Northampton General Hospital NHS
NHS Trust

Public Trust Board

Thursday 24 November 2016

10:30

Board Room
Northampton General Hospital

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NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 24 November 2016
10:30 in the Board Room at Northampton General Hospital

Time		Agenda Item	Action	Presented by	Enclosure
10:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2.	Declarations of Interest	Note	Mr P Farenden	**Verbal**
	3.	Minutes of meeting 29 September 2016	Decision	Mr P Farenden	**A.**
	4.	Matters Arising and Action Log	Note	Mr P Farenden	**B.**
	5.	Patient Story	Receive	Executive Director	**Verbal**
	6.	Chairman's Report	Receive	Mr P Farenden	**Verbal**
	7.	Chief Executive's Report	Receive	Dr S Swart	**C.**
11:00	**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.**
11:25	**OPERATIONAL ASSURANCE**				
	10.	Segmentation of Trusts	Assurance	Dr S Swart	**F.**
	11.	Finance Report	Assurance	Mr S Lazarus	**G.**
	12.	Workforce Performance Report	Assurance	Mrs J Brennan	**H.**
11:50	**STRATEGY**				
	13.	Clinical Collaboration & STP Update	Assurance	Mr C Pallot	**Verbal.**
12:15	**FOR INFORMATION**				
	14.	Integrated Performance Report	Assurance	Mrs D Needham	**I.**
12:25	**COMMITTEE REPORTS**				
	15.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler/Mr P Farenden	**J.**
	16.	Highlight Report from Quality Governance Committee	Assurance	Mr Farenden	**K.**
	17.	Highlight Report from Workforce Committee	Assurance	Mr G Kershaw	**L.**

Time	Agenda Item		Action	Presented by	Enclosure
	18.	Highlight Report from Hospital Management Team	Assurance	Dr S Swart	**Verbal.**
13:00	**19.**	**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 January 2017 in the Board Room at Northampton General Hospital.

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

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

Northampton General Hospital NHS
NHS Trust

Minutes of the Public Trust Board

Thursday 29 September at 09:30 in the Board Room at Northampton General Hospital

Present		
	Mr P Farenden	Chairman (Chair)
	Dr S Swart	Chief Executive Officer
	Mr P Zeidler	Non-Executive Director
	Dr M Cusack	Medical Director
	Ms C Fox	Director of Nursing, Midwifery & Patient Services
	Mr S Lazarus	Director of Finance
	Mr G Kershaw	Non-Executive Director
	Mr D Noble	Non-Executive Director
	Mrs D Needham	Chief Operating Officer and Deputy Chief Executive Officer
	Mrs J Brennan	Director of Workforce and Transformation
	Ms O Clymer	Non-Executive Director
In Attendance		
	Ms K Palmer	Executive Board Secretary
	Ms C Thorne	Director of Corporate Development Governance & Assurance
	Mr C Pallot	Director of Strategy and Partnerships
	Mr C Abolins	Director of Facilities and Capital Development
	Mrs S Watts	Head of Communications
	Ms A Hicks	Clinical Nurse Specialist (FREEDOM Presentation)
	Dr C Topping	Energy And Sustainability Manager(Agenda Item 16)
Apologies		
	Mrs L Searle	Non-Executive Director

TB 16/17 047 Introductions and Apologies

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

Apologies for absence were recorded from Mrs L Searle.

Dr Swart introduced Ms Anne Hicks who delivered a presentation on FREED UK (Foundation for Rural Education, Empowerment and Development) to the Trust Board.

Ms Hicks advised that FREED UK is a charity which supports the deprived rural community of Nandom in the Upper West region of Ghana, and she will be travelling to Ghana on 30 September 16 to volunteer at the charity. Ms Hicks discussed the successful installation of a kitchen and canteen facilities at Nandom Hospital. The facility ensures patients are provided with access to a meal and children's meals are free of charge.

Ms Hicks noted the project this time that she will be involved in will be ensuring the wall around Nandom hospital is built correctly.

Ms Hicks shared with the Board the discovery by Nandom hospital of the combination of Iodine and honey within a gauze dressing which was enabling wounds to heal. There were noted complications if the patient was an undiagnosed diabetic which resulted in a diabetic coma. Following this complication, all patients have a finger prick prior to the gauze being applied.

Ms Hicks followed on from this discovery to discuss the Nandom Diabetes project 2016 which also includes collaborative work with De Montfort University. The introduction of a specialist nurse led diabetes centre will help the community of

Nandom understand diabetes and its complexities.

Dr Swart commented that she found the presentation interesting. She asked Ms Hicks to sum up her experience and how it has helped her in normal day job. Ms Hicks stated that she had worked for the NHS all her life and was proud to work for NHS. When she visited Ghana and sees what the nurses deal with, it puts her working life into perspective.

Dr Swart presented Ms Hicks with the Outstanding Contribution Award from the Best Possible Care Awards.

TB 16/17 048 **Declarations of Interest**

Mr Zeidler declared that he had been appointed Chair of the Children's Charity 'Ride High'.

TB 16/17 049 **Minutes of the meeting 28 July 2016**

The minutes of the Trust Board meeting held on 28 July 2016 were presented for approval.

The Board resolved to **APPROVE** the minutes of the 28 July 2016 as a true and accurate record of proceedings subject to one typographical error.

TB 16/17 050 **Matters Arising and Action Log 28 July 2016**

The Matters Arising and Action Log from the 28 July 2016 were considered.

Action Log Item 63:
Ms Fox confirmed that this action was now closed. The possibility of a future 24 hours in A&E survey has been discussed. Ms Fox stated dialogue would need to be had as to how it could be done again on an operational level and how the data would be analysed.

The Board **NOTED** the Action Log and Matters Arising from the 28 July 2016.

TB 16/17 051 **Patient Story**

Mrs Needham presented the Patient Story and advised that it was from a manager's perspective.

The manager discussed the effort from staff to change the Trust's position from red and the impact it has on the hospital. The involved a deep-dive into patient reviews and focused on the safe discharge of patients. The manager stated that they just want a safe hospital.

Mr Farenden commented that this is an increasing recurrent scenario and shared his concern that the full impact from the proposed social cuts that has yet to be experienced.

The Board **NOTED** the Patient Story.

TB 16/17 052 **Chairman's Report**

Mr Farenden presented the Chairman's Report.

Mr Farenden advised that on his recent Beat the Bug rounds he had noted a positive outlook from the staff and that the staff had felt better than in recent times. Mr Farenden stated that this was commendable.

Mr Farenden has recently attended a Northamptonshire Chair and Non-Executives meeting. The main area for discussion was the challenge faced by the STP and the contribution expected from the acute sector. The attendees had noted the issues

with DTOC and the potential social care position.

Mr Farenden commented that he, Dr Swart and Ms Watts had met with 3 MP's whom gave a sense of understanding to the effect the social care cuts will have on the county.

Mr Farenden noted that the recent AGM attendance was disappointing. Dr Swart had delivered an excellent presentation. Mr Farenden stated that the Trust needed to adopt a different approach to make the public aware of the AGM.

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

TB 16/17 053 Chief Executive's Report

Dr Swart presented the Chief Executive's Report.

Dr Swart commented that nationally and at NGH, as pressure on the NHS increases there is a real danger that the workforce is unable to cope with the demands that are made. This results in demoralisation, along with poor retention and recruitment of staff at all levels. Dr Swart stated that to address the pressure caused by these issues the Trust has displayed a focus on Quality Improvement, the Staff Engagement Strategy and the Communication Strategy with a variety of initiatives that support the development of the workforce. It is highly important that the workforce feels valued.

Dr Swart advised that the Health and Well Being Strategy which is supported through the Health and Well Being Steering Group focuses on how staff can help themselves. The group also highlights attention to the positive rather than the negative.

Dr Swart noted that it was fantastic to receive such excellent feedback at a recent Healthy Workplace Conference at Northampton University. There was a presentation on 'The Northampton General Hospital Journey to a Trust Wide Programme' delivered by Sarah Ash and Anne-Marie Dunkley. It was described as conveying 'infectious enthusiasm' for an impressive programme of work. Dr Swart stated that the Trust and Communication Team need to display support of this programme. Dr Swart advised that the focus will now shift to mental health and that the group need to explore how this can be taken forward.

Dr Swart advised that she had receive a letter from some senior politicians and an independent charity asking for support for setting up a cross-party commission on the future of the NHS and Social Care. Dr Swart commented that it is essential that the Trust can do all it can to improve areas which are within its control.

Dr Swart noted that the Trust is doing reasonable well on its quality measures despite increased pressures and it is vital that staffs are of aware of this.

Dr Swart stated that the STP mandates that the Trust works closely with its staff to deliver the programme. There are still gaps to close with the most focus being on the finances. Dr Swart commented that there have been many discussions on Urgent Care at a local and national level. The Trust has been working collaboratively with Kettering General Hospital to improve the care out of hospital. This means that the two Trusts should have fewer admissions and better discharge arrangements. Dr Swart advised that an agreement needs to be reached on how to count the number of delayed discharges.

Dr Swart reported that risk to patients is still her main concern and that the Trust needs to ensure patients safety is its top priority. On a recent visits to the A&E department Dr Swart was impressed at the positive atmosphere despite the

pressures and could see a huge difference compared to a few years ago. Dr Swart commented that she was proud that the results of our Baseline Patient Safety Questionnaire in A&E. The results were good with a positive view of safety culture in the department. The Trust scored highest out of the 8 Trusts involved in the Baseline Patient Safety Questionnaire. Dr Swart advised that all areas of the hospital need to feel the same amount of support shown to the A&E department. The departments need explore areas that they can take ownership of and improve on.

Dr Swart stated that it was positive to note that the September Junior Doctors strike action was cancelled.

Dr Swart advised that the recent Annual General Meeting lacked attendees and the Trust needs to understand on how best to convey the message to the public, which should hopefully reenergise the membership.

Dr Swart informed the Trust Board that this year the Trust has been shortlisted for an HSJ Award in the Staff Engagement category for the work undertaken to recruit staff to the nurse bank.

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

TB 16/17 054 **Medical Director's Report**

Dr Cusack presented the Medical Director's Report.

Dr Cusack advised that there were no incidents in July or August that met the criteria of a Never Event. One Never Event report was submitted to the CCG for closure and the learning from the report is detailed on page 20 of the report pack. Dr Cusack reported that the Trust's Governance team had also visited Theatres.

Dr Cusack stated that during the reporting period there were three serious incident reports submitted to Nene and Corby Clinical Commissioning Group (CCG) for closure. Dr Cusack commented on incident 2016-8981 on page 22 of the report. It has been agreed that a key area of improvement is to ensure the patient is escalated to the right doctor at the right time.

Dr Cusack gave the Trust Board assurance that although the number of open Serious Incidents that had passed the submission date was great, the Trust has submitted their report and thereafter this CCG has asked further questions. The CCG have shown an interest in Biliary Tract infections and complications of medicine and surgery.

Dr Cusack advised that HSMR for the year to May 2016 remains within the 'as expected' range. It was reported that as was the case in 2015, a 'spike' again seen in SMR during the month of April is being investigated further.

Dr Cusack stated that a case note review is underway as there may be a coding issue linked to bronchitis with pneumonia. This is being reviewed by the Mortality Surveillance Group.

Mr Noble commented that on page 20 of the report pack, the reduction in Serious Incidents over the years looks positive and asked for confirmation of this. There was discussion had that the definitions of an SI had changed along with more robust but concise investigation. Mr Noble asked for narrative to be added to future Medical Directors' reports of this nature along with an explanation on how the investigation of SI's has changed.

Action: Dr Cusack

Mr Kershaw queried how the Trust has dealt with formal feedback from the CCG. Dr

Cusack advised that the first visit to Theatres was positive with a comment made in reference to where laundry was kept. In Maxillofacial, no feedback had been reported. Dr Cusack stated that for Ophthalmology two points had been raised. There was a notable variation on how checks are done between the surgeons and the behaviour of different surgeons. Dr Cusack has addressed these issues within the Directorate.

Ms Thorne commented that at a recent data sharing event focus on Never Events, 100 staff attended. At the data sharing event, staff attended who had been involved in recent Never Events. Mr Farenden queried whether the staff understood the significance of a Never Event.

Ms Thorne stated that staff have shown a positive response to the data sharing events and noted the attendance of an entire theatres team. The possibility of running the event again is in discussion. Mr Farenden asked for clarity on whether staff showed openness to learn. Ms Thorne confirmed that the staff had displayed a willingness to learn at the event. Dr Cusack commented that there had been a shift in thinking in the Theatre Safety Group.

Dr Swart advised that the Medical Directors report needs to encapsulate the variety of learning events and projects for SI's/Never Events.

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

TB 16/17 055 **Director of Nursing and Midwifery Care Report**

Ms Fox presented the Director of Nursing and Midwifery Care Report.

Ms Fox gave the Trust Board a Midwifery update on Sign-up to Safety and the Launch of Newborn Early Warning Track and Trigger (NEWTT) on postnatal wards. The newborn early warning scores are used to detect early deterioration in seemingly healthy babies who have identified risk factors that prompt closer observation, whilst remaining with their mother on the postnatal ward and this was launched in September.

Ms Fox commented that in August 2016 NGH achieved 99.2% harm free care (new harms) and that this is an improvement to the previous month.

Ms Fox reported that in August 2016, a total of 14 patients were harmed whilst in the care of Northampton General Hospital, resulting in 18 pressure ulcers, illustrated in the graph on page 28 of the report. This represents a 36% decrease in the number of patients harmed from the previous month (July 2016). Ms Fox confirmed that she would be bringing a paper to the Quality Governance Committee in October 2016 on where the Trust sits nationally and the work undertaken by the Pressure Ulcer Collaborative.

Action: Ms C Fox

Ms Fox noted that the Trust is in a positive position for HCAI's. Public Health England confirmed that the Trust is seeing a year on year reduction and that the Trust is doing very well in comparison to other Trusts.

Ms Fox drew the Board to page 33 of the report pack which reports on the Friends & Family Test which shows that results still remain above the mean line for the fourth month consecutively for the amount of patients that would recommend the Trust.

Ms Fox gave the Board an End of Life Update which is detailed on page 36 of the report pack. Ms Fox initiated an internal and external review of End of Life Care to provide an overview of the Trust compliance with national guidance. The internal review was undertaken by an Associate Director of Nursing, Head of Governance

and End of Life Project Lead in June 2016. The external review was undertaken by a Specialist Palliative Care Nurse, Matron for Cancer Services and a Chaplain from Ipswich Hospital. Ms Fox reported that the external review rated the Trust as 'requires improvement' after following CQC inspection standards.

Ms Fox advised that the Trust has made significant improvements in the number of patients who have a Dying Person's Care Plan in place reaching 72% of patients and it also demonstrates evidence of senior medical review and discussion with patients and/or family. The Trust also has a local CQUIN related to End of Life care for 2016/17 related to Preferred Place of Death, exploring whether patients achieve their documented preferred place of death, and the reasons why it is and is not achieved.

Ms Fox noted that the Trust was non-compliant with one of the organisational questions in the National Care of the Dying Audit because it had not undertaken a recent survey of bereaved relatives/carers. The team have worked with the Head of PALS and Bereavement to develop a process for capturing the experience of families when they collect the death certificate.

Mrs Needham queried what work had been done with the Patient Experience team. Ms Fox advised that the 'Real Time Right Time' survey launches next week following a positive pilot in the summer. The 'Real Time Right Time' survey results will be available in November/December.

Mr Zeidler drew the Board to page 38 of the report pack and noted the excessive hours to plan. Ms Fox gave the example of if you have 1 HCA planned and then require 1 additional HCA, the actual fill rate would go up to 200%.

Mr Noble queried on page 32 of the report pack that Allebone and EAU are noted to still require improvement and queried what mitigation plans were in place. Ms Fox explained that Allebone was previously Halcot due to ward moves. The ward has also been without a ward manager leading the team since May. The ward manager is due back in post week commencing 03 October 16.

Dr Swart stated that PALS were now running patient listening events with the possibility of Healthwatch included in the future.

Dr Swart commented on the difficulty of knowing what happens to patient following discharge and the Trust could be put in a vulnerable position if this issue is not addressed.

Mrs Brennan shared with the Board that the OD team is working with Ms Fox at looking at both the patient and staff experience within the same area.

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

TB 16/17 056 **Infection Prevention Annual Report**

Ms Fox presented the Infection Prevention Annual Report.

Ms Fox advised that the annual report provides a summary of the performance and developments related to Infection Prevention and Control (IPC) during 2015/2016 and a broad plan of work for 2016/17 which has been tracked by the Infection Prevention Committee since April. Ms Fox stated that the Trust has a legal requirement to protect patients, staff and others from acquiring healthcare associated infections by compliance with the Hygiene Code.

Mr Pallot made the Trust Board aware of the CQUIN requirements next year, all of which appear to be challenging. He gave an example for Sepsis which been merged with the Anti-Microbial CQUIN. The CQUIN requirement will increase workload and

which could present a financial challenge to the Trust is not achieved.

Ms Fox advised that she would be working together with the lead for Sepsis in shadow form to address the challenges discussed.

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

TB 16/17 057 Finance Report

Mr Lazarus presented the Finance Report.

Mr Lazarus advised that the financial performance for the period ended August 2016/17 is a normalised deficit of £5.710m, £230k adv. to the planned deficit of £5.940m.

Mr Lazarus stated that STF funding for Quarter 1 was received from the Department of Health, on behalf of NHS England. Funding for Quarter 2 is anticipated to be received in October. Mr Lazarus noted that this is reliant on the cumulative control total and access targets being achieved.

Mr Lazarus reported that August had been a good month in regards of income and the Trust was able to mitigate previous summer issues.

Mr Lazarus advised that pay expenditure run rate continues to reduce month on month but remains significantly adverse to plan for the year to date.

Mr Lazarus commented that looking forward, an assessment of the financial impact of the emerging Winter plan is prepared and has been agreed. This is particularly in relation to the impact on the elective bed base and outsourcing of elective work to the private sector.

Mr Farenden queried whether Mr Lazarus was confident in the proposed mitigation plans or whether the Trust could still do more. Mr Lazarus stated that there was no definite plan and whilst the Trusts position has improved in month 5, the Trust needs to go forward a couple more months before final plans can be detailed. The Trust also needs further information on the impact of the proposed social care cuts.

Mr Pallot noted that the CCG's financial position is adverse and there could be difficult contract discussions at the end of the year with regard to the final position for 2016/17.

The Board **NOTED** the Finance Report.

TB 16/17 058 Workforce Performance Report

Mrs Brennan presented the Workforce Performance Report.

Mrs Brennan advised that the substantive Workforce Capacity decreased by 22.57 FTE in August 2016 to 4259.56 FTE. Mrs Brennan believed that this is due to staff leaving their permanent post whilst still remaining on the bank, hence the corresponding decrease in capacity.

Mrs Brennan stated that the target compliance rates for Role Specific Training have all been set at 85%. Medicine and Surgery have been set action plans to help achieve this target.

Mrs Brennan reported that the Global Corporate Challenge Awards were held recently and commented that Victoria Ward had done well in being the most active team.

Mrs Brennan discussed the Junior Doctors contract. The judicial review results had been received for whether the Secretary of State was able to impose the new contract. The results were in favour of the Secretary of State. The result is being appealed.

Mrs Brennan advised that Junior Doctors planned to write to Trusts asking their Trust to reconsider implementing the new contract.

Mrs Brennan noted the positive news that the BMA have withdrawn the 3 five day strikes.

Mrs Brennan stated that the Trust has been running Junior Doctor contract sessions. There were 20 – 25 Junior Doctors who attended the previous session and it was apparent that the Junior Doctors do not have all the facts. The Junior Doctors commented that the session was helpful.

Mr Farenden asked for clarity on whether there was a lower level of enthusiasm now for further strikes. Mrs Brennan confirmed that there was a lower level of enthusiasm.

Mr Kershaw queried whether it was known what the financial impact of the Junior Doctors contracts would be. Mrs Brennan reported that at a local level this cannot be quantified until each individual rota is designed. The Junior Doctors will be pay protected for between 4 – 6 years.

Mr Lazarus noted that there are provisions in the forecast for the implications of the Junior Doctors contract but this cannot be estimated exactly.

Dr Cusack stated that the ongoing issues had dented the morale of the Junior Doctors.

Mrs Brennan presented the Occupational Health Annual Plan. There has been a 7% increase in activity from the previous year's figure of 14,238 to 16,396.

Mrs Brennan advised for NGH staff that if the 433 hours of nurse time that has been wasted by patient non-attendance to appointments had instead been used and sold externally at £93 per hour, it would have brought the Trust £40,269 in additional revenue.

Mrs Brennan reported that the flu campaign in 2015/16 showed a reduction in uptake to 65% compared to 2014/15 which was the most successful in the past nine years with a percentage uptake of 71%. A national CQUIN target of 75% has been introduced for 16/17. The data will be collected from October to December 16. Mrs Brennan stated that pop-up clinics will be held in the cyber café and trolley rounds will also be happening at the weekend/evenings. She advised that the marketing campaign this year was "Jab and Grab" with a voucher for a meal in the restaurant for having the vaccine.

Mrs Brennan advised that the number of management referrals had reduced. This is due to a more robust system of triage and better quality referrals, improved communication and education of managers on the sickness absence process.

Mrs Brennan noted that in regards to income generation the yearly target set for OH services of £150,000 was exceeded and the total income for 2015/16 was £216,579 exceeding the target by £66,579. Due to this success the income target has been increased by £86,000 for 2016/17 to £236,000.

Mrs Brennan drew the Board to page 141 of the report pack which details reflection, learning and improvement. An electronic portal has been set up to help support the

NGH recruitment team in pre-employment checks, which had significantly reduced the turnaround time.

Mrs Brennan stated that the Occupational Health Service now has 2 physicians covering 1 day a week each, which has doubled the service but at a less cost than the previously outsourced service.

Mrs Needham queried whether there could be a telephone reminder service for outpatient appointments. Mrs Brennan commented that this could be explored.

Action: Mrs J Brennan

Ms Clymer asked whether there was going to be plan for increasing mandatory training compliance as currently the focus appears to be on role specific training. Mrs Brennan stated that at current role specific training is more of a concern which is why dedicated plans were needed for this target and the mandatory training target had been exceeded.

Mr Zeidler queried whether there were any concerns or triggers to staff leaving their permanent post to work on the bank. Mrs Brennan stated that this was the first time this had been observed in a long time. An audit was done previously and it highlighted that it was predominantly nursing staff. Mrs Brennan acknowledged that nurse retention is a risk and that this is being addressed.

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

TB 16/17 059 STP and Clinical Collaboration Update

Mr Pallot presented the STP and Clinical Collaboration Update.

Mr Pallot advised that full STP submissions including an updated finance template are due to be submitted by the CCG on the 21 October.

Mr Pallot stated that he is the SRO lead for Scheduled Care and reported that good progress had been made on single service models.

Mr Pallot commented that STP delivery and new planning framework is the current key focus. It is noted to be very challenging to work to the agreed 2 year contracts which are linked the STP and control totals.

The Board **NOTED** the STP and Clinical Collaboration Update.

TB 16/17 060 Communications & Engagement Strategy Update

Mrs Watts presented the Communications & Engagement Strategy Update.

Mrs Watts advised of the positive progress made within the communications team. The Communications team has encouraged the specialities to come speak to the team about their objectives and what they need to do to achieve these. The Communications team has been able to suggest the best value for money plans to highlight their services, which will also reflect the Trusts vision and values.

Mrs Watts stated that visual display boards are now utilised more across the Trust.

The communications team have reviewed the recruitment area of the Trust's website and have also supported recruitment open days.

Mrs Watts commented that the Trusts digital footprint now corresponds with the Trust being Northampton's biggest recruiter.

Mrs Watts shared with the Board that the Communication team had been shortlisted for HSJ Award for staff engagement.

Mrs Watts advised that enabling staff to access Trust social media channels from within the workplace is key with the Trust launching the Facebook at Work pilot site recently. Mrs Watts noted that further enquires need to be made.

Mrs Watts discussed that working with TwoFour production company on the junior doctors' television series was going very well. The aim is to raise the profile of training opportunities provided at NGH and encourage a take-up of posts. The TwoFour production company have been very complimentary of the Trust.

Mrs Watts confirmed that there is a redesign of the Trust Internet site underway. A digital design apprentice has recently been employed who is focusing on the building of the new internet site. The new website needs to be kept up to date, accessible and fit for purpose. Mrs Watts stated that there will be more detailed information about the Consultants on the new Internet site.

Dr Swart asked for Mrs Watts to expand on what else TwoFour are focusing on at the Trust. Mrs Watts advised that TwoFour are also filming from a patient and staff experience perspective. The filming is throwing light on a number of different areas. Dr Swart commented that TwoFour are looking at how the Trust responds at all levels and the daily rhythm of the hospital. TwoFour have advised Dr Swart that they are blown away by the passion for patient care.

Mr Farenden queried whether the Trust has editorial input. Dr Swart confirmed that the Trust does. Dr Swart stated that Health Education England had made contact with the Trust to ensure the filming is real and not sensationalised.

Mr Farenden congratulated Mrs Watts on the positive transformation of the Communications department.

Ms Thorne noted the improvements to the Internet but asked whether the intranet site would also be improved. Mrs Watts confirmed that this would be done once improvement work on the internet site was complete.

Ms Clymer believed that the quarterly briefings with MP's to be positive and will benefit the Trust in the future.

The Board **NOTED** the Communications & Engagement Strategy Update.

TB 16/17 061 **Equality and Diversity Strategy Update**

Mrs Brennan presented the Equality and Diversity Strategy Update.

Mrs Brennan advised that the Trust Board is asked to approve the refreshed and reviewed Workforce Equality and Diversity Strategy 2016 to 2019. The strategy focuses on the work already done and progress made on equality, diversity and human rights over the years. The strategy also sets out the Trusts co-ordinated and integrated approach in relation to its workforce. Mrs Brennan confirmed that the organisational effectiveness strategy also underpins this.

Mrs Brennan advised that there will be the introduction of a 360 tool which will help managers and staff within a leadership role.

Mrs Brennan noted that Organisational Development Team to continue to work across the Trust providing Rainbow Risk sessions which link in to the Staff Engagement Strategy.

Mrs Brennan drew the Board to Appendix 1 which incorporates the Trust's values.

Mrs Brennan shared her concern on bullying and harassment at the Trust. There have been recent reports that have evidenced that Black and Minority Ethnic (BME) staffs in the NHS are more likely to experience harassment, bullying and abuse. Mrs Brennan commented that this is being addressed and additional training for managers is being explored.

Ms Clymer noted that she was glad to hear of the work to reduce bullying and harassment at the Trust. Ms Clymer queried that a large proportion of the timescales listed within appendix 1 are ongoing and asked for further clarity on this. Mrs Brennan advised that this is due to the strategy being a 5 year strategy. Ms Clymer asked for this to be explained better within appendix 1.

Action: Mrs J Brennan

Dr Swart commented that this all links back to Quality Improvement work and how it benefits staffs which help improve patient care.

Ms Thorne stated that the Freedom to Speak Up ambassadors will help support staff in reporting concerns.

The Board **NOTED** the Equality and Diversity Strategy Update.

TB 16/17 062 Sustainable Development Strategy

Mr Abolins presented the Sustainable Development Strategy.

Mr Abolins introduced Dr C Topping, Energy and Sustainability Manager to the Trust Board.

Mr Abolins advised that the strategy hopes to minimise the overall impact environmentally, for sustainability to be part of business as usual and ensure the environment is compliant.

Mr Abolins drew the Board to page 194 of the report pack which details the Sustainability Strategy 2016 – 2020. Mr Abolins commented that the Trust's commitment to sustainability is part of its board approved Clinical Services Strategy; one of the five strategic aims is to ensure a sustainable future. This sustainability strategy links with the complementary Travel Plan, Estates Strategy, Food Strategy and Procurement Strategy and ChangingCare@NGH programme.

Mr Abolins advised that the action plan is on page 208 – 210 of the report pack. The plan will be refreshed yearly. The plan will be tracked by the Sustainable Development Committee.

Mr Abolins noted the Climate Change Pledge on page 211 – 212 of the report pack and commented that he would like the Trust to sign up to the pledge.

Mr Farenden complimented Dr Topping on the excellent strategy document.

Ms Clymer queried whether it was hard to embed sustainability into the Trust. Dr Topping stated that she has encountered issues occasionally but noted that she is pleased on the progress the Trust has made. Dr Topping reported that the Trust is ahead of other Trust's in the progress it is making with sustainability.

Ms Clymer asked whether there would be any future plans on tackling the issue of air pollution and the impact it has on the public's health. Dr Topping confirmed that air pollution is the biggest risk to health locally and to address this she has contacted the Borough Council and County Council to see what is being done.

Dr Swart congratulated Dr Topping on the change of staffs' perception of healthy food in the Trust's restaurants.

Mr Farenden advised that the Board supported the strategy and agreed to sign up to the Climate Change Pledge.

The Board **NOTED** the Sustainable Development Strategy and **APPROVED** sign up to the Climate Change Pledge.

TB 16/17 063 **Corporate Governance Report**

Ms Thorne presented the Corporate Governance Report.

Ms Thorne advised that the Corporate Governance Statement had been compiled with the help of the Director of Finance. The SFI's would be circulated to senior colleges and Divisional Managers.

Mr Noble expressed his concern that there was only 15 Declarations of Hospitality reported between April – June 2016. Ms Thorne confirmed that there is a self-reporting systemand regular reminders are circulated to staff and that a running chart could be included in future reports.

Action: Ms Thorne

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

TB 16/17 064 **Integrated Performance Report**

Mrs Needham presented the Integrated Performance Report.

Mrs Needham advised that the Integrated Performance Report had been discussed at all relevant sub-committees.

Mrs Needham drew the Board to page 219 of the report pack which shows improved performance across the whole scorecard. It was noted that July Cancer and August A&E performance was above trajectory. There was a risk reported in August for Cancer, and a risk for A&E in September.

Mrs Needham commented that on the scorecard Stoke patients spending at least 90% of time on the Stroke unit has shown an improved performance. Mrs Needham noted the risk going into Winter with high bed occupancy.

Mrs Needham advised that DTOC still remains high. A new A&E Board has been set up which Dr Swart chairs and whom accountability sits with.

Mrs Needham stated that a new portfolio of projects has been set up to help stabilise the urgent care system over Winter. There is concern that Social Care cuts will reduce the benefits of these projects.

The Trust has received a letter from NHSE/NHSI setting the DTOC target at 2.5% of the Trusts bed base. Mrs Needham reported back that the target was not realistic, however a further letter has been received asking for further explanation from the Trust.

Dr Swart commented that the plan will be submitted advising of the risks and variables the Trust may encounter. Dr Swart stated that A&E Board need to continue with their work and hold the system to account if required.

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

TB 16/17 065 **Highlight Report from Finance Investment and Performance Committee**

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

The Board were provided a verbal update on what had been discussed at the Finance Investment and Performance Committee meeting held on 21 September 2016. 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 Zeidler advised of the key points –

- The Trust will suffer a £1m financial impact this Winter.
- STP needs to be submitted before the Octobers Board of Directors but the STP will be discussed in detail at the Finance Investment and Performance Committee.

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

TB 16/17 066 **Highlight Report from Quality Governance Committee**

Ms Clymer presented the Highlight Report from the Quality Governance Committee.

The Board were provided a verbal update what had been discussed at the Quality Governance Committee meeting held on 23 September 2016. 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.

Ms Clymer advised of the key points –

- The risk EMRAD still holds the Trust.
- The CQC inspection plan was discussed in detail.

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

TB 16/17 067 **Highlight Report from Workforce Committee**

Mr Kershaw presented the Highlight Report from the Workforce Committee.

The Board were provided a verbal update on what had been discussed at the Workforce Committee meeting held on 21 September 2016. 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 advised of the key points –

- Nursing supply and the impact it has on the Trust.
- Medical Education required to present a detailed action plan with timescales at October 16 Workforce Committee.

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

TB 16/17 068 **Highlight Report from Hospital Management Team**

Dr Swart presented the Highlight Report from the Hospital Management Team.

The Board were provided a verbal update on issues discussed at the HMT Meeting on 6 September 2016. 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.

Dr Swart advised that the ongoing issues with EMRAD had been discussed in detail. The Trust has received a letter from the CQC regarding the backlog and potential

	risk to patients that EMRAD currently poses. Dr Swart confirmed that a joint letter with other Trusts is being drafted to respond to the letter received from the CCG. The Board **NOTED** the Highlight Report from the Hospital Management Team.
TB 16/17 069	**Any Other Business** There was no other business to discuss.
	Date of next meeting: Thursday 24 November 2016 at 09:30 in the Board Room at Northampton General Hospital.
	Mr P Farenden called the meeting to a close at 12:00

Public Trust Board Action Log							Last update	15/11/2016
Ref	**Date of meeting**	**Minute Number**	**Paper**	**Action Required**	**Responsible**	**Due date**	**Status**	**Updates**
Actions - Slippage								
NONE								
Actions - Current meeting								
66	Sep-16	TB 16/17 054	Medical Directors Report	Mr Noble asked for narrative to be added to future Medical Directors' reports of this nature along with an explanation on how the investigation of SI's has changed.	Dr Cusack	Nov-16	On agenda	To be included in **November Medical Directors Report**
Actions - Future meetings								
67	Sep-16	TB 16/17 058	Workforce Performance Report	Mrs Needham queried whether there could be a telephone reminder service for outpatient appointments. Mrs Brennan commented that this could be explored.	Mrs Brennan	TBC	TBC	Update to given when available

Northampton General Hospital NHS
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**24 November 2016**

Title of the Report	**Chief Executive's Report**
Agenda item	**7**
Presenter of the Report	Dr Sonia Swart, Chief Executive
Author(s) of Report	Sally-Anne Watts, Head of Communications
Purpose	For 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 Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	None
Actions required by the Trust Board The Trust Board is asked to note the contents of the report	

Enclosure C

Northampton General Hospital NHS
NHS Trust

Public Trust Board
24 November 2016

Chief Executive's Report

1. **Awards**

The work of a variety of staff at NGH has been recognised at a national level and I am pleased to report on the awards they have received or been shortlisted for.

Our team of safeguarding midwives recently won a Nursing Times Award for their innovative work in developing a support group for women and families who have learning disabilities. The 'Chit Chat' group, developed by Emma Fathers, Angela Bithray and Sally Kingston, won the Enhancing Patient Dignity Award and was also shortlisted for the Learning Disabilities Nursing category.

Our communications team achieved a Gold Award for Excellence in Public Sector Communications for the work they did on our nurse bank recruitment campaign. NGH was the only NHS trust shortlisted for the Awards, and one of only four organisations nationally to achieve a Gold Award.

Not to be outdone, our procurement team were equally successful and were winners in the Sustainable Procurement category at the recent Health Care Supply Association (HCSA) Awards.

Three candidates from NGH have been shortlisted for the East Midlands Leadership Academy Recognition Awards. These are Sharron Matthews, pre-op sister, in the category of Leading Service Improvement; Stacey Cheney, ward sister, Inspirational Leader of the Year, and Emma Fathers, named midwife for safeguarding, for Excellence in Patient Experience. The winners will be announced at the Awards ceremony on 1st December.

It is pleasing to see the work of our teams recognised at a regional and national level. I hope their success will encourage others and we are developing a system to encourage and support award nominations.

2. **Urgent care pressures**

The Health Select Committee has recently published its report into winter planning in A&E departments. The report suggests that the Government urgently needs to address the under-funding of adult social care to relieve pressure in A&E departments.

This is a topic which is extremely relevant in Northamptonshire. At a recent meeting with two of our local MPs, Michael Ellis and David Mackintosh, I discussed with them the schemes that we have developed with our partners which will be monitored through the local A&E/Urgent Care board.

For me what is becoming clearer with every passing week is that the A&E crisis has at its heart the lack of sufficient hospital space and the ability to move people through it. We are using more bed days, but we do not have enough beds. We are treating more patients and are using more short stay beds. Our patients have more co-morbidities and those who need to stay longer need more bed days than they did before. The effect of this is a daily battle rhythm that centres around identifying adequate beds for the patients who require admission. This can be a demoralising cycle of activity

causing significant pressures for our staff who remain passionate about providing high quality care and who deliver excellent care on a daily basis. Despite this we are failing to meet mandatory performance targets for urgent care and we know that this provides a risk to quality and safety.

That is why we must have a way of doing something different in terms of the way we provide care. We know that just opening many more beds is not only unaffordable, but doesn't really get to the root of the problem.

Our current plans have many components. These include the realisation that changing the way care is delivered will require investing in and building systems of care in the community. There is a greater emphasis on working with the voluntary sector, improving access to, stabilising and transforming primary care and solving key workforce challenges, transforming the acute hospital landscape, modernising the NHS estate and investing in modern technology.

There has been significant work to agree the long term strategy for urgent care and much of this work features in the Sustainability Transformation Plan (STP). The central imperative of supporting the crisis in A&E provision and the system-wide plan for urgent care is acknowledged as critically important. All partners understand our duty to deliver safe, effective urgent care and agree that urgent stabilisation of the urgent care system is an immediate priority.

The newly-formed A&E Delivery Board has met and agreed to support a portfolio of 14 programmes of work. These programmes will be executed as a total package, rather than in isolation, with the support of all partners.

The programmes of work fall in to 3 categories each of which is important in its own right but all are interlinked.

The categories are

1. Reduce admissions to hospital
2. Improve the efficiency of the treatment of patients during their hospital stay (so they stay for a shorter time, their experience is better and costs are less)
3. Improve the way patients are discharged into the community so reducing their length of stay.

We are aware that all the above areas are important. Published studies indicate that one of the key impediments to efficient care is the space and beds available. In this regard the 10% of patients who stay over 7 days occupy 65% of the beds. A relatively small change in this group would free a lot of bed capacity, be much better for patients, save money and allow for greater efficiency in our hospitals, thereby improving the A&E target as well. We are aware that a current lack of adequate domiciliary care capacity is a key factor in Northamptonshire.

If all the schemes are delivered by next March there will be 10 fewer admissions per day, a reduction in occupied bed days (equivalent to a reduction in 113 beds and reduced transfers of care will fall from up to 15% to 5%). The trajectory for improving A&E performance will also be sustained.

The A&E board also supported partners in resolving all the issues related to different ways of counting and describing delayed transfers of care. The work of the A&E board

going forward must and will also include medium and long term plans that will align with the STP strategy.

3. **Sustainability and Transformation Plan**
The Northamptonshire Sustainability & Transformation Plan sets out how health and social care will develop over the next 5 years. The work very much flows through from previous programmes of work and has taken advantage of the case for change made as part of Healthier Northamptonshire but explicitly sets out to address the 3 top priorities for the NHS nationally**.**

Thus there is a clear understanding that the plans must close the health and well-being gap, the care and quality gap and the funding and efficiency gap. This needs to be done both nationally and locally. The plans in place support the county's Health and Well Being Strategy and have been developed by the 11 key partners across commissioners and providers. Where possible members of the public have also been involved but it is recognised that much more involvement of the public and of all NHS and social care staff will be necessary as the plans move from concept to implementation and there will be opportunities to do this.

The case for change rests around the need to close the gaps identified and the obvious pressures in the system as it is now and are based on the premise that there needs to be more focus on supporting people to stay healthy, more focus on combining the various needs of the individual in a more integrated service provision, more focus on ensuring that patients can be cared for in their own homes and more alternatives to care in hospitals. There is a very clear focus on integrated care with stronger collaboration between hospitals and community services including primary care and the voluntary sector. In order to ensure that acute services meet all the necessary standards there is also a focus on stronger collaboration between specialist services at the main hospitals in Northampton and Kettering.

The current STP also recognises that there will need to be a major emphasis on the development of a more flexible workforce, on underpinning new technology and on the use of facilities across the system.

All the programmes of work together are aimed at improving the health and wellbeing of the population whilst also ensuring value for money so that the NHS in Northamptonshire becomes financially sustainable , more efficient and better able to respond to the challenges of health and social care of the future.

There are, therefore, 4 key strands of work which are set out to improve urgent care, complex care, scheduled care and the prevention of ill health. All of these programmes aim to deliver the right care to the right patient in the right place at the right time in order that safe care is delivered in the most appropriate environment across the 7 day week.

The details of these plans will be published in early December in a format that can be shared with all the respective boards of the organisations involved and with the public.

In some parts of the country there has been debate around the so called secrecy of these plans because there has been a mandate not to publish them. There are also various parts of the country where there are plans in place to redesign, for example A&E departments or maternity or paediatric services. In Northamptonshire there are no plans that aim to change the provision of these services at the 2 main hospitals, but both KGH and NGH have agreed to work together on 10 specialities so that these are

provided in the most efficient way for the population across the hospital sites as appropriate. This work is still in progress and has already involved patients and key staff from both hospitals as well as GPs.

4. **Patient safety**

Our Pascal Safety Survey in A&E recently showed very clearly how much progress had been made in terms of establishing a safety culture. Although there were areas of concern and areas for further work – NGH had the best results in the East Midlands – this is a credit to that team and to the many people who have supported change, and it has spurred them on to share their best practice with others. It is particularly important that as we struggle with day to day pressures we resolutely maintain our focus on what matters most. This means ensuring that the conversations and questions are around seeking assurance that we know who our sickest patients are and are assured that they have had appropriate treatment. A daily safety barometer for the hospital is under development which will help us all to keep this compass point at the centre of what we do.

5. **NHS Improvement Assessment Framework**

NHSI have recently announced a new framework for assessing and monitoring hospitals called the NHSI Single Oversight Framework which will assess us against five themes. These are quality, finance and use of resources, operational performance, strategic change, leadership and improvement capability.

They have put all hospitals into one of four segments with one being described as a trust that will have maximum authority, to four being special measures.

We have been put into segment three, which means we will continue to have a lot of 'mandated support' and a continued high level of scrutiny, the exact form of which is not yet known. This is not really unexpected and 80 out of 137 of acute hospitals are in segments three or four.

Overall we will not see much change immediately in the way we are monitored but if we start to have more significant problems with our performance, finance or quality that might change.

Our patients and the public will have been confused by the variety of ways hospitals have been rated over the years and they will naturally be worried both by the CQC rating of 'requires improvement' and the fact that we are put into a category where it is clear we will be receiving a lot of mandated support.

Fundamentally I believe NGH is a good hospital with some great services and great people. However, we do not always take enough time to reflect on the many excellent things that happen. We need to do more of that and also share those stories with our staff, our patients and our community.

It is important that we also maintain the right balance between acknowledging what is great and making it better still, and listening to issues and problems whilst always keeping our focus on continuous improvement.

One of the most important things we can do is ensure each department thinks about how best to listen to and engage with their workforce and that we also support and encourage this from a wider hospital perspective.

We will be setting up a running programme of Listening Events for staff to encourage and support best practice, and at the same time help people to understand how to take issues forward, and listen to concerns from the ground. Our aim is to have a mix of staff group events, themed events and social sharing events.

We hope to persuade some services to set up learning events for the public and then link this to patients' listening events and to recruitment of volunteers and patient partners. We know we need to do more to enlist the help of our community and more to allow them to help shape our services.

Plans are already underway to re-engage with our members and an Urgent Care Event is being planned for late January. This will provide an opportunity to talk to our staff and local community about the work we are doing to address urgent care issues, and also engage them in helping us achieve the changes we need to make.

I am confident that a programme of listening events for staff, patients and the community will help all of us to feel more connected.

Dr Sonia Swart
Chief Executive

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**24 November 2016**

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

Executive summary

One new Serious Incidents has been reported during the reporting period 1/9/2016 – 31/10/2016 which relates to a Grade 4 pressure ulcer. Two further Serious Incidents remain open and under investigation. Where appropriate immediate actions have been agreed at the SI Group to mitigate against recurrence. Two Serious Incident reports have been submitted to the CCG for closure during the reporting period and the key actions from these are described.

Dr Foster data showed overall mortality expressed as the HSMR and SHMI remains within the 'as expected' range. There is no evidence of a 'weekend effect' in relation to mortality.

The Trust has a number of CQUINs with both NHS Nene and NHS Corby CCGs (CCG) and NHS England – Midlands and East Specialised Commissioning (SCG). Substantial progress has been made in securing CQUIN monies for 2016/17. Areas where the full CQUIN may not be delivered are identified. These are closely tracked through the CQUIN Progress Group. The outline CQUINs for 2017-19 are described.

An update is provided on the progress made in improving the management of sepsis in the Trust.

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 and identify any remedial actions required in the event of a Significant Incident or mortality alert.
Related Board Assurance Framework entries	BAF 1.4, BAF 1.5, BAF 4.1 and BAF 4.2
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (Y/**N**) Is there potential for or evidence that the proposed decision/policy

	will affect different population groups differently (including possibly discriminating against certain groups)?(Y/**N**)
Legal implications / regulatory requirements	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

Public Trust Board
November 2016

Medical Director's Report

1. Clinical Risks

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

The principal risks to clinical care relate to the following areas and are reflected on the Corporate Risk Register. One of the key challenges to the Trust remains the acute pressures on the urgent care pathway. The risks and actions taken in mitigation are reviewed in the Quality Governance and Finance & Performance Committees as described here:

1.1 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	..	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 Trust has and continues to undertake substantial work in order to mitigate the risks to patients posed by the urgent care pressures. This is now coordinated through the Urgent Care Working Group led by the Chief Operating Officer with representation from each of the clinical Divisions. Significant progress has been made through this group including roll out of the SAFER Bundle.

1.2 Difficulties in Securing Sufficient Nursing & Medical Staff

Recruitment of appropriate trained nursing and medical staff is a further on-going risk to the Trust. These risks and mitigating actions are reviewed at the Workforce Committee:

CRR ID	Description	Rating (Initial)	Rating (Current)	Corporate Committee
100	Insufficient nurses and HCAs on a number of wards & insufficient skill mix.	25	25	Workforce
979	Difficulty in recruitment and high turnover in nursing staff groups.	16	16	Workforce
81	Inability to maintain effective service levels due to reduced skilled nursing workforce for the existing	9	16	Workforce

	bed base.			
111	Risks to quality and outcomes due to inability to recruit sufficient medical staff.	16	16	Workforce

The Trust is impacted upon by the nationwide challenges in recruiting clinical staff. The impact of this is particularly acute during periods of pressure on the organisation through urgent care. A wide range of measures have been adopted to increase staff recruitment and retention with some success.

There is further work underway to reduce agency expenditure and key part of which seeks to enhance recruitment of medical staff in particular. It is widely acknowledged that there have been reductions in the number of doctors taking up training posts and this has impacted adversely on rotas in Medicine and Anaesthesia. As gaps in these rotas have emerged at relatively short notice it has not been possible to fully mitigate the impact of this on service provision.

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

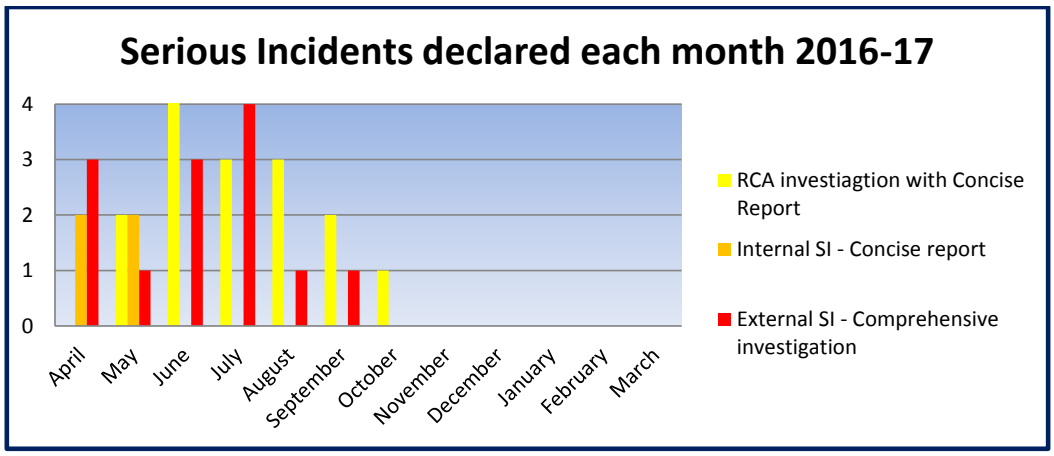
Shown in the table are the numbers of Serious Incidents and Never Events which have been reported on the Strategic Executive Information System (StEIS) by year since 2010:

	10/11	11/12	12/13	13/14	14/15	15/16	16/17
Serious Incidents	27	55	78	115	93	11	9
Never Events	2	2	1	0	1	3	1

At the beginning of 2015/16 the definition of 'Serious Incident' was revised by NHS England. The current definition of a serious incident is where acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) result in:

- Unexpected or avoidable death of one or more people. This includes:
  - suicide/self-inflicted death; and
  - homicide by a person in receipt of mental health care within the recent past
- Unexpected or avoidable injury to one or more people that has resulted in serious harm;
- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:
  - the death of the service user; or
  - serious harm;
- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:
  - healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or
  - where abuse occurred during the provision of NHS-funded care.

The following graph demonstrates the number of declared incidents which have been investigated through a comprehensive root cause analysis (Concise Report) and the External Serious Incidents that have been reported onto STEIS form 1st April to 31st October 2016:



2.1 Never Events in 2016/17

All Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death. There were no incidents reported in September and October 2016 that met the criteria of a Never Event.

2.2 New Serious Incidents

Since the last report to the Board, during the reporting period 1/9/2016 – 31/10/2016, 1 new Serious Incident has been reported onto STEIS. This relates to a patient who was admitted to the Trust with a Grade 4 pressure ulcer.

The two serious incidents at 31st October 2016 which remain **open** and under active investigation are listed below:

STEIS/Datix Ref.	Date Reported on STEIS	STEIS Criteria / SI Brief Detail	Directorate
2016/ 18007 W-64484 W-64534	05 Jul 2016	Allegation of abuse	Urgent Care
2016/22390	22 Aug 2016	Pathology screening result error	Pathology

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).

To date in **2016/17**, 10 Serious Incidents have been reported under the following categories:

- Surgical/invasive procedure
- Sub-optimal care
- Delay in treatment/referral to specialist team
- Slips/Trips/Falls
- Complication during surgery
- Diagnostic incident
- Abuse/alleged abuse
- Maternity/Obstetric incident
- Pressure ulcer

The lessons learned from serious incident investigations, are shared with clinical teams and staff through their local governance forums/groups. These are also shared with staff across the Trust where lessons apply more widely through the publication of safety alerts, bulletins and discussion at team meetings. The lessons learned from Serious Incidents are also included in the quarterly Governance newsletter, 'Quality Street'. Closed Serious Incidents are discussed at the Directorate Governance Meetings as well as the Regional Patient Safety Learning Forum, hosted by the CCG.

2.3 Serious Incidents Submitted for Closure

During the reporting period there were two serious incident reports submitted to Nene and Corby Clinical Commissioning Group (CCG) for closure. The learning identified from these is described below:

2016/12689 & W-62695 - Head & Neck Ophthalmology - Delay in Appointment

This incident has been discussed in detail at the Ophthalmology Governance meeting. Following a review and update of the booking process, a snapshot audit will be undertaken to provide assurance that patients with a forthcoming appointment have been booked appropriately according to their clinical grading.

2016/15015 Sub Optimal Care of Deteriorating Patient

The actions following this incident are summarised below:

- Task and Finish Group to launch revised medical module within VitalPac.
- Entry of clinical observations onto VitalPac limited to registered practitioners.
- Amendment of the SBAR handover tool.
- Review of Bay Ward Rounds.
- Presentation and discussion at 'Share & Learn' event.
- Task and Finish Group established to develop guidance and protocol for fluid balance

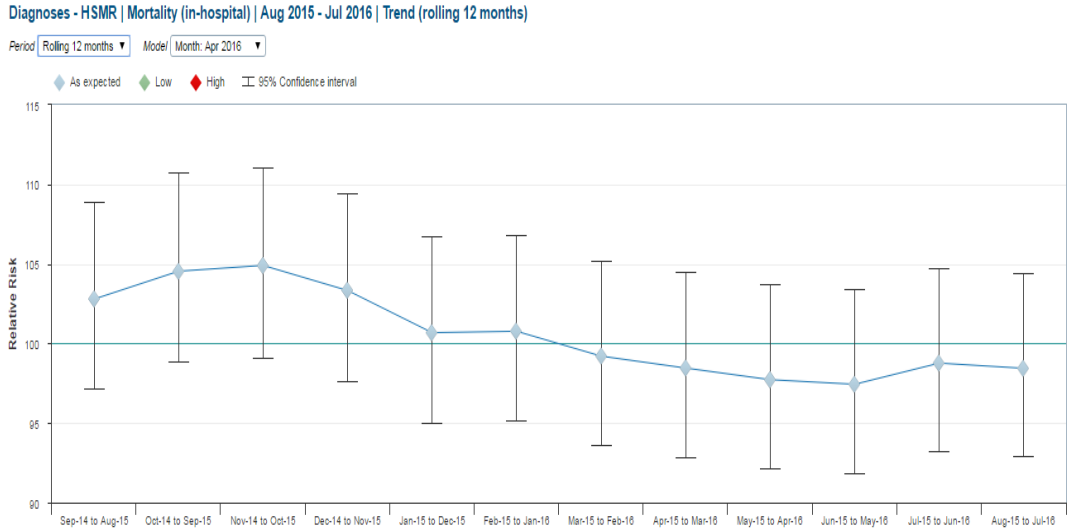
The Governance Team have facilitated Trust wide quarterly events where learning from serious incidents is shared which are open to all of the multidisciplinary team. The most

recent event took place in September focusing on Never Events that had occurred within the Trust. As a follow-up to this, the presentation was further shared at the Trust Grand Round in October.

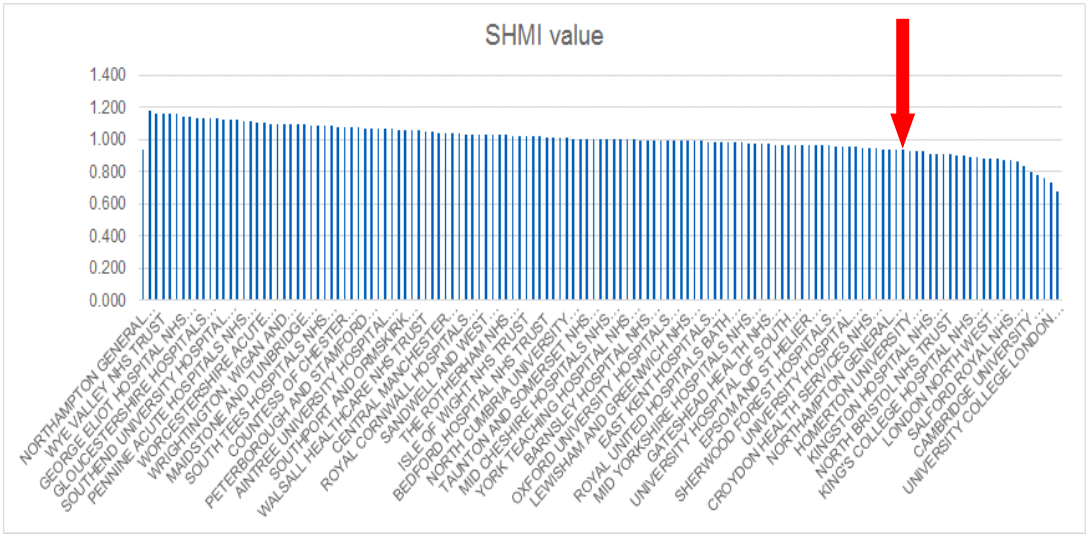
Findings from Serious Incident reports are shared with the patient and/or family by the Governance Team in line with Trust's Duty of Candour.

3. Mortality Monitoring

The HSMR for the year to July 2016 remains with the 'as expected' range at **98.4**. The variation in HSMR during the 12 months to July 2016 is shown in the graph below:

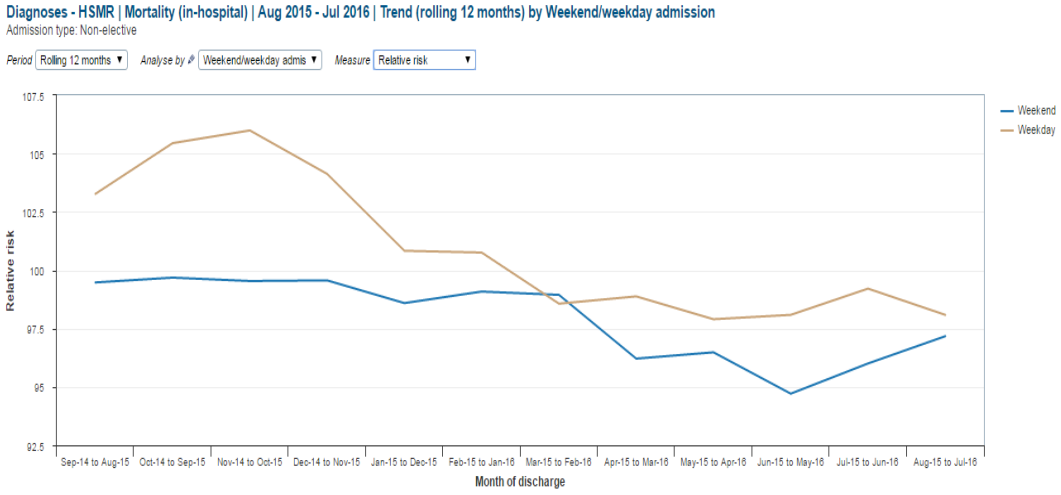


The revised SHMI for the period April 2015 to March 2016 is also within the 'as expected' range at **93.9**. The Trust SHMI value position relative to national peers is shown here:



3.1 Weekend Effects

The HSMR for emergency admissions to the Trust on weekdays (**97.2**) and weekends (**98.1**) remains in the 'as expected' range. The variation in these measures over time is shown here:



3.2 Medical Examiner Role

It is understood that there will be an expectation for Trusts to introduce the role of Medical Examiner though he timescale for this is not yet clear. The Medical Examiner/s will be expected to:

- Review all deaths that occur in hospital
- Review the relevant case notes, speak with doctors involved (where indicated) and meet with the family of the patient
- Complete or agree the death certificate
- Liaise with the Coroner where indicated

The Board will be further updated on the arrangements for this role once the detailed requirements for it have been clarified by NHSE

4. CQUINs

4.1 Performance in 2016/17

The CQUIN framework was introduced in April 2009 as a national framework for locally agreed quality improvement schemes. The income generated from CQUINs for NGH in 2016/17 amounts to approximately **£4.7 million.** The framework aims to embed quality within commissioner-provider discussions and to create a culture of continuous quality improvement, with stretching goals agreed in contracts on an annual basis.

The Trust is required to submit evidence of compliance with the CQUIN milestones in line with the reporting timescales for each CQUIN. To date, all CQUIN milestones were met in Q1 and Q2 – the latest evidence was submitted by NGH on 31st October 2016.

At the latest assessment, it is believed that there is risk to delivery of 9% of the total CQUIN value (£500,620.07) in the following areas:

- Flu Vaccinations (CCG). The CQUIN requirement is to deliver flu vaccine to 75% of frontline clinical staff. There is a partial payment available for performance over 65%.
- Q4 – Sepsis. The target for Q4 set by NHS England for the identification, accurate assessment and appropriate treatment of sepsis within the designated time scale is 90%. Though NGH remains on-track for achieving the Q3 target, the Q4 target is challenging and there is significant focus being directed toward this by the Sepsis team. There is partial payment for a component of the Q4 target (acute in-patient setting).
- Q4 - Antimicrobial Resistance and Stewardship (CCG) – Reduction in consumption. This CQUIN is split into four parts with the risk being centred on three reductions (the total reduction of antibiotic consumption, total reduction of carbapenems and total reduction of piperacillin-tazobactam). We have met the Q1 requirement and it is anticipated we will meet Q2 requirements also.

4.2 2017/19 CQUINs

Documentation was released by NHS England at the end of September 2016, detailing an engagement draft National CQUIN list for 2017 to 2019 (two year CQUINs). The final set of CQUINs was released on 7 November 2016 and is shown below:

Ref	Proposed CQUIN Title (2017/19)
1	Improving staff health and wellbeing 1a. Improvement of Health and Wellbeing of NHS Staff 1b. Healthy Food for NHS staff, visitors and patients 1c. Improving the Uptake of Flu Vaccinations for Front Line Staff within Providers
2	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) 2a. Timely identification of sepsis in emergency departments and acute inpatient settings 2b. Timely treatment for sepsis in emergency departments and acute inpatient settings 2c. Antibiotic review 2d. Reduction in antibiotic consumption per 1,000 admissions
4	Improving services for people with mental health needs who present to A&E.
6	Offering advice and Guidance
7	NHS e-Referrals CQUIN
8a	Supporting Proactive and Safe Discharge – Acute Providers
9	Preventing ill health by risky behaviours – alcohol and tobacco 9a Tobacco screening 9b Tobacco brief advice 9c Tobacco referral and medication offer

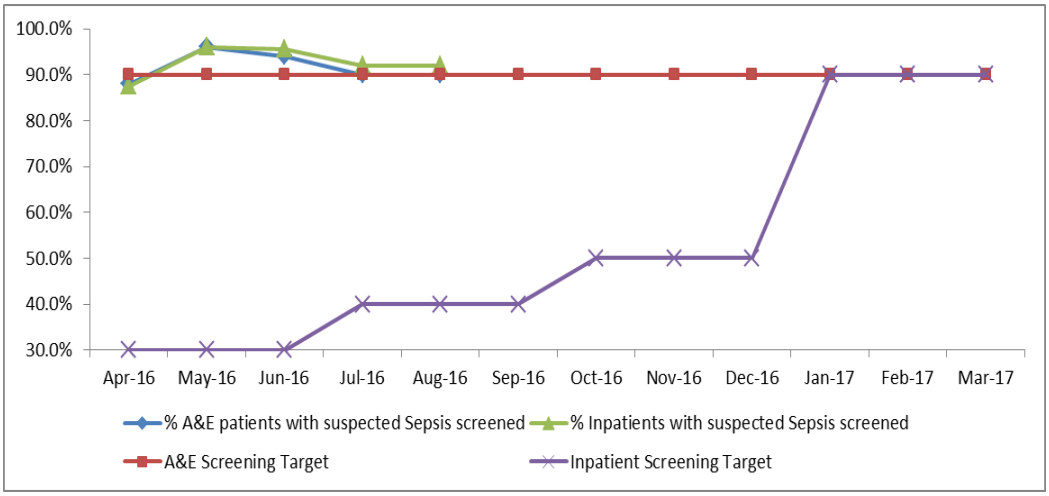
	9d Alcohol screening 9e Alcohol brief advice or referral

5. Sepsis Update

Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with an estimated 106,000 people in the UK surviving sepsis and a further 44,000 deaths attributed to sepsis annually *(source UK Sepsis Trust)*.

Work at NGH has focussed on eliminating delays in antibiotic administration to patients with sepsis by ensuring that those with deranged early warning scores (EWS) are screened for sepsis both on entry to the hospital identification and at the time of the EWS rise.

For patients with 'red flag' sepsis, the intention is to ensure that antibiotics are administered within 60 mins (ED) and 90 mins (in-patients) from the time of diagnosis in at least 90% of cases, in line with the national CQUIN target (above). The Trust performance in ensuring that there is timely screening of patients with suspected sepsis is shown here:



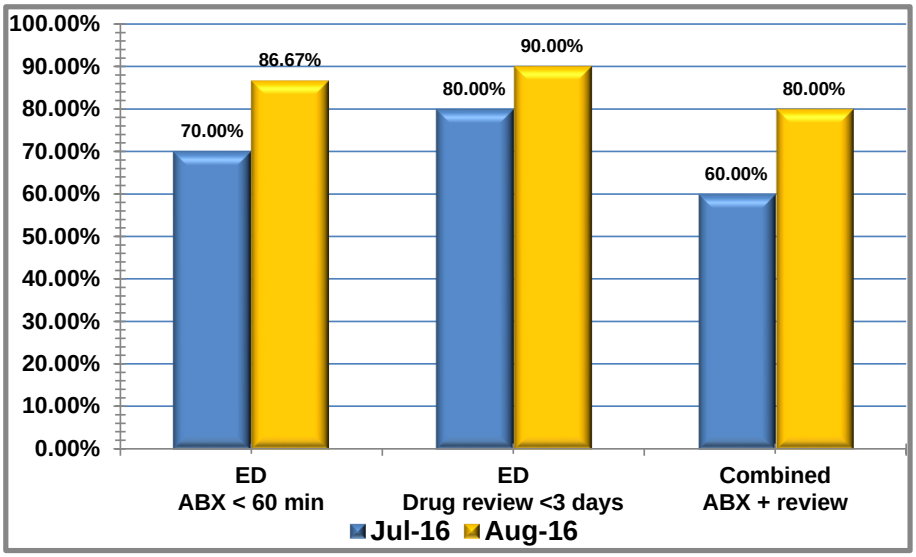
There has been considerable work undertaken not only to ensure timely screening for sepsis but also for review of antibiotic therapy that includes the following:

- 2016/17: Promotion of VitalPac use amongst Consultants/ Senior clinicians and work with supplier to enable NGH to become a test site for the new sepsis functionality, currently in development (estimated to be available in approx 9-12 months)
- Q2-4 16 onwards: Junior doctors - sepsis training and awareness
- Q2-4 16: New assessment / treatment tools are being trialled in Paediatrics and EAU/Benham, outreach and Maternity Services to improve the identification and management of sepsis and to aid the correct coding.
- 2016 onwards: SIM training to be developed further with updated scenarios and guidelines
- Q3-4: Sepsis nurse to be employed to both audit and feedback / educate clinical staff
- Q2-4 onwards: Sepsis awareness promotions using different media i.e. SMS and screensaver campaigns, poster campaigns in staff areas across departments, Grand Rounds, contributions to Insight, team meeting awareness sessions, Matrons' forum,

engagement of departmental clinical leads and CDs to cascade sepsis awareness, email shots to junior doctors, department heads and ward walks with sepsis Clinical Lead.

The response to the awareness initiatives, training and trial tools has been encouraging and there is on-going work to engage clinicians and nursing staff with this.

The positive impact of this work on can be seen in the significant improvement in both rapid screen and timely antibiotic review as shown in the graph below:



The focus in Q3 has been to further concentrate on educating and supporting clinical staff. Automated solutions are being investigated to improve the identification and management of sepsis. There are discussions underway with the Vitalpac supplier, which is developing functionality to support the Sepsis screening and the CQUIN audit criteria. The Pharmacy team continues to work with users of ePMA, which will support the appropriate review of antibiotic therapy.

6. Next Steps

The Serious Incident Group meets on a weekly basis to expedite the agreement & external notification of Serious Incidents.

Mortality within the Trust is closely monitored and reported through the Quality Governance Committee. The Mortality Surveillance Group model has been adopted in accordance with NHSE recommendations and will continue to provide assurance to Trust Board.

Updates will be provided to the Board on CQUINs, Trust Quality Priorities and the Sign Up to Safety programme.

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

Report To	**Public Trust Board**
Date of Meeting	**24 November 2016**

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 Debbie Shanahan, Associate Director of Nursing Senior Nursing & Midwifery Team
Purpose	Assurance & Information

Executive summary

This report provides an update and progress 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:

- Safety Thermometer - The Trust achieved 98.6% harm free care (new harms).
- Pressure ulcers incidence - 7 patients were harmed with a total of 7 pressure ulcers. This shows a decrease in the number of patients harmed for 3 consecutive months.
- Infection prevention - there was 1 patient identified with Clostridium difficile infection, 0 MRSA bacteraemia and 1patient identified with a MSSA bacteraemia.
- There was 1 harmful patient fall in October
- Friends and Family Test (FFT) – The results illustrate that there has been 6 consecutive months of improvement above the mean line. This shows good progress and indicates significant improvements in satisfaction being achieved.
- There is an update from Safeguarding, Midwifery Services and the Nursing and Midwifery Dashboard.
- An overview of the Safe Staffing for the month is provided and an update on the trust actions against the recommendations from 'Operational productivity and performance in English NHS acute hospitals: Unwarranted variations' (2016).

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

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	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.

Public Trust Board
November 2016

Director of Nursing & Midwifery Report

1. Introduction

The Director of Nursing & Midwifery Report presents highlights from projects during the month of October. Key quality and safety standards will be summarised from this monthly report to share with the public on the 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. Midwifery Update

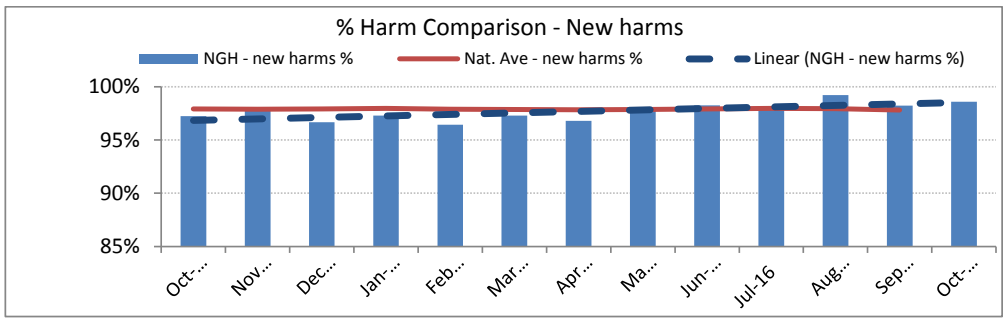
Nursing Times Awards 2016

NGH Maternity Services were recognised in the Nursing Times Awards 2016, for the innovative 'Chit Chat' group, developed by our Midwifery Safeguarding Team, Emma Fathers, Angela Bithray and Sally Kingston. They won the Enhancing Patient Dignity category and were shortlisted in the Learning Disabilities Nursing category.

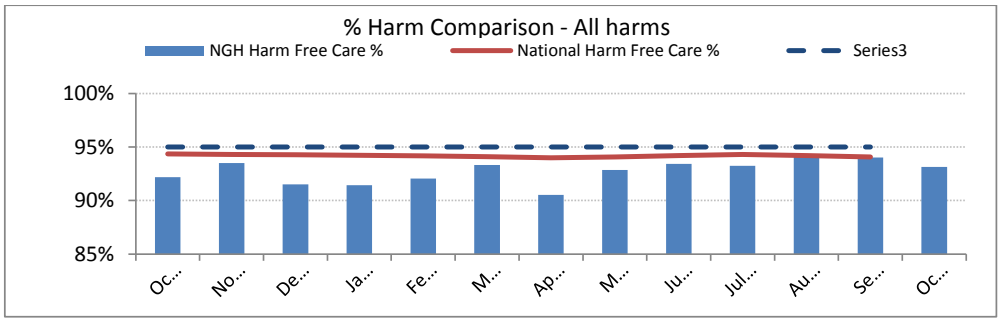
Women with learning disabilities will avoid maternity care often because of lack of confidence and they are also more likely to be vulnerable due to other issues such as mental health concerns or issues with housing and finances. This puts them at a greater risk of poor outcomes during their pregnancy and the postnatal period. The 'Chit Chat' group, not only facilitates engagement with the maternity services it also enables women and their families to develop peer support

3. Safety Thermometer

The graph below shows the percentage of all new harms attributed to the Trust. In October 2016 NGH achieved 98.6% harm free care (new harms). This is a positive increase to the previous month. Please see Appendix 1 for the definition of safety thermometer.



The graph below illustrates the Trust has achieved 93.14% of harm free care in October. Broken down into the four categories this equated to: 0 falls with harm, 0 venous thromboembolism, (VTE), 2 Catheter related urinary tract infections (CRUTI) and 7 'new' pressure ulcers.



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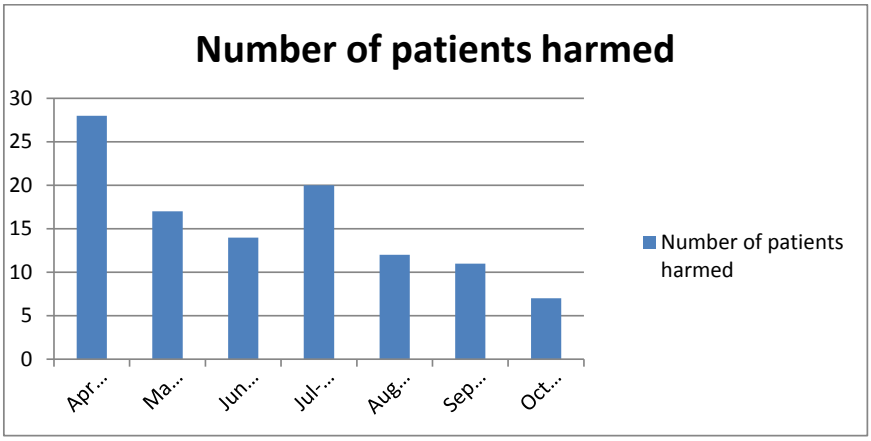
4. Pressure Ulcer Incidence

In October 2016, the Tissue Viability Team (TVT) received a total of 315 datix incident reports relating to pressure damage. Of these the TVT assessed/validated 265 (84%) on the wards and the remainder were validated from photographs.

During the month, a total of 7 patients were harmed whilst in the care of Northampton General Hospital, resulting in 7 pressure ulcers demonstrated in the graph below. There has been a sustained reduction in the number of patients harmed by pressure damage for a third consecutive month.

Suspected deep tissue injuries (sDTI's) are not recorded as pressure damage until the damage can be formally graded. This is because the sDTI's is not recognised by NHS England as a classification. In exceptional circumstances such as the death of a patient or lack of feedback from the community, the damage cannot be graded and the Trust is unable to report as pressure harm. In view of this, our incidence data will be amended to reflect this and the graph below has been altered to reflect these changes.

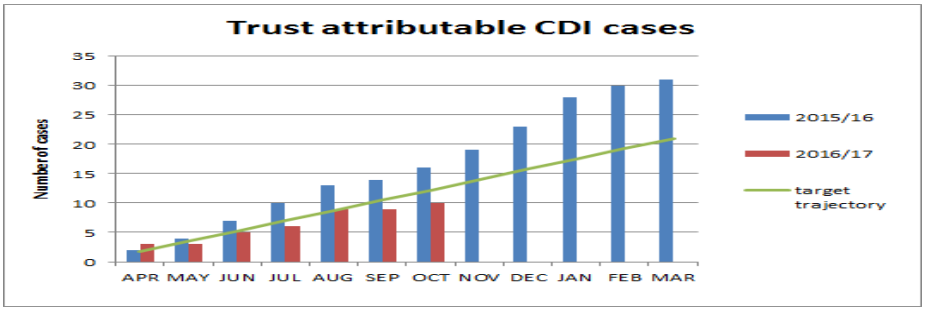


Pressure Ulcer Prevention October Update

- All hospital acquired pressure ulcers are subject to a validation meeting using photographs and reviews with the TVT, Director of Nursing (DoN), Deputy Director of Nursing, and Quality Assurance and Improvement Matron.
- Ward staff attend Share and Learn meetings and review all pressure ulcers. The staff share good practise and have found the forum useful and informative
- A 90 day Rapid Pressure Ulcer Prevention Turnaround Project has been requested by the DoN. Four wards have been invited to take part in this, Knightley, Becket, Cedar and Hawthorn. The first meeting will take place on 02/11/2016.

5. Infection Prevention and Control

Clostridium difficile Infection (CDI)

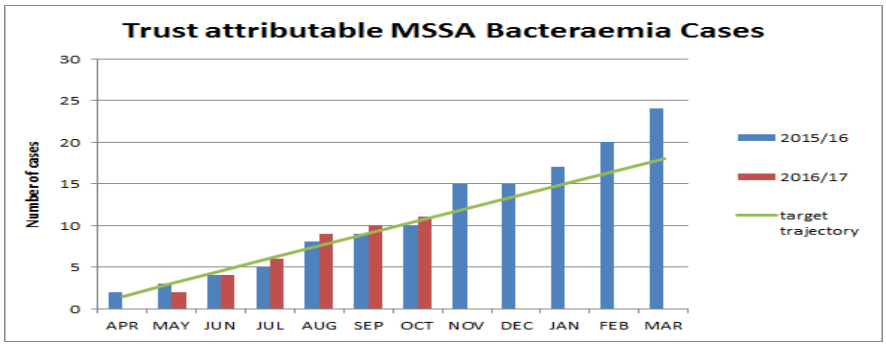


The graph above shows the cumulative total of the number of patients with Trust apportioned CDI. From April 2016 there have been 10 patients with Trust apportioned CDI. There was 1 patient in October who was identified as Clostridium difficile toxin A and B positive whilst an inpatient on Dryden ward. The Post Infection Review (PIR) was performed on 31/10/2016.

MRSA Bacteraemia

For October there has been 0 trust attributable MRSA bacteraemia.

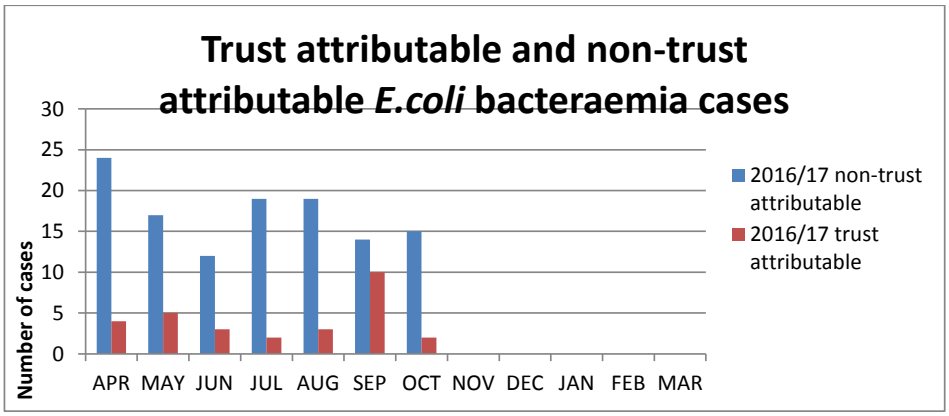
MSSA Bacteraemia



There is no national target set for MSSA bacteraemia. Due to updated guidance from Public Health England (PHE) and a change in formula, the outturn for MSSA bacteraemia for 2015/2016 is at 24 as illustrated in the graph above. The Infection Prevention forward plan has set a revised ambition of no more than 18 cases for 2016/2017. For October 2016 there was 1 Trust attributable MSSA bacteraemia.

Escherichia coli (E.coli) Bacteraemia

There is no national target set for E.coli bacteraemia, for October there were 2 patients with Trust attributable E.coli bacteraemia.



The table below shows the breakdown of source and number of E.coli bacteraemia cases for October 2016. All incidents are investigated and a root cause analysis (RCA) is completed to ensure learning.

Source of Infection	Number of Cases
Unknown	1

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Suspected line infection	1

Outbreaks and incidents
No outbreaks of infection were reported in October 2016.

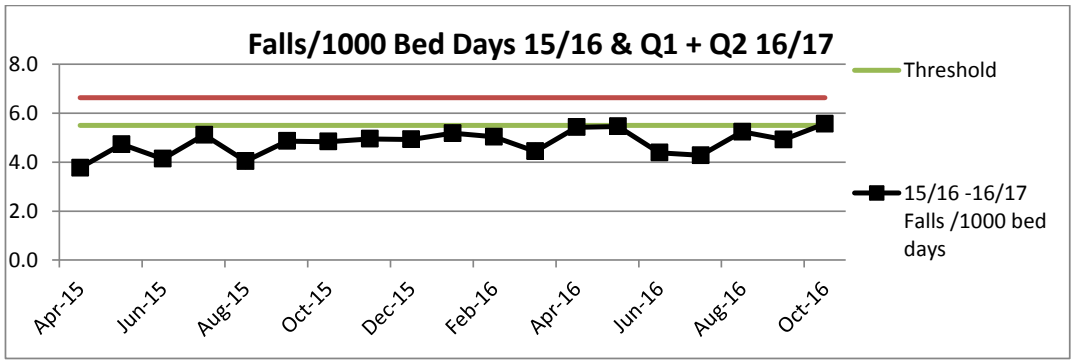
Catheter Related Urinary Tract Infections (CRUTI)
In October 2016 there were 2 Trust attributable CRUTI, in accordance with the safety thermometer data. These were apportioned to Compton ward and the RCA for both cases are in progress.

Key Action and Focus in October 2016

- In October the IPT team performed a bi-monthly hand hygiene audit on 31 wards across the trust, 11 wards scored 100%, 6 wards scored between 90-99% 14 wards scored below 89%. IPT will be re-auditing these 14 wards this week. IPT have also focused on visiting all wards, educating, discussing with staff the 6 stage hand hygiene technique and when to perform hand hygiene, as per the World Health Organisation (WHO) 5 moments of hand hygiene.
- As part of the Clostridium Difficile Collaborative, IPT have visited 21 wards in 21 days and have rolled out the 'C' the difference tool kit trust wide. Key to the success of this project is sustainability. Questioning around the faecal sampling and isolation will continue to be asked on the Beat the Bug Quality visits.

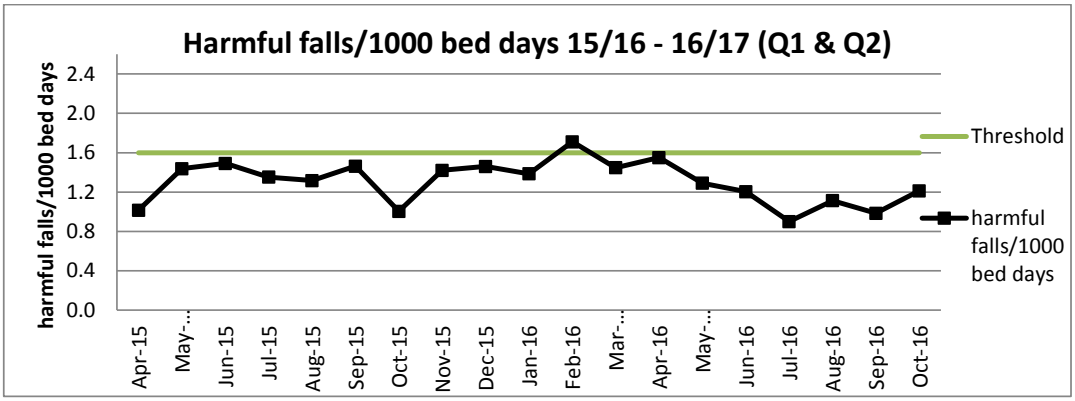
6. Falls Prevention

Falls/1000 bed days
The way in which we calculate our bed days has changed from 1st April 2015; we are now not including bed days from the Maternity. This results in our bed days being lower and therefore may make our falls/1000 bed days appear higher if compared with last year. Therefore as these figures are not comparable with previous years an SPC chart or run chart cannot reliably be generated. Last year's figures are below for information only



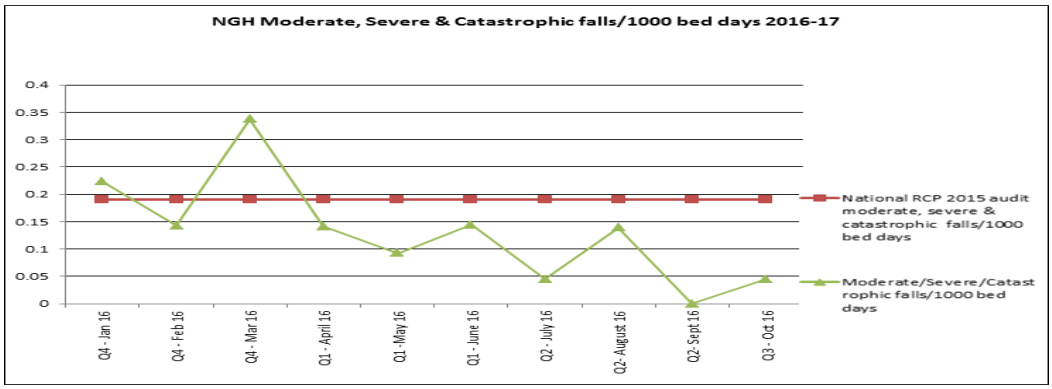
The Trust's Falls/1000 bed days are below the national average, however 0.03 higher in October than the (internally set) target maximum annual target of 5.5 falls/1000 bed days.

The reporting of all falls has been promoted by the Falls Prevention team and this can be seen over the last few months. However the majority of the falls are reported as 'no' or 'low' harm, see following graphs.



Maximum of 1.6 harmful falls/1000 bed days (internally set target).
During October there has been a slight increase in harmful falls. There has been one severe fall in which a patient fell and has fractured their neck of femur. An investigation has commenced.

The graph below highlights only the moderate, severe and catastrophic falls /1000 bed days for the Trust compared with the national audit of 2015, which provides a triangulated overview of patient falls.



Key Action and Focus in October 2016

- The falls team have finalised the new amendments of the falls care plan and is currently being trialled on Holcot Ward.
- A Final draft report has been completed in October following a night time bed rails audit and will be shared at the Falls Multidisciplinary Group meeting on 23rd November. The next bedrail audit will take place in December 2016.

7. Nursing and Midwifery Dashboards

The Nursing and Midwifery Quality Dashboards provides triangulated data utilising quality outcome measures, patient experience and workforce informatics. With the implementation of the Best Possible Care 'Assessment and Accreditation' process a review of the Quality Care Indicators (QCI) has taken place as planned. The proposal was to reduce the QCI dashboard as the Assessment & Accreditation programme was 'rolled-out' across the Trust.

Please see (Appendix 2) for a definition of the Nursing Midwifery Dashboard, (Appendix 3) for the Nursing dashboard, (Appendix 4) for the Maternity dashboard and (Appendix 5) for the Paediatric dashboard for September 2016.

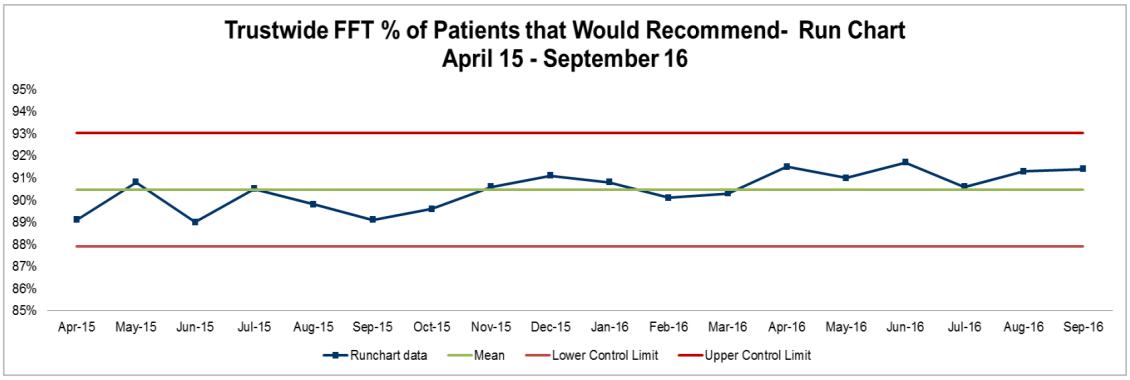
The QCI for October 2016 shows the following:

- Privacy and Dignity has seen the most improvement for 2 consecutive months. Work is on-going within the Divisions to sustain the improvement.

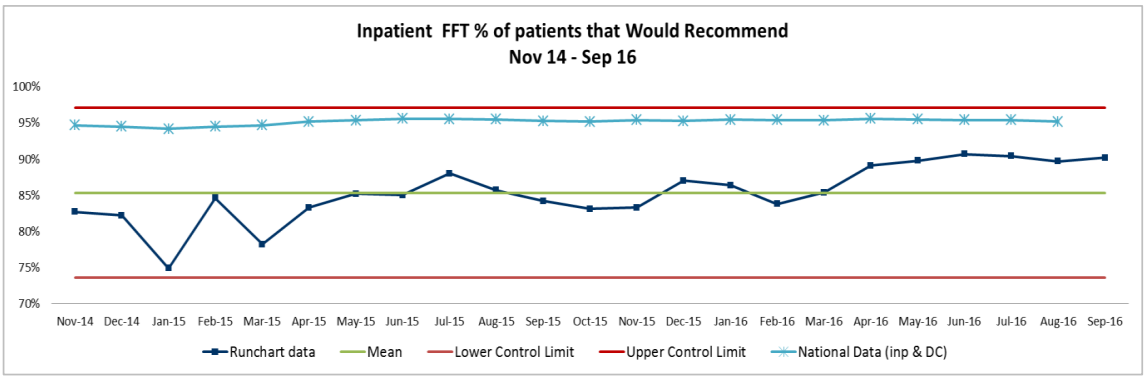
- Compliance with falls assessments and care planning has improved again this month, for the 3rd consecutive month to 94%. The general wards continue to monitor compliance and implement suggestions from the Falls Group.
- Surgical Division has seen a marked improvement in the QCI data from last month with only 3 reds for the division. Head and Neck Ward has seen the biggest improvement in their data. Ward Sisters, Matrons and the ADN are aware and actions are in place to improve outcomes.
- Medical Division has seen an improvement to their QCI data. EAU over the last 3 months has had some slight improvement in the data, however further improvement is required.
    - The newly appointed Matron for Urgent Care is currently reviewing all the QCI data and developing an action plan
    - Falls assessments are being completed, however some patients who are at risk of falls are not having a care plan developed. Matron is looking at the process of ensuring a care plan is developed, if a patient is at risk and linking with the Falls Team for support
    - Protected Mealtimes, Matron and Sister are looking at the process to ensure patients have protected mealtime
    - Privacy and Dignity, Matron and interim Sister are reviewing the audit reflecting on patient views and addressing it within the action plan
    - Leadership – since commencement in post the Matron has been more visible and involved in patient care and staff wellbeing
    - The Matron has arranged a Band 7 and 6 meeting to address leadership and management issues on EAU
    - The Ward Sister has daily huddles and is reminding all staff of the important of the QCI audit, the results and ways to improve
    - Matron will ensure a visible QCI dashboard on EAU with notes on, describing areas of concern
    - First impressions /15 steps the Matron has had fresh eye on the Ward, as she is new in post. She has asked Estates to review EAU looking at odd jobs and to paint communal areas to improve the first impressions. The Matron has requested assistance to improve the clutter and general appearance, through the IPC, 'Going for Gold' Declutter initiative
    - Late observations are at 11% - the Matron reviews all observations daily on vital pack. Matron and Ward Sister inform the ward of the importance of doing observations in a timely fashion. The staff bay work on EAU, a Health Care Assistant and trained nurse are assigned to a bay and are responsible for the timely completion of observations. Ward Sisters, Matrons and the ADN are aware and actions are in place to improve outcomes.
- Women's Children's and Oncology Division, Talbot Butler has sustained the improvement to the QCI data. Spencer Ward has seen an improvement to last month's data. Gosset require improvement with safety thermometer harm free care for the second month. Ward Sisters, Matrons and the ADN/M are aware and actions are in place to improve outcomes.
- First impressions and 15 steps, for the general wards are at 84% showing a slight increase to last month data. Work is underway to improve the clutter and general appearances of the general wards, through the IPC, 'Going for Gold' Declutter initiative.
- There was 1 complaint for October for the general wards. There were 18 PAL's enquiries for the general wards.

8. Friends & Family Test (FFT)

FFT Overview- % Would Recommend Run Charts



Trust-wide results for the amount of patients that would recommend the services provided reached their sixth consecutive month above the mean line. Once this reaches 8 months consecutively the mean line will be rebased.

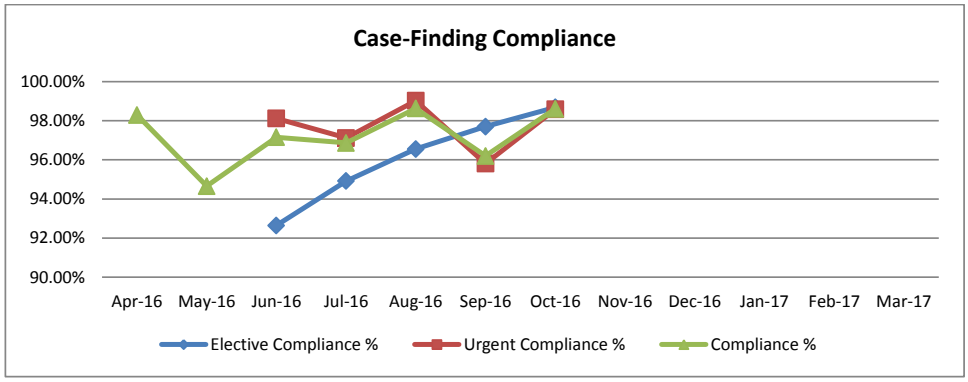


The Inpatient & Day Case results mirror the Trust-wide results and have also had six months of improvement above the mean line. This shows good progress and indicates significant improvements in satisfaction being achieved. In addition to this, September saw the highest number of patients that would recommend since collections began in November 2014.

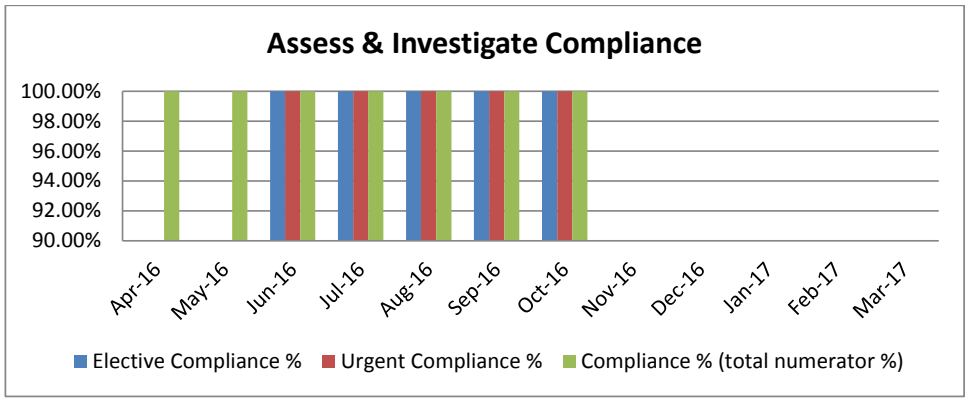
9. Dementia CQUINS

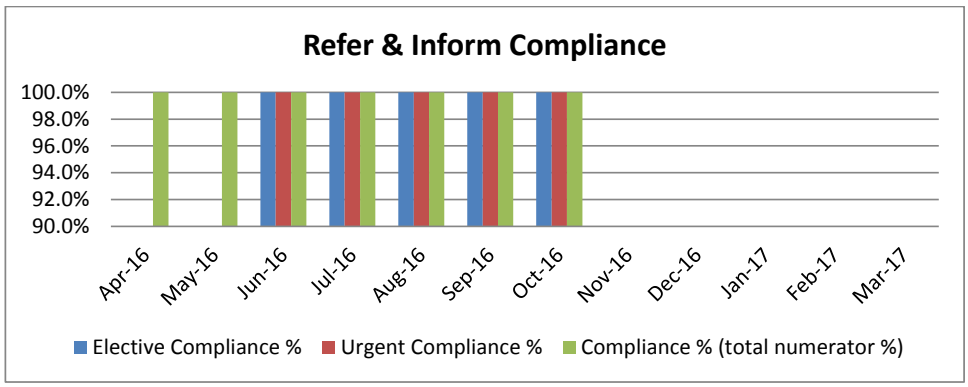
Discharge Summaries

The 2016/17 dementia CQUIN, in contrast to previous years, includes patients admitted via the non-urgent pathway. Planning for the collection of this data was undertaken during Q1 and the subsequent split in compliance figure is reportable from Q2. The overall compliance target remains at 90%, which has been achieved for each element of the CQUIN, as illustrated in the graphs below.



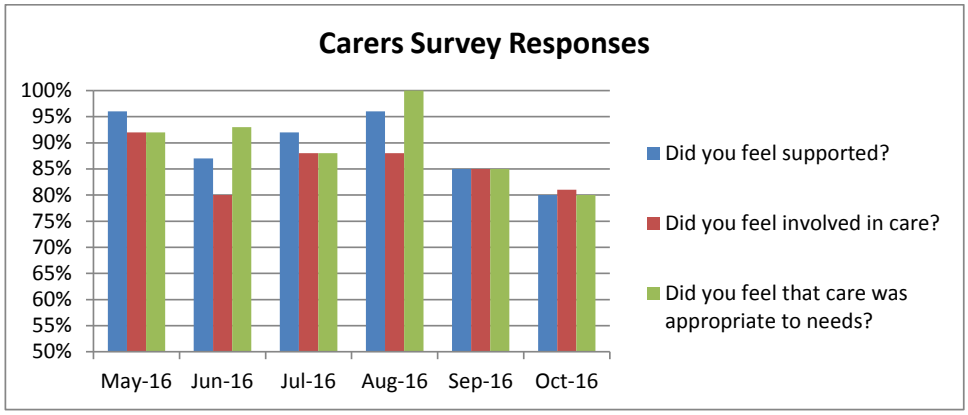
The improvement in compliance for Elective Care (the new component) continues, with a recovery of the slight decrease of compliance in September.





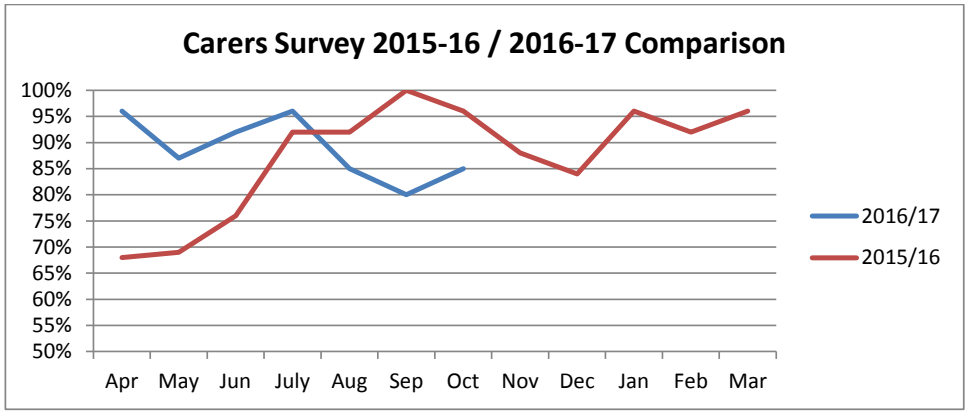
John's Campaign
John's campaign roll out has commenced across the three initial wards, with further wards due to begin over the quarter in line with the implementation plan.

Carers Survey
Whilst no longer part of the CQUIN, the Dementia Liaison Service continues to seek the views of carers in order to make continues improvement to care provided, the key responses for this are shown in graphs below *(n=25).*



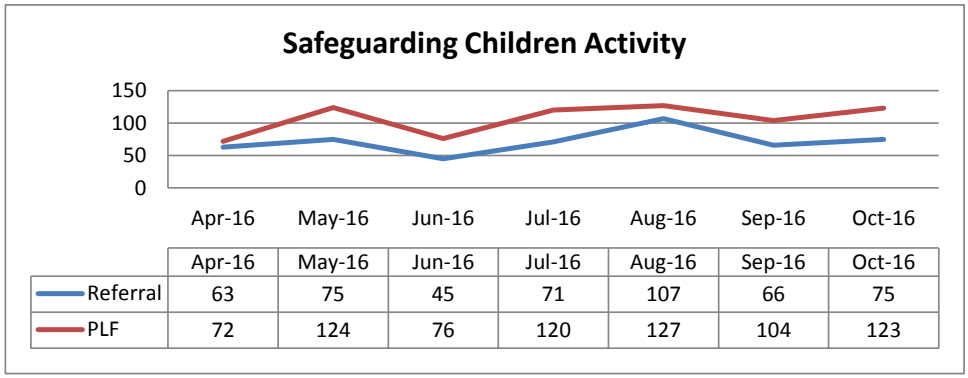
The graph above demonstrates that there has been an overall decrease in satisfaction for the past two months. The carers' questionnaire relies on free text responses to provide an understanding of this, which leads to inherent challenges. Work has been undertaken to amend the questionnaire to include supplementary questions which seek to understand what could be improved in these areas. This will then inform the Dementia Delivery Plan.

The carer's survey has been iterative, however the consistent question "do you feel supported" has been present since the survey was initiated as part of preceding years' CQUINs. The graph below shows the variation between 2015/16 and 2016/17 to date.



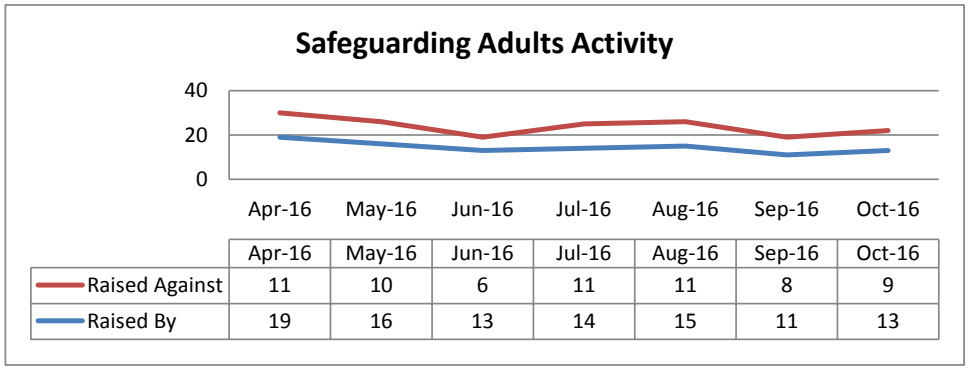
Last year, a drop in carers' satisfaction was seen during Q3; this drop has occurred earlier this year (August). The Dementia Steering Group are due to receive an in depth analysis of this data in the November meeting in order to understand what further strategies can be employed to support carers.

Safeguarding Referral Activity



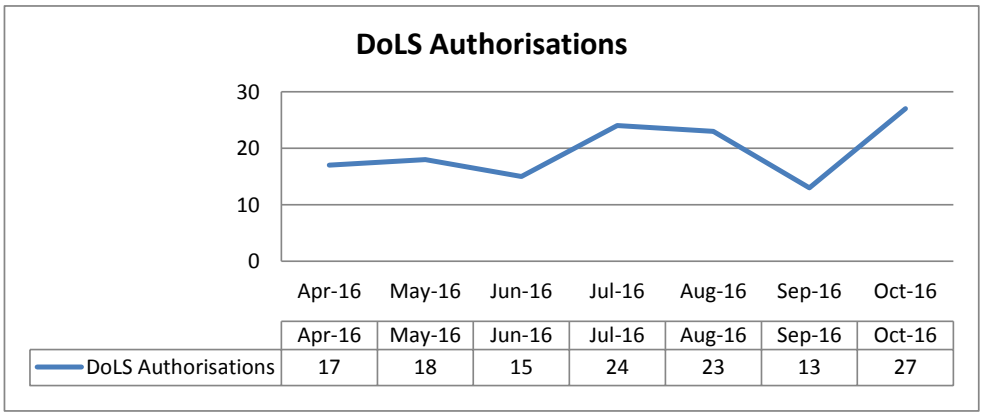
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Referral	63	75	45	71	107	66	75
PLF	72	124	76	120	127	104	123

The summer seasonal variation (peak) has resolved and the referral rate for children at risk of significant harm is reducing. There is a mirroring reduction in the number of liaison referrals, which qualifies the referral reduction, indicating that this is not a failure to act / identify (there would be a marked disparity in this case). The Safeguarding Assurance Group continues to receive audit reports as to the quality of referrals and activity undertaken and these remain of good standard. Safeguarding Adults activity remains relatively static.



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Raised Against	11	10	6	11	11	8	9
Raised By	19	16	13	14	15	11	13

Deprivation of Liberty Safeguards (DOLS)

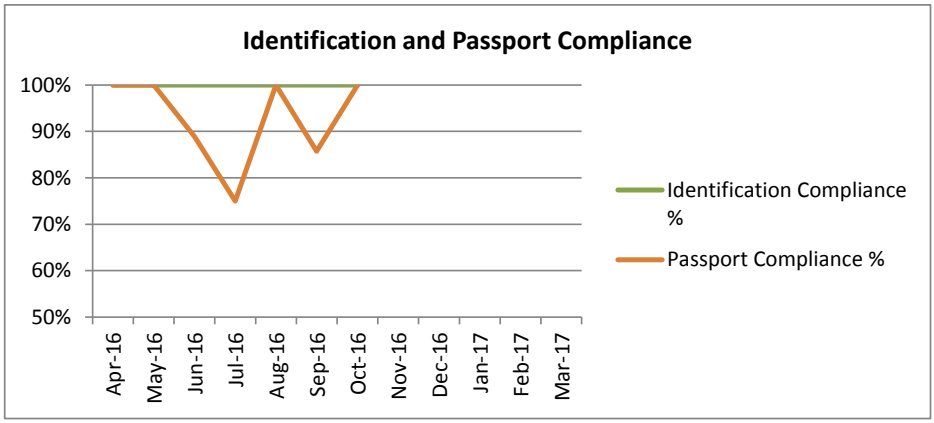


	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
DoLS Authorisations	17	18	15	24	23	13	27

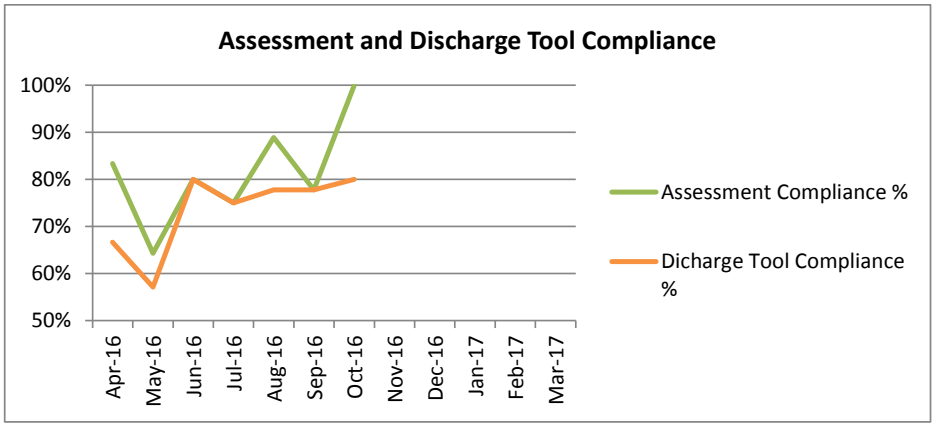
DOLS referrals for October have increased as shown in the graph above, suggesting that the reduction in September was not indicative of a trend. All DOL applications continue to be scrutinised on an individual basis by the safeguarding team to ensure that care is delivered in the least restrictive manner possible.

Learning Disability
The Learning Disability Quality schedule is built around four key components:

- The identification of people with a learning disability who are admitted to hospital; and of those:
- The use of the hospital passport;
- The use of a specific LD admission checklist; and
- The use of a specific discharge tool.



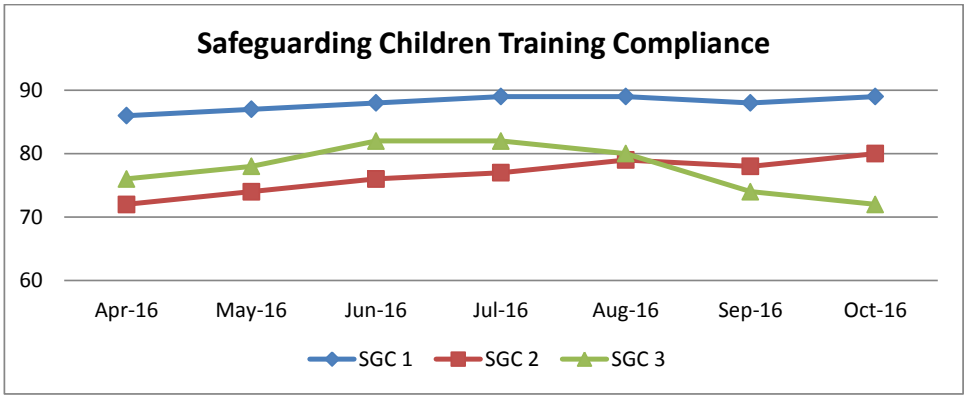
The graph above illustrates the Passport compliance was achieved at 100% for October.



A considerable improvement in the use of the LD assessment tool has been seen in October as demonstrated in the graph above, and continued improvement in compliance with discharge tool use can be seen since the beginning of the year. This particular element has presented challenges previously and this improvement is welcomed.

The Learning Disability Steering Group continues to focus on the quality schedule as an area for improvement and individual scenarios where the target is not achieved are reviewed by the learning disability service.

Education and Training
The following two charts demonstrate the training compliance (Trust position) for Safeguarding Children and Safeguarding Adults respectively:



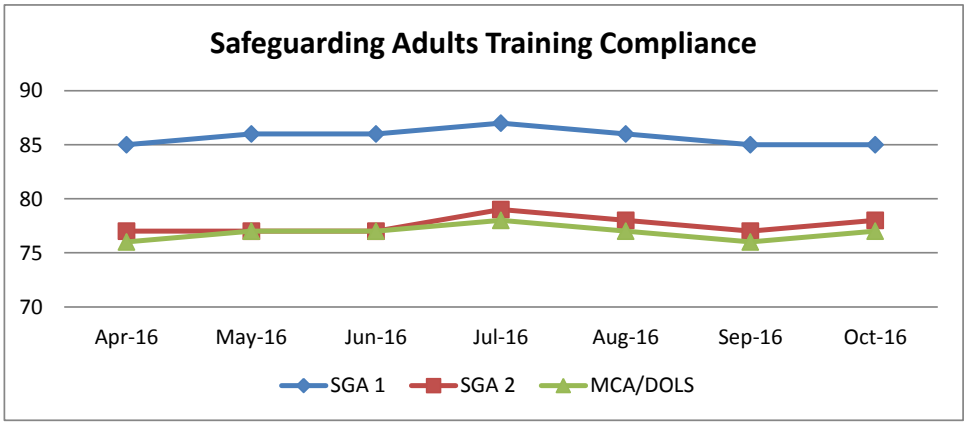
Safeguarding Children Level 3 training has seen a decrease over the past three months. Detailed breakdown for October data is not yet available; however there are clear areas for focused attention based on Divisional data:

Division	Compliant	Non-compliant
Medicine	56% 109 staff in date of 194	44% 85 staff out of date
Surgery	72% 13 staff in date of 18	28% 5 staff out of date
WCO	78% 457 in date of 587	22% 130 staff out of date

Immediate actions taken by the corporate safeguarding service to support the Divisions in the next two months are:

- Immediate, weekly, safeguarding level 3 sessions will be provided;
- Detailed breakdown by individual will be provided at Directorate level to support appropriate training.

Safeguarding training data is provided to the Divisional Triumvirate in the format shown in (Appendix 6) this will continue and will be tailored to meet Divisional needs.



The Safeguarding Team have developed Divisional Dashboards in relation to safeguarding training, for use as a monitoring tool and which are presented by divisional representatives at the Safeguarding Assurance Group.

10. Safe Staffing

Overall fill rate for October 2016 was 103%, compared to 102% in September and 105% in August. Combined fill rate during the day was 99%, compared with 98% in September. The combined night fill rate was 108% compared with the same in September. RN fill rate during the day was 93% and for the night 96%. Please see appendix 7.

11. Safe Staffing comparison within Midlands & East

Safe Staffing fill rate data is collated across the Midlands & East by NHS England (appendix 8). The historical data illustrates the challenges previously faced by Northampton General Hospital in achieving a satisfactory RN Day fill rate. Although this data set is up to, and includes, August 2016 the Committee will be aware that our monthly data has continued to improve. Appendix 9 shows our continued improvement.

12. 'Operational productivity and performance in English NHS acute hospitals: Unwarranted variations' (2016)

Lord Carter's report gave clear direction in regards to aspects of staffing across the hospital setting. The report focused on optimising resources and the development of new metrics to analysis staff deployment, to ensure right teams, right place, and right time thus delivering high quality efficient patient care. There are three areas that the report identifies for nursing & midwifery to focus upon; Care Hours per Patient day, E- Roster and Enhanced Observation of Care.

Care Hours per Patient Day

The report details how to eliminate unwarranted variation in nursing & care staff deployed by the use of 'Care Hours per Patient Day' (CHPPD) which is to be used as the single metric for nursing/care staff.

CHPPD can be used to describe both the hours of care required and staff availability in relation to the number of patients.

CHPPD is calculated by adding the hours of registered nurses to the hours of care workers (healthcare assistance/maternity care workers) and dividing the total by every 24 hours of in-patient admission.

$$\text{Care Hours per Patient Day} = \frac{\text{Hours of registered nurse + Hours of care workers}}{\text{Total number of patients}}$$

The figure that is produced gives the number of hours of care that one patient within that ward / department is receiving in 24hour.
For example: If a medical ward (Knightley) over a month has a CHPPD of '6' then this represents that in 24 hours of patient stay in that ward 6hours of care is given (please refer to this months' Safe Staffing 'Unify' data, appendix 7).

It is proposed by Lord Carter that CHPPD can be used at different levels of the organisation from 'ward to board' and can be reported nationally. Last year NHS England collated data from over 1000 wards which demonstrated a significant variation in staffing levels from 6.3CHPPD to 15.48 CHPPD. It is not clear within the report the variations, if any, in the types of wards in the pilot so it is difficult to draw comparisons with our wards/units.

In line with the national guidance our CHPPD data has been calculated as part of the 'Safe Staffing' metrics on the Trust monthly return to NHS England since April 2016 and is shared with the Workforce Committee (appendix 7).

The national guidance proposes that CHPPD will be a daily metrics by April 2017 for nursing, AHP & medical staffing.

CHPPD within the Trust
Nationally, and within our own Trust, there has been little understanding of the application and benefit of the proposed CHPPD. Therefore the Deputy Director of Nursing attended a recent workshop based on CHPPD. During this workshop Dr K Hurst, national lead for nursing workforce informatics, provided an overview of the CHPPD model. Dr Hurst also highlighted similarities with the Safer Nursing Care Tool (SNCT) that the Trust uses on a bi-annual basis to review our acuity, dependency and therefore support establishment changes.

Dr Hurst recognised that there is still considerable work to be undertaken at a national level to fully understand the CHPPD strengths and weaknesses, in particular the capturing of the acuity and dependency of patient case mix which is currently unclear. However, Dr Hurst is developing a 'user-friendly' tool that will allow organisations to review their 'required' and 'available' CHPPD, in line with the national guidance requirements. This will be shared with the Workforce Committee in due course.

There are two other areas of focus from the Carter report on nurse staffing associated with E-roster and Enhanced Observation of Care.

E-roster
In partnership with Lord Carter's Report the NHS Improvement has developed Rostering Good Practice Guidance. There are two parts to this document; Rostering Policy Checklist and Rostering Audit Tool. As a Trust we have undertaken a gap analysis of the Rostering Policy, Changes have been made in line with the recommendations and the updated Roster Policy has been ratified (Oct. 2016). We have also undertaken the Rostering Audit Tool and have one area to clarify before we are compliant.

Enhanced Observation of Care
Since August 2016 we have had a Quality Improvement Collaborative in place to review the processes for risk assessing, booking, and role undertaken of staff who undertakes Enhanced Observation of Care role. We are currently working with 6 wards across the Trust and this is increasing as we start to agree the standards and 'tests of change'. We have seen a positive decrease in the amount of hours used to support Enhanced Care on the wards during this time. A summary report will be provided by the A.D.N. & Head of Safeguarding for December Workforce Committee.

13. Model Hospital Nursing & Midwifery (N&M) Dashboard

Leading on from Lord Carter Review the development of a 'Model Hospital' has continued to provide hospitals with detailed guidance as to what 'good' looks like. Currently the N&M Dashboard has limited data available to review. No further data has been presented on the 'Model Hospital' dashboard in December.

14. Recommendations

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

Appendix 1

Safety Thermometer Definition

The Department of Health introduced the NHS Safety Thermometer *"Delivering the NHS Safety Thermometer 2012"* the initiative was also initially a CQuIN in 2013/14 to ensure the launch was sustained throughout the nation. The NHS Safety Thermometer is used nationally but is designed to be a local improvement tool for measuring, monitoring, and analysing patient harms and developing systems that then provide 'harm free' care. Developed for the NHS by the NHS as a point of care survey instrument, the NHS Safety Thermometer provides a 'temperature check' on harm that needs be used alongside Trusts data that is prevalence based and triangulated with outcome measures and resource monitoring. The national aim is to achieve 95% or greater harm free care for all patients, which to date the national average is running at 94.2%.

The NHS Safety Thermometer has been designed to be used by frontline healthcare professionals to measure a 'snapshot' of harm once a month from pressure ulcers, falls with harm, and urinary infection in patients with catheters and treatment for VTE. All inpatients (including those patients in theatres at the time but excluding paediatrics) are recorded by the wards and the data inputted onto the reporting system, on average NGH reports on 630+ patients each month. Once the information is validated by the sub-group teams it is uploaded onto the national server to enable a comparator to be produced.

The Safety Thermometer produces point prevalence data on all harms (which includes harms that did not necessarily occur in hospital) and 'new' harms which do occur whilst in hospital – in the case of falls, VTE and CRUTI the classification of 'new' means within the last 72 hours, this is slightly different for pressure damage as 'new' is categorised as development that occurred in our care post 72 hours of admission to hospital and is recorded throughout the patient stay on the Safety Thermometer. Therefore pressure damage is the only category that if the patient remains an in-patient for the next month's data collection it is recorded as 'new' again.

NGH has a rigorous process in place for Safety Thermometer data collection, validation and submission. Four sub-groups for each category exist and are led by the specialists in the area; they monitor their progress against any reduction trajectory and quality schedule target. For pressure damage all harms are recorded on datix throughout the month (not just on this one day) reviews are undertaken to highlight any lapses in care, every area with an incident attends the Share and Learn forums to analyse further the incident and to develop plans for areas of improvement and future prevention.

Appendix 2

Nursing and Midwifery Dashboard Description

The Nursing & Midwifery dashboard is made up of a number of metrics that provide the Trust with "at a glance" RAG rated position against key performance indicators including the quality of care, patient experience, workforce resource and outcome measures. The framework for the dashboard was designed in line with the recommendations set out in the 'High Quality Care Metrics for Nursing' report 2012 which was commissioned by Jane Cummings via the Kings Fund.

The Quality Care Indicators (QCI) is first section of the dashboard and is made up of several observational and review audits which are asked undertaken each month for in-patient areas. There are two types of indicators those questions designed for the specialist areas and those for the general in-patients. The specialist areas were designed against their specific requirements, quality measures and national recommendations; therefore as every area has different questions they currently have their own individual dashboards.

Within the QCI assessment there are 15 sections reviewing all aspects of patient care, patient experience, the safety culture and leadership on the ward – this is assessed through a number of questions or observations in these 15 sections. In total 147 questions are included within the QCI assessment, for 96 of the questions 5 patients are reviewed, 5 staff is asked and 5 sets of records are reviewed. Within parts of the observational sections these are subjective however are also based on the '15 Steps' principles which reflect how visitors feel and perceive an area from what they see, hear and smell.

The dashboard will assist the N&MPF in the assessment of achievement of the Nursing & Midwifery objectives and standards of care. The dashboard is made up using four of the five domains within the 2015/16 Accountability Framework. The dashboard triangulates the QCI data, Safety Thermometer 'harm free' care, pressure ulcer prevalence, falls with harm, infection rates, overdue patient observations (Vitalpac), nursing specific complaints & PALS, FFT results, safe staffing rates and staffing related datix. The domains used are:

- Effective
- Safe
- Well led
- Caring

The Matrons undertake the QCI and upload the data by the 3rd of each month. The N&M dashboard is populated monthly by the Information Team and will be ready no later than the 10th of the month. At the monthly N&MPF the previous month's dashboard will be presented in full and Red and Amber areas discussed and reviewed by the senior nursing team. Due to the timings of the NMPF meeting the current month's QCI data will be presented verbally by the Matrons with particular attention to any below standard sections, if this is a continued pattern and what actions are in place to support the ward in improving these areas. The Senior Nursing & Midwifery Team, led by the Director of Nursing, will hold the Matrons to account for performance at this meeting and will request actions if performance is below the expected standard. The Matrons and ward Sister/Charge Nurse will have two months to action improvements and assure N&MPF with regards to the methodology and sustainability of the actions. The Matrons will be responsible for presenting their results at the Directorate Meetings and having 1:1 confirm & challenge with their ward Sisters/Charge Nurse. The Director of Nursing will highlight areas of good practice and any themes or areas of concern via the N&M Care Report.

Appendix 3

Oct-2016	Medicine															Surgery									
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Allebone	Becket	Benham	Brampton	Collingtree	Compton	Creaton	Dryden	EAU	Eleanor	Finedon	Knightley	Holcot	Victoria	Talbot Butler	Rowan	Willow	Head & Neck	Spencer	Abington	Cedar	Althorp	Hawthorn	General Wards
Falls/Safety Assessment	97.%	97.%	90.%	83.%	90.%	90.%	93.%	93.%	77.%	100.%	97.%	87.%	100.%	96.%	100.%	100.%	100.%	100.%	93.%	100.%	90.%	100.%	92.%	94.%
Pressure Prevention Assessment	95.%	95.%	95.%	85.%	95.%	100.%	92.%	98.%	90.%	95.%	100.%	90.%	93.%	98.%	90.%	100.%	100.%	100.%	98.%	100.%	98.%	100.%	100.%	96.%
Nutritional Assessment	100.%	100.%	93.%	97.%	100.%	100.%	100.%	100.%	83.%	100.%	100.%	100.%	100.%	97.%	98.%	100.%	90.%	100.%	100.%	100.%	100.%	100.%	95.%	98.%
Patient Observation and Escalations	100.%	92.%	100.%	95.%	100.%	100.%	100.%	100.%	92.%	100.%	100.%	96.%	96.%	100.%	96.%	100.%	100.%	100.%	96.%	100.%	100.%	100.%	100.%	98.%
Pain Management	93.%	100.%	100.%	85.%	100.%	100.%	97.%	100.%	96.%	100.%	100.%	100.%	97.%	100.%	90.%	100.%	100.%	100.%	100.%	97.%	93.%	100.%	100.%	98.%
Nursing & Midwifery Documentation - Quality of Entry	100.%	92.%	85.%	91.%	95.%	95.%	93.%	97.%	86.%	100.%	97.%	96.%	91.%	97.%	83.%	98.%	90.%	100.%	86.%	96.%	93.%	97.%	93.%	94.%
Medication Assessment	100.%	96.%	100.%	100.%	97.%	100.%	100.%	100.%	100.%	100.%	100.%	97.%	100.%	100.%	100.%	100.%	95.%	95.%	100.%	100.%	100.%	100.%	95.%	99.%
Patient Experience - Protected Mealtimes (PMT) Observations	100.%	100.%	88.%	88.%	100.%	100.%	100.%	100.%	75.%	100.%	100.%	100.%	88.%	100.%	63.%	88.%	100.%	88.%	100.%	75.%	88.%	88.%	100.%	92.%
Patient Experience - Care Rounds Observe patient records	100.%	100.%	100.%	100.%	100.%	91.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	80.%	91.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	71.%	97.%
Patient Experience - Environment	83.%	100.%	100.%	100.%	83.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	80.%	83.%	83.%	80.%	100.%	100.%	83.%	83.%	100.%	67.%	92.%
Patient Experience - Privacy and Dignity	84.%	91.%	89.%	94.%	94.%	92.%	84.%	88.%	90.%	89.%	96.%	95.%	84.%	75.%	86.%	95.%	89.%	93.%	89.%	92.%	98.%	97.%	81.%	90.%
Patient Safety and Quality	100.%	94.%	96.%	100.%	96.%	94.%	92.%	92.%	76.%	100.%	100.%	100.%	100.%	100.%	88.%	94.%	100.%	94.%	95.%	92.%	96.%	96.%	93.%	95.%
Leadership & Staffing observations	95.%	92.%	95.%	100.%	95.%	95.%	95.%	97.%	79.%	98.%	98.%	97.%	95.%	100.%	87.%	100.%	90.%	92.%	96.%	100.%	99.%	99.%	94.%	95.%
EOL	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	91.%	100.%	100.%		83.%	95.%
SOVA/LD/Cognitive Impairment	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%
First Impressions/15 Steps	83.%	80.%	89.%	51.%	80.%	100.%	100.%	86.%	77.%	83.%	89.%	80.%	89.%	69.%	80.%	80.%	89.%	80.%	80.%	97.%	97.%	86.%	80.%	84.%
Safety Thermometer – Percentage of Harm Free Care	96.43%	88.89%	89.29%	96.67%	85.71%	78.95%	96.55%	85.19%	100.00%	100.00%	100.00%	90.48%	89.66%	94.44%	100.00%	100.00%	82.76%	100.00%	100.00%	92.59%	86.21%	100.00%	87.10%	90.00%
Pressure Ulcers – Grade 2 incidence hosp acquired, (Previous Month)	0	0	0	0	2	0	0	0	0	0	0	1	0	0	1	0	1	0	0	0	1	0	1	7
Pressure Ulcers – Grade 3 incidence hosp acquired, (Previous Month)	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Pressure Ulcers – Grade 4 incidence hosp acquired, (Previous Month)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pressure Ulcers -sDTI's incidence hosp acquired	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Falls (Moderate, Major & Catastrophic)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
HAI – MRSA Bact	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
HAI – C Diff	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient Overdue Observations frequency - <7%	3%	8%	7%	5%	9%	7%	4%	4%	11%	6%	8%	10%	5%	12%	4%	5%	6%	7%	9%	5%	8%	6%	6%	16%
Caring																								
Complaints – Nursing and Midwifery	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Number of PALS concerns relating to nursing care on the wards	3	1	1	2	0	0	2	0	3	0	0	0	1	1	2	0	1	0	1	0	0	0	0	18
Friends Family Test % Recommended	90.9%	90.0%	86.0%	94.1%	58.8%	92.9%	84.1%	96.6%	88.3%	90.0%	95.0%	85.7%	0.0%	0.0%	88.9%	95.5%	100.0%	89.3%	84.2%	94.7%	98.1%	92.8%	91.3%	82.1%
Well Led																								
Staff Nurse Staffing - Registered Staff (day & night combined)																								
Staff Nurse Staffing - Support Worker (day & night combined)																								
Staffing related datix	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0	1	4

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Appendix 4

Quality Care Indicators - Nurse & Midwifery	MATERNITY			
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Balmoral	Robert Watson	MOW	Sturtridge
Quality & Safety				
Postnatal Safety Assessment (Q)	95%	Nil	100%	Nil
SOVA/LD (Q)	Nil	Nil	Nil	Nil
Patient Observation Chart (Q)	100%	Nil	100%	100%
Medication Assessment (Q)	95%	Nil	100%	100%
Environment Observations (Q)	Nil	Nil	100%	100%
HAI – MRSA Bact				
HAI – C Diff				
Drug Administration Incident				
Emergency Equipment – Checked Daily (Q)	100%	Nil	0%	Nil
Patient Quality Boards (Q)	100%	Nil	100%	100%
Controlled Drug Checked (Q)	100%	Nil	100%	100%
Patient Experience				
Complaints – Nursing and Midwifery	0	0		0
Call Bells responses (Q)	Nil	Nil	Nil	Nil
Patient Experience (Q)	88%	Nil	70%	100%
Patient Safety and Quality (Q)	100%	Nil	57%	88%
Leadership & Staffing (Q)	100%	Nil	100%	100%
Management				
Staffing related datix	0	1	0	0
Monthly Ward meetings (Q)	Nil	Nil	100%	100%
Safety and Quality (Q)	100%	Nil	100%	100%
Leadership & Staffing (Q)	Nil	Nil	100%	100%

Ward Overall Results

0
0

Appendix 5

Oct 16	PAEDIATRICS		
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Disney	Paddington	Gosset
Quality & Safety			
Falls/Safety Assessment (Q)	71%	100%	nil
Pressure Prevention Assessment (Q)	82%	100%	92%
Child Observations [documentation] (Q)	94%	100%	92%
Safeguarding [documentation] (Q)	86%	83%	100%
Nutrition Assessment [documentation] (Q)	79%	75%	80%
Medication Assessment (Q)	100%	94%	96%
Pressure Ulcers – Grade 2 incidence hosp acquired	0	0	0
Pressure Ulcers – Grade 3 incidence hosp acquired	0	0	0
Pressure Ulcers – Grade 4 incidence hosp acquired	0	0	0
Pressure Ulcers - sDTI's incidence hosp acquired	0	0	0
Safety Thermometer – Percentage of Harm Free Care	100.00 %	100.00 %	100.00 %
Falls (Moderate, Major & Catastrophic)	0	0	0
HAI – MRSA Bact			
HAI – C Diff			
Patient Overdue Observations frequency - <7%	80%	100%	
Drug Administration Incident			
Patient Experience			
Friends Family Test % Recommended			
Complaints – Nursing and Midwifery	0	0	0
Number of PALS concerns relating to nursing care on the wards	1	0	0
Call Bells responses (Q)	100%	100%	100%
Patient Safety & Quality Environment Observations Observe patient records (Q)	100%	100%	100%
Privacy and Dignity (Q)	95%	100%	100%
Management			
Staffing related datix	0	1	0
Monthly Ward meetings (Q)	100%	94%	100%
Safety and Quality ask 5 staff (Q)	100%	100%	100%
Leadership & Staffing observations (Q)	100%	100%	100%

Ward Overall Results
0
1

Enclosure E

Appendix 6.

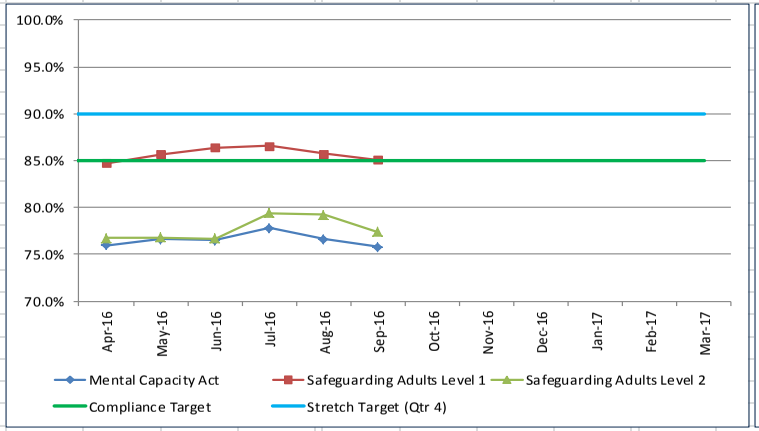
Safeguarding Training Dashboard: Trustwide Compliance

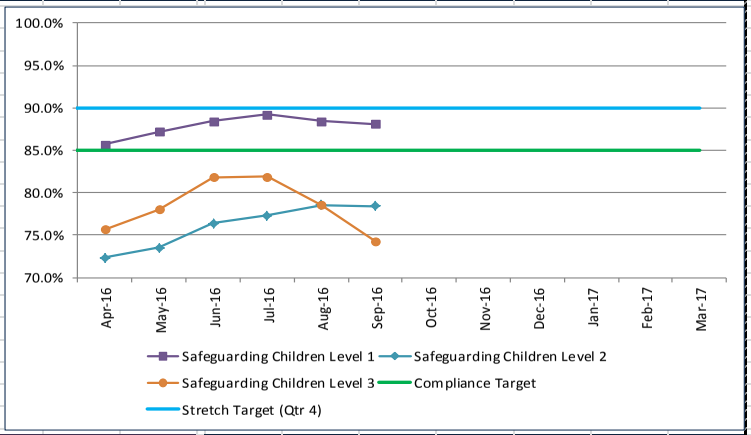
Northampton General Hospital NHS
NHS Trust

Headline Compliance: Month End

Mental Capacity Act & DOLs	Safeguarding Adults Level 1	Safeguarding Adults Level 2	Safeguarding Children Level 1	Safeguarding Children Level 2	Safeguarding Children Level 3
75.8%	85.1%	77.4%	88.1%	78.4%	74.3%

Monthly Compliance





Complinace by Professional Group

Mental Capacity Act & DOLs	
Add Prof Scientific and Technic	72.15%
Additional Clinical Services	81.71%
Administrative and Clerical	38.89%
Allied Health Professionals	83.25%
Medical and Dental	43.72%
Nursing and Midwifery Registered	83.60%

Safeguarding Adults Level 1	
Add Prof Scientific and Technic	91.47%
Additional Clinical Services	90.85%
Administrative and Clerical	87.46%
Allied Health Professionals	88.84%
Estates and Ancillary	83.65%
Healthcare Scientists	89.31%
Medical and Dental	56.47%
Nursing and Midwifery Registered	89.45%

Safeguarding Adults Level 2	
Add Prof Scientific and Technic	76.60%
Additional Clinical Services	86.17%
Administrative and Clerical	28.57%
Allied Health Professionals	82.78%
Medical and Dental	45.74%
Nursing and Midwifery Registered	84.10%

Safeguarding Children Level 1	
Add Prof Scientific and Technic	90.70%
Additional Clinical Services	91.76%
Administrative and Clerical	88.41%
Allied Health Professionals	94.42%
Estates and Ancillary	84.49%
Healthcare Scientists	90.84%
Medical and Dental	65.10%
Nursing and Midwifery Registered	93.64%

Safeguarding Children Level 2	
Add Prof Scientific and Technic	76.19%
Additional Clinical Services	84.15%
Administrative and Clerical	43.75%
Allied Health Professionals	91.18%
Healthcare Scientists	41.38%
Medical and Dental	53.35%
Nursing and Midwifery Registered	86.51%

Safeguarding Children Level 3	
Add Prof Scientific and Technic	20.00%
Additional Clinical Services	72.97%
Administrative and Clerical	60.00%
Allied Health Professionals	66.67%
Healthcare Scientists	100.00%
Medical and Dental	62.70%
Nursing and Midwifery Registered	77.94%

Compliance Data

	MCA & DOLs	SGA 1	SGA 2	SGC 1	SGC 2	SGC 3
Surgery	76.0%	84.5%	79.2%	86.5%	72.9%	76.7%
Medicine	73.7%	82.9%	77.3%	83.7%	71.9%	57.4%
Womens & Childrens	76.8%	84.6%	73.8%	95.3%	94.5%	80.6%
Gynae, Haem & Onc	78.0%	89.4%	83.6%	91.3%	78.3%	71.4%
CSSD	80.7%	87.6%	79.5%	91.5%	82.8%	N/A
Support Services						

Northampton General Hospital NHS
NHS Trust

Ward Staffing Fill Rate Indicator (Nursing, Midwifery & Care Staff) — October 2016

Ward name	Day: Registered midwives/nurses		Day: Care Staff		Night: Registered midwives/nurses		Night: Care Staff		Day: Average fill rate - registered nurses /midwives (%)	Day: Average fill rate - care staff (%)	Night: Average fill rate - registered nurses / midwives (%)	Night: Average fill rate - care staff (%)	Care Hours Per Patient Day (CHPPD): Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall	Actions/Comments	Red Flag
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours										
Abington	1,583.25	1,470.83	1,429.50	1,403.50	1,069.50	1,053.75	1,069.50	1,104.00	92.9%	98.2%	98.5%	103.2%	861	2.9	2.9	5.8	1 x Delay or omisson of regular checks - Personal needs	Escalated appropriately at the time, additional staffing support initially provided. However, further sickness occured during the shift. Night Practitioner available to support the ward as necessary.
Allebone	1,617.55	1,511.50	1,057.75	1,770.00	1,401.75	1,355.75	713.00	1,551.00	93.4%	167.3%	96.7%	217.5%	867	3.3	3.8	7.1		
Althorp	967.75	925.75	638.75	556.75	713.00	714.00	494.50	437.00	95.7%	87.2%	100.1%	88.4%	256	6.4	3.9	10.3		
Becket	2,014.25	1,804.75	1,409.00	1,405.67	1,782.50	1,642.00	713.00	791.75	89.6%	99.8%	92.1%	111.0%	802	4.3	2.7	7.0		
Benham	1,776.25	1,652.75	892.75	1,393.75	1,426.00	1,411.75	713.00	1,355.50	93.0%	156.1%	99.0%	190.1%	798	3.8	3.4	7.3		
MATERNITY COMBINED UNIT: Sturtridge, MOW, Balmoral & Birth Centre	6976.1	7095.0	3492.6	2966.5	6397.3	6315.1	2649.0	2395.0	101.7%	84.9%	98.7%	90.4%	1321	10.5	4.3	14.7		
Brampton	1,390.50	1,230.50	1,066.50	1,125.75	1,069.50	1,069.50	713.00	1,166.25	88.5%	105.6%	100.0%	163.6%	892	2.6	2.6	5.1		
Cedar	1,599.50	1,633.58	1,770.25	1,906.50	1,069.50	1,060.00	1,069.50	1,436.00	102.1%	107.7%	99.1%	134.3%	909	3.0	3.7	6.6	1 x Shortfall of 25% or more of planned RN on shift	Last minute sickness, escalated when notified - care prioritised no harms highlighted
Collingtree	2,356.75	2,111.33	1,772.75	2,050.50	1,782.50	1,747.75	713.00	947.00	89.6%	115.7%	98.1%	132.8%	1239	3.1	2.4	5.5		
Compton	1,069.00	1,040.50	718.75	1,011.00	713.00	713.00	356.50	713.00	97.3%	140.7%	100.0%	200.0%	892	2.0	1.9	3.9		
Creaton	1,774.50	1,706.25	1,667.50	1,834.25	1,058.00	1,068.25	712.25	1,108.25	96.2%	110.0%	101.0%	155.6%	909	3.1	3.2	6.3		
CHILD HEALTH COMBINED: Disney, Gosset & Paddington	7120.0	6441.4	2701.1	2681.8	5527.8	4990.4	1242.0	1286.8	90.5%	99.3%	90.3%	103.6%	982	11.6	4.0	15.7		
Dryden	2,141.00	1,719.83	954.50	961.25	1,426.00	1,401.25	713.00	788.00	80.3%	100.7%	98.3%	110.5%	793	3.9	2.2	6.1		
EAU	2,128.75	2,086.50	1,062.25	1,736.25	1,778.75	1,789.92	1,069.50	1,559.08	98.0%	163.5%	100.6%	145.8%	919	4.2	3.6	7.8	1 x Other Staffing issues – please provide narrative within the description	Staffing deficit of one RN and one HCA but this did not contribute to the incident.
Eleanor	1,058.00	1,066.75	712.00	836.05	713.00	713.00	713.00	862.50	100.8%	117.4%	100.0%	121.0%	335	5.3	5.1	10.4		
Finedon	2,139.00	1,886.50	586.20	648.70	1,069.50	1,069.50	356.50	520.00	88.2%	110.7%	100.0%	145.9%	495	6.0	2.4	8.3		
Hawthorn	1,956.75	1,943.92	1,062.45	1,108.95	1,426.00	1,408.00	954.50	1,083.25	99.3%	104.4%	98.7%	113.5%	892	3.8	2.5	6.2	1 x Other Staffing issues – please provide narrative within the description	Patient care prioritised, escalated appropriately, no harm to patients
Head & Neck	1,066.25	1,032.75	709.50	702.75	897.75	795.00	356.50	445.50	96.9%	99.0%	88.6%	125.0%	413	4.4	2.8	7.2		
Holcot	1,405.50	1,360.75	1,401.00	1,723.75	1,069.50	1,070.25	713.00	1,785.75	96.8%	123.0%	100.1%	250.5%	896	2.7	3.9	6.6		
ITU	6,252.75	5,428.08	819.50	776.25	4,600.00	4,325.58	713.00	728.50	86.8%	94.7%	94.0%	102.2%	399	24.4	3.8	28.2		
Knightley	1,065.75	1,031.00	887.08	1,058.33	1,069.50	1,023.83	356.50	770.75	96.7%	119.3%	95.7%	216.2%	649	3.2	2.8	6.0		
Rowan	1,954.25	1,979.25	1,074.75	1,269.67	1,782.50	1,741.67	713.00	979.75	101.3%	118.1%	97.7%	137.4%	899	4.1	2.5	6.6		
Spencer	954.00	936.33	593.75	573.00	713.00	723.25	356.50	401.50	98.1%	96.5%	101.4%	112.6%	399	4.2	2.4	6.6		
Talbot Butler	2,563.00	2,092.58	1,372.75	1,239.00	1,426.00	1,035.00	713.00	1,161.00	81.6%	90.3%	72.6%	162.8%	854	3.7	2.8	6.5	The numbers of HCA increased on night duty to support patient care due to RN ongoing recruitment. Staffing monitored daily by the Matron and reallocation as required.	
Victoria	1,176.25	1,091.83	695.75	1,037.67	713.00	724.50	356.50	782.00	92.8%	149.1%	101.6%	219.4%	557	3.3	3.3	6.5		
Willow	2,316.00	2,284.33	1,067.50	1,077.00	2,124.75	1,968.75	713.00	874.00	98.6%	100.9%	92.7%	122.6%	876	4.9	2.2	7.1		

Key:
- Below 80% Shift Fill Rate Target
- 80% and Above Shift Fill Rate Target

Enclosure E

Appendix 8
Midlands & East Safe Staffing data.

Safer Staffing Report

Qualified & HCA Summary

Daytime Fill Rates - Registered Midwives/Nurses

	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
Bedford Hospital NHS Trust	96%	91%	95%	92%	93%	93%	93%	94%	93%	93%	95%	94%
East and North Hertfordshire NHS Trust	96%	99%	99%	99%	98%	97%	96%	99%	99%	97%	96%	91%
Kettering General Hospital NHS Foundation Tr	96%	97%	96%	96%	97%	97%	96%	97%	95%	97%	97%	95%
Leicestershire Partnership NHS Trust	104%	105%	106%	104%	104%	101%	100%	105%	108%	106%	106%	105%
Luton and Dunstable Hospital NHS Foundation	91%	90%	92%	94%	94%	91%	89%	91%	92%	92%	91%	92%
Milton Keynes Hospital NHS Foundation Trust	91%	94%	90%	92%	94%	92%	92%	93%	92%	92%	91%	87%
Northampton General Hospital NHS Trus	**85%**	**87%**	**90%**	**91%**	**94%**	**93%**	**93%**	**96%**	**94%**	**94%**	**94%**	**91%**
Northamptonshire Healthcare NHS Foundatior	95%	96%	100%	99%	99%	97%	97%	97%	97%	96%	97%	93%
United Lincolnshire Hospitals NHS Trust	89%	93%	92%	90%	92%	90%	87%	90%	91%	92%	90%	88%
University Hospitals of Leicester NHS Trust	91%	91%	87%	91%	91%	89%	90%	92%	91%	91%	90%	89%
West Hertfordshire Hospitals NHS Trust	84%	93%	91%	92%	93%	92%	92%	94%	95%	96%	94%	93%
The Princess Alexandra Hospital NHS Trust	75%	78%	76%	76%	72%	74%	71%	72%	75%	76%	76%	73%

Daytime Fill Rates - HCA Staff

	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
Bedford Hospital NHS Trust	99%	97%	98%	97%	98%	102%	97%	104%	102%	100%	97%	96%
East and North Hertfordshire NHS Trust	109%	108%	112%	112%	109%	106%	111%	118%	117%	112%	112%	107%
Kettering General Hospital NHS Foundation Tr	94%	96%	101%	99%	95%	97%	93%	95%	95%	98%	97%	102%
Leicestershire Partnership NHS Trust	184%	196%	197%	196%	196%	201%	199%	199%	204%	211%	207%	210%
Luton and Dunstable Hospital NHS Foundation	95%	96%	96%	96%	96%	96%	95%	95%	97%	97%	96%	95%
Milton Keynes Hospital NHS Foundation Trust	91%	93%	91%	92%	98%	93%	96%	101%	109%	114%	119%	119%
Northampton General Hospital NHS Trus	**104%**	**100%**	**102%**	**107%**	**107%**	**106%**	**108%**	**112%**	**111%**	**111%**	**110%**	**107%**
Northamptonshire Healthcare NHS Foundatio	109%	106%	106%	100%	103%	108%	104%	107%	105%	107%	108%	109%
United Lincolnshire Hospitals NHS Trust	103%	104%	103%	101%	103%	98%	94%	100%	98%	99%	98%	99%
University Hospitals of Leicester NHS Trust	93%	94%	93%	94%	92%	86%	89%	92%	94%	94%	92%	95%
West Hertfordshire Hospitals NHS Trust	115%	113%	107%	106%	108%	110%	112%	109%	108%	99%	93%	98%
The Princess Alexandra Hospital NHS Trust	96%	89%	98%	98%	92%	88%	90%	97%	96%	95%	89%	86%

Night-time Fill Rates - Registered Midwives/Nurses

	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
Bedford Hospital NHS Trust	100%	99%	99%	101%	101%	101%	100%	98%	97%	97%	99%	99%
East and North Hertfordshire NHS Trust	100%	101%	102%	99%	100%	101%	100%	100%	100%	100%	100%	96%
Kettering General Hospital NHS Foundation Tr	99%	97%	98%	98%	99%	100%	100%	100%	101%	100%	96%	99%
Leicestershire Partnership NHS Trust	99%	102%	101%	103%	105%	105%	105%	103%	104%	104%	100%	103%
Luton and Dunstable Hospital NHS Foundation	97%	96%	98%	97%	100%	97%	96%	98%	99%	97%	98%	97%
Milton Keynes Hospital NHS Foundation Trust	102%	103%	104%	104%	100%	102%	101%	101%	101%	100%	100%	100%
Northampton General Hospital NHS Trus	**96%**	**95%**	**93%**	**94%**	**95%**	**95%**	**92%**	**95%**	**94%**	**95%**	**96%**	**94%**
Northamptonshire Healthcare NHS Foundatior	103%	107%	105%	105%	106%	104%	103%	105%	103%	101%	102%	102%
United Lincolnshire Hospitals NHS Trust	97%	100%	100%	97%	98%	98%	96%	96%	98%	97%	98%	97%
University Hospitals of Leicester NHS Trust	95%	96%	91%	95%	97%	95%	96%	98%	97%	97%	95%	95%
West Hertfordshire Hospitals NHS Trust	97%	98%	99%	97%	98%	97%	96%	98%	97%	99%	97%	96%
The Princess Alexandra Hospital NHS Trust	85%	83%	84%	83%	81%	82%	87%	79%	80%	81%	82%	79%

Night-time Fill Rates - HCA Staff

	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
Bedford Hospital NHS Trust	122%	105%	99%	111%	108%	106%	107%	112%	112%	111%	111%	111%
East and North Hertfordshire NHS Trust	117%	123%	123%	126%	131%	125%	130%	119%	121%	117%	116%	112%
Kettering General Hospital NHS Foundation Tr	100%	103%	106%	107%	105%	110%	105%	103%	103%	110%	104%	112%
Leicestershire Partnership NHS Trust	179%	186%	185%	181%	181%	188%	195%	191%	195%	204%	203%	207%
Luton and Dunstable Hospital NHS Foundation	99%	96%	91%	95%	94%	94%	96%	96%	97%	99%	100%	98%
Milton Keynes Hospital NHS Foundation Trust	116%	123%	118%	117%	114%	115%	119%	115%	123%	135%	136%	136%
Northampton General Hospital NHS Trus	**139%**	**134%**	**139%**	**133%**	**132%**	**132%**	**133%**	**130%**	**136%**	**129%**	**133%**	**129%**
Northamptonshire Healthcare NHS Foundatio	113%	121%	117%	111%	119%	125%	117%	117%	118%	113%	120%	114%
United Lincolnshire Hospitals NHS Trust	110%	117%	117%	111%	115%	105%	104%	107%	103%	102%	101%	99%
University Hospitals of Leicester NHS Trust	100%	100%	98%	98%	100%	92%	95%	98%	99%	97%	97%	98%
West Hertfordshire Hospitals NHS Trust	111%	106%	103%	105%	109%	110%	111%	106%	111%	109%	107%	104%
The Princess Alexandra Hospital NHS Trust	100%	93%	98%	96%	98%	92%	95%	98%	97%	99%	99%	99%

Overall Fill Rates

	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
Bedford Hospital NHS Trust	101%	96%	97%	98%	98%	99%	97%	99%	98%	98%	99%	98%
East and North Hertfordshire NHS Trust	102%	104%	105%	104%	104%	103%	104%	105%	105%	103%	103%	98%
Kettering General Hospital NHS Foundation Tr	97%	97%	99%	99%	98%	100%	97%	98%	98%	100%	98%	100%
Leicestershire Partnership NHS Trust	140%	146%	147%	145%	145%	147%	147%	148%	151%	154%	153%	154%
Luton and Dunstable Hospital NHS Foundation	95%	94%	94%	95%	96%	94%	93%	94%	96%	95%	96%	95%
Milton Keynes Hospital NHS Foundation Trust	96%	99%	97%	98%	99%	97%	98%	99%	101%	103%	104%	103%
Northampton General Hospital NHS Trus	**97%**	**97%**	**99%**	**100%**	**102%**	**101%**	**101%**	**103%**	**103%**	**102%**	**103%**	**100%**
Northamptonshire Healthcare NHS Foundatior	105%	107%	106%	103%	106%	108%	104%	106%	105%	104%	106%	105%
United Lincolnshire Hospitals NHS Trust	97%	100%	100%	97%	99%	96%	93%	96%	96%	96%	95%	94%
University Hospitals of Leicester NHS Trust	93%	94%	91%	93%	93%	90%	92%	94%	94%	94%	92%	93%
West Hertfordshire Hospitals NHS Trust	98%	100%	98%	98%	100%	100%	100%	100%	100%	99%	97%	96%
The Princess Alexandra Hospital NHS Trust	85%	84%	86%	85%	82%	81%	82%	82%	84%	84%	83%	81%

Key
<90%
90% - 95%
>95% <150%
>150%

Appendix 9

Safe Staffing – Comparison from January 2015 – September 2016

January 2015

	Safe Staffing Report Overall Fill Rates			
	DAY		NIGHT	
	RN	HCA	RN	HCA
Total Fill Rate - %	83.3	98	99.5	134
Total Combined - %	96.2			

September 2015

	Safe Staffing Report Overall Fill Rates			
	DAY		NIGHT	
	RN	HCA	RN	HCA
Total Fill Rate - %	84.7	103	96	140
Total Combined - %	97			

January 2016

	Safe Staffing Report Overall Fill Rates			
	DAY		NIGHT	
	RN	HCA	RN	HCA
Total Fill Rate - %	94	107	95	132
Total Combined - %	102			

September 2016

	Safe Staffing Report Overall Fill Rates			
	DAY		NIGHT	
	RN	HCA	RN	HCA
Total Fill Rate - %	93	109	96	135
Total Combined - %	102			

Key:

<90%	90% - 95%	95% - 100%
	>100%	>150%

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**24 November 2016**

Title of the Report	**Single Oversight Framework – Segmentation**
Agenda item	**10**
Presenter of Report	Sonia Swart Chief Executive Officer
Author(s) of Report	Catherine Thorne – Director of Corporate Development, Governance and assurance
Purpose	The report is presented to the Board for information.
Executive summary This paper describes the purpose of the Single Oversight Framework and how Trusts have now been assigned into segments which determine the level of support they will and intervention they will receive. Northampton General Hospital is assigned to Segment 3.	
Related strategic aim and corporate objective	ALL
Risk and assurance	The segmentation is based on risks related to performance and Care Quality Commission ratings
Related Board Assurance Framework entries	BAF – 1.1 and 1.2
Equality Analysis	N
Equality Impact Assessment	N
Legal implications / regulatory requirements	The Trust is required to meet its NHS constitutional requirements and has a statutory requirement to meet the CQC standards for Quality and Safety and Use of Resources.

Enclosure F

Actions required by the Trust Board

The Board is asked to:

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- To note NGH's assigned segment and note the intervention and support this will now deem necessary for the organisation.

Northampton General Hospital NHS
NHS Trust

Single Oversight Framework for NHS providers: Provider Segmentation

The Single Oversight Framework has been designed to help NHS providers attain, and maintain, Care Quality Commission ratings of 'Good' or 'Outstanding'.
The framework applies from 1 October 2016, and replaces the NHS Trust Development Authority 'Accountability Framework'.

How it works

The Framework will be used to identify NHS providers' potential support needs across five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability

As part of this framework Trusts have been segmented into categories according to the level of support each trust needs. NHS Improvement will use this to signpost, offer or mandate tailored support as appropriate.

Segmentation

Shadow segmentation has been assigned and this will be formalised from November 1st 2016. There are four segments as described in the table (page 2) and Northampton General Hospital NHS Trust is been assigned segment 3 based on performance and our current Care Quality Commission rating of "Requires Improvement".
The table on page 2 shows that 60 out of the 137 acute trusts are in segment 3, and will receive mandated support for concerns about actual or suspected breaches of licence.
A further 20 were listed in segment 4, and will be placed into special measures.

Segment	Total	Acute	Specialist	Mental Health	Community	Ambulance
1	35	5	8	12	9	1
2	106	52	7	37	6	4
3	74	60	2	6	3	3
4	22	20	0	0	0	2

Segment	Description
1	**Providers with maximum autonomy** – no potential support needs identified across our five themes. Lowest level of oversight; segmentation decisions taken quarterly in the absence of any significant deterioration in performance.
2	**Providers offered targeted support** – there are concerns in relation to one or more of the themes. NHS Improvement identifies targeted support that the provider can access to address these concerns, but which they are not obliged to take up. For some providers in segment 2, more evidence may need to be gathered to identify appropriate support.
3	**Providers receiving mandated support for significant concerns** – there is actual/suspected breach of licence, and a Regional Support Group has agreed to seek formal undertakings from the provider or the Provider Regulation Committee has agreed to impose regulatory requirements.
4	**Providers in special measures** – there is actual/suspected breach of licence with very serious/complex issues. The Provider Regulation Committee has agreed it meets the criteria to go into special measures.

NHS Providers commentary

NHS Providers have commented on this as follows "We welcomed publication of the new single oversight framework (SOF) last month as offering a more coordinated approach to measuring NHS providers' performance and targeting the improvement support they need.

Today's shadow segmentation highlights how hard trust leadership teams are working to provide great patient care in a very difficult environment, with the majority of providers (60 per cent) placed in segments one and two.

What the figures do lay bare, however, is the enormous pressure the acute sector is facing, with almost two thirds of these trusts – 80 out of 137 – falling in segments 3 and 4. While the new SOF marks a significant shift from NHS Improvement as it places much greater emphasis on improvement and support, it is difficult to separate the segmentation from the difficult context in which providers are operating. This is one of increasingly challenged finances, a social care system that has now reached a tipping point and rapidly rising demand."

We welcome the way NHSI engaged with the sector during the shadow segmentation process and look forward to working with them to monitor the impact for trusts in each of the four segments. In particular the extent to which those providers in segments 1 and 2 enjoy

autonomy and how trusts can move between segments. We will also work with NHSI to help shape the remaining areas of the SOF that still need developing around strategic change and leadership."

It is clear that there will be a need for NHSI to work with providers to agree those areas where specific targeted support would be most appropriate. It is anticipated that some of the support would come directly from NHSI and some from other providers with Trusts in segments 1 and 2 being encouraged to share best practice and outline what further support they might offer.

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There are a number of areas of the SOF that need further development such as the requirements for the category of strategic change and leadership and the introduction of this Single Oversight Framework for NHS trusts and foundation trusts is a significant shift from the previous regulatory and accountability frameworks operated by Monitor and the TDA. It would appear that this is a pragmatic response from NHSI to balance its combined functions, take account of the challenges facing all providers, and introduce a greater emphasis on improvement and support. The success of this approach will partly depend on the construct of the support offer.

In addition there will need to be some attention paid to the different statutory bases of Trusts and FTs, and to the separation of the functions of regulatory intervention and support. It is expected that the shift in approach will be a gradual one and one to which providers may be able to contribute.

NGH will continue to strive to improve against all the mandatory performance targets, to consistently support a focus based on quality improvement and the development of a workforce fully engaged in challenging agenda that we face and continue to ensure that value for the patient and value for money are equally balanced.

The programme of Board development over the last 12 months has been largely focussed around quality and strategic development. Following participation in the AquA programme, the new quality improvement strategy which is nearing a formal launch will re-emphasise the central premise of quality improvement as the principle for alignment of all efforts within the organisation. The current leadership development programme for NGH management teams will further develop this and our recent enrolment in HSJ solutions and HSJ intelligence will provide our workforce with some additional tools to sit alongside and complement our Quality Improvement teams.

Our ability to move towards delivery of all mandatory standards and targets whilst continuing the focus on all aspects of quality will largely depend on our ability to deliver improved performance in urgent care but there will be a continued emphasis also on the new focus on the delivery of quality cancer care and full participation as part of the newly formed Cancer Alliance. There is a clear recognition that the full solution for NGH as a provider depends on the a well sequenced implementation of the current STP plans and that full participation in system redesign is an imperative for all partners.

The board is asked to note the designated segmentation and the comments made and to continue to support the current programmes of work and the plans for continual board development in order to effectively lead NGH from ' requires improvement ' to ' good'.

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**24 November 2016**

Title of the Report	Financial Position - October (FY16-17)
Agenda item	11
Sponsoring Director	Simon Lazarus, DoF
Author(s) of Report	Andrew Foster, Deputy DoF.
Purpose	To report the financial position for the period ended October 2016/17.

Executive summary

This report sets out the financial position of the Trust for the period ended 31st October. The overall I&E position is a deficit of £7.689m, £0.02m favourable to the year to date plan. This position is measured against the revised I&E control total agreed with NHSI for FY16-17.

Key points:

- STF funding of £5.395m is included in the reported position but excludes funding for Cancer and A&E targets which are below required trajectories.
- Elective activity and income was below expected plan in October due to NEL pressures resulting in ongoing cancellation of lists.
- Pay expenditure run rate reduced by £0.4m month on month but remains significantly adverse (4.2%) to plan for the YTD.
- Agency expenditure is exceeding the authorised cap by £2m (26%) for the YTD.
- The forecast exercise undertaken in July has been updated for M7 results and shows forward risk in delivering the financial control total.
- The Trust has scored “3” against the new NHSI “Finance and use of Resources” metrics.

Related strategic aim and corporate objective	Financial Sustainability
Risk and assurance	The recurrent deficit and I&E plan position for FY16-17 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 Board The Board is asked to note the financial position for the period ended September 2016/17 and to consider the actions required to ensure that the financial plan is delivered.	

Northampton General Hospital NHS
NHS Trust

Financial Position

Month 7 (October)
FY 2016/17

Report to:
Trust Board
November 2016

Enclosure G

1. Overview

	RAG	This Month Oct	Last Month Sep	Change
Statutory Financial Duties				
3 year Cumulative I&E Breakeven duty (£000's)	✗	(37,180)	(36,448)	(732)
Achieving EFL (£000's)	✓	21,278	23,700	2,422
Capital Cost Absorption Duty (%)	✓	3.5%	3.5%	0
Achieving the Capital Resource Limit (£000's)	✓	14,751	14,976	(225)
Financial Sustainability Risk Rating	✓	3	3	0
I&E Position				
Actual in Month Position (£000's)	✗	(732)	(1,246)	515
Forecast in Month Position (£000's)	✗	(510)	(1,259)	749
Actual Year to Date Position (£000's)	✗	(7,689)	(6,956)	(732)
Forecast Year to Date Position (£000's)	✗	(7,689)	(6,956)	(732)
Forecast End of Year I&E Position (£000's)	✗	(15,129)	(15,129)	0
EBITDA %	✗	0.1%	-0.2%	0.3%
Income				
MRET Penalty - YTD (£000's)	✗	(2,573)	(2,206)	(367)
Readmissions YTD - Gross (£000's)	✗	(1,987)	(1,683)	(304)
Contract Fines & Data Challenges (£000's)	✗	(132)	(113)	(19)
Elective variance to plan (£000's)	✗	(282)	(80)	(202)
Daycase variance to plan (£000's)	✗	(85)	50	(136)
Non-Elective variance to plan (£000's)	✓	3,185	2,741	443
Outpatients variance to plan (£000's)	✓	1,306	1,170	135
Operating Costs				
Pay Expenditure (£000's)	✓	16,413	16,819	406
Agency Staff Costs (£000's)	✗	1,423	1,541	118
Agency Staff Cap (£000's)		1,083	1,087	4
Non-Pay - Clinical (£000's)	✓	4,603	4,677	74
Non-Pay - Other (£000's)	✗	2,911	2,789	(122)
Cost Improvement Schemes				
Year to Date Actual (£000's)	✓	6,865	5,652	1,213
Year to Date Plan (£0o0's)		6,485	5,312	1,173
Forecast Delivery (£000's)	✗	10,771	10,771	0
Annual CIP Target (£'000s)		12,900	12,900	0
Capital				
Year to date expenditure (£'000s)		6,743	6,172	
% of annual plan Committed	✗	75%	69%	5%
Annual Capital Expenditure Plan (£000's)	✓	14,751	14,976	(225)
Cash				
In month movement (£000's)	✓	1,165	(4,762)	5,927
In Year movement (£000's)	✓	2,064	899	1,165
New PDC / Temporary borrowing (£000's)	✓	10,942	9,624	1,318
Debtors Balance > 90 days (£000's)	✗	866	1,160	295
Creditors % > 90 days	✓	0%	0%	0%
Cumulative BPPC - by volume (%)	✓	99.1%	99.0%	0.1%

Key issues for this report

This report sets out the financial position of the Trust for the period ended 31st October . The overall I&E position is a deficit of £7.689m, £0.02m favourable to the year to date plan. This position is measured against the revised I&E control total agreed with NHSI for FY16-17.

Key points:

- The Trust continues to perform favourably to plan for the period to October and has included STF funding of £5.395m in the reported position on the basis that it will deliver the financial control total. Delivery against agreed trajectories continues to be adverse for Cancer and for A&E targets in October (see STF criteria and weighting below).
- Elective activity and income was below plan in October due to NEL pressures resulting in cancelled lists.
- Pay expenditure run rate reduced by £0.4m month on month but remains significantly adverse (4.2%) to plan for the YTD.
- Income position continues to include provision for MRET and readmissions penalties but excludes access fines as a condition of meeting the STF criteria.
- Agency expenditure is exceeding the authorised cap by £2.03 m (26%) for the YTD.
- The Trust continues to manage operational cashflow and to meet all commitments as they fall due through access to £7.7m of IRWCSF (deficit funding) and £5.6m of STF funding (subject to reconciliation of STF delivery).
- The forecast exercise undertaken in July has been updated for M7 results and whilst this shows further improvement overall there remains a significant level of forward risk in delivering the financial control total which needs to be addressed (reported under separate cover).
- An assessment of performance against the new NHSI "Finance and use of resources" metrics is included in this report (Appendix 1).

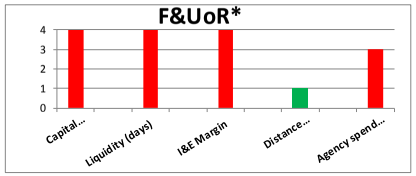
FY16-17 STF criteria and weighting

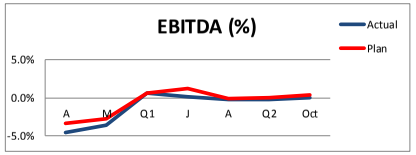
The Trust had not delivered the required trajectories for Cancer (Q2+Oct) and A&E (Oct) performance and as such the YTD value of these elements of the STF (£263k) have not been assumed in the reported position.

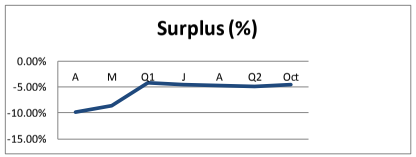
	Weight	Value £k
Finance	70.0%	6,790
RTT	12.5%	1,213
A&E	12.5%	1,213
Cancer	5.0%	485
Diagnostics	0.0%	-
Total	100.0%	9,700

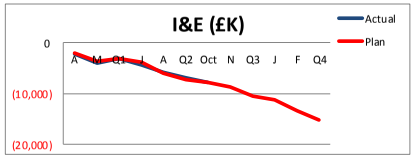
2. KPI & Trend Analysis

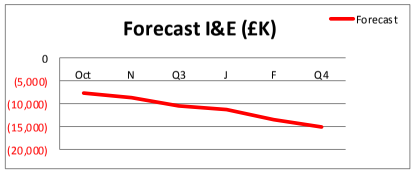
1. Key Metrics

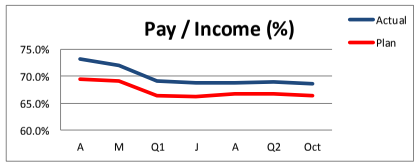




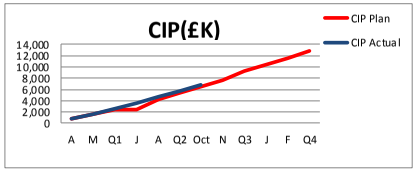


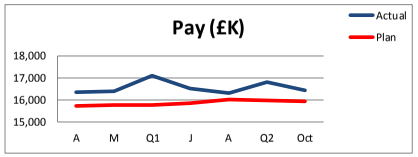


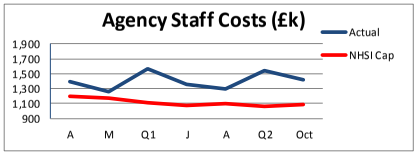


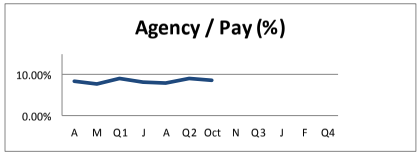


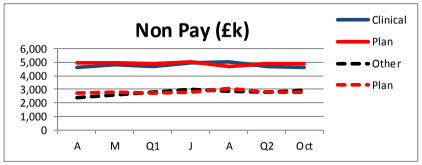
2. I&E Performance

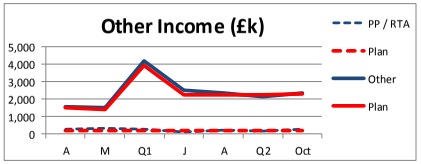




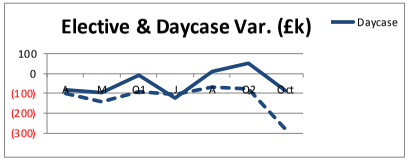


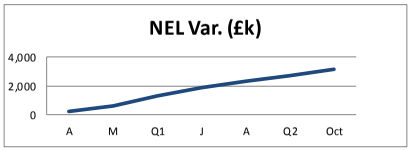


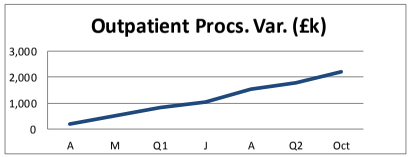


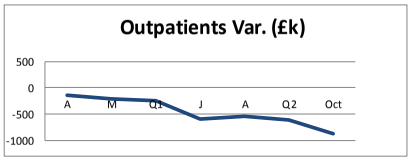


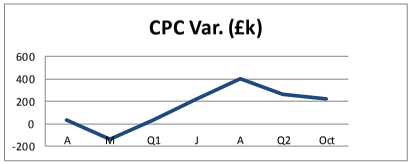
3. SLA Income

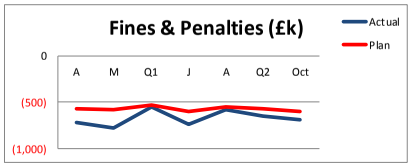




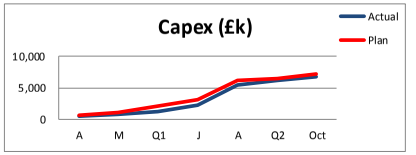


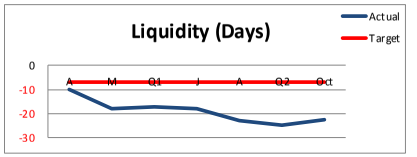


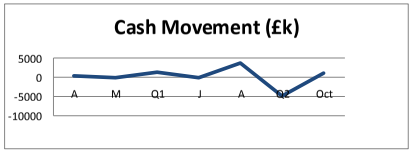


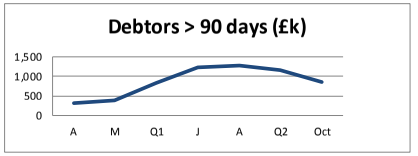


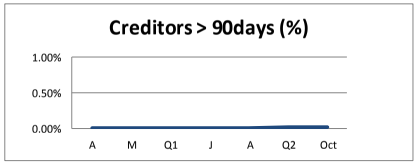
4. Working Capital

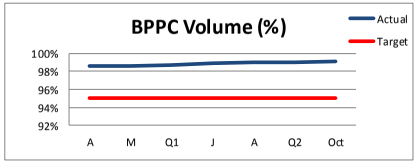












** F&UoP = Finance and Use of Resources metrics – See Appendix 4*

3.0 Income and Expenditure Position

I&E Summary	Actual FY15-16	Annual Plan	YTD plan	YTD Actual	Variance to Plan	Oct 16	Sep 16
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	246,152	256,996	150,013	150,398	385	21,753	21,873
Other Clinical Income	2,444	2,686	1,559	1,657	99	260	163
Other Income	20,872	27,562	15,978	16,604	626	2,354	2,132
Total Income	269,468	287,245	167,550	168,659	1,110	24,367	24,168
Pay Costs	(187,327)	(190,923)	(111,179)	(115,853)	(4,674)	(16,413)	(16,819)
Non-Pay Costs	(88,196)	(92,749)	(53,924)	(52,709)	1,215	(7,514)	(7,466)
CIPs		(0)	0	0	0	0	0
Reserves/ Non-Rec		(3,564)	(1,753)	0	1,753	0	0
Total Costs	(275,523)	(287,236)	(166,855)	(168,562)	(1,707)	(23,927)	(24,285)
EBITDA	(6,055)	9	694	97	(597)	439	(118)
Depreciation	(9,941)	(10,365)	(6,046)	(5,548)	498	(793)	(814)
Amortisation	(9)	(9)	(5)	(5)	0	(1)	(1)
Impairments	3,315	1,590	1,252	(1,918)	(3,170)	(109)	0
Net Interest	(355)	(1,239)	(433)	(348)	85	(66)	(57)
Dividend	(4,041)	(3,501)	(2,042)	(1,990)	52	(284)	(284)
Surplus / (Deficit)	(17,086)	(13,515)	(6,581)	(9,712)	(3,131)	(814)	(1,273)
NHS Breakeven duty adjs:							
Donated Assets	250	(24)	124	106	(18)	(27)	27
NCA Impairments	(3,315)	(1,590)	(1,252)	1,918	3,170	109	0
I&E Position (breakeven duty)	(20,151)	(15,129)	(7,709)	(7,689)	20	(732)	(1,246)

I&E Performance

- Financial performance for the period ended October 2016/17 is a normalised deficit of £7.689m, £20k fav. to the planned deficit of £7.709m.
- SLA income from Commissioners is £0.385m fav. to plan and continues to exclude provision for access fines in accordance with the conditions of the STF regime and standard contract.
- Other income above includes STF funding of £5.395m for the year to date (£263k adv. to plan). Expected deductions to STF funding relate to adverse performance for Cancer £162k (Q2+October) and A&E £101k (October only).
- Pay expenditure £4.674m (4.2%) adverse to plan driven by high costs of agency medical and nursing staff.
- Non-Pay costs £1.215m favourable to plan but further increases predicted during the financial year (notably due to costs of PAS implementation, international nurse recruitment and building maintenance costs, energy and contractual beds).
- Depreciation favourable to plan following completion of Q1 additions to the capital asset register and reassessment of in year phasing of charges.
- Impairment of non-current assets of £109k following receipt of Q2 indices charged in October.

Key Issues

SLA Income (figures in brackets = last month variance)

- Underling position is £1.07m fav. to plan offset by requirement to make provision for potential fines and penalties of £4.7m (£0.7m adv.) for the YTD.
- Elective Inpatient income £0.28m : 3% (£0.08m adv.) adverse to plan due to NEL pressures in October.
- Daycase income £0.09m : 0.6% (£0.05m fav.) adverse to plan for the year to date.
- NEL income £3.185m or 8% fav. (£3.07m fav.) to plan for period to date giving rise to increased MRET penalty exposure.
- Reported income includes assessment of delivery of 86% of CQUIN targets.
- Reported position includes £0.4m of general provisions for data challenges and contract reconciliation issues.

Other Income

- Private Patient income £200k fav. (£163k fav.) to plan.
- RTA income £101k adv. (£99k adv.) to plan.
- Income / Other Generation £626k fav. (£600k fav.) to plan .

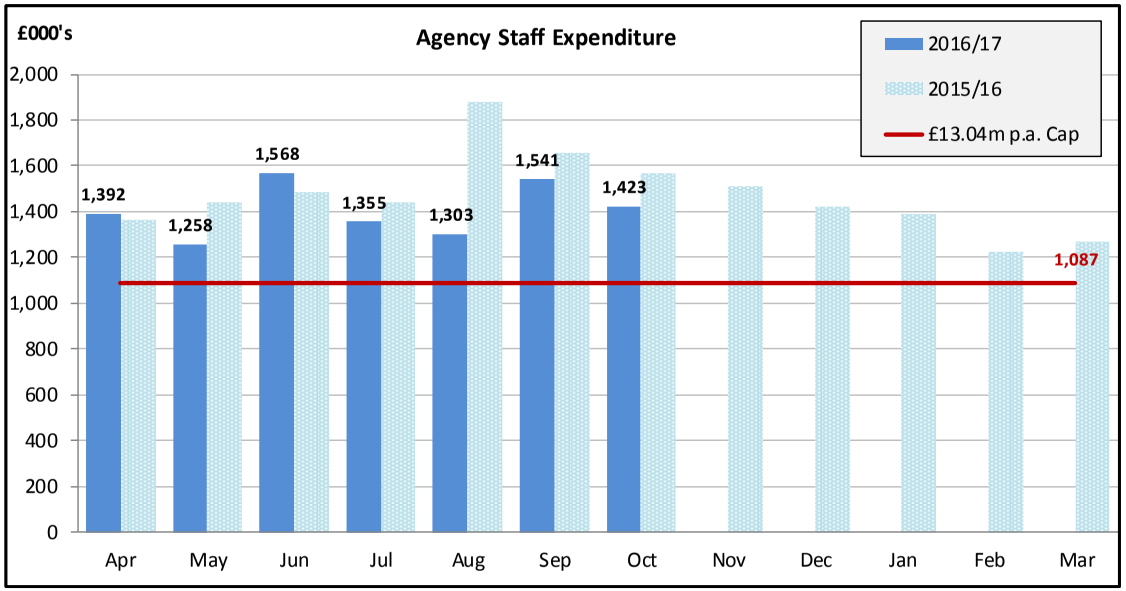
Pay

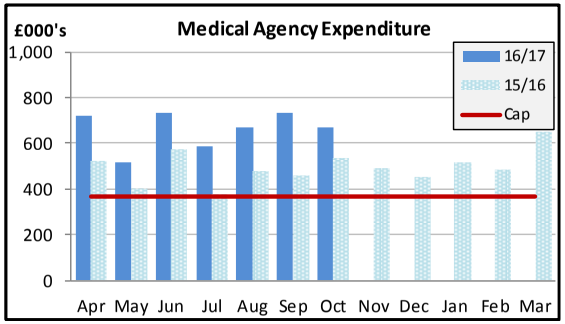
- Total agency staffing costs £1.423m or 8.7% of the total pay bill for October. (NHSI agency cap for FY16/17 is £13.04m pa / £1.09m pcm or 6.6% of planned pay expenditure).
- Medical staffing £1.331m:4.1% adv. (£1.305m adv.) to plan.
- Nursing pay £1.835m: 4.4% adv. (£1.619m adv.) to plan.

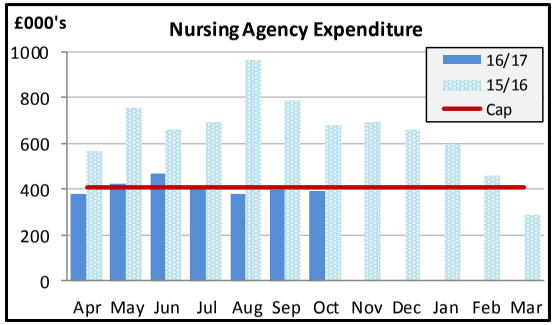
Non-Pay

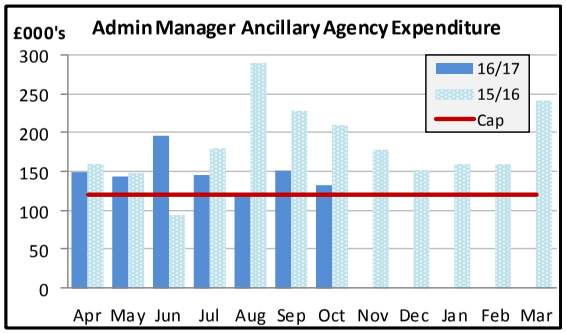
- Drugs £624k (£280k) fav. to plan.
- Staff advertising £106k (£79k) fav. to plan.
- Prosthesis £155k (£160k) fav. to plan.
- Building and engineering £216k (£355k) fav. to plan .
- Energy costs £179k (£134k) fav. to plan.
- IT maintenance / software £626k (£524k) fav. to plan.

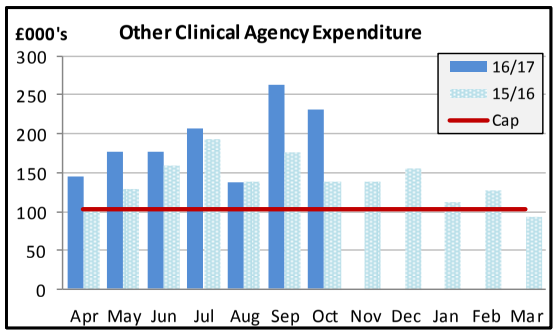
3.1 Agency Staff Expenditure











Key Issues

- **The Trust total expenditure for agency staff in 2015/16 was £17.6m.**
- NHS Improvement issued a expenditure limit of £11.8m for the new financial year 2016/17.
- On appeal, this has been revised to £13.04m.
- **£13.04m is equivalent to a 26% reduction year-on-year across all staff groups.**
- Applying this annual limit equally across the year gives a £1.1m per month cap to keep within.
- **At the end of October the Trust is £2.23m behind this cap.**
- **Agency Expenditure in totality is still not varying much from the £1.4m per month average and is therefore on track to return a £16.8m spend in 16/17, just 5% down on 15/16 levels.**
- Agency Medical Staff expenditure is currently 38% (£1.28m) higher than at this point last year. Urgent Care leading in expenditure. Pathology, Imaging and Oncology seeing the greatest increases year-on-year.
- Agency Other Clinical Staff expenditure reached highest levels seen in the past two months. Theatre practitioners, imaging and cardiology technicians lead the pressure here.
- Nursing agency spend has remained consistent at £400k per month, split broadly £280k on 57wte RNs & £120k on 47wte HCAs.
- Managers and Maintenance staff have not seen the required reductions. Ancillary & Admin are within cap.

4.0 SLA Income by Point of Delivery

		Activity			Finance £000's	
Point of Delivery	Plan	Actual	Variance	Plan	Actual	Variance
AandE	70,302	68,895	(1,407)	8,194	7,925	(268)
Block / CPC	1,606,739	1,659,865	53,126	32,863	33,083	220
CQUIN	-	-		3,201	2,760	(440)
Day Cases	20,541	23,611	3,070	14,430	14,344	(85)
Elective	3,412	3,280	(132)	9,536	9,255	(282)
Elective XBDs	1,244	1,104	(140)	291	253	(38)
Excluded Devices	969	1,133	164	1,037	1,156	120
Excluded Medicines	-	237	237	12,733	12,553	(180)
Non-Elective	24,988	27,229	2,241	39,757	42,942	3,185
Non-Elective XBDs	21,341	21,698	357	4,653	4,487	(166)
Outpatient First	33,856	32,647	(1,209)	5,601	5,411	(191)
Outpatient Follow UP	115,163	107,524	(7,639)	10,851	10,163	(689)
Outpt Procedures	79,990	94,632	14,642	10,704	12,889	2,185
Other Central SLA Income				(267)	(2,131)	(1,865)
CIPs				428		(428)
Total SLA Income (before fines and penaties)	**1,978,549**	**2,041,858**	**63,313**	**154,013**	**155,090**	**1,077**
Fines & Penatlies						
Contract Penalties	2WW			-	(4)	(4)
Contract Penalties	31 Day			-	(11)	(11)
Contract Penalties	62 Day			-	(46)	(46)
Contract Penalties	Cancelled Operations			-	(72)	(72)
Readmissions	Readmissions			(1,621)	(1,987)	(366)
MRET	MRET			(2,379)	(2,573)	(194)
Sub-Total Fines & Penalties				**(3,999)**	**(4,692)**	**(693)**
Grand Total SLA Income				**150,013**	**150,398**	**386**

Key issues

Summary
£386k favourable to plan

CQUIN
£440k adverse to plan

Day Case and Elective Inpatients
£367k adverse to plan

Non elective
£3,185k favourable to plan

Outpatients
£1,306k ahead of plan

A and E

Fines & Penalties
£693k adverse to plan

Total SLA Income showing £386k favourable position to plan, reduced to £163k including STF support.

CQUIN income recognises Q1 as achieved. Assumed 85% achievement across schemes in Q2 and Q3.

Day cases £85k below finance plan but above activity plan due to zero-priced chemotherapy activity included in day cases. Elective inpatients are below plan by 132, dropping by c.100 cases to plan in October (more than half of this relating to Urology and T&O).

Non elective activity is 9% above plan driven by A&E (Emergency Observation Area), Paediatrics, and General, Geriatric and Stroke medicine. There is a corresponding increase in MRET and Readmissions penalties.

The net position on outpatients is an over performance; Paediatrics, Ophthalmology, Respiratory Medicine, Cardiology, Oncology and Dermatology are over performing. Some of this over performance is offset by a negative central adjustment as it relates to a coding and counting change where the financials do not take effect until April 2017 (Ophthalmology).

A&E is £268k below plan.

Non-elective activity 8% above plan giving rise to increased MRET and Readmissions penalties.

4.1 SLA Income by Commissioner

Commissioner	Finance £000's Annual Plan	YTD Plan	Actual	Variance
Nene CCG	202,873	118,585	117,591	(994)
Corby CCG	2,702	1,539	1,456	(83)
Bedfordshire CCG	673	395	370	(25)
East Leicestershire & Rutland CCG	626	360	413	53
Leicester City CCG	43	31	40	9
West Leicestershire CCG	91	40	39	(1)
Milton Keynes CCG	2,609	1,527	1,793	266
SCG	30,762	18,179	20,164	1,985
SCG - Not in Contract Value (inc. He	1,134	525	794	269
Herts & South Midlands LAT	7,552	4,444	4,324	(120)
Cancer Drug Fund	3,131	1,835	1,120	(715)
NCA	3,624	2,187	2,293	107
Other	788	367	-	(367)
Total SLA Income	**256,607**	**150,013**	**150,398**	**386**

Key issues

Nene Contract £994k Under performance	Non-elective activity continues rising. Contractual Penalties, Readmissions and MRET fines are above planned levels mitigating the contractual over-performance. CQUIN, critical care, elective and day case income continue behind plan. Month 7 saw an increase gap against plan, largely due to elective activity and challenge allocation.
Corby CCG £83k adverse to plan	Non elective income behind plan due to a lower than anticipated case-mix in clinical oncology, general surgery and vascular surgery. This is being partially offset by over performance on excess bed days.
Specialised Commissioner £1,985k favourable to plan	Over performance against the radiotherapy by 18% in activity terms, 22% in monetary terms owing to a richer than expected case-mix.

5. Statement of Financial Position

	Balance at 31-Mar-16	Current Month Opening Balance	Current Month Closing Balance	Current Month Movement	Forecast end of year Closing Balance	Forecast end of year Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	160,399	160,399	160,399		160,399	
IN YEAR REVALUATIONS		(5,818)	(6,234)	(416)	(4,225)	(4,225)
IN YEAR MOVEMENTS		6,572	7,265	693	18,222	18,222
LESS DEPRECIATION		(4,756)	(5,548)	(792)	(9,929)	(9,929)
NET BOOK VALUE	160,399	156,397	155,882	(515)	164,467	4,068
CURRENT ASSETS						
INVENTORIES	5,744	6,008	6,268	260	5,494	(250)
RECEIVABLES						
NHS RECEIVABLES	9,742	12,248	13,564	1,316	10,016	274
OTHER TRADE RECEIVABLES	1,250	1,081	1,218	137	1,300	50
RECEIVABLES IMPAIRMENTS PROVISION	(205)	(205)	(205)		(200)	5
CAPITAL RECEIVABLES	21					(21)
NON NHS OTHER RECEIVABLES	118	707	799	92	118	
COMPENSATION RECEIVABLES (RTA)	2,582	2,547	2,572	25	2,657	75
SALARY OVERPAYMENTS	546	472	507	35	475	(71)
SALARY SACRIFICE SCHEMES	468	476	453	(23)	500	32
OTHER RECEIVABLES	525	537	1,060	523	575	50
IRRECOVERABLE PROVISION	(629)	(601)	(601)		(579)	50
PREPAYMENTS	1,923	3,959	3,856	(103)	2,173	250
SUB TOTAL	16,341	21,221	23,223	2,002	17,035	694
NON CURRENT ASSETS FOR SALE	375					(375)
CASH	1,602	2,501	3,666	1,165	1,500	(102)
CURRENT ASSETS	24,062	29,730	33,157	3,427	24,029	(33)
CURRENT LIABILITIES						
NHS PAYABLES	978	2,990	3,058	68	1,478	500
TRADE PAYABLES REVENUE	2,390	2,906	4,179	1,273	3,554	1,164
TRADE PAYABLES FIXED ASSETS	5,192	6,127	5,659	(468)	2,656	(2,536)
TAX AND NI OWED	3,552	3,945	3,814	(131)	3,802	250
NHS PENSIONS AGENCY	2,347	2,336	2,294	(42)	2,497	150
OTHER PAYABLES	823	497	482	(15)	1,223	400
FINANCE LEASE PAYABLE under 1 year	121	121	121		124	3
SHORT TERM LOANS - DH (CAPITAL)	628	628	628		1,700	1,072
SHORT TERM LOANS - DH (REVENUE)		9,624	10,942	1,318		
SHORT TERM LOANS - NON DH	155	144	144		82	(73)
ACCRUALS	7,191	9,692	8,928	(764)	7,941	750
RECEIPTS IN ADVANCE	1,775	1,685	1,479	(206)	1,975	200
PDC DIVIDEND DUE	99	40	302	262		(99)
STAFF BENEFITS ACCRUAL	710	767	767		750	40
PROVISIONS	2,802	2,289	2,286	(3)	2,503	(299)
CURRENT LIABILITIES	28,763	43,791	45,083	1,292	30,285	1,522
NET CURRENT ASSETS / (LIABILITIES)	(4,701)	(14,061)	(11,926)	2,135	(6,256)	(1,555)
TOTAL ASSETS LESS CURRENT LIABILITIES	155,698	142,336	143,956	1,620	158,211	2,513
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year	1,245	1,187	1,177	(10)	1,039	(206)
LOANS over 1 year DH (CAPITAL)	7,186	6,871	9,642	2,771	13,738	6,552
LOANS over 1 year DH (REVENUE)	18,851	18,851	18,851		33,980	15,129
LOANS over 1 year NON DH	166	80	60	(20)	84	(82)
PROVISIONS over 1 year	979	979	979		226	(753)
NON CURRENT LIABILITIES	28,427	27,968	30,709	2,741	49,067	20,640
TOTAL ASSETS EMPLOYED	127,271	114,368	113,247	(1,121)	109,144	(18,127)
FINANCED BY						
PDC CAPITAL	119,258	119,258	119,258		119,258	
PDC TEMPORARY BORROWING						
REVALUATION RESERVE	41,435	37,425	37,118	(307)	38,437	(2,998)
I & E ACCOUNT BALANCE	(33,422)	(33,422)	(33,422)		(33,422)	
I & E CURRENT YEAR		(8,893)	(9,707)	(814)	(15,129)	(15,129)
FINANCING TOTAL	127,271	114,368	113,247	(1,121)	109,144	(18,127)

Key Movements

Non Current Assets

•Depreciation movement of £792k offset by capital expenditure additions of £693k. The In-year revaluation movement £416k as a result of building indexation. Revaluation Reserve reduction (£307k). Impairment element (£109k) is charged to I & E and is included within the monthly deficit.

Current assets

•Increase in Inventories of £260k (Pharmacy decrease £11k, Pacing increase £369k, Pathology decrease £4k, Supplies trading decrease £100k, other £6k increase).
•Increase in NHS receivables of £1,316k. Increase in STF funding (£667k). Decrease in WIP (£99k). Under/over-performance manual accruals increase (£711k). Increase in outstanding Sales Ledger invoices (£178k)
•Increase in other Trade Receivables of £137k.
•Increase in other Non-NHS receivables of £92k.
•Increase in Other Receivables £523k (VAT increase £505k)
•Decrease in prepayments of £103k.
•Increase in cash of £1,165k. Capital Loan received £2,771k, payment of related invoices delayed until December.

Current Liabilities

•Increase in NHS payables of £68k.
•Increase in Trade Creditors of £1.3m.
•Decrease in Trade Payables Fixed Assets £0.5m.
•Decrease in Tax and NI Owed of £0.1m.
•Increase in Short Term Revenue Loan of £1.3m.
•Decrease in accruals of £0.8m.
•Decrease in receipts in advance of £0.2m
•Decrease in PDC Dividends/Interest due of £0.3m.

Non Current Liabilities

•Increase in Capital loan of £2,771k
•Decrease in Salix Loan of £20k

Financing

•Increased deficit in month of £0.8m (includes £0.1m impairment)
•Decrease in Revaluation Reserve of £0.3m

6. Capital Expenditure

Capital Scheme	Plan 2016/17 £000's	M7 Plan £000's	M7 Spend £000's	Under (-) / Over £000's	Plan Achieved %	Actual Committed £000's	Plan Achieved %
Replacement Imaging Equipment (Loan - Tranche 1)	0	0	-8	-8	0%	-7	0%
Replacement Imaging Equipment (Loan - Tranche 2)	4,396	2,296	2,296	0	52%	2,794	64%
Additional Imaging Equipment (Loan)	900	684	669	-15	74%	704	78%
Replacement NPfIT Systems	1,555	684	702	18	45%	1,656	106%
Stock / Inventory System (Loan)	582	145	146	1	25%	352	61%
A&E / Orthopaedics	500	410	411	1	82%	522	104%
Contingency	0	0	0	0	0%	0	0%
Medical Equipment Sub Commiittee	938	227	216	-12	23%	363	39%
Estates Sub Committee	3,319	1,719	1,619	-100	49%	2,744	83%
IT Sub Committee	3,101	1,456	1,146	-310	37%	2,046	66%
60 Bedded Ward	0	0	0	0	0%	0	0%
Other	285	0	0	0	0%	84	29%
Total - Capital Plan	**15,576**	**7,621**	**7,196**	**-425**	**46%**	**11,258**	**72%**
Less Charitable Fund Donations	-450	-78	-78	0	6%	-154	34%
Less NBV of Disposals	-375	-375	-375	0	100%	-94	25%
Total - CRL	**14,751**	**7,168**	**6,743**	**-425**	**46%**	**11,010**	**75%**

Funding Resources	
Internally Generated Depreciation	9,704
Finance Lease - 60 Bedded Ward	0
Capital Loans - Imaging Equipment Tranche 1	0
Capital Loans - Replacement Imaging Tranche 2	4,396
Capital Loans - Additional Imaging Equipment	900
Capital Loans - Stock / Inventory System	600
Capital Loan - Repayment	-694
Other Loans - Repayment	-155
Total - Available CRL Resource	**14,751**
Uncommitted Plan	**0**

Key Issues

- The second linear accelerator has now been delivered and is operational.
- The third linear accelerator has been delivered and planned to be operational in December.
- As a result of the reduced level of capital loans availability nationally and funding the PAS business case internally the Trust is now planning to lease £1m of medical equipment replacements annually within the MESC plan from 2016/17.
- The A&E scheme continues with completion of the fit stop area in August and waiting area / ambulance area in December.
- The initial full year depreciation forecast is currently £9,704k (M6 £9,929k)
- No finance lease costs will be committed in the current financial year in relation to the 60 bedded Ward facility although pre-lease costs are likely to be incurred by the preferred bidder. The project team are currently developing the OBC / FBC for approval by Trust Board and submission to NHSI. The main costs of the scheme are expected to slip into 2017/18.
- The sale of the Harborough Lodge property was completed in April 16.
- A plan has been agreed with Radiology to replace CT and MRI scanners, three x-ray rooms and undertake installation of additional CT scanner in an existing room and a MRI scanner in a new build. Further work is ongoing to determine timescales and expected completion dates to inform the draw down of the agreed capital loan funding . The CT scanner went operational in September. The MRI scanners won't complete in year, with slippage of £1.1m in relation to replacement and £1.3m in relation to new build. This has been reported to NHSI and they have confirmed that the slippage should be manageable.
- The Inventory Management Project team have undertaken site visits and have chosen a preferred supplier, Genesis.

7. Receivables, Payables and BPPC Compliance

Current	Total at October £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	1,218	419	194	102	503
Receivables NHS	12,129	10,503	1,043	220	363
Total Receivables	**13,347**	**10,921**	**1,238**	**322**	**866**
Payables Non NHS	(9,838)	(9,832)		(4)	(2)
Payables NHS	(3,058)	(3,054)	(4)		
Total Payables	**(12,896)**	**(12,886)**	**(4)**	**(4)**	**(2)**

Prior Month	Total at September £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	1,081	348	199	88	445
Receivables NHS	10,812	9,717	371	8	716
Total Receivables	**11,893**	**10,066**	**570**	**97**	**1,160**
Payables Non NHS	(9,033)	(8,913)	(7)	(111)	(2)
Payables NHS	(2,990)	(2,990)			
Total Payables	**(12,023)**	**(11,903)**	**(7)**	**(111)**	**(2)**

Receivables and Payables

- The majority of SLA commissioner monthly invoices were paid on time. Payment from West Leicester CCG was received on 1st Nov. Leicester City CCG is still in a credit balance position due to under performance relating to 2015/16.
- £917k of Over/underperformance Invoices relating to Q1 remain outstanding. These are included in '31 to 60 days' NHS Receivables.
- Continued focus on reducing age profile of non current debt.
- Non-NHS over 90 day debt includes Overseas visitor accounts of £314k, of which £49k are paying in instalments and a high proportion of the balance passed to debt collection agency to recover. Other significant balances include BMI Three Shires £55k and Alliance Medical £38k .
- NHS over 90 day debt predominantly relates to NCA's £382k (£315k), and Kettering General £270k. 61-90 day debt includes a further £90k due from KGH and £82k owed by Oxford University Hospitals FT.
- With the exception of £10k, all registered creditors are current (due within 30 days).

	April	June	Sept	Oct	Cum 2016/17
NHS Creditors					
No.of Bills Paid Within Target	170	196	171	162	1,230
No.of Bills Paid Within Period	179	197	193	162	1,267
Percentage Paid Within Target	**94.97%**	**99.49%**	**88.60%**	**100.00%**	**97.08%**
Value of Bills Paid Within Target (£000's)	1,405	1,761	1,726	1,780	12,526
Value of Bills Paid Within Period (£000's)	1,451	1,762	1,738	1,780	12,588
Percentage Paid Within Target	**96.79%**	**99.98%**	**99.31%**	**100.00%**	**99.51%**
Non NHS Creditors					
No.of Bills Paid Within Target	6,235	8,782	8,226	7,405	53,761
No.of Bills Paid Within Period	6,318	8,883	8,277	7,423	54,220
Percentage Paid Within Target	**98.69%**	**98.86%**	**99.38%**	**99.76%**	**99.15%**
Value of Bills Paid Within Target (£000's)	8,167	9,350	8,988	8,848	59,380
Value of Bills Paid Within Period (£000's)	8,211	9,405	9,005	8,869	59,789
Percentage Paid Within Target	**99.47%**	**99.42%**	**99.81%**	**99.76%**	**99.32%**
Total					
No.of Bills Paid Within Target	6,405	8,978	8,397	7,567	54,991
No.of Bills Paid Within Period	6,497	9,080	8,470	7,585	55,487
Percentage Paid Within Target	**98.58%**	**98.88%**	**99.14%**	**99.76%**	**99.11%**
Value of Bills Paid Within Target (£000's)	9,571	11,112	10,714	10,629	71,906
Value of Bills Paid Within Period (£000's)	9,662	11,167	10,744	10,649	72,377
Percentage Paid Within Target	**99.07%**	**99.51%**	**99.73%**	**99.80%**	**99.35%**

Better Payment Practice Code

- The BPPC performance has been achieved for all targets in October, and cumulative position for year to date. £21k (18 invoices) were paid late including Pharmacy £6k (7 invoices), Estates £3k (2 invoices) and non nurse bank £12k (9 invoices).

8. Cashflow

MONTHLY CASHFLOW	Annual	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
		ACTUAL							FORECAST				
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
RECEIPTS													
SLA Base Payments	246,943	19,343	21,547	20,808	19,889	21,204	20,616	20,582	20,575	20,587	20,587	20,618	20,587
STF Funding	9,619					2,425			1,698	647		2,425	2,425
SLA Performance/ Other CCG Investment	898							-15	0	911		2	
Health Education Payments (SIFT etc)	9,802	798	785	858	821	828	845	821	760	821	821	821	821
Other NHS Income	14,909	1,419	652	2,850	914	1,679	1,074	962	1,072	1,072	1,072	1,072	1,072
PP / Other (Specific > £250k)	3,515	473		764	567	273	476		962				
PP / Other	11,135	1,046	691	711	817	783	907	684	695	1,200	1,200	1,200	1,200
Capital Loan	5,896							2,771	232			859	2,034
Revenue Support Loan	15,129												15,129
Revolving Working Capital Facility - deficit funding	0	2,038	1,554	2,120	1,724	-1,496	1,259	510	963	1,867	743	2,188	-13,469
Revolving Working Capital Facility - STF funding	9,700					4,042	808	808	809	808	808	808	808
Interest Receivable	32	3	4	5	2	3	2	2	2	2	2	2	2
Sale of Assets	585	585											
TOTAL RECEIPTS	**328,163**	**25,706**	**25,232**	**28,117**	**24,734**	**29,741**	**25,987**	**27,126**	**27,768**	**27,915**	**25,234**	**29,995**	**30,610**
PAYMENTS													
Salaries and wages	182,715	15,154	15,035	15,518	15,288	15,180	15,086	15,199	15,256	15,250	15,200	15,200	15,350
Trade Creditors	91,405	6,686	7,882	8,802	7,280	7,288	8,533	7,319	9,102	4,702	6,830	8,728	8,252
NHS Creditors	20,255	1,565	2,063	1,762	1,763	2,030	1,647	1,778	1,822	1,822	1,822	1,000	1,180
Capital Expenditure	19,068	1,864	300	620	404	1,215	705	1,575	747	6,716	1,381	2,454	1,087
PDC Dividend	3,472						1,856						1,616
Repayment of RWC Facility - STF funding	9,700						2,425			2,425		2,425	2,425
Repayment of Loans (Principal & Interest)	1,464					154	460					189	661
Repayment of Salix loan	155	12					85	21					38
TOTAL PAYMENTS	**328,235**	**25,280**	**25,281**	**26,702**	**24,735**	**25,867**	**30,797**	**25,892**	**26,928**	**30,915**	**25,233**	**29,996**	**30,609**
Actual month balance	-72	425	-49	1,415	-1	3,874	-4,810	1,234	840	-3,001	0	0	1
Cash in transit & Cash in hand adjustment	-29	-24	14	15	12	-20	48	-69	-6	1			
Balance brought forward	1,602	1,602	2,003	1,968	3,398	3,409	7,263	2,501	3,666	4,500	1,500	1,500	1,500
Balance carried forward	**1,500**	**2,003**	**1,968**	**3,398**	**3,409**	**7,263**	**2,501**	**3,666**	**4,500**	**1,500**	**1,500**	**1,500**	**1,500**

Key Issues

- Payment of outstanding Quarter 1 over/underperformance invoices is forecast in December as a worse case scenario.
- STF funding for Quarter 2 is due to be received in 2 stages. Finance target element (£1.7m) expected 22nd Nov, Performance target element (£0.65m) expected 1st Dec. This is £81k less than the maximum amount available, due to 2 monthly Cancer Targets not being met. The respective borrowing will be repaid to the DH in Dec (£2.4m).
- The September VAT return was submitted on 31st October with cash being received early in November. It is anticipated that the October return will be submitted in advance of the month end to enable HMRC to process & action the respective payment in November.
- The Trust has drawn down a further £1.3m of Temporary Borrowing (3.5% Interim Revolving Working Capital Support Facility) in October. Further Temporary Borrowing (IRWCSF) of £1.8m has been approved for drawn down in November.
- Capital Expenditure in October was £1.6m, £0.3m more than forecast. Capital Loan was drawn down in October (£2.8m) in line with anticipated scheme expenditure. Related invoices are now not expected to be paid until December. A further £0.2m is approved for draw down in November.
- A further increase in cash held at the end of the month is forecast for November. This takes into consideration the timing difference between the receipt of Capital Loan & STF Funding & the respective invoice payments & borrowing repayments, which are anticipated to be made in December.

9. Risks to the Financial Position

Risk	Financial Drivers	Estimated Value FY16-17 £k	Mitigations	Impact on plan £K
Revenue Risks				
NHSI - Improved Control Total	NHSI has requested the Trust delivers an improved control total of £15.1m deficit (compared to the original planned £27.4m deficit).	2,600	Suspension of access fines. Reduction of to planned level of revenue reserves. Delivery of revised control total gives access to £9.7m of sustainability funding (avoids interest bearing loans).	Currently £0.02m fav. to revised plan (Oct).
Conditions to STF funding	The Trust is required to deliver both financial and performance trajectories to access the £9.7m STF funding. (Conditions assessed on a forecast basis). Trust currently failing to meet Cancer (Q2) and A&E (Q3) trajectories.	9,700	Routine forecasting and controls to be put in place to measure delivery against revised financial and performance trajectories.	£6.8m Financial £2.9m Performance
Non-elective Demand	Requirement to source additional contractual beds / open additional bed capacity on site due to high levels of urgent care demand and DTOCs. Limited additional capacity available in LHE.	1,200	£0.7m included in plan for additional contractual beds. Business case approved by Board in July for additional 36 beds by October 2016 on basis of additional NEL XBD income.	Up to £0.5m dependent on incremental income offset.
Cancellation of Elective activity	RTT pressures leading to lost elective income and requirement to outsource to Private sector. Income loss averaging £0.5m per month in Q4 FY15-16. Winter plan may require closure of T&O beds in Q4. Limited capacity in Private sector may cause backlog to build by March 18.	6,000	£3m included in plan to cover costs of outsourcing primarily for T&O, Ophthalmology and Endoscopy.	Up to further £1.5m
New CQUINS	New national CQUINS may not be deliverable giving rise to loss of income. **100% CQUIN** delivery assumed in plan.	780	Impact assessment ongoing. Local variations submitted to NHSE refuted. Q1 delivery agreed with Commissioners.	390
Contractual Fines & Penalties	The Trust incurred fines (£1m) plus MRET (£3.8m) and Readmissions (£2.8m) penalties in FY15-16. Indications are that a similar level of penalties could be incurred in FY16-17. NENE CCG reporting financial pressures in Q2 (giving rise to potential for increased data challenges).	7,600	The Trust has signed a contract in place with NENE CCG for FY16-17 which includes clauses for Fines and Penalties to be reinvested by the CCG through the agreement of Service Development Improvement Plans (SDIP). £1m provision in income plan for fines and penalties should be lifted under STF double jeopardy rule. Consideration of year end deal with NENE CCG to reduce income volatility risk.	Dependent on SDIP process and delivery of STF conditions
Junior doctors new contract	Cost of new compliant rotas, pay protection, e-rostering and appointment of Guardian.	100	£800k pay reserve in plan but subject to ongoing national negotiations, review of new rotas and pay protection. Introduction of new contract will be staggered over 2 years. First cohort expected Feb 17.	Likely to be minimal impact in 16-17 due to phased implementation.
Vacancy Control	FY16-17 Plan includes requirement for Divisions to manage a (Trust wide) £2m vacancy factor based on known vacancies in March 16.	2,000	Level of current substantive vacancies sufficient to meet vacancy factor but temporary staff costs pushing pay bill significantly over budget at M7.	-
Pay Expenditure	Trust has incurred a £4.7m overspend at M7 and is currently exceeding the revised Agency Cap target. August rotation has resulted in additional shortfall in Junior Doctor rotas, notably in Anaesthetics. Trust is identified as an outlier in terms of increased Pay expenditure by NHSI.	8,057	CIP workstream focused on reducing Medical Staff Agency usage and costs. Specific action being taken by DoN to reduce use of HCA Agency. Non-Pay underspend of £1.2m offsetting impact. Consultants covering out of hours in Anaesthetics.	7,057
CIP delivery	Delivery of CIP target will be challenging in year. £2.6m of CIPs rated as high risk. High level of non-recurrent CIP recorded. Latest risk adjusted forecast gives rise to £2.1m shortfall to plan.	2,129	Ongoing identification of new schemes and mitigating actions. Introduction of strict expenditure controls and delay planned developments.	2,129
NCC Proposed cuts	NCC have proposed a range of cuts to Adult Social Care Services which will adversely impact on the timely discharge of patients if fully implemented.	Unknown	Limited mitigation pending consultation on proposed implementation plans. Likely to see increase in DTOCs giving rise to further beds pressures and Elective income loss. £130 per day fines being charged to NCC under provisions of CCA 2003 (wef 1/8).	Unknown
Potential for abortive Fees (60 Bedded Case)	Trust has appointed Procure 21 partner to progress plans for new 60 bedded facility ahead of NHSI approval. The supplier will incur planning and feasibility costs which will need to be financed by the Trust if the FBC is not approved by NHSI.	440	Instruction issued to Procure 21 partner to limit fees to £440k pre FBC approval.	440
Non-Revenue Risks				
Capital Resources	Capital resources constrained due to reduced levels of deprecation and national loan restrictions.	2,000	Capital plan reduced and provision for up to £1m of operating leases in I&E plan. Option to finance 60 bedded ward facility included in plan as finance lease.	60 beds subject to OBC approval and CRL cover
Cashflow	Revised deficit of £15.18m requires access to IRWCSF and assumes £9.7m of STF Funding.	£24.8m gross deficit	Management of creditors. Improving I&E position ahead of plan. Delay capital expenditure. Advance payment of CCG mandate each month agreed with NENE CCG. DH approval to access to IRWCSF to cover planned deficit only. Receipt of £9.7m STF funding (subject to conditions). IRWCSF of £7.7m plus STF of £4.9m expected up to October (STF confirmation pending Q2 & October delivery).	Provision for interest payments included in plan.

10. Conclusions and Recommendations

Conclusion:

- The Trust has continued to perform on plan overall for the period ended October. This is despite some downturn in delivery of performance trajectories and expected loss of associated STF funding of £263k for the period. This loss of STF funding could be recovered if the Trust can recover performance and meet the required trajectories at the end of Q3.
- Elective income has fallen behind plan in October due to increased NEL demand and capacity pressures with increased risk forecast for the winter period. Surgical Division planning to outsource c.30 elective patients per month from December giving rise to a risk of an increasing RTT backlog if elective capacity is lost over the winter period as currently expected.
- The high level forecast exercise undertaken in July has been updated and is provided under separate cover. Despite the position reported at October, there remains a clear requirement to continue to develop an action plan to address current areas of risk and overspend in order that the Trust can continue to assume access the £9.7m STF funding and deliver the £15.1m deficit control total by the financial year end.
- The rate of pay expenditure has fallen marginally month on month and is now £4.7m (4.2%) adverse to plan for the year to date. In overall terms this variance is being offset by income over performance and the continuing level of non-pay underspend, neither of which may be guaranteed in the second half of the financial year.
- Agency costs are £2.03m (26%) in excess of the required Agency cap trajectory incurring a score of 3 against the new financial and Use of Resources metrics. NHSI continue to place increasing scrutiny on agency controls and expenditure and now require CEO sign off and Board assurance over Agency controls.
- CIP delivery is recorded as exceeding plan again in M7 although the position to date continues to be reliant on a significant element of non-recurrent delivery and with forward risk in terms of high risk schemes yet to be delivered.
- There remains a range of risks to delivery of the £15.1m control total which need to be addressed. NHSI have requested a formal financial recovery plan to underpin delivery of the control total by the year end.

Recommendations & actions

- Focus is maintained on managing the risks to the financial position and reducing the current level of Pay overspend through a formal Financial Recovery Plan agreed by the Executive team.
- Divisions that are not meeting their financial targets continue to be subject to the approved performance management framework and develop action plans to improve financial performance for the remainder of the financial year.
- An assessment of the financial impact of the emerging Winter plan is prepared and agreed particularly in relation to the impact on the elective bed base and outsourcing of elective work to the private sector.
- Urgent work is undertaken to establish clear reasons why the Trust is exceeding the agency cap and how actions developed by clinical Divisions will mitigate this going forward.
- Consideration is given to the recovery of STF performance trajectories for Q3 and Q4.
- The Board reviews the new Financial metrics adopted under the Single Oversight Framework and the implications of the current score.

Appendix 1: Finance & Use of Resources Metrics

Criteria	M7	Score	Weight	Weighted Score
Capital Service capacity (times)	-0.03	4	20.00%	0.80
Liquidity (days)	-22	4	20.00%	0.80
I&E Margin	-0.05	4	20.00%	0.80
Distance From Plan	0.00	1	20.00%	0.20
Agency spend (distance from cap)	26%	3	20.00%	0.60
Overall Score				3.2

Notes

- NHSI introduced the new Single Oversight Framework in September which incudes a new set of Finance metrics applicable to all NHS and Foundation Trusts.
- Officially these metrics come into force from 1/10/16.
- The metrics are similar to those previously used by Monitor to assess Foundation Trusts but now also include a new measure for performance against the Agency cap.
- In a change from the previous metrics the scoring system has been reversed. Therefore a score of **1 is good and 4 poor.**
- For October the Trust has scored 3 primarily due to liquidity, negative EBITDA and exceeding the Agency cap by 26%.

Extract from NHSI Guidance (Sep 16)

Table 1: Finance and use of resources metrics

Area	Weighting	Metric	Definition	Score			
				1	2	3	4[1]
Financial sustainability	0.2	Capital service capacity	Degree to which the provider's generated income covers its financial obligations	>2.5x	1.75-2.5x	1.25-1.75x	< 1.25x
	0.2	Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	>0	(7)-0	(14)-(7)	<(14)
Financial efficiency	0.2	I&E margin	I&E surplus or deficit / total revenue	>1%	1-0%	0-(1)%	≤(1)%
Financial controls	0.2	Distance from financial plan	Year-to-date actual I&E surplus/deficit in comparison to Year-to-date plan I&E surplus/ deficit	≥0%	(1)-0%	(2)-(1)%	≤(2)%
	0.2	Agency spend	Distance from provider's cap	≤0%	0%-25%	25-50%	>50%

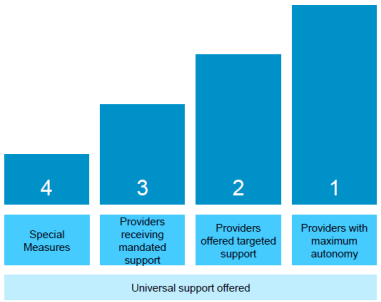
Note: brackets indicate negative numbers

[1] Scoring a '4' on any metric will mean that the overall rating is at least a 3 (ie either a 3 or a 4), triggering a concern.

Single Oversight Framework

NHS Improvement

- On 1 October 2016 NHS Improvement's Single Oversight Framework comes in to force.
- It will provide one framework for overseeing providers, irrespective of their legal form, and is based on the principle of earned autonomy.
- NHS Improvement teams will work with providers to determine the appropriate, tailored, support package for each support need identified.
- Trusts will be placed into one segment overall, based on their overall support needs across the five themes.
- Agency spend will be measured under the 'Finance and use of resources' theme



Report To	**Public Trust Board**
Date of Meeting	**24 November 2016**

Title of the Report	**Workforce Performance Report**
Agenda item	**12**
Presenter of Report	Janine Brennan, Director of Workforce & Transformation
Author(s) of Report	Adam Cragg, Head of Resourcing & Employment Services
Purpose	This report provides an overview of key workforce issues

Executive summary

- The Key Performance Indicators show an increase in contracted workforce capacity and an increase in sickness absence.
- Increase in Mandatory Training and Role Specific Essential Training and a decrease in compliance for Appraisals.
- Francis Crick – Phase 2
- Exception reports for Staff Turnover, Staff Role Specific Training, Staff Appraisals, Vacancy Rates and Sickness Absence.

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 – 2.1, 2.2 and 2.3
Equality Analysis	Is there potential for, or evidence that, the proposed

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	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.

Northampton General Hospital NHS
NHS Trust

Trust Board

Thursday 24th November 2016

Workforce Performance Report

1. Introduction

This report identifies the key themes emerging from October 2016 performance and identifies trends against Trust targets. It also sets out current key workforce updates.

2. Workforce Report

2.1 Capacity

Substantive Workforce Capacity increase by 10.29 FTE in October2016 to 4303.29 FTE. The Trust's substantive workforce is at 90.22% of the Budgeted Workforce Establishment of 4770 FTE.

Annual Trust turnover decreased by 0.07% to 9.86% in October which is above the Trust target of 8%. Turnover within Nursing & Midwifery decreased by 0.38% to 7.92%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust. Turnover also decreased in Add Prof Sci & Technicians, Additional Clinical Services and Medical & Dental. Turnover increased in Allied Health Professionals, Admin and Clerical, Healthcare Scientists and Estates & Ancillary.

Medical Division: turnover decreased by 0.99% to 8.32%

Surgical Division: turnover decreased by 0.07% to 8.51%

Women, Children & Oncology Division: turnover increased by 0.12% to 10%

Clinical Support Services Division: turnover increased by 0.75% to 9.92%

Support Services: turnover increased by 0.22% to 13.35%

The vacancy rates for Allied Health Professionals, Additional Clinical Services, Admin & Clerical and Medical & Dental staff groups all increased in October 2016. Registered Nursing & Midwifery vacancy rate decreased from 11.54% to 10.57%. Healthcare Scientists, Additional Professional Scientific & Technical and Estates & Ancillary staff groups also had a decrease in vacancy rate.

In month sickness absence increased by 0.17% to 3.93% which is above the Trust target of 3.8%. Clinical Support Services and Support Services Divisions were the only ones below the trust target. In total 11 directorate level organisations were below the trust target rate.

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2.2 Capability

Appraisals, Mandatory Training and Role Specific Essential Training

The current rate of Appraisals recorded for October 2016 is 81.86%; this is a decrease of 1.67% from last month's figure of 83.53%.

Mandatory Training compliance increased in October from 85.04% to 85.31% which maintains the position above the Trust target of 85%.

Role Specific Essential Training compliance increased in October to 76.59% from last month's figure of 75.15%.

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

Policies
During the month of October 2016, there were amendments to the following policies:

- Administration of Seasonal Influenza Vaccination – Staff
- Workforce, Equality & Diversity Strategy 2016-2019
- Maternity, Adoption, Paternity & Shared Parental Leave Procedure
- Latex and Dermatitis – Management in Healthcare Workers Policy

Francis Crick – phase 2

The design of the content of phase 2 of the Francis Crick programme has been completed and dates have been identified with the facilitators of each of the sessions.

The programme content mirrors that of the first phase with some minor amendments to reflect the requirements of the audience.

The programme content is reinforced for the learner by the addition of action learning sets, which take place in between taught session providing delegates with the opportunity to reflect on their learning within the context of what they are currently experiencing.

In addition to the action learning sets, which are new for phase two, we are currently working with the Institute of Leadership and Management (ILM) to accredit the programme to a recognised qualification. Delegates will be offered the opportunity to acquire an award and to become a member of the ILM with access to learning resources and literature that will provide them with a wider understanding of what it means to lead and how to develop the necessary skills to do so successfully.

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

Recommendations/Resolutions Required
The Committee is asked to note the report.

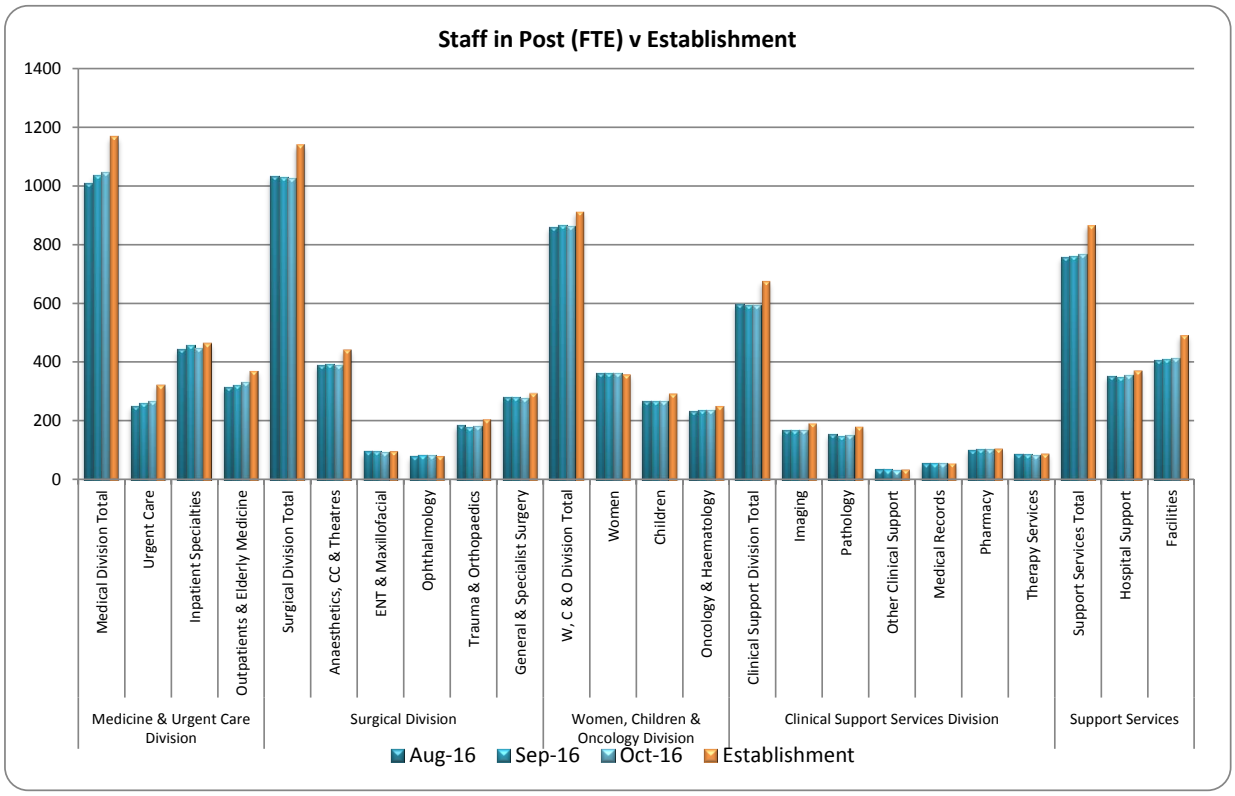
Next Steps
Key workforce performance indicators are subject to regular monitoring and appropriate action is taken as required.

Workforce Committee: Capacity, Capability and Culture Report - October 2016

CAPACITY
Staff in Post

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

Staff in Post (FTE)		Aug-16		Sep-16		Oct-16	Establishment	
Medicine & Urgent Care Division	Medical Division Total	1010.53	↑	1038.38	↑	1048.76	1168.70	89.74%
	Urgent Care	249.57	↑	261.19	↑	267.78	325.69	82.22%
	Inpatient Specialties	445.06	↑	456.18	↓	447.60	467.19	95.81%
	Outpatients & Elderly Medicine	314.90	↑	320.01	↑	332.38	372.82	89.15%
Surgical Division	Surgical Division Total	1033.22	↓	1032.25	↓	1025.19	1141.79	89.79%
	Anaesthetics, CC & Theatres	389.67	↑	393.97	↓	389.07	444.41	87.55%
	ENT & Maxillofacial	95.00	↑	95.96	↓	94.36	100.59	93.81%
	Ophthalmology	79.27	↑	81.43	↓	81.37	84.21	96.63%
	Trauma & Orthopaedics	184.53	↓	176.92	↑	180.29	208.96	86.28%
	General & Specialist Surgery	279.95	↓	279.17	↓	275.30	297.82	92.44%
Women, Children & Oncology Division	W, C & O Division Total	859.66	↑	867.28	↓	864.17	913.40	94.61%
	Women	360.38	↑	363.55	↓	361.96	360.91	100.29%
	Children	267.20	↑	267.82	↓	264.89	295.89	89.52%
	Oncology & Haematology	231.22	↑	235.05	↑	236.38	253.75	93.15%
Clinical Support Services Division	Clinical Support Division Total	597.67	↓	593.17	↑	593.83	677.44	87.66%
	Imaging	167.40	↓	167.10	↓	166.92	195.77	85.26%
	Pathology	153.25	↓	148.72	↑	150.72	184.35	81.76%
	Other Clinical Support	34.06	↑	34.06	↓	32.72	37.93	86.26%
	Medical Records	54.76	↑	54.76	↑	55.76	59.33	93.98%
	Pharmacy	100.91	↑	104.12	↑	104.15	108.72	95.80%
	Therapy Services	87.28	↓	84.41	↓	83.57	91.34	91.49%
Support Services	Support Services Total	758.48	↑	760.67	↑	768.34	868.12	88.51%
	Hospital Support	351.58	↓	349.75	↑	354.15	374.41	94.59%
	Facilities	406.90	↑	410.12	↑	414.19	493.71	83.89%
Trust Total		4259.56	↑	4293.00	↑	4303.29	4770.00	90.22%



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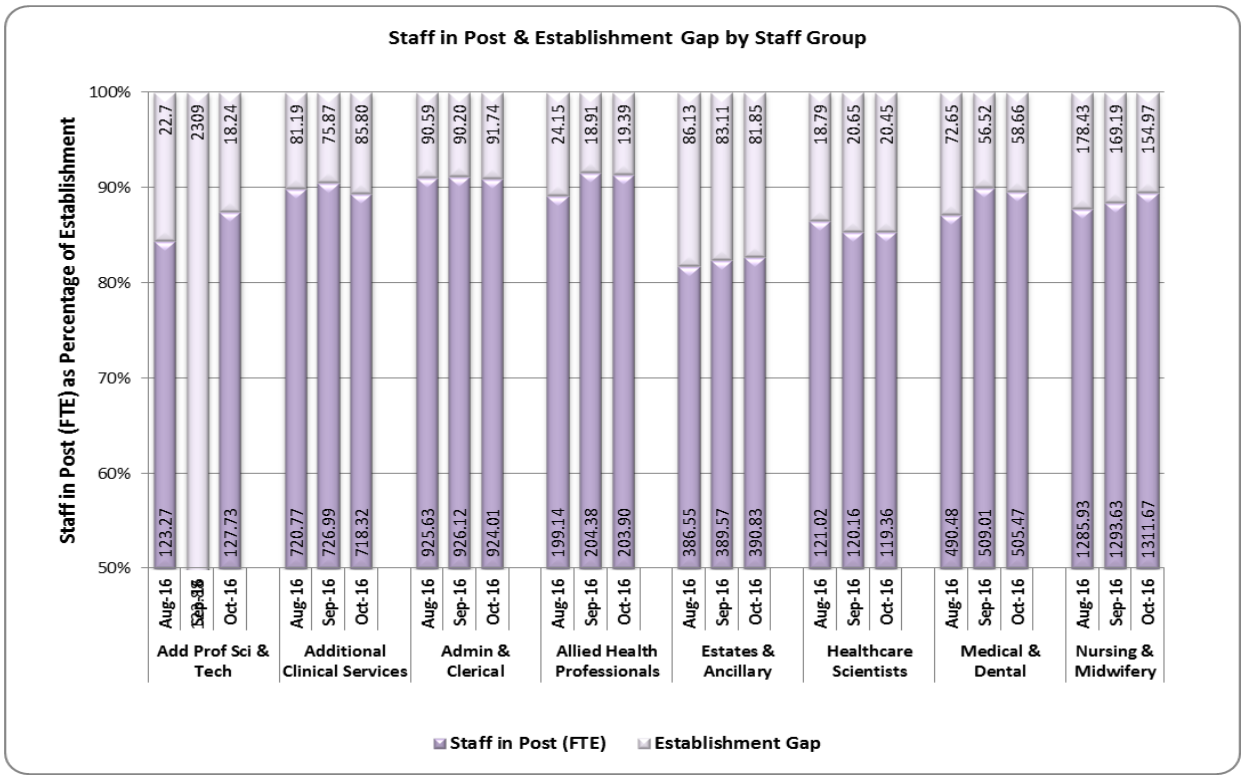
Workforce Committee: Capacity, Capability and Culture Report - October 2016

CAPACITY
Staff Group (FTE v Est)

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

Staff Group Vacancy Rate (Contracted FTE v Establishment)

Staff Group	Aug-16	Sep-16	Sep-16
Add Prof Sci & Tech	16.23%	15.82%	12.49%
Additional Clinical Services	9.89%	9.47%	10.67%
Admin & Clerical	8.91%	8.88%	9.03%
Allied Health Professionals	10.41%	8.47%	8.68%
Estates & Ancillary	18.22%	17.58%	17.32%
Healthcare Scientists	12.72%	14.77%	14.63%
Medical & Dental	11.87%	10.02%	10.39%
Nursing & Midwifery	12.31%	11.54%	10.57%



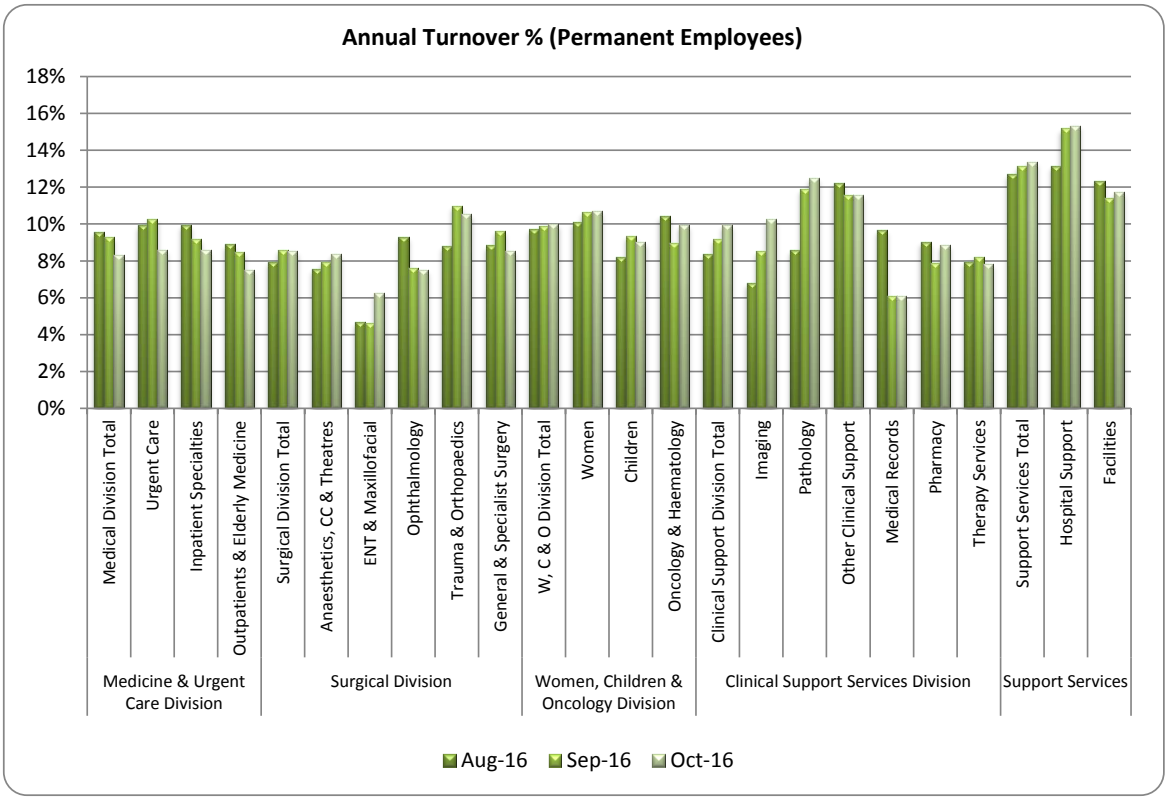
Workforce Committee: Capacity, Capability and Culture Report - October 2016

CAPACITY
Annual Turnover

Figures refer to the year ending in the month stated

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

Annual Turnover (Permanent Staff)		Aug-16		Sep-16		Oct-16
Medicine & Urgent Care Division	Medical Division Total	9.58%	↘	9.31%	↘	8.32%
	Urgent Care	9.93%	↗	10.25%	↘	8.57%
	Inpatient Specialties	9.96%	↘	9.16%	↘	8.58%
	Outpatients & Elderly Medicine	8.88%	↘	8.46%	↘	7.49%
Surgical Division	Surgical Division Total	7.96%	↗	8.58%	↘	8.51%
	Anaesthetics, CC & Theatres	7.55%	↗	7.95%	↗	8.38%
	ENT & Maxillofacial	4.65%	↘	4.60%	↗	6.27%
	Ophthalmology	9.28%	↘	7.61%	↘	7.52%
	Trauma & Orthopaedics	8.79%	↗	10.98%	↘	10.56%
	General & Specialist Surgery	8.82%	↗	9.62%	↘	8.51%
Women, Children & Oncology Division	W, C & O Division Total	9.71%	↗	9.88%	↗	10.00%
	Women	10.10%	↗	10.62%	↗	10.69%
	Children	8.20%	↗	9.33%	↘	9.01%
	Oncology & Haematology	10.45%	↘	8.98%	↗	9.92%
Clinical Support Services Division	Clinical Support Division Total	8.37%	↗	9.17%	↗	9.92%
	Imaging	6.82%	↗	8.53%	↗	10.24%
	Pathology	8.56%	↗	11.89%	↗	12.50%
	Other Clinical Support	12.22%	↘	11.57%	↘	11.56%
	Medical Records	9.69%	↘	6.08%	↗	6.11%
	Pharmacy	9.03%	↘	7.88%	↗	8.84%
	Therapy Services	7.96%	↗	8.23%	↘	7.84%
Support Services	Support Services Total	12.71%	↗	13.13%	↗	13.35%
	Hospital Support	13.14%	↗	15.18%	↗	15.34%
	Facilities	12.34%	↘	11.40%	↗	11.75%
Trust Total		9.60%	↗	9.93%	↘	9.86%



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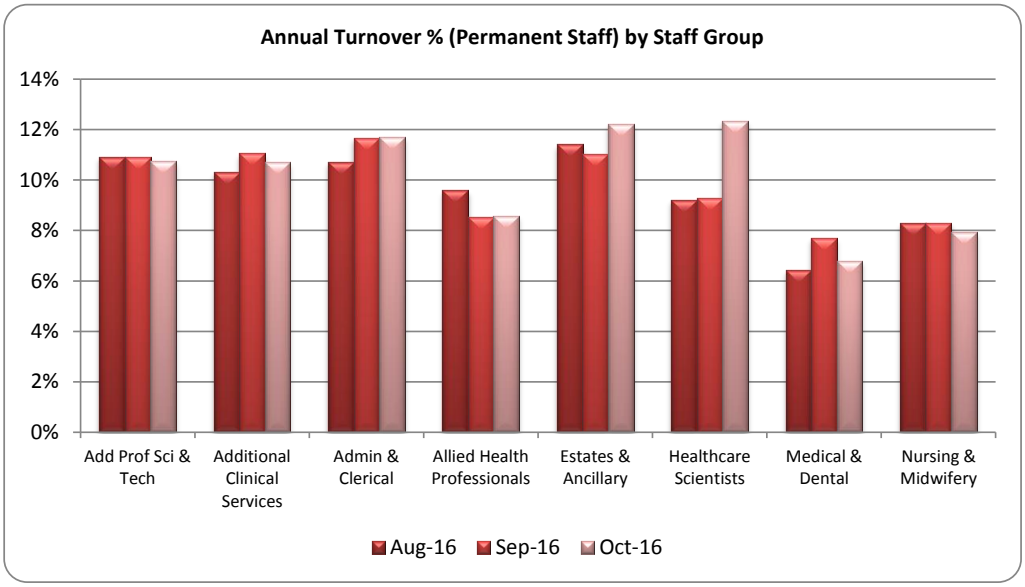
Workforce Committee: Capacity, Capability and Culture Report - October 2016

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	Aug-16		Sep-16		Oct-16
Add Prof Sci & Tech	10.90%	↗	10.91%	↘	10.74%
Additional Clinical Services	10.30%	↗	11.05%	↘	10.69%
Admin & Clerical	10.72%	↗	11.68%	↗	11.71%
Allied Health Professionals	9.58%	↘	8.53%	↗	8.58%
Estates & Ancillary	11.40%	↘	11.03%	↗	12.21%
Healthcare Scientists	9.22%	↗	9.29%	↗	12.35%
Medical & Dental	6.41%	↗	7.70%	↘	6.79%
Nursing & Midwifery	8.27%	↗	8.30%	↘	7.92%



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Women, Children & Oncology Division: turnover increased by 0.12% to 10%
Clinical Support Services Division: turnover increased by 0.75% to 9.92%
Support Services: turnover increased by 0.22% to 13.35%

Staff Vacancies: The vacancy rates for Allied Health Professionals , Additional Clinical Services, Admin & Clerical and Medical & Dental staff groups all increased in October 2016. Registered Nursing & Midwifery vacancy rate decreased from 11.54% to 10.57%. Healthcare Scientists , Additional Professional Scientific & Technical and Estates & Ancillary staff groups also had a decrease in vacancy rate.

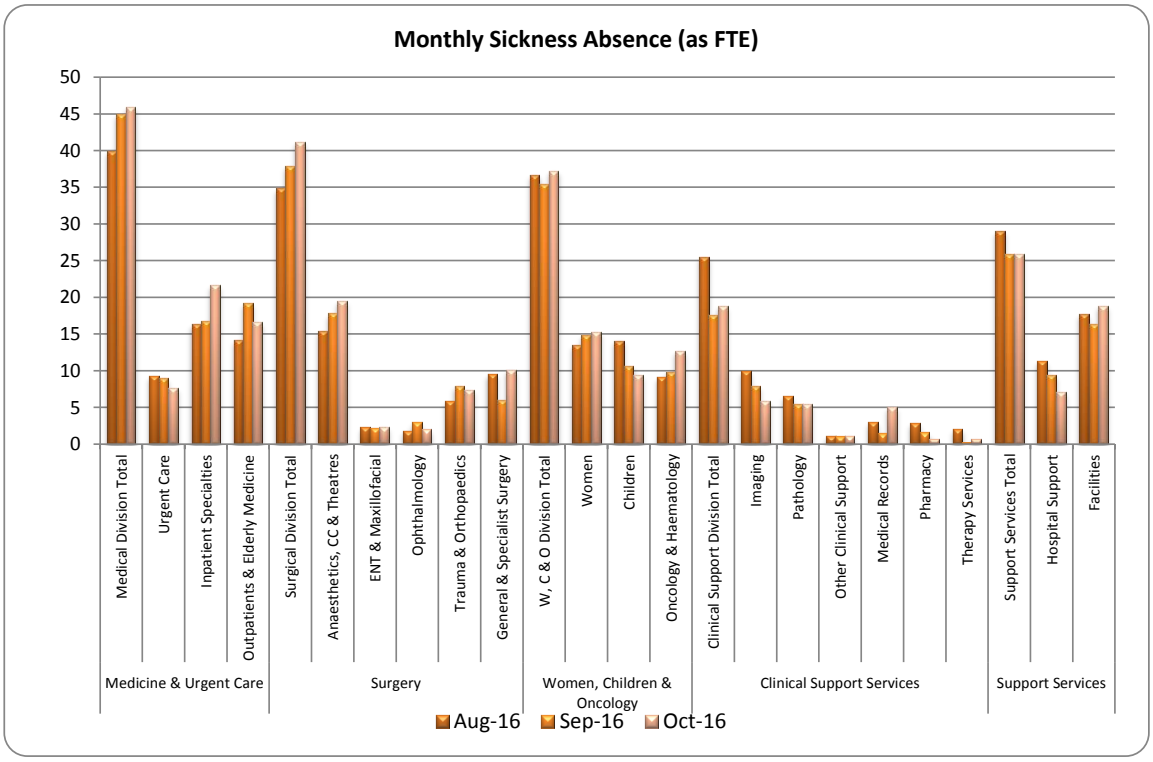
Sickness Absence: In month sickness absence increased by 0.17% to 3.93% which is above the Trust target of 3.8%. Clinical Support Services and Support Services Divisions were the only ones below the trust target. In total 11 directorate level organisations were below the trust target rate.

Workforce Committee: Capacity, Capability and Culture Report - October 2016

CAPACITY
In-Month Sickness

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

Monthly Sickness (as FTE)		Aug-16	Sep-16	Oct-16	Oct-16	Short Term	Long Term
Medicine & Urgent Care	Medical Division Total	39.92	44.99	45.94	4.38%	3.06%	1.32%
	Urgent Care	9.28	9.05	7.58	2.83%	1.78%	1.05%
	Inpatient Specialties	16.38	16.83	21.66	4.84%	3.55%	1.30%
	Outpatients & Elderly Medicine	14.20	19.24	16.65	5.01%	3.46%	1.56%
Surgery	Surgical Division Total	34.82	37.93	41.21	4.02%	2.36%	1.66%
	Anaesthetics, CC & Theatres	15.39	17.78	19.49	5.01%	2.62%	2.39%
	ENT & Maxillofacial	2.29	2.18	2.35	2.49%	2.49%	0.00%
	Ophthalmology	1.84	2.93	1.97	2.42%	2.42%	0.00%
	Trauma & Orthopaedics	5.87	7.95	7.36	4.08%	2.63%	1.46%
	General & Specialist Surgery	9.55	6.00	10.10	3.67%	1.79%	1.88%
Women, Children & Oncology	W, C & O Division Total	36.71	35.43	37.25	4.31%	2.74%	1.58%
	Women	13.44	14.88	15.27	4.22%	2.88%	1.34%
	Children	14.11	10.68	9.35	3.53%	2.08%	1.45%
	Oncology & Haematology	9.16	9.88	12.67	5.36%	3.26%	2.09%
Clinical Support Services	Clinical Support Division Total	25.52	17.58	18.77	3.16%	2.03%	1.13%
	Imaging	9.99	7.95	5.89	3.53%	2.54%	0.99%
	Pathology	6.48	5.46	5.38	3.57%	2.06%	151.00%
	Other Clinical Support	1.14	1.03	1.15	3.50%	0.49%	3.01%
	Medical Records	2.97	1.47	4.98	8.93%	5.64%	3.29%
	Pharmacy	2.86	1.54	0.71	0.68%	0.68%	0.00%
	Therapy Services	2.07	0.23	0.70	0.84%	0.84%	0.00%
Support Services	Support Services Total	28.97	25.82	25.89	3.37%	2.35%	1.02%
	Hospital Support	11.29	9.46	7.05	1.99%	1.43%	0.56%
	Facilities	17.70	16.36	18.85	4.55%	314.00%	1.41%
Trust Total	*As FTE*	166.12	161.80	169.12			
	As percentage	3.90%	3.76%		3.93%	2.56%	1.37%



Enclosure H

Workforce Committee: Capacity, Capability and Culture Report - October 2016

CAPABILITY
Training & Appraisal Rates

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

Mandatory Training Compliance Rate	Directorate	Aug-16	Sep-16		Oct-16	
Medicine & Urgent Care Division	Medical Division Total	80.12%	↑	80.18%	↑	81.20%
	Urgent Care	80.36%	↓	79.11%	↑	80.57%
	Inpatient Specialties	76.11%	↑	77.01%	↑	79.60%
	Outpatients & Elderly Medicine	85.36%	↓	85.28%	↓	83.70%
Surgical Division	Surgical Division Total	85.03%	↓	83.80%	↑	84.69%
	Anaesthetics, CC & Theatres	83.56%	↓	81.24%	↑	82.73%
	ENT & Maxillofacial	83.82%	↓	74.75%	↑	78.56%
	Ophthalmology	83.78%	↑	86.80%	↑	86.98%
	Trauma & Orthopaedics	84.80%	↑	86.75%	↓	86.26%
	General & Specialist Surgery	88.00%	↓	87.70%	↑	87.79%
Women, Children & Oncology Division	W, C & O Division Total	88.31%	↓	87.26%	↑	87.89%
	Women	85.58%	↓	84.73%	↑	85.52%
	Children	90.75%	↓	89.30%	↑	90.16%
	Oncology & Haematology	89.87%	↓	89.01%	↑	89.08%
Clinical Support Services Division	Clinical Support Division Total	90.07%	↓	89.48%	↓	88.06%
	Imaging	86.54%	↓	84.99%	↓	83.98%
	Pathology	89.48%	↓	88.96%	↓	88.36%
	Other Clinical Support	88.63%	↑	88.63%	↓	88.36%
	Medical Records	93.33%	↑	94.44%	↓	92.02%
	Pharmacy	95.22%	↓	94.44%	↓	92.27%
	Therapy Services	90.25%	↓	89.82%	↓	87.35%
Support Services	Support Services Total	88.01%	↓	87.06%	↓	86.41%
	Hospital Support	88.48%	↓	87.34%	↑	88.14%
	Facilities	87.66%	↓	86.84%	↓	85.08%
Trust Total		**85.83%**	↓	**85.04%**	↑	**85.31%**

Workforce Committee: Capacity, Capability and Culture Report - October 2016

CAPABILITY
Training & Appraisal Rates

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

Role Specific Training Compliance Rate	Directorate	Aug-16	Sep-16	Oct-16
Medicine & Urgent Care Division	Medical Division Total	72.62%	72.23%	74.93%
	Urgent Care	74.40%	71.86%	73.00%
	Inpatient Specialties	67.37%	68.43%	73.61%
	Outpatients & Elderly Medicine	78.35%	78.15%	78.82%
Surgical Division	Surgical Division Total	74.97%	74.74%	75.84%
	Anaesthetics, CC & Theatres	72.50%	72.11%	73.18%
	ENT & Maxillofacial	66.55%	60.91%	63.76%
	Ophthalmology	73.22%	72.15%	76.68%
	Trauma & Orthopaedics	78.71%	80.48%	78.24%
	General & Specialist Surgery	78.70%	79.02%	81.15%
Women, Children & Oncology Division	W, C & O Division Total	80.76%	79.80%	80.67%
	Women	76.13%	75.72%	76.17%
	Children	86.31%	84.88%	86.14%
	Oncology & Haematology	84.72%	82.77%	84.46%
Clinical Support Services Division	Clinical Support Division Total	83.19%	77.09%	76.74%
	Imaging	76.90%	73.70%	72.64%
	Pathology	80.62%	59.09%	57.78%
	Other Clinical Support	79.02%	76.19%	74.65%
	Medical Records	100.00%	100.00%	98.59%
	Pharmacy	90.75%	88.11%	88.07%
	Therapy Services	87.40%	88.08%	90.05%
Support Services	Support Services Total	71.83%	67.62%	69.80%
	Hospital Support	72.57%	66.40%	71.18%
	Facilities	70.95%	69.27%	68.09%
Trust Total		**76.44%**	**75.15%**	**76.59%**

Capability

Appraisals
The current rate of Appraisals recorded for October 2016 is 81.86%; this is a decrease of 1.67% from last month's figure of 83.53%.

Mandatory Training and Role Specific Essential Training
Mandatory Training compliance increased in October from 85.04% to 85.31% which maintains the position above the Trust target of 85%.

Role Specific Essential Training compliance increased in October to 76.59% from last month's figure of 75.15%.

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

Enclosure H

Workforce Committee: Capacity, Capability and Culture Report - October 2016

CAPABILITY
Training & Appraisal Rates

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

Appraisal Compliance Rate	Directorate	Aug-16	Sep-16	Oct-16
Medicine & Urgent Care Division	Medical Division Total	75.41%	77.17%	76.68%
	Urgent Care	76.59%	77.82%	79.77%
	Inpatient Specialties	74.81%	75.99%	76.41%
	Outpatients & Elderly Medicine	75.46%	78.35%	74.77%
Surgical Division	Surgical Division Total	87.70%	88.39%	86.77%
	Anaesthetics, CC & Theatres	82.55%	80.94%	80.06%
	ENT & Maxillofacial	79.27%	82.72%	72.50%
	Ophthalmology	90.79%	93.42%	93.33%
	Trauma & Orthopaedics	90.70%	94.55%	91.07%
	General & Specialist Surgery	95.95%	95.44%	96.22%
Women, Children & Oncology Division	W, C & O Division Total	85.30%	87.60%	85.31%
	Women	82.75%	84.60%	79.60%
	Children	83.15%	88.81%	90.49%
	Oncology & Haematology	91.98%	91.18%	89.18%
Clinical Support Services Division	Clinical Support Division Total	81.82%	83.11%	82.33%
	Imaging	75.29%	74.29%	72.83%
	Pathology	81.48%	88.05%	84.47%
	Other Clinical Support	63.41%	57.50%	53.85%
	Medical Records	88.57%	88.57%	91.55%
	Pharmacy	90.35%	89.93%	95.58%
	Therapy Services	86.87%	89.47%	85.11%
Support Services	Support Services Total	77.25%	81.62%	78.61%
	Hospital Support	73.99%	78.20%	77.35%
	Facilities	79.64%	84.19%	79.55%
Trust Total		**81.46%**	**83.53%**	**81.86%**

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**24 November 2016**

Title of the Report	**Operational Performance Report**
Agenda item	**14**
Presenter of Report	Deborah Needham Chief Operating Officer / Deputy Chief Executive
Author(s) of Report	Lead Directors & Deputies
Purpose	For Information & Assurance
Executive summary The paper is presented to provide information and assurance to the committee on all national and local performance targets via the integrated scorecard. Each of the indicators which is Amber/red rated has an accompanying exception report	
Related strategic aim and corporate objective	Focus on quality & safety
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks N Risk of not delivering performance standards Associated fines Patient experience Reputation
Related Board Assurance Framework entries	BAF – 1.2, 3.1
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)

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	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 (N)

Actions required by the Board

The Board is asked to:

- Note the performance report
- Seek areas for clarification
- Gain assurance on actions being taken to rectify adverse performance

Corporate Scorecard

Delivering for Patients:
2016/17 Accountability Framework for NHS Trust Boards

October Performance

The corporate scorecard provides a holistic and integrated set of metrics closely aligned between NHS Improvement 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.

NHS Improvement (NHSI) have published their Single Oversight Framework (SOF) for 2017/18 which aims to provide an integrated approach to oversee trusts, and identify the support needed to deliver high quality, sustainable healthcare services. NHSI will oversee and assess providers' performance against five themes:

	Theme	Overview of oversight measures
1	Quality of Care	NHSI will use CQC's most recent assessments of whether a provider's care is safe, effective, caring and responsive In-year information where available Delivery of the four priority standards for 7-day hospital services
2	Finance and use of resources	Focus on a provider's financial efficiency and progress in meeting its control total Use of resources approach is being co-developed with CQC
3	Operational performance	NHS constitutional standards Other national standards
4	Strategic change	How well providers are delivering the strategic changes set out in the Five Year Forward View with a particular focus on STPs, new care models and devolution (where relevant)
5	Leadership and improvement capability (well-led)	Building on their well-led framework CQC and NHSI will develop a shared system view of what good governance and leadership looks like, including ability to learn and improve

Over the coming period our reporting structure will alter to reflect these themes.

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1. Performance Summary

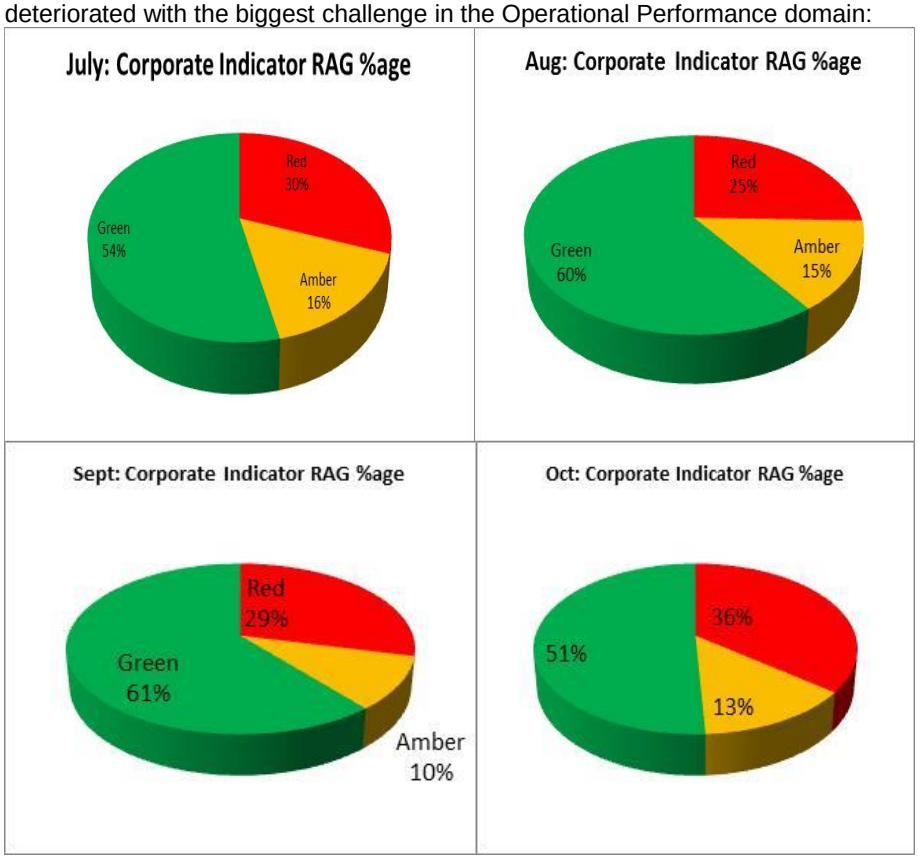
The table below provides an overview of the number of indicators in each domain by their October performance RAG status.

Note any indicators without a target and therefore RAG rating, have been excluded.

October Corporate Indicators: RAG Performance

SOF Theme	Prev Domain	Number				Percentage		
		Red	Amber	Green	Total	Red	Amber	Green
Quality of Care	Caring	4	0	3	7	57%	0%	43%
	Effective	9	0	9	18	50%	0%	50%
	Safe	1	3	8	12	8%	25%	67%
Operational Performance	Responsive	5	3	2	10	50%	30%	20%
Leadership & Improvement	Well Led	2	2	8	12	17%	17%	67%
	Total	21	8	30	59	36%	14%	51%

The trend in RAG performance up to Sept had shown an overall increase in green rated metrics and a reduction in those rated as amber. However October's performance deteriorated with the biggest challenge in the Operational Performance domain:



2. Sustainable Transformation Funding (STF) Performance Metrics

Performance Assessment

3 of the 5 key metric trajectories were met in October; performance slipped below agreed trajectories for A&E 4hr and Cancer 62 days.

STF Funding Key Metrics: Performance Againts Trajectories										
		Apr	May	June	Qtr1	July	Aug	Sept	Qtr2	Oct
A&E 4hr (95%)	Trajectory	88.5	84.0	85.0		87.0	86.0	90.0	90.0	92.0
	Actual	88.5%	89.2%	94.6%	90.8%	91.1%	92.2%	89.3%	90.9%	85.4%
Diagnotiscs (99%)	Trajectory	99.9	99.1	99.1	99.1	99.1	99.1	99.1	99.1	99.1
	Actual	99.9%	99.9%	99.0%	99.7%	99.9%	99.8%	99.5%	99.7%	99.1%
RTT (92%)	Trajectory	92.0	92.0	92.0	92.0	92.0	92.0	92.0	92.0	92.0
	Actual	94.7%	94.5%	94.5%	94.5%	94.7%	94.0%	92.4%	93.5%	92.1%
RTT 52wks+ (0)	Trajectory	0	0	0	0	0	0	0	0	0
	Actual	0	0	0	0	0	0	0	0	0
Cancer 62 days (85%)	Trajectory	75.0	77.2	77.6		78.7	79.5	85.0		85.0
	Actual	70.9%	76.5%	81.7%	76.5%	80.0%	76.9%	71.5%	76.1%	78.8%*
(#%) = National target in brackets										*unfinalised posn

Enclosure I

Northampton General Hospital NHS Trust Corporate Dashboard 2016-17

Corporate Scorecard

	Indicator	Target	AUG-16	SEP-16	OCT-16
Caring	Complaints responded to within agreed timescales	>=90%	80.3%		
	Friends & Family Test % of patients who would recommend: A&E	>=86.1%	86.4%	86.0%	85.3%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	>=95.5%	91.5%	91.8%	92.1%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	>=96.4%	98.9%	96.6%	99.2%
	Friends & Family Test % of patients who would recommend: Outpatients	>=92.5%	91.3%	91.8%	91.7%
	Mixed Sex Accommodation	=0	0	0	8
	Total deaths where a care plan is in place	>=50%	63.2%	68.6%	54.0%
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	>=98%	100.0%	95.5%	100.0%

	Indicator	Target	AUG-16	SEP-16	OCT-16
Effective	Crude Death Rates	1	0.5%	0.9%	1.1%
	Emergency re-admissions within 30 days (elective)	<=3.5%	3.3%	3.4%	3.1%
	Emergency re-admissions within 30 days (non-elective)	<=12%	15.1%	14.0%	11.7%
	Length of stay - All	<=4.2	4.3	4.8	4.5
	Maternity: C Section Rates - Total	<26.2%	29.5%	28.0%	26.3%
	Mortality: HSMR	100	97	98	98
	Mortality: SHMI	100	98	94	94
	# NoF - Fit patients operated on within 36 hours	>=80%	88.4%	80.0%	96.0%
	Stranded patients >75yrs (LOS > 7 DAYS)	<=45%	48.5%	52.9%	51.4%
	Stroke patients spending at least 90% of their time on the stroke unit	>=80%	86.0%	78.7%	78.7%
	Suspected stroke patients given a CT within 1 hour of arrival	>=50%	61.3%	74.2%	68.7%
	VTE Risk Assessment	>=95%	95.6%	95.5%	94.8%

	Indicator	Target	AUG-16	SEP-16	OCT-16
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	>=95%	92.5%	89.1%	84.8%
	Ambulance handovers that waited over 30 mins and less than 60 mins	<=25	239	151	229
	Ambulance handovers that waited over 60 mins	<=10	15	11	47
	Average Ambulance handover times	=15 mins	00:16	00:14	00:17
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	>=93%	96.5%	96.8%	97.3%
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	>=93%	93.3%	100.0%	91.3%
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	>=98%	97.8%	98.6%	100.0%
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	>=94%	93.0%	100.0%	90.0%
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	>=94%	63.6%	83.3%	100.0%
	Cancer: Percentage of patients treated within 31 days	>=96%	96.1%	97.5%	94.2%
	Cancer: Percentage of patients treated within 62 days of referral from hospital specialist	>=85%	90.0%	76.9%	40.0%
	Cancer: Percentage of patients treated within 62 days of referral from screening	>=90%	100.0%	100.0%	100.0%
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	>=85%	76.9%	71.5%	77.1%
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	>=99.1%	99.8%	99.5%	99.9%
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	=0	0	2	0
	RTT over 52 weeks	=0	0	0	0
	RTT waiting times incomplete pathways	>=92%	93.9%	92.6%	92.3%

	Indicator	Target	AUG-16	SEP-16	OCT-16
Finance	CIP Performance	=0	525 Fav	(337) Adv	
	Waivers	=0	5	1	3
	Waivers which have breached	=0	7	3	2

	Indicator	Target	AUG-16	SEP-16	OCT-16
Safe	C-Diff	<=1.75	3	0	1
	Delayed transfer of care	=23	58	73	75
	Dementia: Case finding	>=90%	99.0%	95.8%	98.5%
	Dementia: Initial diagnostic assessment	>=90%	100.0%	100.0%	100.0%
	Falls per 1000 occupied bed days	<=5.5	5.2	4.9	4.3
	Harm Free Care (Safety Thermometer)	>=95%	94.3%	94.0%	93.1%
	MRSA	=0	0	0	0
	Never event incidence	=0	0	0	0
	Number of Serious Incidents Requiring Investigation (SIRI) declared during the period	=0	1	1	0
	Pressure Ulcers (Hospital Acquired) - Grades 2-4	=0	18	14	11
	Transfers: Patients transferred out of hours (between 10pm and 7am)	<=60	44	45	75
	UTI with Catheters (Safety Thermometer-Percentage new)	<=0.25%	0.1%	0.1%	0.3%

	Indicator	Target	AUG-16	SEP-16	OCT-16
Well Led	Data quality of Trust returns to HSCIC (SUS)	>=95%	95.5%	95.5%	95.5%
	Medical Job Planning	>=90%		0%	0%
	Percentage of all trust staff with mandatory training compliance	>=85%	85.8%	85.0%	85.3%
	Percentage of all trust staff with role specific training compliance	>=85%	76.4%	75.1%	76.5%
	Percentage of staff with annual appraisal	>=85%	81.4%	83.5%	81.8%
	Sickness Rate	<=3.8%	3.9%	3.8%	4.0%
	Staff: Trust level vacancy rate - All	<=7%	11.9%	11.1%	
	Staff: Trust level vacancy rate - Medical Staff	<=7%	12.9%	10.0%	
	Staff: Trust level vacancy rate - Other Staff	<=7%	11.5%	11.1%	
	Staff: Trust level vacancy rate - Registered Nursing Staff	<=7%	12.1%	11.5%	
	Turnover Rate	<=8%	9.6%	9.9%	9.8%

Run Date: 09/11/2016 14:15 Corporate Scorecard Run by: JohnsonCJ

Northampton General Hospital NHS Trust

Corporate Scorecard

Delivering for patients:
2016/17 Accountability Framework for NHS trust boards

The corporate scorecard provides a holistic and integrated set of metrics closely aligned between NHS Improvement 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 trajectory for the reminder of the year.

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
A&E: Proportion of patients spending less than 4 hours in A&E	Externally mandated	Finance, Investment and Performance Committee	October 2016

Performance:

Indicator	Target	AUG-16	SEP-16	OCT-16
A&E: Proportion of patients spending less than 4 hours in A&E	>=95%	92.5%	89.1%	84.8%

Driver for underperformance:	Actions to address the underperformance:
• September achieved 84.8%: against an agreed NHSI trajectory 92% • Attendances numbers in ED have increased against the previous month. Patient number were up an additional 2.7% • Delays in 1st Assessment • Bed capacity • Vacancies within medical staffing equating to 24 WTE across all of the grades • Increased acuity is still well above baseline and in upper quartile, this has increased throughout October	• Improve the streaming of patients suitable to access GP services and ambulatory care. Weekend Opening of Ambulatory Care Centre (7 day working) • Improve 1st assessment of attenders in ED. Implementation of revised escalation triggers to begin. 14th November. • Weekly Meetings in place to review delays in 1st assessment • Escalation policy being reviewed • Ensure senior clinical decision makers available during core hours and periods of increased activity. Explore the opportunity of seven day working for senior decision makers • Implementation of Medical Registrar with in ED • Review the use of “Pull model” implemented for speciality areas in Medicine. Stroke Model successful and need replicating across Medicine • Review and Monitor - IC24 contract performance against agreed action plan and the inability to fill GP shifts. Review alternative models to ensure greater GP support for “assessment closer to front door”. • “Confirm and Challenge” to be established regarding “zero length of stay patients” • Improve bed availability and flow before midday.

	• Identify the opportunity to provide short stay assessment on EAU and Benham • Social Worker to support Primary care within ED during November • Current vacancies are out to advert and active recruitment is ongoing.

Lead Clinician:	Lead Manager:	Lead Director:
Dr Jon Timperley	Paul Saunders	Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Mixed Sex Accommodation	Externally Mandated	Finance, Investment and Performance Committee	October 2016

Performance:

Indicator	Target	AUG-16	SEP-16	OCT-16
Mixed Sex Accommodation	=0	0	0	8

Driver for underperformance:	Actions to address the underperformance:
• Capacity pressures have meant that one bay on Benham ward had to be mixed overnight. Three female and three male beds were used. D Needham as executive on call agreed this in order to maintain safety on the site. • Two patients in ITU could not step-down after 24 hours due to no beds available in the right place. This was during the black escalation status.	• Policy is being embedded with the areas impacted. • Matrons of the areas aware of local resolutions available and options to avoid such situations. • The process to be included in the escalation policy in November. • Natalie Green working with critical care to clarify HDU position in declaring mixed sex breeches. They are all side rooms but have no bathroom facilities. • Winter planning to address flow issues to include " ED streaming options", use of interim beds are being worked on in order to improve the capacity of the trust as a whole.

Lead Clinician:	Lead Manager:	Lead Director:
Not applicable	Dione Rogers	Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Length of stay / Stranded Patients / Delayed Transfer of Care	Internally set	Finance, Investment and Performance Committee	October 2016

Performance:

Indicator	Target	AUG-16	SEP-16	OCT-16
Length of stay - All	<=4.2	4.3	4.8	4.5
Stranded patients >75yrs (LOS > 7 DAYS)	<=45%	48.5%	52.9%	51.4%
Delayed transfer of care	=23	58	73	75

Driver for underperformance:	Actions to address the underperformance:
• High numbers of Delayed Transfers of Care (DTOC) resulting in high numbers of 'stranded' patients across Northamptonshire • Pathway for Dementia patients to Angela Grace beds is no longer in place. • Variation in discharge process – lack of empowerment and decision making, handoffs, repeated assessment, process not starting until patient medically fit • Reliance on beds; Insufficient capacity within the home support services • Lack of home support increases demand on bedded solutions resulting in inappropriate placements and increased LOS • Increasing costs of residential care (now £1200 per week) at some homes with a max social funding of £600 per week is resulting in huge 'top ups' that families are saying they cannot afford. This is resulting in families being very reluctant to move patients out at pace	Outflow group is leading the programmes of work: • Discharge process re-design – stream lined process, early discharge planning, local empowerment and timely transfer of needs based information to the discharge SPA • Integrated discharge SPA – multi disciplinary team located together to facilitate and support discharge into home and bed based services, single tracking and reporting, clear escalation. 1.8WTE staff have been allocated to staff the SPA from the NGH discharge team.. • SAFER bundle to be implemented within the trust by October. Aims to ensure all patients have a senior review daily. Trust lead Chris Filed is in post and roll out has begun • Exec led top delays meeting to review the longest staying patients in the trust started first week in October and will take place weekly. Consultant and ward manager will present case to exec led panel for support and challenge in progressing the patients pathway • Right Sizing Home Care Support – capacity modelling, reviewing integration options and increasing capacity • Deep dive reviews of all wards by senior manager and clinicians to

	scrutinise medical plans and ensure they are being followed up robustly • Daily ‘tracking’ sign off meetings between HPT and discharge team • Robust use of the Choice Policy • LOS will continue to remain above base line while the long LOS backlog are discharged (as they only show on the stats after discharge)

Lead Clinician:	Lead Manager:	Lead Director:
Not applicable	Carl Holland	Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Transfers: Patients transferred out of hours (between 10pm and 7am)	Internally set	Finance, Investment and Performance Committee	October 2016

Performance:

Indicator	Target	AUG-16	SEP-16	OCT-16
Transfers: Patients transferred out of hours (between 10pm and 7am)	<=60	44	45	75

Driver for underperformance:	Actions to address the underperformance:
• High pressures in the trust with regards to capacity leading to the opening of all escalation beds. This results in more moves out of hours. • Wards are not identifying patients that are suitable to move into escalation beds early enough to prevent the late moves	• Share this month's result with site team matrons and divisional managers. • Re- boot the process for early identification of suitable patients for escalation. • Monitor late moves into these areas on a daily basis

Lead Clinician:	Lead Manager:	Lead Director:
Not applicable	Dione Rogers	Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Complaints responded to within agreed timescales	Externally mandated	Quality Governance Committee	Oct 2016

Performance:

Indicator	Target	AUG-16	SEP-16	OCT-16
Complaints responded to within agreed timescales	>=90%	**80.3%**		

Driver for underperformance:

- Reporting on August's figures now they have been validated
- Response rate has dropped to 80% compared to 100% this time last year (full team in place)
- 61 complaints received in August compared to 48 this time last year
- 32 cases responded in agreed timescale
- 29 cases had timescale renegotiated
- 12 cases exceeded timescale
- Late or incomplete responses received from the Divisions.
- Maximum holidays within Complaints team plus temporary member of staff also had leave
- Therefore unable to meet internal and external timescales.

Trajectory for achieving 90% or above (green) is January 2017 (report date March 2017). This is based upon the following:

- F/T vacant post has been covered by a part time temporary member of staff who has now left (October)
- New substantive person has joined and commenced three month training programme so will not be fully operational until after Christmas

Actions to address the underperformance:

- Service review undertaken (Making Quality Count) to identify areas for improvement (further work being undertaken in July). Outcome meeting with directorate's 2nd November 2016.
- Tasks are being reviewed to see how this can be addressed moving forwards whilst the new person is training. It is anticipated that minimal change will be possible given the existing hours of the other Complaints Officers (both p/t).
- It is not possible to backfill with administrative staff from within the department as the work is at a higher level and the resources are not compatible.

The impact of this is that the other two Complaints Officers (whose hours are 0.87 & 0.53) will be unable to provide full cover, leaving a shortfall and the risk of a further backlog. The Head of Complaints will be undertaking the training of the new member of staff during this time so will be unable to backfill.	

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Lisa Cooper	Carolyn Fox

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Stroke patients spending at least 90 % of their time on the stroke unit	Externally mandated	Quality Governance Committee.	October 2016

Performance:

Indicator	Target	AUG-16	SEP-16	OCT-16
Stroke patients spending at least 90% of their time on the stroke unit	>=80%	86.0%	78.7%	78.7%

Driver for underperformance:	Actions to address the underperformance:
• The main driver for underperformance this month, as last month was for stroke patients with a short length of stay (1-2 days) not able to access Stroke bed and receiving their care on the Admission wards. • Loss of stroke beds to medical patients on Eleanor-Hyper acute stroke unit. • Patients discharged from A&E or Ambulatory care by Stroke Team, counted as not accessing a Stroke bed. • Delayed discharges due to assessment and wait for social care.	• As from 01/08/16 we agreed with the Site Team that the Stroke Service will manage their own beds, with the agreement that 2 Stroke beds will remain empty on Eleanor at all times. Whilst it has been almost impossible to maintain 2 empty beds, we have clearly improved access to our stroke beds. We nearly achieved our 80% target again this month. • The improvement in our bed management is also illustrated by the % of stroke patients getting to a stroke bed in 4 hours. July 2016 50% (not achieved >60% in past year) August 2016 75% September 2016 81% October 2016 75% • We will continue to encourage and enforce management of our beds and aim to maintain 2 empty beds on Eleanor at all times.

Lead Clinician:	Lead Manager:	Lead Director:
Dr Lyndsay Brawn / Dr Mel Blake	Paul Saunders	Dr Mike Cusack

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Harm Free Care (Safety Thermometer)	Externally mandated	Quality Governance Committee	October 2016

Performance:

Indicator	Target	AUG-16	SEP-16	OCT-16
Harm Free Care (Safety Thermometer)	>=95%	94.3%	94.0%	93.1%

Driver for underperformance:	Actions to address the underperformance:
• Hospital acquired Pressure Ulcers remain above national target, however, improvements have been noted over the past 3 months. • Increase in the number of CRUTI's in October.	• Share & Learn meetings weekly • TVN validation of all suspected PU and photographic evidence of 'harm' for verification at monthly meeting with DoN, DDoN. • Month on month decrease in the number of PU harms incidence since August • 90 day 'Rapid Improvement 'Collaborative commenced with 4 wards • Manual handling advisor commenced in post to support appropriate 'moving' of patients, in particular, with slide sheets • Review of CRUTI's over the past 6 months to understand themes and ward location to be undertaken by IPC team

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Fiona Barnes	Carolyn Fox

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Medical Job Planning	Externally mandated	Workforce committee.	October 2016

Performance:

Indicator	Target	AUG-16	SEP-16	OCT-16
Medical Job Planning	>=90%		0%	0%

Driver for underperformance:	Actions to address the underperformance:
• Job planning not performing against timeframe of Trust trajectory	• Clinical Directors to be notified of date for their respective Directorate Challenge Review meeting prior to end December 2016 • Following job plan Challenge Review, any job that has not been presented and remains in 'discussion' stage consultant will be given 3 month notice period that the plan that is live on the Trust Allocate system will come into effect.

Lead Clinician:	Lead Manager:	Lead Director:
Dr Win Zaw	Sue Jacobs	Dr Mike Cusack

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Staff Annual Appraisal Rate	Internally set	Workforce Committee	October 2016

Performance:

Indicator	Target	AUG-16	SEP-16	OCT-16
Percentage of staff with annual appraisal	>=85%	81.4%	83.5%	81.8%

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 83.57%. • 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. • 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. • An audit was carried out on wards in Medicine falling below 85% compliance. As a result of this, communication was sent out to remind managers on the process of new starters.

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Adam Cragg	Janine Brennan

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Staff Turnover Rate	Internally set	Workforce Committee	October 2016

Performance:

Indicator	Target	AUG-16	SEP-16	OCT-16
Turnover Rate	<=8%	9.6%	9.9%	9.8%

Driver for underperformance:	Actions to address the underperformance:
• Lack of opportunities for progression • Increase in numbers of staff retiring and returning • Increased Trust activity and effect on areas used as escalation areas • Staff survey indicates underlying cultural concerns i.e. bullying and harassment, lack of flexibility, support from line manager • Management of change programs.	• Provision of an opportunity for any nurses that are contemplating leaving to discuss their reasons for doing so with the Nurse Retention Manager. • Review of the exit interview questionnaire process. • Development of an on-boarding questionnaire for new starters. • OD undertaking work to improve the working environment • Staffing being provided with employee voice / Friends and Family Tests • Management Leadership programmes • Introduction of Flexible Retirement policy

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Adam Cragg	Janine Brennan.

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Staff Sickness Rate	Internally set	Workforce Committee	October 2016

Performance:

Indicator	Target	AUG-16	SEP-16	OCT-16
Sickness Rate	<=3.8%	3.9%	3.8%	4.0%

Driver for underperformance:	Actions to address the underperformance:
• Short term absence – 2.56% and long term absence is 1.37% • Short term absence remains the driver. • The illnesses being reported are self-limiting which are all being managed in line with the Trust's trigger points • The staff survey also highlighted that staff put themselves under pressure to attend work	• The HR Advisors are now promoting First for Wellbeing through sickness absence meetings and they are receiving positive comments from affected employees about this service • In relation to actively managing sickness absence levels health and wellbeing has been embedded into 1:1 meetings with line managers with the focus being on early interventions • The sickness absence audit checklist is widely used with managers in particular advising of the importance of return to work interviews • The Health and Well Being Strategy is progressing well and currently there is a focus on providing training on mental health awareness • Staff reaching the Trust's staff sickness absence policy triggers are being met with formally

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Andrea Chown	Janine Brennan.

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Staff Role Specific Training Rate	Internally set	Workforce Committee	October 2016

Performance:

Indicator	Target	AUG-16	SEP-16	OCT-16
Percentage of all trust staff with role specific training compliance	>=85%	76.4%	75.1%	76.5%

Driver for under performance:	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. Further work is being carried out on Blood Training by reviewing the positions that require this. • 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.

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Adam Cragg	Janine Brennan

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Staff Vacancy Rate	Internally set	Workforce Committee	October 2016

Performance:

Indicator	Target	AUG-16	SEP-16	OCT-16
Staff: Trust level vacancy rate - All	<=7%	11.9%	11.1%	Data unavail but expected to be above target
Staff: Trust level vacancy rate - Medical Staff	<=7%	12.9%	10.0%	
Staff: Trust level vacancy rate - Other Staff	<=7%	11.5%	11.1%	
Staff: Trust level vacancy rate - Registered Nursing Staff	<=7%	12.1%	11.5%	

Driver for underperformance:	Actions to address the underperformance:
• There is a national shortage of nursing staff along with a shortage within other professional allied specialities • Change to the shift system (long days) decreases flexibility and therefore staff choose to join the bank • A General Hospital is not as attractive as Teaching Hospitals	• Trust Open Days in difficult to recruit areas • Forging links with local University to recruit Students • Dedicated staff within HR for recruitment and retention • More structured approach to Medical Staffing recruitment • Recruitment timeline down to 9 weeks • Monthly meetings with managers to support clearance processes developing enhanced working relationships • Increase usage of apprenticeship schemes • Overseas recruitment for nurses continues

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Andrea Chown	Janine Brennan.

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Average Ambulance Handover Times	Externally mandated	Finance, Investment and Performance Committee	October 2016

Performance:

Indicator	Target	AUG-16	SEP-16	OCT-16
Ambulance handovers that waited over 30 mins and less than 60 mins	<=25	239	151	229
Ambulance handovers that waited over 60 mins	<=10	15	11	47
Average Ambulance handover times	=15 mins	00:16	00:14	00:17

Driver for underperformance:	Actions to address the underperformance:
• Total attendances numbers in ED have increased against the previous month. Patient number were up an additional 2.7% • Ambulance attendances have increased against previous month. • Acuity remains high across the Trust, and has increased significantly throughout October. • Bed capacity	• RGN to staff corridor in times of increased activity, thus releasing crews. • Early escalation to EMAS silver to request HALO should the need arise. • Discussion with EMAS Regional Operations Manager (ROM) to ensure admission avoidance MDT message is put out to crews. • FIT NIC to assess early and refer patients through to minors/GP from ambulance crews if appropriate. • Two FIT bays (F9, F10) designated for ambulance off load and handover. • Communications to all ED staff to reiterate the importance of using ambulance handover screen.

Lead Clinician:	Lead Manager:	Lead Director:
Dr Jon Timperley	Paul Saunders	Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Maternity C-Section Rates	Externally mandated	Quality Governance Committee.	October 2016

Performance:

Indicator	Target	AUG-16	SEP-16	OCT-16
Maternity: C Section Rates - Total	<26.2%	29.5%	28.0%	26.3%

Driver for underperformance:	Actions to address the underperformance:
• Total Caesarian Section rate has improved by almost 2% and is now only 0.1% above target in the month of October • Elective Caesarean section rate is under the national average 10% (national average 13.2%) • Emergency Caesarean section rate remains above target at 16.3%	• Continue monitoring • Ongoing Emergency Caesarean Section reviews to ensure appropriateness of decision making. • Ongoing Elective Caesarean Section audits – good compliance • Matron – Intrapartum Lead to work on labour ward to support normality and provide challenge and support in clinical decision making • Continue with debriefs following all Caesarean Sections • New appointment to Birth After Caesarean Clinic – working towards multidisciplinary clinic.

Lead Clinician:	Lead Manager:	Lead Director:
Owen Cooper	Rose McKee / Sandra Neale	Dr Mike Cusack

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Friends and Family Test % - Inpatient/Daycase and Outpatients	Externally mandated	Quality Governance Committee	October 2016

Performance:

Indicator	Target	AUG-16	SEP-16	OCT-16
Friends & Family Test % of patients who would recommend: A&E	>=86.1%	86.4%	86.0%	85.3%
Friends & Family Test % of patients who would recommend: Inpatient/Daycase	>=95.5%	91.5%	91.8%	92.1%
Friends & Family Test % of patients who would recommend: Outpatients	>=92.5%	91.3%	91.8%	91.7%

Driver for underperformance:	Actions to address the underperformance:
• The FFT continues to struggle to reach national averages for the % of patients that would recommend. • It is evident that despite the underperformance there is a continued upward trajectory, this is particularly evident within Inpatient and Day cases where we see a month on month improvement and have done for a number of months consecutively. • A&E have seen pressures on the service which have replicated into a decrease in satisfaction. It should also be noted that the national results are continuously changing. • Outpatient services remain .8% below the national average for October. It is not evident whether this is a statistically significant difference.	• Many actions are being undertaken to address performance all of which are evidently having an effect, particularly within Inpatient and Day Case areas. • Particular focus has been given to the areas where the Trust underperformed within the Inpatient survey. It is expected that this will further improve the results from the FFT. • Two further local survey is currently being initiated enabling wards to be able to identify specific areas where they are performing well and whether further improvements need to be made.

Lead Clinician:	Lead Manager:	Lead Director:
N/A	Rachel Lovesy	Carolyn Fox

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Cancer Access Targets	Externally Mandated	Finance, Investment and Performance Committee	October 2016

Performance:

Indicator	Target	AUG-16	SEP-16	OCT-16
Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	>=93%	93.3%	100.0%	91.3%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	>=94%	93.0%	100.0%	90.0%
Cancer: Percentage of patients treated within 31 days	>=96%	96.1%	97.5%	94.2%
Cancer: Percentage of patients treated within 62 days of referral from hospital specialist	>=85%	90.0%	76.9%	40.0%
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	>=85%	76.9%	71.5%	77.1%

Driver for underperformance:	Actions to address the underperformance:
62 day First Treatment 8 tumour sites breached the standard in September in particular Colorectal, Urology and Head & Neck. The Trust saw the highest number of treatments this month with 93.5, there was a concerted effort to treat a number of legacy patients passed 62 days and as a result we encountered the highest number of breaches at 26.5 All tumour sites had breaches with the exception of breast Urology-9.5 breaches out of 25.5 treatments • This tumour site was again the most challenged site with 9.5 breaches and has had a significant impact on the Trust meeting	• Improvements have started to be seen in Urology and Colorectal PTL's going forward, close scrutiny is in place for Head & Neck which is a particularly challenged tumour site. • A Trust-wide Cancer Recovery Programme is moving forward supported by the completed Directorate Action Plan Standardised formatting and cross cutting actions are currently underway to ensure a whole system approach to improvement. Focus operationally continues on: • Cancer Access Policy taken to Cancer Board and approved.

this standard. Recovery work has however started to impact and a marked improvement is anticipated in October Colorectal – 6 breaches out of 8 treatments • This cohort of patients had a mixture of complex investigations and co-morbidities with 1 patient having a delay due to admin (loss of notes) for MDT. Head and Neck – 2 breaches out of 3 treatments (0.5 attributed to Skin on OE) • Late Tertiary referrals, complex diagnostic pathway and patient delay contributed to these breaches this month. There are particular pressures points we are experiencing: Diagnostics: • Histopathology turnaround times appear to have exceeded a 7 days which now requires ongoing review to ensure timely escalation. There is a plan in place to ensure consistent attendance at all MDTs by Pathology all urgent request's will be dealt with in house they will not in future be outsourced. • MRI's continue to exceed the 7 day standard in the cancer pathway, averaging 18 days. Other: • Capacity issues in Oncology are impacting on MDT's due to vacancies and lack of local cover. The directorate is aware and is in the process of recruiting into their vacancies • Provision of timely health records in MDT meetings and OPA's are impacting on cancer pathways due to delayed decision making. Clinical Support Services are aware of these issues and have been asked to action this with immediate effect. **Consultant Upgrades**	• Cancer Operational Policy in draft, anticipated to be fully functional in November. • New tracking tool in development for patients on the PTL, anticipated being available in November. • MDT review and observational assessment planned for November. • Current Pathways with MDT leads for annual review and agreement, almost complete. • E-Learning programme identified for Cancer Services personnel has been agreed to be rolled out. • New RCA template in place for October breaches which include specific consultant review. • Breach panel anticipated to be setup to review the October breaches with the process sitting with the Directorate governance arrangements

Head and Neck failed to meet the standard this month and therefore the Trust failed to meet the local standard of 85% with 1.5 treatments failing out of 6.5.	An operational process has been drafted for final approval to ensure standardisation within the Trust.

Lead Clinician:	Lead Manager:	Lead Director:
Clemens Vonwidekind	Sandra Neale	Deborah Needham

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**24 November 2016**

Title of the Report	**Report from the Finance Investment and Performance Committee**
Agenda item	**15**
Presenter of Report	Paul Farenden, Chairman Phil Zeidler, Non-Executive Director and Chair of Finance Investment and Performance Committee
Author(s) of Report	Paul Farenden, Chairman
Purpose	For Assurance
Executive summary This report from the Chair of the Finance Investment and Performance Committee provides an update to the Trust Board on activities undertaken during the month of October.	
Related strategic aim and corporate objective	Strategic Aim 3,4 and 5
Risk and assurance	Risks assessment provided within the report.
Related Board Assurance Framework entries	BAF 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.

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: ***24 November 2016***

Title	**Finance Committee Exception Report**
Chair	**Paul Farenden**
Author (s)	**Paul Farenden**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met on *19 October 2016* to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:	**Board Assurance Framework entries** *(also cross-referenced to CQC standards)*
• Current financial performance • Financial Forecast • Changing Care • Operational planning and contracting 17/19 • Drivers of the deficit	

Key areas of discussion arising from items appearing on the agenda

- Conflict between financial performance and patient safety i.e. agency spend.
- Risks around the financial forecast
- The RTT backlog
- Risks surrounding the Changing Care Programme

Any key actions agreed / decisions taken to be notified to the Board

C.O.O to pursue CCG in Community Care Schemes.
Extraordinary Board to be held on 16 November 16 to discuss control total and financial plans.

Any issues of risk or gap in control or assurance for escalation to the Board

As above.

Legal implications/ regulatory requirements	The above report provides assurance in relation to CQC Regulations and BAF entries as detailed above.

Action required by the Board

To meet 16 November 16.

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**24 November 2016**

Title of the Report	**Report from the Quality Governance Committee**
Agenda item	**16**
Presenter of Report	Paul Farenden, Chair
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 October.	
Related strategic aim and corporate objective	Strategic Aim 3,4 and 5
Risk and assurance	Risks assessment provided within the report.
Related Board Assurance Framework entries	BAF 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 K

Actions required by the Trust Board

The Trust Board is asked to note the report.

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: *24 November 2016*

Title	**Quality Governance Committee Exception Report**
Chair	**Liz Searle**
Author (s)	**Liz Searle**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met on *21 October 2016* to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:	**Board Assurance Framework entries** *(also cross-referenced to CQC standards)*
LDR Checkpoint Patient Experience Report Claim & Litigation Report – how the Trust can learn and improve.	

Key areas of discussion arising from items appearing on the agenda

Midwifery Scorecard to be included in C Section Audit presented to QGC in December 2016.
EAU – dip in performance on the Nursing Dashboard
Health & Safety Report – Divisions compliance at returning Health & Safety reports now at 76%. Also Improvement Notices across the NHS and healthcare sector can now involve a hefty fine.
Duty of Candour – Trust is compliant

Any key actions agreed / decisions taken to be notified to the Board

G4 pressure ulcer sustained whilst patient was admitted to Avery Healthcare. The Committee received a full report on Pressure Ulcer prevention work going forward

Any issues of risk or gap in control or assurance for escalation to the Board

Legal implications/ regulatory requirements	The above report provides assurance in relation to CQC Regulations and BAF entries as detailed above.

Action required by the Board

Enclosure K

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**24 November 2016**

Title of the Report	**Report from the Workforce Committee**
Agenda item	**17**
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 October.	
Related strategic aim and corporate objective	Strategic Aim 3,4 and 5
Risk and assurance	Risks assessment provided within the report.
Related Board Assurance Framework entries	BAF 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 L

Legal implications / regulatory requirements	Statutory and governance duties
Actions required by the Trust Board The Trust Board is asked to note the report.	

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board for November 2016

Title	**Workforce Committee Report**
Chair	**Graham Kershaw**
Author (s)	**Graham Kershaw**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met o*n 19/10/2016* to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:	**Board Assurance Framework entries** *(also cross-referenced to CQC standards)*
Nurse recruitment and retention action plans. Medical Education Responding to concerns policy Workforce performance Raising concerns policy Making quality count project.	

Key areas of discussion arising from items appearing on the agenda.

Recruitment of nurses continues to be challenging with Mrs Brennan updating the committee on a number of further recruitment activities. Concern was expressed over the loss of the Nurse Retention Manager and that recruitment to the post needs to be of high importance. Ms Fox commented that over the next 2 years the Associate Nurse role will be introduced which will mean a workforce redesign for nursing.

Dr Jeffrey presented the Medical Education Report and stated that the Notification of the Learning Development Agreement (LDA) financial settlement for 2016/17 was received in the last week of September. He then proceeded to review actions planned to improve performance in this area. Concerns were expressed by the committee and further update was required in order to provide assurance that these matters had been resolved.

Dr Cusack presented the Responding to Concerns Policy and advised that there is national guidance which highlights the importance of recognising and correctly managing concerns over the performance and capability of medical staff .Dr Cusack stated that the policy addresses the capability of a practitioner not the practitioners conduct. The Responding to Concerns Policy is in place to highlight the options available to a practitioner if they encounter a problem with their capabilities.

Ms Thorne presented the Raising Concerns Policy for ratification. Ms Thorne stated that there is an expectation that this national policy is adopted by all NHS organisations by 31 March 2017 to ensure a level of consistency nationally, while recognising the need for flexibility locally in terms of process.

Any key actions agreed / decisions taken to be notified to the Board Mandatory training compliance had remained above the 85% target.	
Any issues of risk or gap in control or assurance for escalation to the Board Non other than referred to above	
Legal implications/ regulatory requirements	The above report provides assurance in relation to CQC Regulations and BAF entries as detailed above.
Action required by the Board Note report	

Northampton General Hospital NHS
NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 24 November 2016
10:30 in the Board Room at Northampton General Hospital

Time		Agenda Item	Action	Presented by	Enclosure
10:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2.	Declarations of Interest	Note	Mr P Farenden	**Verbal**
	3.	Minutes of meeting 29 September 2016	Decision	Mr P Farenden	**A.**
	4.	Matters Arising and Action Log	Note	Mr P Farenden	**B.**
	5.	Patient Story	Receive	Executive Director	**Verbal**
	6.	Chairman's Report	Receive	Mr P Farenden	**Verbal**
	7.	Chief Executive's Report	Receive	Dr S Swart	**C.**
11:00	**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.**
11:25	**OPERATIONAL ASSURANCE**				
	10.	Segmentation of Trusts	Assurance	Dr S Swart	**F.**
	11.	Finance Report	Assurance	Mr S Lazarus	**G.**
	12.	Workforce Performance Report	Assurance	Mrs J Brennan	**H.**
11:50	**STRATEGY**				
	13.	Clinical Collaboration & STP Update	Assurance	Mr C Pallot	**Verbal.**
12:15	**FOR INFORMATION**				
	14.	Integrated Performance Report	Assurance	Mrs D Needham	**I.**
12:25	**COMMITTEE REPORTS**				
	15.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler/Mr P Farenden	**J.**
	16.	Highlight Report from Quality Governance Committee	Assurance	Mr Farenden	**K.**
	17.	Highlight Report from Workforce Committee	Assurance	Mr G Kershaw	**L.**

Time	Agenda Item		Action	Presented by	Enclosure
	18.	Highlight Report from Hospital Management Team	Assurance	Dr S Swart	**Verbal.**
13:00	**19.**	**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 January 2017 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).