Northampton General Hospital NHS
NHS Trust

Public Trust Board

Thursday 24 September 2015

09:30

Board Room
Northampton General Hospital

Northampton General Hospital NHS
NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 24 September 2015
09:30 in the Board Room at Northampton General Hospital

Time	Agenda Item	Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**			
	1. Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2. Declarations of Interest	Note	Mr P Farenden	**Verbal**
	3. Minutes of meeting 30 July 2015	Decision	Mr P Farenden	**A.**
	4. Matters Arising and Action Log	Note	Mr P Farenden	**B.**
	5. Patient Story	Receive	Mrs J Brennan	**Verbal**
	6. Chairman's Report	Receive	Mr P Farenden	**Verbal**
	7. Chief Executive's Report	Receive	Dr S Swart	**C.**
10:00	**CLINICAL QUALITY AND SAFETY**			
	8. Medical Director's Report	Assurance	Dr M Cusack	**D.**
	9. Director of Nursing and Midwifery Report	Assurance	Ms C Fox	**E.**
10:20	**OPERATIONAL ASSURANCE**			
	10. Finance Report	Assurance	Mr S Lazarus	**F.**
	11. Workforce Performance Report	Assurance	Mrs J Brennan	**G.**
10:40	**GOVERNANCE**			
	12. Infection Prevention Annual Report	Assurance	Ms C Fox	**H.**
	13. Corporate Governance Quarterly Report	Assurance	Ms C Thorne	**I.**
	14. TDA Self-Certifications	Decision	Ms C Thorne	**J.**
11:05	**STRATEGY**			
	15. Partnership Update • Clinical Collaboration • Healthier Northants • Oncology Alliance	Assurance	Mr C Pallot	**K.**
11:25	**FOR INFORMATION**			
	16. Integrated Performance Report	Assurance	Mrs D Needham	**L.**

Time	Agenda Item		Action	Presented by	Enclosure
11:35	**COMMITTEE REPORTS**				
	17.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler	**M.**
	18.	Highlight Report from Quality Governance Committee	Assurance	Mrs L Searle	**N.**
	19.	Highlight Report from Workforce Committee	Assurance	Mr G Kershaw	**O.**
	20.	Highlight Report from Audit Committee	Assurance	Mr D Noble	**Verbal**
	21.	Highlight Report from Hospital Management Team	Assurance	Dr S Swart	**P.**
12:00	**22.**	**ANY OTHER BUSINESS**		Mr P Farenden	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Trust Board will be held at 09:30 on Thursday 26 November 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

Enclosure A

Minutes of the Public Trust Board

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

Present

	Mr P Farenden	Chairman (Chair)
	Dr M Cusack	Medical Director
	Ms C Fox	Director of Nursing, Midwifery & Patient Services
	Mr G Kershaw	Non-Executive Director
	Mr S Lazarus	Director of Finance
	Mrs D Needham	Chief Operating Officer and Deputy CEO
	Mr D Noble	Non-Executive Director
	Mrs L Searle	Non-Executive Director
	Dr S Swart	Chief Executive Officer
In Attendance		
	Mr C Abolins	Director of Facilities and Capital Development
	Mrs J Brennan	Director of Workforce and Transformation
	Mrs S McKenzie	Executive Board Secretary
	Mr C Pallot	Director of Strategy and Partnerships
	Ms C Thorne	Director of Corporate Development Governance & Assurance
	Mrs S Watts	Head of Communications
Apologies		
	Mrs L Searle	Non-Executive Director
	Mr P Zeidler	Non-Executive Director (Vice Chair)
Not Present		
	Mr N Robertson	Non-Executive Director

TB 15/16 026 Introductions and Apologies

Mr Farenden welcomed those present to the meeting of the Public Trust Board and extended a warm welcome to Ms Fox to her first Public Trust Board meeting.

Apologies for absence were recorded from Mrs Searle and Mr Zeidler.

TB 15/16 027 Declarations of Interest

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

TB 15/16 028 Minutes of the meeting 28 May 2015

The minutes of the Public Trust Board meeting held on 28 May 2015 were presented for approval.

The Board resolved to **APPROVE** the minutes of the 28 May 2015 as a true and accurate record of proceedings.

TB 15/16 029 Matters Arising and Action Log 28 May 2015

The Matters Arising and Action Log from the 28 May 2015 were considered.

The Board **NOTED** the Action Log and Matters Arising from the 28 May 2015.

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

Action: Mrs McKenzie

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TB 15/16 030 **Patient Story**

Dr Swart's patient story was told in the context of stories from patients and staff around the hospital and was a contrast to the one from 6 months ago which was entitled 'stories from trolleys'.

The theme of this series of stories was 'stories from a 7 day hospital – it is the little things that matter'

She started with the story of an elderly lady in her late 80s who had arrived in A&E on Saturday by ambulance. This was a story of a patient who felt let down by services in the community, was isolated socially and was not able to navigate the systems of care in a way that met her needs. The A&E staff were able to connect with her through attending to some simple basic requests and build trust. Her pain was controlled, a few simple tests were done and through the intervention of Age UK workers she was able to go home eventually. During the course of her stay in A&E she was happy to share her story with a number of staff and share her thoughts on her situation in recent months. She commented on how kind the staff were and how they helped her to access suitable food and listened to her. This lady had actually called the ambulance on four occasions over a period of days with pains in her legs. She lived by herself but had some daily assistance at home by a carer. She told Dr Swart that she did not have a particularly good relationship with her GP practice or with the Community Services and described her view of her needs which were to have more personal contact and a route into residential accommodation and more social connections. Ideally for the longer term her wish was to be admitted to a residential home where her husband was residing, however she had been informed that she had not met the criteria.

Dr Swart informed the Board that the patient was lonely and wanted help. Overall she was looking for a more long term plan and had clearly lost faith in the broader system. The A&E staff had done their best with this lady and she had some basic investigations but was not thought to need any specific hospital based treatment. With regard to help in getting this patient home safely, it was fortunate that the AGE UK worker was in A&E and was able to put some arrangements in place to allow the patient to be discharged home safely ensuring that follow ups and an assessment were put in place to make sure all was well.

Dr Swart commented that without this type of intervention there would have been a danger that this lady would have needed admission which could possibly have been prolonged. She informed the Board that staff in A&E gave an overwhelming impression of pride in a job well done and in a commitment to making things better. The Age UK partnership was very successful and this illustrated how involving the voluntary sector could be of benefit. She commented that it was a pleasure to hear a series of stories from the members of staff involved which all commented on the little things that had helped patients in the urgent care setting. The improvements in A&E were clear on that Saturday as was a commitment for the whole hospital to support urgent care which the staff commented on. The short visit that morning from a Consultant in Orthopaedics to ask if he could help was cited as a symbol of support which made a big difference.

The overall message from this story was that more work was needed to be done to help patients understand how they could access services and provide the support needed to stop them believing that an ambulance to A&E was the only way of getting attention.

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Dr Swart related a second story of another patient who also came through A&E that Saturday morning. The staff highlighted a possible problem in terms of pathways. The 70 year old patient was having treatment at the hospital for cancer but lived in the catchment area of one of the referring hospitals. The issue raised by A&E staff was around ensuring that the patients got straight to the specialist ward. He was admitted under the Acute Medical team but the next day was under the Cancer team and had emergency treatment.

Dr Swart went to visit the patient to enquire about his overall treatment at the hospital and the patient commented that he had 3 issues which were all around communication. Overall the patient and his family were very appreciative of the care given but it was evident that they were confused by the lack of effective co-ordinated care. The communication issues related to sharing information across organisations, ensuring that all staff gave consistent advice and ensuring that transport issues between hospitals could be resolved more easily. From a patient's perspective it was highlighted again a lack of system co-ordination. These were relatively small things compared to his overall treatment and compared to the kindness shown but they had a negative impact particularly on his family.

Finally Dr Swart reported to the Board that she had visited various wards and departments at the weekend and the overall feeling from staff was a genuine pride in their work and positivity. A number of staff commented on small things that had made a positive difference to them, this was usually around information shared or feedback given. She went to say that the overwhelming message from both patients and staff was that 'the Trust could never do too much work on communication'.

Overall this series of stories were starkly different from the stories from trolleys on a weekend 6 months ago; the common thread in both was a sense of both patients and staff understanding the challenges for the hospital.

The Board **NOTED** the Patient Story.

TB 15/16 031 **Chairman's Report**

Mr Farenden presented the Chairman's Report.

Mr Farenden informed the Board that he had attended the National Provider Chief Executive Officer and Chair conference in London with Dr Swart. He commented that there were numerous Trusts facing similar issues to Northampton General Hospital (NGH). He commented that he had participated in a number of interviews for Consultants and that it was encouraging that people wanted to work in Northampton which resulted in the Trust being able to make some high quality appointments.

He attended the Healthier Work place Task and Finish Group, a sub-group of the Health and Wellbeing Board, which was designed to improve the health of staff. A good meeting had been had with the former Shadow Governors with regard to the transition into becoming Volunteers. He reported that members were very enthusiastic.

Mr Farenden commented that Dr Swart gave an excellent presentation at the recent Annual General Meeting and it was a good opportunity to say thank you to staff who received long service awards. He commented however that there had been poor representation from the Non-Executive Directors.

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He reported that with his involvement with 'Beat the Bug' he had visited 2 wards namely, Creaton ward which he noted was much improved, however he found conditions on Collingtree ward very unsatisfactory.

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

TB 15/16 032 **Chief Executive's Report**

Dr Swart presented the Chief Executive's Report.

Dr Swart reported that the "hello my name is" campaign would be launched in August which had been started by Dr Kate Granger after she became frustrated with the number of staff who failed to introduce themselves to her when she was an inpatient. Last year we asked patients whether or not they had seen a Doctor in the previous 24 hours and 65% did not know. It was clear that many staff were not introducing themselves or if they did, had not explain their role. Dr Swart commented that for her this was all a key part of professionalism in healthcare and needed to involve all staff, both clinical and non-clinical. As part of the work the Trust had been doing to improve communication with patients, all Doctors in training would be identifiable by their white coats, which would have the Doctor's designation which was the same colour as their lanyard; this supported "colour coded doctors" and illustrated the training grade and experience of the Doctor at glance. Dr Swart commented that her photograph taken earlier in the morning with the Foundation Doctors.

Dr Swart informed the Board that there had been a raft of national announcements and directives which were setting the scene for a different approach to solving the current issues in the NHS. She had attended a number of national and regional meetings where the key elements of the current situation had been clarified and discussed. The main focus at every level had been dealing with the need to stabilise the finances of the NHS which were deteriorating rapidly whilst understanding that transformation of services would be required.

The Board noted that as part of implementing the new clinically led management structure the Trust had embarked on a programme of leadership development, the 'Francis Crick Programme'. Dr Swart commented that overall this was progressing well and the programme had been continually refined to ensure that it was aligned with current issues and understood what further development might be required.

She informed the Board that the Global Corporate Challenge had been a popular initiative and formed part of the work that had been aimed at supporting improved health and wellbeing for staff. Dr Swart and Mr Abolins visited the new facilities in the Cripps Centre which had been welcomed by staff and were proving popular.

Dr Swart reported on Estates development and commented that the new Boots Pharmacy which opened on 22 June was working well. This was a facility which had been welcomed by both patients and staff. The enthusiastic project team from NGH had worked effectively with representatives from Boots and their contractors to enable this project to be successfully delivered to agreed timescales.

The new blood taking unit had been opened by Dr Swart, which finally gave a purpose-built area for phlebotomy. She reported that the neonatal unit on Gosset Ward would be closed for eight weeks to allow essential maintenance work to be carried out and the ventilation system to be replaced. It was noted that the infrastructure work commenced to enable to installation of the new decked car parking facility following which construction would begin. The new car park would provide additional capacity which would be welcomed by patients and staff. Mr Abolins advised that the work was slightly behind by a week however it would be fully functional by the middle of October.

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Dr Swart reported that she attended the Annual General Meeting (AGM) of the Friends of NGH in June. The Friends of NGH supported all the volunteers, ran the buggy service which was much appreciated by patients and visitors, and also raised money for the Trust generally. She commented that a series of initiatives to enhance the volunteer workforce and develop a comprehensive volunteering strategy was being planned and this work would be brought back to a Board of Directors meeting in the near future.

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

TB 15/16 033 **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. The principal risks to clinical care currently related to the ongoing pressure on the urgent care pathway and insufficient nursing and medical staff. These were reflected in the Corporate Risk Register and Board Assurance Framework. Mrs Needham advised that Risk 368 would be reviewed and reported back to the Finance Investment and Performance Committee.

He reported that since the last report to the Board during the reporting period 1 May to 30 June 2015 no new Serious Incidents had been reported and this reflected changes to Serious Incident reporting criteria. Problems identified with training and education were consistent themes among incidents which were submitted for closure.

The Dr Foster data showed overall mortality to have remained within the expected range. The Board noted that 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. It was also noted that the Trust was still at the lower end of the crude mortality within the East Midlands.

Dr Cusack reported that the Patient Safety Academy core team had been revised to support a clinically led structure. The 'Sign Up to Safety' programme would reduce avoidable harm through the delivery of improvement in four key areas by 50% in three years from March 2015 baseline. He reported that on 3 key areas under patient experience namely, Doctors white coats, Vital Pac Doctor and 'Hello my name is' campaign.

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

TB 15/16 034 **Director of Nursing and Midwifery Care Report**

Ms Fox presented the Director of Nursing and Midwifery Report.

Ms Fox 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 June. She informed the Board that the Nursing and Midwifery Care report had been discussed in detail at the July Quality Governance Committee. She confirmed that the Safety Thermometer achieved 94.43% this was above the reported national picture of 94.1%. The Tissue Viability Lead Nurse and Deputy Director of Nursing met with the Clinical Commissioning Group (CCG) Lead and had 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.

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The Board noted that 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 had been replaced throughout July. Following on from the thematic analysis, the Trust had put an order in for 60 Repose Companion mattress/trolley toppers, so that patients identified as at risk of pressure ulcer development would have prompt access to an appropriate pressure relieving surface to reduce risk as soon as they had walked through the doors.

Ms Fox reported that 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 had been included in the Improvement Plan and continued to be monitored weekly. Full analysis of the trends and actions put in place to address any issues identified on the Beat the Bug visits would be presented to and monitored through the IPC Committee from August.

Ms Fox informed the Board that national results for the first National Children and Young people's survey were published by Care Quality Commission (CQC) in June 2015. Overall the survey showed high levels of satisfaction for children, young people and parents that had visited the Trust across August 2014. From reviewing the results it was evident that areas where the Departments were performing well were around information sharing, staff explaining everything clearly and patients/parents feeling that they were able to ask questions.

The Board noted that the Prenatal Diagnosis Team had worked tirelessly with NGH laboratory to enable midwives to request antenatal screening bloods for infectious diseases and Sickle Cell and Thalassaemia via ICE. This achievement had been noted at national level as the Trust was the first hospital to achieve this and a request had been made from the National Programme Manager for Sickle Cell and Thalassaemia, Cathy Coppinger, for a visit to the Trust to see how this had been achieved.

Ms Fox reported that the overall fill rate for June 2015 was 90%, compared to 81% in May. From June 2015 wards provided assurance on the safe staffing for 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. Any shifts that were reported 'Red' would also be reported through the electronic Datix reporting system and would be captured in this report. As reported previously, the Board were reassured that staffing was reviewed by a senior nurse at the twice daily Safety Huddles, Monday to Friday, and daily at weekends. Any wards where staffing was at a minimum level or due to increased acuity and dependency and there was a need for additional staff above planned numbers, movement of staff was made and risk assessed.

The Board were informed that a Trust Cleaning Services appraisal report had been presented in June to the Executive Team. It was agreed that a centralised model which would ensure that there were consistently high standards of cleaning across the Trust and all of the staff who were involved in providing cleaning, food and hydration services would have the training, support and supervision that was needed to ensure that the Trust met the expectations of all the patients and staff. The detail around these proposals would be developed in the course of the next two months and the policy to support the revised protocols and practice would be completed by September.

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In answer to Mr Noble's question about accountability, Ms Fox confirmed that the ward sister was responsible was responsible for cleanliness of the ward. Mr Abolins also confirmed that the new model would retain accountability at ward level.

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

TB 15/16 035 **Update on Progress with Changing Care @ NGH Programme**

Mr Lazarus presented the Update on Progress with Changing Care @ NGH Programme.

Mr Lazarus reported that the aim of Changing Care @ NGH was to provide the basis for sustainable, long term improvements. He made reference to a copy of the latest programme blog which provided an insight into the range of current themes, their activities and the intent to improve the quality of service provision. Mrs Needham commented that staff had welcomed the blog and Mr Kershaw noted that the blog was a very good read and that it would encourage staff to support the programme. Mr Farenden noted that it was all about engagement, involvement and support. Dr Swart commented that it was key to pull out of the programme real benefits and that communication of these to staff was important.

The Board noted that it was clearly the intention to continue to develop the programme and maintain the progress with further implementation and benefits realisation. This would involve more staff in project delivery, assisted by continuing communications activity.

The Board **NOTED** the Update on Progress with Changing Care @ NGH Programme.

TB 15/16 036 **Finance Report**

Mr Lazarus presented the Finance Report.

Mr Lazarus informed the Board that the Finance Report had been discussed in detail at the July Finance Investment and Performance Committee meeting and that the Trust had incurred a deficit of £6m in the first quarter, £23k favourable to plan.

He reported that the Trust Development Authority (TDA) had requested that the Trust considered 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 were emerging which had not been provided for in the financial plan requiring mitigating actions to ensure financial targets could be met.

The Board **NOTED** the Finance Report.

TB 15/16 037 **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 July Workforce Committee meeting and that the report identified the key themes emerging from June 2015 performance and trends against the Trust's targets. She commented that the key performance indicators showed 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 to 70.28%. Mr Noble commented that the appraisal rate had been static at around 70% for a long period of time and asked what processes could be put in place to improve the compliance rate.

Enclosure A

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Mrs Brennan responded that the process had been recently changed and the focus now was on getting this embedded. Mrs Needham commented that compliance was managed through the Divisional performance meetings.

Mrs Brennan informed the Board that the NGH Ward Buddy project was in the final stages of planning and would be launched shortly. 22 ward buddies from the non-clinical areas had confirmed their commitment to be available during times of significant internal incident. Mr Kershaw commented that this was a very good idea. For the Staff Friends and Family Quarter 1 feedback had been received from the non-clinical support areas with a comparison to same group in the same quarter last year. There had been a 35% increase in the number of staff responding. The initial results were showing a positive shift in staff both recommending NGH as a place for treatment and as a place to work.

The Board noted that the Workforce Race Equality Standard (WRES) had been presented and approved by the Workforce Committee and Equality and Diversity Group (Staff) and had now been uploaded onto the Trust's internet. During the coming year work would commence to address any data shortcomings from the baseline data identified by the WRES indicators and regular reports would be presented to the Board.

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

TB 15/16 038 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 July Finance Investment and Performance Committee, Quality Governance Committee and Workforce Committee meetings.

Mrs Needham reported that a full gap analysis against NICE guidance had been requested for Caesarean Section and would be presented to the Executive Team at the next performance meeting. She confirmed that the Trust had made significant internal improvements to help performance against the 95% target, improving efficiencies and ways of working. This had been shown with achievement of the target in June and July. However, Delayed Transfers of Care (DTOCs) were still a main concern. She commented that the Trust was committed to working with the Health and Social Care Economy to not only reduce DTOCs but also avoid admissions.

Mrs Needham informed the Board that the Intermediate Care Team was enhanced with additional capacity over winter. This continued into Q1 with funding from the CCG. She confirmed that the immediate risk for Q2 had now been mitigated as the CCG had agreed to fund the enhanced service until the end of September 2015. The potential impact was equated to approximately 25 beds.

The Board were informed that the 62 day target would not be met for June and July. Mrs Needham commented that late referrals from other hospitals had made it often impossible for the Trust to treat patients within the timescales.

On behalf of the Board, Mr Farenden asked for congratulations and thanks to be passed on to staff for the significant improvement in performance against the 4 hour target.

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

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TB 15/16 039 **Fire Safety Board Compliance Statement**

Mr Abolins presented the Fire Safety Board Compliance Statement.

Mr Abolins provided the Board with an overview of Fire Safety statistics during the past 12 months and provided assurance regarding progress, investment and measures taken during the year to improve Fire Safety resilience within the Trust. The Board noted 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.

Mr Abolins reported that 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 were four main areas identified in these risk assessments that impacted on the ability of the Trust to provide a safe environment for patients, visitors and staff. These were buildings/structural, fire alarm, vertical evacuation and staff training. Findings from these assessments had been used to prioritise fire safety works within the rolling annual capital programme. These works, once completed, would reduce or eliminate the risk but ongoing investment was required to maintain risks at an acceptable level which in turn also demonstrated to the enforcing body that the Trust was satisfactorily managing its fire risk.

Mr Abolins informed the Board that the Fire and Rescue Service followed up their 2013 inspection with another visit during 2014 to review the agreed action plan. The Fire and Rescue Service confirmed in writing to the Trust, that all the actions had been addressed and that the Trust's fire management arrangements were satisfactory.

He reported that from the records of attendance during 2014/15, 4387 members of staff received training which equated to 91% (based on 4800 staff), an increase of 379 (9.5%) over the previous year's attendance. Fire drills had continued during 2014/15 and although there had been an increase in the number of areas where a drill had taken place there was still a shortfall against the 100% target. 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. He confirmed that a review of the Non Smoking policy would heighten awareness.

On behalf of the Board, Mr Farenden thanked Mr Abolins for the comprehensive report. The Board confirmed their assurance for the Chief Executive to sign the Annual Statement of Fire Safety Compliance.

The Board **NOTED** the Fire Safety Board Compliance Statement.

TB 15/16 040 **Declaration of Compliance against Mixed Sex Accommodation**

Ms Fox presented the Declaration of Compliance against Mixed Sex Accommodation.

Ms Fox reported on the Declaration of Compliance against the requirements to eliminate mixed sex accommodation for the fiscal year of 2014/15. She commented that every patient had the right to receive high quality care that was safe, effective and respected their privacy and dignity. NGH was committed to providing every patient with same sex accommodation, because it helped to safeguard their privacy and dignity when they were often at their most vulnerable.

The Board **NOTED** the Declaration of Compliance against Mixed Sex Accommodation.

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TB 15/16 041 **Freedom to Speak Up Report**

Mrs Brennan presented the Freedom to Speak Up Report.

Mrs Brennan informed the Committee that subsequent to submission of the Freedom to Speak Up report the Department of Health had issued its report "learning not blaming". She gave an overview of the key conclusions from that report which the Workforce Committee had considered along with a gap analysis and recommended the approach to be taken by the Board as follows:

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.

It was noted that the Board confirmed that they were assured by the overall proposed approach, agreed with the points discussed at the Workforce Committee and supported the principles.

Dr Swart commented that more detail on the Guardians would be brought back for oversight at the next Public Trust Board meeting. **Action: Dr Swart**

The Board **NOTED** the Freedom to Speak Up Report.

TB 15/16 042 **TDA Self-Certification Report**

Ms Thorne presented the TDA Self-Certification Report.

Ms Thorne 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 June 2015 were discussed and approved.

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

TB 15/16 043 **Update on Healthier Northamptonshire and Vanguard Models**

Mr Pallot presented the Update on Healthier Northamptonshire and Vanguard Models.

Mr Pallot reported that there were three main programmes covered by the Programme and these were presented to the Integrated Steering Group (ISG) of Healthier Northamptonshire (HN) in July. The programme had now started to make real progress with the project team now been fully established.

He reported that the Clinical Collaboration Operational Steering Group had been established and monthly meetings were scheduled through to April 2016.

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Key lead representatives had 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 were not yet confirmed. Most importantly, facilitators and support facilitators were now in place for each speciality and governance structures and documentation now compiled to support speciality work streams.

The speciality work stream project groups had been confirmed and all groups would have had initial joint meetings completed and established by the end of July. This would enable the detailed project and benefits realisation plans to be delivered and would build on the initial milestone planners that had been completed for the 4 original work streams of Orthopaedics, Rheumatology, Radiology, and Ophthalmology; and for an additional Cardiology speciality work stream.

With regard to Collaborative Resource Management (CRM) the ISG update on CRM provided in May highlighted the level of Cost Improvement Plan (CIP) delivered by the 3 Trusts in 2014/15 and their projected CIPs for 2015/16.

Mr Pallot informed the Board that the presentation to Regulators in June noted high level milestones for Integrated Care Closer to Home (ICCtH) invested schemes for which progress must be made on delivery. The ICCtH Delivery Group met weekly to ensure both that momentum was maintained against key aspects of the programme. While this was at a relatively early stage, the group was seeking to make sure that there was a clear and common understanding of the schemes being pursued, that there was a proper reporting process against agreed metrics and that partners were clear on the resourcing required to drive forward their areas.

Mr Pallot reported that the Urgent Care Vanguard application had not been shortlisted for the programme; however the Acute Vanguard application process was currently underway.

The Board **NOTED** the Update on Healthier Northamptonshire and Vanguard Models.

TB 15/16 044 Report from the Finance Investment and Performance Committee

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

The Board were provided with an update on activities undertaken during the month of June and discussed at the Finance Investment and Performance meeting held on 17 June 2015. The 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 Farenden gave a verbal update from the meeting which took place on 22 July 2015 and informed the Board that several items had already been discussed at the meeting today but he reported that the Committee received a quarterly Procurement report; however the Pharmacy Stock report would be brought back to a future meeting.

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

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TB 15/16 045 **Report the Quality Governance Committee**

Mr Noble presented the Report from the Quality Governance Committee (QGC).

The Board were provided with an update on activities undertaken during the month of June and discussed at the QGC meeting held on 19 June 2015.
The 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 Noble gave a verbal update from QGC which took place on 24 July 2015 and informed the Board that several items had already been discussed at the meeting today.

He reported that the Committee had noted and agreed to close off the CQC action plan. Where issues remained outstanding these would continue to be monitored through the Medical and Nursing reports.

The Committee received a report from the Head and Neck Directorate; however the Committee remained unassured although the report gave a helpful update. The Patient Moves report had been presented and the Committee noted that this was a good report highlighting improvement on patient moves and risk assessment. It was acknowledged that this had come a long way since first identified as an issue.

Mr Noble reported that the Pandemic Flu response Plan and the Heatwave Plan which had been presented to the Assurance Risk and Compliance Group were noted and recommended for approval to the Trust Board.

The Board **NOTED** the Report from the Quality Governance Committee and **APPROVED** the Pandemic Flu response Plan and the Heatwave Plan.

TB 15/16 046 **Report from the Workforce Committee**

Mr Kershaw presented the Report from the Workforce Committee.

The Board were provided with an update on the activities undertaken during the month of June and discussed at the Workforce Committee meeting held on 17 June 2015. The 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 Kershaw gave a verbal update from the Workforce Committee which took place on 22 July 2015 and informed the Board that several items had already been discussed at the meeting today. He reported that the Committee had received the Medical Education Annual report and for assurance the Committee would require in future quarterly reports, more detailed information on financial issues and more data on quality. The Committee were informed that 10 overseas nurses joined the Trust during June against a forecast of 7. The Committee received a comprehensive presentation on the standardisation of shift update.

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

TB 15/16 047 **Report from the Hospital Management Team**

Dr Swart presented the Report from the Hospital Management Team (HMT).

Dr Swart reported that HMT met monthly and included all Executive Directors and Divisional Directors. The 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 were invited to take part in a facilitated workshop.

DRAFT

She informed the Board that the meeting on 7 July 2015 was the first meeting where a workshop was held. Brief updates from the Divisions were presented. Members of each Division worked together during the workshop and shared their thoughts on "what was working well" with the new structure and "how it could be better if". The workshop was well attended with good engagement.

There was some positive feedback on how the structure was 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 had been sent to all members of the Divisional Management teams and an update would be provided to HMT in September.

The Board **NOTED** the Report from the Hospital Management Team.

TB 15/16 048 Any Other Business

There were no items of any other business.

Date of next meeting: Thursday 24 September 2015 at 09:30 in the Board Room at Northampton General Hospital.

Mr Farenden called the meeting to a close at 12:00

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.

DRAFT

Enclosure B

Public Trust Board Action Log

Ref	Date of meeting	Minute Number	Paper	Action Required	Responsible	Due date	Status	Updates
							Last update	14/09/2015
Actions - Slippage								
NONE								
Actions - Current meeting								
50	Jul-15	TB 15/16 041	Freedom to Speak Up Report	Dr Swart commented that more detail on the Guardians would be brought back for oversight at the next Public Trust Board meeting.	Dr Swart	Sep-15	On Track	Planned Volunteers Day on 5 October. Verbal update at September Board
Actions - Future meetings								
NONE								

Northampton General Hospital NHS
NHS Trust

Report To	PUBLIC TRUST BOARD
Date of Meeting	24 September 2015

Title of the Report	Chief Executive's Report
Agenda item	7
Presenter of Report	Dr Sonia Swart, Chief Executive
Author(s) of Report	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

<table>
<tr><td>Legal implications / regulatory requirements</td><td>Are there any legal/regulatory implications of the paper (N)</td></tr>
<tr><td colspan="2">Actions required by the Trust Board

The Trust Board is asked to note the contents of the report</td></tr>
</table>

Public Trust Board
24 September 2015

Chief Executive's Report

1. A&E

The number of people coming into hospital is increasing and we are now seeing a daily average of 315 patients in our emergency department. Alongside the increase, we're caring for higher numbers of patients with increasingly complex medical and nursing needs.

This presents enormous challenges for a hospital in one of the UK's biggest growth areas. Despite these pressures, I was pleased to be able to report that, at the end of August 2015, on average 95.74% of the 28,745 patients who attended our A&E department over the previous 3 months had been seen, treated and admitted or discharged within 4 hours. This has been achieved through investment in our infrastructure along with a huge amount of hard work and support from teams throughout the hospital and our colleagues in health and social care.

Board members will be aware of our year-long expansion project for the emergency department to increase capacity in key areas and alleviate pressure on bed space, and our new discharge suite where patients can wait comfortably for their discharge paperwork, prescriptions and transport.

Our joint efforts with Northamptonshire County Council, Northamptonshire Healthcare NHS Foundation Trust and our primary care partners have seen improvements in the speed of the discharge process for patients with complex needs who require additional support.

This is an important achievement for us, our partners and our patient and demonstrates that we can achieve improvement and change despite the increasing pressures we face.

2. Responding to Regulation

Much of my time recently, and that of my executive colleagues, has been spent preparing written responses to regulators and commissioners. A key focus of our work has been to ensure that our responses are reflective of our aims, values and ambitions for the future. We have also been careful to be sure to restate our story of what we want to be as a hospital, and also to listen to as many people (staff and patients) as possible about what matters to them.

Board members will be aware of the work that is already underway to ensure our current plans are aligned around quality, clinical leadership, development of staff and helping all our staff understand what this means for them. At the same time, we have a responsibility to help improve the overall financial position, but we are clear that our efforts must not be undermined with short-term cuts which will risk safety today and sustainability tomorrow.

We want to work with our commissioners in a way that improves care for patients and reduces overall cost. To achieve this will require clarity on how all the available money is being used. We are working with our commissioners in a way that facilitates this and, at the same time, also invests appropriately in services here.

We have provided the Trust Development Authority (TDA) with evidence of the actions taken and indicated that we will work with them and our commissioners to improve the overall situation for the health and social care economy.

Significant progress has been made in quite a number of areas, but further consistent time and effort will be needed, as well as a degree of central support. Our clinically-led structure is key to us ensuring existing cost-savings schemes are on track, as well as helping identify new ones as we move away from thinking about money to thinking about 'value for patient' and 'value for the taxpayer.'

To help us take forward the work we need to do, as well as obtaining an understanding of one another's views, I have had had conversations with a number of people outside the hospital, including the Chief Executive and Chairman of Healthwatch, the Vice Chancellor of the University of Northampton and other senior members of the University, the Chairman and Vice Chairs of the Health and Wellbeing Board, the Director of Public Health, Clinical Commissioning Group (CCG) Accountable Officer and team, Health Education England and more recently, our local MPs.

Within the hospital there have been a number of conversations with managers, clinicians and clinical managers, as well as patients, which have helped inform my thinking. We have also had interesting and useful planning meetings to cover key important issues such as our volunteer strategy, staff recognition awards, aligning our quality and safety issues and our approaches to areas of concern.

I remain impressed with the energy and commitment of many of our teams.

3. Nursing agency spend

New rules for all NHS trust in relation to registered nursing agency spend will take effect from 1 October. The rules will include published lists of approved framework agencies and a cap on the agency nursing expenditure as a percentage of a trust's total nursing staff spend.

In last financial year 7.6% of our total nursing agency spend was on registered nurses. We are now required to reduce agency registered nurse use to 6% of overall nursing spend by the end of Q4, with a further 1% reduction every financial year thereafter until a ceiling of 3% spend is achieved. Performance will be monitored monthly and trusts will be held to account for moving towards the ceiling on a quarterly basis.

Our reliance on agency staff increased significantly in response to the increase in nursing establishment in April 2015 and the subsequent increase in vacant registered nursing posts. Due to the attraction to higher pay rates and flexibility that nursing staff potentially gain when working for an agency, there has been a notable increase in agency use and a decrease in staff working through the Bank. Currently our temporary nursing Registered Nurses are 50% Bank and 50% Agency.

We are now implementing a number of actions to ensure we reduce our nurse agency spend in line with our cap. Four key areas we will be focusing on are: reducing the usage of temporary staff for patients with enhanced care needs; increasing our own Northampton General Hospital (NGH) nurse bank; rostering efficiencies and effectiveness and agency controls.

Divisions will be held to account and progress monitored in regular performance meetings and progress will be reported to the Board.

4. 7 day working

With the expectation that the NHS moves to 7 day working, my executive team have decided to trial working at weekends so that, from September through to November there will be a member of the Executive team on site during the day on both Saturdays and Sundays when on call.

The Executives will not be undertaking site management or manager on call duties, but will provide a visible presence on the wards, talking to staff and patients and generally offering support. The trial will be reviewed and then possibly extended. I will continue my current practice of popping in as well – again this is very much to support the staff who are here, and to listen to the views of patients and staff and get my own personal 'sense' of how things are.

5. Junior doctors

It was a pleasure to be able to welcome all our new doctors in training who started work last month. There is a complex and carefully organised logistical process that takes place behind the scenes to ensure everyone has what they need to start work and is given all the right information. This was again a good team effort from Human Resources, the Postgraduate Centre, the Education teams, Occupational Health, IT, Speciality departments, Resuscitation team, Safety team, Simulation team and many others.

Their efforts led to a number of positive tweets from our junior doctors, as well as numerous positive comments on social media about the white coats, VitalPac and Hello My Name is campaign which we formally launched to coincide with the new intake. For me this is professionalism, innovation, technology and humanity all emphasised at once.

I believe it is important we ensure from the outset that all our doctors in training understand they are a critical part of our workforce. They are here to learn and to deliver care, and both will be better if they are supported and valued and that they know we do value them.

I am sure everyone will try to do their best to welcome our new doctors into **Team NGH** – they will need some help at the start but usually by the end of the year we are sad to see some really excellent people go.

6. Best Possible Care Awards

Earlier this month, for the first time, our Best Possible Care Awards were held off site at The Park Inn by Radisson, Northampton. This wonderful evening would not have been possible without the support of our own hospital charity and the generosity of our external sponsors, whom I was pleased to thank personally on the evening.

More than 150 members of staff attended the award ceremony. Unfortunately we only had 9 award categories on offer, but each of the shortlisted nominees, along with all those who were nominated but not shortlisted, are a testament to the dedication, commitment and contribution that NGH staff give our patients and their colleagues throughout the year.

Northampton General Hospital NHS Trust

Enclosure D

Report To	PUBLIC TRUST BOARD
Date of Meeting	24 September 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.

Two new Serious Incidents have been reported during the reporting period 1/07/2015 – 31/08/2015 which remain open and under investigation. Problems were identified with documentation and clinical assessment in the two incidents which were submitted for closure during this period.

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 medical student 'Aspiring to Excellence' programme ran in August and the 'Delivering Excellence' programme for registrars is scheduled to commence in September. The findings and recommendations from the improvement work undertaken in these programmes will be presenting as part of the Trust's Quality Improvement Day in November 2015.

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 1.4, BAF 1.5, BAF 4.1 and BAF 4.2

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? (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

Actions required by the Trust Board

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

Northampton General Hospital NHS
NHS Trust

Enclosure D

Public Trust Board
24 September 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 Northampton General Hospital (NGH) to the Trust Board.

The principal risks to clinical care relate to the following areas and are reflected on the Corporate Risk Register. The risks and actions taken in mitigation are reviewed in the Corporate Committees described here.

1.1 Difficulties in Securing Sufficient Nursing & Medical Staff

CRR ID	Description	Rating (Initial)	Rating (Current)	Corporate Committee
100	Insufficient nurses and HCAs on a number of wards & insufficient skill mix.	16	25	Workforce
694	Insufficient nursing staff on both the neonatal unit and the paediatric wards.	12	25	Workforce
979	Difficulty in recruitment and high turnover in nursing staff groups.	16	25	Workforce
81	Inability to maintain effective service levels due to reduced skilled nursing workforce for the existing bed base.	9	16	Workforce
111	Risks to quality and outcomes due to inability to recruit sufficient medical staff.	16	16	Workforce

1.2 Pressure On Urgent Care Pathway

CRR ID	Description	Rating (Initial)	Rating (Current)	Corporate Committee
368	Risk to outcomes when demand exceeds capacity within the ED and the Trust.	15	20	Finance and Performance
96	Inconsistent in-patient capacity due to delays in the discharge process resulting in an increased length of stay.	12	16	Finance and Performance
421	Risk to quality due to utilisation of Gynae day care as an escalation area.	16	16	Quality Governance
619	Risk to quality due to utilisation of Heart Centre as an escalation area.	25	16	Quality Governance
731	Risk to quality of haemodialysis service for in-patient and outlier/emergency patients when Northamptonshire Kidney Centre used an escalation area.	20	16	Finance and Performance

The potential impacts of these issues are also described in items BAF 1.4, BAF 1.5, BAF 4.1 and BAF 4.2 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 on the Strategic Executive Information System (StEIS) by year since 2010:

	10/11	11/12	12/13	13/14	14/15	15/16
Serious Incidents	27	55	78	115	93	3
Never Events	2	2	1	0	1	0

The Never Event in 2014/15 related to:

- Wrong site surgery – removal of a tonsillar cyst

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

All recommendations from the investigations have been implemented and are being monitored

2.1 New Serious Incidents

Since the last report to the Board (during the reporting period 1/07/2015 – 31/08/2015) 2 new Serious Incidents have been reported:

A Root Cause Analysis (RCA) is being undertaken into each of these incidents. The Trust has a contractual agreement with the CCG to submit all RCA reports to them within a 60 working day timeframe; provide evidence to support the Duty of Candour requirement; and provide evidence to support the completion of RCA action plans via the Serious Incident Assurance Meetings (SIAM).

A total of 3 Serious Incidents have been reported year to date under the following categories:

- Slips/Trips/Falls
- Unexpected Deterioration
- Death following pulmonary embolism

2.2 Open Serious Incidents

The serious incidents at 31 August 2015 which remain open and under investigation are listed below:

Date of Incident	SI Brief Detail	Directorate	Status
05 Jul 2015	Unexpected deterioration	Inpatient Specialities	Active
29 Jul 2015	Pulmonary Embolism	Outpatient & Elderly & Stroke Medicine	Active

2.3 Serious Incidents Submitted for Closure

During the reporting period 2 serious incident reports were submitted to Nene and Corby Clinical Commissioning Groups (CCG) for closure.

The principal themes identified from the investigations were:

Slips/Trips/Falls	
Theme	**Learning/Actions**
Documentation	Staff did not complete the falls documentation The patient was assessed as high risk of falls (due to age, no other factors) however a falls care plan was not commenced There were no variances for timings of clinical observations recorded within the notes Admission documentation does not contain care plans
Training / Education	Discuss with University the training provided to student nurses on carrying out neurological observations Use of Falls Risk Assessment and care plan to be added to Health and Safety Slide at staff induction
Clinical Assessment	Neurological observations not carried out post-fall There was no falls assessment on transfer between EAU and Head and Neck Ward
Maternity Services	
Theme	**Learning/Actions**
Clinical Assessment	The maternity services should ensure that all midwives and obstetricians know the referral criteria for growth scans which are based on fundal height measurement findings The decision to induce a woman before T+7 must be made by a Consultant Obstetrician; this includes decisions to perform membrane sweeping prior to 40 weeks in a primiparous woman or 41 weeks in a multiparous woman. On admission in labour, a full risk assessment that considers the whole clinical picture must be carried out in order to decide the plan of care for labour and the appropriate care pathway. The maternity services should consider whether to implement a ‘fresh eyes’ approach to the assessment of women on the low risk labour pathway.
Communication	It is incumbent on both the person asking for an opinion and the person giving an opinion to obtain a full picture of the clinical situation, assumptions of normality should not be made. The use of the SBAR tool should therefore be used to ensure communication is optimised.
Policy / Procedure	All guidance and advice in the MEOWS Guideline must be firmly embedded into clinical practice, not just the actions taken in response to a MEOWS score.

3. Inquests

H M Coroner convened 5 Inquests during the reporting period which involved Trust staff either preparing statements or giving evidence at the hearing. The conclusions of the Inquests were 4 Accidental Deaths and 1 Narrative Verdict.

There have been no Schedule 5, Rule 7 letters (previously known as Rule 43 letters) issued by H M Coroner to the Trust.

4. Mortality

The 2014-15 Dr Foster data has now been re-benchmarked and is unlikely to change further. HSMR for the rolling year to May 2015 is 102 and HSMR100 is 103 (both in the 'as expected' range).

The SHMI for the rolling year to end 2014 is confirmed as 101.3 (as expected).

There is no evidence of higher mortality in patients admitted at weekends. The weekday SMR for the year to date is 104, and weekend is 102.

4.1 Service Reviews

Biliary Tract Disease. A review of the pathway has been undertaken at the Mortality & Coding Review Group and a detailed action plan developed. The Surgical Division will be reporting on progress to CQEG in October.

Obstetrics - Non-Instrumental Delivery. The rate of trauma following a non-instrumental delivery remains increased. A report and an action plan on this will be presented to the Mortality & Coding Review Group in October.

5. Patient Safety Academy

The fifth Aspiring to Excellence course was delivered during August 2015. The third Registrar development programme (Delivering Excellence) is planned to commence 24th September 2015.

5.1 Aspiring to Excellence

Fifteen Medical students completed the course this year's. The main focus this year was on the Management of Diabetes. As in previous years there was an emphasis on the following areas:

- Changing clinical culture and behaviour
- Integrating safety into all elements of the patient pathway and everyday behaviours
- Adoption of best practice and evidenced based pathways
- Sustaining improvement and maintaining well defined standards

5.2 Delivering Excellence

The 2015 Registrar Management Course is due to commence on 24th September. This is a 9 week modular course bespoke to NGH with presentations being delivered from members of the Executive Team and Consultant medical staff.

The aim is to provide Registrars with an understanding of the wider issues facing the Trust and in the wider NHS as well as introducing them to the management and leadership challenges they will encounter in their roles as Consultants.

In previous years an important component of the course has been to build on work being developed with our foundation Doctors and final year medical students (as part of our Junior Doctor Safety Board and 'Aspiring to Excellence' programmes).
As such each of the registrars we will be asking to lead on safety based improvement projects for the Trust that will have a positive impact on patient care.

The findings and recommendations of the improvement work undertaken in both of these programmes will be presenting as part of the Trust's Quality Improvement Day which is planned for 27th November 2015.

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

Report To	PUBLIC TRUST BOARD
Date of Meeting	24 September 2015

Title of the Report	Director of Nursing & Midwifery Report
Agenda item	9
Presenter of Report	Carolyn Fox, Director of Nursing, Midwifery & Patient Services
Author(s) of Report	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 & 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 & Honest Care Report.

Key points from this report:

- August was the first month for the new QCI dataset completion, the new questions and reviews incorporate qualitative and quantitative analysis which is triangulated with further workforce and external data to produce the N&M master dashboard
- Safety Thermometer – the Trust achieved 92.73% 'harm free care' in August with a rise in new harms for the first time in 3 months
- In August the number of reported pressure ulcers has risen to 32 the TVN lead is currently identifying any causative factors
- There have been 3 C. Difficile cases reported in August and 1 MRSA bacteraemia.
- In August there have been 2 in-patient falls that have caused at least 'moderate' harm.
- The Friends & Family Test (FFT) 'Would' Recommend %:
  - In-patients – 87.5%
  - Outpatients – 91.6%
  - Maternity – 96%
  - A&E – 84.7%
  - Paediatrics – 91.3%
  - Day Surgery – 92.6%
  - The report summaries the 'Making FFT inclusive' work that the trust is implementing

Enclosure E

- The dementia CQUIN FAIR is updated and for August has achieved 92.2% compliance
- The Maternity report provides an update on the Safety Thermometer for Maternity.
- Safe Nurse Staffing data - Overall fill rate has decreased in August with an average fill rate of 90% throughout the month, a 4% decrease from the previous month.
- Bank and agency usage decreased in August 2015. A total of 137.7 WTE RN shifts were filled with an overall shift fill rate of 83.5%. A total of 160.6 WTE bank and agency HCA shifts were filled, with an overall shift fill rate of 89%.

Related strategic aim and corporate objective	Quality & Safety. We will avoid harm, reduce mortality, and improve patient outcomes through a focus on quality outcomes, effectiveness and safety
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 1.3 and 1.5
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 & Honest Care Report on to the Trust's website which will include safety, staffing and improvement data.

Northampton General Hospital NHS
NHS Trust

Public Trust Board
24 September 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 & 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 (N&M) Quality Dashboard

The N&M Quality Care Dashboard presents the findings from the monthly N&M Quality Care Indicators (QCI) and triangulates with Trust data on workforce, quality and safety reports.

The work with the IT team on the development of the reporting infrastructure was completed in August for the general adult wards and the same building blocks will be used for the specialist areas. The directorate Matrons have used the new indicator questions and been able to upload onto Infoview via their iPads or through the clinical systems portal.
The interface between Infoview and the triangulated master dashboard is the project for September to ensure it is displayed in a meaningful easy access way so that the Directorates and Wards can use the information to concentrate on areas that need a heightened focus.

Themes from the QCI data:

- Initial results from the new QCI dataset have shown some positive results particularly in the areas of Nutritional assessment and the quality entry of the nursing documentation.
- New sections regarding patients in the last few days of life and our patients with cognitive impairments will provide valuable data for those teams and aid in the development of improving care for those patients.
- Falls assessment – continues to be one of the areas across the wards which have a lower compliance than the other assessment and planning components. Focused work is being developed by the falls lead with these results and the RDA audit results which are embargoed until October.
- The pain management section has changed in format and questions are asked of the patients about their pain management whether it is effective and if they believe it is taken seriously. This has highlighted that further work is needed within the medical division where perhaps the focus has not traditionally been regarding assessment and evaluation.
- The Patient Experience sections in the QCI have several new questions in order to gain further understanding from our patients about their care. Some in depth work is needed to develop any themes however a first brief analysis is showing several negative responses regarding the patient's knowledge about their treatment plans, involvement with those care decisions and in particular knowing their planned discharge date.

3. Safety Thermometer

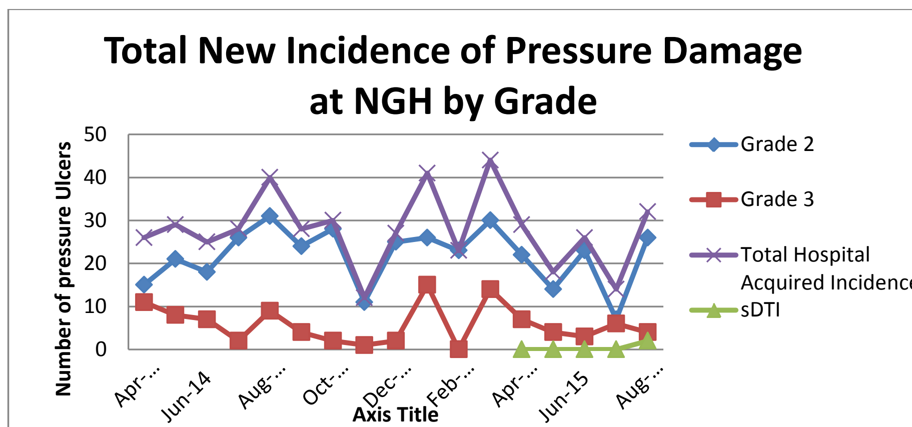
In August 92.73% patients experienced 'harm free care' this is a slight decrease to July's results. An analysis of the data shows this is due to 2 catheter related urinary tract infections, 10 new pressure ulcers and 5 falls with harm, which has not been seen for over 12 months. The Trusts falls lead is reviewing with the areas through the falls group to identify any trends. venous thrombo embolism incidents continued to have zero reported.

Enclosure E

4. Pressure Ulcer Incidence

August saw 29 patients develop a total of 32 pressure ulcers; 26 grade 2, 4 Grade 3/unclassified Grade 3 and 2 patients with suspected deep tissue injury who were discharged over the weekend before validation of grade. This figure is subject to change following review at the Confirm & Challenge meeting, which is scheduled to take place on 21t and 24 September.

Following the Confirm & Challenge meetings on 21 and 24 August, the confirmed numbers of hospital acquired pressures ulcers for July was 13, a reduction of 1 from initial reporting (N&M report August 2015). Of the 7 grade 2 pressure ulcers, 5 have been confirmed as avoidable and the Tissue Viability team is awaiting further information on the remaining 2 before outcome validated. 4 of the 6 Grade 3 ulcers have been validated as avoidable, one unavoidable and the remaining investigation is ongoing.



On review of 2014 data there was a similar rise in pressure ulcer incidents in August as we have seen this year, in order to understand this analysis is underway by the Tissue Viability Lead Nurse regarding staffing levels, particular in the last 2 weeks of August as this was when the peak in reporting happened, the acuity/dependency of the patients and whether there is a particular area that was more affected.

Foam mattresses

Arjo Huntleigh carried out a foam mattress audit as planned across all inpatient areas on 11 & 12 August. Over 100 mattresses were replaced over the 2 days. This was in addition the 200 replaced since end of July.

The Tissue Viability Lead Nurse is liaising with Medical Devices Manager to ensure the Trust has robust plan (financial and auditing) in place with regards to replacement of foam mattresses over the next couple of years.

5. 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.

The table below shows the number of reportable infections acquired in the Trust during the 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**	**1**
Number of infections last month	**3**	**0**
Improvement target for year to-date	**21**	**0**
Actual to-date	**13**	**0**

All Trust apportioned *Clostridium difficile* cases have a Root Cause Analysis (RCA) are reviewed by the Clinical Commissioning Group (CCG) and a decision is made whether these is a lapse of care. To date 6 RCAs have been sent to the CCG to review and a decision has been made on 2 cases where there have been no lapses in care. The trust is awaiting the review of the other 4 cases.

MRSA bacteraemia
In August 2015 there was 1 patient who acquired a MRSA bacteraemia. An initial internal Post Infection Review (PIR) has taken place. Future meetings have been scheduled with the CCG and the findings and actions from this will be presented in next month's report.

Period of Increased Incidence
Holcot ward had a period of increased incidence for the month of August with 2 post 72 hours' cases of *Clostridium difficile* infection within a 28 day period. The ward staff received intensive training on hand hygiene and *Clostridium difficile* infection, this also included attending the ward huddles and the ward meeting. Extra domestic staff was allocated from the cleaning services and the ward underwent an intensive clean which included changing all curtains. The Trust antimicrobial pharmacist undertook an antimicrobial audit and the infection prevention team have maintained enhanced support for Holcot ward.

The Trust Development Authority visit on 3 September 2015
Dr Adams re visited the Trust and provided a matrons master- class which consisted of visiting 4 ward areas with 3 different matrons for each ward area, a member of the infection prevention and control team was also present. Dr Adams took this opportunity to meet with the Estates and Facilities team in the afternoon. Dr Adams verbalised that it was a pleasure to visit the trust and that she was assured that infection prevention control is a key focus for all staff and that there was continued clear ownership from Board to Ward. The matron's masterclass confirmed that the matrons were aware of their roles and responsibilities. Dr Adams was invited by the Carolyn Fox (Director of Nursing and Midwifery and Director of Infection Prevention Control) to revisit the Trust in Spring 2016, where she will attend the infection prevention strategic group.

6. Falls Prevention

Maximum of 5.5 falls/1000 bed days (internally set target)
Falls/1000 bed days this month 4.4 (last month 5.07)

Maximum of 1.6 harmful falls/1000 bed days (internally set target).
Harmful falls/1000 bed days this month 1.32

This month we reported 2 in-patients falls that caused at least 'moderate' harm. Both of these cases within the medical directorate are being reviewed at present with the possibility of being investigated under the Serious Incident process.

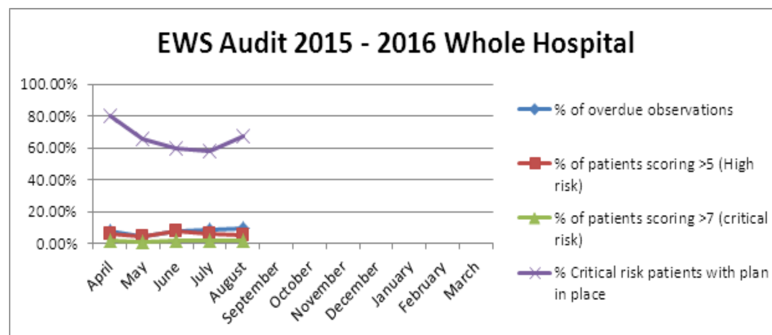
Severity	Number of falls
Moderate	2
Severe	0
Death	0

Work in progress 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 SI's
- On-going training including neurological observation simulation training sessions
- The results for the Royal College Physicians National audit which took place in May 2015 will be released next month, analysis of the themes and areas for improvement is being reviewed by the falls group

7. Early Warning Scores (EWS) Compliance

August saw an improvement in the number of patients deemed at risk due to an elevated EWS with a plan in place, 67% compared to 58% last month. Each ward has a breakdown of the patient and is highlighted as red on the report the ward is requested to produce an action plan for improvements through the Resus team. The technical difficulties regarding the compliance with the frequency of observations has now been resolved by Vitalpac, overall Trust compliance needs improvement as the latest results are 9.76% against an upper limit target of 7%. The wards are again receiving their individual data and are reviewing how to improve going forward.



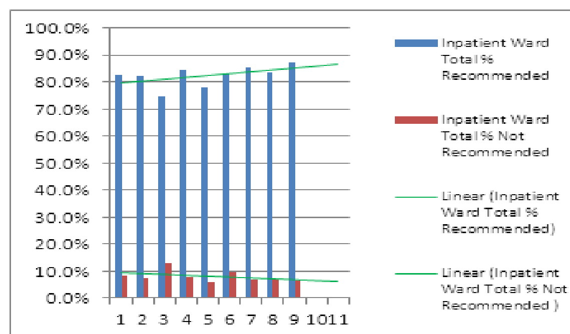
8. Patient Experience

Friends & Family Test (FFT)

Of most significance for July FFT Patient Satisfaction:

Inpatients Wards

- Of those surveyed in July for Inpatients, 87.5% stated they would recommend and 6.7% stated they wouldn't. This is the highest satisfaction levels since collections began through the new methods in November 2014. The forecast trend lines are also showing positive predictions of continued improvement.



- Following a number of months of receiving poor feedback Creaton Ward continue to improve with their % of patients that 'Would' recommend seeing a month on month improvement and reaching above 80% in June (81%) for the first time since February. This will continue to be monitored.
- Concern was raised over Dryden's depreciating levels of satisfaction. From reviewing July's data it is evident that there has been an improvement in satisfaction from patients on the ward. Percentage of patients that would recommend reached 94.3%

Areas of Concern

- They key area of concern for July is Cedar Ward who has seen unstable satisfaction across the past 9 months. Their % of patients that 'Would' recommend has again fallen in July to 70.4% In addition to this the % of patients that wouldn't recommend has increased to 14.8%.
- The Sister and the Matron for the ward have reviewed the feedback from patients and have shared this with the staff on the ward.

Paediatric

- Paediatric wards continue to see high levels of patient satisfaction with 91.3% of patients stating they 'Would' recommend the service, and 4.8% stating they wouldn't. Again, this is higher than seen in previous months and exceeds the inpatient target of 85%.

Maternity

- Maternity continue to see high levels of satisfaction raising no concern with 96% of patients stating they 'Would' recommend the services. This is from a total of 349 responses across the service.

Emergency Departments

- Scores continue to remain around the same level for Emergency Departments with no significant changes through the course of the 9 months. For July the % of patients that 'Would' recommend was 84.7% and the % of patients that wouldn't recommend was 8.4%. This exceeds their target.

Outpatients

- Outpatient departments accumulated received a recommendation percentage of 91.6% and wouldn't recommend percentage of 3.4% in July.

Day Case

- Day Case areas continue to see high levels of satisfaction with 92.6% of patients recommending them in July.

FFT Themes from comments

Inpatients (including Paediatrics until September)

Inpatient positive and negative words are both 'staff'; however it is evident from looking at the number of comments received that the positive far outweigh the negative.

From reviewing the automated themes, again the top theme is staff attitude; this is followed by Environment. When looking at the comments it is evident that this often refers to patients not feeling that there is enough staff on the wards.

Emergency Department
The top negative word for July is ‘Waiting’, with other words following this including ‘Seen’, ‘Wait’ and ‘Time’. This replaces 2 words relating to staff from June. Comments regarding waiting are for both A&E and Eye Casualty;

Outpatients
There were very few negative comments made regarding Outpatient services in July. For the first month in a significant amount of time words relating to ‘Waiting’ have not dominated the dashboard.

Making the FFT Inclusive – Update
In July new Guidance was received from NHS England around making the FFT more inclusive for all of our patients. This specifically focusses on a number of areas;

- Alternative Languages
- Dementia/Confused patients
- Hearing Impaired patients
- Visually Impaired patients
- Patients with a Learning Disability
- Children and Young people (not just parents)

We are required under the new guidance to ensure that we are providing good means for all of our patients to give their feedback and this has meant we have had to implement some additional means of collecting data.

They can be summarised as follows:

Generic Postcards – Generic postcards have been created for the wards which can be used to collect from our patients where an SMS/IVM would not be appropriate. This is particularly suitable for our elderly patients, or for the carers/families of patients that have dementia. Post-boxes have now been placed on 7 wards in the hospital which have a high number of elderly patients and we are currently costing how much this would be to do this everywhere.

Friends and Family Test
Northampton General Hospital NHS
NHS Trust

We value your feedback and continuously look at ways to improve our services.
We would like you to reflect on your recent experience of our service (please tick).
Are you:
The patient | The patient's representative
How likely are you to recommend our ward to your friends and family if they needed similar care or treatment?
Extremely Likely | Likely | Neither likely nor unlikely
Unlikely | Extremely unlikely | Don't know
To which ward does your response refer to?
Date of discharge: ..../......../..........
We would like to be able to include actual comments from our patients in our promotional material. If you do not want your comments used in this way please tick the box.
Please turn over...

Alternative Languages - Work has been undertaken with our FFT Providers to create an online survey which will offer patients the chance to complete the survey in a number of different languages. Three different posters in the top 3 most common first languages in Northampton will be placed across the entire hospital giving patients the option to access it and complete the survey in their preferred language. Comments will then be translated back and marked accordingly so we can ensure we are providing good care for our patients where English is not their first language.

Learning Disability Survey – Our Learning Disability Lead Nurse and Support Worker have devised a method of collecting feedback from our patients that have a Learning Disability. This is currently being given out by them alone when they see patients on the wards. The intention is to expand this further to provide opportunities for the wards/services to support patients to complete the survey or to provide carers/family members with the survey to complete. In the meantime, the Generic Postcard can be given to families and carers who wish to give their feedback on behalf of patients, or used to support patients to answer the question where appropriate.

Children & Young People – Our survey providers have developed a suite of online surveys which are split into different age ranges, starting at age 4. From the 1st of August these have been being sent out following an initial text to Next of Kin, as a link that NoK can click on and give to their children to complete. The hospital had around 20 responses in August from children and we hope to see this increase over the coming months.

In your own words, please could you share the reason given for your answer?

What is your sex?
a) Male
b) Female

Sexual Orientation?
a) Hexterosexual
b) gay/lesbian
a) bisexual

What is your ethnic group?
a) White
b) Mixed/Multiple ethnic groups
c) Asian/Asian British
d) Black/African/Caribbean/Black British
e) Other Ethnic group

What age are you?

Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months? (including any issue/problems related to old age)
a) Yes, limited a lot
b) yes, limited a little
c) No
d) Prefer not to say

Thank you for taking the time to give us your valuable feedback.

NGV0000 08/15

The benefit of the SMS/IVM system is that it caters well for our visually & hearing impaired community as often patients that have an hearing impairment are requesting to be contacted via text for such things as appointment reminders, and our visually impaired patients are likely to have phone adaptations which mean they will be able to respond to an IVM. However to ensure we are an inclusive as possible talks are being had with DeafConnect and the Northamptonshire Association for the Blind (NAB).

Using the FFT date to look for inequalities

In addition to making the FFT inclusive the guidance also stated that NHS Organisations need to be better using the data collected through the FFT to look at feedback in line with patient demographics. This is particularly important for our patients with protective characteristics as we want to ensure we are providing the right care, treatment and support for everyone individually.

9. Safeguarding & Dementia

Dementia CQUIN

The dementia CQUIN FAIR report for this month shows an improvement against the previous two months. However, the payment is aligned to performance by quarter, so there is considerable risk of non-achievement for Q2. The current cumulative position for Q2 is 86.2% which will mean that nearly 97% compliance will be required in September to achieve the figures for quarterly payments.

A weekly position email is being generated and sent to all Divisional Managers and Clinical and Divisional Directors to support compliance, a fuller briefing on this is provided independently to the Quality Governance Committee at the request of the Chair.

Indicator	Target	Trend	Jun-15	Jul-15	Aug-15
Dementia: Case finding	90%	↑	89.6%	80.3%	92.2%
Dementia: Initial diagnostic assessment	90%	↑	100.0%	97.5%	100.0%
Dementia: Referral for specialist diagnosis/follow-up	90%	↔	100.0%	100.0%	100.0%

Safeguarding

The current training compliance picture *[Trustwide data]* for the end of July, against the June position, is shown below:

Enclosure E

	SGA 1	SGA 2	MCA & DOLS	SGC 1	SGC 2	SGC 3
JULY	81%	73%	73%	95%	63%	53%
AUGUST	80%	72%	73%	95%	63%	55%

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 training remains a challenge: as a consequence the Safeguarding Team have reviewed the training methodology and this is now clearly described in the training strategy, which is being received by the September Safeguarding Governance Group.

The strategy describes the requirements in relation to training and the methods used to deliver this. The second, larger piece of work being undertaken by the safeguarding team is to review the competence level required for the various roles within the organisation. This will allow us to refine and accurately reflect the required training needs of staff roles. It is hoped that this will make safeguarding training more accessible and responsive to staff needs, thus enhancing the training compliance.

10. Midwifery Update

FFT

Satisfaction levels remain consistently high throughout maternity services, including the community midwifery services; the postnatal wards achieved a 98% satisfaction level in July, and the community antenatal care achieved 100% satisfaction. Maternity continue to review all narrative feedback, share with the teams and make improvements where possible.

NHS Maternity Safety Thermometer

Maternity are piloting the NHS Maternity Safety Thermometer in September. This tool will provide us with information pertinent to maternity care that will inform quality services and enable us to identify improvements.

Root Cause Analysis Training

As one of the actions identified following the Kirkup Report gap analysis conducted on Maternity, RCA training for the Division has been arranged. All Consultants and Matrons from the WCO Division will be expected to attend the training on 25 September 2015.

NGH Award

Five members of the maternity department have been shortlisted for **CEO's Innovation in Practice Award** and **Non-Clinical Team Award**. This has been a real boost for all the staff in maternity as everyone has worked so hard over the last year and feels proud to be recognised in this way.

Infant Feeding

Preparations are on schedule for the Stage 3 Baby Friendly Initiative (BFI) assessment in October 2015.

11. Safe Nurse Staffing

It is an ongoing requirement of NHS England that all NHS Trust Boards receive a monthly report relating to nurse staffing levels. This report provides an overview of the staffing levels in August 2015 and highlights the mitigation put in place to address any gaps in fill rate and addresses the rationale for the gaps that have been identified.

Overall fill rate for August 2015 was 90%, compared to 94% in July and 90% in June. Combined fill rate during the day was 84% in August compared with 87% in July and 86% in June and for the night 101% compared with 106% in July and 97% in June. RN fill rate during the day was 77% and for the night 89%.

12. August 2015 staffing

A summary of the ward analysis for staffing is included at the end of the report. It is planned that the presentation of this data will change over the next two months. In October there will be an update from the Divisions for each ward that is below 80% 'fill-rate' explaining the actions to maintain patient safety. In November the narrative from the Divisional teams will include any 'harm events' that have been recorded through the incident system (Datix) against wards below 80% 'fill-rate'.

13. Data Quality Review

An initial Data Quality Review of the monthly Safe Nurse Staffing data has been undertaken to ensure that recently updated establishments are accurately presented in the 'Hard Truths' data. As part of this review the following anomalies have been scoped.

- Unfilled duties have been assigned according to the off-duty
- 'Planned' and 'Actual' hours have been checked against clinical activity

A further, more extensive review by the Associate Director of Nursing/Midwifery, Informatics Lead and external support from Project Management Office (PMO) has been requested/commissioned. This detailed review will report back through this report in October.

14. Bank and Agency usage for month of August 2015

Bank and agency usage decreased in August 2015. A total of 160.6 WTE bank and agency HCA shifts were filled, with an overall shift fill rate of 89%. Of the HCA shifts that were requested 44% were to support the care of patients with enhanced care needs and 29.7% were to cover unfilled vacancies.

A total of 137.7 WTE RN shifts were filled with an overall shift fill rate of 83.5%. Of the RN shifts that were requested 74.6% were to cover unfilled vacancies and 57% of the RN temporary staffing workforce is filled by agency staff.

15. Safe staffing for nursing in adult inpatient wards in acute hospitals (NICE, July 2014)

In July 2014 the National Institute for Health and Care Excellence published guidance on safe staffing within the acute hospital. There were 39 recommendations for acute trusts to consider. A detailed gaps analysis is currently being undertaken and will be reported at the October Workforce Committee.

16. Nurse Agency Reduction

As part of the 'Changing Care @NGH' programme there is an extensive work-stream focusing on the reduction of nurse agency usage following the national engagement with all NHS Trusts with proposals for new rules for registered nursing agency spend. This work-stream is reported through the 'Changing Care @NGH' Strategy Board.

17. 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.

Northampton General Hospital NHS
NHS Trust

Report To	PUBLIC TRUST BOARD
Date of Meeting	24 September 2015

Title of the Report	Financial Position Month 5
Agenda item	10
Presenter of Report	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 August 2015/16.

Executive summary

- The I&E position for the period ended August (M5) is a deficit of £10.2m, £0.5m favourable to plan.
- A revised plan including the Board approved stretch target of £0.8m was submitted to the Trust Development authority (TDA) on 11/9 although recent feedback suggests this is unlikely to be accepted by the TDA.
- The Trust has been notified of a 6 % ceiling on Registered Nursing Agency expenditure for Q3 and Q4. The Trust is appealing this on the basis of the current high level of vacancies.
- A range of in year financial risks are evident which are not provided for in the financial plan and require mitigation to ensure financial targets can be met.
- The cumulative breakeven duty target for recovery now stands at £19.6m.
- The overall level of capital resources is likely to be reduced in FY15-16 due to a reduction in forecast deprecation charges and a national squeeze on Department of Health (DH) capital budgets. This will necessitate in year revisions to the capital programme.

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 3.1 (Sustainability); 5.1 (Financial Control); 5.2 (CIP delivery); 5.3 (Capital Programme).
Equality Impact Assessment	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 £2.4m “stretch target”.

Northampton General Hospital NHS Trust

Financial Position
Month 5 FY 2015/16

Report to
Trust Board
September 2015

Enclosure F

1. Overview

The I&E position for the period ended August (M5) is a deficit of £10.2m, £0.75m favourable to plan. SLA income has performed £0.5m above the plan for August but remains adverse for the YTD due to the requirement to make provision for anticipated contractual fines and penalties. Pay costs increased month on month, notably in relation to agency staff. The Trust has accessed £6.5m of the planned (£21m) Working Capital Facility in the period to August .

RAG		This Month	Last Month	Change
	Statutory Financial Duties	**Aug 15**	**Jul 15**	
Red	3 year Cumuative I&E Breakeven duty (£000's)	(19,601)	(16,020)	(3,581)
Green	Achieving EFL (£000's)	38,852	38,852	0
Green	Capital Cost Absorption Duty (%)	3.5%	3.5%	0
Green	Achieving the Capital Resource Limit (£000's)	28,618	28,618	0
Red	Continuity of Service Risk Rating (CoSR)	1.0	1.0	0.0
	I&E Position	**Aug 15**	**Jul 15**	
Red	Actual in Month Position (£000's)	(3,581)	(640)	(2,941)
Red	Forecast in Month Position (£000's)	(4,095)	(862)	(3,233)
Red	Actual Year to Date Position (£000's)	(10,257)	(6,676)	(3,581)
Red	Forecast Year to Date Position (£000's)	(11,017)	(6,922)	(4,094)
Red	Forecast End of Year I&E Position (£000's)	(20,417)	(21,120)	703
Red	EBITDA %	-3.5%	-1.8%	-1.7%

RAG		This Month	Last Month	Change
	Income	**Aug 15**	**Jul 15**	
Red	NENE CCG Variance to plan - YTD (£000's)	347	(299)	646
Red	MRET Penalty - Gross (£000's)	(1,525)	(1,117)	(407)
Red	Readmissions Penalty - Gross (£000's)	(1,151)	(954)	(198)
Red	Contract Fines & Data Challenges (£000's)	(211)	(173)	(39)
Red	Elective variance to plan (£000's)	(858)	(706)	(153)
Green	Daycase variance to plan (£000's)	581	301	280
Green	Non-Elective variance to plan (£000's)	688	725	(36)
Amber	Outpatients variance to plan (£000's)	404	(10)	414
	Operating Costs	**Aug 15**	**Jul 15**	
Amber	Pay Expenditure (£000's)	15,850	15,369	(480)
Red	Agency Staff Costs (£000's)	1,879	1,439	(440)
Red	Agency Staff Cost (%)	11.9%	9.4%	-2.5%
Red	RN Agency % (Ceiling 8%)	11.6%	9.6%	-1.9%
Amber	Non-Pay - Clinical (£000's)	4,146	5,086	940
Amber	Non-Pay - Other (£000's)	2,455	2,409	(46)
	Cost Improvement Schemes	**Aug 15**	**Jul 15**	
Green	Year to Date Actual (£000's)	3,696	2,571	1,125
Grey	Year to Date Plan (£0o0's)	3,624	2,786	838
Amber	Forecast Delivery (£000's)	12,323	10,666	1,657
Grey	Annual CIP Target (£'000s)	12,128	11,325	803

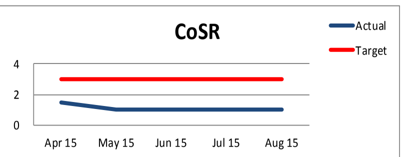
RAG		This month	Last Month	Change
	Capital	**Aug 15**	**Jul 15**	
Green	Year to date expenditure (£'000s)	5,818	4,305	1,513
Green	% of annual plan Committed	33%	27%	6.2%
Green	Annual Capital Expenditure Plan (£000's)	27,425	28,618	(1,193)
	Cash	**Aug 15**	**Jul 15**	
Green	In month movement (£000's)	(1,006)	(1,773)	767
Green	In Year movement (£000's)	1,190	2,196	(1,006)
Red	New PDC / Temporary borrowing (£000's)	6,500	5,159	1,341
Amber	Debtors Balance > 90 days (£000's)	955	868	(87)
Green	Creditors % > 90 days	0%	0%	0%
Green	Cumulative BPPC - by volume (%)	99.9%	99.4%	0.5%

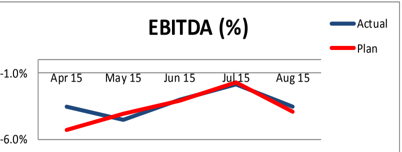
Key issues

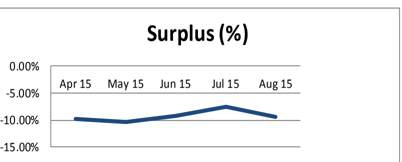
- Following the CEOs response on 21/8, the TDA have issued a further instruction to the Trust to submit a plan to deliver a "stretch target" to improve the I&E position by £2.4m by the financial year end.
- A revised plan including the Board approved stretch target of £0.8m was submitted to the TDA on 11/9.
- The Trust has been notified of a 6 % ceiling on Registered Nursing Agency expenditure for Q3 and Q4. The Trust is appealing this on the basis of the current high level of vacancies.
- A range of in year financial risks are evident which are not provided for in the financial plan and require mitigation to ensure financial targets can be met.
- Operating expenditure is tracking marginally above plan supported by a significant level of vacancies and application of 5/12th of the contingency reserve.
- The CCG have invoiced the Trust for 50% of the income settlement received in FY14-15 (£0.9m) this has been disputed by the Trust and is not included in the reported position.
- The cumulative breakeven duty target for recovery now stands at £19.6m.
- The overall level of capital resources is likely to be reduced in FY15-16 due to a reduction in forecast deprecation charges and a national squeeze on DH capital budgets. This will necessitate in year revisions to the capital programme.

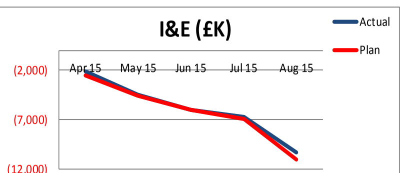
2. Financial Performance Dashboard

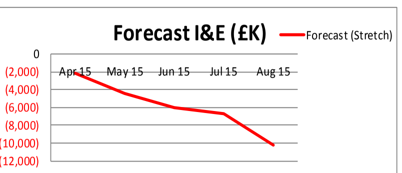
1. Key Metrics

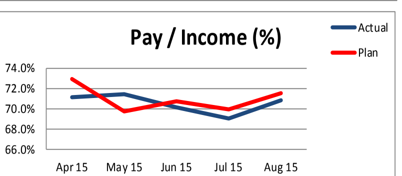




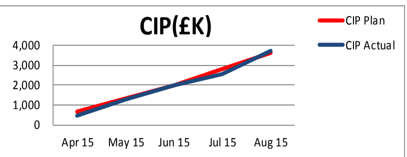


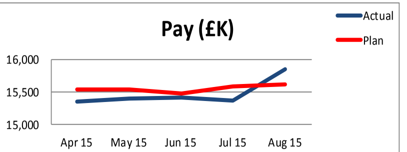


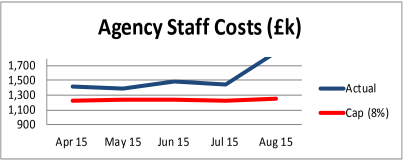


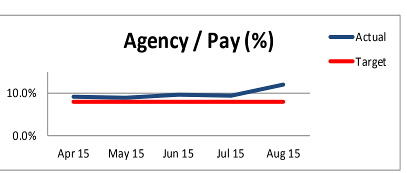


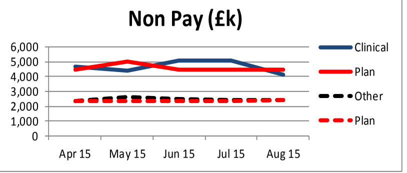
2. I&E Performance

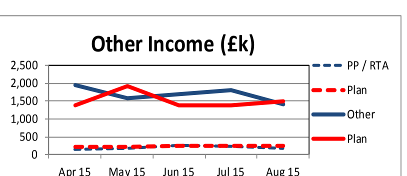




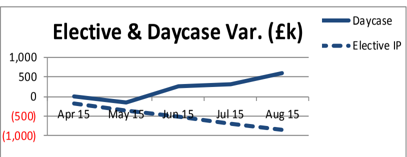


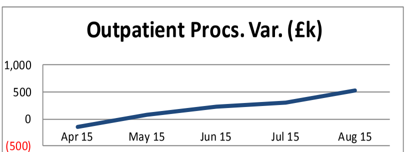


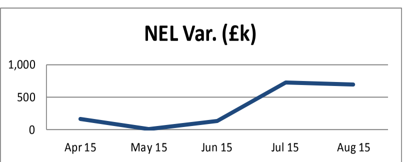


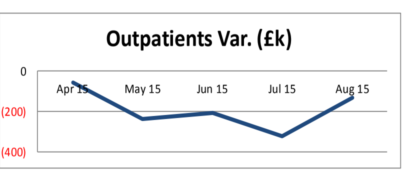


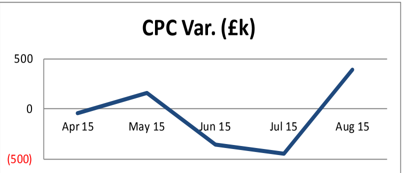
3. SLA Income

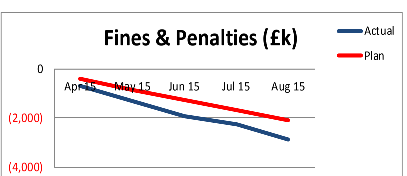




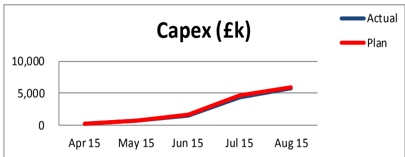


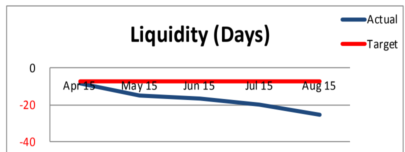


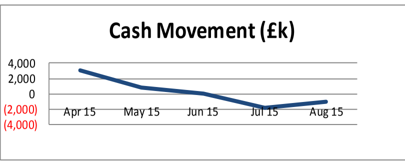


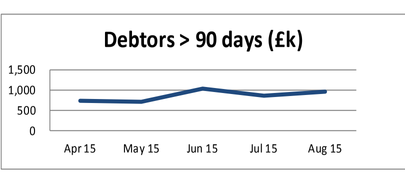


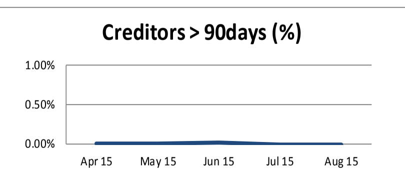
4. Working Capital

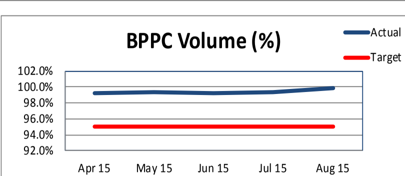












Enclosure F

3. Income and Expenditure Position

I&E Summary	Actual FY14-15	Annual Plan	YTD plan	YTD Actual	Variance to Plan	Aug 15	Jul 15
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	239,776	245,477	100,002	99,806	(196)	18,603	21,205
Other Clinical Income	2,422	2,904	1,210	986	(224)	170	232
Other Income	23,810	17,576	7,474	8,453	979	1,419	1,798
Total Income	266,007	265,957	108,686	109,245	558	20,192	23,236
Pay Costs	(180,225)	(185,700)	(77,736)	(77,372)	364	(15,850)	(15,369)
Non-Pay Costs	(86,832)	(82,689)	(34,687)	(35,736)	(1,049)	(6,591)	(7,495)
CIPs		0	0	0	(0)	0	0
Reserves/ Non-Rec		(1,862)	(506)	0	506	0	0
Total Costs	(267,057)	(270,251)	(112,929)	(113,108)	(179)	(22,440)	(22,865)
EBITDA	(1,050)	(4,294)	(4,243)	(3,863)	380	(2,249)	371
Depreciation	(11,407)	(12,247)	(5,103)	(4,618)	485	(941)	(616)
Amortisation	(11)	(16)	(7)	(7)	0	(1)	(1)
Impairments	(3,338)	0	0	0	0	0	0
Net Interest	27	(516)	(83)	(66)	17	(18)	(15)
Dividend	(4,332)	(4,316)	(1,798)	(1,798)	(0)	(360)	(360)
Surplus / (Deficit)	(20,111)	(21,388)	(11,234)	(10,352)	881	(3,569)	(620)
NHS Breakeven duty adjs:							
Donated Assets	248	268	217	95	(122)	(12)	(20)
NCA Impairments	3,338	0	0	0	0	0	0
I&E Position (breakeven duty)	(16,525)	(21,120)	(11,017)	(10,257)	759	(3,581)	(640)

I&E Performance

- Financial performance for the period ended July 2015/16 is a normalised deficit of £10.257m, £759k fav. to the planned deficit of £11.017m for the same period.
- Pay expenditure run rate increased month on month, notably in relation to agency staffing.
- Income is £558k fav. to plan overall (last month £183k fav).
- Pay expenditure is £364k fav. to plan (last month £602k fav).
- Non-Pay expenditure is £1.049m adv. to plan (last month £1.305m adv).
- 5 months of the planned contingency reserve have been allocated for the year to date (£0.5m fav).
- Forecast position is for delivery of the planned deficit of £21.2m plus the Board approved stretch target actions amounting to £0.8m (revised forecast of £20.4m deficit by the financial year end).
- The in year deprecation charge is £485k fav. to plan reducing the level of internally generated capital resource available to finance the capital plan.
- Interest charges will start to increase as the level of temporary borrowing drawn down increases.

Key issues

SLA Income

- Underling position is £0.2m adv. to plan offset by requirement to make provision for potential contractual fines and penalties.
- EL IP activity £858k (12%) below plan for year to date. (Last month £706k or 12%)
- Daycase activity £581k (6%) above plan for the year to date. (Last month £301k (4%) above plan).
- NEL activity 1% above plan for period to date giving rise to MRET penalty exposure. (Last month 1%). NEL excess bed days 4% above plan (Last month 16%).
- CCG have requested 50% of the FY14-15 income settlement to be repaid in FY15-16. This has been disputed by the Trust and is not included in the reported position (FYE £0.9m)
- CQUIN £0.75m adv. to plan pending Q1 performance review against new targets and contract variation for Urgent Care CQUIN.

Other Income

- Private Patient income £183k adverse to plan. (Last month £136k adv.).
- RTA income £41k adv. to plan. (Last month £17k adv.).
- Income / Other Generation £0.979m fav. to plan led by external drug sales and recharges to Charitable funds.

Pay

- Total agency staffing costs 11% (£7.6m) of the total pay bill for the period to August (see Appendix 1).
- RN Agency 11.6% of RN total RN pay in August (H2 ceiling 8% subject to appeal).
- Medical staff ADH costs £109k in August (Last month £123k).
- Nursing pay expenditure £617k (2%) fav. to plan overall.

Non-Pay

- Drugs £0.7m adv. to plan due to high level of Excluded medicines offset by additional income from Commissioners and unplanned external drug sales to NHFT.
- Prosthesis £179k fav. to plan.
- Energy £368k fav. to plan.
- Consultancy Fees £58k adv. to plan.

4. SLA Income

Point of Delivery	Activity Plan	Activity Actual	Activity Variance	Finance £000's Plan	Finance £000's Actual	Finance £000's Variance
AandE	48,190	47,825	(365)	5,188	5,226	38
Block / CPC	1,073,252	1,156,424	83,172	23,969	24,355	386
CQUIN	-	-		2,330	1,589	(741)
Day Cases	15,455	16,386	931	9,354	9,935	581
Elective	2,719	2,387	(332)	7,275	6,417	(858)
Elective XBDs	888	901	13	201	208	7
Excluded Devices	37	653	616	499	685	187
Excluded Medicines	-	-		7,207	7,441	234
Non-Elective	17,077	17,455	378	27,307	27,473	166
Non-Elective XBDs	12,403	14,740	2,337	2,658	3,180	522
Outpatient First	26,608	25,065	(1,543)	4,215	4,169	(46)
Outpatient Follow UP	82,461	81,407	(1,054)	7,606	7,519	(87)
Outpt Procedures	32,223	33,139	916	4,838	5,375	537
Other Central SLA Income	-	-		(868)	(878)	(11)
CIPs				301		(301)
Total SLA Income (before fine:	**1,311,313**	**1,396,382**	**85,069**	**102,079**	**102,693**	**614**
Fines & Penalties						
Contract Penalties	2WW			-	(3)	(3)
Contract Penalties	62 Day			-	(30)	(30)
Contract Penalties	A&E			-	(49)	(49)
Contract Penalties	Cancelled Operations			-	(13)	(13)
Contract Penalties	CDIFF			-	(50)	(50)
Contract Penalties	RTT - Incomplete			-	(66)	(66)
MRET	MRET			(1,056)	(1,525)	(469)
Readmissions	Readmissions			(1,022)	(1,151)	(129)
Sub-Total Fines & Penalties				**(2,078)**	**(2,887)**	**(809)**
Grand Total SLA Income				**100,002**	**99,806**	**(196)**

Commissioner	Finance £000's Annual Plan	YTD Plan	Actual	Variance
Nene CCG	192,677	78,563	80,025	1,463
Nene CCG - Not in Contract Value	3,073	1,280	165	(1,115)
Corby CCG	3,037	1,242	1,070	(172)
Bedfordshire CCG	443	181	276	95
East Leicestershire & Rutland CCG	527	218	287	69
Leicester City CCG	99	40	18	(22)
West Leicestershire CCG	62	26	28	2
Milton Keynes CCG	2,680	1,091	1,095	4
SCG	30,089	12,352	11,644	(709)
SCG - Not in Contract Value	150	63	-	(63)
Herts & South Midlands LAT	6,667	2,752	3,045	293
Cancer Drug Fund	2,810	1,171	1,304	134
NCA	2,961	1,214	1,684	470
Central (Contingency, Winter, Central provisions)	(1,112)	(491)	(835)	(344)
CIPs	1,286	301		(301)
				-
Total SLA Income	**245,450**	**100,002**	**99,806**	**(196)**

Nene CCG over performance due to the QIPP plan of £1.1m in August and overperformance on non-elective activity £585k. CV for Urgent Care CQUIN requested.

Specialised Commissioner's below plan by £709k; the drivers are: Critical Care (£249k), Radiotherapy (£126k), elective activity (£134k) and CQUIN (£79k).

Key issues

Summary £196k adverse to plan	Total SLA Income showing £196k adverse position to plan.
Blocks / CPC £386k ahead of plan	The lower levels of CCG activity profiled for August has assisted a recovery in the year to date under recovery of income for Critical Care and Radiotherapy. In addition to this the over recovery has increased for pathology, maternity and unbundled diagnostics.
CQUIN £741k adverse to plan	The CCG have not yet provided confirmation of the Quarter 1 achievement of CQUINs and as a result income accrued remains at 85%, with the exception of the urgent care CQUIN which is at 0%.
Elective Inpatients £858k adverse to plan	This remains a significant risk area for the Trust and is unlikely to recover over the winter period. This is largely due to pressures on emergency care. (Top 3 areas: Urology, T&O and ENT).
Outpatients £404k ahead of plan	Due to the low CCG plan for August outpatient procedures are significantly ahead of plan. (Top 3 areas: Ophthalmology, T&O and General Surgery).
Fines & Penalties £809k adverse to plan	£809k for fines & penalties above expected levels relating to: contractual penalties (£211k) which has slowed significantly as the A&E 4 hour target is being achieved, marginal rate penalty (£469k) and readmissions (£129k) due to sustained increases in demand for emergency care. A further general provision has been made for casemix due to the high number of un-coded episodes in this position (£250k).

5. Statement of Financial Position

	Balance at 31-Mar-15	Current Month			Forecast end of year	
	£000	Opening Balance £000	Closing Balance £000	Movement £000	Closing Balance £000	Movement £000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	143,465	143,465	143,465		143,465	
IN YEAR REVALUATIONS		(90)	(93)	(3)	224	224
IN YEAR MOVEMENTS		3,576	5,141	1,565	30,694	30,694
LESS DEPRECIATION		(3,677)	(4,618)	(941)	(12,247)	(12,247)
NET BOOK VALUE	143,465	143,274	143,895	621	162,136	18,671
CURRENT ASSETS						
INVENTORIES	5,961	5,264	5,911	647	6,000	39
RECEIVABLES						
NHS RECEIVABLES	5,036	6,972	6,135	(837)	5,097	61
OTHER TRADE RECEIVABLES	1,437	1,155	1,099	(56)	1,665	228
RECEIVABLES IMPAIRMENTS PROVISION	(455)	(313)	(313)		(400)	55
CAPITAL RECEIVABLES						
NON NHS OTHER RECEIVABLES	216	399	309	(90)	250	34
COMPENSATION RECEIVABLES (RTA)	2,677	2,649	2,638	(11)	2,750	73
SALARY OVERPAYMENTS	499	541	517	(24)	499	
SALARY SACRIFICE SCHEMES	427	484	462	(22)	577	150
OTHER RECEIVABLES	474	310	421	111	524	50
IRRECOVERABLE PROVISION	(851)	(851)	(851)		(800)	51
PREPAYMENTS	1,666	2,786	2,734	(52)	1,700	34
SUB TOTAL	11,126	14,132	13,151	(981)	11,862	736
NON CURRENT ASSETS FOR SALE		792	792			
CASH	1,114	3,310	2,304	(1,006)	1,500	386
CURRENT ASSETS	18,201	23,498	22,158	(1,340)	19,362	1,161
CURRENT LIABILITIES						
NHS PAYABLES	442	1,546	1,668	122	500	58
TRADE PAYABLES REVENUE	1,289	2,782	2,476	(306)	2,100	811
TRADE PAYABLES FIXED ASSETS	2,157	3,582	4,273	691	4,050	1,893
TAX AND NI OWED	3,301	3,321	3,233	(88)	3,500	199
NHS PENSIONS AGENCY	2,182	2,233	2,253	20	2,300	118
OTHER PAYABLES	407	351	328	(23)	400	(7)
SHORT TERM LOANS - DH	159	5,159	6,659	1,500	2,239	2,080
SHORT TERM LOANS - NON DH	208	208	208		215	7
ACCRUALS	6,441	8,113	7,943	(170)	5,500	(941)
RECEIPTS IN ADVANCE	1,777	1,860	1,969	109	1,500	(277)
PDC DIVIDEND DUE		1,328	1,708	380		
STAFF BENEFITS ACCRUAL	721	721	721		650	(71)
PROVISIONS	1,396	1,117	1,074	(43)	1,359	(37)
CURRENT LIABILITIES	20,480	32,321	34,513	2,192	24,313	3,833
NET CURRENT ASSETS / (LIABILITIES)	(2,279)	(8,823)	(12,355)	(3,532)	(4,951)	(2,672)
TOTAL ASSETS LESS CURRENT LIABILITIES	141,186	134,451	131,540	(2,911)	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	2,091	660	15,457	14,026
LOANS over 1 year NON DH	248	248	248		248	
PROVISIONS over 1 year	1,072	1,110	1,110		1,237	165
NON CURRENT LIABILITIES	2,751	2,789	3,449	660	18,573	15,822
TOTAL ASSETS EMPLOYED	138,435	131,662	128,091	(3,571)	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	35,889	35,887	(2)	36,044	165
I & E ACCOUNT BALANCE	(16,684)	(16,684)	(16,684)		(16,684)	
I & E CURRENT YEAR		(6,783)	(10,352)	(3,569)	(21,388)	(21,388)
FINANCING TOTAL	138,435	131,662	128,091	(3,571)	138,612	177

Key Movements

Non Current Assets
•£0.6m increase as additions in M5 exceed depreciation.
•EOY position includes the additions related to loans for replacement imaging equipment, NPfIT systems, car park decking (finance lease) and stock/inventory.

Current assets
•Increase in Inventories £0.6m.
•Decrease in NHS Receivables of £0.8m.
•Increase in Other Trade Receivables of £0.1m.
•Decrease in cash of £1.0m month on month.

Current Liabilities
•Increase in NHS Payables of £0.1m.
•Decrease in Trade Creditors of £0.3m.
•Increase in Trade Creditors Fixed Assets of £0.7m.
•Increase in Short Term Loans DH £1.5m.
•Increase in PDC dividend of £0.4m.
•Decrease in Accruals of £0.2m.
•Increase in Receipts in Advance of £0.1m.

Non Current Liabilities
•Increase of Capital Loan £0.7m.
•EOY position includes the finance lease payable in relation to the car park decking and other capital loans (subject ITFF approval).

Financing
•I&E deficit in month of £3.6m.

N.B. The EOY forecast is currently based on the plan submitted to the TDA in May which forecast a £21.4m deficit (normalised to £21.2m deficit).

6. Capital Expenditure

Capital Scheme	Plan 2015/16 £000's	M5 Plan £000's	M5 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	2,358	2,343	-15	41%	3,938	69%
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)	2,467	0	0	0	0%	0	0%
Stock / Inventory System (Subject to ITFF Bid)	600	0	0	0	0%	0	0%
A&E / Orthopaedics	620	380	380	0	61%	739	119%
Contingency	-726	0	0	0	0%	0	0%
Medical Equipment Sub Commiittee	2,397	963	947	-16	39%	1,028	43%
Estates Sub Committee	4,750	904	920	17	19%	1,759	37%
IT Sub Committee	2,241	695	640	-55	29%	1,065	48%
Other	536	227	233	6	43%	233	43%
Total - Capital Plan	**27,790**	**5,996**	**5,933**	**-63**	**21%**	**9,232**	**33%**
Less Charitable Fund Donations	-365	-115	-115	0	32%	-115	32%
Total - CRL	**27,425**	**5,881**	**5,818**	**-63**	**21%**	**9,117**	**33%**

Funding Resources	
Internally Generated Depreciation	11,204
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	2,467
Capital Loans - Stock / Inventory System	600
Capital Loan - Repayment	-1,480
Total - Available CRL Resource	**27,425**
Uncommitted Plan	**0**

Key Issues

- The Linear Accelerator building works planned to complete in September and go live planned in November.
- The replacement imaging equipment loan approved £5,617k and slippage of £66k has been reprovided from last year. A significant proportion of the equipment has now been ordered, £4,408k.
- The capital loans yet to be approved will require approval by the ITFF, The TDA have indicated that an application received by the end of September could be approved mid November.
- The A&E / Orthopaedics scheme continues in the new financial year, Ambulatory Care is due to complete in September and Emergency Observation is due to be completed in November.
- Full year depreciation forecast is currently £11,204k (was £12,427k).
- Charitable Donations assumptions includes £250k relating to the Chemotherapy appeal.
- Car park decking will be subject to a 10 year finance lease with planned completion in October.
- Capital Committee met on 4/9 to consider implications of reduced depreciation on scope of the current capital programme.

7. Receivables, Payables and BPPC Compliance

Narrative	Total at August £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	1,099	368	316	75	340
Receivables NHS	4,566	2,661	349	941	615
Total Receivables	**5,665**	**3,029**	**665**	**1,016**	**955**
Payables Non NHS	(6,750)	(6,680)	(70)		0
Payables NHS	(1,668)	(1,668)			
Total Payables	**(8,418)**	**(8,348)**	**(70)**		**0**

Narrative	Total at July £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	1,154	583	207	22	342
Receivables NHS	5,403	3,628	1,000	249	526
Total Receivables	**6,557**	**4,211**	**1,207**	**271**	**868**
Payables Non NHS	(6,364)	(6,323)	(41)		0
Payables NHS	(1,546)	(1,546)			
Total Payables	**(7,910)**	**(7,869)**	**(41)**		**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 £227k with a high proportion passed to debt agency to recover, Inhealth £37k, BMI 3 Shires £10k and Boots £14k.
- NHS over 90 day debt predominantly relates to NCA's £400k, NHFT £88k, NHS Bedfordshire CCG £96k and Central Midlands Region LAT £25k.
- 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	July 2015	August 2015	Cumulative 2015/16
NHS Creditors						
No.of Bills Paid Within Target	181	156	150	163	164	814
No.of Bills Paid Within Period	186	157	156	165	164	828
Percentage Paid Within Target	97.31%	99.36%	96.15%	98.79%	100.00%	98.31%
Value of Bills Paid Within Target (£000's)	1,486	1,385	1,831	1,554	1,529	7,785
Value of Bills Paid Within Period (£000's)	1,491	1,385	1,841	1,554	1,529	7,801
Percentage Paid Within Target	99.61%	100.00%	99.47%	99.99%	100.00%	99.80%
Non NHS Creditors						
No.of Bills Paid Within Target	7,114	6,212	6,581	8,920	8,458	37,285
No.of Bills Paid Within Period	7,168	6,240	6,629	8,959	8,470	37,466
Percentage Paid Within Target	99.25%	99.55%	99.28%	99.56%	99.86%	99.52%
Value of Bills Paid Within Target (£000's)	7,676	6,499	6,507	9,603	9,505	39,790
Value of Bills Paid Within Period (£000's)	7,718	6,530	6,529	9,644	9,512	39,932
Percentage Paid Within Target	99.46%	99.53%	99.67%	99.58%	99.92%	99.64%
Total						
No.of Bills Paid Within Target	7,295	6,368	6,731	9,083	8,622	38,099
No.of Bills Paid Within Period	7,354	6,397	6,785	9,124	8,634	38,294
Percentage Paid Within Target	99.20%	99.55%	99.20%	99.55%	99.86%	99.49%
Value of Bills Paid Within Target (£000's)	9,162	7,884	8,338	11,157	11,034	47,575
Value of Bills Paid Within Period (£000's)	9,209	7,915	8,370	11,197	11,041	47,733
Percentage Paid Within Target	99.48%	99.61%	99.62%	99.64%	99.93%	99.67%

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.

8. Cashflow

MONTHLY CASHFLOW	Annual	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
RECEIPTS													
SLA Base Payments	235,254	19,508	18,956	20,342	19,911	19,586	19,300	19,609	19,609	19,609	19,609	19,609	19,609
SLA Performance/ Other CCG I													
Health Education Payments (SIFT e	10,009	759	825	802	793	793	1,086	825	825	825	825	825	825
Other NHS Income	11,323	1,084	731	441	798	612	1,908	1,042	841	841	841	841	1,341
PP / Other (Specific >£250k)	973	396			578								
PP / Other	13,183	1,104	946	1,011	1,445	978	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	14,702					660		2,858	240	167	1,213	3,854	5,710
PDC - Revenue													
Temporary Borrowing	21,400	3,500	1,500			1,500	4,500	3,800	2,500	3,700	400		
Interest Receivable	30	6	2	3	2	2	3	2	3	2	2	2	2
Sale of Assets													
TOTAL RECEIPTS	**307,139**	**26,356**	**22,959**	**22,600**	**23,528**	**24,130**	**27,897**	**29,236**	**25,117**	**26,309**	**24,089**	**26,331**	**28,587**
PAYMENTS													
Salaries and wages	169,991	13,999	14,213	14,194	14,154	14,206	14,175	14,175	14,175	14,175	14,175	14,175	14,175
Trade Creditors	85,956	7,259	6,199	6,122	8,552	8,683	8,282	7,669	7,817	8,725	5,102	6,840	4,707
NHS Creditors	18,140	1,491	1,385	1,841	1,554	1,471	1,708	1,593	1,593	1,593	1,593	1,000	1,317
Capital Expenditure	27,758	490	313	431	1,053	808	1,666	6,340	1,532	1,816	3,219	4,316	5,774
PDC Dividend	4,146						1,988						2,158
Repayment of Loans (Principal & In	506						136						370
Repayment of Salix loan	208						111	12					85
TOTAL PAYMENTS	**306,704**	**23,238**	**22,111**	**22,588**	**25,312**	**25,167**	**28,066**	**29,789**	**25,117**	**26,309**	**24,089**	**26,331**	**28,586**
Actual month balance	435	3,118	849	12	-1,785	-1,037	-169	-553	0	0	0	0	1
Cash in transit & Cash in hand adju	-49	-20	11	-2	12	31	-82						
Balance brought forward	1,114	1,114	4,212	5,072	5,083	3,310	2,304	2,053	1,500	1,500	1,500	1,500	1,500
Balance carried forward	**1,500**	**4,212**	**5,072**	**5,083**	**3,310**	**2,304**	**2,053**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**

Key Issues

- The Trust has now utilised £6.5m (YTD plan was £9m) 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 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 August was £2.3m. This allows the Trust to continue to meet creditor requirements until receipt of monthly SLA income. Further borrowing of £4.5m has been approved by the DH to be drawn down in September to facilitate the half year payment of the PDC Dividend to HMT.
- £0.7m relating to the capital loan for the Replacement Imaging Equipment was drawn down in August and a further £2.9m is planned for September.
- The cashflow now incorporates repayment of loan principals and respective interest charges. Any 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 was forecast to be paid in October but will be delayed until the Trust confirm submission to the ITFF of a permanent solution or the Trust may decide to continue with the extended Revolving Working Capital Facility until the end of the financial year and apply for a permanent solution in April 2016.
- The DH have now extended the Revolving Working Capital Support Facility to £14.9m (was £7.5m).
- Cancer Drug Fund invoices relating to Months 1 – 4 are anticipated to be paid in September. This increases other NHS income in September to £1.9m.

N.B. The EOY forecast is currently based on the plan submitted to the TDA in May which forecast a £21.4m deficit (normalised to £21.2m deficit)

9. Risks & Opportunities

Ref	Opportunity	Potential Value (£k)	Actions to deliver Opportunity	Likelihood	Expected (£k)
1	0.5% Contingency	1,344	Phased equally into YTD position throughout the Financial Year	0%	0
2	Independent Review of MRET	2,300	Independent Review has resulted in reduced 08-09 baseline calculation to date presenting financial risk.	0%	0
3	Reduce / Reinvest Fines & Penalties incurred above plan (see risks 3-6 below)	1,941	Require operational Teams to deliver performance targets and respond to CCG queries. Senior input to SRG,.	2.6%	50
5	Reinvestment of Fines & Penalties (planned) MRET £2.6m; Readmisions £2.4m	5,047	Senior input required at SRG to ensure fines and penalties are reinvested to cover NEL and Winter Pressures	0%	0
6	Increase CIP Delivery to 4%	900	Stretch Target to £12m. Limited scope given current risk profile of exiting schemes.	0%	0
7	Access CCG Non-Recurrent support / Transformation Reserve	3,000	Bid for non-recurrent funds to be developed. CCG have indicated there is no scope for investment ion FY15-16.	0%	0
8	Revenue to Capital	250	Review all major revenue transactions and project cost with a view to capitalising appropriate costs.	50%	125
9	Delay Planned Investments	333	£333k of approved business cases plus Ward expansion plan remains in reserves / in current run rate.	0%	0
10	Technical Adjustments (NCA Valuation Review / Provisions Review)	600	Exercise to review Non-Current Asset lives and Estate valuation to be commissioned as part of CRM initiative. Review of balance sheet provisions to be undertaken in Q4.	50%	300
11	Agency Controls	300	Introduction of mandated cap requires additional controls and individual wards reviews to implement.	33%	100
12	Expenditure Controls	500	Centralised requisition controls to elements non essential / non recurrent expenditure.	46%	228
A	**Total Opportunities (Risk adjusted)**				**803**

	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 - £4.8m + Medium £5.2m)	10,000	Executive lead CIP Steering and CIP themes. Robust managed of delivery through Programme Delivery Team.	26%	2,617
2	Contractual Fines - proposed Ambulance Handover Fines	1,700	CCG proposal to apply fines from August 2015.	65%	1,105
3	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.	100%	873
4	Excess costs of unfunded Winter Pressures	1,600	Prepare winter plan and identify funding source. Senior input to CCG / SRG meetings.	50%	800
5	Increase in Danetre rental costs proposed by PropCo	450	Negotiate improved lease terms / exit Danetre if unaffordable	50%	225
6	Bear Scotland Ruling (Estimate only)	500	Comply with advice from NHS Employers / Legal Advisors.	50%	250
B	**Total Risks (Risk adjusted)**				**5,870**

C	**Net Impact on I&E Position**	**-5,067**

- An assessment of the risks quoted opposite 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 a further £2.4m to £18.8m deficit.
- 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 together with explicit support for the reinvestment of mandatory fines and penalties levied under the ETO Acute contract.
- 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.
- The Board have considered the opportunities and risk as presented at an EO Board meeting in August and concluded that the Trust can only commit to a £0.8m stretch target.

10. Conclusions and Recommendations

Conclusion:

- The Trust has performed significantly ahead of plan in August, notably in relation to reported SLA income from Commissioners.
- The Trust has submitted a revised financial plan to the TDA reflecting the Board approved £0.8m stretch target reducing the overall deficit plan to £20.4m by the financial year end. This will require significant management action and controls given the Trust has incurred a year to date deficit of £10.3m after the first 5 months of the financial year.
- At this stage of the financial year, the Trust has yet to undertake a formal in year I&E forecast exercise to inform the likely range of I&E deficit to inform the delivery of a stretch target.
- The TDA have issued the Trust with formal notification of a 6% celling on Registered Nursing Agency expenditure in Q3 & Q4. The current level of RN agency expenditure in August 11.6%. The Trust has submitted an appeal against the 6% banding on the basis of the high level of substantive nurse vacancies currently being experienced (expected outcome 8% ceiling).
- The overall position remains 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 required.
- 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.
- Due to internal and possible national restrictions in capital funding, the financing and scope of the Capital programme requires review and may necessitate additional external funding options to be explored (e.g. leasing).
- Further work is required to progress an ITFF application in support of key elements of the capital programme. The TDA have indicated the Trust can make an application to the ITFF in November 2015 but this may be rejected in full or in part if the full £2.4m stretch target is not delivered.

Recommendations & actions

1. Rapid implementation of actions to deliver required stretch target and development of detailed I&E forecast to inform likely range of I&E position at the financial year end.
2. Implementation of controls and measures to ensure agency expenditure for registered Nurses does not exceed the expected 8% (subject to appeal) ceiling in Q3 and Q4.
3. 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 and development of mitigating actions to ensure plan is delivered.
4. 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.
5. Review of new CQUIN targets and forecast delivery required based on the Q1 position and CCG contract reconciliation is achieved in accordance with nationally prescribed timescales.
6. The Capital plan is reviewed in light of the reduced depreciation funding available and to ensure any bids to the ITFF are appropriately prioritised and supported by robust business cases.

Appendix 1: Year-to-date Trust Agency Costs by Directorate & Staff Group

Area	Senior Medstaff	Junior Medstaff	Qualified Nursing	Unqualified Nursing	Management Staff	A&C Staff	Other Clinical Staff	Prof & Tech Staff	Ancillary & Estates Staff	Agency as % of Total Pay Mth 5	Total Agency YTD Mth 5	Total Agency YTD Mth 4	Total Agency YTD Mth 3	Total Agency YTD Mth 2	Total Agency YTD Mth 1	Average Month 2014/15
General Surgery	208	33	253	108	-	4	0	3	-	11%	609	456	312	194	90	91
Anaesthesia & Critical Care	-	-	393	20	-	4	25	(3)	5	5%	443	340	256	168	81	78
Trauma & Orthopaedics	(2)	252	307	66	-	-	-	2	-	16%	625	491	376	254	113	77
Ent & Maxfax	97	150	23	16	-	-	-	32	-	14%	317	203	171	103	67	28
Ophthalmology	-	32	-	-	-	-	-	-	-	2%	32	18	6	-	-	6
Surgical Care Management	-	-	-	-	1	-	-	-	-	0%	1	1	1	1	1	4
Surgical Division	**303**	**466**	**975**	**210**	**1**	**8**	**26**	**34**	**5**	**9%**	**2,027**	**1,509**	**1,122**	**720**	**352**	**284**
Inpatient Specialties	230	40	508	312	-	14	4	32	72	6%	1,211	845	776	528	275	279
Outpatient & Elderly Medicine	122	33	113	194	-	-	67	-	-	2%	530	431	264	149	46	36
Urgent Care	44	855	708	141	-	2	-	-	-	8%	1,749	1,462	1,089	691	341	256
Medical Care Management	-	-	-	-	(3)	-	-	-	-	(3%)	(3)	(3)	(3)	-	-	17
General Medicine Division	**396**	**927**	**1,329**	**647**	**(3)**	**15**	**71**	**32**	**72**	**17%**	**3,487**	**2,735**	**2,126**	**1,368**	**662**	**587**
Child Health	(2)	18	235	9	-	-	-	4	1	5%	265	230	187	125	88	50
Obstetrics & Gynae	-	-	29	30	-	-	-	1	2	1%	62	50	40	32	19	14
Oncology/Clin Haematology	(5)	50	38	24	-	-	2	-	-	3%	110	71	31	52	35	90
WC&O Division	**(6)**	**68**	**302**	**63**	**-**	**-**	**2**	**5**	**3**	**3%**	**436**	**351**	**258**	**209**	**142**	**153**
Pathology	-	-	-	-	-	1	-	437	-	15%	438	358	255	152	47	19
Imaging	173	-	-	-	-	-	17	-	-	6%	190	153	117	72	47	23
Research	-	-	-	-	-	-	-	-	-	0%	-	-	-	-	-	-
Pharmacy	-	-	-	-	-	-	30	-	-	2%	30	1	(25)	(46)	(7)	35
Therapy Services	-	-	0	-	-	-	53	-	-	5%	53	46	35	25	25	31
Clinical Support Division	**173**	**-**	**0**	**-**	**-**	**1**	**101**	**437**	**-**	**5%**	**711**	**558**	**382**	**203**	**112**	**108**
Clinical Divisions	**865**	**1,461**	**2,607**	**920**	**(3)**	**24**	**200**	**508**	**79**	**21%**	**6,662**	**5,153**	**3,887**	**2,500**	**1,268**	**1,133**
Hospital Support	24	-	13	2	184	71	19	-	-	0%	313	163	119	118	60	53
Facilities	-	-	-	-	-	10	-	-	511	15%	521	414	284	184	84	92
Support Services	**24**	**-**	**13**	**2**	**184**	**81**	**19**	**-**	**511**	**9%**	**834**	**576**	**403**	**302**	**144**	**145**
Trust Total	**889**	**1,461**	**2,692**	**962**	**181**	**105**	**219**	**508**	**590**	**11%**	**7,608**	**5,729**	**4,290**	**2,802**	**1,412**	**1,278**
									Discrete Monthly Spend		1,879	1,439	1,488	1,390	1,412	1,278

Key Issues

- **At Month 5** £7.6m (£1.52m per month) has been spent on agency costs (avg. £1.28m per month in FY14/15).
- **Medical locum agency costs** in August were an average (for 15/16) £477k. The spend in 15/16 is 5% higher than 14/15, however the Trust is accessing lower rates from the implementation of 247 time direct engagement model.
- **Nursing (RN & HCA) agency costs** have reached the highest level of £970k in August. 11% of the total RN expenditure in 15/16 (£23.9m) has been on agency staff. The Trust is facing an agency RN expenditure limit in Q3 & Q4 and is challenged to reduce this expenditure to 8% of the total RN expenditure.

Appendix 2: Financial Risk Rating

		Aug	Jul
LIQUIDITY RATIO (DAYS)		**£000's**	**£000's**
Working Capital Balance			
Total - Current Assets	+	22,158	23,498
Total - Current Liabilities	+	-34,513	-32,321
Inventories	-	5,911	5,264
Non-Current Assets Held for Sale	-	792	792
(1) Working Capital Balance		**-19,058**	**-14,879**
Gross Employee Benefits	+	-79,004	-62,854
Other Operating Costs	+	-40,465	-32,930
Impairments: IFRIC 12	+	0	0
Depreciation	+	4,618	3,677
Amortisation	+	0	0
Stock Write down	+	27	21
Impairment of Receivables	+	239	168
(2) Annual Operating Expenses	* -1	**114,585**	**91,917**
Liquidity Ratio Days		**-25**	**-20**
(A) LIQUIDITY SCORE		1.0	1.0
Normalised EBITDA - less interest		-3,962	-1,667
Dividends plus finance costs		1,887	1,494
Capital Servicing Capacity (times)		**-2.1**	**-1.1**
(B) CAPITAL SERVICING CAPACITY SCORE		1.0	1.0
CONTINUITY OF SERVICES RATING FOR TRUST		**1.0**	**1.0**

Monitors revised Financial Sustainability Rating will be assessed once adopted by the TDA.

New Financial Sustainability Rating Issued

Monitor have issued a new Financial Sustainability Risk Rating which comes into force from August 2015 and incorporates the following measures of financial robustness and efficiency:

- **liquidity:** days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown.
- **capital servicing capacity:** the degree to which the organisation's generated income covers its financing obligations.
- **income and expenditure (I&E) margin:** the degree to which the organisation is operating at a surplus/deficit.
- **variance from plan in relation to I&E margin:** variance between a foundation trust's planned I&E margin in its annual forward plan and its actual I&E margin within the year.

Monitor considers these measures should be calculated as part of a Board's normal financial reporting.

New Monitor Guidance (extract) August 2015

	Financial criteria	Weight (%)	Metric	Rating categories** 1*	2***	3	4
Continuity of services	Balance sheet sustainability	25	Capital service capacity (times)	<1.25x	1.25 - 1.75x	1.75-2.5x	>2.5x
Continuity of services	Liquidity	25	Liquidity (days)	<(14) days	(14)-(7) days	(7)-0 days	>0 days
Financial efficiency	Underlying performance	25	I&E margin (%)	≤(1)%	(1)–0%	0-1%	>1%
Financial efficiency	Variance from plan	25	Variance in I&E margin as a % of income	≤(2)%	(2)-(1)%	(1)-0%	≥0%

Report To	PUBLIC TRUST BOARD
Date of Meeting	24 September 2015

Title of the Report	Workforce Performance Report
Agenda item	11
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 a decrease in sickness absence. • Increases in compliance rates for Mandatory Training and Role Specific Essential Training and an increase in Appraisal compliance rates. • An update on the Trust Employee Engagement Strategy is provided	
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 – 4.1, 4.2 and 4.3
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	No

Actions required by the Board

The Board is asked to Note the report.

Public Trust Board
24 September 2015

Workforce Performance Report

1. Introduction

This report identifies the key themes emerging from August 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 5.26 FTE in August 2015 to 4128.40 FTE. The Trust's substantive workforce is at 89.09% of the Budgeted Workforce Establishment of 4634.01 FTE.

Annual Trust turnover increased slightly to 11.59% in August which is above the Trust target of 8%. Turnover within Nursing & Midwifery also increased to 12.68%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust. Turnover also increased in the Admin & Clerical, Additional Clinical Services, and Allied Health Professional staff groups, but fell in all others.

In month sickness absence decreased by 0.12% to 3.92% which is just above the Trust target of 3.8%. The Women, Children & Oncology Division, Clinical Support Services Division, and Support Services all achieved a level below the Trust's target of 3.8%.

2.2 Capability

Appraisals, Mandatory and Role Specific Essential Training

The current rate of Appraisals recorded for August 2015 is 74.81%; this is a significant improvement from last month's figure of 70.28%.

Mandatory Training compliance also increased in August to 83.67% and is approaching the Trust target of 85%. All Directorates within the Clinical Support Services Division have a Mandatory Training compliance rate above 85%, as do Hospital Support, Child Health, and Outpatients & Elderly Medicine.

Role Specific Essential Training compliance also increased slightly in August to 70.11%; whilst this is still less than the Trust target it has been increasing month on month since March 2015.

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

Attached is a progress report against the staff engagement strategy. Key highlights include 38 teams (970 staff) have participated in the 'Rainbow Risk' engagement sessions, with 13 teams (300 staff) going on to participate in the 'In your box' sessions.

3. Assessment of Risk

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

4. Recommendations

The Board is asked to note the report.

5. Next Steps

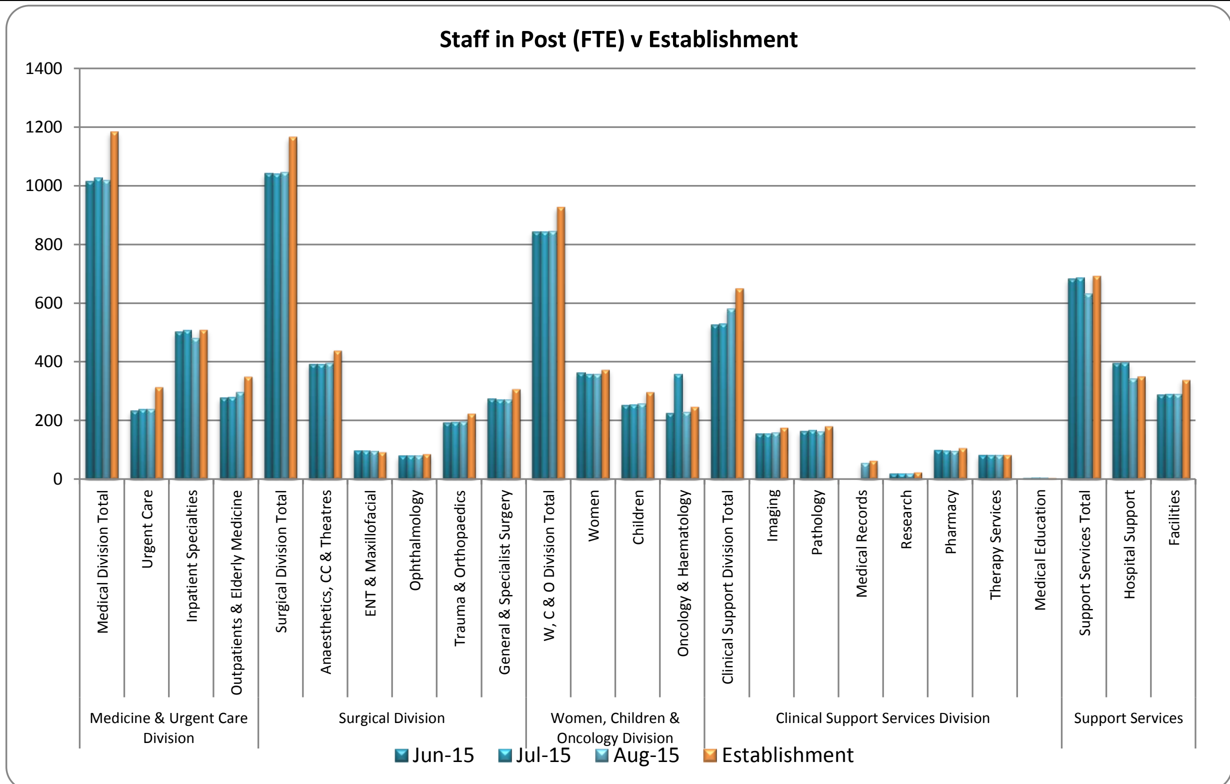
Key workforce performance indicators are subject to regular monitoring and appropriate action is taken as required.

Trust Board: Workforce Capacity and Capability Report - August 2015

CAPACITY
Staff in Post

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

Staff in Post (FTE)		Jun-15		Jul-15		Aug-15	Establishment	
Medicine & Urgent Care Division	Medical Division Total	1018.18	↑	1028.40	↓	1020.03	1186.40	85.98%
	Urgent Care	235.20	↑	238.46	↑	239.40	317.57	75.38%
	Inpatient Specialties	503.33	↑	508.61	↓	480.97	513.16	93.73%
	Outpatients & Elderly Medicine	278.66	↑	280.32	↑	298.66	353.29	84.54%
Surgical Division	Surgical Division Total	1044.58	↓	1042.10	↑	1047.00	1168.47	89.60%
	Anaesthetics, CC & Theatres	393.93	↓	392.30	↑	396.07	442.34	89.54%
	ENT & Maxillofacial	96.83	↓	96.79	↓	96.49	94.14	102.50%
	Ophthalmology	80.33	↑	81.03	↓	80.61	88.16	91.44%
	Trauma & Orthopaedics	193.11	↑	194.47	↑	196.66	226.31	86.90%
	General & Specialist Surgery	274.58	↓	271.73	↓	271.37	310.42	87.42%
Women, Children & Oncology Division	W, C & O Division Total	844.88	↑	844.94	↑	846.91	929.86	91.08%
	Women	363.96	↓	359.10	↓	358.20	376.53	95.13%
	Children	254.02	↑	254.60	↑	258.98	300.73	86.12%
	Oncology & Haematology	225.05	↑	359.10	↓	227.88	249.86	91.20%
Clinical Support Services Division	Clinical Support Division Total	527.73	↑	530.39	↑	581.99	653.36	89.08%
	Imaging	155.66	↓	155.48	↑	159.15	178.68	89.07%
	Pathology	164.73	↑	168.33	↓	163.53	183.12	89.30%
	Medical Records	N/A		N/A		55.57	65.25	85.16%
	Research	19.39	↑	19.39	↑	19.39	25.12	77.19%
	Pharmacy	99.14	↓	96.76	↓	95.66	108.83	87.90%
	Therapy Services	82.29	↑	83.29	↓	81.56	84.93	96.03%
	Medical Education	4.53	↑	5.13	↑	5.13	5.89	87.10%
Support Services	Support Services Total	684.32	↑	687.84	↓	632.46	695.92	90.88%
	Hospital Support	395.97	↑	396.99	↓	342.22	354.33	96.58%
	Facilities	288.35	↑	290.84	↓	290.24	341.59	84.97%
Trust Total		4119.69	↑	4133.66	↓	4128.40	4634.01	89.09%



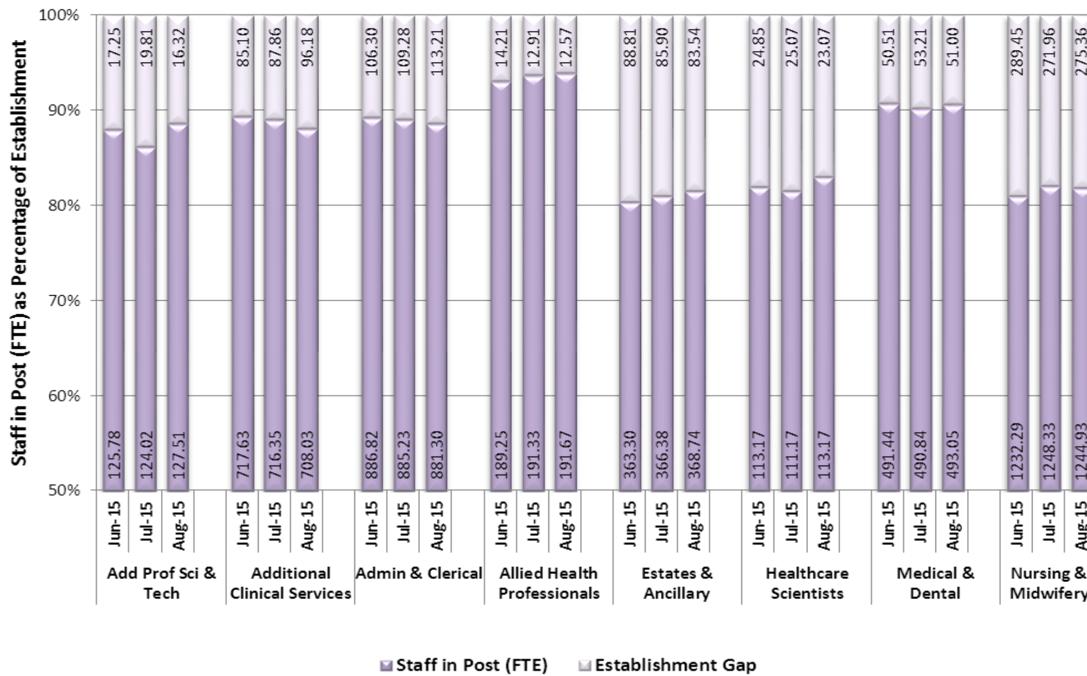
Trust Board: Workforce Capacity and Capability Report - August 2015

CAPACITY
Staff Group (FTE v Est)

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

Staff Group Vacancy Rate (Contracted FTE v Establishment)

Staff Group	Jun-15	Jul-15	Aug-15
Add Prof Sci & Tech	12.06%	13.77%	11.35%
Additional Clinical Services	10.60%	10.93%	11.96%
Admin & Clerical	10.70%	10.99%	11.38%
Allied Health Professionals	6.98%	6.32%	6.15%
Estates & Ancillary	19.64%	18.99%	18.47%
Healthcare Scientists	18.01%	18.40%	16.93%
Medical & Dental	9.32%	9.78%	9.37%
Nursing & Midwifery	19.02%	17.89%	18.11%



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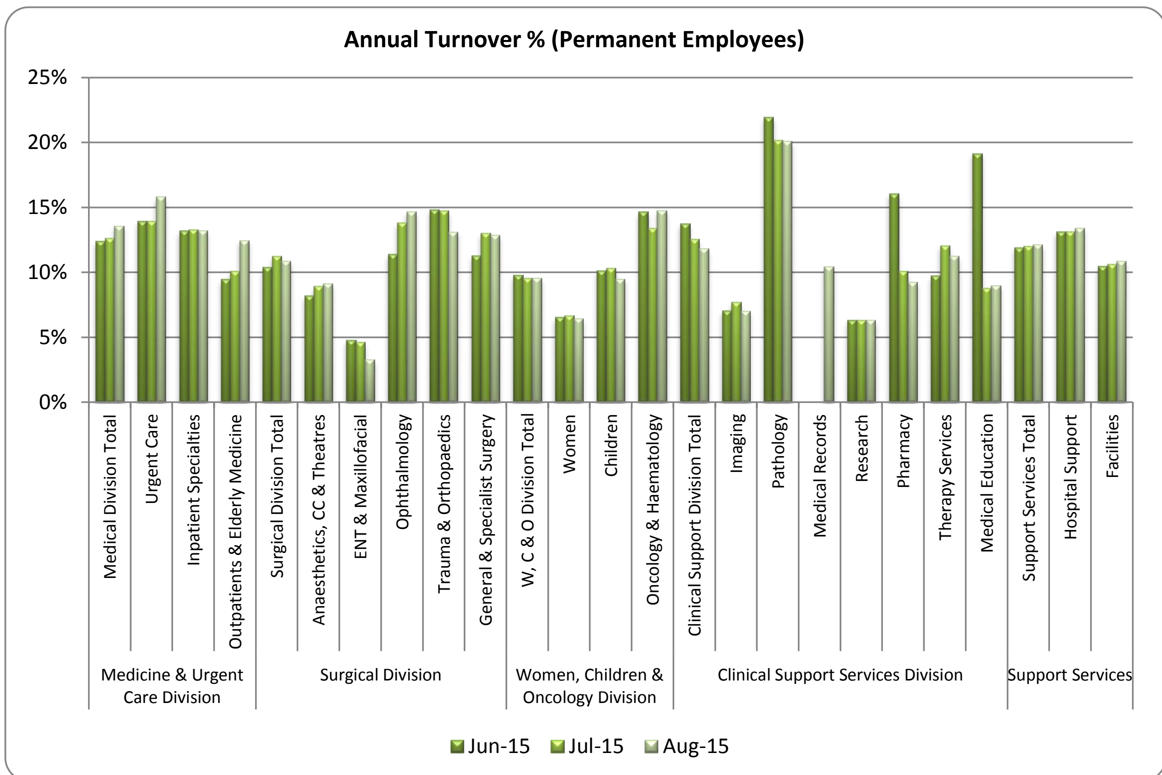
Trust Board: Workforce Capacity and Capability Report - August 2015

CAPACITY
Annual Turnover

Figures refer to the year ending in the month stated

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

Annual Turnover (Permanent Staff)		Jun-15		Jul-15		Aug-15
Medicine & Urgent Care Division	**Medical Division Total**	12.43%	↗	12.65%	↗	13.57%
	Urgent Care	13.96%	↘	13.94%	↗	15.83%
	Inpatient Specialties	13.21%	↗	13.31%	↘	13.24%
	Outpatients & Elderly Medicine	9.48%	↗	10.13%	↗	12.47%
Surgical Division	**Surgical Division Total**	10.39%	↗	11.25%	↘	10.88%
	Anaesthetics, CC & Theatres	8.20%	↗	8.94%	↗	9.16%
	ENT & Maxillofacial	4.82%	↘	4.63%	↘	3.27%
	Ophthalmology	11.40%	↗	13.83%	↗	14.69%
	Trauma & Orthopaedics	14.86%	↘	14.75%	↘	13.13%
	General & Specialist Surgery	11.32%	↗	13.05%	↘	12.90%
Women, Children & Oncology Division	**W, C & O Division Total**	9.77%	↘	9.57%	↗	9.57%
	Women	6.55%	↗	6.66%	↘	6.45%
	Children	10.16%	↗	10.34%	↘	9.50%
	Oncology & Haematology	14.68%	↘	13.41%	↗	14.77%
Clinical Support Services Division	**Clinical Support Division Total**	13.76%	↘	12.56%	↘	11.83%
	Imaging	7.08%	↗	7.71%	↘	7.02%
	Pathology	21.97%	↘	20.19%	↘	20.09%
	Medical Records	N/A		N/A		10.45%
	Research	6.32%	↗	6.32%	↗	6.32%
	Pharmacy	16.08%	↘	10.12%	↘	9.26%
	Therapy Services	9.75%	↗	12.07%	↘	11.28%
	Medical Education	19.16%	↘	8.80%	↗	8.99%
Support Services	**Support Services Total**	11.94%	↗	12.01%	↗	12.15%
	Hospital Support	13.15%	↗	13.15%	↗	13.42%
	Facilities	10.48%	↗	10.63%	↗	10.86%
Trust Total		11.47%	↗	11.54%	↗	11.59%



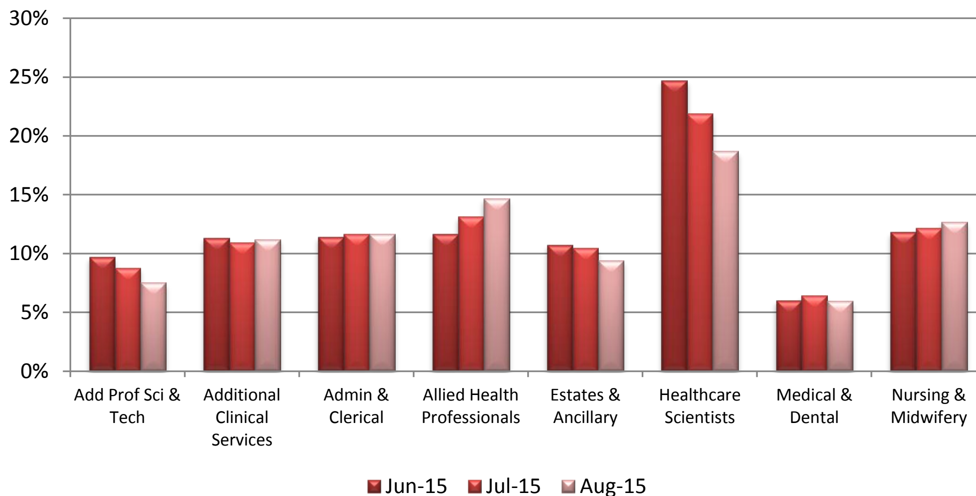
Trust Board: Workforce Capacity and Capability Report - August 2015

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	Jun-15		Jul-15		Aug-15
Add Prof Sci & Tech	9.70%	↘	8.78%	↘	7.53%
Additional Clinical Services	11.32%	↘	10.94%	↗	11.21%
Admin & Clerical	11.42%	↗	11.67%	↗	11.68%
Allied Health Professionals	11.69%	↗	13.13%	↗	14.66%
Estates & Ancillary	10.73%	↘	10.49%	↘	9.40%
Healthcare Scientists	24.73%	↘	21.91%	↘	18.71%
Medical & Dental	6.04%	↗	6.42%	↘	5.99%
Nursing & Midwifery	11.81%	↗	12.19%	↗	12.68%



Capacity

Substantive Workforce Capacity decreased by 5.26 FTE in August 2015 to 4128.40 FTE. The Trust's substantive workforce is at 89.09% of the Budgeted Workforce Establishment of 4634.01 FTE.

Staff Turnover: Annual Trust turnover increased slightly to 11.59% in August which is above the Trust target of 8%. Turnover within Nursing & Midwifery also increased to 12.68%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust. Turnover also increased in the Admin & Clerical, Additional Clinical Services, and Allied Health Professional staff groups, but fell in all others.

Medical Division; Increased by 0.92% to 13.57%.
Surgical Division: turnover decreased by 0.37% to 10.88%.
Women, Children's & Oncology Division; turnover was unchanged at 9.57%.
Clinical Support Services Division; fell below 12%, to 11.83% for the year ending August 2015.

Staff Vacancies: The vacancy rate within Estates and Ancillary staff group decreased further in August to 18.47% but still remains significantly above the Trust vacancy target of 7%. The Registered Nursing & Midwifery vacancy rate increased slightly from 17.89% to 18.11%.

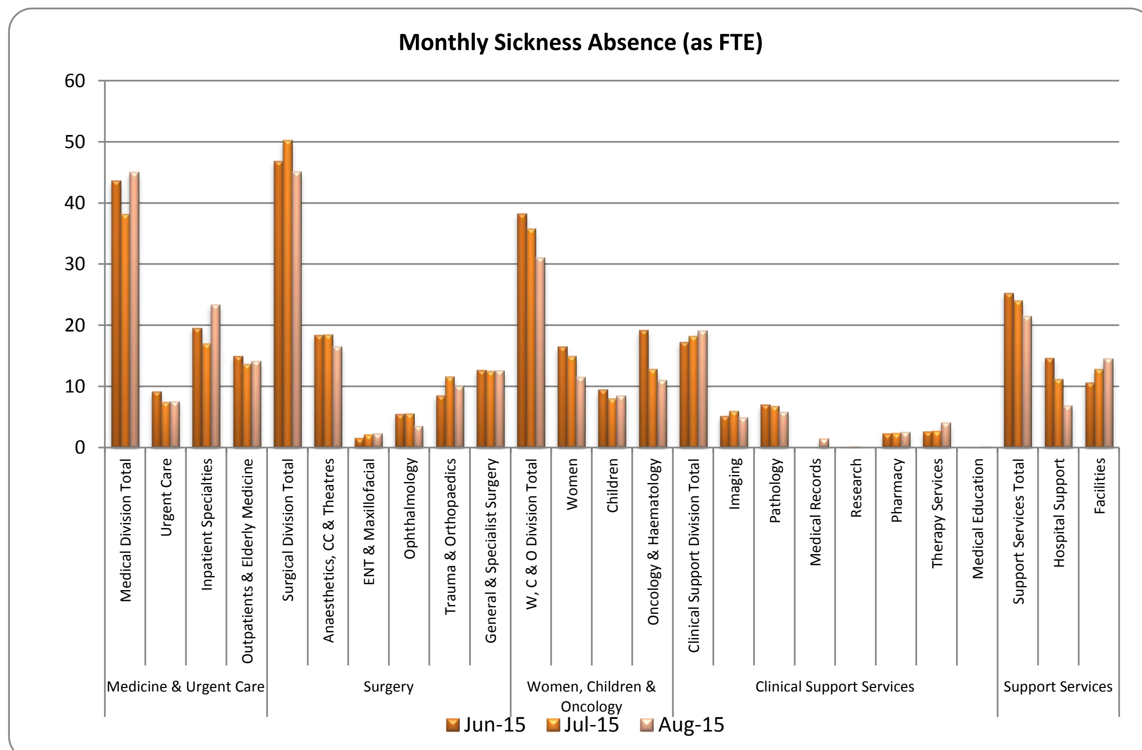
Sickness Absence: In month sickness absence decreased by 0.12% to 3.92% which is just above the Trust target of 3.8% . The Women, Children & Oncology Division, Clinical Support Services Division, and Support Services all achieved a level below the Trust's target of 3.8%.

Trust Board: Workforce Capacity and Capability Report - August 2015

CAPACITY
In-Month Sickness

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

Monthly Sickness (as FTE)		Jun-15	Jul-15	Aug-15	Aug-15	Short Term	Long Term
Medicine & Urgent Care	**Medical Division Total**	43.71	38.26	45.04	4.42%	3.20%	1.22%
	Urgent Care	9.16	7.51	7.52	3.14%	2.72%	0.42%
	Inpatient Specialties	19.58	17.04	23.38	4.86%	3.06%	1.80%
	Outpatients & Elderly Medicine	15.03	13.71	14.13	4.73%	3.80%	0.93%
Surgery	**Surgical Division Total**	46.89	50.33	45.13	4.31%	2.24%	2.06%
	Anaesthetics, CC & Theatres	18.44	18.52	16.56	4.18%	2.20%	1.98%
	ENT & Maxillofacial	1.57	2.13	2.30	2.38%	2.38%	0.00%
	Ophthalmology	5.45	5.58	3.56	4.42%	0.35%	4.07%
	Trauma & Orthopaedics	8.52	11.61	10.07	5.12%	2.13%	2.99%
	General & Specialist Surgery	12.66	12.58	12.62	4.65%	2.94%	1.71%
Women, Children & Oncology	**W, C & O Division Total**	38.28	35.83	31.08	3.67%	2.13%	1.55%
	Women	16.52	14.97	11.57	3.23%	2.35%	0.88%
	Children	9.47	7.97	8.49	3.28%	1.71%	1.56%
	Oncology & Haematology	19.21	12.89	11.03	4.84%	2.25%	2.59%
Clinical Support Services	**Clinical Support Division Total**	17.29	18.25	19.15	3.29%	1.63%	1.66%
	Imaging	5.13	5.99	4.95	3.11%	1.34%	1.77%
	Pathology	7.02	6.82	5.87	3.59%	1.41%	2.18%
	Medical Records	N/A	N/A	1.46	2.63%	1.19%	1.45%
	Research	0.12	0.19	0.06	0.30%	0.30%	0.00%
	Pharmacy	2.33	2.39	2.53	2.64%	1.74%	0.90%
	Therapy Services	2.62	2.73	4.07	4.99%	3.07%	1.92%
	Medical Education	0.07	0.07	0.14	2.64%	2.64%	0.00%
Support Services	**Support Services Total**	25.31	24.07	21.50	3.40%	1.95%	1.45%
	Hospital Support	14.69	11.20	6.88	2.01%	1.42%	0.59%
	Facilities	10.64	12.88	14.60	5.03%	2.56%	2.47%
Trust Total	***As FTE***	170.97	167.00	161.83			
	As percentage	4.15%	4.04%		3.92%	2.32%	1.60%



Enclosure G

Trust Board: Workforce Capacity and Capability Report - August 2015

CAPABILITY
Training & Appraisal Rates

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

Mandatory Training Compliance Rate	Directorate	Jun-15		Jul-15		Aug-15
Medicine & Urgent Care Division	**Medical Division Total**	77.09%	↑	78.70%	↑	80.15%
	Urgent Care	76.50%	↑	78.19%	↑	78.56%
	Inpatient Specialties	74.26%	↑	75.65%	↑	77.80%
	Outpatients & Elderly Medicine	82.71%	↑	84.68%	↑	85.26%
Surgical Division	**Surgical Division Total**	79.60%	↑	80.34%	↑	81.15%
	Anaesthetics, CC & Theatres	81.64%	↑	81.81%	↓	81.70%
	ENT & Maxillofacial	71.76%	↑	72.22%	↑	73.94%
	Ophthalmology	79.40%	↑	79.40%	↑	83.98%
	Trauma & Orthopaedics	76.90%	↑	80.30%	↑	81.75%
	General & Specialist Surgery	81.20%	↑	81.24%	↑	81.48%
Women, Children & Oncology Division	**W, C & O Division Total**	82.51%	↑	83.44%	↑	83.96%
	Women	80.19%	↑	80.66%	↑	81.34%
	Children	84.60%	↑	86.90%	↑	87.18%
	Oncology & Haematology	84.21%	↓	84.18%	↑	84.66%
Clinical Support Services Division	**Clinical Support Division Total**	90.43%	↓	90.32%	↑	91.50%
	Imaging	91.74%	↓	90.50%	↓	89.81%
	Pathology	87.40%	↑	88.89%	↑	90.14%
	Medical Records	N/A		N/A		95.56%
	Research	88.07%	↓	86.42%	↑	88.89%
	Pharmacy	91.52%	↑	92.36%	↑	92.99%
	Therapy Services	92.55%	↓	90.88%	↑	92.75%
	Medical Education	100.00%	↑	100.00%	↑	100.00%
Support Services	**Support Services Total**	86.18%	↑	86.94%	↓	85.97%
	Hospital Support	87.42%	↑	88.42%	↓	87.68%
	Facilities	84.49%	↓	84.21%	↓	84.00%
Trust Total		**82.03%**	↑	**82.87%**	↑	**83.67%**

Role Specific Training Compliance Rate	Directorate	Jun-15		Jul-15		Aug-15
Medicine & Urgent Care Division	**Medical Division Total**	64.89%	↑	65.85%	↓	65.83%
	Urgent Care	60.55%	↑	63.01%	↓	62.30%
	Inpatient Specialties	61.76%	↑	62.03%	↑	62.05%
	Outpatients & Elderly Medicine	74.43%	↑	75.08%	↓	74.44%
Surgical Division	**Surgical Division Total**	69.46%	↑	69.90%	↓	69.23%
	Anaesthetics, CC & Theatres	70.79%	↑	71.66%	↓	70.24%
	ENT & Maxillofacial	62.45%	↓	62.31%	↑	64.04%
	Ophthalmology	68.39%	↑	70.15%	↓	69.18%
	Trauma & Orthopaedics	64.09%	↑	64.28%	↓	63.66%
	General & Specialist Surgery	73.75%	↓	73.71%	↓	73.70%
Women, Children & Oncology Division	**W, C & O Division Total**	70.02%	↑	70.67%	↑	71.42%
	Women	64.57%	↑	64.69%	↑	65.62%
	Children	74.75%	↑	75.68%	↑	77.02%
	Oncology & Haematology	75.95%	↑	77.38%	↓	76.81%
Clinical Support Services Division	**Clinical Support Division Total**	83.35%	↑	84.04%	↑	84.84%
	Imaging	86.17%	↓	85.57%	↓	83.84%
	Pathology	74.04%	↓	73.01%	↑	73.86%
	Medical Records	N/A		N/A		97.14%
	Research	80.37%	↑	81.31%	↓	76.92%
	Pharmacy	86.05%	↑	88.11%	↓	87.72%
	Therapy Services	82.99%	↑	85.53%	↑	89.18%
	Medical Education	100.00%	↑	100.00%	↑	100.00%
Support Services	**Support Services Total**	69.21%	↓	68.79%	↓	67.83%
	Hospital Support	72.01%	↓	71.87%	↓	69.36%
	Facilities	64.14%	↓	63.16%	↑	65.17%
Trust Total		**69.47%**	↑	**70.08%**	↑	**70.11%**

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Trust Board: Workforce Capacity and Capability Report - August 2015

CAPABILITY
Training & Appraisal Rates

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

Appraisal Compliance Rate	Directorate	Jun-15		Jul-15		Aug-15
Medicine & Urgent Care Division	Medical Division Total	58.52%	↑	65.04%	↑	68.76%
	Urgent Care	67.50%	↑	82.30%	↑	88.11%
	Inpatient Specialties	50.52%	↑	57.03%	↑	60.13%
	Outpatients & Elderly Medicine	64.71%	↓	64.38%	↑	66.67%
Surgical Division	Surgical Division Total	71.70%	↑	72.50%	↑	76.39%
	Anaesthetics, CC & Theatres	66.94%	↑	67.22%	↑	71.20%
	ENT & Maxillofacial	50.00%	↑	51.22%	↑	59.26%
	Ophthalmology	64.38%	↑	65.75%	↑	66.67%
	Trauma & Orthopaedics	73.60%	↑	80.30%	↑	85.64%
	General & Specialist Surgery	85.51%	↓	82.37%	↑	84.36%
Women, Children & Oncology Division	W, C & O Division Total	76.06%	↓	74.00%	↑	81.85%
	Women	80.23%	↓	76.81%	↑	79.06%
	Children	74.32%	↓	64.20%	↑	82.63%
	Oncology & Haematology	70.51%	↑	79.75%	↑	86.32%
Clinical Support Services Division	Clinical Support Division Total	81.79%	↓	76.52%	↑	79.91%
	Imaging	82.93%	↓	69.51%	↑	82.04%
	Pathology	79.76%	↓	77.91%	↓	70.66%
	Medical Records	N/A		N/A		88.73%
	Research	75.00%	↓	62.50%	↑	70.83%
	Pharmacy	80.70%	↓	78.57%	↑	81.42%
	Therapy Services	86.17%	↑	86.32%	↓	86.02%
	Medical Education	100.00%	↑	100.00%	↑	100.00%
Support Services	Support Services Total	68.46%	↓	65.23%	↑	67.34%
	Hospital Support	70.34%	↓	68.19%	↑	68.58%
	Facilities	65.95%	↓	61.28%	↑	65.96%
Trust Total		**70.28%**	↑	**70.28%**	↑	**74.81%**

Capability

Appraisals

The current rate of Appraisals recorded for August 2015 is 74.81%; this is a significant improvement from last month's figure of 70.28%.

Mandatory Training and Role Specific Essential Training

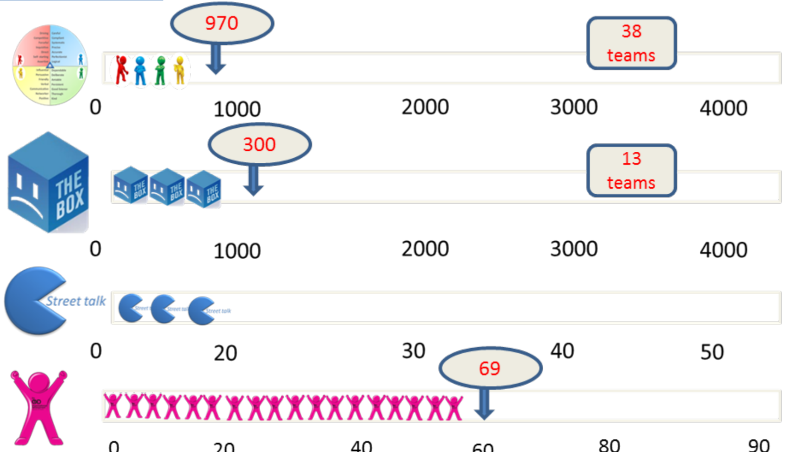
Mandatory Training compliance also increased in August to 83.67% and is approaching the Trust target of 85%.

Role Specific Essential Training compliance also increased very slightly in August to 70.11%.

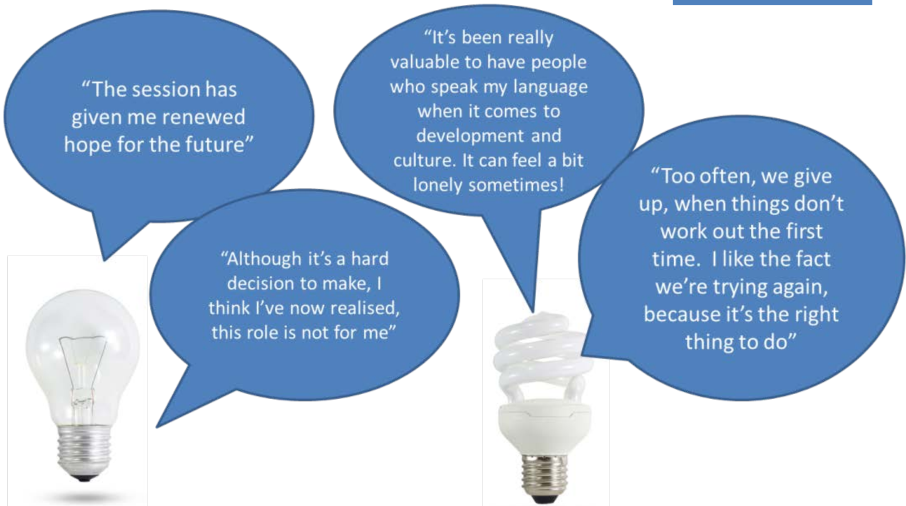
The target compliance rates for Appraisals, Mandatory, and Role Specific Training have all been set at 85%, which should have been achieved by March 2015; this was not done but work continues to achieve this level of compliance.

OD – Progress on one page Update September 2015

Proactive 50%



Mind-set changes



Projects 25%

Project	Update
National Staff survey	Changing of supplier to Quality Health Changes to include all 4,500 staff Electronic and Paper hybrid method for 2015
Staff Awards	180 people confirmed for event. On budget
Leadership development and NGH Leadership model	Introduction of 2 day leadership programme for Bands 6 & 7 Sharing of model via Assistant Directors of Nursing Alignment of all leadership development to NGH model in progress
Ward Buddies	Second training day for ward buddies 11 September 2015
Living and breathing our values	Values in practice pilot successful. To be rolled out via street talk September/October Project being scoped for underpinning behaviours

Reactive 25%

Issue	Result
Overseas recruitment	Working alongside Assistant Director of workforce to support the integration, induction and resilience of the new recruits and the teams in which they operate.
Divisional and Directorate meetings	Observations, coaching and recommendations made to maximise productivity and quality
Quality of appraisals	Introducing an OD approach to vital and difficult conversations for enhanced performance and increased staff engagement.
Local services with specific incidents	1:1 coaching with managers, team support, diagnostics and recommendations
Coaching and support for senior leaders	Supporting the introduction of clinically led model, through coaching for improved understanding and application.

Report To	PUBLIC TRUST BOARD
Date of Meeting	24 September 2015

Title of the Report	Infection Prevention Annual Report
Agenda item	12
Presenter of Report	Carolyn Fox, Director of Nursing, Midwifery & Patient Services
Author(s) of Report	Wendy Foster, Interim Matron Infection Prevention Fiona Barnes, Deputy Director of Nursing
Purpose	Assurance
Executive summary This annual report provides a summary of the performance and developments related to Infection Prevention and Control (IPC) during 2014/15 and a broad plan of work for 2015/16.	
Related strategic aim and corporate objective	Corporate Objective 1 – Focus on Quality & Safety
Risk and assurance	Provides assurance on risks
Related Board Assurance Framework entries	BAF – 1.1, 1.2, 1.3
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)

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	Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? (NO)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper? Yes, to provide assurance in relation to the Health Act 2008 (Updated Check) and Social Care Act.

Actions required by the Trust Board

The Board is asked to note the content of this annual report and to support the work plan moving forward.

Northampton General Hospital NHS
NHS Trust

PUBLIC TRUST BOARD
24 September 2015

Infection Prevention Annual Report

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Enclosure H

1. Introduction

This is a two-part document; a report on the developments and performance related to Infection Prevention and Control (IPC) during 2014/15 and the broad plan of work for 2015/16 to support reducing the risk of healthcare associated infections (HCAIs). The report outlines the challenges faced in-year and the Trusts approach to reducing the risk of to HCAI.

A zero tolerance approach continues to be taken by the Trust towards all avoidable HCAIs. Good IPC practice is essential to ensure that people who use the Trust services receive safe and effective care. Effective IPC practices must be part of everyday practice and be applied consistently by everyone. The publication of the IPC Annual Report is a requirement to demonstrate good governance and public accountability

The report acknowledges the hard work and diligence of all grades of staff, clinical and non-clinical who play a vital role in improving the quality of patient and stakeholders experience as well as helping to reduce the risk of infections. Additionally the Trust continues to work collaboratively with a number of outside agencies as part of its IPC and governance arrangements in particular NHS Nene & NHS Corby Clinical Commissioning Groups.

2. Executive Summary

The annual report for Infection Prevention and Control outlines the Trust's Infection Prevention and Control (IPC) activity in 2014/15. In addition it highlights the role, function and reporting arrangements of the Director of Infection Prevention and Control (DIPC) and the Infection Prevention and Control Team (IPCT).

The structure and headings of the report follow the ten criteria outlined in the Health and Social Care Act 2008; Code of Practice on the prevention and control of infections and related guidance[1].

Reportable Infections

There are four infections that are now mandatory for reporting purposes listed below. MRSA bloodstream infections and *Clostridium difficile* infections are national contractual reduction objectives.

- Meticillin[2] Resistant *Staphylococcus aureus* (MRSA) bloodstream infections
- *Clostridium difficile* infections
- Meticillin Sensitive *Staphylococcus aureus* (MSSA) bloodstream infections
- Escherichia coli (*E.coli*) bloodstream infections

There has been continuing focus on reducing both MRSA bacteraemia rates and *Clostridium difficile* rates, monitored by the Health Protection Agency (HPA) now Public Health England (PHE).

MRSA

The HCAI objective for MRSA blood stream infections for 2014/15 was 0 avoidable MRSA bacteraemia cases.

Cases are defined as non-trust apportioned if blood cultures are collected on the day of admission or the day after; all other cases are apportioned to the Trust. It is the Trust-apportioned cases that included as part of the national HCAI reduction targets.

There is now a standard national process for undertaking a post-incident review (PIR) on all patients who have Trust or non-Trust apportioned MRSA. This involves a multiagency review of

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[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216227/dh_123923.pdf
[2] Meticillin has replaced Methicillin as the approved spelling

the patients care to determine if there have been any lapses of care which would have contributed to the infection.

In 2013/14 the Trust had 2 post 48 hour MRSA bacteraemias, this was matched with a further two post 48 hours MRSA bacteraemias in 2014/2015.

***Clostridium difficile* Infections**
The HCAI national objective set for NGH trust apportioned cases of *Clostridium difficile* infections (CDI) for 2014/15 was no more than 35.

Cases are defined as Trust- apportioned CDI when the patients sample is taken on or after day 3 (day of admission is 0). It is the Trust-apportioned cases that are included as part of the national HCAI reduction targets and the Trusts quality goal.

There have been 28 patients with Trust-apportioned CDI in 2014/15 in total. This represents an 8% increase over 2013/14 which is consistent with national figures.

Meticillin Sensitive *Staphylococcus aureus* Bloodstream Infections
For reporting purposes, cases are apportioned to the Trust as per MSSA bloodstream infections but there are currently no national targets.

During 2014/15 there were 19 post 48 cases of MSSA bacteraemias. This compares with 11 cases in 2012/13 and 6 cases in 2013/14.

***E. coli* Bloodstream Infections**
Although there is mandatory reporting of *E. coli* bloodstream infections, there are no targets and there is no recommendation to apportion cases to acute care or otherwise. This reflects the complexity of *E. coli* infections.

There was a 42% increase in the number of all patients with E.coli bloodstream infections from 2013/14 to 2014/15; from 147 to 209.

Director of Infection Prevention Control (DIPC) Reports to the Board of Directors
The DIPC delivers an Annual Report to the Board of Directors.

The Executive Team receive updates on patients with *Clostridium difficile* infections and MRSA bacteraemias.

The Board of Directors receive:

- Monthly IPC Board Report
- CQEG Monthly Report
- Patient Safety, Clinical Quality & Governance Progress Report (quarterly)

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.

3. Governance and Monitoring

IPC Governance

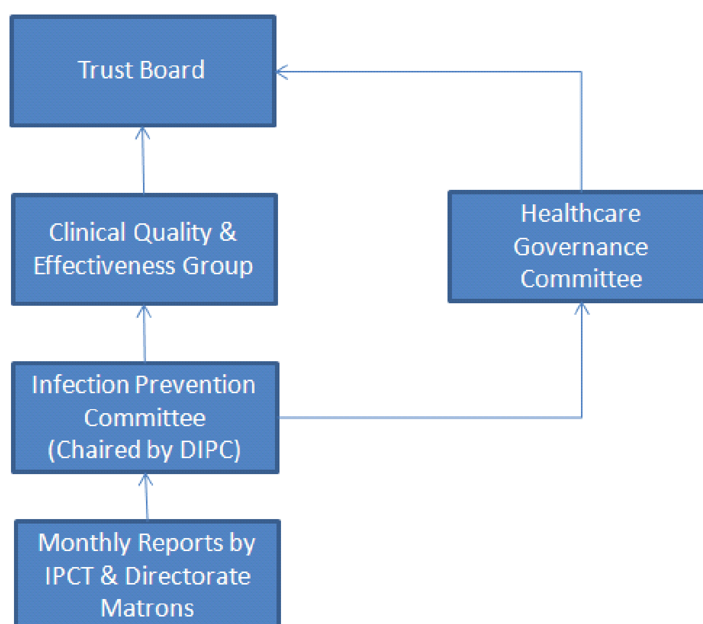
The Board of Directors has collective responsibility for keeping to a minimum the risk of infection and recognises its responsibility for overseeing IPC arrangements in the Trust.

The Trust Director of Infection Prevention and Control (DIPC) role is incorporated into the role of the Director of Nursing, Midwifery & Patient Services.

The DIPC is supported by the Medical Director, Consultant Microbiologist, Deputy Director of Nursing, the Lead Infection Prevention Nurse and the Trust Antimicrobial Pharmacist.

The Infection Prevention and Control Department includes microbiology, virology, wound surveillance, and epidemiology. The IPCT works with pharmacy, facilities, directorate matrons, ward sisters, infection prevention and control link staff and sterile services.

Infection Prevention and Control Committee Structure and Accountability for 2014/15:



The Infection Prevention and Control Committee is the main forum for discussion concerning changes to policy or practice relating to infection prevention and control. The membership of the Committee is multi-disciplinary and includes all Directorate Matrons. The Committee is chaired by the Director of Infection Prevention and Control (DIPC). Decontamination, sterile services and Estate Services also report through the IPCC. The DIPC also provides a monthly report through Healthcare Governance Committee and a verbal update to the Trust Board

Healthcare Governance Committee
The Healthcare Governance Committee was a subcommittee of the Trust Board and reviews areas of concern arising from the IPCC by exception. This committee has since been re-named Quality Governance Committee.

Links to Clinical Governance and Patient Safety
The Infection Prevention Team reports the Trust position in relation to infection prevention and control to the Clinical Quality and Effectiveness Group (CQEG) on a monthly basis. The Directorates include their monthly infection prevention data within their own quarterly reports to CQEG. Learning from MRSA bacteraemia infections is reported through Healthcare Governance, the Patient Safety Learning Forum to representatives from all Directorates for dissemination to Directorate Governance Groups.

Infection Prevention and Control Committee
The Trust Infection Prevention & Control Group provides a forum to support the delivery of a zero tolerance approach to avoidable HCAIs. This Group reports into the Clinical Quality & Effectiveness Group (CQEG) and then Healthcare Governance Committee (HGC) and the Trust Board also receive a monthly IPC report.

Monitoring

Clinical Commissioning Group (CCG)
NHS Nene & Corby CCG is NGH's commissioning organisation. IPC is a key element of quality commissioning and forms part of a joint commissioning quality schedule.

The CCGs participate in the post incident reviews for all patients who develop MRSA bacteraemia in line with the NHS England guidelines for the management of cases. They also oversee the cases of CDI infection, reviewing all cases and attributing any lapses in care.

Northamptonshire Health Economy HCAI Group
The DIPC, Consultant Microbiologist and members of the IPCT are active members of the local health economy group. This group is in existence to drive forward the Northamptonshire approach to infection prevention and control working together to ensure the quality of patient experience throughout the county is of equal good quality.

Infection Control Standards and Assurance
In 2014/15 the Trust declared full compliance with the Care Quality Commission, Section 20 regulation of the Health and Social Care Act (2008) Outcome 8 Cleanliness and Infection Control. This declaration was made with due regard to regulation 12 of the Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.

The Trust continues to undertake a number of interventions in relation to infection prevention and control as detailed within the HCAI Reduction Plan 2014/15. This work is led by the Director of Infection Prevention and Control (DIPC) and supported by the Medical Director and Matron for Infection Prevention and Control.

The IPC Team continues to report numbers of MRSA/CDI to the Executive Team and to the Trust Board on a monthly basis and this is directly referenced in the Corporate Risk Register and Assurance Framework.

4. Healthcare Associated Infection Statistics and Targets

Surveillance
The Infection Prevention & Control Team (IPCT) undertakes continuous surveillance of alert organisms and alert conditions. Patients with pathogenic organisms or specific infections, which could spread, are identified from microbiology reports or from notifications by ward staff. The

IPCT advises on the appropriate use of infection control precautions for each case and monitors overall trends.

Alert Organisms[3]

- MRSA
- *Clostridium difficile*
- Group A *Streptococcus*
- *Salmonella* spp
- *Campylobacter* spp
- *Mycobacterium tuberculosis*
- Glycopeptide resistant *Enterococci*
- Multi - resistant Gram negative bacilli e.g. extended spectrum beta-lactamase (ESBL) producers
- Carbapenemase-producing Enterobacteriaceae (CPE)
- Neisseria meningitides
- Aspergillus
- Hepatitis A
- Hepatitis B
- Hepatitis C
- HIV

Alert Conditions

- Scabies
- Chickenpox and shingles
- Two or more possibly related cases of acute infection e.g. gastroenteritis
- Surgical site infections

Current Actions to Improve Surveillance
On a weekly basis a ward round of all patients with all C.diff cases within the Trust is undertaken by the Consultant Microbiologist, Consultant Gastroenterologist, Antimicrobial Pharmacist and a member of the Infection Prevention Team.

Identified Priorities for 2014/15
In 2014/15, the Trusts HCAI Reduction Delivery Plan set out to:

- Reduce in the number of patients with CDI and achieve the national targets and the Trusts Quality Account
- Reduce in MRSA bacteraemia to achieve the national targets
- Reduce in the number of patients with MSSA bacteraemia

Staphylococcus aureus
All *Staphylococcus aureus* bacteraemias – sensitive to meticillin (MSSA) or resistant to meticillin (MRSA) – are reported on a mandatory basis through the Public Health England (PHE) HCAI Data Capture System (DCS). The Trust's incidence of MSSA and MRSA cases is reported on the PHE website. The incidence of these cases is reported publicly as acute trust attributable or otherwise.

The reduction of **all** avoidable bloodstream infections including MSSA and MRSA continues to be an aim of the Trust.

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[3] Alert organisms are organisms identified as important due to the potential seriousness of the infection they cause, antibiotic resistance or other public health concerns. This is a nationally recognised term; these organisms may be part of mandatory or voluntary surveillance systems and are used as indicators of general infection prevention and control performance.

MSSA
There is a mandatory requirement for all NHS acute trusts to report Meticillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemia from the 1st January 2011.This reflects the zero tolerance approach that the Government has made clear that the NHS should adopt for all Healthcare Associated Infections (HCAIs), while recognising that not all MSSA bacteraemia are HCAIs. Over the past few years, the NHS has made significant progress in reducing MRSA bloodstream and *C. difficile* infections. The availability of a robust and accurate picture of the scale of MSSA infections, nationally and locally, will also support patients in making meaningful choices about their healthcare.

The trust records MSSA bacteraemia cases separately on the web-based system, as they do already for MRSA bacteraemia and the Chief Executive will sign-off on the 15th of the month.

MSSA bacteraemia (Trust-apportioned and non-Trust apportioned cases)

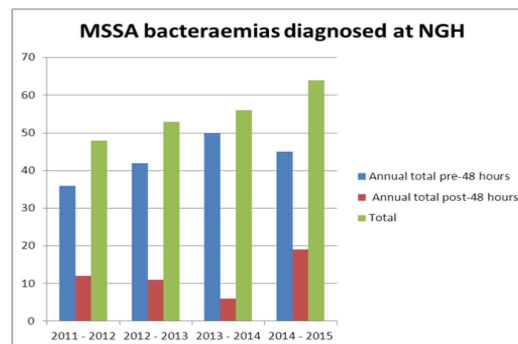

Fig 1

In 2014/15, the Trust investigated the care of the patients with Trust-apportioned MSSA. A key area for focus included soft tissue infections.

MRSA
The Trust investigates every MRSA bacteraemia as an incident and undertakes a post incident review (PIR). These investigations are fed back to a multi-disciplinary group including the DIPC and are accompanied by an action plan as required. These actions are monitored through the IP Team.

The Trust was attributed 2 post 48 hour cases in total, to Cedar and Dryden ward.

Cedar Bacteraemia in January 2015
There were several factors that were highlighted that could have contributed to the infection however good practice was also found.

The patient was very malnourished and had a naso gastric tube replaced several times as patient kept pulling it out. The medical team had several attempts at cannulation and several cannulas were pulled out by the patient. Issues regarding the lack of documentation with Vital Pac were highlighted and this is being addressed across the trust. Staff training in infection preventing was below 85% and this was rectified immediately. There were several issues regarding hand hygiene and non-compliance to the Trust policy from the medical staff. Daily hand hygiene audits, personal protective equipment (PPE) audits and hand hygiene training were commenced and medical staff challenged regarding their practice.

Dryden Bacteraemia in January 2015
Issues highlighted were poor documentation on the Vital Pac system as this patient had several cannulas inserted. There was poor compliance with hand hygiene and personal protective

equipment (PPE) and poor documentation regarding the blood culture. It was noted that good practice was observed in the insertion of a urinary catheter and care, MRSA screen compliant and ward environment audits were 100%.

The learning from these 2 events was shared at the monthly CQEG meeting, IPC and the Trust Board meeting. Additional blood culture awareness training for medical staff and further training on Vital Pac and a more streamlined and transitional approach for rolling Vital Pac into all clinical areas was provided by the IP Team.

MRSA bacteraemia cases 2011 – 2015

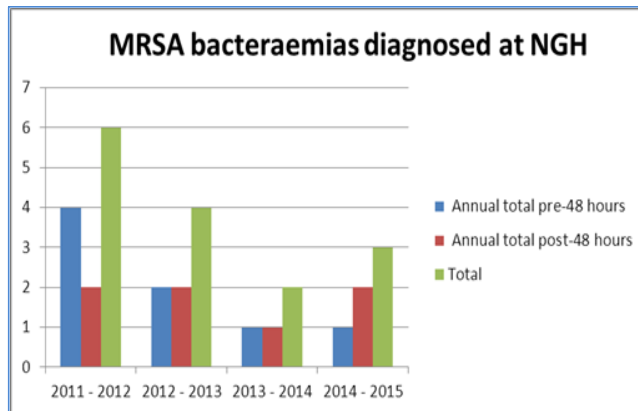

Fig 2

MRSA bacteraemia cases by month 2014/15

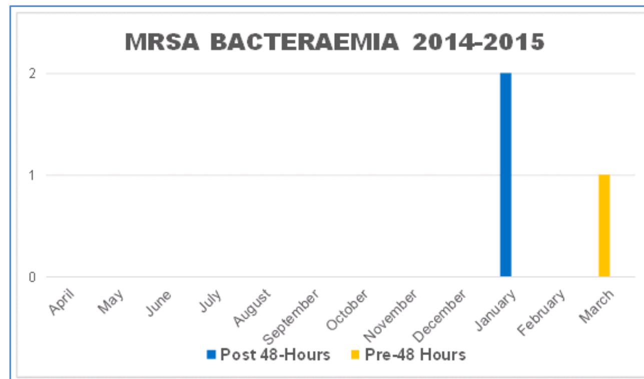

Fig 3

MRSA Colonisation

The graph below reflects the number of cases of MRSA colonisations attributed to the Trust per month during 2014-2015:

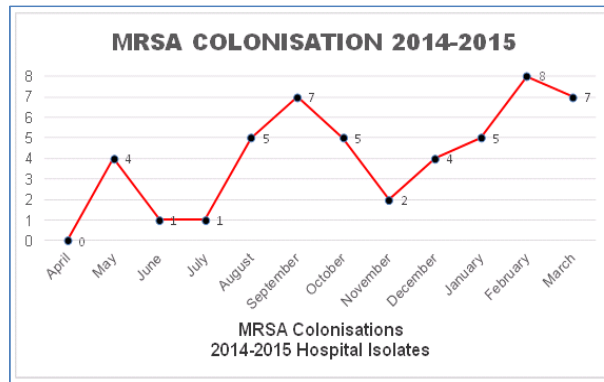

Fig 4

The Trust continues to work with the Clinical Commissioning Group and the whole health economy in continuing to promote excellent HCAI policy and practice.

Special Measures – MRSA Colonisation

A period of increased incidence is defined by Public Health England as 2 or more new cases of post admission MRSA colonisation on a ward in a 28-day period, currently termed 'special measures'. Post admission is defined as any MRSA swab dated over 48 hours after admission.

The IPCT identified a range of 'special measures' which were implemented on any ward that had 2 or more new cases in a 28 day period. Allebone, Creaton, and Victoria ward were on special measures during 2014-2015. The graph below reflects the wards that have been on special measures for MRSA colonisation. The actions from all these special measures are fed back to the Trust Board monthly through the Board Report.

Wards that have 2 or more incidences of MRSA colonisation

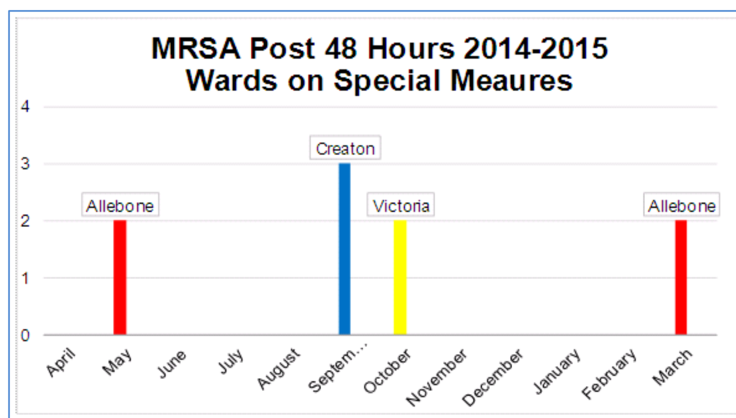

Fig 5

Enclosure H

MRSA Screening
In line with the DH 'MRSA Screening - Operational Guidance 2' the following patient groups are screened as indicated below:

MRSA Screening by Patient Group:

Patient group / Admitted to	Screening
Elective admissions as described in DH letter and operational guidance (excludes some day cases)	Time of listing Eradication of MRSA attempted before admission
Critical Care	On admission to Critical Care and on a weekly basis
Renal dialysis patients	On admission to the programme and quarterly thereafter
All other patients including emergency admissions	On admission
All patients	All patients with a 25 day stay

Northampton General Hospital (NGH) achieved compliance with the requirements for all elective patients to be screened for MRSA colonisation, under the reporting methodology advocated by the Department of Health. The overall compliance for the year for electives was 96% (patient specific verified data) and the overall compliance for non-electives was 99.8%. Efforts continue to achieve greater compliance.

Glycopeptide Resistant E*nterococci* (GRE)
GRE are strains of *enterococci* resistant to the glycopeptide antibiotics (vancomycin and teicoplanin). *Enterococci* are bacteria normally found in the gut that may cause infections including bacteraemia. GRE bacteraemia is strongly associated with prolonged hospital stays and specialist areas such as renal units and intensive care units. GRE bacteraemias may be difficult to treat because only a few effective antibiotics are available. Rates per thousand bed days are not calculated owing to the small number of cases.

***Clostridium difficile* infection (CDI)**
Since January 2004 it has been a mandatory surveillance requirement for the Trust to report cases of *Clostridium difficile* toxin positive stool. Non-inpatient cases detected in the Clinical Microbiology Laboratory must also be reported as part of the NGH data. *Clostridium difficile* cases are no longer subject to a separate target for patients aged 65 years and older, all cases in patients >2 years old are reportable.

The CDI NHS England target for the Trust for 2014/15 was no more than 35 cases. There have been 28 patients with Trust-apportioned CDI in 2014/15 in total as shown in the graph below.

CDI –YTD against the end of year target

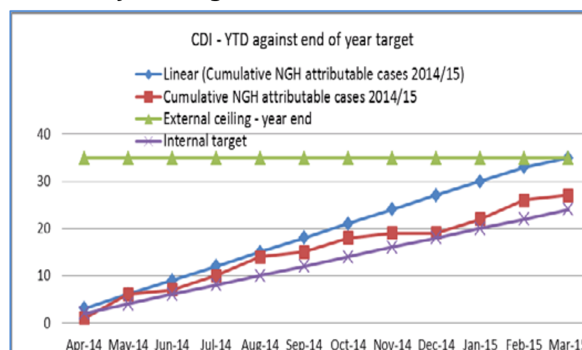

Fig 6

Special Measure actions were implemented for wards that have two or more incidences of *Clostridium difficile* in a 28-day period. Abington, Becket and Allebone ward had been on special measures in this period due to having 2 incidences of CDI. These samples were sent for rybotyping and all were different types confirming no cross infection within the wards.

The weekly CDI Review Team comprising of a Consultant gastroenterologist, Consultant Microbiologist, a member of the Infection Prevention and Control Team and the Antimicrobial Pharmacist continues. All patients who have *Clostridium difficile* have their care and antibiotic management proactively reviewed.

Each CDI case has been investigated by the clinical teams using a root cause analysis (RCA) process and fed back to the IPC Committee. Any gaps in service delivery are discussed and actions agreed at the RCA meeting and monitored by the IPC Team.

There have been no periods of increased incidence for 2014-15 and in all cases the rybotyping was confirmed as distinct.

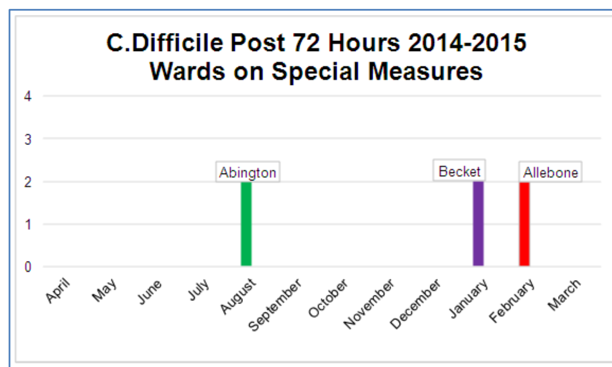

Fig 7

Highlighted actions taken in 2014/15 to reduce the risk of CDI include:

- Implementation of the HCAI Reduction Action Plan and CDI action plan
- The IPC Team have redeveloped the side room summary. This is sent out daily and is now RAG rated to determine patients' priority for side rooms. This supports patient flow and patient safety.
- The IPC Team has provided targeted training with key personnel
- Collaborative work with the Domestic Services Team to put in place enhanced cleaning in areas where there are increase in patients with CDI or GDH
- The use of fidaxomicin has been agreed for the use in patients with moderate and severe disease. This treatment aims to reduce relapse and has the potential reduce the spore formation and hence contamination of the environment.
- Collaborative work with the CCG has continued throughout the year. The health economy root cause analysis tool has now been updated and is in use.

Local Public Health England (PHE) data April 2014/March 2015 – Number of CDI cases

	Trajectory	Actual
Bedford Hospital	18	**14**
East & North Hertfordshire	15	**12**
Northampton General Hospital	35	**28**
Luton & Dunstable Hospital	19	**11**
Milton Keynes Hospital	19	**36**
Kettering General Hospital	28	**33**
West Hertfordshire Hospitals	31	**23**
South Midlands and Hertfordshire	**165**	**157**

While it is a significant achievement to have met the 2014-15 target, the "ambition" set for us for 2015-16 is 21 cases. This will only be met by maintaining the high standards of environmental cleanliness and careful antibiotic prescribing that we have seen this year. Until now we have reported all C.diff toxin positive cases. We must ensure that all patients admitted with diarrhoea have a sample sent within the first 3 days post admission to ensure correct case attribution.

Antimicrobial Resistance: ESBL Producers (Extended Spectrum Beta-lactamase Producers)
ESBLs are a group of enzymes produced by bacteria. The enzymes break down antibiotics such as cephalosporins and penicillin's, but the bacteria are usually susceptible to and hence treatable with the carbapenem antibiotics.

The epidemiology of these bacteria is not fully understood. The emergent nature of this field of microbiology is underlined by the absence of any national case definitions for community or hospital-acquired infections with ESBL producers, or recommendations on what constitutes an episode of infection with ESBL producing bacteria.

ESBL Producing Bacteria (Clinical Isolates)

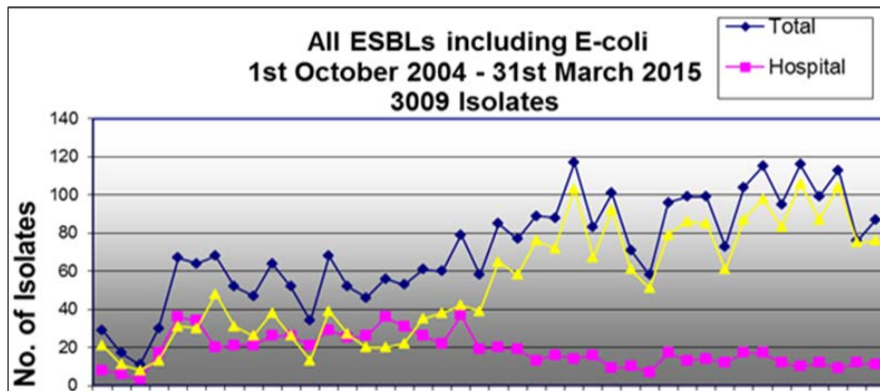

Fig 8

Escherichia Coli (E.coli) bacteraemia
In accordance with the Department of Health Guidelines the IPT commenced mandatory reporting of E coli bacteraemia in June 2011. National data is collated to include all positive results, they are not attributed to either acute of community responsibility.

All ESBL post 48 hour positive blood cultures have detailed data collated and an internal RCA is conducted to highlight any common trends and learn from this analysis. Currently NGH considers all episodes diagnosed after 48 hours as hospital attributed.

On review of the clinical specimen's themes and trends, urosepsis and recurrent UTIs still continue to rank as the highest cause. As the ever increasing drug resistance continues to be seen in all aspects of healthcare the collection of the ESBL data remains of paramount importance for the team to be able to review trends in causes or cases as seen.

Antimicrobial Resistance: CPE (Carbapenemase Producing Enterobactericae)
CPE have similarities to ESBLs but with a wider range of effects on antibiotics – breaking down the carbapenem group of antibiotics.

The DH has issued guidance in the form of a toolkit[4] and this predominantly concentrates on prevention: isolation of high-risk individuals and screening being of particular importance. Focus

[4] Available from here:
http://www.hpa.org.uk/Publications/InfectiousDiseases/AntimicrobialAndHealthcareAssociatedInfections/1312Toolkitforcarbapenementero/

has been given to patients who have been an in-patient abroad in the past 12 months**.** In response to this, the IPC Team has collaborated with other local Trusts and utilising the CPE toolkit has developed the following:

- The Infection Prevention Team have developed a Trustwide CPE Procedural Document
- A Patient Information Leaflet
- A Staff information leaflet
- A Training package on CPE
- A CPE surveillance sheet
- A flowchart and "how to" screen patients how are suspected to CPE

Training on CPE is given at Trust induction, this is an annual update and supported through the clinical staff workbook.

Mandatory Surveillance of Surgical Site Infections
NGH is participating in Surgical Site Infection Surveillance (SSIS) that is co-ordinated by Public Health England (PHE) in order to enhance the quality of patient care, where the rates of SSI's are compared with other hospitals that take part in surveillance. This system demonstrates significant reductions in rates of SSI in hospitals that participate in these benchmarking schemes. For the mandatory surveillance of SSI following orthopaedic surgery, all NHS Trusts must participate in a minimum of one surveillance period in at least on category of orthopaedic procedures, during a financial year that runs from 1st April to 31st March. Each category of the surveillance is based on a 3 month period (quarter). Patients are followed and reviewed during their inpatient stay. Once discharged they are followed up in clinics/outpatients, re-admission or via a post discharge questionnaire that is completed on the 30th day after their surgery. Day of the surgery is counted as day one.

- Patients with no implant insertion, the surveillance of SSI must be stopped on the 30th day after their surgery.
- Patients where an implant was inserted must be followed for up to 1 year after the surgery.

All information of the categories and final reports are captured on a national PHE web-based data system.

NGH Infection Prevention Team (IPT) in collaboration with the Trauma and Orthopaedic Directorate is undertaking five different categories for SSIS each quarter. Total hip replacement and total knee replacement, fractured neck of femur are undertaken each quarter. The IPT then chooses other two categories that may vary each quarter.

Approximately one month after each quarter, the surveillance is reconciled to PHE where the findings are shared with all Trust undertaking surveillance. Quarterly results are reported to Clinical Quality and Effectiveness Group (CQEG) and to Trust Board (see table 1).

Table 1: Surgical Site Infection Surveillance

In financial year 1st April 2014 to 31st March 2015 we have undertaken the following surgical site infection surveillance categories: Total Knee Replacement (TKR), Total Hip Replacement (THR), #NOF, Limb amputation, Spinal surgery, Caesarean sections, Small bowel surgery and Abdominal Hysterectomy.

1st April – 31st March 2014/2015	Total Knee Replacement	Total Hip Replacement	#NOF	Limb Amputation	Spinal	C-Section	Abdominal Hysterectomy	Small Bowel
Total Number of procedures	242	290	333	67	43	330	64	15
No. of SSI inpatient/re-admission	1		5	2		6		1
No. of SSI post-discharge confirmed by healthcare professional/reported by midwife		1				7		
No. of SSI patient reported post discharge			1	2	1	24	4	1
Total infections	1	1	6	4	1	37	4	2

Quarterly SSI reports from 1 April 2014 to 31 March 2015 compared with results from all hospital in this surgical category for the previous 5 years available.

April – June 2014/15

April - June 2014/2015	Total Knee Replace-ment	Results from all hospitals	Total Hip Replace-ment	Results from all hospitals	#NOF	Results from all hospitals	Limb amputation	Results from all hospitals	Spinal	Results from all hospitals
Total Number of procedures	68	123350	80	121422	83	62548	35	1340	20	23064
No. of SSI inpatient/re-admission	0 0%	821 0.7%	0 0%	932 0.8%	3 3.6%	1017 1.6%	0 0%	60 4.5%	0 0%	330 1.4%
No. of SSI post-discharge confirmed by healthcare professional/ midwife	0 0%	288 0.2%	0 0%	169 0.1%	0 0%	46 0.1%	0 0%	2 0.1%	0 0%	13 0.1%
No. of SSI patient reported post discharge	0 0%	No data	0 0%	No data	0 0%	No data	0 0%	No data	0 0%	No data
Total infections	0 0%	1109 0.9%	0 0%	1101 0.9%	3 3.6%	1063 1.7%	0 0%	62 4.6%	0 0%	343 1.5%

Please note: Three fractured neck of femur patients developed wound infections post-surgery from April - June 2014/2015, making our rate of surgical site infections for this patient group above the national average. A root cause analysis (RCA's) was completed for each of the three patients and action plans set out and completed as below:

- Education was provided to Abington and Cedar ward staff with regards to the rationale and process for prophylactic decolonisation
- Education was provided to patients for the rationale and process for prophylactic decolonisation by developing a patient information sheet
- The process was embedded for prophylactic decolonisation by empowering the healthcare assistants to take local ownership of this -
- Staff nurses were educated to ensure that all medication/treatment is clearly signed for -
- Education was provided to the anaesthetics regarding the importance of giving induction antibiotics prior to incision and to give additional prophylactic antibiotics when the patient has MRSA or a previous history of MRSA -
- Education was given regards to starting decolonisation treatment on admission if patients are taken to Abington or Cedar ward from A&E

July – September 2014/15

July – September 2014/2015	Total Knee Replace-ment	Results from all hospitals	Total Hip Replace-ment	Results from all hospitals	#NOF	Results from all hospitals	Spinal	Results from all hospitals	Limb Amputation	Results from all hospitals
Total Number of procedures	52	123085	69	122387	87	63146	23	23727	32	1341
No. of SSI inpatient/re-admission	1 1.9%	825 0.7%	0 0%	941 0.8%	0 0%	997 1.6%	0 0%	349 1.5%	2 6.3%	55 4.1%
No. of SSI post-discharge confirmed by healthcare professional/ midwife	0 0%	279 0.2%	1 1.4%	166 0.1%	0 0%	48 0.1%	0 0%	13 0.1%	0 0%	1 0.1%
No. of SSI patient reported post discharge	0 0%	No data	0 0%	No data	0 0%	No data	1 4.3%	No data	2 6.3%	No data
Total infections	1 1.9%	1104 0.9%	1 1.4%	1107 0.9%	0 0%	1045 1.7%	1 4.3%	362 1.5%	4 12.5%	56 4.2%

Please note: One total knee replacement and two limb amputation patients developed wound infections post-surgery from July – September 2014/2015, making our rate of surgical site infections for this patient group above the national average. A root cause analysis (RCA's) was completed for each of the patients. Due to a small sample size and only one infection for total knee replacement, no further actions were required. There were two patients with post-surgery infections for limb amputation. One patient had a fall on the stump that resulted in cellulitis; one patient had an oozing stump and was waiting for rehoming.

October – December 2014/15

October – December 2014/2015	Total Knee Replace-ment	Results from all hospitals	Total Hip Replacement	Results from all hospitals	#NOF	Results from all hospitals	C-section	Results from all hospitals
Total Number of procedures	74	121905	86	121133	80	63760	330	24919
No. of SSI inpatient/re-admission	0 0%	823 0.7%	0 0%	930 0.8%	1 1.3%	973 1.5%	Total:	
No. of SSI post-discharge confirmed by healthcare professional/ midwife	0 0%	277 0.2%	0 0%	165 0.1%	0 0%	51 0.1%	13 3.9%	950 3.8%
No. of SSI patient reported post discharge	0 0%	No data	0 0%	No data	1 1.3%	No data	24 7.3%	738 3%
Total infections	0 0%	1100 0.9%	0 0%	1095 0.9%	2 2.5%	1024 1.3%	37 11.2%	1688 6.8%

January – March 2014/15

January – March 2014/2015	Total Knee Replacement	Results from all hospitals	Total Hip Replacement	Results from all hospitals	#NOF	Results from all hospitals	Small Bowel	Results from all hospitals	Abdominal Hysterectomy	Results from all hospitals
Total Number of procedures	48	120629	55	119246	83	63927	15	2134	64	1686
No. of SSI inpatient/re-admission	0 0%	800 0.7%	0 0%	921 0.8%	1 1.2%	956 1.5%	1 6.7%	183 8.6%	0 0%	30 1.8%
No. of SSI post-discharge confirmed by healthcare professional	0 0%	278 0.2%	0 0%	173 0.1%	0 0%	51 0.1%	0 0%	4 0.2%	0 0%	7 0.4%
No. of SSI patient reported post discharge	0 0%	No data	0 0%	No data	0 0%	No data	1 6.7%	No data	4 6.3%	No data
Total infections	0 0%	1078 0.9%	0 0%	1094 0.9%	1 1.2%	1007 1.6%	2 13.3%	187 8.8%	4 6.3%	37 2.2%

Untoward Incidents and Outbreaks
Cedar Ward was closed for Norovirus on the 22nd January 2015 and reopened on the 29th January 2015 after a deep clean. Seven patients and six members of staff with diarrhoea and or vomiting were affected. Three samples were confirmed as Norovirus positive. A Serious Incident (SI) report was produced. The key learning points were:

- All staff were made aware of the correct procedures for patients visiting other departments for diagnostic tests during closure of wards for norovirus
- To ensure that all patients with diarrhoea should have a Trust diarrhoea core care plan in place

Influenza
The Trust monitors the PHE advice on flu preparedness working closely with Occupational Health and Resilience Lead.

Ebola Planning
In response to the Ebola virus disease (EVD) outbreaks which occurred for the first time in Guinea, Liberia and Sierra Leone, the Infection Prevention Team worked collaboratively with the Interim Head of Resilience and others. A multidisciplinary team approach was taken to ensure preparedness in the event that a potential case of Ebola should attend the Accident and Emergency Department at NGH.

An Ebola Preparedness Report was circulated throughout the organisation and regular meetings took place to ensure that NGH was prepared. An area for appropriate placement of patients was identified and Fit testing took place with regard to mask wearing and PPE.

An Ebola Preparedness Study Day took place in October 2014; this consisted of presentations by a member of the Infection Prevention and Control Team and the Consultant Microbiologist. This included a demonstration from EMAS on the correct 'donning and doffing' of Personal Protective Equipment (PPE), staff were observed undertaking this process.

The Infection Prevention Team with NHS England and the Consultant microbiologist also observed a 'dummy' run where a pseudo suspected Ebola case was admitted through A and E and all procedures followed by staff were observed this was followed by a debrief from NHS England.

5. Review of Annual Plan

The annual plan was achieved except for one area regarding the further development of an ESBL database. The department was not successful with the anticipated web based surveillance application, ICNet, therefore a business case put forward in October 2014 unfortunately this was not successful and will be put forward to the following year.

Infection Prevention Audits April 2014- March 2015
The following audits were undertaken during the year:

Audit	Overall Hospital Score
Sharps	**98%**
Environment	**90%**
Linen	**96%**
Isolation	**94%**
Waste	**95%**
ANTT	92%
Blood Cultures	77%
PVC	76%
Hand Hygiene	88%
Total Hospital Compliance	**94%**

All IPC audits are presented at the Infection Prevention & Control Committee. Of those which triggered, improvement plans were put into place and PVC and blood cultures were re-audited and presented to the IPC Meeting.

Compliance Criterion	What the registered provider will need to demonstrate
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

6. Hospital Cleaning

The first Patient-Led Assessments of the Care Environment (PLACE) took place this year. This is the new system for assessing the quality of the patient environment. The aim of PLACE (which took over from the long established PEAT programme) is to provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the patient experience of care, cleanliness, the condition, appearance and maintenance of healthcare premises.

The IPCT always participates in these assessments and the Trust continues to achieve acceptable scores in the majority of the assessment process. The assessment which is carried out mainly by patient representatives took place in April 2014.The results were as follows:

- Cleanliness **99.46 %**(95.75%)
- Condition appearance and maintenance **89.6% (**88.7%)
- Privacy, dignity and wellbeing **94.17% (**88.9%)
- Food and hydration **89.63%** (85.41%)

(The figures in brackets are the national average scores)

Whilst this was a snapshot in time it is nevertheless a very good result and is used as evidence by the CQC in their reviews.

Monthly cleaning audits are performed in all directorates with the table below providing an overall average at the end of the year:

Month	%
April	97
May	97
June	97
July	97
August	97
September	97
October	94
November	96
December	96
January	97
February	98
March	98
AVERAGE	**97**

7. Decontamination Service

Sterile Service Department (SSD)

The Sterile Service department processed nearly 160,000 trays and procedure packs between April 2014 and March 2015. The department is taking on an additional new contract to provide fully compliant podiatry services to NHFT starting June 2015 providing the Trust with additional income.

The Sterile Service Department successfully demonstrated compliance against European and British decontamination guidance during a one day external audit and have maintained its ISO9000/13485/Medical Device Directive 93/42/EEC accreditation for 2014/15. The department is now completing monthly Key Performance Indicators (see below).

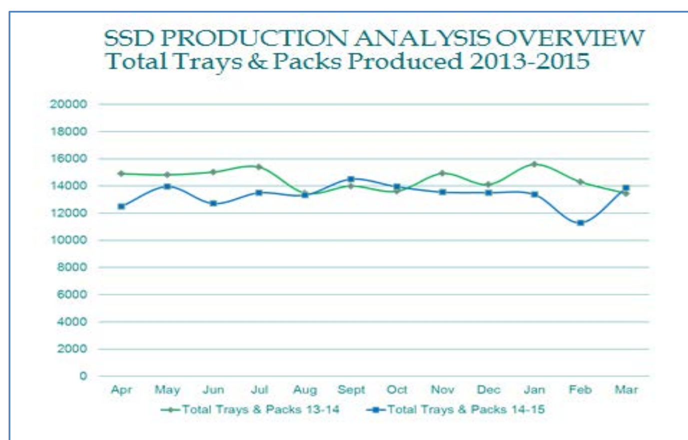

Fig 9

The old NVQ level 3 qualifications in decontamination was replaced with the "Institute of Decontamination Sciences Technician Certificate", the Trust currently has 7 technicians enrolled on this course and are working through the syllabus. Two students were successful in completing this course during the year.

The Department's traceability system is due for further upgrades in the coming year to allow full reporting of the turnaround time from SSD. This will provide the department with the information to monitor its key performance indicators within our service level agreement.

SSD continue to operate machinery according to national guidance in the forms of the CFFP (Choice Framework for Local Policy) guidance which was made available during March 2013, these documents include:

- CFPP 01-01 2013 Management and decontamination of surgical instruments used in acute care
- CFPP 01-06 2013 Management and decontamination of flexible endoscopes

Medical Equipment Library

The Medical Equipment Library (MEL) has continued to work in conjunction with Patient and Nursing Services to streamline the way the Trust orders Ad-Hoc rental mattresses. The entire order process has been reviewed and Key Performance Indicators are now produced to evidence the availability of equipment (and requests) both in and out of working hours.

The T Card system to aid the library in the tracking of VAC therapy pumps, Infusion and Syringe pumps and the new T34 24hr Syringe Drivers is still operational, however a new improved system is required to track pumps such as the T34 McKinley pumps which are sent out with the patient to the community. Further work is underway to investigate RFID (Radio Frequency Identification) to enable all items to be tracked within the Trust.

The Medical Equipment Library was heavily involved in the implementation of the new Autologic pressure relieving mattress from Arjo Huntleigh. This system was put into the Trust to enable us to remove all overlay systems. The implementation of 180 new systems is aimed at reducing the need for ad-hoc orders and to provide patients with another medium to high risk therapeutic mattress system.

Staffing arrangements for the Equipment Library have been reviewed, with Staff from Sterile Services Department now rotating into this area to enable us to have a more robust staffing base. Any shortages of staff in the equipment library can now be filled by SSD technicians.

Endoscopy

The department is fully equipped with single sided AERs, Drying Cabinets and RO water systems. A scope transportation system is in use. The scope transportation system allows flexible endoscopes to be transported safely in a vacuum sealed plastic pouch between users and the endoscopy reprocessing room.

Further discussions are required during the coming year to establish the feasibility of placing storage cabinets in theatre.

Further discussions are also required concerning the capacity of the existing Endoscopy Unit as this does not allow for any service development opportunities. If a new facility is proposed, then pass-through AER's will be specified.

The Authorised Person (Decontamination) continues to sign off test reports, and monitor the weekly tests in conjunction with the Endoscopy Manager.

Trustwide

Work has taken place with the Children's Service providing spirometer services to patients with Cystic Fibrosis.

Work has also taken place with the Pre Assessment Clinic providing Exercise metrics for patients coming in for surgery. This has provided assurances that equipment is being effectively decontaminated between patients.

Forward Plan 2015 - 16

A review and business case to be developed to replace the existing sterile service washer disinfectors (which are now over 14 years old) with larger machines and more efficient machines to meet the additional activity increase for 2015/16.

A business case has been submitted for RFID tracking of all devices from the Equipment Library.

It was recognised that attendance at the Decontamination Committee was poor. Therefore this group has been reformed and turned into the Decontamination User Group where individuals can not only discuss decontamination issues, but also any other issues with the services provided from SSD or MEL.

The Trust Decontamination Lead continues to sit on the Infection Prevention and Control Committee and provides a monthly report on decontamination issues.

8. Information Provision

Compliance Criterion	What the registered provider will need to demonstrate
3	Provide suitable accurate information on infections to service users and their visitors.

The Trust provides all service users with information as required. This includes information leaflets for patients, visitors and staff.

Staff are able to access Trust policies and clinical guidelines, care pathways and care plans to provide condition specific information.

IPC information is also provided for services users via the Trust internet (external) and intranet (internal) sites.

Information is shared internally via the communication teams via a newsletter titled 'Bug Buster' which provides a monthly update on Infection Prevention Control to the Trust. Issues are displayed on notice boards throughout the Trust for all staff to read.

Patient and Public Engagement (PPE)
In February 2014 a review of Patient and Public Involvement (PPI) within NGH proposed a move to adopt the all-encompassing term-Patient and Public Engagement (PPE). This gave rise to the formation of a Patient Engagement network (PEN). The objective of this was to provide a pool of representatives that would support the Trust in a number of activities. Evidence of this may be seen through regular audits e.g. Noise at Night, protected mealtimes and QUEST and of course Friends and Family Test (FFT).

Over the year the Infection Prevention Focus Group had been monitoring visitors hand hygiene and keeping up to date with infection rates generally at their bi-monthly meetings. However, following the changes to the Patient and Public Engagement structure this focus group was discontinued. The chairman of this group was a regular attendee at the monthly IP Committee Meeting and was in agreement to continue to work closely with the IP Team.

This developed into a regular weekly visit to the IP Office and a series of audits to support ongoing work there. These have included surveys of documentation to do with Admissions and Transfers, a study on the knowledge and use by staff members of the Side Room Tool, and a close look at the consistency of application of protocols regarding the use of Octenisan and equivalent washes. In recent weeks the focus has been on the use of protective equipment by members of staff and also of their hand hygiene practices.

Compliance Criterion	What the registered provider will need to demonstrate
4	Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion.

The Trust provides condition specific information to support staff to provide safe care in a variety of ways:

a) Condition specific care plans and care pathways
b) Interdepartmental transfer forms
c) Discharge information – community healthcare providers are informed by the Trust IPC team when patients are discharged as agreed.

Compliance Criterion	What the registered provider will need to demonstrate
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.

9. Antimicrobial Stewardship

Compliance to Trust Antibiotic Policy

The point prevalence audits were performed by Clinical Pharmacists at the Trust over a one day period (23 April and 7 October 2014). The aim was to audit antimicrobial prescribing at the Trust and compliance to the Trusts Antibiotic Policy.

This is in response to the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance. Criteria 9 of which states that procedures should be in place to ensure prudent prescribing and antimicrobial stewardship, there should be an ongoing programme of audit, revision and update.

April 2014

Descriptor	Number	Proportion	Comments
Total number of patients seen	**558**		
Number of patients on antibiotics	**184**	**33%**	This is similar to the results of the October 2013 audit.
Total number of antibiotics prescribed	**252**	**1.4 per patient**	
Number adhered to the policy	**215** **246 (including valid reasons for non-compliance)**	**85.3%** **97.6% (including valid reasons for non-compliance)**	Valid reasons for non-compliance; • Micro approved = 10 (4%) • Based on C&S =0 (0%) • No guidelines for infection = 19 (7.5%) 6 prescriptions (2.4%) did not comply with NGH antimicrobial guidelines
Number of intravenous (IV) prescriptions	**152**	**60%**	This is slightly lower than the previous October 2013 audit (62%).
Number of oral prescriptions	**100**	**39.7%**	This is slightly higher than the previous audit, October 2013 (38%). 10 prescriptions had been switched from IV treatment
Average duration of IV antibiotics	**4.9 days**		This is higher than the average of 3.6 days in October 2013. | As this is a point prevalence audit data is not available for the total course lengths actually given to each individual

Descriptor	Number	Proportion	Comments	
Average duration of oral antibiotics	**3.6 days**		This is higher than the average of 2.9 days in October 2013.	patient.
Duration of antibiotic administration stated on prescription chart	**100**	**39.7%**	This has increased from 36.5% in October 2013. More work needs to be done to ensure reviews are taking place and that all course lengths are documented.	
Number of antimicrobial prescriptions with one or more omitted dose	**10**	**5.4%**	It is worrying that 5.4% of patients taking antibiotic courses have one or more dose omitted. Antibiotics are critical medicines and no doses should be omitted or delayed. The Medication Safety Group is working with all the wards to reduce omitted doses. The data collected for this standard will be looked at in more detail.	

October 2014

Descriptor	Number	Proportion	Comments	
Total number of patients seen	**579**		558 patients were audited in April 2014. This is the highest number ever covered.	
Number of patients on antibiotics	**208**	**35.9%**	The proportion is slightly higher than April 2014, 33% of patients were receiving antibiotics.	
Total number of antibiotics prescribed	**243**	**1.2 per patient**	This is lower than April 2014 when 1.4 antimicrobials were prescribed per patient.	
Number adhered to the policy	**191** **230 (including valid reasons for non-compliance)**	**78.6%** **94.7% (including valid reasons for non-compliance)**	Valid reasons for non-compliance; • Micro approved = 25 (10.2%) • Based on C&S = 5 (2.1%) • No guidelines for infection = 9 (3.7%) 13 prescriptions, 5.3% did not comply with NGH antimicrobial guidelines	
Number of intravenous (IV) prescriptions	**150**	**62%**	This is comparable to the previous audit in April 2014 (60%).	
Number of oral prescriptions	**93**	**38%**	This is comparable to the previous audit in April 2014 (40%).	
Average duration of IV antibiotics	**3.9 days**		This is lower than the average of 4.9 days in April 2014. *(Lifelong and long term courses approved by microbiology were excluded)*	As this is a point prevalence audit data is not available for the total course lengths actually given to each individual patient.
Average duration of oral antibiotics	**3 days**		This is lower than the average of 3.6 days in April 2014. *(Lifelong and long term courses approved by microbiology were excluded)*	

Descriptor	Number	Proportion	Comments
Duration of antibiotic administration stated on prescription chart	**101**	**41.6%**	This has increased from 39.7% April 2014. More work needs to be done to ensure reviews are taking place and that all course lengths are documented.
Number of antimicrobial prescriptions with one or more omitted dose	**17**	**7%**	It is worrying that 7% of patients taking antibiotic courses have one or more dose omitted; this has increased from 5.4%. Antibiotics are critical medicines and no doses should be omitted or delayed. The Medication Safety Group is working with all the wards to reduce omitted doses. The data collected for this standard will be looked at in more detail.

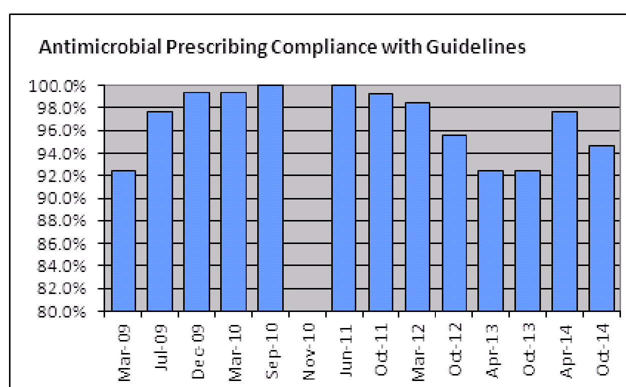

Fig 10

These biannual audits will be repeated and are scheduled for April 2015 and October 2015.

If poor compliance is noted then this is followed up immediately, for example each report comments on the very low numbers of prescribing deviations.

Training initiatives
Junior Doctors training was delivered on 10th April 2014.

Antibiotic campaigns
European Antibiotic Awareness Day provides a platform to support and promote national campaigns about prudent antibiotic use in the community and in hospitals. On November 18th 2014 awareness was raised via a presentation on the Trusts corporate screensaver focusing on antibiotic guardianship and resistance.

An article on the issues surrounding growing resistance to antibiotics was published in the December edition of Insight magazine

Antimicrobial Stewardship Group
An Antimicrobial Stewardship Group was set up in 2012. The remit of this group is to develop and implement the organisation's antimicrobials programme for all adults and children admitted to hospital. The last meeting in February 2014 was attended by the consultant microbiologist, antimicrobial pharmacist and minute taker. At the CQEG meeting on 13th March 2015 the Divisional Directors were asked to think about how the Trust's Antimicrobial Stewardship Group could be re-formatted and restarted.

Developments in the last year have included:

- Bi-annual antimicrobial point prevalence audit (April and October)
- IV to oral switch audit conducted by pre-registration pharmacist
- Various PGD reviews and ratification
- Quarterly review of datix reports related to antimicrobials
- Screen saver to promote Microguide smartphone app
- New drug applications approved by Formulary Committee:

    - Octenidine nasal gel – for patients intolerant and/or resistant to mupirocin and when mupirocin is not available
    - Azithromycin - prophylaxis of exacerbations in bronchiectasis (long term)
    - Moxifloxacin – drug resistant TB and for patients intolerant to other therapies
    - Fidaxomicin - on recommendation of microbiologist in line with the PHE Guidelines for treatment of C.Difficile

Compliance Criterion	What the registered provider will need to demonstrate
6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.

10. Staff Development and Training

All staff roles include IPC in the job description. How this is applied is outlined at the individual's local induction when in post.

Training was a key tool in improving staff knowledge on IPC practices in 2014/15. The IPCT delivered training across the entire spectrum of staff and for a wide range of purposes from generic Trust-wide sessions at induction to bespoke training on very specific issues.

The IPCT participates in Trust Induction for all new starters including junior doctors. The IPCT also supports specific induction training to all grades of staff as requested by each service.

The IPCT fully support the Trust mandatory training programme, delivering sessions for all staff at mandatory training sessions. These sessions are recorded on the Trust central training records

Compliance with attendance at key IPC training (induction, annual mandatory and ANTT training) is tracked within the IPC Reports.

Developments

On the 25th November 2014 the Infection Prevention Team celebrated their fifth annual study day.

Forty five members of nursing, HCA and midwives came together from across the Trusty to learn more about different aspects of infection prevention and control. The event was sponsored by five companies whose infection prevention products we use.

Jane Bradley, the Interim director of nursing and also the director of infection prevention and control, gave a very motivating welcome address. There were varied presentations ranging for CPE to the urinary catheter care plan and how we are using the acronym HOUDINI.

Feedback was very positive, staff found it very informative, interesting and motivating. The IP team are looking into having a study day every six months instead of annually as these are such a success.

Compliance Criterion	What the registered provider will need to demonstrate
7	Provide or secure adequate isolation facilities.

11. Isolation Facilities

The current proportion of single rooms is 8% across the Trust. Some specialities have requested more single room capacity due to local need. The options of increasing side room capacity is challenging due to the age of significant parts of the Trust.

The target time for isolating patients with unexplained (and potentially infectious diarrhoea) is less than two hours. This is monitored by the IPC team and reports to the IPC Committee monthly.

Each ward has access to the Electronic Side Room monitoring Tool. This identifies who is managed in a side room and the reason for their isolation and each ward identifies patients who can be transferred out of single rooms in the event that another patient requires isolation. This is checked daily by a member of the Infection Prevention and Control Team.

For advice and support the IPC team are available for advice 08:30-19:00 Monday – Friday. There is an on-call microbiology service for advice outside of these hours.

NGH process is that for isolation cleaning out of hours the Domestic Office can be contacted up to 7:30pm daily and after 7:30 staff liaise with the Site Management Team to organise domestic service.

Compliance Criterion	What the registered provider will need to demonstrate
8	Secure adequate access to laboratory support as appropriate.

12. Laboratory Services

Diagnostic microbiology is provided on site as part of NGH pathology services.

Compliance Criterion	What the registered provider will need to demonstrate
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

The Trust has policies, guidelines and standard operating procedures in line with the Health and Social Care Act 2008; Code of Practice on the prevention and control of infections and related guidance.

These documents are monitored utilising a variety of audit tools to measure staff compliance with guidance. Additionally through induction and ad-hoc bespoke sessions, training for all staff types is undertaken to ensure they are kept informed of current guidance.

13. Audit Programme

Saving Lives

The Trust has taken significant steps in embedding the Saving Lives programme into daily activities of clinical care. The overall aim of Saving Lives is to ensure that all staff recognise how they can contribute to reducing infection rates and adopt best practice to achieve this. High impact interventions are used to reduce the risk of healthcare associated infection. Each of these interventions has a simple evidence based tool that reinforces the actions that clinical staff must undertake 'every time' for key procedures in order to significantly reduce infection.

The aim is to increase the reliability of clinical processes and reduce unwarranted variation in care delivery. The compliance ranges from 80% to 100% each month and is RAG rated accordingly.

Peer review was introduced whereby Modern matrons undertook these audits on other clinical areas to compare results and check assurance that those results were compliant.

Matrons Dashboard
The Matrons are required to populate an Infection Prevention compliance dash board each month with the percentages from the high impact interventions within the Saving Lives. The results are RAG rated and fedback at the IPCC, receiving constructive challenge from the DIPC. Areas that are non-compliant are raised by exception to the Healthcare Governance Committee (HGC) to report actions being undertaken to resolve any issues.

The Health Assure, formally the Performance Accelerator
The Trust is registered with the Care Quality Commission (CQC) under the Health and Social Care Act 2008, and as a legal requirement must protect patients, staff and others from acquiring health care associated infections by compliance with the Hygiene Code.

The Hygiene Code evidence has been loaded onto the Health Assure platform which is on-line corporate software that provides boards and management teams with assurance and information needed to plan, manage and report on key performance indicators.

All the evidence has been uploaded and there is one area that is partially compliant (amber).This is criteria 2 due to three facilities policy review dates having expired. They are cleaning services, Food Services and Estates maintenance policy.

Beat the Bug, Save the Skin, Stop the Clot: Board Quality Visit
To support the on-going HCAI agenda across the Trust all Executive and Non-Executive Directors and the Trust Chairman participate in a 'Board Quality Visit' on a monthly basis. This 'inspection', facilitated by the IPCT involves visiting clinical areas with a similar inspection programme to the CQC visit. Each of the Executive Directors visits 2/3 areas and audits the clinical area against set criteria. Data from the visits is collated by the IPCT for the monthly IPC Committee to review.

The reviews are still being seen as very positive by staff on the wards, and the output from the reviews is beneficial, therefore it is important to maintain regular visits.

Compliance Criterion	What the registered provider will need to demonstrate
10	Ensure so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.

14. Occupational Health

Occupational Health services continue to be provided by the Health and Wellbeing Centre. This service provides pre-employment health checks, vaccination and assessment of immunity.

The Health and Wellbeing Centre also supports staff screening, advice and treatment in the event of outbreaks or incidents requiring staff screening or treatment.

The flu campaign of 2014/2015 was again successful in achieving 76.9% of front line staff vaccinated. Although the campaign appears less productive than that of 2013/2014 it was still a positive campaign in comparison to the National uptake figures as published by Public Health England.

15. Summary

Eliminating avoidable healthcare associated infections has remained a top priority for the public, patient and staff. The Infection Prevention team, through their plan of work, have implemented a programme so work which has been supported by colleagues at all levels through the organisation.

Particularly notable successes include:

- Maintaining low levels of C. Difficult and were within our trajectory for 2014/15
- Maintaining low levels of surgical site infections
- Successful planning and implementation for procedures to identify and manage the admissions of patients with suspected Ebola infections

However, a number of key risks and challenges exist and are covered in the plan of work for 2015/16.

Author(S)	Patricia Wadsworth – previous Lead Matron Wendy Foster – Interim Lead Matron Gary Hunt – Decontamination Lead Claire Salt – Anti-Microbial Pharmacist Claire Brown – Occupational Health Fiona Barnes – Deputy Director of Nursing
Owner	Carolyn Fox
Date	14th September 2015

Appendix 1

IPCT Structure 2014/15

Post	Post holder	WTE
Board Executive Lead (DIPC)	Mrs J Bradley / Mrs R Corser	Not defined
DIPC	Mrs J Bradley / Mrs R Corser	Not applicable
Chair of the Trust Infection Prevention and Control Group	Mrs J Bradley / Mrs R Corser	Not applicable
Consultant Medical Microbiologist	Dr A Bentley Dr M Minassian	Not defined
Band 8a IPC Matron	Mrs P Wadsworth	1 x 1.0
Band 7 IPC Nurse	Mrs W Foster Mrs H Slyne	1 x 1.0 ML/1 x 1.0
Band 6 IP Support Nurses	Mrs R Pounds Mrs J Hart Mrs T Arnold Mrs P Dominguez	3.6 WTE ML/1 x 1.0
Band 3 Administration and clerical support	Vacant	1 x 1.0

Appendix 2 – TERMS OF REFERENCE 2014/2015

TERMS OF REFERENCE – INFECTION PREVENTION & CONTROL COMMITTEE

Purpose of Committee

The role of the Infection Prevention and Control Committee is to ensure that there is a managed environment within the Trust that minimises the risk of infection to patients, staff and visitors. The group is responsible for providing professional advice at a strategic and operational level to the Trust.

Functions - Trust

1. To ensure the Trust adheres to the Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance, Health and Social Care Act (2008), (the "Hygiene Code").
2. To fulfil its statutory and other responsibilities as provider of health services, achieving and maintaining the standards required by the Care Quality Commission and other National/Regulatory/Professional bodies for example, Saving Lives.
3. To review trust policies, procedures and guidance for the prevention and control of infection and to monitor their implementation; ensuring that such policies reflect relevant legislation and published professional guidance.
4. To monitor Directorate performance regarding adherence to infection control practice by reviewing "High Impact Intervention" scores, the Trust Hand Hygiene Observational Audit Tool" scores and other relevant information provided on the matron's information dashboard.
5. To ensure that there is an annual infection control programme of activity submitted to and approved by the Trust Board and to ensure that the programme has clearly defined objectives, to provide advice on the effective use of resources for implementation of the plan and to provide assistance in the effective implementation of the plan.
6. To receive, review and endorse the annual Infection Prevention and Control Report.
7. To receive reports on specific problems with respect to the incidence of infection or of infection risks for evaluation and discussion, and to make appropriate recommendations.
8. To discuss relevant issues presented by The Infection Prevention & Control Team (IPCT) and any other member of the committee.
9. To be responsible for major decisions related to control of infection matters.
10. To make recommendation to other committees and departments within the Trust on all infection control matters and techniques, and advise when necessary on the selection of equipment appropriate to the prevention of infections.
11. To promote and facilitate education of all grades and disciplines of staff in procedures for the prevention and control of infection report compliance.
12. To ensure that prevention and control of infection is considered as part of all service development activity.
13. To disseminate information and advice on prevention and control of infection to all appropriate Trust Directorates.
14. To monitor the performance of the infection prevention and controls programme and make suggestions for improvement.

Membership

The membership of the group will consist of:

- Director of Nursing, Midwifery & Patient Services (Chair and DIPC)
- Deputy Director of Nursing
- Director of Facilities/Deputy Director of Facilities
- Senior Infection Prevention & Control Nurse
- Consultant Microbiologist
- Modern Matron
- Sterile Services Manager/Trust Decontamination Lead
- Occupational Health Manager
- Infection prevention and Control Nurse (HPA)
- Patient Representative
- Commissioning Services

The Committee would have the power to co-opt any person necessary to assist in its deliberations

Relationships to other Committees

The Infection Prevention and Control Committee is a subgroup of the Clinical Quality and Effectiveness Group, which in turn reports to the Healthcare Governance Committee and through to Trust Board.

In attendance

Minute taker

Reporting Arrangements

The DIPC reports to the Trust Board monthly.
The Lead IPC Nurse reports to Healthcare Governance Committee monthly operational IP issues.
The Lead IPC Nurse produces an Annual Report for the Trust Board through the Healthcare Governance Committee.
The DIPC, Director of Nursing and Lead IPC Nurse reports and participates in the Whole Health Economy Infection Control meeting.

Distribution of Minutes

1. All members of the Committee
2. Chairman
3. Chief Executive
4. Medical Director
5. Clinical Directors
6. Directorate Managers
7. Minutes on the Intranet Site

Frequency of meetings

Duration – 2 hours

Meetings should take place monthly but extraordinary meetings may be arranged at the discretion of the Chair e.g. at the time of an outbreak of infection. Attendance at a minimum of 8 meetings per annum is required by all members. Meetings take place monthly a week before CQEG

Quorum

A quorum shall consist of seven members, who should include the Chair or Director of Patient and Nursing Services (DIPC) or his/her nominated deputy and a senior member of the Infection Prevention Team.
There is an expectation that were a core member cannot attend that they nominate a deputy. This representative should have delegated decision making responsibility.

Decision Making

The terms of reference will be reviewed every two years or sooner if necessary. The date of the next review will be October 2016.
IPCC is authorised by the Trust to monitor and assist in compliance with the Code of Practice for the prevention and control of Healthcare Associated Infections. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by IPCC.

Declaration of Interest

Nil to declare

Appendix 3

Healthcare Associated Infection Reduction Plan 2015-16

Priorities and key goals for 2015-16

- A reduction in the number of patients with CDI (<21 cases)
- Zero patients with MRSA bacteraemia
- A 25% reduction in the number of patients with MSSA bacteraemias (<15 cases)
- Sustain measurement of CRUTI prevalence through Safety Thermometer Strategic Group and action plan
- Sustain measurement of surgical site infection infections through PHE SSI surveillance system

The plan is built upon the criteria of the Health and Social Care Act (2008) Code of Practice for Adult Social Care on the Prevention and Control of Infections and Related Guidance (2015). This set out ten criteria against which the trust is assessed on how it complies with registration requirements of infection prevention.

BRAG Key	
(blue)	**Complete**
(green)	**On-track**
(amber)	**Delivery issues**
(red)	**Unable to deliver**

Hygiene Code Compliance Criterion 1 – Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them

Objective	Programme of work (action)	Timeframe and milestones	Lead	BRAG Q1	BRAG Q2	BRAG Q3	BRAG Q4	Progress and comments
1 a There are appropriate management and monitoring arrangements for a zero tolerance approach to HCAIs	To agree the corporate priorities for HCAI reduction for 2015-16							
	Clinical teams to undertake case review using principles of RCA and PIR and present to IPC: • All cases of MRSA bacteraemia • All cases of NGH attributed CDI • All cases of NGH attributed MSSA bacteraemia • All cases of NGH attributed E.coli bacteraemia							
	All deaths due to CDI (recorded on part 1a of the death certificate) and the CDI 30 day mortality data to be reported quarterly to IPC and CQEG.	Q1 reported Aug 15	Consultant microbiologis t					
1 b Promote a culture of continuous quality improvement in IPC	Review and update IPC terms of reference and IPOG terms of reference	Sept 2015	IP Matron					
	Provide monthly reports to IPC	Monthly	IP Matron					
	Provide monthly reports to CQEG	Monthly	IP Matron					
	Provide monthly reports to the Trust Board	Monthly	DIPC					
	Present surveillance data regarding HCAIs to IPC	Monthly	Consultant micro.					
	Monitor the progress of the TDA delivery action plan at IPOG meetings	Monthly	DIPC					
	Implement IP audit plan for 2015-16 and report monthly at IPC. *(For further information please refer to the IP annual audit plan).*	Monthly	IP Matron					
	Implement the IP surveillance plan for 2015-16 and report quarterly at IPC. *(For further information please refer to the IP surveillance plan).*	Monthly	IPSSN					
	IPT to conduct '*Beat the bug*' ward quality visits with members of the executive team	Monthly	IPT & executive team					

Hygiene Code Compliance Criterion 2 – Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention of infections

Objective	Programme of work (action)	Timeframe and milestones	Lead	BRAG Q1	BRAG Q2	BRAG Q3	BRAG Q4	Progress and comments
2 a Maintenance of a clean, safe and appropriate environment which facilitates the prevention and control of HCAI	The trust Head of Hotel Services will review the Cleaning Policy and report key issues monthly to IPC	November 2015	Head of Hotel Services					Q2 – sent to PDG
	Review monthly cleaning audit scores at IPOG	Monthly	IP Matron & Matrons					
	Introduce PAS 5472 cleaning standards into trust Cleaning Policy, Cleaning Frequencies and Schedules and Cleaning Audit Tools	December 2015	IPN					
	Explore electronic cleaning audit tool and implementation of high frequency touch point cleaning as routine	December 2015	IPN & Domestic Manager					
	Introduce IP & Estates risk assessment to be completed prior to Estates work commencing n.b. IPT to be involved in any Estates works from the project commencement	Ongoing	IP Matron & Estates Projects Lead					
	The trust Head of Estates will report key issues monthly to IPC	Monthly	Head of Estates					
2 b Decontamination standards are monitored and adhered to	The trust Decontamination Lead will ensure that the Decontamination Group operates according to its terms of reference and reports monthly to the IPC	Monthly	Decontamination Lead					
2 c Water safety requirements are monitored and adhered to	The trust Water Safety Lead will ensure that the Water Safety Group operates according to its terms of reference and reports quarterly to the IPC	Aug 2015 Nov 2015 Feb 2016	Estates Maintenance Manager					

Hygiene Code Compliance Criterion 3 – Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

Objective	Programme of work (action)	Timeframe and milestones	Lead	BRAG Q1	BRAG Q2	BRAG Q3	BRAG Q4	Progress and comments
3 a To improve antimicrobial prescribing and stewardship	The trust Antimicrobial Lead will ensure that the Antimicrobial Stewardship Group will operate according to its terms of reference	Bimonthly	Antimicrobial Lead					
	The Antimicrobial Lead will report key issues quarterly to the IPC	Quarterly	Antimicrobial Lead					
	Antimicrobial audits will be presented to IPC	Quarterly	Antimicrobial pharmacist					
	To identify a way forward for Antimicrobial Stewardship from October 2015	October 2015	Divisional Director for Clinical Support Services					

Hygiene Code Compliance Criterion 4 – Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion

Objective	Programme of work (action)	Timeframe and milestones	Lead	BRAG Q1	BRAG Q2	BRAG Q3	BRAG Q4	Progress and comments
4 a Provide useful information for staff on the prevention and control of infections	Produce a monthly IP newsletter to share updates and key information on infections with staff across the trust	Monthly	IPT					Q1 and Q2 newsletters complete
	Produce screensavers or posters as required to clarify IP procedures and processes	Ongoing	IP Matron					Q1 – posters: commode cleaning, PPE. Screensavers: label catheter bags Q2 – poster: blue tray cleaning. Screensavers: IV lines, blood culture, patient fans
	Send out information via email system to communicate updates on IP practices or polices as required e.g. during outbreaks	Ongoing	IP Matron					
4 b Provide useful information for	Produce a monthly IP newsletter to share updates and key information on infections to be displayed on two notice boards in the	Monthly	IPTeam					

Hygiene Code Compliance Criterion 4 – Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion

Objective	Programme of work (action)	Timeframe and milestones	Lead	BRAG Q1	BRAG Q2	BRAG Q3	BRAG Q4	Progress and comments
patients and visitors on the prevention and control of infections	hospital corridors							
	Provide information leaflets on key infections e.g. C.difficile, MRSA, ESBLs, surgical site infections to patients	Ongoing	IP Team					
	Provide outbreak information to patients and visitors regarding ward closures and preventing the spread of infection	Q3 & Q4						

Hygiene Code Compliance Criterion 5 – Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing the infection on to other people

Objective	Programme of work (action)	Timeframe and milestones	Lead	BRAG Q1	BRAG Q2	BRAG Q3	BRAG Q4	Progress and comments
5 a To improve CPE screening and care of suspected, presumptive or confirmed positive cases	To write a CPE procedural document, send to PDG chair for approval and upload on to the IP policy list on the intranet	June 2015	IPN					Completed June 2015
	To work with urgent care and POAC to embed the CPE admission screening criteria and process	Oct 2015	IPN					
	To develop a CPE grab pack	Oct 2015	IPN					
	To monitor numbers of screens and results and report positive cases to IPC	Monthly						
5 b To remain within the C.diff trajectory of 21 cases for 2015-16	To put C.diff trajectory on to the risk register and review quarterly	June 2015	IP Matron					
	To generate a C.diff database with the support of PHE	Oct 2015	IP Matron					
	To develop a C.diff grab pack	Sept 2015	IPT					Completed Sept 2015
	To continue to identify wards that require support for 1 case of C.diff or period of increased incidence (2 or more cases within 28 days), conduct RCA for all post admission C.diff cases and maintain the C.diff antigen positive surveillance	Ongoing	IPT					Q1: Q2: 1 period of increased incidence on Holcot

Hygiene Code Compliance Criterion 5 – Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing the infection on to other people

Objective	Programme of work (action)	Timeframe and milestones	Lead	BRAG Q1	BRAG Q2	BRAG Q3	BRAG Q4	Progress and comments
	To develop and implement a C.diff forward plan	September 2015	IP Matron					
5 c To minimise the risk of infection to patients by conducting MRSA screening and managing patients who are colonised or infected with MRSA effectively	To maintain MRSA screening processes according to trust MRSA policy and monitor elective and emergency screening compliance	Monthly						
	IPT to conduct daily surveillance of previous MRSA positive inpatients.	On-going						
5 d To minimise the risk of cross-infection for alert organisms	IPT to review all patients who acquire an alert organism infection and provide ongoing advice and support to medical and nursing staff regarding IP care	On-going						
	IPT to conduct surveillance and management of outbreaks of infection, e.g. clusters of MRSA, *Clostridium difficile, and* Norovirus outbreaks	Ongoing	IPT					

Hygiene Code Compliance Criterion 6 – Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection

Objective	Programme of work (action)	Timeframe and milestones	Lead	BRAG Q1	BRAG Q2	BRAG Q3	BRAG Q4	Progress and comments
6 a Staff receive appropriate IP training	IP is part of induction and mandatory training. IP mandatory training is to be monitored and reported to CQEG by the trust Mandatory Training lead. *(For further information regarding IP training provision please refer to the IP annual mandatory training plan).*	Monthly	Mandatory Training Lead					Trust IP compliance for Q2 is 65.9%
	IP training lesson plans to be generated to	Sept 2015	IPN					

Hygiene Code Compliance Criterion 6 – Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection

Objective	Programme of work (action)	Timeframe and milestones	Lead	BRAG Q 1	BRAG Q 2	BRAG Q 3	BRAG Q 4	Progress and comments
	provide evidence of content of sessions to the Mandatory Training lead to align with the East Midlands streamlining mandatory training hub							
	Non-clinical training to be changed to three yearly refresher period to align with the East Midlands streamlining mandatory training hub	Ongoing	IPN / MT lead					Change agreed at IPC in July 2015. Currently awaiting MT Lead to agree start date
	Clinical workbook and assessment sheet to be launched	May 2015	IPN					Completed May 2015
	Videos of IP scenarios to be filmed and incorporated into IP annual update training	Oct 2015	IPSSN					
6 b IP workforce and capability	Ensure that all IPT members are skilled, knowledgeable and have an appraisal process in place to ensure clear objectives and development needs	Ongoing	DIPC / IP matron					

Hygiene Code Compliance Criterion 7 – Provide or secure adequate isolation facilities

Objective	Programme of work (action)	Timeframe and milestones	Lead	BRAG Q 1	BRAG Q 2	BRAG Q 3	BRAG Q 4	Progress and comments
7 a To provide advice regarding appropriate isolation use	IPT to undertake daily review of the urgent care wards: A&E, EAU & Benham ward to identify patients admitted that require isolation	Daily	IPSNs					
	To attend the safety huddle twice daily to provide isolation and IP advice	Daily	IPSNs / IPN / IP matron					
	IPT to undertake daily review of the Side Room Monitor Tool and RAG rate each isolation room to facilitate the Site Management Team in effective patient placement	Daily	IPSNs					
	To conduct an annual trustwide audit of isolation facilities as per the annual audit plan and report findings to IPC the following month	Nov 2015	IPT					

Hygiene Code Compliance Criterion 8 – Secure adequate access to laboratory support

Objective	Programme of work (action)	Timeframe and milestones	Lead	BRAG Q1	BRAG Q2	BRAG Q3	BRAG Q4	Progress and comments
8 a The microbiology laboratory is accredited	The diagnostic microbiology is provided on site as part of the NGH pathology services. The Microbiology Laboratory Manager ensure that accreditation is achieved annually	Annually	Microbiology Laboratory					

Hygiene Code Compliance Criterion 9 – Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections

Objective	Programme of work (action)	Timeframe and milestones	Lead	BRAG Q1	BRAG Q2	BRAG Q3	BRAG Q4	Progress and comments
9 a To ensure that evidence based IP policies and associated procedural documents are available	The IP policies and associated procedural documents are reviewed regularly and in accordance with new guidance	November 2015	IPN					Policy review commenced 1st September 2015. On agenda for IPC Sept 17th
	IP policies and procedural documents are audited as per the IP annual audit programme in accordance with the requirements of the Hygiene Code	Monthly	IPT					Q1 planned audits all competed Q2 planned audits all completed

Hygiene Code Compliance Criterion 10 – Ensure so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that staff are suitably educated in the prevention and control of infection associated with the provision of healthcare

Objective	Programme of work (action)	Timeframe and milestones	Lead	BRAG Q1	BRAG Q2	BRAG Q3	BRAG Q4	Progress and comments
10 a To ensure that healthcare workers are protected from communicable diseases and from work exposures	Occupational health advice is available for staff	Ongoing	Occupational Health Team					
	Occupational Health Team provide a monthly report to IPC regarding key issues	Monthly	Occupational Health Team					
	Infection Prevention training is mandatory for all staff and reported monthly to CQEG by the Mandatory Training Lead	Monthly	Mandatory Training Lead					End of Q2 – IP training compliance is 65.9%

Northampton General Hospital NHS
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Report To	PUBLIC TRUST BOARD
Date of Meeting	24 September 2015

Title of the Report	**Corporate Governance Quarterly Report**
Agenda item	**13**
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	Information
Executive summary This report provides the Board with information on a range of corporate governance matters and in particular includes formal reporting on the Use of the Trust Seal pursuant to the Trust's Standing order 12.3.	
Related strategic aim and corporate objective	N/A
Risk and assurance	This report provides assurance to the Board in respect to compliance with Standing Orders and the Trust's Standards of Business Policy
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? (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**)

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Legal implications / regulatory requirements	This report provides the Board with information on a range of corporate governance matters and in particular includes formal reporting on the Use of the Trust Seal pursuant to the Trust's Standing order 12.3

Actions required by the Trust Board

The Trust Board is asked to:

- To note the Use of the seal and numbers of staff declarations

Northampton General Hospital NHS
NHS Trust

Public Trust Board
24 September 2015

Corporate Governance Report
May - August 2015

1. Introduction
This report provides the Board with information on a range of corporate governance matters and in particular includes formal reporting on the Use of the Trust Seal pursuant to the Trust's Standing order 12.3.

2. Use of the Trust Seal
The Trust's Standing Orders require that periodic reports are made to the Board detailing the use of the Trust's Seal. The Seal will 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.

Reference	Date	Description
188	19 May 2015	Sunny side: Deed of covenant with owners
189	29 May 2015	Lease relating to part of Building 41 on NGH site and Boots UK Ltd.
190	19 June 2015	Contract for the provision of an Integrated Blood solution with Roche Diagnostics Ltd UK

3. Declarations of Hospitality
Staff within the Trust are required by the Standards of Business conduct Policy to declare any hospitality and/or gifts received. Staff are given regular reminders through Trust communication mechanisms regarding their liabilities in respect to the requirements of this policy.

- May – August 2015: 37 declarations received

4. Declarations of Interest
There were no new declarations of interest by Trust Board members

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Northampton General Hospital NHS
NHS Trust

Report To	PUBLIC TRUST BOARD
Date of Meeting	24 September 2015

Title of the Report	TDA Self-Certifications
Agenda item	14
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 August 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 August 2015	

NHS Trust Development Authority: Oversight and monthly self-certification

Year: 2015/16 Month: August 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 August 2015 the Trust did not meet targets for: • Operations cancelled and re booked within 28 days • 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 have been in during August 2015 to provide extra support to the Trust.	Sept 2015
11	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	Yes		

	For Clinical Quality that,	Response	Comment	Timescale for Compliance
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	**24 September 2015**

Title of the Report	**Partnership Update**
Agenda item	**15**
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 Northants Programme, Clinical Collaboration and Oncology Alliance.
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 following Appendices are attached. Appendix 1 Clinical Collaboration Delivery Framework Reporting Dashboard Appendix 2 Risk Register Appendix 3 Re-presented Integrated Care Closer to Home (ICCtH) Schemes list (incl 'High Impact' schemes) Appendix 4 14/15 Q1 performance summary Appendix 5 ICCtH Risk Register	
Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? 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

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	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)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper. No

Actions required by the Trust Board

The Board is asked to:

- To note current progress with the programme

Northampton General Hospital NHS
NHS Trust

Public Trust Board
24 September 2015

Partnership Update

1. Introduction
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 September.

2. Acute Clinical Collaboration
The Clinical Collaboration Operational Steering Group (CCOSG) is now embedded.

On the 11 August 2015 the CCOSG ratified the delivery framework structure and reporting dashboard for the speciality work streams, and provided further updates on speciality work stream progress. All established work streams are now working to deliver milestones in stage 2 of the framework structure. Please see appendix 1 for a copy of the reporting dashboard.

Individual speciality workgroup structures are all now in-place and high level draft benefit models for all work streams have also been documented for ongoing work stream adjustment and development. It must be acknowledged however the full benefits realisation plans will only be finalised once new clinical models have been designed.

Summary of Latest Action Taken
- Draft initial benefit models completed for Rheumatology, Orthopaedics, Cardiology, Ophthalmology and Radiology
- Work stream structures completed for Rheumatology, Orthopaedics, Cardiology, Ophthalmology and Radiology
- Action logs in place for work streams

High level work commenced to review
- Service line delivery costs
- Service specific updated activity
- Procurement collaborative change savings
- Asset/capital alignment for work streams
- Speciality project workgroup monthly meetings are established for all of the current work streams, Rheumatology, Orthopaedics, Cardiology, Ophthalmology and Radiology

Key new headlines for workgroups include
- Project risk log in place
- Updated current expenditure on speciality service provision costs

Rheumatology
- 4 week audit against care provision criteria to determine current patient provision needs (where and by whom), scheduled for end September. This follows an initial current activity data collection completed in August
- Patient engagement forums arranged took place in both the north and south of the county on 9 & 10 September
- Patient referral administration process is being mapping for both Trusts
- Next work stream meeting scheduled on 15 September
- New Consultants x 2 at KGH now in post - attending next workgroup meeting

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Orthopaedic

- Clinical re-engagement workshop scheduled for 22 September 2015, activity/outline data update in progress scheduled for completion by 16 September
- Reviewing options for service alignment for further procurement benefit opportunities – A range of procurement opportunity options are being worked up and costed to identify potential savings.
- Mapping of current clinician workforce and speciality skills outline commenced – Northampton General Hospital (NGH) completed, awaiting Kettering General Hospital (KGH)
- Reviewing Service Line Reporting (SLR) costs for both Acute Trust services – indicative costs from KGH now available, NGH to be completed by 14 September
- Rough potential new service model options produced – for discussion and high level agreement at scheduled workshop 22 September 2015

Ophthalmology

- Project group meetings commenced – clinical engagement/attendance remains challenging
- High level vision clarification and modelling agreement meeting scheduled for 30 September. Model options draft outlines to be compiled from this meeting.
- Re-engagement workshop being scheduled for 21 October
- Collaborative procurement initiatives reviewed with further reviews of capital asset opportunities commenced

Radiology

- Project group meetings established –work stream meetings have been rearranged to facilitate operational leadership attendance and gain momentum, with all work stream meetings now scheduled to take place on KGH site, next meeting 24 September. GP representation confirmed
- Task and finish work commenced to document draft countywide ultrasound referral criteria, now to be refined to a final agreed draft copy
- Clinical engagement forum with primary care (GPs) x 4 planned end September (Corby, Northampton, Daventry, Wellingborough) Plan to introduce new US referral criteria to GPs.
- Mapping of current workforce and speciality skills outline commenced – with site leads
- East Midlands Radiology procurement consortium (EMRAD) go live rollout at both sites confirmed but not aligned Nov 2015 NGH March 2016 KGH. Impact on project work being reviewed.
- Looking at procurement opportunities – awaiting contrast medium information to work up opportunities for alignment and financial saving – Agreement in principle for move to use same/like contrast mediums.

Cardiology

- Work group meetings established – next meeting 21 September
- Two areas for collaboration agreed. Heart Failure and Cardiac Rehabilitation. Adherence to current acute care pathways in place agreed
- Standardised countywide heart failure service alignment agreement. Awaiting approval of KGH/north of county business case by commissioners to increase opportunities for collaborative approach to service establishment
- Agreement to plan countywide cardiac rehabilitation pathway, currently being mapped by the management leads at either Trust

Financial Implications

High level draft initial benefit models have been completed for work-streams however service models need to be identified and worked up for options appraisal before any costings can be identified against these.

Some procurement savings have already been identified following initial collaborative service developments and are reflected in Acute Trusts individual in year savings outlines. Current initial sum to date circa £163K.

Key Risks

- Work stream groups now established however some challenges continue with clinical leadership and service lead engagement. Relaunch workshops are being arranged to increase momentum for some areas specifically Orthopaedics and Ophthalmology
- Resource/ capacity to support change management process against conflicting demand
- Strategic IT infrastructure alignment, will there be affordable/workable solutions for IT system connectivity
- Financial information on Trusts costs format/assumptions differences, making savings identification difficult and risk of potential increased cost from format alignment
- Growth in referral activity may put a strain on the system and limit capacity to implement transformational change

3. Integrated Care Closer to Home (ICCtH)

3.1 Regulator oversight

The ICCtH Delivery group continue to report progress against the milestones set out within the regulator presentation at the last Tri-Partite Meeting to ensure delivery against the agreed 0-3months milestones, 3-6 month milestones, and 6 month+. There will be a requirement for the HN Programme Management Office (PMO) to provide an update to the regulator submission. There is an expectation that project plans are kept up to date, and system-wide Project Managers are able to provide progress against commitments within the regulator submission on request.

3.2 Integration of Local 'High Impact' Urgent Care schemes into ICCtH

It was agreed by Healthier Northamptonshire partners that the schemes or service changes identified, and agreed, as Local 'High Impact' Urgent Care schemes should 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.

See Appendix 3 for the re-presented list of ICCtH schemes including the 'High Impact' areas.

3.3 2015/16 Q1 Performance

Against the agreed ICCtH target (ICCtH PID April 2015) non-elective reduction of 1950 for 15/16 the Q1 figures report a negative variance to plan of -19 as reported by the programme. The key question is whether this corroborates with activity levels at the acute trusts or whether both ICCtH and the Trusts are over-performing.

In addition the locality variance v target breakdown is as follows

By Locality	Mth 1	Mth 2	Mth 3	Variance	Q1 Plan	Q1 Actual
Corby	22	41	8	71	903	833
Daventry	25	-15	-33	-23	606	630
East Northants	-4	31	8	35	897	862
Kettering	-19	37	5	23	1279	1256
Northampton Central	38	16	8	62	1173	1112
Northampton South & East	23	35	10	68	899	831
Northampton West	32	-21	18	29	1100	1071
South Northants	-38	-11	16	-33	464	496
Wellingborough	-16	22	-34	-28	875	904

(a negative variance reflects poor performance against target)

Enclosure K

Apart from Northampton west and South Northants, which have seen improved performance, performance has slowed in all areas in M3. Of particular note are Daventry and Wellingborough which are also off-target for Q1. Practice level data for the Localities is being prepared and will be shared with the Locality Chairs for action.

Whilst current approved schemes have delivered against plan, Commissioners need to consider revised NEL targets, schemes, and appropriate remedial action in light of ongoing and sustained system pressures and the delivery gap against Better Care Fund (BCF). Any revisions and new schemes should be delivered alongside the various system partners including, primary and secondary health providers, social care and the voluntary and community sector.

See Appendix 4 for full Q1 detail.

3.4 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. 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 partners are clear on the resourcing required to drive forward their areas.

At last month's ISG, both the Collaborative Care Teams (CCT) and Care Homes scheme were highlighted as an area for escalation due to a number of CCT schemes due to cease September 15 and lack of agreement re the future of the Care Homes project. In light of this, both schemes have been a focus of the ICCtH Delivery Group and an update has been provided for the Board below:

3.4.1 Collaborative Care Teams (CCT)
Clinical Lead – Raf Poggi
Project lead – Louise Tarplee

All localities now have a CCT Scheme but at different stages of implementation; there are now 4 specific models that are being implemented.

- Clinically led model led by GP Federations
- Social Model led by Age UK
- Individual practices
- Integrated model (Corby)

It has also been identified that there is a need for an IT Solution to support the implementation of the Age UK Model – being explored further. Having 3 specific models will enable an evaluation to support Nene/Corby Clinical Commissioning Groups (CCGs) in agreeing a model of care for the future. There is a need to ensure that all models are appropriately piloted. Some providers were due to finish in October 2015 although the Governing Body has approved funding through to March 2016 to enable evaluation and input to 2016/17 Commissioning intentions.

It has been identified that CCTs are not embedded within practice for a number of reasons. Work has already been completed with providers and there is now a plan in place for the Clinical and Management lead to meet with all the providers to ensure they are implementing the agreed model and achieving against the KPIs.

We are also working with our GP practices to ensure they use risk stratification and personal knowledge to identify patients and to refer them to the CCT. Clear clinical leadership and direction, as well as clarity of evaluation and monitoring, will support the embedding of this service into practices.

An evaluation framework has been developed to enable Corby/Nene CCGs to measure success in reducing non elective admissions and a full evaluation of the schemes that have been implemented across the County.

The CCT scheme does not currently review High Intensity Users but there is an ability to include these patients. Further work needs to be concluded and a process implemented to ensure the list is forwarded from acute providers to CCT providers and acted upon.

The following recommendations were approved at the Nene CCG Governing Body on:

1. The extension of the scheme for all providers in accordance with current Service Specification at a cost of £202,000 to ensure that all schemes continue to the end of March 2016

2. The evaluation of the scheme to be undertaken end November 2015 for presentation and discussion of proposals in January 2016

3. East Northants / Kettering Localities to progress with the Age UK Social model as implemented in Wellingborough locality and approved at Locality Boards

3.4.2 Care Homes
Clinical Lead – Raf Poggi
Project lead – Julie Lemmy

Since the last ICCtH Board meeting a Service Specification for the Care Homes project has been agreed with the Locality Chairs which will include the expansion of the scheme to all the Nene CCG Localities (the Corby CCG care home scheme is integrated with the CCT project) and include both Nursing and Residential Care Homes. The scheme will see an alignment of GP practices to individual care homes, streamlining the point of contact (patient choice re GP will still apply).

A Care Homes Working Group Terms of Reference have now been developed which include the governance link into the ICCtH Board.

3.4.3 Intermediate Care
Clinical Lead – Raf Poggi
Project lead – Lisa Riddaway

An Intermediate Care programme is being developed as part of the wider HN / ICCtH programme to develop and deliver a 3 year strategy to:

- Improve intermediate care across sectors
- Propose new models of care, pathways and ways of working across the system

To be underpinned by a delivery plan that identifies tasks and actions split across:

- Workforce including community nursing, CCTs, skills and new roles
- System enablers including bed configuration, discharge to assess, new pathways and models of care
- Assessments including falls

Aligning to ICCtH this will include a number of areas identified as a key focus within this, including:

- Community nursing
- Intermediate care gap (health)
- ICT pathways
- Phlebotomy
- Care records
- Care Coordination Centre (CCC)

3.5 ICCtH Delivery Group

The delivery group continue to review of areas for escalation to the board and any interdependencies that may impact on delivery. In addition to this, a number of actions have also been delivered:

- Development of a matrix which highlights projects within ICCtH scope, and how this has changed over the last 12 months; to include; BCF projects, Urgent Care projects, and funding decisions

- Developed an ICCtH Risk register (Appendix 5) whereby, review of Red risks/issues has become a standing agenda item at delivery group meetings
- Reviewed Q1 performance; with agreed actions that include provision of locality breakdown performance

The next steps for the ICCtH delivery group are to:
- Ensure that the projects are being managed and driven forward against clear plans and with appropriate resources
- 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 +
- Review NEL targets against existing and new projects and bring into line with BCF
- Identify key issues/risks and propose mitigation actions
- Ensure the Delivery Group fits with the revised system governance arrangements

3.6 ICCtH Clinical Engagement

The Medical Director's Advisory Group (MDAG) continues to be the key channel for clinical engagement over all areas of HN, including ICCtH. This is further supported through the work, particularly, of Drs Raf Poggi and Tom Evans.

In light of a wider system review of Governance, further work and review to ensure clinical engagement structures are clear and supported is required.

4. Collaborative Resource Management

This update just concerns that provided to the ISG from NGH. The Collaborative Resource Management (CRM) work-stream has identified seven key areas of work which are being taken forward across the Health Economy by each organisation sharing best practice and knowledge and resources where appropriate.

- VAT
- Leasing
- Fixed Assets
- Procurement
- Energy Prices
- Statutory Mandatory Training
- Occupational Health

NGH has currently progressed the following items as follows:

VAT – Recent tender and award of new VAT advisors with benefits already identified in terms of enhanced VAT recovery in July. Future work will focus on compliance, capital expenditure and contracted out services. The Trust has also recently Commissioned 3rd party pharmacy dispensing which over time is expected to yield significant savings in relation to outpatient drugs dispensing.

Leasing – Recent award of lease advisory services contract to Capita Leasing with successful tender of Car Park decking and Cardiac Cath Lab achieving attractive finance rates. Further work now underway to consolidate lease arrangements and ensure secondary lease periods represent value for money. Capita have provided in house training for finance staff at no cost.

Fixed Assets – The Trust has engaged DTZ Ltd to undertake a full modern equivalent valuation of its land and buildings. (This exercise has previously been undertaken at KGH). Work is expected to commence in September with an early view on outputs due within 10-12 weeks. The Trust is working with its External auditors to consider the implications of adopting any revised valuation and has also sought

5. South East Midlands Oncology Alliance

All three organisations in the Alliance have now approved the proposal to form a federation across the East Midlands and have nominated their Directors of Strategy to sit on the Board that will govern the process.

The first meeting of the Board has not yet taken place and further updates will be provided on a quarterly basis to the Board.

Acute Clinical Collaboration Project NGH and KGH	Rheumatology		Orthopaedic		Radiology		Opthalmology		Cardiology		
Key Milestones	% Complete	Delivery confidence 1-5	% Complete	Delivery confidence 1-5	% Complete	Delivery confidence 1-5	% Complete	Delivery confidence 1-5	% Complete	Delivery confidence 1-5	Comment
Stage 1 - up to end July 2015											
Shared Vision	100	5	100	5	100	5	100	5	100	5	
Identified leadership/team	100	5	100	5	100	5	100	5	100	5	Key leads identified for all work streams
Set up Structure & Meeting Schedule	100	5	100	5	100	5	90	5	90	5	Work stream meetings scheduled for all specialities. Established in most, scheduled to take place by 10th August for Cardiology and Opthalmology July within , structures
Key Strategic Objective/Outcomes	100	5	100	5	100	5	100	5	100	5	
Scope In/out	100	5	100	5	100	5	100	5	100	5	
SWOT/ baseline position/understand each others service	100	5	100	5	100	5	90	5	100	5	
Understand /mapped pathways/identified opportunities	100	5	100	4	100	5	80	4	100	5	
Scoped interdependencies/ benefits/risks	100	5	100	5	100	5	80	4	100	4	Workshop planned for Orthopaedic work stream to complete 22/9/15. Opthalmology to be completed 12/8/15
How will engagement be done, patients/partners/teams	100	5	70	4	70	4	70	4	70	4	Comms lead actively engaged with Operational Steering Group to support. Planned public engagement in September with Rheumatology. Engagement events to be completed for other specialties in November in line with production of proposed service models.
High level analysis, activity/quality	80	5	80	4	80	4	80	4	80	4	Initial High level analysis (2013/14) completed for all work streams but being refreshed to reflect 2014/15 position-expected completion; end August. Live time activity audit /monitoring ongoing for Rheumatology to reflect demand clinical requirements.
Stage 2 - Aug - Sept 2015											
Develop Service Model- identify what must do, should do, could do,	20	5			20	5			20	4	To be reviewed at end August and end September
Develop plan for new service delivery											Awaiting outcome from Commissioners of KGH Heart Failure service bus case
Options Appraisal and Impact Assessment (Strategic objectives/Contract/ Quality)											
Wider engagement partners/public	20	5							10	3	Expected completion date-End November in line with production of proposed service models
Commence delivery of immediate opportunities											
Procurement opportunities	20	4	30	4	30	4	20	4	20	4	
Patient pathway standard alignment											
Future workforce plans	20	4	20	5	20	5	20	4	20	5	
Prepare Options proposal for approval											
Stage 3 Oct-Dec 2015											
Preferred option business case development (approval during this period)											
Communication and engagement	20	5									
Implementation Plan; Operational delivery structure Short/medium/long term plan with key milestones & KPI's											
Contract negotiation/arrangement											
Shared governance structure for new service model											
Stage 4 Jan - Mar 2016											
Implementation/delivery											
Sustainable/review/evaluate											
Contract arrangements in place											
Stage 5 -Apr 2016											
Review and refresh											

V1

Author - Kathy Harvey Clinical Collaboration Facilitator. Position for 19 August 2015

Northampton General Hospital NHS Trust

Appendix 2

DRAFT Clinical Collaboration Risk Register v 0.3

14 September 2015

ID	Raised By	Date Raised	Risk Description	Pre-mitigation			Mitigating Action	Post-mitigation			Action Owner	Action Target Date	Status	Date of Last Review	Date of Next Review
				Impact	Likelihood	RAG Score		Impact	Likelihood	RAG Score					
001	Peter Watson	06/07/2015	Ability to meet across sites effecting pace of change.	Medium	Possible	6	Use of teleconferences to reduce travel requirements and enable cross site working to plan and implement developments.	Low	Unlikely	4 (G)					
002	Peter Watson	06/07/2015	Ability to train/attract and retain workforce required to deliver new models of delivery could impact on ability to deliver transformational redesign.	Medium	Possible	6	Establish workforce planning stream within programme, link to wider Healthier Northamptonshire and Northamptonshire Workforce Plan.	Low	Unlikely	4 (G)					
003	Peter Watson	06/07/2015	Financial information on Trust costs is produced in the same format using the same assumptions to enable it's use to compare potential savings across site.	Medium	Possible	6	Financial leads to be assigned from both Trust to work together to ensure financial information uniform across Clinical Collaboration Programme.	Low	Unlikely	4 (G)					
004	Peter Watson	06/07/2015	Alignment with commissioning cycle may impact on ability to deliver change across the health economy if planned transformation not synchronised with changes in Primary Care.	Medium	Possible	6	Initial step to add Dr Az Ali (Clinical Director Planned Care Nene CCG) to CCP steering group.	Low	Unlikely	4 (G)					
005	Peter Watson	06/07/2015	Growth in referral activity may put strain on the system and limit capacity to implement transformational changes	Medium	Possible	6	CCG to support management of referalls from Primary Care as clinicall appropriate	Low	Unlikely	4 (G)					
006	Peter Watson	06/07/2015	Tertiary providers and specialist commissioners support redesign and repatriation of activity	Medium	Possible	6	Align to strategies. Partner engagement	Low	Unlikely	4					
007	Peter Watson	06/07/2015	Embed information technology as tool to support and drive through innovation	Medium	Possible	6	Information Technology identified as a stream of the CCP	Low	Unlikely	4 (G)					
008	Kathy Harvey	11/08/2015	Service alignment option reviewes may identify activity currently not adequately coded/ renumerated	Medium	Possible	6									
009	Peter Watson	08/07/2015	Impact of moving specialties to multiple sites on clinical training programmes/numbers	Medium	Possible	9 (A)	Engagement with training establishements and service/workforce leads	Low	Unlikely	4 (G)					
010	Kathy Harvey	11/08/2015	Clinical/operational level engagement challenging due to competing immediate demands and insufficient capacity to address issues/actions. Potential for delayed momentum /progress.	High	Possible	12	Additional re-engagement workshops arranged for specialities where risks greatest. Escalated to director level representation	Medium	Possible	9 (A)					
011															
012															
013															
014															
015															
016															
017															
018															
019															
020															
021															
022															
023															
024															

Appendix 3

BCF Submission ICCtH schemes (Jan '15)	ICCtH (Apr '15)	BCF Redesign Dashboard (July '15)	6 High Impact Schemes (July '15)
Community Case Management	**Community Case Management**	**Community Case Management**	
Collaborative Care Teams*	Collaborative Care Teams*	Collaborative Care Teams*	
		CCT - Wellingborough	
		CCT - South Northants	
		CCT - Daventry	
		CCT - Northampton	
Care Homes Support Service*	Care Homes Support*	Care Homes*	
Telehealth/Telecare*	Telehealth*	Technology/tele health/tele care*	
Carer Support*		Carers Support*	
		Risk Stratification	High Intensity Users
End of Life Pathway	End of Life Register		
COPD	COPD Community Support		
	GP Extended Hours		
Crisis Intervention & Admission Avoidance	**Crisis Intervention & Admission Avoidance**	**Crisis Intervention & Admission Avoidance**	
Acute Psychiatric Liaison*	Acute Psychiatric Liaison*	Acute Psychiatric Liaison*	
Falls Crisis Response Service*	Crisis Response Falls service*	Crisis Response to Falls / Falls ambulance*	
Dementia Step-up*	Dementia Step-up*	OPMH/Dementia Intermediate Care*	
Primary Care Streaming	Primary Care Streaming & Ambulatory Care		
Ambulatory Care			
Alcohol Treatment Unit	Alcohol Treatment Unit		
GP Extended Hours			
	Crisis Escalation ICT		
	Community Hospital Step-up		
Discharge & Intermediate Care	**Discharge & Intermediate Care**	**Discharge & Intermediate Care**	
	Integrated Discharge Team	Integrated Discharge Teams	
Domiciliary Care Capacity*	Domiciliary care capacity to support discharge*	Domiciliary Care*	Domiciliary Care*
Stepping Stones*		Stepping Stones*	
Discharge to Assess*	Discharge to Assess*	Discharge to Assess*	Discharge to Assess*
Intermediate Care Team*		Intermediate Care Teams*	
Community Hospitals*	Community Beds review*	Community Hospital step up*	
Specialist Care Centres*		Specialist Care Centres*	
Community Nursing*		Community Nursing*	
START Reablement Service*		START*	
		Community Equipment	
		Rehab Beds	
Dementia Step-down & Reablement*	Dementia Intermediate care pathway*		Dementia Step-down*
			Reablement (Facilitated Early Discharge)
			Discharge Control Centre (agreed not to progress)
		Care Closer to Home/BCF Enablers	
		Disabled Facilities Grants	
		Social Care Capital Grant	
		Joint Commissioning Capacity	
		Care Bill Implementation	
		Transformation Schemes outside of BCF contributing to Performance Fund	
		Additional investment in Collaborative Care Teams	
		Additional psychiatric liaison	
		Support to Residential homes	
		Falls Ambulances	
		End of Life (visible patient record system)	
		Tele health	
		COPD	
		Community Hospital step up	
		Dementia Intermediate Care	
		NHFT Intermediate Care	
		Prevention & Wellbeing	
		Integrated Alcohol working	
		Early identification & management of infections	
		New Service Specifications to be agreed by September 15	
		Community Nursing spec	
		Intermediate Care	
		Response and Management of Falls	
		Response and Management of End of Life	
		Children's Services	
		Developing Personal Health Budgets in acute & Community up to 1% of spend	

*= BCF funded/part-funded

Re-presented ICCtH schemes (Aug '15)

	Community Case Management	Notes	Start	Continue	More	Stop
1	Collaborative Care Teams					
	Locality-based x9				?	
2	Care Homes Support					
	Residential	Expansion - with room for significant NEL impact				
	Nursing	Existing				
3	Telehealth	?? Link to FFF pilots/trial??				
4	Carers Support	?? What is this??				
5	Risk Stratification					
	GP top 50	Number of inter-related issues tied up with better use of shared data				
	A&E top 50					
	Co-morbidity					
	Data-sharing					
	Capacity & Predicitive Planning					
6	End of Life					
	Register (records)	?? In tender process??				
	Coordination					
7	COPD Community Support	?? Include within CCTs??				
8	GP Extended Hours	?? Where is this at??				
	Crisis Intervention & Admission Avoidance					
9	Acute Psychiatric Liaison					
10	Falls service			??		??
11	Primary Care Streaming	?? KGH/NGH contracts in place				
12	Ambulatory Care	?? Is this a separate scheme??				
13	Dementia					
	Pathway review (Acute/Mental Health/Social Care)	Links to Intermediate care and Community Beds			?	
	Step-up				?	
	Step-down				?	
14	Alcohol					
	Integrated working	Need to clarify alignment	??			
	Treatment Unit	Is there a need/desire to resurrect this? Potential NEL impact?	??			
	Discharge & Intermediate Care					
15	Integrated Discharge Team	?? Link to intermediate care				
16	Domiciliary care capacity to support discharge	?? Link to intermediate care				
17	Stepping Stones	?? What is this??				
18	Discharge to Assess	?? Link to intermediate care				
19	Intermediate Care					
	Pathway	Links to Community Beds and Dementia			?	
	Specification				?	
	Care Coordination Centre				?	
	Crisis Response				?	
	Home-based				?	
	Bed-based				?	
	Reablement				?	
20	Community Beds				?	
	Review need (incl number of beds)/pathways (incl step-up/step-down)	Links to Internediate care and Dementia			?	
	Community Hospitals				?	
	Specialist Care Centres				?	
21	Community Nursing	?? Link to intermediate care				
22	START	?? Link to intermediate care			?	
23	Community Equipment	Assume now covered in new contract??				
24	Reablement (Facilitated Early Discharge)	?? Link to intermediate care			?	

Enclosure K

ICCtH 2015/16 Q1

	April	May	June	July	August	September	October	November	December	January	February	March	Total / Year to Date performance
ICCtH Target NEL Reduction Below CCG Growth Plan	72	71	78	105	105	157	173	209	231	232	250	267	1950
KGH Actual performance against growth plan for ICCtH HRG Codes	-31	117	5										91
NGH Actual performance against growth plan for ICCtH HRG Codes	93	17	1										111
Combined performance against growth plan for ICCtH HRG Codes	62	134	6										202
Performance to ICCtH Plan	-10	63	-72										-19

Note : a minus value means performance worse than plan, positive numbers are delivery better than plan

By Locality	Mth 1	Mth 2	Mth 3	Variance	Q1 Plan	Q1 Actual
Corby	22	41	8	71	903	833
Daventry	25	-15	-33	-23	606	630
East Northants	-4	31	8	35	897	862
Kettering	-19	37	5	23	1279	1256
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Northampton South & East	23	35	10	68	899	831
Northampton West	32	-21	18	29	1100	1071
South Northants	-38	-11	16	-33	464	496
Wellingborough	-16	22	-34	-28	875	904

Healthier Northamptonshire

Escalation Risk Register for
Integrated Care Closer to Home
August 2015

Appendix 5

ICCtH Risks

Project Ref	Status		Risk	Impact (1-5)	Likelihood (1-5)	Factor	Risk Owner	Mitigating Action	Progress to date	Closure Date
All ICCtH	Risk	Open	Projects do not produce clear implementation plans for 15/16	5	2	10	SROs	HN PMO to support development of implementation plans	ICCtH has developed Programme Initiation Document (PID) with an implementation plan for 15/16 this has been presented at operation Executive (24.3.15) the PID has been agreed in principle CRM are revisiting scope of the financial savings for the portfolio CC have developed 1st draft of PID this has been reviewed by ISG a final version of PID will be presented for July ISG	
All ICCtH	Risk	Open	Financial plan for 15/16 needs to be clearly defined for each of the project areas. Each of the SROS to be clear on the finance challenge for the ICCtH portfolio and the projects contribution.	4	2	8	CEOs	PMs to be accountable for delivery the financial saving for their project		
All ICCtH	Risk	Open	Poor internal and external communications may limit understanding and 'buy in' to the programme	3	4	12	HN PMO	Communication Leads to develop Communications and Engagement Plan for healthier Northamptonshire Programme	Comms and engagement plan presented in June, from which comms leads working to.	
All ICCtH	Risk	Open	If there are delays in agreeing the resources required for each of the portfolios areas the realisation of both financial and non financial benefits will be impacted for 15/16	3	4	12	SROs	Gain additional Programme support for Portfolios	GEM resources have started to support the ICCtH Portfolio	
Care Homes	Risk	Open	Uptake by practices of Care Homes Scheme	4	3	12	LT	Alignment of practices with care homes GP Engagement – review of localities where take up is low Clinical Lead to visit practices that do not uptake the specification	Service Specification to GB on 18th August for agreement.	
CCTS	Risk	Open	Impact of CCT on NEL Admissions	4	3	12	LT	Clinical Lead / Programme Manager to meet with all providers of CCTs to ensure working to the service specification Ongoing programme of review of practices who are outliers in respect of NEL admission to ensure they are utilising CCTs. Implementation of CCT Steering Group as a performance management meeting	Programme of visits w/c 17th and 24th August	
CCTS	Risk	Open	Schemes due to cease September 15	4	2	8	LT	Approval to extend all schemes to March 16	GB Approved- The extension of the scheme for all providers in accordance with current Service Specification at a cost of £202,000 to ensure that all schemes continue to the end of March 2016	
All ICCtH	Risk	Open	Failure to deliver HN financial expectation of £279m challenge	5	2	10	SROs	Each SRO to be accountable for delivery the financial saving for their Portfolio		
All ICCtH	Risk	Open	Non-delivery of BCF schemes	5	2	10	SROs			
All ICCtH	Risk	Open	Lack of clear communication and engagement planning within Projects	4	3	12	DM	DM to work with comms representatives from each organisation to complete a HN comms calendar to include activity and forward planning across the three HN portfolios	DM getting people to complete matrix of comms activity.	
COPD	Risk	Open	Patients may not be referred into the new service at CSH.	4	3	12	PH / RG	Discuss with primary care through 'protective learning time'; Advertising and recruiting campaign; Ensure that referrals continue from HF and COPD nurses; Ensure that referrals are received from NHFT.		
COPD	Risk	Open	The existing service at Lakelands may not be used to its full capacity.	4	3	12	PH / CL	As above		
COPD	Risk	Open	There may not be 'consistent messages' given by Lakelands and Cynthia Spencer.	4	3	12	RG / CL	Regular meetings to be held between the organisations. To include discussions regarding content changes and feedback from patients.		
Dementia Intermediate Care	Risk	Open	Intermediate Care is short term project, if Nene CCG wish to continue beyond November 2015, Procurement advice will need to sought re whole service will have to go out to tender.	4	3	12	Gerry McMurdie	Procurement advice will need to sought re whole service will have to go out to tender.	Gerry developing a revised spec which has been extended for 6 months	
Falls ambulance	Risk	Open	Failure of EMAS to recruit to Paramedic Vacancies	3	3	9	Mark Gregory	Move of service into main contract allowing for longer term staff contract offers		
Falls ambulance	Risk	Open	Community capacity limits availability to access care pathway	4	3	12	Mark Gregory	Align service to ICC2H programme to ensure suitable and safe pathway outputs.		
Care Homes	Risk	Open	Practices will not engage with delivering the Care Home Scheme	3	3	9	LT	Nene CCG will work with GP federations to ensure they are fit for purpose and are able to deliver against the service specification		
Care Homes	Risk	Open	Practices unhappy that they are not paid the remaining 35% risk gain share funding	3	3	9	LT	To mitigate this evaluation of data will be shared and localities will continue to work with practices. Lessons learnt will be shared with practices who have not achieved but wish to deliver next year to ensure success. There will not be a risk gain share in agreement for future schemes		
		New	Lack of governannce within ICCtH Portfolio impacts on realisation of both financial and non financial benefits for 15/16	4	4	16	SROs	Review of governance structure	HN Team have developed a Transitional arrangements paper which addresses each HN Programme. To be presented at ISG on 01/09/2015. SR developing overall governance arrangements for HN - awaiting reciept of	

As at 14/09/2015

Enclosure K

Healthier Northamptonshire
Better Health, Better Care, Better Value

ICCtH Issues

Project Ref		Status	Risk	Impact (1-5)	Likelihood (1-5)	Factor	Risk Owner	Mitigating Action	Progress to date	Closure Date
All ICCtH	Issue	New	There has been winter funding set aside in 2014/15 for additional integrated care assessors. Funding to embed this permanently is not currently identified. It is likely to be of the order of £250k per annum.	4	4	16				
Dom Care	Issue	New	Outstanding issue is that of domiciliary care, and achieving sufficient levels, with further flexibility for peaks, so that the whole health and social care flow can be maintained.	4	4	16	CEOs	Ops Exec will undoubtedly need to reach an agreement on levels required and the process by which the resources for this can be assured		
All ICCtH	Issue	Open	Insufficiently detailed forward planning (e.g. Implementation plans) which impedes the ability to deliver overall HN Programme	4	3	12	CEOs	Each portfolio (CC, CRM, ICCTH) to provide sufficiently detailed short term and medium term plans by 1st November	Implementation plans being developed by portfolios	
						0				
						0				
						0				

As at 14/09/2015

Northampton General Hospital NHS
NHS Trust

Report To	PUBLIC TRUST BOARD
Date of Meeting	24 September 2015

Title of the Report	Integrated Performance Report and Corporate Scorecard
Agenda item	16
Presenter(s) of Report	Deborah Needham, Chief Operating Officer/Deputy CEO Dr Michael Cusack, Medical Director Carolyn Fox, Director of Nursing, Midwifery and Patient Services Janine Brennan, Director of Workforce and Transformation
Author(s) of Report	Deborah Needham, Chief Operating Officer/Deputy CEO Dr Michael Cusack, Medical Director Carolyn Fox, Director of Nursing, Midwifery and Patient Services Janine Brennan, Director of Workforce and Transformation
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 Scorecard and Exception reports have been discussed in detail at the Finance Investment and Performance Committee, Workforce Committee and Quality Governance Committee.

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.

Enclosure L

Related strategic aim and corporate objective	Be a provider of quality care for all our patients
Risk and assurance	Risk of not delivering Urgent care and 62 day performance standards Potential Financial fines for performance below standard Reputation risk for Performance below standard Potential poor patient experience
Related Board Assurance Framework entries	BAF - 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) 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	Jun-15	Jul-15	Aug-15
C.1	Written complaints rate	None	↑	57	51	46
C.2	Complaints responded to within agreed timescales	90%	↑	98.0%	100%	100%
C.3	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	85%	↓	88.7%	90.5%	89.2%
C.4	Friends & Family Test % of patients who would recommend: A&E	87%	↑	83.6%	84.7%	84.3%
C.5	Friends & Family Test % of patients who would recommend: Maternity	95%	↓	97.1%	96.0%	95.4%
C.6	Friends & Family Test % of patients who would recommend: Outpatients	90%	↓	90.4%	91.6%	90.7%
C.7	Mixed Sex Accommodation	0	→	0	0	0
C.8	Total deaths where a care plan is in place	50%	↑	37.0%	36.0%	37.0%
C.9	Transfers: Patients moved with a risk assessment completed	100%	↑	92.3%	100%	98.6%

Effective

	Indicator	Target	Trend	Jun-15	Jul-15	Aug-15
E.1	Emergency re-admissions within 30 days (adult elective)	None	↓	1.4%	1.4%	1.7%
E.2	Emergency re-admissions within 30 days (adult non - elective)	None	↑	6.9%	7.4%	7.1%
E.3	Length of stay - All	4.2	↑	11.1	3.7	5.5
E.4	Length of stay - Elective	2.7	↑	4.1	2.9	2.8
E.5	Length of stay - Non Elective	4.7	↑	12.4	4.7	6.7
E.6	Maternity: C Section Rates - Total	<25%	↑	29.1% (118)	25.8% (110)	25.8% (98)
E.7	Maternity: C Section Rates - Emergency	<14%	↑	17.2% (70)	15.3% (65)	14.8% (57)
E.8	Maternity: C Section Rates - Elective	<10%	↑	11.8% (48)	10.6% (45)	10.7% (41)
E.9	Compliance to C Section Nice Guidance	Yes		Awaiting confirmation		
E.10	Mortality: SHMI	Within expected range	→	101	101	101
E.11	Mortality: HSMR	Within expected range	→	101	103	102
E.12	Mortality: HSMR - Weekend	Within expected range	↑	102	102	100
E.13	Mortality: HSMR - Week day	Within expected range	↓	101	104	103
E.14	Mortality: Low risk conditions	Within expected range	↓	69	76	88
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	↓	133	56	237
E.18	# NoF - Fit patients operated on within 36 hours	80%	↓	81.8%	85.2%	75.0%
E.19	Stroke patients spending at least 90% of their time on the stroke unit	80%	↑	63.0%	68.6%	73.7%
E.20	Suspected stroke patients given a CT within 1 hour of arrival	50%	↓	64.0%	66.0%	58.0%

Safe

	Indicator	Target	Trend	Jun-15	Jul-15	Aug-15
S.1	C-Diff	Ave. 1.75 per mth	→	3	3	3
S.2	Dementia: Case finding	90%	↑	89.6%	80.3%	92.2%
S.3	Dementia: Initial diagnostic assessment	90%	↑	100.0%	97.5%	100%
S.4	Dementia: Referral for specialist diagnosis/follow-up	90%	→	100%	100%	100%
S.36	Falls per 1,000 occupied bed days	5.5	↑	4.0	5.1	4.0
S.6	Harm Free Care (Safety Thermometer)	93%	↑	94.4%	93.3%	92.7%
S.7	Medical Notes: Availability for clinics	99%	↑	98.5%	98.1%	99.6%
S.8	Medical notes: Documentation - Doctors	90%	↓	New questions	73.7%	66.8%
S.9	Medical notes: Documentation - Nurses	90%	↓	67.4%	70.2%	67.6%
S.10	Medical notes: Documentation - Allied Health	90%	↑	75.3%	83.8%	86.8%
S.11	Medication incidents that cause significant harm	0	→	0	0	0
S.12	MRSA	0	↓	0	0	1
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 3.4 p/mth	↓	3	2	4
S.16	Pressure Ulcers: Avoidable grade 2	Max 12.3 p/mth	↑	10	15	5
S.17	Number of Serious Incidents Requiring Investigation (SIRI) declared during the period	0	↓	0	1	1
S.18	Open CAS alerts	0	→	0	0	0
S.19	UTI with Catheters (Safety Thermometer-Percentage new)	0.4%	↓	0.0%	0.2%	0.3%
S.20	VTE Risk Assessment	95%	↓	98.0%	97.3%	95.0%
S.21	Transfers: Patients transferred out of hours	0	↓	52	42	69
S.22	Percentage of patients cared for outside of specialty	<10%	↑	15.9%	12.5%	13.0%
S.23	Percentage of discharges before midday.	>25%	↓	21.5%	21.5%	21.2%
S.24	Number of cancelled operations due to bed availability	0	↑	26	8	14
S.32	TTO's sent by Taxi	0	→	0	0	0

Responsive

	Indicator	Target	Trend	Jun-15	Jul-15	Aug-15
R.1	A&E: Proportion of patients spending less than 4 hours in A&E	95%	↓	95.3%	96.6%	95.4%
R.2	A&E: 4hr SitRep reporting	95%	↑	95.1%	96.4%	95.8%
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	↑	92.3	114.6	85.6
R.6	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	93%	↑	90.1%	95.3%	96.0%
R.7	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	93%	↑	80.9%	96.2%	97.4%
R.8	Cancer: Percentage of patients treated within 62 days of referral from screening	90%	↑	95.8%	94.7%	100%
R.9	Cancer: Percentage of patients treated within 62 days of referral from hospital specialist	80%	↑	100%	75%	100%
R.10	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	85%	↑	77.1%	71.9%	77.2%
R.11	Cancer: Percentage of patients treated within 31 days	96%	↓	96.7%	96.0%	95.0%
R.12	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	94%	→	100%	100%	100%
R.13	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	98%	↑	98.8%	100%	100%
R.14	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	94%	↓	99.0%	98.9%	94.9%
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	↑	1	1	0
R.17	RTT for admitted pathways: Percentage within 18 weeks	90%	↓	92.8%	89.7%	85.1%
R.18	RTT for non- admitted pathways: Percentage within 18 weeks	95%	↓	98.2%	95.4%	95.8%
R.19	RTT waiting times incomplete pathways	92%	↓	95.0%	95.6%	95.0%
R.20	RTT over 52 weeks	0	→	0	0	0
R.21	Delayed transfer of care	0	↑	54.0	60.8	43.0

Well Led

	Indicator	Target	Trend	Jun-15	Jul-15	Aug-15
W.1	Friends & Family: % of staff that would recommend the trust as a place of work	N/Applic	N/Applic	Q1 = 67.6%	Not applic.	
W.2	Data quality of Trust returns to HSCIC (SUS)	90%	↓	93.3%	88.9%	Not avail.
W.3	Turnover Rate	8%	↓	11.5%	11.5%	11.6%
W.4	Sickness rate	3.8%	↑	4.2%	4.0%	3.9%
W.5	Staff: Trust level vacancy rate - All	7.0%	↑	14.1%	11.0%	10.9%
W.5	Staff: Trust level vacancy rate - Medical Staff	7.0%	↑	9.3%	9.8%	9.4%
W.5	Staff: Trust level vacancy rate - Registered Nursing Staff	7.0%	↑	19.0%	17.5%	18.1%
W.5	Staff: Trust level vacancy rate - Other Staff	7.0%	↓	12.3%	12.5%	12.6%
W.9	Staff: Temporary costs & overtime as a % of total pay bill	None	↓	13.2%	13.5%	Not Avail.
W.10	Percentage of staff with annual appraisal	85%	↑	70.3%	70.3%	74.8%
W.11	Percentage of all trust staff with mandatory training compliance	85%	↑	82.0%	82.9%	83.7%
W.12	Percentage of all trust staff with role specific training compliance	85%	↑	69.5%	70.1%	70.1%

Finance

	Indicator	Target	Trend	Jun-15	Jul-15	Aug-15
F.1	Surplus / Deficit	0 Fav		(73) Adv	313 Fav	518 Fav
F.2	Income	0 Fav		566 Fav	179 Fav	376 Fav
F.3	Pay	0 Fav		63 Fav	219 Fav	(238) Adv
F.4	Non Pay	0 Fav		(798) Adv	(669) Adv	256 Fav
F.5	Bank & Agency / Pay %	7.5%		8.1%	7.9%	11.2%
F.6	CIP Performance	0 Fav		80 Adv	(144) Adv	N / Avail

Section	Red Rated	Amber Rated	Green Rated	None	Total
Caring	1	2	5	1	9
Effective	5	4	8	3	20
Safe	9	3	13	0	25
Responsive	5	0	16	0	21
Well-Led	7	2	0	3	12
Finance	2	0	3	1	6
Total	29	11	45	8	93

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Trust Board Corporate Scorecard

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

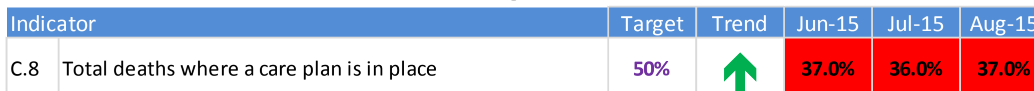
Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Total deaths where a care plan is in place	Report period:	August 2015

Driver for underperformance:	Actions to address the underperformance:
• There have been concerns raised that it may not be appropriate to include Critical Care within the End of Life Care scorecard • There has been concerns raised that the target percentage for EAU and Benham is not achievable as they are acute assessment areas • The SPCT/EOLC team have developed a process to enable them to support teams to care for patients in the last days of life, attending the daily patient safety huddle and collecting details of patients thought to be dying. Most patients are screened on the same day by the team and support is given to apply the 5 key priorities of care of a dying person and their family. The Trust has a care plan that provides a format for applying the 5 key priorities and enable teams to develop a holistic plan of care with the patient and family. Despite this process and documentation, the trust is not meeting the 50% target of patients with an individualised plan of care. • New Doctors started in Aug 2015	• A meeting will be set up with Dr Leng, Dr Ali, Dr Reilly and Wendy Smith. Date to be confirmed. • Wendy Smith and Dolly Barron met with Fiona Barnes to discuss this. Wendy Smith has asked for the assessment units and the corporate scorecard targets to be added to the agenda of the End of Life Care Strategy Group meeting on September 30th 2015. Lowering the target for the two assessment areas or developing a bundle tool for applying the five key priorities of care of a dying person in these areas will be discussed. Wendy Smith will update Fiona Barnes after the strategy meeting for a plan forward. • Benham have achieved the target this month at 63%. 47% of patients who died on EAU and Benham combined had an individualised care plan in place and therefore a target performance of 50% does seem reasonable. • Individual divisions should develop their own action plan for achieving the target set on this corporate scorecard as the reasons for underperformance are varied. The End of Life/Specialist Palliative Care Team will support teams with this and support teams in delivering the actions. • The divisions should seek way to improve care planning with patients and families so that they can receive care that is of a high standard. • FY1 teaching booked for 13.10.2015 – SPCT to deliver • FY2 teaching booked for 20.10.2015 – SPCT to deliver • Surgical training booked for 16.10.2015 – SPCT to deliver
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
September 2015	50%
Lead for recovery:	**Lead Director:**
Dr Christine Elwell	Dr Mike Cusack

Historical Target Performance



Indicator		Target	Trend	Jun-15	Jul-15	Aug-15
C.8	Total deaths where a care plan is in place	50%	↑	37.0%	36.0%	37.0%

Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Length of Stay	Report period:	August 2015

Driver for underperformance:	Actions to address the underperformance:
• Data includes Avery bed LOS: these patients within Avery are awaiting care packages to be arranged or placements • DTOC's have reduced within August, thanks to strong collaborative working of all parties within Health economy. • Focus in August has been on patients will LOS 100+ which has vastly reduced patient numbers • New starters of Junior doctor across the trust has led to Increased LOS due to transition into trust	• LOS will be split by NGH/ Avery to see step changes, and will be updated in LOS work stream • LOS workstream themes continue with very good performance "Status at a glance" white board discharge RAG rating, which is audited weekly • ECIST recommendations being implemented, and ward workspace being re invigorated to commence October 2015
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
Ongoing monitoring	5
Lead for recovery:	**Lead Director:**
Sue McLeod Dr Warren Pickering	Deborah Needham

Historical Target Performance

Indicator		Target	Trend	Jun-15	Jul-15	Aug-15
E.3	Length of stay - All	4.2	↑	11.1	3.7	5.5
E.5	Length of stay - Non Elective	4.7	↑	12.4	4.7	6.7

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Patients cared for in Escalation Area	Report period:	August 2015

Driver for underperformance:	Actions to address the underperformance:
• Escalation areas were utilised when necessary to ensure the safe care of patients when flow was reduced. • August saw the arrival of new junior Doctors, which inevitably impacted flow and the need to use escalation areas	• The Optimised Emergency Care and LOS themes of the changing care at NGH programme continue to make improvements throughout the Emergency Care Pathway. • The Assessment Units continue to embed enhanced ways of working to improve flow earlier in the day • The discharge Suite now has substantive staff and centralised booking of NSL transport • The Site has embedded the new way of managing beds, whereby divisions take accountability for their own activity that day, including patient flow and bed availability.
Forecast date (month) fo*r meeting the standard*	Forecast performance for next reporting period:
Target measure will be reviewed in the next month	Target measure will be reviewed in the next month
Lead for recovery:	Lead Director:
Rebecca Brown	Deborah Needham

Historical Target Performance

Indicator		Target	Trend	Jun-15	Jul-15	Aug-15
E.17	Patients cared for in an escalation area (occ bed days)	**0**	↓	**133**	**56**	**237**

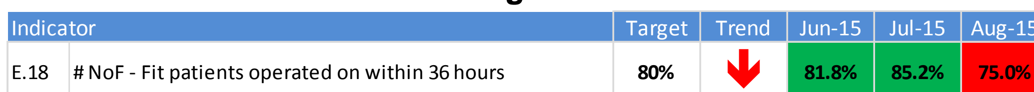
Enclosure L

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	# NoF - Fit patients operated on within 36 hours	Report period:	August 2015

Driver for underperformance:	Actions to address the underperformance:
• Drop in performance from 75% in July to 67% in August. Target is 85% • Insufficient trauma operating time at times – audit undertaken in June 2015 identifies a requirement for 3 operating sessions/day to meet trauma demand. Currently 2 sessions operating/day allocated to trauma. • More clinically urgent trauma may take priority on the day over #NOF	• Additional lower limb consultant commenced 27/7/15 • Elective activity taken down to accommodate trauma – however will have an effect on 18 week RTT • Proposal to increase trauma operating to 3 sessions/day and reduce elective activity by half a session/day. To be discussed with Consultants and Exec team. Will require review of job plans. • This is still under discussion.
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
December 15	70%
Lead for recovery:	**Lead Director:**
Fay Gordon	Dr Mike Cusack

Historical Target Performance



Indicator		Target	Trend	Jun-15	Jul-15	Aug-15
E.18	# NoF - Fit patients operated on within 36 hours	80%	↓	81.8%	85.2%	75.0%

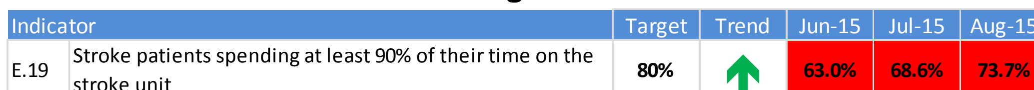
Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Stroke patients spending at least 90% of their time on the stroke unit	Report period:	August 2015

Driver for underperformance:	Actions to address the underperformance:
• Ring fenced beds on Eleanor, a source of concern as pathway has not always been adhered to out of hours. • Repatriation policy for KGH not being adhered too, site office escalating when repatriations do not take place in a timely manner, i.e. one per day.	• Agreement with site team regarding ring fenced beds and flowchart of escalation • Stroke consultant liaising with site team of potential patients who need repatriated internally to stroke beds. • Constant monitoring of inappropriate transfers out of hours. • Repatriation policy currently being re written and will be actioned by Rebecca Brown through UCWG South to ensure engagement of all parties
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
December 15	75%
Lead for recovery:	**Lead Director:**
Dr Lyndsey Brawn	Dr Mike Cusack

Historical Target Performance



Indicator		Target	Trend	Jun-15	Jul-15	Aug-15
E.19	Stroke patients spending at least 90% of their time on the stroke unit	80%	↑	63.0%	68.6%	73.7%

Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	C-Diff Incidents	Report period:	August 2015

Driver for underperformance:	Actions to address the underperformance:
• 3 post 72 hours cases of Clostridium difficile infection (CDI) for August 2015 • 2 cases on one ward • 1 case on another ward	• Root Cause Analysis (RCA) has been undertaken on all 3 cases as per National Guidance. • The staff on the ward with 2 cases of CDI received intensive training on hand hygiene and *Clostridium difficile* infection, this also included attending the ward huddles and the ward meeting. • Extra domestic staff were allocated from the cleaning services and the ward received a whole curtain change. • The trust antimicrobial pharmacist undertook an antimicrobial audit. • The infection prevention team will maintain enhanced support for this ward
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
September 15	2
Lead for recovery:	**Lead Director:**
Wendy Foster	Carolyn Fox

Historical Target Performance

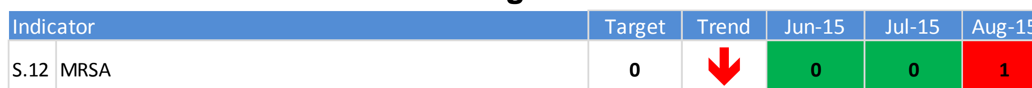
Indicator		Target	Trend	Jun-15	Jul-15	Aug-15
S.1	C-Diff	Ave. 1.75 per mth	→	3	3	3

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	MRSA bacteraemia Incident	Report period:	August 2015

Driver for underperformance:	Actions to address the underperformance:
• 1 post 48 hours MRSA bacteraemia	• Meetings have been held and a Post Infection Review is in the process of being completed. • The Trust is following its robust RCA process to identify causes and learning to ensure it is not repeated. • There has been full multi-disciplinary team involvement. • The Trust is reviewing IPC processes with Avery care home to ensure compliance.
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
September	0
Lead for recovery:	**Lead Director:**
Wendy Foster	Carolyn Fox

Historical Target Performance



Indicator		Target	Trend	Jun-15	Jul-15	Aug-15
S.12	MRSA	0	↓	0	0	1

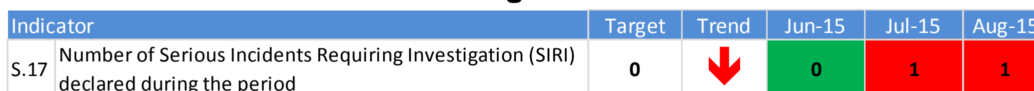
Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Serious Incidents Requiring Investigation (SIRI) declared during the period	Report period:	August 2015

Driver for underperformance:	Actions to address the underperformance:
• As yet to be defined, as full report awaited • Good practice maintained whilst awaiting further investigation.	• Procedures and processes being reviewed within stroke service. • Service audits already completed as part of investigation. • Await recommendation from investigation.
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
September 2015	0
Lead for recovery:	**Lead Director:**
Sue McLeod	Dr Lyndsey Brawn

Historical Target Performance



Indicator		Target	Trend	Jun-15	Jul-15	Aug-15
S.17	Number of Serious Incidents Requiring Investigation (SIRI) declared during the period	0	↓	0	1	1

Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Transfers: Patients transferred out of hours	Report period:	August 2015

Driver for underperformance:	Actions to address the underperformance:
• Reduced bed flow through the Trust and use of escalation areas • Bed occupancy levels remaining high, moves OOH are required. Once occupancy reduces, moves OOH will reduce further	• The Trust is making changes throughout the Emergency Care Pathway to improve flow earlier in the day, including: o Greater utilisation of the Discharge Suite o Reduced admissions though the launch of the new ACC o Improved Board/Ward rounds o Better use of EDD's o DTA project
Forecast date (month) for *meeting the standard*	Forecast performance for next reporting period:
Target measure will be reviewed in the next month	Target measure will be reviewed in the next month
Lead for recovery:	Lead Director:
Rebecca Brown	Deborah Needham

Historical Target Performance

Indicator		Target	Trend	Jun-15	Jul-15	Aug-15
S.21	Transfers: Patients transferred out of hours	0	↓	52	42	69

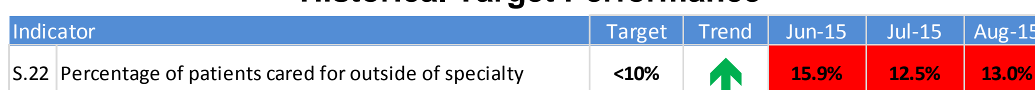
Enclosure L

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Percentage of patients cared for outside of specialty	Report period:	August 2015

Driver for underperformance:	Actions to address the underperformance:
• Demand on teams remains high with bed flow impeded at times; thus, patients are moved to an available bed.	• The Site has embedded the new way of managing beds, whereby divisions take accountability for their own activity that day, including patient flow and bed availability. • The Assessment Units continue to embed enhanced ways of working to improve flow earlier in the day • The discharge Suite now has substantive staff and centralised booking of NSL transport to help improve flow earlier in the day • Improving the clinical review for outlying patients
Forecast date (month) for *meeting the standard*	**Forecast performance for next reporting period:**
December 15	12%
Lead for recovery:	**Lead Director:**
Rebecca Brown	Deborah Needham

Historical Target Performance



Indicator		Target	Trend	Jun-15	Jul-15	Aug-15
S.22	Percentage of patients cared for outside of specialty	<10%	↑	15.9%	12.5%	13.0%

Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Percentage of discharges before midday	Report period:	August 2015

Driver for underperformance:	Actions to address the underperformance:
• Performance has remained static the past three months but requires improvement. • Discharge actions not being completed early enough in the day	• The LOS teams continue to embed processes with improve this figure. • Enhanced performance metrics have been developed to support and challenge the ward on such data. • Greater Utilisation of the Discharge Suite earlier in the day • Improved Board/Ward rounds
Forecast date (month) for *meeting the standard*	Forecast performance for next reporting period:
December 15	22%
Lead for recovery:	Lead Director:
Rebecca Brown	Deborah Needham

Historical Target Performance

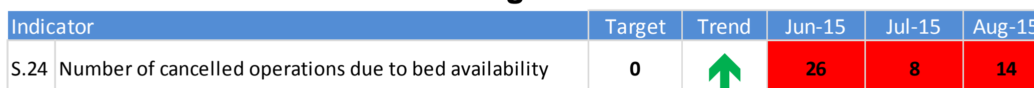
Indicator		Target	Trend	Jun-15	Jul-15	Aug-15
S.23	Percentage of discharges before midday.	>25%	↓	21.5%	21.5%	21.2%

Enclosure L

Trust Board Corporate Scorecard
Exception Report

<table>
<tr><td>Target underperformed:</td><td>Number of cancelled operations due to bed availability</td><td>Report period:</td><td>August 2015</td></tr>
<tr><td colspan="2">Driver for underperformance:</td><td colspan="2">Actions to address the underperformance:</td></tr>
<tr><td colspan="2">• Operations have been cancelled due to greater use of escalation areas throughout August.
• In severe escalation (RED) all non-urgent patients are cancelled to ensure safety for emergency patients</td><td colspan="2">• The Trust is making changes throughout the Emergency Care Pathway to improve flow earlier in the day, high level actions include:
o Greater utilisation of the Discharge Suite
o Reduced admissions though the launch of the new ACC
o Improved Board/Ward rounds
o Better use of EDD’s
o DTA project</td></tr>
<tr><td colspan="2">Forecast date (month) for meeting the standard</td><td colspan="2">Forecast performance for next reporting period:</td></tr>
<tr><td colspan="2">Target measure will be reviewed in the next month</td><td colspan="2">10</td></tr>
<tr><td colspan="2">Lead for recovery:</td><td colspan="2">Lead Director:</td></tr>
<tr><td colspan="2">Rebecca Brown</td><td colspan="2">Deborah Needham</td></tr>
</table>

Historical Target Performance



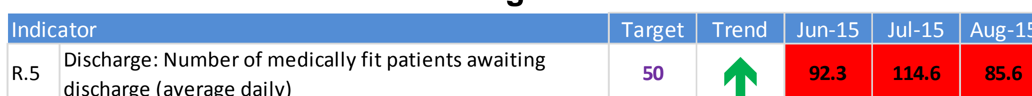
Indicator		Target	Trend	Jun-15	Jul-15	Aug-15
S.24	Number of cancelled operations due to bed availability	0	↑	26	8	14

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Discharge: Number of medically fit patients awaiting discharge (average daily)	Report period:	August 2015

Driver for underperformance:	Actions to address the underperformance:
• Reduced to the lowest in 3 months	• The Trust has taken the role of Project lead on the Discharge-To-Assess project. This will ensure a specific cohort of complex patients requiring re-ablement will have their assessment out of an acute setting, therefore, making the acute bed available earlier. • Additional support from OCS/CRT • Improved Board rounds with input from ECIST • Greater focus on the 'simple' discharges process
Forecast date (month) for *meeting the standard*	Forecast performance for next reporting period:
December 15	70
Lead for recovery:	Lead Director:
Rebecca Brown	Deborah Needham

Historical Target Performance



Indicator		Target	Trend	Jun-15	Jul-15	Aug-15
R.5	Discharge: Number of medically fit patients awaiting discharge (average daily)	50	↑	92.3	114.6	85.6

Trust Board Corporate Scorecard
Exception Report

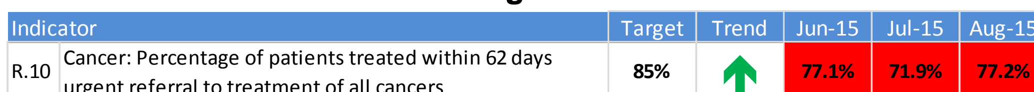
Target underperformed:	Cancer Access Targets	Report period:	August 2015

Driver for underperformance:	Actions to address the underperformance:

• ***COMMENTRY IS FOR VALIDATED JULY DATA***
• 62 day:
  o Patient choice to delay
  o Delay to diagnostics / capacity issues
  o Late referrals
  o Complex pathways
• Upgrade: - small denominator, patient had change of treatment plan
• **Full report is being submitted to F&P**
	• To agree weekly pre-operative clinics for colorectal patients
	• Transfer 2ww haematology bookings from haematology secretaries to the 2ww booking team
	• Meetings set up with Colorectal and Urology administration teams to assist in pushing patients through the 62 day pathway.
	• In order to assist in the management of the Cancer processes and pathways a 'Breaking the Cycle' rapid improvement event, similar to that undertaken in A&E, will be worked up.

Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
62 day September	85%
Lead for recovery:	**Lead Director:**
Directorate Managers/Tracey Harris	Deborah Needham

Historical Target Performance



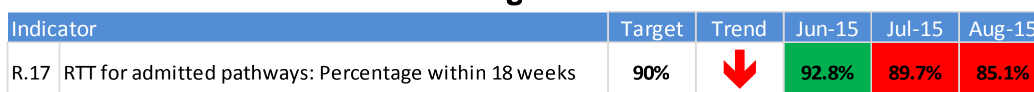
Indicator		Target	Trend	Jun-15	Jul-15	Aug-15
R.10	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	**85%**	↑	**77.1%**	**71.9%**	**77.2%**

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	RTT for admitted pathways: Percentage within 18 weeks	Report period:	August 2015

Driver for underperformance:	Actions to address the underperformance:
• Focus on Ongoing RTT as requested by the TDA. This focus will impact on the admitted target which has been agreed locally through the CCG and nationally via the TDA and will not result in any fines or penalties. • Admitted and non-admitted RTT will continue to be recorded until October.	• To continue to focus on ongoing until October in readiness for the national revision of the RTT targets, this requires sanctioning by parliament. • The weekly performance meeting continues to ensure that no patient waits over 52 weeks across all RTT pathways
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
Standard will no longer exist after October	87- 89%
Lead for recovery:	**Lead Director:**
Rebecca Brown	Deborah Needham

Historical Target Performance



Indicator		Target	Trend	Jun-15	Jul-15	Aug-15
R.17	RTT for admitted pathways: Percentage within 18 weeks	90%	↓	92.8%	89.7%	85.1%

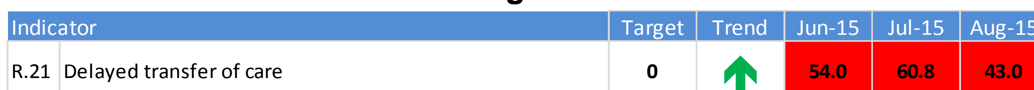
Enclosure L

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Delayed transfer of care	Report period:	August 2015

Driver for underperformance:	Actions to address the underperformance:
• The figure has reduced to under 50, a big achievement for the Trust • Capacity of external Health and Social teams remains challenging	• The Trust has taken the role of Project lead on the Discharge-To-Assess project. This will ensure a specific cohort of complex patients requiring re-ablement will have their assessment out of an acute setting, therefore, making the acute bed available earlier. • The discharge team have been realigned and approaching the management of DTOC patients differently.
Forecast date (month) for *meeting the standard*	**Forecast performance for next reporting period:**
Target measure will be reviewed in the next month. Target should be 2.5% of bed base	<40
Lead for recovery:	**Lead Director:**
Rebecca Brown	Deborah Needham

Historical Target Performance



Indicator		Target	Trend	Jun-15	Jul-15	Aug-15
R.21	Delayed transfer of care	0	↑	54.0	60.8	43.0

Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Staff Turnover Rate	Report period:	August 2015

Driver for underperformance:

Staff Group	Jul-15	Aug-15
Add Prof Sci & Tech	8.78%	7.53%
Additional Clinical Services	10.94%	11.21%
Admin & Clerical	11.67%	11.68%
Allied Health Professionals	13.13%	14.66%
Estates & Ancillary	10.49%	9.40%
Healthcare Scientists	21.91%	18.71%
Medical & Dental	6.42%	5.99%
Nursing & Midwifery	12.19%	12.68%

- Annual Trust turnover increased slightly to 11.59% in August which is above the Trust target of 8%.
- Turnover within Nursing & Midwifery also increased to 12.68%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust.
- Turnover also increased in the Admin & Clerical, Additional Clinical Services, and Allied Health Professional staff groups, but fell in all others.
- Medical Division; Increased by 0.92% to 13.57%.
- Surgical Division: turnover decreased by 0.37% to 10.88%.
- Women, Children's & Oncology Division; turnover was unchanged at 9.57%.
- Clinical Support Services Division; fell below 12%, to 11.83% for the year ending August 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. Focussed work is being done within nursing to provide additional support to new recruits and elicit why nurses are leaving the Trust

Forecast date (month) for meeting the standard	Forecast performance for next reporting period:
Jan 16	11.65%
Lead for recovery:	**Lead Director:**
Andrea Chown	Janine Brennan

Historical Target Performance

Indicator		Target	Trend	Jun-15	Jul-15	Aug-15
W.3	Turnover Rate	8%	↓	11.5%	11.5%	11.6%

Enclosure L

Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Staff Vacancy Rates	Report period:	August 2015

Driver for underperformance:

Staff Group	Jul-15	Aug-15
Add Prof Sci & Tech	13.77%	11.35%
Additional Clinical Services	10.93%	11.96%
Admin & Clerical	10.99%	11.38%
Allied Health Professionals	6.32%	6.15%
Estates & Ancillary	18.99%	18.47%
Healthcare Scientists	18.40%	16.93%
Medical & Dental	9.78%	9.37%
Nursing & Midwifery	17.89%	18.11%

- The vacancy rate within Estates and Ancillary staff group decreased further in August to 18.47% but still remains significantly above the Trust vacancy target of 7%.
- The Registered Nursing & Midwifery vacancy rate increased slightly from 17.89% to 18.11%.
- 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.
- 71 International nurses have commenced employment between January and July 2015 and 98 individuals have accepted the offers made from the international programme.
- A pilot of 5 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	17.5% in nursing 12% in other staff groups
Lead for recovery:	**Lead Director:**
Andrea Chown	Janine Brennan

Historical Target Performance

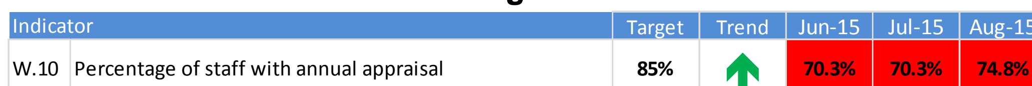
Indicator		Target	Trend	Jun-15	Jul-15	Aug-15
W.5	Staff: Trust level vacancy rate - All	7.0%	↑	14.1%	11.0%	10.9%
W.5	Staff: Trust level vacancy rate - Medical Staff	7.0%	↑	9.3%	9.8%	9.37%
W.5	Staff: Trust level vacancy rate - Registered Nursing Staff	7.0%	↑	19.0%	17.9%	18.11%
W.5	Staff: Trust level vacancy rate - Other Staff	7.0%	↓	12.3%	12.5%	12.61%

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Staff Annual Appraisal Rates	Report period:	August 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% in March 2015. 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, 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:**
March 2016	77%
Lead for recovery:	**Lead Director:**
Sandra Wright	Janine Brennan

Historical Target Performance



Indicator		Target	Trend	Jun-15	Jul-15	Aug-15
W.10	Percentage of staff with annual appraisal	85%	↑	70.3%	70.3%	74.8%

Enclosure L

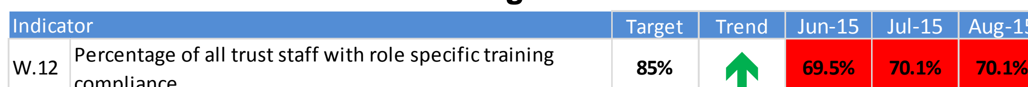
Northampton General Hospital NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Staff – Role Specific Training	Report period:	August 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:**
March 2015	71.5%
Lead for recovery:	**Lead Director:**
Sandra Wright	Janine Brennan

Historical Target Performance



Indicator		Target	Trend	Jun-15	Jul-15	Aug-15
W.12	Percentage of all trust staff with role specific training compliance	85%	↑	69.5%	70.1%	70.1%

Enclosure M

Northampton General Hospital NHS Trust

Report To	PUBLIC TRUST BOARD
Date of Meeting	24 September 2015

Title of the Report	Report from the Finance Investment and Performance Committee
Agenda item	17
Presenter of Report	Phil Zeidler, Non-Executive Director and Chair of Finance Investment and Performance Committee
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 August.	
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 1.2, 5.1, 5.2 and 6.3
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
24 September 2015

Report from the Finance Investment and Performance Committee meeting 19 August 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

Finance Report

The Committee were advised the I&E position for the period ended July showed a deficit of £6.7m year to date and was £265k favourable to plan, however underlying position highlighted a shortfall of income compared to the plan. Operating expenditure was tracking marginally above plan but was supported by a significant level of vacancies and the application of 4/12th of the contingency reserve. The overall position remained heavily reliant on the management of pay expenditure and the current level of vacancies underpinning CIP delivery.

Changing Care@NGH Programme Report

The Committee were advised the Latest Thinking Forecast (LTF) at Month 4 was £11.299m, a slight increase from M3, however of the £2,976k delivered to date, £1,523k (51%) was non recurrent. The Committee reiterated the importance of the Changing Care Programme being aligned not only financially but also with quality improvement and efficiency which was the overall purpose of the programme, whilst making cost savings.

The Committee also requested a clearer distinction between the LTF (currently broadly on track) and the risk adjusted figures (currently £2m off track).

TDA Stretch Target request

The Committee reviewed draft responses to the Trust Development Authority (TDA) and Nene Clinical Commissioning Group (CCG) regarding the request for a stretch target and supported the proposed approach.

Operational Performance

The Committee heard improvements in the 4 hour A&E target had been maintained, and whilst early August had been challenging the staff were committed to delivering the target for the 3rd month running. The Trust had been focused on reducing the numbers of Delayed Transfers of Care (DTOCs) and this had resulted in significant improvements with 43 patients currently awaiting discharge.

The Committee were informed that continued focus and pace was being applied to Cancer targets. The Intensive Support Team and the TDA had reviewed pathways and offered ideas and support for improvements but their final reports were still awaited. In order to assist in the management of the Cancer processes and pathways a 'Breaking the Cycle' rapid improvement event, similar to that undertaken in A&E, would be worked up and reported back to the Committee.

Proposal to address Capacity and Demand Gap Winter 2015
The Committee were presented with three options to ensure that the Trust had sufficient bed capacity to manage the rise in demand this winter and as to how the Trust would manage the surges in demand and ensure patient safety. It was anticipated a further 40 – 83 beds would be required, dependent upon bed occupancy at the time.

The options were:
Outsource elective work – due to underperformance in Surgery and Orthopaedics, this would not be economically viable and could result in further loss of income but was being explored further.

Increase Capacity - this would not provide capacity within the required timeframe and would be at considerable cost to the Trust, and was therefore discounted for the present.

Reduce ALOS (average length of stay) or simple complex discharge – this is currently work in progress and part of the Changing Care @NGH programme and continues to be the key driver to assist increased capacity. The Discharge to Assess (DTA) project had been fully worked up within the Health Economy, and although it was currently unclear as to whether or not the Commissioners would be funding this, the Deputy Chief Operating Officer confirmed that by the end of September, processes would be in place internally to roll out a non-bedded solution to meet the capacity shortfall

The Committee requested assurance as to why this option would succeed given reducing LOS was a long held ambition that has hitherto been challenging to deliver. The Committee were advised that governance processes within Charging Care Programme and the progress and results achieved to date on the Urgent Care Programme using new methods of implementation provided a springboard on which to launch this work.

The Committee were badvised that contingency plans were in place in the form of escalation areas

Nurse Recruitment 2016/17 Business Case
The Committee received a proposal to continue the recruitment of overseas nurses in order to meet the Trust's staffing requirements. National level supply would not reach 95% of demand until 2018/19 according to government and there was some evidence that with the introduction of Nurse Revalidation might result in an increased number of nurses choosing to retire.

The Committee supported the business case, subject to the Workforce Committee's approval, including an allocation of funds to support the Nurse Retention strategy.

Northampton General Hospital NHS
NHS Trust

Report To	PUBLIC TRUST BOARD
Date of Meeting	24 September 2015

Title of the Report	Report from the Quality Governance Committee
Agenda item	18
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 August.	
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 1.1, 1.3, 1.4, 1.6 and 2.1
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? (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 N

Actions required by the Trust Board

The Trust Board is asked to note the report.

Public Trust Board
24 September 2015

Report from the Quality Governance Committee meeting held on 21 August 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 – Fractured Neck of Femur

Dr Cusack reported that performance had improved substantially and this should be sustained and he requested that Divisional Director for Surgery, Dr Wilkinson, produced an action plan. Dr Wilkinson highlighted that there would be the introduction of a second morning Trauma list which would start at the beginning of October and he suggested a report should be fed back after that time so the new list had time to take effect. It was agreed Dr Wilkinson would report back in December.

Matters Arising C-Section

It was reported that at the Quality Governance Committee the previous month the C section rate and NICE guidance compliance work had been discussed. The Maternity Directorate had undertaken a gap analysis of compliance with NICE guidance and there were some areas of partial noncompliance. These gaps had now been risk assessed. The Committee requested that the Divisional Director should attend the next Quality Governance meeting to bring an updated assurance report following this work.

Quality Impact Assessment Scorecard

Review and discussion on measures had taken place. The Committee agreed that the leads would review the baseline and data to be sure that it is correct. However we will move to a more quality improvement model of measuring impact.

Ophthalmology Report

Dr Wilkinson reported that the number of backlog of patients awaiting reviews had greatly improved and stood at 1871 and all follow ups to March had been completed. The Committee noted that the results of the quality impact report would be presented to the Committee next month and this item would continue to be tracked.

Corporate Scorecard for Quality

Dr Cusack reported that the Stroke service had yet to achieve the 90% target and performance in July was 68.6%. Mrs Searle reported that it had previously been agreed that two beds would constantly be reserved for stroke but this had not been sustained. Dr Cusack pointed out that this was down to patient bed pressures. Mrs Needham would look into this further.

Nursing and Midwifery Report

A discussion was had on pressure ulcers and our constant challenge to improve. Ms Fox has implemented a new Quality Improvement approach which will run over the next year. TDA coming on the 3rd September to run an infection control master class and review the action plan. Beat the bug themes discussed. The Committee asked for a general update on progress on Cedar and Allebone. Congratulations and thanks were extended to the Midwifery division for their work for enabling easy requests for sickle cell and thalassemia screening and completing the Family Origin Questionnaire via ICE. First Trust in the Country to achieve this.

Medical Directors report
No in month Dr Foster data was available, this was due to Dr Foster. This made it difficult for the Committee to feel assured about the mortality data. SHMI slightly up 101.3. HMSR 98.5 but not risk adjusted. National Emergency Laparotomy Audit had been completed with a very good result making NGH one of the best in the country.

The Committee requested that the concern regarding the anticoagulant services be added to the Action log and she requested an update at the next meeting.

Highlight reports were received from the Assurance, Compliance and Risk Group and the Clinical Quality and Effectiveness Group.

Northampton General Hospital NHS
NHS Trust

Report To	PUBLIC TRUST BOARD
Date of Meeting	24 September 2015

Title of the Report	Report from the Workforce Committee
Agenda item	19
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 August.	
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 4.1, 4.2, 4.3
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)

Enclosure O

<table>
<tr><td>Legal implications / regulatory requirements</td><td>Statutory and governance duties</td></tr>
<tr><td colspan="2">Actions required by the Trust Board

The Trust Board is asked to note the report.</td></tr>
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Northampton General Hospital NHS
NHS Trust

Public Trust Board
24 September 2015

Report from the Workforce Committee meeting held on 19 August 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

1. Nurse Recruitment Strategy

It was reported that there had been a successful trip to Romania in July where the panel was able to make offers to 21 successful candidates, some of whom would be arriving in August. A return trip to Romania is planned to recruit another 15 nurses. In addition 15 nurses from India, who already had the International English Language Test (IELTS), would be interviewed via Skype.

Within the Trust there are a number of Healthcare Assistants (HCAs) who had a nurse registration within their country of origin. Following a successful bid to the Local Education, Training Council (LETC) the process for supporting this group of staff was on going. Interviews and assessment processes were completed in July for 25 applicants. Outcomes of the assessment/interview process would be available following a review meeting with South Leicestershire College. The next stage for the successful candidates would be the IELTS 6 week preparation programme and IELTS test. A report would be submitted to the Local Education Training Council (LETC) on completion of this process.

It was reported that plans were being developed to work with Kettering General Hospital (KGH) and Northamptonshire Healthcare Foundation Trust (NHfT) to hold a countywide Recruitment event in London. The Royal College of Nursing had agreed to host this event and discussion were taking place with HEART radio re advertising the event. Whilst a date had not yet been finalised this might be in early November and would focus on highlighting the benefits of living and working within Northamptonshire.

The Finance Committee had approved the Nurse Recruitment business case for 2016/17 to the maximum value of £900,000 and the Director of Workforce and Transformation requested the Workforce Committee's approval to use some of this to fund a retention post. The Committee agreed to the funding of a retention post.

The Director of Nursing, Midwifery and Patient Services (DoN) advised that the standardisation of shifts would benefit the workforce in that this would mean an increase of 47wte in registered nurses and 35wte of healthcare assistants.

It was also noted that more work was needed around encouraging nursing students from the University of Northampton. The DoN reported that out of a cohort of 70, 35 had been allocated to Northampton General Hospital.

2. Nurse revalidation

The DoN provided an update on the revalidation of registered nurses and midwives with the Nursing & Midwifery Council (NMC) and the approach being taken by the Trust to support staff compliance with the new NMC process. The Revalidation Strategy Group had continued to work on the implementation action log. Key areas achieved following previous report included, planned

workshops for staff due to revalidate in April-June 2016 and Bank only registrants have been identified and included in the process for substantive staff.

3. Organisational Effectiveness Strategy Update
A report provided information and progress in relation to the Making Quality Count, continuous improvement programme. It was noted that the programmes for Tranche 2 had been completed and highlighted the Geriatric Emergency Medicine project for care of the geriatric and dementia patient in Urgent Care. This had resulted in a 50% reduction in complaints from this area.

Tranche 3 was near completion and Tranche 4 would be commencing in the near future. The Chief Executive commented that it was important for the momentum to continue with these projects.

4. Key performance indicators
These showed an increase in contracted workforce employed by the Trust, and a decrease in sickness absence. Increases in compliance rates for Mandatory Training and Role Specific Essential Training (ROK) compliance were seen but there was no change in Appraisal compliance rates. Position relating to number of in month changes for employee relations cases was noted.

It was also reported that Trust turnover increased to 11.54% in June and that was above the Trust target of 8%. Also in month sickness absence decreased in July by 0.11% to 4.04%, which was still above the Trust target of 3.8%.

The Director of Workforce and Transformation advised that a significant number of people had not received their incremental pay despite having had a successful appraisal and reported problems with payroll on a number of areas, including on call pay protection and salary sacrifice. Actions would be taken to ensure that all staff would be reimbursed with the salary that they should have received. Concern was expressed at the impact this could have on staff morale.

5. Staff survey
The Trust had taken the decision this year to extend the National Staff Survey to include all staff as opposed to a random sample of 850 as in previous years. This had been made possible by moving to an electronic survey in the main and by changing the supplier the Trust uses for this process. Quality Health would send electronic links to all 4,000 staff that have an NGH email address. For staff that did not currently have a Trust email account a paper copy would be delivered to their home address.

6. Hard Truths Report
The DoN reported on the planned versus actual staffing levels across the inpatient areas. The overall fill rate for July 2015 was 94%, compared to 90% in June. Temporary staffing usage had increased in month along with overall staff in post.

The DoN stated that she would like to change the format of the report to streamline and triangulate and record harm and mitigate risk. An additional column would be added to record low/medium or severe harm and if this was directly linked to fill rate. The Committee were in agreement to change the format of the report.

7. Medical Locum Agency Costs Report
The Committee received a report which set out the action taken in relation to Medical Agency spends.

The year to date savings achieved through this project were £162K (to week ending 26 July 2015) which was above plan. Since the introduction of 247 time off framework agencies account for around 19% of the bookings, whereas previously it was much higher at circa 45%.

The report also updated on the Medical Productivity theme. This project was primarily aimed at reducing demand for agency staff and hence a focus on recruitment. The Trust had experienced significant difficulties with the recruitment of training grade doctors. In addition to the unfilled vacancies, 4 junior doctors were unable to commence as planned in August due to a combination

of their not having had visas or not been GMC registered. This matter had been escalated to the Deanery.

8. Appraisal and Revalidation Annual report and Statement of Compliance
The Medical Director provided the evidence that allowed the Committee to sign off the Statement of Compliance. It was noted that for the period 1 April 2014 – 31 March 2015 the Trust had a prescribed connection to 292 doctors for revalidation purposes. The Trust's Responsible Officer made positive recommendations for 71 doctors all had been approved by the GMC. The majority of licensed doctors were expected to be revalidation for the first time by the end of March 2016.

The Committee were advised that the Trust had not adopted a policy in relation to dealing with medical staff's underperformance however HR had developed a policy that was currently with the Trust's lawyers. It was suggested that HR review the Re-mediation policy in light of this.

9. Medical Workforce Strategy
The Medical Director reported that amendments to the Strategy had been incorporated and presented the Strategy to the Committee for approval. An implementation plan was scheduled to be presented to the Committee in December.

Northampton General Hospital NHS
NHS Trust

Enclosure P

Report To	PUBLIC TRUST BOARD
Date of Meeting	24 September 2015

Title of the Report	Report from the Hospital Management Team
Agenda item	21
Presenter of Report	Dr Sonia Swart, Chief Executive Officer
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 – 1 September 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

Actions required by the Trust Board

The Trust Board is asked to note the report.

Public Trust Board
24 September 2015

Report from the Hospital Management Team (HMT) meeting held on 1 September 2015

Introduction
This report from the Hospital Management Team provides an update on activities undertaken and also draws the Board's attention to any other issues of significance, interest and associated actions required.

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.

Key Issues
Dr Swart gave a verbal update on the performance against the 4hour standard and thanked all staff for their hard work over the past few months. She also commented on progress on financial sustainability and the Boards ongoing concern with regard to the challenge of the changing care programme and the TDA request to reduce the deficit plan.

Finance
Mr Lazarus gave an update of the issues relating to funding the capital programme and the requirement to reduce capital spend across IT, Estates and medical equipment.

Divisional updates
Each Divisional Director/Manager was invited to update on key areas of focus following their monthly performance meetings:

Medicine
Mrs McLeod presented the exception report for the division of Medicine, she asked HMT to note the recent difficulties with insufficient endoscopy capacity to meet the increasing demand. A business case to recruit 2 additional nurse endoscopists had been agreed by the executive team and recruitment to those posts would now commence. There was further discussion regarding the vacancy rate of 28% since August for junior doctors at NGH.

Women's, Children's, Cancer and Oncology/Haematology Division
Mr von Widekind presented the exception report for Women's, Childrens, Cancer, and Oncology & Haematology. The main area of focus for the division at present is cancer and whilst good progress has been made with 2ww and 31 day pathways the 62 day pathway for most tumour sites remains a real challenge. There was a brief discussion about breaking the cycle (BTC) for cancer which will be a rapid improvement event similar to the previous urgent care BTC, although cancer improvement would need to be undertaken over a longer period of time.

Surgery
Dr Wilkinson presented the exception report for the division of surgery. He said that whilst MDSU was not being used as an escalation area the directorate were able to increase their income and reduce the waiting list, the use of MDSU for emergency patients poses an ongoing risk to income and waiting times through the winter months especially as the directorate has now ceased outsourcing elective activity.

There was a discussion about vacancies in theatres and a suggestion that not all vacancies were being put to the bank and/or agency. A key area of work for the division is the link with MK for vascular, progress is slow but provides a great opportunity for collaboration outside Northamptonshire.

Clinical Support Services
Mrs Neale presented the exception report for clinical support services and updated HMT on the positive collaborative working across NGH and KGH for radiology. She also asked HMT to note that the radiology service at Weston Favell would cease at the end of March 2016.

Workshops
There were 2 workshops at the meeting. The first was a presentation following the recent structure review.

The output of the review was presented to the HMT, the key points to note were:

- It was thought this was the correct structure for the organisation.
- Some changes were required in the nursing structure at divisional level.
- Some staff were unhappy about others bypassing the hierarchy
- An additional Directorate Manager is required to split Ophthalmology from Head and Neck.
- Increased governance support is required
- Better and more timely information (scorecards) is required

The second workshop was a presentation on Regulation, Scrutiny and the Importance of Assurance; the basics were presented to HMT including the board assessment framework, how this is developed and used.

Northampton General Hospital NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 24 September 2015
09:30 in the Board Room at Northampton General Hospital

Time	Agenda Item	Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**			
	1. Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2. Declarations of Interest	Note	Mr P Farenden	**Verbal**
	3. Minutes of meeting 30 July 2015	Decision	Mr P Farenden	**A.**
	4. Matters Arising and Action Log	Note	Mr P Farenden	**B.**
	5. Patient Story	Receive	Mrs J Brennan	**Verbal**
	6. Chairman's Report	Receive	Mr P Farenden	**Verbal**
	7. Chief Executive's Report	Receive	Dr S Swart	**C.**
10:00	**CLINICAL QUALITY AND SAFETY**			
	8. Medical Director's Report	Assurance	Dr M Cusack	**D.**
	9. Director of Nursing and Midwifery Report	Assurance	Ms C Fox	**E.**
10:20	**OPERATIONAL ASSURANCE**			
	10. Finance Report	Assurance	Mr S Lazarus	**F.**
	11. Workforce Performance Report	Assurance	Mrs J Brennan	**G.**
10:40	**GOVERNANCE**			
	12. Infection Prevention Annual Report	Assurance	Ms C Fox	**H.**
	13. Corporate Governance Quarterly Report	Assurance	Ms C Thorne	**I.**
	14. TDA Self-Certifications	Decision	Ms C Thorne	**J.**
11:05	**STRATEGY**			
	15. Partnership Update • Clinical Collaboration • Healthier Northants • Oncology Alliance	Assurance	Mr C Pallot	**K.**
11:25	**FOR INFORMATION**			
	16. Integrated Performance Report	Assurance	Mrs D Needham	**L.**

Time		Agenda Item	Action	Presented by	Enclosure
11:35	**COMMITTEE REPORTS**				
	17.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler	**M.**
	18.	Highlight Report from Quality Governance Committee	Assurance	Mrs L Searle	**N.**
	19.	Highlight Report from Workforce Committee	Assurance	Mr G Kershaw	**O.**
	20.	Highlight Report from Audit Committee	Assurance	Mr D Noble	**Verbal**
	21.	Highlight Report from Hospital Management Team	Assurance	Dr S Swart	**P.**
12:00	**22.**	**ANY OTHER BUSINESS**		Mr P Farenden	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Trust Board will be held at 09:30 on Thursday 26 November 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).