Northampton General Hospital NHS
NHS Trust

Public Trust Board

Thursday 30 July 2015

10:00

Board Room
Northampton General Hospital

Northampton General Hospital NHS
NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 30 July 2015 at 10:00 in the Board Room at Northampton General Hospital

Time		Agenda Item	Action	Presented by	Enclosure
10:00	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2.	Declarations of Interest	Note	Mr P Farenden	**Verbal**
	3.	Minutes of meeting 28 May 2015	Decision	Mr P Farenden	**A.**
	4.	Matters Arising and Action Log	Note	Mr P Farenden	**B.**
	5.	Patient Story	Receive	Executive Director	**Verbal**
	6.	Chairman's Report	Receive	Mr P Farenden	**Verbal**
	7.	Chief Executive's Report	Receive	Dr S Swart	**C.**
10:20	**CLINICAL QUALITY AND SAFETY**				
	8.	Medical Director's Report	Assurance	Dr M Cusack	**D.**
	9.	Director of Nursing and Midwifery Report	Assurance	Ms C Fox	**E.**
10:45	**OPERATIONAL ASSURANCE**				
	10.	Update on progress with Changing Care@NGH Programme	Assurance	Mr S Lazarus	**F.**
	11.	Finance Report	Assurance	Mr S Lazarus	**G.**
	12.	Workforce Performance Report	Assurance	Mrs J Brennan	**H.**
	13.	Integrated Performance Report	Assurance	Mrs D Needham	**I.**
11:25	**GOVERNANCE**				
	14.	Fire Safety Board Compliance Statement	Assurance	Mr C Abolins	**J.**
	15.	Declaration of Compliance against Mixed Sex Accommodation	Assurance	Ms C Fox	**K.**
	16.	Freedom to Speak Up Report	Assurance	Mrs J Brennan	**To follow L.**
	17.	TDA Self-Certifications	Decision	Ms C Thorne	**M.**
12:00	**STRATEGY**				
	18.	Update on Healthier Northamptonshire and Vanguard Models	Assurance	Mr C Pallot	**N.**

Time		Agenda Item	Action	Presented by	Enclosure
12:15	**COMMITTEE REPORTS**				
	19.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Farenden	**O.**
	20.	Highlight Report from Quality Governance Committee	Assurance	Mrs L Searle	**P.**
	21.	Highlight Report from Workforce Committee	Assurance	Mr G Kershaw	**Q.**
	22.	Highlight Report from Hospital Management Team	Assurance	Mrs D Needham	**R.**
12:35	**23.**	**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 24 September 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).

Northampton General Hospital NHS
NHS Trust

Minutes of the Public Trust Board

Thursday 28 May 2015 at 09:30 in the Board Room at Northampton General Hospital

Present		
	Mr P Farenden	Chairman (Chair)
	Dr M Cusack	Medical Director
	Mr S Lazarus	Director of Finance
	Mrs D Needham	Chief Operating Officer
	Mr D Noble	Non-Executive Director
	Mr N Robertson	Non-Executive Director
	Mrs L Searle	Non-Executive Director
	Dr S Swart	Chief Executive Officer
	Mr P Zeidler	Non-Executive Director (Vice Chair)
In Attendance		
	Mr C Abolins	Director of Facilities and Capital Development
	Mrs F Barnes	Deputy Director of Nursing
	Mrs J Brennan	Director of Workforce and Transformation
	Mrs S McKenzie	Executive Board Secretary
	Mr T Oakes	Learning Disability Project Worker (Agenda item 5)
	Mr M Oram	GS1 Programme Manager (Agenda item 17)
	Mr C Pallot	Director of Strategy and Partnerships
	Mr A Rivans	Head of Procurement (Agenda item 17)
	Ms C Thorne	Director of Corporate Development Governance & Assurance
	Mrs S Watts	Head of Communications
	Mrs D Wigley	Learning Disability Liaison Nurse(Agenda item 5)
Apologies		
	Mrs R Corser	Interim Director of Nursing, Midwifery & Patient Services
	Mr G Kershaw	Non-Executive Director

TB 15/16 001 Introductions and Apologies

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

Apologies for absence were recorded from Mrs Corser and Mr Kershaw.

TB 15/16 002 Declarations of Interest

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

TB 15/16 003 Minutes of the meeting 26 March 2015

The minutes of the Trust Board meeting held on 26 March 2015 were presented for approval.

The Board resolved to **APPROVE** the minutes of the 26 March 2015 as a true and accurate record of proceedings.

TB 15/16 004 Matters Arising and Action Log 26 March 2015

The Matters Arising and Action Log from the 26 March 2015 were considered.

The Board **NOTED** the Action Log and Matters Arising from the 26 March 2015.

Further actions were noted and would be added to the log and circulated.

Action: Mrs McKenzie

TB 15/16 005 Patient Story

Dr Swart introduced and welcomed Mrs Wigley and Mr Oakes to the Trust Board meeting and she informed the Board that it had been a number of years since a report had come to the Trust Board regarding learning disabilities.

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Mrs Wigley reported that evidence had shown health inequalities for people with a learning disability leading to sub optimal care and even premature deaths. In 2011 the Trust had a serious incident regarding a lady with learning disabilities. Following this incident the Trust had done a lot of work to improve the care of patients with a learning disability including appointing a full time Learning Disability Liaison Nurse, introducing a programme of learning disability awareness training, development of easy read leaflets and embedded use of the Hospital Passport. Most recently employing Tom Oakes, for one day a week as a support worker who helps patients with learning disability and hospital staff to better understand each other.

Mrs Wigley related a story about a patient who had autism, severe learning disabilities, challenging behaviour and complex needs. She informed the Board how the patient's treatment involved a lot of planning and co-ordination with all the various teams involved, including the patient's mother. Mrs Wigley concluded that this patient story demonstrated the significant improvements had been made to care for patients with a learning disability, even with some of the most challenging and complex needs. Key to the success was listening to the expertise of the patient's mother, involving her with all the planning and collaboration from all professionals involved. Mrs Wigley commented that improvement of hospital experience and enhancing health outcomes for individuals was paramount. The Board were informed that a letter of thanks had been received from the patient's mother especially noting that all staff involved listened and took notice even of the smallest of details.

Mr Farenden on behalf of the Board thanked Mrs Wigley and Mr Oakes for attending.

The Board **NOTED** the Patient Story.

TB 15/16 006 **Chairman's Report**

Mr Farenden presented the Chairman's Report.

Mr Farenden informed the Board that along with his continued involvement with 'Beat the Bug' and visits to A&E he had attended a Trust Development Authority (TDA) planning meeting with Executive colleagues and thereafter had a 1:1 with Jeff Worall from the TDA on shared perspectives on the hospital. He reported that he spent an hour off site with a complainant whose husband had died and that he was able to provide assurance that lessons had been learnt and actions put in place. He reported that he had a 1:1 with Darin Seiger, Chair of Nene Clinical Commissioning Group (CCG) expressing concerns on the lack of action in the health economy in relation to delayed discharges.

Mr Farenden reported that he had attended a chairs meeting of Northamptonshire Healthcare Foundation Trust (NHfT) and Kettering General Hospital (KGH) where a discussion was had around concerns regarding capacity planning and investment to address Delayed Transfers of Care (DTOCs). He commented that the Trust needed to continue to challenge to move this issue forward.

Lastly Mr Farenden commented on Dr Swart's blog this week which gave very powerful and strong messages concerning issues faced by the Trust and how they were being addressed. He noted that it was very timely and well-focused.

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

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TB 15/16 007 **Chief Executive's Report**

Dr Swart presented the Chief Executive's Report.

Dr Swart reported that following the Care Quality Commission (CQC) inspection in January 2014 the warning notice that had been issued by the CQC at that time had now been formally lifted. The Trust had acted quickly to resolve all issues raised in the notice and that there had been a superb response from clinical and managerial staff to ensure effective action plans were prepared and implemented without delay. The Board received monthly updates and the Trust had oversight meetings from the TDA and Nene CCG and others, and it was clear that all the matters raised had been addressed. Unfortunately there had been a delay in receiving the report and, after numerous contacts with the CQC, Dr Swart wrote formally to Professor Sir Mike Richards in early April to ask for a response. Subsequently the Trust received a letter from him with an apology for the delay, a letter withdrawing the warning notice and the report from the September visit. The report also referred to the improved leadership and governance. As soon as it had been finalised Board members, staff and the wider community would be made aware and it would be available for everyone to read.

Dr Swart reported that towards the end of April the TDA came to look at the Trust's infection control processes and noted some areas where improvement was needed. There were some practical issues around cleaning standards, some governance issues around policies and reporting, and some ownership issues in terms of involvement in Root Cause Analysis (RCA). The TDA would be coming back in two months to monitor progress.

Over recent months the Trust had been involved in a number of discussions with the TDA and Commissioners which had covered performance against various targets. The Trust was requested to deliver improved performance against the cancer target and the urgent care target and also improvement on the financial position by becoming more efficient internally. Currently discussions were still taking place about these matters and also with partners in the health economy about the DTOCs that put so much pressure on the Trust clinically, operationally and financially.

Dr Swart reported that a contract had been agreed with the Commissioners and plans for the coming year had been submitted to the TDA. If the Trust delivered all the quality and efficiency improvements and activity continued at present levels, the deficit would be £21.2 million 2015/16. The TDA would monitor the Trust very carefully on the way finances were managed during the year.

The Board were informed that the Changing Care @ NGH programme was now underway and specific communications would be sent out to staff to explain this clinically led and managerially supported programme of work. The Board noted that the programme was essential for the Trust. The Healthier Northamptonshire programme had not delivered change as quickly as it should and the Regulators (TDA, Monitor and NHS England) had met with all the Chief Executive Officers to give them a challenge to improve this rapidly. Numerous meetings had taken place about this in the last couple of weeks and also numerous meetings about the failure to resolve the issue of DTOCs.

Dr Swart reminded the Board members about the Trust's Best Possible Care Awards event which would take place on 18 September 2015 and that it provided an ideal opportunity for the Trust to recognise, reward and celebrate what staff had achieved by going above and beyond what might normally be expected of them in their various roles.

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Lastly, following the General Election Dr Swart informed the Board that she wrote an open letter to David Cameron that was also sent out via Twitter and to all Trust staff. In the letter she set out in very simple terms her view of what was needed at Northampton General Hospital (NGH) and in essence, a key part of her message to him was that NGH and the wider NHS needed stabilisation and transformation, but this needed to be planned and resourced. This was a view that resonated with many NHS staff and also with the many people who have had the opportunity to view and comment via social media**.** Mr Robertson asked whether the Board should formally endorse the tweet and the members agreed to do so.

Mrs Searle commented that not all Chief Executives of NHS Trusts come from a medical background and that she felt it was a very powerful message that Dr Swart had advocated.

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

TB 15/16 008 Approval of Annual Report and Annual Accounts 2014/15

Mr Lazarus presented the Annual Report and Annual Accounts 2014/15.

Mr Lazarus reported that the annual report and annual accounts 2014/15 were presented at the extra-ordinary Audit Committee which had taken place earlier in the morning and the Committee had recommended approval to the Trust Board. It was therefore proposed that the documents would be signed off by the Deputy Chief Executive and the Director of Finance early next week and submitted to the Department of Health (DH) by KPMG by 5 June 2015.

Mr Lazarus also presented the Draft Management Representation Letter to the Turst Board, which was formally approved.

The Board **APPROVED** the Annual Report and Annual Accounts 2014/15 and the Draft Management Representation Letter.

TB 15/16 009 Medical Director's Report

Dr Cusack presented the Medical Director's Report.

Dr Cusack reported that the Medical Director's report had been discussed in detail at the May Quality Governance Committee. He advised that the principal risks to clinical care currently related to the on-going pressure on the urgent care pathway with its impact on the escalation areas and insufficient nursing and medical staff. These risks were reflected in the Corporate Risk Register and the Board Assurance Framework.

Dr Cusack reported that since the last report to the Board (during the reporting period 1/01/2015 – 28/02/2015) seven new Serious Incidents had been reported. A RCA had been undertaken into each of these incidents. The Trust had a contractual agreement with the CCG to submit all RCA reports to them within a 45 day timeframe for incidents reported 2014/15 or 60 day timeframe for incidents reported 2015/16.

The Board noted that no new data had been released by Dr Foster this month. The January and February data was expected to be released together at the end of May. Unconfirmed data might be available earlier which suggested that despite the increasing number of deaths in January the Hospital Standardised Mortality Ratio (HSMR) had not risen further.

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The data for Q2 2014-2015 showed a further improvement in performance. Standard Hospital Mortality Indicator (SHMI) for the year to September 2014 was 99 and the lowest to date. Q2 was 93 also lowest to date. Analysis of the SHMI performance for this period had shown outstanding good performance in stroke and peripheral vascular disease.

Dr Cusack reported that there had been an increase in mortality nationally during the autumn and winter months. The unadjusted number of deaths following admission rose in the months following October 2014. This peaked in February and had since fallen, the downward trajectory had continued in April and May. Mortality Review 6 would commence shortly and would review 50 deaths which occurred in January 2015. This review would focus on readmissions, 35 consecutive patients following a readmission within 30 days, and deaths in A&E, 15 consecutive patients. He confirmed that future reports would contain an update on the 'Sign up to Safety' campaign.

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

TB 15/16 010 Director of Nursing and Midwifery Care Report

Mrs Barnes presented the Director of Nursing and Midwifery Report.

Mrs Barnes provided an update and progress report on a number of clinical projects and improvement strategies that the Nursing and Midwifery senior team worked on during the month of April. She informed the Board that the Nursing and Midwifery Care report had been discussed in detail at the May Quality Governance Committee.

She confirmed that the Nursing and Midwifery Quality Dashboard aggregated compliance was 86% for April which was a slight decrease from March (89%). This was caveated by the fact that some data which added to the overall percentage was currently absent. Mrs Searle commented that the RAG rating for the Dashboard had been discussed at the Quality Governance Committee and that further work was needed.

Mrs Barnes informed the Board that in April there was a slight decrease in the number of reported pressure ulcers compared to March; there were a total of 24 grade 2 pressure ulcers and six grade 3 pressure ulcers, with a further three under review. There had been one C. Difficile case reported in April and no cases reported of MRSA bacteraemia.

The Board noted that with regard to Hard Truths, April saw an increase in planned hours versus actual hours due to the budgetary uplift in the nursing establishments in line with the third year of the nurse staffing strategy. Bank and agency usage and demand decreased in April 2015. Fill rate during the day continued to remain lower than at night and this would be addressed by the pending consultation to standardise shift patterns alongside a review of the flexible working arrangements which had been delayed and would commence in June 2015.

The TDA visited the Trust in April 2015 to review the Trust's adherence to the Hygiene Code. An improvement action plan had been produced by the Multi-Disciplinary Team (MDT) and progress reviewed at bi-weekly meetings. The TDA were visiting the Trust again on 17 June 2015.

Mrs Barnes commented that wards and clinicians often found it difficult to identify patients who were in the last few days of life. The Trust implemented the Dying Persons Care Plan in July 2014 which provided a framework for the provision of individualised care in the last few days/hours of life and approximately 30% of patients who were recorded as expected deaths had a Personalised Care Plan/End of Life plan in place.

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Mrs Barnes highlighted to the Board that the difficulty of overseas nurses' integration into ward teams had been identified. Mrs Brennan confirmed that work was underway to address this and that a workshop would be set up with Ward Sisters to understand the potential barriers to true integration and support Ward Managers in engaging with their new staff from day one. Mrs Brennan informed the Board that the nurse recruitment was behind target and that a disappointing trip to Italy and Romania had produced 14 nurses one of which was a paediatric nurse. Mrs Brennan commented that recruitment was taking place in the Philippines and India next month however questioned whether the Trust should now recruit additional staff from the Philippines to cover the European shortages. Dr Swart commented that the figures needed to be reviewed but that it was important to have nurses with good communication skills. After discussion the Board agreed that Mrs Brennan would bring a proposal to the Executive Team who would action as a matter of urgency.

Action: Executive Team

The Board **NOTED** the Director of Nursing and Midwifery Report.

TB 15/16 011 Kate Lampard Lessons Learned Report: Progress Update

Mrs Barnes presented the Kate Lampard Lessons Learned Report: Progress Update.

Mrs Barnes provided the Board with a position summary in relation to the recommendations made by Kate Lampard in her final report into the Savile enquiries. A progress report which would be submitted to the TDA was also included. She reported that the Trust could be satisfied that there was significant assurance available to the Board in relation to the various themes identified by the Lampard report. The Trust had previously responded proactively and positively to the various interim reports. The Board noted that where there were gaps in positive assurance, work remained ongoing and Mrs Barnes provided assurance to the Board that there were robust implementation plans in place to achieve the necessary actions in a timely manner.

The Board noted that the final report provided nine recommendations directly to NHS Trusts. Additional recommendations existed for the Department of Health and NHS England. The report recommendations, detailed in full, were contained in the progress report and in summary, the recommendations focused on:

- Access and influence
- Governance
- Safeguarding arrangements
- Safer recruitment
- Volunteers and volunteering

Ms Thorne commented that she would liaise with the CQC regarding checks in place for inspectors on site. **Action: Ms Thorne**

Ms Thorne suggested that it would be prudent to include Healthwatch given the access they have to patients and this could be undertaken through the patient experience and safeguarding teams. With regard to the Shadow Governors they would be managed in line with the requirements for all volunteers. Dr Swart commented that there was still quite a lot of work to be done and that a reciprocal process was needed to be put in place for members of voluntary sectors who work in the Trust.

Mrs Searle enquired if the completion date against the two amber items on the action plan were the original completion dates. Mrs Barnes responded that she would find out and follow up after the meeting. **Action: Mrs Barnes**

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Mr Farenden commented on behalf of the Board that assurance was received and that a robust implementation plan was in place.

The Board **NOTED** the Kate Lampard Lessons Learned Report: Progress Update.

TB 15/16 012 Finance Report

Mr Lazarus presented the Finance Report.

Mr Lazarus reported that the Finance Report had been discussed in detail at the May Finance Investment and Performance Committee meeting and that the Trust had made a reasonable start to the new financial year and was currently £0.4m favourable to plan. He commented that the Cost Improvement Programme (CIP) delivery was below planned levels indicating a need to review Divisional CIP plans and performance. Mr Lazarus highlighted the importance of the Changing Care @ NGH programme. Mrs Needham commented that the programme was key and a challenge and the Divisions were starting to be more integrated into the programme.

The Board **NOTED** the Finance Report.

TB 15/16 013 Workforce Performance Report

Mrs Brennan presented the Workforce Performance Report.

Mrs Brennan reported that the Workforce Performance Report had been discussed in detail at the May Workforce Committee meeting and that the report identified the key themes emerging from April 2015 performance and trends against the Trust's targets.

She commented that the substantive workforce capacity decreased by 27.78 FTE in April 2015 to 4115.27 FTE. The Trust's substantive workforce was at 88.68% of the Budgeted Workforce Establishment of 4640.62FTE. However there was an increase in the establishment for trained nurses from 1417FTE in March to 1519FTE in April, as these vacancies were not able to be filled as a result of the nurse recruitment difficulties. The vacancy rate within Registered Nursing & Midwifery, overall, had increased to 18.08% as a result of additional investment in the new financial year.

She reported that information from the Health and Social Care Information centre showed that sickness trends for the period October 2014 to December 2014 increased compared to the same period the previous year showing the average sickness rate for that period was 4.56% rising from 4.25%. The Trust's average for that period was 4.80%. This demonstrated a rising trend nationally across the NHS moving from 3.9% in May 2014 to 4.8% in December 2014. Acute Trusts saw a similar rise from 4% to 4.9%. The Trust's in month rate in May 2014 was 4.06% which rose to 4.88% in December.

The Board noted that the Appraisal compliance rate reduced to 70.22% and noted work was ongoing to support all areas to ensure that staff appraisals were carried out at the appropriate time and notified as per the process. Mandatory Training compliance decreased slightly in April to 80.14%. Role Specific Essential Training compliance increased slightly in April to 68.12%. Mrs Brennan commented that an analysis of areas and occupational areas to ascertain where the gaps were had not been concluded. Mrs Brennan confirmed to Mr Farenden that results of the analysis would be presented to the Workforce Committee.

Mrs Brennan informed the Board that a total of 394 members of staff returned the Staff Survey, constituting a 47% response rate. Of the 29 key findings, relevant to acute sector, this year there had been an improvement in 17 of the key findings, 6 deteriorated, four had stayed the same and two could not be compared.

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She advised that the appendix attached to her report set out in detail the key findings together with the progress underway through the Organisational Effectiveness Strategy which was designed to address the underlying cultural and organisational issues that influenced staff perceptions about the Trust, their work environment and their role. Dr Swart commented that the Francis Crick programme was part of moving to a clinically led structure.

The Board **NOTED** the Workforce Performance Report.

TB 15/16 014 **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 the recent May Finance Investment and Performance Committee, Quality Governance Committee and Workforce Committee meetings.

Mrs Needham commented that it was looking likely that 94% would be achieved in May and that staff had worked phenomenally hard, however the main challenge was DTOCs and as at today the figure was 92. She commented that the system capacity and demand model should be ready in the next few weeks and that 6 Scheme were being worked up between NHfT, the CCG and the Trust to reduce DTOCs. Mr Farenden enquired which organisation was leading on the model and Mrs Needham confirmed that NHfT were the lead, however all organisations had contributed. Mr Farenden enquired when it could be expected that the Trust would be back on track and Mrs Needham responded that the last two weeks had been positive and the acuity had decreased. The target would only be sustained if DTOCs reduced to less than 18.

Mr Farenden commented that 94% with 92 DTOCs was a commendable achievement. Dr Swart commented that given the degree of demand and the issue with DTOCs the Trust continued to do very well. Mrs Needham commented that with regard to the performance data the Trust was in the top quartile and Dr Swart advised that if the figure reduced to 40 the Trust would hit target.

Dr Cusack advised that Stroke patients spending 90% time on the stroke unit target had been due to previous incorrect allocation of stroke beds. The Board noted this was a fall in previous compliance in this area and Dr Cusack commented that he expected levels to improve. With regard to Cancer targets Mrs Needham advised that May was looking positive and had been managed tightly at Directorate level.

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

TB 15/16 015 **Corporate Governance Report**

Ms Thorne presented the Corporate Governance Report.

Ms Thorne provided the Board with information on a range of corporate governance matters and in particular included formal reporting on the Use of the Trust Seal pursuant to the Trust's Standing order 12.3. She commented that the Trust's Standing Orders required that periodic reports were made to the Board detailing the use of the Trust's Seal. The Seal would generally be used for contracts in excess of the financial limits delegated to the Chief Executive under the Standing Financial Instructions, and for property matters, including disposals, acquisitions and leases.

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She reported that staff within the Trust were required by the Standards of Business Conduct Policy to declare any hospitality and/or gifts received. Following regular staff reminders the following numbers were received:

- January to March 2015: 91 declarations received
- March to May 2015: 18 declarations received

Mr Noble commented that the Audit Committee noted that awareness had increased and they were very pleased with the reporting and monitoring. Ms Thorne commented that it had been discussed at Audit Committee whether a solution linking standards of business with the Appraisal process could be implemented.

The Board noted that there were no new declarations of interest by Trust Board members.

The Board **NOTED** the Corporate Governance Report.

TB 15/16 016 Draft Quality Account 2014/15

Ms Thorne presented the Draft Quality Account 2014/15.

Ms Thorne reported that there was a statutory requirement for all Trusts to produce an annual Quality Account and currently the Trust was in a consultation process in respect to the Quality Priorities for the coming year which had been described within the Quality Account. The Board noted that the report was presented in draft as assurance that timelines for its production were met and to receive feedback where appropriate on content, particularly quality priorities. Ms Thorne thanked Dr Cusack and Mrs Corser for reviewing the Quality Account. She commented that she had received more useful comments from the Quality Governance Committee. She had also received some responses from external stakeholders and any particular issues highlighted would be incorporated if appropriate. The Board were informed that any further amendments should be emailed to Ms Thorne. **Action: All Board members**

Ms Thorne informed the Board that the final Quality Account would be presented to the Board of Directors in June for signing off and thereafter quarterly Quality Account reports would be received by the Quality Governance Committee from Dr Cusack.

The Board **NOTED** the Draft Quality Account 2014/15.

TB 15/16 017 GS1 Compliance Funding Bid

Mr Pallot presented the GS1 Compliance Funding Bid and introduced Mr Oram and Mr Rivans who gave a comprehensive presentation on the GS1/PEPPOL Strategic Outline Plan.

The Board noted that the use of GS1 standards had been included in a number of NHS policies and publications from the Department of Health. Compliance with GS1 standards was also now part of the NHS standard contract for Acute Trusts and regulation was expected shortly from the EU relating to implantable medical device identification utilising bar code technology. Through recent discussion with the DH Procurement Directorate it was understood that there would be an opportunity to bid for some central funding in order to develop GS1 standards within a small number of Acute Trusts which would then act as demonstrator sites for the remainder of the NHS.

Mr Oram reported that the NHS procurement team had been populating the DH GS1 business case tool in anticipation of submitting a bid for central funding in June. Should the Trust be successful in the bid, it would present a great opportunity to pump prime the development of GS1 which in turn would provide visibility of the full

patient pathway, enabling improved patient outcomes, safety and efficiency. Informal feedback indicated that the Trust was already well advanced in comparison with similar Trusts in the NHS, and therefore with the work currently underway to develop an Inventory Management solution, the Trust was well placed to take the GS1 initiative forward as a pilot site.

After discussion the Trust Board approved the GS1 Compliance Funding Bid and thanked Mr Oram and Mr Rivans for their informative presentation.

The Board **APPROVED** the GS1 Compliance Funding Bid.

TB 15/16 018 **Clinical Strategy Implementation Plan Update**

Mr Pallot presented the Clinical Strategy Implementation Plan Update.

Mr Pallot provided an update to the Board on the generation of the implementation plan for the clinical strategy. It had been built upon the presentation given to the Board of Directors in April 2015 and provided high level details of each of the workstreams that would deliver the strategy over the next 5 years.

He reported that in order to deliver high quality, safe and sustainable care for the future the Trust's aim was to provide core resilient district general hospital services, local specialist services and to support the drive to provide more non urgent care in the community. This would be achieved by greater efficiencies and productivity and collaboration with local and tertiary providers.

Mr Pallot informed the Board that the final Implementation Plan would be presented to the Board of Directors in June. **Action: Mr Pallot**

The Board **NOTED** the Clinical Strategy Implementation Plan Update.

TB 15/16 019 **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 April 2015 were discussed and approved.

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

TB 15/16 020 **Terms of Reference Hospital Management Team**

Dr Swart presented the Terms of Reference for the Hospital Management Team for approval.

The Board **APPROVED** the Terms of Reference for the Hospital Management Team.

TB 15/16 021 **Report from the Finance Investment and Performance Committee**

Mr Zeidler presented the Report from the Finance Investment and Performance Committee.

Mr Zeidler provided an update to the Board on activities undertaken during the month of April and discussed at the Finance Investment and Performance meeting held on 22 April 2015. This report covered any issues of significance, interest and associated actions that were required and had been agreed to be taken forward by the Committee.

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Mr Zeidler gave a verbal update from the meeting which took place on 20 May 2015 and informed the Board that several items had already been discussed at the meeting today but he advised the Board that the Committee had discussed the arbitration process with regard to the Contract and that the review was due by the end of June.

The Committee received a report on the Changing Care @ NGH Programme and Service Line Reporting. The Committee approved the disposal of Harborough Lodge Renal Unit and agreed to recommend to the Trust Board the approval of changing the status to an asset held for sale.

The Inventory Management Business Case had been presented and the Committee were advised that the Outline Business Case would implement an Inventory Management solution within Main Theatres and Manfield Theatres which had been developed by the Trust's Inventory Management Project Group. Whilst in principle the case was supported, there were concerns with regard to the funding and affordability. However the Committee agreed to support the proposal in principle and for further assurance agreed that a financial appraisal paper would be brought back to the next Committee meeting.

The Performance Management Framework was received and after discussion the Committee requested that amendments to the Framework be made and be brought back for further review.

The Board **NOTED** the Report from the Finance Investment and Performance Committee.

TB 15/16 022 **Report the Quality Governance Committee**

Mrs Searle presented the Report from the Quality Governance Committee (QGC).

Mrs Searle provided an update to the Board on activities undertaken during the month of April and discussed at the QGC meeting held on 24 April 2015. This report covered any issues of significance, interest and associated actions that were required and had been agreed to be taken forward by the Committee.

Mrs Searle gave a verbal update from QGC which took place on 22 May 2015 and informed the Board that the minutes of the meeting held on 24 April 2015 contained some errors and the Committee agreed that all members would submit their changes and the minutes would be agreed at the next meeting.

The Committee received confirmation that there had been 3 patient related complaints with regard to end of life care. A correction was noted that an error occurred in the Quality Impact Assessment report relating to the backlog of Ophthalmology outpatients appointments waiting.

An update was received on CQC and confirmation that the report had been received and inaccuracies highlighted. With regard to the Corporate Scorecard the issues of concern were C-section rates, Pressure ulcers 9 grade 3 pressure ulcers reported.

The Committee received an update on the progress to date in achieving the standards for 7 day services and the implementation plan for 2015/16. The Information Governance Annual Report was received and the Committee noted the risks and actions.

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Highlight Reports were received from the Assurance Risk and Compliance Group, Patient and Carer Experience and Engagement Group and Clinical Quality and Effectiveness Group.

The Board **NOTED** the Report from the Quality Governance Committee.

TB 15/16 023 **Report from the Workforce Committee**

Mr Robertson presented the Report from the Workforce Committee.

Mr Robertson provided an update the Board on the activities undertaken during the month of April and discussed at the Workforce Committee meeting held on 22 April 2015. This report covered any issues of significance, interest and associated actions that were required and had been agreed to be taken forward by the Committee.

Mr Robertson gave a verbal update from the Workforce Committee which took place on 20 May 2015 and informed the Board that the Committee received a presentation from members of the Human Resources (HR) team working with the Improving Quality and Efficiency team on the Making Quality Count methodology in order to develop a mechanism to reduce the length of time taken for disciplinary investigations. The HR Team gave a detailed presentation and talked through each phase of their project to demonstrate how they had used the methodology to come to their conclusions.

The Committee received assurance that following recent issues elsewhere regarding checks on overseas nursing recruits' qualifications the Trust's procedures were robust and in line with best practice. An update was received on the progress regarding developing nurse training programmes in conjunction with the wider health education providers. The Committee were made aware that the Trust was currently engaged in a number of challenging industrial relations matters and also updated on the Standardised Shift pattern exercise.

The Committee noted a decrease in sickness absence, which was pleasing, as it should impact upon capacity issues, but it should be noted this still remained higher than the Trust target. The Appraisal compliance rate had reduced which was a concern. HR were working to support all areas to ensure that staff appraisals were carried out at the appropriate time and notified as per the process. Mandatory Training compliance decreased slightly in April.

Finally, the Committee noted that changes had occurred in the running of the Cripps facility. It was reported that a 10-year contract commencing on 6 May 2015 had been agreed with a company called Triology to run the CRIPPS centre.

The Board **NOTED** the Report from the Workforce Committee.

TB 15/16 024 **Report from the Audit Committee**

Mr Noble presented a verbal update from the Audit Committee.

Mr Noble updated the Board on the activities undertaken and discussed at the Audit Committee meeting held on 27 May 2015 and reported that the Committee recommended that the Board approved the Annual report and Annual Accounts 2014/15. The Committee agreed that the reports could be prepared on a going concern basis in spite of the current and projected deficit based on written assurances from the TDA that they would ensure the liquidity of the Trust.

The Committee noted that KPMG had, as last year, given an 'except for' opinion on the accounts based on the deficit position and the failure of the Trust to meet key targets relating to A&E and cancer waiting times. KPMG assured the Committee that this was in common with many other Trusts.

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The Committee were very pleased with the professionalism of the Trust's Finance Team in preparing on time, a sound set of detailed accounts which withstood the close scrutiny of Audit. The Committee also recommended approval and signature of the Management Representation Letter. The Committee noted the ISA 260 Audit Highlights memorandum which recommended actions relating to pharmacy stock, salary overpayments, and the ongoing deficit.

The Committee received the Internal Audit Annual Report, noting that the Head of Internal Audit reported an overall 'reasonable assurance' opinion. The reason behind the reasonable assurance was that the programme of audit revealed three areas where they could only give limited assurance. These were Procurement, E-rostering and Information Governance. It was noted that better understanding was required to become compliant. The Committee also received and approved the Internal Audit Plan for 2015/16.

The Committee received the Local Counter Fraud Annual Report. It was reported that NHS Protect had stated that a specific policy was required which was not in place although all the elements of a good policy were currently in standing instructions. The Committee approved the 2015/16 Counter Fraud work plan.

The Committee received a verbal assurance from the Chief Operating Officer on the actions undertaken to improve training, planning and processes in the area of Referral to Treatment (RTT) outsourcing and the increased involvement of procurement professionals. The Committee were concerned at the high level of waivers connected with overseas nurse recruitment and requested the Director of Workforce and Transformation to attend the September meeting to give assurance.

The Committee reviewed the Salary Overpayments report which continued to show an unacceptably high level of overpayments which appeared to result from non-compliance with processes. The Executive Team were tasked to produce a plan to reduce the level of overpayment and report to the next Audit Committee.

The Committee reviewed the Data Quality Strategy and recommended that the Trust Board adopt this Strategy.

The Board **NOTED** the Report from the Audit Committee and the Board **APPROVED** the Data Quality Strategy.

TB 15/16 025 **Any Other Business**

There were no items of any other business.

Date of next meeting: Thursday 30 July 2015 at 09:30 in the Board Room at Northampton General Hospital.

Mr Farenden called the meeting to a close at 11:50

The Trust Board **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.

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Public Trust Board Action Log							Last update	21/07/2015
Ref	**Date of meeting**	**Minute Number**	**Paper**	**Action Required**	**Responsible**	**Due date**	**Status**	**Updates**
Actions - Slippage								
NONE								
Actions - Current meeting								
45	May-15	TB 15/16 010	Director of Nursing and Midwifery Report	Regarding recruitment of additional staff from the Philippines to cover the European shortages. Mrs Brennan would bring a proposal to the Executive Team who would action as a matter of urgency.	Executive Team	Jun-15	Actioned	Proposal brought to ET and approved.
46	May-15	TB 15/16 011	Kate Lampard Lessons Learned Report: Progress Update	Ms Thorne commented that she would liaise with the CQC regarding checks in place for inspectors on site	Catherine Thorne	Jun-15	Actioned	Response from CQC Inspector received 8 July 2015: 'All CQC Inspectors, Inspection Managers, Bank Inspectors and Specialist Advisors have an enhanced DBS check from CQC. In addition we ask all staff to update us on any potential conflict of interests on an annual basis.'
47	May-15	TB 15/16 011	Kate Lampard Lessons Learned Report: Progress Update	Mrs Searle enquired if the completion date against the two amber items on the action plan were the original completion dates.	Fiona Barnes	Jun-15	Actioned	Confirmation from Mrs Barnes that the two dates for completion were the original dates.
48	May-15	TB 15/16 016	Draft Quality Account 2014/15	The Board were informed that any amendments should be emailed to Ms Thorne.	Catherine Thorne	Jun-15	Actioned	Comments received and incorporated.
49	May-15	TB 15/16 018	Clinical Strategy Implementation Plan Update	Mr Pallot informed the Board that the final Implementation Plan would be presented to the Board of Directors in June.	Chris Pallot	Jun-15	Actioned	Presented to the Board of Directors on 25 June 2015
Actions - Future meetings								
NONE								

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30 July 2015**

Title of the Report	**Chief Executive's Report**
Agenda item	**7**
Presenter of Report	Dr Sonia Swart, Chief Executive
Author(s) of Report	Dr Sonia Swart, Chief Executive Sally-Anne Watts, Head of Communications
Purpose	Information and assurance
Executive summary The report highlights key business and service issues 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 Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
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)

Enclosure C

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

Actions required by the Trust Board

The Trust Board is asked to note the contents of the report

Public Trust Board
30 July 2015

Chief Executive's Report

1. Hello my name is

It was a privilege to be able to welcome Dr Kate Granger to NGH on 17 June when she spoke to a packed Large Hall in the Cripps Post Graduate Medical Centre as part of an event set up for doctors in training. She received enthusiastic support and a standing ovation. Her passionate approach as a patient, a doctor, an educator and a human being was clear for all to see. A powerful reminder of what really matters in healthcare and also of how privileged we all are to be able to be part of it and connect with patients at seminal moments in their lives.

We will be launching the Northampton General Hospital (NGH) version of 'Hello my name is...' in August, speared on by our own observations and using Kate's ambitious campaign to set the scene. Last year we asked patients whether or not they had seen a doctor in the previous 24 hours - 65 percent did not know. It is clear that many staff do not introduce themselves - or if they do, do not explain their role. Quite a number of patients also are confused by so many different people asking the same questions; we clearly have work to do to assist patients so that they understand who all the staff are and what they are there to do. For me this is all a key part of professionalism in healthcare and needs to involve all our staff, both clinical and non-clinical, but we need to have a particular focus on our doctors in training who provide much of the first line medical care.

As part of the work we are doing to improve communication with our patients, who often do not know or realise when they have been reviewed by a doctor. So, starting from August with the new intake, by December 2015 all our doctors in training will be identifiable by their white coats, which will have show their designation and have Doctor written on the back.

2. National Developments and the implications for NGH

There have been a raft of national announcements and directives which are setting the scene for a different approach to solving the current issues in the NHS. I have attended a number of national and regional meetings where the key elements of the current situation have been clarified and discussed.

The main focus at every level has been dealing with the need to stabilise the finances of the NHS which are deteriorating rapidly whilst understanding that transformation of services will be required. There will be increased national intervention to ensure an improved grip on spending including salaries, consultancy usage and agency spend. There are also plans for a new regulatory approach to combine quality and safety issues with measures of value for money and efficiency. The focus on population health and partnership working as laid out in the five year forward view will be strengthened and tested over the coming months. It is of interest that there has been a renewed national focus on the importance of clinical leadership as a critical success factor in successful transformation of services.

For NGH we need to continually refresh and strengthen our own approach to the current environment and, whilst we have set out our direction of travel in our clinical strategy, the need to implement this at pace becomes a key imperative.

In practical terms this means that, while we are developing a cogent response to the financial pressure, we need to be clear that we are doing this in the context of rising demands, changing needs and the need to innovate. What this exposes is that the current model of service provision is becoming more and more stretched and will, therefore, need to change.

We need to consistently move towards models of care which are less fragmented (and therefore bring in health and social care, primary and secondary care, physical and mental health), less medicalised (focusing on prevention and health promotion), less hospital dependant (focused more on providing other services that are not acute dominated) and more adaptive (less dependent on historical attachments to institutions).

Like most acute hospitals we are predicting a financial deficit. Understanding the drivers of this deficit and moving from a deficit plan to a sustainable financial position will require all our internal efforts to be aligned and effective and will also require the development of a range of sustainable, trusting relationships with commissioners and other providers of care. We see our future as one of moving to being a different kind of local hospital - one that is delivering best possible care in a clinically-led organisation that addresses the challenges of providing excellent care for our population and is based on increased partnership working with other providers of care (health and social).

In practical terms, in the context of having been asked to increase our planned cost improvements this year in order to improve the national position, it is clearly essential that we deliver the Changing Care@NGH programme and the Clinical Collaboration Programme with Kettering General Hospital (KGH). The underpinning programmes within NGH focus on quality and safety and high quality outcomes for patients, development of staff, and organisational effectiveness and are all part of delivering our Clinical Strategy. Our success in delivering all of these underpins all our plans for developing a sustainable hospital providing care of which can be proud. All of our plans also rest on the successful implementation of our clinically led management structure which is key to the delivery of a programme of work based on quality improvement.

It is of interest that two of our local MPs, Michael Ellis and David Mackintosh have been in discussion with Jeremy Hunt about the development of our hospital site and we have arranged a meeting with them to discuss this further. We will be discussing how to incrementally improve our acute facilities whilst also moving towards our concept of a ‘Health Campus’ with some services on our site which are not of the traditional acute hospital type.

3. Leadership Development

As part of implementing our new clinically led management structure we have embarked on a programme of leadership development, the ‘Francis Crick Programme’. Overall this is going well and we are continually refining the programme to ensure that we align it with current issues and understand what further development may be required.

We have also started a new programme for Consultant Medical Staff who have joined NGH in the last year or so and can help all our senior clinical staff to understand how to help us embed our values and continually improve services for patients. This is part of our plan to harness the energy and enthusiasm of our workforce and nurture the talented people who work here. This will become increasingly important as we respond to the many national pressures and for our medical workforce the recent announcements from the DH only serve to remind us how important discretionary effort is.

4. Health and Wellbeing of Staff

The Global Corporate Challenge has been a popular initiative and forms part of the work that is aimed at supporting improved health and wellbeing for our staff. We now have our own NGH Choir and introduced lunchtime ballroom dancing lessons as a consequence of our Strictly NGH competition. The new facilities in the Cripps Centre have been welcomed by our staff and are proving popular.

These initiatives will form part of our broader strategy for developing the improved health and wellbeing of our staff and we will be used as a spring board to bring together various initiatives and align the efforts of our organisational development, occupational health, communications teams and others.

5. Estates developments

The new Boots pharmacy opened on 22 June and is working well. This is a facility which has been welcomed by both patients and staff. The enthusiastic project team from NGH have worked effectively with representatives from Boots and their contractors to enable this project to be successfully delivered to agreed timescales.

I was pleased to open the new blood taking unit, which finally gives us a purpose-built area for phlebotomy. This is a long overdue and necessary facility for our patients. Other developments in pathology include the installation of new haematology and biochemistry equipment. It is essential that we ensure our facilities and the equipment we use are fit for purpose if we are to achieve our aim of providing the best possible care.

Our neonatal unit on Gosset Ward will be closed for eight weeks to allow essential maintenance work to be carried out and the ventilation system to be replaced. We are using the opportunity to also refurbish the ward. Whilst the work is underway the unit has relocated to the paediatric assessment unit, which in turn has relocated to Paddington ward.

We know the age of parts of our estate means that modern facilities such as air conditioning are not readily available. This in turn has an impact on both our patients and our staff. The recent hot weather was difficult for many patients and I am pleased to say that we have now been able to install and commission a new refrigeration plant which is now supplying conditioned air to Abington and Becket wards.

The infrastructure work to enable to installation of our new decked car parking facility will be complete by 20 July, following which construction will begin. The new car park provides additional capacity which will be welcomed by patients and staff.

6. IT in the spotlight

Our Information Technology (IT) team and our suppliers, Secure IT Environments Ltd, were shortlisted for the Business Green Leaders awards and made the final five with their green IT project of the year, which was the development of our second data centre. Although the team did a great job, they were up against some stiff competition and narrowly lost out to the overall winner.

7. Friends of NGH

I was pleased to attend the Annual General Meeting (AGM) of the Friends of NGH in June. Our Friends support all our volunteers, run the buggy service which is much appreciated by our patients and visitors, and also raise money for us generally. We are indebted to their commitment and contribution to our hospital. We are planning a series of initiatives to enhance our volunteer workforce and develop a comprehensive volunteering strategy and this work will be brought back to a Board of Directors meeting in the near future.

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30 July 2015**

Title of the Report	**Medical Director's Report**
Agenda item	**8**
Presenter of Report	Dr Michael Cusack, Medical Director
Author(s) of Report	Dr Michael Cusack, Medical Director
Purpose	Assurance

Executive summary

The principal risks to clinical care currently relate to the on-going pressure on the urgent care pathway and insufficient nursing and medical staff. These are reflected in the Corporate Risk Register and BAF.

Since the last report to the Board (during the reporting period 1/05/2015 – 30/06/2015) no new Serious Incidents have been reported. This reflects changes to SI reporting criteria. Problems identified with training and education were consistent themes among incidents which were submitted for closure.

Dr Foster data showed overall mortality to have remained within the expected range. There was no evidence of a difference in mortality associated with the delivery of care to emergency patients admitted on a weekday compared with those admitted at the weekend.

The Sign up to Safety campaign is described as is the introduction of white coats, Vitalpac Doctor and the 'Hello my name is campaign..'.

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, 2, 6, 7 & 11.

Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? No Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? No
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.

Northampton General Hospital NHS
NHS Trust

Public Trust Board
30 July 2015

Medical Director's Report

1. Clinical Risks

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

The principal risks to clinical care currently remain the same as in the last report and relate to the pressure on the urgent care pathway and difficulties in securing sufficient nursing and medical staff. These issues are reflected in the following risks and the associated controls are fully described in the Trust Corporate Risk Register.

ID	Description	Rating (Initial)	Rating (Current)	Corporate Committee
979/ 100/ 694	Insufficient levels of nurses and HCA across the Trust resulting in high use of bank & agency nurses. Insufficient skill mix of registered and non –registered staffing levels on the wards and in specialist areas.	15	25	Workforce
368	1. Risk of A&E performance being adversely affected due to the demands on the service. 2. Possible congestion within the ED as a result of poor capacity and flow throughout the hospital.	16	20	Finance & Performance
96	Delays in the discharge process resulting in an increased length of stay.	12	16	Finance & Performance
111	Inability to recruit sufficient medical staff.	16	16	Workforce
421/ 619/ 731	Risk to safety and experience due to utilisation of Gynaecology Day Care, the Heart Centre and Renal Unit as escalation areas.	16	16	Quality Governance/ F&P

The potential impacts of these issues are also described in items BAF 2, BAF 6, BAF 7 and BAF 11 within the Board Assurance Framework.

2. Summary Serious Incident Profile

Shown in the table are the numbers of Serious Incidents and Never Events which have been reported by year since 2010:

	10/11	11/12	12/13	13/14	14/15	15/16
Serious Incidents	27	55	78	115	93	1
Never Events	2	2	1	0	1	0

The Never Event in 2014/15 related to:

- Wrong site surgery – removal of a tonsillar cyst
  All recommendations from the investigation have been implemented and are being monitored

The Never Events which occurred 2010-13 related to wrong-site surgery.

2.1 New Serious Incidents
Since the last report to the Board (during the reporting period 1/05/2015 – 30/06/2015) no new Serious Incidents have been reported

2.2 Open Serious Incidents
The serious incidents at 30 June 2015 which remain open and under investigation are listed below:

Date of Incident	SI Brief Detail	Directorate	Status
19 Mar 2015	Maternity Services	Womens	Active
27 Feb 2015	Slips / Trips / Falls	Inpatient Specialities	Active

2.3 Serious Incidents Submitted for Closure
Eight serious incident reports were submitted to Nene and Corby Clinical Commissioning Group (CCG) for closure during the January and February 2015. Four related to Grade 3 Pressure Ulcers. The principal themes identified from the investigations were:

Grade 3 Pressure Ulcer	
Theme	**Learning/Actions**
Clinical Assessment	Complete assessment in line with hospital guidelines. On admission pressure areas should be checked by nursing staff Complete daily skin inspection and repositioning schedule
Communication / Handover	Ensure pressure care is handed over on each shift
Equipment	Use preventative equipment e.g. Repose trough, Aderma
Training	Staff to receive pressure ulcer training
Medication Error	
Theme	**Learning/Actions**
Training / Education	The training packages for prescribers should be reviewed by the responsible trainer to ensure that the processes for managing alterations to prescriptions is clearly articulated.
Policy / Procedure	The training material and the corresponding policy for Oxygen prescribing should include the appropriate documentation on the volume and % of oxygen administered.
Communication / Handover	A hand over process should be developed that describes the role and responsibilities of the medical staff providing cover for the Avery wards, including out of hours and escalation situations.

Maternity Services	
Theme	**Learning / Actions**
Equipment	The portable ultrasound scan (USS) machine should always be kept in the designated area of labour ward. If it is required to be used in other clinical areas within the maternity service, the labour ward co-ordinator should be informed about that location. Every attempt should be made to return the portable USS machine to labour ward as soon as possible if taken to a different clinical area
Documentation	Health care professionals must discuss and document options around planned place of birth with the woman. They should also document that written information leaflet has been provided (Choices in Maternity Care, including place of birth, NGH 2014)
Policy / Procedure	The maternity services should agree in what circumstances there is the requirement for the Labour ward Coordinator and the Obstetric Registrar to be present on Labour ward when transfers occur from the Birth Centre / Home. The aim of this will be to enable effective teamwork and facilitate an early initial assessment during an emergency situation The maternity services should review the labour assessment guidance to ensure consistency of practice around the measurement of fundal height during labour

Unexpected collapse	
Theme	**Learning / Actions**
Education / Training	Education of primary and secondary care colleagues about the importance of stridor as a clinical sign and presentation and management of tracheitis. Reminder to ensure such patients are seen by seniors with low threshold for admission to be incorporated into clinical simulation
Policy / Procedure	Protocol for prescription and administration of salbutamol to children in A&E Review of discharge policy from A&E to include the need for documentation of a clear discharge plan in the notes with clear criteria for nurse led discharge or medical review, documentation of safety netting and consideration of the need for discharge observations. Put in place systems - for recording sample signatures for locum/agency staff in A&E - For locum/agency staff clearly recording names and GMC numbers in patient documentation.
Staffing	Continue to recruit Registered Children's Nurses. Review monthly at Trust Board. Ensure this stays on risk register

Delayed Diagnosis (ITU)	
Theme	**Learning/Actions**
Awareness	Ensure staff in all areas where Central Venous Catheters (CVC) are inserted to be made aware of the incident
Training / Education	Methods of confirming CVC placement to be included in critical care nurse education. This will involve all unit nursing staff being made aware of the 4 methods of checking CVC placement – Insertion using ultrasound guidance, blood gas analysis of blood from CVC, waveform analysis and Chest X-ray. It will be added to the competency pack used for staff new to ITU and this competency will need to be signed off by a senior member of staff during the nurses' supernumerary period on the unit Practical sessions already provided for medical staff regarding CVC insertion to be formalised. The sessions will be taught by consultants or senior registrars who are experienced at CVC line insertion and will include both theoretical and practical components, plus a multiple choice assessment at the end of the session.
Policy / Procedure	CVC insertion guideline to be updated, ratified and available on NGH intranet CVC care guideline to be updated to include confirmation of line placement and troubleshooting methods
Documentation	Promote improved documentation of communication between healthcare team members regarding concerns in the patient notes CVC line insertion stickers for formal documentation of indication, insertion site and confirmation of placement.

3. Mortality

The Dr Foster data is now current to the end of 2014-2015. HSMR reflects the increased number of deaths seen during Q3 and Q4 and is currently 103.4 (as expected). It is unlikely to rise above this level following a final re-benchmark and will therefore remain within the 'expected' range for 2014-2015.

The HSMR crude mortality for 2014/15 remains unchanged from the previous year at 3.6%. The median crude mortality for the East Midlands during this period was 4.2% [range 3.3 – 5.2%].

As reported previously, there is no evidence of a difference in mortality associated with the delivery of care to emergency patients admitted on a weekday (SMR 102) compared with those admitted at the weekend (SMR 104).

There are no new SHMI data to report beyond September 2014. The publication of the SHMI for Q4 2014 is expected to be within the next month. It is expected to rise marginally above 100.

3.1 Service Reviews

Hepatopancreaticobiliary diagnoses. As reported previously, this composite group has been flagged as showing an elevated mortality. Following successive reviews at the Mortality Group, work to improve the pathway is underway shared between radiology, endoscopy, surgery and medicine is being undertaken. The performance across these diagnoses will continue to be closely monitored and fed back to the relevant specialties.

'Acute and unspecified renal failure'. Am increased mortality has been identified in this patient group [SMR 138]. However, the mortality for the nephrology service taken as a whole is 'as expected'. The excess deaths are among patients admitted to acute medical and surgical specialties. The national CQIN for Acute Kidney Injury is being actively delivered and it is anticipated that this will lead to a significant improvement in local outcomes.

4. Sign Up For Safety

The Sign up to Safety campaign is part of a national initiative aiming to improve the safety of patient care. It has the ambition of halving avoidable harm in the NHS over the next three years and saving 6,000 lives as a result.

The NGH Aim/Outcome is to reduce avoidable harm by 50% through the delivery of improvements in four key areas by March 2018 from Trust March 2015 baseline.
The primary drivers were developed on the basis of safety concerns and avoidable harm within the hospital. The projects continue work from the safety academy and reflect lessons learnt from serious incidents, audit results, case note reviews or areas for improvement identified by operational staff employed within the Trust. These primary drivers and the secondary drivers which underpin them are described in figures 1 and 2.

The safety improvement projects that support the sign up to safety programme have tangible links with the changing care work streams but will be reported separately beginning in Q2.

5. Patient Experience

During August three key elements related to patient experience will be launched - namely white coats for medical staff, Vital Pac doctor and the '# Hello my name is…' campaign. The overall aim is to improve patient perception and experience and further improve the escalation and management of sick and deteriorating patients.

When the Department of Health produced guidance on dress code that came to be known as the 'bare below the elbow' policy in 2007, white coats became obsolete for medical staff. There is no direct evidence that this reduced UK Hospital Infection Rates. However, it has inadvertently contributed to a medical workforce that can look unprofessional. There is local evidence that patients would prefer doctors to wear a white coat and that this would assist with identifying them in clinical areas. Foundation Year 1 doctors will be provided with white coats at induction with all doctors in training expected to be wearing a white coat in patient facing areas by the end of Q3.

The doctors white coats will include a colour to designate their training grade and experience. They will also include a large pocket which will house the Vital Pac doctor device. This would look both professional and allow the device to be viewed and to receive alerts as needed, both remotely and within clinical areas.

Vital Pac doctor devices will ensure the information quickly reaches the correct Doctor and nursing staff escalating a patient concern can expect a response within 2 minutes.

During February 2015 NGH signed up to support a campaign to the "Hello my name is.." campaign. This was started by Dr Kate Granger who became frustrated with the number of staff who failed to introduce themselves to her when she was receiving treatment for cancer. Since leaving hospital, Dr Granger has started a campaign asking NHS staff to make a pledge to introduce themselves in future to their patients.

The above three improvement initiatives form part of a Trust wide safety and quality initiative and will be formally delivered and implemented during the August 2015 doctor induction programme.

6. Next Steps

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

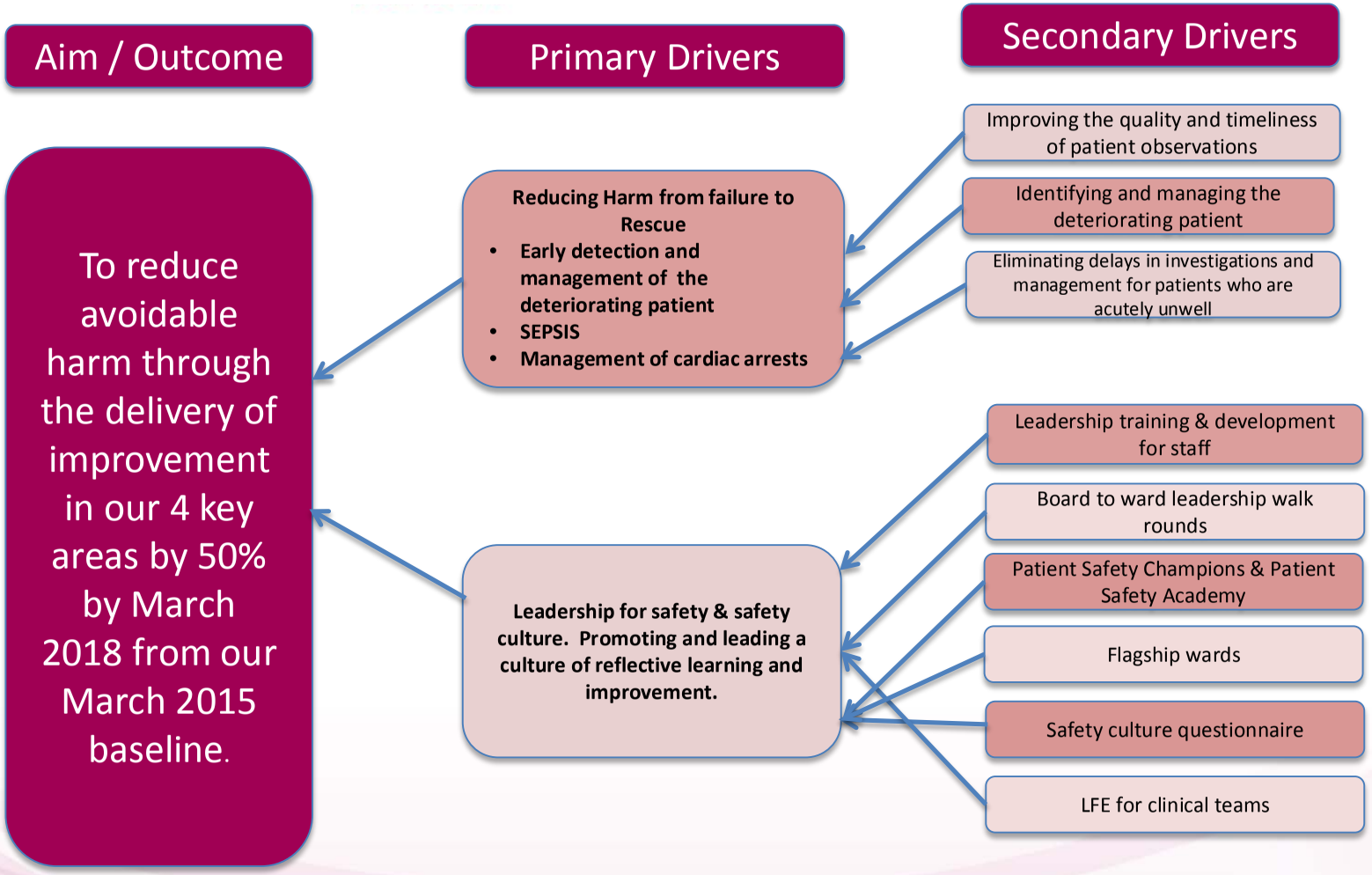
Mortality within the Trust is closely monitored and reported through the Quality Governance Committee.

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

Northampton General Hospital NHS
NHS Trust

Sign up to SAFETY
LISTEN LEARN ACT

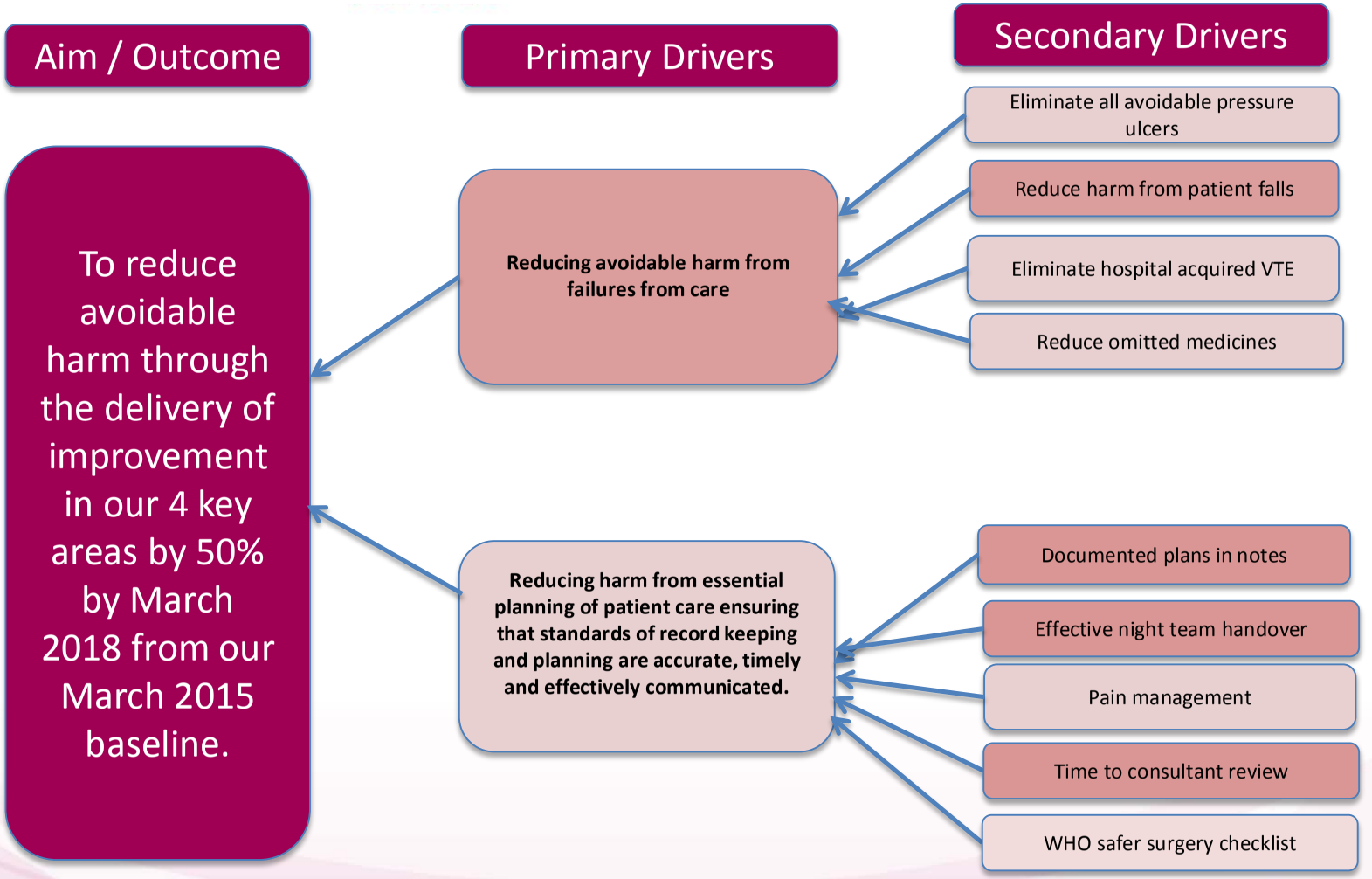
NHS



Northampton General Hospital NHS
NHS Trust

Sign up to SAFETY
LISTEN LEARN ACT

NHS



Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30 July 2015**

Title of the Report	**Director of Nursing & Midwifery Report**
Agenda item	**9**
Presenter of Report	Carolyn Fox, Director of Nursing, Midwifery and Patient Services
Author(s) of Report	Rachael Corser, Director of Nursing, Midwifery & Patient Services (Interim) Fiona Barnes, Deputy Director of Nursing 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 and Midwifery senior team are working on. An abridged version of this report, providing an overview of the key quality standards, will become available on the Trusts website as part of the Monthly Open and Honest Care Report.

Key points from this report:

- Work to improve data quality of Nursing and Midwifery Quality Dashboard has made steady progress, the new quality metrics are now a web base designed and ready for July's audit which will be presented in August's Nursing & Midwifery Care Report
- Safety Thermometer – achieved 94.43% this is above the reported National picture of 94.1%.
- In June there were a total of 26 grade 2 pressure ulcers and 4 grade 3 pressure ulcers (2 being suspected Deep Tissue Injury (sDTI)) these will be reviewed through the normal Confirm and Challenge meetings
- There have been 3 C. Difficile cases reported in June and 0 MRSA bacteraemia. Further work and actions have been underway following the visit from the Trust Development Authority reviewing the Trust compliance against the Hygiene Code.
- In June there have been 0 in-patient falls that have caused at least 'moderate' harm.
- The Friends & Family Test 'Would' Recommend %:
  - In-patients – 85%
  - Outpatients – 90%

Enclosure E

- Maternity – 95%
- A&E – 87%

- Compliance with CQUINN data for quarter 1 for Dementia care is discussed as is the compliance of safeguarding training across the Trust.
- Maternity summary includes excellent work between prenatal diagnosis team and the laboratories to facilitate midwives requesting a variety of blood tests.
- Hard Truths provides a detailed summary of our planned versus actual staffing levels across the inpatient areas, including Bank usage. The bi-annual review of acuity and dependency has been undertaken in April and is reported upon. A summary of the Trusts compliance with the National Quality Board 'How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery & care staffing capacity and capability' is discussed.

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 Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
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 and Honest Care Report on to the Trust's website which will include safety, staffing and improvement data.

Public Trust Board
30 July 2015

Director of Nursing & Midwifery Report

1. Introduction
The Director of Nursing & Midwifery Report presents highlights from projects during the month of June. Key quality and safety standards will be summarised from this monthly report to share with the public on the Northampton General Hospital (NGH) website as part of the 'Open and Honest' Care report. This monthly report supports the Trust to become more transparent and consistent in publishing safety, experience and improvement data, with the overall aim of improving care, practice and culture.

2. Nursing and Midwifery Quality Dashboard
The Nursing and Midwifery Quality Dashboard presents the findings from the monthly Nursing and Midwifery Standards audit. Work is progressing as planned with the Informatics team on developing the reporting infrastructure to support the new Quality Indicator questions for the general adult wards. The web base technology has been designed and piloted by the Quality Improvement Matrons. This will be ready for the Directorate Matrons to use with their July data.

In comparison to the previous month there have been the following key changes:
- Allebone continues to flag as a ward requiring additional support from the Quality Improvement and Assurance Matron in light of their staffing fill rates, avoidable pressure ulcers acquired on the ward and poor documentation. Although their Friends and Family Test (FFT) data in June is significantly improved, sustainable improvements are needed in the overall patient experience
- Emergency Assessment Unit (EAU) has seen a decrease in their Quality Care Indicators (QCI) compliance. Support for the Ward Sister and Matron will be provided by the Quality Improvement and Assurance Matrons in the areas requiring focus.
- Benham Ward continue to have increased support, particularly to ensure sustainable improvement in their cleanliness standards and their patient experience
- Willow have seen a fall in their assessment and documentation indicators, but maintain their good results within the patient experience sections – work is underway with the ward team and the Matron to sustain improved documentation results
- Brampton Ward has sustained and improved on all metrics
- Collingtree Ward have also sustained their previous improvement this month
- Victoria Ward has seen an improvement across all areas from the previous month

Across the general wards the main areas of focus are:
- Falls assessment – there has been a slight improvement however continues to be the focus particularly in re-assessment completion
- Privacy and Dignity is the least performing subtotal with 2 Reds and 10 Yellows

3. Clinical Commissioning Group Quality Team unannounced visits to the Trust
During April, May & June (Quarter 1) the NHS Nene and NHS Corby Clinical Commissioning Group (CCG) Quality Team undertook planned unannounced visits to the Trust. During the visit the Quality team are assessing the quality of care, patient safety and patient experience that clinical teams provide. The CCG visits are comprehensive and 'reflect' the Care Quality Commission (CQC) inspections which involve speaking to staff, patients, relatives and review notes, documentation and the environment.

The wards visited in Quarter 1 were; Willow, Talbot Butler and Benham. The CCG also undertook an unplanned announced visit to EAU. The following provides a summary on the findings from each ward visit. Following a CCG visit the ward develop an improvement plan in accordance with the recommendations made. This is reported and monitored through the Divisional Governance structure and summary feedback is provided to Nursing & Midwifery Professional Forum to share learning.

Willow:
The evidence seen by the visiting team suggests the ward team provide care that is compassionate, empathetic and with dignity, this was also supported by patient feedback. Documentation was good and the evaluations demonstrated appropriate assessments and provision of care. The ward team appreciated a visit from the Chief Executive with many patients commenting positively about their experience on the ward to the Chief Executive and the accompanying non-executive. The ward management team appear to be well respected and have a common vison for the ward. However it was also noted that staff felt that senior staff (above Matron) do not understand the pressures the ward team are under. The visiting team also noted that staff want to keep patients safe and aspire to a high standard of care. However whilst there was evidence of learning when things go wrong, there have been no formal structures to support staff such as staff meetings and clinical supervision was not embedded. The visiting team believe that the ward would benefit from external feedback on the things that they are doing well and support to embed the systems, processes and ideas for continued reflection and improvement. These will be part of the improvement plan.

Talbot Butler:
The CCG team found that Talbot Butler ward has a team of staff who have been providing quality care to their patients including responding to call bells promptly and provide analgesia when requested. Documentation of patient assessment and ongoing evaluation of care were comprehensive, including medical staff entries.

The visiting team also noted that morale amongst some staff is low and staff report feeling isolated and unsupported by senior staff outside the ward. The staff that were spoken to spoke with care and compassion and were frustrated that they felt unable to provide the level of care that they would like to due to the trust wide staffing pressures.

Benham:
Through the visit the team found that Benham assessment Unit had a dedicated team of staff who want to provide high quality care to their patients. Patients were complimentary about the care they received on the ward and the staff. Staff morale appeared good and the team felt well supported by the ward sister and matron but feel that more senior staff within the trust do not understand the complexity and acuity of their patient group or the daily pressures the team feel under.

EAU:
The CCG Safeguarding Team had been alerted to a safeguarding concern that had been raised by the CQC with Northamptonshire County Council. The concern had come from the relative of a patient who had been on EAU. Some of the elements of the concern were that a patient hadn't been able to eat because; their false teeth hadn't been put in and the patient had not been able to reach their dinner from their bed, and there was nobody to help, that the patient call bell was coiled up out of the way and that all call bells for patients were out of reach. The evidence seen and heard by the visiting team suggests that the patients seen on the day of the visit had access to their call bells and, where required, were supported to eat and drink. Staff were recording how and whether people are eating and drinking but not the amounts of food and fluid taken. There was only one recommendation which was for the trust to consider how they can accurately record food and fluid intake of patients.

4. Safety Thermometer

In June 94.43% patients experienced 'harm free care' which is the first time the Trust has been above 94%. The national benchmark for June on the website is 94.1% which means NGH is again above the national trend.

This month saw a slight improvement in the reduced number of new pressure ulcers which is the third month that there has been a slight improvement on this point prevalence audit. The remaining three categories all had zero incidents on the day which is the reason for the >94% result.

5. Pressure Ulcer Prevention and Management

Further to the pressure ulcer thematic review that was presented and discussed at Quality Governance Committee (QGC) in June, the actions identified to address the issues have been included in the Trust Wide Pressure Ulcer Prevention Action Plan and shared at the QGC. The action plan will be monitored through the Nursing and Midwifery Professional Forum and Clinical Quality and Effectiveness Group (CQEG).

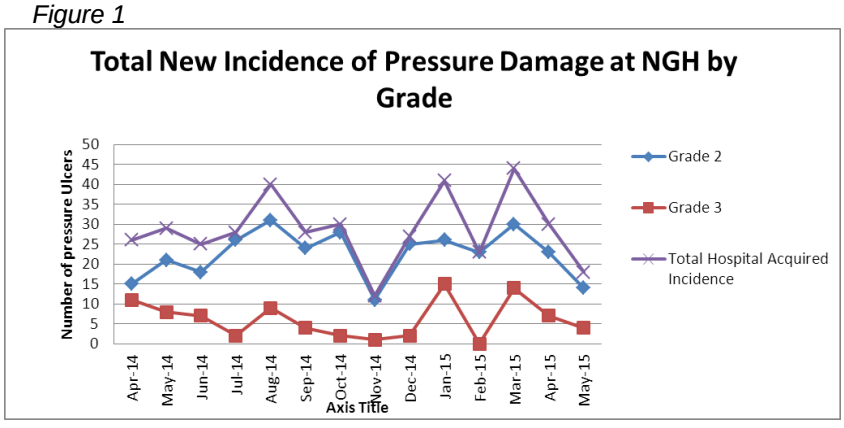
5.1 Pressure Ulcer Incidence

In June there was a total of 30 possible hospital acquired pressure ulcers of which 26 were grade 2 and 2 Unclassified Grade 3's and 2 suspected Deep Tissue Injury (sTDI). This figure is subject to change following review at the Confirm & Challenge Meeting, which is scheduled to take place on 20th and 24th July. Reassessment of those patients with sTDI's will take place and this will determine their evolution and categorisation.

Following the Confirm and Challenge Meetings in June for the pressure ulcers that developed in May, the confirmed numbers of hospital acquired pressures ulcers changed to 18, a reduction of 8. 14 Grade 2's of which 10 have been validated as avoidable at present, the 7 deemed unavoidable will be sent for confirmation/agreement.

April's submissions have been verified with the results being, of the 7 Grade 3 pressure ulcers reported, 4 are recorded as avoidable and 3 unavoidable.

Figure 1



5.2 Quality Schedule

The Tissue Viability Lead Nurse and Deputy Director of Nursing met with the CCG Lead and have provisionally agreed (subject to confirmation by CCG) to a 20% reduction in avoidable grade 2 pressure ulcers – this equates to a total of 148 ulcers for the year and a 25% reduction in Grade 3 avoidable pressure ulcers, or 41 ulcers over the year.

5.3 Foam mattress replacement programme

A mattress audit and subsequent replacement programme had been planned in August 2015. In light of the increased number of mattresses requiring condemning upon adhoc inspection, an additional 200 mattresses have been replaced throughout July. A re-enforcement of the process for checking mattresses has been outlined to the ward Sisters and Matrons in line with policy.

Monitoring will be undertaken by the Tissue Viability Team, and a database has been set up by which to monitor ongoing compliance with the policy. The planned external mattress audit with Arjo Huntleigh for 11 & 12 August will still be undertaken as scheduled.

5.4 Pressure relief in A&E
Following on from the thematic analysis, the Trust has put an order in for 60 Repose companion mattress/trolley toppers, so that patients identified as at risk of pressure ulcer development will have prompt access to an appropriate pressure relieving surface to reduce risk as soon as they have walked through our doors. It is anticipated that these "toppers" will move with the patient to the assessment areas and Abington Ward.

6. Health Care Associated Infections (HCAIs)

HCAIs are infections acquired as a result of healthcare interventions.

We have a zero tolerance policy to infections and are working towards preventing and reducing them; part of this process is to set improvement targets. If the number of actual cases is greater than the target then we have not improved enough.

The table below shows the number of infections we have had this month and the previous month, plus the improvement target for 2015/16 and results for the year to date.

	C.difficile	MRSA
Number of infections this month	**3**	**0**
Number of infections last month	**3**	**0**
Improvement target for year to-date	**21**	**0**
Actual to-date	**7**	**0**

For 2015/16, the contractual sanction that can be applied to each C. difficile case in excess of an acute organisation's objective will remain at £10,000.

6.1 Special measures for June
No wards were on special measures in June.

Please note that the surveillance for April 2015 is still ongoing as patients are monitored via a questionnaire or followed up 30 days after their operation date.

6.2 Improvement action plan update
Weekly Improvement Plan meetings continue, chaired by the Director of Infection Prevention Control, focusing on areas where compliance against the Hygiene Code is at risk. There remains an elevated risk with Criterion 2, particularly in relation to the standards of cleanliness and hygiene.

A Trust Cleaning Services Appraisal report was presented by the in June to the Executive Team. It was agreed that a centralised model will ensure that we have consistently high standards of cleaning across the Trust and all of our staff who are involved in providing our cleaning, food and hydration services will have the training, support and supervision they need to ensure that we meet the expectations of all our patients and staff. The detail around these proposals will be developed in the course of the next two months and the policy to support the revised protocols and practice will be completed by September.

The follow up visit from the Infection Prevention Control (IPC) lead at the Trust Development Authority (TDA) confirmed that it was evident that a significant amount of work had been undertaken since the previous visit; however there remained areas that needed to be improved upon; additional actions have been included in the Improvement Plan and continue to be monitored weekly.

6.3 Beat the Bug
These quality visits continue and 23 wards were reviewed for the month of June 2015. The findings were:

- Patient equipment clean and not taped
- High and Low level dust
- Patient equipment taped and not clean
- Aseptic non-touch technique (ANTT) trays being left and washed in the ward hand wash basin
- Contaminated commodes
- Full analysis of the trends and actions put in place to address any issues identified on the Beat the Bug visits will be presented to and monitored through the IPC Committee from August.

7. Falls Prevention

7.1 Maximum of 5.5 falls/1000 bed days (internally set target)
Falls/1000 bed days this month 4.00 (last month 4.59)

7.2 Maximum of 1.6 harmful falls/1000 bed days (internally set target).
Harmful falls/1000 bed days this month 1.15
This month we reported 0 in-patient falls that caused at least 'moderate' harm.

7.3 Training
77% (as of end of May 2015) of staff are trained in slips, trips and falls. Breaking down these figures reveals that a low percentage of Doctors (in training) are complaint. In order to address this doctors are being signposted towards a new national e-learning program ‘CareFall’ which it is hoped will improve the training figures.

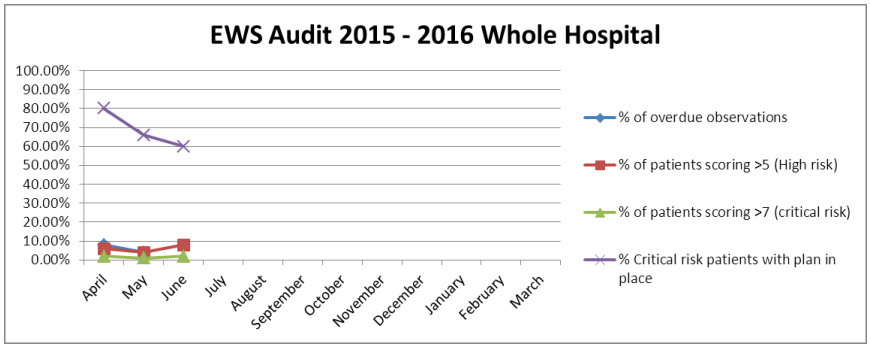
Falls Training by Directorate (data at end of May 2015):

General Surgery	80% in date
Medicine	74% in date
Women’s & Children’s and Oncology	79% in date

7.4 Work underway to reduce the falls rate/improve post fall care:
- Working with pharmacy re medication review
- Work to improve percentage of patients getting lying and standing BP checked
- On-going thematic analysis of serious incidents
- On-going training including neurological observation simulation training sessions
- Delirium policy drafted-Dementia Action Group to take this forward.
- RCP National audit took place in May 2015-this will identify areas for further improvement work once the results are available

8. EWS Compliance

The % of patients scoring >5 on their EWS who have a treatment plan has fallen for the third month, each ward highlighted as red on the report have been requested to produce an action plan for improvements through the Resus team. Due to the interruption of Vitalpac in June the compliance results are unavailable at present and so therefore a comparison for overdue observations is unavailable.



9. Patient Experience

9.1 Friends & Family Test

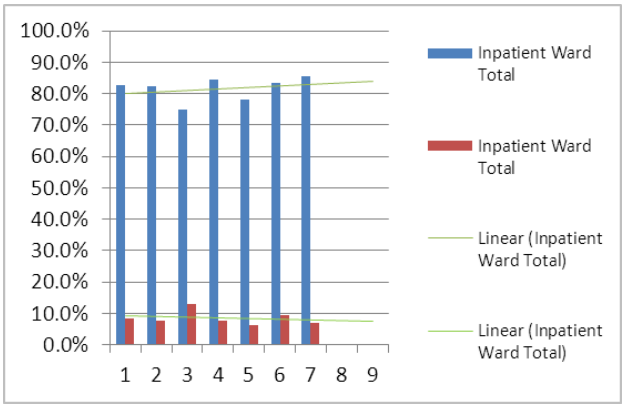
FFT Satisfaction Targets:
Following the review of the results collected across the six months since the introduction of the new data collection methods, targets have been identified for the percentage of 'Would' Recommends for the following areas:

- Inpatients & Day Cases: 85%
- Outpatients: 90%
- Maternity: 95%
- A&E: 87%

Of most significance for May FFT Patient Satisfaction:

Inpatients Wards:

- Of those surveyed in May for Inpatients, 85.4% stated they would recommend and 7.1% said they wouldn't. May saw Inpatients achieve their highest satisfaction rates since the data collection methods changed in November 2014
- From reviewing the 7 months of trend data (November (1) December (2) and January (3) February (4) March (5) April (6) May (7)) it is evident that the prediction trend lines are showing continued predicted improvements in both the Would recommend and a decrease in Wouldn't recommends

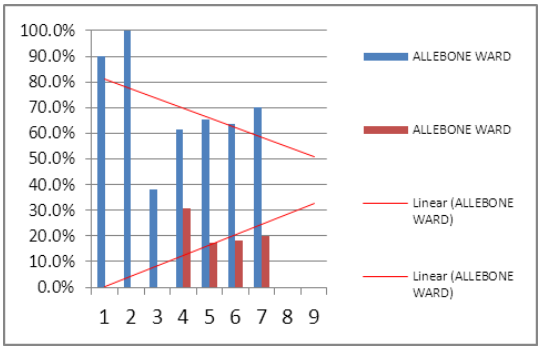


- From breaking down Inpatients per ward it is evident that there has been an improvement in satisfaction with a number of areas showing positive trend lines for both sections. Abington, Becket, Althorp, Head & Neck, Finedon, Hawthorn, Rowan and Willow

- Areas that fell below the target of 85% were; Allebone (70%), Benham (80%), Cedar (83%), Creaton (80%), Dryden (72.7%), EAU (79.8%), Knightley (80%), Rowan (83.8%) and Spencer (83.6%)

Areas of Concern:

- Of most concern for May is Allebone
- Allebone had seen continued improvements with their highest 'Would' recommends achieved since December for May. However this is still low at 70% and their Wouldn't recommends have risen again month on month since March
- Allebone have not reached the target of 85% 'Would' recommend since December 2014



- Work is taking place within the ward to review any issues. Progress will be monitored and if it continues to depreciate and progress not made Ward Managers will be invited to attend the Patient & Carer Experience & Engagement Group to update on the actions they are taken to address this

Paediatrics:

- Paediatric wards achieved 85% of parents/patients stating that they would recommend, and 8% stating they wouldn't

Emergency Departments:

- A&E (including Eye Casualty and Ambulatory Care) have seen their satisfaction levels reach the highest score they have seen since data collection began in November, reaching a combined score of 89.8% for would recommends and 6.7% for wouldn't
- This also means A&E achieved their target to reach 87% of patients recommending them

Maternity (4 points in the care pathway):

- Maternity continue to see high levels of satisfaction raising no concern with 96% of patients stating they would recommend and just 2% stating they wouldn't.
- Maternity achieved their target of 95% of patients recommending them

Outpatients:

- Outpatient departments accumulated received a recommendation percentage of 91% and wouldn't recommend percentage of 4%
- Outpatients achieved their target of 90% of patients recommending them

The regular theme that emerges each month for the Outpatient comments are consistently mentioning words relating to delays, cancellations and waiting. This information has been fed back to the services.

9.2 FFT for Children and Young People - Update
The surveys have now been finalised for use with Children and Young people within:

- A&E
- Eye Casualty
- Outpatient Departments
- Day Case Areas
- Paediatric Inpatients

Final arrangements are being made with the IT department regarding the data extract to be sent to our external company. This will go live at the end of July and data will be reported to the committee within due course.

9.3 The National Children & Young Peoples Survey 2014 – National CQC results
National results for the first National Children and Young people's survey were published by CQC in June 2015. The format of the survey is different to those run for other areas as it included 3 different types of questionnaires, tailored for different age ranges of children. The first version, 0-7 year, was completed by parents. The second and third versions (8-11 and 12-15 year olds) contained an initial section for completion by the child/young person and a second section for completion by parent/carers. The sample was taken from Childrens & Young People that attended either as an inpatient or as a day case in August 2014.

When comparing NGH's performance against that of the national averages we can see that NGH performed as 'Better' than the national average in 2 questions and 'worse' than the national average in none. The rest of the scores were in the 'About the Same' category meaning they were in line with the national average.

The questions where NGH performed 'better' in were:

All Parents and Carers said:
- Staff explained to parents and carers what would be done during the operation or procedure

Children and Young People said:
- Hospital staff told them what to do or who to talk to if worried about anything when home

Overall the survey shows high levels of satisfaction for our children, young people and parents that have visited us across August 2014. From reviewing the results it is evident that areas where the departments are performing well are around information sharing, staff explaining everything clearly and patients/parents feeling that they were able to ask questions. Only one question fell just outside of the 80% mark at 79% relating to communication and this was, 'Did members of staff treating your child communicate with them in a way that your child could understand.' It was extremely positive to see the question 'Were you given information about how your child should use the medicines?' scoring so highly (99%) as this is a consistent issue area within the adult inpatient survey. It appears lessons can be learnt around the communication from Paediatrics in this area.

10. Safeguarding & Dementia
10.1 Dementia CQUIN
The dementia CQUIN report for this month includes the end-of-quarter position for Q1. As can be seen below, despite a recent slip in the case finding indicator *[for reference, a slip of 0.4% = 1 patient]* the overall position for the end of quarter is positive. This is likewise true of the referral indicator, which has seen a marked improvement since the April slip.

Indicator	Target	Trend	Apr-15	May-15	Jun-15	Q1
Dementia: Case finding	90%		90.1%	90.2%	89.6%	90.0%
Dementia: Initial diagnostic assessment	90%		100.0%	100.0%	100.0%	100.0%
Dementia: Referral for specialist diagnosis/follow-up	90%		83.3%	92.3%	100.0%	91.7%

As with previous months and influenced by the relatively small numbers [n] of patients who comprise the cohort for the various elements of the indicators; there remains a degree of risk associated with achieving the target on a monthly basis. As demonstrated; where there is a failure on one or more elements, these are recovered in-quarter; usually the following month.

Work has commenced with Informatics colleagues to identify, if possible a process of identifying early trend *in-month* to attempt to address shortfall rather than work on a model that is based on in-quarter recovery, as is currently used.

The carer's survey [data below] has been significantly developed this quarter and as referenced in previous reports, the new survey will commence in Q2. This will allow the Trust to really understand the needs of this cohort of carers in a meaningful way and for the first time, interpret and report these centrally *[via the Patient and Carers Experience and Engagement Group].* Therefore this month's data, which reports only against compliance / non-compliance, will be redeveloped for next month's highlight report.

Indicator	Target	Trend	Apr-15	May-15	Jun-15	Q1
% CQUIN Compliance	90%		100.0%	104.0%	100.0%	101.3%
Trend Analysis			200.0% 0.0%			

10.2 Safeguarding

The Trust remains involved in a non-accidental injury case which is currently subject to family court proceedings. No other Local Authority Designated Officer (LADO) referrals or allegations against staff have been received in Q1.

The current training compliance picture *[Trustwide data]* for the quarter is shown below:

	April	May	June	Trend
SGA 1	79%	79%	80%	
SGA 2	68%	70%	71%	
MCA & DOLS	73%	73%	73%	
SGC 1	94%	95%	95%	
SGC 2	59%	59%	62%	
SGC 3	47%	52%	52%	

Enclosure E

As can be seen, although the majority of areas show an increase; this is small *[representing ~100 staff]*, there remains only the level one safeguarding children training that meets the internal target of 85%.

Compliance with safeguarding adults training is more encouraging; however this too is considerably lower than the anticipated target of 85%.

As reported last month, the organisational response to the Lampard Report offered the Board significant assurance in relation to the recommendations from the Savile enquiries. The Safeguarding Team have reviewed outstanding elements and these have been completed *[subject to policy ratification due process],* with slip of one month on one action point, now recovered.

Following the TIAA internal audit, the following actions have been completed:

- Ratification of the Safeguarding Adults Policy [June 15]
- Extension to the Safeguarding Children's Policy until December 2015.

The Safeguarding Children Policy requires to be re-developed to make it more manageable and accessible to staff and to ensure compliance with *Working Together to Safeguard Children [2015].* There is a minimal risk associated with this; however there has been no substantive legislative change since the policy was produced therefore this risk is widely mitigated.

11. Midwifery Update

11.1 Antenatal Screening QA

Preparations begin for the National Antenatal Screening QA due in January 2016. There is collaborative work between five different areas to ensure initiation right through to closure of the loop for Antenatal and Neonatal screening.

11.2 Antenatal Infectious Diseases in Pregnancy Screening and Sickle Cell & Thalassaemia

The Prenatal Diagnosis team have worked tirelessly with NGH lab to enable midwives to request antenatal screening bloods for infectious diseases and Sickle Cell & Thalassaemia via ICE. This will assist the community midwives in their antenatal clinics, reduce the risk of transcription errors and provided a robust system for completion of the Family Origin Questionnaire which is pertinent to the Sickle Cell & Thalassaemia screen. This achievement has been noted at National level as we are the first hospital to achieve this and a request has been made from the National Programme Manager for Sickle Cell & Thalassaemia Cathy Coppinger for a visit to the Trust to see how this has been achieved.

11.3 Medway

Since appointment of Clinical Change Mangers work with Medway is progressing well. There has been a reduction in minor errors and an increase in specialist areas using Medway. Work continues with support from David Churchill and Tom Powell to improve the connectivity in the community. Once stable connectivity has been achieved the move towards the paper light process can progress. Collaboration with KGH Medway is being sought and would be welcomed in order to smooth the cross border concerns.

11.4 Partnership working with Child Health (Transitional Care)

A 4 bedded bay on Robert Watson is now being used to pilot transitional care. Nurses and Midwives are working closely together to provide care for our babies with special requirements. This pilot will be reviewed after 10 weeks and an assessment made as to whether this can continue. A business case is being developed to find a more permanent solution to keep these babies alongside their mothers.

11.5 Patient Experience
The Interim Maternity Survey Report has just been sent through and demonstrates a significant improvement in patient satisfaction when compared with our 2013 data. From an eligible population of 336 women who birthed their babies in February 2015, 150 returned their survey forms (44.6%)

We have improved in 40 out of 45 questions, with 22 showing a significant increase in satisfaction of over 5 points. This is comparable with our monthly FFT data which is great news. It reflects the excellent work and care that is being delivered to the families using our services both in the hospital and the community.

Examples of the questions answered from the patient's perspective:

B6	Got enough information from midwife/doctor to help you decide where to have your baby?	Increased by a massive 17 points - improvement
B17	During antenatal care, were you involved enough in decisions about your care?	Increased by 7 points - improvement
C13e	Left alone by midwives/doctors at a time when it worried you? No not at all	Increased by 5 points - improvement
D5	In hospital after the birth, were you treated with kindness and understanding?	Increased by 8 points - improvement
F10	Did you have confidence and trust in the midwives you saw after going home?	Increased by 6 points - improvement

We await the final report in a couple of months.

11.6 Barrett Birth Centre
There were 154 births in Q1 2015/16 having provided care for 192 women.
In caring for the 192 women 82% use the pool for labour, birth or both with 44.8% having a water birth.

The Intrapartum transfer rate is particularly good when compared to national statistics:

Primips 35 Postnatal 7 Transfer rate 27 % (National 40%)
Multips 3 Postnatal 3 Transfer rate 3.8% (National 13%)

11.7 Breast Feeding rates (initiation) % for Q1 2015/16
The breast feeding rates throughout Q1 has increased month on month – April 72.6%, May 74.5% and June 78%.

As an initiative to improve the information sharing and successful implementation of breast feeding in the early days NGH has commissioned Ann Davison from Baby Ways to work 30 hours a week on the postnatal wards. The role is to work in a supernumerary capacity supporting and helping to embed BFI best practise. One of the objectives is to implement 11 o'clock stop and focus on a reduction in supplementation of feeds. The latest audit following her appointment in April 2015 showed a significant improvement.

Maternity Support Workers have been appointed to work in the community. There is a drive in the community to improve the communication on infant feeding choices.
NGH will be assessed for BFI stage 3 in October 2015.

12. Hard Truths Update

It is an ongoing requirement of NHS England that all NHS Trust Boards receive a monthly report relating to nurse staffing levels. A detailed report has been received by the Workforce Committee; a summary is within this report. It is also a requirement set out within The National Quality Board Guide to Nursing, Midwifery & Care Staffing Capacity & Capability (2014) that Trust Boards review nurse staffing based on an evidenced based tool. The outcome of this bi-annual review that was undertaken in April 2015 is summarised in section 16 of this paper.

In line with the staffing strategy (2014-2017) for NGH that was agreed by the Trust Board in 2013, the agreed uplift to the nurse staffing establishment across the adult inpatient areas came into effect from April 2015. This equated to an additional 72.53 WTE RNs from month 1.

This additional uplift has been included in the recruitment trajectory but will be forecast in two stages. 51.70 RNs will be built into the recruitment pipeline from April 2015 and the subsequent 20.83 RN's will be added from October 2015.

This uplift will have an impact on our overall fill rate as whilst there has been an uplift in the overall ward budgets, the staff in post will be reflected in the recruitment trajectory.

Overall fill rate for June 2015 was 90%, compared to 81% in May. Combined fill rate during the day was 86% in June compared with 72% in May and for the night 97% compared with 101% in May. RN fill rate during the day was 79% and for the night 82%. This reflects the additional uplift into the budgets increasing our planned hours for RNs with a steady but challenging recruitment process.

From June 2015 wards provide assurance on the safe staffing for each shift through the declaration of a RAG rating which will reflect the overall safety of the ward reflecting staffing, skill mix, temporary staffing and patient acuity and dependency.

Any shifts that are reported are 'Red' should also be reported through the electronic datix reporting system and will be captured in this report.

13. June 2015 staffing

A full breakdown of the ward analysis is included in appendix 1.

There were a total of 133 bed days occupied as additional capacity to support the increase in Demand on our urgent care pathway; 50% less than the previous month having a significant impact on staffing fill rates. These additional beds will be staffed by the staff on our inpatients ward areas, and where possible, back fill will come from the temporary nursing workforce, this will impact on the overall ward fill rate.

As reported previously, the Board should be reassured that staffing is reviewed by a senior nurse at the twice daily safety Huddles Monday to Friday, and daily at a weekend. Any wards where staffing is at a minimum level or due to increases in acuity and dependency there is a need for additional staff above planned numbers, movement of staff is made and risk assessed.

All datix have been reviewed. Risk assessment forms that are completed when there are any staff moves are returned to and monitored by the Associate Directors of Nursing.

14. Number of incidents reported by staff in June 2015

A total of 24 incidents were reported relating to staffing concerns in June, compared with 14 in May and 16 in April. All incidents reported no harm to patients with the exception of the incident of poor staffing reported from HDU which was reported as an outcome of low harm due to the unit having no shift coordinator on the shift in question. 13 out of the incidents were reported regarding staffing levels on a Friday, Saturday and Sunday.

14.1 Staffing Status per shift and Red Flag Incidents in June 2015
All areas that were reported as 'red' were risk assessed and plans were made to move staff (without detriment to those areas), in order to change all ward status' to AMBER. (NB – Code Red & End of Life are Trust wide indicators of acuity & dependency). This is an indication of the acuity and dependency of the patients at the time of reported at the huddle. This information will be triangulated with actual harm and incidents reported.

Area	Red Staffing declarations		Code Reds	End of Life	SOVA/DOLS /EC
ED	2		NA		
EAU	4		23	2	11
Benham	2		13	1	3
Allebone	8		8	3	12
Becket	4		8	1	5
Brampton	1		2	3	
Compton	0		1		12
Creaton	1		5	1	16
Collingtree	8		2		3
Dryden	7		28	2	3
Eleanor	0		9	3	7
Finedon	1		1	1	3
Holcot	0		4	4	14
Knightley	1				2
Victoria	4				9
Talbot Butler	1		11	3	2
Abington	4		2		9
Althorp	4		2		
Cedar	12		2	1	4
Hawthorn	2		2	1	1
HDU/ITU	0		NA		5
Head & Neck	1		1		2
Rowan	0		5	1	
Willow	3		8	3	1
Spencer	0		3		
MDSU/GDCU NHC	21				

STATUS	**NGH RAG Rating System for Staffing Levels**; **DESCRIPTOR**
GREEN	Shift is at planned & funded levels which is equal to or above an RN 1:8 ratio
AMBER	Shift is below planned & funded levels, however it is deemed within safe levels by the NIC and senior nursing team using professional judgement, acuity, dependency, skill mix & activity. Minor delays inpatient care may occur but will not be detrimental to their overall care and safety. Matron is aware and monitoring the situation
RED	Shift is below planned & funded levels to a point that the NIC and senior nursing team have concerns regarding safety which could result in detrimental delays in patient care. Steps are being taken to mitigate risk and Datix reports submitted

15. Bank and Agency usage for month of June 2015

Bank and agency usage and demand decreased in June 2015. In June, a total of 148.6 WTE bank and agency HCA shifts were requested, compared to 171.6 WTE in May and a total of 144.1 WTE RN shifts were requested compared to 181.5 WTE in April. The reason for 45% of the HCA shift requests is to support patients with enhanced care needs and 70% of the reasons for the RN shifts is to fill unfilled vacancies.

16. Safer Nursing Care Tool – Biannual review

In line with national Expectations (NQB, 2014) and guidance (Safe Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals, NICE, July 2014) a bi-annual review of the nursing skill mix using an appropriate methodology should be undertaken. The skill mix review has been undertaken across adult inpatient areas; specialist inpatient, critical care and emergency departments are no included in this review at the moment.

In April 2015 the Trust undertook a skill mix review across the general wards using the evidence based acuity and dependency tool, Safer Nursing Care Tool (SNCT). The key findings of this audit are presented below.

There is evidence to suggest that overall Trust wide acuity was reduced during the month of April 2015 compared with previous months which is a significant factor for those areas where budget increases had been made in line with high level activity in the previous year's uplifts.

16.1 Presentation of findings

The findings of the SNCT audit are presented in a summary table appendix 2. It should be noted that our 'Specialist wards' have not had a skill mix review against their acuity and dependency due to the limitations of the SNCT but will undertake a local review of their own staffing against speciality national guidance/best practice as necessary.

The summary table presents the funded establishment for 2015/16, SNCT recommended establishment and the difference between the two. Both data sets are presented as WTE qualified and unqualified staff. The Trusts current establishment supports the Ward Sister role working 2 days 'supervisory' and 3 days 'clinical' and a coordinator on the 'early shift', which has been included in the SNCT data. The previous year's SNCT data is also presented.

16.2 Key findings and analysis

At the time of the review, demand for Level 1 capacity was reduced. Rowan, Beckett, Head & Neck and Willow had on average only 50% of their Level 1 beds filled with Level 1 patients during April.

Talbot Butler are funded to establish the day unit (EAB) yet the review only includes the inpatient facility leading to an outcome that suggests there is an over establishment of Registered Nurses (RNs)

Holcot and Eleanor require further validation of their data to confirm whether the information reported is accurate. The matron for this area will undertake this piece of work over the coming weeks.

There is a newly published acuity and dependency tool for use in assessment areas and this tool was used for the first time this year to evaluate the data produced by EAU and Benham. The division have already recognised the need for additional RNs to support the increase in acuity and dependency and this is being supported through the business planning process.

The Trust has committed to increasing registered nursing establishments to a 1:8 ratio where appropriate across the day and night as recommendations set out in NICE guidelines (2014).

The skill mix has been adjusted to reflect the National Royal College of Nursing (RCN) recommendation unless it is recognised that a higher ratio of registered nurses is required, i.e. Becket Ward at 70:30 (respiratory Medicine), and in other areas, Elderly Care a skill mix of 60:40 is acceptable if the numbers of staff to patients is 1:8.

Although the SNCT is recommended as the evidence based audit tool 'of choice' from the NICE guidance it does have its limitations for smaller wards (below 18 beds) due to the need for a minimum of two staff on each shift. Of particular note is Althorp, Head & Neck, Compton, Knightley and Victoria.

16.3 Summary of the Nurse Staffing Review

When undertaking a staffing review using the SNCT there are still some anomalies against our current establishment. However, the professional judgement of the senior nursing team would not, in general, want to alter the current establishment. For those areas where there appears to be significant under/over establishment further review will be required.

In previous years the SNCT has been one of three pieces of data that would be considered as part of the preparation for developing the Business Case for the next year of the Nurse Staffing Strategy. The other pieces of data would be the current establishment and a summary of the Ward Sisters professional view of the establishment required for his/her ward. However, during the past 6 months the Director of Nursing has met with all of the Ward Sisters to review establishment and skill mix. These meetings have been attended by the Finance and Workforce teams' to ensure there is individual support for each Ward Sister. Therefore for the general wards there has been on-going professional review of the nursing establishment and discussions have occurred during this process.

The following are all relevant considerations when reviewing the data submitted following this period of review:

- Data provided as part of the urgent care programme has identified that levels of patient acuity were reduced across the Trust for all in patients for April 2015 which is the period of time that the SNCT review occurred. This will inevitably have impacted on the data provided for the clinical areas.
- As part of the Shift Standardisation review it is anticipated that there will need to be a review of roles and responsibilities as start and finish times change. It would be appropriate and beneficial to ensure all staff groups are reappraised of their individual responsibilities to ensure efficient working. This will be particularly relevant once all staffing vacancies have been filled.
- A data set specifically for assessment units has been applied for the first time since publication this year (demonstrated by an establishment of -8.5wte on Benham and -7.3wte on EAU).
- It appears that those patients requiring Enhanced Observation of Care (specials), have not been consistently identified via the data as there has been a change to the scoring that should be applied for this specific patient group from a level 1b to a level 2 to the time requirements involved in caring for this patient type. This could account for the SNCT over establishment of HCAs.
- Historically the data gained in the September SNCT review is used to inform budget setting for the next financial year.
- Challenges with ongoing Registered Nurse recruitment mean that wards are continually working below budgeted establishments with increased reliance on temporary nursing staff. On a daily basis staffing is supported through the Trust wide Clinical 'Safety Huddles'. The Corporate Nursing team will ensure that all wards are safely staffed, that poor fill rate is identified and mitigated and Red Flag risks are correlated for each clinical area to provide an overview of the Trust on a shift by shift basis.
- Further updates will be provided to the Trust Board as Specialist service reviews are undertaken.

17. National Quality Board – Nurse Staffing Expectations

In November 2013 the National Quality Board published a document which outlined 10 expectations in relation to nursing and midwifery staffing (How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery & care staffing capacity and capability). In February 2014 the Director of Nursing and Midwifery provided a gap analysis against this document and identified that the Trust was:

- Compliant with expectations 1, 3, 5, 6, 7, 8
- Further actions to take to achieve compliance with expectations: 2, 4, 9
- Expectation 10 is the responsibility of the CCG

We have revisited the recommendations and the Trust is now compliant with all the relevant recommendations for the Trust.

18. Recommendations

The Trust 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.

MEDICINE Safe Staffing Report June 2015 (M3)

Northampton General Hospital NHS Trust

Nursing Informatics

ID	Care Group	Speciality	Ward/Unit	Band	M12 Budget WTE 14/15	M1 Budget WTE 15/16	M1 Uplift WTE 15/16	M3 SIP WTE 15/16	M3 Vacancy WTE 15/16	% Vacancy	M2 Leavers WTE	M3 Starters WTE		DAY HOURS: Planned RN	Additional RN	Acutal RN	Planned HCA	Additional HCA	Actual HCA	% RN		% HCA		NIGHT HOURS: Planned RN	Additional RN	Acutal RN	Planned HCA	Additional HCA	Actual HCA	% RN		% HCA		Sickness Absence RN %	Sickness Absence HCA %
	Medicine	326 - ACUTE INTERNAL MEDICINE	Allebone	2-4	17.99	19.92	1.93	18.93	0.99	5%	1.00	0.00	↓	2162.0	0.0	1428.2	2020.0	155.0	1881.5	66.1%	↓	86.5%	↓	1200.0	11.0	902.0	600.0	530.6	1116.3	74.5%	↓	98.7%	↓	9.5%	0.4%
				5-7	25.28	26.78	1.50	18.53	8.25	31%	1.00	2.00	↑																							
	Medicine	340 - RESPIRATORY MEDICINE	Becket	2-4	19.66	19.43	-0.23	19.97	-0.54	-3%	0.00	0.00	↔	2418.0	5.0	1684.8	1950.0	167.0	1813.5	69.5%	↓	85.7%	↓	1178.0	19.0	1196.8	600.0	333.4	931.9	100.0%	↔	99.8%	↓	4.3%	7.6%
				5-7	27.58	29.42	1.84	19.47	9.95	34%	0.00	0.00	↔																							
	Medicine	Male Assesment Unit	Benham	2-4	11.38	11.38	0.00	10.53	0.85	7%	0.00	0.00	↔	2174.5	0.0	1783.7	874.0	547.5	1313.2	82.0%	↑	92.4%	↑	1200.0	4.5	1210.0	599.3	262.0	858.8	100.5%	↑	99.7%	↑	1.6%	9.0%
				5-7	26.59	26.59	0.00	21.67	4.92	19%	0.00	0.00	↔																							
	Medicine	430 - GERIATRIC MEDICINE	Brampton	2-4	14.80	14.80	0.00	13.48	1.32	9%	1.00	0.00	↓	1787.5	27.5	1546.5	1323.0	144.5	1289.0	85.2%	↑	87.8%	↑	1200.0	0.0	999.8	600.0	60.0	653.0	83.3%	↑	98.9%	↑	3.1%	4.8%
				5-7	17.26	23.37	6.11	19.33	4.04	17%	0.00	0.00	↔																							
	Medicine	326 - ACUTE INTERNAL MEDICINE	Collingtree	2-4	21.47	19.92	-1.55	24.93	-5.01	-25%	0.00	0.00	↔	2656.5	12.5	2055.0	2024.0	40.0	2059.5	77.0%	↑	99.8%	↓	1500.0	10.0	1393.4	600.0	230.0	810.0	92.3%	↑	97.6%	↓	3.6%	4.3%
				5-7	30.65	34.58	3.93	18.13	16.45	48%	0.53	0.00	↓																							
	Medicine	300 - GENERAL MEDICINE	Compton	2	10.11	4.63	-5.48	10.73	-6.10	-132%	0.60	1.00	↑	1287.5	7.5	1084.8	839.5	391.0	1181.5	83.8%	↑	96.0%	↓	860.0	20.0	670.0	0.0	632.0	632.0	76.1%	↓	100.0%	↔	9.2%	7.2%
				5-7	13.49	17.67	4.18	12.56	5.11	29%	0.00	0.00	↔																							
	Medicine	326 - ACUTE INTERNAL MEDICINE	Creaton	2-4	16.51	18.21	1.70	15.33	2.88	16%	0.00	1.00	↑	1963.0	0.0	1527.5	1783.0	669.5	2264.5	77.8%	↓	92.3%	↑	923.7	0.0	904.2	600.0	806.7	1396.7	97.9%	↑	99.3%	↓	1.4%	1.3%
				5-7	24.13	24.59	0.46	16.60	7.99	32%	1.00	0.00	↓																							
	Medicine	320 - CARDIOLOGY	Dryden	2-4	9.11	11.38	2.27	10.00	1.38	12%	0.00	0.00	↔	2488.0	12.5	1531.7	897.0	65.5	775.5	61.3%	↓	80.6%	↓	1190.0	32.3	1212.3	590.0	100.2	660.2	99.2%	↑	95.7%	↑	2.9%	1.7%
				5-7	26.58	30.19	3.61	19.20	10.99	36%	0.67	1.00	↑																							
	Medicine	Female Assessment unit	EAU	2-4	16.45	17.07	0.62	14.60	2.47	14%	0.00	0.00	↔	2687.0	0.0	1999.5	1333.0	321.2	1515.7	74.4%	↓	91.6%	↑	1500.3	30.0	1465.0	897.5	288.0	1200.0	95.7%	↓	101.2%	↑	6.5%	2.9%
				5-7	32.27	32.68	0.41	23.39	9.29	28%	0.00	2.00	↑																							
	Medicine	300 - GENERAL MEDICINE	Eleanor	2	7.40	7.40	0.00	5.60	1.80	24%	0.00	0.00	↔	1332.0	0.0	1030.5	647.5	364.5	913.0	77.4%	↓	90.2%	↓	600.0	10.0	600.0	300.0	365.3	656.8	98.4%	↓	98.7%	↓	1.4%	6.4%
				5-7	14.09	15.40	1.31	13.27	2.13	14%	1.00	0.00	↓																							
	Medicine	361 - NEPHROLOGY	Finedon	2-4	6.89	7.97	1.08	8.00	-0.03	0%	0.00	0.00	↔	2542.5	0.0	1615.5	448.0	256.5	577.0	63.5%	↓	81.9%	↓	1125.0	0.0	1096.0	375.0	160.5	533.5	97.4%	↑	99.6%	↓	1.2%	7.9%
				5-7	25.30	28.03	2.73	19.00	9.03	32%	1.00	1.00	↔																							
	Medicine	328-STROKE MEDICINE	Holcot	2-4	16.27	15.25	-1.02	15.60	-0.35	-2%	0.00	1.00	↑	1934.0	0.0	1611.0	1317.0	396.5	1628.5	83.3%	↑	95.0%	↑	1320.0	10.3	1264.8	660.0	473.0	1089.0	95.1%	↑	96.1%	↑	1.7%	13.4%
				5-7	20.75	25.50	4.75	23.88	1.62	6%	0.00	0.00	↔																							
	Medicine	326 - ACUTE INTERNAL MEDICINE	Knightley	2-4	11.15	8.54	-2.61	10.73	-2.19	-26%	0.00	0.00	↔	1154.0	13.0	820.8	1101.0	350.0	1338.5	70.3%	↓	92.2%	↑	900.0	0.0	650.0	0.0	620.0	620.0	72.2%	↑	100.0%	↔	3.5%	13.5%
				5-7	15.20	17.67	2.47	12.73	4.94	28%	0.00	0.00	↔																							
	Medicine	300 - GENERAL MEDICINE	Victoria	2-4	12.52	4.63	-7.89	12.53	-7.90	-171%	1.00	0.00	↓	1340.5	12.5	884.0	1266.5	440.5	1595.0	65.3%	↑	93.4%	↑	899.5	0.0	650.3	0.0	920.0	920.0	72.3%	↓	100.0%	↔	2.8%	18.4%
				5-7	16.19	17.67	1.48	11.20	6.47	37%	0.00	0.00	↔																							

SURGERY Safe Staffing Report June 2015 (M3)

Northampton General Hospital NHS Trust

Nursing Informatics

ID	Care Group	Speciality	Ward/Unit	Band	M12 Budget WTE 14/15	M1 Budget WTE 15/16	M1 Uplift WTE 15/16	M3 SIP WTE 15/16	M3 Vacancy WTE 15/16	% Vacancy	M2 Leavers WTE	M3 Starters WTE		DAY HOURS: Planned RN	Additional RN	Acutal RN	Planned HCA	Additional HCA	Actual HCA	% RN		% HCA		NIGHT HOURS: Planned RN	Additional RN	Acutal RN	Planned HCA	Additional HCA	Actual HCA	% RN		% HCA		Sickness Absence RN %	Sickness Absence HCA %
	Surgery	110 - TRAUMA & ORTHOPAEDICS	Abington	2-4	20.15	20.15	0.00	21.24	-1.09	-5%	0.00	0.00	↔	1999.3	0.0	1263.6	1785.0	148.0	1497.0	63.2%	↓	77.4%	↓	1302.4	20.5	1225.0	990.0	177.5	1166.5	92.6%	↓	99.9%	↓	2.2%	3.9%
				5-7	22.63	24.62	1.99	14.33	10.29	42%	1.00	0.00	↓																							
	Surgery	110 - TRAUMA & ORTHOPAEDICS	Althorp	2-4	9.48	9.84	0.36	10.87	-1.03	-10%	0.00	0.00	↔	1228.5	0.0	964.0	995.5	96.0	899.5	78.5%	↓	82.4%	↑	810.0	0.0	595.5	300.0	139.0	389.0	73.5%	↓	88.6%	↓	6.3%	10.4%
				5-7	13.73	16.05	2.32	9.83	6.22	39%	1.00	0.00	↓																							
	Surgery	110 - TRAUMA & ORTHOPAEDICS	Cedar	2-4	21.09	21.86	0.77	23.32	-1.46	-7%	0.00	2.00	↑	2240.9	0.0	1548.1	2024.0	76.5	1789.2	69.1%	↑	85.2%	↓	1140.5	0.0	1121.3	855.0	57.0	894.0	98.3%	↑	98.0%	↓	11.4%	0.9%
				5-7	20.93	26.33	5.40	17.94	8.39	32%	0.00	1.00	↑																							
	Surgery	120 - ENT	Head & Neck	2-4	8.62	7.97	-0.65	12.20	-4.23	-53%	0.00	0.00	↔	1340.5	22.5	1209.0	446.0	152.0	557.5	88.7%	↓	93.2%	↓	730.0	0.0	620.0	300.0	80.5	367.8	84.9%	↓	96.7%	↓	3.4%	16.5%
				5-7	15.95	16.57	0.62	17.80	-1.23	-7%	0.00	0.00	↔																							
	Surgery	100 - GENERAL SURGERY	Hawthorn	2-4	17.03	15.81	-1.22	12.21	3.60	23%	0.80	0.00	↓	2240.7	0.0	1893.6	1263.5	117.5	1299.5	84.5%	↓	94.1%	↓	1080.8	0.0	1019.5	738.0	90.8	792.8	94.3%	↓	95.7%	↓	1.3%	8.6%
				5-7	24.51	27.78	3.27	21.16	6.62	24%	2.00	0.00	↓																							
	Surgery	192 - CRITICAL CARE MEDICINE	ITU	2	9.67	11.04	1.37	9.89	1.15	10%	0.00	0.00	↔	5524.3	19.0	4793.6	859.8	11.3	824.3	86.5%	↑	94.6%	↑	4117.0	52.0	4255.8	690.0	23.0	812.8	102.1%	↑	114.0%	↓	4.3%	13.6%
				5-8A	80.14	95.80	15.66	70.66	25.14	26%	1.00	1.00	↔																							
	Surgery	301 - GASTROENTEROLOGY	Rowan	2-4	17.84	14.34	-3.50	16.32	-1.98	-14%	0.00	0.00	↔	2422.5	6.0	2176.5	1333.5	0.0	1244.0	89.6%	↓	93.3%	↑	1161.0	126.8	1197.3	540.0	0.0	540.0	93.0%	↓	100.0%	↓	5.0%	5.0%
				5-7	29.91	29.83	-0.08	27.03	2.80	9%	1.00	0.00	↓																							
	Surgery	100 - GENERAL SURGERY	Willow	2-4	12.40	14.34	1.94	13.56	0.78	5%	0.00	1.00	↑	2746.0	0.0	2250.0	1340.5	75.0	1310.8	81.9%	↑	92.6%	↓	1620.8	9.0	1521.1	540.0	64.0	604.8	93.3%	↑	100.1%	↓	10.7%	11.9%
				5-7	31.76	35.49	3.73	27.56	7.93	22%	0.00	0.00	↔																							

WCO Safe Staffing Report June 2015 (M3)

Northampton General Hospital NHS Trust

Nursing Informatics

ID	Care Group	Speciality	Ward/Unit	Band	M12 Budget WTE 14/15	M1 Budget WTE 15/16	M1 Uplift WTE 15/16	M3 SIP WTE 15/16	M3 Vacancy WTE 15/16	% Vacancy	M2 Leavers WTE	M3 Starters WTE		DAY HOURS: Planned RN	Additional RN	Acutal RN	Planned HCA	Additional HCA	Actual HCA	% RN		% HCA		NIGHT HOURS: Planned RN	Additional RN	Acutal RN	Planned HCA	Additional HCA	Actual HCA	% RN		% HCA		Sickness Absence RN %	Sickness Absence HCA %
	WCO	560- MIDWIFE LED CARE	Barrett Birth Centre & HBT	2-4	5.40	10.47	5.07	6.75	3.72	36%	0.00	0.00	↔	1575.8	0.0	1492.3	670.0	0.0	365.0	94.7%	↓	54.5%	↑	1314.0	11.5	939.8	688.0	0.0	412.0	70.9%	↑	59.9%	↑	11.2%	3.7%
				5-7	14.94	24.39	9.45	22.55	1.84	8%	0.00	0.00	↔																							
	WCO	420 - PAEDIATRICS	Disney	2-4	6.05	9.82	3.77	4.79	5.03	51%	0.00	0.00	↔	2507.5	38.0	1751.8	901.0	0.0	425.5	68.8%	↓	47.2%	↑	862.5	149.0	928.8	345.0	12.0	181.0	91.8%	↓	50.7%	↓	2.3%	4.2%
				5-7	22.77	21.79	-0.98	5.83	15.96	73%	0.00	0.00	↔																							
	WCO	420 - PAEDIATRICS	Gosset	2-4	6.84	13.09	6.25	5.24	7.85	60%	0.00	0.00	↔	2892.5	0.0	2226.1	1136.0	0.0	368.0	77.0%	↑	32.4%	↑	2668.0	34.5	1903.1	621.0	0.0	196.0	70.4%	↓	31.6%	↓	8.9%	2.2%
				5-7	49.11	48.21	-0.90	39.68	8.53	18%	0.61	1.00	↑																							
	WCO	560- MIDWIFE LED CARE	Sturtridge	2-4	24.30	26.36	2.06	26.13	0.23	1%	0.00	0.00	↔	4556.0	233.8	4010.4	2143.8	0.0	1763.5	83.7%	↓	82.3%	↓	4042.8	11.5	3697.4	1352.0	23.5	1243.8	91.2%	↑	90.4%	↑	5.7%	4.2%
				5-8A	66.24	66.46	0.22	66.29	0.17	0%	0.00	0.00	↔																							
	WCO	420 - PAEDIATRICS	Paddington	2	6.78	11.43	4.65	7.63	3.80	33%	0.00	0.00	↔	2841.5	46.5	2614.3	1397.5	4.5	530.0	90.5%	↑	37.8%	↓	2024.5	0.0	1814.5	345.0	0.0	149.5	89.6%	↓	43.3%	↑	9.7%	7.5%
				5-7	44.11	41.75	-2.36	7.53	34.22	82%	0.00	1.60	↑																							
	WCO	560- MIDWIFE LED CARE	Robert Watson	2-4	12.43	17.53	5.10	14.15	3.38	19%	0.73	0.00	↓	1127.0	152.3	1102.7	1192.6	171.5	940.3	86.2%	↓	68.9%	↓	1023.5	11.5	871.0	564.9	0.0	586.6	84.2%	↑	103.8%	↑	7.6%	2.7%
				5-7	16.20	17.57	1.37	16.03	1.54	9%	0.00	0.00	↔																							
	WCO	502 - GYNAECOLOGY	Spencer	2-4	7.81	7.40	-0.41	5.09	2.31	31%	0.00	0.00	↔	1065.0	45.0	1018.4	673.5	93.5	658.3	91.7%	↓	85.8%	↑	600.0	0.0	603.5	300.0	50.0	350.0	100.6%	↑	100.0%	↔	7.3%	20.8%
				5-7	13.91	13.00	-0.91	11.73	1.27	10%	0.00	0.00	↔																							
	WCO	800 - CLINICAL ONCOLOGY	Talbot Butler	2-4	11.46	13.17	1.71	8.93	4.24	32%	2.67	0.00	↓	2761.9	30.0	2202.8	987.8	354.3	1176.5	78.9%	↓	87.7%	↓	1100.0	0.0	890.0	520.0	420.0	930.0	80.9%	↓	98.9%	↓	12.8%	24.5%
				5-7	29.75	31.98	2.23	23.93	8.05	25%	0.60	0.00	↓																							

Key:

M1 Vacancy Factor
(Budget v. Staff in Post)

- Under Established
- Over Established
- Fully Established
- 5% or less Under Established

M12 / 1 Starters v. Leavers

- ↓ Reduction in WTE SIP
- ↔ No change in WTE SIP
- ↑ Increase in WTE SIP

Staffing Levels

- Less than 90% Shift Fill Rate
- 90 - 120% Shift Fill Rate
- Over 120% Shift Fill Rate
- ↓ Decrease in Shift Fill Rate Compared With Previous Month
- ↔ No Movement in Shift Fill Rate Compared With Previous Month
- ↑ Increase in Shift Fill Rate Compared With Previous Month

Nursing Shift Pattern Analysis - NGH v SNCT

Ward	No. of Beds	RN Shifts Needed for '1 RN for 8 Beds'	Total WTE			Budgeted WTE 2015-16		Combined Total	SNCT summary 2015		Combined Total	NGH v SNCT (variance) 2015		Combined Total	SNCT summary (2014)		Combined Total
			E	L	N	Qual	UnQual		Qualified + Mgt.	UnQual		Qualified	UnQual		Qualified + Mgt.	UnQual	
Abington	28	4	9	8	6	24.6	20.2	44.8	28.2	14.1	42.3	-3.6	6.1	2.5	26.4	16.2	42.6
Althorp	18	3	6	5	3	16.1	9.8	25.9	12.6	5.7	18.3	3.5	4.1	7.6	15.0	7.0	22.0
Cedar	29	4	9	7	6	26.3	21.9	48.2	29.2	14.6	43.8	-2.9	7.3	4.4	27.7	17.1	44.8
Hawthorn	30	4	9	8	6	27.8	15.8	43.6	27.2	13.5	40.7	0.6	2.3	2.9	29.8	13.8	43.6
Head & Neck	14	2	5	5	3	16.6	8.0	24.5	13.2	5.9	19.1	3.4	2.1	5.4	14.9	6.9	21.8
Rowan	30	4	9	6	5	29.8	14.3	44.2	25.2	12.5	37.7	4.6	1.8	6.5	31.2	14.3	45.5
Spencer	14	2	6	3	3	13.0	7.4	20.4	11.7	5.0	16.7	1.3	2.4	3.7	12.6	5.5	18.1
Willow	28	4	9	9	6	36.5	14.3	50.8	31.6	12.3	43.9	4.9	2.0	6.9	32.7	12.0	44.7
Allebone	28	4	7	7	4	26.8	19.9	46.7	28.6	14.3	42.9	-1.8	5.6	3.8	31.1	15.7	46.8
Becket	26	4	10	9	6	29.4	19.4	48.9	26.3	10.4	36.7	3.1	9.0	12.2	29.0	11.6	40.6
Benham	28	4	7	7	6	26.6	11.4	38.0	35.1	14.1	49.2	-8.5	-2.7	-11.2	32.3	13.4	45.7
Brampton	27	4	7	5	5	23.4	14.8	38.2	21.4	14.3	35.7	2.0	0.5	2.5	26.5	15.9	42.4
Collingtree	40	5	11	10	7	34.6	19.9	54.5	38.5	19.7	58.2	-3.9	0.2	-3.7	37.8	19.3	57.1
Compton	18	3	6	4	3	17.7	4.6	22.3	14.8	8.6	23.4	2.9	-4.0	-1.1	17.6	11.7	29.3
Creaton	28	4	9	8	5	24.6	18.2	42.8	26.7	13.3	40.0	-2.1	4.9	2.8	27.4	14.7	42.1
Dryden	22	3	7	6	5	30.2	11.4	41.6	31.3	12.5	43.8	-1.1	-1.1	-2.2	29.3	9.7	39.0
EAU	32	4	9	9	8	32.7	17.1	49.8	40.0	16.3	56.3	-7.3	0.8	-6.6	36.4	14.7	51.1
Eleanor	12	2	6	4	3	15.4	7.4	22.8	13.7	5.0	18.7	1.7	2.4	4.1	13.0	5.9	18.9
Holcot	27	4	8	6	5	25.5	15.3	40.8	19.4	11.6	31.0	6.1	3.7	9.8	30.0	15.1	45.1
Knightley	21	3	5	4	4	17.7	8.5	26.2	16.5	7.8	24.3	1.2	0.7	1.9	21.7	10.6	32.3
Talbot Butler	30	4	10	8	5	32.0	13.2	45.2	24.8	12.3	37.1	7.2	0.9	8.1	28.5	11.4	39.9
Victoria	18	3	7	6	3	17.7	4.6	22.3	13.4	7.6	21.0	4.3	-3.0	1.3	19.9	9.6	29.5
Total						**544.8**	**297.4**	**842.2**	**529.4**	**251.4**	**780.8**	15.4	**46.0**	**61.4**	**570.8**	**272.1**	**842.9**

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30 July 2015**

Title of the Report	**Update on Changing Care @ NGH with respect to Quality**
Agenda item	**10**
Presenter of Report	Simon Lazarus, Director of Finance
Author(s) of Report	Simon Lazarus, Director of Finance Richard Hall, Kingsgate CIP Transition Advisor Programme Delivery Team members
Purpose	To provide information and assurance that Changing Care @ NGH is addressing improvement in the quality of services provided to our patients.

Executive summary

NGH has adopted a holistic approach to the delivery of savings and improvement in the quality and efficiency of services provided to our patients. The aim of Changing Care @ NGH is therefore to provide the basis for sustainable, long term improvements. This report contains a copy of the latest programme blog which provides an insight into the range of current activities and the intent to improve the quality of service provision.

Related strategic aim and corporate objective	Focus on Quality & Safety and to ensure a sustainable future for the Trust
Risk and assurance	The Trust's standardised approach to risk management is being employed as relates to service change and improvement projects. The risks to programme delivery and consequent mitigating actions are regularly reviewed by the PMO and Changing Care Steering Group. Risks that relate to operational activity are owned and managed by the Divisions.
Related Board Assurance Framework entries	BAF27: Risk of Trust failing to deliver sufficient savings

Enclosure F

Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? No Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? No
Legal implications / regulatory requirements	There are no legal or regulatory implications associated with this paper, however, all CIP projects identified for delivery in 2015/16 will require assessment for Quality Impact Assessment using the Trust's established processes.

Actions required by the Trust Board

Members of the Board are requested to note the approach and progress being made by Changing Care @ NGH to improving the quality of services provided to our patients.

Northampton General Hospital NHS
NHS Trust

Public Trust Board
30 July 2015

Update on Changing Care @ NGH with respect to Quality

1. Introduction

This report provides information about the progress Changing Care @ NGH is making to improve services and the quality of care provided to our patients.

2. Background

Context

2.1 Since April the Trust's CIP programme has been rebranded to reflect a more holistic approach to the delivery of savings and improvement in the quality and efficiency of services provided to our patients.

2.3 The scope of the programme includes all the major opportunities for efficiency improvement across the Trust. As a result, it has been aligned to other programmes of work, such as Making Quality Count and the Patient Safety Academy. This has been successful in ensuring that resources are applied where they are needed most and aligned in terms of their intentions to improve quality.

2.4 The approach to the governance of the programme is also aligned to both the Executive and Clinical leadership of the Trust, following a structured approach managed by the programme delivery team. This team comprises members of staff from the PMO, IQE and Kingsgate.

2.4 Whilst there is a clear requirement for the programme to deliver improved efficiency (details of the progress with savings is contained in the Finance report) it can only do this in a sustainable way if the improvements to services and consequently the quality of care provided to patients are embedded and real.

Clinical Involvement and Communications

2.6 Clinical involvement in the programme remains a vital part of the overall approach to delivery. This ranges from attendance by Divisional Directors at the Changing Care steering group to clinical leaders playing a very active and committed part in delivering the projects which underpin the programme.

2.7 In the early stages of the development and set up of the programme, communications were necessarily restricted to those staff directly involved in contributory or leadership roles within the programme. As progress was made, however, in moving from set-up to implementation the opportunity arose to communicate more widely to staff both the rationale for each of the themes of work and the progress being made. In early June the first all-staff communications were released alongside a fortnightly blog provided to members of the programme organisation. The latter is also now accessible to all staff who have access to a work station via a Changing Care button on the intranet front page.

2.8 For the July all-staff briefing, the programme delivery team has produced a blog which provides a clear indication of the effort being made by everyone involved in the programme to make a difference in terms of the quality of services provided to our patients. This is attached in **Appendix 1**.

Enclosure F

3. Risks

3.1 It is acknowledged that reliance solely on traditional approaches to cost improvement programmes is not sustainable in the long term due to the potential negative impact on service quality. The aim of Changing Care @ NGH is therefore to provide the basis for sustainable, long term improvements.

3.2 To achieve the objectives of the programme a cross-organisational approach has been adopted. This requires more than just improved governance and rigour in the implementation of plans. It has been encouraging to see the improvement in behaviours of those associated with the programme to adopt the new projects and address the extensive improvements required. Of course, as the level of commitment required to realise further benefits is increased more effort will be required by all concerned.

Legal/Regulatory Considerations

3.7 There are no legal or regulatory implications associated with this paper, however, all CIP projects identified for delivery in 2015/16 will require assessment for Quality Impact Assessment using the Trust's established processes. This will ensure that:

- No project can proceed without QIA approval
- Sufficiently detailed implementation plans are available for each initiative within a clear structure for delivery

4. Recommendations

4.1 Members of the Board are requested to note the approach and progress being made by Changing Care @ NGH to improve the quality of services provided to our patients.

5. Next Steps

5.1 It is clearly the intention to continue to develop the programme and maintain the progress with further implementation and benefits realisation. This will involve more staff in project delivery, assisted by continuing communications activity.

Changing Care @ NGH
2015 – 2017

PROGRAMME BLOG No. 3 / Monday 20 July 2015

This is the third in a series of regular updates on the progress which Changing Care themes are making to achieve important quality and efficiency improvements.

As the implementation progresses, the focus is on delivery of tangible benefits which we should all notice. We are doing this by introducing new methods and tools which will help us to work more efficiently and improve the quality of care we provide for our patients. Whether we work in the front line or in support services, Changing Care initiatives will only benefit our services and our patients if all of us at every level support our theme leaders to deliver.

Changing Care aims to demonstrate in real time NHS England's definition of 'quality', encompassing care that is clinically effective in the eyes of patients and clinicians, care that is safe and care that provides as positive an experience as possible for patients.

What is Changing Care doing to achieve this?
Programme initiatives span all service areas, but here are a few examples of change:

Firstly, our hospital environment; the Portering project is creating a sustainable, safer service by recruiting substantive porters rather than relying on agency staff. Porters support all our services and a committed, well trained portering team is essential to the smooth running of the hospital. The service is also planning the introduction of improved task management and communications technology. Meanwhile, the Housekeeping initiative is looking at options intended to create a more hygienic, safer and more organised place for us to work in and for our patients.

In the emergency department, we achieved the 95% target in June, thanks to the continued dedication of our staff and the introduction of new processes. We are facilitating 'unblocking' methods to increase flow across inpatient areas, working alongside the Safety Academy, which is dedicated to improving patient safety and quality.

Our inpatients are starting to benefit from a more efficient and positive experience both on arrival and also at the other end of their stay; the Theatres group is now reviewing its new scheduling policy which is intended to form the basis of an improved service with more patient throughput. There has also been a 10% increase in the use of *'expected day of discharge'* methods for patients, improving safe and timely discharge. Audits are taking place to understand the reasons for readmissions, and plans to follow up patients once discharged aim to reduce readmission rates in the future.

Later in July, outpatients will benefit from appointments auto-reminder texts (over 65s will still be phoned), aiming to reduce the number of Did Not Attends (DNAs) by enabling patients to cancel/re-book rather than fail to attend, enabling others to take their place. Clinics will be run more efficiently and more patients will be seen quicker.

Are we considering the impact of these changes?
Understanding the impact that change initiatives have on our services and staff is key to successful change. We have consolidated our quality impact assessment (QIA) process across the Trust by co-ordinating both divisional QIAs and the Changing Care QIAs from the central project management office (PMO). Quality risks to patients, staff and our services are graded and monitored continuously by the PMO alongside divisional and project owners. Any planned changes with the potential to impact quality are graded, monitored, then mitigation is planned so that risks are minimised.

Changing Care @ NGH
2015 – 2017

Below this programme update you'll find individual theme activities and progress highlights. If you have any queries or comments, please email: Kate Terrell Gray, Project Manager / Theme Support, or / in her absence, Innocent Muza, Project Management Office Leader.

Calling all Theme and Clinical Leaders!

If you would like to proactively provide content for future blogs, please contact Kate Terrell Gray or Innocent Muza with your contributions.

Overall Programme Status

While most themes are already implementing change, others are also focusing on involving staff, analysing data and planning before launching into implementation. This will ensure that safety and quality are not impacted and that we can measure whether themes really do deliver tangible benefits.

Programme Overview

Key achievements:

- The agency reduction theme moves a-pace with Dr Jonathon Timperley and Dr Tom Odbert leading our Indian recruitment visit at the end of July, aiming to employ middle grade doctors to A&E and other specialties.
- The coding initiative continues to educate staff on best practice identification methods and processes. The benefit of coding the right thing at the right time for the right patient is that we not only generate the correct income but also record accurate data, enabling informed decision making (linking to our clinical strategy) plus we improve the quality of our service line reporting (SLR) information and most importantly the quality of service provided to our patients.
- Substantive porters are currently being recruited to create a sustainable, safer service for our patients before the winter period.
- The Length of Stay Theme (LOS) is starting to deliver - there has been a 10% increase trust-wide in the use of 'expected day of discharge' (EDD) for patients. Having a date to aim for helps clinical teams prioritise their work and enables better bed management. Further work is taking place to ensure that patients are kept informed of their EDD.
- In ED, we have achieved the 95% target in June thanks to continued staff dedication across the Trust.

Programme Finances

Programme themes have delivered £683k in Q1 2015/16, against a planned delivery of £582k. The overall plan including Divisional CIPs required delivery of £2,006k in the first 3 months versus the actual delivery for this period of £1,965k, behind plan by £41k.

Further work is being done to identify recurrent savings opportunities to ensure that once delivered, improvements are sustained year on year. As

a result, we have made progress in replacing non-recurrent CIPs with recurrent CIPs to the value of £428k in month 3.

Linking CCP with Trust-wide programmes

The patient safety and quality improvement projects previously encompassed within the patient safety academy portfolio have been aligned with the changing care workstreams to support and act as a catalyst for the improvement work to begin, whilst reducing the risk of repetition or duplication.

Patient Safety Academy

The safety academy will continue to front load improvement projects, "unblock" any bottle necks that may delay or hinder safety and quality projects, whilst bringing together learning from what we have done before, building on existing and new initiatives, and further embedding the safety and quality improvement work in operations.

The safety academy core team has been revised to support a clinically led structure. Divisional Directors have been asked to identify clinical project leads who will become key contacts and have responsibility to lead specific improvement projects within the division with support from the safety academy.

During the transition period in Q1 it was necessary for the safety academy to support the completion of many of the improvement reports which provide assurance of progress made and the impact on patient care and quality. The responsibility for future improvement work and the completion of progress reports to provide assurance will in due course become business as usual for nominated leads within the Divisions.

The role of the safety academy will become more of an improvement facilitator and enabler whilst providing safety science and quality improvement support and education.

The safety academy will be the guardian for safety and quality working in synergy with the changing care delivery team whilst still increasing staff engagement in quality and improvement projects related to patient safety.

Themes

Brief highlight reports from themes (A-Z)

Agency Reduction + 247 Time

Medics

Medical Agency

While Drs Timperley and Odbert travel to India to recruit more middle grade doctors to A&E and other specialties, a good practice guide is being created for managers out in the divisions. This handbook will advise on how to maximise our internal staff pool before turning to agencies to fill junior rotas. This is a simple manager's guide, and tips include recruiting junior doctors onto our locum bank so that they can benefit from additional shifts. We are keen to develop our locum bank so that we can rely on a flexible temporary workforce that is familiar with our senior clinicians, ways of working and quality standards. This is more difficult to achieve

with agency locums. This managers' guide will be published around the beginning of August.

247 Time direct engagement / payment model – agency locums
247 Time & Medical Staffing delivered have delivered £135k savings on agency locum VAT payments to-date. From this week onwards, we will report savings from 247 Time made on actual weeks of work rather than invoiced work (which sometimes related to work done weeks or months previously). This is showing a far more accurate picture of booking behaviour and subsequent savings, with only 17% of locum bookings being made through off-framework agencies. This compares favourably with the 45% of bookings in March. This is good news for departments and patients, as government framework agencies are obliged to comply with the rigorous terms of the framework, meaning that our agency locums will also have been checked, inoculated, trained and will be up-to-date with their annual appraisals and medical licence revalidation.

Medical Staffing has been working hard to develop stronger relationships with the new set of Government framework agencies that we are linked to through 247 Time. Meetings will continue until the end of July, after which agencies that work hard for us will be moved to the top of a tiered system. We aim to wipe out locum bookings through off-framework agencies (which will need to be phased out following new Government guidance) benefitting also from reduced costs, by the end of the year.

Agency Reduction

■

Nursing

Challenge meetings are progressing with wards and the team has been successful in identifying certain areas where roster inefficiencies have led to overspends. These issues are in the process of being tackled and improvements should be measureable in coming months. The NHS Professionals meeting is booked for 20th July (a possible opportunity to simplify and improve management of agency bookings) and this will be key in terms of enabling the project team to understand and challenge some of the NHSP assumptions and claims around potential savings that may exist.

Nursing agency expenditure has recently been subject to additional scrutiny at government level and the TDA will be announcing a number of measures for tacking nursing agency spend later in the year. The project team are currently working with the Trust Executive Team to ensure that NGH is as prepared as possible for these changes.

Back Office

Each back office area has been asked to review its services and identify non-value adding processes, areas which need to be developed or automated and areas where increased collaboration could be an option.

An executive-led vacancy control panel for corporate back office functions began its work in w/c 6 July, led by the Directors of Finance and Workforce with quality impact assessment by the Medical Director or Director of Nursing.

Changing Care @ NGH
2015 – 2017

Business Case Delivery

Our Business Cases this year have quality improvements at the heart of their proposals. Whether for the provision of services closer to home for patients, more sustainable and therefore safer clinical rota cover, or better services through expansion and investment in new procedures, the Trust has looked to invest in developments that provide both a return on investment financially and improved services for the people of Northamptonshire.

Business cases will be supported by the soon to be launched Business Case Scorecard, which will be used for monitoring and escalation for off-track cases. This is the first year in which NGH has introduced a more robust process that follows business cases post-approval stage.

Clinical Strategy

We have now completed an assessment of the links between clinical strategy initiatives, business cases and the Changing Care programme to ensure that we avoid duplication in monitoring and reporting the ongoing developments.

As previously stated, the clinical strategy delivery work is the responsibility of the Divisions.

Data Completeness

Update: Data Completeness – In a nutshell

Whilst the majority of our data capture is very good, there are some areas that need to be improved. The main areas of concern are ensuring the correct GP's are recorded on our systems and all relevant investigations and procedures are captured accurately. If we improve our processes this will lead to an improvement in patient safety and income capture – ensuring that we get paid for the work we do.

- Making sure that we charge the correct level of income to cover the costs of treating our patients
- Improved information on how much income each service generates
- Provides visibility as to each individual specialty rather than grouped with the general specialty
- Increased visibility ensures that each service is adequately commissioned
- Capturing all activity to charge
- Associated codes are also captured which may result in a richer case-mix
- Assists with the decision making in the trust with regards to the clinical strategy and improve the quality of our service line reporting (SLR) information

Can you help?

We need you to consider how patient information is being input onto iPM and whether you feel confident that you have all the necessary information

to populate the required fields. Some of the data that is required may not seem relevant or that important - however each required field contributes to patient safety and helps to increase the amount of income that we receive- this income is used to help run our hospital and to improve the quality of care for our patients.

Who to ask for advice:

Clare Hall – Information
Jess Merson – Income
Ben Greasley – Coding
Laura Grant – IQE/Programme Delivery Team

Facilities & Estates

The F&E theme is dedicated to increasing the levels of quality of services delivered to staff and patients. Two initiatives are currently delivering on this intention:
Housekeeping Services: The theme supports the provision of a clean and safe environment to a high standard in which to deliver health care, via progressing accountability and ownership at all levels from board to ward. This is seeking to ensure that tangible improvements without compromise to quality, are achieved. Proposals intended to provide improved team working, cross-cover and coordination of the services are currently being developed.

Portering Services: We are in the process of converting temporary posts into our substantive establishment to ensure a sustainable, constant Portering Service that colleagues can rely on in anticipation of the winter months. The service is also planning enhancements to overall management of portering by seeking to introduce improved task management and communications technology.

Innovation & Research

This theme is developing some new approaches to the way NGH promotes and adopts clinical research. By conducting more clinical research the results can help to improve the quality of patient pathways.

The embryonic process which scrutinises new studies has so far identified 11 commercial studies in which we have expressed an interest. We are waiting to see if we will be selected as a site for any of these new projects. The identification and management process for research will be further refined. Work is ongoing to align this workstream with the transitional changes ongoing in the national R&D programme.

Length of Stay

The 11 sub-projects are progressing well, notably with a 10% increase in the use of expected day of discharge for patients. Training and refresher training on criteria-led discharge (previously known as nurse-led discharge) is starting on the Surgical wards on the 14th July.
The Board Rounds Group is rolling out a simplified white board across all wards and are having input from ESIST to improve the consistency of board rounds trust wide. The Green Card team is evaluating two different IT solutions - ICE & Vitalpak to identify which one is most suitable for

NGH. These are all long term projects that will lead to improved communications and reduce delays to patient discharges.

Medical Productivity

The process of reviewing and updating job plans is well under way. Stage I Challenge Review meetings continue with directorates to ensure that all consultants have an up-to-date, mutually agreed job plan for 2015/16. Job plans need to reflect the duties undertaken ensuring continuous improvement and sustainability of the delivery of safe, high quality and efficient services to our patients.

Collation of detail regarding SPA lead roles and activity continues. To-date 157 pro-forma templates have been distributed. An initial review of responses will be presented to the Changing Care Steering Group at their meeting on 21 July with a granular review during August to ensure that activity meets Trust and directorate requirements, there is consistency and activity remains appropriate to the long term provision of patient and service quality and care.

Nursing Productivity

The consultation relating to shift standardisation for nursing staff in adult inpatient wards commenced on 8 June 2015. Presentations led by Rachael Corser, Director of Nursing and Anne Thomas, Associate Director of Midwifery took place initially with just over 500 staff attending these presentations. The consultation is for 45 days and during June and July the Ward Sisters/Charge Nurses have been carrying out one-to-one meetings to support the staff. The consultation closes on 22 July 2015.

Optimised Clinical Admin

Our Clinical A&C workforce is one of the key points of contact that our patients have and one of our greatest ambassadors: whether it be arranging an appointment, checking in at clinic, telephoning for information or an update - this group of staff impact greatly on a patient's experience of our Trust.

They also undertake the management and validation of waiting lists, ensuring that our patients are seen when they should be or intervening action is taken to keep them safe. Good Clinical A&C services are efficient, knowledgeable, timely and professional. As we move forwards with this project, delivering a high quality patient experience is at the centre of our approach.

Optimised Emergency Care

The Trust achieved the 95% target in June, thanks to the continued dedication of its staff. Nevertheless, the target remains a daily challenge with the trust experiencing high numbers of attendances and admissions. Furthermore, Delayed Transfers of Care (DTOC's), where patients have been clinically stable for more than 72hrs and still awaiting discharge have reduced in comparison to previous months, however remain higher than the levels expected and continue to impede bed flow. The project has made positive steps over the last month, with weekly performance meetings running to review breaches and hold specialities to account. ED

have gone paper light in Majors and Minors to streamline processes and improve data collection.

The Assessment Units continue to embed 'ideal' processes and are proving successful. The new Ambulatory Care Centre is under development and will be completed over the summer and will have a big impact on how we manage the front door.

The Trust has launched a new approach to managing the twice daily safety huddles to maximise impact, and the discharge teams are working with the wider health economy to launch a number of schemes to reduce DTOCS, including Discharge-To-Assess. Over the coming months, focus on the forthcoming Winter will be a priority to start planning and implement specific schemes in preparation.

Thank you to everyone for their hard work throughout June.

Outpatient Clinics

This year, our work focuses on ensuring that we provide a better patient experience. Through the management of DNAs and patient cancellations we will be able to provide appointments to people that need them more quickly. In March 2015, we re-arranged over 6,000 appointments / instances of patient contact. Maintaining a low rate of clinic cancellations will ensure that we see patients when we say we will.

The implementation of partial booking will enable us to have a better oversight of our upcoming capacity to see patients, supporting this being delivered by our substantive workforce, as well as providing a more present timeframe to patients to make appointments that they can realistically attend. We will also be considering our Speciality first to follow-up ratios with Clinicians to ensure that we are a clinically effective organisation.

When we started this Project, our DNA rate was 8.3%; our hospital cancellations rate was 4.1%, and our patient cancellation rate was at 3.3% - over the coming months we expect to see an improvement in these key rates. (All figures quoted are at a Trust level.)

Pharmacy Management

The new Boots Outpatient Pharmacy opened its doors on the 22nd June 2015 in Hospital Street. This externally managed pharmacy aims to provide a high level of prompt, focused service to our patients who should notice a reduction in waiting times and excellent customer service at the counter.

There is a link on the Street intranet page that will hopefully answer any questions you may have regarding the way that it will support you in delivery of your services.

Procurement

Now that the Inventory Management system business case has been approved by the Executive team and the Finance, Investment and Performance Committee, work has begun to start planning implementation and associated business process change.

In addition, the strategically important GS1 outline plan has been developed, presented to the Trust Board and submitted to the Department of Health. GS1 is a widely adopted approach to identifying, capturing, and sharing information – about assets, services, people, locations and more – making it possible for organisations to operate more efficiently.

Readmissions

The clinical audit of readmissions in Medicine is underway and we are looking forward to processing the results in the next few weeks. To-date we have been able to save £47k through better application of the readmission exclusion criteria and through data validation.

One of our planned projects is to trial post-discharge phone calls to a specific category of patients. It is hoped that this will be able to reduce emergency readmissions through providing reassurance to the patient and by arranging specialty input where required.

Seven Day Working

With considerable evidence having emerged over the last ten years linking the reduced level of service provision at the weekend to poor outcomes for patients admitted to hospital as an emergency, quality is a huge part of the seven day working theme. Hospitals are expected to meet patient and public expectations by providing a consistent service, no matter what day of the week it is.

Delivery of this equitable provision will drive up clinical outcomes and improve patient experience by reducing the risk of morbidity and mortality following weekend admission in a range of specialties. Our 5 chosen clinical standards this year are central to our ambitions for a safer hospital – they are as follows:

- Patient Experience
- Time to 1st Consultant Review
- MDT Review
- Diagnostics
- On-going Patient Review

The project team is working with Clinical Directors and other key colleagues to define where and how services need to develop to better meet our and our patients' aspirations for care and experience across the seven days.

Theatre Efficiency

Progress is being made towards improving the scheduling and booking process for patients undergoing elective surgery. Potentially this will increase theatre capacity, allowing patients to receive their surgery sooner, increase the amount of notice patients receive of their operation date and reduce the number of patients who are cancelled on the day of surgery for non-clinical reasons. This is needed because in Q1 2015/16, 97 timetabled theatre sessions were not utilised.

The draft Theatres Policy, which will underpin the updated service, is currently being reviewed and the deadline for feedback was 17th July.

There are no simple ‘quick fixes’ to improving utilisation of our operating theatres, but a common theme of the work done to date is the need to improve team working and communication between specialties, clinicians and management. All concerned are working hard to improve the working environment and services for our patients.

Workforce Development

The Workforce Development Group has started to determine the specific areas where there will be an initial focus on understanding the reasons for overtime. These include areas in the Clinical Support Services, Facilities and Hospital Support. In addition, the group has agreed that the Learning and Development department should recruit to more apprentice roles so that the divisions can appoint apprentices into existing vacancies.

The group is also reviewing the number, type and value of overpayments across the Trust to identify if there needs to be a review of processes. This is intended to result in approaches to fix existing problems.

In addition we are seeking to extend the Rewardwise and GreenCar schemes. These schemes offer staff the opportunity to purchase cars, electronics and other goods at competitive prices whilst at the same time providing savings for NGH that means we can invest in the services we provide to patients. By providing a portion of salary to make the purchase, staff pay less tax and NGH’s costs are lower.

For more details of the purchasing opportunities and benefits please contact Laura Grant in the programme delivery team.

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30 July 2015**

Title of the Report	**Finance Report**
Agenda item	**11**
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 June 2015/16.

Executive summary

- The Trust has incurred a deficit of £6m in the first quarter, £23k favourable to plan.
- The TDA have requested that the Trust consider a "stretch target" and to set out measures to improve the planned deficit position of £21.2m by the year end.
- A range of in year financial risks are emerging which are not provided for in the financial plan requiring mitigating actions to ensure financial targets can be met.
- Operating expenditure is tracking to plan supported by a significant level of vacancies and the application of 3/12th of the contingency reserve.
- Temporary staff costs of £2m (13.1%) in month. Agency costs increased in June to £1.488m (or 9.7% of the total pay bill).
- The cumulative breakeven duty target for recovery stands at £15.4m at the end of June and will need to be addressed by the development of the Financial Sustainability plan.

Related strategic aim and corporate objective	Develop IBP which meets financial and operational targets.
Risk and assurance	The recurrent deficit and I&E plan position for FY15-16 signal another challenging financial year ahead and the requirement to develop a medium term financial strategy to deliver financial balance in the medium term.

Related Board Assurance Framework entries	BAF 17, 18 and 19
Equality Analysis	N/A
Legal implications / regulatory requirements	NHS Statutory Financial Duties
Actions required by the Committee The Board is asked to note the report and consider the overall financial position in relation to the TDA request to agree a “stretch target”.	

Northampton General Hospital NHS
NHS Trust

Financial Position
Month 3 FY 2015/16

Report to
Trust Board
July 2015

Enclosure G

1. Overview

The I&E position for the period ended June (M3) is a deficit of £6.0m, £23k favourable to plan. SLA income has performed £0.5m below plan due to the requirement to make provision for anticipated contractual fines and penalties. The position includes the YTD plan for the CIP programme which has remained on plan in June but supported primarily through non-recurrent pay vacancies. The Trust has accessed £5m of the planned (£21m) Working Capital Facility in the period to June.

RAG		This Month	Last Month	Change
	Statutory Financial Duties	**Jun 15**	**May 15**	
	3 year Cumuative I&E Breakeven duty (£000's)	(15,379)	(13,779)	(1,599)
	Achieving EFL (£000's)	38,852	38,852	0
	Capital Cost Absorption Duty (%)	3.5%	3.5%	0
	Achieving the Capital Resource Limit (£000's)	28,618	28,618	0
	Continuity of Service Risk Rating (CoSR)	1.0	1.0	0.0
	I&E Position	**Jun 15**	**May 15**	
	Actual in Month Position (£000's)	(1,599)	(2,309)	710
	Forecast in Month Position (£000's)	(1,526)	(2,024)	498
	Actual Year to Date Position (£000's)	(6,037)	(4,437)	(1,599)
	Forecast Year to Date Position (£000's)	(6,060)	(4,534)	(1,526)
	Forecast End of Year I&E Position (£000's)	(21,120)	(21,273)	153
	EBITDA %	-3.0%	-4.0%	1.0%

RAG		This Month	Last Month	Change
	Income	**Jun 15**	**May 15**	
	NENE CCG Variance to plan - YTD (£000's)	(958)	(595)	(363)
	MRET Penalty - Gross (£000's)	(763)	(498)	(265)
	Readmissions Penalty - Gross (£000's)	(701)	(445)	(256)
	Contract Fines & Data Challenges (£000's)	(455)	(352)	(104)
	Elective variance to plan (£000's)	(503)	(349)	(154)
	Daycase variance to plan (£000's)	256	(154)	410
	Non-Elective variance to plan (£000's)	139	15	123
	Outpatients variance to plan (£000's)	23	(164)	186
	Operating Costs	**Jun 15**	**May 15**	
	Pay Expenditure (£000's)	15,414	15,395	(19)
	Agency Staff Costs (£000's)	1,488	1,390	(98)
	Agency Staff Cost (%)	9.7%	9.0%	-0.6%
	Non-Pay - Clinical (£000's)	5,092	4,420	(672)
	Non-Pay - Other (£000's)	2,521	2,604	83
	Cost Improvement Schemes	**Jun 15**	**May 15**	
	Year to Date Actual (£000's)	1,965	1,292	673
	Year to Date Plan (£0o0's)	2,006	1,309	697
	Forecast Delivery (£000's)	11,125	11,156	(31)
	Annual CIP Target (£'000s)	11,325	11,325	0

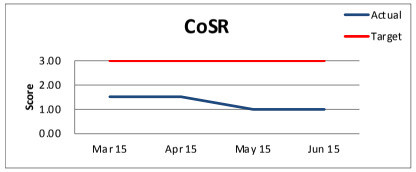
RAG		This month	Last Month	Change
	Capital	**Jun 15**	**May 15**	
	Year to date expenditure (£'000s)	1,549	731	818
	% of annual plan Committed	24%	20%	4.2%
	Annual Capital Expenditure Plan (£000's)	28,618	28,618	0
	Cash	**Jun 15**	**May 15**	
	In month movement (£000's)	11	860	(849)
	In Year movement (£000's)	3,969	3,958	11
	New PDC / Temporary borrowing (£000's)	5,159	5,159	0
	Debtors Balance > 90 days (£000's)	1,038	709	329
	Creditors % > 90 days	0%	0%	0%
	Cumulative BPPC - by volume (%)	99.2%	99.4%	-0.2%

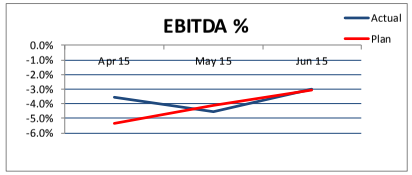
Key issues

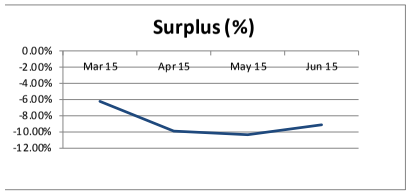
- The TDA have requested that the Trust consider a "stretch target" and to set out measures to improve the planned deficit position by the year end.
- A range of in year financial risks are emerging which are not provided for in the financial plan and mitigating actions to ensure financial targets can be met.
- Operating expenditure is tracking to plan supported by a significant level of vacancies and application of 3/12th of the contingency reserve.
- Temporary staff costs of c. £2m (13%) in month. Agency costs increased in June to £1.488m (or 9.7% of the total pay bill).
- SLA income is £0.5m adverse to plan, primarily due to the provision for anticipated fines and penalties.
- Daycase activity improved in June. Elective activity remains adverse to plan both in terms of activity and financial value with activity being outsourced in T&O due to capacity constraints.
- Progress to date in relation to the independent review of the MRET position suggests there may be a financial risk to the Trust on conclusion of the review.
- The cumulative breakeven duty target for recovery is £15.4m at the end of June.

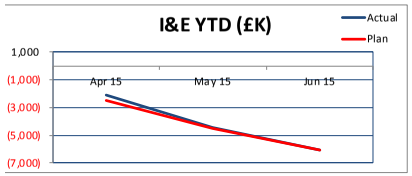
2. Financial Performance Dashboard

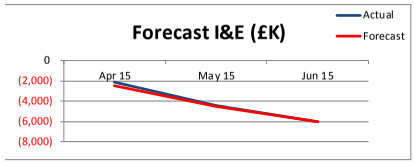
1. Key Metrics

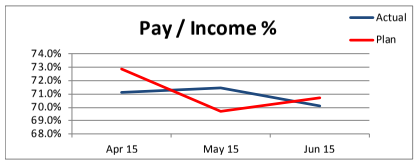




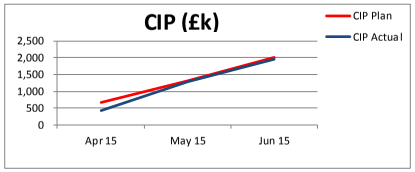


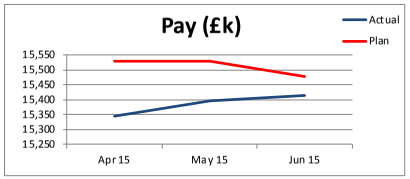


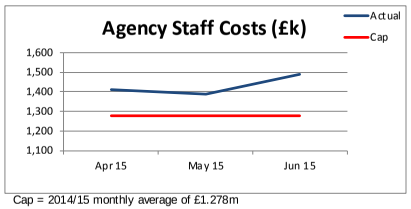




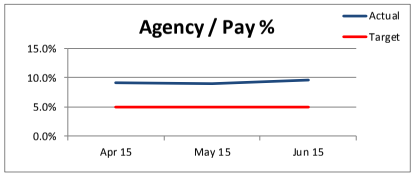
2. I&E Performance

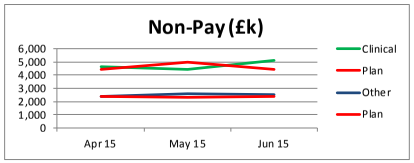


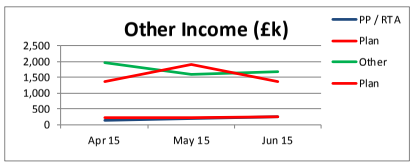




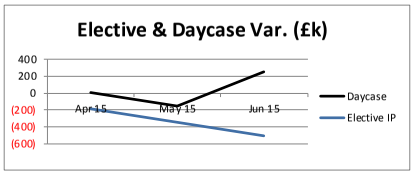
Cap = 2014/15 monthly average of £1.278m

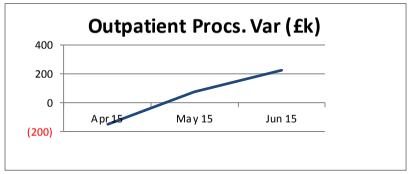


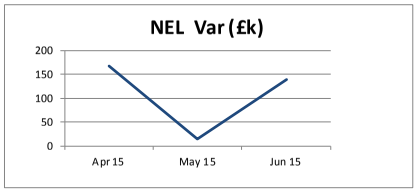


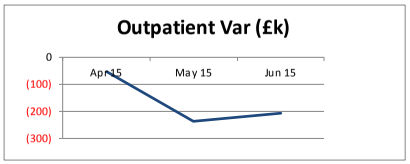


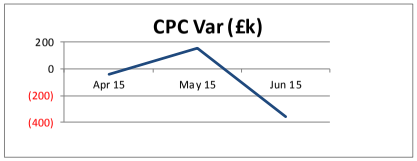
3. SLA Income

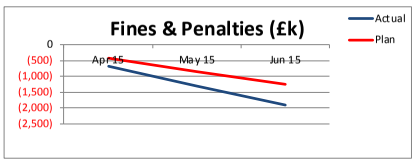




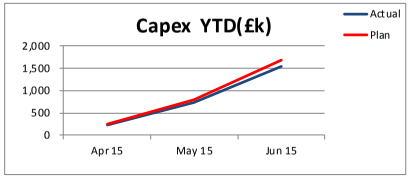


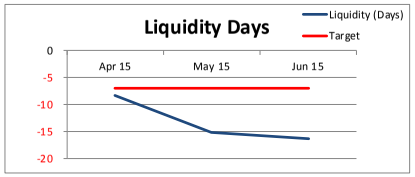


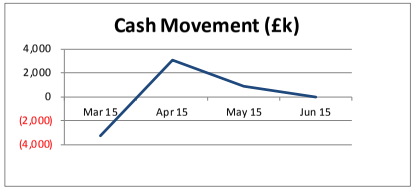


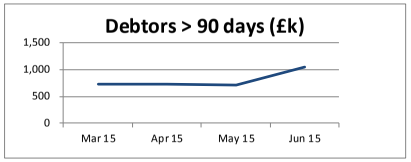


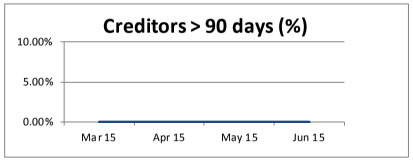
4. Working Capital

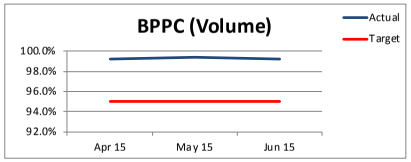












3. Income and Expenditure Position

I&E Summary	Actual FY14-15	Annual Plan	YTD plan	YTD Actual	Variance to Plan	Jun 15	May 15
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	239,776	245,477	60,465	59,998	(467)	20,848	19,669
Other Clinical Income	2,422	2,904	726	583	(143)	251	185
Other Income	23,810	17,401	4,648	5,236	588	1,682	1,588
Total Income	266,007	265,782	65,839	65,817	(21)	22,782	21,442
Pay Costs	(180,225)	(185,400)	(46,536)	(46,153)	383	(15,414)	(15,395)
Non-Pay Costs	(86,832)	(82,558)	(21,015)	(21,650)	(636)	(7,614)	(7,024)
CIPs		0	0	0	(0)	0	0
Reserves/ Non-Rec		(2,117)	(296)	0	296	0	0
Total Costs	(267,057)	(270,076)	(67,847)	(67,803)	44	(23,028)	(22,419)
EBITDA	(1,050)	(4,293)	(2,008)	(1,985)	23	(246)	(978)
Depreciation	(11,407)	(12,247)	(3,062)	(3,062)	(0)	(1,021)	(1,003)
Amortisation	(11)	(16)	(4)	(4)	0	(1)	(1)
Impairments	(3,338)	0	0	0	0	0	0
Net Interest	27	(516)	(38)	(33)	4	(14)	(14)
Dividend	(4,332)	(4,316)	(1,079)	(1,079)	(0)	(360)	(356)
Surplus / (Deficit)	(20,111)	(21,388)	(6,190)	(6,163)	27	(1,641)	(2,351)
NHS Breakeven duty adjs:							
Donated Assets	248	268	130	126	(4)	42	42
NCA Impairments	3,338	0	0	0	0	0	0
I&E Position (breakeven duty)	(16,525)	(21,120)	(6,060)	(6,037)	23	(1,599)	(2,309)

I&E Performance

- Financial performance for the period ended June 2015/16 is a normalised deficit of £6.037m, £23k fav. to the plan of £6.06m for the same period.
- Operating expenditure run rate increased month on month, notably non-pay.
- Income is £12k adverse to plan overall (last month £545k adv).
- Pay expenditure is £383k fav. to plan (last month £320k fav).
- Non-Pay expenditure is £636k adv. to plan (last month £102k fav).
- 3 months of the planned contingency reserve have been allocated for the year to date (£0.3m fav).
- Forecast position remains for delivery of the planned deficit of £21.1m by the financial year end (subject to the management and mitigation of in year financial risks).

Key issues

SLA Income

- Underling position is £0.2m fav. to plan offset by requirement to make provision for potential fines and penalties.
- EL IP activity £542k (12%) below plan for year to date. (Last month £383k or 13%)
- Daycase activity £256k (5%) above plan for the year to date. (Last month £154k (4%) below plan).
- NEL activity 1% above plan for period to date giving rise to MRET penalty exposure. (Last month 2%).
- CQUIN income accrued at 80% of plan pending Q1 review of delivery against new targets.

Other Income

- Private Patient income £133k adverse to plan. (Last month £126k adv.).
- RTA income £10k adv. to plan. Last month £34k fav.).
- Income / Other Generation £588k fav. to plan led by external drug sales and recharges to Charitable funds

Pay

- Pay expenditure £383k fav. to plan. (Last month £302k fav.).
- Agency staffing costs 9.7% (£4.3m) of the total pay bill for the period to June.
- Locum medical staff and ADH costs £79k in June.
- Nursing pay expenditure £466k (2.5%) fav. to plan overall.
- Pay position achieved after YTD CIP target of £1.1m applied.

Non-Pay

- Significant increase in Excluded medicines expenditure in June (offset by additional income from Commissioners).
- Prosthesis £53k fav. to plan.
- Lab Consumables £154k fav. to plan.
- Consultancy Fees £140k adv. to plan.
- Staff advertising £23k adv. to plan.
- Office Equipment £51k adv. To plan.

3.1 Pay Expenditure

Staff Numbers (WTE) Analysis	Plan Mth 3	Permanent Staff worked Month 3	Temporary Staff worked Month 3	Variance
	WTE	WTE	WTE	WTE
Medical Staff	541.947	481.62	29.35	(30.98)
Nursing Staff	2080.18	1672.75	268.55	(138.88)
Managerial and Administration	981.58	847.78	50.68	(83.12)
Other Clinical Staff	307.47	276.53	11.23	(19.71)
Scientific and Technical Staff	379.45	325.83	5.20	(48.42)
Estates Staff	30.65	24.45	3.00	(3.20)
All other Staff	421.46	378.23	39.10	(4.13)
Cost Challenges	(97.33)	-	-	97.33
Total WTE	4,743	4,007	407	(328)

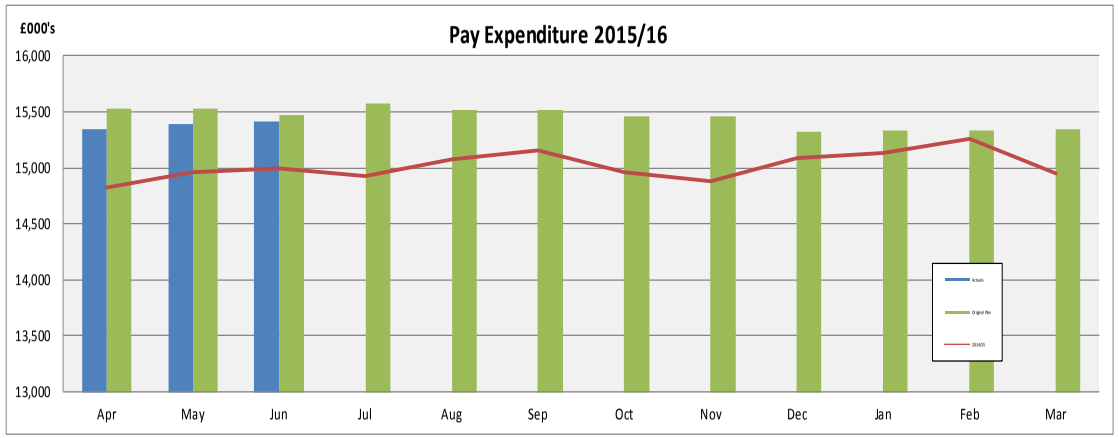
Permanent Staff Worked Trend	April 2015/16	May 2015/16	June 2015/16
	WTE	WTE	WTE
Medical Staff	480.60	481.14	481.62
Nursing Staff	1686.54	1666.54	1672.75
Managerial and Administration	841.23	843.92	847.78
Other Clinical Staff	269.11	266.54	276.53
Scientific and Technical Staff	329.85	325.24	325.83
Estates Staff	24.99	24.45	24.45
All other Staff	370.61	381.62	378.23
Cost Challenges	-	-	-
Total WTE	4,003	3,989	4,007

Temporary Staff Worked Trend	April 2015/16	May 2015/16	June 2015/16
	WTE	WTE	WTE
Medical Staff	40.57	35.46	29.35
Nursing Staff	257.16	273.36	268.55
Managerial and Administration	61.58	52.25	50.68
Other Clinical Staff	21.89	12.23	11.23
Scientific and Technical Staff	13.99	11.46	5.20
Estates Staff	0.00	0.00	3.00
All other Staff	37.44	40.42	39.10
Cost Challenges	-	-	-
Total WTE	433	425	407

Pay Costs Analysis (Month 3)	Plan Mth 3	Permanent Staff worked Month 3	Temporary Staff worked Month 3	Variance
	£'000	£'000	£'000	£'000
Medical Staff	4,355	3,724	649	18
Nursing Staff	6,158	4,991	1,056	(111)
Managerial and Administration	2,382	2,116	55	(211)
Other Clinical Staff	1,000	907	45	(48)
Scientific and Technical Staff	1,113	925	115	(74)
Estates Staff	84	67	15	(3)
All other Staff	718	653	99	34
Cost Challenges	(332)	-	-	332
Total Pay Cost	15,477	13,382	2,032	(63)

Permanent Staff Pay Costs	April 2015/16	May 2015/16	June 2015/16
	£'000	£'000	£'000
Medical Staff	3,790	3,787	3,724
Nursing Staff	4,884	4,927	4,991
Managerial and Administration	2,105	2,134	2,116
Other Clinical Staff	880	895	907
Scientific and Technical Staff	958	947	925
Estates Staff	70	70	67
All other Staff	639	665	653
Cost Challenges	-	-	-
Total Pay Cost	13,326	13,425	13,382

Temporary Staff Pay Costs	April 2015/16	May 2015/16	June 2015/16	Temp staff costs over total pay costs
	£'000	£'000	£'000	%
Medical Staff	642	487	649	14.8%
Nursing Staff	1,015	1,124	1,056	17.5%
Managerial and Administration	152	119	55	2.5%
Other Clinical Staff	72	7	45	4.7%
Scientific and Technical Staff	34	122	115	11.0%
Estates Staff	4	11	15	18.0%
All other Staff	99	100	99	13.1%
Cost Challenges	-	-	-	
Total Pay Cost	2,017	1,970	2,032	13.2%

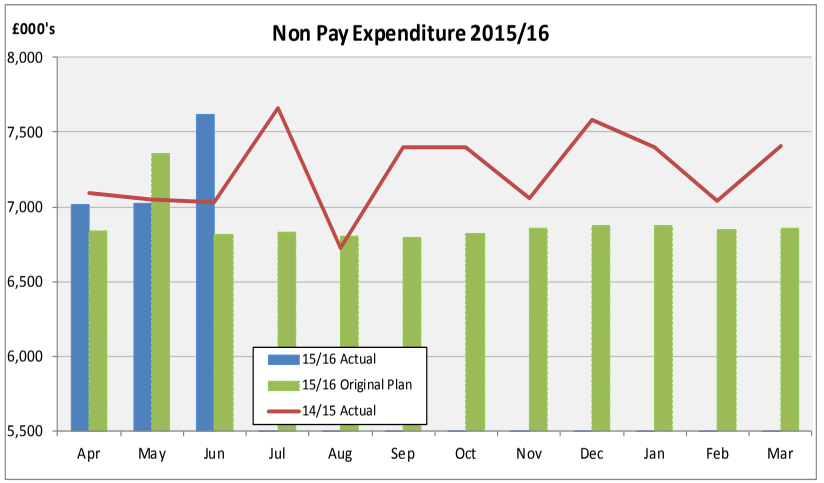


Key Issues

- Pay costs are £63k fav. to plan in the month and £383k fav. the year to date. This is mainly driven by high vacancy levels which were budgeted for on a full year effect basis (i.e. nursing investment). The fav. variance includes the YTD value of the pay CIP.
- Vacancy levels compared to plan are at 328WTE after usage of temporary staff which amounts to 407WTE in the month highlighting the level of real underlying vacancies.
- The WTE plans / as well as pay costs, have been reduced for non-recurrent WTE CIPs (pending finalised CIP schemes), and the under-spend in the month has been counted as non-recurrent pay CIP delivery year to date. The CIP plan has therefore been delivered against pay although on a non-recurrent basis in the main.
- Temporary staff cost bill has risen again from the previous month (12.8% of total pay in month 2 compared to 13.2% in month 3). In particular medical staffing has risen to 14.8% of total medical staff pay expenditure (11.4% in Month 2).
- Overall pay has continued to rise in quarter 1 and as fill rates improve for both agency and substantive posts for budgeted vacancies this will continue to increase during the year alongside anticipated incremental drift.
- Higher temporary staffing costs and higher CIP assumptions in future months together with rising pay costs (as increments increase) imply an increasingly challenging pay position compared to plan for future months noting that to date the fav. pay position has helped keep the Trust on plan overall at the end of the first quarter.

3.2 Non-Pay Expenditure

	Plan 2015/16	YTD M3 Actual	YTD M3 Plan	Variance	April Actuals	May Actuals	June Actuals
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Clinical Non Pay - Fixed							
Equipment Hire	1,257	275	314	39 Fav	97	90	88
Equipment Maintenance	3,777	916	947	31 Fav	272	326	321
Clinical Non Pay - Fixed Total	**5,034**	**1,191**	**1,261**	**70 Fav**	**369**	**416**	**409**
Clinical Non Pay - Variable							
Prosthesis	2,664	613	666	53 Fav	138	174	300
Patient & Surgical Appliances	3,035	660	758	98 Fav	202	266	193
Patient Clothing & Travel	63	27	16	(11) Adv	5	17	5
Lab Equipment Consumables	4,432	954	1,107	154 Fav	307	241	406
Blood	1,681	339	420	82 Fav	89	126	124
Medicines	23,977	6,999	6,395	(603) Adv	2,471	2,035	2,503
Medical & Surgical Items	11,984	3,032	2,961	(71) Adv	950	1,026	1,056
Dressings	995	257	249	(8) Adv	73	98	87
Medical Gases	210	55	53	(3) Adv	23	22	10
X-Ray Consumables	1	(1)	0	1 Fav	(1)	0	0
Clinical Non Pay - Variable Total	**49,041**	**12,935**	**12,625**	**(310) Adv**	**4,257**	**4,004**	**4,684**
Clinical Non Pay - Total	**54,075**	**14,126**	**13,886**	**(240) Adv**	**4,626**	**4,420**	**5,092**
Non Clinical Non Pay - Fixed							
Building & Engineering Equipment	2,824	691	706	15 Fav	183	257	251
Cleaning Equipment	556	134	139	5 Fav	40	43	51
Energy & Utilities	3,399	677	795	118 Fav	156	329	191
Rates	782	196	195	(1) Adv	65	65	65
Printing & Stationery	1,013	249	279	30 Fav	107	53	89
Computer Equipment & Maintenance	2,623	677	656	(21) Adv	170	296	208
Communications	904	248	226	(22) Adv	71	82	95
Office Equipment	70	69	18	(51) Adv	10	38	21
Non Pay CIP's	(2,663)	0	(663)	(663) Adv	0	0	0
Non Pay QIPP's	0	0	0	-	0	0	0
Other Fee's	4,691	891	1,201	311 Fav	330	253	297
Losses & Compensations	725	273	181	(91) Adv	41	101	130
CNST	5,932	1,483	1,483	0 Fav	494	494	494
Consultancy Fee's	838	350	210	(140) Adv	98	107	145
Training	864	207	218	10 Fav	68	60	80
Travel & Benefits	1,364	280	345	65 Fav	101	100	78
Staff Advertising	697	197	174	(23) Adv	127	29	42
Non Clinical Non Pay - Fixed Total	**24,618**	**6,620**	**6,163**	**(457) Adv**	**2,060**	**2,308**	**2,238**
Non Clinical Non Pay - Variable							
Patient Provisions	1,503	342	375	33 Fav	142	109	91
Patient Linen	1,112	250	278	28 Fav	80	85	85
Non Clinical Non Pay - Variable Total	**2,615**	**592**	**653**	**61 Fav**	**222**	**193**	**176**
Non Clinical Non Pay - Total	**27,234**	**7,212**	**6,816**	**4,775 Fav**	**2,283**	**2,501**	**2,415**
Expenditure SLAs:							
NHFT Expenditure SLA's	1,249	312	312	0 Fav	103	103	107
Sub-Total Non-Pay	**82,558**	**21,650**	**21,015**	**(636) Adv**	**7,012**	**7,024**	**7,614**



Key Issues

- **Non-Pay expenditure for month 3 is £798k adverse to plan in month and £636k adverse for the year to date.**
- The significant increase in June spend is on Medicines expenditure. The increased use of excluded medicines, is recovered in the income from commissioners. Additionally the introduction of Boots 3rd Party Pharmacy service required a £0.2m stock transfer, which is also recovered in income.
- Medicines aside there are some other pressures on non pay budgets in June:
- Firstly from higher levels of Orthopaedic activity requiring prostheses.
- Lab Consumables enters a period of changeover as Pathology actions new machinery/contracts which will see a reduction in spend in the coming months.
- Losses and compensations costs are volatile in nature, but also includes legal costs for the Trilogy leisure development.
- Consultancy costs have been incurred supporting the Changing Care agenda.
- It is difficult to validate the non-pay CIP at this stage as limited schemes have been identified / validated. The aim is to allocate the CIP fully to appropriate budget lines when this is available.

4. SLA Income

Point of Delivery	Activity Plan	Activity Actual	Activity Variance	Finance £000's Plan	Finance £000's Actual	Finance £000's Variance	Var %
Elective Daycase	9,242	9,704	462	5,594	5,850	256	5%
Elective Inpatients	1,663	1,422	(242)	4,451	3,909	(542)	-12%
Elective Excess Bed Days	543	700	157	123	163	40	32%
Non Elective	10,326	10,414	88	16,499	16,664	164	1%
Non Elective Excess Bed Days	7,502	7,343	(159)	1,608	1,582	(26)	-2%
New Outpatients	16,393	14,651	(1,742)	2,594	2,423	(171)	-7%
Follow Up Outpatients	50,807	50,438	(370)	4,679	4,643	(36)	-1%
Outpatient Procedures	19,848	19,939	91	2,985	3,214	229	8%
CQUIN	-	-		1,386	1,109	(277)	-20%
Block Contracts - Fixed	-	-		3,958	3,920	(38)	-1%
Cost Per Case	657,292	676,713	19,421	6,504	6,145	(359)	-6%
A&E	28,784	28,704	(80)	3,028	3,063	35	1%
EOA							
ITU							
Maternity	3,620	3,957	337	4,019	4,147	128	3%
Excluded Medicines				4,422	4,605	183	4%
Excluded Devices	23	411	388	307	454	147	48%
Other Central SLA Income	-	-		(484)	29	513	-151%
CIPs				55		(55)	
Total SLA Income (before fines and penaties)	**806,044**	**824,396**	**18,352**	**61,726**	**61,918**	**192**	**1%**
Fines & Penatlies							
Contract Penalties	2WW			-	(2)	(2)	
Contract Penalties	31 Days						
Contract Penalties	62 Day			-	(18)	(18)	
Contract Penalties	A&E			-	(49)	(49)	
Contract Penalties	Cancelled Operations			-	(10)	(10)	
Contract Penalties	MRSA						
Contract Penalties	RTT			-	(32)	(32)	
Data Challenges	Challenges			-	(345)	(345)	
MRET	MRET			(638)	(763)	(125)	
Readmissions	Readmissions			(626)	(701)	(75)	
Sub-Total Fines & Penalties				**(1,264)**	**(1,920)**	**(656)**	
Grand Total SLA Income				**60,465**	**59,998**	**(464)**	

Key issues

SLA Income Summary

- Total SLA Income showing £464k adverse position to plan.

Elective Inpatients

- £542k adverse to plan at Month 3. Top four areas against plan: Urology, ENT, Cardiology and Gynaecology.

Outpatients

- Outpatient firsts appointments are below plan (£171k).
- Significant areas are T&O, Ophthalmology and Gynaecology & all below run rate of 14/15.
- Outpatient follow up appointments are below plan (£36k).
- Outpatient procedures are £229k favourable to plan & offset the under performance in outpatients first and follow-ups. T&O is over performing in this area due to new codes being introduced in 2015/16 for knee shoulder & elbow procedures.

Cost Per Case

- Overall showing a £359k underperformance. Underperformance in Critical Care (£249k) and Radiotherapy (£162k).

Risks to the income position:

- Elective activity fails to increase in line with the planning assumptions or is further disrupted by winter pressures (potentially c.£2m underperformance at the year end).
- Nene CCG challenges are in the region of £300k per month noting that any actual or perceived improvements in coding are being challenged as a coding & counting change with the CCG withholding payment.
- The CCG successfully validate the data supporting Ambulance handover fines in year.
- The MRET rebasing arbitration case is currently being independently reviewed. However, the historic assumptions are being re-worked and this may have a detrimental financial impact.

5. Statement of Financial Position

	Balance at 31-Mar-15	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	143,465	143,465	143,465		143,465	
IN YEAR REVALUATIONS		10	9	(1)	224	224
IN YEAR MOVEMENTS		(61)	757	818	30,694	30,694
LESS DEPRECIATION		(2,041)	(3,062)	(1,021)	(12,247)	(12,247)
NET BOOK VALUE	**143,465**	**141,373**	**141,169**	**(204)**	**162,136**	**18,671**
CURRENT ASSETS						
INVENTORIES	5,961	5,524	5,441	(83)	6,000	39
RECEIVABLES						
NHS RECEIVABLES	5,036	3,738	4,942	1,204	5,097	61
OTHER TRADE RECEIVABLES	1,437	1,538	1,724	186	1,665	228
RECEIVABLES IMPAIRMENTS PROVISION	(455)	(455)	(455)		(400)	55
CAPITAL RECEIVABLES						
NON NHS OTHER RECEIVABLES	216	410	248	(162)	250	34
COMPENSATION RECEIVABLES (RTA)	2,677	2,639	2,615	(24)	2,750	73
SALARY OVERPAYMENTS	499	468	544	76	499	
SALARY SACRIFICE SCHEMES	427	373	499	126	577	150
OTHER RECEIVABLES	474	209	455	246	524	50
IRRECOVERABLE PROVISION	(851)	(851)	(851)		(800)	51
PREPAYMENTS	1,666	2,427	2,570	143	1,700	34
SUB TOTAL	**11,126**	**10,496**	**12,291**	**1,795**	**11,862**	**736**
NON CURRENT ASSETS FOR SALE		792	792			
CASH	1,114	5,072	5,083	11	1,500	386
CURRENT ASSETS	**18,201**	**21,884**	**23,607**	**1,723**	**19,362**	**1,161**
CURRENT LIABILITIES						
NHS PAYABLES	442	490	1,071	581	500	58
TRADE PAYABLES REVENUE	1,289	1,410	3,625	2,215	2,100	811
TRADE PAYABLES FIXED ASSETS	2,157	1,199	1,552	353	4,050	1,893
TAX AND NI OWED	3,301	3,373	3,441	68	3,500	199
NHS PENSIONS AGENCY	2,182	2,254	2,250	(4)	2,300	118
OTHER PAYABLES	407	345	344	(1)	400	(7)
SHORT TERM LOANS - DH	159	5,159	5,159		2,239	2,080
SHORT TERM LOANS - NON DH	208	208	208		215	7
ACCRUALS	6,441	7,897	7,532	(365)	5,500	(941)
RECEIPTS IN ADVANCE	1,777	1,693	1,677	(16)	1,500	(277)
PDC DIVIDEND DUE		575	951	376		
STAFF BENEFITS ACCRUAL	721	721	721		650	(71)
PROVISIONS	1,396	1,255	1,171	(84)	1,359	(37)
CURRENT LIABILITIES	**20,480**	**26,579**	**29,702**	**3,123**	**24,313**	**3,833**
NET CURRENT ASSETS / (LIABILITIES)	**(2,279)**	**(4,695)**	**(6,095)**	**(1,400)**	**(4,951)**	**(2,672)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**141,186**	**136,678**	**135,074**	**(1,604)**	**157,185**	**15,999**
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year					1,631	1,631
LOANS over 1 year DH	1,431	1,431	1,431		15,457	14,026
LOANS over 1 year NON DH	248	248	248		248	
PROVISIONS over 1 year	1,072	1,072	1,110	38	1,237	165
NON CURRENT LIABILITIES	**2,751**	**2,751**	**2,789**	**38**	**18,573**	**15,822**
TOTAL ASSETS EMPLOYED	**138,435**	**133,927**	**132,285**	**(1,642)**	**138,612**	**177**
FINANCED BY						
PDC CAPITAL	119,240	119,240	119,240		119,240	
PDC TEMPORARY BORROWING					21,400	21,400
REVALUATION RESERVE	35,879	35,892	35,892		36,044	165
I & E ACCOUNT BALANCE	(16,684)	(16,684)	(16,684)		(16,684)	
I & E CURRENT YEAR		(4,521)	(6,163)	(1,642)	(21,388)	(21,388)
FINANCING TOTAL	**138,435**	**133,927**	**132,285**	**(1,642)**	**138,612**	**177**

Key Movements

Non Current Assets

- £0.2m decrease as depreciation exceeds additions in M3.
- EOY position includes the additions related to loans for replacement imaging equipment, NPfIT systems, car park decking (finance lease) and stock/inventory.

Current assets

- Decrease in Inventories £0.1m.
- Increase in NHS Receivables of £1.2m.
- Decrease in Other Trade Receivables of £0.2m.
- Increase in Salary Overpayments of £0.1m.
- Increase in Salary Sacrifice Schemes of £0.1m.
- Increase in Other Receivables of £0.2m.
- Increase in Prepayments of £0.1m.
- No change in Cash, this allows us to continue to pay creditors until the SLA income is received on 15 July.

Current Liabilities

- Increase in NHS Payables of £0.6m.
- Increase in Trade Creditors of £2.2m.
- Increase in Trade Creditors Fixed Assets of £0.4m.
- Increase in PDC dividend of £0.4m.
- Decrease in Accruals of £0.4m.

Non Current Liabilities

- EOY position includes the Finance Lease Payable related to the car park decking and capital loans.

Financing

- Deficit in month of £1.6m.

6. Capital Expenditure

Capital Scheme	Plan 2015/16 £000's	M3 Plan £000's	M3 Spend £000's	Under (-) / Over £000's	Plan Achieved %	Actual Committed £000's	Plan Achieved %
Linacc corridor	470	470	470	0	100%	470	100%
Replacement Imaging Equipment (Approved)	5,683	191	190	-1	3%	3,853	68%
Replacement Imaging Equipment (Subject to ITFF Bid)	6,552	0	0	0	0%	0	0%
Additional Imaging Equipment (Subject to ITFF Bid)	2,200	0	0	0	0%	0	0%
Replacement NPfIT Systems (Subject to ITFF Bid)	2,617	0	0	0	0%	0	0%
Stock / Inventory System (Subject to ITFF Bid)	600	0	0	0	0%	0	0%
A&E / Orthopaedics	620	160	87	-73	14%	359	58%
Contingency	443	0	0	0	0%	0	0%
Medical Equipment Sub Commiittee	2,407	182	184	2	8%	499	21%
Estates Sub Committee	4,750	211	181	-30	4%	736	16%
IT Sub Committee	2,241	331	326	-4	15%	772	34%
Other	385	135	111	-24	29%	152	39%
Total - Capital Plan	**28,968**	**1,679**	**1,549**	**-130**	**5%**	**6,841**	**24%**
Less Charitable Fund Donations	-350	0	0	0	0%	0	0%
Total - CRL	**28,618**	**1,679**	**1,549**	**-130**	**5%**	**6,841**	**24%**

Funding Resources	
Internally Generated Depreciation	12,247
SALIX	265
Capital Loans - Imaging Equipment (Approved)	5,617
Capital Loans - Replacement Imaging Equipment	6,552
Capital Loans - Additional Imaging Equipment	2,200
Capital Loans - NPfIT Systems	2,617
Capital Loans - Stock / Inventory System	600
Capital Loan - Repayment	-1,480
Total - Available CRL Resource	**28,618**
Uncommitted Plan	**0**

Key Issues

- The Linear Accelerator Corridor works continue with the first replacement linear accelerator due for delivery on 17 July.
- The replacement imaging equipment loan approved £5,617k and slippage of £66k has been reprovided from last year. Replacement plans are being discussed with Radiology and Radiotherapy.
- The capital loans yet to be approved will require approval by the ITFF, The TDA have indicated that an application received by the 24 July could be approved on 18 September although additional assurances are now being required to support the application process.
- The A&E / Orthopaedics scheme continues in the new financial year.
- Full year depreciation forecast is currently £12,427k.
- Charitable Donations assumptions includes £250k relating to the Chemotherapy appeal.
- The car park decking is planned for 2015/16 but this will be subject to a 10 year finance lease.

7. Receivables, Payables and BPPC Compliance

Narrative	Total at June £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	1,724	385	786	49	504
Receivables NHS	3,373	2,421	305	113	534
Total Receivables	**5,097**	**2,806**	**1,091**	**162**	**1,038**
Payables Non NHS	(5,178)	(5,154)	(23)	(1)	0
Payables NHS	(1,071)	(1,070)			(1)
Total Payables	**(6,249)**	**(6,224)**	**(23)**	**(1)**	**(1)**

Narrative	Total at May £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	1,537	890	64	204	379
Receivables NHS	1,447	650	225	241	331
Total Receivables	**2,984**	**1,540**	**289**	**445**	**710**
Payables Non NHS	(1,459)	(1,459)			0
Payables NHS	(147)	(143)	(4)		
Total Payables	**(1,606)**	**(1,602)**	**(4)**		**0**

Receivables and Payables

- All SLA commissioner monthly invoices were paid on time.
- Continued focus on reducing age profile of non current debt.
- For Non NHS over 90 days this includes Overseas visitors accounts for £256k with a high proportion passed to debt agency to recover, Fairview Health Partnership (Pharmacy) £11k (now paid) and CRIPPS invoices £124k due to be written off following the wind up of the CRIPPS centre in May.
- NHS over 90 day debt predominantly relates to NCA's.
- Predominantly 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.

Narrative	April 2015	May 2015	June 2015	Cumulative 2015/16
NHS Creditors				
No.of Bills Paid Within Target	181	156	150	487
No.of Bills Paid Within Period	186	157	156	499
Percentage Paid Within Target	**97.31%**	**99.36%**	**96.15%**	**97.60%**
Value of Bills Paid Within Target (£000's)	1,486	1,385	1,831	4,702
Value of Bills Paid Within Period (£000's)	1,491	1,385	1,841	4,718
Percentage Paid Within Target	**99.61%**	**100.00%**	**99.47%**	**99.67%**
Non NHS Creditors				
No.of Bills Paid Within Target	7,114	6,212	6,581	19,907
No.of Bills Paid Within Period	7,168	6,240	6,629	20,037
Percentage Paid Within Target	**99.25%**	**99.55%**	**99.28%**	**99.35%**
Value of Bills Paid Within Target (£000's)	7,676	6,499	6,507	20,682
Value of Bills Paid Within Period (£000's)	7,718	6,530	6,529	20,777
Percentage Paid Within Target	**99.46%**	**99.53%**	**99.67%**	**99.55%**
Total				
No.of Bills Paid Within Target	7,295	6,368	6,731	20,394
No.of Bills Paid Within Period	7,354	6,397	6,785	20,536
Percentage Paid Within Target	**99.20%**	**99.55%**	**99.20%**	**99.31%**
Value of Bills Paid Within Target (£000's)	9,162	7,884	8,338	25,384
Value of Bills Paid Within Period (£000's)	9,209	7,915	8,370	25,494
Percentage Paid Within Target	**99.48%**	**99.61%**	**99.62%**	**99.57%**

BPPC Compliance

- The BPPC performance has been maintained in the new financial year with all targets achieved in year to date by volume and value with the payments team continuing to achieve processing within the targets once approved.
- No major issues have been encountered to date.
- Performance is contingent on access to DH Working Capital Facility.

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	235,588	19,508	18,956	20,342	19,913	19,609	19,609	19,609	19,609	19,609	19,609	19,609	19,609
SLA Performance/ Other CCG Investment													
Health Education	9,779	759	825	802	793	825	825	825	825	825	825	825	825
Other NHS Income	10,409	1,084	731	441	756	1,403	856	856	856	856	856	856	856
PP / Other (Specific > £250k)	396	396											
PP / Other	13,142	1,104	946	1,011	1,252	1,130	1,100	1,100	1,100	1,100	1,100	1,100	1,100
Salix Capital Loan	265									65	100	100	
PDC - Capital													
Capital Loan	15,504					660	3,462	609	1,178	1,329	1,709	2,196	4,361
PDC - Revenue													
Temporary Borrowing	21,400	3,500	1,500			1,500	5,000	2,700	3,300	3,500	400		
Interest Receivable	30	6	2	3	2	2	3	2	3	2	2	2	2
Sale of Assets													
TOTAL RECEIPTS	**306,513**	**26,356**	**22,959**	**22,600**	**22,716**	**25,129**	**30,854**	**25,701**	**26,870**	**27,286**	**24,600**	**24,688**	**26,753**
PAYMENTS													
Salaries and wages	169,998	13,999	14,213	14,194	14,191	14,175	14,175	14,175	14,175	14,175	14,175	14,175	14,175
Trade Creditors	87,739	7,259	6,199	6,122	8,766	8,792	7,787	7,581	7,833	8,704	5,296	6,094	7,307
NHS Creditors	18,302	1,491	1,385	1,841	1,593	1,593	1,708	1,593	1,593	1,593	1,593	1,000	1,317
Capital Expenditure	24,928	490	313	431	872	1,406	4,926	2,126	3,269	2,814	3,536	3,419	1,326
PDC Dividend	4,146						1,988						2,158
Repayment of Loans (Principal & Interest)	757						160	214					384
Repayment of Salix loan	208						111	12					85
TOTAL PAYMENTS	**306,077**	**23,238**	**22,111**	**22,588**	**25,422**	**25,966**	**30,854**	**25,701**	**26,870**	**27,286**	**24,600**	**24,688**	**26,752**
Actual month balance	436	3,118	849	12	-2,706	-838	0	0	0	0	0	0	1
Cash in transit & Cash in hand adjustment	-49	-20	11	-2	-39								
Balance brought forward	1,114	1,114	4,212	5,072	5,083	2,337	1,500	1,500	1,500	1,500	1,500	1,500	1,500
Balance carried forward	**1,500**	**4,212**	**5,072**	**5,083**	**2,337**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**

Key Issues

- The Trust has now utilised £5m (plan was £6m) of Temporary Borrowing as part of the Revolving Working Capital Support Facility introduced by the Department of Health to support Trust's cash flows in 2015/16. This facility will be utilised until such time that permanent PDC Revenue Support is granted.
- The funding period for the facility is from mid-month to mid-month. The carried forward balance at the end of June was £5.0m, higher than anticipated and as such no further temporary borrowing is required in July. The next planned draw down will be £1.5m in August.
- Further draw down of the Capital Loan for the replacement imaging is now scheduled to recommence in August £0.7m.
- The cashflow statement now incorporates repayment of loan principals and respective interest charges.
- Temporary borrowing is subject to an interest charge of 3.5% calculated on a daily basis.
- There is a 1% commitment fee associated with the £21.4m Revenue Support Funding included in the 15/16 financial plan. This is currently forecast to be paid in October.

9. Risks to the Financial Position

	Risks not in I&E Plan	Unmitigated Risk (£k)	Action to mitigate risk	Likelihood	Residual Risk (£k)
1	CIP delivery risk (schemes rated as High Risk - £3.4m / Medium risk £3.8m)	7,200	Executive lead CIP Steering and CIP themes. Robust managed of delivery through Programme Delivery Team.	37%	2,682
2	YTG value of unplanned CCG Data challenges (based on Q1)	1,035	£345k of data challenges raised by CCG in Q1.	90%	932
3	YTG value of unplanned MRET / Readmissions (above plan based in Q1)	600	Limited mitigation possible.	90%	540
4	YTG value of unplanned Contractual Fines (based on Q1)	333	Cancer, A&E Cancelled Ops and Incomplete RTT fines	90%	300
5	Proposed Ambulance Handover Fines (to be introduced by NENE CCG Aug 15)	1,100	CCG proposal to apply fines from August 2015.	75%	825
6	Independent Review of 08-09 MRET Baseline (30% impact of £3m reduction)	1,000	Trust to prepare robust defence and evidence to support all movements from calculated baseline.	50%	500
7	CCG claw back of 50% of FY14-15 Income settlement	873	Trust refusal to accept invoice as not part of FY14-15 year end settlement agreement.	50%	437
8	Inability to recruit sufficient nursing staff leading to increased use of premium cost agency staff.	1,000	Nurse staff recruitment strategy. Funding set aside for international recruitment. Consultation process to be undertaken to standardise shift systems.	50%	500
9	Excess outsourcing costs of achieving Referral to Treatment target (risk notably in T&O, Ophthalmology and Endoscopy).	300	£1.2m of Outsourcing costs included in financial plan and reserves.	50%	150
10	Excess costs of unfunded Winter Pressures	1,400	Prepare winter plan and identify funding source. Senior input to CCG / SRG meetings.	60%	840
11	Increase in Danetre rental costs proposed by PropCo	450	Negotiate improved lease terms / exit Danetre if unaffordable	50%	225
12	HMRC compliance	500	Ensure Off-Payroll contractors comply with HMRC and DH guidelines.	50%	250
13	Bear Scotland Ruling (historc back pay estimate only)	500	Comply with advice from NHS Employers / Legal Advisors.	50%	250
	Total Risks (Risk adjusted)				**8,430**

- An assessment of the risks quoted above has been used as a basis for responding the TDA in relation to the development of a stretch target aimed at improving the overall I&E deficit plan of £21.2m by the financial year end.
- Further work to quantify the risks is required together with the development of an in year I&E forecast to provide further assurance that all of the risks can be contained within the financial plan target.
- Further discussions and Q1 contract reconciliation is required with Commissioners to understand the full extent of the contractual risks faced for the remainder of the financial year.
- The Trust is developing a range of mitigations and additional CIP schemes to offset the risks and ensure that the Trust delivers to the financial plan and monthly trajectory agreed at the start of the year.

10. Conclusions and Recommendations

Conclusion:

- The Trust continues to perform in line with plan at the end of Q1. It is imperative that this position continues and the Trust can continue to demonstrate delivery of financial targets at Q2 and beyond.
- Regulators have requested that the Trust agrees a "stretch target" to improve the level of planned deficit by the financial year end. At the current stage of the financial year there are a range of significant risks which will require management to ensure delivery of the £21.1m deficit target and before significant improvements could be guaranteed.
- The overall position is heavily reliant on the management of Pay expenditure and the current level of vacancies underpinning CIP delivery. This position cannot be relied upon as the financial year progresses without decisive action to reduce premium staffing costs and manage or dis-establish vacant posts.
- Regulators have made explicit statements about the need to control costs (namely consultancy and agency expenditure) and the Trust will need to ensure it can comply with emerging guidance and targets. Were this to require a reduction in expenditure evidence to date suggests this will be challenging given the current environment.
- The Trust has a range of revenue reserves which need to be carefully managed. These reserves represent the only source of funding to meet any unplanned costs, risks or mitigations for CIP slippage in year.
- Robust performance management of Divisional finances needs to be embedded at an early stage of the financial year. At present both the Medicine and Surgical Divisions are subject to escalated performance reviews.
- The Trust has continued to manage the operational cashflow position but needs to agree the approach to securing the capital loan funding required to fulfil the Capital expenditure program from the Independent Trust Financing Facility with the TDA. The assurances required to support an ITFF application are likely to be more substantial than previously required.

Recommendations & actions

1. Review of projected Agency expenditure and control measures to be undertaken taking into consideration CIP and recruitment initiatives currently planned.
2. Risk assessment and ongoing review of CIP delivery compared to plan is undertaken with a focus on the major deliverables for the year to go.
3. A plan to manage the cost implications of Winter pressures is drawn up on the assumption that no further CCG funding will be made available in year.
4. Review of new CQUIN targets and forecast delivery required ahead of Q1 review.
5. The sustainability plan is further developed alongside additional assurances required to support the ITFF capital loan application in September.
6. Consider next steps required to manage adverse Divisional performance.
7. Consider response to emerging guidance from regulators in relation to reducing consultancy and agency costs.

Appendix 1: Continuity of Service Risk Rating (CoSR)

		June 15 ACTUAL	May 15 ACTUAL	Apr 15 ACTUAL	Mar 15 ACTUAL
LIQUIDITY RATIO (DAYS)		**£000's**	**£000's**	**£000's**	**£000's**
Working Capital Balance					
Total - Current Assets	+	23,607	21,884	19,240	18,046
Total - Current Liabilities	+	-29,702	-26,579	-19,377	-20,370
Inventories	-	5,441	5,524	6,095	5,961
Non-Current Assets Held for Sale	-	792	792		0
PFI Prepayments - Current Portion	+	0	0		
Financial Assets Available for Sale	+	0	0		
Current Assets held for Sale by Charitable Funds	+	0	0		
Current Liabilities held for Sale by Charitable Funds	+	0	0		
(1) Working Capital Balance		**-12,328**	**-11,011**	**-6,232**	**-8,285**
Annual Operating Expenses					
Gross Employee Benefits	+	-45,523	-31,394	-15,681	-184,613
Other Operating Costs	+	-26,353	-16,083	-7,957	-101,531
Impairments: IFRIC 12	+	0	0	0	3,338
Depreciation	+	3,062	2,041	1,038	11,407
Amortisation	+	0	0	0	0
Stock Write down	+	15	10	0	80
Impairment of Receivables	+	126	50	19	646
(2) Annual Operating Expenses		**68,673**	**45,376**	**22,581**	**270,672**
Liquidity Ratio Days		**-16**	**-15**	**-8**	**-11**
(A) LIQUIDITY SCORE		**1**	**1**	**2**	**2**
CAPITAL SERVICING CAPACITY					
Normalised EBITDA - less interest		-2,006	-1,739	-773	-1,299
Annual Debt Service		1,128	750	364	4,520
Capital Servicing Capacity (times)		**-1.8**	**-2.3**	**-2.1**	**-0.3**
(B) CAPITAL SERVICING CAPACITY SCORE		**1.0**	**1.0**	**1.0**	**1.0**
CONTINUITY OF SERVICES RATING		**1.0**	**1.0**	**1.5**	**1.5**

Key issues

The continuity of services risk rating incorporates two common measures of financial robustness:

(i) liquidity: days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown.

(ii) capital servicing capacity: the degree to which the organisation's generated income covers its financing obligations.

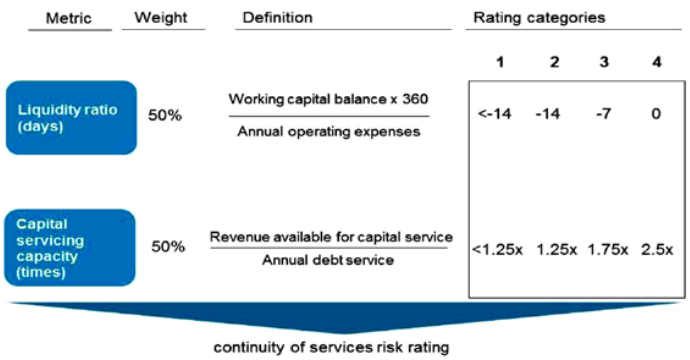
Current Score

- 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 £20.2m deficit plan.
- Forecast score of 1 overall.
- Liquidity score will reduce if planned deficit not maintained.
- "Revolving" Working Capital Facility in place.

Monitor Guidance (extract)



Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30 July 2015**

Title of the Report	**Workforce Performance Report**
Agenda item	**12**
Presenter of Report	Janine Brennan, Director of Workforce & Transformation
Author(s) of Report	Sandra Wright, Assistant Director of Workforce Development
Purpose	This report provides an overview of key workforce issues
Executive summary • The key performance indicators show a decrease in contracted workforce employed by the Trust, and an increase in sickness absence. • Increases in compliance rates for Mandatory Training and Role Specific Essential Training compliance and a decrease in Appraisal compliance rates.	
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 Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (Y/N) No Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (Y/N) No

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Legal implications / regulatory requirements	No

Actions required by the Trust Board

The Trust Board is asked to:

- Note the report

Northampton General Hospital NHS
NHS Trust

Public Trust Board
30 July 2015

Workforce Performance Report

1. Introduction

This report identifies the key themes emerging from June 2015 performance and identifies trends against Trust targets. It also sets out current key workforce updates.

2. Workforce Report

2.1 Capacity

Substantive Workforce Capacity decreased by 6.44 FTE in June 2015 to 4119.69 FTE. The Trust's substantive workforce is at 88.81% of the Budgeted Workforce Establishment of 4638.52 FTE.

Trust turnover increased to 11.47% in June which is above the Trust target of 8%. Overall turnover within Nursing & Midwifery has increased slightly to 11.81%. Turnover fell in the Allied Health Professional, Estates & Ancillary and Medical & Dental staff groups, but rose in all others.

In month sickness absence increased by 0.43% to 4.15%, which means an increase to above the Trust target of 3.8%. However, both Clinical Support Services Division and Support Services achieved a level below the Trust's target of 3.8%.

Sickness Absence Benchmarking

Data available from the Health & Social Care Information Centre (HSCIC) I-View Database enables comparison with other trusts, either regionally or by benchmarking with similar-sized organisations. The latest data currently available is for February 2015.

Compared to the other acute trusts in the East Midlands, NGH has above average sickness, although it fares better than Lincolnshire and Sherwood Forest Hospitals, and has a generally lower absence rate than Kettering General Hospital.

NGH is classified in the HSCIC database as a Medium Acute Trust, and in comparison with other such trusts nationally, we have above average sickness absence rates. Of the 35 trusts in this benchmark group, NGH has been ranked as having between the 7th and 11th highest absence rate for each of the twelve months to February 2015.

Looking at specific staff groups, NGH also has higher than average sickness compared with other medium acute trusts in the Nursing & Midwifery, HCAs & Helpers, and Admin & Clerical staff groups for the twelve months to February 2015, but lower than the average for benchmark trusts in all other staff groups.

More detail is available in Appendix 1.

Ward Buddies

The NGH Ward Buddy project is in the final stages of planning and will be launched shortly. 22 ward buddies from our non-clinical areas have confirmed their commitment to be available during times of significant internal incident. All the Buddies will need to evidence that they are up to date in their mandatory training and in addition will attend a half-day development session where they will learn more about the role, where it will be made clear on where they can provide support and when they should signpost to others. They will work through case studies and learn some of the practical tasks such as making beds.

Enclosure H

The Ward Buddies will be 'activated' once a significant internal incident is declared, but to ensure the maintenance of skills, it is anticipated that each Buddy will undertake the role no less than three times a year. A three-way agreement between Buddy, line manager and ward manager will be administered and held by the HR team. Invitations to attend the development session will be sent over the next few weeks.

2.2 Capability

Appraisals, Mandatory and Role Specific Essential Training

Appraisal compliance rate reduced to 70.28%, this is a reduction of 2.85% on last month's figures. There are still significant numbers of staff who do not have an in-date appraisal, some of whom are at the top of their incremental scale.

Mandatory Training compliance increased in June to 82.03% from 81.14% in May.

The Review of Knowledge sessions are being continuously reviewed in response to feedback and are now being offered on a drop in basis; this appears to have had a positive impact upon the numbers attending the sessions, although it is no longer possible to detect non-attendees.

Role Specific Essential Training compliance also increased slightly in June to 69.47%.

The Learning & Development Department are providing support to areas in order that they are able to achieve a compliance rate of 85% across Appraisals, Mandatory Training and Role Specific Essential Training.

2.3 Culture

Staff Friends and Family (SFFT) Quarter 1: non-clinical support areas

Feedback has been received from the non-clinical support areas with a comparison to same group in the same quarter last year. There has been a 35% increase in the number of staff responding. The initial results are showing a positive shift in staff both recommending NGH as a place for treatment and as a place to work; questions and results are below:

How likely are you to recommend NGH to friends and family if they needed care or treatment?

- 74% Likely or highly likely ↑ 5%
- 17% were neither likely nor unlikely ↓ 8%
- 6% were unlikely or high unlikely ↔

(3% didn't know)

How likely are you to recommend NGH to friends and family as a place to work?

- 68% Likely or highly likely ↑1%
- 18% were neither likely nor unlikely ↔
- 14% were unlikely or high unlikely ↓ 1%

Full response to staff will be themed and shared out across the Trust in July.

Workforce Race Equality Standard (WRES)

The WRES has been presented and approved by the Workforce Committee and Equality and Diversity Group (Staff) and has now been uploaded onto the Trusts internet. During the coming year work will commence to address any data shortcomings from the baseline data identified by the WRES indicators.

3. Assessment of Risk

Managing workforce risk is a key part of the Trust's governance arrangements.

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.

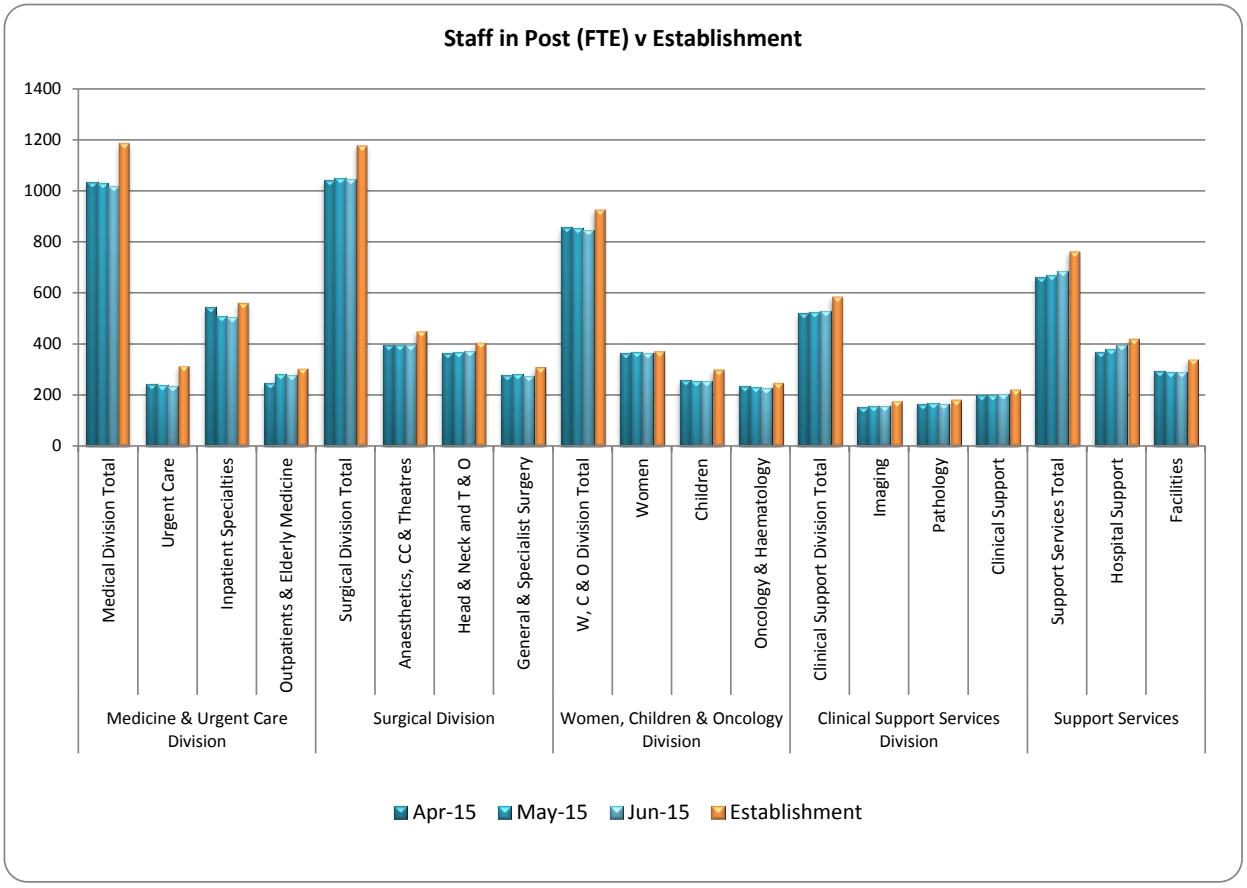
Enclosure H

Trust Board : Capacity and Capability Report - June 2015

CAPACITY
Staff in Post

Establishment RAG Rates:	< 88%	88-93%	> 93%

Staff in Post (FTE)		Apr-15		May-15		Jun-15	Establishment	
Medicine & Urgent Care Division	Medical Division Total	1035.30	↓	1030.29	↓	1018.18	1185.99	85.85%
	Urgent Care	243.93	↓	239.20	↓	235.20	315.99	74.43%
	Inpatient Specialties	542.58	↓	507.73	↓	503.33	561.37	89.66%
	Outpatients & Elderly Medicine	246.99	↑	281.55	↓	278.66	306.25	90.99%
Surgical Division	Surgical Division Total	1042.10	↑	1049.17	↓	1044.58	1176.47	88.79%
	Anaesthetics, CC & Theatres	396.98	↓	393.71	↑	393.93	451.55	87.24%
	Head & Neck and T & O	362.34	↑	366.42	↑	370.27	406.90	91.00%
	General & Specialist Surgery	276.98	↑	283.25	↓	274.58	310.92	88.31%
Women, Children & Oncology Division	W, C & O Division Total	856.70	↓	854.10	↓	844.88	926.58	91.18%
	Women	363.67	↑	366.73	↓	363.96	373.65	97.41%
	Children	259.51	↓	256.11	↓	254.02	300.73	84.47%
	Oncology & Haematology	232.53	↓	230.26	↓	225.05	249.46	90.21%
Clinical Support Services Division	Clinical Support Division Total	519.62	↑	523.51	↑	527.73	586.78	89.94%
	Imaging	154.29	↑	155.24	↑	155.66	178.68	87.12%
	Pathology	166.07	↑	166.73	↓	164.73	183.14	89.95%
	Clinical Support	198.27	↑	199.54	↑	205.35	223.42	91.91%
Support Services	Support Services Total	661.55	↑	669.05	↑	684.32	762.70	89.72%
	Hospital Support	368.78	↑	379.45	↑	395.97	421.28	93.99%
	Facilities	292.76	↓	289.60	↓	288.35	341.42	84.46%
Trust Total		4115.27	↑	4126.13	↓	4119.69	4638.52	88.81%



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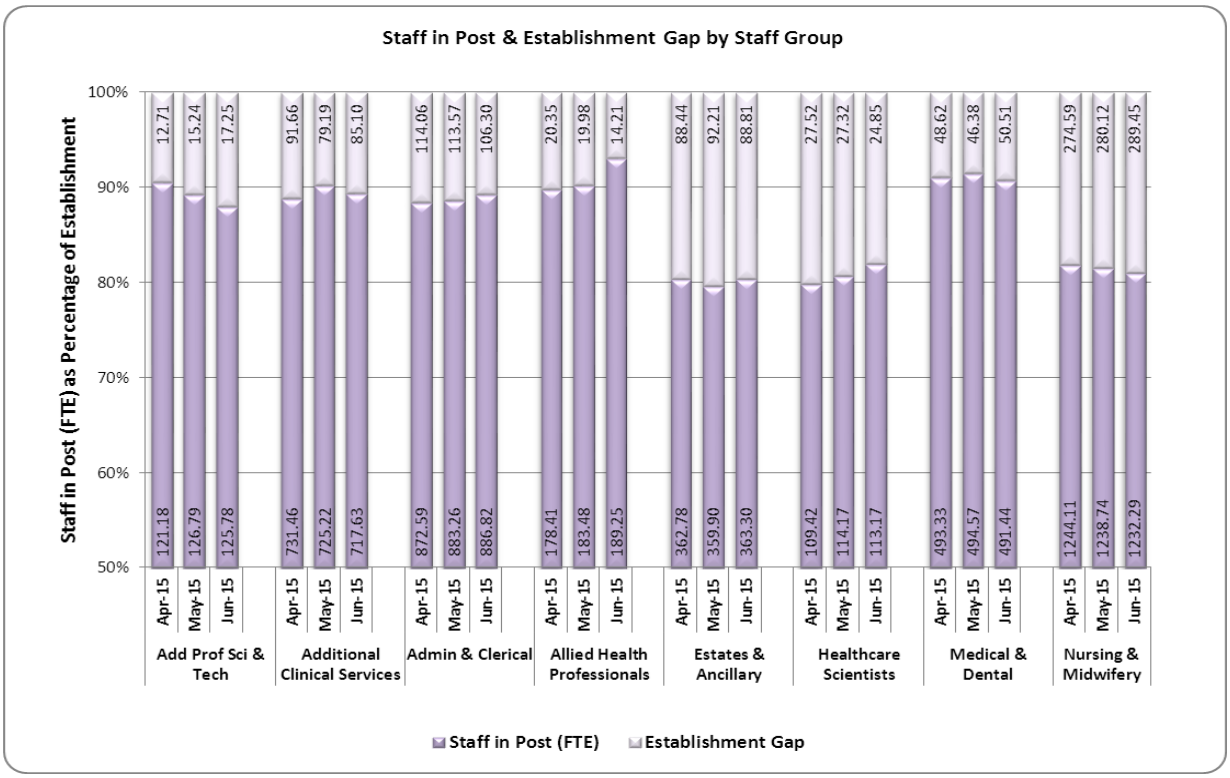
Trust Board : Capacity and Capability Report - June 2015

CAPACITY
Staff Group (FTE v Est)

Vacancy RAG Rates:	> 12%	7 - 12%	< 7%

Staff Group Vacancy Rate (Contracted FTE v Establishment)

Staff Group	Apr-15	May-15	Jun-15
Add Prof Sci & Tech	9.49%	10.73%	12.06%
Additional Clinical Services	11.14%	9.84%	10.60%
Admin & Clerical	11.56%	11.39%	10.70%
Allied Health Professionals	10.24%	9.82%	6.98%
Estates & Ancillary	19.60%	20.40%	19.64%
Healthcare Scientists	20.10%	19.31%	18.01%
Medical & Dental	9.86%	8.57%	9.32%
Nursing & Midwifery	18.08%	18.44%	19.02%



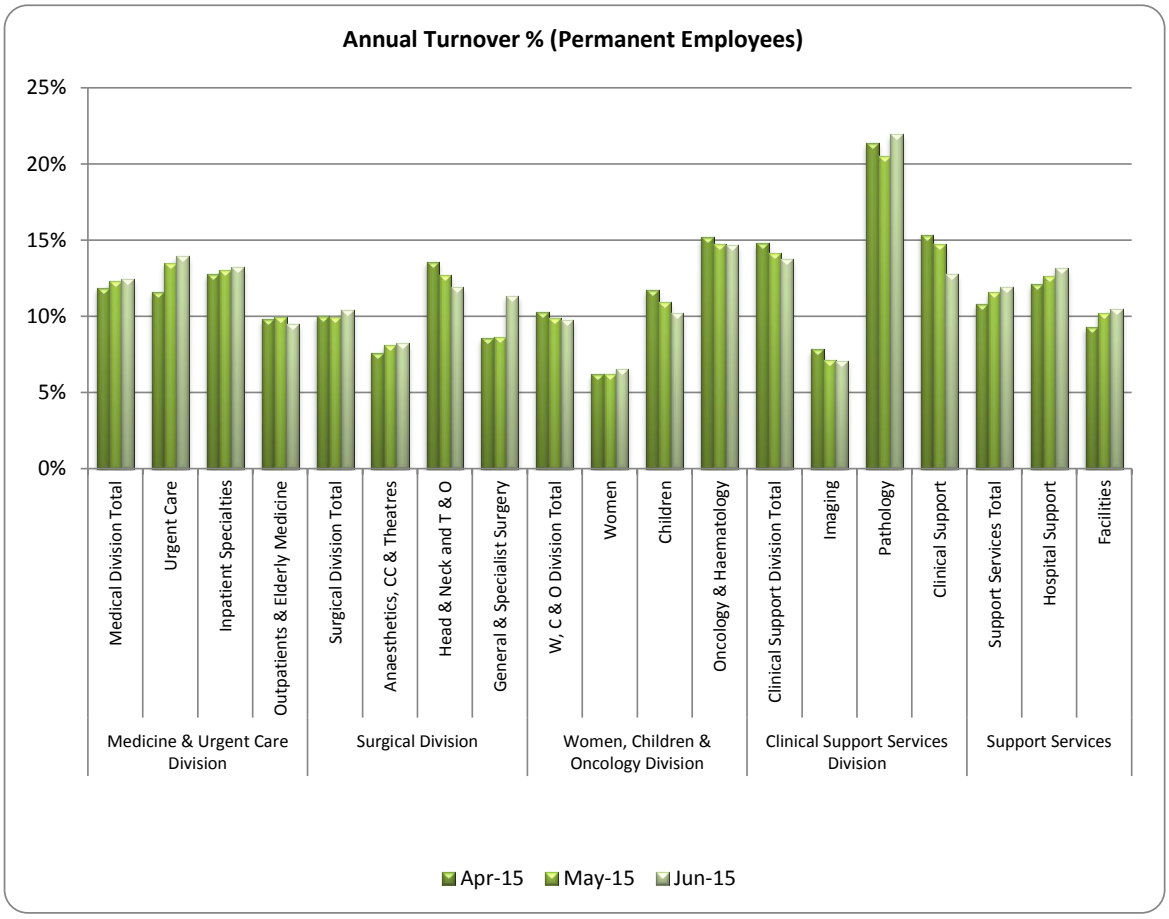
Trust Board : Capacity and Capability Report - June 2015

CAPACITY
Annual Turnover

Figures refer to the year ending in the month stated

Turnover RAG Rates:		
> 10%	8 - 10%	< 8%

Annual Turnover (Permanent Staff)		Apr-15	May-15	Jun-15
Medicine & Urgent Care Division	Medical Division Total	11.86%	12.29%	12.43%
	Urgent Care	11.60%	13.47%	13.96%
	Inpatient Specialties	12.78%	13.02%	13.21%
	Outpatients & Elderly Medicine	9.83%	9.91%	9.48%
Surgical Division	Surgical Division Total	9.99%	9.91%	10.39%
	Anaesthetics, CC & Theatres	7.58%	8.12%	8.20%
	Head & Neck and T & O	13.55%	12.69%	11.91%
	General & Specialist Surgery	8.57%	8.60%	11.32%
Women, Children & Oncology Division	W, C & O Division Total	10.25%	9.90%	9.77%
	Women	6.17%	6.22%	6.55%
	Children	11.73%	10.95%	10.16%
	Oncology & Haematology	15.19%	14.74%	14.68%
Clinical Support Services Division	Clinical Support Division Total	14.83%	14.11%	13.76%
	Imaging	7.80%	7.11%	7.08%
	Pathology	21.39%	20.54%	21.97%
	Clinical Support	15.31%	14.72%	12.76%
Support Services	Support Services Total	10.82%	11.55%	11.94%
	Hospital Support	12.11%	12.66%	13.15%
	Facilities	9.30%	10.22%	10.48%
Trust Total		11.29%	11.31%	11.47%



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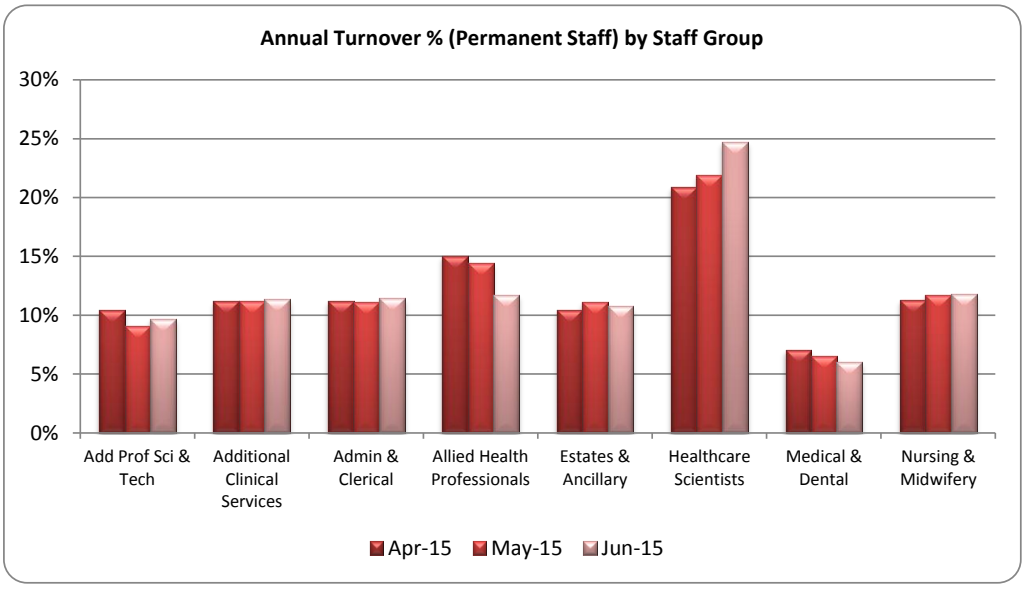
Trust Board : Capacity and Capability Report - June 2015

CAPACITY
Turnover by Staff Group

Turnover RAG Rates:		
> 10%	8 - 10%	< 8%

Annual Turnover Rate for Permanent Staff *Figures refer to the year ending in the month stated*

Staff Group	Apr-15		May-15		Jun-15
Add Prof Sci & Tech	10.38%	↘	9.07%	↗	9.70%
Additional Clinical Services	11.22%	↘	11.17%	↗	11.32%
Admin & Clerical	11.19%	↘	11.08%	↗	11.42%
Allied Health Professionals	14.98%	↘	14.40%	↘	11.69%
Estates & Ancillary	10.42%	↗	11.09%	↘	10.73%
Healthcare Scientists	20.85%	↗	21.88%	↗	24.73%
Medical & Dental	7.00%	↘	6.54%	↘	6.04%
Nursing & Midwifery	11.30%	↗	11.73%	↗	11.81%



Capacity

Substantive Workforce Capacity decreased by 6.44 FTE in June 2015 to 4119.69 FTE. The Trust's substantive workforce is at 88.81% of the Budgeted Workforce Establishment of 4638.52FTE.

Staff Turnover: Trust turnover increased further to 11.47% in June which is above the Trust target of 8%. Turnover within Nursing & Midwifery increased to 11.81%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust. Turnover fell in the Allied Health Professional, Estates & Ancillary and Medical & Dental staff groups, but rose in all others.
Medical Division; Increased by 0**.14**%, although turnover fell to 9.48% within Outpatients & Elderly Medicine.
Surgical Division: turnover increased to 10.39%.
Women, Children's & Oncology Division; further reduction in turnover in this division, now standing at 9.77%.
Clinical Support Services Division; fell below 14%, to 13.76% for the year ending June 2015.

Staff Vacancies: The vacancy rate within Estates and Ancillary staff group decreased in June but still remains significantly above the Trust vacancy target of 7% at 19.64%. The Registered Nursing & Midwifery vacancy rate has grown again to 19.02%, partly as a result of additional investment added in the new financial year; it has however increased further from 18.08% in April.

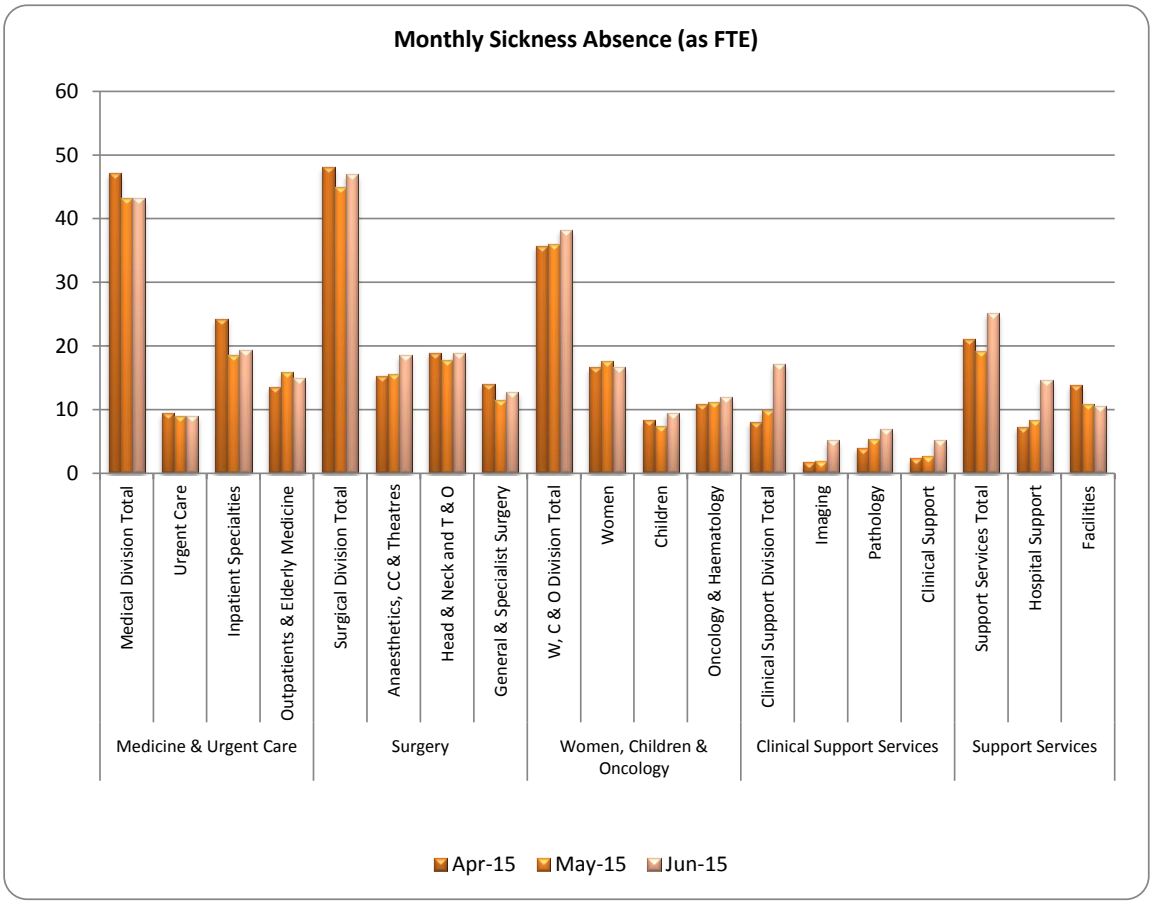
Sickness Absence: In month sickness absence increased by 0.43% to 4.15% which takes it back above the Trust target of 3.8% . However, both Clinical Support Services Division and Support Services achieved a level below the Trust's target of 3.8%.

Trust Board : Capacity and Capability Report - June 2015

CAPACITY
In-Month Sickness

Sickness % RAG Rates:		
> 4.2%	3.8-4.2%	< 3.8%

Monthly Sickness (as FTE)		Apr-15	May-15	Jun-15	Jun-15	Short Term	Long Term
Medicine & Urgent Care	Medical Division Total	47.21	43.27	43.27	4.25%	2.56%	1.69%
	Urgent Care	9.39	8.99	9.03	3.84%	2.23%	1.60%
	Inpatient Specialties	24.25	18.53	19.38	3.85%	2.77%	1.08%
	Outpatients & Elderly Medicine	13.58	15.79	14.94	5.36%	2.46%	2.89%
Surgery	Surgical Division Total	48.15	44.90	47.01	4.50%	2.69%	1.81%
	Anaesthetics, CC & Theatres	15.24	15.51	18.51	4.70%	2.66%	2.04%
	Head & Neck and T & O	18.95	17.81	18.96	5.12%	2.55%	5.57%
	General & Specialist Surgery	13.99	11.44	12.80	4.66%	3.25%	1.41%
Women, Children & Oncology	W, C & O Division Total	35.72	36.04	38.27	4.53%	2.08%	2.45%
	Women	16.58	17.60	16.74	4.60%	1.93%	2.67%
	Children	8.33	7.38	9.45	3.72%	1.99%	1.74%
	Oncology & Haematology	10.81	11.10	12.04	5.35%	2.45%	2.90%
Clinical Support Services	Clinical Support Division Total	8.00	9.89	17.20	3.26%	2.39%	0.87%
	Imaging	1.76	1.97	5.14	3.30%	3.30%	0.00%
	Pathology	3.90	5.29	6.87	4.17%	2.36%	1.81%
	Clinical Support	2.36	2.61	5.15	2.51%	1.74%	0.77%
Support Services	Support Services Total	21.10	19.13	25.18	3.68%	2.55%	1.13%
	Hospital Support	7.23	8.27	14.65	3.70%	2.87%	0.82%
	Facilities	13.82	10.83	10.55	3.66%	2.11%	1.55%
Trust Total	*As FTE*	160.50	153.49				
	As percentage	3.90%	3.72%		4.15%	2.47%	1.68%



Enclosure H

Trust Board : Capacity and Capability Report - June 2015

CAPABILITY
Training & Appraisal Rates

Training & Appraisal RAG Rates:		
< 80%	80 - 84.9%	> 85%

Mandatory Training Compliance Rate	Directorate	Apr-15	May-15	Jun-15
Medicine & Urgent Care Division	Medical Division Total	74.95%	76.01%	77.09%
	Urgent Care	75.37%	77.57%	76.50%
	Inpatient Specialties	72.29%	72.99%	74.26%
	Outpatients & Elderly Medicine	80.12%	80.13%	82.71%
Surgical Division	Surgical Division Total	76.27%	77.97%	79.60%
	Anaesthetics, CC & Theatres	79.70%	80.23%	81.64%
	Head & Neck and T & O	73.21%	75.16%	76.16%
	General & Specialist Surgery	75.69%	78.52%	81.20%
Women, Children & Oncology Division	W, C & O Division Total	82.41%	82.73%	82.51%
	Women	81.58%	80.67%	80.19%
	Children	83.46%	85.22%	84.60%
	Oncology & Haematology	82.65%	83.50%	84.21%
Clinical Support Services Division	Clinical Support Division Total	88.93%	88.70%	90.43%
	Imaging	90.19%	90.32%	91.74%
	Pathology	85.99%	84.10%	87.40%
	Clinical Support	90.26%	91.02%	91.71%
Support Services	Support Services Total	84.41%	86.09%	86.18%
	Hospital Support	85.86%	87.41%	87.42%
	Facilities	82.60%	84.38%	84.49%
Trust Total		**80.14%**	**81.14%**	**82.03%**

Role Specific Training Compliance Rate	Directorate	Apr-15	May-15	Jun-15
Medicine & Urgent Care Division	Medical Division Total	64.91%	64.85%	64.89%
	Urgent Care	58.57%	59.59%	60.55%
	Inpatient Specialties	62.94%	61.74%	61.76%
	Outpatients & Elderly Medicine	75.93%	75.22%	74.43%
Surgical Division	Surgical Division Total	67.28%	67.99%	69.46%
	Anaesthetics, CC & Theatres	69.34%	70.00%	70.79%
	Head & Neck and T & O	63.86%	64.81%	64.58%
	General & Specialist Surgery	68.39%	68.92%	73.75%
Women, Children & Oncology Division	W, C & O Division Total	67.41%	68.51%	70.02%
	Women	62.60%	63.30%	64.57%
	Children	70.94%	72.55%	74.75%
	Oncology & Haematology	73.16%	74.48%	75.95%
Clinical Support Services Division	Clinical Support Division Total	82.83%	84.11%	83.35%
	Imaging	86.49%	86.40%	86.17%
	Pathology	73.31%	73.65%	74.04%
	Clinical Support	82.52%	85.10%	83.67%
Support Services	Support Services Total	70.03%	70.02%	69.21%
	Hospital Support	72.60%	72.84%	72.01%
	Facilities	65.86%	65.31%	64.14%
Trust Total		**68.12%**	**68.73%**	**69.47%**

Trust Board : Capacity and Capability Report - June 2015

CAPABILITY
Training & Appraisal Rates

Training & Appraisal RAG Rates:		
< 80%	80 - 84.9%	> 85%

Appraisal Compliance Rate	Directorate	Apr-15	May-15	Jun-15
Medicine & Urgent Care Division	Medical Division Total	61.52%	61.58%	58.52%
	Urgent Care	70.12%	71.55%	67.50%
	Inpatient Specialties	53.37%	51.75%	50.52%
	Outpatients & Elderly Medicine	69.78%	70.24%	64.71%
Surgical Division	Surgical Division Total	68.15%	71.76%	71.70%
	Anaesthetics, CC & Theatres	66.76%	69.97%	66.94%
	Head & Neck and T & O	58.24%	62.14%	66.19%
	General & Specialist Surgery	82.80%	86.43%	85.51%
Women, Children & Oncology Division	W, C & O Division Total	76.53%	80.35%	76.06%
	Women	78.44%	84.04%	80.23%
	Children	74.22%	75.39%	74.32%
	Oncology & Haematology	75.63%	79.41%	70.51%
Clinical Support Services Division	Clinical Support Division Total	79.26%	85.51%	81.79%
	Imaging	80.98%	88.34%	82.93%
	Pathology	72.62%	79.88%	79.76%
	Clinical Support	82.76%	87.93%	82.70%
Support Services	Support Services Total	70.23%	72.35%	68.46%
	Hospital Support	70.27%	75.78%	70.34%
	Facilities	70.18%	67.99%	65.95%
Trust Total		70.22%	**73.13%**	**70.28%**

Capability

Appraisals
The current rate of Appraisals recorded for June 2015 is 70.28%; this is a decrease on last month's figures of almost 3 percent.

Mandatory Training and Role Specific Essential Training
Mandatory Training compliance increased in June to just over 82% (82.03%).

Role Specific Essential Training compliance also increased in June to 69.47%.

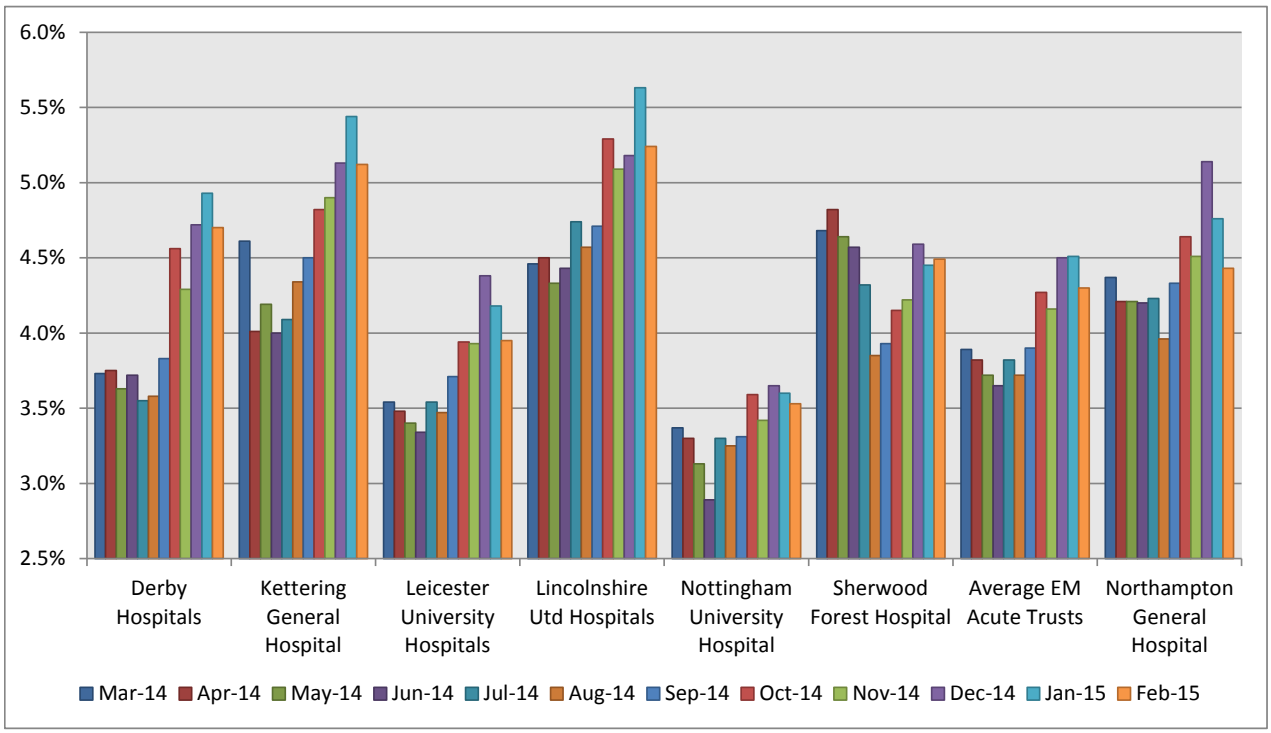
The target compliance rates for Appraisals, Mandatory, and Role Specific Training have all been set at 85%, which should have been achieved by March 2015; this was not done but work continues to achieve this level of compliance.

Enclosure H

Sickness Absence Rates for NGH compared to East Midlands Acute Trusts and all Medium Acute Trusts

In-Month Sickness Absence: East Midlands Acute Trusts

	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Derby Hospitals	3.73%	3.75%	3.63%	3.72%	3.55%	3.58%	3.83%	4.56%	4.29%	4.72%	4.93%	4.70%
Kettering General Hospital	4.61%	4.01%	4.19%	4.00%	4.09%	4.34%	4.50%	4.82%	4.90%	5.13%	5.44%	5.12%
Leicester University Hospitals	3.54%	3.48%	3.40%	3.34%	3.54%	3.47%	3.71%	3.94%	3.93%	4.38%	4.18%	3.95%
Lincolnshire Utd Hospitals	4.46%	4.50%	4.33%	4.43%	4.74%	4.57%	4.71%	5.29%	5.09%	5.18%	5.63%	5.24%
Nottingham University Hospital	3.37%	3.30%	3.13%	2.89%	3.30%	3.25%	3.31%	3.59%	3.42%	3.65%	3.60%	3.53%
Sherwood Forest Hospital	4.68%	4.82%	4.64%	4.57%	4.32%	3.85%	3.93%	4.15%	4.22%	4.59%	4.45%	4.49%
Average EM Acute Trusts	3.89%	3.82%	3.72%	3.65%	3.82%	3.72%	3.90%	4.27%	4.16%	4.50%	4.51%	4.30%
Northampton General Hospital	***4.37%***	***4.21%***	***4.21%***	***4.20%***	***4.23%***	***3.96%***	***4.33%***	***4.64%***	***4.51%***	***5.14%***	***4.76%***	***4.43%***



Data available from the Health & Social Care Information Centre (HSCIC) I-View Database enables comparison with other trusts, either regionally or by benchmarking with similar-sized organisations. The latest data currently available is for February 2015.

Compared to the other acute trusts in the East Midlands, NGH has above average sickness, although it fares better than Lincolnshire and Sherwood Forest Hospitals, and has a generally lower absence rate than Kettering General Hospital.

NGH is classified in the HSCIC database as a Medium Acute Trust, and in comparison with all other such trusts nationally, we have above average sickness absence rates. Of the 35 trusts in this benchmark group, NGH has been ranked with between the 7th and 11th highest absence rate for each of the twelve months to February 2015.

In-Month Sickness Absence: NHS Acute Trusts (Medium)

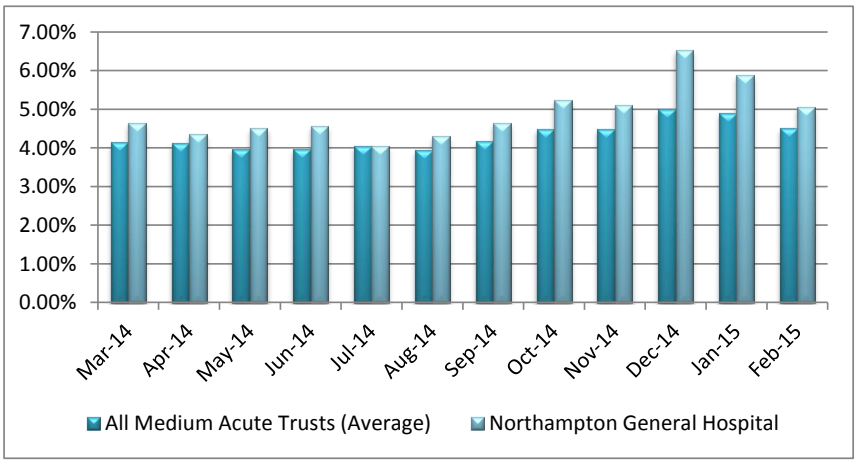
	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Northampton Gen	*4.37%*	*4.21%*	*4.21%*	*4.20%*	*4.23%*	*3.96%*	*4.33%*	*4.64%*	*4.51%*	*5.14%*	*4.76%*	*4.43%*
Rank - Highest to Lowest Rate	*7*	*9*	*7*	*9*	*11*	*11*	*8*	*9*	*11*	*8*	*9*	*11*
Aintree Uni	4.03%	4.12%	3.88%	4.24%	4.37%	4.16%	4.34%	4.84%	4.51%	4.95%	4.61%	4.37%
Ashford & St Peter's	3.10%	3.08%	2.97%	2.65%	2.79%	2.69%	2.89%	2.84%	2.87%	3.39%	2.97%	2.63%
Basildon & Thurrock Uni	3.84%	3.90%	3.52%	3.52%	3.54%	3.65%	4.11%	4.42%	4.41%	4.60%	4.58%	4.27%
Bolton	5.34%	5.27%	4.87%	4.74%	4.86%	4.47%	4.70%	5.01%	4.98%	5.49%	5.19%	4.94%
Colchester Uni	3.92%	3.53%	3.41%	3.74%	3.71%	3.75%	3.78%	4.28%	4.58%	4.72%	5.16%	5.05%
Croydon Health	2.60%	2.69%	2.79%	3.19%	3.48%	3.46%	3.24%	3.43%	3.21%	3.76%	3.68%	3.47%
Dudley Group	3.64%	3.68%	3.21%	3.40%	3.42%	3.31%	3.58%	4.02%	4.20%	4.51%	4.73%	4.17%
Ealing Hosp	3.93%	3.91%	3.88%	4.18%	4.33%	4.46%						
Frimley Health	2.59%	2.37%	2.64%	2.98%	2.78%	2.46%	3.31%	3.51%	3.44%	3.61%	3.51%	3.28%
Great Western Hosp	3.78%	3.60%	3.49%	3.42%	3.34%	3.57%	3.57%	3.56%	3.57%	3.99%	4.12%	3.70%
Heatherwood & Wex Park	3.34%	3.21%	3.19%	3.29%	3.42%	3.27%						
Homerton Uni	3.48%	2.99%	2.66%	2.82%	2.77%	2.75%	2.89%	3.11%	2.87%	3.35%	3.32%	3.57%
Ipswich	3.65%	3.43%	3.31%	3.28%	2.84%	2.79%	2.82%	3.00%	3.27%	3.83%	4.14%	3.77%
Luton & Dunstable Uni	3.23%	3.08%	2.97%	3.22%	3.19%	2.94%	3.09%	3.22%	3.11%	3.55%	3.66%	3.30%
Medway	3.46%	3.73%	4.02%	3.80%	3.80%	3.52%	4.29%	4.71%	4.46%	4.42%	4.50%	3.96%
Mid Essex Hosp	3.41%	3.23%	3.27%	3.44%	3.64%	3.24%	3.30%	3.85%	3.88%	4.18%	4.43%	3.90%
Morecambe Bay Uni	4.79%	4.86%	4.40%	4.47%	5.03%	4.90%	5.26%	5.41%	5.99%	5.75%	5.53%	4.68%
North Tees & Hartlepool	4.61%	4.37%	3.85%	4.07%	4.25%	4.39%	4.41%	4.39%	4.75%	5.23%	5.27%	4.86%
Peterborough & Stamford	3.71%	3.89%	3.92%	3.69%	3.84%	3.70%	3.73%	4.26%	3.85%	4.30%	4.08%	3.79%
Rotherham	4.42%	4.73%	4.68%	4.69%	4.95%	4.63%	4.84%	5.17%	5.67%	6.18%	5.90%	5.47%
Royal Bournemouth & Christ	3.44%	3.35%	3.16%	3.44%	3.77%	3.84%	4.09%	4.22%	3.84%	4.15%	4.41%	4.25%
Royal Surrey Co Hosp	3.12%	3.03%	2.82%	2.72%	2.74%	2.62%	2.95%	3.33%	3.14%	3.52%	3.53%	3.45%
Royal United Bath	3.70%	3.35%	3.10%	3.47%	3.63%	3.57%	3.99%	4.21%	4.33%	4.90%	4.71%	5.18%
Sherwoodorest	4.68%	4.82%	4.64%	4.57%	4.32%	3.85%	3.93%	4.15%	4.22%	4.59%	4.45%	4.49%
Shrewsbury & Telford	4.22%	3.96%	3.91%	3.94%	4.16%	4.10%	4.25%	4.20%	4.39%	4.69%	4.59%	4.41%
South Devon	4.05%	4.56%	3.94%	3.90%	4.06%	3.85%	4.20%	4.51%	4.52%	4.45%	4.20%	4.29%
Southend Uni	3.50%	3.45%	3.16%	3.37%	3.37%	2.59%	3.00%	3.09%	3.14%	3.42%	3.81%	3.31%
St Helen's & Knowsley	3.66%	3.77%	3.42%	3.68%	3.60%	3.40%	3.62%	3.78%	3.91%	4.08%	4.06%	3.73%
Stockport	4.27%	4.17%	4.08%	4.25%	4.43%	4.06%	4.04%	4.79%	4.94%	5.15%	5.18%	5.12%
Taunton & Somerset	3.42%	3.19%	3.61%	3.91%	3.63%	3.52%	3.17%	3.76%	4.24%	4.43%	4.02%	3.84%
Walsall Health	4.46%	4.59%	4.30%	4.22%	4.25%	4.12%	4.49%	5.17%	5.21%	5.83%	5.33%	4.96%
West Hertfordshire Hosp	3.28%	3.17%	3.16%	3.28%	3.51%	3.78%	4.04%	4.13%	4.05%	4.32%	4.18%	3.89%
Whittington	3.01%	3.00%	2.96%	3.27%	3.11%	3.29%	3.14%	3.58%	3.37%	3.47%	3.53%	3.31%
Wrightington Wig & Leigh	4.28%	4.51%	4.50%	4.42%	4.57%	4.53%	4.81%	5.12%	4.75%	5.35%	5.09%	4.63%
All Medium Acute Trusts (Average)	**3.82%**	**3.77%**	**3.62%**	**3.73%**	**3.80%**	**3.66%**	**3.84%**	**4.13%**	**4.14%**	**4.47%**	**4.41%**	**4.14%**

Looking at specific staff groups, NGH also has generally higher than average sickness than other medium acute trusts. The graphs below illustrate rates for the Nursing & Midwifery and HCAs & Helpers staff groups for the twelve months to February 2015.

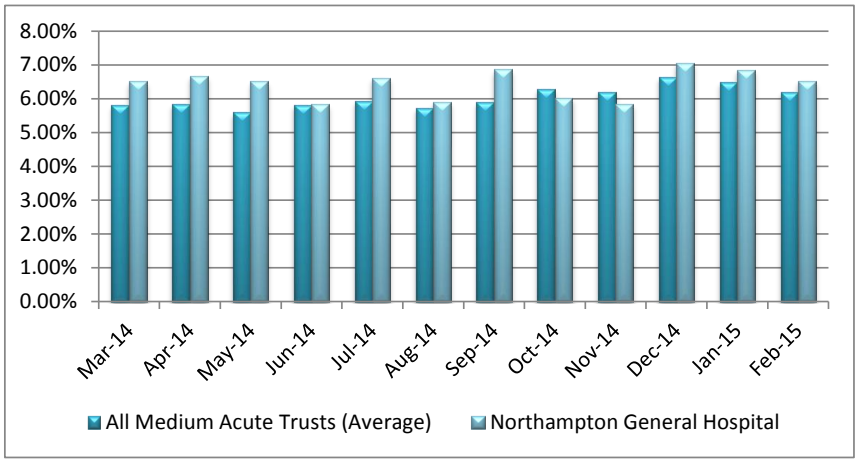
Looking at all other staff NGH also has higher rates in the Admin & Clerical group, but lower than the average for benchmark trusts in all other staff groups.

Sickness Absence by Staff Group: Compare NGH and All Medium Acute Trusts

Nursing and Midwifery Registered	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
All Medium Acute Trusts (Average)	4.13%	4.12%	3.96%	3.97%	4.04%	3.95%	4.18%	4.48%	4.48%	5.00%	4.89%	4.51%
Northampton General Hospital	4.65%	4.36%	4.50%	4.56%	4.04%	4.29%	4.63%	5.24%	5.11%	6.53%	5.89%	5.05%

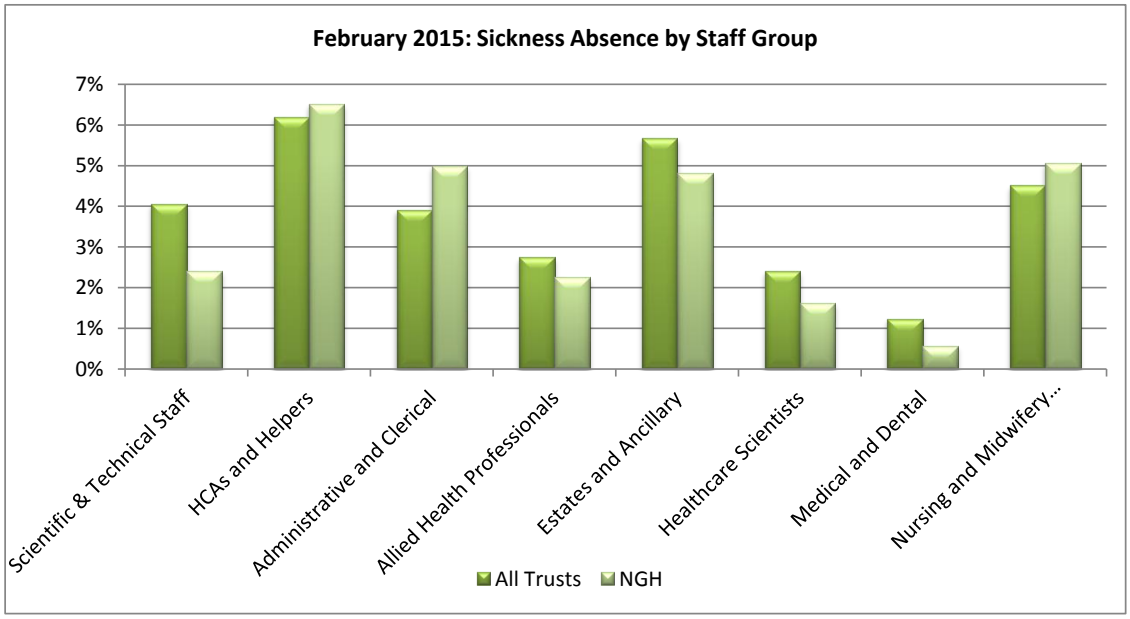


HCAs & Helpers	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
All Medium Acute Trusts (Average)	5.81%	5.84%	5.59%	5.82%	5.92%	5.71%	5.89%	6.28%	6.21%	6.63%	6.48%	6.19%
Northampton General Hospital	6.51%	6.67%	6.51%	5.83%	6.62%	5.91%	6.86%	6.02%	5.84%	7.06%	6.84%	6.52%



Sickness Absence by Staff Group: NGH v All Medium Acute Trusts - February 2015

	All Trusts	NGH
Scientific & Technical Staff	4.05%	2.41%
HCAs and Helpers	6.19%	6.52%
Administrative and Clerical	3.91%	4.99%
Allied Health Professionals	2.74%	2.25%
Estates and Ancillary	5.67%	4.81%
Healthcare Scientists	2.41%	1.62%
Medical and Dental	1.23%	0.56%
Nursing and Midwifery Registered	4.51%	5.05%



Enclosure H

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30 July 2015**

Title of the Report	**Integrated Performance Report and Corporate Scorecard**
Agenda item	**13**
Presenter(s) of Report	Deborah Needham, Chief Operating Officer Dr Michael Cusack, Medical Director Carolyn Fox, Director of Nursing, Midwifery and Patient Services
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.

Detailed reports on Urgent Care and Cancer Standards have been presented to the Finance Investment and Performance Committee on 22 July 2015.

Related strategic aim and corporate objective	Be a provider of quality care for all our patients

Enclosure I

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
Related Board Assurance Framework entries	BAF 11, 12 and 23
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (Y/N) No Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (Y/N) No
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper (Y/**N**)

Actions required by the Trust Board

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

Northampton General Hospital NHS Trust Quality Scorecard 2015-16

Caring

	Indicator	Target	Trend	Apr-15	May-15	Jun-15
C.1	Written complaints rate	None		50	41	57
C.2	Complaints responded to within agreed timescales	90%	↑	95.8%	91.0%	98.0%
C.3	Friends & Family Test % of patients who would recommend: Inpatient/I	85% *	↓	86.5%	90.2%	88.7%
C.4	Friends & Family Test % of patients who would recommend: A&E	87% *	↓	85.3%	89.8%	83.6%
C.5	Friends & Family Test % of patients who would recommend: Maternity	95% *	↑	93.4%	93.9%	97.1%
C.6	Friends & Family Test % of patients who would recommend: Outpatients	90% *	⇔	90.5%	90.5%	90.4%
C.7	Mixed Sex Accommodation	0	⇔	0	0	0
C.8	Expected deaths where a care plan was in place	=>75% *	↑	48.3%	61.8%	49.1%
C.9	Transfers: Patients moved with a risk assessment completed	100%	↓	100%	94.8%	92.3%

Effective

	Indicator	Target	Trend	Apr-15	May-15	Jun-15
E.1	Emergency re-admissions within 30 days (adult elective)	None	⇔	1.7%	1.4%	3.16%
E.2	Emergency re-admissions within 30 days (adult non - elective)	None	⇔	7.0%	8.2%	15.15%
E.3	Length of stay - All	4.2	↓	6.2	7.1	11.1
E.4	Length of stay - Elective	2.7	↓	6.7	2.6	4.1
E.5	Length of stay - Non Elective	4.7	↓	5.7	8.0	12.4
E.6	Maternity: C Section Rates - Total	<25%	↓	27.68% (106)	25.9% (101)	29.1% (118)
E.7	Maternity: C Section Rates - Emergency	<14%	↓	13.4% (51)	13.4% (53)	17.2% (70)
E.8	Maternity: C Section Rates - Elective	<10%	↑	14.24% (55)	12.1% (48)	11.8% (48)
E.9	Compliance to C Section Nice Guidance	Yes		Awaiting confirmation		
E.10	Mortality: SHMI	Within expected range	⇔	Data from Dr Foster not avail.	99	99
E.11	Mortality: HSMR		↓		101	103
E.12	Mortality: HSMR - Weekend		↓		101	104
E.13	Mortality: HSMR - Week day		↓		100	102
E.14	Mortality: Low risk conditions		↑		78	70
E.15	Mortality: Maternal Deaths	0	⇔	0	0	0
E.16	NICE compliance	80%	⇔	99.4%	99.4%	99.4%
E.17	Patients cared for in an escalation area (occ bed days)	0	↑	211	295	133
E.18	# NoF - Fit patients operated on within 36 hours	80%	↑	64.8%	70.5%	75.0%
E.19	Stroke patients spending at least 90% of their time on the stroke unit	80%	↓	87.0%	65.9%	63.0%
E.20	Suspected stroke patients given a CT within 1 hour of arrival	50%	↑	62.5%	64.7%	64%

Safe

	Indicator	Target	Trend	Apr-15	May-15	Jun-15
S.1	C-Diff	Ave. 3 per mth	⇔	0	3	3
S.2	Dementia: Case finding	90%	↓	90.1%	90.2%	89.60%
S.3	Dementia: Initial diagnostic assessment	90%	⇔	100%	100%	100%
S.4	Dementia: Referral for specialist diagnosis/follow-up	90%	↑	83.3%	92.3%	100%
S.5	Falls per 1,000 occupied bed days	5.8	↑	3.8	4.6	4
S.6	Harm Free Care (Safety Thermometer)	93%	↑	93.9%	93.3%	94.4%
S.7	Medical Notes: Availability for clinics	99%	⇔	98.9%	98.6%	98.5%
S.8	Medical notes: Documentation - Doctors	90%	↑	71.4%	67.9%	73.1%
S.9	Medical notes: Documentation - Nurses	90%	↑	67.5%	63.7%	67.5%
S.10	Medical notes: Documentation - Allied Health	90%	↓	88.2%	87.0%	75.3%
S.11	Medication incidents that cause significant harm	0	⇔	0	0	0
S.12	MRSA	0	⇔	0	0	0
S.13	Never event incidence	0	⇔	0	0	0
S.14	Pressure Ulcers: Avoidable grade 4	0	⇔	0	0	0
S.15	Pressure Ulcers: Avoidable grade 3	Max 3 p/mth *	↑	13	4	3
S.16	Pressure Ulcers: Avoidable grade 2	Max 13 p/mth *	↑	23	15	10
S.17	Number of Serious Incidents Requiring Investigation (SIRI) declared during the period	0	↑	1	0	0
S.18	Open CAS alerts	0	⇔	0	0	0
S.19	UTI with Catheters (Safety Thermometer-Percentage new)	0.4%	↑	0.0%	0.31%	0.0%
S.20	VTE Risk Assessment	95%	⇔	97.8%	98.2%	98.0%
S.21	Transfers: Patients transferred out of hours	0	↑	58	77	52
S.22	Percentage of patients cared for outside of specialty	<10%	↑	17.7%	16.6%	15.9%
S.23	Percentage of discharges before midday.	>25%	⇔	19.7%	21.7%	21.5%
S.24	Number of cancelled operations due to bed availability	0	↓	39	19	26
S.32	TTO's sent by Taxi	0	⇔	0	0	0

Responsive

	Indicator	Target	Trend	Apr-15	May-15	Jun-15
R.1	A&E: Proportion of patients spending less than 4 hours in A&E	95%	↑	92.2%	93.6%	95.3%
R.2	A&E: 4hr SitRep reporting	95%	↑	90.9%	94.1%	95.1%
R.3	A&E: 12 hour trolley waits	0	⇔	0	0	0
R.4	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	99%	⇔	100%	100%	100%
R.5	Discharge: Number of medically fit patients awaiting discharge (average daily)	50 *	↓	Not Available	85	92
R.6	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	93%	↓	93.1%	92.8%	90.1%
R.7	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	93%	↓	92.4%	90.6%	82.4%
R.8	Cancer: Percentage of patients treated within 62 days of referral from screening	90%	↑	80.0%	93.3%	93.8%
R.9	Cancer: Percentage of patients treated within 62 days of referral from hospital specialist	80%	⇔	100%	100.0%	100.0%
R.10	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	85%	⇔	75.2%	85.1%	73.4%
R.11	Cancer: Percentage of patients treated within 31 days	96%	⇔	95.7%	99.2%	95.9%
R.12	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	94%	⇔	100%	100.0%	100.0%
R.13	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	98%	⇔	100%	100%	98.4%
R.14	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	94%	⇔	100%	97.2%	97.8%
R.15	Operations: Urgent Operations cancelled for a second time	0	⇔	0	0	0
R.16	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	0	↓	2	0	1
R.17	RTT for admitted pathways: Percentage within 18 weeks	90%	↑	88.5%	91.7%	92.8%
R.18	RTT for non- admitted pathways: Percentage within 18 weeks	95%	↑	97.5%	98.6%	98.2%
R.19	RTT waiting times incomplete pathways	92%	⇔	95.8%	96.0%	95.0%
R.20	RTT over 52 weeks	0	⇔	0	0	0
R.21	Delayed transfer of care	0	↑	59.75	60.20	54.0

Well Led

	Indicator	Target	Trend	Apr-15	May-15	Jun-15
W.1	Friends & Family: % of staff that would recommend the trust as a place of work	N/Applic	N/Applic	Q1 = 67.6%		
W.2	Data quality of Trust returns to HSCIC (SUS)	90%	↓	93.3%	93.3%	88.9%
W.3	Turnover Rate	8%	⇔	11.3%	11.3%	11.5%
W.4	Sickness rate	3.8%	⇔	3.9%	4.4%	4.2%
W.5	Staff: Trust level vacancy rate - All	<7%	⇔	11.2%	11.1%	14.1%
W.5	Staff: Trust level vacancy rate - Medical Staff	<7%	↓	9.9%	8.6%	9.3%
W.5	Staff: Trust level vacancy rate - Registered Nursing Staff	<7%	↓	18.1%	18.4%	19.0%
W.5	Staff: Trust level vacancy rate - Other Staff	<7%	↑	13.0%	12.7%	12.3%
W.9	Staff: Temporary costs & overtime as a % of total pay bill		⇔	13.5%	13.1%	13.2%
W.10	Percentage of staff with annual appraisal	85%	↓	70.2%	73.1%	70.3%
W.11	Percentage of all trust staff with mandatory training compliance	85%	↑	80.1%	81.1%	82.0%
W.12	Percentage of all trust staff with role specific training compliance	85%	↑	68.1%	68.7%	69.5%

Finance

	Indicator	Target	Trend	Apr-15	May-15	Jun-15
F.1	Surplus / Deficit	0 Fav		397 Fav	(300) Adv	(73) Adv
F.2	Income	0 Fav		269 Fav	(814) Adv	566 Fav
F.3	Pay	0 Fav		186 Fav	134 Fav	63 Fav
F.4	Non Pay	0 Fav		(176) Adv	304 Fav	(798) Adv
F.5	Bank & Agency / Pay %	7.5%		8.4%	8.3%	8.1%
F.6	CIP Performance	0 Fav		(223) Adv	176 Fav	80 Adv

Section	Red Rated	Amber Rated	Green Rated	None	Total
Caring					0
Effective					0
Safe					0
Responsive					0
Well-Led					0
Finance					0
Total	0	0	0	0	0

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 stable performance delivery over 3 month period

Targets marked with * are local targets

Northampton General Hospital NHS Trust

Northampton General Hospital NHS Trust

Trust Board Corporate Scorecard

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

Delivering for patients:
2015/16 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, Responsiveness, Effective, Well Led, Safe and Finance, many items within each area were provided within the TDA Framework with a further number of in-house metrics identified from our previous quality scorecard which were considered important to continue monitoring.

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.

Each indicator which is highlighted as red has an accompanying exception report highlighting the reasons for underperformance, actions to improve performance and forecast data for recovery.

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Friends & Family Test % of patients who would recommend A&E	Report period:	June 2015
Driver for underperformance:		Actions to address the underperformance:	
• A&E (including Eye Casualty & Ambulatory Care) have an internal target of 87% for patients that would recommend the service. • There are no national targets and local targets have been identified through reviewing the averages received across a 6 month period. • June saw performance drop by 6.2% meaning the service did not reach their targeted satisfaction level.		• In June changes made to the Symphony system meant far more patients than normal received an FFT survey from within the A&E department. This had a significant impact on both the response rate and the satisfaction scores received. IT have amended the extract to ensure this is prevented moving forward. • All of the comments received for June have been sent to the managers of the department for review and actions will be taken to address any underperformance from the issues identified.	
Forecast date (month) for meeting the standard		Forecast performance for next reporting period:	
August		Improvement	
Lead for recovery:		Lead Director:	
Rachel Lovesy, Head of Patient Experience & Engagement		Rachael Corser	

Historical Target Performance

Indicator		Target	Trend	Apr-15	May-15	Jun-15
C.4	Friends & Family Test % of patients who would recommend: A&E	87% *	⇩	85.3%	89.8%	83.6%

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Expected deaths where a care plan was in place	Report period:	June 2015

Driver for underperformance:	Actions to address the underperformance:
• Expected Death is determined by what is recorded on the E-DN. This is not always accurate • e.g. 5/13 patients whose death was unexpected were on the EOLC register and 2 patients had a dying person care plan • The patient is formally recognised but the trust care plan is not used and the plan of care does not reflect the 5 key priorities of care of a dying person. • The time scale between recognition of a dying patient and the patient dying is short hours and therefore a care plan is not developed. • Inconsistency in senior medical reviews of Patient care. • No formal recognition that a patient is likely to die in the next day's /hours of life documented in the patient notes. Often informal phraseology such as "comfort care" "TLC" and "keep comfort" is documented • Some wards do not have a MDT which may affect ward led decision making, the continuation of futile treatment and no formal recognition that a patient is at risk of dying	• Change the performance target to *Total deaths where a care plan is in place* to reflect national directives of measuring against total hospital deaths and change the metrics to a 50 % target, allowing 25% of deaths likely to be unexpected and 25% for improvement. • Informal End of Life Care ward based training is available from the SPCT Mon – Sat to support ward staff to develop skills of recognising patients who are likely to die in the next day's/hours and developing care plans with patients and/or their families. • In line with national directive, patients who are under the care of the Trust for 4 hours or less will be not be included in the report • EOL/SPCT to implement AMBER on Becket ward in July to enable early recognition when a patient is likely to die in the next hours/days • Support Eleanor, Holcot and Knightley wards to continue to embed AMBER into clinical practice • EOL/SPCT to attend the daily patient safety huddle and support for those teams looking after patients thought to be dying.
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
August 2015	50% of total deaths
Lead for recovery:	**Lead Director:**
Dr C Elwell, Cancer Lead Clinian	Dr Mike Cusack

Historical Target Performance

Indicator		Target	Trend	Apr-15	May-15	Jun-15
C.8	Expected deaths where a care plan was in place	=>75% *	⇩	48.3%	61.8%	49.1%

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Cancer Access Targets	Report period:	June 2015

Driver for underperformance:	Actions to address the underperformance:
• 2ww: Breast capacity • 2ww Breast Symptomatic: capacity • 62 day: Complex patients, referral sent to surgeon in error, late referrals from KGH, cancellation of HDU bed, endoscopy capacity, delay to diagnostic • *May validated*	• Fortnightly meetings between radiology and surgery to ensure consultant attendance at the one-stop clinics is coordinated • Confirm & Challenge at tumour site level with Divisional / Directorate Managers • Recovery plan developed with key actions that need to be implemented by Directorates • Full Exception report detailed later
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
62 day July	85.1%
Lead for recovery:	**Lead Director:**
Matt Tucker, Divisional Manager	Deborah Needham

Historical Target Performance

Indicator		Target	Trend	Apr-15	May-15	Jun-15
R.6	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	93%	⇩	93.1%	92.8%	90.1%
R.7	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	93%	⇩	92.4%	90.6%	82.4%
R.10	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	85%	⇔	75.2%	85.1%	73.4%

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:	June 2015

Driver for underperformance:	Actions to address the underperformance:
• ENT Patient on 4 June • Consultant decision that patient could be cancelled due to more clinically urgent case requiring surgery.	• Patient transferred to next available list 18/06/15 • Directorate to investigate and identify alternative mitigations for future patient cancellations
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
• July 2015	0
Lead for recovery:	**Lead Director:**
Rebecca Brown, Deputy Chief Operating Officer	Deborah Needham

Historical Target Performance

Indicator		Target	Trend	Apr-15	May-15	Jun-15
R.16	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	0	⇩	2	0	1

Enclosure I

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Length of Stay	Report period:	June 2015

Driver for underperformance:	Actions to address the underperformance:
• DTOCs: Patients that have completed their acute episode are deemed Clinically stable to leave the trust. The number of which at any given time can range from 90 to 120 patients. Of this proportion that has been referred for external support become DTOC's. The number of DTOC's varies daily, however remains consistently above 50 with peaks upwards of 80 on a regular basis. • This cohort of patients can have very long lengths of stay, often up to 100+ days which increases the overall ALOS • There is a full report on DTOC at the end of this report.	• The HPT have worked with Northampton Borough Council to reduce the housing delays. A member for NBC now attends the tracking meeting weekly to expedite discharges. • Escalation of delays on daily conference call with Health NCC partners. • Work is being undertaken to improve the timeliness of the Passport completion appears to be improved. • A months trial on Collingtree using ward workspace and an electronic passport has been completed. The learning form this is being evaluated. • An analysis of Dr Fosters LOS results: presented to LOS steering group • Each speciality is now tasked to analyse their results and take action. This is monitored at the LOS group. • An external review on the discharge process evaluated a number of options going forward The outcome of which was to close the Discharge Control Centre off site and work towards a Discharge to assess model, aimed at starting in September of this year. • Board round audits taking place and starting to show improvement. • Action plan in place for discharge working across all agencies particularly housing in place for patients. • Enhanced recovery group reviewing pathways. Patients been actively monitored via LOS group • Every ward being reviewed for early board rounds – senior doctor led.
Forecast date (month) for meeting the standard	Forecast performance for next reporting period:
Ongoing monitoring	8 days
Lead for recovery:	Lead Director:
Sue McLeod, Divisional Manager Dr Warren Pickering, Clinical Director	Debbie Needham

Historical Target Performance

Indicator		Target	Trend	Apr-15	May-15	Jun-15
E.3	Length of stay - All	**4.2**		**6.2**	**7.1**	**11.1**
E.4	Length of stay - Elective	**2.7**		**6.7**	**2.6**	**4.1**
E.5	Length of stay - Non Elective	**4.7**		**5.7**	**8.0**	**12.4**

Enclosure I

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Maternity: C Section Rates	Report period:	June 2015

Driver for underperformance:	Actions to address the underperformance:
• Our C section rate has been maintained at a steady state, whilst others nationally have continued to rise (KGH rate currently 29%)	• We are regularly auditing our practice against nice guidelines, please find enclosed most recent reports. Appendix 1 - Audit report indication for c Appendix 3 - Debrief Audit Summary Repor Caesarean Audit - Governance Quarter
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
Ongoing monitoring	
Lead for recovery:	**Lead Director:**
Mr Owen Cooper, Clinical Director	Dr Mike Cusack

Historical Target Performance

Indicator		Target	Trend	Apr-15	May-15	Jun-15
E.6	Maternity: C Section Rates - Total	<25%	↓	27.68% (106)	25.9% (101)	29.1% (118)
E.7	Maternity: C Section Rates - Emergency	<14%	↓	13.4% (51)	13.4% (53)	17.2% (70)
E.8	Maternity: C Section Rates - Elective	<10%	↑	14.24% (55)	12.1% (48)	11.8% (48)

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	A&E 4 hour target and bed capacity indicators	Report period:	June 2015

Driver for underperformance:	Actions to address the underperformance:
95% TARGET • The Trust achieved the target in June @ 95.31%. Nevertheless, the following challenges remain: • Acuity within the base wards is generally reducing to baseline figures; however, the Assessment Units remain higher. • The number of admissions remains consistent and slightly higher than the previous month. • ED attendance figures have remained high throughout June, higher than the previous month • Delayed discharges fluctuated, however remained high at the end of June • Flow has not been available early enough every day, causing a backlog in the Urgent Care Directorate. **PATIENTS CARED FOR IN ESCALATION AREA** • Reduced by more than 50% in June • Escalation areas were utilised when necessary to ensure the safe care of patients when flow was reduced. **PATIENT TRANSFERS OOH** • Lowest during the Qtr. due to good flow allowing patients to be transferred within hours. • However, due to the bed occupancy levels remaining high, moves OOH are required. Once occupancy reduces, moves OOH will reduce further **PERCENTAGE OF PATIENTS CARED FOR OUT OF SPECIALITY** • The figure for June is the lowest for the qtr. • Demand on teams remains high with bed flow impeded at times; thus, patients are moved to an available bed. **PERCENTAGE OF DISCHARGES BEFORE MIDDAY** • The LOS teams continue to embed processes with improve this figure. • Enhanced performance metrics have been developed to support and	• New way of managing beds, whereby divisions take accountability for their own activity that day, including patient flow and bed availability. • Review by ECIST for site management, recommendations will be incorporated into the appropriate theme of the Changing Care @ NGH Programme. • The Assessment Units are continuing to follow specific ways of working to maximise flow and turnover of patients. • The Primary Care Streaming service has been commissioned by NGH directly and has been launched. • Development of the new ACC unit has begun and the team are working closely with Primary Care to develop the ACC department and a re-launch with Primary Care once development is complete is being planned. • Close working with the health economy to launch a number of schemes including Discharge-To-Assess. • Comms plan in place and open day held to recruit new DR's within Urgent Care. • ED has launched paper light processes within Minors and Majors, to reduce manual collection of information and streamline the pathway. • A project has been launched in collaboration with EMAS to ensure an improved handover process, by utilising software. This is scheduled to be launched in July. • The Discharge Suite will have centralised booking in July.

challenge the ward on such data. **NUMBER OF CANCELLED OPERATIONS DUE TO BED AVAILBAILITY** • The number of outliers is the lowest in the Qtr., but still causing operations to be cancelled. • Teams will continue to support earlier flow and reduce outliers. • In severe escalation (RED) all non-urgent patients are cancelled to ensure safety for emergency patients **PATIENTS MOVED WITH A RISK ASSESSMENT** • Decreased slightly in June • Full report available at Quality Committee	
Forecast date (month) for *meeting the standard*	Forecast performance for next reporting period:
July 15	95%
Lead for recovery:	Lead Director:
Rebecca Brown, Deputy Chief Operating Officer	Deborah Needham

Historical Target Performance

Indicator		Target	Trend	Apr-15	May-15	Jun-15
E.17	Patients cared for in an escalation area (occ bed days)	0	⇧	211	295	133

Indicator		Target	Trend	Apr-15	May-15	Jun-15
S.21	Transfers: Patients transferred out of hours	0	⇧	58	77	52
S.22	Percentage of patients cared for outside of specialty	<10%	⇧	17.7%	16.6%	15.9%
S.23	Percentage of discharges before midday.	>25%	⇔	19.7%	21.7%	21.5%
S.24	Number of cancelled operations due to bed availability	0	⇩	39	19	26

Indicator		Target	Trend	Apr-15	May-15	Jun-15
C.9	Transfers: Patients moved with a risk assessment completed	100%	⇩	100%	94.8%	92.3%

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	#NOF 36 hours/BPT	Report period:	June 2015

Driver for underperformance:	Actions to address the underperformance:
• Month on month improvement – up to 75% in June from 65%. • High number of patients not fit for surgery within 36 hours.	• Identify factors for implementing early optimisation of unfit patients. • Lower limb locum commencing 27th July to enable additional #NOF cases to be undertaken in a timely manner.
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
July 2015	80%
Lead for recovery:	**Lead Director:**
Dr Bhutta/Mr Auld, T&O Consultants	Dr Mike Cusack

Historical Target Performance

Indicator		Target	Trend	Apr-15	May-15	Jun-15
E.18	# NoF - Fit patients operated on within 36 hours	80%	⇧	64.8%	70.5%	75.0%

Enclosure I

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Staff: Trust Turnover Rate	Report period:	June 2015

Driver for underperformance:

Staff Group	May-15	Jun-15
Add Prof Sci & Tech	9.07%	9.70%
Additional Clinical Services	11.17%	11.32%
Admin & Clerical	11.08%	11.42%
Allied Health Professionals	14.40%	11.69%
Estates & Ancillary	11.09%	10.73%
Healthcare Scientists	21.88%	24.73%
Medical & Dental	6.54%	6.04%

- Trust turnover increased further to 11.47% in June which is above the Trust target of 8%. Turnover within Nursing & Midwifery increased to 11.81%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust. Turnover fell in the Allied Health Professional, Estates & Ancillary and Medical & Dental staff groups, but rose in all others.
- Medical Division; Increased by 0.14%, although turnover fell to 9.48% within Outpatients & Elderly Medicine.
- Surgical Division: turnover increased to 10.39%.
- Women, Children's & Oncology Division; further reduction in turnover in this division, now standing at 9.77%.
- Clinical Support Services Division; fell below 14%, to 13.76% for the year ending June 2015.

Actions to address the underperformance:

- The majority of reasons for turnover are recorded as voluntary resignations so the HR Business Partners continue to raise this at their DMBs together with explaining the importance of completing the Trust wide exit interview process
- Retirement continues to be a reason for individuals leaving so consideration is being made to alternatives to full retirement i.e. wind down, step down and a flexible retirement policy is out for consultation at present.
- Engagement and development programmes via OD
- Implementation of Retention Strategy within Nursing.

Forecast date (month) for meeting the standard	Forecast performance for next reporting period:
Oct 15	11.75%
Lead for recovery:	**Lead Director:**
Andrea Chown, Deputy Director of HR	Janine Brennan

Historical Target Performance

Indicator		Target	Trend	Apr-15	May-15	Jun-15
W.3	Turnover Rate	8%	⇔	11.3%	11.3%	11.5%

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Staff: Sickness	Report period:	June 2015

Driver for underperformance:

	Jun-15	Short Term	Long Term
Medical Division Total	4.25%	2.56%	1.69%
Urgent Care	3.84%	2.23%	1.60%
Inpatient Specialties	3.85%	2.77%	1.08%
Outpatients & Elderly Medicine	5.36%	2.46%	2.89%
Surgical Division Total	4.50%	2.69%	1.81%
Anaesthetics, CC & Theatres	4.70%	2.66%	2.04%
Head & Neck and T & O	5.12%	2.55%	5.57%
General & Specialist Surgery	4.66%	3.25%	1.41%
W, C & O Division Total	4.53%	2.08%	2.45%
Women	4.60%	1.93%	2.67%
Children	3.72%	1.99%	1.74%
Oncology & Haematology	5.35%	2.45%	2.90%
Clinical Support Division Total	3.26%	2.39%	0.87%
Imaging	3.30%	3.30%	0.00%
Pathology	4.17%	2.36%	1.81%
Clinical Support	2.51%	1.74%	0.77%
Support Services Total	3.68%	2.55%	1.13%
Hospital Support	3.70%	2.87%	0.82%
Facilities	3.66%	2.11%	1.55%
As FTE			
As percentage	4.15%	2.47%	1.68%

- Sickness absence increased by 0.43% to 4.15% which takes it back above the Trust target of 3.8%. However, both Clinical Support Services Division and Support Services achieved a level below the Trust's target of 3.8%.

Actions to address the underperformance:

- The HR Advisor in Medicine is currently focusing on supporting the managers to meet with all staff who have met the triggers for short term sickness absence. In addition Outpatients has high levels of long term sickness which is being closely monitored.
- Within Women's Children's and Oncology there is a focus on dealing with long term sickness absence.
- Within Surgery the HR Business Partner together with the HR Advisor are currently undertaking analysis of stress related sickness absence to identify whether the stress is work related or personal.

Forecast date (month) for meeting the standard	Forecast performance for next reporting period:
October 2015	4.3%
Lead for recovery:	**Lead Director:**
Andrea Chown, Deputy Director of HR	Janine Brennan

Enclosure I

Historical Target Performance

Indicator		Target	Trend	Apr-15	May-15	Jun-15
W.4	Sickness rate	3.8%	⇔	3.9%	4.4%	4.2%

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Staff: Vacancy rates (Nurses & Other)	Report period:	June 2015

Driver for underperformance:

Staff Group	May-15	Jun-15
Add Prof Sci & Tech	10.73%	12.06%
Additional Clinical Services	9.84%	10.60%
Admin & Clerical	11.39%	10.70%
Allied Health Professionals	9.82%	6.98%
Estates & Ancillary	20.40%	19.64%
Healthcare Scientists	19.31%	18.01%
Medical & Dental	8.57%	9.32%
Nursing & Midwifery	18.44%	19.02%

- The vacancy rate within Estates and Ancillary staff group decreased in June but still remains significantly above the Trust vacancy target of 7% at 19.64%.
- The Registered Nursing & Midwifery vacancy rate has grown again to 19.02%, partly as a result of additional investment added in the new financial year; it has however increased further from 18.08% in April.
- The Trust vacancy rate target is 7%

Actions to address the underperformance:

- Proactive Recruitment campaign within nursing – this includes overseas recruitment and local specific recruitment events.
- 44 international nurses have commenced employment between January and June 2015 and 98 individuals have accepted the offers made from the international programme.
- A pilot of Clinical Apprentices will commence in September.
- Some vacancies within Additional Prof Scientific & Technical are being held pending new equipment which may necessitate a skill mix review.
- New roles are being developed within Estates & Ancillary including Technical Apprentices

Forecast date (month) for meeting the standard	Forecast performance for next reporting period:
March 2016	19.5% in Nursing 12% in Other
Lead for recovery:	**Lead Director:**
Sandra Wright / Andrea Chown, Deputy Directors of HR	Janine Brennan

Historical Target Performance

Indicator		Target	Trend	Apr-15	May-15	Jun-15
W.5	Staff: Trust level vacancy rate - Registered Nursing Staff	<7%	⇩	18.1%	18.4%	19.0%
W.5	Staff: Trust level vacancy rate - Other Staff	<7%	⇧	13.0%	12.7%	12.3%

Enclosure I

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Staff: Staff Appraisal Rates	Report period:	June 2015
Driver for underperformance:		Actions to address the underperformance:	
• The Trust set a target of 85% compliance for appraisals in line with the CCG's expectation. The CQC requirement was for an improvement, which we have made with compliance ratings increasing from 41% in March 2014 to 70.85%. Whilst we have not achieved our target we have undoubtedly improved. There is no national target; the only benchmark data available is that contained within the national staff survey whereby the trust achieved 87% against a national average of 85%.		• Continue to embed appraisal process into all areas, providing 1:1 support through regular monthly meetings with some directorates or as requested. Refinements are being made to the process as a result of the Street Talk session and Survey Monkey results, these include modifying the paperwork and increase communication on processes. • All Divisional Directors and Divisional Managers will be reminded to have as one of their objectives that at least 85% of their staff must have an in-date Appraisal.	
Forecast date (month) for meeting the standard		Forecast performance for next reporting period:	
October 2015		76%	
Lead for recovery:		Lead Director:	
Sandra Wright, Deputy Director of HR		Janine Brennan	

Historical Target Performance

Indicator		Target	Trend	Apr-15	May-15	Jun-15
W.10	Percentage of staff with annual appraisal	85%	⇩	70.2%	73.1%	70.3%

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Staff: Role Specific Training Rates	Report period:	June 2015

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 March 2015 is 85% as per the Quality Schedule set by the CCG; however this is not a national mandate	• Scoping of RSET against job roles and positions has been completed and uploaded into system to ensure accuracy of reporting. There has been further refinement, in particular to Blood Training which expects an increase in % of compliance. • Following 1:1 sessions with Ward Managers, the L&D Manager is providing further support through training them in understanding the reports to use them to monitor individual training and forecasting. • L&D continue to focus on areas of low % of compliance and provide awareness to relevant Directors, Divisional Managers, Service Managers, Matrons and Ward Sisters. • New Appraisal process encouraging uptake of Mandatory training & RSET by requiring staff to have in-date training in order to incrementally progress.
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
Dec 2015	71.5%
Lead for recovery:	**Lead Director:**
Sandra Wright, Deputy Director of HR	Janine Brennan

Historical Target Performance

Indicator		Target	Trend	Apr-15	May-15	Jun-15
W.12	Percentage of all trust staff with role specific training compliance	85%	⇧	68.1%	68.7%	69.5%

Enclosure I

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Dementia: Case Finding	Report period:	June 2015
Driver for underperformance:		Actions to address the underperformance:	
• Medical staff not completing the required assessments. • NB this is an unusual deviation – in the past 12 months this indicator has failed only once.		• Continuing education and support of medical colleagues in undertaking the dementia screening. • Development of data capture to provide in-month scrutiny of position [currently not available]	
Forecast date (month) for meeting the standard		Forecast performance for next reporting period:	
July 2015		>90%	
Lead for recovery:		Lead Director:	
Ben Leach, Head of Safeguarding and Dementia		Dr Mike Cusack	

Historical Target Performance

Indicator		Target	Trend	Apr-15	May-15	Jun-15
S.2	Dementia: Case finding	90%	⇩	90.1%	90.2%	89.60%

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Medical Notes Documentation	Report period:	June 2015

Driver for underperformance:	Actions to address the underperformance:
• The audit findings are reported in the Quarterly Patient Safety and Clinical Quality & Governance progress report. • Clinical engagement to the local Modernisation Group has been poor. • Absence of audit data returns.	• Dataset for medical audits revised in line with Royal College of Physician standards and retaining elements recommended by CQC/GMC. • Dataset rolled out for commencement Q2, July 2015. • Data capture and reporting tools being revised to reflect revised dataset. • Escalation process established to address non completion of data returns. • Audits to be shared with directorates, Clinical Directors and Divisional Directors on a monthly basis for review and discussion at governance meetings and improvement action plans to ensure locally owned. • Educational sessions for auditors and data collectors continue. • *Note: for Q2, July, August, September audit tools for medical audits will differ from nursing and allied health. Following review of medical dataset, at completion of August audit, dataset to be rolled out to nursing and allied health for commencement of Q3.*
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
Quarter 2 Medical Quarter 4 Nursing	90%
Lead for recovery:	**Lead Director:**
Susan Jacobs, Project Manager to the Medical Director	Dr Mike Cusack

Historical Target Performance

Indicator		Target	Trend	Apr-15	May-15	Jun-15
S.8	Medical notes: Documentation - Doctors	90%	↑	71.4%	67.9%	73.1%
S.9	Medical notes: Documentation - Nurses	90%	↑	67.5%	63.7%	67.5%
S.10	Medical notes: Documentation - Allied Health	90%	↓	88.2%	87.0%	75.3%

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30 July 2015**

Title of the Report	**Annual Fire Safety Report 2014/15**
Agenda item	**14**
Presenter of Report	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 Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? No Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? No

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 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

Northampton General Hospital NHS
NHS Trust

ANNUAL FIRE SAFETY REPORT

APRIL 2014 to MARCH 2015

David A Waddoups
Fire Safety Advisor
Northampton General Hospital

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 certificate – see appendix 1 for the Trust's local annual certificate.

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 review of fire safety compliance was completed in 2014. The resulting action plan is being monitored through Fire Committee.

A further audit of fire management arrangements was completed by Northants Fire and Rescue Service in 2013. The resulting action plan has been completed and a subsequent visit by Northants Fire and Rescue Service during 2014 resulted in a letter to the Trust confirming that all actions had been addressed and the Trust's fire management arrangements were satisfactory.

Following a Fire Committee recommendation the Fire Safety Advisor had discussions with Governance regarding the inclusion of fire risk assessments on Datix. From these discussions it was agreed that the assessments should be on Datix.

To date common areas, plant rooms, residential areas and some staff areas have been recorded on Datix, leaving patient areas to be completed before the end of 2015. Placing the assessments on Datix will inform department managers of the significant findings that are their responsibility and to ensure remedial actions are actioned.

Individual site wide fire related risks have been entered separately onto Datix, these include fire resisting doors, fire dampers, emergency lighting, compartmentation and cavity barriers in Oxford construction.

3.0 Fire Risk Assessments

During 2014/15 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, an automatic fire detection system, staff training, emergency plans and an on-site Fire Response Team.

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

Building works incorporating Fire Safety completed during 2014/15 include:

- Completion of alterations to form new A & E resuscitation area including new and improved fire barriers, fire and smoke dampers, fire alarm and automatic fire detection system, emergency lighting system and extension of the automatic fire suppression system
- Completion of extension to A & E to form new GP Assessment Unit including new fire barriers, new fire and smoke dampers, new fire alarm

and automatic fire detection system and new emergency lighting system

- Completion of alterations to form new Discharge Suite including new fire alarm and automatic fire detection system, new emergency lighting system and a new external ramped bed fire escape route
- Completion of alterations to form a new Blood Taking Unit including extension to the existing fire alarm and automatic fire detection system and new emergency lighting system
- Completion of works to form new Fracture and Orthopaedic clinic including cavity barriers and fire dampers

Consultation has taken place with architects regarding fire safety recommendations on further works in A and E, the relocation of Orthopaedic Outpatients and third party pharmacy on Hospital Street for 15/16 capital works.

3.2 Fire Alarm System

The Trust's fire alarm and automatic fire detection system continues to function correctly and has been extended and improved as building works and alterations take place to ensure that it complies with the relevant British Standards, HTM's and codes of practice.

A verification survey of the systems sounder circuits has been completed which will assist in the 'cause and effect' of detector circuits to be set and refined. Investment to improve and upgrade the system will need to extend into future years as part of a continued phased improvement and as components become unavailable. These risks are being monitored and plans are in place to maintain them at an acceptable level which in turn also demonstrates to the enforcing body that the Trust is satisfactorily managing its fire risks.

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.

3.3.1 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 Adviser 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.

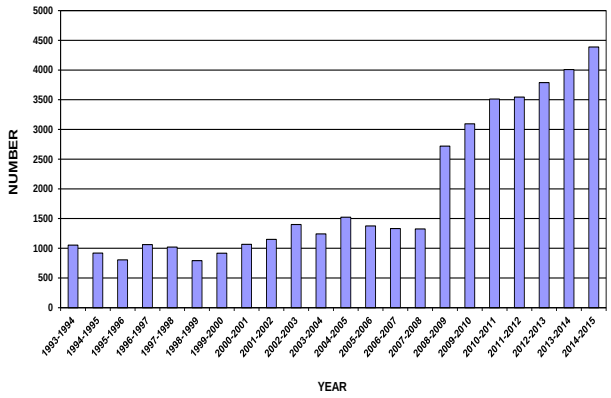
3.3.2 Attendance

From the records of attendance during 2014/15, 4387 members of staff received training which equates to 91% (based on 4800 staff), an increase of 379 (9.5%) over the previous year's attendance.

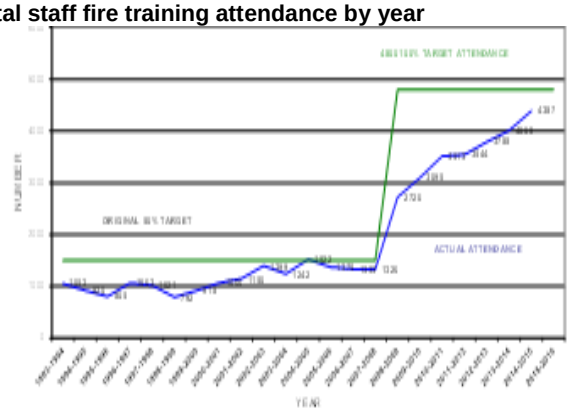
Training at Danetre has been undertaken to ensure that NGH staff working there are up to date with their training.

The Trust Fire Safety Advisor reports attendance compliance to the Trust Fire Committee and 6 monthly reports to the Trusts Health and Safety Committee.

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 the Trust Health and Safety Committee and the Assurance, Risk and Compliance Group.



Total staff fire training attendance by year



Actual staff fire training attendance Vs target

3.3.3 Fire Drills

Fire drills have continued during 2014/15 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%, 2013 – 44% and 2014 – 45%.

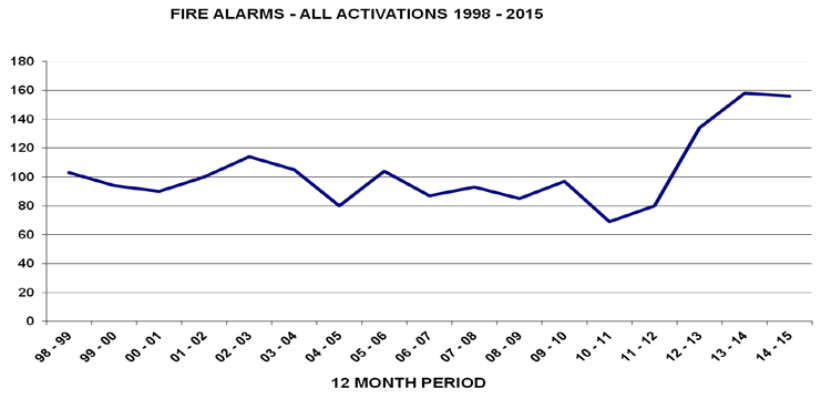
Without effecting service delivery and patient care, further increases in fire drills will prove challenging. The current method of conducting a drill has been reviewed by the Trust's Fire Manager and Fire Safety Advisor and a training session has been delivered to remind managers of their responsibilities under the Fire policy and make them aware of the support available.

Fire evacuation/drill sessions are being arranged for 2015 with the intention of training staff on the process of using fire plans, carrying out actual evacuations and providing assurance without effecting patient care.

In the meantime the Trust Fire Safety Advisor is continuing 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 the Trust Health and Safety committee and the Assurance, Risk and Compliance Group.

4.0 Fire Alarms Activations

There were a total of 156 actuations of the fire alarm during the reporting period, a decrease of 3 from the last report.



Fires

Five fire incidents occurred on site (5 recorded for 2013/14), 2 were caused by smoking materials, 1 occurred in A & E, 1 occurred in Cripps Recreation and the last was a fire in Sturtridge bin store.

Good Intents (GI)

The 20 (20 recorded for 2013/14) good intents were caused by members of staff operating a call point suspecting a fire after smelling smoke/burning.

Pre Warnings (2F)
There were 78 pre-warnings (93 for 2013/14) recorded of which 37 (51–13/14) were unknown causes, 9 (16-13/14) were caused by high temperature, 6 by contractors, 5 by cooking, 3 by oil mist, 2 by salt dust, 2 by dust, 2 by fumes, 2 by toast and the remainder were steam, aerosol, nebuliser, pollution, smoking and lastly shake and vac.

Detector Actuations
50 actuations (39 for 2013/14) of detectors can be summarised as follows –
12 unknown, 7 cooking, 7 contractor, 5 toast, 4 steam leak, 3 steam, 2 faults and then dust, drug taking, oil mist, burnt towel, overheated plastics, salt dust, electric kettle, water leak, aerosol and electric motor.

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

As an immediate response the Trust reviewed its operational fire policy, fire procedures and risk assessments to ensure that the FRS change in policy did not increase risk to patients, staff, visitors and premises. It was decided that the procedures already in place for dealing with fires and fire alarms were substantive and would remain without exception.

Since the 1st of April 2014 there have been 58 activations of the fire alarm system between 0800 and 2000h which would previously have had an FRS response but which were successfully dealt with by the Trusts Fire Response Team. The FRS did attend on 3 occasions during this time. There were 22 actuations of the fire alarm between 2000 and 0800h resulting in 18 attendances of the FRS.

5.0 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 external audit of the Trusts fire safety management for compliance with HTM 05-01 completed in 14/15 and, subsequent action plan, has provided further assurance that the existing systems are sufficient. It highlighted minor improvements and focused on the need to improve on annual fire drill compliance. Actions to address the recommendations are underway and on target to meet the agreed target dates.

The fire alarm and automatic fire detection system is a fully functioning part of the fire safety measures in the hospital. It has received substantial investment

in it to reach the standard it is now however there is still more that needs to be done to ensure that it continues to maintain this high standard.

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 learnt have been used for new works.

Training all Trust staff on an annual basis continues to be a challenge but training places are available to enable this to be completed. Attendance figures have continued to improved year on year but further work is still required.

Appendix 1

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.	

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30 July 2015**

Title of the Report	**Declaration of Compliance against Mixed Sex Accommodation**
Agenda item	**15**
Presenter of Report	Carolyn Fox, Director of Nursing, Midwifery & Patient Services
Author(s) of Report	Natalie Green, Associate Director of Nursing
Purpose	Assurance & Information
Executive summary • The attached document is the Trust declaration of compliance against the requirements to eliminate mixed sex accommodation for the fiscal year of 2014/15.	
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 Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)

Enclosure K

Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper - NO

Actions required by the Board

For information only.

Northampton General Hospital NHS
NHS Trust

Delivering Same-Sex Accommodation
Declaration of compliance – July 2015

Northampton General Hospital is proud in its achievement of continuing in eliminating mixed sex accommodation.

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

We are proud to confirm that mixed sex accommodation has been eliminated in our trust. Patients who are admitted will only share their bed area with members of the same sex, and same sex toilets and bathrooms will be close to their bed area.
Within our day case areas separate toilet and changing facilities are in place and same sex lists are in operation where appropriate.

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

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

Same sex-accommodation means:

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

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

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

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

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

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

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

same-sex accommodation:
your privacy, our responsibility

DH Department of Health

Enclosure K

What are our plans for the future?

In any new developments we will be ensuring facilities are planned to promote same sex accommodation.
Patients and public are involved in any new facilities to ensure they are fit for purpose
We have a Privacy & Dignity Forum which meets quarterly and is attended by Dignity Champions from every ward.

How will we measure success?

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

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

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

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

Northampton General Hospital NHS
NHS Trust

Public Trust Board

AGENDA ITEM 16

Enclosure L

Freedom to Speak Up Report

Enclosure L

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30 July 2015**

Title of the Report	**Freedom to Speak Up report**
Agenda item	**16 – Enclosure L**
Presenter of Report	Janine Brennan Director of Workforce & Transformation
Author(s) of Report	Janine Brennan Director of Workforce & Transformation
Purpose	For decision and assurance
Executive summary The report sets out the Trust's response to the Freedom to speak up report produced by Sir Robert Francis QC.	
Related strategic aim and corporate objective	Focus on quality and safety Enable Excellence through our People
Risk and assurance	The report provides assurance in relation to the Trust's response to the report
Related Board Assurance Framework entries	N/A
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? No Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? No
Legal implications / regulatory requirements	Freedom to Speak Up will form part of the CQC regulatory framework.

Actions required by the Board

The Board is asked to approve the report and confirm it is satisfied that it is assured in relation to the proposed approach to addressing the requirements of the Francis report and the Department of health report ‘ Learning not blaming’.

Northampton General Hospital NHS
NHS Trust

Public Trust Board
30 July 2015

Freedom to Speak up Report

1. Introduction

The document, Freedom to Speak Up, is the fourth published report associated with standards of care at the Mid Staffordshire NHS Foundation Trust (Mid Staffs) in the period 2005-2008. That review was set up in response to on-going disquiet about the treatment of NHS staff who raise concerns at work.

Following this, on 16 July 2015 the Department of health released its report 'Learning not blaming' in response to the Francis report.

This report sets out the proposed response to that review.

2. Freedom to Speak Up overview

The Francis report recognises that whilst the culture of reporting has improved there are still staff experiencing poor treatment from NHS colleagues when concerns are raised and that this is a barrier to patient safety, it states that, "*speaking up is essential in any sector where safety is an issue".*

The report goes on to present evidence of staff whose experience has been very poor, citing incidents of bullying, oppressive behaviour and harrowing experiences. It also suggests that some groups of staff are more vulnerable than others, this included agency and locum staff, students and trainees, BME groups and staff working in Primary Care.

Whistleblowing is covered by the Public Interest Disclosure Act, which prevents whistle blowers from suffering detriment or unfavourable treatment or victimisation from employers or co-workers after they have made a qualifying disclosure. A qualifying disclosure comprises:

- Criminal offences
- Failure to comply with legal obligations
- Miscarriages of justice
- Threats to the health and safety of an individual
- Damages to the environment or
- A deliberate attempt to cover up any of the above.

It does not cover matters relating to individual's employment; those matters are dealt with through the Trust's grievance procedure.

The report does recognise the fact that some staff may raise concerns to protect themselves when performance management is underway but states that vast majority of concerns raised are made in good faith and with valid cause. It indicates there is a lack of consistency in both approach and response nationally.

Report Findings
The report presents five overarching themes. These are the need for:

- Culture change
- Improved handling of cases
- Measures to support good practice
- Particular measures for vulnerable groups
- Extending the legal protection

For each of the five themes the report presents 20 principles in total along with and corresponding actions for review. The themes and actions are presented at appendix 1.

The report concludes that though many cases are handled well, many are not. This has a disproportionate effect on others who then choose not to speak up and two key recommendations are made:

- **Recommendation 1** *All organisations which provide NHS healthcare and regulators should implement the principles and actions set out in the report, in line with good practice described in this report.*

- **Recommendation 2** *The Secretary of State for Health should review at least annually the progress made in the implementation of these principles and actions and the performance of the NHS in handling those concerns and the treatment of those who raise them, and to report to Parliament*

The Department of Health report 'learning not blaming' sets out its response to that report and the key issues for note for the Trust board are as follows:

- All Trusts should have an independent person to whom staff can raise concerns.
- The role shall be called the "Freedom to Speak Up Guardian"
- The F2SU Guardian is expected to be appointed by the Chief Executive to act in a genuinely independent capacity
- The F2SU Guardian would raise concerns with the Trust Chief Executive or the Board. They may also raise issues with the Independent National Officer (see below) if they have lost confidence, or consider good practice has not been followed in how the organisation was handling concerns.
- Health Education England should produce guidance on what training will be needed for the F2SU Guardian, along with a curriculum that NHS organisations can use to ensure training provided is of sufficiently high standard
- NHS England, Monitor and NHS TDA will produce a standard integrated policy and procedure for reporting incidents and raising concerns
- An Independent National Officer should be appointed by the CQC by December 2015
- The Independent National Officer shall produce guidance on factors that need to be taken into account when recruiting to the F2SU Guardian. However if Trusts feel confident to appoint their Guardian without this guidance, they should not wait for the guidance to be published. Any appointment should be made within the principles set out in the Freedom to Speak Up review

A gap analysis is attached for the Board's consideration.

3. Assessment of Risk
Freedom to Speak Up principles will form part of the CQC assessment under the 'Well led' domain and therefore a failure to respond appropriately creates a risk for the Trust.

4. Recommendations

The Board are asked to consider the gap analysis and recommendations of the Workforce Committee and decide the approach to be taken. The key decisions required are:

1. That in accordance with principle 11 (a) that a small number of volunteers be appointed to the Freedom to Speak Up Guardian role and that those individuals shall be subject to an assessment process to establish they have the right skills and aptitude to satisfactorily carry out the functions of that role and that they be trained in carrying out that role.
2. That those Guardians operate in line with the principles set out in the 'learning not blaming report and report to the Chief Executive. A framework will be developed to enable managerial support to be provided to the Guardians. This will be developed in conjunction with the special governors who are keen to support this initiative.
3. Determine if the Board agree with the proposal made by the Workforce Committee with regard to principle 11(b) role of a designated Non Executive Director and (c) role of a designated Director – neither of which were considered to be appropriate by the Workforce Committee.

The Board is also asked to confirm that it is assured by the overall proposed approach.

5. Next Steps

The agreed approach will be implemented as directed by Trust Board.

Recommendation: 1	All organisations which provide NHS healthcare and regulators should implement the Principles and Actions set out in this report in line with the good practice described in this report.		
Recommendation: 2	The Secretary of State for Health should review at least annually the progress made in the implementation of these Principles and Actions and the performance of the NHS in handling concerns and the treatment of those who raise them, and report to Parliament.		
Principles and Actions			
Culture Change			
Principle No:	**Principles**	**Actions**	**Trust Response *(Exec lead)***
Principle 1	Culture of safety: Every organisation involved in providing NHS healthcare, should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns.	1.1: Boards should ensure that progress in creating and maintaining a safe learning culture is measured, monitored and published on a regular basis.	The organisational governance has been modified and there is now a Workforce subcommittee of the Board. The workforce report includes indicators related to staff raising concerns. The Quality Governance Committee has oversight and receives assurance on matters relating to patient safety. There is a Patient Safety Academy in place, led by the Medical Director that focusses on improving patient safety. The Trust has openly set out and communicated its core values that are entirely consistent with the principles contained in the Freedom to Speak up report as follows: • We put patient safety above all else • We aspire to excellence • We reflect, we learn, we improve • We respect and support each other.
		1.2: System regulators should regard departure from good practice, as identified in this report, as relevant to whether an organisation is safe and well-led.	**N/A**
Principle 2	Culture of raising concerns: Raising concerns should be part of the normal routine business of any well led NHS organisation	2.1: Every NHS organisation should have an integrated policy and a common procedure for employees to formally report incidents or raise concerns. In formulating that policy and procedure organisations should have regard to the descriptions of good practice in this report	The Trust has an incident reporting system and policies in relation to their use. The incident reporting policy will be reviewed to ensure it considers good practice described within the Freedom to speak up report *(Director of Corporate Development, Governance and Assurance)*

			The Raising Concerns Policy requires review in light of good practice with the report to incorporate guidance on how to raise a concern (employees) and how to deal with concerns (Managers) *(Director of Workforce and Transformation)*
		2.2: NHS England, NHS TDA and Monitor should produce a standard integrated policy and procedure for reporting incidents and raising concerns to support Action 2.1.	**N/A**
Principle 3	Culture free from bullying: Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.	3.1: Bullying of staff should consistently be considered, and be shown to be, unacceptable. All NHS organisations should be proactive in detecting and changing behaviours which amount, collectively or individually, to bullying or any form of deterrence against reporting incidents and raising concerns; and should have regard to the descriptions of good practice in this report.	The Trust has a bullying and harassment policy in place. Unacceptable behaviour, such as bullying by staff towards other staff is dealt with as a disciplinary offence through the Trust Disciplinary policy. Incidents are monitored and reported to the Workforce Committee. *(Director of Workforce and Transformation)*
		3.2: Regulators should consider evidence on the prevalence of bullying in an organisation as a factor in determining whether it is well-led.	**N/A**
		3.3: Any evidence that bullying has been condoned or covered up should be taken into consideration when assessing whether someone is a fit and proper person to hold a post at director level in an NHS organisation.	The Trust complies with the Fit and Proper Purpose test and as such all Directors must sign a Fit and Proper Person's declaration and references from previous employers are sought. Trust compliance against those requirements is currently subject to an internal audit review. *(Director of Workforce and Transformation)* Recent amendments have been made to the Recruitment and Selection Policy to incorporate these requirements.
Principle 4	Culture of visible leadership: All employers of NHS staff should demonstrate, through visible leadership at all levels in the organisation that they welcome and encourage the raising of concerns by staff.	4.1: Employers should ensure and be able to demonstrate that staff have open access to senior leaders in order to raise concerns, informally and formally.	The Trust Board undertake a programme of Board to Ward visits where staff have an opportunity to discuss issues. The Board participate in 'Beat the bug' infection control rounds. Executives and Non-Executive Directors regularly do 'walk abouts' to talk to staff.

			There is a daily safety huddle for nursing staff led by senior staff. Other departments also hold regular huddles led by senior leaders within the team The Exec team provide a monthly core briefing to the organisation where staff have an opportunity to ask questions. The CEO sends out a regular blog to staff. *(Board and Exec team)*
Principle 5	Culture of valuing staff: Employers should show that they value staff who raise concerns, and celebrate the benefits for patients and the public from the improvements made in response to the issues identified.	5.1: Boards should consider and implement ways in which the raising of concerns can be publicly celebrated	Given investigations under the Whistle-blowing policy can be traumatic for all of those involved the Trust has recently developed a new approach: ***Values in Practic***e that has been piloted in two areas (Pathology and Dryden Ward). This approach is more constructive and consists of listening events whereby a staff have the opportunity for a one to one, or group session with two independent officers. The approach adopts a positive inquiry approach and focusses around the application in practice of the Trust values, thus any issues regarding safety, behaviour etc. would be revealed through this process. This incorporates feedback sessions to staff based on what has been shared and what actions are being taken as a result of the Values in Practice event – this effectively publicly celebrates our ability to listen, reflect and improve what we do and staff are publicly thanked for their contribution to the exercise. This will be used as an alternative to a traditional investigation under the whistle-blowing policy in appropriate cases. Feedback from staff from the pilots has been very positive *(Director of Workforce and Transformation)* In addition events and incidents raised either through serious incidents or whistleblowing which results in a formal investigation, lessons learnt are identified and feedback to staff is provided. The Trust runs a ***'Making Quality Count'*** quality improvement training programme whereby teams identify and work on areas in their service that they want to improve. This is a team based learning event which over a period of 6 months teams work to change/improve their service. The 'Making Quality Count' programme

			culminates in a Viva with the executive team whereby support is given and learning encouraged and celebrated followed by an open sharing event where the teams provide presentations on the areas they wished to improve and what and how they did it and the difference it has made to key stakeholders. The **Best Possible Care Awards** include a Patient Safety Award, though it does not specifically reference whistle-blowing in relation to this it does recognise people that place patient safety at the heart of their practice. The Workforce Committee discussed this and agreed that the current system was adequate and did not feel that a whistle-blowers award would be appropriate, particularly since most whistle –blowers wish for their anonymity to be preserved.
Principle 6	Culture of reflective practice: There should be opportunities for all staff to engage in regular reflection of concerns in their work.	6.1: All NHS organisations should provide the resources, support and facilities to enable staff to engage in reflective practice with their colleagues and their teams.	Directorates have governance meetings for discussion and reflection on incidents and patient safety matters. Further work is required on improving shared learning from Divisional governance meetings *(Director of Corporate Development, Governance and Assurance, Medical Director and Director of Nursing)* Reflective practice is an integral part of revalidation for registered health professionals. The new ***Values in Practice*** process actively encourages staff to reflect and share any concerns *(Director of Workforce and Transformation).* Examples of where the trust encourages reflection and learning include: • The ***'Making Quality Count'*** programme contains a methodology where staff use tools to truly understand the root cause of service issues and then take steps to address these using a structured methodology. • The annual ***'Aspire to Excellence'*** programme

			which includes medical students and junior doctors who work on key themes around patient safety by identifying issues and developing solutions to those issues. These are then rolled out across the Trust. • The Simulation suite enables staff to practice clinical simulations in a safe environment and to learn from that simulation to drive safe practice.
Better Handling of Cases			
Principle No:	**Principles**	**Actions**	**Trust Response**
Principle 7	Raising and reporting concerns: All NHS organisations should have structures to facilitate both informal and formal raising and resolution of concerns.	7.1: Staff should be encouraged to raise concerns informally and work together with colleagues to find solutions.	The Trust has a 'Raising concerns at Work policy which includes the opportunity for staff to raise issues both formally and informally. Review the Raising Concerns at Work Policy to ensure the informal process gives emphasis on working with colleagues to find solutions. Develop top tips for workers and top tips for managers in dealing with issues. *(Director of Workforce and Transformation)* Directorates hold governance meetings for discussion and reflection on incidents and patient safety matters. Further work is required on improving shared learning from Divisional governance meetings *(Director of Corporate Development, Governance and Assurance, Medical Director and Director of Nursing)* The clinical huddle (Nursing) allows staff to raise immediate concerns relating to patient safety issues.
		7.2: All NHS organisations should have a clear process for recording all formal reports of incidents and concerns, and for sharing that record with the person who reported the matter, in line with the good practice in this report	Formal concerns raised through the Raising Concerns at Work policy are registered with HR and reported to the Workforce Committee. Following an investigation the individual who raised the concerns receives feedback. The policy will be reviewed to ensure it complies with good practice. **(***Director of Workforce and Transformation).* The trust has an incident reporting system and supporting policies.

			The incident reporting policy will be reviewed to ensure it considers good practice described within the Freedom to speak up report *(Director of Corporate Development, Governance and Assurance)*
Principle 8	Investigations: When a formal concern has been raised, there should be prompt, swift, proportionate, fair and blame-free investigations to establish the facts.	8.1: All NHS organisations should devise and implement systems which enable such investigations to be undertaken, where appropriate by external investigators, and have regard to the good practice suggested in this report.	Where concerns are raised through the Raising Concerns at work policy an independent investigator from outside the area concerned is appointed with clear terms of reference. This is reported through the Workforce Committee. The Trust has used external investigators in appropriate cases e.g. T & O however it is not financially viable or necessary to appoint external investigators in all cases. The Trust has Serious Incident policies and a Serious Incident Group chaired by the Medical Director to oversee these investigations.
Principle 9	Mediation and dispute resolution: Consideration should be given at an early stage to the use of expert interventions to resolve conflicts, rebuild trust or support staff who have raised concerns.	9.1: All NHS organisations should have access to resources to deploy alternative dispute resolution techniques, including mediation and reconciliation to: • address unresolved disputes between staff or between staff and management as a result of or associated with a report raising a concern • repair trust and build constructive relationships	The Trust has access to external mediation and has evidence of utilising external mediation experts for dispute resolution As set out above the new ***'Values in Practice'*** initiative adopts a more conciliatory approach and will be used in appropriate situations. *(Director of Workforce and Transformation)*
Measures to support good practice			
Principle No:	**Principles**	**Actions**	**Trust Response / *(Exec lead)***
Principle 10	Training: Every member of staff should receive training in their organisation's approach to raising concerns and in receiving and acting on them.	10.1: Every NHS organisation should provide training which complies with national standards, based on a curriculum devised jointly by HEE and NHS England in consultation with stakeholders. This should be in accordance with the good practice set out in this report.	All new starters are made aware of the importance of raising concerns at the Trust Induction. An awareness raising campaign took place during 2014. The Francis Crick Leadership and Management development programme incorporates a focus on adopting an approachable and listening management style and culture and incorporates key aspects of governance and safety. The trust should develop training which complies with national standards, based on a curriculum devised jointly

			by HEE and NHS England in consultation with stakeholders when this becomes available. *(Director of Workforce and Transformation)* *Note: NHS Employers have provided a response to the national consultation that a national curriculum would not be appropriate and nor would mass roll out of training which could be costly.*
Principle 11	Support: All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality. They should also provide staff who raise concerns with ready access to mentoring, advocacy, advice and counselling.	11.1: The Boards of all NHS organisations should ensure that their procedures for raising concerns offer a variety of personnel, internal and external, to support staff who raise concerns including: a) a person (a 'Freedom to Speak Up Guardian') appointed by the organisation's chief executive to act in a genuinely independent capacity b) a nominated non-executive director to receive reports of concerns directly from employees (or from the Freedom to Speak Up Guardian) and to make regular reports on concerns raised by staff and the organisation's culture to the Board c) at least one nominated executive director	The current Raising Concerns at Work (Whistleblowing) Policy gives details of which managers concerns can be raised with, at which stage of the process. It includes reference to the National Whistleblowing Helpline and the external organisations that concerns can be raised with (CQC). Trade Union representatives actively support staff in dealing with concerns. a) Experience in other organisations has demonstrated that: a large amount of the issues raised relate to employment and non-whistleblowing matters, that these roles can overlap with PALs, they tend to act more as a listening role for staff (circa 90% do not want action to be taken). The Workforce Committee have debated this and support the development of a small team of Volunteer 'Freedom to Speak Up Guardians' that work alongside PALs service but focus on listening to concerns from staff (whereas PALs focus on supporting patients) and providing guidance on how to take the matter forward if the individual so wishes. Training would be provided to these individuals. b) This appears to conflict with a NED's role which is to focus on strategy and assurance rather than dealing with executive or operational matters. The time required to do this could potentially be considerable. Reporting is currently undertaken by the Director of Workforce and Transformation to the Workforce Committee that includes Non-Executive Directors. The Workforce Committee discussed this and agreed it was not appropriate to designate an individual NED as that role would be carried out by the Guardians and other officers set out within the Trust policy. c) It is noted that this could be time consuming

		to receive and handle concerns	(receiving reports, providing support, deciding action to be taken, engaging appropriate resources/support) and mean that the director is not able to carry out their role effectively. This is not recommended by the Workforce Committee as it is felt that additional resource, probably in the form of a deputy director to remove workload from the Director would be needed. This could also be seen to undermine line management which is where responsibility should lie. There are current safeguards in place that enable staff to refer to an alternative manager if they do not feel they can raise it with their line manager or if indeed the line manager is involved in the issue.
		d) at least one nominated manager in each department to receive reports of concerns	d) The policy allows for a number of managers to receive concerns. Restricting it to one person could be time consuming and would incur additional cost.
		e) a nominated independent external organisation (such as the Whistleblowing Helpline) whom staff can approach for advice and support.	e) The trust policy provides contact details and references to external organisations that can be contacted. *Note: NHS Employers have responded to national consultation on the basis that they do not believe there should be one named individual and that whilst they support the concept of named individuals it should be for employers to determine the model that works best locally and they would not recommend that one person takes up the role.*
		11.2: All NHS organisations should have access to resources to deploy counselling and other means of addressing stress and reducing the risk of resulting illness after staff have raised a concern.	The trust has an Occupational Health department which can access counselling for staff. The Trust has a policy regarding support for staff reporting an incident / concern.
		11.3: NHS England, NHS TDA and Monitor should issue joint guidance setting out the support required for staff who have raised a concern and others involved.	**N/A**
Principle 12	Support to find alternative employment in the NHS: Where a NHS worker who has raised a concern cannot, as a result, continue in their current employment, the NHS should fulfil its moral obligation to offer	12.1: NHS England, the NHS Trust Development Authority and Monitor should jointly devise and establish a support scheme for NHS workers and former NHS workers whose performance is sound who can demonstrate that they are having difficulty finding employment in the NHS as	**N/A**

	support.	a result of having made protected disclosures.	
		12.2: All NHS organisations should actively support a scheme to help current and former NHS workers whose performance is sound to find alternative employment in the NHS	The Trust should review relevant HR policies when a national/regional support scheme is identified for workers whose performance is sound following raising concerns. *(Director of Workforce and Transformation)*
Principle 13	Transparency: All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.	13.1: All NHS organisations that are obliged to publish Quality Accounts or equivalent should include in them quantitative and qualitative data describing the number of formally reported concerns in addition to incident reports, the action taken in respect of them and feedback on the outcome	The Trust produces an annual Quality account and will include any related data within the report. *(Director of Workforce and Transformation and Director of Corporate Development, Governance and Assurance)*
		13.2: All NHS organisations should be required to report to the National Learning and Reporting System (NLRS), or to the Independent National Officer described in Principle 15, their relevant regulators and their commissioners any formally reported concerns/public interest disclosures or incidences of disputed outcomes to investigations. NLRS or the Independent National Officer should publish regular reports on the performance of organisations with regard to the raising of and acting on public interest concerns; draw out themes that emerge from the reports; and identify good practice.	The trust currently reports incidents to NRLS via the Datix reporting system and will ensure that should further guidance be forthcoming the organisation complies with reporting requirements. (*Director of Corporate Development, Governance and Assurance)*
		13.3: a) CEOs should personally review all settlement agreements made in an employment context that contain confidentiality clauses to satisfy themselves that such clauses are genuinely in the public interest. b) All such settlement agreements should be available for inspection by the CQC as part of their assessment of whether an organisation is well-led. c) If confidentiality clauses are to be	The Trust does not incorporate confidentiality clauses within settlement agreements other than to set out that the details of the agreement itself are confidential. It is not used to effectively 'gag' individuals in relation to specific whistleblowing events. In the rare event of settlement agreements being used this clause will be amended to incorporate the need for the trust to share this with the CQC if requested. The CEO will review and approve these. *(Director of Workforce and Transformation)* The Trust would follow the TDA process and therefore

		included in such settlement agreements for which Treasury approval is required, the trust should be required to demonstrate as part of the approval process that such clauses are in the public interest in that particular case. d) NHS TDA and Monitor should consider whether their role of reviewing such agreements should be delegated to the Independent National Officer recommended under Principle 15.	be required to justify this in the public interest in order for the TDA and subsequently the Treasury to approve this. *(Director of Workforce and Transformation)*
Principle 14	Accountability: Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising or receiving and handling concerns. There should be personal and organisational accountability for: • poor practice in relation to encouraging the raising of concerns and responding to them • the victimisation of workers for making public interest disclosures • raising false concerns in bad faith or for personal benefit acting with disrespect or other unreasonable behaviour when raising or responding to concerns inappropriate use of confidentiality clauses.	14.1: Employers should ensure that staff who are responsible for, participate in, or permit such conduct are liable to appropriate and proportionate disciplinary processes.	This is provided for by the Trust Disciplinary policy, which includes a right of appeal where formal action is taken.
		14.2: Trust Boards, CQC, Monitor and the NHS TDA should have regard to any evidence of responsibility for, participation in or permitting such conduct in any assessment of whether a person is a fit and proper person to hold an appointment as a director or equivalent in accordance with the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 regulation 5.	The Trust complies with the requirements of the Fit and Proper Persons Test (which is currently subject to internal audit review to verify this) and as such all Directors must sign a Fit and Proper Person's declaration and references from previous employers are sought as are other checks required under those directions. *(Director of Workforce and Transformation (EDs)*
		14.3: All organisations associated with the provision, oversight or regulation of healthcare services should have regard to any evidence of poor conduct in relation to staff who have raised concerns when deciding whether it is appropriate to employ any person to a senior management or leadership position and whether the organisation is well-led.	The Trust complies with the requirements of the Fit and Proper Persons Test (which is currently subject to internal audit review to verify this) and as such all Directors must sign a Fit and Proper Person's declaration and references from previous employers are sought as are other checks required under those directions.. *(Director of Workforce and Transformation)*
Principle 15	External Review: There should be an Independent National Officer (INO) resourced jointly by national systems regulators and oversight bodies and authorised by them to carry out the functions described	15.1: CQC, Monitor, NHS TDA, and NHS England should consider and consult on how such a post might jointly be created and resourced and submit proposals to the Secretary of State, as to how it might carry out these functions in respect of on-going	**N/A**

	in this report, namely:	and future concerns.	
Principle 16	Coordinated Regulatory Action: There should be coordinated action by national systems and professional regulators to enhance the protection of NHS workers making protected disclosures and of the public interest in the proper handling of concerns.	16.1: CQC, Monitor, NHS TDA in consultation with the Department of Health should work together to agree procedures and define the roles to be played by each in protecting workers who raise concerns in relation to regulated activity. Where necessary they should seek amendment of the regulations to enable this to happen	**N/A**
		16.2: Healthcare professional regulators should review their procedures and processes to ensure compliance with the good practice set out in this report and with this Principle	**N/A**
Principle 17	Recognition of organisations: CQC should recognise NHS organisations which show they have adopted and apply good practice in the support and protection of workers who raise concerns.	17.1: CQC should consider the good practice set out in this report when assessing how organisations handle staff concerns. Good practice should be viewed as a positive factor contributing to a good or outstanding rating as part of their well-led domain.	**N/A**
Particular measures for vulnerable groups			
Principle No:	**Principles**	**Actions**	**Trust Response / *(Exec lead)***
Principle 18	Students and Trainees: All principles in this report should be applied with necessary adaptations to education and training settings for students and trainees working towards a career in healthcare.	18.1: Professional regulators and Royal Colleges in conjunction with Health Education England should ensure that all students and trainees working towards a career in healthcare have access to policies, procedure and support compatible with the principles and good practice in this report.	**N/A**
		18.2: All training for students and trainees working towards a career in healthcare should include training on raising and handling concerns	**N/A**
Principle 19	Primary Care: All principles in this report should apply with necessary adaptations in primary care.	19.1: NHS England should include in its contractual terms for general/primary medical services standards for empowering	**N/A**

		and protecting staff to enable them to raise concerns freely, consistent with these Principles.	
		19.2: NHS England and all commissioned primary care services should ensure that each has a policy and procedures consistent with these Principles which identify appropriate external points of referral which are easily accessible for all primary care staff for support and to register a concern, in accordance with this report.	**N/A**
		19.3: In regulating registered primary care services CQC should have regard to these Principles and the extent to which services comply with them.	**N/A**
Enhancing the legal protection			
Principle No:	**Principles**	**Actions**	**Trust Response / *(Exec lead)***
Principle 20	Legal protection should be enhanced	20.1: The Government should, having regard to the material contained in this report, again review the protection afforded to those who make protected disclosures, with a view to including discrimination in recruitment by employers (other than those to whom the disclosure relates) on grounds of having made that disclosure as a breach of either the Employment Rights Act 1996 or the Equality Act 2010.	**N/A**
		20.2: The list of persons prescribed under the Employment Rights Act 1996 should be extended to include all relevant national oversight, commissioning, scrutiny and training bodies including NHS Protect, NHS England, NHS Clinical Commissioning Groups, Public Health England, Health watch England, local Health watch, Health Education England, Local Education and Training Boards and the Parliamentary and Health Services Ombudsman.	**N/A**
		20.3: The Government should ensure that	**N/A**

		its proposal to widen the scope of the protection under the Employment Rights Act 1996 includes all students working towards a career in healthcare	

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30 July 2015**

Title of the Report	**TDA Self-Certifications**
Agenda item	**17**
Presenter of Report	Catherine Thorne, Director of Corporate Development, Governance and Assurance
Author(s) of Report	Catherine Thorne, Director of Corporate Development, Governance and Assurance
Purpose	Decision

Executive summary

From 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 refreshed 2015/16 Accountability Framework, the Trust is required to complete two self-certifications for Board Governance and Monitor licence conditions.
The attached report details for the month of June 2015 the proposed submission.

The Board will declare compliance with all Monitor licence conditions

The Board will declare:

- compliance with 11 out of the 14 board governance statements
- 2 are rated as at risk
  - 4 - Financial position/Going Concern
  - 10 - Compliance with targets
- 1 is rated non-compliant
  - 5 – compliance with framework

Related strategic aim and corporate objective	All
Risk and assurance	Compliance with performance targets and financial statutory duties
Related Board Assurance Framework entries	All

Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (Y/**N)** Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (Y/**N**)
Legal implications / regulatory requirements	Meeting financial statutory duties
Actions required by the Trust Board The Board is asked to: • Discuss and approve the Monitor Licensing Requirements and Trust Board Statements self-certifications for June 2015	

Northampton General Hospital NHS
NHS Trust

NHS Trust Development Authority: Oversight and monthly self-certification

Year: 2015/16 Month: June 2015

Compliance Statement: Compliance with Monitor License requirements for NHS Trusts

	Compliance with monitor license requirements for NHS Trusts: License Condition	Compliant	Comments
1	**Condition G4** – Fit and proper persons as governors and Directors	Y	This licence condition prevents licensees from allowing unfit persons to become or continue as governors or directors (or those performing similar or equivalent functions). In exceptional circumstances and at Monitor's discretion we may issue a licence without the licensee having met this requirement.
2	**Condition G5** - Having regard to Monitor guidance	Y	This licence condition requires licensees to have regard to any guidance that Monitor issues.
3	**Condition G7** – Registration with the Care Quality Commission	Y	This licence condition requires providers to be registered with the CQC (if required to do so by law) and to notify us if their registration is cancelled.
4	**Condition G8 –** Patient Eligibility and selection criteria	Y	This condition requires licence holders to set transparent eligibility and selection criteria for patients and to apply these in a transparent manner
5	**Condition P1 -** Recording of information	Y	Under this licence condition, Monitor may oblige licensees to record information, particularly information about their costs, in line with guidance to be published by Monitor.
6	**Condition P2 -** Provision of information	Y	Having recorded the information in line with Pricing condition 1 above, licensees can then be required to submit this information to Monitor
7	**Condition P3 -** Assurance report on submissions to monitor	Y	When collecting information for price setting, it will be important that the information submitted is accurate. This condition allows Monitor to oblige licensees to submit an assurance report confirming that the information they have provided is accurate.
8	**Condition P4 -** Compliance with the National Tariff	Y	The Health and Social Care Act 2012 requires commissioners to pay providers a price which complies with, or is determined in accordance with, the National Tariff for NHS health care services. This licence condition imposes a similar obligation on licensees, i.e. the obligation to charge for NHS health care services in line with the National Tariff.
9	**Condition P5 -** Constructive engagement concerning local tariff indicators	Y	The Act allows for local modifications to prices. This licence condition requires licence holders to engage constructively with commissioners, and to try to reach agreement locally, before applying to Monitor for a modification.

	Compliance with monitor license requirements for NHS Trusts: License Condition	Compliant	Comments
10	**Condition C1 -** The right of patients to make choices	Y	This condition protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have a choice of provider. This condition applies wherever patients have a choice of provider under the NHS Constitution, or where a choice has been conferred locally by commissioners.
11	**Condition C2 -** Competition oversight	Y	This condition prevents providers from entering into or maintaining agreements that have the object or effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users. It also prohibits licensees from engaging in other conduct which has the effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.
12	**Condition IC1 –** Provision of integrated care	Y	The Integrated Care Condition applies to all licence holders. The Integrated Care Condition is a broadly defined prohibition: the licensee shall not do anything that could reasonably be regarded as detrimental to enabling integrated care. It also includes a patient interest test. The patient interest test means that the obligations only apply to the extent that they are in the interests of people who use health care services.

Board Statements: For each statement, the Board is asked to confirm:

	For Clinical Quality that,	Response	Comment	Timescale for Compliance
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 regime (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.	Yes		
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements	Yes		
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.	Yes		
	For Finance that,			
4	The board is satisfied that the trust shall at all times remain a	Risk	The 2015/16 operating plan is a deficit plan	March 2016

	For Clinical Quality that,	Response	Comment	Timescale for Compliance
	going concern, as defined by relevant accounting standards in force from time to time.			
	For Governance that,			
5	The board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.	No	The Trust is failing to meet all performance targets as described in statement 10 below	
6	All current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner	Yes		
7	The board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of occurrence and the plans for mitigation of these risks.	Yes		
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.	Yes		
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.hmtreasury.gov.uk).	Yes		
10	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all commissioned targets going forward.	Risk	During June the Trust did not meet targets for: • Operations cancelled and re booked within 28 days • Cancer 2ww • Cancer 2ww breast • Target for cancer treatment within 62 days There is a rapid recovery plan in place for Cancer performance and the TDA and Intensive Support team will be providing extra support to the Trust during August 2015.	Sept 2015

	For Clinical Quality that,	Response	Comment	Timescale for Compliance
11	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	Yes		
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.	Yes		
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	Yes		
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.	Yes		

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30 July 2015**

Title of the Report	**Update on Healthier Northamptonshire and Vanguard Models**
Agenda item	**18**
Presenter of Report	Chris Pallot, Director of Strategy & Partnerships
Author(s) of Report	Chris Pallot, Director of Strategy & Partnerships
Purpose	To provide an update on the Healthier Northamptonshire Programme and applications to the Vanguard Programme to pilot new models of care in the NHS.

Executive summary

This summary is concerned with the three main programmes covered by the Programme and was presented to the Integrated Steering Group (ISG) of Healthier Northamptonshire (HN) in July. Much of this information is similar to that provided in an update to the joint regulators in June 2015.

The report also provides an update on the Urgent Care and Acute Vanguard application processes that are currently underway.

Related strategic aim and corporate objective	Corporate objective 2
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks
Related Board Assurance Framework entries	BAF – 2.2
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (N)

Enclosure N

	Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper: No
Actions required by the Trust Board/Committee The Board is asked to: • To note the updates provided for Healthier Northamptonshire and Vanguard Programme	

Public Trust Board
30 July 2015

Update on Healthier Northamptonshire and Vanguard Models

1. Healthier Northamptonshire

This summary is concerned with the three main programmes covered by the Programme and was presented to the Integrated Steering Group (ISG) of Healthier Northamptonshire (HN) in July. Much of this information is similar to that provided in an update to the joint regulators in June 2015.

1.1 Acute Collaboration

The programme has now started to make real progress with the project team (appendix 1) being fully established. The Clinical Collaboration Operational Steering Group has been established and monthly meetings are scheduled through to April 2016.

Key lead representatives have been identified for IT, Information and Finance at each acute site however lead representatives for support functions to represent both organisations for attendance at Clinical Collaboration Operational Steering Group not yet confirmed.

Most importantly, Facilitators and support facilitators now in place for each speciality and governance structures & documentation now compiled to support speciality work streams.

The Speciality work stream project groups being confirmed and all groups will have had initial joint meetings completed & established by the end of July. This will enable the detailed project and benefits realisation plans to be delivered. This will build on the initial milestone planners that have been completed for the 4 original work streams of

- Orthopaedics
- Rheumatology
- Radiology
- Ophthalmology
- & for additional Cardiology speciality work stream

A risk log in place with key overarching risks including

- Re-invigorating clinical engagement across both acute organisations/ ability for staff to meet across sites affecting pace of change
- IT infra-structure /connectivity between organisations will require investment
- Financial information on Trusts costs format/assumptions differences, making savings identification difficult

A high-light of the reports for each of the work-streams is listed below:

Rheumatology:

- All patient pathways mapped. High level 1st benefit realisation exercise completed
- 4 week current activity data collection in progress
- Patient engagement forums planned for Sept

Orthopaedics:

- Project group meeting established by end July, planning re-engagement workshop
- Focus for initial development identified

Ophthalmology:

- Project group meeting established by end July
- Reviewing opportunities for joint procurement
- One stop OP planned to commence at Kettering General Hospital (KGH) in line with Northampton General Hospital (NGH) pathway

Enclosure N

Radiology:

- Project group meeting established by end July
- Some opportunities for joint procurement implemented reviewing additional opportunities
- Working on draft countywide ultrasound referral criteria and primary care guidance

Cardiology:

- Patient pathways mapped
- Business cases developed to standardise heart failure service across the county

1.2 Collaborative Resource Management

The ISG update on CRM provided in May highlighted the level of Cost Improvement ['CIP'] delivered by the 3 Trusts in 2014/15 and their projected CIPs for 2015/16, which demonstrated that the 3 Trusts were on track for delivery of CIP in line with the levels anticipated in the Proof of Concept published and agreed in September 2014.

The update also stated that the Trusts had agreed to simplify the approach to delivery and that only part of this would be run through the Healthier Northamptonshire Programme delivery structure.

Further review following work with Deloitte and in preparation for the regulator presentation in early June 2015 demonstrated that even though this was simplified approach compared to the recommendations in Proof of Concept it felt too disconnected from the mainstream of day to day Trust delivery and accountability.

This led to the 3 Trust Chief Executive Officers (CEOs) agreement in June to bring all of the delivery 'in-house' to the 3 Trusts, with reporting and assurance on a 'light touch' basis through to Healthier Northamptonshire ISG and partners to confirm that there is delivery in line with the overarching commitments within the Proof of Concept. This avoids the risk of superimposing additional degrees of complexity to delivery structures where they do not add value.

This is a summary of the Collaborative Resource Management (CRM) discussion held in June and the agreed actions.

1. The 3 Trusts are committed to working collaboratively on corporate and back office savings and efficiencies, known as Collaborative Resource Management.

2. The Trusts have stated that, at present, they are not considering comprehensive change to organisational structures through moves to integrate whole departments across the 3 Trusts, although specific areas may be integrated if there is a compelling case for this.

3. Experience of CRM since Proof of Concept indicates that the use of an additional programme structure under the Healthier Northamptonshire Programme banner has not helped target energies and instead, has created an additional strand of priorities alongside existing ones within Trusts. CEOs have therefore agreed that they will communicate within their Trusts that they will have all Cost Improvement Programme efficiencies (whether or not they are joint approaches with another Trust) driven directly through their own Programme Management Offices (PMOs). Any additional resource requirements will be raised by the relevant Trust director through normal Trust processes.

4. There is still an expectation that the 7 'task' areas identified as part of the regulator presentation are the right things to do and CEOs will require these to be followed through as part of their overall organisational CIPs and will hold their directors to account internally.

5. To ensure that there is still transparency of this work, the 3 Trusts' Cost Improvement Programmes will highlight all areas where these are part of a collaborative approach, so that these can be identified as required as part of the whole system assurance required either by partners or by joint regulator review.

6. The CEOs also considered the 3 strategic areas of Estates, IM&T and HR/Training. These will also now be driven locally by the 3 Trusts as important enablers either to support

improved care or to drive future efficiencies, but CEOs will expect these to be driven through Director leads.

- Dr Sonia Swart agreed to organise a session of CEOs and Strategy Directors with Andrew Fearn from Nottingham University Hospital Trust (NUHT). This is being followed through for a suitable date.
- CEOs agreed to review work delivered to date on Estates (Shaping the Future), with Dr Sonia Swart to speak to Charles Abolins (NGH) about leading some whole system work focused on the objective of making better use of the existing estate of the 3 organisations. This has been followed through.
- CEOs will ask their HR Directors to come up with proposals on shared workforce strategy proposals.

1.3 Integrated Care Closer to Home (ICCtH)
The presentation to Regulators in June noted high level milestones for ICCtH invested schemes for which progress must be made on delivery.

The ICCtH schemes progress for months 0-3 have been noted in table 1 below.

In addition to the work progressing against the Programme Initiation Document for ICCtH, it was also agreed by Healthier Northamptonshire partners that the schemes or service changes which supported Urgent Care delivery should start to be integrated into the ICCtH Programme. This would help ensure that there was an appropriate prioritisation of projects and resource to reflect not just the medium to long term transformational needs but also the solutions to address current operational pressures.

This report therefore covers first the update on ICCtH projects and services, but also encloses an update email from SRB chair Stuart Rees on the Urgent Care plans and priorities.

1.4 ICCtH Schemes
The ICCtH Delivery group meets weekly, to ensure both that; momentum is maintained against activity noted and that progress is measured. To include, the review of areas for escalation to the board and any interdependencies that may impact on delivery. While this is at a relatively early stage, the group is seeking to make sure that there is a clear and common understanding of the schemes being pursued, that there is a proper reporting process against agreed metrics and that partners are clear on the resourcing required to drive forward their areas.

The approach being taken through the Better Care Fund (Joint Commissioning) reporting process has been strengthened during this period so it may be possible as part of governance arrangements overall to streamline some of the delivery and reporting process.

Scheme update:
Table 1

0 - 3 Months Timescale	Outcome agreed within Regulator Plan (10th June 15)	Update on progress	Planned Delivery Date	Status	Owners]
ICCtH					
Collaborative Care Teams (CCT)	Implementation of CCTs across majority of locations. Data submitted for evaluation. Staffing models finalised.	All CCTs now live. NELs by GP practice are being evaluated in an attempt to understand which models are working.	30 June 2015		Louise Tarplee Mark Gregory (Corby)
NHFT/KGH Integrated Care Model (ICM)	Development of a detailed finance/activity model, Agree an MOU and launch a monthly ICM Partnership Board.	On track KGH and NHFT – with the support of Health and Social Care Commissioners – have already agreed a strategic outline case to create an integrated Care Model are in the early stages of its implementation	31 July 2015		Dominic Hardisty

Enclosure N

0 - 3 Months Timescale	Outcome agreed within Regulator Plan (10th June 15)	Update on progress	Planned Delivery Date	Status	Owners]
ICCtH					
Intermediate Care	Workshops to develop new model of care held. Delivery of integrated service specifications for rehabilitation and reablement between health and social care.	A series of workshops have been delivered between Jan-June 2015 (seven in total) to develop the model of care across the county. The model of care as a Strategic Framework briefing was presented to the HSC Exec on the 17 June, and the recommendations made await approval to be taken forward.	31 July 2015		Lisa Riddaway
Care Homes	Following development of a new Service Specification the scheme in its current form will be ceased with 6 months' notice to all providers.	Nene -Service Spec awaiting final agreement. Following this the service will be re-commissioned. Corby- Delivered through NHFT	30 June 2015		Louise Tarplee
Acute Liaison	First phase of service live.	Implemented a AHL service at both sites , this is currently providing a 24/7 service but is being supported to deliver via the Crisis resolution home treatment service. There is recruitment underway to recruit permanent staffing to the AHL service and reduce pressure on CRHT	30 June 2015		Rachel Douglas-Clark
Falls Ambulance	Business Case Agreed. Project fully operational. Completed recruitment of Suitable Paramedics and Emergency Care.	Milestones delivered and the service fully operational. At present the service is not delivering against core KPIs and this has been raised with the trust as a contract query.	30 June 2015		Mark Gregory

The next steps for the ICCtH delivery group are to-

- Agree the proposed performance management process and tighten up the timetable for performance reporting
- Continue to report progress against milestones set out within the regulator presentation to ensure we deliver against the agreed 0-3months milestones, 3-6 month milestones, and 6 month +.
- Ensure that the projects are being managed and driven forward against clear plans and with appropriate resources
- Integrate the emerging urgent care plans into the delivery programme.

2 New Models of Care – Vanguard Applications

2.1 Urgent and Emergency Care Vanguard

This particular vanguard process closed to applications on 15 July 2015 with the application at appendix 2 being submitted on behalf of the county.

The national guidance stated that the successful Vanguard sites will be expected to:

• create and implement, as rapidly as possible, scalable and replicable urgent and emergency care models. They will be expected to commit to increasing their ambition and accelerating their intended pace of change

• do the 'right things right', based on the Keogh Review's 'Safer, Faster, Better' good practice guide, no reinventing wheels or embarking on 'quick fixes' or 'easy wins' that are only likely to make marginal quality improvements. There will be explicit requirements on implementing best practice and national policy expectations, for example on implementing integrated 111 and out of hours services

• support and empower their System Resilience Groups (SRGs) and Urgent and Emergency Care Networks to set standards and establish new ways of working that cut across traditional organisational boundaries. They will be fully committed to the recently issued NHS England guidance for UEC networks;

In addition it stated that the UEC Vanguard group will:

• comprise a small number of enthusiastic and energetic participating systems, drawn from across different geographies, working as a group

• receive early access to tools and guidance developed through the UEC review

• have a strong focus on unblocking current system constraints and national barriers to change, e.g. information sharing and payment methods

• enjoy clear commitment and sponsorship from the national NHS bodies and their CEOs
• benefit from direct practical support, through an expanded role for ECIST working under the aegis of the new care models programme. Professor Sir Bruce Keogh and Professor Keith Willett will provide clinical leadership for the UEC Vanguard programme

• access to transformation funding.

• develop and test new system-wide outcome indicators, drawing on the established work of the UEC review

• work as a group, to learn from each other.

On Thursday 16 July it was confirmed that the Northamptonshire submission had not been shortlisted for the programme.

2.2 Acute Systems Vanguard
The purpose of this care model is to develop radical new options for acute care collaboration with applications being submitted by 31 July 2015.

The selection process will be the same as for all other vanguards. There will be a shortlisting process followed by in-depth interviews, video recorded sessions and voting by the other applicants. This will be held in September. It is expected that there will be a maximum of 6-8 vanguards nationally.

Critically, each submission must focus on addressing 3 "gaps": health and wellbeing, care and quality and funding. These are commonly referred to as "the triple aims".

In addition, the following will be tested as part of the assessment of the application.

- Clinical engagement
- Patient & citizens involvement in developing the application
- Ability to deliver locally.

These values of the programme must be demonstrated throughout the application.

Success of each application will also depend on the ability to deliver nationally replicable programmes. We must demonstrate and support replication and make explicit reference to this in our submission.

If successful the New Care Model support programme will comprise of: national support, cohort activities, targeted investment for bespoke activities (not to support deficits) and packages for accelerated learning.

The guidance which has been released as part of the process states the following:

"The programme will create a limited number of additional, well-defined, strategic choices for NHS foundation trusts (FTs) and NHS trusts that enable them to rethink their clinical models and business models, beyond the confines of their existing organisational boundaries, or indeed their immediate local health care system.

These options are likely to include, but are not limited to:

- innovative forms of ***Accountable Clinical Networks****, such as through* ***joint NHS-led vehicles*** *running particular services, characterised by clear leadership, with decision rights to reshape care, backed by a clear organisational form;*
- ***NHS service franchises*** *such as Moorfield@, The Marsden@;*
- ***NHS management groups*** *or* ***chains of multiple organisations****, for example under a NHS "foundation group".*

The aim of this programme, is not to support the implementation of traditional acute mergers or reconfiguration programmes. Instead, the focus of the programme will be to develop replicable new organisational arrangements that support quality, productivity and efficiency improvements2 in acute services.

At a minimum, applicants are expected to already have in place:

• a clear and ambitious vision of what they want to achieve and of how the new model will help promote the health and well-being of the population, increase the quality and person-centredness of care for their patients, and improve efficiency for the taxpayer within available resources;
• a shared commitment to making swift progress in the development of the new model;
• effective managerial and clinical leadership, including leadership for engagement, and the capacity and capability to succeed.

Applicants will also need to show:

• an appetite to engage intensively with other sites across the country, and with national bodies, in a co-designed and structured programme of support aimed at:

a. identifying, prioritising and tackling national barriers experienced locally;
b. developing common rather than unique local solutions that can easily be replicated by subsequent sites; and
c. assessing progress, through a staged development process.
• a commitment to co-design local and national metrics and to demonstrate progress against them, including real-time monitoring and evaluation of health and care quality outcomes, the costs of change, and the benefits that accrue;
• a willingness to share data as required to support the development and operation of the new model."

Stakeholder communications and engagement will be central to a successful Vanguard application and subsequent implementation. Our aim is to harness the energy and commitment of our staff, patients and the community we serve to develop and support new relationships and new ways of working.

A communications and engagement plan will be developed. In the meantime our focus will be to:

- Develop and agree key messages with our partner organisations
- Identify and segment our stakeholders to ensure our communications and engagement activity is effective
- Identify existing and new opportunities for communications and engagement
- Agree timescales
- Provide assurance to stakeholders that their opinions will help inform ongoing development and implementation

The draft application is listed at appendix 2 and at the time of writing is awaiting feedback from KGH.

University Hospitals of Leicester NHS Trust is also submitted an application for this programme involving NGH and KGH. This is for the oncology partnership that the Board is aware of and would reflect a different model of collaboration from that proposed with KGH. The document is still being written and so cannot be presented to the Board at this time.

3 Recommendation

The Board is asked to note the updates provided for the Healthier Northamptonshire and Vanguard programmes. An update on the success or otherwise of the Vanguard application will be presented to the next Board meeting.

Kettering General Hospital NHS
NHS Foundation Trust

Northampton General Hospital NHS
NHS Trust

Clinical Collaboration Implementation Project Group Structure

CLINICAL COLLABORATION IMPLEMENTATION GROUP

Executive Sponsors:	C. Culpin – Director of Strategic Development & Corporate Governance - KGH C. Pallot – Director of Strategy & Partnerships- NGH
Project Management:	K. Harvey –KGH/NGH P. Watson – Nene CCG K Spellman - NGH
Facilitators Support:	Tim O Donovan – Nene CCG Debbie Stanley – Corby CCG

Speciality Work Stream Lead representations:

Finance Lead: IT Lead: Christina Malcolmson Information Lead:

OPTHALMOLOGY	RHEUMATOLOGY	RADIOLOGY	ORTHOPAEDIC	CARDIOLOGY	DERMATOLOGY
Clinical Leads: Jayshree Menon Tristan McMullan Project Lead: Peter Watson (Kathy Harvey in Support) Management Lead:	Clinical Leads: James Taylor Lillian Lawson Project Lead: Jessamie Hockings Management Lead: Dawn Sharples	Clinical Leads: David Walter/ Mohammed Hajaj Project Lead: Kathy Harvey (Peter Watson in support) Management Lead:	Clinical Leads: David Gidden Dipen Menon Project Lead: Peter Watson & Kathy Harvey Management Lead:	Clinical Lead: Simon Hetherington Patrick Davey Project Lead: Kathy Harvey Management Lead: Maxine White	Clinical Lead: TBC Project Lead: TBC Management Lead: TBC

Acute Trust Organisational Support Leads			
IT Christina Malcolmson -NGH Colin Jervis -KGH	**Information** Andy Frost -KGH Sean McGarvey -NGH	**Finance** Lisa Longhurst/John Wasniowski -NGH -KGH Procurement Lead : Alan Rivens NGH	**Workforce** Sandra Wright -NGH -KGH

June 2015

Enclosure N

Forward View into Action

REGISTRATION OF INTEREST FOR FUTURE MODELS OF ACUTE CARE COLLABORATION

Q1. Who is making the application?

This Application is submitted by ---------- CEO ---------- NHS Trust
Contact details: ----------

The application is on behalf of The Healthier Northamptonshire Acute Clinical Collaboration Work Stream.

The clinical collaboration is largely between the following two acute providers, however, wider health economy partners are supporting this work

Acute clinical collaboration providers

- Kettering General Hospital NHS Foundation Trust (KGH)
- Northampton General Hospital NHS Trust, (NGH)

Health economy partners who fully engaged in this work and supportive of this expression of interest

- Northamptonshire Healthcare NHS Foundation Trust (NHFT)
- Northamptonshire County Council (NCC)
- NHS Nene Clinical Commissioning Group (Nene CCG)
- NHS Corby Clinical Commissioning Group (Corby CCG)
- Voluntary Impact Northamptonshire
- 3Sixty, Lakeside Plus and GP Alliance partners

Q2. What are you trying to do?

Our objective is to co-develop innovative patient pathways and service models that will deliver best practice standards for patients across both hospitals by embedding collaborative working between the two acute providers in Northamptonshire. This will enable clinically, operationally and financially sustainable services to be delivered for patients across Northamptonshire and beyond.

Our vision is to maximise benefits for patients by ensuring the delivery of best practice standards consistently across both hospitals, positively impacting on their experience of care and outcomes and delivering efficiencies for the wider system.

In addition, we envisage the following benefits:

- increased economies of scale providing opportunities for cost reduction
- standardisation of processes and systems streamlining care pathways
- shared workforce to support effective recruitment and retention
- access to a wider set of expertise and skills set through a shared workforce
- maintain the level of clinical services in the county and maximising tertiary links for those services which are best delivered elsewhere

The programme is ambitious and will deliver large scale clinical and organisational change. This is something both organisations have been planning for a number of years. We are now seeing real progress with stronger relationships being established and shared governance frameworks being created with support from clinical commissioners.

The hospitals are keen to work outside the confines of their existing boundaries and have

DRAFT

committed their clinical and managerial teams to review existing services and take a joint view on future delivery rather than one constrained by traditional organisational structures. We are establishing clinical bodies that think 'team Northamptonshire' rather than as two organisations working together.

We are already exploring opportunities for horizontal collaboration and networking of services across sites with a focus on caring for our population as a whole whilst maintaining the organisational identity of both Trusts. Already plans are in development for a single countywide rheumatology service. Others will follow.

Our approach will be to:

- Learn from previous external reviews and recommendations
- Commit to an engaging in clinically-led service transformation
- Commit to engage with patients, public and members

Fundamental governance arrangements, sharing information agreements and principles of collaborative working have been stated in a memorandum of understanding agreed by both organisations Trust Boards. A more detailed shared governance framework is being created.

Q3. Please articulate how your vision will deliver clinically and financially sustainable high quality acute services to maintain local access for patients and their families and/or how you will help codify and replicate effective clinical and managerial operating models in order to reduce avoidable variations in the cost and quality of care?

The vision for this work is set around the objectives of the triple aim.

1. Improving the patients experience of care

- Design of new delivery frameworks, through horizontal integration that ensure new models of care are sustained
- Reduce avoidable variation in the quality of care by implementing standardised pathways cross-county to deliver best practice
- Specialty level reviews to ensure clinical quality metrics and operational standard are delivered in a sustainable manner
- Patients get access to expertise appropriate to their clinical need
- Clear and understandable access to services in their area, easy access to outpatient services, shared standardised information
- Commitment to engage and involve the patients and citizens of Northamptonshire

2. Improving the health of populations

- Integrating care across all boundaries and with the partners listed above to focus on improving health and wellbeing as well as treating ill-health
- Foundation of health and wellbeing campuses on each site in partnership with NCC
- Implementation of telehealth and risk stratification in partnership with commissioners to focus redesign efforts and establishment of new patient pathways

3. Reducing cost of healthcare and improving efficiency

- Reduce avoidable variation in the cost by implementing standardised pathways cross-county to deliver best practice and pathway efficiencies, ensuring uniform access and treatment for all patients.
- Development of a financial model to ensure financial risks & benefits are shared equitably between partners
- Speciality level reviews to ensure clinical, operational and financial sustainability into the

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future

- Delivering critical mass for services where thresholds apply, establishing collaborative clinical speciality teams, benefitting from efficiencies of scale with infrastructure alignment to meet single service delivery.
- Streamlining of clinical workforce resources across services through management of patient flows, i.e. right person, right time, and matching clinical resources to service demand.
- Consolidate service specific outpatient booking with optimised appointment efficiency through centralised appointment booking systems delivering savings from shared administration workforce/ skill mix review and reduction in wasted appointments.
- Expand common procurement approaches and processes particularly in ophthalmology and orthopaedic services, looking at both consumable and capital procurement, with the benefit of reduced cost for purchase and on going maintenance. This will also support safe cross site service delivery for equipment operators.
- Improved estates efficiency through delivery of localised care at peripheral sites, releasing capacity across acute settings
- Development of Integrated IT systems where possible with shared software costs and avoidance of duplication such as requested diagnostics. This will be facilitated by the East Midlands-wide procurement of a new PACs system and the Clinical Network Project, Chaired by the NGH CEO
- Development and implementation of countywide on call rotas to minimise time lost to compensatory rest, associated reduced cost from cross site speciality cover and maximising ability to deliver seven day week services.
- Review of diagnostic tests of low clinical value and refinement and standardisation of Direct Access guidance for GPs to reduce "unnecessary" examination requests improving patient experience and reducing avoidable cost.
- Standardise countywide discharge planning and length of stay for elective pathways
- Potential for virtual clinics reducing demand for consultant led follow up e.g. - Medical Retina, and step down cataract patients from secondary care to Optometrists, reducing costs for consultant level and secondary care provision and bringing on-going care access closer to patients.
- Development of new musculo-skeletal service with joint leadership by the Trusts providing integrated orthopaedic, rheumatology and radiology support. Integrated with health partners to deliver seamless care

Q4. Please describe where you are currently and what steps you have already taken in thinking through and delivery towards your proposed care model.

As partner organisations we recognise the need to collaborate in delivering acute services in Northamptonshire. Further to a number of external reviews both organisations are keen ensure that clinical teams are empowered to shape future services with patients and their teams. The Trusts are ready to progress with implementation through joint team working, and delivering new models of integration.

The two acute Trust providers (NGH & KGH) are already working collaboratively on a range of clinical pathways with lead provider models which include Vascular, Stroke and ENT. Traditional reconfiguration review programmes, most recently as part of the Challenged Health Economy Programme. As a result of this, Clinical Collaboration (CC) between KGH and NGH has been identified as a key work-stream within the Healthier Northamptonshire Programme. This will transform and integrate health and social care to support the local population to live longer, healthier lives and to deliver sustainable services.

A Collaboration Steering Board has been established between KGH and NGH has been established within an overarching programme governance structure, a Programme Initiation Document and speciality-level work plans. The scope of services for transformation has

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commenced with 5 initial specialities: rheumatology, radiology, orthopaedics, opthalmology and cardiology.

Clinical and managerial leads have been identified for each work-stream and a proof of concept for each speciality has been agreed between the joint clinical bodies of the Trusts. A Memorandum of Understanding has been agreed by both Trust Boards and will be used to support delivery.

Q5. Where do you think you could get to over the next year?
(Please describe the changes, realistically, that could be achieved by then.)

We will have embedded functioning speciality work groups and redesigned each of the services listed above, thus making significant progress against work stream milestones. Achievements we would aim to achieve would include;

- Condition specific service model proposals developed and agreed with Commissioners and embedded in their Intentions and 2016/17 contract negotiations
- Countywide service for rheumatology designed and ready for implementation, jointly managed by the Trusts
- Defined outcome measures and benefits realisation plan
- Single point of access for specialities designed with centrally managed administrative support hub agreed.
- Agreement to consolidate specific elective services across our geographic sites
- Countywide standardised service specification for imaging developed that uses standard protocols and removes any imaging tests that yields a low clinical value outcome.
- Integrated elective orthopaedic outpatient service that will serve the county (single access for all referrals).
- Extended centralised procurement framework to standardise orthopaedic and ophthalmology products to deliver reduced wastage and standardise processes.
- Develop joint consultant rota proposals for ophthalmology and radiology.

Q6. What do you want from a structured national programme?
(Aside from potential investment and recognition: i.e. what other specific support is sought?)

By being part of the new care models programme will, with expert support, afford us the greatest opportunity to develop radical new organisational options and arrangements for accelerated implementation for best practice outcomes, benefit realisation and long term sustainability.

A traditional barrier to change has been the ability to design new financial mechanisms that enable risk and reward to be transparently shared between partners leading to new organisational arrangements for service delivery. We see this as a key benefit of the programme.

In addition, the following benefits of being included in a national programme appeals to us:

- Access to external expertise to assist with developing new of models of organisational form that support the programme and wider sustainability of the hospitals
- Support for key clinicians/staff to gain peer advice for services development, including expert facilitation and additional challenge to maximise change options based on knowledge and experience.
- Support to replicate learning across the remainder of the Trusts clinical services at pace and providing an evidence base to support wider NHS learning
- Support to develop a financial framework that supports the programme, leads to transparency between the partners and which balances risk and reward
- Specialist advice on defining measures to track the successful implementation of new models of care
- Specialist external contracting/tendering/legal expertise when exploring alternative

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service provision options • Support for investment/development of information system connectivity between organisations, shared wireless infrastructure, clinical portal overview and possible fibre connection.

Please send the completed form to the New Care Models Team (england.newcaremodels@nhs.net) by **31 July.**

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Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30 July 2015**

Title of the Report	**Report from the Finance Investment and Performance Committee**
Agenda item	**19**
Presenter of Report	Paul Farenden, Chairman
Author(s) of Report	Phil Zeidler, Non-Executive Director and Chair of Finance Investment and Performance Committee
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 June.	
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 Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (Y/**N**) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (Y/**N**)
Legal implications / regulatory requirements	Statutory and governance duties

Enclosure O

Actions required by the Trust Board

The Trust Board is asked to note the report.

Public Trust Board
30 July 2015

Report from the Finance Investment and Performance Committee meeting 17 June 2015

1. The Purpose of the Report

This report from the Finance Investment and Performance Committee provides an update on activities undertaken since the last meeting and also draws the Board's attention to any other issues of significance, interest and associated actions required.

2. Key points to be raised in the report

Recruitment of A&E medical staff

The Committee received an A&E Medical Staff Overseas Recruitment report to approve the decision for international recruitment to eliminate current vacancy levels and locum usage and have a consistent workforce for the Trust's Urgent Care pathway. The proposal was to recruit 15wte middle grade doctors from India to support the vacancies in A&E. The costs identified were £124k for the recruitment plus relocation expenditure of £75k maximum, there was a stepped structure in terms of rebates for unsuccessful candidates who would protect the Trust to a certain level, with in-year benefits were in the region of £280k and full year benefits of c. £1m. The Committee requested some benchmarking on relocation expenses that other Trust's paid for international moves was done to ensure the Trust was competitive, and the Committee approved the initiative.

Financial Performance

The Committee was advised Month 2, showed a deficit of £4.4m, £0.1m favourable to plan. Income had performed £0.7m below plan due provisions for anticipated contractual fines and penalties and under performance in elective and day case activity compared to plan. The favourable position included the YTD plan for the CIP programme which had recorded increased delivery in May primarily through non-recurrent pay vacancies.

The Regulators had emphasised the need for cost controls, focused on consultancy and agency expenditure. The Committee noted that the increased cost of temporary staffing remained a concern and the current trajectory for both pay and non-pay expenditure presented a degree of risk going forward compared to the plan and prior year run rate trends.

The Trust is still awaiting the outcome of an independent external review of the Marginal Rate Emergency Threshold (MRET). Until the outcome of this review was known provision for the existing level of MRET penalty would be made in the reported position.

Changing Care @ NGH

The Committee was advised that the latest thinking forecast at M2 was £11.156m against a plan of £11.325m; this had increased from M1 by £1.149m. The committee felt there was insufficient information in the report to provide assurance, particularly around risks and mitigation. The Committee also requested some cross reference to the Healthier Northants programme.

Operational Performance
The Committee was advised that performance of A&E continued to improve month on month. The number of Delayed Transfers of Care (DTOCs) had reduced, but remained higher than levels required.

The Committee was advised that with regard to discharge to assess and domiciliary care, along with the other 4 schemes were being worked up into business cases to support care closer to home. Cases were to be presented to the Urgent Care Board next week. The Committee were reminded that if activity increased as expected in line with the increase last year, the Trust would require between 35-70 additional beds.

Work had been carried out on a mobile ward however it was confirmed that the Trust did not have a footprint close enough to the site. The Committee were advised that there were 4 options, outsourcing beds, the use of care homes, reduction in Average Length of Stay (ALOS) for simple discharges and reduction in DTOCs. The Committee requested that a proposal to address the capacity and demand gap for winter 2015 be brought back next month.

The Trust had received a review by Emergency Care Intensive Support Team (ECIST), and recommendations would be incorporated into the appropriate theme of the Changing Care @ NGH Programme.

The Committee was advised the Cancer targets continued to be challenging. The Committee raised concerns over the apparent delay in delivering many of the items noted on the cancer action plan, and requested further assurance that the plan was prioritised appropriately and the committee could see evidence of pace and management grip.

The Committee approved the Performance Management Framework.

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30 July 2015**

Title of the Report	**Report from the Quality Governance Committee**
Agenda item	**20**
Presenter of Report	Liz Searle, Non-Executive Director and Chair of Quality Governance Committee
Author(s) of Report	Liz 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 June.	
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 Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (Y/**N**) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (Y/**N**)
Legal implications / regulatory requirements	Statutory and governance duties

Actions required by the Trust Board

The Trust Board is asked to note the report.

Northampton General Hospital NHS
NHS Trust

Public Trust Board
30 July 2015

Report from the Quality Governance Committee meeting held on 19 June 2015

1. The Purpose of the Report

This report from the Quality Governance Committee provides an update on activities undertaken since the last meeting and also draws the Board's attention to any other issues of significance, interest and associated actions required.

2. Key points to be raised in the report

Matters Arising
The number of patients waiting Ophthalmology appointments is 742. The correction made in the last minutes was again incorrect and the Committee were assured this was now correct. All other matters were on track or on the Agenda.

QIA Scorecard
The Committee received the QIA Scorecard. The Scorecard was noted. Three further items had been discussed and would appear on the Scorecard next month. There was a discussion around the issues that the Committee should not just rely on the scorecard alone but ensure we have triangulated quality data.

CQC Update
An update was received on the gap analysis related to the Key Lines of Enquiry. The section on Well Led was not presented here as it will form an item for discussion at the next Board of Directors. A progress plan will be completed and shared with the Committee.

Corporate Scorecard for Quality
The scorecard was much improved with less greyed out areas.

Nursing and Midwifery report
Within the report there was an update on pressure ulcers. We continued to be an outlier for the numbers of Pressure ulcers. There were a number of issues to be address for example what happens to patients in A&E who wait a long time and why there are so many ulcers on heels which suggests poor moving and handling. Why we are not detecting ulcers at stage one as 56% patients developed pressure ulcers between 4-14 days so earlier in their stay. An action plan will be developed and will return to the CQEG and Committee. The Committee were very concerned and lacked assurance at this point.

The Trust Development Authority (TDA) undertook a review of the Trust's compliance against the Hygiene Code in April and made a number of recommendations, all of which were being addressed prior to their visit. On 17 June 2015 Dr Adams, the TDA regional IPC lead, revisited to review actions and improvements. Whilst it was acknowledged that there are significant improvements across many areas, it was identified that there are some areas of practice that are of concern and therefore our ability to demonstrate compliance against the Hygiene Code is at risk. The Committee were informed that actions have been put in place to address this.

A very helpful and frank discussion continued on the use of the beat the Bug rounds and how these issues are being highlighted but not actioned. The Executive Team will review the outcomes of the Beat the Bug rounds and the process for improvement. This will be brought back to the Committee.

The Committee asked that the Childrens and young people's Friends and Family Test is included as part of future reports. Concern was expressed on the 56% compliance rate for safeguarding training level 3 in Women's and Childrens health. This is to be reviewed. The overall compliance with training is low and this has been elevated to a risk of 12 on the risk register. It was also noted that the Safeguarding Vulnerable Adults and Childrens Policies still requires updating. The committee requested that this be given priority. The Dashboard was reviewed and a query about Creaton and if they needed any further support. This may be due to the change in type of patients. This will be reviewed.

Kirkup Report Gap analysis was noted and progress against actions to be reported back in October. Francis Review Action Plan was noted.

Medical Director's report
All exceptions noted. The Obstetrics Governance Committee will be receiving a report on Obstetric Trauma and this will come back to the committee in due course. Learning form a delayed Diagnosis incident was shared. The patient Safety Strategy was shared and commended. Monitoring going forward will take place in the future Medical Director Reports and the new Quality and Safety report.

Final Quality Account was reviewed.

The Corporate Risk Register for Quality was reviewed. It was noted that 3 risks had worsened their score, 3 had stayed the same and 2 had improved their score. Discussion was had on how improvement can be maintained.

Highlight Reports and minutes were received from the Assurance Risk and Compliance Group and the Clinical Quality and Effectiveness Group.

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30 July 2015**

Title of the Report	**Report from the Workforce Committee**
Agenda item	**21**
Presenter of Report	Graham Kershaw, Non-Executive Director and Chair of Workforce Committee
Author(s) of Report	Graham Kershaw, Non-Executive Director and Chair of Workforce Committee
Purpose	For Assurance
Executive summary This report from the Chair of the Workforce Committee provides an update to the Trust Board on activities undertaken during the month of June.	
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 Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (Y/N) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (Y/N)
Legal implications / regulatory requirements	Statutory and governance duties

Enclosure Q

Actions required by the Trust Board

The Trust Board is asked to note the report.

Public Trust Board
30 July 2015

Report from the Workforce Committee meeting held on 17 June 2015

The Purpose of the Report

This report from the Workforce Committee provides an update on activities undertaken since the last meeting and also draws the Board's attention to any other issues of significance, interest and associated actions required.

Key points to be raised

Nurse recruitment continues to be very challenging with turnover running at nearly 12%. The Director of Nursing (DoN) was requested to provide a detailed analysis of why staffs were leaving and a forecast of leavers and what action was being undertaken. The DoN informed the Committee that a review of the Retention Strategy would be presented to the Committee in September.

The recent recruitment exercise in Europe had not been very productive. A considerable number of offers were made with a low level of acceptance due to candidates being registered with several agencies. A recruitment campaign in the Philippines has been successful but we had not managed to undertake any recruitment in India as originally planned, as a consequence HR were now looking at recruiting again from Portugal.

The Committee were informed that the Trust currently employed a significant number of Healthcare Assistants (HCAs) who are registered nurses in their country of origin but did not hold registration with the Nursing and Midwifery Council (NMC). In order to be considered for the new NMC international assessment process individuals required a live certificate of completion of the International English Language Testing System (IELTS); this had previously been a barrier for our international HCAs. To support them an IELTS preparation course had been sourced with a local College, with a view to increasing the individual's chances of passing the test at the required level. A scoping exercise had been undertaken which identified 34 substantive staff and 4 bank staff who might be considered as eligible for NMC registration. It was confirmed that this process could potentially support an increase in Registered Nurse numbers and aid retention of a group of staff that had worked at the Trust for a number of years.

At the moment we had approximately 200 nurse vacancies the majority of which are being filled by agency staff. Concerns were expressed at the meeting about the accuracy of the vacancy data being presented and it was asked that HR and Finance as a matter of urgency review this.
In summary despite a high level of recruitment activity the Board cannot be assured that the vacancy gap will be substantially closed.

The DoN provided an update of the proposed nurse revalidation process and the approach to be taken by the Trust to support staff compliance with the new Nursing and Midwifery Council (NMC) process. The Revalidation Implementation Group chaired by the Director of Nursing, Midwifery and Patient Services had continued to work on the implementation action log and confirmed that the State of Readiness report for Trust Development Authority (TDA) had been completed. Committee noted that revalidation had been added to the Patient & Nursing Services Risk Register and a Risk Log would be maintained. Regular updates would be provided to the Committee on the progress of the implementation group, recommendations would be presented for support and approval as necessary.

The DoN presented the Hard Truths Report and as part of this reported on the planned versus actual staffing levels across the inpatient areas. April saw an increase in planned hours due to the budgetary uplift in the nursing establishments in line with the third year of the nurse staffing strategy. The uplift continued to have an impact on the overall fill rate until the recruitment to the uplifted vacancies had been made.

The DoN confirmed that the overall fill rate for May 2015 was 81%. Fill rate during the day continued to remain lower than at night and this would be addressed by the consultation to standardise shift patterns alongside a review of the flexible working arrangements, which had commenced in June 2015. As from June 2015 wards would provide assurance on the safe staffing of each shift through the declaration of a RAG rating which would reflect the overall safety of the ward reflecting staffing, skill mix, temporary staffing and patient acuity and dependency. This would be reported on by way of summary at this Committee from July.

It was reported that the overall acuity of patients had increased over the course of May, which placed increased demand on staff requirements. Additional reasons for the gaps in ward fill rates included; the fact that there were two days in May where escalation capacity was closed; 352 bed days were staffed with staff from the adult inpatient areas, providing additional pressure on the staffing planned hours; requirement to staff discharge suite for approximately 50 hours in the month out of the ward staffing establishment. In response to questioning the Committee were assured that staffing was reviewed by a senior nurse at the twice daily Safety Huddles Monday to Friday and daily at a weekend. Any wards where staffing was at a minimum level or due to increases in acuity and dependency there was a need for additional staff above planned numbers, movement of staff was made and risk assessed.

A number of challenging Industrial relation matters are being managed by HR that the board need to be aware of. These include paid compensatory rest for medical staff, Nursing shift pattern changes and managers on call rota to support 7 day working.

The HR team gave updates on progress with the People and Organisational Development strategies. It was clear from this that there was a lot activity underway which was resulting in some changes in various workforce performance targets.

1. Trust sickness rate had dropped to 3.7%, which was below the Trust target of 3.8%. This was the second month in a row were a drop had been recorded.
2. There had been no new grievance opened during the last month by staff members.
3. Improvements in appraisal, mandatory training and RSET rates had been seen.
4. 5 suspensions had been closed in the month along with the introduction of the new streamlined suspension process, which should reduce substantially the time taken to investigate and decide on a suspension cases.

The Medical Director presented a detailed report to the committee on medical appraisal and this assured the committee that our system met all necessary requirements. The Medical Director went on to present a detailed update on the medical workforce strategy. Dr Cusack reported that the strategy pulled together a number of existing work streams, together with new areas of focus in order to begin development of a vision for the medical workforce. He reported that the strategy had been out to consultation with the Divisional Directors and that they had incorporated their comments. Dr Cusack confirmed that there would be a resource cost involved in collecting data and metrics. He advised that an implementation plan would be put together and that presented to the Committee in due course.

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30 July 2015**

Title of the Report	**Report from the Hospital Management Team**
Agenda item	**22**
Presenter of Report	Deborah Needham, Chief Operating Officer/Deputy CEO
Author(s) of Report	Deborah Needham, Chief Operating Officer/Deputy CEO
Purpose	For Information & Assurance
Executive summary This report provides an update to the Trust Board on activities undertaken at the Hospital Management Team meeting – 7th July 2015.	
Related strategic aim and corporate objective	Strategic Aims - All
Risk and assurance	Risks assessment provided within the report.
Related Board Assurance Framework entries	BAF 1.2, 1.5, 1.7, 2.1, 4.1, 4.2, 5.1
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
Legal implications / regulatory requirements	Statutory and governance duties

Enclosure R

Actions required by the Trust Board

The Trust Board is asked to note the report.

Public Trust Board
30 July 2015

Report from the Hospital Management Team (HMT)

The Purpose of the Report
This report from the Hospital Management Team (7th July 2015) provides an update on activities undertaken and also draws the Board's attention to any other issues of significance, interest and associated actions required.

Key points to be raised
The HMT meets monthly and includes all Executive Directors and Divisional Directors, Divisional Directors share progress, concerns and risks following their monthly performance meetings with the Chief Operating Officer and Executive team.

Every other month the wider management team; Divisional Managers, Directorate Managers, Matrons and Clinical Directors are invited to take part in a facilitated workshop. The meeting on 7th July 2015 was the first meeting were a workshop was held.

Divisional updates
Each Division were invited to update on key areas of focus following their monthly performance meetings.

Surgery reported on the difficulty relating to the unavailability of sterile theatre packs causing cancellation of operations due to no kit, the directorate had arranged a meeting with the sterile services team and would feedback or escalate if they were unable to resolve the issues.

Medicine reported that Endoscopy capacity was still a key risk and the directorate are working on clarifying capacity and demand along with solutions to address the increase in demand which has been due to recent national health campaigns. They also reported the challenges which occur when the Brampton ward lift breaks down which has now been escalated to the managers at Thyssens (our lift contractor).

Clinical Support Services are currently working well as a division; collectively the directorates are generating a financial surplus and pursuing a stretch CIP.

Women's, Children's, Cancer and Oncology Division have seen an increase in discharges before 10am and FFT performance for the division is improving. There is further work to be done on ensuring the CIP is recurrent and increased support from finance had been requested, the division is currently reporting a deficit of £138k against plan.

Workshop – Review of structure
Members of each division worked together during the workshop and shared their thoughts on "what is working well" with the new structure and "how it could be better if".

The workshop was well attended and with good engagement. There was some positive feedback on how the structure is working and some general comments on areas to improve, the management of governance in the directorates and the requirement to have accurate, timely information being the most common.

A survey has been sent to all members of the divisional management teams and an update will be provided to the HMT in September.

Any other Business
There were no items of any other business.

Northampton General Hospital NHS
NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 30 July 2015 at 10:00 in the Board Room at Northampton General Hospital

Time		Agenda Item	Action	Presented by	Enclosure
10:00	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2.	Declarations of Interest	Note	Mr P Farenden	**Verbal**
	3.	Minutes of meeting 28 May 2015	Decision	Mr P Farenden	**A.**
	4.	Matters Arising and Action Log	Note	Mr P Farenden	**B.**
	5.	Patient Story	Receive	Executive Director	**Verbal**
	6.	Chairman's Report	Receive	Mr P Farenden	**Verbal**
	7.	Chief Executive's Report	Receive	Dr S Swart	**C.**
10:20	**CLINICAL QUALITY AND SAFETY**				
	8.	Medical Director's Report	Assurance	Dr M Cusack	**D.**
	9.	Director of Nursing and Midwifery Report	Assurance	Ms C Fox	**E.**
10:45	**OPERATIONAL ASSURANCE**				
	10.	Update on progress with Changing Care@NGH Programme	Assurance	Mr S Lazarus	**F.**
	11.	Finance Report	Assurance	Mr S Lazarus	**G.**
	12.	Workforce Performance Report	Assurance	Mrs J Brennan	**H.**
	13.	Integrated Performance Report	Assurance	Mrs D Needham	**I.**
11:25	**GOVERNANCE**				
	14.	Fire Safety Board Compliance Statement	Assurance	Mr C Abolins	**J.**
	15.	Declaration of Compliance against Mixed Sex Accommodation	Assurance	Ms C Fox	**K.**
	16.	Freedom to Speak Up Report	Assurance	Mrs J Brennan	**To follow L.**
	17.	TDA Self-Certifications	Decision	Ms C Thorne	**M.**
12:00	**STRATEGY**				
	18.	Update on Healthier Northamptonshire and Vanguard Models	Assurance	Mr C Pallot	**N.**

Time		Agenda Item	Action	Presented by	Enclosure
12:15	**COMMITTEE REPORTS**				
	19.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Farenden	**O.**
	20.	Highlight Report from Quality Governance Committee	Assurance	Mrs L Searle	**P.**
	21.	Highlight Report from Workforce Committee	Assurance	Mr G Kershaw	**Q.**
	22.	Highlight Report from Hospital Management Team	Assurance	Mrs D Needham	**R.**
12:35	**23.**	**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 24 September 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).