on 2013-2014, which the Trust is on target to achieve.

	Avoidable Target per Quarter	Q1	Q2	Q3	Q4
Grade 2 *avoidable/unavoidable*	21	42/12	44/39 tbc		
Grade 3 *avoidable/unavoidable*	10	18/7	9/4 tbc		

Local Pressure Ulcer CQUIN
The Quarter 2 report for the local CQUIN, which suggest that the Trust remains on target to achieving 100% payment, has been submitted to the CCG.

5. Health Care Associated Infections (HCAIs)

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

	C.difficile	MRSA
Number of infections this month	**3**	**0**
Number of infections last month	**1**	**0**
Improvement target for year to-date	**35**	**0**
Actual to-date	**18**	**0**

Ebola awareness day took place on Friday 31 October 2014. Five workshops were undertaken throughout the day and there were 87 attendees from frontline staff. This will be continued with further workshops and adapted and refined according to national and local information received.

6. Falls Prevention

Falls/1000 bed days this month 3.91 (last month 3.96) against the National average of 6.75 (2010/11)

This month we reported 0 in-patient falls that caused at least 'moderate' harm.

Severity	Number of falls
Moderate	0
Severe	0
Death	0

95% of patients received a falls risk assessment within 12 hours of admission, above the target of 90% for the second consecutive month.

77% of patients at risk of falling had a completed falls care plan; this is below the internal target of 80%. This is an improvement on September's figures of 73%. Areas RAG rated red will have additional input and support from the Falls Team to help them improve.

7. Friends & Family Test

Of most significance for September's FFT data:

- Inpatients achieved a response rate of **29.78%**
- Maternity services obtained a response rate of **38.27%**
- A&E were below their response rate target obtaining a response rate of **14.75%,** it should be noted that the CQUIN for A&E's performance is dependent upon reaching 15% in Q1 and 20% in Q4. There is no reporting within Q2 and Q3.
- Day case areas obtained a response rate of **27.41%**
- Paediatrics achieved a response rate of **68.15%**

Areas that have underperformed are notified. It is expected that once the new electronic solution has been rolled out to inpatient services response rates will improve across all areas that are currently underperforming.

Of most significance for September's Net Promoter Scores (NPS):

- Inpatient services obtained a score of 54, significantly lower than the score of 62 in August
- A&E (including Ambulatory Care and Eye Casualty) obtained a score of 61, again a decrease from the score in August of 68, however still above the internal target
- Maternity services achieved a score of 77, an improvement from August where the score was 74
- Day case areas achieved a score of 84, significantly higher than the target and 2 points higher than August.
- Paediatrics achieved an excellent score of 62, a decrease from the score in August of 73 and below the expected internal target of 70.

For areas that have a low NPS the breakdown of the response types are reviewed to identify the percentages of patients that would recommend, against the percentage of patients that wouldn't. The comments for the area are also reviewed to see if there are any particular problems identified. If an area has a high level of patients that wouldn't recommend, and they have a number of negative comments, then a plan is requested from the area for improvement. However, if on further inspection it is found that there is not a high level of patients that 'wouldn't recommend' then the score will be reviewed the next month to see whether this was an outlier or whether the low score continues. If it does continue for a further month then an action plan is requested.

Roll out of FFT to Outpatient & Day Case Areas

As part of the national CQUIN, NGH was required to roll out the FFT to all Outpatient and Day Case Areas (including Paeds) by 1 October to receive part year CQUIN payment. Due to the magnitude of this task, external providers Healthcare Communications are supporting this on the hospital's behalf, as well as roll out to the rest of the hospital to ensure a uniformed approach.

Of most significance:

- From the 1 - 31 October 24,473 text messages were sent to patients for NGH Outpatient feedback, a further 697 were sent to Danetre patients
- Of these, 7112 patients opted to give their feedback via SMS or automated voice message
- In addition to this, 3090 messages were sent to Day Case patients across the 2 sites, with 1005 responses being received
- The CQUIN was achieved on 1 October due to the electronic roll out being of success
- Reporting will commence in December 2014

Improvement work

Inpatient Website

From a project completed earlier in the year it was identified that patients requested to have certain pieces of information available to them. Previously bedside booklets were produced, however these are now outdated and a number of them have gone missing on the wards. Therefore the external website has been updated to include a number of pieces of relevant information, and a link will be added to the Hospedia Bedside Terminals for patients to access all the information within the webpage – this exceeds information available via a leaflet and is cost effective. In addition, the 'essentials' will be placed into a leaflet with information on how to access more information on the bedside terminals.

Patient Experience Webpages:
New webpages have been created for Patient Experience on the external website. These provide public information on 3 key areas:

1. Collecting patient feedback
2. Listening and understanding what patients tell us
3. Acting on what patients have said

This will be updated monthly to let the public know how we are performing with the FFT, and what projects are being undertaking to improve the patient experience within NGH.

Patient Experience & Engagement Logo
A logo has been created supported by Medical Illustrations as a way of branding all patient experience and patient engagement work. This is being used on the website and will be used in all future patient experience and engagement work.

8. Patient Safety Academy

Flagship Ward:
During October, observations continued and an assessment of the environment /ergonomics of the ward completed. Agreement has been received via Charitable funds to support with the purchase of furniture and some simple alterations to enable the concept of bay working to take place. The required alterations and furniture are now planned and ordered. The Task & Finish Group has meeting dates planned for the year ahead. Terms of Reference for the group and the treatment plan has been agreed. The following is a brief outline of what is encompassed within the treatment plan:

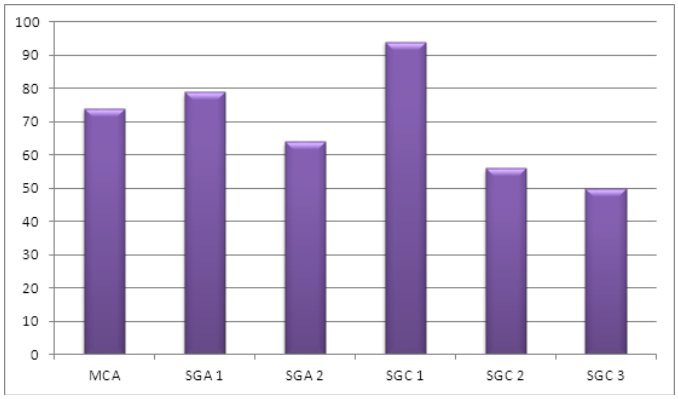
Environment / Ergonomics: Bay working Changes to Reception area Day room usage Office / MDT room usage Ward signage Ward clutter Ward noise Health & safety Location & signage of clinical equipment Layout schematic	**Communication:** Ward white boards / bay boards Ward huddles Ward rounds Team meetings Clear plan – EDD Transfer & handover Dedicated time when a patient can see a Dr. Praise a day / week IT
Medical & Nursing KPI's: EWS escalation & late observations Manual BP's Reducing preventable cardiac arrests Documentation Team Nursing Drug rounds & omissions Fluid balance Patient weights MT & role specific training Nutrition Pressure prevention Falls eRostering (all professions)	**Patient Experience:** Sleep well initiative All patients to know who their Consultant is Daily plan After care advice on discharge including follow up appointments etc. Visiting times Ticket home Pain management Do patients & relatives feel they can challenge their care Involvement in dementia care

The coloured areas above have been highlighted as the initial priorities to commence in November 2014.

9. Safeguarding Update

Training

The current position is shown below. Figures remain reasonably static. As previously reported, the alteration in the national competences for safeguarding children has resulted in a change in the compliance levels – this has been anticipated and sufficient training options are available to compensate.



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

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

The use of E-learning [pre-existing provision] has been expanded to include the higher levels of training and the Workbook model will become available from December 2014.

Allegations relating to NGH

In July 2014 the Safeguarding Team changed the process for managing Adult Safeguarding referrals made regarding NGH. This has resulted in a more robust method of delivering meaningful outcomes for patients. There remain some challenges within the new process, however these are being resolved and the new established Safeguarding Group will receive the first report on the trends and themes of this data in January 2015.

Governance

Despite a small delay, the inaugural meeting of the refreshed safeguarding governance group met in October. Moving forward, this group will provide a report in relation to activity; whilst key nursing issues will continue to be reported by exception through this report.

Learning Disability

The Learning Disability Project Worker has been in place for five weeks and is proving to be very successful. The post-holder has benefited from excellent bespoke training packages to complete his mandatory training and each department has exceeded expectations to make this training accessible and relevant.

As the post holder begins to develop links with the wards, this work will become more autonomous; supporting patients with a learning disability and their carers whilst in hospital, thus improving the patient's experience of acute care.

Common Assessment Framework (CAF)
CAF continues to present a challenge, however the Trust has delivered consistently on the agreed target of 4 CAFs per quarter for this financial year. Building on this success and the continued impetus of the Northamptonshire Improvement Board, NGH have agreed an ambitious, but achievable stretch target of 8 CAFs for the next two quarters of the year.

10. Supervision of Midwives (SOM)

The annual external audit of Supervisor of Midwives by the East Midlands LSA performed in July 2014 report has been received by the Trust and the recommendations will be presented in December Nursing and Midwifery Care Report.

An action plan has been developed from the recommendations made and will be monitored at SOM's meetings and the Obstetric Governance Group.

11. Recommendations

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

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**27 November 2014**

Title of the Report	**Medical Director's Report**
Agenda item	**11**
Sponsoring Director	Dr Michael Cusack, Medical Director
Author(s) of Report	Dr Michael Cusack, Medical Director
Purpose	Assurance

Executive summary

Red (>15) operational risks - Seven new risks have been added to the corporate risk register and a further three risks have been upgraded.

SIs and incidents - There are 12 open serious incidents which are under investigation. Problems with documentation were a consistent theme from incidents closed in October

Mortality - HSMR: rebased figures within expected range.
SHMI within expected range.

Draft IMR (December 2014) - Draft report suggests an 'elevated risk' for a composite basket of gastroenterology and liver diagnoses. This group is monitored quarterly and have not shown significantly adverse outcomes during the last year.

Related strategic aim and corporate objective	Be a provider of quality care for all our patients
Risk and Assurance	Risks to patient safety if the Trust does not robustly investigate root causes identify remedial actions required and ensure cross Trust learning to prevent recurrence of SI.
Related Board Assurance Framework entries	BAF 1
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (Y/**N**) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(Y/**N**)

Enclosure G

Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper

Actions required by the Trust Board

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

Public Trust Board
27 November 2014

Medical Director's Report

1. Safety and Quality

The purpose of this report is to highlight areas of concern in respect to quality and safety at NGH to the Board.

1.1 Summary Risk Profile

There are currently 45 Risks on Corporate Risk Register with a risk score of 15 or above (on 22 October 2014).

Risk Rating	Number of risks 22 Oct 2014	Number of risks – 10 Sep 2014	Number of risks – 15 July 2014	Number of risks – 19 May 2014	Number of risks – 15th April 2014
25	2	2		1	0
20	5	7	8	9	8
16	24	21	21	21	21
15	14	11	11	9	7
Total	45	41	40	40	36

1.2 New Risks Added to the Corporate Risk Register

Seven new risks have been preliminarily added to the Corporate Risk Register. These risks were discussed and agreed at the Risk Group meeting on 14th November 2014.

ID	Description	Rating (Initial)	Theme	Executive Lead	Directorate
599	Potential risk to patient safety resulting from delays due to inability to locate necessary equipment.	16	Equipment	Director of Facilities	Facilities
659	Risk of suboptimal care if recovery staff are unavailable for emergency and elective spinal/ epidural caesarean sections	15	Clinical Quality & Safety	Medical Director	Theatres and Anaesthetics
684	Potential risk of injury from delivery beds which require repair of stirrup lithotomy rests.	15	Clinical Quality & Safety	Director of Finance	O & G
691	Insufficient middle grade medical cover for the paediatric unit due to staffing shortage.	15	Clinical Quality & Safety	Medical Director	Child Health
696	CCG Operational Plan targets providers with £16.3m of Out of Contract QIPP schemes including £8.3m of unidentified QIPP schemes and £3.5m of data challenges.	16	Finance	Director of Finance	Finance
706	Unreliable YAG laser may result in a	16	Clinical	Director of	Ophthalmol

Enclosure G

ID	Description	Rating (Initial)	Theme	Executive Lead	Directorate
	delays to necessary ophthalmic treatment.		Quality & Safety	Finance	ogy

1.3 Risk Rating Increased During October 2014
Three risks have been assessed as having an increased risk rating and therefore have been escalated to the Corporate Risk Register.

ID	Description	Theme	Directorate	RR Change
121	Loss of day case capacity when the MD unit has been opened to increase bed capacity	Clinical Quality & Safety	T & O	RR increased to 15
437	Risk of breach of national target for endoscopy.	National Standards	General Surgery	RR increased to 15
469	Lack of resilience in radiotherapy service stemming from an inability to recruit to vacant consultant posts.	Clinical Quality & Safety	Oncology & Haematology	RR increased to 16

1.4 Board Assurance Framework (BAF)
There are currently 19 risks listed on the Board Assurance Framework. No risks have been added or removed from the BAF during the last reporting period. All actions on the BAF were updated during October and are now under review for November.

Strategic Aim	Number of Risks identified
1. Focus on Quality & Safety	8
2.Exceed Patient expectations	2
3.Stregthen local services	5
4.Enabelling Excellence through our people	3
5. Ensure a sustainable future	1

sk Rating	Number of strategic risks on BAF
20	4
16	5
15	1
12	4
10	2
9	1
6	2

2. Summary Serious Incident Profile
Serious incidents by year - 2010 to present:

	10/11	11/12	12/13	13/14	14/15 (to date)
Serious Incidents	27	55	78	115	55
Never Events	2	2	1	0	1

Never events in 2010 - 13 relate to:	Never events in 2014/15 relate to:
4 wrong site surgery	**1** wrong site surgery – removal of tonsillar cyst

2.1 Coroner's Inquests / Concerns

Schedule 5 Section 7 (formerly Rule 43)

None to date

Open Serious Incidents as at 31 October 2014:

Date	Directorate	SI Brief Detail	Status
Aug 2014	Medicine	Grade 3 Pressure Ulcer - Brampton Ward	Active
Aug 2014	T & O	2 x Grade 3 pressure ulcer - Plaster Room	Active
Sep 2014	Medicine	Care of the deteriorating patient	Active
Sep 2014	Medicine	Grade 3 pressure ulcer	Active
Sep 2014	Pathology / Maternity	Antenatal Screening - delay in positive result	Active
Sep 2014	Medicine	Grade 3 Pressure Ulcer	Active
Sep 2014	General Surgery	Grade 3 Pressure Ulcer	Active
Sep 2014	Pathology	Mortuary trolley accident	Active
Sep 2014	Maternity	Delay in removal of vaginal pack	Active
Sep 2014	Surgery	Retained Swab - breast	Active
Oct 2014	Child Health	Safeguarding Child	Active
Oct 2014	Medicine	Grade 3 Pressure Ulcer	Active

Themes from Serious Incidents submitted for closure October 2014:

Grade 3 Pressure Ulcers – unavoidable: Finedon, Victoria	
Theme	Learning / Actions
Documentation	Staff to be informed of the importance of completion of documentation
Clinical Assessment	Inaccurate Waterlow risk assessments Staff to apply Aderma below oxygen tubing
Training / Education	Staff to attend pressure ulcer training to ensure they are aware of the importance of early escalation of pressure damage

Enclosure G

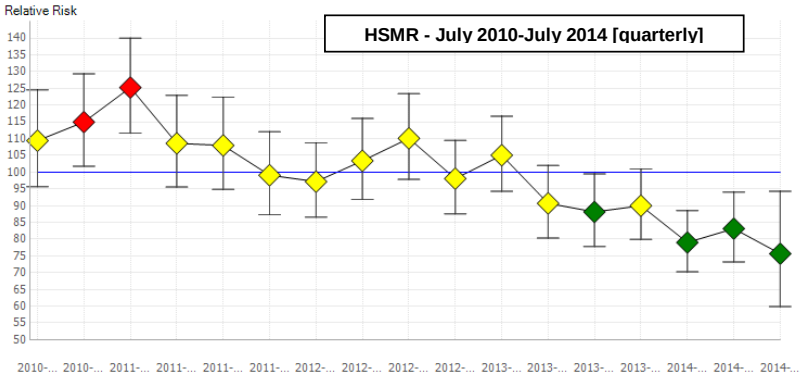
Falls resulting in fracture – Knightley	
Theme	Learning / Actions
Clinical Assessment	Feedback to staff re falls assessment and strategies when confusion fluctuates Review of care plans post fall
Documentation	Nursing documentation to be more specific - learning programme on recording in notes to be introduced for all ward staff to access Clinical decision to be documented in notes if flat lift kit used
Sub-optimal care of the deteriorating patient – Allebone	
Theme	Learning / Actions
Communication / Handover	Handover process to be reviewed and refined Ward Round process to be reviewed and re-shaped to include an MDT approach

3. Mortality Overview

3.1 HSMR

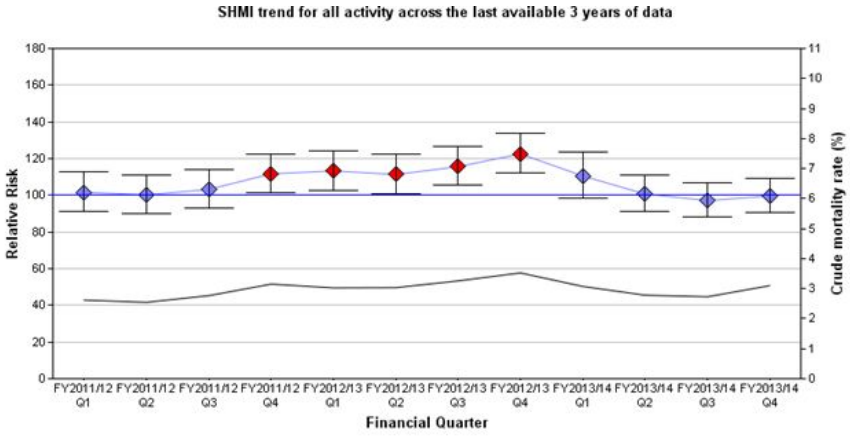
The previously documented fall in mortality continues. The complete re-benchmarked dataset has yet to be published, but 'remodelled' mortality suggests that the HSMR for 2013-2014 will remain within the 'expected' range. The remodelled HSMR is **93.8** [rolling year to date], and **95.6** for 2014-2015.

HSMR crude mortality for 2014-2015 remains 3.1% [East Midlands range 3 – 4.6, average 3.6%].

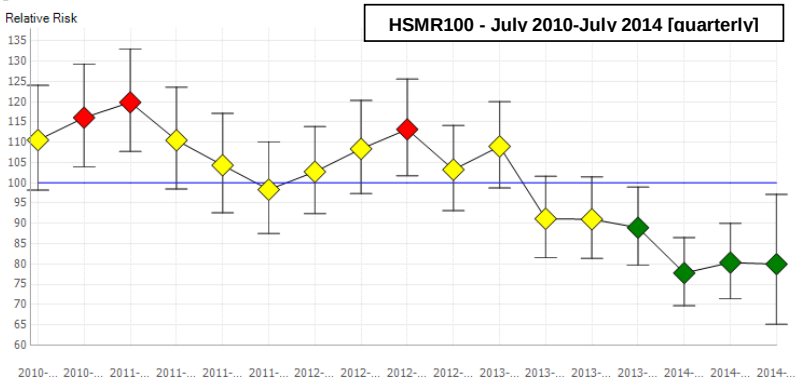


3.2 SHMI

The latest data release is to March 2014 and was 101 which remained within the 'expected' range.



This is the lowest level seen for more than 2 years. It is expected to remain at this level for the immediate future as it tracks the **HSMR 100** which remained low during in 2012-2013 [see below].



3.3 Recent Alerts & Other Reviews

Leukaemia and Non-Hodgkin Lymphoma

There has been an adverse performance alert for Non-Hodgkin's Lymphoma, which was anticipated. Both this diagnosis and leukaemia are subject to a clinical notes review by the Haemoncology team who will be presenting their findings to the Mortality and Coding Review Group at the end of November.

3.4 CQC Draft IMR

Elevated risk	Composite indicator: In-hospital mortality - Gastroenterological and hepatological conditions and procedures
Elevated risk	NHS England inpatients score from Friends and Family Test (% change) (01-Aug-13 to 31-Jul-14)
Elevated risk	Ratio of the total number of days delay in transfer from hospital to the total number of occupied beds (01-Apr-14 to 30-Jun-14)
Elevated risk	Whistleblowing alerts (18-Jul-13 to 29-Sep-14)
Risk	The proportion of cases assessed as achieving compliance with all nine standards of care measured within the National Hip Fracture Database. (01-Jan-13 to 31-Dec-13)
Risk	SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator (01-Apr-14 to 30-Jun-14)
Risk	TDA - Escalation score (01-Jun-14 to 30-Jun-14)
Risk	NHS Staff Survey - KF7. The proportion of staff who were appraised in last 12 months (01-Sep-13 to 31-Dec-13)
Risk	NHS Staff Survey - KF9. The proportion of staff reported receiving support from immediate managers (01-Sep-13 to 31-Dec-13)
Risk	NHS Staff Survey - KF10. The proportion of staff receiving health and safety training in last 12 months (01-Sep-13 to 31-Dec-13)
Risk	Safeguarding concerns (23-Sep-13 to 22-Sep-14)

The December 2014 draft report is available for consultation, and suggests an 'elevated risk' for a composite basket of gastroenterology and liver diagnoses [emergency admissions].

Several diagnosis groups within this basket [biliary tract disease, gastrointestinal haemorrhage, alcohol related liver disease] have been previously investigated, and continue to be monitored quarterly but have not shown significantly adverse outcomes during the last year. This monitoring will continue, and confirmation will be sought that all deaths in this group during the alert period have been reviewed through specialty M&M.

4. Next Steps

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

Mortality within the Trust is closely monitored and reported through the Quality Governance Committee.

This Board is asked to seek clarification where necessary and assurance regarding the information contained within this report.

The format and content of this report has been updated. The Board is asked to provide feedback and comment on this.

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**27 November 2014**

Title of the Report	**Integrated Performance Report and Corporate Scorecard**
Agenda item	**12**
Sponsoring Director	Deborah Needham, Chief Operating Officer Dr Mike Cusack, Medical Director Jane Bradley, Director of Nursing, Midwifery and Patient Services (Interim)
Author(s) of Report	Deborah Needham, Chief Operating Officer
Purpose	The paper is presented for discussion and assurance

Executive summary

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

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

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

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

Related strategic aim and corporate objective	Be a provider of quality care for all our patients
Risk and assurance	Risk of not delivering Urgent care and 62 day performance standards Potential Financial fines for performance below standard Reputation risk for Performance below standard Potential poor patient experience

Enclosure H

Related Board Assurance Framework entries	BAF 11, 12 and 23
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper (Y/**N**)

Actions required by the Trust Board

The Trust Board are asked to review and scrutinise the exception report and note the positive achievements presented in the report.

Northampton General Hospital NHS
NHS Trust

Public Trust Board
27 November 2014

Trust Board Corporate Scorecard

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

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

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

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

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

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

Enclosure H

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Friends & Family Test: Score	Report period:	October 2014

Driver for underperformance:	Actions to address the underperformance:
Currently the Trust does not have any national targets for FFT scores and therefore the decision was made to set our own internal targets of 60 for A&E and 70 for all other services. Inpatients services have struggled to attain the internal score, obtaining a particularly low score in September of 54. Although this has improved to 58 in October, it is still 12 points off the internal target. A&E are far more consistent in attaining their target, however October saw them fall under the target by 3 points. NHS England's methods for identifying satisfaction are changing to reviewing the responses given as a percentage of would recommend against wouldn't recommend. This format provides more insight into satisfaction than the NPS, and will be reported as standard from December 2014. It should also be noted that new methods for collecting data may have an impact on the scores obtained, as patients are responding at home as opposed to when they are still within the hospital. This should be considered when reviewing future scores.	• Comments will be reviewed both for A&E and Inpatients to identify any themes of dissatisfaction and where improvements can be made. • Areas with a particularly low NPS will be identified and improvement plans will be requested. • In addition to this Organisational Development are now supporting the patient experience agenda by approaching low performing areas and working with the service to resolve any issues. • Scores will be reviewed against the new percentage scores to ensure a full picture of performance is available to assess satisfaction and identify issue areas.
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
December	Same
Lead for recovery:	**Lead Director:**
Rachel Lovesy, Patient Experience and Engagement Lead	Jane Bradley, Interim Director of Nursing and Midwifery

Historical Target Performance

Indicator	Target	Trend	Aug-14	Sep-14	Oct-14
Friends & Family Test: Inpatient score	70	⇧	62	54	58
Friends & Family Test: A&E score	60	⇩	68	61	57

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Maternity Caesarean Section Rates	Report period:	October 2014

Driver for underperformance:	Actions to address the underperformance:
The increase in El C/S is due to overbooking the first half of October, because we were planning for a closure of the Labour ward theatres for essential maintenance work. Emergency Work can fluctuate (as we are looking here at small numbers.) We are compliant with NICE Guidelines regarding CS. Most of our deviance from national figures comes from elective surgery where we involve women in decision regarding mode of delivery.	Continue work to make consultant body and Registrars aware high C section rates. Review of Caesarean action plan in next Obstetric Governance meeting. Regional review of compliance with NICE Guidance under consideration (current opinion is that a significant number of units do not offer women choice) The Elective C/S numbers are expected to even out in time. Meetings to use obstetric database for ongoing audit. Advice and support provided to promote normal delivery following a previous C section. Continue to offer women support and encouragement for vaginal birth after CS (VBAC)
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
For November 2014	25 - 27%
Lead for recovery:	**Lead Director:**
Mr von Widekind	Deborah Needham

Historical Target Performance

Indicator	Target	Trend	Aug-14	Sep-14	Oct-14
Maternity: C Section Rates - Total	<25%	↓	25.8%	26.9%	30.9%
Maternity: C Section Rates - Emergency	<14%	↓	15.2%	15.0%	16.8%
Maternity: C Section Rates - Elective	<10%	↓	10.6%	11.0%	14.1%

Enclosure H

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Healthcare Records Audit	Report period:	October 2014

Driver for underperformance:	Actions to address the underperformance:
The audit findings are reported in the Quarterly Patient Safety and Clinical Quality & Governance Progress report It has been acknowledged that positive progress has been limited. Despite the introduction of a new revised question set the area remains poor. There has been an absence of audit data available to share at departmental level.	The content of the audit has been reviewed. The dataset has retained the elements recommended by the academy of royal colleges / CQC / GMC. Case notes to be audited in each departmental. Consultant leads for this are being sought. Audit to be undertaken by medical staff, nurses and allied health professionals. Agreement with audit leads to actively share monthly data with each department and to seek appropriate action plans for improvement. Performance monitoring at directorate governance meetings.
Forecast date (month) for meeting the standard	Forecast performance for next reporting period:
April 2015	
Lead for recovery:	Lead Director:
Dr Jonny Wilkinson	Dr Michael Cusack

Historical Target Performance

Indicator	Target	Trend	Aug-14	Sep-14	Oct-14
Medical notes: Documentation - Doctors	95%	⇔	62.3%	66.5%	66.2%
Medical notes: Documentation - Nurses	95%	⇓	60.5%	60.4%	57.4%
Medical notes: Documentation - Allied Health	95%	⇓	75.9%	71.7%	70.9%

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Pressure Ulcers: Avoidable grade 2 (incidence)	Report period:	Sept position reported in Oct 2014

Driver for underperformance:	Actions to address the underperformance:
Of the pressure ulcers reported in September under half were device related.	Following the trial of new oxygen administration equipment which has built in features to relieve the pressure on the ear, this has been rolled out to all wards and NGH are only purchasing this type of equipment. Old stock has now been depleted and only new equipment is being ordered by the wards.
Training	Staff members attending training has again increased this month.
Completion of skin checks on every shift	Trial of new care rounding and SSKIN evaluation document trialled, further trial to take place in November and then distributed to all wards.
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
Quarter 4	Reduction in device related pressure ulcers.
Lead for recovery:	**Lead Director:**
Fiona Barnes	Jane Bradley

Historical Target Performance

Indicator	Target	Trend	Aug-14	Sep-14	Oct-14
Pressure Ulcers: Avoidable grade 2 (incidence) - verification of current month required prior to publishing	7	⇧	17	15	Awaiting verification

Enclosure H

Trust Board Corporate Scorecard
Exception Report

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

Driver for underperformance:	Actions to address the underperformance:
• Continued demand on front door services • Poor flow through the Trust • Availability of beds early enough in the day • Higher acuity of Patients at weekends • Large volumes of patients presenting at specific times causing blocks • High numbers of system and placement delays	• Urgent Care Board monthly • Daily Performance meetings • ED redevelopment of new Resus and GP streaming areas on track to be completed in January. • Positive ED recruitment day, 50% of band 5 nurses appointed to and filled HCA gap. • Saturday and Sunday discharge teams • Implementation of winter funding schemes including additional capacity. • 3 times a week review of Assessment unit top 6 long staying patients to ensure flow. • Continued development of the Ambulatory Care Centre • Ongoing Recruitment Drive for clinical staff • Additional beds through Avery Healthcare to ensure correct patients in acute bed • Continued development of the frail elderly pathways to ensure early assessment • Developing new working practices for better management and utilisation of Assessment Units • ECIST visit actions (24th June) incorporated into the Urgent Care Programme • Predictive planning technology improvements being continuously made, including speciality specific data • Continued development of the frail elderly pathways to ensure early assessment
Forecast date (month) for meeting the standard	Forecast performance for next reporting period:
November 14	95.80%
Lead for recovery:	Lead Director:
Work stream leads	Deborah Needham

Historical Target Performance

Indicator	Target	Trend	Aug-14	Sep-14	Oct-14
A&E: Proportion of patients spending more than 4 hours in A&E	95%	⇧	91.28%	90.51%	92.06%
A&E: 4hr SitRep reporting	95%	⇩	91.44%	91.15%	90.32%

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Diagnostics: Number of patients waiting more than 6 weeks for a diagnostic test	Report period:	October 2014
Driver for underperformance:		Actions to address the underperformance:	
Three out of six members of the Endoscopy Waiting List team left at the same time, one of which was the Waiting List Coordinator. Junior members only left within the team therefore lack of knowledge and experience. Insufficient amount of staff left to book patients for endoscopic procedures		• Continued micromanagement of the waiting list team and office by the Endoscopy Sister and the Service Manager. • Recruitment completed and staff in post. Return of the Band 4 Coordinator from long term sick leave 17/11/14. • Continued provision of support and training for staff. • All empty sessions backfilled. • Outsourcing patient to Three Shires • Saturday sessions booked as from 22/11/14 • Weekly team meetings and PTL reviews.	
Forecast date (month) for meeting the standard		Forecast performance for next reporting period:	
January 2015		December 2014	
Lead for recovery:		Lead Director:	
Rebecca Brown		Deborah Needham	

Historical Target Performance

Indicator	Target	Trend	Aug-14	Sep-14	Oct-14
Diagnostics: Number of patients waiting more than 6 weeks for a diagnostic test	0	⇧	1	4	1

Enclosure H

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Cancer Access Targets - *31 days* - *62 days urgent referral to treatment of all cancers* - *31 day subsequent drug* - *62 days of referral from screening* - *62 days of referral from hospital specialist* -	Report period:	October 2014

Driver for underperformance:	Actions to address the underperformance:
• 31 day: 2 of the 6 breaches were surgical cancellations due to no HDU / ITU capacity. Require 8 more treatments to meet this standard. • 62 day: Patient choice, late referrals, endoscopy administration bookings impacted on this standard • 31 day subsequent treatment: 1 patient chose to delay treatment, a second required eye surgery as the priority before chemotherapy • 62 day screening: 1 patient chose to discuss reconstruction options at another hospital, 1 gynae breach due to surgical capacity • 62 day upgrade: 1.5 breaches, 1 due to complex pathway the other had delays to diagnostics	Limit the number of cancer surgical cancellations Book endoscopy 2ww appts within 14 days and move towards 7 days Ensure oncology reciew chemotherapy breaches Review surgical capacity in gynaecology Ongoing work with PET CT to increase capacity, review CT capacity for cancer patients
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
31 day first treatment: November 31 day subsequent: November 62 day screening: November 62 day upgrade: November 62 day: November	
Lead for recovery:	**Lead Director:**
Services Managers/Tracey Harris	Deborah Needham

Historical Target Performance

Indicator	Target	Trend	Aug-14	Sep-14	Oct-14
Cancer: Percentage of patients treated within 62 days of referral from screening	90%	↓	97.1%	94.1%	86.2%
Cancer: Percentage of patients treated within 62 days of referral from hospital specialist	80%	↓	60.0%	100.0%	57.1%
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	85%	↓	84.4%	79.2%	73.6%
Cancer: Percentage of patients treated within 31 days	96%	↓	96.8%	97.6%	95.6%

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Report period:	October 14

Driver for underperformance:	Actions to address the underperformance:
Elective list cancelled on the day due to excess trauma. Consultant undertaking elective list then left Trust without working notice period. The two cancelled patients were outsourced to Three Shires with clear directive they required surgery within 28 days. Despite further instructions Three Shires failed to offer dates within 28 day period.	Face to face meeting with Three Shires to stress importance of following instructions with regards to on the day cancellations. Three Shires to notify NGH within 24 hours if they do not have the capacity to rebook TCI within 28 days.
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
November 2014	November 2014
Lead for recovery:	**Lead Director:**
Rebecca Brown	Deborah Needham

Historical Target Performance

Indicator	Target	Trend	Aug-14	Sep-14	Oct-14
Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	0	⇔	1	2	2

Enclosure H

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Friends & Family Test: Response Rate – A&E Services	Report period:	October 2014
Driver for underperformance:		Actions to address the underperformance:	
A&E have a national target of 15%, which will rise to 20% in Quarter 4 2014-15. They struggle to obtain this target month on month and again have fallen short in October.		The struggles in A&E have been identified and a new method of collecting data has been implemented in mid-October following a poor start to the month. November will be the first full month of data with the new methods and it is expected for the Trust to see an immediate improvement in the response rates.	
Forecast date (month) for meeting the standard		Forecast performance for next reporting period:	
November 2014		Improvement	
Lead for recovery:		Lead Director:	
Rachel Lovesy, Patient Experience & Engagement Lead		Jane Bradley	

Historical Target Performance

Indicator	Target	Trend	Aug-14	Sep-14	Oct-14
Friends & Family: NHS England A&E response rate	15%	⇩	14.7%	14.8%	14.2%

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Staff: Trust Turnover Rate	Report period:	October 2014
Driver for underperformance:		Actions to address the underperformance:	
Generic themes across the Trust: • Work life balance • Retirement • Voluntary resignation following change programme • Dismissal • Career development • Relocation • Health reasons		• Full consideration of flexible working requests • Consider alternatives to full retirement i.e. wind down, step down • Offer career breaks where service permits • Engagement programmes via OD • Review reporting mechanism • HR Business Partners and Advisors to raise concerns at Directorate Management Boards where appropriate	
Forecast date (month) for meeting the standard		Forecast performance for next reporting period:	
Lead for recovery:		Lead Director:	
Andrea Chown		Janine Brennan	

Historical Target Performance

Indicator	Target	Trend	Aug-14	Sep-14	Oct-14
Staff: Trust turnover rate	8%	⇩	9.4%	9.4%	9.9%

Enclosure H

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Staff: Trust Level Sickness Rate	Report period:	October 2014
Driver for underperformance:		Actions to address the underperformance:	
Generic themes across all areas of the Trust: • Re-organisation of structures • Lack of stability • Changes that involve terms and conditions of employment • Government intervention on pay • Increasing demands on staff capacity • Seasonal sickness • Musculoskeletal		• Both long and short term sickness absences are being actively managed through the Trusts sickness absence policy • HRBP's and Advisors work closely with managers to provide guidance & support in the management of sickness • Departments are being encouraged to recruit to establishment i.e. Portering • Process for ER investigations being reviewed to accelerate timelines and minimise duration of suspended staff through MQC commencing 12 November 2014 • Flu campaign – 65% of all staff received as at beginning of November • Occupational Health and risk assessments • Analysis of stress absence carried out which indicates highest levels of stress within Therapy services - 1.59%, Site Management team - 1.22% and Obstetrics and Gynaecology - 1.09%. To be shared at November Workforce Directorate meeting for any potential action	
Forecast date (month) for meeting the standard		Forecast performance for next reporting period:	
Lead for recovery:		Lead Director:	
Andrea Chown		Janine Brennan	

Historical Target Performance

Indicator	Target	Trend	Aug-14	Sep-14	Oct-14
Staff: Trust level sickness rate	3.8%	⇩	4.38%	4.33%	4.40%

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Percentage of staff with annual appraisal	Report period:	October 2014
Driver for underperformance:		Actions to address the underperformance:	
Different appraisal processes in recent years have led to limited information being provided to the L&D Department on in-date appraisals.		All staff should have an in-date appraisal and will need to have a further review aligned to incremental dates as per the new appraisal process. Embedding process into all areas. 1:1 meetings with areas that require additional support in understanding process; paperwork; requirements or queries about the data. Appraisal audit in place to ensure quality of audits. Consistent message about monitoring of appraisals with regards to accuracy	
Forecast date (month) for meeting the standard		Forecast performance for next reporting period:	
March 2015		75.58%	
Lead for recovery:		Lead Director:	
Sandra Wright		Janine Brennan	

Historical Target Performance

Indicator	Target	Trend	Aug-14	Sep-14	Oct-14
Staff: Percentage of staff with annual appraisal	80%	⇩	72.7%	73.7%	71.4%

Enclosure H

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Role Specific Training Compliance Rates	Report period:	October 2014
Driver for underperformance:		Actions to address the underperformance:	
Mandatory Training Review in 2013 reduced the number of subjects of which many of those that were originally Mandatory are now Role Specific Essential Training. The target to be achieved by October 2014 is 80% and 85% in March 2015 as per the Quality Schedule Due to the completed scoping exercise it has become apparent that for some subjects staff will have accessed training that is not required by their role.		New Appraisal process encouraging uptake of Mandatory training & RSET by requiring staff to have in-date training in order to incrementally progress. 1:1 sessions & "drop-ins" for Ward Sisters to support understanding of requirements and how to achieve increased compliance. Scoping of RSET against job roles and positions has been completed and uploaded into system to ensure accuracy of reporting however there will continue to be some refinements. L&D Manager to attend Quality Confirm & Challenge meetings with Ward Sisters from November 2014.	
Forecast date (month) for meeting the standard		Forecast performance for next reporting period:	
March 2015		68%	
Lead for recovery:		Lead Director:	
Sandra Wright		Janine Brennan	

Historical Target Performance

Indicator	Target	Trend	Aug-14	Sep-14	Oct-14
Staff: Percentage of all trust staff with role specific training	80%	⇩	62.3%	64.7%	64.5%

Northampton General Hospital NHS Trust Corporate Scorecard 2014-15

Caring

Indicator	Target	Trend	Aug-14	Sep-14	Oct-14
Complaints rate per bed days	None	⇧	0.24%	0.26%	0.23%
Complaints responded to within agreed timescales	90%	⇧	68%	87%	89%
Friends & Family Test: Inpatient score	70	⇧	62	54	58
Friends & Family Test: A&E score	60	⇩	68	61	57
Friends & Family Test: Maternity score	70	⇩	74	77	74
Mixed Sex Accommodation	0	⇔	0	0	0
Patients in last days of life with a care plan in place	None	⇧	35.6%	17.8%	21.9%
Transfers: All patients moved / transferred out of hours	None	⇩	39	56	62
Transfers: Patients moved with a risk assessment completed	None	⇧	36	47	61

Effective

Indicator	Target	Trend	Aug-14	Sep-14	Oct-14
Emergency re-admissions within 30 days (adult elective) *****	None	⇩	1.45%	1.18%	1.45%
Emergency re-admissions within 30 days (adult non - elective) *****	None	⇧	2.67%	2.03%	1.88%
Length of stay - All	None	⇧	4.76	4.82	4.58
Length of stay - Elective	None	⇔	3.08	2.74	2.82
Length of stay - Non Elective	None	⇧	5.00	5.19	4.88
Maternity: C Section Rates - Total	<25%	⇩	25.8%	26.9%	30.9%
Maternity: C Section Rates - Emergency	<14%	⇩	15.2%	15.0%	16.8%
Maternity: C Section Rates - Elective	<10%	⇩	10.6%	11.0%	14.1%
Mortality: SHMI*	Within expected range	⇧	105.3	105.3	101.0
Mortality: HSMR**		⇩	90	84.4	93.8
Mortality: HSMR - Weekend**		⇩	86.8	88.1	94.0
Mortality: HSMR - Week day**		⇩	84.41	83.2	91.9
Mortality: Low risk conditions**		⇩	75.57	71.3	80.0
Mortality: Maternal Deaths	0	⇔	0	0	0
NICE compliance	80%	⇩	98.0%	98.0%	96.8%
Number of patients cared for in an escalation area	None	⇩	139	58	163
# NoF - Fit patients operated on within 36 hours	80%	⇧	88.6%	68.2%	72.7%
Percentage of patients cared for outside of specialty (General Medicine)	None	⇧	14.2%	13.3%	12.0%
Stroke patients spending at least 90% of their time on the stroke unit	80%	⇩	96.2%	81.3%	80.95%
Suspected stroke patients given a CT within 1 hour of arrival	50%	⇩	68%	66%	57%

Safe

Indicator	Target	Trend	Aug-14	Sep-14	Oct-14
C-Diff	Ave. 3 per mth	⇩	4	1	3
Dementia: Case finding	90%	⇩	93.0%	90.2%	84.0%
Dementia: Initial diagnostic assessment	90%	⇔	90.6%	100.0%	100%
Dementia: Referral for specialist diagnosis/Follow-up	90%	⇧	90.0%	91.0%	100%
Falls per 1,000 occupied bed days	5.8	⇧	4.91	3.96	3.91
Harm Free Care (Safety Thermometer)	93%	⇧	88.7%	91.9%	92.63
Medical Notes: Availability for clinics***	99%	⇔	98%	99%	98%
Medical notes: Documentation - Doctors	95%	⇔	62.3%	66.5%	66.2%
Medical notes: Documentation - Nurses	95%	⇩	60.5%	60.4%	57.4%
Medical notes: Documentation - Allied Health	95%	⇩	75.9%	71.7%	70.9%
Medication errors (administration)	None	⇩	12	9	21
MRSA	0	⇔	0	0	0
Never event incidence	0	⇔	0	1	0
Pressure Ulcers: Total grade 3 & 4 hospital acquired (incidence)	None	⇧	7	4	2
Pressure Ulcers: Avoidable grade 3 & 4 (incidence) - verification of current month required prior to publishing	3	⇩	3	4	Awaiting verification
Pressure Ulcers: Avoidable grade 2 (incidence) - verification of current month required prior to publishing	7	⇧	17	15	
Open Serious Incidents Requiring Investigation (SIRI) - Declared during the period	None	⇧	4	10	3
Open CAS alerts	0	⇔	0	0	0
TTO's sent by taxi	0	⇔	0	0	Not avail
UTI with Catheters (Safety Thermometer-Percentage new)	0.4%	⇩	0.32%	0.31%	0.47%
VTE Risk Assessment	95%	⇧	95.9%	96.4%	96.9%

Responsive

Indicator	Target	Trend	Aug-14	Sep-14	Oct-14
A&E: Proportion of patients spending more than 4 hours in A&E	95%	⇧	91.28%	90.51%	92.06%
A&E: 4hr SitRep reporting	95%	⇩	91.44%	91.15%	90.32%
A&E: 12 hour trolley waits	0	⇔	0	0	0
Diagnostics: Number of patients waiting more than 6 weeks for a diagnostic test	0	⇧	1	4	1
Discharge: Number of medically fit patients awaiting discharge (average daily)	None	⇩	80	79	83.25
Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	93%	⇧	89.1%	90.1%	94.0%
Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	93%	⇧	95.9%	95.9%	97.8%
Cancer: Percentage of patients treated within 62 days of referral from screening	90%	⇩	97.1%	94.1%	86.2%
Cancer: Percentage of patients treated within 62 days of referral from hospital specialist	80%	⇩	60.0%	100.0%	57.1%
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	85%	⇩	84.4%	79.2%	73.6%
Cancer: Percentage of patients treated within 31 days	96%	⇩	96.8%	97.6%	95.6%
Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	94%	⇧	90.9%	96.9%	100.0%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	98%	⇩	98%	100.0%	93.6%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	94%	⇧	97.5%	100.0%	100.0%
Operations: Urgent Operations cancelled for a second time	0	⇔	0	0	0
Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	0	⇔	1	2	2
RTT for admitted pathways: Percentage within 18 weeks	90%	⇧	92.3%	90.8%	94.1%
RTT for non- admitted pathways: Percentage within 18 weeks	95%	⇧	97.7%	98.0%	98.4%
RTT waiting times incomplete pathways	92%	⇩	97.0%	96.9%	96.6%
RTT over 52 weeks	0	⇔	0	0	0

Well Led

Indicator	Target	Trend	Aug-14	Sep-14	Oct-14
Friends & Family: NHS England Inpatient response rate	25%	⇩	31.8%	29.8%	28.4%
Friends & Family: NHS England A&E response rate	15%	⇩	14.7%	14.8%	14.2%
Friends & Family: NHS England Maternity response rate	20%	⇩	31.0%	38.3%	30.7%
Friends & Family: Net Promoter Score of staff that would recommend the trust as a place of work ****	None	⇧	-1 (Prev Quarter was -11)		Not applic
Data quality of Trust returns to HSCIC (SUS)	None		Mth 5 data not expected to be provided until late Nov 2014		
Staff: Trust turnover rate	8%	⇩	9.4%	9.4%	9.9%
Staff: Trust level sickness rate	3.8%	⇩	4.38%	4.33%	4.40%
Staff: Trust level vacancy rate - Doctors	<5%	⇧	4.6%	6.6%	5.7%
Staff: Trust level vacancy rate - Nurses	<5%	⇩	10.6%	10.8%	11.7%
Staff: Trust level vacancy rate - Other	<3%	⇔	12.5%	12.3%	12.4%
Staff: Temporary costs & overtime as a % of total pay bill	None	⇩	13.5%	13.5%	15.6%
Staff: Percentage of staff with annual appraisal	80%	⇩	72.7%	73.7%	71.4%
Staff: Percentage of all trust staff with mandatory training compliance	80%	⇩	78.2%	78.4%	78.8%
Staff: Percentage of all trust staff with role specific training compliance	80%	⇩	62.3%	64.7%	64.5%

Finance

Indicator	Target	Trend	Aug-14	Sep-14	Oct-14
Activity v. Plan - YTD			Awaiting confirmation of format		
Income v. Plan - YTD	Fav	⇩	(1,410) Adv	(1,836) Adv	Not avail
Expenditure Pay v. Plan - YTD	Fav	⇩	(1,476) Adv	(1,926) Adv	Not avail
Expenditure Non-Pay v. Plan - YTD	Fav	⇩	(2,249) Adv	(3,010) Adv	Not avail
Surplus/(deficit) v. Plan - YTD	Fav	⇩	(4,754) Adv	(6,723) Adv	Not avail
Capital v. Plan YTD			Awaiting confirmation of format		
CIP delivery v. Plan YTD	Fav	⇧	657 Fav	668 Fav	Not avail

Section	Red Rated	Amber Rated	Green Rated	None	Total
Caring	2	1	2	4	9
Effective	3	1	9	7	20
Safe	3	3	9	6	21
Responsive	9	0	10	1	20
Well-Led	5	1	2	6	14
Finance	0	0	0	7	7
Total	22	6	32	31	91

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

* SHMI 2013-14 (published October 2014)

** HSMR Rolling year Aug 2013 to July 2014

***Currently a manual audit until central reporting is in place

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

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

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**27 November 2014**

Title of the Report	**Finance Report Month 7**
Agenda item	**13**
Sponsoring Director	Simon Lazarus, Director of Finance
Author(s) of Report	Andrew Foster, Deputy Director of Finance
Purpose	To report the financial position for the period ended October 2014/15.

Executive summary

- The I&E position for the period ended October is a £11.5m deficit with the forecast position a projected deficit of £16.7m (subject to delivery of a range of recovery actions).
- Detailed forecast "Control Totals" have now been agreed with most directorates and confirm delivery of a £16.7m deficit by the financial year end.
- A formal offer has been received from NENE CCG to settle the 2014-15 contract. The offer made by the CCG included an additional £2m of Winter funding but fell some £6m short of the best case income requirement on a like for like basis.
- The TDA have supported the Trust in submitting an application to the ITFF for £21m of financing to support the I&E position (£13.8m) and to enable the purchase the first phase of the overdue Imaging replacement project (£7.2m).
- The achievement of the FRP forecast is being hampered by the current forecast SLA offer received by NENE CCG. Additional work is required with the CCG to agree MRET, readmissions and the treatment of nest practice tariffs relating to NEL activity.

Related strategic aim and corporate objective	Develop IBP which meets financial and operational targets.
Risk and assurance	There are a range of financial risks which pose a direct risk to delivery of the financial plan for 2014-15.
Related Board Assurance Framework entries	BAF 17, 18,19
Equality Impact Assessment	N/A

Legal implications / regulatory requirements	NHS Statutory Financial Duties
Actions required by the Committee The Board is asked to consider the recommendations of the report and the outcome of the review of the contractual position with NENE CCG, LAT and TDA.	

Northampton General Hospital NHS
NHS Trust

Financial Position
Month 7 2014/15

Report to
Trust Board
November 2014

Enclosure I

1. Performance against Statutory Duties & Key Issues

	YTD Actual	YTD Forecast	Variance	Forecast outturn	Full Year Plan	Variance
Statutory Financial Duties:	£'000	£'000	£'000	£'000	£'000	£'000
Delivering I&E Breakeven duty	-£11,541	-£10,556	£ 985 Adv	-£16,760	-£7,829	£ 8,931 Adv
Achieving EFL (£000's)				£19,044	£18,925	£119
Achieving the Capital Resource Limit (£000's)	£4,513	£5,312	£ 799 Fav	£19,664	£19,664	-£0
Better Payment Practice Code:						
Volume of Invoices	94.06%	95.00%	0.94% Adv	94.00%	95.00%	1.00% Adv
Value of Invoices	96.46%	95.00%	1.46% Fav	95.00%	95.00%	-

Financial Performance

- Financial performance for the period ended October 2014 is a normalised deficit of £11.5m (September £11.9m), £1m worse than forecast.
- The position in the month of October was a surplus of £0.3m, £0.7m worse than forecast.
- The forecast I&E position continues to give rise for concern with the most likely deficit of £16.7m, assuming all CIP plans are fully delivered through additional recovery measures.
- The Trust reviewed the I&E forecast with the TDA on 17t October although no formal agreement of a year end control total was reached and the TDA view remains that the Trust can deliver a best case forecast of £14.2m deficit.
- The net cashflow position at the end of October improved to £1.5m. The DH approved the Trust's application for a further £3m (total £7m) of temporary borrowing which has been fully drawn down at the start of November. The TDA have agreed to submit the Trust's application for permanent financing to the ITFF in November as planned.

Capital Expenditure

- Delivery of the full plan is contingent on the Trust making a successful application to the Independent Trust Financing Facility (ITFF) for £7.2m of new PDC loans in 14-15.
- An in year review of the current capital plan has concluded and generated additional £0.5m contingency to support cashflow and provide additional contingency to support the FRP.

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

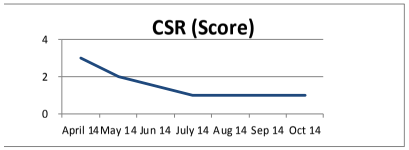
- The EFL for 14/15 has been increased to £18.9m(+ve) reflecting the utilisation of £3.4m internal year end cash balances requested by DH as part of the Q1 FIMS return.
- Temporary borrowing has allowed an improvement in the volume of invoices paid on time in October with 98% of suppliers having been paid within 30 days for the year to date.

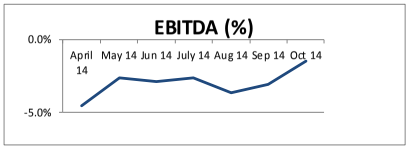
Key issues

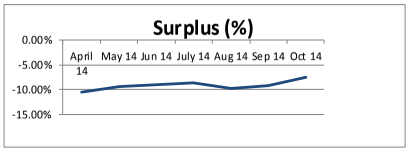
- The I&E position for the period ended October is a £11.5m deficit with the forecast position a projected deficit of £16.7m (subject to delivery of a range of recovery actions).
- The FRP process has been operating for 1 month. A range of risks have emerged which require ongoing focus and management. (See FRP exception report).
- Detailed forecast "Control Totals" have now been agreed with most directorates and confirm delivery of a £16.7m deficit by the financial year end.
- On 6/11 the CCG have made a formal offer to settle the 2014-15 contract. The offer made by the CCG included an additional £2m of Winter funding but fell some £6m short of the best case income requirement on a like for like basis.
- A four way meeting with the CCG, LAT and NTDA took place on the 14/11 to discuss the contractual position. It is expected that the TDA will agree a formal control total following the outcome of this meeting.
- The forecast for CIP delivery is for underlying slippage of £2.6m which has been offset by a range of additional mitigations generated through the FRP process.
- The TDA have supported the Trust in submitting an application to the ITFF for £21m of financing to support the I&E position (£13.8m) and to enable the purchase the first phase of the overdue Imaging replacement project (£7.2m).
- Kingsgate commenced work on site on 13th November to develop the FY15-16 CIP plan.
- The achievement of the FRP forecast is being hampered by the current forecast SLA offer received by NENE CCG. Additional work is required with the CCG to agree MRET, readmissions and the treatment of best practice tariffs relating to NEL activity.

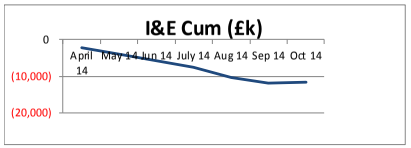
2.0 Financial Performance Dashboard

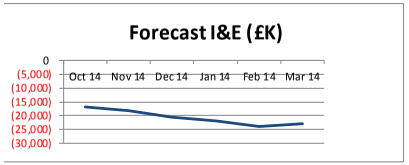
1. Key Metrics

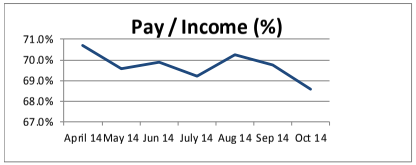




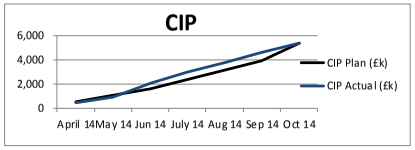


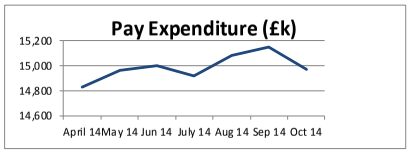


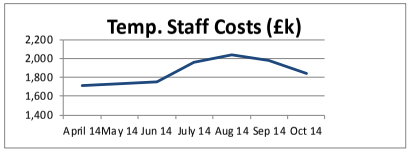


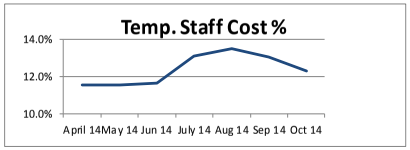


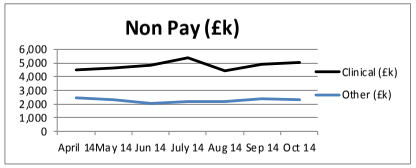
2. I&E Perfromance

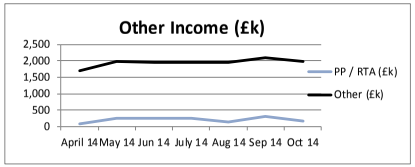




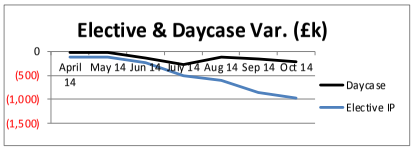


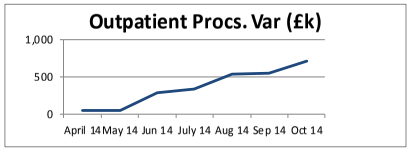


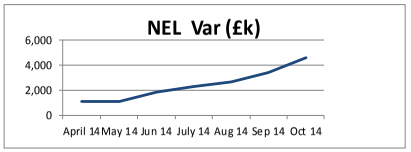


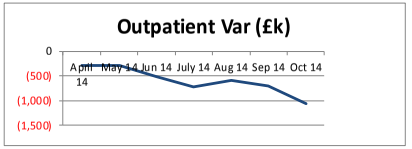


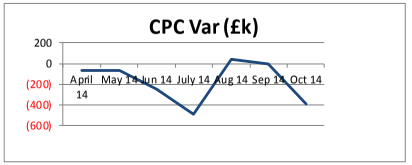
3. SLA Income

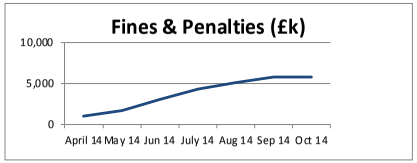




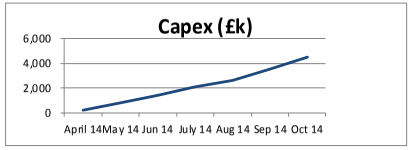


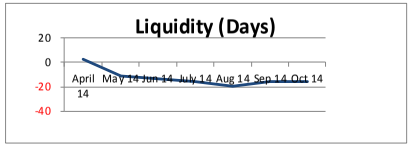


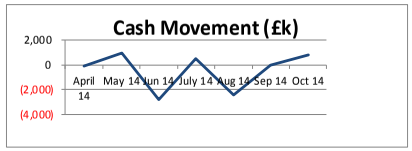


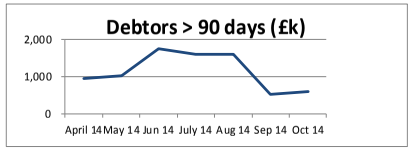


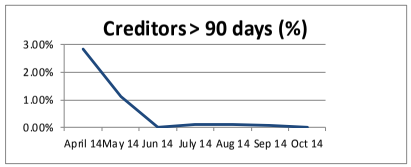
4. Working Capital

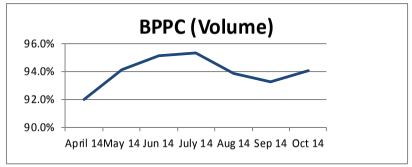












2.1 “Most Likely” I&E Forecast 14-15 (base M7+5)

	Mth1 Actuals £000's Apr	Mth2 Actuals £000's May	Mth3 Actuals £000's Jun	Mth4 Actuals £000's Jul	Mth 5 Actuals £000's Aug	Mth 6 Actuals £000's Sep	Mth 7 Actuals £000's Oct	Mth 8 Forecast £000's Nov	Mth 9 Forecast £000's Dec	Mth 10 Forecast £000's Jan	Mth 11 Forecast £000's Feb	Mth 12 Forecast £000's Mar	EOY Forecast £000's 2014-15	EOY FRP Target £000's 2014-15	Var to Target £000's 2014-15
SLA Clinical Income	19,194	19,600	19,093	19,975	18,091	20,040	21,906	20,233	19,433	20,560	19,644	21,671	**239,439**	**240,291**	**-852**
Other Clinical Income	92	251	252	267	141	325	172	213	213	213	213	204	**2,555**	**2,573**	**-18**
Other Income	1,695	1,981	1,947	1,950	1,937	2,090	1,991	1,980	2,062	1,970	1,970	2,115	**23,689**	**23,446**	**243**
Total Income	**20,981**	**21,831**	**21,292**	**22,191**	**20,168**	**22,456**	**24,068**	**22,426**	**21,708**	**22,743**	**21,827**	**23,990**	**265,682**	**266,309**	**-627**
Pay Costs	-14,829	-14,961	-14,999	-14,923	-15,082	-15,152	-14,968	-15,314	-15,434	-15,522	-15,526	-15,641	**-182,351**	**-182,311**	**-40**
Non-Pay Costs	-7,091	-7,049	-7,027	-7,658	-6,727	-7,399	-7,400	-7,163	-7,204	-7,302	-7,139	-5,860	**-85,017**	**-85,086**	**68**
Reserves															
Total Costs	**-21,920**	**-22,010**	**-22,027**	**-22,580**	**-21,809**	**-22,550**	**-22,367**	**-22,477**	**-22,638**	**-22,825**	**-22,664**	**-21,502**	**-267,368**	**-267,397**	**28**
EBITDA	**-939**	**-179**	**-735**	**-390**	**-1,641**	**-94**	**1,701**	**-50**	**-930**	**-82**	**-837**	**2,489**	**-1,686**	**-1,088**	**-599**
Depreciation	-982	-1,062	-735	-960	-967	-974	-989	-959	-959	-959	-959	-960	**-11,465**	**-11,465**	**1**
Amortisation	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	**-10**	**-10**	**0**
Impairments						-359			-869				**-1,228**	**-1,228**	**1**
Net Interest	2	2	2	2	1	1	4	2	2	2	2	2	**24**	**25**	**-0**
Dividend	-367	-367	-367	-394	-374	-374	-417	-378	-378	-378	-378	-378	**-4,550**	**-4,490**	**-60**
Surplus / (Deficit)	**-2,288**	**-1,608**	**-1,836**	**-1,743**	**-2,982**	**-1,799**	**299**	**-1,386**	**-3,134**	**-1,417**	**-2,173**	**1,153**	**-18,914**	**-18,256**	**-658**
Breakeven Assesssment:															
Donated Asset adjustment	-47		-3	44	26	3	33	33	33	33	33	31	**217**	**268**	**-51**
Impairments						359			869				**1,228**	**1,228**	
I&E Postion (month)	**-2,335**	**-1,608**	**-1,839**	**-1,699**	**-2,956**	**-1,437**	**332**	**-1,353**	**-2,232**	**-1,385**	**-2,140**	**1,184**	**-17,469**	**-16,760**	**-709**
I&E Postion (Cum)	**-2,335**	**-3,943**	**-5,781**	**-7,480**	**-10,437**	**-11,874**	**-11,541**	**-12,895**	**-15,127**	**-16,512**	**-18,652**	**-17,469**			

Key issues

- Gross forecast allowing for all known cost pressures is for a deficit of £24.7m if no action taken to reduce current run rate.
- Recovery actions of £8.1m reduce the deficit to a most likely position of £16.7m deficit (after adjustment for impairments and donated assets).
- Applying M7 YTD results highlights a potential gap of £0.7m in delivery by the financial year end.
- Current FRP gap due to inability to release full NEL income provision in October following CCG stance on A&E EOA tariff which remains the subject of ongoing negotiation.
- Pay expenditure currently tracking to forecast overall.
- Non-Pay expenditure currently tracking to forecast.
- Other income ahead of forecast by £0.25m.
- TDA formal agreement to year end control total remains outstanding.
- Risk: Costs of increasing nurse recruitment may escalate and are not directly covered in the forecast.
- Risk :Consideration of recent ruling on overtime payments – year end provision / increase in leave payments may be required.

3.0 YTD Income and Expenditure Position

I&E Summary	FRP Forecast	YTD Forecast	YTD Actual	Variance to Forecast	In month Actuals	In month Forecast	In month Var to Forecast
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	240,291	138,751	137,898	(853)	21,906	22,576	(671)
Other Clinical Income	2,573	1,509	1,499	(10)	172	213	(41)
Other Income	23,446	13,415	13,590	176	1,991	1,893	99
Total Income	266,309	153,674	152,987	(687)	24,069	24,682	(613)
Pay Costs	(182,311)	(104,875)	(104,910)	(35)	(14,968)	(15,169)	202
Non-Pay Costs	(85,086)	(50,419)	(50,350)	68	(7,400)	(7,145)	(255)
CIPs		0	0	0	0	0	0
Reserves/ Non-Rec		0	0	0	0		0
Total Costs	(267,397)	(155,294)	(155,261)	33	(22,367)	(22,314)	(53)
EBITDA	(1,088)	(1,620)	(2,273)	(654)	1,701	2,368	(666)
Depreciation	(11,465)	(6,597)	(6,671)	(74)	(989)	(1,008)	19
Amortisation	(10)	(6)	(6)	0	(1)	(1)	0
Impairments	(1,228)	(1,228)	(359)	869	0	(869)	869
Net Interest	25	14	14	(0)	4	2	2
Dividend	(4,490)	(2,601)	(2,662)	(61)	(417)	(378)	(39)
Surplus / (Deficit)	(18,256)	(12,036)	(11,956)	80	299	114	185
NHS Breakeven duty adjs:	0						
Donated Assets	268	251	56	(195)	33	31	2
NCA Impairments	1,228	1,228	359	(869)	0	869	(869)
I&E Position (breakeven duty)	(16,760)	(10,557)	(11,541)	(984)	332	1,014	(682)

I&E Performance

- Financial performance for the period ended October 2014 is a normalised deficit of £11.5m, compared to a forecast deficit of £10.6m giving rise to an adverse variance of £0.9m for the year to date.
- Income is £0.7m adverse to forecast.
- Pay expenditure is £35k adverse to forecast.
- Non-Pay expenditure is £68k favourable to forecast.
- Non-current asset impairments of £1.2m are forecast by the financial year end.
- The most likely forecast position is a deficit of £16.7m.
- The impairment forecast for the CEF scheme has been delayed by 1 month and is now expected to be assessed in November.

Key issues

SLA Income

- Underling overperformance offset by requirement to make provision for potential fines and penalties.
- EL IP activity £980k (9%) below plan for year to date.
- Daycase activity £225k (2%) behind plan for the year to date.
- NEL activity 11% above plan for period to date giving rise to increased MRET exposure.
- CCG challenging payment for NEL and A&E observation area activity.

Other Income

- Private Patient income £34k adverse to YTD forecast.
- RTA income £10k favourable to YTD forecast.
- Income / Other Generation £176k favourable to YTD forecast.

Pay

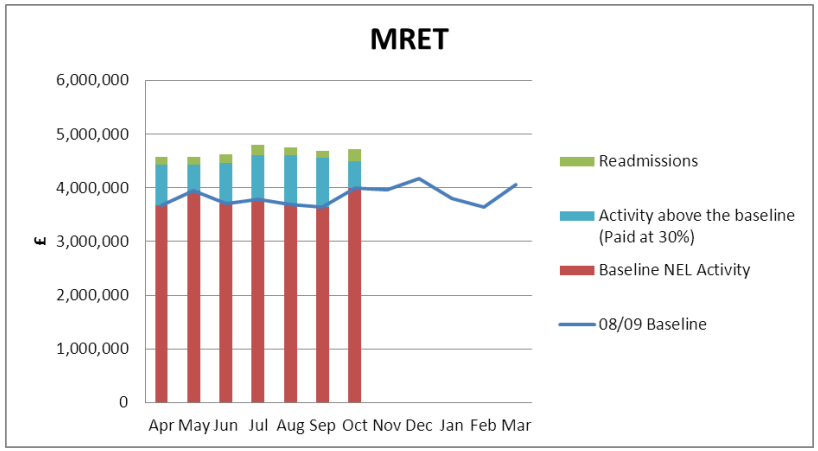
- Pay expenditure £35k fav. to YTD forecast with temporary staffing costs 12% of total pay bill.
- Locum medical staff and ADH costs £747k (£92k adv. to YTD forecast).
- Nursing pay expenditure £282k fav. to YTD forecast.

Non-Pay

- Static M6 to M7 at £7.4m per month delivering forecast projections for the YTD.
- Medicines £83k adv. to YTF forecast.
- Consultancy Fees £46k adverse to YTD forecast.
- Training £55k adverse to YTD forecast.
- Travel and benefits £16k adv. to YTD forecast.

4.0 SLA Income

Point of Delivery	Activity Plan	Activity Actual	Activity Variance	Finance £000's Plan	Finance £000's Actual	Finance £000's Variance
Elective Daycase	22,179	21,456	(723)	13,544	13,320	(225)
Elective Inpatients	4,159	3,643	(516)	10,913	9,933	(980)
Elective Excess Bed Days	1,704	1,114	(590)	409	265	(144)
Non Elective	27,875	32,332	4,457	45,068	49,965	4,898
Non Elective Excess Bed Days	18,833	17,791	(1,042)	4,353	4,056	(298)
New Outpatients	37,313	35,270	(2,043)	5,642	5,379	(263)
Follow Up Outpatients	81,000	75,313	(5,687)	6,942	6,508	(435)
Non Cons Led Outpatients New	15,251	12,369	(2,882)	1,364	1,153	(211)
Non Cons Led Outpatients Follow Up	29,302	25,324	(3,978)	1,226	1,081	(146)
Outpatient Procedures	35,957	42,290	6,333	6,298	7,014	716
CQUIN				3,113	2,798	(315)
Block Contracts - Fixed				11,971	11,971	(0)
Cost Per Case	1,532,929	1,481,474	(51,455)	13,154	12,759	(395)
A&E	61,073	64,824	3,751	6,068	6,639	571
Excluded Medicines				8,703	9,966	1,263
Excluded Devices		906	906	883	1,140	257
Contract Challenges		31	31	79	(2,598)	(2,677)
Readmissions				(977)	(654)	324
MRET				(911)	(2,634)	(1,723)
Other Central SLA Income	(8,727)	(2,221)	6,506	(740)	(160)	580
Productivity CIPs				1,731		(1,731)
Total SLA Income				**138,832**	**137,898**	**(934)**



Key issues

Underlying Performance

The Trust is implementing a financial recovery plan (FRP) with strict control totals to ensure the Organisation delivers its reported year end value. At month 7 the assumed income position within this FRP was £138.8m, the actual income reported is £137.9m showing an under performance of £0.9m. The reason for this is not being able to release provisions in the absence of local price agreements for the emergency observation area; and given the recent CCG offer any further release of provisions would present a risk to the reported position of the Trust.

Progress has now been made in agreeing other data challenges for M1-4, and the provision has been reduced to reflect this and estimates for the outstanding months have been estimated at these levels. There is a risk of receiving further coding and counting queries relating to the increase in outpatient procedures and there is no further provision to cover this. This is being rejected on the basis of following best practice.

Another significant risk is if Ambulance Fines are levied in year. This is subject to the data being robust enough to use as a basis of measurement. The CCG are working with EMAS to improve the data quality.

5. Statement of Financial Position

	Balance at 31-Mar-14	Current Month			Forecast end of year	
		Opening Balance	Closing Balance	Movement	Closing Balance	Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
Opening Net Book Value	143,694	143,694	143,694		143,694	
In year revaluations		(740)	(741)	(1)	(1,551)	(1,551)
In year movements		3,755	4,758	1,003	19,446	19,446
Less depreciation		(5,682)	(6,671)	(989)	(11,615)	(11,615)
Net Book Value	143,694	141,027	141,040	13	149,974	6,280
Current Assets						
Inventories	5,136	5,572	5,924	352	5,300	164
Receivables:						
NHS Debtors	6,902	4,530	5,815	1,285	6,200	(702)
Other Trade debtors	1,710	1,222	1,172	(50)	1,800	90
Debtor impairments provision	(675)	(351)	(351)		(500)	175
Capital receivables						
Non NHS other debtors	236	491	467	(24)	250	14
Compensation debtors (RTA)	2,694	2,761	2,699	(62)	2,900	206
Other receivables	1,058	1,030	919	(111)	1,300	242
Irrecoverable provision	(548)	(547)	(548)	(1)	(600)	(52)
Prepayments & accruals	1,124	3,004	3,037	33	1,100	(24)
	12,501	12,140	13,210	1,070	12,450	(51)
Non Current Assets for sale		268	268			
Cash	4,445	677	1,492	815	1,000	(3,445)
Total Current Assets	22,082	18,657	20,894	2,237	18,750	(3,332)
Current Liabilities						
NHS	637	3,447	2,837	(610)	637	
Trade Creditors Revenue	1,302	3,780	3,390	(390)	1,523	221
Trade Creditors Fixed Assets	3,261	1,205	1,504	299	2,057	(1,204)
Tax and NI owed	3,433	3,374	3,324	(50)	3,500	67
NHS Pensions agency	2,201	2,211	2,196	(15)	2,300	99
Other creditors	374	388	350	(38)	374	
Short term loans	285	285	285		220	(65)
Accruals	6,658	6,557	6,565	8	6,500	(158)
Receipts in advance	535	670	3,157	2,487	500	(35)
PCD Dividend due			417	417		
Staff benefits accrual	811	712	712		750	(61)
Provisions < 1 yr	2,338	1,868	1,707	(161)	857	(1,481)
Total Current Liabilities	21,835	24,497	26,444	1,947	19,218	(2,617)
Net Current Assets	247	(5,840)	(5,550)	290	(468)	(715)
Non-Curent Assessts +/- Net Current Assets	143,941	135,187	135,490	303	149,506	5,565
NON CURRENT LIABILITIES						
Short Term Loans > 1 year	341	164	164		230	(111)
Provsions > 1 year	1,384	1,169	1,169		998	(386)
Net Current Liabilities	1,725	1,333	1,333		1,228	(497)
Total Assets Employed	142,216	133,854	134,157	303	148,278	6,062
Financed by:						
PDC Capital	103,611	107,611	107,611		119,267	15,656
Revaluation Reserve	35,727	35,619	35,619		35,404	(323)
I & E balance	2,878	2,878	2,878		2,878	
I & E current year		(12,254)	(11,951)	303	(9,271)	(9,271)
FINANCING TOTAL	142,216	133,854	134,157	303	148,278	6,062

Key Movements

Non Current Assets

•Little movement in M7 as additions slightly exceed depreciation.

•Revaluation of Boiler House (CEF Scheme) delayed till November. (Impairment expected).

Current assets

•Increase in Inventories predominantly pharmacy of £0.4m.

•Increase in NHS Receivables of £1.3m.

•Decrease in Other Receivables £0.1m.

•The end of month cash position, exceeds the £0.5m target expected by the TDA as a result of utilising the temporary borrowing facility but was predominantly as a result of NHS late payments received by NHFT £449k, we had arranged for Herts & S.Midlands LAT to pay the November SLA early but was received in October £627k and the VAT reclaim £330k was received on 31 October.

Current Liabilities

•Decrease in NHS Creditors of £0.6m.

•Decrease in Trade Creditors of £0.4m.

•Increase in Fixed Asset Creditors of £0.3m.

•Increase in PDC dividend of £0.4m.

•Increase in Receipts in advance of £2.5m – includes quarterly block of £1.6m from Nene CCG, £0.3m from Corby CCG and £0.6m from Herts & S.Midlands LAT previously mentioned.

•Decrease in current provisions £0.2m utilised in month.

Non Current Liabilities

•No movements.

Financing

•Surplus in month of £0.3m

6. Capital Expenditure

Capital Scheme	Plan 2014/15 £000's	YTD Plan £000's	YTD Spend £000's	Under (-) / Over £000's	Plan Achieved %	Actual Committed £000's	Plan Achieved %	EOY Forecast	Under (-) / Over £000's
Linacc corridor	0	0	0	0	0%	0	0%	0	0
Replacement Imaging Equipment	7,207	0	3	3	0%	9	0%	7,207	0
SHSWTF - E Prescribing National Funding	738	290	205	-85	28%	564	76%	738	0
CEF Scheme	275	275	259	-16	94%	262	95%	262	-13
A&E / Orthopaedics	2,331	1,460	1,135	-325	49%	2,400	103%	2,400	68
Contingency	368	0	0	0	0%	0	0%	298	-70
Medical Equipment Sub Committee	1,684	516	522	6	31%	765	45%	1,684	0
Estates Sub Committee	3,658	1,211	841	-370	23%	1,700	46%	3,667	9
IT Sub Committee	2,787	1,518	1,501	-17	54%	2,167	78%	2,788	1
Other	942	287	293	6	31%	297	31%	948	6
Total - Capital Plan	**19,991**	**5,558**	**4,758**	**-799**	**24%**	**8,164**	**41%**	**19,991**	**0**
Less Charitable Fund Donations	-327	-245	-245	0	75%	-264	81%	-327	0
Total - CRL	**19,664**	**5,312**	**4,513**	**-799**	**23%**	**7,899**	**40%**	**19,664**	**0**

Key Issues

- Linear Accelerator Corridor is linked to first linear accelerator replacement in MES in existing bunker and has now been slipped till 2015/16
- Allocation of contingency: £485k has been approved for the Discharge Lounge and £120k for monitoring equipment for A&E.
- Replacement Imaging Equipment, this will be resubmitted to Independent Trust Finance Facility in November once the revised EOY position has been agreed with the TDA.
- SHSWTF - E Prescribing National Funding is the second year of approved funding from DH and has been matched by £300k of Trust funds
- CEF Scheme - this is now due to complete in November.
- There is a current contingency of £0.368 million (was £0.675 million in M6) N.B this includes £268k related to sale of Camelot Way .
- Full year depreciation forecast is currently £11.615 million (was £11.615 million in M6) and includes revised phasing associated with the replacement imaging equipment.
- Charitable Donations assumptions for additions in year are assumed £327k (was £327k in M6) .

7. Receivables, Payables and BPPC Compliance

Narrative	Total at Oct £000's	0 to 30 Days £000's	31 to 60 Days £000's	61 to 90 Days £000's	Over 90 Days £000's
Receivables Non NHS	1,171	429	252	59	431
Receivables NHS	4,245	3,591	262	211	181
Total Receivables	**5,416**	**4,020**	**514**	**270**	**612**
Payables Non NHS	(4,894)	(4,888)	(6)		
Payables NHS	(2,837)	(2,837)			
Total Payables	**(7,731)**	**(7,725)**	**(6)**		

Narrative	Total at Sept £000's	0 to 30 Days £000's	31 to 60 Days £000's	61 to 90 Days £000's	Over 90 Days £000's
Receivables Non NHS	1,222	457	260	48	457
Receivables NHS	2,960	2,379	376	130	75
Total Receivables	**4,182**	**2,836**	**636**	**178**	**532**
Payables Non NHS	(4,983)	(4,933)	(39)	(5)	(6)
Payables NHS	(3,446)	(3,406)	(40)		
Total Payables	**(8,429)**	**(8,339)**	**(79)**	**(5)**	**(6)**

Narrative	April 2014	May 2014	June 2014	July 2014	August 2014	Sept 2014	Oct 2014	Cumulative 2014/15
NHS Creditors								
No.of Bills Paid Within Target	165	170	138	177	169	250	105	1,174
No.of Bills Paid Within Period	200	180	159	188	177	271	111	1,286
Percentage Paid Within Target	82.50%	94.44%	86.79%	94.15%	95.48%	92.25%	94.59%	91.29%
Value of Bills Paid Within Target (£000's)	1,080	1,586	1,729	1,465	1,487	2,401	1,461	11,209
Value of Bills Paid Within Period (£000's)	1,164	1,643	1,875	1,566	1,497	2,574	1,519	11,838
Percentage Paid Within Target	92.84%	96.53%	92.22%	93.52%	99.29%	93.29%	96.18%	94.69%
Non NHS Creditors								
No.of Bills Paid Within Target	6,363	6,405	6,280	8,057	6,359	6,461	8,703	48,628
No.of Bills Paid Within Period	6,897	6,649	6,435	8,418	7,232	7,147	8,881	51,659
Percentage Paid Within Target	92.26%	96.33%	97.59%	95.71%	87.93%	90.40%	98.00%	94.13%
Value of Bills Paid Within Target (£000's)	7,759	8,607	7,382	8,796	7,545	7,541	9,314	56,945
Value of Bills Paid Within Period (£000's)	8,214	8,667	7,575	9,058	7,975	7,900	9,431	58,819
Percentage Paid Within Target	94.46%	99.31%	97.46%	97.10%	94.62%	95.45%	98.76%	96.81%
Total								
No.of Bills Paid Within Target	6,528	6,575	6,418	8,234	6,528	6,711	8,808	49,802
No.of Bills Paid Within Period	7,097	6,829	6,594	8,606	7,409	7,418	8,992	52,945
Percentage Paid Within Target	91.98%	96.28%	97.33%	95.68%	88.11%	90.47%	97.95%	94.06%
Value of Bills Paid Within Target (£000's)	8,840	10,193	9,111	10,261	9,032	9,942	10,775	68,154
Value of Bills Paid Within Period (£000's)	9,378	10,310	9,449	10,625	9,472	10,473	10,950	70,657
Percentage Paid Within Target	94.26%	7.00%	96.42%	96.58%	95.35%	94.92%	98.40%	96.46%

Receivables and Payables

- Continued focus on reducing age profile of non current debt.
- MK CCG SLA was paid late due to internal issue all other SLA (Commissioners) paid on time.
- 317 accounts (£336k) have now been passed to CCI Legal Ltd to pursue on our behalf which is a significant element of the remaining non NHS over 90 day debt relating predominantly to overseas visitors
- NHS over 90 day debt relates to £50k MK NHS FT, £21k Nene CCG, £29k UHL NHST and £73k NCA's.
- All of registered creditors current (due within 30 days).
- Appropriate provision and write off has been made in accordance with the stated DH and local Trust policies.

BPPC Compliance

- BPPC has improved from last month to (94.06% by volume, 96.46% by value) with the payments team continuing to achieve processing within the targets once approved.
- The volume of temporary staffing invoices continues to be the main area of poor performance Trust wide. 31% (32% in M6) of all invoices paid late by value and 62% (63% in M6) of by number (1.26% value & 4.27% number of all invoices paid). In October 19% by value (35% in M5) and 18% by number (77% in M5) of all invoices paid late related to the bank office. Work is ongoing with bank office to improve invoice processing and they hope to have caught up on their backlog in September.

8. Cashflow

MONTHLY CASHFLOW	Annual	ACTUAL APR	MAY	JUN	JUL	AUG	SEP	OCT	FORECAST NOV	DEC	JAN	FEB	MAR
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
RECEIPTS													
SLA Base Payments	231,985	16,228	23,419	18,511	21,229	18,365	18,358	21,575	17,967	18,372	21,217	18,372	18,372
SLA Performance/ Other CCG Investment	-5,000									-2,000	-2,000		-1,000
Health Education Payments (SIFT etc)	9,491	130	2,089	218	1,525	20	792	766	766	799	799	799	786
Other NHS Income	21,331	3,110	1,187	675	1,113	1,432	2,421	1,976	1,718	1,582	2,457	1,432	2,226
PP / Other (Specific > £250k)	1,745	264		348	418	385		330					
PP / Other	12,093	952	941	973	768	800	1,150	1,009	1,100	1,100	1,100	1,100	1,100
Salix Capital Loan	125										60	65	
PDC - Capital	7,656										449	2,789	4,418
PDC - Revenue	14,000									12,000	2,000		
Temporary Borrowing							4,000		3,000	-7,000			
Interest Receivable	29	3	2	2	2	1	2	4	2	3	2	2	4
TOTAL RECEIPTS	293,456	20,689	27,638	20,727	25,055	21,003	26,723	25,660	24,553	24,857	26,084	24,560	25,907
PAYMENTS													
Salaries and wages	167,614	14,056	14,151	14,043	13,862	13,940	13,848	13,963	13,950	13,950	13,950	13,950	13,950
Trade Creditors	86,483	3,909	9,598	6,905	8,261	7,610	7,469	8,588	8,575	7,118	7,216	6,293	4,941
NHS Creditors	18,626	1,123	1,645	1,874	1,566	1,524	2,397	1,563	1,611	1,611	1,711	1,000	1,000
Capital Expenditure	19,275	1,749	1,231	667	828	370	600	706	1,356	2,509	2,929	3,711	2,619
PDC Dividend	4,541						2,223						2,318
Repayment of Loans													
Repayment of Salix loan	301						177						124
TOTAL PAYMENTS	296,840	20,837	26,625	23,489	24,518	23,444	26,715	24,821	25,492	25,188	25,806	24,954	24,952
Actual month balance	-3,384	-148	1,014	-2,761	537	-2,441	9	840	-939	-332	278	-394	955
Cash in transit & Cash in hand adjustment	-62	48	-24	-7	-12	44	-26	-24	-60				
Balance brought forward	4,445	4,445	4,345	5,335	2,567	3,092	694	677	1,492	493	162	439	45
Balance carried forward	1,000	4,345	5,335	2,567	3,092	694	677	1,492	493	162	439	45	1,000

Key Issues

- No further temporary borrowing support was required in October, although £3m was arranged for 3 November and this facility will be converted to permanent borrowing during the financial year due to planned I&E deficit.
- TDA requirement not to exceed £0.5m month end balance set as a stipulation of the temporary borrowing facility as a result of NHS invoices which had been under query being resolved and paid late in the month, arrangement with Herts & S. Midlands LAT for early payment of their SLA in November resulted in payment being received on 23 October and the VAT claim was credited on 31 October.
- Cash flow plan includes £5m reduction to SLA income relating to fines and under performance.
- Revised capital PDC loans of £7.2m included in forecast relating to the replacement Imaging equipment, application to Independent Trust Financing Facility (ITFF) has now been submitted for approval in November.
- Capital expenditure profile includes a further revised planned phasing of the replacement Imaging equipment.
- As a result of the impact of fines and underperformance, cash availability will impact creditor payments in March.
- The EOY closing cash balance has been reduced to £1m as a requirement of the ITFF submission and may result in further cash flow issues in the new financial year as the main contract payments aren't received until the 15th of the month

9. Conclusions and Recommendations

Conclusion:

The financial position for October continues to show signs of underlying improvement when compared to the first six months of the financial year. The position compared to forecast has been adversely impacted by the CCG's stance in relation to the tariff for the A&E Emergency Assessment Area meaning the Trust could not fully release the provision for non-payment as previously forecast for October. At present this issue gives rise to a potential income variance of £0.8m adv. by the financial year end and remains subject to negotiation.

October sees the first full month where comparisons can now be drawn in relation to directorate performance against agreed control totals. Operating expenditure overall is tracking closely to forecast although several directives are adrift of the agreed FRP control totals in October. A series of escalation meetings will be held in November to understand the position for these areas in more detail and to address the adverse position.

The Trust has been able to refine the level of provisions for fines and penalties through a series of meetings and exchanges of correspondence regarding the likely forecast outturn for SLA contractual income. There remains however some areas of significant difference in the application of PbR rules between the Trust and CCG, most notably in the areas of MRET, Readmissions penalties and the application of best practice tariffs for NEL activity. The Trust was successful in attracting an additional £2m of winter funding to add to the £0.7m previously agreed. Work is ongoing to assess the net impact of this additional funding as a potential means of mitigation against emerging cost pressures and risks which were not included in the FRP forecast. The current risks to delivery of the FRP forecast are the likelihood of significant international nurse recruitment costs, the impact of the ETA overtime ruling and the potential for a significant shortfall in forecast CCG income based on the CCG's formal year end settlement offer.

The TDA have yet to formally approve the Trust's deficit control total for FY14-15. The Trust position remains that the most likely forecast position is a deficit of £16.7m but this is highly dependent on successful negotiations with NENE CCG in relation to the forecast SLA position. It is anticipated that the TDA will make a further judgement after the joint meeting between the LAT, TDA and CCG on 14th November. Cashflow continues to be constrained and has been supported by additional temporary borrowing. Significant work has been undertaken to ensure TDA support for the Trust's application for permanent financing to support the revenue position and planned capital programme. It is expected that the ITFF will hear the Trusts application on 27th November and a decision will be announced shortly after that date.

Recommendations & actions

- Ongoing review of all FRP actions with escalation meetings for all areas currently adverse to plan.
- Review ongoing arrangements for managing the CIP programme and ensure resources are aligned to key risks / areas for delivery.
- Further work required with CCG to align forecast assumptions and formalise MRET and winter pressures funding assumptions.
- Further review of agency usage to be undertaken and aligned to ongoing recruitment pipeline.
- Develop greater understanding of potential risks to the financial position which are not currently covered by the FRP.
- Continue to seek mitigations to offset potential shortfalls in the FRP forecast.

Appendix 1: Continuity of Service Risk Rating (CSR)

		M7 ACTUAL	M6 ACTUAL	M5 ACTUAL	M4 £000's	M3 £000's	M2 £000's	M1 £000's	EOY £000's
LIQUIDITY RATIO (DAYS)		**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Working Capital Balance									
Total - Current Assets	+	20,894	18,657	19,729	20,531	18,959	20,206	23,757	18,750
Total - Current Liabilities	+	-26,444	-24,497	-28,119	-26,300	-23,247	-22,837	-23,334	-19,218
Inventories	-	5,924	5,572	5,739	5,615	5,543	5,311	4,860	5,300
Non-Current Assets Held for Sale	-	268	268	0	0	0	0		
PFI Prepayments - Current Portion	+		0	0	0	0	0		
Financial Assets Available for Sale	+		0	0	0	0	0		
Current Assets held for Sale by Charitable Funds	+		0	0	0	0	0		
Current Liabilities held for Sale by Charitable Funds	+		0	0	0	0	0		
(1) Working Capital Balalnce		**-11,742**	**-11,680**	**-14,129**	**-11,384**	**-9,831**	**-7,942**	**-4,437**	**-6,035**
Annual Operating Expenses									
Gross Employee Benefits	+	-107,450	-92,113	-76,644	-61,185	-45,895	-30,521	-30,521	-179,314
Other Operating Costs	+	-57,418	-49,024	-40,287	-32,587	-23,964	-16,195	-16,195	-94,053
Impairments: IFRIC 12	+	359	359	0	0	0	0	0	1,228
Depreciation	+	6,671	5,682	4,708	3,740	2,780	2,045	2,045	11,615
Amortisation	+		0	0	0	0	0	0	0
Stock Write down	+		0	0	0	0	0	0	0
Impairment of Receivables	+							0	0
(2) Annual Operating Expenses	* -1	**157,838**	**135,097**	**112,223**	**90,032**	**67,078**	**44,672**	**44,672**	**260,448**
Liquidity Ratio Days		**-16**	**-16**	**-19**	**-15**	**-13**	**-11**	**-3**	**-8**
(A) LIQUIDITY SCORE		**1**	**1**	**1**	**1**	**2**	**2**	**3**	**2**
CAPITAL SERVICING CAPACITY									
Revenue Available for Debt Service		-2,505	-4,205	-4,110	-2,416	-2,028	-1,249	-938	7,832
Annual Debt Service		2,839	2,422	1,871	1,497	1,102	735	367	8,888
Capital Servicing Capacity (times)		**-0.9**	**-1.7**	**-2.2**	**-1.6**	**-1.8**	**-1.7**	**-2.6**	**0.9**
(B) CAPITAL SERVICING CAPACITY SCORE		**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**
CONTINUITY OF SERVICES RATING		**1.0**	**1.0**	**1.0**	**1.0**	**1.5**	**1.5**	**2.0**	**1.5**

Key issues

CSR

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

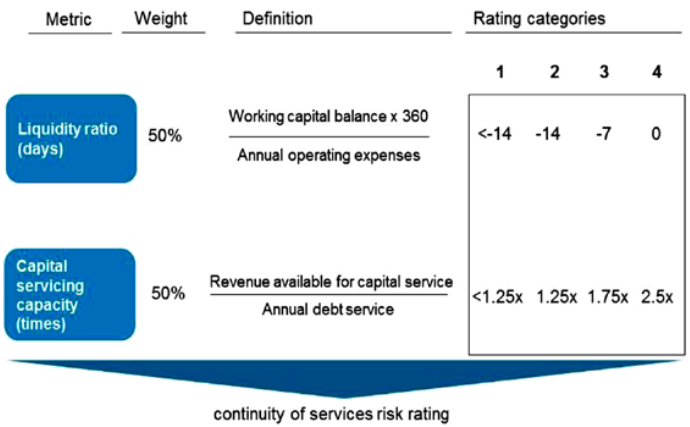
Current Score

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

Forecast EOY

- Forecast based on achievement of £7.8m deficit plan.
- Forecast score of 1.5 overall.
- Liquidity score will reduce if planned deficit not maintained / ITFF application unsuccessful.
- 14-15 TDA system support funding unconfirmed.

Monitor Guidance (extract)



Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**27 November 2014**

Title of the Report	**Workforce Report**
Agenda item	**14**
Sponsoring Director	Janine Brennan, Director of Workforce & Transformation
Author(s) of Report	Joanne Wilby, Workforce Planning & Information Manager
Purpose	This report provides an overview of key workforce issues

Executive summary

The key matters affecting the workforce include:

- The key performance indicators show a decrease in Total Workforce Capacity (excluding Medical Locums) employed by the Trust, and an increase in annual average sickness absence.
- An update on Mandatory and Role Specific Essential Training, and Appraisals.
- An update on Flu vaccination take up by staff
- An update on Organisational Development issues including Staff Survey Responses and Staff Friends & Family Test

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

Enclosure J

Actions required by the Trust Board

The Board is asked to note the report

Northampton General Hospital NHS
NHS Trust

Public Trust Board
27 November 2014

Workforce Report

1. Introduction

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

It also sets out current key workforce updates.

2. Workforce Report

2.1 Key Workforce Performance Indicators

The key performance indicators show:

Sickness Absence

The financial year to date rate for sickness absence increased to 4.25%, and the annual rolling increased to 4.40%. In month sickness absence increased by 0.58% to 4.69% which is above the Trust target.

The non-medical sickness absence rate for the General Surgery Care Group increased to 5.12%. The rates in Anaesthetics Critical Care &Theatres, General Surgery, Trauma & Orthopaedics, Ophthalmology, and ENT & Maxillo-Facial all increased, while the rates fell in the Women's & Children's directorates; ENT & Maxillo-Facial and Child Health were below the trust target of 3.8%.

The non-medical sickness absence rate for the General Medicine Care Group increased to 5.51%. Sickness was higher in the Pharmacy, Oncology & Haematology, and General Medicine directorates, but fell in Pathology, Radiology & Therapies. All directorates with the exception of Oncology & Haematology and General Medicine are below the trust target of 3.8%.

The non-medical sickness rate for Support Services moved above the trust target, to 4.44% in October. Within this figure Facilities increased to 5.22% and Hospital Support to 3.81%.

Medical & Dental staff sickness absence in October was 1.25%.

Workforce Capacity

Total Workforce Capacity (including temporary staff but excluding Medical Locums) decreased by 31.81 FTE in October to 4,403.94 FTE. The Trust remains below the Budgeted Workforce Establishment of 4,561.76 FTE.

Substantive workforce capacity decreased by 3.32 FTE to 4,090.11 FTE. Temporary workforce capacity (excluding Medical Locums) decreased by 28.49 FTE to 313.83 FTE.

Enclosure J

2.2 Workforce Updates

Appraisals

The current rate of completed PDP's or Appraisals recorded is 71.34%; this is a decrease on last month's figures and is possibly reflective of the large number of staff who were due to have an appraisal to coincide with their incremental rise in October. When Agenda for Change was first implemented if staff were then at the top of their pay band they were automatically given an incremental date of October 1st which is why we have a large percentage of our staff due an increment at that date.

Despite significant improvements being made within the Trust on appraisal compliance there are still a number of staff who have not yet had an appraisal. For those staff that were due to have an appraisal between April and October, via the new process, information has not been received on almost 700 staff of which approximately 50% of them are at the top of their pay band and would therefore not be expecting an incremental pay rise. This then suggests that further work is required to ensure that all managers should ensure, within their objectives, that their staff have had an appraisal. Many areas have, however, made positive progress on their appraisal compliance since the beginning of the year and are being supported to improve.

This means that we have not achieved our target of 80% by October, despite plans being put in place to ensure a significant improvement in October. This will be subject to discussions with the Chief Operating Officer and relevant directors as appropriate and will be subject to an increased focus at the divisional performance review meetings.

The audit on the quality of appraisals is proving informative and some issues have been identified which will be addressed on an individual basis. The current process is currently being reviewed to see whether any modifications are required; this will be facilitated by a Street Talk (workshop) session in December.

Mandatory and Role Specific Essential Training

The Mandatory & Role Specific Essential Performance Wave is continuing to embed across the Trust with on-going support to all areas provided as required. Mandatory Training compliance increased slightly to 78.78% in October.

RSET compliance stood at 64.50% in October, a slight drop from 64.74% in September; the project of scoping Role Specific Essential Training aligned to roles and uploading the information into ESR was recently completed. Work will continue to fine-tune the competence requirements against individual positions, and some issues remain with the mass update of records, which are being investigated. Ongoing refinements to RSET scope will be required as new roles are developed and skill requirements change.

This means that we have not achieved our target of 80% by October. This will be subject to discussions with the Chief Operating Officer and relevant Directors as appropriate and will be subject to an increased focus at the divisional performance review meetings.

Dialogue between the Trust and McKesson / ESR is ongoing to identify data inconsistencies between OLM and ESR and secure a resolution. Whilst it is felt that these have reduced in number, one suggestion being that as systems have been upgraded the glitch may have been inadvertently fixed, there is still a requirement to ensure that data provided by the L&D department accurately reflects the training staff have accessed in order to improve compliance. McKesson have also agreed to develop a programme that would be able to identify where there are errors and rectify them. This however does require some questions to be answered to ensure the reliability of the programme.

Occupational Health

As at 10 November 2014, the Flu vaccination rate for staff for the DoH return was 62%. This has already exceeded last year's final total. The team have now finished 'Flu Central' and are focussing on visiting wards/departments to carry out the vaccinations.

2.3 Organisational Development

DoOD Network

Do Organisational Development is a network of staff from all levels and areas of the organisation who are actively supporting the OD agenda. On Wednesday 5th November, we held our first event, inviting current and aspiring DoODs to come along and meet the team and find out more about what we do. We spoke to people from all over the hospital, sharing cakes and chocolates and 30 new recruits signed up and joined us, making a total of 53 NGH DoODs.

National Staff Survey

As at 10th November the Staff Survey percentage return rate is 39% (333 have been returned). This is slightly above the return rate this time last year. The OD team continue to spread the word using a roadshow type approach and are utilising the recently recruited DoOD network.

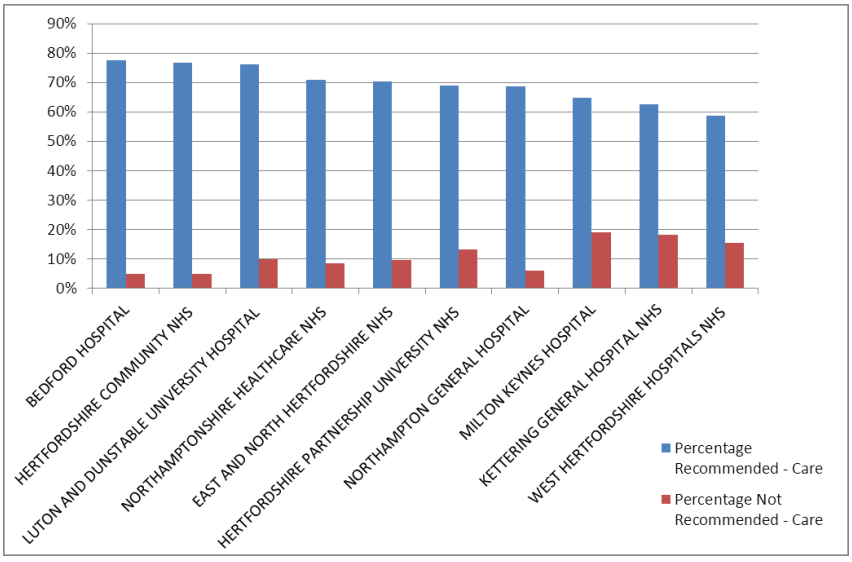
Rainbow Risk

We have now completed facilitation of the Rainbow risk session for 350 staff from all areas of the organisation, with bookings over the next 6 weeks to cover a further 150. Feedback has been overwhelmingly positive.

Staff Friends and Family Test

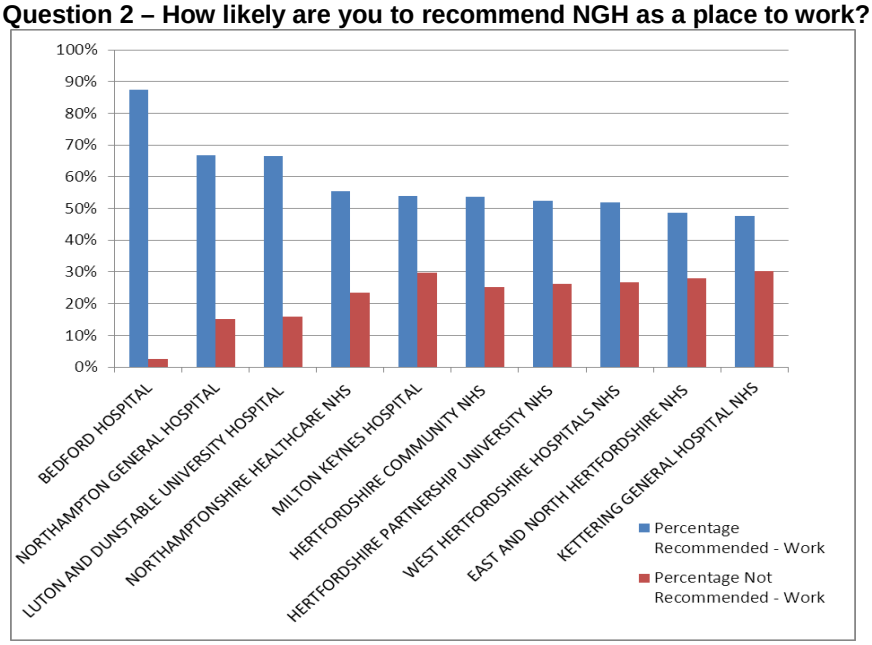
The national staff friends and family test results were made available on line in September for Quarter one. The results show NGH data in comparison to other Trusts from across the region.

Question 1 – How likely are you to recommend NGH as a place for treatment?



Enclosure J

Question 2 – How likely are you to recommend NGH as a place to work?



Policy Changes

None to report. The Trust currently has 46 live policies, 10 of which are in the process of being reviewed.

3. Assessment of Risk

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

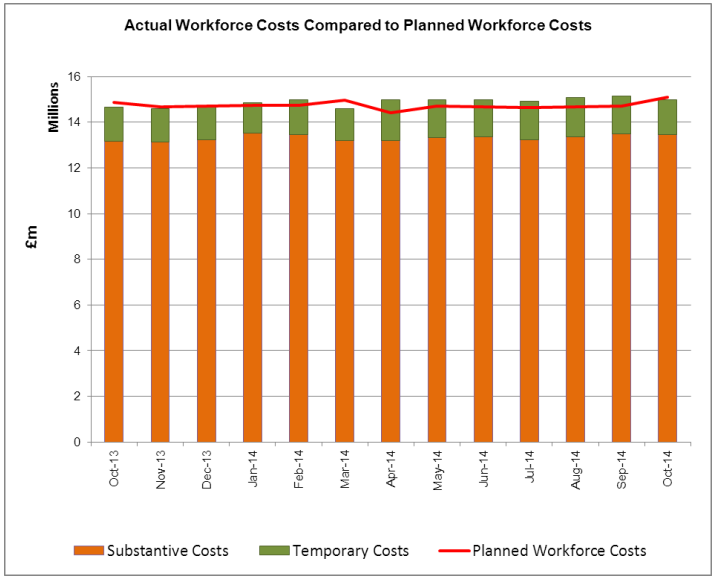
4. Recommendations/Resolutions Required

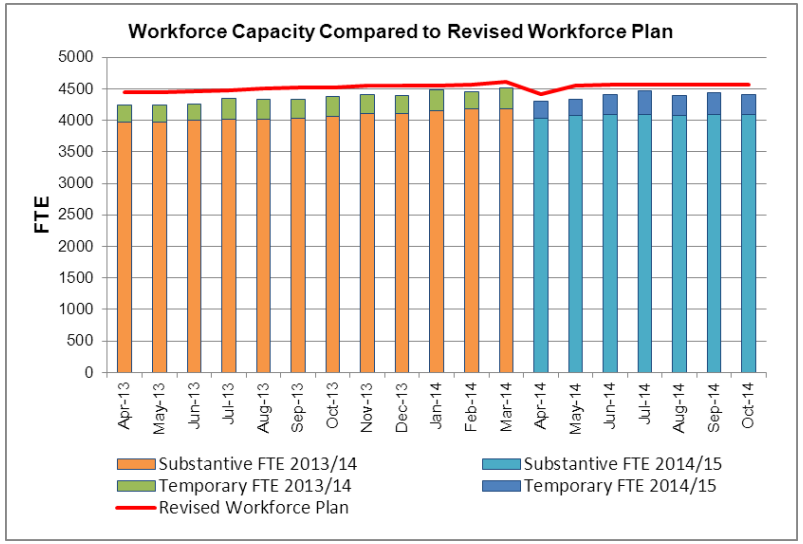
The Board is asked to note the report.

5. Next Steps

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

Human Resources Workforce Performance Indicators 2014/15 Month 07





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Substantive Costs 2013/14 (£1,000's)	12927	12979	13057	13056	13070	13111	13153	13148	13238	13521	13470	13193
Substantive Costs 2014/15 (£1,000's)	13197	13317	13353	13235	13349	13486	13453					
Temporary Costs 2013/14 (£1,000's)	1311	1370	1399	1444	1371	1443	1493	1460	1420	1325	1530	1387
Temporary Costs 2014/15 (£1,000's)	1774	1674	1646	1688	1740	1665	1517					
Planned Workforce Costs 2013/14 (£1,000's)	14296	14307	14341	14358	14400	14411	14876	14691	14710	14738	14752	14981
Planned Workforce Costs 2014/15 (£1,000's)	14422	14702	14669	14630	14681	14701	15113					

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Substantive FTE 2013/14	3,976	3,977	4,000	4,016	4,013	4,035	4,059	4,108	4,110	4,149	4,179	4,185
Substantive FTE 2014/15	4,040	4,080	4,090	4,097	4,076	4,093	4,090					
Temporary FTE 2013/14	266	263	260	329	329	305	316	303	291	334	269	324
Temporary FTE 2014/15	267	250	324	368	312	342	314					
Revised Workforce Plan 2013/14	4,452	4,450	4,462	4,476	4,502	4,522	4,522	4,553	4,555	4,558	4,564	4,619
Revised Workforce Plan 2014/15	4,420	4,551	4,561	4,564	4,567	4,561	4562					

Workforce Expenditure

Total Workforce Expenditure (all pay elements) decreased by £181,589 in October to £14.969m (this is below plan for Month 7).

Substantive workforce expenditure decreased by £33,185 to £13,452,731.

Temporary Workforce Expenditure (including Medical Staff) decreased by £148,404 to £1,516,717, equating to 10.13% of the total workforce expenditure.

Workforce Capacity

Total Workforce Capacity (including temporary staff but excluding Medical Locums) **decreased by 31.81 FTE in October to 4,403.94 FTE. The Trust remains below the Budgeted Workforce Establishment of 4,561.76 FTE.**

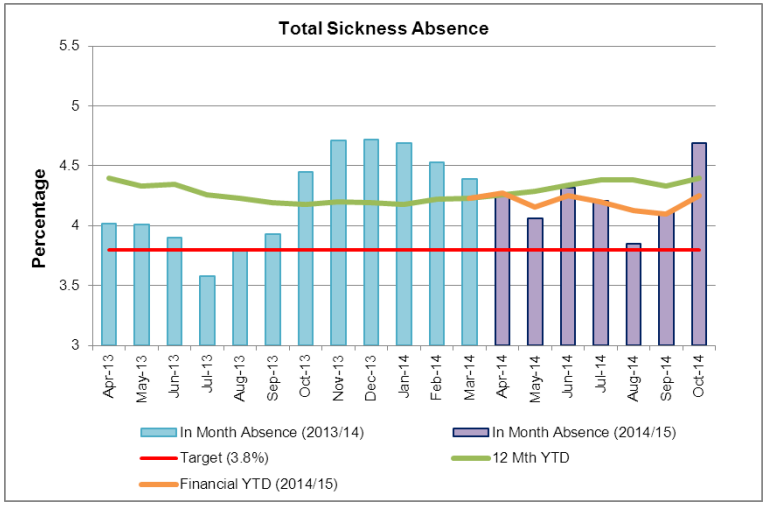
Substantive workforce capacity decreased by 3.32 FTE to 4,090.11 FTE.

Temporary workforce capacity (excluding Medical Locums) **decreased by 28.49 FTE to 313.83 FTE.**

Enclosure J

Human Resources Workforce Performance Indicators 2014/15 Month 07

	Key Performance Indicators					
	Threshold	Trust Taraget	Trust Actual	Medicine	Surgery	Support Services
Substantive Workforce against Budgeted Establishment (% FTE)	Under 95% Over 97% 95 - 97% Over 100%	95%	89.66%	87.69%	92.83%	86.77%
Temporary Workforce Capacity (excluding Medical Staffing)	Over 5% 4.5 - 5% Under 4.5%	5%	7.13%	9.74%	6.05%	**2.84%**
Total Substantive Workforce plus Temporary Workforce against Budgeted Establishment (% FTE) (excluding Medical Staffing)	Under 95% Over 97% 95 - 97% Over 100%	100%	**96.54%**	97.16%	98.81%	89.31%
% Staff Turnover (excluding internal transfers)	Under 8% Over 8%	8%	9.99%	11.72%	8.73%	8.81%



Trust Target 3.8%	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
In Month Absence (2013/14)	4.02	4.01	3.90	3.58	3.80	3.93	4.45	4.71	4.72	4.69	4.53	4.39
In Month Absence (2014/15)	4.27	4.06	4.32	4.21	3.85	4.11	4.69					
12 Month YTD (2013/14)	4.40	4.33	4.35	4.26	4.23	4.19	4.18	4.20	4.19	4.18	4.22	4.23
12 Month YTD (2014/15)	4.26	4.29	4.34	4.38	4.38	4.33	4.40					
Financial YTD (2014/15)	4.27	4.16	4.25	4.20	4.13	4.10	4.25					

Workforce Capacity

- In summary for Nursing, the total utilisation (Bank & Agency Filled) was 33,663 hours (207 FTE), which is a decrease of 1366 hours compared with the previous month.
- Bank & Agency Fill Rates for Nursing: Bank fill rate = 43.34% (increase of 1.54%), Agency fill rate = 30.11% (decrease of 0.14%). Total bank & agency fill rate = 73.45% (increase of 1.4% compared with the previous month).

Sickness Absence

The financial year to date rate for sickness absence increased to 4.25%, and the annual rolling average increased to 4.40%. In-month Sickness Absence increased by 0.58% to 4.69% which is above the Trust target of 3.8%.

- Short term sickness absence increased to 3.05%.
- Long term sickness absence decreased slightly to 1.64% which remains below Trust Target.
- The total calendar days lost to sickness absence increased by 1038 to 7003 days lost.
- The number of days lost per employee increased to 1.48 days.

Human Resources Workforce Performance Indicators 2014/15 Month 07

	Surgery Care Group										
	Directorate										
	Threshold	Target	Anaesthetics, Critical Care & Theatres	Surgery	Site Bed Team	Surgical Care Management	Trauma & Orthopaedics	Ophthalmology	ENT & Maxillofacial	Women	Children
Short Term Sickness Absence		1.60%	3.94%	3.91%	5.67%	0.00%	3.42%	4.23%	3.43%	3.85%	1.09%
Long Term Sickness Absence		2.20%	4.36%	1.28%	0.00%	0.00%	0.66%	4.83%	0.00%	1.24%	0.69%
Total Sickness Absence	Over 4.2% 3.9-4.2% Under 3.8%	3.80%	8.30%	5.19%	5.67%	0.00%	4.08%	9.06%	3.43%	5.09%	1.78%

Surgery Care Group Summary

- The non-medical sickness absence rate for the General Surgery Care Group increased to 5.12%. The rates in Anaesthetics CC&T, Gen Surgery, T&O, Ophthalmology, and ENT & MaxFax all increased, while the rates fell in the Women's & Children's directorates; ENT and Children were below the trust target of 3.8%.
- The highest ward based sickness was on Willow Ward with 9.01%, all short-term absence. The highest increase in total sickness was on Balmoral Ward, moving from 0% in September to 6.34% in October, the majority being long-term sickness for one individual.

	Medicine Care Group								
	Directorate								
	Threshold	Target	Pharmacy	Pathology	Radiology	Therapies	Oncology & Clinical Haematology	Medical Care Management	General Medicine & Emergency
Short Term Sickness Absence		1.60%	2.70%	2.53%	1.83%	2.03%	3.34%	0.00%	4.38%
Long Term Sickness Absence		2.20%	0.00%	1.29%	0.61%	1.29%	2.59%	0.00%	2.33%
Total Sickness Absence	Over 4.2% 3.9-4.2% Under 3.8%	3.80%	2.70%	3.82%	2.44%	3.32%	5.93%	0.00%	6.71%

Medicine Care Group Summary

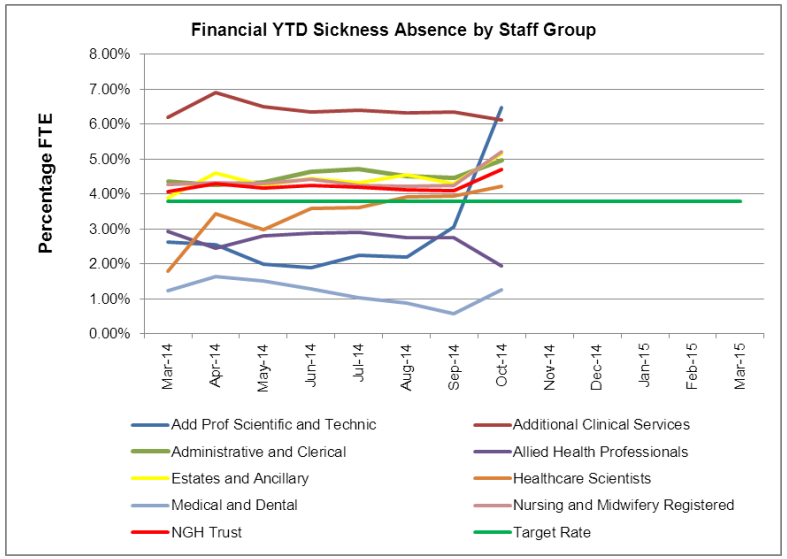
- The non-medical sickness absence rate for the General Medicine Care Group increased to 5.51%. Sickness was higher in Pharmacy, Oncology & Haematology, and Gen Medicine directorates, but fell in Pathology, Radiology & Therapies. Only Oncology & Haematology and Gen Medicine are above the trust target of 3.8%.
- Collingtree Ward has the highest ward-based sickness rate at 12.35%, including the highest short-term rate of 10.37%.Compton has improved from 15.14% in September to 7.64% in October, due to a large reduction in long-term sickness from 12.73% to 3.54%.

	Support Services				M&D
	Directorate				
	Threshold	Target	Facilities	Hospital Support	Medical & Dental
Short Term Sickness Absence		1.60%	2.76%	2.26%	1.05%
Long Term Sickness Absence		2.20%	2.46%	1.55%	0.20%
Total Sickness Absence	Over 4.2% 3.9-4.2% Under 3.8%	3.80%	5.22%	3.81%	1.25%

Hospital Support and Medical & Dental Summary

- The non-medical sickness rate for Support Services moved above the trust target, to 4.44% in October. Facilities increased to 5.22% and Hospital Support to 3.81%.
- Medical & Dental staff sickness absence in October was 1.25%.

Human Resources Workforce Performance Indicators 2014/15 Month 07



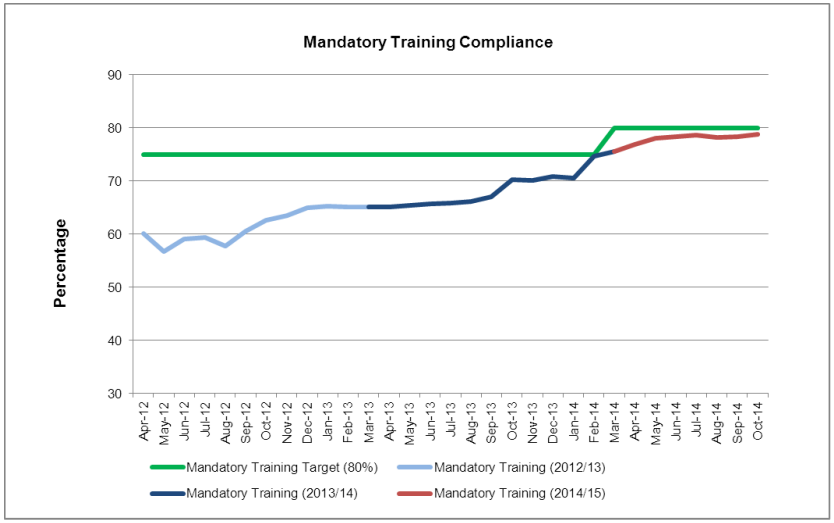
	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Add Prof Scientific and Technic	2.63%	2.56%	1.98%	1.90%	2.23%	2.19%	3.06%	6.48%					
Additional Clinical Services	6.20%	6.90%	6.50%	6.36%	6.41%	6.33%	6.34%	6.12%					
Administrative and Clerical	4.36%	4.27%	4.34%	4.64%	4.72%	4.52%	4.47%	4.97%					
Allied Health Professionals	2.94%	2.45%	2.81%	2.87%	2.90%	2.74%	2.76%	1.95%					
Estates and Ancillary	3.88%	4.61%	4.24%	4.44%	4.33%	4.54%	4.29%	5.15%					
Healthcare Scientists	1.79%	3.44%	2.99%	3.58%	3.61%	3.91%	3.94%	4.23%					
Medical and Dental	1.23%	1.64%	1.50%	1.28%	1.03%	0.87%	0.58%	1.25%					
Nursing and Midwifery Registered	4.26%	4.31%	4.30%	4.43%	4.26%	4.22%	4.25%	5.20%					
NGH Trust	4.06%	4.29%	4.16%	4.25%	4.20%	4.13%	4.10%	4.69%					
Target Rate	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%

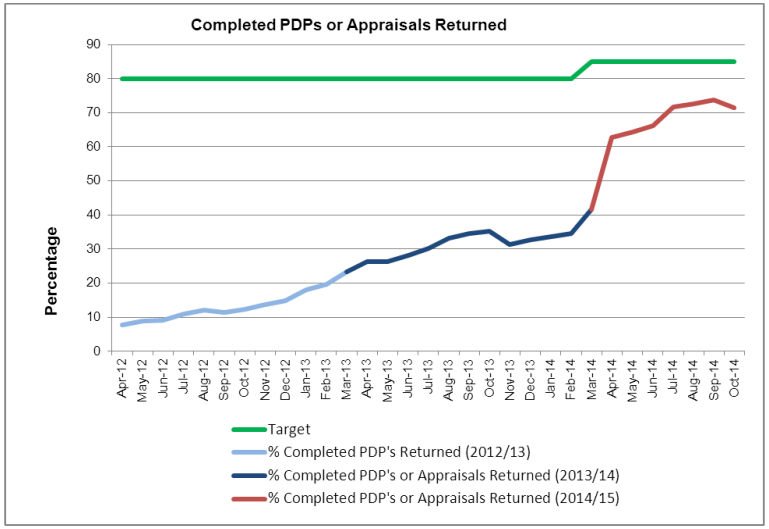
	Key Performance Indicators					
	Threshold	Trust Target	Trust Actual	Medicine	Surgery	Support Services
Sickness Absence Rate (%) - in Month (all staff)	4.2% & over >3.8% <4.2% 3.8% or less	3.80%	4.69%	4.99%	4.51%	4.39%
No. of completed PDPs returned & completed Appraisals	Under 75% 75 - 79% 80% & over	80% by Oct-14	71.35%	74.40%	71.79%	63.25%
% Statutory & Mandatory Training Compliance	Under 75% 75 - 79% 80% & over	80% by Oct-14	78.78%	79.52%	77.76%	79.69%
% Role Specific Training Compliance	Under 75% 75 - 79% 80% & over	80% by Oct-14	64.50%	66.86%	62.07%	69.03%

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

- The current rate of completed PDP's or Appraisals recorded in ESR is 71.35%, the first drop in the rate since March.
- Mandatory Training compliance has improved further to 78.78%, just short of the October target of 80%.
- RSET compliance decreased slightly to 64.50%. Work is continuing to fine-tune the competence requirements against individual positions. Ongoing refinements to RSET scope will be required as new roles are developed and skill requirements change.

Human Resources Workforce Performance Indicators 2014/15 Month 07





Mandatory Training Target 80%	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Mandatory Training (2012/13)	60.09	56.68	59.03	59.42	57.71	60.59	62.68	63.47	64.93	65.31	65.2	65.2
Mandatory Training (2013/14)	65.14	65.4	65.75	65.93	66.09	66.97	70.23	70.20	70.84	N/A	74.68	75.51
Mandatory Training (2014/15)	76.91	78.06	78.42	78.65	78.2	78.35	78.78					

Completed and Returned PDP Target 85%	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% Completed PDP's Returned (2012/13)	7.83	8.95	9.02	10.93	11.98	11.35	12.24	13.72	14.89	18.07	19.65	23.35
% Completed PDP's Returned (2013/14)	26.28	26.22	28.04	30.12	33.06	34.62	35.17	31.27	32.76	33.58	34.52	41.71
% Completed PDP's Returned (2014/15)	62.81	64.30	66.09	71.75	72.69	73.74	71.35					

Role-Specific Essential Training

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

Enclosure J

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**27 November 2014**

Title of the Report	**Fire Safety Annual Report 2013/14**
Agenda item	**15**
Sponsoring Director	Charles Abolins, Director of Facilities and Capital Development
Author(s) of Report	Stuart Finn, Head of Estates and Deputy Director of Facilities David Waddoups, Fire Safety Advisor
Purpose	For assurance and approval

Executive summary

The report highlights Fire Safety statistics during the past 12 months and provides assurance regarding progress, investment and measures taken during the year to improve Fire Safety resilience within the Trust

Related strategic aim and corporate objective	• To be a provider of quality care for all patients • Provide appropriate care for our patients in the most effective way
Risk and assurance	The report highlights areas of risk and proposes measures to mitigate those risks
Related Board Assurance Framework entries	BAF 5 Failure of the Estate infrastructure
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (No) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(No)
Legal implications / regulatory requirements	Compliance with the Regulatory Reform (Fire Safety) Order 2005 and compliance with the Department of Health Fire Safety Policy contained within HTM 05-01

Actions required by the Trust Board

The Trust Board is asked to note the actions taken to improve Fire Safety within the Trust during the past 12 months, the Annual Statement of Fire Safety Compliance and to support the ongoing investment and actions to mitigate risks related to Fire Safety on Trust premises.

Enclosure K

Northampton General Hospital NHS
NHS Trust

ANNUAL FIRE SAFETY REPORT

APRIL 2013 to MARCH 2014

David A Waddoups
Fire Safety Advisor
Northampton General Hospital

Enclosure K

1.0 Introduction

This report has been produced to provide the Trust Board with an overview of the current position of fire safety and to provide assurance that the Trust is meeting its statutory responsibilities.

2.0 Governance and Assurance

All fire safety arrangements within the Trust are modelled on the recommendations made by the Department of Health's Firecode fire safety guidance documents. These are referenced and supported within the Trust's Fire Safety Policy.

The Department of Health announced in 2013, that an Annual Certificate of Fire Safety Compliance is no longer necessary but Trusts should implement a similar local annual certificate – see appendix 1.

To provide assurance to enforcing bodies that the Trust is complying with its statutory obligations and has a plan of action for dealing with gaps in compliance an independent audit of fire management arrangements was completed by Northants Fire and Rescue Service in 2013. The resulting action plan is being monitored through Fire committee.

Northants Fire and Rescue Service revisited site during 2014 to monitor progress against the actions raised in their 2013 audit and subsequently wrote to the Trust to confirm that all actions had been addressed and the Trust's fire managements arrangements were satisfactory.

3.0 Fire Risk Assessments

During 2013/14 new fire risk assessments continued to be completed for all areas owned or occupied by the Trust, in addition to reviewing the existing assessments. There are four main areas identified in these risk assessments that impact on the ability of the Trust to provide a safe environment for patients, visitors and staff. These are;
Buildings/structural, Fire alarm, Vertical evacuation and Staff training.

Findings from these assessments have been used to prioritise fire safety works within the rolling annual capital programme. These works, once completed, will reduce or eliminate the risk but ongoing investment is required to maintain risks at an acceptable level which in turn also demonstrates to the enforcing body that the Trust is satisfactorily managing its fire risk.

3.1 Buildings/Structural

Hospitals are designed and constructed to allow patients to remain inside, within fire safety compartments, should a fire occur in another part of the building. This requires them to be constructed using high levels of fire resistance to divide the building into designated compartments.

The Trust occupies many buildings dating from 1793, some of which have been built using construction methods that no longer satisfy current standards, for example the "Oxford Method". The affected buildings using "Oxford" were built in the late 1970s and currently house: Main Theatres, A&E, Fracture Clinic, Radiology, ITU/HDU and neighbouring wards. This construction method relied on the fire integrity of a suspended asbestos ceiling to provide fire resistance to the floor above and the steel frame of the building. The void created by the suspended ceiling was not provided with cavity barriers, allowing a very large uncompartmented area through which fire, smoke and heat could spread unchecked.

The Trust has carried out remedial work, on a phased basis, by installing cavity barriers in the voids during capital upgrading works. Asbestos ceiling tiles require specialist removal that would require lengthy closure of areas during the work, it is therefore operationally impractical to check the extent to which further fire compartmentation is required however it is considered that the areas still requiring work include: Benham Ward, Eleanor Ward, parts of ITU/HDU, parts of Radiology and part of Main theatres.

The risk has been mitigated by the installation of an automatic fire suppression system throughout the basement and other high-risk areas such as kitchens, stores and medical records, automatic fire detection system, staff training, emergency plans and an on site Fire Response Team. Over the past three years there have been substantial works to upgrade the fire alarm system by the installation of additional automatic fire detection and the upgrade of the systems control panels.

When the opportunity arises through capital refurbishment or emergency repair works fire safety improvements are always included wherever practicable.

Building works incorporating Fire Safety completed during 2013/14 include:

- Completion of alterations including improved fire barriers, dampers, fire detection, etc in Urology, Endoscopy, Colposcopy, Eyes reception (including new fire shutters) and Robert Watson
- Extension of the misting system to A&E bin store and nursing floor corridors and bin store
- Installation of flashing beacon/sounders across site to improve evacuation for the hard of hearing
- Fire panel improvement works to improve the functionality of the fire detection system
- New fire evacuation window and access routes across roof from ITU/HDU
- Additional lift controls to enable lifts 2 & 3 (serving ITU/HDU and main theatres) to be used by the fire service as an evacuation lift

3.2 Fire Alarm System

The Trust's fire alarm has been extended and modified to ensure that it covers the whole site in accordance with relevant codes of practice and guidance.

The fire alarm system installed throughout the hospital continues to function. A verification survey of the systems circuits is currently underway and will enable the 'cause and effect' of each circuit to be set and refined.

The remaining risks are being monitored and mitigation plans are in place but ongoing investment is required to maintain risks at an acceptable level which in turn also demonstrates to the enforcing body that the Trust is satisfactorily managing its fire risk.

3.3 Staff Training

It is a statutory requirement of the Regulatory Reform (Fire Safety) Order and a mandatory requirement of Firecode that all members of staff undertake annual fire training and take part in a fire drill. Annual fire training forms part of the Trust's core mandatory training requirements. Where patients are dependent on the staff for their safe evacuation this training is vital.

i. Training sessions

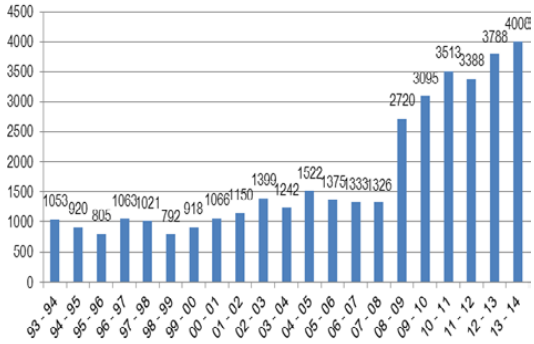
Training is delivered by the Trust Fire Safety Advisor but is organised through Learning and Development cluster and mandatory training days and the Review of Knowledge sessions. In addition, training within a number of departments across the Trust has also been provided by the Trust Fire Safety Advisor as requested by those areas.

E learning through the NHS Core-learning unit is approved as a means of providing fire training without attending a formal session. However it is only appropriate for staff not expected to evacuate patients and only when used every other year between face to face fire training. There is sufficient training capacity available to staff to enable the Trust's target to be met.

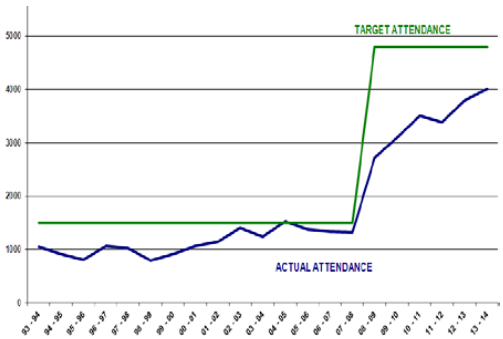
ii. Attendance

From the records of attendance during 2013/14, 4008 members of staff received training which equates to 83.5% (based on 4800 staff), an increase of 220 (4.6%) over the previous year's attendance.

The Trust Fire Safety Advisor has continued regular contact with Directorate Managers reminding them of the requirement for all staff to attend fire training and advising them on how to achieve compliance. This is also being monitored by the Trust Fire Committee and reported through CQEG.



Total staff fire training attendance by year



Actual staff fire training attendance against target

iii. Fire Drills

Fire drills have continued during 2013/14 and although there has been an increase in the number of areas where a drill has taken place there is still a shortfall against the 100% target. Areas with a current drill have continually increased year on year; 2011 – 17%, 2012 – 26% and 2013 – 44%.

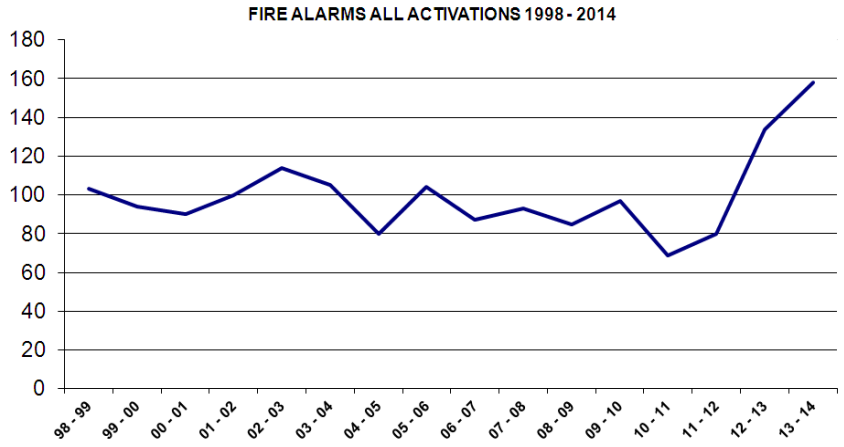
Without affecting service delivery and patient care, further increases in fire drills will prove challenging. The current method of conducting a drill is under review by the Trust's Fire Manager and Fire Safety Advisor with the intention of developing a process of testing fire plans and providing assurance without affecting patient care.

In the meantime the Trust Fire Safety Advisor has started regular contact with Directorate managers reminding them of the requirement to have a current emergency/evacuation

plan. This is also being monitored by the Trust Fire Committee and reported through CQEG.

4.0 Fire Alarm Activations

There were a total of 159 activations of the fire alarm during the reporting period, an increase of 25 from the last report.



Fires

Six fire incidents occurred on site (3 recorded for 2012/13), 2 were caused by smoking materials, 2 occurred in ITU/HDU, 1 occurred in William Kerr, 1 occurred in Radiology and the last was a car fire outside Accident and Emergency.

Good Intents

The 21 (15 recorded for 2012/13) good intents were caused by members of staff operating a call point suspecting a fire after smelling smoke/burning.

Pre Warnings

There were 93 pre-warnings (79 recorded for 2012/13) - 51 were unknown causes, 16 were caused by high temperature, 7 by dust and the remainder were detectors either going out of sensitivity or, briefly sensing smoke/dust/aerosols but were not enough to trigger a full alarm.

Detector Actuations

39 actuations (36 recorded for 2012/13) of detectors can be summarised as follows – Unknown caused 10, Cooking caused 6, Steam caused 6, Toast caused 4, Detectors sensing, smoke dust or fumes accounted for the remaining 13.

Northamptonshire Fire and Rescue Service (FRS) response to emergency calls

Northamptonshire Fire and Rescue Service (FRS) informed the Trust that as from 1st April 2014 they would not to mobilise FRS resources to any Automatic Fire Alarm (AFA) to any county hospital between the hours of 8am-8pm. During this time they would expect Hospital staff to investigate their fire activation and only call FRS if the activation has been caused by a confirmed fire.

As an immediate response the Trust reviewed it's operational fire policy, procedures and risk assessments to ensure that the FRS change in policy did not increase risk to patients, staff, visitors and premises. The Trust's Fire manager wrote to FRS strongly challenging their proposal. FRS has responded and agreed to meet the Trust to discuss our concerns – at the time of this report the meeting had not yet taken place.

6.0 Conclusion:

Continued investment in fire safety through the annual capital plan has allowed the Trust to ensure that building/structural fire risks are eliminated or mitigated as much as practicable.

The Fire and Rescue Service audit completed in 2013 highlighted gaps in the Trust's fire management arrangements. All actions have been addressed within timescales and approved by the Fire and Rescue Service and these actions are now part of the Trust's continuous fire management plan.

There has been an increase in alarm activations over the previous 2 years and although the causes have been minor, the responses to these have been timely and effective.
Continued analysis of these activations has identified causes and lessons learned have been used for new works. 2014/15 analysis (to date) has already shown encouraging reductions in activations with a 12% fall.

Training all Trust staff on an annual basis continues to be a challenge. Attendance figures have improved year on year but further work is still required.

Northampton General Hospital NHS
NHS Trust

ANNUAL STATEMENT of FIRE SAFETY COMPLIANCE

NHS Organisation Code:	NHS Organisation Name: Northampton General Hospital NHS Trust	
I confirm that for the period 1st January 2014 to 31st December 2014, all premises which the Trust owns, occupies or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order 2005, and:		
1	There are no significant risks arising from the fire risk assessments.	
OR 2	The Trust has developed a programme of work to eliminate or reduce as low as reasonably practicable the significant fire risks identified by the fire risk assessment.	Yes
OR 3	The organisation has identified significant fire risks, but does NOT have a programme of work to mitigate those significant fire risks.*	
*Where a programme to mitigate significant risks HAS NOT been developed, please insert the date by which such a programme will be available, taking account of the degree of risk. Date:		
4	During the period covered by this statement, has the organisation been subject to any enforcement action by the Fire & Rescue Authority? If Yes outline the details of the enforcement action in Annex A – Part 1.	No
5	Does the organisation have any unresolved enforcement action pre-dating this Statement? If Yes outline the details of unresolved enforcement action in Annex A – Part 2.	No
6	The organisation achieves compliance with the Department of Health Fire Safety Policy, contained within HTM 05-01, by the application of Firecode or some other suitable method.	Yes
7	There is a current fire safety policy in place.	Yes
Fire Safety Manager	Name: Stuart Finn	
	E-mail: stuart.finn@ngh.nhs.uk	
Contact details:	Telephone: 01604 545903	
	Mobile:	
Chief Executive Name:	Dr Sonia Swart	
Signature of Chief Executive:		
Date:		
Statement to be completed and forwarded to – the Chief Executive, Director responsible for fire safety and the Fire Safety Manager.		

Enclosure K

Northampton General Hospital NHS
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**27 November 2014**

Title of the Report	**Complaints Annual Report 2013-2014**
Agenda item	**16**
Sponsoring Director	Jane Bradley, Interim Director of Nursing, Midwifery & Patient Services
Author(s) of Report	Lisa Cooper, Complaints Manager Jill Birmingham, Complaints Administration Supervisor
Purpose	This paper is presented in accordance with: • NHS Statutory Complaints Regulations • CQC Outcome 17 To provide the Committee / Board with assurance regarding the management of complaints within the Trust

Executive summary

A summary of complaints for 2012-2013, incorporating any cases that were upheld by the Parliamentary & Health Service Ombudsman and any high profile external reports released into the public domain, regarding complaints**.**

Key points

- Adherence to Statutory Complaints Regulations
- The Trust received 526 complaints in 2013-2014 when compared to 538 in 2012-2013.
- 82% of complaints were responded to within the timescale agreed with the complainant versus 84% in 2012-2013 (at the time of writing this report)
- 18 new Ombudsmen cases were received (2 from 2010/2011, 1 from 2011/2012, 9 from 2012/2013 and 6 from 2013/2014). 3 cases were partly upheld, with one of those not requiring any further action. For the other two cases a summary is detailed within the main body of the report, along with the recommendations made, and the Trust's progress to date
- 'Patient care' and 'delays / cancellations' provoked the highest number of complaints this year. However, there has been a significant improvement in the number of complaints that relate to delays / cancellations, with a significant reduction from 102 last year, to 77 this year. The number of complaints relating to communication has reduced again for the third consecutive year with 52 complaints this year when compared to 103 last year.
- Head & Neck and Trauma & Orthopaedics saw the most improvement in terms of a reduction in the number of complaints received, which has been consistent over the last 3 years. However, it should also be noted that Accident & Emergency also saw a reduction in complaints for the second consecutive year with a difference of 14. Radiology, Oncology, Medicine and General Surgery all saw an increase in the number of complaints received about their services.

Related strategic aim and corporate objective	To improve clinical quality and safety

Risk and assurance	This report does not present any risks to the Trust but provides reassurance on the complaints handling arrangements that are in place
Related Board Assurance Framework entries	BAF 1
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? **NO** Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? **NO**
Legal implications / regulatory requirements	There are no legal/regulatory implications of the paper

Actions required by the Trust Board

The Board is asked to challenge where appropriate the contents of this report

Northampton General Hospital NHS
NHS Trust

Public Trust Board
27 November 2014

Complaints Annual Report 2013-2014

1. Introduction

This annual report is to provide board assurance regarding the standard of complaints handling arrangements that are currently in place within the organisation. The reformed NHS Complaints system is now in its 5th year of operation. During this time the complexity of complaints continues to increase involving a number of different directorates within the organisation and/or a number of different organisations (NHS / Social Care for Adults). The aim of our complaints handling procedures, here at NGH, is to ensure that the pathway, for each complaint received, is acted upon in a way that meets the needs of the individual involved. This may be achieved through a formal written response or a local resolution meeting involving members of Trust staff, along with the patient / complainant and members of their family.

At NGH it is always our aim to make local complaint handling a positive experience for those who seek to access the service. Through the 4C's (comments, concerns, complaints, compliments) members of the public are provided with a range of options that they may choose from. This involves initial support and advice from front line staff to seeking further on the spot information and advice from our Patient Advice & Liaison Service (PALS), or our Complaints Team. Furthermore it is our wish to continually improve our complaints handling arrangements in order to respond to patients' dissatisfaction more effectively in terms of providing a high standard of customer service and good practice.

The process that we follow within this organisation intends to achieve:

- More flexibility through offering a number of different options to patients, relatives and carers through the 4 C's (comments, concerns, complaints, compliments)
- Offering more local resolution meetings at an earlier stage
- Learning from complaints and concerns to improve our services

We take pride in the way in which we manage our complaints as it is important to us that the process, the decision making and the way in which we communicate are as straight forward and effective as possible and meet the needs of the individuals accessing the service. We ensure that we agree the points to be investigated, with the complainant at the earliest opportunity, and we often offer meetings on either a local or formal basis. Through our letter of response, which may involve a number of different clinical areas and/or other organisations, we aim to provide various remedies through the issuing of an apology, explanation or financial redress where appropriate.

A gap analysis has been undertaken on the Clwyd/Hart report and an action plan developed to ensure that we learn and develop moving forwards, and that changes are made. The vision for this Trust is for complaints to make a difference and to help to improve public services for everyone who comes to this hospital.

2. Body of Report

- The Trust received 526 complaints in 2013-2014 when compared to 538 in 2012-2013.
- 82% of complaints were responded to within the timescale agreed with the complainant versus 84% in 2012-2013 (at the time of writing this report)
- 18 new Ombudsmen cases were received (2 from 2010/2011, 1 from 2011/2012, 9 from 2012/2013 and 6 from 2013/2014). 3 cases were partly upheld, with one of those not requiring any further action. For the other two cases a summary is detailed within the main body of the report, along with the recommendations made, and the Trust's progress to date
- 'Patient care' and 'delays / cancellations' provoked the highest number of complaints this year. However, there has been a significant improvement in the number of complaints that relate to delays / cancellations, with a significant reduction from 102 last year, to 77 this year. The number of complaints relating to communication has reduced again for the third consecutive year with 52 complaints this year when compared to 103 last year.
- Head & Neck and Trauma & Orthopaedics saw the most improvement in terms of a reduction in the number of complaints received, which has been consistent over the last 3 years. However, it should also be noted that Accident & Emergency also saw a reduction in complaints for the second consecutive year with a difference of 14. Radiology, Oncology, Medicine and General Surgery all saw an increase in the number of complaints received about their services.

3. Assessment of Risk

There are no risks associated with this report.

Complaints management is a valuable mandatory process, which has been given even greater emphasis following publication of the Clwyd / Hart report. The Trust has policies and resources in place to manage the process and mitigate the risk posed by complaints and the handing of them.

4. Recommendations

The Board is asked to challenge where appropriate the contents of this report

5. Next Steps

Once this report has been approved by the board, a copy will be released to our commissioners, in line with normal practice, and a further copy will be placed on to the Trust's website. Both of these actions are in accordance with the Statutory Complaints Regulations.

Northampton General Hospital NHS
NHS Trust

Enclosure L

COMPLAINTS ANNUAL REPORT

1 APRIL 2013 - 31 MARCH 2014

Date:	July 2014
Prepared by:	Lisa Cooper-Complaints Manager
	Jill Birmingham-Complaints Administrator
Approved by:	Fiona Barnes, Deputy Director of Nursing

TRUST OVERVIEW

1. Introduction

This report provides information on complaints received by Northampton General Hospital NHS Trust during the period 1st April 2013 – 31st March 2014.

2. Performance monitoring

There were 526 complaints recorded from 1st April 2013 to 31st March 2014 compared to 538 complaints received the previous year. From the 1st April 2009 the NHS Complaints Regulations state that the timescale in which the Trust should respond to the complaint must be agreed / negotiated directly with the complainant. The Trust's overall performance has been detailed in the table below and is recorded every month in the Trust's Balanced Scorecard.

	2012/13	**2013/14**
Total no of complaints for the year	538	526
Percentage of complaints responded to within the agreed timescale *including 271 renegotiated timescales	84%	82%*
Total no of points (issues) of dissatisfaction (see section 2.3) Average points (issues) of dissatisfaction per complaint	2209 4.11	1516** 2.88
Total patient contacts/episodes (Provided by Service Development)	483,408	571,868
Percentage of complaints versus number of patient contacts/episodes	0.11%	0.09%

***It should be noted that due to a reporting fault on Datix only the two main points of dissatisfaction can be extracted. This means that this does not represent a true figure for this financial year. This will be rectified when the Trust moves to a web based system later this financial year.*

Complainants continue to be offered a meeting involving members of the complaints and clinical teams. Additionally, increased efforts are being put into achieving resolution at a local level at an earlier stage.

Complaints data is submitted on a quarterly basis to the Clinical Quality & Effectiveness Group and is also included within the Patient Safety, Clinical Quality & Governance Progress Report. The data relates to the following specific areas:

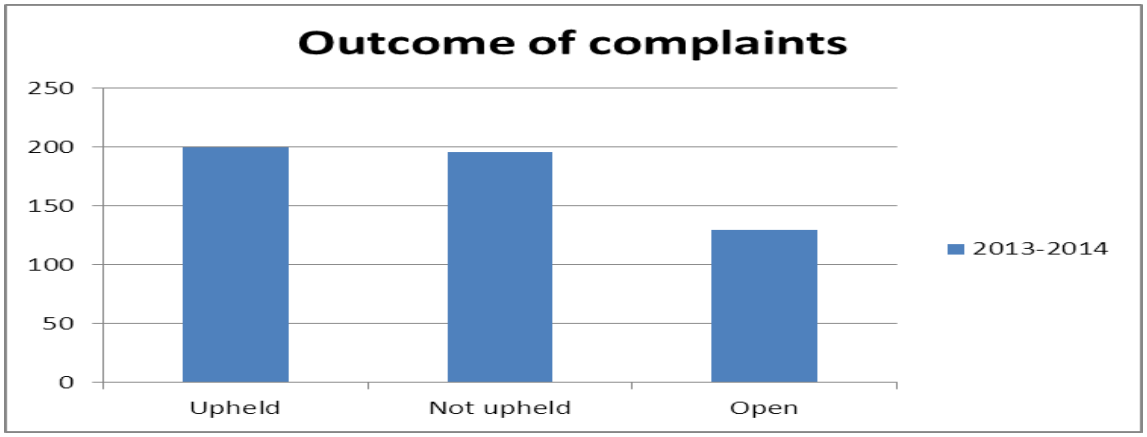
- trend analysis
- learning from complaints
- total numbers of complaints received
- 4 C's forms received + subject

2.1 Acknowledgements & timescales

100% of complainants were sent a letter of acknowledgement within 3 working days. 82% of complainants received a full response in line with the NHS Complaints Procedure (within agreed timescales) in comparison to 84% the previous year. For those people who waited longer than the agreed timescale for a response, the majority agreed to an extension of time, in line with the Complaints Regulations, and all were offered remedies to their complaints as outlined in the Parliamentary & Health Service Ombudsman's 'Principles for Remedy' publication.

2.2 Outcome of complaints

For every complaint that is received the Trust is required to categorise the outcome.
This information is now provided annually to the Department of Health in the KO41a report and is included here for the first time. Therefore there is currently no historical data to complete a comparison.



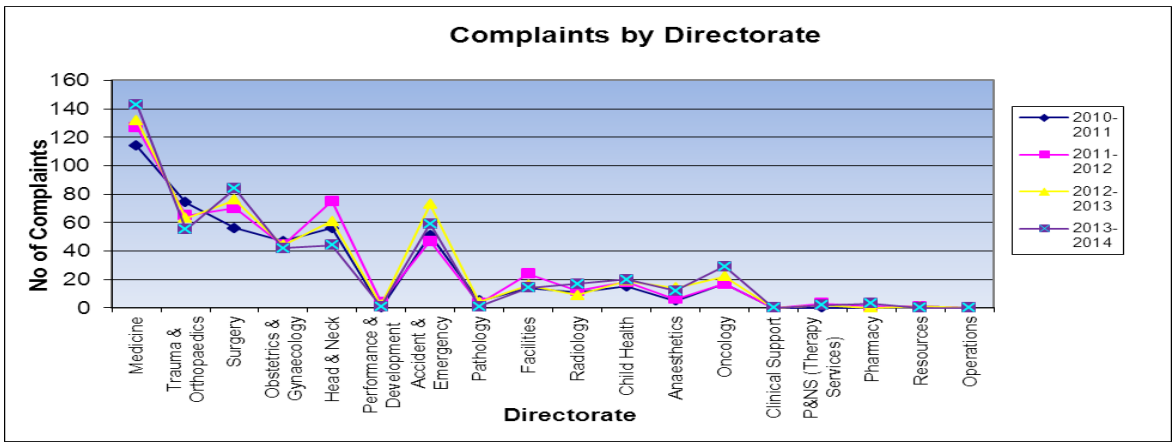
In the Department of Health KO41a report the outcome of complaints is only split between those that are upheld, and those that are not upheld. In the context of KO41a, upheld must be recorded if any aspect of the complaint was substantiated. This is detailed on the graph above, along with the number of complaints that were 'open' at the time that this report was prepared. As these complaints are not yet concluded it is not possible to assign a category to them at this stage. However, it should also be noted that the number of upheld complaints consists of a number of sub-outcomes, which are detailed in the table below:

Sub-outcome	Number
Partially upheld	54
Procedural Change	15
Staff Reminded	84
Training Required	3
Fully upheld	44

It is only possible to assign one sub-outcome to each complaint. Many complaints may have been partially upheld, or fully upheld, but also had a staff reminded sub-outcome and be recorded under that category. It is not therefore possible, using this information to say to what extent complaints were upheld fully or partially. There is a further sub-outcome which refers to complaints where no further action was required. As these are complaints that are not upheld they are not included within the table above. There were 196 complaints that are registered within this category.

2.3 Complaints by Directorate

The graph below shows the number of complaints, by directorate as a comparison, for the last 4 financial years. It should be noted that this information shows only the primary (main) directorate involved.



Of the 526 complaints received, 170 related to more than one directorate and/or another NHS healthcare provider or Social Care for Adults. When compared to the previous year (2012/2013 - 175) this number has only decreased very slightly. However, the size and complexity of complaints (i.e. number of questions being raised and the number of directorates/organisations involved) continues to rise. This should not be confused with the points of dissatisfaction, which relate to the different type of issues being raised.

2.4 Parliamentary & Health Service Ombudsman (PHSO)

Where the Trust was unable to resolve complaints locally, the complainants were advised that they may wish to contact the Parliamentary & Health Service Ombudsman to seek an Independent Review of their case.

Whilst the majority of complaints were resolved through local resolution a total of 18 new cases progressed to the Parliamentary and Health Service Ombudsman for investigation, in comparison to 16 the previous year. 3 cases were partly upheld, 2 of which had recommendations made and 1 did not require any further action. In addition to this 8 cases were closed without investigation and 7 currently remain open. A breakdown of the cases is detailed below:

Total number of complaints that progressed to the PHSO in 2013/2014	**Cases currently under review**	**Cases not upheld or closed without investigation**	**Cases partially or fully upheld**	**Financial remedies for PHSO cases (total costs paid)**
18 Including: 2 from 2010/2011 1 from 2011/2012 9 from 2012/2013 6 from 2013/2014	7	8	3 partly upheld (2 with recommendations, 1 without)	£500 (1 case)

***A summary of the complaints, with recommendations, that were upheld by the Ombudsman in the reporting year 2013-2014:**

Ref number: MW/2009/12922 – Patient A

Patient A experienced 3 miscarriages and 1 stillbirth between becoming pregnant for the first time in 2007, and her last pregnancy in December 2009. During this time she was cared for by (amongst others) a consultant obstetrician & gynaecologist at NGH. After the patients last pregnancy in December 2009, she became generally unwell. On the evening of 28th December 2009 an out of hours GP referred the patient to the duty (on call) medical team at NGH. However, the EAU was full, and so the Trust staff took the patient to the A&E department. After about 2 hours the patient's condition was noted to deteriorate rapidly and she suffered a series of cardiorespiratory arrests. Sadly the doctors were unable to resuscitate the patient and she died shortly after midnight.

A subsequent post mortem identified that the patient died from congestive heart failure due to an acute myocardial infarction and diffuse myocardial fibrosis (scarring of the heart muscle) with disease of the small blood vessels, associated with systemic lupus erythematosus (a systemic autoimmune disease whereby the immune system attacks the body's own cells and tissues), resulting in inflammation and tissue damage.

The concerns raised by the patient's relative (obstetric care, and care received in the A&E department) were investigated as an Serious Incident (SI) and never a complaint however, when the relative was dissatisfied with the outcome of the SI he took his concerns to the Ombudsman, who made the decision to investigate it as though it was a complaint.

The Ombudsman's investigation identified a number of issues regarding the care that the patient received:

- Whilst a triage nurse appropriately assessed the patient within 15 minutes of her arrival to the A&E department, she did not assess her pain; did not take her to the resuscitation area; and incorrectly assessed her as needing to see doctors within a maximum of 60 minutes instead of 10 minutes.
- Doctors did not see, assess, or arrange the necessary investigations until the patient had been in the department for 2 hours following her arrival.
- In these two important points, the triage nurse and the doctors did not act in line with the established good practice or the guidance set out in emergency triage.
- Additionally the nurses did not closely monitor the patient. In view of her abnormal observations upon arrival her observations should have been taken every 15 to 30 minutes, but this was not done.
- The staff only took the patients observations twice before she was eventually moved to the resuscitation area.
- The nursing staff omitted to calculate the patients early warning score, as they should have done
- Whilst the nurses later contacted doctors several times to try to expedite the medical review, they did not take the required action set out in the NICE acutely ill guidance, to ensure that this happened promptly, which her symptoms required
- Whilst the action identified and taken through the Trust's SI investigation did demonstrate learning from this case, it did not identify all of the shortcomings in the patients care (in the A&E department). In particular it did not identify the triage nurses failure to: recognise the seriousness of the patient's condition when she arrived; allocate an appropriate triage category; and send her to the resuscitation area.
- In view of these omissions the Trust investigation was not proportionate and the response (SI report) was not open and accountable

Outcome:
Care – the care received in the A&E department fell so far below what it should have been that it amounted to **service failure**.

SI – THE Ombudsman has weighed up what the Trust got right, and what it did not do so well and in view of this **does not find** that the handling of the SI was so poor that it amounts to maladministration.

Areas of good practice were also identified:

- The care provided by the consultant obstetrician & gynaecologist was appropriate and in line with NICE antenatal guidance and established good practice.
- The consultant 'got it right' with regard to the care that he provided for the patient and her complex clinical background
- The fact that the Trust, with the relative's agreement, investigated the issues through its SI process, and not as a complaint was acceptable and not felt to be either inappropriate or unreasonable as the relative was involved in these decisions.
- The Trust met with the relative through the SI process to discuss and understand his concerns
- The Trust acknowledged and apologised for the shortcomings identified and reassure the relative of the learning that had taken place to improve the service
- An appropriate response was provided regarding the patients maternity care

NGH FINAL ACTION:
- Action plan developed focussing on triage, Early Warning Score, Escalation, SI investigation and complaints
- Remedial action was, and continues to be taken in light of the Ombudsman's investigation by both the Trust and the areas concerned. The outcome of the investigation was presented at the Patient Safety Learning Forum by the Head of Complaints.
- Apology provided along with reassurance of the action taken

- A copy of the action plan and evidence is to be sent to the relative, CCG, CQC, TDA, PHSO.
- The action plan is being monitored by the Complaints Department. Evidence has been provided to offer reassurance of the action taken, and a further letter providing an update will be issued to the complainant and the relevant external organisations, once complete. This is in accordance with the Ombudsman's recommendations.

Ref Number: 10/11-281 – Patient B
Patient B was a 65 year old man with a history of diabetes, blocked arteries, severe kidney failure, high blood pressure and heart disease. His right leg had previously been amputated below the knee. The patient's wife stated that in the early hours of Saturday 8th May 2010 her husband vomited brown fluid, bled from his rectum and had a serious pain in his right side. As a consequence he was transferred to NGH by ambulance to the A&E department.

The patient arrived in the A&E department at 7.26am and he was assessed at 7.31am at which time his body temperature, breathing rate and level of consciousness were all within the normal range. However, his heartbeat was significantly raised and his blood pressure was significantly low. The patient was assigned a triage category of 3 which meant that he should be seen by a doctor within 1 hour.

The patient was not seen by a doctor until 8.50am when it was noted that he was complaining of abdominal pain and rectal bleeding. The doctor also noted that the patient had a history of significant illnesses. Attempts to insert a tube into the patients vein (a drip) had failed, so the doctor decided to move him to the resuscitation area in order for a central line to be sited. Transfer to the resuscitation area took place at 10am by which time partial bloods had been taken for testing. By 10.30am the doctor had not managed to site the central line and so a more senior doctor was asked to try. The line was inserted at 11am and the patient started to receive IV fluids at 11.10am.

A catheter was inserted at 11.50am and at 12.30pm an abdominal x-ray was performed to check the central line. At 12.30pm the patient received IV Paracetamol and later Morphine although the time is illegible for this. At 12.45pm a plan for how best to care for the patient was drawn up, which included the continuation of IV fluids, along with pain relief, chest and abdominal x-rays and an anti-sickness and anti ulcer drug. An immediate review by someone from the HDU was also suggested.

Shortly after 12.45pm the patient was reviewed by the HDU outreach team, who diagnosed sepsis and recommended a transfer to the HDU along with the insertion of an arterial line and a tube through his nose and into his stomach (for feeding and giving of drugs), antibiotics for the sepsis and that he should have an ECG. At 1.20pm the patient received his first dose of antibiotic treatment. The blood test results and abdominal x-rays were reviewed at 1.30pm and an abdominal CT scan was agreed. At 2.00pm the patient was transferred to the HDU.

The patient was reviewed again at 4.15pm and his blood pressure was found to still be low and his abdomen was swollen and tender. There were no signs of active internal bleeding, although there were clinical signs (low blood pressure, high heart rate)that suggested that this might be the case and his blood test results suggested an 'overwhelming infection'. The source of infection was considered to originate in the patients abdomen. His condition did not improve and his low blood pressure was not responding to the fluids he was being given. He was considered to be too unwell to have a CT scan performed.

At 4.50pm a doctor explained to the patients wife that her husband was critically unwell, was not responding to treatment and was not suitable for invasive ventilation. The patient's condition continued to deteriorate and he died at 5.50pm. The Coroner's view following a post mortem was that the patient had suffered heart failure as a result of septicaemic shock and pre-existing diabetes, heart disease and chronic kidney failure.

The Ombudsman categorised the complaint into 10 key areas:

1. Poor treatment – not upheld
2. Not receiving dialysis – not upheld
3. Not giving the patient a CT scan – not upheld
4. Not giving the patient a blood transfusion – not upheld
5. Understaffing – not upheld
6. Inappropriate diagnosis – not upheld
7. Poor record keeping – comments made but not upheld
8. Poor communication – not upheld
9. End of life care – not upheld
10. **Lack of urgency - upheld**

Issues:
There were some failings identified in some aspects of care and treatment that the patient received in the A&E department.

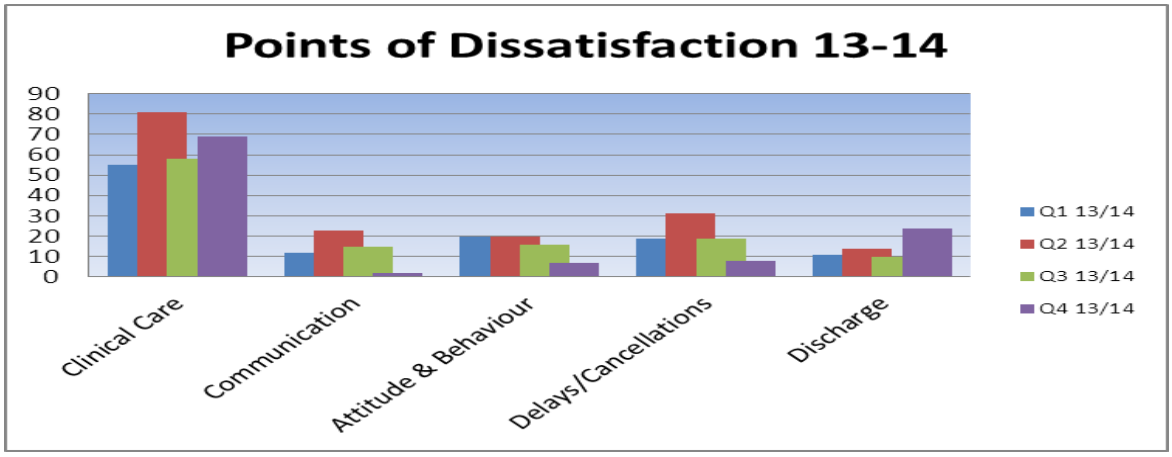
a) Triage category should have been higher than a 3 meaning that he would have been seen within 10 minutes, not 1 hour 20 minutes
b) Delay in transfer to the resuscitation area (had to wait a further 1 hour 10 minutes)
c) Delay to gain IV access – an alternative route into the bone marrow should have been attempted rather than wait for a central line / senior doctor
d) The delay in transfer to the resuscitation area also meant a delay in the administering of fluids. The sequence of events taking all of this into account took 3 hours and 40 minutes after the patients arrival to the department

Outcome:
Lack of urgency - the care received in the A&E department fell so far below what it should have been that it amounted to **service failure**. The Ombudsman's advisor stated that he **does not think** that the events would have had an impact on the outcome. Therefore the service failure did not lead to an injustice to the family. The complaint is **PARTLY** upheld.

NGH FINAL ACTION:

- Action plan developed focussing on triage, lack of urgency and record keeping
- Remedial action was, and continues to be taken in light of the Ombudsman's investigation by both the Trust and the areas concerned. The outcome of the investigation was presented at the Patient Safety Learning Forum by the Head of Complaints.
- Apology provided along with reassurance of the action taken
- The action plan is being monitored by the Complaints Department. Evidence has been provided to offer reassurance of the action taken, and a further letter providing an update will be issued to the complainant and the relevant external organisations, once complete. This is in accordance with the Ombudsman's recommendations.
- A copy of the action plan and evidence has been sent to the relative, CCG, CQC, TDA, PHSO.

2.5 Trend Analysis
The following table provides the top 5 themes emerging from complaints, in line with the Trust's quarterly reporting process. Last year's data has also been provided in order to show comparison data.



Each of these themes breaks down into a number of sub-categories and the main issue for the top 5 themes are as follows:

Primary theme	**Sub-category (includes)**
Clinical care (this consists of a number of different aspects)	Diagnosis (delay, failure, incorrect), Procedure, Opinion, Pain Management, Tests, Documentation, Results, Other
Communication	General verbal or written communication with either a patient or a relative
Delays / cancellations	Delay in appointment being issued, or the appointment has been cancelled
Discharge	All aspects relating to patient discharges
Attitude & Behaviour	Attitude, Behaviour of staff

The following actions are being taken to improve the quality and safety of patient care:

Primary theme	**Actions that have or are being taken**
Clinical care (Escalation of care and pain management)	The Patient Safety Academy has undertaken a campaign on EWS escalation. The campaign highlights are: -Better understanding of the code red system and escalation protocol -Data on the nursing indicators shared drive is now more accessible to staff -Staff understanding that each bedside TV needs to be registered to the -patient, thus giving the patient access to the patient safety video >400 patients spoken with about their views on the safety video and leaflet -154 ward visits undertaken >200 members of staff spoken with -481 patient charts reviewed Work is now being taken forwards on pain management focussing on the following key areas: -Pain scores -Understanding pain management -The right level of pain relief -Documentation including new paperwork -Prescriptions for pain medication
Delays / Cancellations	Work is being undertaken at a senior level to improve the problems

Primary theme	Actions that have or are being taken
	that patients are experiencing with delayed and cancelled appointments. This is across key areas within the organisation:

2.6 Compliments

As part of the 4 'C's process members of the public are also encouraged to tell us when they believe that we have 'got it right'. This feedback is monitored through the Trust's quarterly reporting schedule (along with complaints).

What our patients are saying about Northampton General Hospital NHS Trust:
(Source 4 'C's compliment forms)

"*I would just like to say that having been in your hospital 4 times in the last year Hawthorn ward, where I am now, is run by wonderful nurses who are very professional, cheerful and a total credit to the NHS. Without these nurses the NHS would never survive".*

"We have found Northampton General to be very efficient i.e. tests and results have been carried out quickly. There has always been a doctor to answer any questions we have had. All staff i.e. cleaning, junior nurses, staff nurses etc… are very friendly and kind and extremely hard working. We would like to say how clean the ward and areas are. We were also quite surprised at the choice and quality of food".
(Creaton ward)

"Thank you for listening to me rant and putting up with my crying. Thank you for listening to my concerns and putting my mind at ease. You have an amazing ward and an even more amazing team of staff. We will never be able to thank you enough".
(Gosset ward)

"The staff have been wonderful and looked after my sister in law so well. Even though they have been very busy they have taken all the time that was needed to explain to all of us the treatment and outcome making a very distressing hard time more bearable. Thank you so much".
ITU

3. Learning from complaints

The Trust requests action plans for ALL complaints where learning has been identified.

The following subjects have been identified through the learning from complaints:

- Communication
- Infection Control
- Procedural changes
- Discharge
- Confidentiality
- Administration
- Waiting times
- Attitude & Behaviour
- Documentation

As of the 1st April 2014 the Trust's Complaints Department will track and monitor learning and action plans through to completion via Health Assure. This will provide a more robust process which offers the Trust better assurance of the action taken, and the evidence provided. This will continue to be monitored through the quarterly complaints report which is issued to the Clinical Quality & Effectiveness Group (CQEG).

Learning through consultants appraisals
Each consultant has an annual appraisal with a member of the Trust's senior team. Through this process the consultant must provide details of all complaints that have been received about them (or a member of their clinical team) during the previous 12 months. A summary/list of the complaints is provided by the Complaints Team to ensure that the appropriate information is available for each appraisal and that the Trust is compliant with current external guidance. Additionally, any complaints that are received which relate directly to the attitude & behaviour of a consultant are immediately copied to the Medical Director, as part of the initial process. An essential part of this process is to ensure that consultants and their clinical teams learn from complaints.

Reporting Forums
Learning from complaints is disseminated across the organisation through the Trust's Patient Safety, Clinical Quality & Governance Progress Report and the CQEG report. These reports are produced on a quarterly basis by the Complaints Team. The Complaints Manager attends the Patient Safety Learning Forum and the CQEG at which time high level learning is presented/discussed before being disseminated to other staff by the managers present.

4. Complaints Surveys & Audits

Survey / Audit

There is 1 survey planned for 2014-2015 and there have not been any audits / survey's completed this year.

5. Staff Support

The internal memorandum that is sent out with new complaints now includes a more detailed section on supporting staff. The following information is now included within all internal memo's that relate to new complaints:

"NGH is committed to ensuring that staff are supported in the undertaking of their roles and responsibilities. As such the Trust has developed a 'Policy for the support of staff following a complaint, claim or incident'. This policy can be accessed via the Trust's intranet. Additionally if you feel that it would be helpful to discuss this complaint and/or your report, please do not hesitate to contact me on extension 5774"

When complaints are sent out internally, they are accompanied by a memo with the above information detailed therein.

6. Key Priorities / Improvements

The Complaints and PALS teams continue to work very closely in order to fully support the 4 C's within NGH. It is recognised that ongoing improvements must be considered at all times, in order to continually review the process with the aim to providing an improved service to visitors to the site, and those who use either the Complaints or PALS services.

Subject	Key priorities/ improvements
PALS, Bereavement & Complaints - Delivering a high standard of service	The aim is to maintain a high standard of service to members of the public, internal customers (staff) and other organisations including the provision of support, advice, information and guidance. Following the review of the governance structure it was recognised that the resources that were in place did not meet the demands of the service, given the increased number of PALS enquiries and complaints received, and the complexity of these cases. In view of this, changes were made to increase the hours for two of the part time staff. Additionally, in recognition of the continuing complexity of complaints a 20 hour complaints officer has recently been appointed.
Improved working practices	There has been a significant change to the way in which learning and evidence are monitored. Learning is now entered on to Health Assure

Subject	Key priorities/ improvements
	with evidence linked through folders on the Governance drive. This process is managed by the Head of Complaints in conjunction with the Care Group Governance Managers. Current status reporting is provided within the CQEG quarterly complaints report.
Training	• Formal complaints training continues to be provided, is featured within the mandatory training prospectus and is offered at 2 levels. Bespoke training sessions are also provided individually and as a group. • PALS awareness briefings • Training also provided through the band 7 training programme 2014 • Profession specific training is now also being provided
4 C's implementation	The Head of Complaints and the Head of PALS & Bereavement deliver talks to explain the process and the importance of trying to resolve any issues as and when they arise and the benefits that a pro-active approach to local resolution provides for both patients and staff. This underpins the Trust's aim to achieve local resolution at the earliest opportunity. The availability of the 4 C's posters and leaflets are now included as one of the Quest criteria for wards.
Response rate	The response rate has dropped significantly through this reporting year and overall was (average) 82% at the time that this report was prepared. There have been a number of contributory factors to this: • Incomplete / late responses provided by the directorates • Resources within the complaints team due to staffing changes A 20 hour band 5 complaint officer has been appointed which will improve this moving forwards, once the person has completed her training.
Reopened complaints	The Trust has a target of less than 5% of reopened complaints, which is set by the CCG. The team has worked hard to provide high quality responses that fully address the points raised. Currently reporting at 5%.
Care group implementation	The Complaints team are aligned with the care group structure by having a named point of contact for each area. This continues to work well.
Reporting	Following receipt of the Clwyd/Hart report the Head of Complaints completed an in depth gap analysis of areas relating to complaints but also incorporating PALS. An action plan has since been developed and this will be taken forward through the financial year 2014-2015. Further information on this is detailed in the recommendations for 2013-2014. Complaints data is provided for the following reports / groups: • KO41a (Department of Health) • Quality Account • Equality annual report • Healthcare Governance Committee • CQEG + PALS • Patient Safety + PALS • Corporate Balanced Scorecard • Directorate monthly compliance/assurance reports • Monthly ward data + PALS • Triangulated analysis report + PALS • Consultant (doctors) appraisal reports • Adhoc reports

Subject	Key priorities/ improvements

Recommendations for 2014-2015:

- The key priority for this financial year is to improve the processes for the monitoring and implementation of learning from complaints. Work has already commenced and a draft process has been put in place. This is currently being disseminated to the appropriate staff and actions / evidence are now being monitored through Health Assure. This is a significant piece of work but will offer the Trust a more robust process, with the required level of assurance.
- To maintain the high standard of service that has been achieved by the team and to regularly review the resources and practice in the Complaints Service to ensure that the service meets the need of the organisation and the patients/relatives that access it.
- To maintain compliance with the CQC standards and the CCG Key Lines of Enquiry and ensure that action is taken and evidence is monitored accordingly.
- To continue to work on the development of a more refined internal process for handling SI's that also link to PALS, Complaints, Claims, Inquests, and Bereavement Services and for this to be included within the 4 C's policy when it is reviewed later this year.
- Provide information to patients, through complaint responses, in relation to improvement initiatives that are taking place within the organisation (i.e. noise at night, sleep well campaign).
- Review and implement any recommendations from the Clwyd/Hart report, where learning has been identified, with the support of the Trust's senior team.

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**27 November 2014**

Title of the Report	**Emergency Preparedness Report**
Agenda item	**17**
Sponsoring Director	Deborah Needham, Chief Operating Officer
Author(s) of Report	Luke Martin, Interim Head of Resilience
Purpose	The report is being presented to the board to provide assurance that the Trust is appropriately prepared to respond to any internal significant incidents or external major incidents.

Executive summary

As an acute provider of NHS Funded Care, the Trust is required to evidence appropriate planning for and response mechanisms for a wide range of emergencies and business continuity incidents. These requirements are set out by the Civil Contingencies Act, 2004 NHS England's Emergency Preparedness, Resilience and Response (EPRR) Framework 2013.

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

Related strategic aim and corporate objective	Patient Safety Strategy - The Trust will develop safer systems to ensure that every member of staff understands their role in delivering safer care and works towards that goal every day.
Risk and assurance	The report aims to provide assurance that these risks have been mitigated through the various actions described within the report for each key area.
Related Board Assurance Framework entries	BAF – NA
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? *No*

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	Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? No – all patients presenting with the described symptoms will be treated in exactly the same manner.
Legal implications / regulatory requirements	As an acute provider of NHS Funded Care, the Trust is required to evidence appropriate planning for and response mechanisms for a wide range of emergencies and business continuity incidents. These requirements are set out by the Civil Contingencies Act, 2004 NHS England's Emergency Preparedness, Resilience and Response (EPRR) Framework 2013.
Actions required by the Trust Board The Board is asked to confirm that they are happy with the level of preparedness currently in place within the Trust and approve the contents of the Report.	

Northampton General Hospital NHS
NHS Trust

Emergency Preparedness Report 2014

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Luke Martin
Interim Head of Resilience
5 November 2014

Executive Summary

As an acute provider of NHS Funded Care, the Trust is required to evidence appropriate planning for and response mechanisms for a wide range of emergencies and business continuity incidents. These requirements are set out by the Civil Contingencies Act, 2004 NHS England's Emergency Preparedness, Resilience and Response (EPRR) Framework 2013.

The criteria for the assessment by NHS England differ to last year's criteria. Although a straight comparison cannot be made, an analysis shows a significant improvement in the Trust's position compared to last year's assessment. One significant area of change has been the introduction of a specific Chemical, Biological, Radiological and Nuclear (CBRN) set of assessments detailing the specific arrangements in place within the Trust, and this has resulted in additional requirements being added into the work programme for 2014 -2015.

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

The Emergency Planning and Business Continuity Programme has undergone a complete transformation over the past 12 months and has significantly improved the Trust's capabilities to plan for and respond to a Major Incident or failure in service provision.

The key areas that will be prioritised within the Emergency Planning and Business Continuity work stream for 2014 – 2015 will be Chemical, Biological & Radiological Incident Management; Major and Internal Significant Incident Planning and Training and Exercising.

The Emergency Planning and Business Continuity Team through the Trust's Resilience Planning Group will continue to engage with clinical and corporate teams to ensure the work programme is delivered to standard and timescale.

Therefore, it is clearly visible that the current programme is maturing year-on-year and if the current cycle is maintained, then the Trust will continue to improve the level of preparedness and meet its obligations as a provider of NHS Funded Care.

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Overview

The Emergency Preparedness, Resilience and Response activities at Northampton General Hospital are made up of two distinct but closely linked work streams:

- Resilience Planning is the activity of the trust to ensure its capability to contribute to the county response to a major incident. This is likely to involve the provision of urgent health care to those affected by the incident.

- Business Continuity Management is the activity of the trust to ensure its ability to continue to provide its critical services in the face of an incident or event directly affecting the staff, resources, property or suppliers of the trust.

Legislative Background

The Civil Contingencies Act 2004 created two tiers of responder to major incidents. As a Category One responder the trust has six duties:

- Risk Assessment
- To Plan
- To develop a Business Continuity Programme
- Co-operate with other responders
- Warn and inform the public
- To share Information with partner agencies

In addition to this the Department of Health and Commissioning Board have published a range of guidance material, the key element being the Department of Health Emergency Planning Guidance 2005 (due for review) which places a responsibility on the Chief executive of all NHS Trusts to:

'Ensure that their organisation has a Major Incident Plan in place that will be built on the principles of risk assessment, co-operation with partners, emergency planning, communicating with the public and information sharing. The plan will link into the organisations arrangements for ensuring business continuity as required by the CCA 2004'

The provision of Resilience Planning is included in the CQC standards 4, 6 and 10.

The Chief Operating Officer is currently the Trusts Accountable Emergency Officer (AEO) and day to day operational management of the Trust's Resilience and Business Continuity workstreams is managed by the Deputy Chief Operating Officer who line manages the Head of Resilience and the Associate Resilience Manager

Planning Priorities 2014 - 2015

The key areas that the Trust will be focusing on as a priority for the forthcoming 12 months will be:

- Major Incident Planning, Training and Exercising.
- Chemical, Biological, Radiological Incident Preparedness, Training and Exercising.
- On-Call Management Personal Development and Update Training for Incident Response.

Resilience Planning Group

The Trust has a Resilience Planning Group that meets quarterly. All standing members of the group are required to attend a minimum of 80% of the meetings held each financial year and not be absent for two consecutive meetings without the permission of the chair of the group.

The Group includes representation from all areas within the Trust and other Directors and Officers of the Trust may be asked to attend at the request of the Chair. Only the group Chair and relevant members are entitled to be present at a meeting of the group, but others may attend by invitation of the Chair. External partner agencies will be invited in if there are specific agenda items that require multi-health partner involvement.

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

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

- Ensuring that the Trust is compliant with the requirements of the Civil Contingencies Act 2004.
- Ensuring that the Trust can satisfy the requirements of external standards, legislation and statutory requirement.
- Ensuring that the Trust is engaged at a strategic, tactical and operational level with National, Regional and local health and multi-agency resilience agendas specifically: Local Health Resilience Partnership; Northamptonshire Local Resilience Forum and its sub groups.
- Ensuring appropriate Trust input via Operational and Resilience routes into multi-agency plans, procedures and policies.
- Ensuring that the Trust has a robust and tested Major Emergency Plan in place and that staff have been trained in their roles.
- Ensuring that the trust has a range of emergency plans in place to respond to specific emergency situations such as Pandemic Influenza, Communicable Disease Outbreaks, Mass Casualty and CBRN.
- Ensuring that staff are trained to an appropriate level with respect to role and function in an emergency situation
- Ensuring that the Trust and all of its Directorates have robust Business Continuity Management plans in place which would enable the continued delivery of key services even whilst responding to an emergency.
- Ensuring that all Divisions are involved in the emergency planning and resilience agenda and that updates, potential risks and new initiatives are shared with respective management teams.
- Ensuring that the trust meets any standards and deadlines for emergency planning initiatives set by the Hertfordshire & South Midlands Area Team and NHS Nene Clinical Commissioning Groups.

- To provide a forum to exchange information, and promote good practice in emergency planning across the trust.

Core Standards Submission 2014 - 2015

The Trust is required to benchmark each theme within the Core standards submission against the following compliance levels:

- Fully Compliant
- Partially Compliant
- Non-Compliant

The table below provides an overview of the Trust's position against the Core Standard which is described through a series of 47 criteria:

Theme	Number of Criteria	Compliance Level		% of Overall Compliance
Governance	7	Fully	5	71%
		Partial	2	
		Non-Compliant	0	
Duty to maintain plans – emergency plans and business continuity plans	20	Fully	13	59%
		Partial	9	
		Non-Compliant	0	
Command and Control (C2)	7	Fully	3	43%
		Partial	4	
		Non-Compliant	0	
Duty to communicate with the public	2	Fully	2	100%
		Partial	0	
		Non-Compliant		
Information Sharing – mandatory requirements	1	Fully	0	0%
		Partial	1	
		Non-Compliant		
Co-operation	5	Fully	5	100%
		Partial	0	
		Non-Compliant	0	
Training And Exercising	4	Fully	1	25%
		Partial	3	
		Non-Compliant		

On the basis of the Self-Assessment process carried out by the Trust, the decision was made to declare an overall rating of Partially Compliant which is an acceptable position with 60% of all criteria being Fully Compliant. There are 5 main areas that are Partially Compliant with a brief overview of each area later in the report.

Overview of Key Areas

Ebola Preparedness

The Trust has an internal report that has been prepared to enable the Trust to provide assurance as to the level of preparedness within the Trust to handle any potential Ebola Patient. The report focuses on the three key areas identified by NHS England to all Acute Trusts along with providing details of the Trust's Response arrangements.

All key areas identified within the planning process (Accident & Emergency, Paediatrics and Critical Care) have are undergoing a rigorous process of training and exercising to ensure that they are ready to respond to any potential situation. Key staff members within the Trust have also attended multi-agency training to examine the wider health economy impact and the role of Northampton General Hospital.

Governance

The key area that the Trust is focusing on from an EPRR perspective is the structure and processes used to carry out post incident debriefing, whilst the Trust does carry this out following every incident, the structure and timescales are under review following the decision to move to the new clinically lead structure within the Trust.

Duty to maintain plans – emergency plans and business continuity plans

The key area that the Trust is focusing on from an EPRR perspective is the level of Business Continuity planning carried out within the Trust. This is being updated through the introduction of new templates to meet the ISO 22301:2012 Societal Security standard now employed by the NHS. As part of the yearly update requirements, all other plans are being reviewed and updated to take into account the latest guidance.

Command, Control and Communication (C3)

The key area within Governance that the Trust is focusing on from an EPRR perspective is ensuring all staff fulfilling Incident Management roles have received appropriate training and are maintaining an appropriate CPD portfolio. Training plans are being developed to address this shortfall, and training will follow a rolling 12 month cycle.

Information Sharing

The key area within Governance that the Trust is focusing on from an EPRR perspective is the ability of the Trust to adopt a clearer process to share information within the Northamptonshire Health Economy and with other relevant agencies.

Training and Exercising

The key area within Governance that the Trust is focusing on from an EPRR perspective is currently reviewing and updating all of the training and exercising requirements to ensure appropriate level of training for all staff at all levels within the Trust.

Future Actions

The key areas that will be prioritised within the Emergency Planning and Business Continuity work stream for 2014 – 2015 will be Chemical, Biological & Radiological Incident Management; Major and Internal Significant Incident Planning and Training and Exercising. This will be done through the Core Standards Submission at Appendix 1 in conjunction with the Resilience Work Plan attached at Appendix 2 that was developed as a result to provide the Strategic direction for the Trust.

Through both of these documents, the key stakeholders from around the Trust will be responsible for completing the actions assigned to them with the support from members of the Resilience Planning Group who will continue to engage with clinical and corporate teams to ensure the work programme is delivered to standard and timescale.

Regular meetings will be held throughout the year to ensure that the programme of work remains on track, with regular updates being provided as and when required to the Trust Board when key milestones are reached and following any major exercise or incident occurring.

Appendix 1 – Core Standards Submission 2014 – 2015

Trustwide Core Standards

Core standard		Clarifying information	Evidence of assurance	Self-assessment Rating	Commentary, Evidence, References to be supplied.	Action to be taken	Lead	Timescale
Governance								
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)		• Ensuring accountable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergeny Preparedness Resilience and Response, and Business Continuity Management agendas • Having a documented process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible. • Appointing an	GREEN	Trust has nominated AEO which is the Chief Operating Officer, All EPRR day to day management undertaken by Head of Resilience reporting to the Deputy Chief Operating Officer	**Regular update meetings to continue between Deputy and Chief Operating Officers.**	**Rebecca Brown**	Complete
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Lessons identified from your organisation and other partner organisations. NHS organisations and providers of NHS funded care treat EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating and maintaining plans to ensure that they reflect: - the undertaking of risk assessments and any changes in that risk assessment(s) - lessons identified from exercises, emergencies and business continuity incidents - restructuring and		GREEN	Resilience Work programme is in place that is updated following the bi-monthly meetings of the Resilience Planning Group and circulated to all members		**Head of Resilience**	Complete

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Core standard		Clarifying information	Evidence of assurance	Self-assessment Rating	Commentary, Evidence, References to be supplied.	Action to be taken	Lead	Timescale
		changes in the organisations - changes in key personnel - changes in guidance and policy	emergency preparedness, resilience and response (EPRR) professional(s) who can demonstrate an understanding of EPRR principles. • Appointing a business continuity management (BCM) professional(s) who can demonstrate an understanding of BCM principles. • Being able to provide evidence of a documented and agreed corporate policy or framework for building resilience across the organisation so that EPRR and Business continuity issues are mainstreamed in processes,					
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Arrangements are put in place for emergency preparedness, resilience and response which: • Have a change control process and version control • Take account of changing business objectives and processes • Take account of any changes in the organisations functions and/ or organisational and structural and staff changes • Take account of change in key suppliers and contractual arrangements • Take account of any updates to risk assessment(s) • Have a review schedule • Use consistent		GREEN		Review and update the Policy to incorporate the latest guidance as part of on-going review of all Trust EPRR documents.	**Head of Resilience**	Complete

Core standard		Clarifying information	Evidence of assurance	Self-assessment Rating	Commentary, Evidence, References to be supplied.	Action to be taken	Lead	Timescale
		unambiguous terminology, • Identify who is responsible for making sure the policies and arrangements are updated, distributed and regularly tested; • Key staff must know where to find policies and plans on the intranet or shared drive. • Have an expectation that a lessons identified report should be produced following exercises, emergencies and /or business continuity incidents and share for each exercise or incident and a corrective action plan put in place. • Include references to other sources of information and supporting documentation	strategies and action plans across the organisation. • That there is an approporiate budget and staff resources in place to enable the organisation to meet the requirements of these core standards. This budget and resource should be proportionate to the size and scope of the organisation.					
4	The accountable emergency officer will ensure that the Board and/or Governing Body will receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken	After every significant incident a report should go to the Board/ Governing Body (or appropriate delegated governing group) . Must include information about the organisation's position in relation to the NHS		AMBER	Post incident template has now been developed and is in use for all Significant / Major Incidents. Annual EPRR report is submitted to Trust Board every year.	Outstanding debriefs to be completed and submitted to Trust Board. Process for post-incident debriefing and reporting to be developed as part of Resilience Work	**Head of Resilience**	31/10/2014

Core standard		Clarifying information	Evidence of assurance	Self-assessment Rating	Commentary, Evidence, References to be supplied.	Action to be taken	Lead	Timescale
	by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	England EPRR core standards self assessment.				Plan. Full debriefs will organised within 30 days of incidents occuring and reports will be submitted within 40 days to the Trust Board.		
Duty to assess risk								
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver it's functions.	Risk assessments should take into account community risk registers and at the very least include reasonable worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment (including denial of access); • fuel shortages; • surges and escalation of activity; • IT and communications; • utilities failure; • response a major incident / mass casualty event	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments • Version control • Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages • Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans.	GREEN	Corporate, Resilience and Divisional risk registers are in place and are regualrly reveiwed at governance meetings. Resilience specific register reveiwed at every Resilience Planning Group meeting.		**Divisional EPRR Leads**	31/12/2014
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.			GREEN	Risk Planning Guidance is cascaded from the Local Resilience Forum		**Head of Resilience**	31/12/2014

Core standard		Clarifying information	Evidence of assurance	Self-assessment Rating	Commentary, Evidence, References to be supplied.	Action to be taken	Lead	Timescale
		• supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites) There is a process to consider if there are any internal risks that could threaten the performance of the organisation's functions in an emergency as well as external risks eg. Flooding, COMAH sites etc.	• Sharing appropriately once risk assessment(s) completed					
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Other relevant parties could include COMAH site partners, PHE etc.		AMBER	No sharing currently takes place with external partners. Internal sharing takes place via the Resilience Planning Group on bi-monthly basis.	Initiate and document the sharing process for relevant risks with appropriate partenr agencies	Head of Resilience	31/03/2015
Duty to maintain plans – emergency plans and business continuity plans								
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan))	Relevant plans: • demonstrate appropriate and sufficient equipment (inc. vehicles if relevant) to deliver the required responses • identify	GREEN	Major Incident Plan currently under review due to change in command & control	Complete review and ratification of new policy	**Head of Resilience**	31/12/2014
		corporate and service level Business Continuity (aligned to current nationally recognised BC standards)		AMBER	Plans currently not up to the required ISO22301:2012 Standard now being adopted by the NHS	New templates have been developed and circulated to all departments for completion of a service specific Business Impact	**Head of Resilience / General Managers**	31/03/2015

Core standard		Clarifying information	Evidence of assurance	Self-assessment Rating	Commentary, Evidence, References to be supplied.	Action to be taken	Lead	Timescale
	resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):		locations which patients can be transferred to if there is an incident that requires an evacuation; • outline how, when required (for mental health services), Ministry of Justice approval will be gained for an evacuation; • take into account how vulnerable adults and children can be managed to avoid admissions, and include appropriate focus on providing healthcare to displaced populations in rest centres; • include arrangements to co-ordinate and provide mental health support to patients and			analysis and Business Continuity Management Plan. Templates have been adapted from another Trust who were sucessful in gaining ISO22301:2012 accreditation.		
		HAZMAT/ CBRN - see separate checklist on tab overleaf		GREEN		CBR Response Policy under review in light of IOR guidance for Acute Trust's	**Head of Resilience**	31/12/2014
		Severe Weather (heatwave, flooding, snow and cold weather)		GREEN	Severe Weather Plan has been ratified by Resilience Planning Group		**Head of Resilience**	Complete
		Pandemic Influenza		GREEN		Pandemic Influenza Plan currently under review - Awaiting input from LHRP Pan Flu Sub Group and Secondary Care & Surge Planning Working Group	**Head of Resilience**	Complete
		Mass Countermeasures (eg mass prophylaxis, or mass vaccination)		AMBER	No plan currently written for the Trust	Develop, write and submit plan for ratification based on Pan Flu Vacination	**Head of Resilience**	01/06/2015
		Mass Casualties		GREEN	Covered by LRF Mass Casualty planning.	Trust plan to be developed	**Head of Resilience**	Complete
		Fuel Disruption		GREEN	LRF Plan covers this for	Will also be	**Divional**	Complete

Core standard		Clarifying information	Evidence of assurance	Self-assessment Rating	Commentary, Evidence, References to be supplied.	Action to be taken	Lead	Timescale
			relatives, in collaboration with Social Care if necessary, during and after an incident as required; • make sure the mental health needs of patients involved in a significant incident or emergency are met and that they are discharged home with suitable support • ensure that the needs of self-presenters from a hazardous materials or chemical, biological, nuclear or radiation incident are met. • for each of the types of emergency listed evidence can be either within existing response plans or as stand alone		the Trust	incorporated into Divisional Business Continuity Plans.	**EPRR Leads**	
		Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care)		GREEN		Trust Surge and Capacity Plans currently under review.	**Head of Resilience**	Complete
		Infectious Disease Outbreak		GREEN	Plan currently live and has been reveiwed in light of Ebola HF risks		**Infection Prevention & Control Specialist Nurse**	Complete
		Evacuation		AMBER		Plan under developemnt currently with support from External partners through LRF	**Head of Resilience**	31/03/2015
		Lockdown		GREEN	Plans in place for all areas of the Hospital and managed by Security Manager / LSMS in conjunction with Departmental Leads.		**Portering &Security Manager**	Complete
		Utilities, IT and Telecommunications Failure		GREEN	Plans in place held by IT / Estates & Facilities department		**Deputy Director Estates & Facilitites / Deputy Director ICT**	Complete
		Excess Deaths/ Mass Fatalities		GREEN	Covered by LRF Excess Deaths Plan / Internal surge plan also exisits with links between Milton Keynes and Kettering and		**Head of Resilience**	Complete

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Core standard		Clarifying information	Evidence of assurance	Self-assessment Rating	Commentary, Evidence, References to be supplied.	Action to be taken	Lead	Timescale
			arrangements, as appropriate.		formal arrangements with local undertakers			
		Firearms incidents in line with National Joint Operating Procedures		AMBER	MTFA Plan being developed for the Trust in conjunction with Northants Police and linking to Stay Safe guidance from NaCTSO	Finalise MTFA plan	**Head of Resilience**	31/12/2014
9	Ensure that plans are prepared in line with current guidance and good practice which includes:	• Aim of the plan, including links with plans of other responders • Information about the specific hazard or contingency or site for which the plan has been prepared and realistic assumptions • Trigger for activation of the plan, including alert and standby procedures • Activation procedures • Identification, roles and actions (including action cards) of incident response team • Identification, roles and actions (including action cards) of support staff including communications • Location of incident control centre (ICC) from which emergency or business continuity incident will be managed	• Being able to provide documentary evidence that plans are regularly monitored, reviewed and systematically updated, based on sound assumptions: • Being able to provide evidence of an approval process for EPRR plans and documents • Asking peers to review and comment on your plans via consultation • Using identified good practice examples to develop emergency plans	AMBER	Not in place for all plans currently - will be reveiwed as part of ongoing reviews being carried out: • plans are regularly monitored, reviewed and systematically updated, based on sound assumptions: • The approval process for EPRR plans and documents is via divisional governance groups and for all Trust wide plans through the Resilience Planning Group. • Currently peers from other organisations are not asked to review and comment on Trust plans via consultation • Currently plans do not allow for the unexpected and cannot be scaled up or down depending on the nature of the incident as there are only two options listed - full call out or nothing. • All plans currently have	Ensure all plans are reveiwed to take into account the requirements of this standard	**Head of Resilience**	01/02/2015

Core standard		Clarifying information	Evidence of assurance	Self-assessment Rating	Commentary, Evidence, References to be supplied.	Action to be taken	Lead	Timescale
		• Generic roles of all parts of the organisation in relation to responding to emergencies or business continuity incidents • Complementary generic arrangements of other responders (including acknowledgement of multi-agency working) • Stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • Contact details of key personnel and relevant partner agencies • Plan maintenance procedures (Based on Cabinet Office publication Emergency Preparedness, Emergency Planning, Annexes 5B and 5C (2006))	• Adopting plans which are flexible, allowing for the unexpected and can be scaled up or down • Version control and change process controls • List of contributors • References and list of sources • Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).		version control and change process controls in place as any changes have to be approved by procedural document groups. • List of contributors is available for every plan on the front page. • References and list of sources are not listed in every plan currently. • Currently not all plans explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).			
10	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business	Enable an identified person to determine whether an emergency has occurred - Specify the procedure that person should adopt in making	• Oncall Standards and expectations are set out • Include 24-hour arrangements	GREEN	All calls 24/7 go through Site Manager and then rota held for access to On-call Manager and On-Call Executive Team. Clinical Site Managers are responsible for initiating		**Head of Capacity / Deputy Chief Operating Officer**	Complete

Core standard		Clarifying information	Evidence of assurance	Self-assessment Rating	Commentary, Evidence, References to be supplied.	Action to be taken	Lead	Timescale
	continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	the decision - Specify who should be consulted before making the decision - Specify who should be informed once the decision has been made (including clinical staff)	for alerting managers and other key staff.		the Trust's response to any incidents and notifying the On-Call Executive / Manager.			
11	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Decide: - Which activities and functions are critical - What is an acceptable level of service in the event of different types of emergency for all your services - Identifying in your risk assessments in what way emergencies and business continuity incidents threaten the performance of your organisation's functions, especially critical activities		AMBER	Covered by Business Continuity Plans / Business Impact Analysis	Ensure all areas complete update of business continuity plans to ISO 22301 standard as per Core Standard number 8	**Head of Resilience / General Managers**	15/01/2015
12	Arrangements explain how VIP and/or high profile patients will be managed.	This refers to both clinical (including HAZMAT incidents) management and media / communications management of VIPs and / or high profile management		AMBER	Operation Consort plan is under development in conjunction with Northants Police and EMAS	Complete review and ratification of new plan	**Head of Resilience**	15/01/2015

Core standard		Clarifying information	Evidence of assurance	Self-assessment Rating	Commentary, Evidence, References to be supplied.	Action to be taken	Lead	Timescale
13	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content		• Specifiy who has been consulted on the relevant documents/ plans etc.	GREEN	Internal Governance procedure in place for all Policies and Procedures, internal plans goto the Resilience Planning Group	New governance structure currently undergoing consultation and once finalised all plans will need to be reviewed	**Head of Resilience / Deputy Chief Operating Officer**	Complete
14	Arrangements include a debrief process so as to identify learning and inform future arrangements	Explain the de-briefing process (hot, local and multi-agency, cold)at the end of an incident.		AMBER	Debrief process exists but is not documented fully in relevant plans	Document debrief process - links to Core Standard number 4	Head of Resilience	31/03/2015
Command and Control (C2)								
15	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	Organisation to have a 24/7 on call rota in place with access to strategic and/or executive level personnel	Explain how the emergency on-call rota will be set up and managed over the short and longer term.	GREEN	All calls 24/7 go through Site Manager and then rota held for access to On-call Manager and On-Call Executive Team. Documented in Corporate Major Incident Plan	**C2 Structure currently under review in light of new Management Structure.**	**Head of Resilience**	Complete
16	Those on-call must meet identified competencies and key knowledge and skills for staff.	NHS England publised competencies are based upon National Occupation Standards .	Training is delivered at the level for which the individual is expected to operate (ie operational/ bronze, tactical/	AMBER	Plans in place to provide Strategic, Tactical and Operational Training to all Managers across the Trust.	**Publish dates Trust-wide to relevant staff**	**Head of Resilience**	01/05/2015

Core standard		Clarifying information	Evidence of assurance	Self-assessment Rating	Commentary, Evidence, References to be supplied.	Action to be taken	Lead	Timescale
			silver and strategic/gold). for example strategic/gold level leadership is delivered via the 'Strategic Leadership in a Crisis' course and other similar courses.					
17	Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Control Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	This should be proportionate to the size and scope of the organisation.	Arrangements detail operating procedures to help manage the ICC (for example, set-up, contact lists etc.), contact details for all key stakeholders and flexible IT and staff arrangements so that they can operate more than one control centre and manage any events required.	GREEN	Incident Coordination Centre document exists and is used.	Review and update the Policy to incorporate the latest guidance as part of on-going review of all Trust EPRR documents.	**Head of Resilience**	Complete
18	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.			GREEN	Logbooks have been issued to all key staff and central list of serial numbers held by Head of Resilience		**Head of Resilience**	Complete

Core standard		Clarifying information	Evidence of assurance	Self-assessment Rating	Commentary, Evidence, References to be supplied.	Action to be taken	Lead	Timescale
19	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.			AMBER	Currently done by the Trust but not documented.	Include in relevant plans as part of individual reveiws.	**Head of Resilience**	31/12/2014
20	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.	Both acute and ambulance providers are expected to have in place arrangements for accessing specialist advice in the event of incidents chemical, biological, radiological, nuclear, explosive or hazardous materials		AMBER	No current arrangements	To be documented in relevant plans	**Head of Resilience**	31/12/2014
21	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	Both acute and ambulance providers are expected to have arrangements in place for accessing specialist advice in the event of a radiation incident		AMBER	No current arrangements	To be documented in relevant plans	**Head of Resilience**	31/12/2014
Duty to communicate with the public								

Core standard		Clarifying information	Evidence of assurance	Self-assessment Rating	Commentary, Evidence, References to be supplied.	Action to be taken	Lead	Timescale
22	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Arrangements include a process to inform and advise the public by providing relevant timely information about the nature of the unfolding event and about: - Any immediate actions to be taken by responders - Actions the public can take - How further information can be obtained - The end of an emergency and the return to normal arrangements Communications arrangements/ protocols: - have regard to managing the media (including both on and off site implications) - include the process of communication with internal staff - consider what should be published on intranet/internet sites - have regard for the warning and informing arrangements of other Category 1 and 2 responders and other	• Have emergency communications response arrangements in place • Be able to demonstrate that you have considered which target audience you are aiming at or addressing in publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous information campaigns to inform the development of	GREEN	Corporate Communications Team have detailed media handling policy in place		**Head of Communications**	Complete

Core standard		Clarifying information	Evidence of assurance	Self-assessment Rating	Commentary, Evidence, References to be supplied.	Action to be taken	Lead	Timescale
		organisations.	future campaigns • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'. • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes. • Being able to demonstrate					

Core standard		Clarifying information	Evidence of assurance	Self-assessment Rating	Commentary, Evidence, References to be supplied.	Action to be taken	Lead	Timescale
			that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work.					
23	Arrangements ensure the ability to communicate internally and externally during communication equipment failures		• Have arrangements in place for resilient communications, as far as reasonably practicable, based on risk.	GREEN	IT Disaster Recovery plans in place.Switchboard Failure Plans held by Estates & Facilitites.		**Deputy Director Estates & Facilitites / Deputy Director ICT**	Complete
Information Sharing – mandatory requirements								
24	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	These must take into account and inclue DH (2007) Data Protection and Sharing – Guidance for Emergency Planners and Responders or any guidance which supercedes this, the FOI Act 2000, the Data Protection Act 1998	• Where possible channelling formal information requests through as small as possible a number of known routes. • Sharing	GREEN	Escalation plans in place to communicate issues / incidents to the CCG for onward dissemination to LRF and other partners. External communications to members of the public via trust social media feeds as per the Corporate Communications plan		**Head of Resilience / Head of Communications**	Complete

Core standard		Clarifying information	Evidence of assurance	Self-assessment Rating	Commentary, Evidence, References to be supplied.	Action to be taken	Lead	Timescale
		and the CCA 2004 'duty to communicate with the public', or subsequent / additional legislation and/or guidance.	information via the Local Resilience Forum(s) / Borough Resilience Forum(s) and other groups. • Collectively developing an information sharing protocol with the Local Resilience Forum(s) / Borough Resilience Forum(s). • Social networking tools may be of use here.					
Co-operation								
25	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)		• Attendance at or receipt of minutes from relevant Local Resilience Forum(s) / Borough Resilience Forum(s) meetings, that meetings take place and memebership is quorat. • Treating the	GREEN	LRF Executive meetings attended by AEO and minutes received by Head of Resilience		**Chief Operating Officer**	Complete
26	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA			GREEN	Open lines of communications maintained with other Category 1 responders by Head of Resilience		**Head of Resilience**	Complete
27	Arrangements include how mutual aid	NB: mutual aid agreements are wider		GREEN	No plans currently in place	Incorporate into revised major	**Head of Resilience**	Complete

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Core standard		Clarifying information	Evidence of assurance	Self-assessment Rating	Commentary, Evidence, References to be supplied.	Action to be taken	Lead	Timescale
	agreements will be requested, co-ordinated and maintained.	than staff and should include equipment, services and supplies.	Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership as strategic level groups • Taking lessons learned from all resilience activities • Using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to consider policy initiatives • Establish mutual aid agreements • Identifying useful lessons from your own practice and those learned from collaboration with other responders and strategic			incident plan		
30	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties	Examples include completing of SITREPs, cascading of information, supporting mutual aid discussions, prioritising activities and/or services etc.		GREEN	Currently have informal arrangements for support of NHS England and CCG workstreams via Head of Resilience		**Head of Resilience**	Complete
33	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level			GREEN	LHRP Executive Meetings attended by AEO		**Chief Operating Officer**	Complete

Core standard		Clarifying information	Evidence of assurance	Self-assessment Rating	Commentary, Evidence, References to be supplied.	Action to be taken	Lead	Timescale
			thinking and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to share them with colleagues • Having a list of contacts among both Cat. 1 and Cat 2. responders with in the Local Resilience Forum(s) / Borough Resilience Forum(s) area					
Training And Exercising								

Core standard		Clarifying information	Evidence of assurance	Self-assessment Rating	Commentary, Evidence, References to be supplied.	Action to be taken	Lead	Timescale
34	Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	• Staff are clear about their roles in a plan • Training is linked to the National Occupational Standards and is relevant and proportionate to the organisation type. • Training is linked to Joint Emergency Response Interoperability Programme (JESIP) where appropriate • Arrangements demonstrate the provision to train an appropriate number of staff and anyone else for whom training would be appropriate for the purpose of ensuring that the plan(s) is effective • Arrangements include providing training to an appropriate number of staff to ensure that warning and informing arrangements are effective	• Taking lessons from all resilience activities and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership and network meetings to share good practice • Being able to demonstrate that people responsible for carrying out function in the plan are aware of their roles • Through direct and bilateral collaboration, requesting that other Cat 1. and Cat 2 responders take	AMBER	Currently under development	Complete and submit for approval and sign off training plan for all levels of staff linked to the National Occupational Standards available. Major Incident Training for all staff Trustwide to be reveiwed and all staff to complete refresher training	Head of Resilience	15/01/2015

Core standard		Clarifying information	Evidence of assurance	Self-assessment Rating	Commentary, Evidence, References to be supplied.	Action to be taken	Lead	Timescale
35	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	• Exercises consider the need to validate plans and capabilities • Arrangements must identify exercises which are relevant to local risks and meet the needs of the organisation type and of other interested parties. • Arrangements are in line with NHS England requirements which include a six-monthly communications test, annual table-top exercise and live exercise at least once every three years. • If possible, these exercises should involve relevant interested parties. • Lessons identified must be acted on as part of continuous improvement. • Arrangements include provision for carrying out exercises for the purpose of ensuring warning and informing arrangements are effective	part in your exercises • Refer to the NHS England guidance and National Occupational Standards For Civil Contingencies when identifying training needs. • Developing and documenting a training and briefing programme for staff and key stakeholders • Being able to demonstrate lessons identified in exercises and emergencies and business continuity incidentshave been taken forward • Programme and schedule for future updates of training and exercising (with links to multi-	AMBER	Exercise Schedule currently under development	Complete and submit for approval list of all exercise requirements in the Trust and participation in extrenal exercises.	Head of Resilience	Ongoing
36	Demonstrate organisation wide (including oncall personnel) appropriate			GREEN	Exercise Harris due on 3/10/14 and Exercise Dolphin March 2015	Confirm level of participation for Exercise Dolphin	**Head of Resilience**	Complete

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Core standard		Clarifying information	Evidence of assurance	Self-assessment Rating	Commentary, Evidence, References to be supplied.	Action to be taken	Lead	Timescale
	participation in multi-agency exercises		agency exercising where appropriate) • Communications exercise every 6 months, table top exercise annually and live exercise at least every three years			with CCG / Area Team		
37	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.			AMBER	No CPD portfolio currently held by any on-call managers or directors.	Portfolio to be developed for all incident managers (on-call directors and managers) to enable CPD evidence to be accrued and post incident self appraisals to be captured to evidence learning, development and incident management.	Head of Resilience	31/12/2014

Preparedness							
38	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	Arrangements include: • command and control interfaces • tried and tested process for activating the staff and equipment (inc. Step 1-2-3 Plus) • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • communications planning for public and other agencies • interoperability with other relevant agencies • access to national reserves / Pods • plan to maintain a cordon / access control • emergency / contingency arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving arrangements • Version control	AMBER	CBR Response Policy to be updated in line with new IOR Guidance for Acute Trusts and submitted for ratification.	Head of Resilience	31/10/2014

39	Staff are able to access the organisation HAZMAT/ CBRN management plans.	Decontamination trained staff can access the plan	• Site inspection • IT system screen dump	GREEN		Head of Resilience	Complete
40	HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation.	• Documented systems of work • List of required competencies • Impact assessment of CBRN decontamination on other key facilities • Arrangements for the management of hazardous waste	• Appropriate HAZMAT/ CBRN risk assessments are incorporated into EPRR risk assessments (see core standards 5-7)	AMBER	Risk assesments to be completed by A&E EPRR Lead Consultant and A&E Service Manager	A&E Service Manager / A&E EPRR Lead Consultant	31/10/2014
41	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.		• Resource provision / % staff trained and available • Rota / rostering arrangements	AMBER	Training to be completed to ensure adequate service provision.	A&E Service Manager / A&E EPRR Lead Consultant	31/10/2014
42	Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident and this specialist advice is available 24/7.	• For example PHE, emergency services.	• Provision documented in plan / procedures • Staff awareness	GREEN		Head of Resilience	Complete
43	There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff.	• Acute and Ambulance service providers - see Equipment checklist overleaf on separate tab • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.n	• completed inventory list (see overleaf) or Response Box (see Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities (NHS London, 2011))	AMBER	A&E Service Manager / A&E EPRR Lead Consultant to produce detailed inventory and ensure this is available within the department.	**A&E Service Manager / A&E EPRR Lead Consultant**	31/10/2014

		hs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/					
44	The organisation has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required (NHS England published guidance (May 2014) or subsequent later guidance when applicable)	There is a plan and finance in place to revalidate (extend) or replace suits that are reaching the end of shelf life until full capability of the current model is reached in 2017		AMBER	Extra suits to be requested from NHS England to make the full quota required.	**Head of Resilience**	31/10/2014
45	There are routine checks carried out on the decontamination equipment including: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other decontamination equipment	There is a named role responsible for ensuring these checks take place	**Suits have been extended to Feb 2015. Other checks currently not in place**	AMBER	**Schedule to be developed and implemented by A&E**	**Head of Resilience / A&E Service Manager**	01/03/2015
46	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for:		No plan in place due to previous reliance on internal CBRN decon facility that is not fit for purpose currently. RAM Gene monitors	AMBER	Schedule to be developed and implemented by Estates & Facilities	**Deputy Director Estates & Facilitites**	31/12/2014

	A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other equipment		have been mis-placed. All Tents and other equipment tested 23/09/14.				
47	There are effective disposal arrangements in place for PPE no longer required.	(NHS England published guidance (May 2014) or subsequent later guidance when applicable)	Discussions currently underway with Deputy Head of Hotel Services and external contractors for waste disposal	AMBER	Ensure process is documented and formal agreements in place	**Deputy Hotel Services Manager**	31/10/2014
48	The current HAZMAT/ CBRN Decontamination training lead is appropirately trained to deliver HAZMAT/ CBRN training		No training completed for last two years	AMBER	Liaise with EMAS regarding training following on from initial conversations with Andy Dunn and Martin Claydon	**Head of Resilience / Service Manager - A&E**	31/10/2014
49	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	• Documented training programme • Primary Care HAZMAT/ CBRN guidance • Lead identified for training • Established system for refresher training so that staff that are HAZMAT/ CBRN decontamination trained receive refresher training within a reasonable time frame (annually). • A range of staff roles are trained in decontamination techniques • Include HAZMAT/	• Show evidence that achievement records are kept of staff trained and refresher training attended • Incorporation of HAZMAT/ CBRN issues into exercising programme	AMBER	Not currently in place - training needs to be updated to reflect IOR guidance. Training booked for 10/10/14 and will be included in Exercise Matrix.	**Head of Resilience / Service Manager - A&E**	30/01/2015

		CBRN command and control training • Include ongoing fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a suspected or confirmed infectious respiratory virus • Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/					
50	The organisation has sufficient number of trained decontamination trainers to fully support it's staff HAZMAT/ CBRN training programme.		No trainers available within the Trust	AMBER	Liaise with EMAS regarding training following on from initial conversations with Andy Dunn and Martin Claydon	**Head of Resilience / Service Manager - A&E**	30/01/2015
51	Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	• Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London,	Plans in place, however not documented fully in current plans, New IOR Guidance to be rolled out to all ED staff over the next 3 months.	AMBER	To be included in revised CBRN plan.	**Head of Resilience / Service Manager - A&E**	31/10/2014

		2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf)					

Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months.

Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months.

Green = fully compliant with core standard.

Appendix 2 – Resilience Work Plan 2014 – 2015

Number	Description	Date on Work Plan	Current Progress	Action Plan	Lead Person	Status	Due Date
MI1	Finalise Trust Major Incident Alerting System	29/09/2014	Doctors data now being supplied.	Awaiting feedback from 360 as to feasability of the proposed system upgrades requested by the Trust	Head of Resilience	Ongoing	31/03/2015
MI2	Develop MI Call Out Exercises with Switchboard	29/09/2014	No exercises currently in place.	Develop schedule of exercising in-line with CCG / Area Team schedule of testing for every 6 months	Head of Resilience	Ongoing	31/12/2014
MI3	Trust Major Incident Plan	29/09/2014	Rewrite of plan currently in progress	Submit for internal review with comments due back by middle of October. Submit to Resilience Planning group and PDG in November	Head of Resilience	Ongoing	31/12/2014
MI4	Ensure that the Trust CBR Plan is reveiwed and the latest IOR Guidance is incorporated	29/09/2014	Rewrite of plan currently in progress	Submit for internal review with comments due back by middle of October. Submit to Resilience Planning group and PDG in November	Head of Resilience	Ongoing	31/12/2014
MI5	Trust MTFA Response Policy	29/09/2014	Plan in final stages of development – interoperability work needs completing with Blue Light Agencies	Submit for internal review with comments due back by middle of October. Submit to Resilience Planning group and PDG in November	Head of Resilience	Ongoing	31/03/2015
MI6	Trust Evacuation Policy	29/09/2014	Plan in final stages of development – interoperability work needs completing with Blue Light Agencies with assistance from Estates	Submit for internal review with comments due back by middle of October. Submit to Resilience Planning group and PDG in November	Head of Resilience	Ongoing	11/06/2015
MI7	Trust Capacity Management Plan	29/09/2014	Rewrite of plan currently in progress	Submit for internal review with comments due back by middle of October. Submit to Resilience Planning group and PDG in November	Head of Resilience	Ongoing	31/12/2014

Number	Description	Date on Work Plan	Current Progress	Action Plan	Lead Person	Status	Due Date
MI8	Resilience Risk Register	29/09/2014	Latest version to be completed and submitted to Resilience Planning Group for review.	All risks to be reviewed by appropriate departments and to be reviewed bi-monthly	Head of Resilience	Ongoing	Ongoing
MI9	Resilience Planning Group Terms of Reference	29/09/2014	Requires publication and amendment of membership	New membership to be determined and updated attendees to be included in next meeting.	Head of Resilience	Ongoing	31/10/2014
MI13	Critical Care Surge Plan	29/09/2014	To be incorporated in Trust Capacity, Escalation and Patient Movement Policy	Submit for internal review with comments due back by middle of October. Submit to Resilience Planning group and PDG in November	Head of Resilience	Ongoing	31/12/2014
MI14	Paediatric Surge Plan	29/09/2014	To be incorporated in Trust Capacity, Escalation and Patient Movement Policy	Submit for internal review with comments due back by middle of October. Submit to Resilience Planning group and PDG in November	Head of Resilience	Ongoing	31/12/2014
MI15	Pandemic Influenza Policy	29/09/2014	Rewrite of plan currently in progress	Submit for internal review with comments due back by middle of October. Submit to Resilience Planning group and PDG in November	Head of Resilience	Ongoing	20/02/2015
MI16	Staff Major Incident Handbook	29/09/2014	Ongoing document development	Finalise document development	Head of Resilience	Ongoing	31/12/2015
MI17	Internal Significant Incident Policy	29/09/2014	Plan finalised	Will be submitted to PDG in October	Head of Resilience	Ongoing	31/10/2014
CB1	Ensure that A&E have HAZMAT/ CBRN decontamination risk assessments in place in line with the latest IOR Guidance.	29/09/2014	No risk assesments currently in place	To be completed by A&E Service Manager and submitted to Head of Resilience with involvement relevant staff members.	Service Manager A&E	Ongoing	31/01/2015
CB2	Ensure that A&E Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.	29/09/2014	Limited cover available but needs to be reveiwed by A&E SMT.	To be completed by A&E Service Manager and submitted to Head of Resilience with involvement relevant staff members.	Service Manager A&E / ED Sisters	Ongoing	31/01/2015
CB3	Ensure that A&E Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident.	29/09/2014	Currently limited awareness within A&E Team by Consultants only	To be documented in revised MIP / CBRN Response Policy	Head of Resilience	Ongoing	31/01/2015
CB4	Ensure that A&E produce and maintain an accurate inventory of equipment required for decontaminating patients and that they hold appropriate equipment to ensure safe decontamination of patients and protection of staff.	29/09/2014	Limited equipment currently held	To be completed by A&E Service Manager and submitted to Head of Resilience with involvement relevant staff members.	Service Manager A&E	Ongoing	31/03/2015
CB5	Increase the number of PRPS suits to the minimum recommended levels as per NHS England guidance	29/09/2014	Currently hold 20 suits - needs to be increased.	Discussions to be had with NHS England to procure additional suits.	Head of Resilience	Ongoing	31/10/2014
CB6	Ensure that A&E and Estates & Facilities have a schedule for routine checks to be carried out on the decontamination equipment including: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other decontamination equipment	29/09/2014	Limited testing in place due to previous reliance on internal CBR decontamination room.	To be completed by A&E Service Manager / Deputy Director of Estates & Facilitites and submitted to Head of Resilience with involvement from relevant staff members.	Service Manager A&E / Deputy Director Estates & Facilitites	Ongoing	31/01/2015

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Number	Description	Date on Work Plan	Current Progress	Action Plan	Lead Person	Status	Due Date
CB7	Ensure that A&E and Estates & Facilities have a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other equipment	29/09/2014	Limited testing in place due to previous reliance on internal CBR decontamination room.	To be completed by A&E Service Manager / Deputy Director of Estates & Facilitites and submitted to Head of Resilience with involvement from relevant staff members.	Service Manager A&E / Deputy Director Estates & Facilitites	Ongoing	31/01/2015
CB8	Ensure that documented process is in place for the disposal for PPE no longer required.	29/09/2014		To be completed by A&E Service Manager / Deputy Director of Estates & Facilitites and submitted to Head of Resilience with involvement from relevant staff members.	Service Manager A&E / Deputy Director Estates & Facilitites	Ongoing	20/02/2015
CB9	Ensure that Estates & Facilities maintain the regular testing schedule for the portable CBR Decontamination equipment	29/09/2014	Limited testing in place due to previous reliance on internal CBR decontamination room.	To be completed by A&E Service Manager / Deputy Director of Estates & Facilitites and submitted to Head of Resilience with involvement from relevant staff members.	Service Manager A&E / Deputy Director Estates & Facilitites	Ongoing	Every 3 months
CB10	Ensure that the Trust holds an appropriate number of Training PRPS suits to facilitate the Trust's training program	29/09/2014	Currently hold limited suits	Stockholding needs to be reviewed in conjunction with EMAS	Head of Resilience	Ongoing	31/01/2015
CB11	Ensure that A&E hold all the necessary ancilliary equipment required for safe, effective and prompt decontamination of patients from an incident.	29/09/2014	Limited equipment currently held	To be completed by A&E Service Manager and submitted to Head of Resilience with involvement relevant staff members.	Service Manager A&E	Ongoing	31/01/2015
CB12	Ensure that A&E order and hold relevant numbers of Chemical Equipment Assessement Kits (ChEAKs) (available to order via PHE)	29/09/2014	None currently held	To be completed by A&E Service Manager and submitted to Head of Resilience with involvement relevant staff members.	Service Manager A&E	Ongoing	31/01/2015
CC1	National Occupational Standards to be reveiwed and job descriptions and standards developed for all on-call teams	29/09/2014	Not in place		Head of Resilience	Ongoing	31/12/2014
CC2	Ensure that Trust Plans detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during all internal significant incidents, major incidents or business continuity incidents.	29/09/2014	In place however not documented	Needs to be included in revised MIP	Head of Resilience	Ongoing	
CC3	Ensure all Trust Plans detail the arrangements for access to 24-hour specialist advice for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials,	29/09/2014	Currently limited awareness within A&E Team by Consultants only	To be documented in revised MIP	Head of Resilience	Ongoing	
CC4	Ensure that all Trust Plans detail the arrangements for access to a 24-hour radiation protection supervisor for all	29/09/2014	Currently limited awareness within A&E Team by Consultants only	To be documented in revised MIP	Head of Resilience	Ongoing	

Number	Description	Date on Work Plan	Current Progress	Action Plan	Lead Person	Status	Due Date
	Radiation Incidents.						
CC5	Develop and implement new C2 structure in line with new Corporate Governance structure	29/09/2014		To be documented in revised MIP	Head of Resilience	Ongoing	
BC1	Develop Service Level Business Impact Analysis and Business Continuity Response Plans	29/09/2014	Current plans do not meet the correct ISO 22301:2012 standard as were written under the old BS standards	To be completed by 31/11/2014	Service Managers	Ongoing	31/11/2014
BC2	Develop Divisional Level Business Impact Analysis and Business Continuity Response Plans	29/09/2014	Current plans do not meet the correct ISO 22301:2012 standard as were written under the old BS standards	To be completed by 31/11/2014	General Managers	Ongoing	31/11/2014
BC3	Ensure all Plans include how to continue prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	29/09/2014	Current plans do not meet the correct ISO 22301:2012 standard as were written under the old BS standards	To be completed by 31/11/2014	General Managers	Ongoing	31/11/2014
BC4	Develop Corporate Level Business Continuity Plan and Business Impact Analysis	29/09/2014	Current plans do not meet the correct ISO 22301:2012 standard as were written under the old BS standards	To be completed by 31/11/2014	Head of Resilience	Ongoing	31/11/2014
BC5	Review Business Continuity Policy and Update in Line with ISO22301:2012	29/09/2014	Current plans do not meet the correct ISO 22301:2012 standard as were written under the old BS standards	To be completed by 31/11/2014	Head of Resilience	Ongoing	31/11/2014
MA1	Develop and implement Firearms Incident Response Plan	29/09/2014		Plan under development	Head of Resilience	**Ongoing**	**30/04/2015**
MA2	Develop and Implement Mass Countermeasures Plan	29/09/2014		Plan under development	Head of Resilience	**Ongoing**	**31/05/2015**
MA3	Develop and Implement Trust On-Site and Off-site Evacuation Plan	29/09/2014		Plan under development	Head of Resilience	**Ongoing**	**31/06/2015**
MA4	Develop and Implement Operation Consort Plan	29/09/2014		Plan under development	Head of Resilience	**Ongoing**	**01/06/2015**
MA5	Develop and Implement Major Incident Rapid Discharge Plan (CCG)	29/09/2014		Plan under development	Head of Resilience	**Ongoing**	**31/12/2015**
MA6	Police Site Specific Response Plan (Northants Police Leading)	29/09/2014		Plan under development	Head of Resilience	**Ongoing**	31/03/2015
RM1	Review and manage the Trust Resilience Risk Register in line with LRF CRR and Risk Assesment Guidance	29/09/2014		awaiting latest Risk guidance from the LRF prior to review	Head of Resilience	Ongoing	31/01/2015
RM2	Ensure that all Trust risk assessments are informed by, and consulted and shared with relevant external partners.	29/09/2014		awaiting latest Risk guidance from the LRF prior to review	Head of Resilience	Ongoing	31/01/2015
IE1	Ensure that Trust Board receives no less frequently than annually reports on exercises, significant incidents and major incidents	29/09/2014	Currently does not happen. Only Resilience Plan submitted and annual report to Trust board	Needs to be documented fully	Head of Resilience	Ongoing	31/12/2014
IE2	Ensure that all plans refelct the Trust debrief process so as to identify learning and inform future arrangements	29/09/2014		Needs to be documented fully	Head of Resilience	Ongoing	31/12/2014

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Number	Description	Date on Work Plan	Current Progress	Action Plan	Lead Person	Status	Due Date
TE1	Develop and Implement training plan with a training needs analysis and implement ongoing training of staff required to deliver the response to emergencies and business continuity incidents	29/09/2014		Training plan under development	Head of Resilience	Ongoing	31/12/2014
TE2	Deliver further CBRN practical training sessions (Activation, Decontamination Team, Set Up)	29/09/2014		Training plan under development	ED EPRR Lead Consultant	Ongoing	31/12/2014
TE3	Develop, arrange & deliver CBRN exercise (Activation, Decontamination Team, Set Up, Patient Management)	29/09/2014		Training plan under development	Head of Resilience	Ongoing	31/12/2014
TE4	Develop and Implement an ongoing exercising programme that includes an exercising needs analysis.	29/09/2014		Training plan under development	Head of Resilience	Ongoing	31/12/2014
TE5	Develop and Implement a continuous personal development portfolio demonstrating training and/or incident /exercise participation and ensure all incident commanders (oncall directors and managers) maintain the Portfolio	29/09/2014		Portfolio under development	Head of Resilience	Ongoing	20/02/2015
TE6	Ensure that an appropriate HAZMAT/ CBRN Decontamination training lead is identified and receives appropriate training to deliver HAZMAT/ CBRN training	29/09/2014		Appropriate staff to be identified by Service Manager A&E and HOR to source training via EMAS	Head of Resilience / Service Manager A&E	Ongoing	31/12/2015
TE7	Ensure that all CBRN Internal training is based upon the new IOR guidance and uses the appropriate material.	29/09/2014	Has been incorporated into revised CBRN plan	Will be submitted to PDG in October	Head of Resilience	Ongoing	31/10/2014
TE8	Ensure that the Trust has sufficient number of trained decontamination trainers to fully support the A&E HAZMAT/ CBRN training programme.	29/09/2014		Appropriate staff to be identified by Service Manager A&E and HOR to source training via EMAS	Head of Resilience / Service Manager A&E	Ongoing	31/12/2015
TE9	Ensure that all Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	29/09/2014	Training to be delivered to A&E Staff starting on the 10/10/14	Ongoing training to be scheduled into the ED Training Program	ED EPRR Lead Consultant	Ongoing	31/12/2014
TE10	Loggist Training	29/09/2014	Training package written	Further dates to be published	Head of Resilience	Ongoing	31/12/2014
TE11	External Exec Strategic Management Training	29/09/2014	Training dates booked for Exec Team	Follow up dates from the CCG needed	CCG	Ongoing	31/12/2014
TE12	Internal Exec Strategic Management Training	29/09/2014	Training package written	Further dates to be published	Head of Resilience	Ongoing	31/12/2014
TE13	Internal Tactical Management Training	29/09/2014	Training package in progress of being written	Further dates to be published	Head of Resilience	Ongoing	31/12/2014
TE14	Internal Operational Management Training	29/09/2014	Training package in progress of being written	Further dates to be published	Head of Resilience	Ongoing	31/12/2014

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**27 November 2014**

Title of the Report	**Revised Terms of Reference:** • **Audit Committee** • **Quality Governance Committee** • **Finance Investment and Performance Committee** • **Remuneration and Appointments Committee** • **Trust Board**
Agenda item	**18**
Sponsoring Director	Mr P Farenden, Chairman
Author(s) of Report	Dr S Swart, Chief Executive
Purpose	Approval and Ratification

Executive summary

The Deloitte report into governance processes at NGH (May 2014) made a number of recommendations at Board and Committee level that related to the existing governance structure and the lack of clarity in responsibilities and reporting.

The Terms of Reference listed below were approved at the September Committee meetings and are now presented to the Trust Board for ratification:

- Revised IHGC (now renamed as Quality Governance Committee)
- Revised Finance Committee (now renamed as Finance Investment and Performance)
- Audit Committee

Draft Terms of Reference are presented for approval:

- Trust Board
- Remuneration and Appointments Committee

Related strategic aim and corporate objective	All
Risk and assurance	Compliance with Standing Orders of the Trust
Related Board Assurance Framework entries	BAF - N/A
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N)

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	Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	Meeting financial statutory duties

Actions required by the Board

The Committee is asked to:

- Approve draft Terms of Reference for:
  - Trust Board
  - Remuneration and Appointments Committee

- Ratify Terms of Reference for:
  - Quality Governance Committee
  - Finance Investment and Performance Committee
  - Audit Committee

- Note new names of Committees in respect to;
  - Quality Governance Committee (previously IHGC)
  - Finance Investment and Performance Committee (Previously Finance Committee)

AUDIT COMMITTEE

TERMS OF REFERENCE

Membership	• No less than three Non-Executive Directors
Quorum	• Three Non-Executive Directors
In Attendance	• Director of Finance • External Audit • Internal Audit • Local Counter Fraud • CEO to present Annual Governance Statement, draft internal audit plan and the annual accounts. • Other Executive Directors as requested to present key papers
Frequency of Meetings	• At least four meetings per year
Accountability and Reporting	• Accountable to the Trust Board • Highlight report to the Trust Board by Chair of Committee after each meeting • Minutes available to all Trust Board members Annual report to the Trust Board on actions taken to comply with terms of reference
Date of Approval by Trust Board	• November
Review Date	• 12 months review

AUDIT COMMITTEE

TERMS OF REFERENCE

1. Constitution

The Trust hereby resolves to establish a Committee of the Trust Board to be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference.

2. Membership

The Committee shall be appointed by the Board from amongst the non-executive directors of the Trust and shall consist of not less than three members. The Trust Board should satisfy itself that at least one member of the Committee has recent and relevant financial experience.

One of the members will be appointed chair of the Committee by the Board. In the absence of the Chair appointed by the Trust Board, once of the non-executive directors will be elected by those present to Chair the meeting.

The Chairman of the Trust shall not be a member of the Committee.

3. Quorum, Frequency of meetings and required frequency of attendance

No business shall be transacted unless two members of the Committee are present.

Meetings shall be held not less than four times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

Members of the Committee should attend regularly and should not be absent for more than two consecutive meetings.

4. In attendance

The Director of Finance and appropriate internal and external audit representatives shall normally attend meetings.

The counter fraud specialist will attend a minimum of two committees a year.

The Accountable Officer should be invited to attend meetings and should discuss at least annually with the audit committee the process for assurance that supports the governance statement. He or she should also attend when the Committee considers the draft annual governance statement and the annual report and accounts.

Other executive directors/managers should be invited to attend, particularly when the Committee is discussing areas of risk management or operation that are the responsibility of that director/manager.

Representatives from other organisations (e.g. NHS Protect) and other individuals may be invited to attend on occasion.

The Board and Committee Secretary shall be secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and committee members.

At least once a year, the Committee should meet privately with the Committee should meet privately with the external and internal auditors.

5. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference and to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

6. Duties

6.1 Integrated Governance, Risk Management and Internal Control

The committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical) that supports the achievement of the organisation's objectives.

In particular, the committee will review the adequacy and effectiveness of:

- All risk and control-related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other independent assurance, prior to submission to the Board
- The underlying assurance processes that indicate the degree of the achievement of the organisations objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications
- The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State Directions and as required by NHS Protect.

In carrying out this work the committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key committees so that it understands processes and linkages.

6.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets the *Public Sector Internal Audit Standards, 2013* and provides appropriate independent assurance to the Audit Committee, Chief Executive and Trust Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service and the costs involved
- Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework.

- Considering the major findings of Internal Audit work (and management's response) and ensuring co-ordination between the Internal and External Auditors to optimise audit resources
- Ensuring that the Internal Audit function is adequately resources and has appropriate standing within the organisation
- Monitoring the effectiveness of internal audit and carrying out an annual review.

6.3 External Audit

The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the Board when appropriate)
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
- Reviewing all external audit reports, including the report to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services

6.4 Other Assurance Functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (for example, the Care Quality Commission, NHS Litigation Authority, etc.) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies, etc.)

The Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. In particular, the committee will work in close liaison with the Quality Governance Committee and the Finance, Investment and Performance Committee and will meet formally with these committees at least twice per year.

In reviewing the work of the Quality Governance Committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

6.5 Counter fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Protect's standards and shall review the outcomes of work in these areas.

6.6 Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit) as they may be appropriate to the overall arrangements.

6.7 Financial Reporting

The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Audit Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- Letter of representation
- Explanations for significant variances

6.8 Whistleblowing

The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

7. Accountability and Reporting arrangements

The Committee shall report to the Board on how it discharges its responsibilities.

The minutes of the Committee's meetings shall be formally recorded by the Board and Committee Secretary and submitted to the Board. The Chair of the Committee, via a formal highlight report, shall draw the attention of the Board any issues that require disclosure to the Board or require executive action.

The Committee will report to the Board at least annually on its work in support of the annual governance statement, specifically commenting on:

- The fitness for purpose of the assurance framework
- The completeness and 'embeddedness' of risk management in the organisation
- The integration of governance arrangements

- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business
- The robustness of the processes behind the quality account.

This annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

8. Sub-committees and reporting arrangements

The Committee shall have the power to establish sub-committees for the purpose of addressing specific tasks or areas of responsibility. In accordance with the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee unless expressly authorised by the Trust Board.

The terms of reference, including the reporting procedures of any sub-committees must be approved by the committee and regularly reviewed.

9. Administration

The Committee shall be supported administratively by the Board and Committee Secretary – his or her duties in this respect will include:

- Agreement of agendas with the Chair and attendees
- Preparation, collation and circulation of papers in good time
- Ensuring that those invited to each meeting attend
- Taking minutes and helping the Chair to prepare reports to the Board
- Keeping a record of matters arising and issues to be carried forward
- Arranging meetings for the Chair – for example with the internal/external auditors or local counter fraud specialists
- Maintaining records of members' appointments and renewal dates etc
- Advising the Committee on pertinent issues/areas of interest/policy developments
- Ensuring that action points are taken forward between meetings
- Ensuring that Committee members receive the development training they need

10. Requirement for review

These terms of reference will be formally reviewed by the Committee at least annually.

11. FOI Reminder

The minutes (or sub-sections) of the Board, unless deemed exempt under the Freedom of Information Act 2000, shall be made available to the public, through the meeting papers.

Appendix 1 – Audit Committee Business Cycle

Audit	Item	Lead	To Note/ Assurance/ Approval	Committee Escalated From	Sep-14	Dec-14	Mar-15	Jun-15	Sep-15	Dec-15	Mar-16
General Business	Apologies for Absence	Chair	To Note	N/A	x	x	x	x	x	x	x
	Declarations of Interest	Chair	To Note	N/A	x	x	x	x	x	x	x
	Minutes of Previous Meeting	Chair	Approval	N/A	x	x	x	x	x	x	x
	Matters Arising	Chair	To Note	N/A	x	x	x	x	x	x	x
Corporate Governance	Board Assurance Framework	Dir. of Governance	Assurance	N/A		x			x		x
	Review of the Risk Management Process Governance and Systems	Dir. of Governance	Assurance	Risk Group		x	x			x	
	Review Draft Annual Governance Statement	Dir. of Governance	Assurance	N/A			x	x			
	Review Annual Report and Accounts	Dir. of Finance	Assurance	N/A					x		
	Review of Quality Account	Medical Director	Assurance	N/A					x		
	Review of Statutory Compliance (Health and Safety)	Dir. of Facilities and Capital Dev.	Assurance	N/A		x					x
Financial Focus	Agree Final Annual Report and Accounts Timetable and Plans	Dir. of Finance	Approval	N/A	x					x	
	Review Annual Report and Accounts Progress	Dir. of Finance	Assurance	N/A			x				
	Review Audited Accounts and Financial Statements (inc. External Audit Opinion)	Dir. of Finance	Assurance	N/A				x			
	Review Risks and Controls around Financial Management	Dir. of Finance	Assurance	N/A		x			x		x
	Review changed to the SOs, SFIs and SoD and Changes to Accounting Policies	Dir. of Finance	Assurance	N/A		x	x		x		x
	Review Losses and Special Payments	Dir. of Finance	Assurance	N/A	x	x	x	x	x	x	x
Internal Audit	Review and Approve Annual Internal Audit Plan	Head of Internal Audit/Dir. of Finance	Approval	N/A			x				
	Review and Approve Internal Audit Terms of Reference	Head of Internal Audit/Dir. of Finance	Approval	N/A			x				
	Annual Review of the Effectiveness of Internal Audit	Head of Internal Audit/Dir. of Finance	Assurance	N/A		x					x
	Review Internal Audit Progress Reports	Head of Internal Audit/Dir. of Finance	Assurance	N/A	x		x		x	x	x
	Receive Annual Internal Audit Report and Associated Opinions	Head of Internal Audit/Dir. of Finance	Assurance	N/A			x	x			
External Audit	Agree External Audit Plan and Fees	Head of External Audit/Dir. of Finance	Approval	N/A			x				
	Review the Effectiveness of External Audit	Head of External Audit/Dir. of Finance	Assurance	N/A			x				
	Review External Audit Progress Reports	Head of External Audit/Dir. of Finance	Assurance	N/A	x	x	x	x	x	x	x
	Receive the External Auditor's Report to those charged with Governance	Head of External Audit/Dir. of Finance	Assurance	N/A				x			
	Receive/Consider the External Auditor's Annual Audit Letter	Head of External Audit/Dir. of Finance	Assurance	N/A					x		

Audit	Item	Lead	To Note/ Assurance/ Approval	Committee Escalated From	Sep-14	Dec-14	Mar-15	Jun-15	Sep-15	Dec-15	Mar-16
Counter Fraud	Review and Approve the Annual Work plan for Counter Fraud Activity	Local Counter Fraud Specialist/Dir. of Finance	Approval	N/A			x				
	Review Counter Fraud Progress Reports	Local Counter Fraud Specialist/Dir. of Finance	Assurance	N/A	x	x	x		x	x	x
	Review the Organisation's Annual Self-Review against NHS Protect's Standards	Local Counter Fraud Specialist/Dir. of Finance	Assurance	N/A			x				
	Review the Effectiveness of those carrying out Counter Fraud Activity	Local Counter Fraud Specialist/Dir. of Finance	Assurance	N/A		x					x
	Receive the Annual Report on Counter Fraud Activity	Local Counter Fraud Specialist/Dir. of Finance	Assurance	N/A				x			
Committee Governance	Plan how to Discharge the Committee's Duties	Dir. of Governance	Approval	N/A			x				
	Self-Assess the Committees Effectiveness and Review Terms of Reference	Dir. of Governance	Approval	N/A		x					x
	Produce the Annual Audit Committee Report	Dir. of Governance	Approval	N/A			x				
	Private Discussions with Internal and External Auditors	Committee Chair	To Note	N/A					x		

Appendix 2 – Standard Agenda

Northampton General Hospital NHS
NHS Trust

A G E N D A
Audit Committee

Date
Time and Venue

Time		Agenda Item	Presented by	Enclosure
GENERAL BUSINESS				
	1.	Introductions and Apologies	Chair	
	2.	Declarations of Interest	Chair	
	3.	Minutes of meeting	Chair	
	4.	Matters Arising and Action Log	Chair	
CORPORATE GOVERNANCE				
	5.	Board Assurance Framework		
	6.	Note the business of other Board committees		
FINANCIAL FOCUS				
	7.	Review of Losses and Special Payments		
INTERNAL AUDIT				
	8.	Review of Internal Audit Progress Report		
EXTERNAL AUDIT				
	9.	Review of External Audit Reports		
COUNTER FRAUD				
	10.	Review of Counter Fraud Progress Report		
COMMITTEE GOVERNANCE				
	11.	Highlight Report to the Board		

Time	Agenda Item		Presented by	Enclosure
	12.	Any Other Business		

DATE OF NEXT MEETING

The next meeting will be held at time on date in the venue

QUALITY GOVERNANCE COMMITTEE

Terms of Reference

Membership	• Non-Executive Director (Chair) • One other Non-Executive Director • Chief Executive • Director of Nursing, Midwifery and Patient Services • Medical Director • Chief Operating Officer • Director of Workforce and Transformation • Director of Finance • Director of Strategy and Partnerships • Director of Facilities and Capital Development • Director of Corporate Development, Governance and Assurance • Divisional Clinical Directors (4)
Quorum	• Seven Members with at least one Non-Executive Directors (including the Chair)
In Attendance	• Deputy Director of Nursing • Head of Communications • Board and Committee Secretary
Frequency of Meetings	• Monthly
Accountability and Reporting	• Accountable to the Trust Board • Summary report to the Trust Board after each meeting from Chair • Minutes available to all Trust Board members on request • Annual report to the Trust Board on actions taken to comply with terms of reference
Date of Approval by Trust Board	• November 2014
Review Date	• 12 months review

QUALITY GOVERNANCE COMMITTEE (QGC)

TERMS OF REFERENCE

1. Constitution

The Trust hereby resolves to establish a Committee of the Trust Board to be known as the Quality Governance Committee (the Committee). The purpose of the Committee is to ensure there is an effective system of integrated governance, risk management, and internal control across the clinical activities of the organisation that support the organisation's objectives of delivering the best possible outcomes of care to patients.

2. Membership

The Chair, Non-Executive and Executive members of the Committee shall be appointed by the Trust Board. The Trust Board should satisfy itself that the Chair of the Committee has recent and relevant clinical experience.

The membership includes Director of Workforce and Transformation, Director of Strategy and Partnerships, Director of Facilities and Capital Development and the Director of Corporate Development, Governance and Assurance. The four Divisional Clinical Directors are also members of this Committee.

3. Quorum, Frequency of meetings and required frequency of attendance

No business shall be transacted unless seven members of the Committee are present. This must include not less than one Non-Executive Board members including the Chair.

The committee will meet monthly. Members of the Committee are required to attend a minimum of 80% of the meetings held each financial year and not be absent for two consecutive meetings.

4. In attendance

In addition to the agreed membership, other Board members shall have the right to attend. Other directors and officers of the Trust may be asked to attend at the request of the Chair. Only the Committee Chair and relevant members are entitled to be present at a meeting of the Committee, but others may attend by invitation of the Chair of the Committee.

5. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference and to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee can also recommend the provision of expert advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

6. Duties

The Committee has three reporting domain sub-groups;

1. The Assurance, Risk, and Compliance Group. (Chaired by the Director of Corporate Development, Governance and Risk).
2. The Patient and Carer Experience Group. (Chaired by the Director of Nursing, Midwifery and Patient Services).
3. Clinical Quality and Effectiveness Group (CQEG) (Chaired by the Medical Director).

Through each of the Chairs of the three sub-groups, the Committee will receive assurance from the Chair of the sub-group on;

6.1 Policy, Planning and Strategy

- The Committee will oversee the planning and development of quality and governance activities in the Trust.
- The Committee will ensure that the Trust's strategy for quality and governance is being delivered, and ensure the robust development of the Trust's quality and governance plans.
- The Committee will encourage and foster greater awareness of quality and governance throughout the organisation at all levels.
- The Committee will ensure the development and ratification of new clinical, quality and governance policies via the Trust's Procedural Document Group. This group will report to the Committee through CQEG.
- The Committee will oversee the development of the Quality Accounts and oversee the monitoring and reporting process.

6.2 Monitoring and Delivery

- The Committee will report and provide assurance to the Trust Board through the Chair of the Committee on the quality of healthcare provided by the Trust.

- The Committee will gain assurance from the Chairs of each of the three reporting domain groups. Each domain group represents an aggregated group of further sub-groups. **(*Appendix 1* -** organogram of domain reporting groups to QGC and other Committees of the Trust Board)

- The Committee will monitor the system and process for capturing and responding to service user and carer feedback through the Chair of the Patient and Carer Experience sub-group.

- The Committee will monitor the system and process for capturing and responding to the effectiveness and outcomes of care provided to patients through the Chair of the CQEG sub-group.

- The Committee will monitor the system and process in place in respect to CQUIN delivery through the Chair of the CQEG sub-group.

- The Committee will monitor health and safety management systems and processes throughout the organisation, through the Chair of the Assurance Risk and Compliance sub-group.

- The three domain sub-groups will each provide a highlight report to QGC provided in advance of the meeting to be presented by the Chair of the group. The reporting domain groups represent an aggregated group of further meeting groups as identified in ***Appendix 1*.**

- The report by each Chair will include the key findings and issues discussed within the domain group that was agreed to be escalated at QGC for information or consideration.

- Where delivery becomes sub-optimal the focus of assurance for the Committee will be in options to be considered, the turnaround solutions and actions the Divisions have agreed at HMT to progress together with timeframes for delivery. The operational delivery and accountability of the Divisions is through HMT.

- Through the membership of QGC, the Committee will receive assurance directly from Divisional Clinical Directors of the delivery and commitment to deliver high quality, effective outcomes for patients within a robust governance framework.

- The Committee will monitor the system and processes in place in relation to compliance with the CQC and other relevant regulatory compliance standards, through the Assurance, Risk and Compliance sub-group.

- Receive and challenge the annual reports from each of the domain reporting groups. In addition annual reports in respect to Safeguarding Adults and Children, Infection control, NICE compliance etc.

6.3 Risk Management

- Review quality risks on the Corporate Risk Register (CRR) at each meeting and ensure alignment with the Board Assurance Framework (BAF).

- The Committee will seek assurance over the arrangements within the Trust for managing high clinical and non-clinical risks, together with the robustness of associated mitigating actions.

6.4 Other Matters

The Committee will also set the specification and ensure the development of the components of quality and governance through each of the three reporting sub-groups. This to include;

- Clinical effectiveness and evidence based practice
- Training and development and continuous professional development
- Staff skills and competencies
- Professional reviews and appraisals
- Clinical audit outcomes
- Patient complaints, clinical and non-clinical claims
- NICE guidelines
- Serious Incidents.

7. Accountability and Reporting arrangements

The minutes of the Committee meetings shall be formally recorded by the Director of Corporate Development, Governance and Assurance and Committee Secretary. Copies of the minutes of Committee meetings shall be available to all Trust Board members.

The Committee Chair shall prepare a summary report on to the Trust Board after each meeting of the Committee. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require escalation to the full Trust Board.

8. Sub-committees and reporting arrangements

The Committee shall have the power to establish sub-committees for the purpose of addressing specific tasks or areas of responsibility. In accordance with the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee unless expressly authorised by the Trust Board.

The terms of reference, including the reporting procedures of any sub-committees must be approved by the Committee and reviewed.

The Quality Governance Committee has three reporting sub-groups each with their own Terms of Reference. In addition, the business cycles of each of these groups are aligned with the Business Cycle of the QGC.

1. The Assurance, Risk, and Compliance Group. (Chaired by the Director of Corporate Development, Governance and Risk).
2. The Patient and Carer Experience Group. (Chaired by the Director of Nursing, Midwifery and Patient Services).
3. Clinical Quality and Effectiveness Group (CQEG) (Chaired by the Medical Director).

9. Administration

The Quality Governance Committee shall be supported administratively by the Director of Corporate Development, Governance and Assurance and Committee Secretary whose duties in this respect will include:

- Agreement of the agenda for Committee meetings with the Chair;
- Collation of reports and papers for Committee meetings;
- Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward;
- Advising the Committee on pertinent matters
- Agreeing the reporting cycle of the Committee with the Chair of the Committee and the Director of Corporate Development, Governance and Assurance that is aligned with the business cycle of the Trust Board.

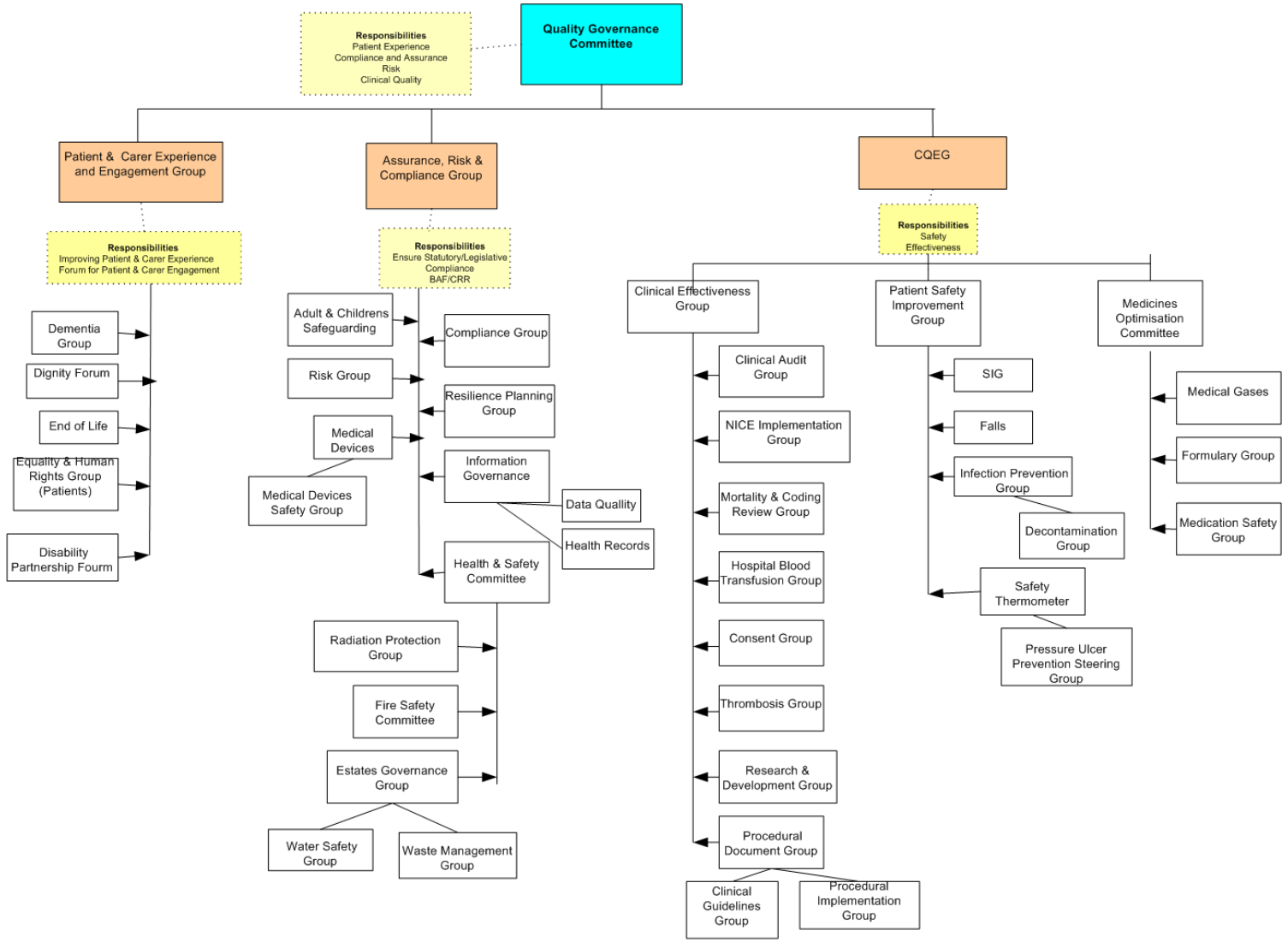
10. Requirement for review

These terms of reference will be formally reviewed by the Committee at least annually.

11. FOI Reminder

The minutes (or sub-sections) of the Board, unless deemed exempt under the Freedom of Information Act 2000, shall be made available to the public, through the meeting papers.

Appendix 1- organogram of domain reporting groups to QGC



Appendix 2 – Quality Governance Committee Cycle of Business

Quality Governance	Item	Lead	To Note/ Assurance/ Approval	Committee Escalated From	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
General Business	Apologies for Absence	Chair	To Note	N/A	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Declarations of Interest	Chair	To Note	N/A	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Minutes of Previous Meeting	Chair	Approval	N/A	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Matters Arising	Chair	To Note	N/A	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Clinical Quality, Safety and Effectiveness	Report from the CQEG Chair	Dir. Nursing/Medical Director	Assurance	CQEG		x	x	x	x	x	x	x	x	x	x	x	x	x
	Clinical Audit Annual Report	Medical Director	Assurance	CQEG											x			
	Nursing and Midwifery Report	Dir. of Nursing	Assurance	N/A	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Corporate Scorecard	Medical Director	Assurance	ARCG	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Medical Director's Report	Medical Director	Assurance	N/A	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	QIA Report	Dir. Nursing/Medical Director	Assurance	N/A	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Clinical Audit Annual Plan	Medical Director	Assurance	CQEG						x								
	Approval of Quality Account	Medical Director/Dir. Nursing	Approval	CQEG							x							
	Quality Report Review of sections	Dir. Nursing	Assurance	CQEG	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Quality Strategy	Medical Director/Dir. Nursing	Approval	CQEG								x						
Compliance Governance and Risk	Report from the Assurance and Compliance Group Chair	Dir. Governance	Assurance	ARCG			x	x	x	x	x	x	x	x	x	x	x	x
	Patient Safety Strategy	Dir. Nursing	Approval	CQEG			x											
	QGAF	Dir. Governance	Assurance	All														
	CQC Compliance Report	Dir. Governance	Assurance	ARCG				x			x			x			x	

Quality Governance	Item	Lead	To Note/ Assurance/ Approval	Committee Escalated From	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
	Information Governance Toolkit Compliance Report	Dir. Strategy and Partnerships	Assurance	ARCG								x						
	Board Assurance Framework & Corporate Risk Register	Dir. Governance	Assurance	All			**x**		**x**			**x**			**x**			**x**
	Meeting Schedule and Cycle of Business	Dir. Governance	Assurance	N/A							**x**							
	Committee Effectiveness Review	Dir. Governance	Assurance	N/A								**x**						
Patient & Carer Experience and Engagement	Report from the Patient & Carer Experience and Engagement Group	Dir. of Nursing	Assurance	PCEEG			x	x	x	x	x	x	x	x	x	x	x	x
	Patient & Carer Experience and Engagement Annual Report	Dir. Nursing	Assurance	PCEEG			x											
	Patient & Carer Experience and Engagement and Complaints Strategy	Dir. Nursing	Approval	CQEG													x	
	ECLIPS	Dir. Nursing	Assurance	All			x			x			x			x		
	Patient Survey Results	Dir. Nursing	Assurance	PCEEG							x							

Appendix 3 – Standard Agenda Template

Quality Governance Committee

DRAFT

Date

Time and Venue

Time	Agenda Item		Presented by	Enclosure
GENERAL BUSINESS				
	1.	Introductions and Apologies	Chair	
	2.	Declarations of Interest	Chair	
	3.	Minutes of meeting	Chair	
	4.	Matters Arising and Action Log	Chair	
CLINICAL QUALITY, SAFETY AND EFFECTIVNESS				
	5.	Quarterly Quality Report	Director of Nursing and Medical Director	
	6.	Report from CQEG	Chair of CQEG	
	7.	Report from the Patient and Carer Experience Group	Chair of Patient and Carer Experience Group	
COMPLIANCE				
	8.	Report from the Assurance and Compliance Group	Director of Corporate Development, Governance and Assurance	
GOVERNANCE				
	9.	Board Assurance Framework and Corporate Risk Register	Director of Corporate Development, Governance and Assurance	
	10.	Committee Report to the Trust Board	Chair	
	11.	**Any Other Business**	Chair	
DATE OF NEXT MEETING The next meeting will be held at xx time on xxx date in the (venue)				

FINANCE, INVESTMENT & PERFORMANCE COMMITTEE

TERMS OF REFERENCE

Membership	• Non-Executive Director (Chair) • Two other Non-Executive Directors • Chief Executive • Director of Finance • Chief Operating Officer • Director of Workforce and Transformation • Director of Strategy and Partnerships • Director of Facilities and Capital Planning • Director of Nursing, Midwifery and Patient Services
Quorum	• Six members including a minimum of two Non-Executive Directors
In Attendance	• Deputy Director of Finance • Assistant Director Improving Quality and Efficiency • Head of Communications • Board and Committee Secretary • Associate Directors of Finance (as required)
Frequency of Meetings	• Monthly
Accountability and Reporting	• Accountable to the Trust Board • Report to the Trust Board after each meeting • Minutes available to all Trust Board members on request • Annual report to the Trust Board on actions taken to comply with terms of reference
Date of Approval by Trust Board	• November 2014
Review Date	• 12 months review

Northampton General Hospital NHS
NHS Trust

FINANCE, INVESTMENT AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. Constitution

The Trust hereby resolves to establish a Committee of the Trust Board to be known as the Finance, Investment and Performance Committee (the Committee).

The principle aim of the Committee is to maintain a detailed overview of the Trust's assets and resources in relation to the achievement of financial targets and business objectives and the financial stability of the Trust. In addition, this committee is responsible for ensuring the delivery of all key performance metrics. This will include:-

- overseeing the development and maintenance of the Trust's medium and long term financial strategy;
- reviewing and monitoring the delivery of the annual financial plan and its link to operational performance and quality;
- reviewing and monitoring operational performance;
- overseeing financial risk evaluation, measurement and management scrutiny and oversight of the capital programme;
- ensure the finance function is fit for purpose and , key financial policies and objectives align with Trusts objectives
- consider and make recommendations regarding the self-declarations for the Trust in respect to the compliance with the oversight and escalation process to the Trust Development Agency (TDA)
- consideration of major investment decisions
- consideration of material transactions and governance issues

2. Membership

The Chair of the Committee and non-executive members shall be appointed by the Trust Board. The Trust Board should satisfy itself that at least one non-executive member of the Committee has recent and relevant financial experience.

In the absence of the Chair appointed by the Trust Board, one of the Non-Executive Directors will be elected by those present to Chair the meeting.

3. Quorum, Frequency of meetings and required frequency of attendance

No business shall be transacted unless six members of the Committee are present. This must include not less than two non-executive Board members.

In the event that the Director of Finance is not available, the Deputy Director of Finance must attend.

The Committee will normally meet monthly, but not less than quarterly. Members of the Committee are required to attend a minimum of 80% of the meetings held each financial year and not be absent for two consecutive meetings without the permission of the chair of the committee.

4. In attendance

In addition to the agreed membership, other Board members shall have the right to attend. Other directors and officers of the Trust may be asked to attend at the request of the Chair. Only the Committee Chair and relevant members are entitled to be present at a meeting of the Committee, but others may attend by invitation of the Chair.

5. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference and to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee can also recommend the provision of expert advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

6. Duties

Financial Strategy

- To consider the financial strategy, ensuring that the financial objectives are consistent with the strategic direction and quality priorities.
- To review the long term financial model (LTFM) and seek assurance that the LTFM and IBP are aligned together with the wider health economy plans.
- To oversee the development and management of the rolling capital programme including scrutiny of the prioritisation process, forecasting and remedial action, and report to the Board accordingly
- To provide assurance on the robustness of the Annual Planning Process
- To review key medium term planning assumptions
- To review NHS TDA/Monitor/LAT /CCG/NHS England, etc publications around financial and operating environment and their link to planning assumptions and models
- To ensure that the financial forecast and associated recovery plans are robust and are delivered

Monitoring Performance

- Monitor the divisional and overall Trust achievement of the financial strategy, and financial targets, associated activity targets and how these relate to the performance of the trust in non-financial domains such as patient safety and effectiveness.
- To review the Trusts short and medium term financial performance of the Transformation Programme, including any mitigation plans for the identified risks and provide assurance to the Trust Board that appropriate action is being taken.
- Developing high level metrics to focus the Committee on areas where corrective action may need to be developed and monitoring agreed actions
- Monitor the Trust KPIs and associated actions, the performance scorecard, and activity and financial performance.
- Monitor the outcomes of the quarterly performance reviews and the associated remedial actions agreed
- To monitor and scrutinise the Trust procurement plan, ensuring it drives value for money across purchasing and supplies

- To scrutinise financial and non-financial performance, trends, projections and underlying data on a monthly basis so that assurance can be sought around any action plans that address emerging patterns in finance or activity.
- To scrutinise the trust transformation programme including trends, projections and underlying data on a monthly basis so that assurance can be sought around any action plans that address emerging patterns in delivery.
- To consider the annual reference costs and review profitability analyses using service line reporting.
- Provide oversight of the Trust Charitable Funds Group and associated plans.
- To review the annual accounts, any going concerns and the statement of internal governance prior to Audit Committee and Board approval

Financial Risk Management

- To review financial risk and advise the Board accordingly
- Review and evaluation of key financial risks and associated mitigating actions
- Development of risk management process around the evaluated risks linking to Board Assurance Framework providing assurance around active financial risk management

Business Case consideration, Capital and Service Investment Programme management

- To perform a preliminary review of proposed major investments.
- To establish the overall controls which govern business case investments and to receive assurances on the approvals process for Business Cases approved by the Hospital Management Team and making recommendations to the Trust Board when the level of approval exceeds the limits set in the Trust Scheme of Delegation.
- To ensure that robust processes are followed, evaluating, scrutinising and monitoring investments so that benefits realisation can be confirmed in line with the Trust's Capital Investment Policy.
- To ensure testing of all relevant options for larger business cases prior to detailed workup
- To focus on financial metrics within cases e.g. payback periods, rate of return etc.

Other Matters

- To examine the fitness for purpose of the finance function compared to the scale of the financial challenge.
- To seek assurance of financial governance arrangements
- To consider ad hoc financial issues that arise and associated actions
- In conjunction with the Audit Committee, periodically consider changes required to Trust Standing Financial Instructions due to structural change within the Trust, developments in the wider statutory/regulatory framework.
- To oversee arrangements for outsourced financial functions and shared financial services.
- To consider such other matters and take such other decisions of a generally financial nature as the Board shall delegate to it.

7. Accountability and Reporting arrangements

The minutes of the Committee meetings shall be formally recorded by the Board and Committee Secretary. Copies of the minutes of Committee meetings shall be available to all Trust Board members on request.

The Committee Chair shall prepare a report on to the Trust Board after each meeting of the Committee. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full trust Board, or require executive action whilst the Board are considering the information including within the monthly finance, performance and improving quality and efficiency reports.

8. Sub-committees and reporting arrangements

The Committee shall have the power to establish sub-committees for the purpose of addressing specific tasks or areas of responsibility. In accordance with the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee unless expressly authorised by the Trust Board.

The terms of reference, including the reporting procedures of any sub-committees must be approved by the committee and regularly reviewed.

9. Administration

The Finance, Investment and Performance Committee shall be supported administratively by the Board and Committee Secretary whose duties in this respect will include:

- Agreement of the agenda for Committee meetings with the Chair;
- Collation of reports and papers for Committee meetings;
- Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward;
- Advising the Committee on pertinent matters.

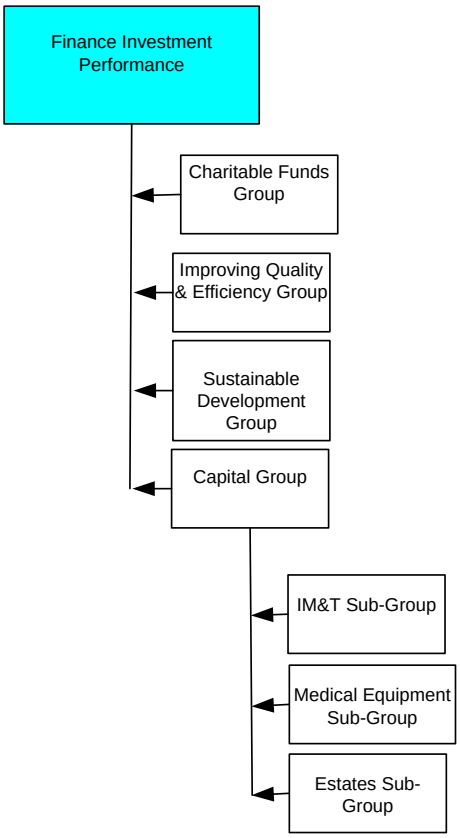
10. Requirement for review

These terms of reference will be formally reviewed by the Committee at least annually.

11. FOI Reminder

The minutes (or sub-sections) of the Board, unless deemed exempt under the Freedom of Information Act 2000, shall be made available to the public, through the meeting papers.

Appendix 1. – Finance, Investment and Performance Committee Structure



Appendix 2 – Finance, Investment and Performance Committee Business Cycle

Finance and Investment	Item	Lead	To Note/ Assurance/ Approval	Committee Escalated From	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
General Business	Apologies for Absence	Chair	To Note	N/A	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Declarations of Interest	Chair	To Note	N/A	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Minutes of Previous Meeting	Chair	Approval	N/A	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Matters Arising	Chair	To Note	N/A	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Finance and Investment	Report from the Capital Committee Chair	Dir. Finance/Dir. Facilities	Assurance	Capital Committee		x		x		x		x		x		x		x
	IQE Report	Dir. Workforce and Transformation	Assurance	IQE Group	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Report from the Charitable Funds Sub-Committee Chair	Dir. Finance	Assurance	Charitable Funds Sub-Committee			x						x					
	Procurement Report	Dir. Facilities and Capital	Assurance				x				x				x			
	Finance Report	Dir. Finance	Assurance	N/A	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	SLR Report	Dir. Finance	Assurance	N/A	x				x			x		x				x
	Charitable Funds Annual Accounts	Dir. Finance	Assurance	Charitable Funds Sub-Committee								x						
	Procurement Strategy	Dir. Facilities and Capital															x	
	Review of Annual Accounts and Annual Governance Statement	Dir. Finance	Assurance	N/A								x						
	Estates Strategy	Dir. Facilities and Capital	Approval	Capital Committee													x	
	Carbon Management and Sustainability Annual Report	Dir. Facilities	Assurance	Capital Committee		x												
	Information Technology Strategy	Dir. Strategy and Partnerships	Approval	IT Sub-Committee												x		
Performance	Operational Performance Report inc Urgent Care & Cancer Reports and Corporate Scorecard	Chief Operating Officer	Assurance	N/A	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Integrated Business Plan	Dir. Strategy and Partnerships	Approval	Hospital Management Team				x	x	x	x							
	Performance Management Framework	Dir. Strategy and Partnerships	Approval	Hospital Management Team						x								
	TDA Board Self Certifications	Dir. Strategy and Partnerships	Approval	N/A		x		x		x		x		x		x		x

Finance and Investment	Item	Lead	To Note/ Assurance/ Approval	Committee Escalated From	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Governance	Board Assurance Framework & Corporate Risk Register	Dir. Governance/Medical Director	Assurance	All		x		x		x		x		x		x		x
	Meeting Schedule and Cycle of Business	Dir. Governance	Assurance	N/A							x							
	Committee Effectiveness Review	Dir. Governance	Assurance	N/A								x						

Appendix 3 – Standard Agenda

Northampton General Hospital NHS
NHS Trust

A G E N D A

Finance Committee

Date

Time and Venue

Time		Agenda Item	Presented by	Enclosure
GENERAL BUSINESS				
	1.	Introductions and Apologies	Chair	
	2.	Declarations of Interest	Chair	
	3.	Minutes of meeting	Chair	
	4.	Matters Arising and Action Log	Chair	
FINANCE AND INVESTMENT				
	5.	Finance Report	Director of Finance	
	6.	Report from the IQE Group		
	7.	Report from the Capital Committee		
	8.	Report from the Charitable Funds Sub-Committee		
PERFORMANCE				
	9.	Performance Exception Report	Chief Operating Officer	
	10.	TDA Board Self-Certifications	Director of Strategy and Partnerships	
GOVERNANCE				
	11.	Board Assurance Framework and Corporate Risk Register		
	12.	Committee Report to the Trust Board	Chair	
	13.	**Any Other Business**	Chair	

DATE OF NEXT MEETING

The next meeting will be held at time on date in the venue

REMUNERATION AND APPOINTMENTS COMMITTEE

TERMS OF REFERENCE

Membership	• Trust Chairman • Five Non-Executive Directors
Quorum	• Any three members or a majority of the appointed non-executive directors and chairman if that is lower
In Attendance	• Chief Executive (not in attendance for discussions regarding own Remuneration and Appointments) • Director of Workforce and Transformation (not in attendance for discussions regarding own Remuneration and Appointments) • Board and Committee Secretary
Frequency of Meetings	• As required but least annually
Accountability and Reporting	• Accountable to the Trust Board • Report to the Trust Board after each meeting • Minutes available to all Trust Board members on request
Date of Approval by Trust Board	• November 2014
Review Date	• 12 months review

REMUNERATION AND APPOINTMENTS COMMITTEE

TERMS OF REFERENCE

1. Constitution

The Trust hereby resolves to establish a Committee of the Trust Board to be known as the Remuneration and Appointments Committee (the Committee). The purpose of the Committee is to ensure there is an effective system of integrated governance, risk management, performance, workforce and internal control across the clinical activities of the organisation that support the organisation's objectives.

2. Membership

- Trust Chairman
- Five Non-Executive Directors.

3. Quorum, Frequency of meetings and required frequency of attendance

No business shall be transacted unless any three members or a majority of the appointed Non-Executive Directors and chairman if that is lower, are in attendance.

The Committee will meet monthly, but not less than quarterly. Members of the Committee are required to attend a minimum of 80% of the meetings held each financial year and not be absent for two consecutive meetings.

4. In attendance

In addition to the agreed membership, the Chief Executive (not in attendance for discussions regarding own Remuneration and Appointments) and the Director of Workforce and Transformation (not in attendance for discussions regarding own Remuneration and Appointments) may be invited to attend at the request of the Chair.

Only the Committee Chair and relevant members are entitled to be present at a meeting of the Committee, but others may attend by invitation of the Chairman.

5. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference and to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee can also seek outside expert advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

6. Duties

The primary role of the Remuneration and Appointments Committee is to establish a formal process for developing policy on executive remuneration and to oversee the appointment process for executive directors.

The Remuneration and Appointments Committee will determine the Remuneration and terms of service for the Chief Executive and executive directors, acting in accordance with the scheme of

delegation and reservation of powers to the Board and approve any non-contractual benefits in relation to the termination of employment for executive directors.

The Remuneration & Appointments committee will oversee the process for the appointment of new members to the Trust board of directors ensuring that there is a formal, lawful procedure in place.

The Committee will also ensure that systems and processes are in place for the development of board members where appropriate.

Key Functions:

- To determine salary levels for the Chief Executive and executive directors, ensuring that basic salaries are maintained at a level which allows the organisation to retain directors and compete in the market place.
- To make external comparisons with other similar size and type of trust to ensure competitiveness.
- To ensure that any pay increases are awarded both in relation to performance and to an assessment of market movement based on independent data.
- To ensure that any supplementary/performance payments relate to the satisfactory performance of the organisation.
- To ensure that contractual obligations to individual directors are honoured and that contracts are reviewed from time to time to ensure that they remain up to date and appropriate.
- To agree any associated benefits that will form part of the overall Remuneration and Appointments package, including car allowances and relocation expenses.
- To agree and propose severance arrangements to the NHS TDA for any directors and for any non-contractual severance arrangements at any grade. Contractual terminations for non-director staff in excess of £100k also require NHS TDA Remuneration Committee approval.
- To ratify the recommendations of the advisory committee for employer local clinical excellence awards
- To receive a written report from the Chief Executive summarising the performance of the executive directors against their agreed objectives, both as a team and individuals, upon which the committee can base its assessment for salary reviews.
- Oversee the development and implementation of effective appraisal processes for directors.
- Oversee the appointment process for executive directors, ensuring that there is a non-executive director on all final interview panels.

7. Accountability and Reporting arrangements

The minutes of the Committee meetings shall be formally recorded by the Board and Committee Secretary. Copies of the minutes of Committee meetings shall be available to all Trust Board members on request.

The Committee Chair shall prepare a report on to the Trust Board after each meeting of the Committee. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full trust Board, or require executive action whilst the Board are considering the information including within the monthly finance, performance and improving quality and efficiency reports.

8. Sub-committees and reporting arrangements

The Committee shall have the power to establish sub-committees for the purpose of addressing specific tasks or areas of responsibility. In accordance with the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee unless expressly authorised by the Trust Board.

The terms of reference, including the reporting procedures of any sub-committees must be approved by the committee and regularly reviewed.

9. Administration

The Trust Board shall be supported administratively by the Board and Committee Secretary whose duties in this respect will include:

- Agreement of the agenda for Committee meetings with the Chair;
- Collation of reports and papers for Committee meetings;
- Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward;
- Advising the Committee on pertinent matters.

10. Requirement for review

These terms of reference will be formally reviewed by the Committee at least annually.

11. FOI Reminder

The minutes (or sub-sections) of the Board, unless deemed exempt under the Freedom of Information Act 2000, shall be made available to the public, through the meeting papers.

TRUST BOARD

TERMS OF REFERENCE

Membership	• Chairman of the Trust Board • Five Non-Executive Directors • Chief Executive • Director of Finance • Director of Nursing, Midwifery and Patient Services • Medical Director • Chief Operating Officer
Quorum	• Six members (including at least two Non-Executive Directors and two Executive Directors)
In Attendance	• Director of Strategy and Partnerships • Director of Workforce and Transformation • Director of Facilities and Capital Development • Director of Corporate Development, Governance and Assurance • Head of Communications • Board and Committee Secretary
Frequency of Meetings	• At least six meetings per year
Accountability and Reporting	• Accountable to the Secretary of State for Health
Date of Approval by Trust Board	• November 2014
Review Date	• 12 months review

TRUST BOARD

TERMS OF REFERENCE

1. Constitution

The Northampton General Hospital NHS Trust is a statutory body which came into existence on 01 April 1994 under The Northampton General Hospital National Health Service Trust (Establishment) Order 1993 No 2561.

NHS Trusts are governed by Act of Parliament, namely the National Health Service Act 2006 (NHS Act 2006), the National Health Service (Consequential Provisions) Act 2006. The functions of the Trust, and thus the Trust Board are conferred by this legislation.

The powers of the Trust established under statute shall be exercised by the Board meeting in public session except when the nature of the business to be transacted is confidential in nature and would be prejudicial to the public interest, when business will be transacted in closed session.

2. Membership

In accordance with the Membership and Procedure Regulations, the composition of the Board shall be:

- The Chairman of the Trust Board
- Five Non-Executive Directors
- The Chief Executive
- The Director of Finance
- The Director of Nursing, Midwifery and Patient Services
- The Medical Director
- The Chief Operating Officer

The Trust Board shall have not more than 11 and not less than 8 members (unless otherwise determined by the Secretary of State for Health and set out in the Trust's Establishment Order or such other communication from the Secretary of State).

3. Quorum, Frequency of meetings and required frequency of attendance

No business shall be transacted at a meeting of the Board unless at least half of the whole number of the voting directors is present, including at least two Executive Directors and two Non-Executive Directors.

If an Executive Director is unable to attend a meeting of the Board, an alternative may be appointed to attend the meeting, or part of it, if so requested by the Chairman. Any such alternative shall not be counted as part of the required quorum, nor shall they have voting rights, unless they have been formally appointed by the Board as an Interim/Acting Director.

Meetings of the Board shall be held at such times as the Board may determine. The Board will routinely formally meet on a bi-monthly basis.

Meetings of the Board are held in two parts, a confidential session and a public session.

Board members are required to attend a minimum of 80% of meetings held each financial year and not be absent for two consecutive meetings. An attendance list will be kept and circulated to the membership with the minutes.

4. In attendance

In addition to the membership, the following shall participate in Board meetings in a non-voting capacity:

- Director of Strategy and Partnerships
- Director of Workforce and Transformation
- Director of Facilities and Capital Development
- Director of Corporate Development, Governance and Assurance
- Head of Communications
- Board and Committee Secretary (minutes)

The Board may invite non-members to attend its meetings as it considered necessary and appropriate.

5. Authority

NHS Trusts are governed by Act of Parliament, namely the National Health Service Act 2006 (NHS Act 2006), the National Health Service (Consequential Provisions) Act 2006. The functions of the Trust, and thus the Trust Board are conferred by this legislation.

The Board shall define, and regularly review the functions is exercises on behalf of the Secretary of State.

6. Duties

The purpose of the Board is to:

- Provide leadership to the Trust to promote achievement of the Trust's principle purpose;
- Set the vision, values, goals and strategic direction of the Trust;
- Agree the Trust's financial and strategic objectives, including approval of the annual business plan and financial plan;
- Oversee the implementation of the Trust's strategic objectives
- Monitor the performance of the Trust and ensure that the Executive Management Team manage the Trust within resources available in such a way as to:
    - Ensure the safety of patients and the delivery of high quality care;
    - Protect the health and safety of Trust employees and all others to whom the Trust owes a duty of care;
    - Make effective and efficient use of resources;
    - Promote the prevention and control of Healthcare Associated Infection;

- Comply with all relevant regulatory, legal and code of conduct requirements;
- Maintain high standards of ethical behaviour, corporate governance and personal conduct in the business of the Trust;
- Maintain the high reputation of the Trust both with reference to local stakeholder and the wider community.

- Ensure that the Trust has adequate and effective governance and risk management systems in place;
- Review and approve the Trust's annual report and accounts;
- Ensure the Trust fulfils the requirements of registration with the Care Quality Commission;
- Promote and develop appropriate partnerships with other organisations in accordance with the Trust's values and strategic direction.
- The Board will ensure that all matters that have been reserved to the Board for its collective decision are dealt with accordingly.
- The Board will receive and consider high level reports on matters material to the Trust detailing in particular, information and action with respect to:
  - Clinical quality and safety; including infection prevention and control;
  - Human resource matters;
  - Operational performance and delivery;
  - Patient experience and engagement intelligence;
  - Financial performance;
  - The identification and management of risk;
  - Matters pertaining to the reputation of the Trust;
  - Any other significant issue that is deemed appropriate.
- The Board will participate in a development programme and series of assessments to ensure it in a state of readiness for Foundation Trust status.

7. Accountability and Reporting arrangements

The Board will be chaired by the Chairman of Northampton General Hospital NHS Trust, or in their absence, the Non-Executive Director nominated as vice-chair.

The Trust Board is accountable to the Secretary of State for Health.

8. Sub-committees and reporting arrangements

The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, or sub-committees which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees and their specific executive powers shall be approved by the Board.

The committees established by the Board are:

- Audit Committee
- Finance, Investment and Performance Committee
- Quality Governance Committee
- Workforce Committee (Task and Finish Group)
- Remuneration and Appointments Committee.

The Board will receive summary reports from each of its committees.

9. Compliance and effectiveness

The Board shall self-assess its performance following each Board meeting and undertake a formal comprehensive self-assessment of performance annually.

10. Administration

The Trust Board shall be supported administratively by the Board and Committee Secretary whose duties in this respect will include:

- Agreement of the agenda for Board and Board committee meetings with the Chair and chief Executive
- Collation of reports and papers for Board meetings
- Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward
- Advising the Board on governance matters

The agenda for each meeting will be circulated seven working days in advance; together with any supporting papers, and will be distributed by the secretariat to the Board.

Any items to be place on the agenda are to be sent to the secretariat to the Board ten working days ahead of the meeting, accompanied by all relevant background papers. Tabled papers will not be accepted unless given approval by the Chairman.

The Chairman will ensure that all interests are formally declared by Board members prior to the commencement of proceedings. In particular, the declarations will include details of all professional and personal relationships and other relevant and material interests (pecuniary and non-pecuniary) specifically related to the business to be transacted as per the agenda.

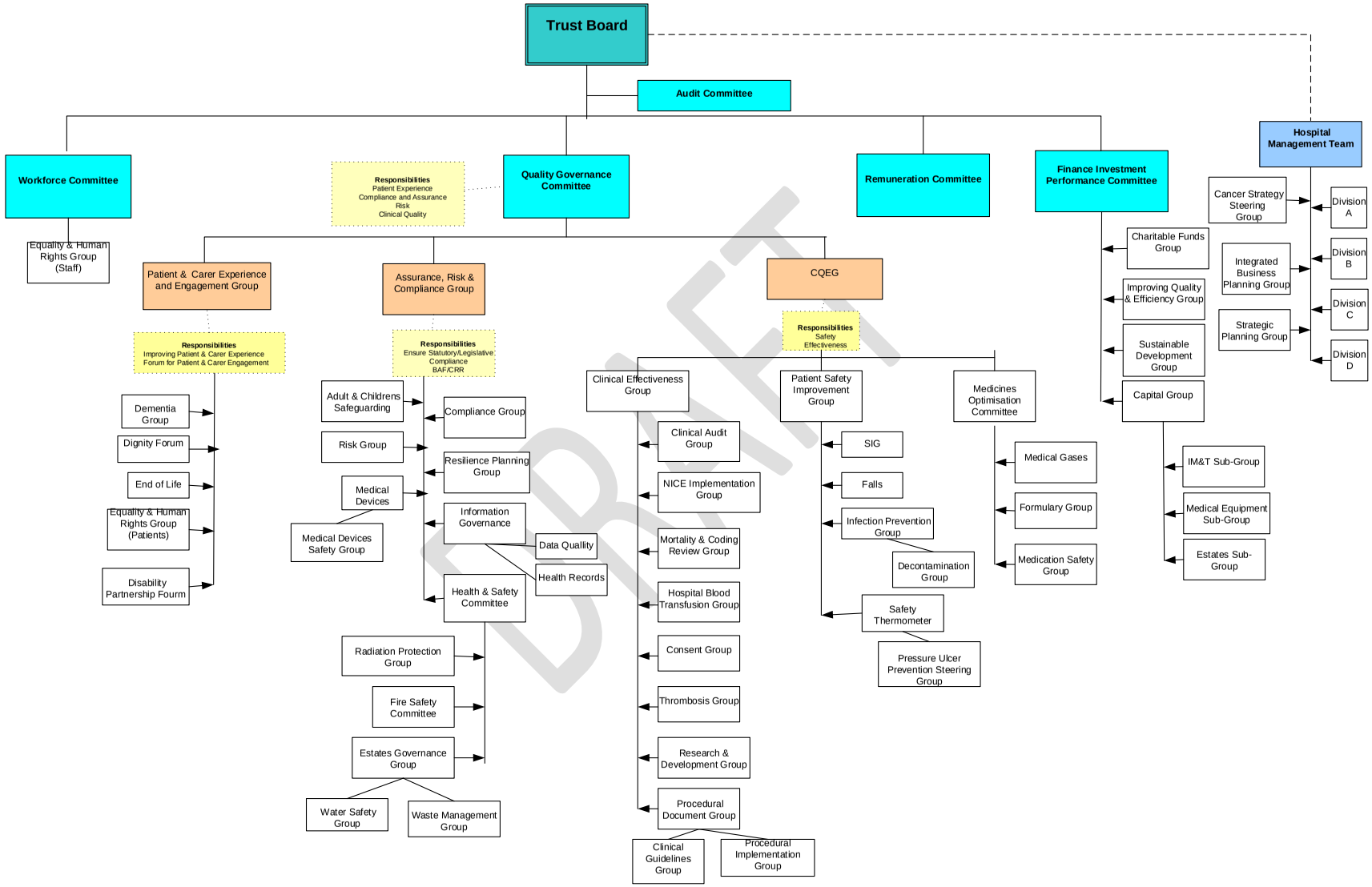
11. Requirement for review

These terms of reference will be formally reviewed by the Board in April of each year, and may be amended by the Board to reflect changes in circumstances which may arise.

12. FOI Reminder

The minutes (or sub-sections) of the Board, unless deemed exempt under the Freedom of Information Act 2000, shall be made available to the public, through the meeting papers.

Appendix 1 –Trust Board Committee Structure



Appendix 2. Cycle of Business

Trust Board & Board of Directors	Item	Lead	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
			Board	BoD	Board		Board	BoD	Board	BoD	Board	BoD	Board		Board	BoD
General Business	Apologies for Absence	Chair	x	x	x		x	x	x	x	x	x	x		x	x
	Declarations of Interest	Chair	x	x	x		x	x	x	x	x	x	x		x	x
	Minutes of Previous Meeting	Chair	x		x		x	x	x	x	x	x	x		x	x
	Matters Arising	Chair	x	x	x		x	x	x	x	x	x	x		x	x
	Chairman's Report	Chair			x		x		x		x		x		x	
	Chief Executive's Report	Chief Executive	x	x	x		x	x	x	x	x	x	x		x	x
Quality	Patient Story	Dir. of Nursing	x		x		x		x		x		x		x	
	Report from the Quality Governance Committee	QGC Chairman	x	x	x		x	x	x	x	x	x	x		x	x
	Director of Nursing Report	Dir. of Nursing	x		x		x		x		x		x		x	
	Medical Director Report	Medical Director	x		x		x		x		x		x		x	
	Same Sex Accommodation Board Statement of Compliance	Dir. of Nursing											x			
	Approval of Quality Account	Medical Director									x				x	
Assurance	Report from the Audit Committee	Audit Committee Chair	x				x		x		x				x	
	Report from the Finance, Investment and Performance Committee	Finance Chair	x	x	x		x	x	x	x	x	x	x		x	x
	Report from the Workforce Committee	Dir. Workforce Chair	x	x	x		x	x	x	x	x	x	x		x	x
	Integrated Performance and Corporate Scorecard	Chief Operating Officer	x	x	x		x	x	x	x	x	x	x		x	x
	Board Assurance Framework & Corporate Risk Register (Private)	Dir. Governance/Medical Director	x		x		x		x		x		x		x	
	Corporate Objectives - 14/15 Annual Report	Dir. Strategy and Partnerships									x					
	Corporate Objectives - 14/15 Progress Update	Dir. Strategy and Partnerships		x				x				x				
	Fire Safety Board Compliance Statement	Dir. Facilities and Capital Dev.											x			
	TDA Self Certifications	Dir. Strategy and Partnerships	x		x		x		x		x		x		x	
Strategy	Integrated Business Plan	Dir. Strategy and Partnerships							x							

Trust Board & Board of Directors	Item	Lead	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
			Board	BoD	Board		Board	BoD	Board	BoD	Board	BoD	Board		Board	BoD
	Corporate Objectives - 15/16 Approval	Dir. Strategy and Partnerships							x							
	Organisational Development/Effectiveness Strategy	Dir. Workforce											x			
	Communications Strategy	Dir. Strategy and Partnerships	x										x			
	Engagement Strategy	Dir. Strategy and Partnerships	x										x			
	Risk Management Strategy	Dir. Governance/Medical Director													x	
Governance	Annual Board Effectiveness Report	Dir. Governance										x				
	Annual CQC Compliance Report	Dir. Governance/Medical Director									x					
	Annual Report, Accounts and Annual Governance Statement and Auditors Letter of Representation	Dir. Finance & Dir. Governance									x					
	Corporate Governance Report - Any amendments to SO's, SoD, SFIs - Annual Register of Directors Interest Report - Annual Register of Gifts and Hospitality Report - Annual Report on the Use of the Trust Seal - Review of Compliance with the NHS Constitution	Dir. Finance and Dir. Governance											x			
	Board Meeting Schedule and Cycle of Business	Dir. Governance						x								
	Review of Committee ToR and Work plans	Dir. Governance								x						
Annual Reports	Emergency Preparedness Annual Report inc Winter Plan	Chief Operating Officer			x											
	Fire Safety Annual Report	Dir. Facilities and Capital Dev.			x											
	Risk Management Annual Report	Dir. Governance											x			
	Health and Safety Annual Report	Dir. Facilities and Capital Dev.	x													
	Security Management Annual Report	Dir. Facilities and Capital Dev.		x												
	Complaints Annual Report	Dir. Nursing			x											
	Safeguarding Annual Report	Dir. Nursing	x													
	Research and Development Annual Report	Medical Director		x												
	Infection Prevention Annual Report	Dir. Nursing	x													
	SIRO Annual Report	Dir. Strategy and Partnerships									x					

Appendix 3 – Standard Agenda

Northampton General Hospital NHS
NHS Trust

A G E N D A
Public Trust Board

Date

Time and Venue

Time		Agenda Item	Presented by	Enclosure
GENERAL BUSINESS				
	1.	Introductions and Apologies	Chairman	
	2.	Declarations of Interest	Chairman	
	3.	Minutes of meeting	Chairman	
	4.	Matters Arising and Action Log	Chairman	
	5.	Chairman's Report	Chairman	
	6.	Chief Executive's Report	Chief Executive	
QUALITY				
	7.	Patient Story	Director of Nursing	
	8.			
ASSURANCE				
	9.	Report from the Quality Governance Committee	Committee Chair	
	10.	Report from the Finance, Investment and Performance Committee	Committee Chair	
	11.	Report from the Workforce Committee	Committee Chair	
	12.	Integrated Performance and Quality Report	Chief Operating Officer	
	13.	Board Assurance Framework and Corporate Risk Register	Director of Governance and Assurance	

Time	Agenda Item		Presented by	Enclosure
STRATEGY				
	14.			
	15.			
GOVERNANCE				
	16.			
	17.			
	18.	**Any Other Business**	Chairman	
DATE OF NEXT MEETING The next meeting will be held at time on date in the venue				
RESOLUTION – CONFIDENTIAL ISSUES: The Trust Board is invited to adopt the following: "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).				

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**27 November 2014**

Title of the Report	**Report from the Chair of Finance Investment and Performance Committee (FIP)**
Agenda item	**19**
Sponsoring Director	Mr P Zeidler, Non-Executive Director and Chair of Finance Investment and Performance Committee
Author(s) of Report	Mr P Farenden, Chairman
Purpose	For Assurance
Executive summary This report from the Chair of the Finance Investment and Performance Committee provides an update to the Trust Board on activities undertaken during the month of October	
Related strategic aim and corporate objective	Strategic Aim 3,4 and 5
Risk and assurance	Risks assessment provided within the report.
Related Board Assurance Framework entries	BAF 18-23
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (Y/**N**) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(Y/**N**)
Legal implications / regulatory requirements	Statutory and governance duties

Actions required by the Trust Board

The Board is asked to note the report.

Northampton General Hospital NHS
NHS Trust

Public Trust Board
27 November 2014

Report from the Chair of Finance, Investment and Performance Committee (FIP)

1. The Purpose of the Report

This report provides an update to the public November Trust Board from the Chair of the Finance, Investment and Performance (FIP) Committee, on activities undertaken during the month of October. This report draws the Board's attention to any issues of significance, interest and associated actions that are required and have been agreed to take forwards by the Committee.

It is intended that a summary report by the Chair of FIP Committee is presented at each Public Board meeting.

2. Financial Position (Month 6)

The Committee were advised that the current month end (M6) position was an £11.9m deficit with a projected deficit of £16.7m by year end, subject to delivery of a range of recovery actions. The Committee noted that at M6, the CIP delivery was £668k ahead of plan but there was a potential slippage of £2.6m by year end that would be addressed through the Financial Recovery Plan (FRP) process.

The Committee noted that the FRP process had been firmly embedded across all Directorates that included central actions to control expenditure through formalised vacancy and requisition control panels. The Committee requested the Director of Nursing and Midwifery to provide a detailed report in November to provide assurance that the central actions implemented will control the effective and appropriate use of agency staff. The Committee has made it clear that the Trust is required to have a robust recruitment strategy to support the reduction of the use of expensive agency staff by ensuring that any vacancies are recruited to in a more timely way and that quality of care is not compromised during the process of cost containment.

The Committee were informed that the Trust had formally reviewed and agreed the Financial Recovery Plan (FRP) and I&E position with the Trust Development Authority (TDA) Executive Team at a meeting held on 17 October 2014.

The Committee discussed the challenging cash flow position in light of the I&E position and recognised that further DH temporary borrowing would be required. A further draft application has been submitted to the TDA prior to onward submission to the (Independent Trust Financing Facility (ITFF) in November. The Committee recognised that the earliest potential 'draw down' (if approved) would be expected in December. The Committee also noted that the increased clinical risk of not replacing ageing Imaging equipment covered by the application has been highlighted as a significant risk by the Trust to the TDA.

3. Financial Recovery Plan

The Committee were provided an overview of the TDA Briefing which included the Financial Forecast and Financial Recovery Plan and also received confirmation that the formal external review on the financial position, requested by the TDA, had been completed. The external review supported that the most likely year end position (based

on known assumptions) was a deficit of £16.7m. It was recognised by the Committee that further work was required with the CCG to align forecast assumptions and formalise MRET and winter pressures funding assumptions.

The Committee noted that if the Trust received approval of the £16.7m, that it would expect an absolute guarantee that internal accountability and controls were in place to ensure that the Trust would not go beyond the £16.7m planned deficit. The Committee requested further clarity around all the control mechanisms in place in order that the Committee could assure the Board that there were robust controls in place to prevent any further deterioration in the financial position. The Committee were also informed of a series of challenging meetings with directorates led by the Chief Operating Officer and Director of Finance, to work towards agreement of revised control totals to underpin the recovery of the Trust current financial position.

The Committee discussed the robust approach being taken by the Trust for negotiating the contract for 2015/16 and supported the different approach proposed for establishing the activity baseline growth and MRET rebasing. In addition, the Committee were informed that the TDA had requested further detail on planned CIP schemes and they were planning to attend at the November Finance Committee meeting.

4. Trust Performance

The Chief Operating Officer provided the Month 6 Operational Performance Report. The Committee noted that the TDA had acknowledged the Trust consistently achieved the 18 week RTT and was one of the only Trusts nationally that achieved this.

The Committee discussed the actions being undertaken to address the areas of underperformance. It was also noted that the number of Delayed Transfers of Care (DTOCs) remained high despite twice weekly tracking meetings. An Integrated Discharge Team had been established who are accountable to the System Resilience Group (SRG), formally known as the Urgent Care Working Group. It was noted that the additional Domiciliary Care is expected to reduce the DTOC numbers towards the end of October and into November so it is anticipated to see an improvement should been seen against the 95% target over the forthcoming weeks.

The Committee were advised that the second tranche of winter funding would include redevelopment of the discharge lounge and provision of 12 dementia beds. The Committee noted that the SRG would continue to work though each of the winter funding schemes to ensure they delivered as expected. The Committee were advised by the COO that the TDA recognised the pressures of the DTOC and were assured by the actions that the Trust was undertaking.

The Committee were informed that the Cancer Management Team have been working closely with tumour site teams and service managers to implement the Cancer Action Plan, the detail of which was discussed at a recent the Board of Directors meeting.

5. Carbon Management and Sustainability Annual Report

The Committee received the annual report and were informed that the Trust had met the government target of a 10% reduction in carbon emissions by 2015 and ended the year just 2.5% above its stretch target of 25% reduction in carbon emissions. The addition of the new energy infrastructure through the Green Energy Scheme would ensure that longer term targets of a 34% reduction in emissions up to 2020.

The Committee were informed that the Trust applied for and had been selected to receive £2.7million from a Department of Health Energy Efficiency fund. The scheme would save over £500,000 in energy-related costs and 3000 tonnes of carbon each year. The

biomass boiler, new Combined Heat and Power plant and economiser fitted to one of the remaining steam boilers would start to produce savings through 2014/2015. In addition to this the Trust received £370,000 in Salix funding in order to continue the upgrade of insulation, lighting and building controls. This would continue into the next year with a further £121,000 loan already agreed.

Finally, the Committee were advised that the Trust would be working towards 'Investors in the Environment' Accreditation to gain external verification and recognition of the Trust's environmental improvements.

On behalf of the Board, the Committee extended their thanks and appreciation to the Director of Facilities and his team for all of their commitment and hard work to ensure that the Trust met and exceeded its obligations in the reduction of carbon emissions and promoting a greener environment.

6. Recommendation to the Board
The Board is asked to note the report

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**27 November 2014**

Title of the Report	**Report from the Chair of Quality Governance Committee**
Agenda item	**20**
Sponsoring Director	Mrs L Searle, Non-Executive Director and Chair of Quality Governance Committee
Author(s) of Report	Mrs L Searle, Non-Executive Director and Chair of Quality Governance Committee
Purpose	For Assurance
Executive summary This report from the Chair of the Quality Governance Committee (QGC) provides an update to the Trust Board on activities undertaken during the month of October	
Related strategic aim and corporate objective	Strategic Aim 3,4 and 5
Risk and assurance	Risks assessment provided within the report.
Related Board Assurance Framework entries	BAF 18-23
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (Y/**N**) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(Y/**N**)
Legal implications / regulatory requirements	Statutory and governance duties

Enclosure P

Actions required by the Trust Board

The Board is asked to note the report.

Public Trust Board
27 November 20914

Report from the Chair of Quality Governance Committee (QGC)

1. Purpose

This report provides an update to the Trust Board on activities undertaken during the month of October and discussed at the QGC meeting held on 24 October 2014. This report draws the Board's attention to any issues of significance, interest and associated actions that are required and have been agreed to take forwards by the Committee.

It is intended that a summary report by the Chair of QGC is presented at each Public Board meeting.

2. Patient Safety, Clinical and Quality

2.1 The Committee were advised that the Quality Impact Assessment (QIA) policy had been updated and was now in the process of being ratified. The Committee were assured that the group involved in the Improving Quality and Efficiency (IQE) process focussed on developing measures that were true indicators of the impact on patient quality and care before approving schemes, rather than a focus on the financial consequence.

In addition, the Committee were advised of two schemes implemented:

- nurse delivered intraocular injections for Medical Retina Disease
- reduced length of stay due to enhanced recovery for elective caesarean section

2.2 The Director of Nursing and Midwifery presented a nursing and midwifery comprehensive report. The Committee were not assured on the following areas and asked for a further detail at the next meeting:

- **QuEST**. - The N&M Dashboard (QuEST) had showed some improvement from the previous month and that where there were action plans in place to improve some clinical areas these were being progressed.

- **Staffing** – The Committee was informed that the majority of wards (bar four) had met the threshold of 80% for staffing levels. It was noted that there had been short term sickness that was not covered by bank or agency staff therefore requiring internal moves of staff to maintain safe staffing levels.

  The Committee expressed great concern in staffing levels and whilst (in the main) staffing reached the 80% threshold, the impact on patient care and the increased burden on remaining staff could not be overestimated. The Committee asked if the Trust had enough nurses to ensure that a safe service was being provided. Dr Swart responded that a recruitment strategy was needed to support both recruitment and greater retention of staff locally

The Committee requested further information to provide assurance that there were sustainable staffing levels to ensure delivery of safe services and requested the Director of Nursing to forward the Committee's appreciation for all the hard work undertaken by the nurses at the hospital.

- **Pressure Ulcers** – The Committee were informed that there had been a 25% decrease from the previous month of hospital acquired pressure ulcers and did acknowledge that this was significant improvement. The Local CQUIN includes implementation and compliance of the SSKIN bundle to support the reduction in hospital acquired pressure ulcers and at the end of Quarter 1 the CCG reported the Trust was on target to achieve this.

2.3 The Committee were updated with the very positive results following a recent survey that asked patients about their pain, and how this was managed. The feedback received was that 98% patients felt that their pain was well managed. This feedback triangulates directly with a noticeable decline in complaint letters to the CEO on this particular topic.

2.4 The Medical Director presented his detailed report to the Committee. It was reported that there had been a sustained improvement in the HSMR at 89.7% and the SHMI was anticipated to remain within the expected range.

The Committee was informed that ten serious incidents were reported in September and one required further review in respect to its classification. The eight serious incidents submitted for closure within the agreed timescale have resulted in action and learning to cover the areas of documentation, clinical assessment, communication, training and education and escalation of care. Action plans to ensure that learning takes place have been developed and are tracked for their delivery.

2.5 The Committee were updated in respect to actions undertaken following the Saville Enquiry Assurance Report. In August 2014, the TDA Chief Executive wrote to all NHS Trust Chief Executives urging a critical review of existing safeguarding arrangements; with a view to strengthening those where necessary.

The Committee can provide assurance to the Board that following the Saville Report a review has been undertaken within the Trust and that that detail was presented to the Committee. The Committee can confirm that the Trust has adopted the recommendations and to confirm that the Trust has systems and processes in place to reduce the likelihood of events detailed within the Saville enquiry reports.

3. Compliance and Performance

3.1 CQC Action Plan

The Committee were given an update by the Deputy Director of Quality and Governance on current progress on collating the evidence for both the High Level Action Plan and the Compliance Action Plan added to both to ensure the availability of up to date information for the CQC. The CQC made an unscheduled visit in September and made a number of largely favourable comments. The full report is awaited.

The Committee was advised that some deadlines set internally for completion had been missed - however the Committee were assured that the deadline of March 2015 would be met. The minor gaps and concerns in the collation of evidence for the Compliance Action Plan in relation to the quality report in the following areas:

- **Section 1 - Patient Flow**
  Achievement of the 4 hour target and patient moves, particularly around capturing patient experience
- **Section 2 – Urgent Care**
  Review of the triage process to ensure children attending A & E are appropriately prioritised. This is expected to be completed by December 2014
- **Section 5 – Governance**
  Delays in initiating action plans following complaints. As reported to the Committee the previous month, the pathway would not be implemented until December 2014
- **Section 6 – End of Life**
  The reviewed End of Life Trust policy was due to be submitted to the Procedural Document Group in October and is expected to be uploaded onto the Trust Intranet by November 2014
- **Section 8 – Record Keeping / Management**
  Delays in the availability of medical records was being addressed and actions were expected to be completed by December 2014

3.2 CQC Updates

The Deputy Director of Quality and Governance informed the Committee that the CQC had just published their new NHS Acute Hospitals Provider Handbook (September 2014) The Governance Team were currently reviewing the revised guidance that would follow the Key Lines of Enquiry (KLOE) approach to establish how to implement the new guidance to be in place from April 2015.

Finally, the Committee were informed that the CQC were seeking changes to the Health & Social Care Act to implement a legal duty of Candour, to come into effect this month. In addition, the Trust is developing a process to support the implementation of the 'Fit & Proper Persons' checks for Directors of the Board. This will become an established part of the recruitment process and is planned to be in place from December 2014.

4. Corporate Scorecard

The Medical Director presented the scorecard and the Committee were assured on most items. The Committee requested further information to be able to be fully assured on the performance in the following areas;

- Fractured Neck of Femur (time to surgery) and the planned audit
- Pressure Ulcers – it was noted by the Committee that progress was being made and members were keen to see the recent improvement maintained.

5. Governance

5.1 The Committee received and noted:

- Research and Development Annual report
- Highlight report from CQEG received.

5.2 The Committee were presented with the draft Terms of Reference for 3 sub reporting groups - CQEG, Assurance, Compliance & Risk and Patient & Carer Experience and Engagement Groups which were discussed and commented on. However it was agreed that further work on these was required in terms of the reporting groups under the Committee for approval at the November meeting.

6. Recommendations

The Board is asked to note the report.

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**27 November 2014**

Title of the Report	**TDA Self-Certification**
Agenda item	**21**
Sponsoring Director	Chris Pallot, Director of Strategy and Partnerships
Author(s) of Report	Karen Spellman, Deputy Director of Strategy and Partnerships
Purpose	Decision

Executive summary

At the beginning of April 2013, the NHS Trust Development Authority (TDA) published a single set of systems, policies and processes governing all aspects of its interactions with NHS trusts in the form of 'Delivering High Quality Care for Patients: The Accountability Framework for NHS Trust Boards'.

In accordance with the Accountability Framework, the Trust is required to complete two self-certifications in relation to the Foundation Trust application process. Draft copies of these are attached as Appendix 1 and 2 for discussion and approval.

Related strategic aim and corporate objective	All
Risk and assurance	Compliance with performance targets and financial statutory duties
Related Board Assurance Framework entries	BAF 19-25
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	Meeting financial statutory duties

Enclosure Q

Actions required by the Trust Board

The Trust Board is asked to:

- approve the Monitor Licensing Requirements and Trust Board Statements self-certifications for October 2014 at Appendix 1 and Appendix 2

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Compliance Monitor

Monthly Data.

CONTACT INFORMATION:

Enter Your Name: Dr Sonia Swart

Enter Your Email Address: sonia.swart@ngh.nhs.uk

Full Telephone Number: 01604544206 Tel Extension:

SELF-CERTIFICATION DETAILS:

Select Your Trust: Northampton General Hospital NHS Trust

Submission Date: 30/11/2014 Reporting Year: 2014/15

Select the Month

- ○ April
- ○ May
- ○ June
- ○ July
- ○ August
- ○ September
- ○ October
- ○ November
- ○ December
- ○ January
- ○ February
- ○ March

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

1. **Condition G4** – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions).

2. **Condition G7** – Registration with the Care Quality Commission.

3. **Condition G8** – Patient eligibility and selection criteria.

4. **Condition P1** – Recording of information.

5. **Condition P2** – Provision of information.

6. **Condition P3** – Assurance report on submissions to Monitor.

7. **Condition P4** – Compliance with the National Tariff.

8. **Condition P5** – Constructive engagement concerning local tariff modifications.

9. **Condition C1** – The right of patients to make choices.

10. **Condition C2** – Competition oversight.

11. **Condition IC1** – Provision of integrated care.

Further guidance can be found in Monitor's response to the statutory consultation on the new NHS provider licence: The new NHS Provider Licence

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COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

		Comment where non-compliant or at risk of non-compliance
1. Condition G4 Fit and proper persons as Governors and Directors.	Yes	
		Timescale for compliance:
2. Condition G7 Registration with the Care Quality Commission.	Yes	
		Timescale for compliance:
3. Condition G8 Patient eligibility and selection criteria.	Yes	
		Timescale for compliance:

		Comment where non-compliant or at risk of non-compliance
4. Condition P1 Recording of information.	Yes	
		Timescale for compliance:

5. Condition P2
Provision of information.

Yes

Timescale for compliance:

6. Condition P3
Assurance report on submissions to Monitor.

Yes

Timescale for compliance:

7. Condition P4
Compliance with the National Tariff.

Yes

Timescale for compliance:

Comment where non-compliant or at risk of non-compliance

8. Condition P5
Constructive engagement concerning local tariff modifications.

Yes

Timescale for compliance:

9. Condition C1
The right of patients to make choices.

Yes

Timescale for compliance:

10. Condition C2
Competition oversight.

Yes

Timescale for compliance:

11. Condition IC1
Provision of integrated care.

Yes

Timescale for compliance:

Submit

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Board Statements

Monthly Data.

CONTACT INFORMATION:

Enter Your Name: Dr Sonia Swart

Enter Your Email Address: sonia.swart@ngh.nhs.uk

Full Telephone Number: 01604544206 Tel Extension:

SELF-CERTIFICATION DETAILS:

Select Your Trust: Northampton General Hospital NHS Trust

Submission Date: 30/11/2014 Reporting Year: 2014/15

Select the Month

- April
- May
- June
- July
- August
- September
- October
- November
- December
- January
- February
- March

BOARD STATEMENTS:

CLINICAL QUALITY
FINANCE
GOVERNANCE

The NHS TDA's role is to ensure, on behalf of the Secretary of State, that aspirant FTs are ready to proceed for assessment by Monitor. As such, the processes outlined here replace those previously undertaken by both SHAs and the Department of Health.

In line with the recommendations of the Mid Staffordshire Public Inquiry, the achievement of FT status will only be possible for NHS Trusts that are delivering the key fundamentals of clinical quality, good patient experience, and national and local standards and targets, within the available financial envelope.

BOARD STATEMENTS:

For CLINICAL QUALITY, that

1. The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight (supported by Care Quality

Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.

1. CLINICAL QUALITY Indicate compliance.	Yes
Timescale for compliance:	
RESPONSE:	
Comment where non-compliant or at risk of non-compliance	

BOARD STATEMENTS:

For CLINICAL QUALITY, that

2. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.

2. CLINICAL QUALITY
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For CLINICAL QUALITY, that

3. The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.

3. CLINICAL QUALITY
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For FINANCE, that

4. The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.

4. FINANCE
Indicate compliance.

Risk

Timescale for compliance:

31/03/2015

RESPONSE:

Comment where non-compliant or at risk of non-compliance

The outline financial plan for 2014-15 is highlighting a significant financial gap.

BOARD STATEMENTS:

For GOVERNANCE, that

5. The board will ensure that the trust remains at all times compliant with has regard to the NHS Constitution.

5. GOVERNANCE
Indicate compliance.

No

Timescale for compliance:

30/11/2014

RESPONSE:

Comment where non-compliant or at risk of non-compliance

The Trust is not meeting its national performance targets. See statement 10 for further details.

BOARD STATEMENTS:

For GOVERNANCE, that

6. All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate.

6. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

7. The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of it occurring and the plans.

7. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

8. The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.

8. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

9. An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).

9. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

10. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the relevant TDA quality and governance indicators; and a commitment to comply with all known targets going forwards.

10. GOVERNANCE
Indicate compliance.

Risk

Timescale for compliance:

30/11/2014

RESPONSE:

Comment where non-compliant or at risk of non-compliance

The Trust is failing or is at risk of failing the following targets:
- A&E 4 hour transit time
- Cancer 62 Day Wait and 2ww standards

Progress against the agreed Improvement Plan for Urgent Care and Cancer is progressing and is reviewed in detail at the Trust Finance Committee. There is an existing risk relating to the recruitment of appropriately skilled medical and nursing staff and a risk regarding the steep rise in attendances at A&E and subsequent admissions and delayed transfers of care in the current year. At present, the Board has insufficient assurance that there are adequate mechanisms in place to reduce or divert demand.

BOARD STATEMENTS:

For GOVERNANCE, that

11. The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.

11. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

12. The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.

12. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

13. The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.

13. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

14. The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.

14. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

Submit

Northampton General Hospital NHS
NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 27 November 2014
09:30 in the Board Room at Northampton General Hospital

Time		Agenda Item	Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2.	Declarations of Interest	Note	Mr P Farenden	**Verbal**
	3.	Minutes of meeting 25 September 2014	Decision	Mr P Farenden	**A.**
	4.	Matters Arising and Action Log	Note	Mr P Farenden	**B.**
	5.	Patient Story	Receive	Dr S Swart	**Verbal**
	6.	Chairman's Report	Receive	Mr P Farenden	**Verbal**
	7.	Chief Executive's Report	Receive	Dr S Swart	**C.**
10:00	**CLINICAL QUALITY AND SAFETY**				
	8.	Sign up to Safety	Decision	Mrs J Bradley	**D.**
	9.	Nurse Staffing Report	Assurance	Mrs J Bradley	**E.**
	10.	Director of Nursing and Midwifery Report	Assurance	Mrs J Bradley	**F.**
	11.	Medical Director's Report	Assurance	Dr M Cusack	**G.**
10:40	**OPERATIONAL ASSURANCE**				
	12.	Integrated Performance Report and Corporate Scorecard	Assurance	Mrs D Needham	**H.**
	13.	Finance Report	Assurance	Mr S Lazarus	**I.**
	14.	Workforce Report	Assurance	Mrs J Brennan	**J.**
11:15	**ANNUAL REPORTS**				
	15.	Fire Safety Annual Report	Assurance	Mr C Abolins	**K.**
	16.	Complaints Annual Report	Assurance	Mrs J Bradley	**L.**
	17.	Emergency Preparedness Annual Report	Assurance	Mrs D Needham	**M.**
11:45	**GOVERNANCE**				
	18.	Revised Terms of Reference for: • Audit Committee • Quality Governance Committee • Finance Investment and Performance Committee • Remuneration Committee • Trust Board	Decision	Mr P Farenden	**N.**

Time		Agenda Item	Action	Presented by	Enclosure
	19.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler	**O.**
	20.	Highlight Report from Quality Governance Committee	Assurance	Mrs L Searle	**P.**
	21.	TDA Self-Certification	Decision	Mr C Pallot	**Q.**
12:00	**22.**	**ANY OTHER BUSINESS**		Mr P Farenden	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Trust Board will be held at 09:30 on Thursday 29 January 2015 in the Board Room at Northampton General Hospital

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

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

The Themes for discussion in the closed agenda are: Contractual matters and Clinical Strategy