Northampton General Hospital NHS
NHS Trust

Public Trust Board

Thursday 26 May 2016

09:30

Board Room
Northampton General Hospital

Northampton General Hospital NHS
NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 26 May 2016
09:30 in the Board Room at Northampton General Hospital

Time		Agenda Item	Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2.	Declarations of Interest	Note	Mr P Farenden	**Verbal**
	3.	Minutes of meeting 31 March 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.**
10:05	**CLINICAL QUALITY AND SAFETY**				
	8.	Medical Director's Report	Assurance	Dr M Cusack	**D.**
	9.	Director of Nursing and Midwifery Report	Assurance	Ms C Fox	**E.**
	10.	Midwifery Learning Disability Group Presentation	Receive	Ms C Fox	**Presentation.**
	11.	Approval of Quality Account	Assurance	Dr M Cusack	**F.**
10:25	**OPERATIONAL ASSURANCE**				
	12.	Finance Report	Assurance	Mr S Lazarus	**G.**
	13.	Workforce Performance Report	Assurance	Mrs J Brennan	**H.**
10:45	**STRATEGY**				
	14.	Sustainability and Transformation Plan Update	Assurance	Mr C Pallot	**I.**
10:55	**GOVERNANCE**				
	15.	Approval of Annual Report and Annual Accounts 2015/16	Decision	Mr S Lazarus	**J.**
	16.	Corporate Governance Report	Assurance	Mrs C Thorne	**K.**
	17.	Approval of Risk Management Strategy	Decision	Mrs C Thorne	**L.**

Time	Agenda Item		Action	Presented by	Enclosure
11:00	**FOR INFORMATION**				
	18.	Integrated Performance Report	Assurance	Mrs D Needham	**M.**
11:15	**COMMITTEE REPORTS**				
	19.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler	**N.**
	20.	Highlight Report from Quality Governance Committee	Assurance	Mrs L Searle	**O.**
	21.	Highlight Report from Workforce Committee	Assurance	Mr G Kershaw	**P.**
	22.	Highlight Report from Audit Committee	Assurance	Mr D Noble	**Q.**
	23.	Highlight Report from Hospital Management Team	Assurance	Dr S Swart	**R.**
11:45	**24.**	**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 28 July 2016 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 31 March 2016 at 09:30 in the Board Room at Northampton General Hospital

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

TB 15/16 115 Introductions and Apologies

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

Apologies for absence were recorded from Mr C Abolins.

TB 15/16 116 Declarations of Interest

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

TB 15/16 117 Minutes of the meeting 28 January 2016

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

Mr Zeidler queried whether the written report from the Antenatal & Newborn audit completed by Midlands and East Screening Quality Assurance Service on 14 January 2016 had been received. Ms Fox advised that it would be reported back to the Quality Governance Committee once received.

The Board resolved to **APPROVE** the minutes of the 28 January 2016 as a true and accurate record of proceedings.

TB 15/16 118 Matters Arising and Action Log 28 January 2016

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

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

TB 15/16 119 Patient Story

Dr Cusack presented the Patient Story.

Dr Cusack informed the Board that the Patient Story highlighted the intense pressure on staff and how this pressure impacts on patient care. Dr Cusack had spoken with the patient and their family on Sunday, then again on Tuesday. The patient suffers

from mild dementia and had recently had a fall. The patient had first contacted their GP for an appointment but due to GP unavailability an ambulance was called. Despite Accident and Emergency being extremely busy, the patients family advised that he was very well cared for, they were well communicated and were frequently updated. The patient was admitted to Benham Ward for a period of two days. The family note that it was hard to gain a clear understanding from the nursing team of the plan for their father; feedback was constantly being chased by the family. The ward doctor met with the family and was unable to advise when the patient could be discharged as the doctor needed further discussions with a more senior doctor. The family was led to believe that the patient would be discharged on Easter Sunday. Plans were made by the family at home in line with the advised discharge date. The daughter sought clarification of a discharge time; however the nursing staff were unclear and again waited confirmation from the doctor. The doctor advised that blood tests were needed and then to be checked thereafter. The senior doctor did not attend Sunday afternoon to take bloods due to an increased workload; therefore the patient was not discharged. The patient was discharged on the Tuesday following a senior doctor review.

Dr Cusack advised the Board that the family did not wish to make a complaint but for the Board to be aware in understanding the difficulties that were encountered. The experience spoiled their Easter and the patient spent extra days in hospital which were not needed. The bed that was occupied could have been used more appropriately and their patient experience could have been improved.

Mr Farenden thanked Dr Cusack for sharing this story and that it was very important that lessons were learnt.

The Board **NOTED** the Patient Story.

TB 15/16 120 **Chairman's Report**

Mr Farenden presented the Chairman's Report.

Mr Farenden informed the Board that he had attended a Board Development Session in Nottingham which he had found extremely useful. The session confirmed the Trusts focus on the quality of care it delivers and the Trusts contribution to the event was valuable.

Mr Farenden reported that he attended a Chairman's, CEO and Senior NHS Officials event in London with Dr Swart. Don Berwick presented at the event, and Mr Farenden noted that Don Berwick was very perceptive of where the NHS is and where the NHS is heading.

Locally Mr Farenden has met with colleagues within the Health Economy and discussion was based around the STP with a focus on its development and delivery.

Mr Farenden referred to a Staff Survey Seminar he recently attended. Mr Farenden found the seminar encouraging as clear progress was noted for the first time in years.

Mr Farenden shared his belief that valuing the staff is a clear priority for the Trust. He said he was humbled by the commitment and dedication of the staff in the current difficult circumstances. Mr Farenden gives the staff his full support, encouragement and shares his thanks for the outstanding job they all do.

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

TB 15/16 121 **Chief Executive's Report**

Dr Swart presented the Chief Executive's Report.

Dr Swart informed the Board that she had recently attended a Chairman's, CEO and Senior NHS Officials event in London with Mr Farenden. Don Berwick, a senior fellow at the Institute for Healthcare Improvements gave his recommendations on how the NHS can be improved and these are highlighted as to how they are adopted at Northampton General Hospital (NGH) in the Chief Executive's Report. Dr Swart shared a brief summary of these with the Board. Quality improvement is the main focus of Don Berwick's recommendations and this is demonstrated at NGH by the Improving Quality And Efficiency Team, Organisational Development Team and the Changing Care@NGH Programme. The empowering of staff and ensuring that the staff feel valued was also touched on which the clinically led structure at NGH encompasses. The standardisation of procedures where possible, but also the understanding that procedures need to be customised for patients in line with patient centred care. Also, financial support is needed for front line services.

Dr Swart commented that she agrees with the discussed recommendations.

Dr Swart reported that the Trust has involved foundation junior doctors and medical students in quality improvement and patient safety through improvement projects and audits. Dr Swart noted that good work had been done with the junior doctors by involving them in campaign pitches locally, nationally and internationally.

Dr Swart was disappointed that the Trust had been ranked in a bottom league position in the national ranking of hospitals that learn from error, considering the learning from error programme and audit systems for doctors in training that are in place at the Trust. Dr Swart advised that the list was linked to questions on the staff survey in relation to the reporting of incidents. This matter is being addressed and an improved system on capturing the reporting of incidents is being developed.

Dr Swart would like the Board to take note the upcoming junior doctor strike. The impact on the whole workforce will be high and it is important to support the workforce who are in on the strike days.

Dr Swart advised that emergency pressures are at their highest with the need for the 60 beds critical in reducing these pressures slightly.

The Annual General Meeting is to be held on 17 September 2016. Dr Swart shared that re-engaging the member base is important and plans are to be put in place to attract voluntary staff.

Dr Swart shared with the Board the approach to Septembers Best Possible Care Awards. Dr Swart reported that more sponsorship is needed. Mr P Farenden confirmed he would be able to support this. Dr Swart also stated that work will be done with HR and Communications in the lead up to the event.

The financial challenge has been escalating monthly. Dr Swart informed the Board that the nationally mandated plan for the next 5 years is being followed; however it does present some challenges. Dr Swart believes the benefits in terms of quality of care need to be received from year 1.

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

TB 15/16 121 **Medical Director's Report**

Dr Cusack presented the Medical Director's Report.

Dr Cusack reported to the Board of a very successful recruitment event in Leicester. Current Foundation Year 1 and Foundation Year 2 junior doctors were involved in a 'campaign pitch' which involved them speaking freely on a recruitment video on what

their experience had been as a junior doctor at NGH. The junior doctors commented that their experience was positive, that they gained extensive experience and were supported in their training. NGH has 32 placements available for Foundation Year 1 junior doctors and there has been 35 potential candidates show interest which is the first time the programme has been oversubscribed.

Dr Cusack advised the Board on the progress of the 3 Never Events that have been recorded in 2015/16. A focus will be given to the culture in Theatres and consideration given to the processes the Theatre teams follow. Dr Cusack shared that simulation suite scenarios are being developed to further imbed the use of the WHO checklist.

Dr Cusack stated that 2 Serious Incident Reports have now been submitted to the Nene and Corby Clinical Commissioning group for closure.

Dr Cusack advised that NGH will be hosting the countywide Northamptonshire mortality meeting on 20 May 2016. These meetings are very positive with discussions on the future of how process and detection can be improved.

The 7th Trust Wide Mortality Case Note Review is now complete. Dr Cusack stated that the focus was on specific sub sets of patients who are on low risk or were post-operative patients.

Dr Cusack identified that the Quality Improvement Strategy had been discussed in detail at prior Board meetings. The Quality Improvement Strategy is in draft format and a final copy will be brought to a future Board meeting. Mr Farenden queried the timescale of this; Dr Cusack advised that the Quality Improvement Strategy should be available in final format in 2 months time.

Mr Noble asked for further clarity on the tooth extraction Never Event which happened in September 2015 and is still open 6 months later. Dr Cusack reported that the detection of the event was not noted until December 2016 at a dental appointment. Dr Cusack noted that learning had been received from this Never Event and due to this; the first version of the report has been reworked.

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

TB 15/16 122 **Director of Nursing and Midwifery Care Report**

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

Ms Fox provided an update and progress report on a number of clinical projects and improvement strategies that the Nursing and Midwifery senior team had been working on. She informed the Board that the Nursing and Midwifery Care report had been discussed in detail at the March Quality Governance Committee.

Ms Fox advised that the Pressure Ulcer Collaborative had been extended. The Pressure Ulcer Steering Group also continues to meet to ensure a reduction in patient harm. The reporting of pressure ulcers has changed and Ms Fox will monitor the data following these changes to see if an improvement is recorded. The changes hope to ensure pressure ulcers are tracked more efficiently and increase the cumulative data.

Ms Fox provided an update on HCAIs. The C.diff numbers look likely to finish year end at 30, with the CCG only identifying 1 lapse in care after review. The IPT has reviewed each case and this information will be presented at Aprils Quality Governance Committee. There has been one MRSA bacteraemia and a root case analysis is underway. Ms Fox shared with the Board that the Trust is below the national average for C.diff and MRSA incidents.

Ms Fox advised the Board that the falls data is still above the internal trajectory on the statistical process chart and that the rate appears to be rising over the last few months. Ms Fox assured the Board that attention is being given to this and will be discussed at Aprils Quality Governance Committee as well as at the SI Group.

Ms Fox drew the Board's attention to the Friends & Family Test data on page 35 of the report. Ms Fox advised the Board that she will provide a run chart in April's Trust Board.

Ms Fox was pleased to share with the Board that Trust had been shortlisted for two national awards at the NHS England FFT Awards 2016. The awards have been set up to recognise the way patient and staff feedback are used to improve healthcare services.

Ms Fox reported the Dementia CQUIN was met in Q2, Q3 and Q4. This positive progress is being taken into 2016/17 although it the Dementia CQUIN will no longer be categorised as a national CQUIN.

Ms Fox advised that the Dying Person Care Plan use will be closely monitored to ensure all patients receive an individualised plan of care.

Ms Fox reported on the registered nurse fill rates. Mr Kershaw noted that it was positive that day nurse fill rate numbers were no longer in the red. Mr Kershaw commented that the Workforce Committee were encouraged by this and would like to show recognition to the hard work with recruitment. Mr Farenden is also encouraged by the nurse fill rate and the reduction of the use of agency staff.

Mr Farenden queried whether the increased rate in falls could be connected to the recent MRSA Bacteraemia? Ms Fox assured the Board that there was no connection and the falls were witnessed. Mr Farenden therefore questioned whether the falls could be linked to training issues; Ms Fox assured the Board that this was not the case and clarity needs to be ascertained as to whether the fall could be classed as a collapse.

Mr Farenden asked how the improvement of the bank had been shared and received with nursing bank staff. Ms Fox advised that nurse band 6 and 7 has been recognised at the correct pay grade and a non-pensionable bonus scheme has also been introduced. Ms Fox stated that the Senior Nursing Team had met with nursing bank staff on improvements and confirmed that the above ideas had come from these meetings. Ms Searle queried whether there was a mechanism in place to the capture the numbers of hours staff are doing; Ms Fox confirmed that there was.

Ms Searle requested that Ms Fox share the update of recording new harms in pressure ulcers. Ms Fox advised that she had investigated the collation of pressure ulcer data. The findings of the investigation have concluded that existing pressure ulcers have been counted as a new pressure ulcer every month; therefore increased the number of recorded new pressure ulcers which is not a true representation. Ms Fox has corrected this to show as existing pressure ulcers, rather than as a new harm. Ms Fox and Dr Swart have discussed this with the TDA with no objections noted. Also, if the pressure ulcer changes from grade 2 to a grade 3, how will this be recorded; it will be recorded as new harm. This improvement will also improve the Safety Thermometer data which will be reflected in April 2016 data collation.

Mr Noble shared with the Board that the nursing report was very encouraging; however in the Medical Director's Report it is noted on page 19 the difficulty in recruitment and high turnover in nursing staff group at a current rating of 25. Ms Fox advised that the risk needs to be split between specialist and inpatient wards. Ms

Fox reported that the fill rate listed in the Nursing and Midwifery report focuses on inpatient wards. Mrs Brennan clarified that the demand for nursing staff still outstrips the supply and that the figures within the Nursing and Midwifery report contains bank and agency staff.

Mrs Clymer queried the reaction from staff in relation to the new collation of pressure ulcer data. Ms Fox advised that once the first month of data has been collected and analysed, then it will be shared with staff for feedback.

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

TB 15/16 123 **Finance Report**

Mr Lazarus presented the Finance Report.

Mr Lazarus reported that the Trust should still be able to achieve the £20.4m deficit control total with the delivery of the urgent care CQUIN. Mr Lazarus advised the Board that no year-end deal had been made at present with the CCG. Mr Lazarus stated that a reduction in cost had helped neutralise the impact of reduced income..

Mr Zeidler queried the disputed prior year balance and whether there was an update on this. Mr Pallot confirmed that there is no contractual basis to the CCG's claim but even so they had no yet cancelled the invoice. Mr Farenden confirmed the Board's position that the Trust will not pay this invalid invoice or account for any such liability.

The Board **NOTED** the Finance Report.

TB 15/16 124 **Workforce Performance Report**

Mrs Brennan presented the Workforce Performance Report.

Mrs Brennan reported that the Trust's substantive workforce had increased to 92.5%. Mrs Brennan would like the Board to note that it is likely that current sickness absence are indicative of the pressures staff are currently under as well as the predictable seasonal trend.

Mrs Brennan advised that Board that the flu vaccination uptake was slightly decreased this year; however this could have been influenced by the negative publicity shared nationally last year. The Department of Health flu survey data should be published in April/May 2016 and Mrs Brennan believes NGH will have performed well in the East Midlands. A CQUIN has been set for next year at a 75% target for staff vaccines.

Mrs Brennan reported that the current rate of appraisals is down at 80.23%. This may be attributed to the large number of new starters in February 2016 who will not yet has started the appraisal process. However she advised the board that in the recent staff survey the Trust scored in the top 20% of the country for appraisal rates.

Mrs Brennan advised that mandatory training compliance is down; however there has been an increase in role specific training.

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

TB 15/16 125 **Clinical Collaboration & Healthier Northants Update**

Mr Pallot presented the Clinical Collaboration & Healthier Northants Update.

Mr Pallot reported that in line with the Delivering the Forward View NHS planning guidance 2016/17 – 2020/21, work has started with KGH to form an acute element of the STP. In-line with expectations, this update was identical to that presented at HMT and KGH's Trust Management Committee. Mr Pallot advised that a consistent

message needs to be delivered between the two Trusts.

Mr Pallot shared with the Board progress to date on the clinical collaboration between the two Trusts and this is detailed on page 79 of the report.

Mr Pallot reported that a 'mini' HMT needs to be established between the two Trusts to help build working relationship, operational management and further discuss clinical collaborations. This group will meet every 6 weeks to ensure all new and existing pathways run with a consistent approach. Mr Pallot stated that financial support from the CCG is essential is enabling the acute trusts to move forward with clinical collaboration plans. The Clinical Collaboration Steering Board are keen to move discussions with KGH forward. Mr Farenden agrees that this discussions need to happen and that will only further demonstrate NGH's contribution to the Health Economy.

Dr Swart advised that the CEO Group had discussed the need for clinical collaboration engagement. It was agreed that the strategy would be led by the two Directors of Strategy and Partnerships, who will work with the CCG on implementation. Dr Swart reported that Rheumatology is the test case and will need all the Board's support to ensure work can commence on the clinical collaboration of other specialities.

Mr Zeidler noted that the progress to date with Cardiology had encountered some difficulties. The CCG has approved NGHs service development bid for establishing heart failure services outside of hospital; however KGHs was not approved. Mr Zeidler advised that if the two Trusts are trying to work together then this cannot be a positive outcome. Mr Pallot stated that unfortunately the CCG had now indicated that they wished to remove the funding from NGH and that as a result the heart-failure service across the county may not move forward.

The Board **NOTED** the Clinical Collaboration & Healthier Northants Update.

TB 15/16 126 **Emergency Preparedness Annual Report**

Mrs Needham presented the Emergency Preparedness Annual Report.

Mrs Needham reported on the Emergency Preparedness, Resilience and Response Plan (EPRR). Mrs Needham advised that the Resilience Planning Group meets bi-monthly to discuss the EPRR plan. The group focuses on Resilience and Business Continuity work streams. Mrs Needham asked the Board to note Appendix 1 of the report which details the review of the Resilience Responsibility Arrangements held by the Trust. Tiaa confirmed that NGH is subsequently compliant in meeting these standards.

Mrs Needham reported on the Core Standards Submission against the compliance levels of fully compliant, partially compliant and non-compliant. Mrs Needham stated the emergency plans were tested live in 2015 and these included Ebola, Internal Significant Incidents and the junior doctor strikes. The report indicates that a learning programme will need to be implemented departmentally and a working plan is in place for this.

Mrs Searle thanked Mrs Needham for her good report and commented on her surprise to note that Command and Control (C2) scored low on overall compliance. Mrs Needham advised that this is owing to evidence needed to be shown on the management of Gold Command. The Policy outlines strict criteria which the core standards are not realistic to meet. Mrs Searle also asked for clarification on the low compliance scoring of Training and Exercising. Mrs Needham reported that this was linked to decontamination in A&E. This can be a challenge due to the releasing of staff for a full days training. Mrs Needham confirmed that 60% of staff with this

responsibility are trained. Mrs Needham was requested to appendix the training schedule at next month's Board of Directors.

Action: Mrs D Needham

Mr Farenden confirmed that the Board are assured by Mrs Needham's report.

The Board **NOTED** the Emergency Preparedness Annual Report.

TB 15/16 127 Integrated Performance Report

Mrs Needham presented the Integrated Performance Report and Corporate Scorecard and informed the Board that all areas had been covered in detail at the recent January Finance Investment and Performance Committee, Quality Governance Committee and Workforce Committee meetings.

Mrs Needham made the Board aware of the strain the whole Trust was under due to urgent care pressures. Mrs Needham advised that the volume of patients was increasing and H1N1 was still present. Mrs Needham stated that she is extremely proud of staff despite urgent care pressures.

Mrs Needham advised that day room beds are still in use and is happy to share with the Board that patient feedback in these areas is still positive.

Mrs Needham would like the Board to note that if the Trust continues to operate under the increasing pressure, the 18 week and diagnostic targets will not be met. 12 hour trolley waits are also a significant cause for concern moving into April 2016.

Ms Clymer stated that on a recent Board to Ward visit in heart surgery, she was impressed with how the ward team were dealing with the increased pressures.

Ms Searle expressed her concern at the impact on patients on waiting lists and the quality of care concern that links with this.

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

TB 15/16 128 Staff Survey

Mrs Brennan presented the Staff Survey Report.

Mrs Brennan reported that all staff within the Workforce were invited to complete the staff survey. She was pleased to report that the overall staff engagement score had increased from 3.6% to 3.75%. It was also pleasing to note that findings from the survey showed increases in staff recommending the Trust as a place to work, staff motivation and staff saying they could contribute to improvements at work.

Mrs Brennan advised that the trend analysis shows a trajectory of improvement since 2012. Overall there were 10 statistically significant improvements, no deteriorations and we had moved from 18 key findings ranked in the lowest 20% reducing by 50% to 9 key findings.

Mrs Brennan reminded the board that the approach to improving the staff experience was through our Organisational Effectiveness Strategy: Connecting for Quality, Committed to Excellence, and the survey had shown year on year improvement since its introduction. Mrs Brennan outlined the key aspects of this strategy that included the Francis Crick Leadership and Management Development Programme for senior leaders operating in the new clinically led structure, and the staff engagement strategy which had now seen over 1200 staff participate in the Rainbow Risk sessions. She advised that 4 Trust wide 'Street Talk' events have been held with further 21 local events. There are currently 69 volunteers DoOD's from across

NGH.

Mrs Brennan advised that some of the teams participating in the Making Quality Count (continuous improvement) development programme had been nominated and won awards at the Best Possible Care Awards last year.

Mr Farenden commented that he was encouraged by the improvement in the staff survey findings. Mr Farenden queried whether staff have been made aware of the positive feedback; Mrs Brennan is working on this.

Ms Searle stated that the report was good to read and is pleased that the OD strategy has carried on its implementation. The benefits from the OD strategy can clearly been seen with the improvements with staff engagement noted in the report.

The Board **NOTED** the Staff Survey Report.

TB 15/16 129 Highlight Report from the Finance Investment and Performance Committee

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

The Board were provided an update on activities undertaken during the month of February and discussed at the Finance Investment and Performance Committee meeting held on 23 March 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 Noble gave a verbal update from the Finance Investment and Performance Committee which took place on 23 March 2016 and informed the Board that several items had already been discussed under the Finance Report at the meeting today.

He informed the Board that key areas of discussion were:

- The gap analysis in the Carter Report was useful as it highlighted gaps that needed to be addressed. Going forward this will be a permanent enclosure with the Changing Care @ NGH Programme report which is discussed at the Finance Investment and Performance Committee.

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

TB 15/16 130 Highlight Report the Quality Governance Committee

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

The Board were provided an update on activities undertaken during the month of December and discussed at the QGC meeting held on 24 March 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 Searle gave a verbal update from the meeting which took place on 24 March 2016 and informed the Board that several items had already been discussed under the Medical Director's Report and the Director of Nursing's Report at the meeting today.

She informed the Board that key areas of discussion arising from items appearing on the agenda were:

- The new harm recording of pressure ulcers which will improve the data collation for the Safety Thermometer.
- The Trust scoring near the bottom of non-learning organisations.

- The approval of the IG Toolkit.
- 3 SI's reported.
- The inclusion of coroner reports in the Medical Director's report for the first time at QGC.

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

TB 15/16 131 **Highlight Report from the Workforce Committee**

Mr Kershaw presented the Report from the Workforce Committee.

Mr Kershaw gave a verbal update from the meeting which took place on 23 March 2016 and informed the Board that several items had already been discussed under the Workforce Report at the meeting today.

He informed the Board that key areas of discussion arising from items appearing on the agenda were:

- Recruitment of nurses from Europe is becoming difficult with the main focus of recruitment from India and the Philippines.
- The retention of nurses was detailed in the Nurse Recruitment and Retention strategy with plans moving forward to look at 'Pathway to Excellence' strategy.
- Medical appraisals and revalidation had become a concern in Oncology.
- Consultant of the week to commence in Oncology; this will ensure that each day a consultant is responsible for all patients on the ward as well as providing leadership and training for junior doctors. Dr Cusack will provide feedback quarterly to the Workforce Committee.

Mrs Brennan advised the Board that nurses were now included on the tier 2 list. Due to this, from April 2017 the cost of sponsorship will raise from £100 to £1000.

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

TB 15/16 131 **Highlight Report from the Audit Committee**

Mr Noble presented the Report from the Audit Committee.

The Board were provided an update on activities undertaken and these were discussed at the Audit Committee meeting held on 24 March 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. He informed the Board that key areas of discussion arising from items appearing on the agenda were:

- External audit report showed no significant issues and the timetable seemed reasonable.
- The Internal Audit Charter was reviewed and was recommended approval at the next Audit Committee.
- Limited reassurance was given to the Nurse Agency Staff Audit: Fiona Barnes attended the Audit Committee were satisfied with Fiona Barnes reassurance on this audit.
- Limited reassurance was given to Health and Safety Audit: Mr Abolins presented an action plan to the Audit Committee and the Audit Committee would like verification that actions set out in the plan have been taken.

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

TB 15/16 132 **Highlight Report from the Hospital Management Team**

Enclosure A

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

Dr Swart reported that the meeting on 08 March 2016 HMT Workshop and included the wider management team; Divisional Managers, Directorate Managers, Matrons and Clinical Directors.

Dr Swart advised that areas of discussion were divisional updates, clinical collaboration progress update, changing care work stream update and a communications workshop.

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

TB 15/16 133 **Any Other Business**

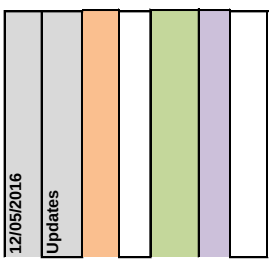
There were no items of any other business.

Date of next meeting: Thursday 28 April 2016 at 09:30 in the Board Room at Northampton General Hospital.

Mr P Farenden called the meeting to a close at 11:10

Public Trust Board Action Log							Last update
Ref	Date of meeting	Minute Number	Paper	Action Required	Responsible	Due date	Status
Actions - Slippage							
NONE							
Actions - Current meeting							
Actions - Future meetings							
NONE							

Enclosure B


12/05/2016
Updates

Northampton General Hospital NHS
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**26 May 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
26 May 2016

Chief Executive's Report

1. **Patient safety**
   NGH was one of five hospitals shortlisted for the Hospital Patient Safety Award from CHKS. This national award for outstanding performance in providing a safe hospital environment for patients is based on a range of indicators, including rates of hospital-acquired infections and overall death rates and death rates from stroke, heart attack and fractured femur as well as some outcome data that includes complications. The data has been taken from our nationally submitted data which is also used by our commissioners. Unfortunately we didn't win the award, but this is the first time we have been in the top five hospitals for the award and reflects our core value of putting patient safety above all else.

2. **Junior doctors' strike action**
   The unprecedented strike action in April was well planned for by all our teams and was a fantastic example of people pulling together to make things safe for patients. Overall my personal sense was one of calm, pride and, for some enjoyment, of the team challenge - in effect a great team building exercise. The wards liked having their consultants around and I did not hear anyone complain.

   There will undoubtedly be more strike action to come and it is likely that the challenge will increase so there will need to be more planning. We are taking the learning from the strike action to improve our planning processes generally and also at times such as Bank Holidays which do have an impact on activity.

   The impact of the strike action has been very much felt by our patients, especially those who have had their elective admissions cancelled and re-arranged and we are receiving complaints about the long waits. We are carefully looking at how we can address this issue without spending any more money as going into more and more deficit is not an option, but equally we are mindful of the overall impact on the patient experience.

3. **Quality Improvement**
   This year we delivered a number of presentations at the International Forum on Quality & Safety in Healthcare which was held in Gothenburg in April. This was an impressive achievement for a small hospital. We are already planning to contribute to next year's forum, which will be held in London and hope to deliver some of the plenary sessions there.

   Our quality improvement work is led by Dr Philip Pearson as Senior Lecturer in Quality Improvement, supported by the University of Leicester. He is ably assisted by the patient safety team led by Jane Bradley and Celia Warlow. International recognition such as this is the result of several years' work in this area initially very much championed by Jane Bradley, who has consolidated her role in QI work under the direction of our medical and nursing directors and remains committed to assisting our medical students and junior doctors in this area.

   Teaching and assisting our doctors in training in this way brings benefits for everyone but we have been particularly keen to use QI work as a way of engaging our trainees and ensuring the topics they work on are aligned with our overall priorities. It is this energy and alignment which has led to the University interest and support for our work. We recently had a great example of this at the Quality Committee where two junior doctors presented an excellent piece of work relating to improvements for patients with learning disabilities. I was also pleased to learn that one of our Junior Doctors on the Junior Doctor Safety Board

won the Medical Women's Foundation Elizabeth Garrett Anderson prize for her work on standardising cannula trollies.

Our quality improvement strategy is now being finalised. This will bring together all the aspirations we have to help ensure that everyone who works here can fulfil our core value of aspiring to excellence. The simple message for all staff is that living this value means that everyone not only delivers care but has a role in improving it.

Developing all our people to understand how to improve quality and safety incorporates key elements of behaviour and leadership. We know this work has to dovetail with the improvement culture that supports clinical governance and, after two years' progress, are now at the point where we are ready to start to bring it into business as usual. I am hopeful that the work we are undertaking with our students and doctors in training, as well as with some of student nurses, will ultimately lead to stronger partnerships with our Universities

4. Sustainability and transformation plan

We are actively involved in the development of the sustainability and transformation plan (STP) for the county. We hope the plan will build on the work we have already done and help us move this forward to a level where we can start to implement new ways of working. The STP will need to include some ambitious projects that represent fundamental changes in the way care is delivered and must include plans to improve our urgent care system and our delivery of key constitutional standards as well as deliver enough efficiency savings to sustain our system. This is a very challenging task and one which will continue long past the submission date at the end of June.

For NGH this will mean working more closely with KGH, building on the collaborative work that is already underway and looking at new ways of working together to improve the quality and efficiency of the services we provide. At the same time we will also need to work more closely with primary and community care, to ensure that the local population has access to the right care for them in the right place, at the right time.

Delivering a successful transformation plan will depend on successfully looking at how we address some critical enablers such as workforce, IT and estates. It will require good clinical engagement and consultation with patients.

5. Best Possible Care Awards

Despite the pressures faced by our staff, every day we continue to receive comments and compliments from patients, their families and carers about the great care our staff provide. Our social media accounts on Facebook and twitter are also regularly used by our patients to comment favourably on the care they receive.

Last year our Best Possible Care Awards were held for the first time outside the hospital and, building on the success of that event, we plan to have a Gala Award Ceremony at The Park Inn, Northampton on the evening of Friday 30th September. This year we are aiming to have more staff attending, we have an additional award category of Clinical Educator of the Year, and we are committed to seeking sponsorship for this event. We are grateful to the support we receive from both our charitable fund and local businesses which enables us to recognise, reward and celebrate our staff who go above and beyond what might normally be expected of them.

Nominations are currently being sought from staff, patients, relatives and carers, as well as from the public and our local health and social care colleagues. I am sure all board members will want to join me at the event on 30th September.

Dr Sonia Swart
Chief Executive

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 May 16**

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

Five new Serious Incidents (including a Never Event) have been reported during the reporting period 01/03/2016 – 30/04/2016 which remain open and under investigation. Where appropriate immediate actions have been agreed at the SI Group to mitigate the risk recurrence – of these, three serious incidents which have been reported in 2016/17 (since 01/04/2016). Three External Serious Incident reports have been submitted to the CCG for closure. Two of these incidents relate to previously reported Never Events. Eleven inquests have been convened during the reporting period. The learning identified is described in the report.

Dr Foster data showed overall mortality expressed as the HSMR and SHMI remains within the 'as expected' range. The rates of Charlson and palliative care coding rate remain below the national average. At the time of the Board meeting, NGH will have hosted the countywide mortality meeting on 20th May. The 7th Trust wide mortality case note review has been completed which focused on low-risk and post-operative patients. The details of this review will be presented at the July Board meeting.

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 /	Are there any legal/regulatory implications of the paper

regulatory requirements	

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
26 May 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. The key challenge 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	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

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.	16	25	Workforce
979	Difficulty in recruitment and high turnover in nursing staff groups.	16	25	Workforce
81	Inability to maintain effective service levels due to reduced skilled nursing workforce for the existing bed base.	9	16	Workforce
111	Risks to quality and outcomes due to inability to recruit sufficient medical staff.	16	16	Workforce

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	3
Never Events	2	2	1	0	1	3	0

The Never Events in 2015/16 relates to:

Wrong site surgery - Dentistry

There has been a full RCA investigation of an incident involving 'Wrong Site Surgery' which occurred within Dentistry. This has been submitted to the CCG and the actions below have/will be implemented as a result of the recommendations:

- Surgical site marking and verification policy has been updated to include the use of a dental chart
- All parts of notes, records and radiographs must be thoroughly checked before surgery
- Checklist sticker for use on consent forms will be created
- Ensure clinic notes are available for review in signing off associated correspondence
- Review of facilities to ensure that relevant radiology available for review when taking consent
- Review of consultant rotas to ensure there is adequate cover for clinical activities during annual leave
- WHO surgical checklist to be included in updated annual mandatory training for all theatre staff
- All staff involved to attend 'Learning from Errors' training within the simulation suite. The learning from this Serious Incident will be incorporated into 'Learning from Errors' Training - focussing on the use of the WHO checklist and site marking

Incorrect Device – Ophthalmology

The investigation into this incident has been concluded and the report submitted to the CCG. The actions below have/will be implemented as a result of the recommendations:

- A Standard Operating Procedure(SOP) for use in cataract surgery has been agreed by all surgeons
- Nursing and surgical staff will receive update training in the best practice for double checking of devices/implants
- Concerns regarding the labelling of the implant box have been highlight labelling to the MHRA and manufacturer
- Full incident report has been shared through the Governance team in each area
- A summary report containing he key learning has been shared with all theatre staff at morning briefings

Wrong site surgery – Gynaecology

This incident remains under investigation. In advance of this, immediate actions have been introduced (reported in the last Board report). The findings and recommendations of the investigation will be reported to the Board in July.

2.1 New Serious Incidents

Since the last report to the Board (during the reporting period 1/3/2016 – 30/4/2016) 5 new Serious Incidents have been reported.

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

A total of 14 Serious Incidents were reported in 2015/16 under the following categories:

- Slips/Trips/Falls
- Unexpected Deterioration
- Delayed diagnosis
- Infection Control issue
- Medication incident
- Maternity
- Wrong site surgery
- Delay in instituting treatment/referral to specialist team

From 1/4/2016 there have been 3 Serious Incidents reported under the following categories:

- Surgical/invasive procedure
- Sub-optimal care

2.2 Open Serious Incidents

The serious incidents at 30th April 2016 which remain open and under investigation are listed below:

Date of Incident	SI Brief Detail	Status
24 Dec 2015	Wrong site surgery **(Never Event)**	Active
06 Dec 2015	Digit amputation	Active
03 Feb 2016	Fall - Dislocation	Active
05 Jan 2016	Fall - Parenchymal Haemorrhage	Active
24 Feb 2016	Deteriorating During Interhospital Transfer	Active
10 Mar 2016	Failure to Escalate Following Deterioration	Active

29 Mar 2016	Surgical Error	Active
31 Mar 2016	Retained Item in theatre	Active
19 Jun 2015	Hyperkalaemia	Active

2.3 Serious Incidents Submitted for Closure

During the reporting period there were three serious incident reports submitted to Nene and Corby Clinical Commissioning Group (CCG) for closure. Two of these incidents relate to the Never Events described earlier. The third incident was related to the use of medication Azithromycin). The recommendations following a detailed investigation of this incident are:

Medication – Azithromycin incident

- Consultant to re-check medical information in clinic letters
- Changes to the medication to be documented in the 'medication list' section of the departmental clinic letter template
- Add flag for Azithromycin to GP 'System 1'
- Communication regarding this incident and the risks identified to all pharmacies
- Discussion of prioritization of introduction of Electronic Prescribing to the Out Patients clinics with the EPMA team
- Review of current system of copied out-patient prescriptions and their transfer to GPs

2.4 Inquests

H M Coroner convened 11 Inquests during the reporting period which involved Trust staff either preparing statements or giving evidence at the hearing. The conclusions of the Inquests were 2 narrative conclusions, 1 death from natural causes, 6 accidental deaths and 2 deaths from industrial diseases.

The Learning identified from the inquests described is outlined below:

- To review the process for the handover of information when patients are discharged to care/nursing homes

Process review

Since the 25 April 2016 the Governance Department has instigated a formal risk assessment process where the medical records of the patient are reviewed by the Clinical Governance Manager or Head of Governance to determine if there are any concerns over the care/treatment given. This process will also take into account issues such as nutrition and hydration, falls history, family or GP concerns. This information is triangulated with that obtained from the previous process.

2.5 DNACPR

The British Medical Association (BMA), the Resuscitation Council (UK), and the Royal College of Nursing (RCN) have issued updated guidance regarding anticipatory decisions about whether or not to attempt CPR which take into account developments in clinical

practice and in law. Further updates to this guidance are expected, however, the fundamental underpinning ethical principles remain unchanged.

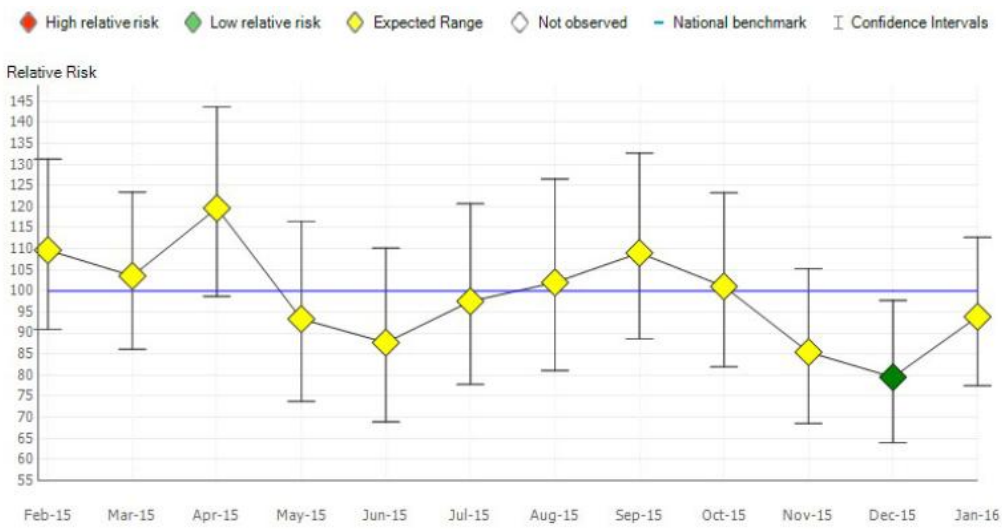
The Resuscitation Council has concluded a consultation process on a national DNACPR review and it is hoped that standardised national DNACPR documentation will be released imminently.

Capsticks solicitors provided a multidisciplinary educational teaching session at the Trust on issues relating to DNACPR on 6th May 2016 with a high level of attendance. Further education meetings are planned. DNACPR is discussed at the safety huddles and monitored through the QCI audit undertaken by the nursing and midwifery staff.

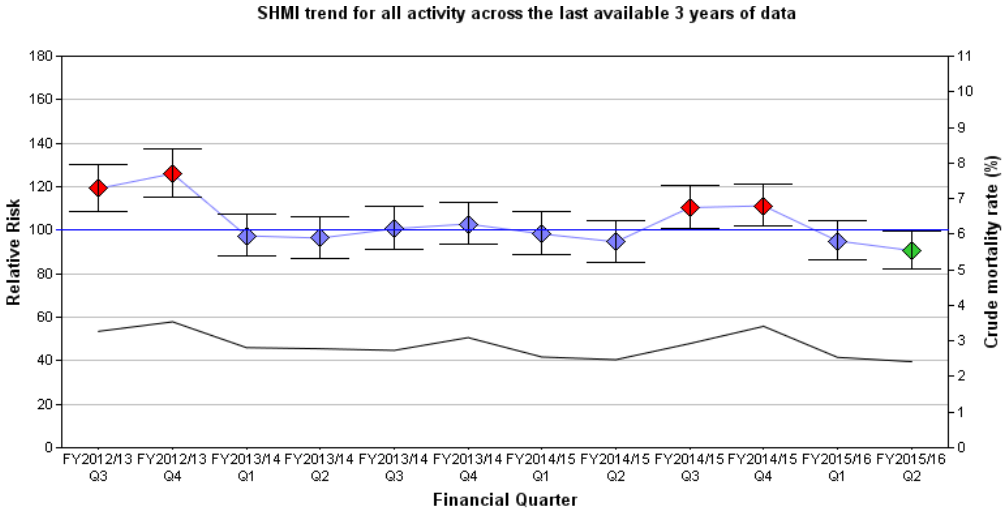
Information regarding the community DNACPR process has been widely shared at educational/academic meetings and through the safety huddles.

3. Mortality Monitoring

The HSMR for the year to January 2016 (latest Dr Foster data) remains with the 'as expected' range at **98.4.** T The overall 12 month trend is shown in the graph below:



The SHMI data which records deaths which occur both in hospital and within 30 days of discharge for the year to September 2015 (latest HSCIC data) remains within the 'as expected' range at **102.1**. The SHMI trend is shown below:



3.1 Weekend Effects

For the rolling year ending to January 2016 there was no statistical difference between the standardised mortality rates for weekend [**97.4**] and weekday admissions [**98.2**].

3.2 Coding

The NGH palliative care coding rate is currently 2.74% of HSMR inpatient spells which remains below the national average of 3.34% despite the revision of the uploaded Trust data. This potentially reflects local practices where clinical teams manage the end of life care for patients who are known to them without referral for input from the specialist palliative care team. There is considerable work is underway in relation to the end of life patient pathway within the Trust which seeks to address this shortfall in uptake/referral.

The index of Charlson Co-morbidity Coding rates has reduced in 2015/16 relative to the national rate with an upper quartile rate of 24.8% vs. 25.0% (national rate). The clinical coding team are undertaking work internally to understand this change.

3.3 Countywide Northamptonshire Mortality Meeting

The first countywide mortality meeting took place in 2015 as part a local CQUIN. Due to the success of this event a further meeting was hosted at KGH later that year. NGH will be hosting the countywide meeting on May 20th 2016. The meeting will focus on Sepsis and AKI and will incorporate a Grand Round presentation. It is anticipated that the CEO of NCEPOD will attend to discuss to on-going national audits, mortality review and their recent review of sepsis management in the UK.

3.4 Trust wide mortality case note review

The analysis of 7th Trust wide mortality case note review has been completed. This review has focused on low-risk and post-operative patients. The outcome of the review will be presented to the Board in July.

4. 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 provide assurance to Trust Board.

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

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 May 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 Jason King, 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 – In April 2016 the Trust achieved over 95% harm free care with new harms
- In April the number of reported pressure ulcers was 38. These will be validated in May at the 'Share and Learn forum.
- There has been 3 C. Difficile case reported in April, 0 MRSA Bacteraemia,
- In April there has been 3 in-patient falls that has caused severe harm and are currently under investigation.
- FFT in March– Inpatients 84%, OPD 91.2%, Emergency Dept. 85.2% and Maternity 95% 'would' recommend
- Welcome to Margot Emery the new End of Life project lead who has replaced Wendy Smith
- Safe Staffing -Overall fill rate in April was 103%, with a combined fill rate of 102% throughout the month
- The report also provides an overview of the Care Hours Per Patient Day (CHPPD) metrics that the Trust is required to submit to NHS Improvement from April 2016.

Enclosure E

Related strategic aim and corporate objective	Quality & Safety. We will avoid harm, reduce mortality, and improve patient outcomes through a focus on quality outcomes, effectiveness and safety
Risk and assurance	The report aims to provide assurance to the Trust regarding the quality of nursing and midwifery care being delivered
Related Board Assurance Framework entries	BAF 1.3 and 1.5
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper - NO

Actions required by the Trust Board

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

The Trust 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.

Trust Board
26 May 2016

Director of Nursing & Midwifery Report

1. Introduction

The Director of Nursing & Midwifery Report presents highlights from projects during the month of April. 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

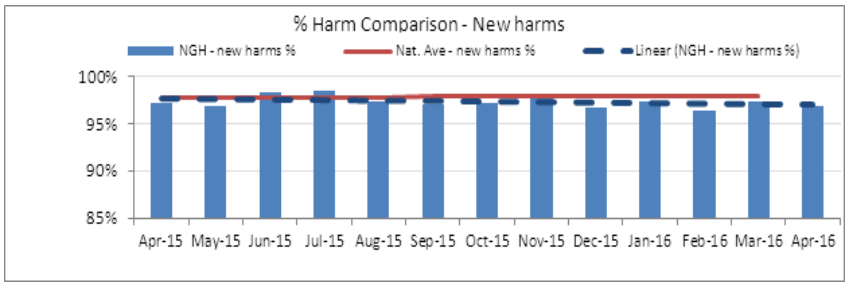
At the beginning of 2016 the patient's safety culture work in eight acute trusts in the East Midlands will commence with online safety attitudes/climate surveys for the workforce in emergency departments and maternity units in all acute trusts.

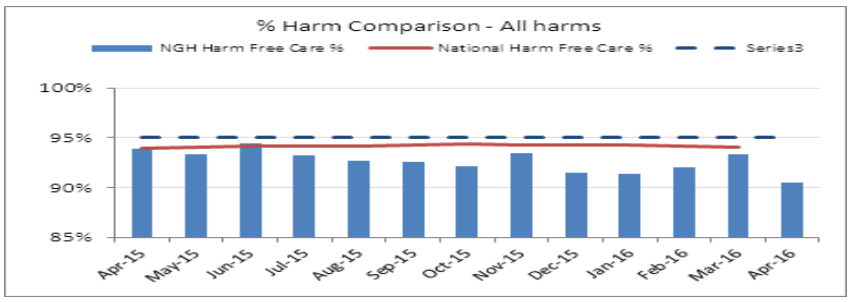
The surveys will be organised and analysed by Pascal Metrics. Pascal Metrics will also support the delivery of strategies to improve the culture of patient safety in these services based on the results of the surveys.

This is a four year programme of culture assessment which provides diagnostic and 'actionable' insights into organisational and unit level cultures which enable the development of data driven training programmes to address areas of risk and opportunity.

3. Safety Thermometer

Please see appendix 1 for a definition of Safety Thermometer. The graph below shows the percentage of all new harms attributed to the Trust. In April 2016 NGH achieved 95% harm free care (new harms).



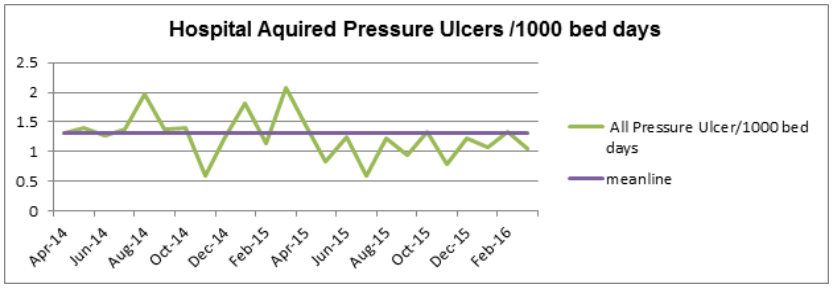


In April 2016 NGH achieved 90.53% of harm free care, with 3.21% of patients on the day recorded in the category of 'new' harm (sustained during whilst they were in our care) which is a

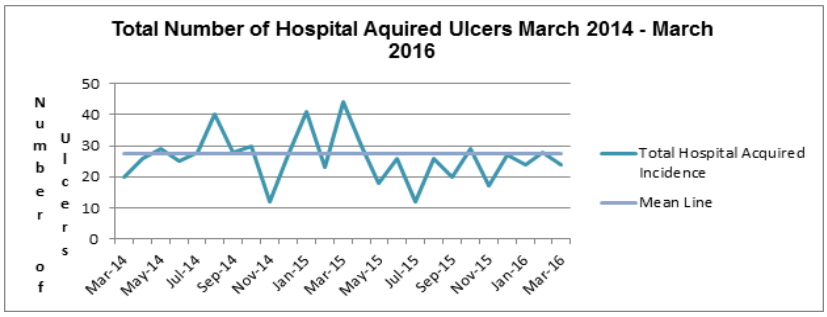
Enclosure E

deterioration from March 2016 which was 2.70%. Broken down into the four categories this equated to: 3 falls with harm, 0 VTE, 3 CRUTI and 14 'new' pressure ulcers.

4. Pressure Ulcer Incidence



The graph above shows the pressure ulcers/1000 bed days in relation to hospital acquired pressure damage.



The graph above shows the total number of hospital acquired pressure sores from March 2014 to March 2016.

Lapse in Care Identified which may have attributed to the pressure damage	
➢ Moving and handling issue recognised	
➢ Non-compliance of skin inspection	Regularity of skin inspections especially where devices are present
➢ Delays in use of preventative aids	Lack of documented evidence of when implemented
➢ Inaccurate Waterlow Scoring	Non-inclusion of all current and past conditions.

The table above provides detail of the lapses in care which may have attributed to the development of pressure damage.

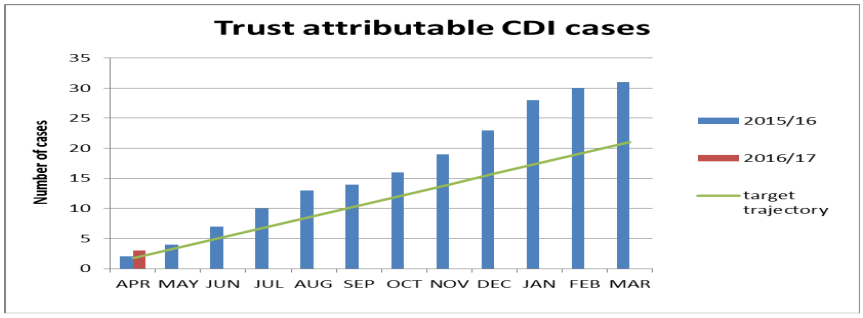
5. Infection Prevention and Control NHS Improvement Programme

The key focus for IPT is working with NHS Improvement on an Infection Prevention and Control Improvement Programme. The launch of the event was April 12th 2016. The Trust is partaking with 22 other Trusts in a 90 day collaborative. The launch provided an opportunity to meet with other organisations to share good practice and work together to raise the profile of infection prevention and to make a measurable and sustainable difference.

In reviewing the themes from our 31 patient cases with *C.difficile* infection one of the key themes identified that further work is required around prompt faecal sampling, Therefore our overall aim is to improve the timeliness of obtaining faecal samples in 3 wards within our Trust and therefore improve patient outcomes by identifying *C.difficile* infection earlier by September 2016.

In the 30 days leading up to the next collaborative event May 11th 2016, the IPT in collaboration with Collingtree, Willow and Allebone wards, and an expert group of staff members from these ward areas are using PDSA cycles (Plan Do Study Act) to undertake tests of change and drive improvement. Monthly updates will be provided in this report.

Performance Information
Clostridium difficile Infection
Clostridium difficile infection (Trust apportioned)



The graph above shows that there have been 3 cases of *C.diff* apportioned to the Trust for the month of April 2016. A Root Cause Analysis (RCA) will be undertaken for each case.

MRSA Bacteraemia
The Post Infection Review has been completed for the patient that acquired a trust attributable MRSA bacteraemia in March 2016. Blood cultures were taken as well as a urine sample which both isolated MRSA.

Appropriate root cause analyses were undertaken. There were some areas of good practice as well as some learning outcomes for the GP and our medical staff. These will be taken forward and shared within the Division. For April there has been 0 trust attributable MRSA bacteraemia.

MSSA Bacteraemia
MSSA Bacteraemia (Trust attributable cumulative totals)

There is no national target set for MSSA bacteraemia. The Infection Prevention forward plan has set an ambition of no more than 15 cases for 2016/2017. For April 2016 there were no cases.

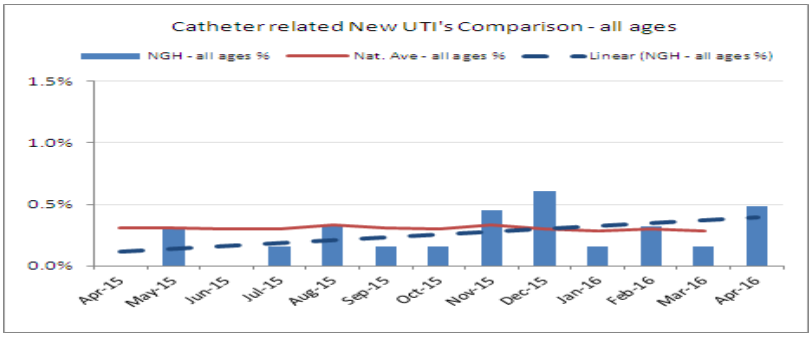
Escherichia coli (*E.coli*) Bacteraemia

There is no national target set for *E.coli* bacteraemias. For April there were 4 trust attributable cases.

Source of Infection	Number of Cases
Urosepsis	3
Intra-abdominal sepsis	1
Unknown	0

The table above provides the breakdown of source and number of *E.coli* bacteraemia cases for April 2016.

Catheter Related Urinary Tract Infections (CRUTI)

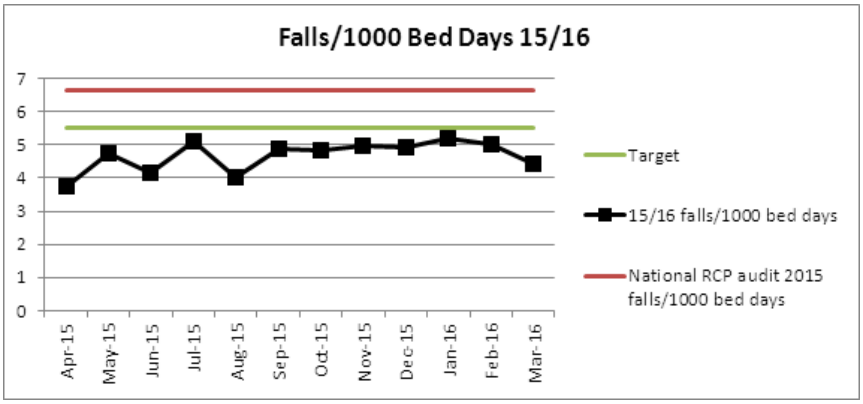


The graph above shows that for April 2016 there were 3 trusts attributable CRUTI's on Compton, Holcot and Knightley wards. RCA's to be performed on all 3 cases. April is 'Catheter Care' month and work will be undertaken with these 3 wards. The Infection Prevention Team will also be reviewing the themes and ward location of the identified CRUTI from April 2015-April 2016.

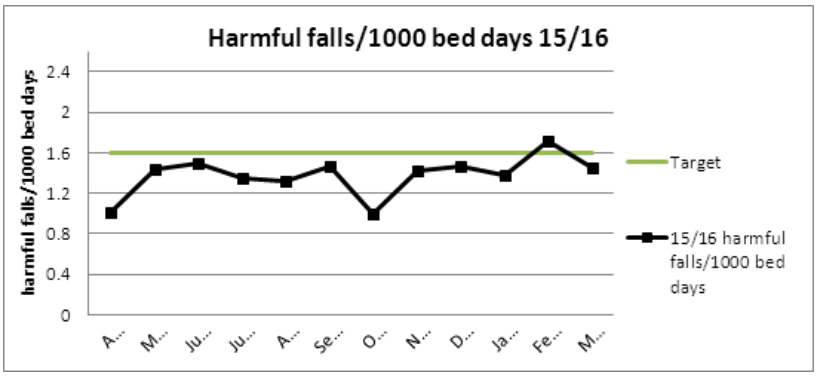
6. Falls Prevention

Falls/1000 bed days

The way in which we calculate our bed days has changed from 1st April; we are now not including bed day from the Barret Birth Centre. This results in our bed days being lower and 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 (Statistical Process Chart) or run chart cannot reliably be generated. Last year's figures are below for information only.



The Trust's Falls/1000 bed days is below the national average and the (internally set) target. The maximum number of 1.6 harmful falls/1000 bed days is the internally set target. April 2016 has seen a result of 1.55 harmful falls per/1000 bed days. The graph below shows the falls per 1000 bed days which resulted in moderate, severe or catastrophic harm.



Falls resulting in moderate, severe or catastrophic harm

This month

Severity of injury	Number of falls last month
Moderate	0
Severe	1
Death	2

This month we reported 3 in-patient falls that caused at least 'moderate' harm. Some of these falls are still being investigated and the severity of the injury may be reviewed once the investigation is complete. One fall resulted in severe harm; a fractured neck of femur (hip). 2 patients died after they fell and the cause of their death is currently being investigated.

Work underway to reduce the falls rate/improve post fall care:

- On-going thematic review of serious incidents
- Training as part of cluster days, simulation suite sessions (including neurological observation simulation training sessions for Nurses) and junior doctors training.
- New simulation suite session piloted in April 2016 was very successful-plan to role out
- Support/training to wards RAG rated red in completion of the falls risk assessment and/or care plan

7. Nursing and Midwifery Dashboard

Please see appendix 2 for a definition of the Nursing Midwifery dashboard and appendix 3 for the dashboard.

The Quality Care Indicators (QCI) for April 2016 shows the following:

- Protected mealtimes section is the area of the month with most of the red and amber ratings. On further examination of this, this was due to the fact that a number of the questions which related to this were left blank, therefore giving a negative response.
- Compliance with falls assessments and care planning has improved over the last 6 months. Ward areas continue to monitor and implement suggestions from the falls subcommittee.
- Creaton, Allebone, Talbot Butler and Hawthorn have on average have a higher number of sections within the questions which are flagging amber and red. The divisional and directorate nursing meetings 'share and learn' sessions will be held to review reasons and implement a 'test of change' to allow us to begin to see improvements.
- The section which covers privacy and dignity is showing a negative response with regards to patient understanding of their estimated date of discharge, noise at night and having not being shown the Patient Safety Video. Work is being undertaken divisionally to improve this.

8. Friends & Family Test

FFT Annual Overview- % Would Recommend Run Charts

Run charts have been produced for Inpatients, Day Cases, A&E (including ED, Eye Casualty & Ambulatory Care), Births and Postnatal Ward, appendix 4.

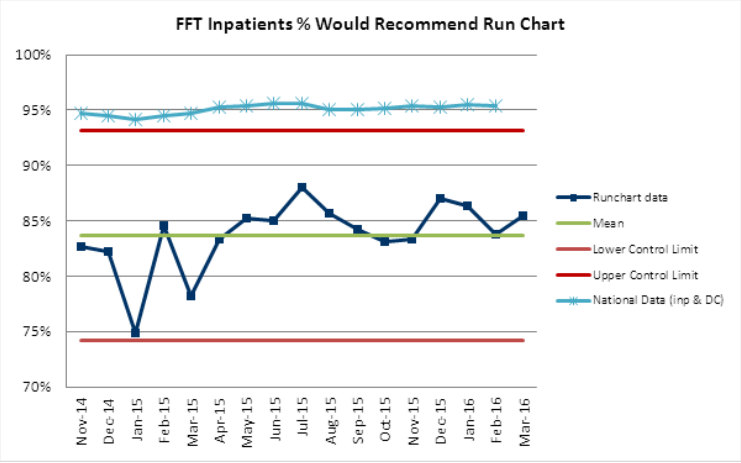
The Run charts contain all data points available, for Inpatients and A&E these begin at November 2014, for all other areas these start at April 2015.

All Run charts have mean lines, the current mean points at which 2015/2016 ended are as follows;

Area	Mean % Would Recommend	March % Would Recommend	National Average for Feb 16
Trustwide	90%		N/A
Inpatients	84%	85.4%	95.4%
Day Case	92.4%	92.5%	95.4%
A&E	85.2%	84.4%	84.9%
Outpatients	91.2%	91.4%	92.4%
Birth	95%	91.4%	96.3%
Postnatal Wards	92.4%	92.5%	93.7%

The mean lines will be rebased following improvement work which is scheduled to take place during 2016/2017.

In addition to mean lines, upper and lower control limits have been set to 3 Standard Deviation Points from the mean. Therefore moving forward, if the data point goes beyond the upper or lower control limit, then there is probably “special cause variation” - something different is going on to cause this variation. Wards will be reviewed against the mean to identify areas that are performing lower than the Trusts average. Inpatient Wards have performed below the national average for a period of time. Below is the run chart from Nov-14 till Mar-15



It is evident from looking at the run chart that improvements have begun to be made for Inpatient services, particularly when comparing Nov-14 through to Apr-15. From May-15, 8 points fall above the mean line out of 11. For March, Inpatient wards, postnatal wards and A&E all made improvements in their % of patients that would recommend, when compared with February. Figures for March are included within the table below.

9. Nursing and Midwifery Professional Practice and Development

Healthcare Assistant Workforce

Healthcare Assistant recruitment, training and care certificate remains positive following additional recruitment drives and programmes. We are at a point of core vacancies being less than the number in clearance. Specialist areas continue to recruit locally. All successful applicants who meet the criteria for joining the Bank are automatically signed up.

Care Certificate – 26 new Healthcare Assistants have completed the Care Certificate in the last quarter. Clinical Apprenticeships – 6 commenced in April 2016.

Preceptorship

Preceptorship and clinical skills programmes continue for the new international nurses with an additional cultural programme following a successful bid to the Local Education Training Board commencing in May 2016.

International Nurse Recruitment

A further 3 international nurses from India and the Philippines have passed their OSCE following an intensive preparation course, led by the Clinical Skills Educator and Corporate Practice Development Nurse.

Pre-registration Agenda

PL@N (Practice Learning at Northampton) pilot has commenced on Rowan and Knightley, initial feedback is great with a positive response from social media generating lots of interest.
Recruitment to the next cohort for the Open University pre-registration part time programme has commenced. This follows a competitive recruitment process for the region and again we have HCAs in the top percentile.

Revalidation

A further 23 registrants have successfully revalidated for May 2016. Workshops continue of a monthly basis.

10. Dementia

Discharge Summaries

The Dementia CQUIN for 2016/17 has changed in format from preceding years. Previously, the Trust was required to report on various elements that made up the "FAIRI"; case finding, diagnostic assessment, referral for follow-up and plan of care. For this financial year, the focus of the CQUIN is the final element of the inpatient pathway: discharge, utilising the final element of last years' CQUIN framework.

The nature of CQUIN, still requires the FAIRI – now well embedded - process to be utilised, as the identification of the cohort of patients is cumulative; however there is no reporting requirement for this.

The milestone indicator for Q1 is for the Trust to scope, in conjunction with the CCG the data capture method for the expanded discharge summaries element: this year to include all admitted patients (previous years excluded elective admissions). The current proposal is to undertake this using the dementia assessment algorithm available with VitalPac Doctor in order to identify the cohort of patients effectively and to ensure the appropriate information is provided to carers (both professional and informal) on discharge.

John's Campaign

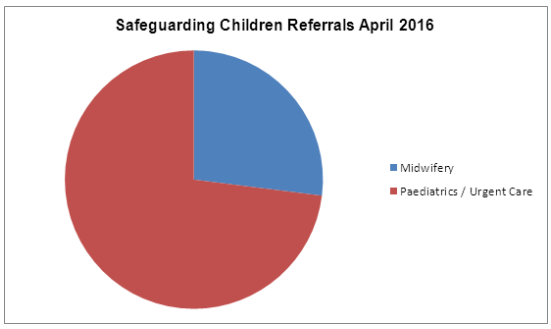
The second dementia related CQUIN relates to the support offered to carers and family members of those living with dementia and is aimed at supporting hospitals to welcome carers according to patients' needs and not restricted by visiting hours.

The is no quarter one milestone associated with this CQUIN, however work has begun to understand the scope of change required to undertake this CQUIN and prioritise accordingly.

Carers' Survey (Indicator 3c 2015/16)
The carers' survey is not continued in this year's CQUIN, however will continue as 'business as usual' as part of the dementia liaison service given the excellent compliance rate (100%) and valuable feedback provided last year.

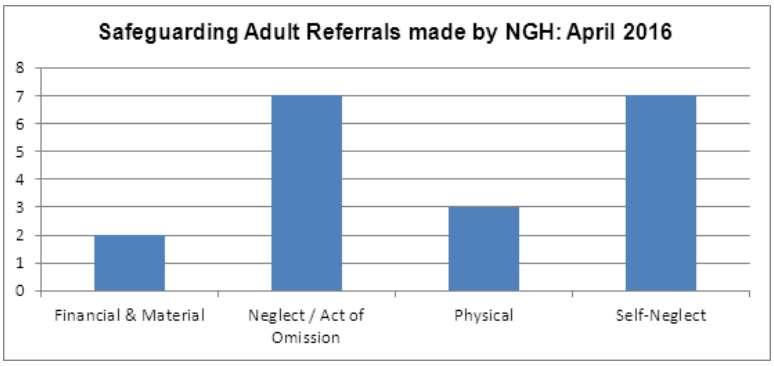
11. Safeguarding

Safeguarding Children



Themes emerging from Urgent Care referrals this month included parental mental illness and the impact on parenting, and domestic abuse. In maternity, safeguarding concerns related to parental drug and alcohol use, Looked After Children as parents and parents with Learning Disability.

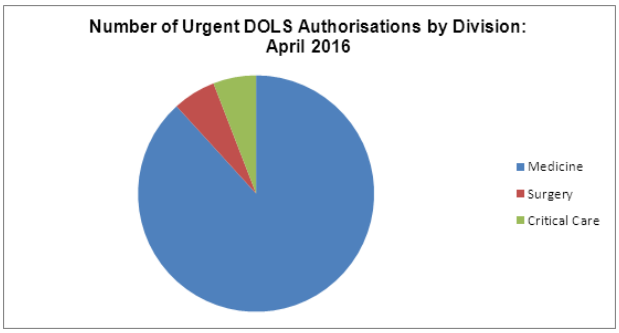
Adult Safeguarding



The Trust made 19 safeguarding referrals during March, the nature of these is illustrated in the chart above. There is an increasing trend in referral for self-neglect, which supports the inclusion of this as a separate category within safeguarding, through the Care Act 2014. The Trust is an active partner in the Health Economy Safeguarding Confernece on 27th May (as part of safeguarding awareness week), where self-neglect will be a key focus of the afternoon session.

The Trust received 11 referrals ***against*** the organistion in April 2016. The overriding theme continues to relate to discharge processes and arrangements. A further piece of thematic analysis will be undertaken as this is now a consistant theme within the safeguarding referrals.

Deprivation of Liberty Safeguards
The Trust granted **17 urgent authorisations** under DOLS in April 2016. The bias between the Divisions remains, as expected, towards Medicine:



Critical Care is highlighted (whilst being part of the Surgical Division), owing to the focus on this area following the Cheshire West and subsequent rulings in relation to patients who are unconscious / sedated and managed in an intensive setting; given the first arm of the 'acid test' for DOLS: *"total supervision and control".*
At the time of writing, 8 patients are awaiting assessment by the supervisory body. As discussed in previous reports, whilst the responsibility for the assessment remains with the Supervisory Body, the patients' remain under the care of NGH. Following discussion at the Safeguarding Assurance Group, this has been raised to the Trust Risk Register.

Inspection of services for children in need of help and protection, children looked after and care leavers
In February 2016 the county hosted an Ofsted inspection of Services for children in need of help and protection; children looked after and care leavers. This also included a review of the effectiveness of the Local Safeguarding Children Board. This report was published on 27th April 2016. This inspection is set against the backdrop of the previous inspection cycle. In 2013, Ofsted found services for children and young people to be inadequate. This judgement was based on three successive inspections.

The outcome of the most recent inspection found that the services in Northamptonshire required improvement in all the domains inspected. There were no recommendations directly for Health Agencies as a result of the inspection and no grading attributed. There are however clear areas where cross-cutting themes will require appropriate attention to support change within the partnership. The Local Authority are required to produce a second phase improvement plan, to be signed off by partners, within 70 days of receipt of the report. It is anticipated that the Health Economy will contribute thought the established governance processes led by the CCG.

12. End of Life Care

The new End of Life Care Project Lead, Margot Emery, took up her new role in April, replacing Wendy Smith. At the final CQC End of Life Action Plan Meeting on 5th May, it was agreed that there would be a new governance process and structure to support both the development of End of Life care across the trust, and the assurance process. At the same time, the need to streamline the many End of Life care reporting requirements was acknowledged. It was therefore agreed that the new arrangement will be as follows:

In each quarterly period, there will be a monthly End of Life Care Operational Group Meeting. This will have agreed Terms of Reference, and will report to the quarterly End of Life Steering Group. The membership of this group is under review.

On the third month of each quarterly period there will be a quarterly End of Life Steering Group Meeting. This will have agreed Terms of Reference, and will receive and address exception reports. It will have responsibility for driving the End of Life care improvement agenda and will report into CQEG. Membership of the group is currently under review. All end of life key performance indicator data, including that related to the Preferred Place of Death CQUIN, will be prepared and submitted using the CQEG template, and will go to CQEG via the Steering Group. Ward level data relating to performance indicators will continue to go to the wards via the Matrons. Ward Managers and Matrons will develop their own action plans as appropriate.

It is envisaged that this arrangement will replace all current End of Life care data submission and governance meetings with immediate effect.

13. Complaints Summary

Completed service compliance figures for complaints for February 2016, reported in April 2016, have seen a drop from 83% to 76%. This is based upon the receipt of a total of 45 new complaints, 37 of which were reported upon within the agreed timescale, 28 required a renegotiated timescale with 11 cases exceeding this. The reason for the drop in compliance is due to a number of factors; Trust on escalation requiring staff to be operational causing late or incomplete responses, a backlog of complaints which has developed due to staffing challenges within the Complaints team (i.e. vacancies, sickness, necessity for colleagues to backfill). This has been revisited through the corporate risk register and the rating has since been reviewed and revised accordingly.

Action is currently being taken to improve the situation with the services of a temporary complaints officer secured, for three days per week. The Head of Complaints also continues to backfill to support the team on a daily basis.

14. Safe Staffing Update

It is an ongoing requirement of NHS England that all NHS Trust Boards receive a monthly report relating to nurse staffing levels. This report provides an overview of the staffing levels in April 2016 and highlights the mitigation put in place to address any gaps in fill rate and addresses the rationale for the gaps that have been identified.

Overall fill rate for April 2016 was 103%, compared to 101% in March and in February. Combined fill rate during the day was 102% compared with 98% in March. The night fill rate has increased to 106% in April from 104% in March. RN fill rate during the day was 96% and for the night 95%. Please see appendix 5.

14.1 Safe Staffing data comparison across the Midlands & East

Safe Staffing fill rate data is collated across the Midlands & East by NHS England (appendix 6). 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, February 2016 the Committee will be aware that our monthly data has continued to improve. Appendix 7 shows our continued improvement.

14.2 Care Hours Per Patient Day (CHPPD)

In line with the recent publication of 'Operational productivity and performance in English NHS acute hospitals: Unwarranted variations' 2016 (Carter report) the Trust must submit monthly data on Care Hours Per Patient Day (CHPPD). The report states that:

'we recommend that from April 2016 that CHPPD becomes the principal measure of nursing & care support.'

CHPPD is calculated by the total hours of care in 24hrs divided by the number of patients on the ward at 23:59hr.

The CHPPD will be calculated through our current 'Safe Staffing Unify' submission, however, at this stage it has not been made clear what the 'parameters' of the data sets are.

Although a national template has not been provided we have used our current 'unify' template and our 'bed occupancy' data for the month of April to provide our first 'shadow' CHPPD data set (appendix 5). However, without the detailed guidance it is difficult to 'interpret and benchmark' this data. From the original 25 trusts who participated in the pilot study there was a variance between 6.3 – 15.48 CHPPD across the wards, with a median of 9.13 CHPPD. However, it is not know the

type /speciality of wards within the pilot. From the April data our data shows median of 6.9CHPPD and average of 8.52 CHPPD.

In the future it is expected that the Trust will collect & collate this data on a daily basis but it is believed that this will not be for a further 6 months. Future updates will be shared with the Board as the information is provided by NHS Improvement.

Recommendations

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

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, 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.

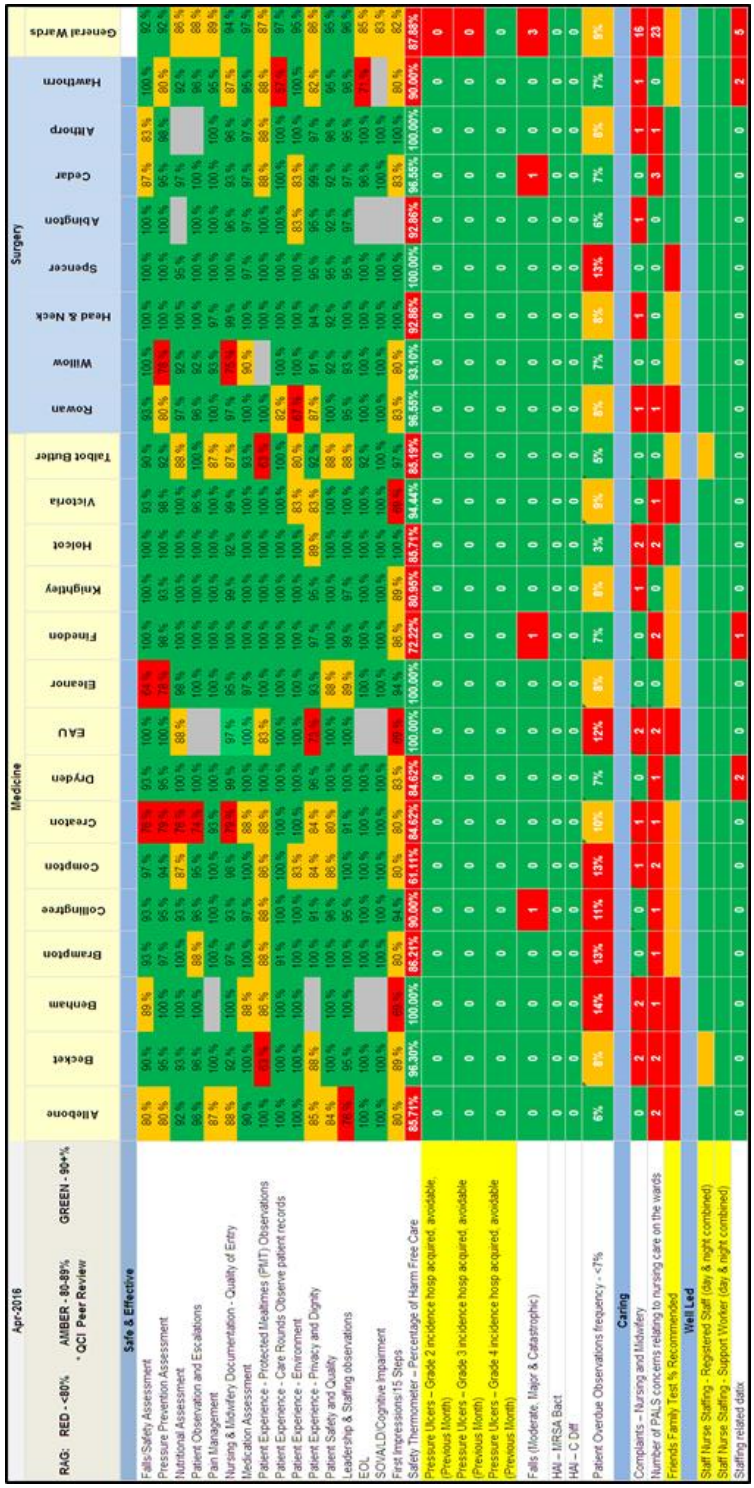
Within the QCI assessment there are 15 sections reviewing all aspects of patient care, patient experience, the safety culture and leadership on the ward – this is assessed through a number of questions or observations in these 15 sections. In total 147 questions are included within the QCI assessment, 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

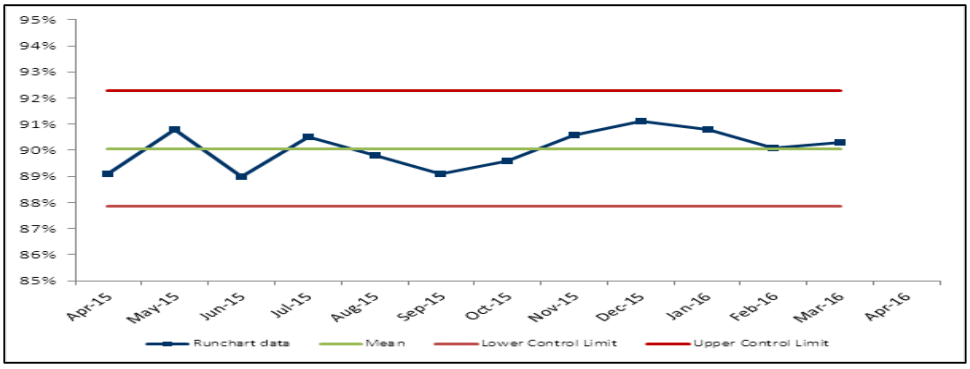
The Matrons undertake the QCI and upload the data by the 3rd of each month. The N&M dashboard is populated monthly by the Information Team and will be ready no later than the 10th of the month. At the monthly N&MPF the previous month's dashboard will be presented in full and Red and Amber areas discussed 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
Nursing and Midwifery Dashboard- April 2016

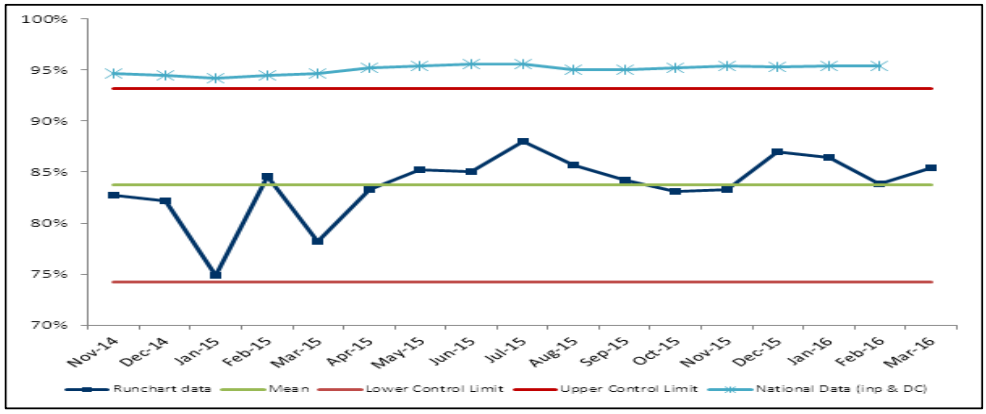


Appendix 4

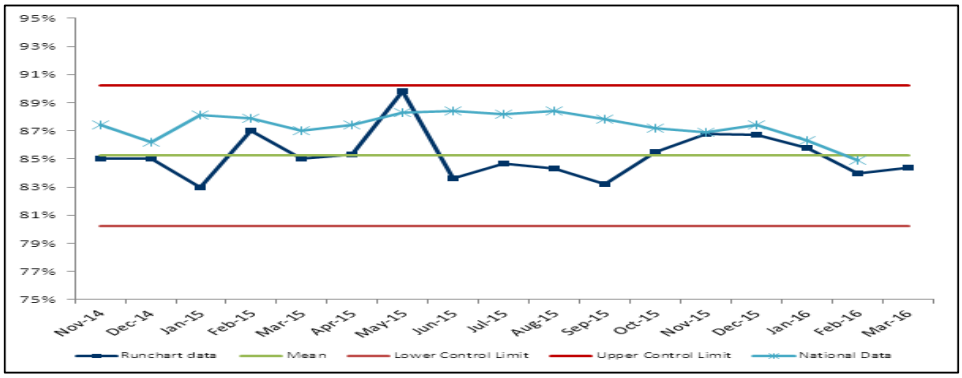
Trust wide FFT % Would Recommend Run Chart



Inpatient FFT % Would Recommend Run Chart

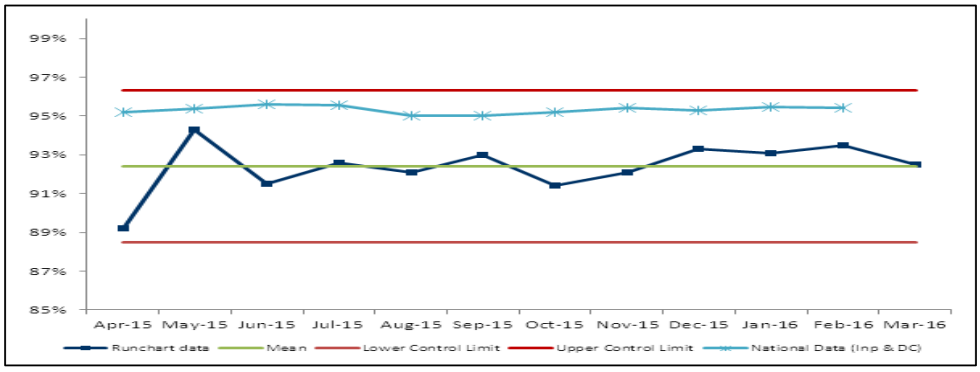


A&E FFT % Would Recommend Run Chart

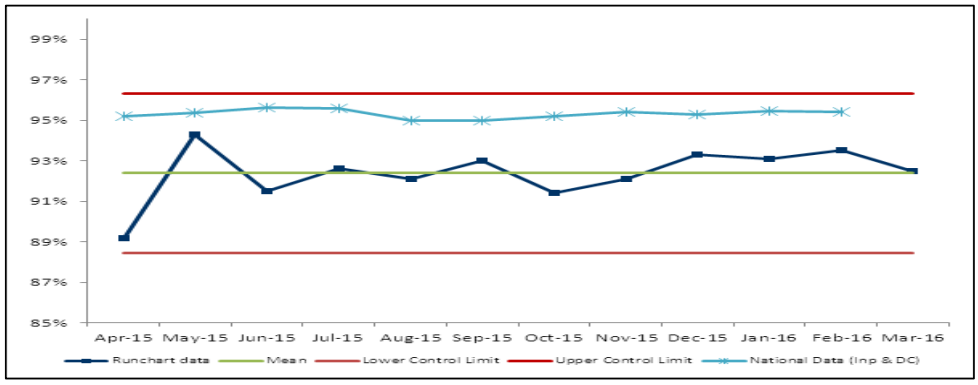


Enclosure E

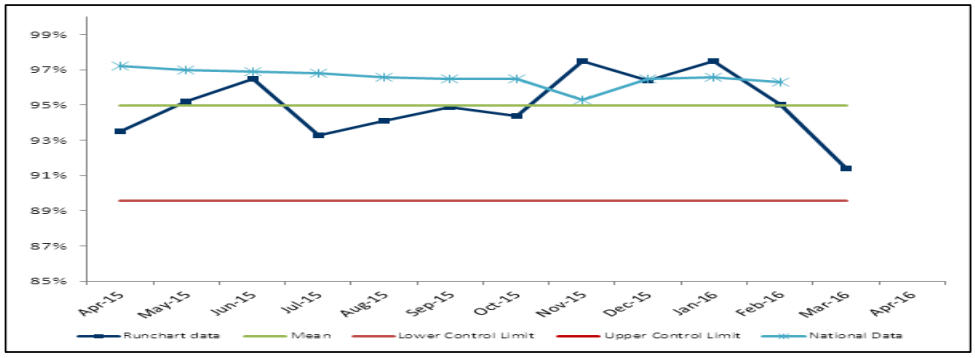
Day Case FFT % Would Recommend Run Chart



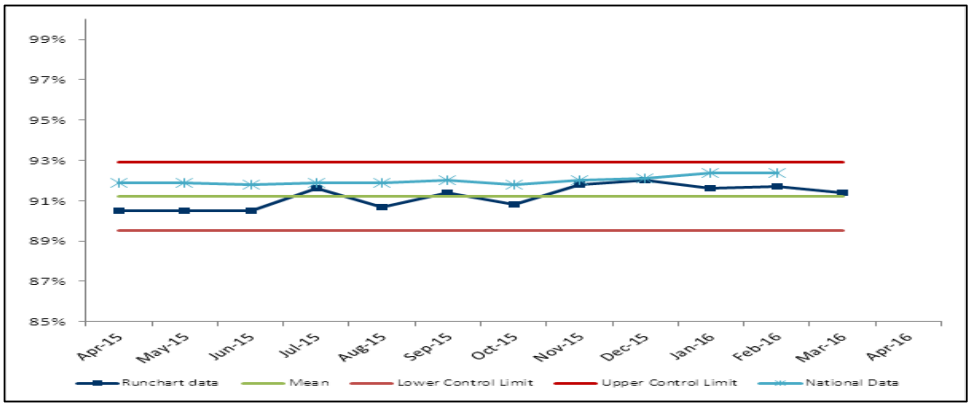
Postnatal Wards FFT % Would Recommend Run Chart



Birth FFT % Would Recommend Run Chart



Outpatients FFT % Would Recommend Run Chart



Enclosure E

Appendix 5

Northampton General Hospital NHS
NHS Trust

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

Ward name	Day: Registered midwives/nurses: Total monthly planned staff hours	Day: Registered midwives/nurses: Total monthly actual staff hours	Day: Care Staff: Total monthly planned staff hours	Day: Care Staff: Total monthly actual staff hours	Night: Registered midwives/nurses: Total monthly planned staff hours	Night: Registered midwives/nurses: Total monthly actual staff hours	Night: Care Staff: Total monthly planned staff hours	Night: Care Staff: Total monthly actual staff hours	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 (%)	Number of Patients	CHPPD Hours	Actions/Comments	Red Flag
Abington	1495.0	1478.2	1380.5	1629.8	1141.5	1128.0	1045.8	1414.5	98.9%	118.1%	98.8%	135.3%	816	6.9		
Allebone	1594.5	1706.6	1621.5	1594.8	1069.5	1058.0	689.8	1081.0	107.0%	98.4%	98.9%	156.7%	831	6.5		
Althorp	922.3	956.3	724.3	665.0	678.5	656.0	460.0	518.2	103.7%	91.8%	96.7%	112.6%	284	9.8		
Becket	1969.5	1724.0	1378.0	1514.3	1725.0	1610.0	690.0	798.0	87.5%	109.9%	93.3%	115.7%	786	7.2		
Benham	1718.3	1686.8	858.5	1045.0	1380.0	1408.8	690.0	936.3	98.2%	121.7%	102.1%	135.7%	697	7.3		
MATERNITY COMBINED UNIT: Sturtridge, MOW, Balmoral & Birth Centre	6871.25	6265.17	3643	3503.5	6547.5	5987.33	3068.25	2578.33	91.2%	96.2%	91.4%	84.0%	1869	9.8		
Brampton	1297.5	1344.0	1026.3	1491.0	1325.8	1347.3	690.0	1283.3	103.6%	145.3%	101.6%	186.0%	833	6.6		
Cedar	1546.0	1535.0	1711.0	1779.3	1230.5	1177.5	1035.0	1195.8	99.3%	104.0%	95.7%	115.5%	853	6.7		
Collingtree	2316.8	2124.8	1711.0	2497.5	1725.0	1715.1	690.0	1311.4	91.7%	146.0%	99.4%	190.1%	1188	6.4		
Compton	1019.0	1069.3	698.0	1021.0	690.0	690.0	345.0	690.0	104.9%	146.3%	100.0%	200.0%	537	6.5		
Creaton	1607.3	1551.3	1374.3	1559.3	1380.0	1173.5	690.0	1120.1	96.5%	113.5%	85.0%	162.3%	827	6.5		
CHILD HEALTH COMBINED: Disney, Gosset & Paddington	7545	6730.7	2571.75	2195	5631.25	5241.83	1189.5	1000	89.2%	85.4%	93.1%	84.1%	998	15.2		
Dryden	2041.5	1752.5	931.5	910.3	1380.0	1414.5	690.0	789.3	85.8%	97.7%	102.5%	114.4%	755	6.4		
EAU	2069.3	1971.3	1032.3	1362.3	1725.0	1712.8	1035.0	1294.8	95.3%	132.0%	99.3%	125.1%	822	7.7		
Eleanor	1035.0	1010.0	690.0	757.0	690.0	690.0	690.0	782.0	97.6%	109.7%	100.0%	113.3%	334	9.7		
Finedon	2070.0	1889.5	465.8	466.0	1035.0	1041.8	345.0	551.3	91.3%	100.1%	100.7%	159.8%	477	8.3		
Hawthorn	1897.3	1899.0	1035.0	1081.5	1380.0	1358.3	931.5	998.8	100.1%	104.5%	98.4%	107.2%	810	6.6		
Head & Neck	1063.3	1061.5	692.0	657.5	874.0	772.3	345.0	394.5	99.8%	95.0%	88.4%	114.3%	397	7.3		
Holcot	1569.3	1380.9	1035.5	1513.8	1380.0	1288.0	690.0	1322.3	88.0%	146.2%	93.3%	191.6%	858	6.4		
ITU	4719.0	5073.4	670.5	683.3	4087.3	3883.5	621.0	607.8	107.5%	101.9%	95.0%	97.9%	315	32.5		
Knightley	1035.3	1012.8	862.5	1261.8	1035.0	978.8	345.0	782.8	97.8%	146.3%	94.6%	226.9%	626	6.4		
Rowan	1886.8	1940.5	1011.5	1229.7	1725.0	1712.8	690.0	975.5	102.8%	121.6%	99.3%	141.4%	845	6.9		
Spencer	916.0	918.4	546.8	575.5	690.0	692.8	345.0	347.8	100.3%	105.3%	100.4%	100.8%	363	7.0		
Talbot Butler	2330.0	2076.3	1336.0	1218.1	1380.0	1034.0	690.0	1079.3	89.1%	91.2%	74.9%	156.4%	825	6.6	Improved picture for HCAs in April 2016 - numbers on night duty increased to support patient care. HCA recruitment 2 started and 3 expected. Improving picture for RN's,RN recruitment continues and 5wte have commenced work. RN ongoing recruitment Staffing monitored daily by the Matron and reallocation as required.	
Victoria	1037.5	1029.3	690.0	1017.8	690.0	701.5	345.0	724.5	99.2%	147.5%	101.7%	210.0%	535	6.5		
Willow	2220.0	2196.6	1032.5	1308.3	1989.5	1934.8	690.0	1026.8	98.9%	126.7%	97.2%	148.8%	827	7.8		

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

Appendix 6 – Regional Safer Staffing Data

Daytime Fill Rates - Registered Midwives/Nurses												
	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Bedford Hospital NHS Trust	94.37%	97.17%	94.12%	95.15%	94.39%	94.52%	95.56%	91.36%	95.30%	92.08%	92.97%	93.20%
East and North Hertfordshire NHS Trust	96.06%	98.68%	96.69%	96.58%	94.48%	94.50%	95.95%	98.51%	99.42%	98.90%	97.94%	96.59%
Hertfordshire Partnership NHS Foundation Trust	100.68%	102.45%	100.70%	103.40%	97.17%	96.13%	96.43%	101.69%	102.92%	101.69%	99.96%	99.43%
Kettering General Hospital NHS Foundation Trust	95.96%	95.40%	95.87%	95.93%	90.89%	96.01%	96.28%	96.66%	95.93%	95.84%	97.41%	97.48%
Luton and Dunstable Hospital NHS Foundation Trust	91.83%	94.98%	94.46%	93.77%	93.56%	90.52%	90.93%	89.55%	92.12%	94.07%	93.79%	91.14%
Milton Keynes Hospital NHS Foundation Trust	97.29%	96.85%	97.34%	100.27%	98.40%	91.47%	91.07%	93.52%	90.48%	92.12%	94.17%	92.34%
Northampton General Hospital NHS Trust	**83.06%**	**79.46%**	**79.35%**	**78.96%**	**79.25%**	**78.53%**	**84.67%**	**87.11%**	**90.37%**	**90.74%**	**93.86%**	**93.00%**
Northamptonshire Healthcare NHS Foundation Trust	92.45%	91.63%	97.00%	98.68%	93.34%	90.86%	95.01%	96.23%	100.24%	99.46%	99.37%	96.88%
West Hertfordshire Hospitals NHS Trust	92.30%	92.76%	95.55%	93.66%	92.15%	84.16%	83.56%	93.11%	90.60%	92.00%	93.38%	92.39%
Lincolnshire Community Health Services NHS Trust	89.69%	91.35%	88.55%	91.75%	88.42%	88.31%	89.88%	88.04%	94.42%	93.53%	87.34%	89.15%
Leicestershire Partnership NHS Trust	102.66%	107.24%	108.99%	100.79%	100.91%	101.24%	104.31%	104.63%	106.24%	104.01%	104.20%	100.95%
Lincolnshire Partnership NHS Foundation Trust	110.91%	115.66%	112.54%	114.01%	101.93%	105.17%	111.67%	107.97%	108.41%	114.25%	105.26%	103.61%
United Lincolnshire Hospitals NHS Trust	84.59%	85.87%	82.66%	87.50%	88.33%	88.50%	89.14%	93.40%	92.30%	90.31%	92.02%	89.63%
University Hospitals of Leicester NHS Trust	90.97%	93.64%	90.32%	91.19%	90.32%	90.16%	90.51%	91.42%	87.19%	90.98%	90.51%	89.47%

Daytime Fill Rates - HCA Staff												
	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Bedford Hospital NHS Trust	93.93%	100.31%	100.85%	95.62%	100.53%	98.67%	99.31%	96.80%	98.44%	96.97%	97.52%	101.56%
East and North Hertfordshire NHS Trust	109.99%	119.98%	114.91%	120.24%	118.82%	113.00%	109.29%	107.95%	112.39%	112.01%	109.11%	106.25%
Hertfordshire Partnership NHS Foundation Tru	111.72%	104.65%	108.64%	104.96%	112.15%	112.76%	107.48%	111.71%	113.07%	110.58%	115.68%	113.64%
Kettering General Hospital NHS Foundation Tr	99.94%	99.90%	103.12%	102.83%	94.87%	94.89%	94.27%	96.14%	100.55%	99.32%	94.50%	97.06%
Luton and Dunstable Hospital NHS Foundation	92.63%	93.17%	92.28%	96.22%	95.09%	96.27%	95.41%	96.18%	95.94%	95.56%	96.14%	95.54%
Milton Keynes Hospital NHS Foundation Trust	99.63%	95.79%	101.41%	99.82%	102.21%	99.92%	90.65%	92.98%	91.26%	92.40%	98.12%	93.48%
Northampton General Hospital NHS Trust	**100.46%**	**100.52%**	**96.34%**	**98.06%**	**102.39%**	**99.86%**	**103.54%**	**100.17%**	**101.52%**	**106.90%**	**107.23%**	**106.39%**
Northamptonshire Healthcare NHS Foundatio	101.84%	102.62%	101.75%	105.47%	103.86%	107.58%	109.36%	106.50%	105.70%	100.40%	102.67%	108.44%
West Hertfordshire Hospitals NHS Trust	96.39%	103.46%	108.06%	106.92%	104.73%	110.75%	115.50%	112.81%	107.00%	106.04%	107.70%	109.50%
Lincolnshire Community Health Services NHS T	95.47%	101.30%	98.81%	94.32%	97.18%	97.24%	102.21%	96.77%	95.00%	98.29%	98.77%	95.98%
Leicestershire Partnership NHS Trust	201.43%	193.79%	191.19%	181.59%	181.77%	186.83%	184.44%	195.98%	197.07%	195.84%	195.65%	200.58%
Lincolnshire Partnership NHS Foundation Trus	86.40%	90.46%	89.06%	95.31%	97.41%	90.62%	92.11%	92.04%	94.16%	95.89%	92.53%	100.33%
United Lincolnshire Hospitals NHS Trust	98.52%	103.42%	103.43%	104.62%	108.54%	105.89%	102.54%	104.50%	103.34%	101.31%	103.09%	98.03%
University Hospitals of Leicester NHS Trust	92.52%	94.24%	91.17%	93.50%	91.30%	92.40%	93.14%	94.18%	93.17%	93.89%	92.13%	86.02%

Night-time Fill Rates - Registered Midwives/Nurses												
	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Bedford Hospital NHS Trust	101.04%	104.68%	99.94%	99.43%	102.32%	99.04%	99.63%	99.17%	98.87%	101.24%	100.70%	100.74%
East and North Hertfordshire NHS Trust	99.86%	97.31%	98.49%	98.77%	98.43%	97.81%	99.92%	101.17%	101.67%	98.87%	99.69%	100.95%
Hertfordshire Partnership NHS Foundation Trust	100.64%	100.09%	100.72%	102.65%	98.50%	97.68%	99.61%	99.35%	102.22%	100.03%	99.67%	101.43%
Kettering General Hospital NHS Foundation Trust	100.36%	97.44%	99.76%	96.57%	93.52%	97.91%	98.93%	96.82%	98.38%	98.11%	99.33%	100.26%
Luton and Dunstable Hospital NHS Foundation Trust	99.33%	99.28%	98.75%	98.09%	99.95%	96.65%	96.93%	95.76%	97.62%	97.32%	99.62%	97.08%
Milton Keynes Hospital NHS Foundation Trust	109.80%	113.17%	115.43%	114.15%	110.59%	104.13%	101.75%	103.41%	103.64%	103.69%	99.69%	101.92%
Northampton General Hospital NHS Trust	**100.88%**	**86.36%**	**88.83%**	**82.43%**	**93.21%**	**91.38%**	**95.74%**	**94.53%**	**93.48%**	**94.07%**	**95.23%**	**95.01%**
Northamptonshire Healthcare NHS Foundation Trust	100.09%	98.87%	101.36%	101.11%	100.53%	101.42%	103.42%	106.80%	105.09%	104.57%	106.23%	104.18%
West Hertfordshire Hospitals NHS Trust	99.44%	97.90%	99.42%	98.72%	97.98%	96.22%	96.90%	98.03%	98.51%	97.48%	97.51%	96.79%
Lincolnshire Community Health Services NHS Trust	87.76%	88.72%	97.72%	89.35%	88.47%	89.14%	92.30%	92.94%	95.47%	94.09%	94.49%	85.13%
Leicestershire Partnership NHS Trust	97.24%	98.24%	100.91%	95.47%	96.03%	97.87%	99.12%	102.25%	101.15%	102.73%	104.88%	104.86%
Lincolnshire Partnership NHS Foundation Trust	101.42%	99.63%	101.91%	106.84%	100.94%	93.36%	96.32%	99.00%	98.76%	104.21%	103.53%	97.00%
United Lincolnshire Hospitals NHS Trust	89.84%	91.33%	93.53%	94.39%	96.97%	96.60%	96.83%	99.63%	99.66%	97.06%	98.31%	98.26%
University Hospitals of Leicester NHS Trust	97.19%	98.92%	95.97%	96.21%	94.29%	94.31%	94.91%	96.10%	91.42%	94.79%	96.57%	94.97%

Night-time Fill Rates - HCA Staff												
	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Bedford Hospital NHS Trust	115.75%	117.30%	114.90%	108.84%	107.55%	115.80%	121.99%	104.91%	99.07%	110.69%	108.20%	105.75%
East and North Hertfordshire NHS Trust	124.33%	128.88%	120.97%	119.67%	117.50%	121.52%	117.15%	122.59%	123.24%	126.06%	131.04%	125.48%
Hertfordshire Partnership NHS Foundation Tru	114.97%	122.59%	123.35%	113.84%	121.53%	118.79%	121.18%	117.05%	121.15%	115.98%	116.35%	115.89%
Kettering General Hospital NHS Foundation Tr	116.70%	112.85%	118.95%	114.17%	102.80%	101.22%	99.71%	102.99%	106.14%	107.33%	105.34%	109.55%
Luton and Dunstable Hospital NHS Foundation	92.43%	97.02%	98.17%	96.33%	98.31%	99.23%	98.52%	95.90%	91.39%	95.22%	93.81%	94.03%
Milton Keynes Hospital NHS Foundation Trust	111.34%	117.31%	117.98%	117.23%	124.39%	113.52%	115.55%	122.66%	118.10%	117.13%	114.49%	115.06%
Northampton General Hospital NHS Trust	**131.14%**	**126.40%**	**132.38%**	**134.04%**	**138.37%**	**137.96%**	**139.11%**	**133.51%**	**138.58%**	**133.13%**	**131.93%**	**131.81%**
Northamptonshire Healthcare NHS Foundatio	114.71%	113.24%	113.60%	116.66%	115.01%	115.81%	112.58%	121.17%	116.98%	111.12%	119.25%	124.71%
West Hertfordshire Hospitals NHS Trust	98.08%	98.97%	102.99%	102.41%	98.64%	100.17%	110.64%	106.13%	103.15%	104.97%	109.04%	110.05%
Lincolnshire Community Health Services NHS T	91.69%	99.44%	101.72%	95.53%	100.29%	99.91%	89.13%	96.48%	92.26%	96.74%	98.94%	104.83%
Leicestershire Partnership NHS Trust	185.94%	181.88%	177.08%	167.45%	169.75%	174.05%	178.66%	185.94%	185.18%	180.99%	180.84%	188.21%
Lincolnshire Partnership NHS Foundation Trus	101.43%	99.34%	100.13%	102.80%	103.55%	102.12%	99.46%	102.20%	97.52%	101.80%	105.96%	109.75%
United Lincolnshire Hospitals NHS Trust	108.71%	111.52%	111.40%	116.91%	116.41%	113.83%	110.41%	116.87%	117.23%	111.40%	114.88%	105.10%
University Hospitals of Leicester NHS Trust	103.21%	106.30%	98.69%	99.41%	101.20%	98.01%	100.00%	99.92%	98.39%	98.04%	100.17%	91.61%

Overall Fill Rates												
	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Bedford Hospital NHS Trust	98.99%	102.62%	99.90%	98.32%	99.56%	99.60%	100.97%	96.33%	97.41%	97.91%	98.00%	98.64%
East and North Hertfordshire NHS Trust	102.95%	105.74%	103.43%	104.47%	102.88%	102.07%	102.08%	103.75%	105.22%	104.49%	104.22%	102.93%
Hertfordshire Partnership NHS Foundation Trust	108.11%	107.13%	108.91%	106.33%	108.60%	107.82%	106.92%	108.74%	110.82%	108.08%	109.52%	108.97%
Kettering General Hospital NHS Foundation Trust	101.04%	99.46%	101.88%	100.23%	94.17%	96.97%	96.98%	97.46%	99.16%	98.91%	98.33%	99.83%
Luton and Dunstable Hospital NHS Foundation Trust	94.15%	96.16%	95.81%	95.84%	96.37%	94.65%	94.66%	93.55%	94.33%	95.47%	95.91%	94.12%
Milton Keynes Hospital NHS Foundation Trust	102.42%	102.78%	104.90%	105.46%	105.09%	98.80%	96.25%	99.18%	97.08%	97.77%	99.00%	97.49%
Northampton General Hospital NHS Trust	**96.63%**	**91.43%**	**91.03%**	**89.80%**	**93.94%**	**92.70%**	**97.35%**	**96.79%**	**98.80%**	**100.15%**	**101.90%**	**101.34%**
Northamptonshire Healthcare NHS Foundation Trust	101.53%	101.11%	102.75%	105.16%	102.57%	103.66%	104.98%	106.53%	106.37%	102.91%	105.57%	107.92%
West Hertfordshire Hospitals NHS Trust	96.11%	97.25%	100.21%	99.06%	97.33%	95.43%	97.61%	100.35%	98.03%	98.20%	99.61%	99.53%
Lincolnshire Community Health Services NHS Trust	91.65%	95.64%	95.80%	92.84%	93.28%	93.47%	94.49%	93.36%	94.44%	95.88%	94.63%	93.42%
Leicestershire Partnership NHS Trust	146.36%	145.06%	144.54%	136.03%	136.82%	139.05%	140.48%	145.94%	146.65%	145.13%	145.47%	146.85%
Lincolnshire Partnership NHS Foundation Trust	98.34%	100.55%	99.54%	103.66%	100.58%	97.51%	99.69%	99.65%	99.48%	103.28%	100.59%	103.02%
United Lincolnshire Hospitals NHS Trust	91.87%	94.21%	93.62%	96.77%	98.59%	97.70%	96.77%	100.45%	99.83%	97.19%	99.04%	95.63%
University Hospitals of Leicester NHS Trust	94.14%	96.39%	92.75%	93.76%	92.62%	92.46%	93.13%	94.04%	90.67%	93.29%	93.41%	90.28%

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

NHS England East Midlands use a variation of the RAG originally launched with the Safe Staffing data

Appendix 7 – Safer Staffing Northampton Fill Rates

February 2016	Safe Staffing Report Overall Fill Rates February 2016			
	DAY		NIGHT	
	RN	HCA	RN	HCA
Total Fill Rate	93%	106%	95%	131%
Combined Fill Rate	98%		106%	
Total Combined	101%			

March 2016	Safe Staffing Report Overall Fill Rates March 2016			
	DAY		NIGHT	
	RN	HCA	RN	HCA
Total Fill Rate	93%	108%	92%	133%
Combined Fill Rate	98%		104%	
Total Combined	101%			

April 2016	Safe Staffing Report Overall Fill Rates April 2016			
	DAY		NIGHT	
	RN	HCA	RN	HCA
Total Fill Rate	96%	112%	95%	130%
Combined Fill Rate	102%		106%	
Total Combined	103%			

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

The key used by NHS England is for illustration only, there are no regional or national targets

Report To	**TRUST BOARD**
Date of Meeting	**May 2016**

Title of the Report	**2015/16 Quality Account**
Agenda item	**11**
Presenter of Report	Dr. M. Cusack, Medical Director
Author(s) of Report	Mr. S. Hawes, Corporate Governance Manager
Purpose	To provide a provisional 2015/16 Quality Account

Executive summary

The trust has a statutory requirement to produce an annual Quality Account reflecting the quality of services we deliver when compared to local and national targets. This Quality Account must be approved by Board, in advance of the deadline for upload to NHS Choices by **30 June 2016.**

Quality Accounts are both retrospective and forward looking. They look back on the previous year's information regarding quality of services and look forward, explaining the Trusts priorities for quality improvement over the coming year

The 2015/16 Quality Account (Appendix 1) has been produced in draft and has been presented in a draft format to QGC where comments received have been incorporated.

A draft 2014/15 Quality Account was sent to the required external stakeholders (Overview & Scrutiny Committee, HealthWatch Northamptonshire and NHS Nene & NHS Corby CCGs) for their comments. Comments have been received from the Overview & Scrutiny Committee and are included in this draft with comments still awaited from the other two stakeholders who have until the end of May to respond.

The external auditors are auditing the 2015/16 Quality Account and are seeking limited assurance for two indicators (FFT and C.Diff).

The draft, at the request of medical illustrations, is mainly text based to enable them to efficiently provide a desk top published version when required and once finalised will be sent to Medical Illustrations for desk top publishing.

As with last year's Quality Account it will be a standalone document and not part of the Annual Report.

Related strategic aim and corporate objective	
Risk and assurance	Provides assurance that the statutory requirement to produce a

	Quality Account with mandated content by the due deadline will be met. Failure to produce and publish the Quality Account by the submission deadline of 30 June 2016 would amount to a breach of statute and could bring adverse publicity on the Trust.
Related Board Assurance Framework entries	
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 The Health Act 2009 requires all NHS providers of healthcare services in England to provide a Quality Account each year.

Actions required by the Trust Board
The Board is asked to:

- Approve the 2015/16 Quality Account
- Provide delegated authority to the Medical Director to approve any minor changes prior to final submission/upload to NHS Choices.
- Authorise the Chief Executive to sign the final version

Trust Board
26 May 2016

2015/16 Quality Account

1. Introduction

The trust has a statutory requirement to produce an annual Quality Account reflecting the quality of services we deliver when compared to local and national targets. It also identifies areas for quality improvement in the coming year which should focus on all the domains of quality;

- Patient Safety
- Clinical Effectiveness
- Patient Experience

Quality Accounts are both retrospective and forward looking. They look back on the previous year's information regarding quality or services and look forward, explaining the Trusts priorities for quality improvement over the coming year.

2. Timeline

The Quality Account must be uploaded to the NHS Choices website by ***30 June 2016***; but prior to this will be required to be signed off by Trust Board, Audit Committee and our external auditors. Reports have previously been presented to QGC where feedback has been incorporated

The Quality Account must be sent for review to local partners/ stakeholders, namely:

- NHS Nene and Corby Clinical Commissioning Group
- Healthwatch Northamptonshire
- Northamptonshire County Council Health Social Care Overview and Scrutiny Committee

Staff, patients, public and the stakeholders above have had input into the 2015/16 Quality Account through asking them for their suggestions for the trusts Quality Priorities, to focus on during 2016/17.

3. Quality Account 2015/16

In preparing the 2015/16 Quality Account attention is given to a number of documents:

- The Quality Accounts toolkit (Toolkit)
- NHS England letter dated 3 February 2016 on Reporting Arrangement 2015/16 (NHSE)
- Guidance for NHS Trusts on arrangements for external assurance 2014/15 (External)
- Quality Accounts: a guide for Local Involvement Networks (LINks); Quality Accounts: a guide for Overview and Scrutiny Committees;
- Other NHS Trusts Quality Accounts (Others)
- Health Act 2009 and The National Health Service (Quality Accounts) Regulations 2010 (HA)
- NGH Quality Accounts including comments from external stakeholders (Previous)

The Toolkit and HA state that each Quality Account must cover the following:

Part1

- A statement on quality from the Chief Executive (or equivalent) of the organisation and a statement from the senior employee outlining that to the best of that person's knowledge the information in the document is accurate (in regulations);

Part2

- Priorities for improvement (in regulations) – the forward looking section of the report is your opportunity to show clearly your plans for quality improvement within your organisation and why you have chosen those priorities for improvement. You should also demonstrate how the organisation is developing quality improvement capacity and capability to deliver these priorities;
- Statements relating to quality of NHS services provided (in regulations) – content common to all providers which makes the accounts comparable between organisations and provides assurance that the Board has reviewed and engaged in cross-cutting initiatives which link strongly to quality improvement;

Part3

- Review of quality performance (for provider determination) – report on the previous year's quality performance offering the reader the opportunity to understand the quality of services in areas specific to your organisation;
- An explanation of who you have involved (for provider determination) and engaged with to determine the content and priorities contained in your Quality Account (in line with current equality legislation and the Health Act 2009); and
- Any statements provided from your commissioning PCT, LINks or OSCs (in regulations) including an explanation of any changes you made to the final version of your Quality Account after receiving these statements.

The 2015/16 Quality Account is not split into the constituent three parts set out above, instead is set out in nine sections which allows for a more flowing report. The table below details the provisional Quality Account contents, why it is required and comments as to the actual content.

Title	Requirement	Comments
SECTION ONE		
What is a Quality Account	Toolkit 4.10	Taken from NGH Quality Account 2015/16 to explain what a Quality Account is and why it has been produced
Northampton General NHS Trust	Previous	Taken from NGH Quality Account 2015/16 to inform readers about NGH and what services we offer
Statement on Quality from the Chief Executive	HA & Toolkit	Written by the Chief Executive
Statement of Directors' Responsibilities	HA & External & Toolkit	The wording for this is taken from the Guidance for NHS Trusts on arrangements for external assurance 2014/15 published in January 2015
SECTION TWO		
Quality at the Heart	Previous	This has been written to enable the Quality Account to reflect how the trust views quality aligning it to our visions and values
Quality Priorities 2016/17	Toolkit 4.13 & HA	It is a requirement to include at least three priorities for improvement in this forward looking section. The priorities were chosen after consultation with staff, stakeholders and the public.

SECTION THREE		
Quality Priorities 2015/16	Toolkit 4.15	This provides an opportunity to report back on the progress of the previous year's priorities. N.B. *In relation to Sign up to Safety the data relates up to Q3 only as data for Q4 is currently being validated.*
SECTION FOUR		
Our Improvements in 2015/16	Previous	NGH staff have provided the content for this area
Implementing Duty of Candour	NHSE	The NHS England letter dated 3 February 2016 on Reporting Arrangements 2015/16 asked the Trust to consider including this information
Learning from Patient Feedback	Toolkit 5.17	This has been provided as a joint report from PALs, Complaints and Patient Experience and covers the wording mandated by the Toolkit
NHS Staff Survey	NHS	This was provided by Human Resources
Care Quality Commission	Toolkit 4.71 & NHSE	This was provided by Governance and covers some wording mandated by the Toolkit. The NHS England letter dated 3 February 2016 on Reporting Arrangements 2015/16 asked the Trust to consider including the two grids
SECTION FIVE		
National Clinical Audits and National Confidential Enquiries	Toolkit 4.31 & 4.36	This was provided by Clinical Audit and covers the wording mandated by the Toolkit
Local Audits	Toolkit 4.32	This was provided by Clinical Audit and covers the wording mandated by the Toolkit
Participation in Clinical Research	Toolkit 4.57	This was provided by Clinical Research and covers some of the wording mandated by the Toolkit
Commissioning for Quality and Innovation	Toolkit 4.64	This was provided by Governance and covers the wording mandated by the Toolkit
Local Quality Requirements	Previous	This was provided by Governance as further evidence of the quality metrics the trust has
SECTION SIX		
NHS Number and General Medical Practice Code Validity	Toolkit 4.78	This was provided by Informatics and uses the wording mandated by the toolkit
Information Governance Toolkit	Toolkit 4.82	This was provided by Information Governance and covers the wording mandated by the toolkit
Clinical Coding Error Rate	Toolkit 4.84	This was provided by Coding and covers the wording mandated by the toolkit
Core Quality Indicators	Toolkit 4.77 & NHSE	The NHS England letter dated 16 February 2012 on Reporting Requirements for 2011/12 and Planned Changes for 2012/13 introduced mandatory reporting against a small core set of quality indicators. These indicators were introduced in 2012/13 and have been developed since then. The requirement is now set out in the NHS

		England letter dated 3 February 2016 on Reporting Arrangements for 2015/16. It not only sets out those indicators which must be included but also mandates it should be in table format with the score shown for at least the last two reporting periods and they must be compared against national averages and high/low scores. The letter further dictates that for each of the indicators the following statement must be included: • The [name of trust] considers that this data is as described for the following reasons [insert reasons]. • The [name of trust] [intends to take/has taken] the following actions to improve this [percentage/proportion/score/ rate/number], and so the quality of its services, by [insert description of actions]. The data is taken from the HSCIC website by Governance. The Quality Account has used the wording above as a guide with the Core Quality Indicators still covering the requirements
Hospital Mortality Monitoring	Previous	This was provided by Clinical Audit
2015/16 Corporate Scorecard	Previous	This was provided by Informatics
Review of Performance	Previous	This was provided by Informatics
Review of Services	Toolkit 4.26	This was provided Contracting
Review of Quality	Previous	This was provided by Strategy
SECTION SEVEN		
External Stakeholder Feedback	Toolkit 4.104 & 8.2 & HA Stakeholders & NHSE	A draft Quality Account was sent to NHS Nene and NHS Corby CCGs, HealthWatch Northamptonshire and Northamptonshire County Council Overview and Scrutiny Committee. Comments have been received from the Overview & Scrutiny Committee and are included in this draft with comments still awaited from the other two stakeholders who have until the end of May to respond.
SECTION EIGHT		
Independent Auditors Limited Assurance report	External & NHSE	A draft has been sent to our external auditors and they have provided initial feedback – any comments made are being addressed as indicated. See Appendix 2. The auditors have to audit two indicators (from four) and the trust decided that the following would be audited:

		• Rate of clostridium difficile infections • FFT patient element score The auditors are yet to conduct this audit.
SECTION NINE		
Abbreviations	Previous	Included to assist readers with abbreviations contained with the report.

4. Assessment of Risk

Failure to meet the deadline for submission of the 2014/15 Quality Account may bring the Trust negative publicity and may bring extra scrutiny on the Trust through the questioning of our commitment on quality.

5. Recommendations

The Board is asked to:

- Approve the 2015/16 Quality Account
- Provide delegated authority to the Medical Director to approve any minor changes prior to submission to NHS Choices.
- Authorise the Chief Executive to sign the final version

6. Next Steps

- Finalise the external audit
- Receive and provide a response (if required) to the stakeholder feedback
- Commence and finalise medical illustration input
- Upload to NHS Choices by 30 June 2015.

Northampton General Hospital NHS
NHS Trust

Quality Account

2015/16

Enclosure F

Contents

SECTION ONE

WHAT IS A QUALITY ACCOUNT?

A Quality Account is a report about the quality of services by an NHS healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public. Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of treatments that patients receive and patient feedback about the care provided.

The Department of Health requires providers to submit their Quality Account to the Secretary of State by uploading it to the NHS Choices website by June 30 each year. The requirement is set out in the Health Act 2009. Amendments were made in 2012, such as the inclusion of quality indicators according to the Health and Social Care Act 2012. NHS England or Clinical Commissioning Groups (CCGs) cannot make changes to the reporting requirements

NORTHAMPTON GENERAL HOSPITAL NHS TRUST

Northampton General Hospital NHS Trust provides general acute services for a population of 380,000 and hyper-acute stroke, vascular and renal services to people living throughout whole of Northamptonshire, a population of 692,000.

The Trust is also an accredited cancer centre and provides cancer services to a wider population of 880,000 who live in Northamptonshire and parts of Buckinghamshire. In addition to the main hospital site, which is located close to Northampton town centre, the Trust also provides outpatient and day surgery services at Danetre Hospital in Daventry.

The principal activity of the Trust is the provision of free healthcare to eligible patients. We are a hospital that provides the full range of outpatients, diagnostics, inpatient and day case elective and emergency care and also a growing range of specialist treatments that distinguishes our services from many district general hospitals. We also provide a very small amount of healthcare to private patients.

We are constantly seeking to expand our portfolio of hyper-acute specialties and to provide services in the most clinically effective way. Examples are developments in both urological cancer surgery and laparoscopic colorectal surgery placing the Trust at the forefront of regional provision for these treatments.

We also train a wide range of clinical staff, including doctors, nurses, therapists, scientists and other professionals. Our training and development department offers a wide range of clinical and non-clinical training courses, accessed in a variety of ways through a range of media including e-learning. The Trust has excellent training facilities which were recently upgraded.

Division: Medicine & Urgent Care

Directorate	Services			
Urgent Care	A&E	Benham	EAU	Ambulatory Care
In patient Specialities	Cardiology	Nephrology	General medicine	Gastroenterology
	Endoscopy	Thoracic medicine		
Outpatient & Elderly & Stroke Medicine	Neurology	Rheumatology	Dermatology	Geriatric Medicine
	Stroke services	Rehabilitation	Main Outpatients	Neurophysiology
	Diabetes	Endocrinology	Day Case Area	Danetre Outpatients

Division: Surgery

Directorate	Services			
Anaesthetics, Critical Care & Theatres	Anaesthetics	Critical Care	Theatres	Pain Management
	Pre-operative assessment			
Head & Neck & Trauma and Orthopaedics	Audiology	ENT	Maxillo Facial Surgery	Opthalmology
	Oral Surgery	Orthodontics	Restorative Dentistry	Trauma & Orthopaedics
General & Specialist Surgery	Colorectal Surgery	General Surgery	Plastic Surgery	Upper GI Surgery
	Vascular	Urology	Endocrine Surgery	Breast Surgery

Division: Women's & Children's and Oncology / Haematology services and Cancer Services

Directorate	Services			
Women's	Gynaecology	Obstetrics	Gynaecological Oncology	
Children's	Neonatology	Paediatrics	Community Paediatrics	Paediatric Audiology
	Paediatric Physiotherapy	Community Paediatric Nursing		
Oncology / Haematology services and Cancer Services	Clinical Oncology	Medical Oncology	Haematology	Radiotherapy
	Palliative Care	Cancer services		

Division: Clinical Support Services

Directorate	Services			
Imaging	Breast Screening	Imaging Physics	Interventional Radiology	Radiology
	Nuclear Medicine	Medical Photography		
Pathology	Microbiology	Histopathology	Biochemistry	Immunology
	Infection Prevention			
Clinical Support	Therapies	Pharmacy	Medical Education	Research & Development

STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

During 2015/16 Northampton General Hospital (NGH) NHS Trust has continued to focus on delivering high quality care for patients. We aim to put quality improvement at the core of all our services and this report gives an overview of some of the work done in 2015/16 and sets out the plans for improving the quality of services in specific areas for next year and beyond.

During 2015/16 Northampton General experienced very high levels of demand for emergency services as was the case in the NHS nationally. This presented challenges for our staff and for our patients and has had an impact on our ability to deliver planned services. Despite this, our staff have remained committed to delivering the best care that they can and have continued to work towards the hospital's overall aim of 'Best Possible Care' with the values that support that ambition. We have improved the care that we give to our patients who require emergency admission over the last 2 years and we aim to continually improve urgent care in collaboration with partners in the health and social care economy. We know that if we can succeed in collaboratively improving urgent care in Northamptonshire, the hospital planned services will be able to flourish.

Delivering high quality care requires us to constantly review the care we provide. In order to better meet the needs of our patients and to support this work, the Trust has signed up to a national campaign called Sign Up to Safety that aims to make the NHS the safest healthcare system in the world. A key component of this work centres on listening to and involving our staff, our patients and the local community we serve. It is important that all our staff understand the values of the Trust and what it means for them to aspire to excellence, to reflect, learn and improve and to respect and support each other and our patients. In order to deliver Best Possible Care, we know that we must be a learning organisation committed to developing individuals, teams and leaders to be able to put these values into practice. The simple message that all staff have a duty both to deliver care and improve care is increasingly built in to induction training.

The views of our staff, patients and their carers have been incorporated into our Quality priorities for next year and our Quality Improvement Strategy 2015-18 which describes how we will achieve the aspirations we have for our services. Over the next 3 years we have committed to a programme of work that will ensure that our services become safer, more effective and provide those who use them with a more positive experience.

Our work to reduce avoidable harm and save more lives continues and is at the centre of our Quality Improvement work and increasingly this work needs to involve all our partners in Health and Social Care in order to ensure we can support patient centred care in the community where possible. Getting patients home safely has been a particular focus and this work will be essential as pressure on services increases

We have strengthened the path set out in our Clinical Strategy by working closely in partnership with other hospitals including Kettering General Hospital and the University Hospitals of Leicester and with providers of community services and primary care. An example of this can be seen through our collaborative work with Kettering General Hospital covering a range of specialities and with Northamptonshire Healthcare where we have

worked on solutions to improve the situation for patients who are waiting to leave the hospital and for patients who need special care at the end of their lives. This signals our intention to focus on providing care that best meets the needs of the population of Northamptonshire and not just on the patients who have traditionally used our hospital services.

During 2015/16 year we have also continued to imbed the clinically led structure which was introduced in January 2015. Despite the acknowledged operational challenges, we are now beginning to reap the benefits of this transition with our clinical staff being at the forefront of decision making within the Trust. Our staff survey results are now starting to show a positive change in our staff's perceptions of the hospital and we are determined to build on this.

The Trust has made significant progress against the quality priorities we set ourselves in 2015/16. For example:

- Although we still have too many patients who cannot leave hospital for home as quickly as we or they would like, we have improved our discharge processes and are committed to improving this further
- End of life care continues to be a priority for us with on-going work streams building on the foundations laid through the CQUIN (Commissioning for Quality and Innovation) and our NGH quality priorities to ensure that patients who are approaching the end of their life are identified and receive the appropriate care
- The foundations for Sign up to Safety had been laid ensuring continuous reporting against agreed metrics to achieve the best possible care for our patients
- Complaint responses have improved throughout the year with all complaints being acknowledged within three working days
- We have continued to invest in our staff though programmes of leadership and development focussed on improving quality

The Trust has been recognised nationally through a number of awards including a national Award for Using Information for Improvement and Assurance, a national Award for Leadership and Innovation in Cancer Nursing and nomination for a CHKS national patient safety award. Following some very successful work involving doctors in training , medical students and student nurses in quality improvement resulting in national and international presentations, we have strengthened our links with University of Leicester and the University of Northampton and hope to extend this work further in the future

We recognise that further work is needed to build upon the progress made in 2014/15 and this on-going activity will be accorded a high priority within the Trust as we go forward into 2016/17.

Providing health care is not without risk and we acknowledge that we do not get it right every time and for every patient. This quality report outlines our ambition to further reduce preventable harm across our organisation. The coming year will provide us with further opportunities to make improvements to the care that we provide to our patients and their carers. Our quality priorities for 2016/17 will again focus on delivering care to our patients that is safe, effective, reliable and compassionate.

We also recognise that a key challenge for the coming year and for the future will be to contribute effectively to planning and implementing the changes required to transform the

Northamptonshire Health and Social Care system and to ensure that patient centred, high quality care remains central to this work.

Despite the pressures we face including the unprecedented levels of emergency activity and the need for significant and transformation change, there is no doubt that many patients receive excellent care and many of our staff, show exceptional commitment day after day. I remain proud of Northampton General and of our staff who so often pull together to do the very best for our patients. It is only right that I end by thanking each and every one of them and reflect on the privilege of being able to do so.

Dr Sonia Swart
Chief Executive

STATEMENT OF DIRECTORS' RESPONSIBILITIES

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (in line with requirements set out in Quality Accounts legislation).

In preparing their Quality account, directors should take steps to assure themselves that:

- The Quality Account presents a balanced picture of the trust's performance over the reporting period
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm they are working effectively in practice
- The data underpinning the measure of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review
- The Quality Account has been prepared in accordance with any Department of Health guidance
- The directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Signed ……
25 June 2016
Paul Farenden
Chairman

Signed ……
25 June 2016
Dr Sonia Swart
Chief Executive

SECTION TWO

QUALITY AT THE HEART OF NGH

Quality has always been an integral component of our work at NGH. Our Quality Strategy sets the ambition and aim for our existing and planned work for us to provide the best possible care for all of our patients. Quality within the Trust focuses on three core areas:

1. *Patient safety*
   - There will be no avoidable harm to patients from the healthcare they receive.
   - This means that our systems are reliable and effective, the environment is clean and safe and our staff have received all relevant training to ensure that harmful events will never happen.

2. *Effectiveness of care*
   - The most appropriate treatments, interventions, support and services will be provided at the right time and in the right place to those patients who will benefit.
   - Our patients will have healthcare outcomes which achieve those described in the NHS Outcomes Framework and NICE quality standards

3. *Patient experience*
   - Patients will experience compassionate, caring and communicative staff who work in partnership with patients, relatives and carers to achieve the best possible health outcomes.

Hospitals protect and cherish life - NGH is no exception. Successful organisations are also characterised by strong values and a clear guiding vision.

At NGH, our **vision** is simply stated: “To provide the best possible care for all our patients.”

The **Values** that we work by to support our vision are equally straightforward and uncompromising:

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

QUALITY PRIORITIES 2016/17

Quality is at the heart of everything we do. We will continuously improve the quality of our services across the Trust. There are five key priorities that we will focus on in the coming year. Setting these priorities for 2015/16 involved a process of consulting staff, external stakeholders and volunteers on what should be included. The Quality Priorities that have been agreed for 2015/16 are shown below and are aimed to deliver our key goal:

- To reduce mortality
- To reduce harm
- To provide reliable care
- To improve patient experience

We will deliver our priorities through our clinically led divisional structure as part of our overarching programme of Changing Care at NGH supported by our Patient Safety Academy. It is crucial that the progress with each of these priorities is closely monitored to ensure the best possible care for our patients. Each of these Quality Priorities will be overseen by the Medical and Nursing Directors and reported to the Quality Governance Committee on a quarterly basis.

We have aligned our Quality Priorities for 2016/17 within our quality improvement portfolio, building upon the work of previous quality improvement strategies; enabling us to provide the best possible care to every patient.

Our Quality Improvement Strategy is aligned with our Quality Priorities and was developed with input from staff through focus groups and lessons learnt from complaints, serious incidents and asking staff what quality means for them. This takes into account the recommendations of the Francis Report, Berwick Review and the principles from the Sign up To Safety Campaign that aims to make the NHS the safest health care system in the world.

The aims of this strategy are to ensure that patients and service users of NGH receive safe, effective services with a positive patient experience. We will demonstrate a year on year improvement against baseline, within all measurable benchmarks.

Each of the six quality priorities is underpinned by a number of work streams to enable us to measure successful outcomes.

1. Aim: Reducing Harm from Failure to Rescue

As measured by:

- timeliness of observations
- Identification of the deteriorating patient
- Eliminating delays in investigations
- Sepsis care bundle

2. Aim: Reduce Avoidable Harm from Failures in Care

As measured by:

- Avoidable pressure ulcers
- Falls with harm

- Hospitals acquired VTE
- Omitted medicines

3. Aim: To Deliver Patient and Family Centred Care

As measured by:

- Friends and family test
- National CQC patient surveys
- NHS Choices
- Dementia carers survey

4. Aim: To Lead and Promote a Reflective Culture of Safety and Improvement

As measured by:

- Safety culture questionnaire
- Learning from errors (reduction in repeat incidents)
- Qualitative feedback from Board to ward walk rounds

5. Aim: To ensure operational processes support essential planning, delivery and record keeping

As measured by:

- Night team handover
- Time to Consultant Review
- WHO safer surgery checklist

6. Aim: To Deliver Reliable and Effective care (Care Bundles)

As measured by:

- Intentional rounding
- SSkin
- Stroke care
- Sepsis 6
- Heart Failure
- Ventilated acquired pneumonia
- Dementia (butterfly care)

In order to accomplish our aims we must continue to learn and embed a range of quality methods at all levels within the organisation.

We will build on our performance and efficiency to create a culture of continuous quality improvement. Our goal is to become a learning organisation in which every member understands their role in delivering clinical quality and works towards that goal every day. We will continue to place considerable emphasis on understanding our systems in greater detail, working towards excellence, engaging all of our employees in improvement whilst using small tests of change to build momentum and learning from mistakes.

Quality metrics around our strategic goals are agreed by the Quality Governance Committee, a sub-committee of the Board, in consultation with the clinical leads and Divisional Management teams. They will reflect our aspirations and vision and the priorities that we have identified will be monitored through the Quality Governance Committee.

Primary Driver	Secondary Driver
Reducing Harm from Failure to Rescue	**Project 1**- Improving the quality and timeliness of patient observations
	Project 2 - Identifying and managing the deteriorating patient
	Project 3 - Eliminating delays in investigations and management for patients who are septic
Leadership for Safety & Safety Culture. Promoting and Leading a Culture of Reflective Learning and Improvement	**Project 4** - Leadership training & development for staff
	Project 5 - Board to ward leadership walk rounds
	Project 6 - Patient Safety Champions & Patient Safety Academy
	Project 7 - Safety culture questionnaire
	Project 8 - LFE for clinical teams
Reducing avoidable harm from failures from care	**Project 9** - Eliminate all avoidable pressure ulcers
	Project 10 - Reduce harm from patient falls
	Project 11 - Eliminate hospital acquired VTE
	Project 12 - Reduce omitted medicines
Reducing harm from essential planning of patient care ensuring that standards of record keeping and planning are accurate, timely and effectively communicated	**Project 13** - Effective night team handover
	Project 14 - Pain management
	Project 15 - Time to consultant review
	Project 16 - WHO safer surgery checklist
Patient & Family Centred Care	**Project 17** – Communication deep dive to identify key issue areas within the patient journey
	Project 18 – Implementation of Patient Beside Information Booklet and Bedside Placemat
	Project 19 – Initiate a set of Feedback Events with patients
	Project 20 – Create a repository of patient stories
Reliable Care – Deliver evidence based care via a “bundles” for particular treatments with inherent risks	**Project – 21** Myocardial infarction
	Intentional rounding
	SSKin
	Stroke Care
	Sepsis 6
	Heart failure
	VAP

SECTION THREE

QUALITY PRIORITIES 2015/16: A REVIEW

In our Quality Account 2014/15 we chose five key priorities to focus on in 2015/16. The progress and outcome of these are shown below.

Quality Priority One – Supporting Patients in Getting Home

Why this was chosen
Our patients and staff told us about how delays in discharge from hospital impact upon them. By reviewing and improving our ward based processes, including those for admission and discharge we can improve the patient experience by reducing the number of days spent in hospital, and save bed days thus increasing efficiency and capacity.

What we intended to do
Achieve greater coordination of teams and services such as pharmacy and hospital transport to ensure timely discharge. Show improved discharge planning resulting in a reduction of average length of stay and demonstrate an increased number of patients discharged on their planned date of discharge.

How we performed

- A 'Dragons Den' was established and continues to review all patients with a LOS of greater that 10 days
- We have had a focus has been on improving weekend discharges through new process and have ensured that clinical reviews occur in a timely way
- The percentage of opportunities for a 'board round' to take place has increased to 91 %
- Our 'criteria-led' discharge process has shown a modest increase to 28.02% of in-patients
- The RAP meetings have been maintained with good work developing from these in relation to ward moves and a change of focus for our speciality wards

Quality Priority Two – Listen to Our Patients

Why this was chosen
Where things go wrong it is important we take the necessary steps to avoid reoccurrence and in the instance of a complaint to take steps to ensure it is investigated thoroughly with a timely response provided to the complainant and that any learning is shared.

What we intended to do
Ensure complaints are quickly and robustly investigated with appropriate actions recorded and followed through also to ensure that any lessons learnt are shared across the organisation and embedded.

How we performed

KPI	Q4
3 working days acknowledgement	Achieved
Maximum of 5% reopened	0.9%
Local response rate target of 90%	Average response time = 90% (Apr-Jan)
Complaints information monitoring	• Quarterly reporting presented to QGC • ECLIPSS inspections in place for 2015/16 • Monthly meetings taking place for all areas of Patient Experience (PE, Complaints, PALS) to monitor and identify areas of concern at the earliest opportunity. • Bi-Monthly meetings to review the action plan from the Clwyd Hart report (incorporating other high level publications) • Directorate / divisional governance (dashboard) reporting has been introduced and further development is ongoing. This is shared Trust-wide through the Governance drive • An audit was undertaken in September covering complaints handling, reporting and learning – The action plan is being actively implemented.
Development / Learning plans	• All information to be entered on to Health Assure system • Further work to be undertaken to support the Complaints Team to complete process within expected timeframes. The action plan for this has been developed. • Learning from complaints will be included within quarterly divisional reports.

Quality Priority Three – Invest in our Staff

Why this was chosen
Genuine leaders understand that they have a direct impact on the motivation and engagement of their staff. Employee engagement is a workplace approach designed to ensure that employees are committed to their organisation's goals and values, motivated to contribute to organisational success, and are able at the same time to enhance their own sense of well-being thereby feeling valued, supported and listened to.

What we intended to do
Develop an effective culture and way of working through the implementation of the Employee Engagement Strategy. Develop a continuous improvement culture and equip staff to lead service improvement in their own area. Roll out of leadership programmes. Support the development of an environment for a healthy culture with values shared across the trust. In so doing there is an expectation that this will improve the engagement of our staff.

How we performed

Success	Metric	Outcome
Enrolment of staff in leadership programmes	Enrolment of 50 participants on Francis Crick Programme	50
	Enrolment of 15 participants on Consultant Development Programme	15
	Enrolment of 24 participants over 2 cohorts on Ward Sister Leadership Programme	
	Enrolment of 36 participants over 3 cohorts on First Steps in Team Leadership	
Improved staff survey results	Improvement in overall Staff engagement score from Staff Survey in comparison to 2014	2014 = 3.61 2015 = 3.75
Improved staff FFT results	Improvement in Staff recommending NGH as a place for treatment and as a place to work across all areas	
Completion of in the box session	150 staff completed 'in the box' workshop	335
Improved staff FFT results	Reduction in rollover negative feedback trends from qualitative data captured on Staff Friends and Family test.	↓
Staff completed Rainbow risk	1500 staff completed Rainbow risk	1240
Street talk	8 street talk events	4
DoOD network	100 NGH DoODs in network	67
Appraisal completion	Achievement of corporate appraisal compliance target of 85%	81.89%
Staff turnover	Improvement towards corporate target of 8% for turnover	11.40%
Sickness absence	Improvement towards corporate target of 3.8% sickness absence	4.08%
Attendance on mandatory and role specific training	Achievement of corporate mandatory training compliance target of 85%	84.50%
	Achievement of corporate role specific training compliance target of 85%	74.04%
Involvement in local innovation events	200 people involved in six hat thinking tool in local areas.	238
Participation in Making Quality Count programme	Enrolment 100 participants in Making Quality Count Development Programme	148
Number of improvement projects undertaken	25 Improvement projects undertaken using D5 methodology	29

Quality Priority Four – Sign up to Safety

Why this was chosen
Our pledges were composed using an awareness of our performance against qualitative and safety KPI`s and the feedback received from our staff and patients. We have focussed on areas which we believe are important and where we can make improvements. Being part of Sign up to Safety will provide additional focus and drive for achievements of our goals and a platform to share with the wider NHS our Safety improvement work.

What we intended to do
Commit to NHS England's patient safety improvement quest to reduce avoidable harm by 50 per cent in three years**.** Develop and implement a safety improvement plan to meet the five Sign Up to Safety Pledges: putting safety first; continually learn; being honest; collaborating; and being supportive.

How we performed
Please note this data is up to Q3 with Q4 data currently being validated.

Aim: To reduce late observations by 30% by March 2018

Late Observations:
Late observation data is now collected via VitalPac and circulated to all adult wards as part of a monthly EWS audit analysis.

EWS Audit – whole Hospital	Apr	May	June	July	Aug	Sept	Oct.	Nov	Dec
% of late observations	7.94%	unava ilable	8.07%	8.23%	9.76%	8.6%	8.83%	8.03%	8.59%

NGH has placed a threshold of acceptance at 7%. Any ward that is consistently above that level is required to have an action plan in place. This data is also monitored as a regular agenda item at the Resuscitation Committee and CQEG.

Trial of Manual Observations:
A trial of taking observation with a manual sphygmomanometer was undertaken on the Hospital Flagship ward. Two PDSA cycles were undertaken demonstrating:

- 100% of readings were lower when checked with the dynamap but no more than 10mmHG in both systolic and diastolic measurements.
- In 61% of patients a repeated automated BP was needed in order to gain a reading.
- 43% of patients found the automated attempt uncomfortable. There is anecdotal belief that it may also cause bruising.

The results demonstrate a real time improvement in undertaking manual BP readings against automated. Whilst during both PDSA cycles there were no critically ill patients the potential of a 10mmHG difference could be quite significant.

The Flagship ward will now change over to manual observations during early 2016.

Aim: To reduce cardiac arrest calls by15% by March 2019.

1. **Monthly EWS Audits:**

There has been an increased focus on the audit since April identifying how many patients are scoring within the critical level >7 EWS. Compliance is then based upon whether these

patients have an appropriate plan in place. This data is sent to all adult wards monthly and discussed as a regular agenda item at the Resuscitation Committee and CQEG.

EWS Audit - Whole Hospital	April	May	June	July	August	September	October	November	December
% Monthly compliance (critical risk pts. With plan)	80%	66%	60%	58%	67%	100%	67%	50%	80%

Ensuring an appropriate plan is in place is multi-faceted, from correct level medical review through to ceilings of care and DNACPR. The Resuscitation Officers are working with clinical teams to give point of care education.

2. **Working with CCOT to review critically scoring >7EWS patients:**

A task and finish group is to be set up in February 2016 to discuss options for improving escalation pathways.

3. **Monitoring time from referral to medical review:**

Due to some transitional problems VitalPac 'closing the loop' module has been temporarily suspended. It is planned to be reactivated during Q4.

4. **Presenting at Academic meetings:**

There are currently discussions ongoing as to the best forum for presenting and discussing preventable cardiac arrest call data. This continues to be discussed at CQEG.

5. **Sharing learning from Cardiac arrest calls:**

Since September feedback on each cardiac arrest call is fed back to the clinical teams involved with the call and the patient care. This IS also discussed at the appropriate M&M meeting within the division.

Aim: To improve the screening of potentially septic patients & time to administration of antibiotics in severe sepsis.

CQUIN data collection ongoing and on track.

Sepsis group continue to meet with minuted action points. Specific work currently ongoing to support Oncology patients in A&E out of hours, the size of the paediatric septic case load, maternity sepsis guideline and a study of maternity sepsis involving the Microbiology department.

The new sepsis screening tools are being disseminated currently across appropriate clinical areas however this is taking longer than planned.

NCEPOD sepsis audit report and gap analysis currently ongoing.

Aim: To develop a safety improvement culture as part of the roll out of the NGH Leadership model, producing leaders who are; Trusted, Motivate staff & Committed to excellence.

IQE update: Currently on track to meet all MQC targets, excellent participation from the current cohort. A number of projects in the pipeline for the next cohort already which will go through the selection process based on organisational impact in January.

OD update: Currently on track to meet OD targets, participation in Values activity has widened to include an 'open' session in the cyber café and inclusion on Trust Induction. A catch up session is being planned in January for newly appointed consultants in order to bring them up to speed with the existing Consultant Development programme.
Feedback from the FCP dates delivered by Ove Arup has been very positive and the

remaining sessions are still to be planned with Academy.

Aim: The purpose of the safety round is first to send a message of commitment and it also fuels a culture for change pertaining to patient safety

During Q3 31 Executive Safety Rounds were completed in October and November, no visits were completed in December.

Octobers Board to Ward theme focussed on staff health and well-being and asked colleagues in non-clinical areas if they felt supported by their superiors and work colleagues. Board members asked staff if they attended regular team meetings and informed colleagues of the health and well-being initiatives in place at NGH asking staff for their ideas and view on what future health and well-being initiatives could be developed and introduced.

November's board to ward involved executive visit's to 27 in patient areas to discuss preparation and concerns regarding the pending junior doctors industrial action which was planned of November 2015. The resilience plan that had been developed had addressed many of the concerns raised. Extra safety huddles and rounding by senior staff was planned. The proposed industrial action for November was cancelled; however the November board to ward did provide assurance of plans in place and further action required to improve communication and keep staff appraised of planned industrial action.

Aim: To increase year on year the number and activity of safety champions within the Hospital.

The database for Safety Champions has been cleansed with areas contacted regarding their status. This is also reported via the quarterly Patient Safety, Quality & Governance reports.

It is planned that throughout 2016 an appropriate QI training plan will be developed and local activity of the champions will be monitored accordingly. A newsletter will be developed on from this as an additional method of communication between the Safety Academy and the safety champions.

Aim: To roll out QI initiatives across all wards that have proven sustainability from the flagship test bed.

During Q3 2014 Holcot ward was successful in a bid to be utilised as a QI test bed to trial, test and introduce QI initiatives that would provide the best possible care for patients. The projects focussed on four key areas: Environment, Nursing & Medical KPI's, Communication and Patient Experience. The project working group worked on a plan consisting of 33 treatments of which 13 had demonstrated proven sustainability.

The senior Nursing team under the direction of the Director of Nursing will identify from the portfolio of successful QI initiatives a roll out and adoption plan which will be operationalised via the Quality and Improvement Matrons.

Aim: Increase staffs perception of safety culture across four key areas: general safety: individual performance: team and job satisfaction and incidents and concerns.

During the latter part of Q3, EMPSC commissioned a bespoke Safety Culture and leadership programme to support healthcare providers this has been offered to NGH. The programme is

for a 4 year commitment to measure safety culture and climate.

The TDA are in support of using a reflective safety culture tool MaPSF that helps organisations understand their level of development with respect to the value organisations place on patient safety.

During Q4 a decision will be made to confirm organisational preference to measure safety culture and climate as this has inference with the staff survey and the biannual safety culture and climate questionnaires that are currently in use.

Aim: 50% of all ward & clinical teams to attend Learning from Error (LFE) sessions within the Simulation Suite.

LFE design and attendance data:
LFE training has now been implemented for wards and clinical teams. Meetings set with matrons and sisters to explain the importance of the sessions and how we can make them bespoke to wards/teams.
Screen saver to be advertised frequently throughout 2016.
All wards who now call for simulation training are booked onto the LFE training days; the session is then designed around common themes and incidents that have occurred on their ward. Discussions are currently ongoing as to how best to encourage medical staff attendance.
To discuss further with DME how to encourage consultants to teach on LFE days and for this to be acknowledged as learning from their Governance SI report.
LFE staff trained so far – 22% of relevant Trust staff.

Practice change agreements:
As of December 2015 all participants are asked to agree to take one thing back into their practice. This will be further developed and refined throughout 2016 with themes explored and reported upon.

Aim: To reduce the number/percentage of pressure ulcers by 10% by March 2019

There has been no significant improvement in the number of hospital acquired pressure ulcers (HAPU's) when compared to last quarter, however when compared with the same period last year, there is an improvement of 27%.

In order to improve our patient care a 'break-through series' model of quality improvement has been commenced to address the causes of HAPU and reduce the number of pressure ulcers within the organisation. This work has been led by the TVN Team and Quality Assurance & Improvement matrons under the direction of the Director of Nursing, Midwifery & Patient Services.

This Pressure Ulcer Collaborative Programme consists of 3 learning sessions, with the first session having taken place on 25th November 2015. The use of a collaborative model will provide a framework to optimise the likelihood of success for the organisation. It is most effective when there is a deficit in quality which can be identified by teams as "unacceptable" and when there are pockets of excellence which can be used to promote learning. The focus for the first learning session was on prevention of heel pressure ulcers as this accounts for 36% of all HAPU's within the organisation.

The first learning session was extremely well attended, 95 % of clinical areas had one or more representative. The audience included student nurses, therapists, Doctor and a patient

representative. The day was a huge success and very well evaluated with many staff acknowledging that the key to success is engagement, alignment and collaboration of the clinical teams. Following the first day of the Collaborative each ward/department has the opportunity to complete small tests of change to improve/reduce harms caused by pressure over a 2 month period. All attendees were asked to make a "pledge" to reduce pressure damage within their clinical areas, the notion is to get all staff to agree to the commitment made and sign, see example below.

From January 2016 the Confirm & Challenge meeting will change its name to Share & Learn as voted by Ward Sisters, this name change reflects the modifications to its focus; sharing best practice; identifying key themes and learning lessons.

Aim: To reduce harm from (in-patient) falls by 15% by March 2019

Targets Achieved (all internally set):

- 90% or more of patients receive a falls risk assessment on admission.
- 80% or more of patients have all components of the falls care plan completed
- Trust's falls rate is below the (internally set) maximum of 5.5 falls/1000 bed days.
- The Trust's harmful falls rate/1000 bed days are below the internally set maximum of 1.6.
- The Trusts' falls/1000 bed days and harmful falls rate is below the national average as measured by the Safety Thermometer (point prevalence) and the RCP in patient falls audit (incident data).

Review current process for post falls review and make appropriate changes
A review of the current paperwork and processes is ongoing. The start of this project was delayed whilst we sort out a suitable junior doctor to assist in this review. It is expected to be completed at the end of April 2016.

Develop a delirium policy to manage patients with confusion
A draft of this policy was circulated by the Dementia Steering group for comment in December 2015.

Aim: To reduce harm to patients admitted to NGH by eliminating avoidable VTE events by 2019 (excluding maternity). The trust is below the national average, hence we aim to maintain and marginally improve year on year

Thrombosis meetings have now been commenced and consultants informed of the need to attend to discuss RCA's of any HATS.

Thromboprophylaxis nurse continues to deliver VTE teachings. Both Clinical lead and project lead are working together to refresh the teaching sessions and devise an assessment to be completed at the end of each session.

The anticoagulation department is planning to hold an education day in 2016 to raise the profile of the service and the work it carries out. This will also provide an opportunity for more informal teaching and find out from nurses what educational needs they have in relation to VTE.

Further review to activate the VTE RA on VitalPac will progress during Q4.

Aim: To reduce omitted doses of medicines* by 10% in Year 1 and thereafter by 20% Year

on Year to March 2019

The Safety Thermometer has not been fully implemented across the trust due to lack of capacity. Wards targeted for MST, matched those where roll out of ePMA was achieved, plus two wards from the surgical division. ePMA roll out across the trust is in progress and on track.

The Omitted medicines strategy has not been formalised. The draft safety plan includes a work stream for omitted doses which contains a risk assessment and action plan. Further development is planned for Q4.

Aim: Patients requiring an internal transfer will have a documented transfer plan in place and appropriate staff escort. Patient transfers out of hours will be risk assessed. Deteriorating patients or patients with a EWS >7 will be discussed at night team handover

Some work has taken place with regards to patient moves. A recent internal audit has been completed, the review of which is due to take place in the monthly patient moves meeting.

The night team handover work has commenced. A baseline audit was conducted in Quarter 3 2015. Discussions are ongoing regarding a standard operating procedure for the handover and a relaunch to underpin the importance of following this standard. This is planned for Q4.

There is a patient transfer checklist in place and patient moves leaflet. Discussions currently ongoing as to how this is audited on a regular basis.

There is a point prevalence audit for all adult wards which demonstrates monthly how many patients across all general adult wards are triggering above 7 on VitalPac and then of those who have an appropriate plan in place.

EWS Audit - Whole Hospital 2015	April	May	June	July	August	September	October	November	December
% of patients scoring >7 (critical risk)	2%	1%	2%	2%	2%	2%	3%	1.37%	1%
% Critical risk patients with plan in place	80%	66%	60%	58%	67%	100%	67%	50%	80%

Aim: To increase the number of ward based nurses competent to complete a pain score and timely reassessment

1. **Produce gap analysis for pain score training on acute wards**
   Small task and finish group met on 2nd December 2015 and a GAP analysis tool designed and sent out to all Adult Inpatient Ward Managers and Matrons**.**
2. **Plan Training Schedule**
   This will commence following the results of the GAP analysis
3. **Monitor Pain Management QCI Data**
   Data was collected for all adult inpatient areas for October, November and December 2015 and recorded as results for medical wards, surgical wards and the Trust as a whole
4. **Acute Pain Team to Audit accuracy of pain scores on patients they review**
   Data has been collected by pain team since 18th November 2015. From the 42 patients seen 40% show a 2 or more point difference in pain scores (0-3 scale). Wards tend to record a lower score than the pain team assessment

Aim: All emergency admissions will be seen and have a thorough clinical assessment by a suitable consultant. The standard applies to emergency admissions via any route, not just the Emergency Department

1. Recording of NEWS is well established, however a system will be required for utilising the data for this project and this will be developed during Q4. An audit undertaken during Q3 demonstrated a 90% compliance.
2. This data currently is only available from a notes review. During a notes review in Q3 (as part of the self-assessment test required by NHS England) a 42% compliance was demonstrated. The notes review is currently being repeated, across a wider range of specialities and results will be available in Q4. Recording % of patients assessed within 6 hours is only available through notes review.
3. Recording Consultant involvement in high risk patients is also only available through notes review and since the number of patients within this category is small it is possible that the notes review will not capture this information. All acute specialities have a plan for achieving the 14 hour assessment goal.

Aim: Never Events are Serious, largely preventable patent safety incidents that should not occur if the available preventative measures have been implemented.

Three Surgical Never Events have been reported.

These serious incidents are in the process of being investigated. The existing theatre processes including use of the WHO Checklist are robust. However, further emphasis of the "time out phase "is being reinforced with the full attention and focus of the team. The operating surgeons are ensuring that the theatre teams are involved fully and understand what procedure is to take place and re-checks this at the 'time-out' stage of the safety checklist.

Audit actions to provide assurance compliance have been completed and remain on track. Monthly WHO audits are completed by Clinical audit staff and have received appropriate training re WHO audit criteria.

LFE simulation training for multidisciplinary theatre based teams are in place and numbers of staff trained via discipline is recorded.

Teaching DVD is remains available on all Computers via the hospital intranet.
Theatre manager documents all members of staff who join the theatre team with the date they were trained in WHO.

Quality Priority Five – Improve End of Life Care

Why this was chosen
Wards find difficulty in identifying patients at the immediate end of their life. If this were improved, patients would be placed on the end of life register and receive better care as a result

What we intended to do
All wards to identify patients who are imminently dying and to notify through the safety huddle so the patient is placed on the end of life register. Improved uptake of end of life care

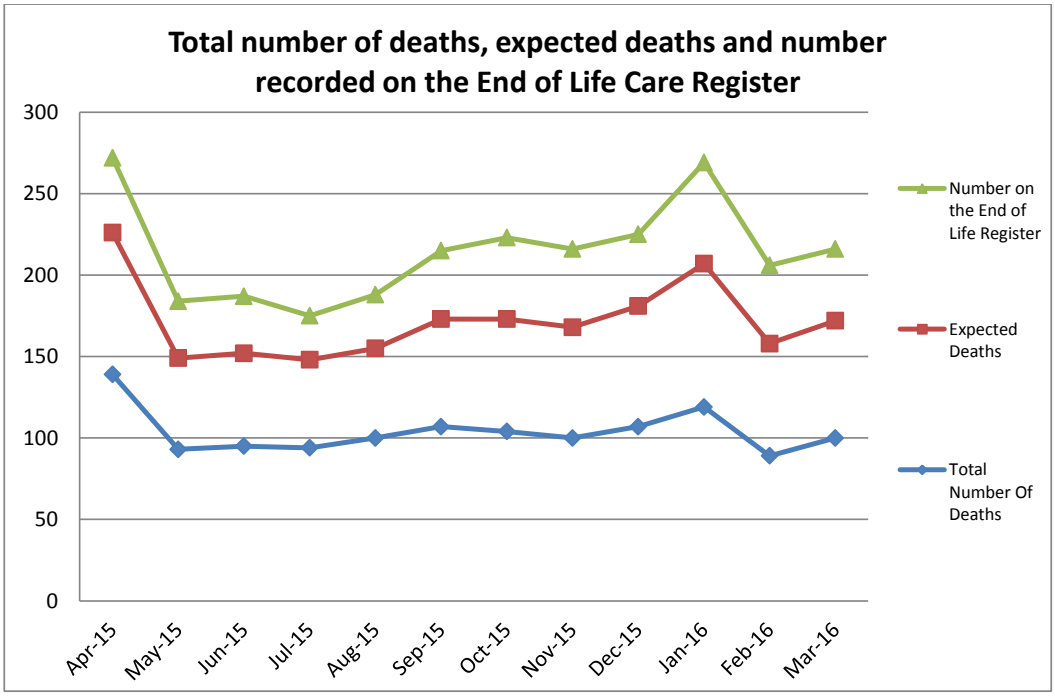
How we performed
- Specialist Palliative Care/End of Life Care Team to maintain the trust End of Life Care register

- Specialist Palliative Care/End of Life Care Team support clinical teams in the development and implementation of Personalised Care Plans for patients identified as imminently dying
- Increase in the use of the dying person care plan for patients who were recognised to be in the last hours/days of life
- The table below shows the figures for the year

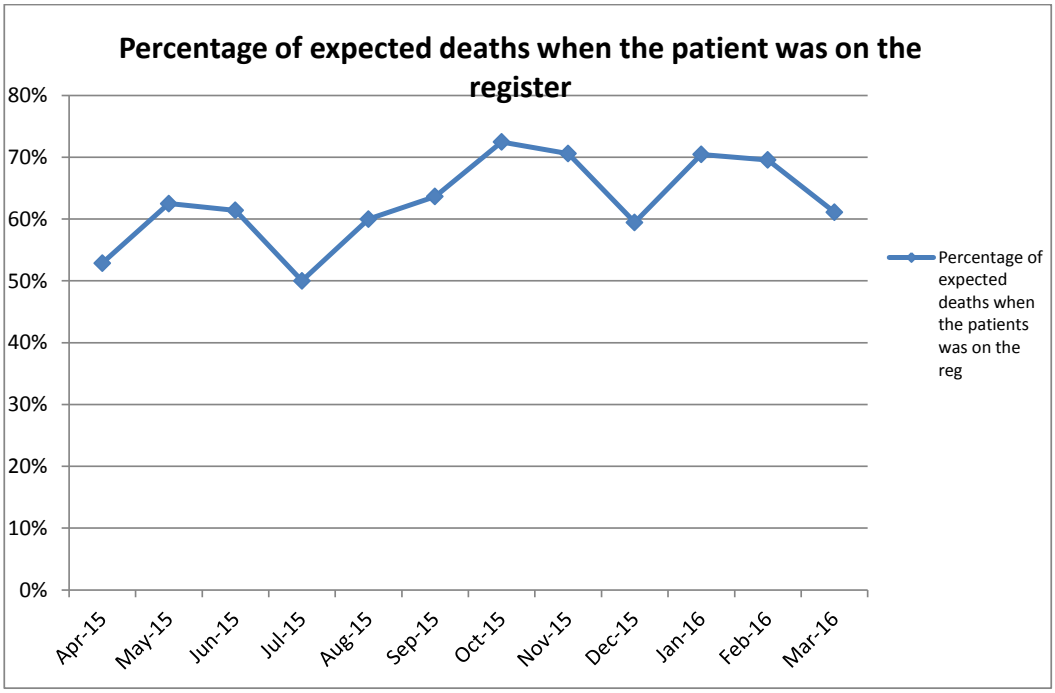
	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Total Number Of Deaths	139	93	95	94	100	107	104	100	107	119	89	100
Expected Deaths	87	56	57	54	55	66	69	68	74	88	69	72
DPCP										60	48	40
Number on the End of Life Register	46	35	35	27	33	42	50	48	44	62	48	44
Percentage of expected deaths when the patients was on the register	53%	63%	61%	50%	60%	64%	72%	71%	59%	70%	70%	61%

Percentage of patients on EOL register	33%	33%	40%	34%	45%	46%	43%	57%	50%	50%	54%	40%

The two graphs (graph 1 and graph 2) below demonstrate an upward trend in identifying patients who are likely to die in the next few hours/days within the trust.

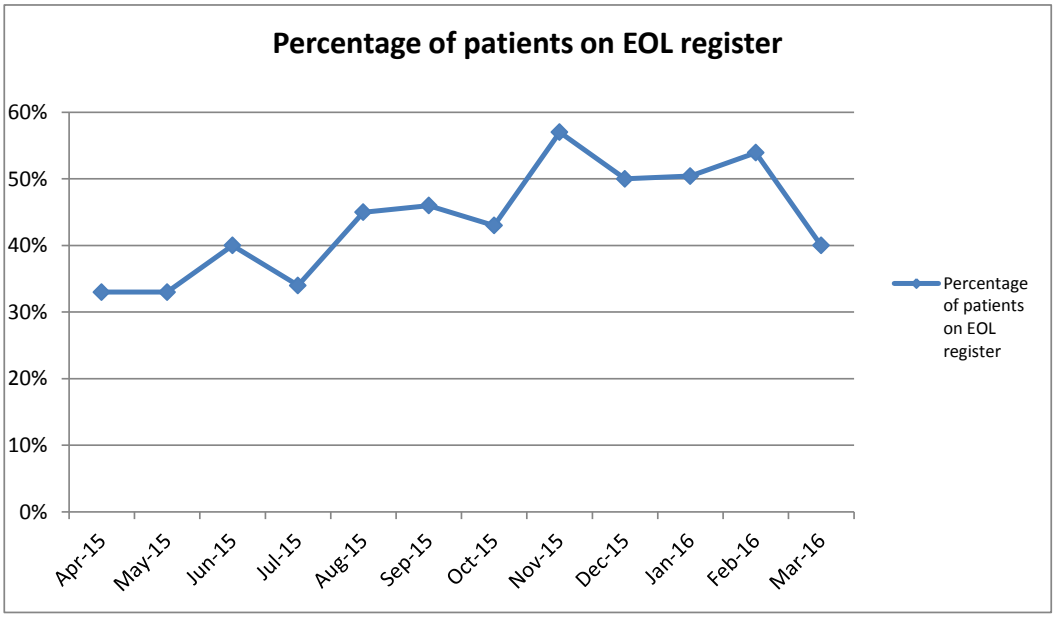


Graph 1



Graph 2

Graph 3 below demonstrates the percentage of patients who died at NGH with a Dying Person Care Plan (measured against total deaths)



Graph 3

SECTION FOUR

OUR IMPROVEMENTS IN 2015/16

During 20115/16 NGH continued to aim to deliver best possible care and one way of delivering this was supported by a number of improvements throughout the year. In addition to some of the specific improvements, the senior team has worked with staff to develop an aligned programme of work to ensure that quality improvement and efficiency of services receive the emphasis required and that all energy and resources are centred on these.

The underpinning governance structures to monitor quality have been improved, the organisation has continued to develop it's clinically led divisional structure underpinned by a supportive culture and a formal development programme Due to the number of improvements NGH has made only a handful can be shown below

Domain/s - Patient Experience, Effectiveness of Care
Project - Reduce the waiting times for all patients that attend the pre-operative assessment service to 30 minutes maximum wait.
Change / Outcomes

- Reduced waiting times from 3 hours to 30 mins max
- 220 additional patients seen between December 15 to February 16
- Previously up to 10 patients a day were being turned away, now this is zero
- Visual management implemented to aid managing the performance and sustainment of the department.

Domain/s - Patient Safety, Patient Experience
Project - Geriatric Emergency Medicine (GEM): providing excellent care to older people in ED.
Change / Outcomes

- Improved falls assessments and consequently targeted intervention
- Introduced and embedded cognitive impairment screening
- Improved the care environment by setting up new quiet GEM bays, supported by NGH charitable funds. Of patients coded as having dementia or confusion, 81% were cared for in a GEM Bay and of patients coded as frail, 44% were cared for in a GEM Bay.
- Improved pain management in hip fractures; introduced new processes for timeliness and fascia-iliaca blocks to A&E
- Patient complaints decreased by 34%
- Visual management – wall mounted filing system in GEM Bays to act as visual prompt, introduced Butterfly's to A&E, stickers for wristbands & notes, alerts on our IT system Symphony.

Domain/s - Patient Experience, Effectiveness of Care
Project - Improving patient and staff experience in the Diabetes department
Change / Outcome

- Significant reduction in backlog of letters from 460 to 5
- Sustained efficiencies, typing waiting fallen from 45 days to 3 days
- Reduction in patient enquiries and complaints

- Important improvements for patients care pathway and safety.

Domain - Effectiveness of care
Project - Increasing utilisation of Ophthalmology theatres
Change / Outcome

- Change in rosters has seen a steady increase in theatres starting on time. In December 2014, late starts were costing nearly £2000 and by November 2015 the cost dropped to below £250.
- Improved process for obtaining patient consent; saving time
- Ring fencing pre-op slots for cataract patients; improved quality and saved time
- Increased numbers of cases (from 4 to 8) being added to some consultants lists.

Domain/s - Patient Experience, Effectiveness of Care
Project - Reduce the waiting times for all patients that attend the pre-operative assessment service to 30 minutes maximum wait.
Change / Outcomes

- Reduced waiting times from 3 hours to 30 mins max
- 220 additional patients seen between December 15 to February 16
- Previously up to 10 patients a day were being turned away, now this is zero
- Visual management implemented to aid managing the performance and sustainment of the department.

Domain/s - Patient Experience, Effectiveness of Care
Project - Reduce hospital acquired pressure ulcers.
Change / Outcomes

- Have achieved overall reduction in avoidable pressure ulcer harms from 2014/15
    - 18% reduction overall
    - 22% reduction in Grade 3
    - 21% reduction in Grade 2
- Focused training from Tissue Viability Service with wards where pressure ulcers have been identified as a problem
- 60 Pressure Reducing Mattress overlays Repose Companion) purchased for A&E , for all GEM patients admitted to department
- Pressure Ulcer Collaborative -The use of this model will provide a framework to optimise the likelihood of success for the organisation (in reducing harm caused by Pressure damage). It is most effective when there is a deficit in quality which can be identified by teams as “unacceptable” and when there are pockets of excellence which can be used to promote learning.
- All inpatient areas have action plans in place to ensure the reduction in pressure ulcers and learning continues
- Work ongoing with Matrons for Improvement and Assurance, Moving and Handling Team and Tissue Viability to reduce the harms caused by poor moving and handling practices

Domain/s - Patient Experience, Effectiveness of Care
Project – Inpatient falls
Change / Outcomes

- On a monthly basis
    - 90% or more of patients receive a falls risk assessment on admission

    - Trust's falls rate/1000 bed days is below 5.5 falls/1000 bed days.
- On a quarterly basis
    - Trust's harmful falls rate/1000 bed days is below 1.6 each
    - Trust's Harmful falls rate is below the national average as measured by the Safety Thermometer (point prevalence).
- Roll out of post fall neurological observation simulation suite session for Nursing staff trust wide
- Creation of different methods of training; e.g. workbook and new simulation suite training sessions
- Bespoke falls training has been devised for the specialist nurses for older people
- 'FRAX' bone health assessment tool has been added to all iPads
- Review of the Trust's falls care plan with input from members of the NICE guideline and quality standards committee
- Pilot of bay working on flagship ward

Domain/s - Patient Experience, Effectiveness of Care
Project – Maternity
Change / Outcomes

- The Trust were successful in securing partial funding from the Department of Health to implement an innovative midwife led pathway which aims to improve the detection, investigation and management of small-for-gestational-age babies in women who smoke during pregnancy
- The maternity and neonatal services are working together to develop a new Transitional Care ward on Robert Watson Ward.
- A new and innovative weekly support group has been implemented by the Midwifery Safeguarding team. It is aimed at supporting women with a learning disability/difficulty or requiring additional support (Hidden Voices of Maternity

Domain/s - Patient Experience, Effectiveness of Care
Project – Bereavement Service
Change / Outcomes

- As part of the 'Kings Fund Enhancing the Healing Environment' project that a team from NGH took part in, a facility was identified to create a dedicated bereavement care service and now forms part of the Trust Patient Advice & Liaison Service (PALS)/Bereavement Service
- Designated an early national 'Gold Standard Bereavement Service' pilot site
- Development of the 'What happens now' making arrangements following a death information booklet for relatives & next of kin
- Provision of a single central point and dedicated office for medical staff to complete the medical certificate of cause of death (MCCD) and discuss with coroner if required.
- All adult deaths referred to the Service

Domain/s - Patient Experience, Effectiveness of Care
Project – Infection Prevention
Change / Outcomes

- We have achieved an overall reduction of 67% in C.diff cases since 2009
- Sustained compliance with hand hygiene practices to minimise infection
- SIGHT campaign in January 2016 across trust
- 98.5% compliance with correct antibiotic prescribing procedures

- We have achieved an overall reduction in MRSA bacteraemias since 2009
- Sustained compliance with hand hygiene practices to minimise infection
- Sustained achievement in MRSA screening for both emergency and elective admissions

Domain/s - Patient Experience, Effectiveness of Care
Project – Stroke
Change / Outcomes

- An exercise group, run in collaboration with the gym's own instructors and personal trainers, was set up after a successful pilot showed that patients made huge physical and psychological gains by attending the group.
- The results show that all patients increased the speed they were able to walk 10 metres with and without a walking aid
- All patients increased the distance they were able to walk in 6 minutes by at least 50 metres
- Our balance assessments show that any patient who attended the group at a medium to high falls risk moved to a low falls risk post completion of the group.
- All participants felt their mood either stayed the same or improved over the course of the 10 weeks and everyone felt that their quality of life, function, confidence and general wellbeing had improved significantly

Domain/s - Patient Experience, Effectiveness of Care
Project – Vascular
Change / Outcomes

- Vascular Nurse Specialist participates on diabetic foot round at KGH
- Nurse led Vascular Clinic at Corby Diagnostic Centre
- Exercise programme for patients with Intermittent Claudication, at Corby Physiotherapy Department Corby Diagnostic Centre

General Areas of Improvement

Additional Parking - The staff car park has been radically overhauled with the addition of a one-storey structure laid on top of current spaces in car park 1. This has enabled additional spaces to be available for our patients and visitors.

Outpatient Pharmacy - A new outpatient pharmacy was opened in June 2015, operated by Boots in collaboration with our existing pharmacy service. This has allowed our own highly-skilled pharmacy staff to prioritise their ward-based work.

Blood Taking Unit - Our blood taking unit has moved to new larger premises and extended its opening hours to provide an improved service for patients.

Closer Links with the University of Northampton - NGH and the University of Northampton have a research agreement to further improve the care of hospital patients and the wellbeing of local people.

IMPLEMENTING DUTY OF CANDOUR

The introduction of the CQC Regulation 20 is a direct response to recommendation 181 of the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust 1, which recommended that a statutory duty of candour be introduced for health and care providers.

To meet the requirements of Regulation 20, the Trust has to:

- Tell the relevant person, in person, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, and provide support to them in relation to the incident, including when giving the notification.
- Provide an account of the incident which, to the best of our knowledge, is true of all the facts we know about the incident as at the date of the notification.
- Advise the relevant person what further enquiries the provider believes are appropriate.
- Offer an apology.
- Follow up the apology by giving the same information in writing, and providing an update on the enquiries.
- Keep a written record of all communication with the relevant person.

As a Trust a significant amount of work has been undertaken to ensure we are compliant with the statutory and contractual requirements. Duty of candour training has been included in all the incident reporting/investigating and root cause analysis training given to staff.

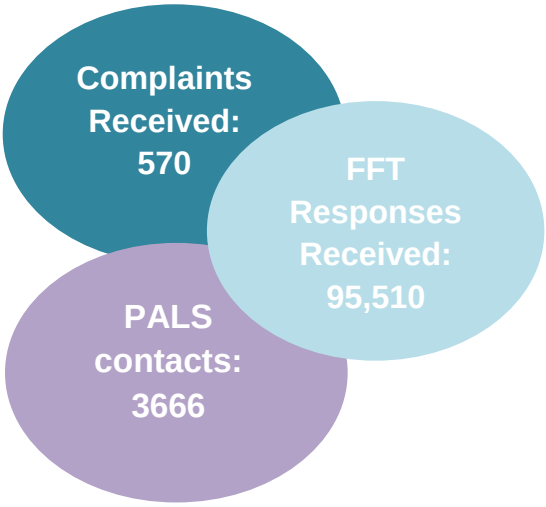
The Trust's Clinical Risk Manager has attended departmental, directorate and divisional meetings to talk through the process with the clinicians and ensure they are aware of the expectations and their own responsibilities.

Since the introduction of the regulation, the Governance Team have audited compliance that all patients/relevant person(s) who have been involved in an incident which has resulted in moderate harm or above have received an apology.

The Trust is then sending a letter following up from the verbal apology to the patient/relevant person(s) with the outcome of the investigation.

From feedback received from the clinicians a crib sheet/sticker was requested to support them in ensuring the correct information is documented when they make an apology. The use of the stickers is due to be implemented in May 2016.

LEARNING FROM PATIENT FEEDBACK
(ENCOMPASSING THE FRIENDS & FAMILY TEST, COMPLAINTS & PALS)



Complaints Performance 2015/2016

100%	Percentage of complaints acknowledged within 3 working days
90%	Percentage of responses provided to complainant by agreed deadline

Complaints Performance 2014/2015

100%	Percentage of complaints acknowledged within 3 working days
Ave 81%	Percentage of responses provided to complainant by agreed deadline

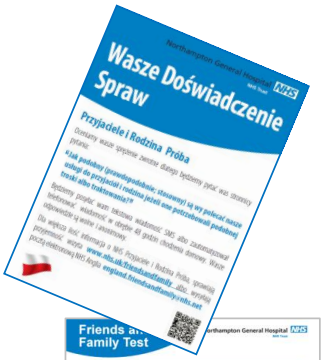
What are our patient's main concerns?

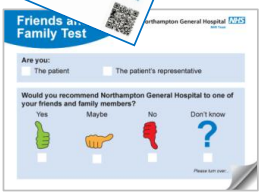
The following Word Cloud has been produced from the Complaints and Friends & Family Test subjects most used throughout 15/16 Q4.

The Friends & Family Test

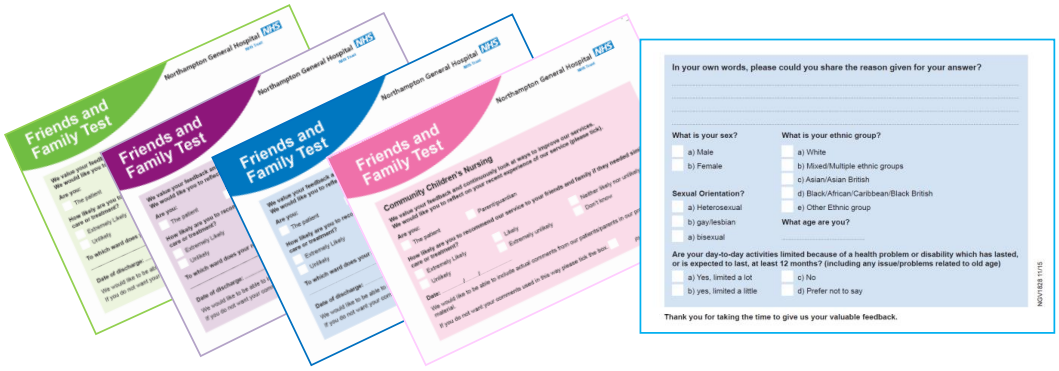
The Patient Experience teams within NGH spend time collating information that is received about the services that we provide, from our patients. Feedback may be received through a number of different sources including complaints, concerns, patient stories, friends and family test and surveys which may be completed during or after a patient's admission. All of this information provides the Trust with vital intelligence as to how we may improve our services.

The Friends & Family test, which is used across the NHS, is an excellent source of information for the Trust to obtain feedback by answering simple questions about the patients experience whilst they have been attending or admitted to hospital. In 2015 the methods used to collect the Friends & Family Test were expanded from collecting through SMS Text messaging and Interactive Voice Messaging, to ensure inclusivity to all patients. This includes;





- Multiple language posters giving a web link to an online survey in the patients preferred language
- A bespoke children's survey to ensure feedback is collected from children as well as parents/guardians
- The development of a suite of postcards and installation of 70+ post-boxes throughout the hospital including questions relating to equality and diversity
- Creation of an easy read FFT postcard



Northampton Generals' inclusivity has been recognised by NHS England who shortlisted the hospital for an award at the Insight Awards in March 2016.

To support the changes to the FFT, throughout December 2015 the FFT was relaunched to both the hospital and the public. As part of the relaunch, 2 Compliments Trees, funded by Northamptonshire Health Charitable Funds, were put up in the hospital displaying positive comments from the FFT responses. In addition to this, members of the public were able to give their own compliments by writing on blank baubles. The completed baubles have been shared with the teams throughout the hospital.

In addition to this, in order to showcase some of the exciting changes that have been made throughout the hospital as a result of patient feedback, the hospital created a video of 10 improvements to the tune of 'the 12 days of Christmas'. The track was sung by a combination of the NGH Choir and staff in Northamptonshire Health Charitable Funds, all standing around the Compliments Christmas Tree. Each of the 10 lines to the song features the improvement which has been made, along with a number of the hospitals staff. Through YouTube the video has had 160 views; however the real success was through uploading the video to Facebook. To date, the video has been viewed by over 5000 people. Many people commented on the video, including both staff and patients. Here are just some of the many wonderful comments;

'You guys are awesome just brilliant, wishing everyone at Northampton General a very Happy Christmas and a massive Thank you for all you do. Well done everyone!'

Triangulating Feedback

Patients are able to provide their feedback to the hospital in a number of different ways including the Friends & Family Test, PALS, Complaints, Online Reviews and Social Media sites. Each of these different sources provides a wealth of information regarding the patient's experience. To ensure the areas where patients are voicing dissatisfaction, are identified correctly, the feedback from all of these sources is triangulated quarterly. This includes;

- Combined reporting structure incorporating Complaints & Concerns produced on a quarterly basis and presented to the Trust's Quality Governance Committee
- Introduction of a complaints survey and covering letter to obtain feedback in order to continuously improve the complaints service and the way in which complaints are handled across the Trust
- Data from Patient Experience, Complaints and PALS is themed and compared to identify commonalities and areas for improvement based upon patient experience across the organisation
- ECCLIPSS (Experience, Complaints, CCG, Legislation, PALS, Safeguarding and [Nursing] Standards) meetings held quarterly to discuss triangulation data and identify clinical areas in which to undertake an internal QuEST inspection.

The table below provides an example of the triangulated themes from 15/16 Q3.

Area	Primary Theme
Complaints	Clinical Treatment
	Communication
	Cancellations
FFT	Waiting Times
	Communication
	Care (Medical & Nursing)
PALS Concerns	Communication
	Delays
	Care (Medical & Nursing)
Online Reviews	Communication
	Care (Medical & Nursing)

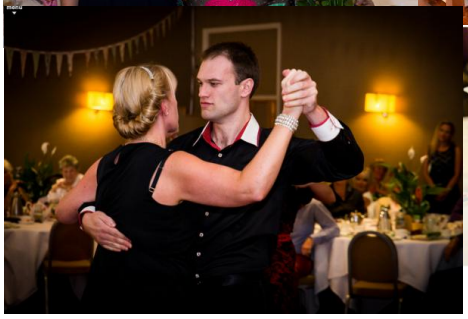
Improvement Projects

Outpatient
One of the most commonly identified problem areas in Outpatients is waiting times. The Outpatient Project, managed by the Improving Quality & Efficiency team, is focusing its improvements around waiting times, within the areas that have been identified within the patient experience triangulated data as detailed previously.

Next Steps: The project was identified in 15/16 and will continue to run in 16/17. All KPI's and progress will be monitored through feedback during the next financial year.

Do it for Dementia
The Do it for Dementia (DIFD) fundraising campaign had an active year within 15/16. The main focus for this year was around identifying where expenditure would take place and fundraising. The Tea Dance held in September at Sedgebrook Hall was the main event held for the year. Everything for the day was donated by generous people and businesses throughout Northampton. The event raised £1400.

The first piece of reminiscence equipment was purchased with the money raised. The My Life equipment includes a large portable computer and a tablet. The software contains video clips, pictures, and music bites which can be played with our dementia patients



within the hospital. To support the use of the software on the wards, a number of volunteers have been trained to use the computers with our patients with dementia.

At the end of 15/16 the campaign had raised a total of **£13,591**.

Next Steps: The DIFD campaign will be taken over by Northamptonshire Health Charitable Funds during 16/17 with the aims of the campaign directly reflecting and supporting those of the strategic aims of the organisation.

NHS Staff Survey

The 2015 annual National NHS Staff Survey took place during September to November 2015. A total of 4676 surveys were sent directly to all staff and 1442 members of staff returned the survey.

Of the 32 key findings this year there has been improvement in 9, no deteriorations, 13 have stayed the same and 10 could not be compared. This is again an overall improvement and continues our positive trend of improvement over the last 3 years.

The Trust has statistically improved since 2014 in:

- Overall Staff Engagement
- Staff recommendation of the organisation as a place to work or receive treatment
- Support from immediate managers
- % appraised in the last 12 months
- % feeling pressure in last 3 months to attend work when feeling unwell
- % experiencing physical violence from staff in last 12 months
- % experiencing harassment, bullying, abuse from patients, relatives or the public in the last 12 months
- % experiencing discrimination at work in the last 12 months
- % witnessing potentially harmful errors, near misses or incidents in the last month
- Staff confidence & security in reporting unsafe clinical practice

The Trust was in the top 20% for Acute Trusts in:

- % appraised in last 12 months

The Trust was above average for Acute Trusts in

- Effective team working
- % experiencing discrimination at work in the last 12 months

Key areas for improvement when comparing us to other trusts:

- Staff satisfaction with resourcing and support
- Staff satisfaction with the opportunities for flexible working patterns
- Staff experiencing physical violence from patients
- Organisation and management interest in and action on health and wellbeing
- Staff witnessing potentially harmful errors, near misses or incidents

Work is already underway on these however we are aware that a number of these areas are influenced by pressure in the system, particularly in relation to increasing urgent care workload and acuity, compounded by national staff shortages in key areas such as doctors and nursing staff, which undoubtedly impacts on staff. We are actively recruiting new staff and providing support to staff to help them to cope with the day to day pressures they face in an ever increasingly challenging environment in which to provide high quality care.

Staffs most positive perceptions

- Staff are trusted to do their job
- Staff agree that their role makes a difference to patients and service users
- Staff know how to report concerns about unsafe clinical practice and the organisation encourages reporting of incidents
- Staff have received mandatory training in the last 12 months
- Staff have had an appraisal in the last 12 months
- Staff agree that they always know what their work responsibilities are
- The organisation takes positive action on health and wellbeing
- The organisation is fair with regards to career progression and promotion
- Staff agree that training has helped them to stay up-to-date with professional requirements
- Staff agreed that their manager has supported them to access training, learning or development

We recognise that overall the survey shows improvement however it highlights some areas of concern and the Trust continues to work to improve the results, through the work of its Organisational Development Team and the Improving Quality and Efficiency Team to bring about a fundamental shift in culture, where everyone is focused on quality, continuous improvement and meaningful staff engagement to sustainably improve staff satisfaction at work.

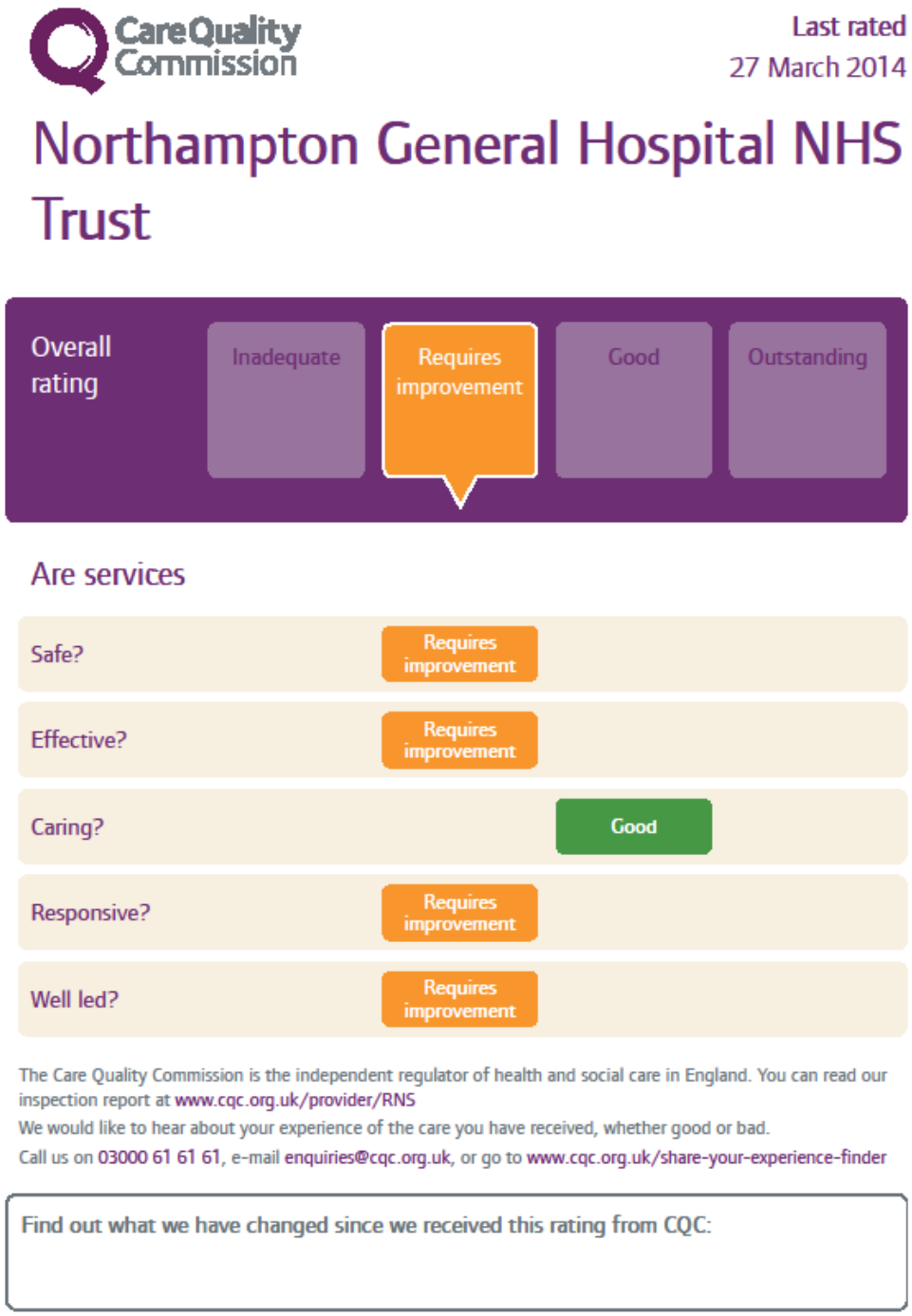
CARE QUALITY COMMISSION

The Trust is registered with the Care Quality Commission under the Health and Social Care Act 2008. The CQC are the independent health and adult social care regulator. Their job is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care. They do this by monitoring, inspecting and regulating services to make sure they meet fundamental standards of quality and safety.

NGH currently has no conditions attached to registration and has not been required to take part in any special reviews or investigations under section 48 of the Health and Social Care Act 2008.

All NHS organisations that are obliged to publish Quality Accounts or equivalent should include in them quantitative and qualitative data describing the number of formally reported concerns in addition to incident reports, the action taken in respect of them and feedback on the outcome.

The Trusts CQC grid below shows the outcome of CQC inspections where numerous areas were categorised as “Good”. Actions are ongoing to address those areas identified as “Requiring Improvement” or “Inadequate”.



Last rated
23 June 2015

Northampton General Hospital NHS Trust

Northampton General Hospital

	Safe	Effective	Caring	Responsive	Well led	Overall
Urgent and emergency services (A&E)	Not rated	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Intensive/critical care	Requires improvement	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Services for children & young people	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
Outpatients	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Reference: medical not found	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

SECTION FIVE

NATIONAL CLINICAL AUDIT AND CONFIDENTIAL ENQUIRIES

Participation in National Clinical Audits and National Confidential Enquiries continues to be a high priority and during 2015/16, Northampton General Hospital aimed to participate in all relevant projects included in the Quality Account list.

The Quality Account list includes a variety of different topics and ways of collecting data. Some of the projects collect data for a short period of time (snapshot audits) and others collect data continually on the management of certain conditions. Some of the larger projects have developed to include several different work streams for example questions about the structure of the service provided (organisational questionnaires), questions about the process of individual patient care (case note reviews) and questions about the patient experience (patient questionnaires). NGH has achieved a very high level of participation with the only exceptions being the Core Audit of the National Diabetes Audit and the National Ophthalmology Audit (Data has not been entered to these due to IT issues and is being addressed to try and find local solutions). The following table gives details of all Quality Account audits and confidential enquiries to which Northampton General Hospital submitted data in 2015/16. Percentage participation is included for snapshot audits. For audits that collect data on a continual basis, the local percentage participation and data quality are reviewed when reports are published and plans made for improvement if needed.

Name of Audit	**Participated Y/N**	**Percentage Participation**
Perinatal Mortality (MBRRACE)	Y	Data collection ongoing
National Neonatal Audit Programme (NNAP)	Y	Data collection ongoing
Paediatric asthma (British Thoracic Society)	Y	100%
Diabetes (RCPH National Paediatric Diabetes Audit)	Y	Data collection ongoing
Emergency use of Oxygen (British Thoracic Society)	Y	100%
UK Cystic Fibrosis	Y	Data collection ongoing
Chronic Obstructive Pulmonary Rehabilitation (British Thoracic Society)	Y	100%
Cardiac Arrest (National Cardiac Arrest Audit)	Y	Data collection ongoing
Adult Critical Care (Case Mix Programme)	Y	Data collection ongoing
National Emergency Laparotomy Audit (NELA)	Y	Year 2 – 100% Year 3 – Data collection ongoing

Diabetes (National Adult Diabetes Audit)	Y/N	Core Audit – No data entered
		National Pregnancy in Diabetes - Data collection ongoing
		Foot Care Audit – Year 2 data collection ongoing
		Inpatient Audit – 100%
Rheumatoid and Early Inflammatory Arthritis	Y	65% (Estimate)
UK IBD Audit (Biologics)	Y	Data collection ongoing
Hip, knee and ankle replacements (National Joint Registry)	Y	Data collection ongoing
Elective Surgery (National PROMS Programme)	Y	Data collection ongoing
Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)	Y	Data collection ongoing
National Vascular Registry	Y	Data collection ongoing
Procedural sedation in adults (CEM)	Y	100%
Vital Signs (CEM)	Y	100%
VTE risk in lower limb immobilisation(CEM)	Y	100%
Acute Myocardial Infarction and other ACS (MINAP)	Y	Data collection ongoing
Heart Failure Audit	Y	Data collection ongoing
Stroke National Audit Programme (SSNAP)	Y	Data collection ongoing
Cardiac Arrhythmia (Cardiac Rhythm Management Audit)	Y	Data collection ongoing
Renal Replacement Therapy (Renal Registry)	Y	Data collection ongoing
Lung Cancer (National Lung Cancer Audit)	Y	Data collection ongoing
Bowel Cancer (National Bowel Cancer Audit Programme)	Y	Data collection ongoing
Prostate Cancer Audit	Y	Data collection ongoing
Oesophago-gastric Cancer (National O-G Cancer Audit)	Y	Data collection ongoing
Falls and Fragility Fracture Programme (Include National Hip Fracture Database	Y	NHFD - Data collection ongoing
		Inpatient Falls – 100%
		FLSDB Organisational Audit
Severe Trauma	Y	87%
National Ophthalmology	N	no data entered
UK Parkinson's Audit	Y	100%

National Confidential Enquiries (NCEPOD)	Y	Mental Health in Acute Hospitals – 100%
		Non-invasive Ventilation (early stages – patient

		identification spreadsheet submitted) Acute Pancreatitis – 100%
National Audit of Blood Transfusion – Audit of Red Cell and Platelet Transfusion in Haematology	Y	100%
National Audit of Blood Transfusion – Lower GI Bleeding and the Use of Blood	Y	100%

National reports (including hospital specific and individual consultant specific results where appropriate) are published at varying intervals. Most audits will report annually but some provide more frequent updates. The audit department monitors the publication of reports and shares them with the clinical leads. The clinical leads are asked to review the report and recommendations, share the findings with their colleagues and assess the need for changes to their practice. The recommendations made are wide ranging and some examples of changes that have been made following the review of national audit recommendations are given below.

- Clinical effectiveness
    - Review of the use of antibiotics in patients with pneumonia with a focus on increasing the number of patients who receive combination therapy when needed.
    - Review of screening (retinopathy of prematurity) for eligible babies and a change in the frequency with which Ophthalmologists visit Gosset Ward.
- Patient Safety
    - Development of a Board Level Falls Steering Group.
    - Organisation of “Protected Team Time” for the Paediatric Diabetes Team to improve the co-ordination of care.
    - Review of intubation protocol for neonates.
    - Development of a “seizure tray” for paediatric patients presenting to the Emergency Department following a seizure to ensure that treatment is in line with national guidance.
    - Development of care pathway for patients undergoing emergency laparotomy.
- Patient experience
    - Review of patient pathway to reduce the time to chest X-ray in patients with suspected pneumonia.
    - Review of the scheduling of theatre lists to improve access to theatre for patients requiring a total hip replacement following a fractured neck of femur.
- Service Improvement
    - Trust wide Quality Improvement Project for the measurement of lying and standing blood pressure as part of the approach to the management of falls.
    - Development of a dedicated clinic to monitor 2 year neurodevelopmental outcomes of babies on Gosset Ward.
- Communication
    - Revision of electronic communication between the Emergency Department and General Practitioners to include information about the patient’s cognitive state where appropriate.
    - Development of an information leaflet for carers of patients with cognitive impairment who present to the Emergency Department.
- Data quality and documentation

    - Using the recently published report from the National Prostate Cancer Audit to continue to identify areas where the quality of data entered can be improved further.
    - Creating regular time slots to capture data for the National Neonatal Audit Programme to improve data quality.
    - Local audit to improve the documentation of mental health issues and Mental State Examination in Emergency Department patients.
- Resources
    - The building of a dedicated assessment room in the Emergency Department for patients presenting with mental health conditions.
- Recruitment of Staff
    - Appointment of an additional staff member to the Falls Team.
    - Appointment of an additional Paediatric Diabetes Nurse Specialist.

LOCAL CLINICAL AUDIT

There were 87 local clinical audits including 17 specifically against NICE guidance registered in 2015/16. Some examples are outlined below together with the actions arising to improve clinical quality, patient experience and patient safety. All leads are required to complete a registration form and are offered help and advice with planning their clinical audit and implementing the resulting recommendation. All registered audits completed by October 15 were eligible for entry to the Trust Quality Improvement Day. The following were two of the audits presented there:

- Audit to assess care for patients admitted with Parkinson's Disease in NGH (including compliance with NICE CG35)
    - Action Plan
    - Develop a flagging system to alert all patients admitted with Parkinson's disease in NGH.
    - Education of all ward staff and patients based on Get It on Time campaign.
    - Develop in-patient pathway and Nil by Mouth guidance for patients admitted with Parkinson's disease.

- Intravenous Cyclophosphamide: prescription and monitoring of intravenous cyclophosphamide in Rheumatology
    - Aims
    - To establish that intravenous cyclophosphamide is used by the Rheumatology department according to regional guidelines (as agreed by EMRAN).
    - Identify any areas that can be improved to raise patient safety.
    - Objectives:
    - Are we adhering to all aspects of the cyclophosphamide administration guidelines, post cyclophosphamide monitoring and care
    - Establish the type and frequency of infections and other adverse events occurred in this patient population

PARTICIPATION IN CLINICAL RESEARCH

The number of patients receiving NHS services provided by Northampton General Hospital NHS Trust from April 2015 to March 2016 that were recruited during that period to participate in research approved by a research ethics committee was around 1000. To date 658 have recruited to 58 studies on the National Institute of Health Research portfolio within this financial year

Participation in clinical research demonstrates NGH's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

We have demonstrated our engagement with the National Institute for Health Research (NIHR) by participating in many clinical trials, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS. Our engagement with clinical research also demonstrates NGH's commitment to testing and offering the latest medical treatments and techniques to our patients.

COMMISSIONING FOR QUALITY AND INNOVATION

NHS Nene and NHS Corby Clinical Commissioning Groups are NGHs main commissioners. We receive part of our income from them through an agreed CQUIN scheme where prior to the start of the financial year negotiations take place to agree specialist projects which bring about innovative quality improvement for our patients. Our CQUIN agreements with them are both local agreements and part of a national agenda.

In 2015/16 NGH agreed six local CQUINs and four national CQUINs. NGH also have secondary commissioners known as Specialised Commissioners who are Leicester and Lincolnshire Area Team, NHS England. In 2015/16 NGH agreed seven specialist CQUINs.

TYPE	CQUIN INDICATOR NAME	Q1 Status	Q2 Status	Q3 Status	Q4 Status
LOCAL	Electronic Holistic Needs Assessment and Care Planning				
	AMBER Care Bundle				
	Heart Failure Rehabilitation				
	Heart Failure – single point of access				
	Psychological Support in Stroke Care				
	Improving delivery of Speech and Language therapy to Stroke patients at NGH				
NATIONAL	Acute Kidney Injury				
	Sepsis Screening				
	Sepsis Antibiotic Administration				

	Dementia and Delirium - Find, Assess, Investigate Refer and Inform				
	Dementia and Delirium - Staff Training				
	Dementia and Delirium - Supporting Carers				
	Reducing the proportion of avoidable emergency admissions to hospital				
SPECIALIST	Eligible patients receiving a NICE DG10 compliant test with provision of monitoring data				
	Vascular services Quality improvement programme for outcomes of major lower limb amputation				
	Multi-system auto-immune rheumatic diseases network				
	To reduce delayed discharges from ICU to ward level care by improving bed management in wards				
	2 Year outcomes for infants <30 weeks gestation				
	Standardising the Children's Cancer MDT decision making process				
	Neonatal Critical Care – Reducing Clinical Variation and Identifying Service Improvement Requirements by ensuring data completeness in the 4 NNAP Audit Questions identified				

For 2016/17, NGH have agreed with NHS Nene and NHS Corby Clinical Commissioning Groups five local CQUINs and three national CQUINs. NGH have also agreed three specialist CQUINs with NHS England.

TYPE	CQUIN INDICATOR NAME
LOCAL	Delayed Transfers of Care
	End of Life Care Pathways
	Dementia: John's Campaign
	Dementia Discharge Summaries
	Acute Kidney Injury
NATIONAL	NHS Staff Health and Wellbeing - Introduction of health and wellbeing initiatives - Healthy food for NHS staff, visitors and patients - Improving the uptake of flu vaccinations for front line staff within Providers
	Timely identification and treatment of Sepsis - Timely identification and treatment for sepsis in emergency departments - Timely identification and treatment for sepsis in acute inpatient settings
	Antimicrobial Resistance and Antimicrobial Stewardship - Reduction in antibiotic consumption per 1,000 admissions

	- Empiric review of antibiotic prescriptions
SPECIALIST	Pre-term Babies Hypothermia Prevention
	Two year follow up assessment for very preterm babies
	Multi-system Auto-immune Rheumatic Diseases MDT Clinics, Data Collection and Policy Compliance

LOCAL QUALITY REQUIREMENTS

The NHS Standard Contract contains quality requirements where NGH is required to report against certain indicators on a periodic basis. The quality requirements are set out in Schedule 4 of the NHS Contract and are collectively known as the Quality Schedule. They are split into six quality sections which include Operational Standards and National Quality Requirements. They also include Local Quality Requirements which are agreed locally with our commissioners and are derived from a variety of sources.

We report to our commissioners quarterly on all the relevant local quality requirements submitting evidence and demonstrating where we meet the requirements.

Quality Requirement for 2016/17
End of Life care
Patient Safety
Learning
Quality Care for Patients with a Learning Disability
Patient Experience
Nutrition and Hydration
WHO Surgical Checklist
National Early Warning Score
Safeguarding
Workforce
VTE
Pressure Tissue Damage
Service Specifications
Quality Assurance regarding any trust sub-contracted services (list of services to be provided by the trust)

SECTION SIX

NHS NUMBER AND GENERAL MEDICAL PRACTICE CODE VALIDITY

The trust submitted records between April 2015 and January 2016 to the Secondary Users service for inclusion in the Hospital Episode Statistics which are included in the latest published data as below and compared to the previous year's results.

Period - Apr15 to Jan16	Valid NHS Number	Valid GMPC
Inpatients	99.6%	100%
Outpatients	99.9%	99.9%
A&E	98.1%	98.8%

Period – Apr 14 to Jan 15	Valid NHS Number	Valid GMPC
Inpatients	99.7%	100%
Outpatients	99.9%	100%
A&E	97.2%	99.2%

Comparison	Valid NHS Number	Valid GMPC
Inpatients	-0.1%	0.0%
Outpatients	0.0%	-0.1%
A&E	+0.9%	-0.4%

INFORMATION GOVERNANCE TOOLKIT

The Information Governance Toolkit version 13 was completed and submitted on 31 March 2016 with an overall score of 81% and a return of 'Satisfactory'

For version 12 (2014/15) submission, the potential issue raised was the lack of a robust risk assessment processes embedded in our information risk management framework. The Information Governance team developed a risk assessment checklist to enable the Trust's Information Asset Owners (IAOs), carry out appropriate risk assessment for the different systems under their remit. This enabled the Trust to have adequate assurance not just on potential risk but increased the robustness of our information mapping (data flows) and our information asset register.

As with all risk management programmes; this is an ongoing programme, dispatched in phases to ensure all information systems within the Trust are assessed annually.

There remain 2 main areas which have seen significant improvement but have not attained the Trust's target. These are:

- 112 Information Governance Mandatory Training – the Trust is required to achieve 95% staff compliance in information governance training within a year's cycle. This has been a continuous struggle to achieve however; the information governance

team will be implementing new initiatives to improve the Trust's compliance figures. The final training figure at submission is up by 12.6% from the previous year (2015)

- 300's Information Security Assurance - further work is required to ensure that our processes are robust and are adequately maintained in identifying and managing risks. The Trust has developed an Information Asset Register with detailed system risk assessments and Information Asset Owners. Annual information governance training for Information Asset Owners will be implemented as part of the information governance specific training needs analysis.

  The Registration Authority (RA) process will be fully reviewed in line with the requirements of the IG toolkit.

An action plan, work schedule and a comprehensive confidentiality/information governance audit programme have been developed for a more proactive and robust approach to the Information Governance Toolkit, with particular attention paid to the above areas. This will be monitored through the Information Governance Group chaired by the Director of Corporate Development Governance and Assurance (the Senior Information Risk Owner- SIRO) with regular reports to the Assurance, Risk and Compliance Group.

CLINICAL CODING ERROR RATE

Objective/Method

To assess Northampton General Hospital NHS Trust Women's, Children's and Oncology coding performance against recommended achievement levels for Information Governance Toolkit Requirement 505. Exactly 200 episodes were audited using the NHS Classification Service Clinical Coding Audit Methodology Version 9.0.

Results

	% Accuracy	IG Level 2 Requirements	IG Level 3 Requirements
Primary Diagnosis	94.00%	90.00%	95.00%
Secondary Diagnoses	88.31%	80.00%	90.00%
Primary Procedure	92.05%	90.00%	95.00%
Secondary Procedures	90.99%	80.00%	90.00%

Conclusions

The results met the necessary requirements to achieve an Information Governance Level 2 rating.

The majority of errors in both the diagnostic and procedural coding were not repeated and were related to incorrect indexing or potentially lack of indexing fully. There were repeated errors around meconium in new-borns and the omission of gestational age as a subsidiary code.

As with previous audits, the highest source of error came from missed comorbidities or significant additional clinical problems. The ward based extraction may be a contributing

factor here and this should be reviewed in the lead up to the implementation of HRG4+ and the altered complication and comorbidity structure.

There were a high number of unspecified ventouse and forceps deliveries coded and though no errors were attributed here, consideration should be given to improving the specificity of these codes.

Recommendations

- To develop an information report that highlights OPCS codes requiring an additional code of Y95 where it is not present.
  Timescale for completion: 1 month

- To undertake some work with midwives in order to better record level of mid and low forceps/ventouse deliveries within the case notes.
  Timescale for completion: 3 months

- To review ward based coding and the potential for missed comorbidities leading into the new HRG4+ tariff.
  Timescale for completion: 5 months

CORE QUALITY INDICATORS

In 2009, the Department of Health established the National Quality Board bringing the DH, the CQC, Monitor, the National Institute for Health and Clinical Excellence and the National Patients Safety Agency together to look at the risk and opportunities for quality and safety across the whole health system. The National Quality Board requires reporting against a small, core set of quality indicators for the reporting period, aligned with the NHS Outcomes Framework.

Performance data for NGH is included together with the NGH data from the 2014/15 Quality Account. Where available, data has been provided showing the national average as well as the highest and lowest performance for benchmarking purposes. All information for the reporting period has been taken from the Health and Social Care Information Centre and the links provided therein.

Domain 1 Preventing people from dying prematurely, and
Domain 2 Enhancing quality of life for people with long term conditions

Summary Hospital-Level Mortality Indicator
SHMI is a hospital level indicator which measures whether mortality associated with hospitalisation was in line with expectations. Scores are split into bands

- SHMI Banding = 1 indicates that the trust's mortality rate is 'higher than expected'
- SHMI Banding = 2 indicates that the trust's mortality rate is 'as expected'
- SHMI Banding = 3 indicates that the trust's mortality rate is 'lower than expected'

Data has been made available to the Trust by the Information Centre with regard to the value and banding of the SHMI. For the reporting period October 2014 – September 2015 this shows the Trusts SHMI was 102 and placed the trust in Band 2. In the Trust's 2014/15

Quality Account the Trust reported a score of 98 for the period October 2013 – September 2014. This again placed the Trust in Band 2.

National performance for SHMI available from HSCIC for the period October 2014 – September 2015 showed the following values:

- The national average was 100
- The highest score was 117
- The lowest was 65

In accordance with the reporting toolkit, the Trust can confirm that it considers that the data to be as described as it has been verified through both an internal and external quality assurance process.

The Trust has taken the following actions to improve this outcome marker and the quality of our services. The mortality data is analysed whenever it is updated. The function of Trust Mortality Review Group has been amended in line with NHS England recommendations. These meetings monitor Trust performance and address areas of concern. The Trust undertakes regular detailed case note reviews which are reported through the Quality Governance Committee to the Board and has participated in the countywide morbidity and mortality meetings.

Domain 3 – Helping people to recover from episodes of ill health or following injury

Patient Reported Outcome Measures scores (PROMs)
PROMs measure a patient's health status or the health-related quality of life from the patient's perspective, typically based upon information gathered from a questionnaire which patients complete before and after the following procedures:

- Hip replacement surgery
- Knee replacement surgery
- Groin hernia surgery
- Varicose veins surgery

The data made available to the Trust by the Information Centre with regard to the Trust's PROMs (adjusted average health gain) is shown in the table below:

PROMs	***NGH Performance***		***National Performance***		
	Reporting Period 2015/16	***Quality Account 2014/15***	***Reporting Period Ave.***	***Reporting Period High***	***Reporting Period Low***
Groin hernia surgery	0.103 (provisional Apr15 to Dec15)	0.075	0.087 (provisional Apr15 to Dec15)	0.132 (provisional Apr15 to Dec15)	0.024 (provisional Apr15 to Dec15)
Varicose vein surgery	N/A (provisional Apr15 to Dec15)	N/A	0.100 (provisional Apr15 to Dec15)	N/A (provisional Apr15 to Dec15)	N/A (provisional Apr15 to Dec15)
Hip replacement surgery	0.528 (provisional Apr15 to Dec15)	22.491	0.449 (provisional Apr15 to Dec15)	0.543 (provisional Apr15 to Dec15)	0.270 (provisional Apr15 to Dec15)
Knee replacement surgery	0.328 (provisional Apr15 to Dec15)	18.535	0.331 (provisional Apr15 to Dec15)	0.395 (provisional Apr15 to Dec15)	0.215 (provisional Apr15 to Dec15)

In accordance with the reporting toolkit the trust can confirm that it considers that the data is as described, as it has been verified by a process of internal and external quality assurance.

The data for these procedures suggests that the Trust performance is above that reported nationally. The Trust has continued to undertake work before, during and after surgery to further improve outcomes and the quality of our services. There are in addition to this, we seeking to improve our theatre performance through work which within our Changing Care @NGH transformation programme.

Emergency re-admissions to hospital within 28 days of discharge
Some emergency readmissions following discharge from hospital are unfortunately an unavoidable consequence of the original treatment. There are others that could potentially be avoided through ensuring the delivery of optimal treatment according to each patient's needs, careful planning and support for self-care.

The following data were available to the Trust from the Information Centre (during the reporting period) with regard to this:

- The percentage of patients aged 0-15 readmitted to NGH within 28 days of being discharged from a hospital which forms part of the Trust in 2011/12 was 13.15%. The national average for this period was 2.68% (the highest rate was 14.94% and the lowest was 0%). In 2014/15 the Trust reported a readmission rate of 9.3%.

- The percentage of patients aged 16 or over readmitted to NGH within 28 days of being discharged from a hospital which forms part of the Trust for 2011/12 was 11.15%. In 2014/15 the Trust readmission rate was 8.7%. The national average performance available from HSCIC for 2011/12 was 11.45% (highest rate was 17.72% and the lowest was 0%).

In accordance with the reporting toolkit the trust can confirm that it considers that the data is as described, as it has been verified by a process of internal and external quality assurance.

NGH has taken the following actions to improve the rates, and the quality of its services by:

- Improving discharge planning with an aim to reduce readmissions
- Working to improve the discharge process to ensure that early and effective planning for discharge is undertaken
- Work to reduce re-admissions to hospital form part of our Changing Care @NGH transformation programme.

Domain 4 – Ensuring that people have a positive experience of care

Responsiveness to the personal needs of patients
This indicator forms part of the NHS Outcomes Framework with patient experience being a key measure of the quality of care.

The data made available to the Trust by the Information Centre with regard to the Trusts responsiveness to the personal needs of its patients during the reporting period, shows the Trusts score was 66.5% (2014/15). In the trusts 2014/15 Quality Account the Trust reported a score of 68.6% (2013/14).

National performance available from HSCIC for the period 2014/15 showed the following:

- The national average was 38.9%
- The highest score was 86.1%
- The lowest was 54.4%

The results show NGH to be above the national average in relation to this measure. NGH continues to review patient experience and build on the work previously undertaken across the Trust.

Staff who would recommend the trust to their family or friends
This indicator forms part of the NHS Outcomes Framework with patient experience being a key measure of the quality of care.

The data made available to the Trust by the Information Centre with regard to the percentage of staff employed by, or under contract to, the trust who would recommend the Trust as a provider of care to their family or friends. During the reporting period the trusts score was 52% (2015). In the Trusts 2014/15 Quality Account the Trust reported a score of 52% (2014).

National performance available from HSCIC for the period 2015 showed the following:

- The national average was 67%
- The highest score was 93%
- The lowest was 38%

In accordance with the reporting toolkit the trust can confirm that it considers that the data is as described, as it has been verified by a process of internal and external quality assurance.

NGH has a working group focusing on this area which a high priory for the Trust. The data is under review within our divisional structure to identify specific areas for improvement, and so the quality of our services. The trust aims to increase staff engagement and is developing a process for triangulation between performance, experience and engagement.

Friends and Family Test – Patient
The data made available (percentage recommended) by National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre for all acute providers of adult NHS funded care, covering services for:

- Inpatients score for March 2016 was 89%. In the Trusts 2014/15 Quality Account the Trust reported a score of 78% for March 2015. The national average for March 2016 was 67%, the highest score was 93% and the lowest was 38%. This shows the Trust is above the national average for this parameter.

- Patients discharged from Accident and Emergency (types 1 and 2) for March 2016 was 84%. In the Trusts 2014/15 Quality Account the trust reported a score of 85% for March 2015. The national average for March 2016 was 84%, the highest score was 99% and the lowest was 49%. This shows the Trust being above the national average for this parameter.

In accordance with the reporting toolkit the trust can confirm that it considers that the data is as described, as it has been verified by a process of internal and external quality assurance.

This is an area of acute focus for the Trust and the work undertaken to improve our performance is detailed in Section 4 of this document.

Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm

Venous Thromboembolism
VTE (deep vein thrombosis and pulmonary embolism) can cause death and long-term morbidity, but many cases of VTE acquired in healthcare settings are preventable through effective risk assessment and prophylaxis.

The data made available to the Trust by the Information Centre show the percentage of patients who were admitted to hospital and had their risk of venous thromboembolism assessed during the reporting period was 96.2% (Q3 2015/16). In the Trusts 2014/15 Quality Account the Trust reported a score of 97% for February 2015. The national average for Q3 2015/16 was 95.6%, the highest score was 100% and the lowest was 78.5%.

In accordance with the reporting toolkit the trust can confirm that it considers that the data is as described, as it has been verified by a process of internal and external quality assurance.

NGH has taken action to improve our performance and the quality of our services, by further developing systems to ensure risk assessments are undertaken and promoted. Where there is evidence of hospital acquired thrombosis this is investigated through an RCA which reported to the Thrombosis Committee and learning shared in the clinic division. Our aim is to achieve 100% compliance with VTE risk assessment for our patients.

Rate of Clostridium difficile (C.Diff) infection
C.Diff can cause symptoms including mild to severe diarrhoea and sometimes severe inflammation of the bowel and should not be associated with hospital treatment.

Data has been made available to the Trust by the Information Centre with regard to the rate of C.Diff infection per 100,000 bed-days. This is reported within for patients aged 2 years or older. These data show that during the reporting period the rate was 11.6/100,000 bed-days (2014/15). In the Trust 2014/15 Quality Account the trust reported a rate of 10.2 in 2013/14. The national average for 2014/15 was 14.53/100,000 bed-days (the highest rate was 62.2 and the lowest was 0). These show the Trust performance to be below the national average.

In accordance with the reporting toolkit the trust can confirm that it considers that the data is as described, as it has been verified by a process of internal and external quality assurance.

NGH has taken the following actions to improve the percentages, and the quality of its services by:

- Further development of Infection Prevention Group
- Staff training in hand hygiene and infection prevention
- Sending stool samples in a timely manner
- Prompt isolation of patient's with diarrhoea
- Improved antimicrobial stewardship.

Patient Safety
An open reporting and learning culture is important to enable the NHS to identify trends in incidents and implement preventative action.

The data made available to the Trust by the Information Centre (during the reporting period) with regard to this is shown below.

	NGH Performance		***National Performance***		
	Reporting Period 2015/16	***Quality Account 2014/15***	***Reporting Period Ave.***	***Reporting Period High***	***Reporting Period Low***
The number of patient safety incidents reported within the trust	3,722 (Apr 15 - Sep 15)	3,738 (Apr 14 - Sep 14)	4,237 (Apr 15 - Sep 15)	12,080 (Apr 15 - Sep 15)	347 (Apr 15 - Sep 15)
The rate (per 1,000 bed days) of patient safety incidents reported within the trust	31.1 (Apr 15 - Sep 15)	32.44 (Apr 14 - Sep 14)	40 (Apr 15 - Sep 15)	117 (Apr 15 - Sep 15)	15.9 (Apr 15 - Sep 15)
The number of such patient safety incidents that resulted in sever harm or death	6 (Apr 15 - Sep 15)	13 (Apr 14 - Sep 14)	17.8 (Apr 15 - Sep 15)	89 (Apr 15 - Sep 15)	0 (Apr 15 - Sep 15)
The percentage of such patient safety incidents that resulted in sever harm or death	0.16% (Apr 15 - Sep 15)	0.4% (Apr 14 - Sep 14)	0.42% (Apr 15 - Sep 15)	4.8% (Apr 15 - Sep 15)	0 (Apr 15 - Sep 15)

In accordance with the reporting toolkit, the Trust can confirm that it considers that the data for these are as described, due to it having been verified by internal and external quality checking.

The results show that the trust is below the national average for the level of harm. The Trust has sought to improve our safety culture through regular engagement with staff via newsletters, through learning events such as 'Dare to Share' and regular attendance at ward and department meetings.

HOSPITAL MORTALITY MONITORING

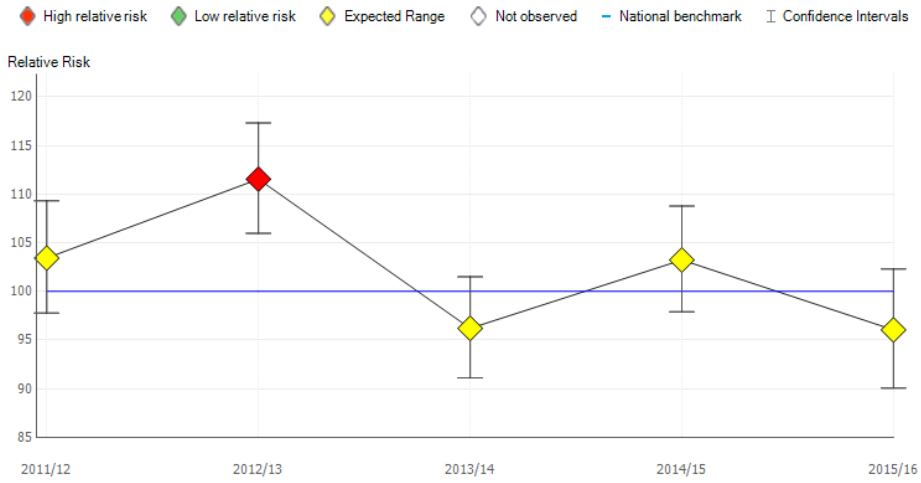
NGH uses 3 headline mortality monitoring tools which are benchmarked against all other hospitals in England and examine inpatient mortality rates. 2 indicators [HSMR and HSMR 100] are provided to the Trust by Dr Foster™ 3 months in arrears. HSMR [Hospital Standardised Mortality Ratio] measures mortality from the 56 most common and serious conditions causing >80% hospital deaths: HSMR 100 looks at all hospital deaths. Both mortality indicators are case mix adjusted, taking into account the age of each patient and their general health before their admission. These indicators can be analysed in detail to identify areas of adverse performance which require further analysis and investigation.

The information is reviewed in detail each month by the Associate Medical Director, and a structured report is presented to the Medical Director and discussed at CQEG and Trust Board Quality Governance Committee. The findings and planned actions for any areas of concern are presented monthly to the Mortality Review Group.

During 2015/16 the management of patients with biliary tract disease, pancreatic cancer, cellulitis, operations on peptic ulcer and perineal tears following instrumental and non-instrumental vaginal delivery were reviewed and action plans are in progress. CQC uses HSMR 56 as part of its assessment process when inspecting Trusts.

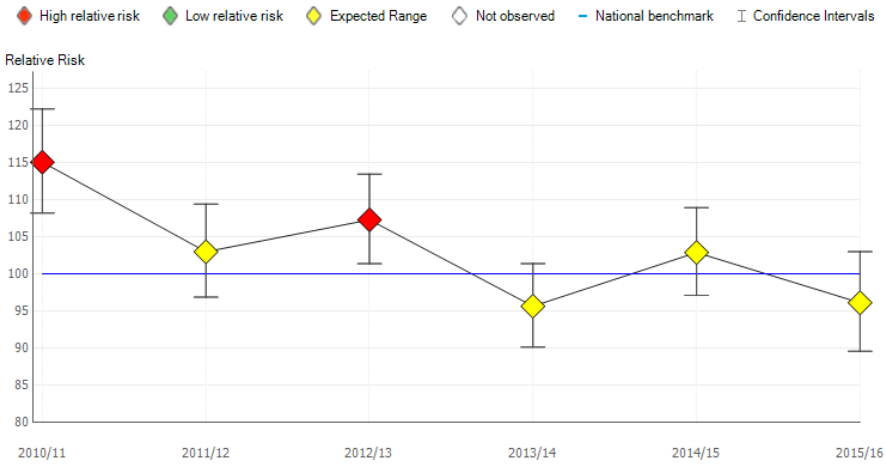
Both of the above measures (HSMR 100 and HSMR (56) show improvement since 2011. Performance during 2014/15 was as expected; performance in 2015/16 [to December 2015] remains within the expected range. HSMR 56 has seen a very good performance for the rolling year.

HSMR 100

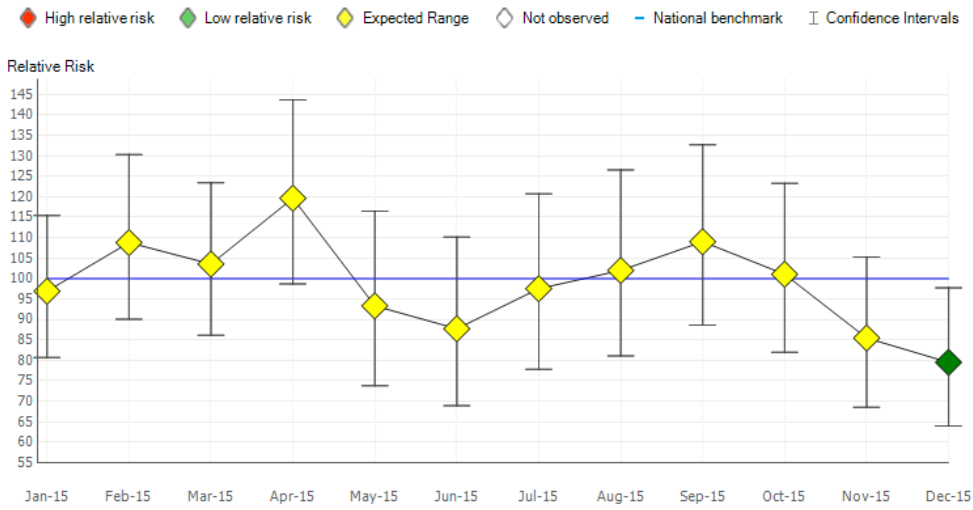


HSMR 100 year on year performance

HSMR [56]

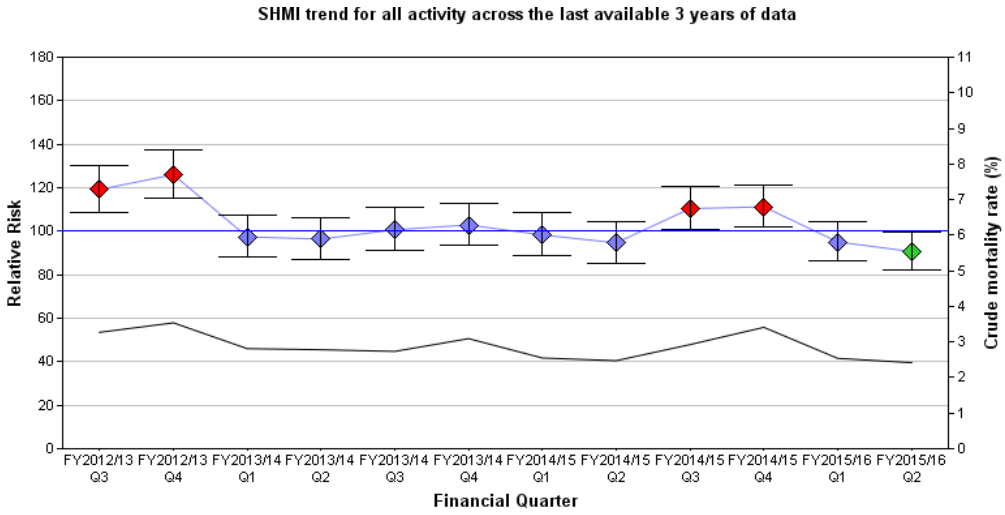


HSMR 56 year on year performance



HSMR 56 rolling year performance

A third metric, SHMI [Summary Hospital-level Mortality Indicator] is also used, provided by DH 6 months in arrears since 2010. It looks not only at hospital mortality, but also deaths that occur within a month of discharge, which may therefore reflect the care received outside the hospital. It also has a different case mix adjustment method, and so is not directly comparable to HSMR. Trust performance assessed by this method remains at expected levels in the latest published data [SHMI for the rolling year October 14 – September 15].



NHS England has provided a framework for Mortality Governance with which the Trust is broadly compliant through the use of Dr Foster information, monthly review at Mortality Review Group, and reporting to Trust Board.

CORPORATE SCORECARD 2015/16

Section	Red Rated	Amber Rated	Green Rated	None	Total
Caring	0	1	2	9	12
Winter Pressures	1	0	0	4	5
Effective	3	2	16	3	24
Safe	9	1	12	1	23
Responsive	10	0	11	0	21
Well-Led	6	4	1	2	13
Finance	4	0	4	0	8
Total	33	8	46	19	106

KEY	
↑	Improving performance over 3 month period
↓	Reducing performance over 3 month period
→	Stable performance delivery over 3 month period

Caring	Indicator		Target	Trend	Mar-16
	C.1	Written complaints rate	None	↓	46
	C.2	Complaints responded to within agreed timescales	=>90%		Awaiting
	C.3	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	95.4% (Feb 16)	↓	89.3%
	C.4	Friends & Family Test % of patients who would recommend: A&E	84.9% (Feb 16)	↓	84.4%
	C.13	Friends & Family Test % of patients who would recommend: Maternity - Antenatal Community	95.3% (Feb 16)	↓	97.3%
	C.14	Friends & Family Test % of patients who would recommend: Maternity - Birth	96.3% (Feb 16)	↓	91.4%
	C.15	Friends & Family Test % of patients who would recommend: Maternity - Postnatal Ward	93.7% (Feb 16)	↑	95.8%
	C.16	Friends & Family Test % of patients who would recommend: Maternity - Postnatal Community	98.0% (Feb 16)	↑	100%
	C.6	Friends & Family Test % of patients who would recommend: Outpatients	92.4% (Feb 16)	↓	91.4%
	C.7	Mixed Sex Accommodation	0	→	0
	C.8	Total deaths where a care plan is in place	=>50%	↓	50.0%
	C.9	Transfers: Patients moved with a risk assessment completed	100%	↑	95.9%

Winter Pressures	Indicators		Target	Trend	Mar-16
	WP.1	Escalation Areas Open	0	↓	653
	WP.2	Patient Ward Moves (between 9pm & 8am) - NEL ONLY	To be agreed	↓	83
	WP.3	Cancelled Operation Numbers (Clinical & Non Clinical)	To be agreed	↑	302
	WP.4	Patient who need to be readmitted if transport arrives too late	To be agreed	↓	15
	WP.5	A&E Trolley waits 8hrs 1 min to 12hrs (DTA to admission)	To be agreed	↓	162

		Indicator	Target	Trend	Mar-16
Responsive	R.1	A&E: Proportion of patients spending less than 4 hours in A&E	=>95%	↓	81.0%
	R.2	A&E: 4hr SitRep reporting	=>95%	↓	80.6%
	R.3	A&E: 12 hour trolley waits	0	→	0
	R.4	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	=>99%	↓	99.80%
	R.5	Discharge: Number of medically fit patients awaiting discharge (average daily)	=<50	↑	106
	R.6	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	=>93%	↑	97.0%
	R.7	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	=>93%	↓	99.3%
	R.8	Cancer: Percentage of patients treated within 62 days of referral from screening	=>90%	↓	86.7%
	R.9	Cancer: Percentage of patients treated within 62 days of referral from hospital specialist	=>85%	↓	83.3%
	R.10	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	=>85%	↑	79.5%
	R.11	Cancer: Percentage of patients treated within 31 days	=>96%	↑	96.0%
	R.12	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	=>94%	↑	100%
	R.13	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	=>98%	↑	100%
	R.14	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	=>94%	↑	100%
	R.15	Operations: Urgent Operations cancelled for a second time	0	→	0
	R.16	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	0	↑	2
	R.17	RTT for admitted pathways: Percentage within 18 weeks	=>90%	↓	78.9%
	R.18	RTT for non- admitted pathways: Percentage within 18 weeks	=>95%	↑	93.6%
	R.19	RTT waiting times incomplete pathways	=>92%	↓	93.6%
	R.20	RTT over 52 weeks	0	↑	0
	R.21	Delayed transfer of care	0	↓	105

		Indicator	Target	Trend	Mar-16
Effective	E.1	Emergency re-admissions within 30 days (adult elective)	None	↑	2.5%
	E.2	Emergency re-admissions within 30 days (adult non - elective)	None	↑	10.7%
	E.3	Length of stay - All	=<4.2	↑	4.34
	E.51	Length of stay - All (Excl. Compton, Blenheim & Cliftonville wards)	=<4.2	↑	3.27
	E.4	Length of stay - Elective	=<2.7	↑	2.19
	E.52	Length of stay - Elective (Excl. Compton, Blenheim & Cliftonville wards)	=<2.7	↑	1.97
	E.5	Length of stay - Non Elective	=<4.7	↑	5.39
	E.53	Length of stay - Non Elective (Excl. Compton, Blenheim & Cliftonville wards)	=<4.7	↑	4.17
	E.6	Maternity: C Section Rates - Total	<26.2%	↑	24.6% (97)
	E.7	Maternity: C Section Rates - Emergency	<13.0%	↓	13.7% (54)
	E.8	Maternity: C Section Rates - Elective	<13.2%	↑	10.9% (43)
	E.10	Mortality: SHMI	Within expected range	→	102
	E.11	Mortality: HSMR		↑	98
	E.12	Mortality: HSMR - Weekend		↑	89
	E.13	Mortality: HSMR - Week day		↑	98
	E.14	Mortality: Low risk conditions		↓	89
	E.15	Mortality: Maternal Deaths	0	→	0
	E.16	NICE Technology Appraisal Guidance compliance	=>80%	↑	98.0%
	E.17	Patients cared for in an escalation area (occ bed days)	0	↓	653
	E.18	# NoF - Fit patients operated on within 36 hours	=>80%	↑	96.8%
	E.19	Stroke patients spending at least 90% of their time on the stroke unit	=>80%	↑	81.8%
	E.20	Suspected stroke patients given a CT within 1 hour of arrival	=>50%	↑	70.4%
	E.47	% Weekend Discharges against Week Day Discharges	=>80%	↓	43.5%
	E.54	% Daycase Rate		↓	88.3%

	Indicator		Target	Trend	Mar-16
Well Led	W.1	Friends & Family: % of staff that would recommend the trust as a place of work	N/Applic	↓	43%
	W.2	Data quality of Trust returns to HSCIC (SUS)	=>90%	→	93.3%
	W.3	Turnover Rate	=<8%	↑	10.80%
	W.4	Sickness rate	=<3.8%	↑	3.97%
	W.5	Staff: Trust level vacancy rate - All	=<7%	↑	7.3%
	W.5	Staff: Trust level vacancy rate - Medical Staff	=<7%	↓	10.87%
	W.5	Staff: Trust level vacancy rate - Registered Nursing Staff	=<7%	↑	11.36%
	W.5	Staff: Trust level vacancy rate - Other Staff	=<7%	↑	8.44%
	W.9	Staff: Temporary costs & overtime as a % of total pay bill	None	↓	16.4%
	W.10	Percentage of staff with annual appraisal	=>85%	↑	81.9%
	W.11	Percentage of all trust staff with mandatory training compliance	=>85%	↑	84.5%
	W.12	Percentage of all trust staff with role specific training compliance	=>85%	↑	74.0%
	W.15	Medical Job Planning	100%	→	81.0%

		Indicator	Target	Trend	Mar-16
Safe	S.1	C-Diff	Ave. 1.75 per mth	↑	1
	S.38	C-Diff incidents apportioned to NGH care			Awaiting review
	S.2	Dementia: Case finding	=>90%	↑	97.3%
	S.3	Dementia: Initial diagnostic assessment	=>90%	→	100%
	S.4	Dementia: Referral for specialist diagnosis/follow-up	=>90%	→	100%
	S.36	Falls per 1,000 occupied bed days	=<5.5	↑	4.1
	S.6	Harm Free Care (Safety Thermometer)	94.08% (Mar 16)	↑	93.3%
	S.7	Medical Notes: Availability for clinics	=>99%	↑	99.1%
	S.11	Medication incidents that cause significant harm	0	→	0
	S.12	MRSA	0	↓	1
	S.13	Never event incidence	0	↑	0
	S.14	Pressure Ulcers: Avoidable grade 4	0	→	0
	S.15	Pressure Ulcers: Avoidable grade 3	Max 3.4 p/mth	↓	5
	S.16	Pressure Ulcers: Avoidable grade 2	Max 12.3 p/mth	↓	17
	S.17	Number of Serious Incidents Requiring Investigation (SIRI) declared during the period	0	↓	2
	S.18	Overdue CAS alerts	0	→	0
	S.19	UTI with Catheters (Safety Thermometer-Percentage new)	0.28% (Mar 16)	↑	0.16%
	S.20	VTE Risk Assessment	=>95%	↓	95.1%
	S.21	Transfers: Patients transferred out of hours	0	↑	98
	S.22	Percentage of patients cared for outside of specialty	<10%	↑	18.0%
	S.23	Percentage of discharges before midday.	>25%	↓	18.8%
	S.24	Number of cancelled operations due to bed availability	0	↑	39
	S.32	TTO's sent by Taxi	0	→	0

REVIEW OF PERFORMANCE 2015/16

The table below shows a snapshot of the Trusts performance activity up to 31 March 2016 with a comparison to the previous year's activity.

Activity	2014/15	2015/16	Difference	% Difference
Emergency inpatients	40,349	43,456	3,107	8%
Elective inpatients	6,208	5,824	-384	-6%
Elective day cases	38,346	39,610	1,264	3%
New outpatient attendances – consultant led	80,037	83,474	3,437	4%
Follow-up outpatient attendances – consultant led	149,977	155,562	5,585	4%
New outpatient attendances – nurse led	38,571	42,127	3,556	9%
Follow-up outpatient attendances – nurse led	114,953	43,456	39,459	34%
Total number of outpatient DNAs	30,350	154,412	4,420	15%
Patients seen in A&E	109,305	34,770	4,874	4%
Number of babies born	4,685	114,179	41	1%
Average length of stay (in days)	3.55	4,726	0.81	23%

REVIEW OF SERVICES

During 2015/16 NGH provided and/or sub-contracted xx NHS services.

The income generated by the NHS services reviewed in 2015/16 represents 100% of the total income generated from the provision of NHS services by NGH for the reporting period 2015/16.

REVIEW OF QUALITY

The trust manages and monitors quality on an ongoing basis day to day through the management arrangements and formally through its committee structure.

The Assurance Risk and Compliance Group and Clinical Quality Effectiveness Group all meet monthly and receive differing assurance reports on aspects of quality and governance, both from individual divisions and directorates and on a trust-wide basis. These include reports on infection control, pathology, compliance with NICE guidance, clinical effectiveness

and audit, external reviews, risk management, incidents, complaints, PALS and claims management, CQC compliance. Both groups report and escalate any issues to the Quality Governance Committee, which is a trust board subcommittee and also meets monthly. This committee reviews other information including the quarterly Patient Safety, Clinical Quality & Governance Progress Report. This comprehensive report incorporates an overview of quality and performance across the trust in nine key sections: Introduction and executive summary, ongoing trust-wide priorities, failure to plan, failure to rescue, failures of care, learning from error, emergency care, assurance with national standards, directorate reports and quality scorecards. The Quality Governance Committee reports and escalates any issues to the Trust Board.

SECTION SEVEN

EXTERNAL STAKEHOLDER FEEDBACK

NHS Nene Clinical Commissioning Group and NHS Corby Clinical Commissioning Groups

Healthwatch Northamptonshire

Northamptonshire County Council

FAO: Simon Hawes
Quality Assurance Manager
Governance Department
Northampton General Hospital
Cliftonville
Northampton
NN1 5BD

Please ask for: Jenny Rendall
Tel: 01604 367560
Our ref:
Your ref:
Date: 18 May 2016

Dear Simon

Re: Quality Account 2015-16

The NCC Health, Adult Care & Wellbeing Scrutiny Committee formed a working group of its members to consider a response to your Quality Accounts 2015-16. Membership of the working group was as follows:

- Councillor Sally Beardsworth
- Councillor Eileen Hales
- Councillor Sylvia Hughes
- Mr Andrew Bailey (Carers Voice Representative)

The formal response from the Health & Social Care Scrutiny Committee based on the working group's comments is as follows:

In relation to all quality accounts the Working Group noted that page 6 of the Nene CCG Quality Contract for GP practices stated:

> *At present services in the community are not able to meet demand and are not well integrated and co-ordinated. In particular there is insufficient intermediate care and domiciliary care provision and an over reliance on bedded solutions to healthcare. There are enormous budget pressures facing health and social care which have to be managed whilst large scale transformation of services is undertaken.*

In view of this comment the Quality Account Working Group would have liked to have seen in quality accounts this year how the NHS Trusts would be supporting primary care through this

transformation process whilst acknowledging that the social care sector has much to contribute as well.

The formal response from the Health, Adult Care & Wellbeing Scrutiny Committee to your quality account based on the working group's comments is as follows:

- It was felt more information on partnership work was required. For example how was NGH engaging with professional and voluntary carers? What was the relationship between the NHS and NCC Social Services.
- There was data missing that the working group would have liked to have seen. For example the percentage of patients who returned to the service.
- The working group would have liked to have seen information on how you achieved targets and where possible exceeded the targets in effectiveness under Part 2.
- There was no sense from the Quality Account of how carers and families were involved when considering a package for a patient who was being discharged.
- The working group would have liked to have seen some information on how NGH would address the need for resource to be in place within the complaints team in part 3 under the learning and development plan. An organisation could not listen to complaints if there was no-one in place to listen and address them.
- The working group were also aware that many patients waited for some hours whilst medicines were mixed by pharmacists to be administered to them or when waiting for medicines before discharge. The working group would have been interested to hear how this could be improved.
- Glossaries were not complete. EG. LFE
- It was noted many services were rated as 'requires improvement' although end of life care was rated as 'good'.
- In Part 3 of the quality account it states there is an aim of helping people to get home but no information was provided regarding who they worked with and how to assist people home.
- No information was provided in terms of returning patients. There was no evidence of whether strategies to return people home worked or did not work.
- It would have been nice to have seen a paragraph regarding staff survey results.
- Progress with staff appeared positive and the working group noted that better support responses from staff was a step towards providing better patient care.
- The way in which staff could provide comments back to NGH was commended.
- The summary towards the rear of the document was very good. It was noted the arrows clearly denoted where the issues were.

Please do not hesitate to contact Democracy Officer, Jenny Rendall should you have any queries relating to this response, whose contact details can be found at the bottom of the first page of this letter.

Yours sincerely
On behalf of the Health, Adult Care & Wellbeing Scrutiny Committee

Councillor Sally Beardsworth
Deputy Chairman

NGH response:

We thank Northamptonshire County Council for their valued feedback on reviewing a draft of the Quality Account. Since the draft Quality Account was sent for review further updates have been made. We can confirm we continue to work very closely with the CCG and GP Federation to support and develop intermediate care for our patients.

SECTION EIGHT

INDEPENDENT AUDITORS LIMITED ASSURANCE REPORT

SECTION NINE

ABBREVIATIONS

	#	Fracture
A	A&E	Accident and Emergency
	AKI	Acute Kidney Injury
	ACS	Ambulatory Care Service
	ASGBI	Association of Surgeons of Great Britain and Ireland
B	BP	Blood Pressure
C	CCG	Clinical Commissioning Group
	C.Diff	Clostridium Difficile
	CEM	College of Emergency Medicine
	CIA	Cartoid Interventions Audit
	CIP	Cost Improvement Programme
	COPD	Chronic Obstructive Pulmonary Disease
	CNS	Cancer Nurse Specialist
	CT	Computed Tomography
	CQC	Care Quality Commission
	CQEG	Clinical Governance and Effectiveness Group
	CQUIN	Commissioning for Quality and Innovation
	C Section	Caesarean Section
D	DAHNO	Data for Head and Neck Oncology
	DH	Department of Health
	DNA	Did Not Attend
	DoOD	Do Organisational Development
	DTOC	Delayed Transfer of Care
E	EMRAN	East Midlands Rheumatology Area Network
	ePMA	electronic prescribing medicines administration
	ERAS	Electronic Residency Application Service
F	FFT	Friends and Family Test
	FY1	First Year 1
G	GMPC	General Medical Practice Code Validity
H	HSMR	Hospital Standardised Mortality Ratio
	HWN	Healthwatch Northamptonshire
I	ICU	Intensive Care Unit
	IGT	Information Governance Toolkit

K	KPI	Key Performance Indicators
	KGH	Kettering General Hospital NHS Foundation Trust
L	LFE	Learning from errors
M	MBRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
	MDT	Multi-Disciplinary Team
	MINAP	Myocardial Ischaemia National Audit Project
	MRI	Magnetic resonance imaging
	MRSA	Methicillin-Resistant Staphylococcus Aureusis
	MUST	Malnutrition Universal Screening Tool
N	NCC	Northamptonshire County Council
	NCEPOD	National Confidential Enquiry into Patient Outcome and Death
	NGH	Northampton General Hospital NHS Trust
	NICE	The National Institute for Health and Care Excellence
	NICOR	National Institute for Cardiovascular Outcomes Research
	NMET	Non-Medical Education and Training
	NNAP	National Neonatal Audit Programme
	NVD	National Vascular Database
P	PALS	Patient Advice and Liaison Service
	PCEEG	Patient & Carer Experience and Engagement Group
	PPEN	Patient & Public Engagement Network
	PROMs	Patient Reported Outcome Measures
Q	QELCA	Quality End of Life Care for All
	QI	Quality Improvement
R	RCPH	Royal College of Paediatrics and Child Health
	R&D	Research and Development
	RTT	Referral to Treatment
S	SHMI	Summary Hospital-level Mortality Indicator
	SHO	Senior House Officer
	SIRO	Senior Information Risk Owner
	SSKIN	Surface, Skin inspection, Keep moving, Incontinence/moisture, Nutrition/hydration
	SSNAP	Sentinel Stroke National Audit Programme
T	TARN	Trauma Audit Research Network
	TTO	To Take Out
U	UTI	Urinary Tract Infection
V	VTE	Venous Thromboembolism
W	WHO	World Health Organisation

Y	YTD	Year to Date

If you would like more information please contact:

Medical Director and Director of Nursing
Northampton General Hospital NHS Trust
Cliftonville
Northampton
NN1 5BD

Northampton General Hospital NHS
NHS Trust

Report To	**TRUST BOARD**
Date of Meeting	**26 May 2016**

Title of the Report	Financial Position April (Month 1) FY16-17
Agenda item	12
Sponsoring Director	Simon Lazarus, DoF
Author(s) of Report	Andrew Foster, Deputy DoF.
Purpose	To report the financial position for the period ended April 2016/17.

Executive summary

This report sets out the financial position of the Trust for the period ended 30th April (Month 1). The overall I&E position is a deficit of £2.2m, £0.3m adverse to plan.

- Cumulative deficit for recovery now stands at £31.7m. Extended break even recovery period will need to be negotiated with NHSI (beyond 3 years).
- Income position continues to include provision for fines and penalties (including MRET and readmissions) pending agreement of suspension / reinvestment under agreed NENE CCG contract.
- Significant shortfall in CQUIN income expected (notably for antimicrobial resistance).
- Increase in pay run rate due to new pay wards, NI increases and additional agency expenditure (non-nursing).
- Agency cap of £11.8m imposed by NHSI for FY16-17 (c. £980k pcm) or 6% of current pay bill. Overall agency costs 8.5% of pay bill although RN nursing has fallen to 5.3%.
- CIP programme ahead of plan in month 1 primarily for Agency Nursing and Procurement initiatives.
- NHSI has approved an Interim Revolving Working Capital Facility (IRWCSF) of £18.9m, of which £2m was drawn down in April.
- The Trust has yet to receive formal feedback from NHSI in relation to approval of the financial plan submitted in April.

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 April 2016/17 and to consider the actions required to ensure the financial position is recovered within planned levels in quarter 1.	

Northampton General Hospital NHS
NHS Trust

Financial Position
Month 1 FY 2016/17

Report to
Trust Board
May 2016

Enclosure G

1. Overview

	RAG	This Month Apr 16	Last Month Mar 16	Change
Statutory Financial Duties				
3 year Cumulative I&E Breakeven duty (£000's)	▼	(31,631)	(29,436)	(2,194)
Achieving EFL (£000's)	◆	44,971	26,297	(18,674)
Capital Cost Absorption Duty (%)	◆	3.5%	3.5%	0
Achieving the Capital Resource Limit (£000's)	◆	27,459	17,859	9,600
Financial Sustainability Risk Rating	▼	1.0	2.0	(1.0)
I&E Position				
Actual in Month Position (£000's)	▼	(2,220)	90	(2,310)
Forecast in Month Position (£000's)	▼	(1,909)	92	(2,001)
Actual Year to Date Position (£000's)	▼	(2,194)	(20,092)	
Forecast Year to Date Position (£000's)	▼	(2,194)	(20,092)	
Forecast End of Year I&E Position (£000's)	▼	(1,909)	(20,092)	
EBITDA %	▼	-4.6%	-2.2%	
Income				
MRET Penalty - Gross (£000's)	▲	(331)	(363)	32
Readmissions Penalty - Gross (£000's)	▼	(300)	(257)	(43)
Contract Fines & Data Challenges (£000's)	▲	(90)	(186)	96
Elective variance to plan (£000's)	▲	(100)	(566)	466
Daycase variance to plan (£000's)	▼	(83)	76	(159)
Non-Elective variance to plan (£000's)	▲	257	(243)	500
Outpatients variance to plan (£000's)	▼	40	460	(420)
Operating Costs				
Pay Expenditure (£000's)	▲	16,362	16,006	(356)
Agency Staff Costs (£000's)	▲	1,392	1,252	(140)
Agency Staff Cost (%)	▲	8.5%	7.8%	-0.7%
RN Agency % (Ceiling 6%)	▼	5.3%	3.3%	-2.0%
Non-Pay - Clinical (£000's)	▲	4,631	3,999	(632)
Non-Pay - Other (£000's)	▼	2,379	3,204	825
Cost Improvement Schemes				
Year to Date Actual (£000's)	▲	843	1,310	(467)
Year to Date Plan (£0o0's)	▲	749	1,720	(971)
Forecast Delivery (£000's)	▼	9,840	12,003	(2,163)
Annual CIP Target (£'000s)		12,900	12,125	775
Capital				
Year to date expenditure (£'000s)	▲	564	17,859	
% of annual plan Committed	▲	91%	100%	
Annual Capital Expenditure Plan (£000's)	▲	27,834	17,877	9,957
Cash				
In month movement (£000's)	▲	401	(3,281)	3,682
In Year movement (£000's)	▲	401	488	(87)
New PDC / Temporary borrowing (£000's)	▲	2,038	18,851	
Debtors Balance > 90 days (£000's)	▲	321	349	28
Creditors % > 90 days	◆	0%	0%	0%
Cumulative BPPC - by volume (%)	◆	98.6%	99.2%	-0.6%

Key issues for this report

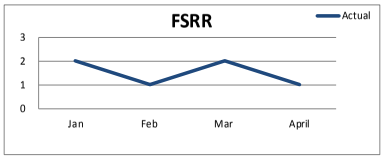
This report sets out the financial position of the Trust for the period ended 30th April (Month 1). The overall I&E position is a deficit of £2.2m, £0.3m adverse to plan.

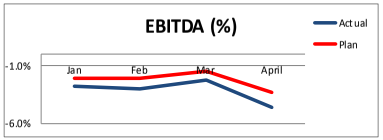
Key points:

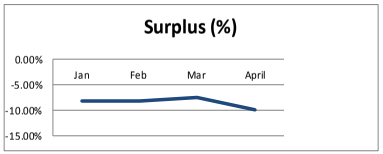
- Cumulative deficit for recovery now stands at £31.6m. Extended break even recovery period will need to be negotiated with NHSI (beyond 3 years).
- Significant increase in EFL due to additional revenue support loans and increased capital expenditure plans (e.g. 60 bedded ward).
- Income position continues to include provision for fines and penalties (including MRET and readmissions) pending agreement of suspension / reinvestment under agreed NENE CCG contract.
- Significant shortfall in CQUIN income expected (notably for antimicrobial resistance).
- Increase in pay run rate due to new pay wards, NI increases and additional agency expenditure (non-nursing).
- Agency cap of £11.8m imposed by NHSI for FY16-17 (c. £980k pcm) or 6% of current pay bill.
- Overall agency costs 8.5% of pay bill although RN nursing has fallen to 5.3%.
- CIP programme ahead of plan in month 1 primarily for Agency Nursing and Procurement initiatives.
- Risk adjusted CIP forecast gives rise to a potential shortfall of £3.1m compared to plan of £12.9m.
- Phasing of 60 bedded ward likely to slip due to delays in Procure 22 process and requirement for TDA business case approval.
- NHSI has approved an Interim Revolving Working Capital Facility (IRWCSF) of £18.9m, of which £2m was drawn down in April.
- The Trust has yet to receive formal feedback from NHSI in relation to approval of the financial plan submitted in April.

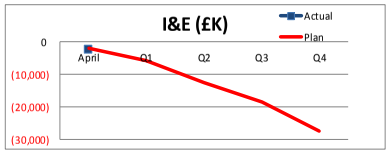
2. Financial Performance KPI Trend Analysis

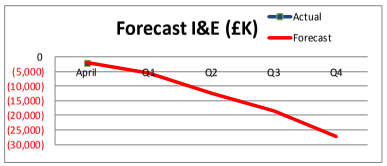
1. Key Metrics

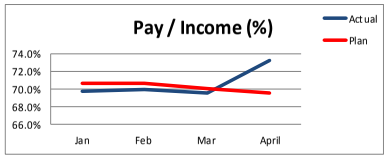




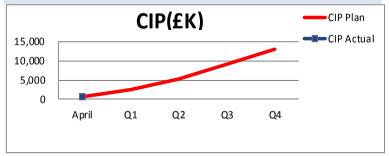


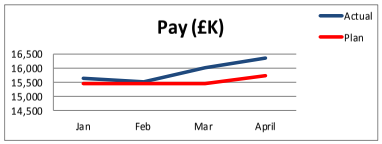


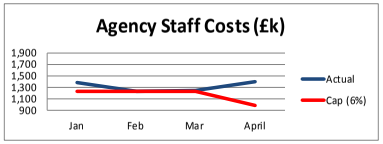


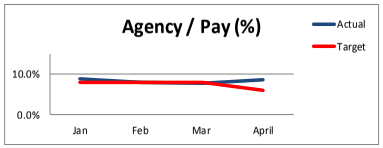


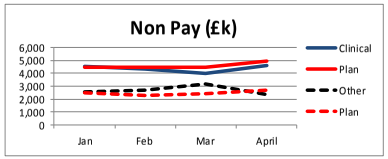
2. I&E Performance

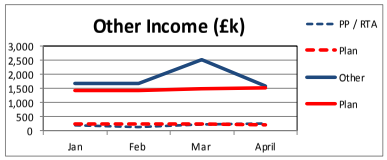




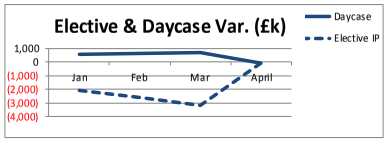


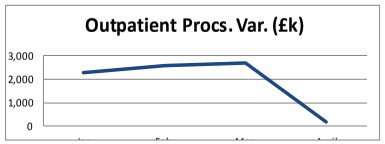


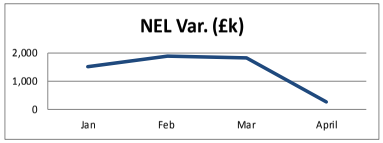


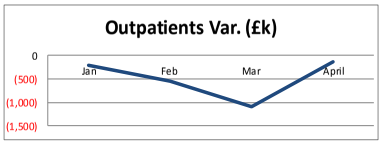


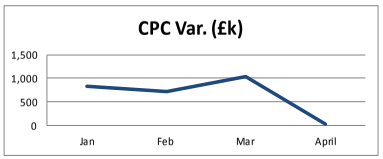
3. SLA Income

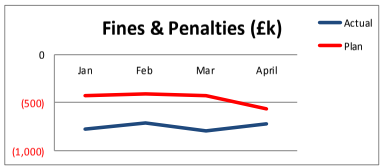




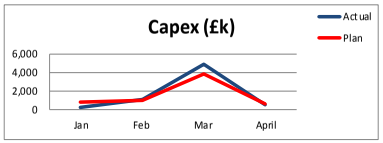


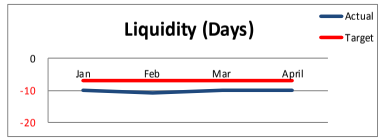


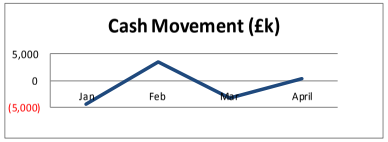


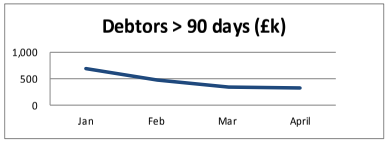


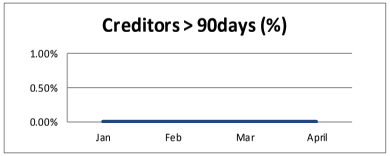
4. Working Capital

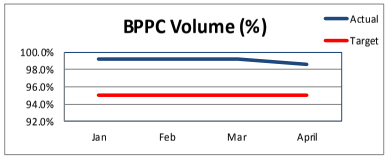












3. Income and Expenditure Position

I&E Summary	Actual FY15-16	Annual Plan	YTD plan	YTD Actual	Variance to Plan	Apr 16	Mar 16
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	246,152	255,200	20,872	20,494	(379)	20,494	21,540
Other Clinical Income	2,444	2,686	222	266	44	266	245
Other Income	20,872	18,630	1,540	1,584	44	1,584	2,522
Total Income	269,468	276,516	22,634	22,344	(290)	22,344	24,306
Pay Costs	(187,327)	(191,322)	(15,733)	(16,362)	(629)	(16,362)	(16,006)
Non-Pay Costs	(88,196)	(93,608)	(7,641)	(7,010)	631	(7,010)	(7,090)
CIPs		(0)	0	0	0	0	0
Reserves/ Non-Rec		(3,849)	(7)	0	7	0	0
Total Costs	(275,523)	(288,779)	(23,381)	(23,372)	9	(23,372)	(23,096)
EBITDA	(6,055)	(12,262)	(747)	(1,028)	(282)	(1,028)	1,210
Depreciation	(9,941)	(10,365)	(864)	(864)	0	(864)	(730)
Amortisation	(9)	(9)	(1)	(1)	0	(1)	(1)
Impairments	3,315	(1,590)	(529)	0	529	0	0
Net Interest	(355)	(1,239)	(42)	(36)	6	(36)	(53)
Dividend	(4,041)	(3,501)	(292)	(292)	(0)	(292)	(295)
Surplus / (Deficit)	(17,086)	(28,966)	(2,474)	(2,220)	254	(2,220)	131
NHS Breakeven duty adjs:							
Donated Assets	250	(24)	36	26	(10)		(41)
NCA Impairments	(3,329)	1,590	529	0	(529)		0
I&E Position (breakeven duty)	(20,165)	(27,400)	(1,909)	(2,194)	(285)	(2,220)	90

I&E Performance

- Financial performance for the period ended April 2016/17 is a normalised deficit of £2.19m, £285k adv. to the planned deficit of £1.909m.
- SLA income from Commissioners is £0.4m adv. to plan with underperformance across most points of delivery and provision for fines of £90k plus MRET and Readmissions penalties.
- Pay expenditure considerably above plan giving early cause for concern. Includes impact of new pay awards and NI increase.
- Non-Pay costs favourable to plan but run rate likely to increase as the financial year progresses (notably PAS implementation, Nurse Recruitment and Building maintenance costs).
- Interest cost likely to increase as additional capital and revenue support loans are drawn down during the financial year.

Key issues

SLA Income

- Underling position is £0.2m adv.to plan with additional requirement to make provision for potential fines and penalties of £0.7m in the month.
- Elective Inpatient income £0.1m (8%) adv. to plan .
- Daycase income £83k (4%) above plan for the year .
- NEL activity 4% above plan for period to date giving rise to MRET penalty exposure. NEL excess bed day income 3 above plan.
- Reported income includes assessment of delivery of 85% of CQUIN targets but assumes no delivery of the Antimicrobial CQUIN which is deemed to be unachievable as currently defined by NHSE.

Other Income

- Private Patient income £83k fav. to plan.
- RTA income £38k adv. to plan.
- Income / Other Generation £44k fav. to plan.

Pay

- Total agency staffing costs 8.5% (£13m) of the total pay bill for April. NHSI agency cap for FY16/17 is £11.8m or c.6%. (see Appendix 1).
- RN Agency 5.3% of RN pay for the year (ceiling assumed as 6%).
- Nursing pay expenditure £194k (3%) adv. to plan overall.

Non-Pay

- Drugs £135k fav. to plan.
- Staff advertising £53k fav. to plan.
- Prosthesis £76k fav. to plan.
- Building and engineering £108k fav. to plan .
- Printing & Stationary £33k fav. to plan.
- Computer maintenance / software £86k fav. to plan.
- Travel and benefits £78k fav. to plan.

4.0 SLA Income by Point of Delivery

Point of Delivery	Activity Plan	Activity Actual	Activity Variance	Finance £000's Plan	Finance £000's Actual	Finance £000's Variance
AandE	9,924	9,234	(690)	1,157	1,084	(72)
Block / CPC	225,289	245,208	19,919	4,632	4,661	29
CQUIN	-	-		374	309	(65)
Day Cases	2,801	3,188	387	1,968	1,884	(83)
Elective	466	452	(14)	1,302	1,202	(100)
Elective XBDs	170	98	(72)	40	23	(17)
Excluded Devices	136	182	46	145	111	(34)
Excluded Medicines	-	-		1,785	1,717	(68)
Non-Elective	3,542	3,934	391	5,629	5,868	239
Non-Elective XBDs	3,019	1,726	(1,293)	658	677	18
Outpatient First	4,804	4,606	(198)	795	765	(30)
Outpatient Follow UP	16,785	15,630	(1,155)	1,576	1,470	(106)
Outpt Procedures	11,350	12,144	794	1,515	1,690	175
Other Central SLA Income				(63)	(248)	(184)
CIPs				95		(95)
Reserves / Contingency				(167)		167
Fines & Penatlies						
Contract Penalties	2WW			-	(1)	(1)
Contract Penalties	31 Day			-	(2)	(2)
Contract Penalties	62 Day			-	(7)	(7)
Contract Penalties	A&E			-	(71)	(71)
Contract Penalties	Cancelled Operations			-	-	
Contract Penalties	CDIFF			-	-	
Contract Penalties	MRSA			-	-	
Contract Penalties	RTT - Incomplete			-	(10)	(10)
MRET	MRET			(336)	(331)	5
Readmissions	Readmissions			(231)	(300)	(69)
Sub-Total Fines & Penalties				**(567)**	**(720)**	**(153)**
Grand Total SLA Income				**20,872**	**20,494**	**(379)**

Key issues

Summary
£379k adverse to plan

CQUIN
£65k adverse to plan

Day Case and Elective Inpatients
£183k adverse to plan

Non elective
£239k favourable to plan

Outpatients
£40k ahead of plan

Fines & Penalties
£153k adverse to plan

Total SLA Income is £379k adverse position to plan mainly driven by fines and penalties and provision for challenges in month 1. The junior doctor strike impact can be seen in the under performance on planned care.

Assumed no income for the antimicrobial resistance scheme and 85% achievement for other schemes in Month 1.

Day cases 4% below finance plan but above plan in activity due to a negative casemix variance. Elective inpatients are below plan by 14 (3%) generating an under performance. Both of this is mostly offset with the central reserves held for RTT / Elective inpatient pressures.

Non elective activity is 11% above plan driven by general medicine and paediatrics. Due to the number of uncoded data the activity for non elective bed days is significantly under plan (financial value has been estimated for M1).

The net position on outpatients is an overperformance; Paediatrics, Ophthalmology and Urology are over performing offsetting an under performance on T&O which needs further investigation.

A&E and other operational standard penalties are contributing towards this position. NENE CCG contract includes mechanism (as part of the SDIP* schedule) to seek suspension of fines / reinvestment back into the Trust. The mechanism for this needs to be clarified, the CCG have indicated this would be predicated on a business case submission to support this reinvestment.

*Service Development & Improvement Plan

5. Statement of Financial Position

	Balance at 31-Mar-16	Current Month			Forecast end of year	
		Opening Balance	Closing Balance	Movement	Closing Balance	Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	160,399	160,399	160,399		160,399	
IN YEAR REVALUATIONS					7,932	7,932
IN YEAR MOVEMENTS			939	939	28,805	28,805
LESS DEPRECIATION			(864)	(864)	(10,365)	(10,365)
NET BOOK VALUE	**160,399**	**160,399**	**160,474**	**75**	**186,771**	**26,372**
CURRENT ASSETS						
INVENTORIES	5,744	5,744	5,668	(76)	5,494	(250)
RECEIVABLES						
NHS RECEIVABLES	9,742	9,742	9,531	(211)	10,016	274
OTHER TRADE RECEIVABLES	1,250	1,250	954	(296)	1,300	50
RECEIVABLES IMPAIRMENTS PROVISION	(205)	(205)	(205)		(200)	5
CAPITAL RECEIVABLES	21	21		(21)		(21)
NON NHS OTHER RECEIVABLES	118	118	273	155	118	
COMPENSATION RECEIVABLES (RTA)	2,582	2,582	2,539	(43)	2,657	75
SALARY OVERPAYMENTS	546	546	516	(30)	475	(71)
SALARY SACRIFICE SCHEMES	468	468	402	(66)	500	32
OTHER RECEIVABLES	525	525	523	(2)	575	50
IRRECOVERABLE PROVISION	(629)	(629)	(629)		(579)	50
PREPAYMENTS	1,923	1,923	2,386	463	2,173	250
SUB TOTAL	**16,341**	**16,341**	**16,290**	**(51)**	**17,035**	**694**
NON CURRENT ASSETS FOR SALE	375	375		(375)		(375)
CASH	1,602	1,602	2,003	401	1,500	(102)
CURRENT ASSETS	**24,062**	**24,062**	**23,961**	**(101)**	**24,029**	**(33)**
CURRENT LIABILITIES						
NHS PAYABLES	978	978	1,230	252	1,478	500
TRADE PAYABLES REVENUE	2,390	2,390	2,621	231	5,074	2,684
TRADE PAYABLES FIXED ASSETS	5,192	5,192	3,462	(1,730)	2,500	(2,692)
TAX AND NI OWED	3,552	3,552	3,867	315	3,802	250
NHS PENSIONS AGENCY	2,347	2,347	2,301	(46)	2,497	150
OTHER PAYABLES	823	823	454	(369)	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)			2,038	2,038		
SHORT TERM LOANS - NON DH	155	155	144	(11)	82	(73)
ACCRUALS	7,191	7,191	8,423	1,232	7,941	750
RECEIPTS IN ADVANCE	1,775	1,775	1,800	25	1,975	200
PDC DIVIDEND DUE	99	99	428	329		(99)
STAFF BENEFITS ACCRUAL	710	710	767	57	750	40
PROVISIONS	2,802	2,802	2,682	(120)	2,503	(299)
CURRENT LIABILITIES	**28,763**	**28,763**	**30,966**	**2,203**	**31,649**	**2,886**
NET CURRENT ASSETS / (LIABILITIES)	**(4,701)**	**(4,701)**	**(7,005)**	**(2,304)**	**(7,620)**	**(2,919)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**155,698**	**155,698**	**153,469**	**(2,229)**	**179,151**	**23,453**
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year	1,245	1,245	1,236	(9)	11,039	9,794
LOANS over 1 year DH (CAPITAL)	7,186	7,186	7,186		13,738	6,552
LOANS over 1 year DH (REVENUE)	18,851	18,851	18,851		46,251	27,400
LOANS over 1 year NON DH	166	166	166		84	(82)
PROVISIONS over 1 year	979	979	979		226	(753)
NON CURRENT LIABILITIES	**28,427**	**28,427**	**28,418**	**(9)**	**71,338**	**42,911**
TOTAL ASSETS EMPLOYED	**127,271**	**127,271**	**125,051**	**(2,220)**	**107,813**	**(19,458)**
FINANCED BY						
PDC CAPITAL	119,258	119,258	119,258		119,258	
PDC TEMPORARY BORROWING						
REVALUATION RESERVE	41,435	41,435	41,435		49,377	7,942
I & E ACCOUNT BALANCE	(33,422)	(33,422)	(33,422)		(33,422)	
I & E CURRENT YEAR			(2,220)	(2,220)	(27,400)	(27,400)
FINANCING TOTAL	**127,271**	**127,271**	**125,051**	**(2,220)**	**107,813**	**(19,458)**

Key Movements

Non Current Assets
•Negligible movement although spend exceeds depreciation £0.1m.

Current assets
•Decrease in Inventories of £0.1m.
•Decrease in NHS Receivables £0.2m.
•Increase in Cash of £0.4m.
•Increase in Prepayments of £0.5m.
•Increase in Non NHS Other Receivables £0.2m.
•Decrease in Other Receivables of £0.3m.
•Decrease in Non Current Asset Held for Sale £0.4m.

Current Liabilities
•Increase in NHS Payables of £0.3m.
•Increase in Trade Creditors of £0.2m.
•Decrease in Trade Payables Fixed Assets £1.7m.
•Increase in Tax and NI Owed of £0.3m.
•Decrease in Other Payables of £0.4m.
•Increase in Short Term Revenue Loan of £2.0m.
•Increase in Accruals of £1.2m.
•Increase in PDC Dividends Due of £0.3m.
•Decrease in Provisions of £0.1m.

Non Current Liabilities
•Negligible movement in non current liabilities.

Financing
•Increased Deficit in Month £2.2m

6. Capital Expenditure

Capital Scheme	Plan 2016/17 £000's	M1 Plan £000's	M1 Spend £000's	Under (-) / Over £000's	Plan Achieved %	Actual Committed £000's	Plan Achieved %
Replacement Imaging Equipment - Tranche 1 (Loan	1,122	0	0	0	0%	2	0%
Replacement Imaging Equipment - Tranche 2 (Loan)	4,396	217	217	0	5%	2,405	55%
Additional Imaging Equipment - CT / MRI (Loan)	2,200	0	0	0	0%	513	23%
Replacement NPfIT Systems	2,288	250	285	35	12%	299	13%
Stock / Inventory System (Loan)	600	50	8	-42	1%	0	0%
A&E / Orthopaedics	500	100	42	-58	8%	86	17%
Medical Equipment Sub Commiittee	938	37	0	-37	0%	46	5%
Estates Sub Committee	3,319	9	143	134	4%	325	10%
IT Sub Committee	3,101	333	244	-89	8%	598	19%
60 Bedded Ward	10,000	0	0	0	0%	0	0%
Other	195	0	0	0	0%	133	38%
Total - Capital Plan	**28,659**	**996**	**939**	**-57**	**3%**	**4,408**	**15%**
Less Charitable Fund Donations	-450	0	0	0	0%	0	0%
Less NBV of Disposals	-375	-375	-375	0	100%	-375	25%
Total - CRL	**27,834**	**621**	**564**	**-57**	**2%**	**4,033**	**14%**

Funding Resources	
Internally Generated Depreciation	10,365
Finance Lease - 60 Bedded Ward	10,000
Capital Loans - Imaging Equipment (Approved)	1,122
Capital Loans - Replacement Imaging Equipment	4,396
Capital Loans - Additional Imaging Equipment	2,200
Capital Loans - Stock / Inventory System	600
Capital Loan - Repayment	-694
Other Loans - Repayment	-155
Total - Available CRL Resource	**27,834**
Uncommitted Plan	**0**

Key Issues

- The second linear accelerator has now been delivered and planned to go operational in June 16.
- The third linear accelerator is due to be delivered in August and planned to go operational in November 16.
- 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 in the new financial year with planned completion of fit stop area in August.
- The initial full year depreciation forecast is currently £10,365k.
- The 60 bedded ward is included as a 10 year finance lease although with planning timescales likely to slip into 2017/18.
- The Harborough Lodge sale has been now completed in April.
- 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.
- The stock inventory project team have undertaken site visits and hope to chose a preferred supplier by the end of June.

7. Receivables, Payables and BPPC Compliance

Narrative	Total at April £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	954	302	371	56	225
Receivables NHS	7,962	7,176	520	170	96
Total Receivables	**8,916**	**7,478**	**891**	**226**	**321**
Payables Non NHS	(6,082)	(6,017)	(65)		
Payables NHS	(1,230)	(1,230)			
Total Payables	**(7,312)**	**(7,247)**	**(65)**		

Narrative	Total at March £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	1,271	684	205	146	236
Receivables NHS	8,306	7,846	253	95	112
Total Receivables	**9,578**	**8,530**	**458**	**241**	**349**
Payables Non NHS	(7,582)	(7,563)	(17)	(2)	(0)
Payables NHS	(978)	(964)	(14)		
Total Payables	**(8,560)**	**(8,527)**	**(31)**	**(2)**	**(0)**

Receivables and Payables

- All SLA commissioner monthly invoices were paid on time.
- Continued focus on reducing age profile of non current debt.
- For Non NHS over 90 days this includes Overseas visitors accounts of £200k of which £62k are paying in instalments and a high proportion of the balance passed to debt collection agency to recover and Private Patients £20k.
- NHS over 90 day debt predominantly relates to NCA's £29k, Public Health England £26k and NHS Trusts £37k.
- All of registered creditors are predominantly current (due within 30 days).
- Appropriate provision and write off has been made in accordance with the stated DH and local Trust policies.

Narrative	April 2016/17
NHS Creditors	
No.of Bills Paid Within Target	170
No.of Bills Paid Within Period	179
Percentage Paid Within Target	**94.97%**
Value of Bills Paid Within Target (£000's)	1,405
Value of Bills Paid Within Period (£000's)	1,451
Percentage Paid Within Target	**96.79%**
Non NHS Creditors	
No.of Bills Paid Within Target	6,235
No.of Bills Paid Within Period	6,318
Percentage Paid Within Target	**98.69%**
Value of Bills Paid Within Target (£000's)	8,167
Value of Bills Paid Within Period (£000's)	8,211
Percentage Paid Within Target	**99.47%**
Total	
No.of Bills Paid Within Target	6,405
No.of Bills Paid Within Period	6,497
Percentage Paid Within Target	**98.58%**
Value of Bills Paid Within Target (£000's)	9,571
Value of Bills Paid Within Period (£000's)	9,662
Percentage Paid Within Target	**99.07%**

BPPC Compliance

- The BPPC performance has been achieved except for NHS by number, 9 invoices (£46k) were paid late and the April target was missed by 1 invoice although the payments team continuing to achieve processing within the targets once approved.
- Of the 92 invoices (£91k) that were paid late in April, 22 invoices (£21k) related to agency invoices.

8. Cashflow

MONTHLY CASHFLOW	Annual	ACTUAL APR	MAY	JUN	JUL	AUG	SEP	FORECAST OCT	NOV	DEC	JAN	FEB	MAR
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
RECEIPTS													
SLA Base Payments	247,569	19,343	21,882	20,458	20,458	20,678	20,678	20,678	20,678	20,678	20,678	20,678	20,678
SLA Performance/ Other CCG Investment													
Health Education Payments (SIFT etc)	9,803	798	785	822	822	822	822	822	822	822	822	822	822
Other NHS Income	15,396	1,419	1,265	1,407	2,729	1,072	1,072	1,072	1,072	1,072	1,072	1,072	1,072
PP / Other (Specific > £250k)	829	473	356										
PP / Other	13,926	1,076	850	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200
Salix Capital Loan													
PDC - Capital													
Capital Loan	8,318				521		3,215	1,155		1,600	555		1,272
Revenue Support Loan	27,400												27,400
Revolving Working Capital Facility		2,038	1,554	2,120	1,724	2,945	2,121	1,399	1,831	2,736	2,172	3,614	-24,254
Interest Receivable	25	3	2	2	2	2	2	2	2	2	2	2	2
Sale of Assets	585	585											
TOTAL RECEIPTS	**323,850**	**25,735**	**26,694**	**26,009**	**27,456**	**26,719**	**29,110**	**26,328**	**25,605**	**28,110**	**26,501**	**27,388**	**28,192**
PAYMENTS													
Salaries and wages	179,654	15,154	14,900	15,050	14,900	14,900	15,050	14,900	14,900	15,050	14,900	14,900	15,050
Trade Creditors	96,681	6,686	9,064	8,130	7,758	8,293	5,132	7,873	8,123	8,652	8,314	10,162	8,494
NHS Creditors	19,966	1,565	1,822	1,822	1,822	1,822	1,822	1,822	1,822	1,822	1,822	1,000	1,000
Capital Expenditure	22,372	1,893	1,406	1,007	2,975	1,545	4,781	1,721	760	2,586	1,465	1,138	1,095
PDC Dividend	3,512						1,786						1,726
Repayment of Loans (Principal & Interest)	1,583					159	474					189	761
Repayment of Salix loan	156	12					66	12					66
TOTAL PAYMENTS	**323,924**	**25,310**	**27,192**	**26,009**	**27,455**	**26,719**	**29,111**	**26,328**	**25,605**	**28,110**	**26,501**	**27,389**	**28,192**
Actual month balance	-73	425	-498	0	0	0	-1	0	0	0	0	0	0
Cash in transit & Cash in hand adjustment	-29	-24	-5			0						0	
Balance brought forward	1,602	1,602	2,003	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500
Balance carried forward	**1,500**	**2,003**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**

Key Issues

- The Trust has drawn down £2.0m of Temporary Borrowing in April (agreed with DH).
- The 16/17 revised plan submitted to NHSI forecast an increased deficit of £27.4m, which exceeds the Trust's existing RWC Facility Limit of £18.9m.
- The sale of Harborough Lodge completed in April, value £585k.
- It was anticipated that invoice payments may have been significantly delayed until 15th of each Month when contract payments are due. DH are now only funding Temporary Borrowing to the value of the monthly forecast deficit as per the April plan submission (£27.4m deficit).
- Following decisions with Nene CCG, monthly SLA payments are now expected to be received during the first week of the month. This will facilitate Creditor payments to continue to be made in a timely manner throughout each month.
- Further Temporary Borrowing of £1.6m has been approved by DH for drawn down in May.
- Capital loans may only be drawn for the purpose for which they were awarded.

9. Risks to Financial Position

Risk	Financial Drivers	Estimated Value £K	Mitigations	Impact on plan £K
Revenue Risks				
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.	2,000	£0.7m included in plan for additional contractual beds. £1.3m included in plan for cost of new 60 bedded facility.	-
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.	6,000	£3m included in plan to cover costs of outsourcing primarily for T&O, Ophthalmology and Endoscopy.	Up to further £3m based on Q4 run rate
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. Antimicrobial resistance CQUIN cannot be achieved £350k.	780
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.	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 t Improvement Plans (SDIP).£1m provision in income plan for fines and penalties.	Dependent on SDIP process
Junior doctors new contract	Cost of new compliant rotas, pay protection, e-rostering and appointment of Guardian.	600 to 1,000	£600k pay reserve in plan but subject to ongoing national negotiations, review of new rotas and pay protection. Introduction of new contract will be staggerred over 2 years.	Unknown but likely to be minimal in 16-17.
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.	-
CIP delivery	Delivery of CIP target will be challenging in year. £6.9m of CIPs rated as high risk. Latest risk adjusted p[position gives rise to £4.5m shortfall to plan.	4,500	Ongoing identification of new schemes and mitigating actions. Introduction of strict expenditure controls and delay planned developments.	3,500
Non-Revenue Risks				
Capital Resources	Capital resources constrained due to reduced levels of deprecation and national loan restrictions.	2,200	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 FBC approval and CRL cover
Cashflow	Projected deficit of £27.4m requires direct cash support. NHSI likely to impose strict limitations to accessing RWCSF currently (April 16) approved at £18.9m.	8,500	Management of creditors. Improving I&E position ahead of plan. Delay capital expenditure. Advance payment of CCG mandate each month agreed with NENE CCG.	8,500

10. Conclusions and Recommendations

Conclusion:

- The Trust has performed adversely to plan in the first month of the financial year and must take steps to address the shortfall and live within the plan set by the Board in April for the remainder of the year.
- Whilst month 1 results are not always a good barometer, it is clear that pay costs have increased over an above budgeted levels which may give rise to a concerning trend if repeated in May.
- CIP delivery is recorded as exceeding plan in M1 and it is important to understand the relationship between this good performance and the overall financial position compared to budget.
- Non-pay budgets are currently underspending but it is clear that several key programmes have yet to incur significant costs in the first month of the year. Focus must be maintained on the key areas of PAS implementation, Nurse recruitment, Consultancy Fees, and Building and Engineering costs (post MEA valuation).
- The Trust continues to make provision for likely fines and penalties despite contractual clauses which may require the CCG to suspend or reinvest sanctions. As these provision have yet to be fully tested it is prudent to make provision in the income position for the possibility of contractual penalties and non-reinvestment of MRET and readmissions penalties directly with the Trust.
- There have been a number of early calls on the Trust revenue reserves (notably RTT audits) which will reduce the level of contingency in the plan going forward. A range of outstanding business cases identified in the IBP process also require consideration and where approved funding to be identified.
- It is becoming clear that the 60 Bedded Ward business case may slip beyond the 16-17 financial year giving rise to in year opportunities to utilise the funding earmarked for this purpose.
- The Trust is currently managing cashflow with cooperation from NENE CCG and by accessing the DH approved £18.851m IRWCSF.
- There are a range of potential risks to the financial position which require management and mitigation of the overall plan of a £27.4m is to be delivered.

Recommendations & actions

- Further analysis of the M1 performance to be undertaken notably in relation to the adverse pay position.
- Early discussion with NENE CCG in relation to suspension of fines and reinvestment of penalties in accordance with the agreed approach reached as part of the FY16-17 contract.
- Analysis of key non-pay underspends with measures put in place to understand forecast and plans for the remainder of the financial year.
- DoF to manage and approve all allocations from revenue reserves.
- Review of delivery of vacancy factors applied to budget to be undertaken.
- Ensure that all Divisions are delivering to plan and managed in accordance with the Performance Management Framework.
- Discussion required with NHSI to confirm status of the financial plan submitted in April and also the extension of the statutory break-even period.

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

Area	Senior Medstaff	Junior Medstaff	Qualified Nursing	Unqualified Nursing	Management Staff	A&C Staff	Other Clinical Staff	Prof & Tech Staff	Ancillary & Estates Staff	Agency as % of Total Pay Mth 1	Total Agency YTD Mth 1	Annual Spend 2015/16	Average Month 2015/16
General Surgery	26	9	14	10	-	-	-	2	-	5%	62	1,189	99
Anaesthesia & Critical Care	-	28	36	1	-	-	0	19	-	5%	84	994	83
Trauma & Orthopaedics	-	45	20	15	-	-	3	-	-	11%	84	1,272	106
Ent & Maxfax	26	39	6	3	-	-	-	4	-	16%	78	721	60
Ophthalmology	26	-	-	-	4	-	-	-	-	10%	30	233	19
Surgical Care Management	-	-	-	-	-	-	-	-	-	0%	-	1	0
Surgical Division	**78**	**122**	**76**	**29**	**4**	**-**	**3**	**26**	**-**	**8%**	**339**	**4,409**	**367**
Inpatient Specialties	1	75	53	32	-	-	6	-	-	10%	167	2,921	243
Outpatient & Elderly Medicine	84	-	16	32	-	-	11	-	-	10%	144	1,593	133
Urgent Care	81	148	99	17	-	-	-	-	-	26%	345	3,833	319
Medical Care Management	-	-	-	-	-	-	-	-	-	0%	-	(3)	(0)
General Medicine Division	**166**	**224**	**168**	**82**	**-**	**-**	**17**	**-**	**-**	**15%**	**657**	**8,344**	**695**
Child Health	2	12	10	1	-	-	-	-	-	2%	26	487	41
Obstetrics & Gynae	3	(4)	4	2	-	-	-	-	-	0%	4	191	16
Oncology/Clin Haematology	29	22	3	2	-	1	-	-	-	7%	58	485	40
WC&O Division	**35**	**30**	**17**	**4**	**-**	**1**	**-**	**-**	**-**	**3%**	**88**	**1,163**	**97**
Pathology	24	-	-	-	-	-	-	49	-	13%	73	901	75
Imaging	40	-	-	-	-	-	8	-	-	7%	48	421	35
Research	-	-	-	-	-	-	-	-	-	0%	-	-	-
Pharmacy	-	-	-	-	-	-	23	-	-	8%	23	99	8
Therapy Services	-	-	-	-	-	-	16	-	-	7%	16	167	14
Clinical Support Division	**64**	**-**	**-**	**-**	**-**	**-**	**48**	**49**	**-**	**8%**	**161**	**1,588**	**132**
Clinical Divisions	**343**	**376**	**261**	**115**	**4**	**1**	**68**	**75**	**-**	**9%**	**1,244**	**15,504**	**1,292**
Hospital Support	-	-	1	1	63	8	2	-	-	6%	75	647	54
Facilities	-	-	-	-	-	-	-	-	66	7%	66	1,488	124
Support Services	**-**	**-**	**1**	**1**	**63**	**8**	**2**	**-**	**66**	**6%**	**141**	**2,134**	**178**
Trust Total	**343**	**376**	**262**	**117**	**68**	**9**	**70**	**75**	**66**	**8%**	**1,385**	**17,639**	**1,470**
									Discrete Monthly Spend		**1,385**		**1,470**

Key Issues

- **At Month 1** £1.385m was spent on agency staff. This is an improvement on the 15/16 average month of £1.47m, but short of the £11.8m p.a. / £0.98m per month target assigned to the Trust. An annual limit of £11.8m expenditure on agency staff is equivalent to 6% of total pay spend.
- **Medical locum agency costs** have surged in April to £719k (15% of the total medical staff expenditure). This is 50% above the average of last year and represent the greatest risk of the Trust keeping within the £11.8m total agency cap.
- **Nursing (RN & HCA) agency costs** of £379k is down the 15/16 Q4 average of £448k/mth. This agency expenditure is 6% of the total RN/HCA spend.

Report To	**Public Trust Board**
Date of Meeting	**26 May 2016**

Title of the Report	**Workforce Performance Report**
Agenda item	**13**
Presenter of Report	Janine Brennan, Director of Workforce & Transformation
Author(s) of Report	Adam Cragg, Head of Resourcing & Employment Services Sam Wright, Workforce Systems Manager
Purpose	This report provides an overview of key workforce issues
Executive summary • The key performance indicators show an increase in contracted workforce employed by the Trust, and an increase in sickness absence from March 2016. • Increase in compliance rate for Mandatory Training and Appraisals and a decrease in compliance for Role Specific Essential Training.	
Related strategic aim and corporate objective	Enable excellence through our people
Risk and assurance	Workforce risks are identified and placed on the Risk register as appropriate.
Related Board Assurance Framework entries	BAF – 4.1, 4.2 and 4.3

Enclosure H

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

Actions required by the Board

The Board is asked to Note the report.

Northampton General Hospital NHS
NHS Trust

Public Trust Board
Thursday 26 May 2016

Workforce Performance Report

1. Introduction

This report identifies the key themes emerging from April 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 increased by 8.81 FTE in April 2016 to 4270.80 FTE. The Trust's substantive workforce is at 90.02% of the Budgeted Workforce Establishment of 4744.05 FTE. It is important to note that the Budgeted Workforce Establishment rose in April 2016 by a total of 146.21 FTE from 4597.84 FTE to 4744.05 FTE,

Annual Trust turnover decreased by a further 0.22 to 10.58% in April which is above the Trust target of 8%.

In month sickness absence increased by 0.14% to 4.11% which is above the Trust target of 3.8%. The Medical and Surgical Divisions were above the trust target. In total 7 directorate level organisations were below the trust target rate.

2.2 Capability

Appraisals, Mandatory Training and Role Specific Essential Training

The current rate of Appraisals recorded for April 2016 is 82.71%; this is a further improvement following the dip in February but does quite not take the figure back to the January high point of 83.29%.

Mandatory Training compliance increased in April from 84.5% to 85.13% to reach the Trust target of 85%.

Enclosure H

Role Specific Essential Training compliance decreased in April to 73.70%, this was mainly due to Blood Training competence requirements being changed this month.

3. Assessment of Risk

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

4. Recommendations/Resolutions Required

The Committee is asked to note the report.

5. Next Steps

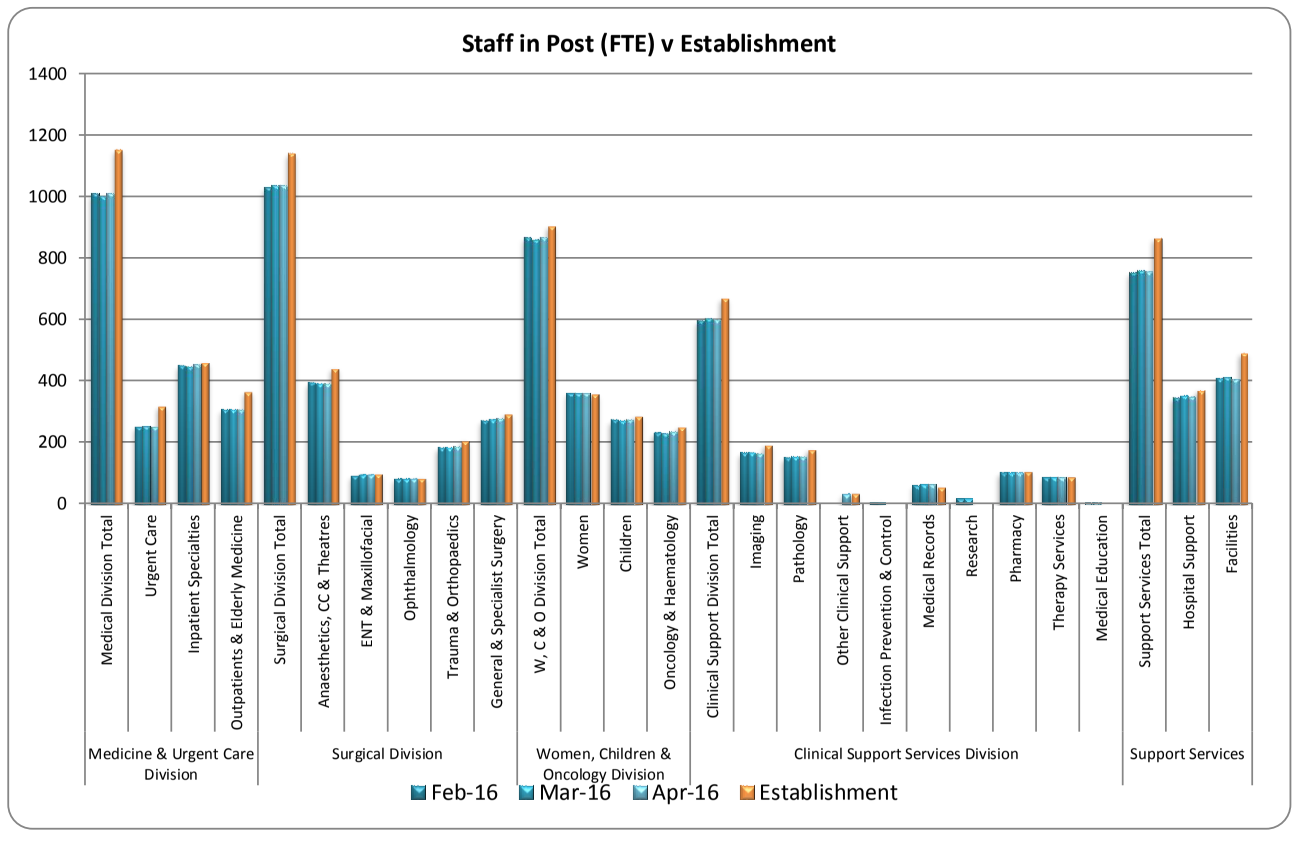
Key workforce performance indicators are subject to regular monitoring and appropriate action is taken as required.

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

CAPACITY
Staff in Post

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

Staff in Post (FTE)		Feb-16		Mar-16		Apr-16	Establishment	
Medicine & Urgent Care Division	Medical Division Total	1009.89	↓	1002.07	↑	1011.88	1155.37	87.58%
	Urgent Care	252.34	↓	250.14	↑	250.81	320.67	78.21%
	Inpatient Specialties	450.69	↓	445.46	↑	452.84	463.52	97.70%
	Outpatients & Elderly Medicine	305.85	↓	305.47	↑	307.23	368.18	83.45%
Surgical Division	Surgical Division Total	1029.26	↑	1036.26	↑	1037.82	1142.98	90.80%
	Anaesthetics, CC & Theatres	393.26	↓	392.09	↓	391.83	444.14	88.22%
	ENT & Maxillofacial	92.60	↑	96.40	↓	94.72	101.43	93.38%
	Ophthalmology	81.82	↑	82.57	↑	83.17	86.87	95.74%
	Trauma & Orthopaedics	184.20	↑	184.40	↑	185.35	209.01	88.68%
	General & Specialist Surgery	271.59	↑	275.01	↑	277.95	295.73	93.99%
Women, Children & Oncology Division	W, C & O Division Total	866.94	↓	860.28	↑	866.35	906.71	95.55%
	Women	360.99	↓	358.02	↓	357.52	360.74	99.11%
	Children	272.32	↓	271.64	↑	273.04	289.26	94.39%
	Oncology & Haematology	231.77	↓	228.77	↑	233.93	253.86	92.15%
Clinical Support Services Division	Clinical Support Division Total	596.84	↑	602.31	↓	599.36	671.94	89.20%
	Imaging	166.20	↓	165.80	↓	165.18	195.70	84.40%
	Pathology	149.12	↑	154.12	↓	153.25	180.06	85.11%
	Other Clinical Support				↑	33.05	37.93	87.13%
	Infection Prevention & Control	7.01	↑	7.01	↓			
	Medical Records	60.44	↑	61.71	↑	61.84	58.33	106.02%
	Research	19.74	↓	19.24	↓			
	Pharmacy	102.68	↑	102.72	↓	101.40	108.58	93.39%
	Therapy Services	85.45	↑	85.53	↓	84.65	91.34	92.68%
	Medical Education	4.20	↑	4.20	↓			
Support Services	Support Services Total	753.02	↑	761.06	↓	755.39	867.05	87.12%
	Hospital Support	345.43	↑	351.16	↓	350.14	373.34	93.79%
	Facilities	407.59	↑	409.90	↓	405.26	493.71	82.08%
Trust Total		4255.95	↑	4261.99	↑	4270.80	4744.05	90.02%

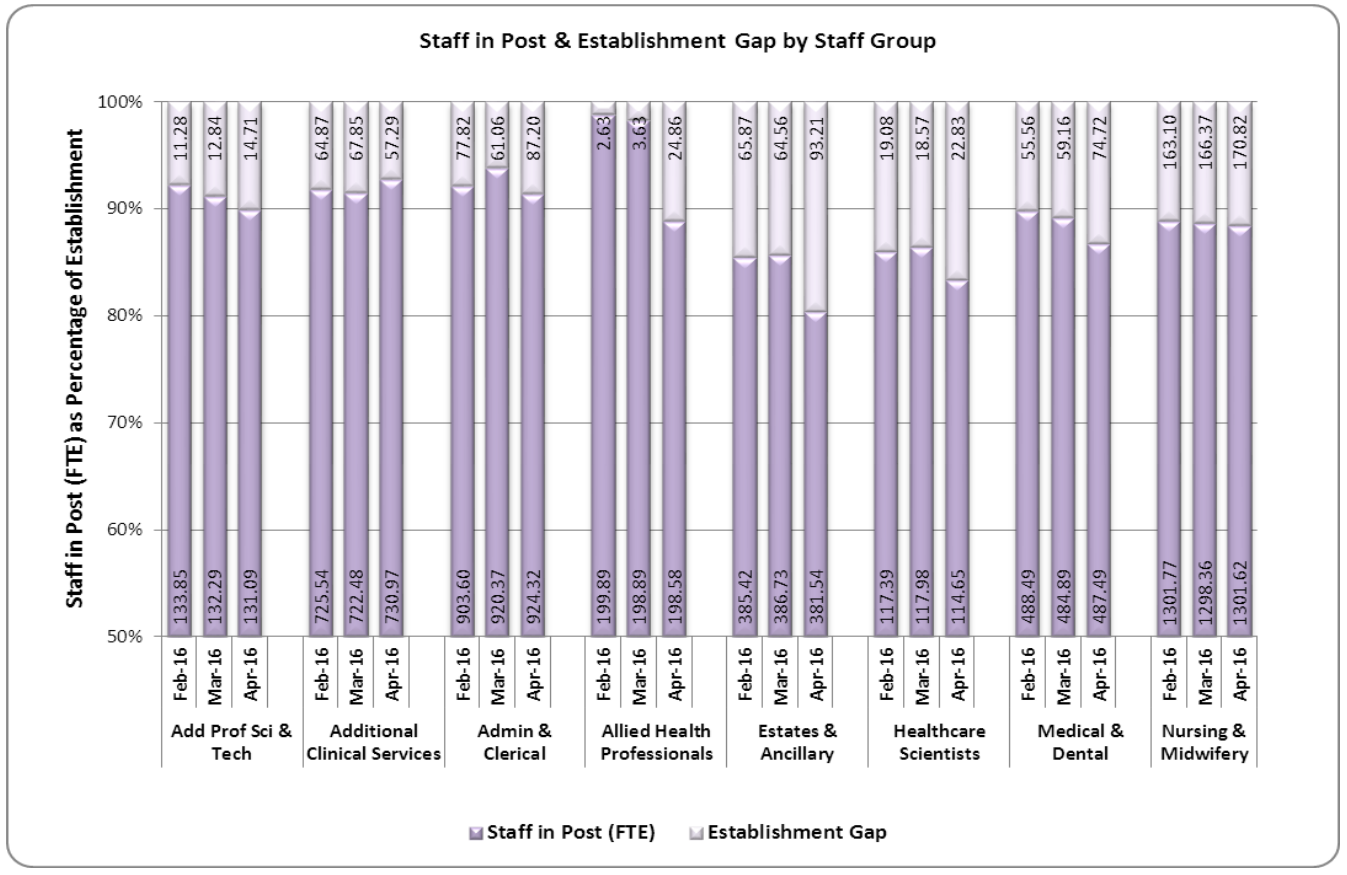


CAPACITY
Staff Group (FTE v Est)

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

Staff Group Vacancy Rate (Contracted FTE v Establishment)

Staff Group	Feb-16	Mar-16	Apr-16
Add Prof Sci & Tech	7.77%	8.85%	10.09%
Additional Clinical Services	8.21%	8.59%	7.27%
Admin & Clerical	7.93%	6.22%	8.62%
Allied Health Professionals	1.30%	1.79%	11.13%
Estates & Ancillary	14.60%	14.31%	19.63%
Healthcare Scientists	13.98%	13.60%	16.61%
Medical & Dental	10.21%	10.87%	13.29%
Nursing & Midwifery	11.13%	11.36%	11.60%



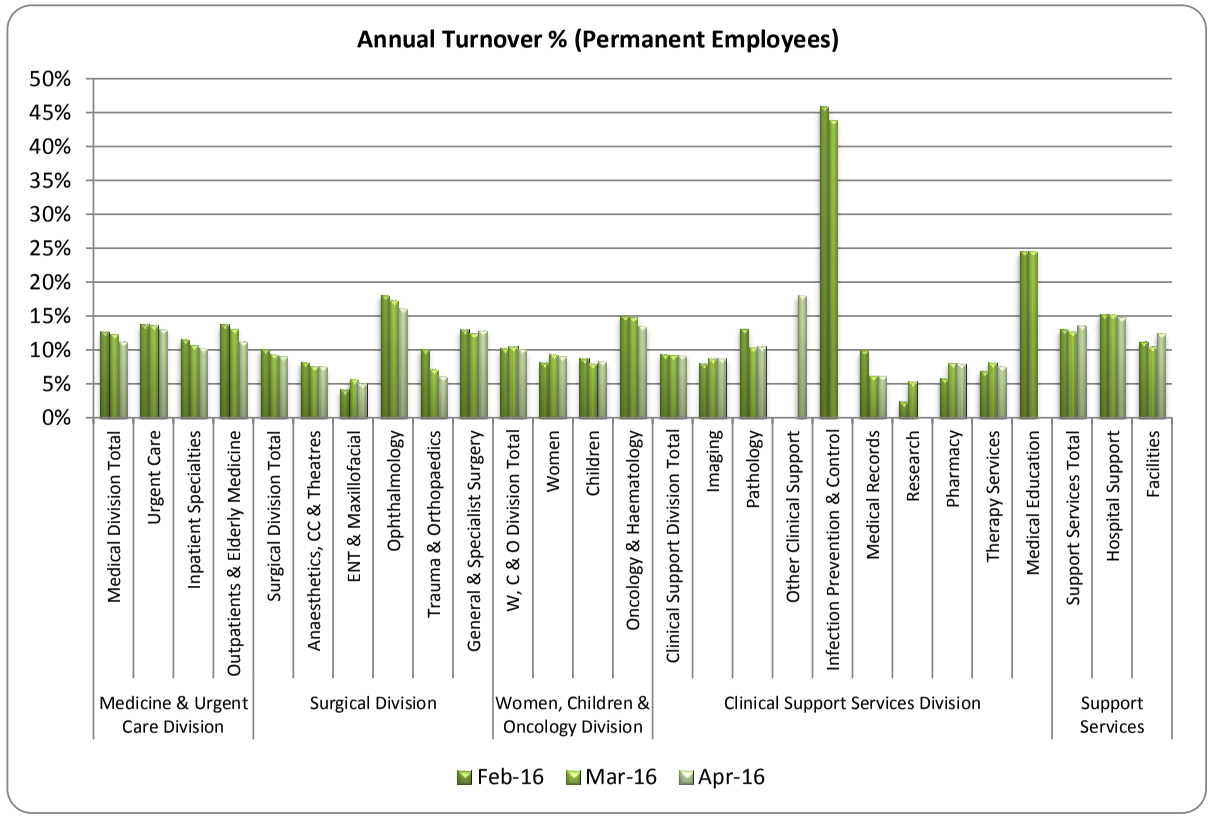
Workforce Committee: Capacity, Capability and Culture Report - April 2016

CAPACITY
Annual Turnover

Figures refer to the year ending in the month stated

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

Annual Turnover (Permanent Staff)		Feb-16		Mar-16		Apr-16
Medicine & Urgent Care Division	Medical Division Total	12.76%	↘	12.25%	↘	11.26%
	Urgent Care	13.75%	↘	13.70%	↘	13.06%
	Inpatient Specialties	11.63%	↘	10.74%	↘	10.27%
	Outpatients & Elderly Medicine	13.71%	↘	13.23%	↘	11.30%
Surgical Division	Surgical Division Total	10.14%	↘	9.27%	↘	9.06%
	Anaesthetics, CC & Theatres	8.18%	↘	7.60%	↘	7.54%
	ENT & Maxillofacial	4.17%	↗	5.60%	↘	5.08%
	Ophthalmology	17.99%	↘	17.28%	↘	16.07%
	Trauma & Orthopaedics	10.14%	↘	7.16%	↘	6.16%
	General & Specialist Surgery	13.01%	↘	12.41%	↗	12.87%
Women, Children & Oncology Division	W, C & O Division Total	10.26%	↗	10.49%	↘	10.08%
	Women	8.13%	↗	9.34%	↘	9.07%
	Children	8.78%	↘	8.07%	↗	8.24%
	Oncology & Haematology	15.06%	↘	14.88%	↘	13.47%
Clinical Support Services Division	Clinical Support Division Total	9.41%	↘	9.14%	↗	9.18%
	Imaging	8.08%	↗	8.76%	↘	8.72%
	Pathology	13.22%	↘	10.39%	↗	10.52%
	Other Clinical Support				↗	18.07%
	Infection Prevention & Control	45.87%	↘	43.82%		
	Medical Records	9.87%	↘	6.30%	↘	6.23%
	Research	2.42%	↗	5.36%		
	Pharmacy	5.84%	↗	8.00%	↗	8.05%
	Therapy Services	6.81%	↗	8.13%	↘	7.55%
	Medical Education	24.59%	↗	24.59%		
Support Services	Support Services Total	13.09%	↘	12.70%	↗	13.56%
	Hospital Support	15.23%	↘	15.20%	↘	14.82%
	Facilities	11.26%	↘	10.53%	↗	12.46%
Trust Total		11.19%	↘	10.80%	↘	10.58%

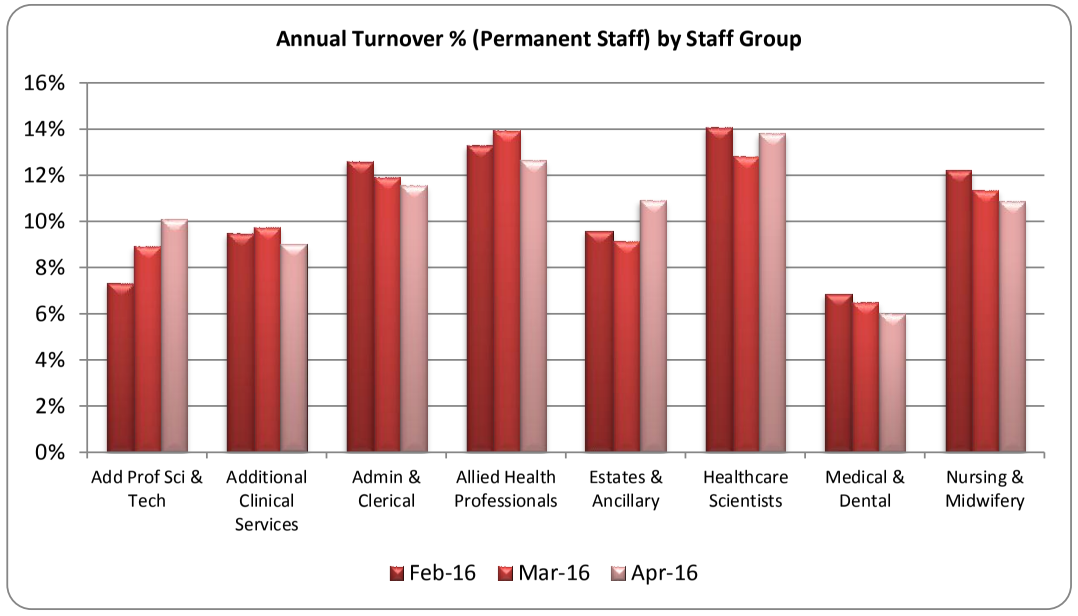


CAPACITY
Turnover by Staff Group

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	Feb-16		Mar-16		Apr-16
Add Prof Sci & Tech	7.31%	↗	8.93%	↗	10.10%
Additional Clinical Services	9.47%	↗	9.76%	↘	8.99%
Admin & Clerical	12.61%	↘	11.92%	↘	11.58%
Allied Health Professionals	13.29%	↗	13.94%	↘	12.66%
Estates & Ancillary	9.57%	↘	9.14%	↗	10.93%
Healthcare Scientists	14.10%	↘	12.83%	↗	13.82%
Medical & Dental	6.84%	↘	6.51%	↘	6.02%
Nursing & Midwifery	12.21%	↘	11.34%	↘	10.87%



With effect from 1 April 2016, a new directorate level organisation was created within the Clinical Support Services Division, which comprised Infection Prevention & Control, Research & Development, Medical Education, Nutrition, and Clinical Support Services Management.

Capacity: Substantive Workforce Capacity increased by 8.81 FTE in April 2016 to 4270.80 FTE. The Trust's substantive workforce is at 90.02% of the Budgeted Workforce Establishment of 4744.05 FTE.

Staff Turnover: Annual Trust turnover decreased by a further 0.22 to 10.58% in April which is above the Trust target of 8%. Turnover within Nursing & Midwifery decreased by 0.47% to 10.87%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust. Turnover also decreased in all other staff groups with the exception of Additional Professional Scientific & Technical, Estates & Ancillary and Healthcare Scientists.

Medical Division: turnover decreased to 11.26%
Surgical Division: turnover decreased by just 0.21% to 9.06%
Women, Children & Oncology Division: turnover decreased by 0.41% to 10.08%
Clinical Support Services Division: turnover increased by 0.04% to 9.18%
Support Services: turnover increased from 12.70% to 13.56%

Staff Vacancies: The vacancy rate within the Additional Clinical Services staff group decreased slightly in April from 8.59 to 7.27%. The vacancy rates for all other staff groups increased this month with the biggest increase being in the Estates & Ancillary staff group which went increased from 14.31 to 19.63%. The Registered Nursing & Midwifery vacancy rate increased slightly from 11.36% to 11.60%.

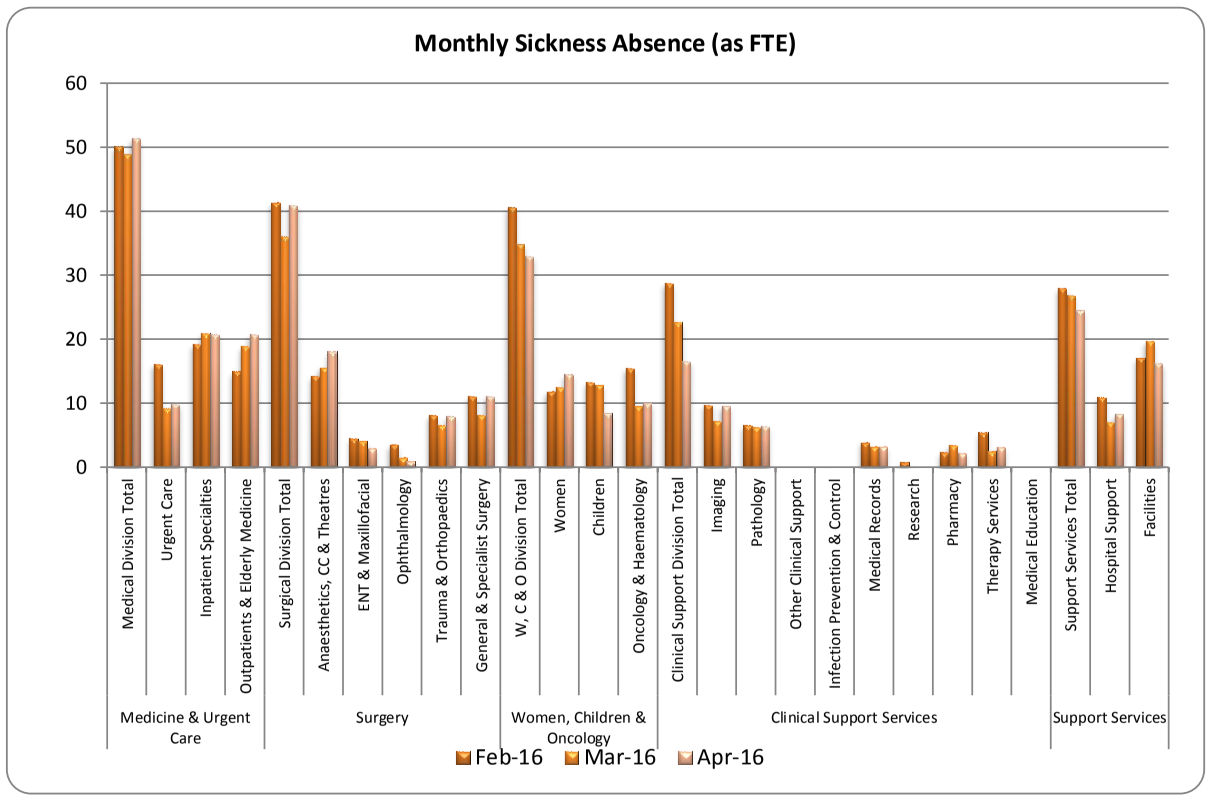
Sickness Absence: In month sickness absence increased by 0.14% to 4.11% which is above the Trust target of 3.8%. The Medical and Surgical Divisions were above the trust target. In total 7 directorate level organisations were below the trust

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

CAPACITY
In-Month Sickness

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

Monthly Sickness (as FTE)		Feb-16	Mar-16	Apr-16	Apr-16	Short Term	Long Term
Medicine & Urgent Care	Medical Division Total	50.19	48.90	51.40	5.08%	2.75%	2.34%
	Urgent Care	16.05	9.16	9.81	3.91%	2.01%	1.91%
	Inpatient Specialties	19.20	20.89	20.88	4.61%	2.56%	2.06%
	Outpatients & Elderly Medicine	14.93	18.85	20.77	6.76%	3.64%	3.12%
Surgery	Surgical Division Total	41.38	36.06	40.99	3.95%	2.16%	1.78%
	Anaesthetics, CC & Theatres	14.24	15.64	18.02	4.60%	3.06%	1.54%
	ENT & Maxillofacial	4.53	4.04	2.98	3.15%	1.07%	2.08%
	Ophthalmology	3.51	1.61	0.88	1.06%	0.58%	0.48%
	Trauma & Orthopaedics	8.09	6.53	8.01	4.32%	1.98%	2.33%
	General & Specialist Surgery	11.08	8.09	11.06	3.98%	1.90%	2.08%
Women, Children & Oncology	W, C & O Division Total	40.66	34.84	32.92	3.80%	2.27%	1.53%
	Women	11.91	12.46	14.44	4.04%	2.36%	1.68%
	Children	13.32	12.90	8.44	3.09%	2.06%	1.03%
	Oncology & Haematology	15.51	9.47	10.04	4.29%	2.41%	1.88%
Clinical Support Services	Clinical Support Division Total	28.83	22.59	16.54	2.76%	2.76%	1.51%
	Imaging	9.77	7.18	9.56	5.79%	3.92%	1.87%
	Pathology	6.52	6.21	6.41	4.18%	2.25%	1.93%
	Other Clinical Support	N/A	N/A	0.00	2.68%	2.68%	0.00%
	Infection Prevention & Control	0.07	0.00				
	Medical Records	3.97	3.22	3.30	5.33%	2.62%	2.70%
	Research	0.79	0.11				
	Pharmacy	2.30	3.40	2.25	2.22%	1.43%	0.79%
	Therapy Services	5.40	2.49	3.18	3.76%	3.15%	0.61%
	Medical Education	0.00	0.00				
Support Services	Support Services Total	28.01	26.87	24.55	3.25%	2.25%	1.00%
	Hospital Support	10.88	7.09	8.33	2.38%	1.56%	0.81%
	Facilities	17.08	19.72	16.21	4.00%	2.83%	1.17%
Trust Total	*As FTE*	188.96	169.20	175.53			
	As percentage	4.44%	3.97%		4.11%	2.42%	1.69%



CAPABILITY
Training & Appraisal Rates

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

Mandatory Training Compliance Rate	Directorate	Feb-16	Mar-16	Apr-16
Medicine & Urgent Care Division	Medical Division Total	80.89%	81.14%	81.30%
	Urgent Care	83.33%	83.09%	82.52%
	Inpatient Specialties	78.30%	78.12%	78.55%
	Outpatients & Elderly Medicine	82.57%	83.88%	84.27%
Surgical Division	Surgical Division Total	84.12%	84.96%	85.78%
	Anaesthetics, CC & Theatres	85.46%	85.72%	85.59%
	ENT & Maxillofacial	78.09%	77.48%	79.00%
	Ophthalmology	88.55%	88.10%	90.59%
	Trauma & Orthopaedics	81.08%	83.25%	85.02%
	General & Specialist Surgery	84.73%	86.46%	87.23%
Women, Children & Oncology Division	W, C & O Division Total	84.91%	86.23%	86.11%
	Women	85.41%	86.59%	84.49%
	Children	85.91%	88.10%	88.92%
	Oncology & Haematology	82.74%	83.23%	84.57%
Clinical Support Services Division	Clinical Support Division Total	86.72%	87.06%	88.91%
	Imaging	85.90%	85.96%	89.13%
	Pathology	80.74%	82.16%	84.12%
	Other Clinical Support			92.06%
	Infection Prevention & Control	87.50%	90.28%	
	Medical Records	87.39%	87.28%	89.47%
	Research	88.07%	90.60%	
	Pharmacy	93.97%	94.07%	94.11%
	Therapy Services	87.97%	87.17%	88.77%
	Medical Education	100.00%	100.00%	
Support Services	Support Services Total	84.21%	84.13%	85.04%
	Hospital Support	84.77%	83.32%	83.68%
	Facilities	83.78%	84.74%	86.07%
Trust Total		**83.93%**	**84.50%**	**85.13%**

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

CAPABILITY
Training & Appraisal Rates

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

Role Specific Training Compliance Rate	Directorate	Feb-16	Mar-16	Apr-16
Medicine & Urgent Care Division	Medical Division Total	68.93%	69.41%	70.42%
	Urgent Care	70.20%	70.53%	73.38%
	Inpatient Specialties	64.73%	66.28%	66.18%
	Outpatients & Elderly Medicine	73.83%	72.89%	73.70%
Surgical Division	Surgical Division Total	73.03%	73.20%	71.80%
	Anaesthetics, CC & Theatres	76.01%	74.84%	73.82%
	ENT & Maxillofacial	64.70%	63.80%	61.50%
	Ophthalmology	71.75%	71.01%	69.28%
	Trauma & Orthopaedics	70.32%	71.99%	71.55%
	General & Specialist Surgery	73.47%	75.01%	72.51%
Women, Children & Oncology Division	W, C & O Division Total	76.52%	77.89%	76.83%
	Women	75.28%	77.21%	73.26%
	Children	78.22%	79.73%	81.87%
	Oncology & Haematology	76.86%	76.52%	77.83%
Clinical Support Services Division	Clinical Support Division Total	83.55%	83.89%	84.60%
	Imaging	80.83%	81.89%	82.74%
	Pathology	76.58%	77.23%	77.89%
	Other Clinical Support			79.27%
	Infection Prevention & Control	78.00%	84.00%	
	Medical Records	89.19%	86.84%	92.21%
	Research	71.43%	75.00%	
	Pharmacy	87.42%	87.74%	89.83%
	Therapy Services	90.03%	88.73%	87.93%
	Medical Education	100.00%	100.00%	
Support Services	Support Services Total	69.58%	69.81%	69.40%
	Hospital Support	69.25%	69.21%	69.09%
	Facilities	70.04%	70.61%	69.82%
Trust Total		**73.43%**	**74.04%**	**73.70%**

CAPABILITY
Training & Appraisal Rates

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

Appraisal Compliance Rate	Directorate	Feb-16	Mar-16	Apr-16
Medicine & Urgent Care Division	Medical Division Total	80.85%	77.96%	76.65%
	Urgent Care	89.33%	84.34%	82.87%
	Inpatient Specialties	75.57%	73.16%	71.93%
	Outpatients & Elderly Medicine	80.88%	79.18%	77.92%
Surgical Division	Surgical Division Total	89.33%	91.16%	91.16%
	Anaesthetics, CC & Theatres	88.28%	91.51%	89.89%
	ENT & Maxillofacial	85.90%	83.33%	85.90%
	Ophthalmology	90.54%	94.67%	96.00%
	Trauma & Orthopaedics	92.00%	94.32%	93.22%
	General & Specialist Surgery	89.45%	90.04%	91.92%
Women, Children & Oncology Division	W, C & O Division Total	82.73%	83.86%	84.81%
	Women	80.10%	83.42%	82.59%
	Children	84.13%	84.87%	89.74%
	Oncology & Haematology	85.96%	83.76%	83.19%
Clinical Support Services Division	Clinical Support Division Total	83.00%	83.91%	84.96%
	Imaging	72.99%	75.29%	78.74%
	Pathology	92.31%	92.55%	88.82%
	Other Clinical Support			82.50%
	Infection Prevention & Control	50.00%	50.00%	
	Medical Records	77.03%	84.21%	87.01%
	Research	80.00%	79.17%	
	Pharmacy	94.07%	92.37%	93.16%
	Therapy Services	80.41%	78.35%	79.17%
	Medical Education	100.00%	100.00%	
Support Services	Support Services Total	65.05%	72.58%	76.28%
	Hospital Support	68.00%	66.23%	66.05%
	Facilities	62.87%	77.30%	83.93%
Trust Total		**80.23%**	**81.89%**	**82.71%**

Capability

Appraisals
The current rate of Appraisals recorded for April 2016 is 82.71%; this is a further improvement following the dip in February but does not take the figure back to the January high point of 83.29%.

Mandatory Training and Role Specific Essential Training
Mandatory Training compliance increased slightly in April from 84.5% to 85.13% to reach the Trust target of 85%.

Role Specific Essential Training compliance decreased slightly in April to 73.70%, this was mainly due to Blood Training competence requirements being changed this month.

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.

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 May 2016**

Title of the Report	**Sustainability and Transformation Plan Update**
Agenda item	**14**
Presenter of Report	Chris Pallot, Director of Strategy and Partnerships
Author(s) of Report	Chris Pallot, Director of Strategy and Partnerships
Purpose	This paper is presented to the Board to inform and update members on progress made towards delivering the Plan.
Executive summary This paper largely replicates the most recent update provided to the Sustainable Transformation Plan (STP) Board and is provided to ensure consistency of message across all organisations. Additions in this version include the overall governance framework for delivery of the STP and additional detail on the acute transformation element.	
Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? All
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks: No
Related Board Assurance Framework entries	
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/

Enclosure I

	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)?(Y/N)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper: No
Actions required by the Trust Board The Board is asked to note the update	

Northampton General Hospital NHS
NHS Trust

Public Trust Board
26th May 2016
Sustainability and Transformation Plan Update

1. Update on Progress

This paper largely replicates the most recent update provided to the Sustainability & Transformation Plan (STP) Board and is provided to ensure consistency of message across all organisations. Additions in this version include the overall governance framework for delivery of the STP and additional detail on the acute transformation element.

The purpose of the STP is for 'every health and social care system to come together, to create its own ambitious local blueprint for accelerating its implementation of the Forward View'. The emphasis is on developing a plan that meets the needs of local populations and is not focused on individual organisations. STPs' scope includes health, local government and voluntary organisations (where appropriate) within the locality. STPs require strong local leadership and the appropriate governance structures.

Fundamentally, the STP must demonstrate how the '…NHS locally will balance its books'. The guidance makes clear that the STP process will be the single way that organisations are accepted onto programmes for transformational funding from 2017/18 onwards. The guidance also makes it clear that the 'most compelling and credible' STPs will receive the earliest additional funding from April 2017 onwards.

The STPs are expected to address 'national challenges' set out in the guidance, but the emphasis is on creating a clear vision and plan for the area and answering the following:

- How will you close the health and well-being gap?
- How will you drive transformation to close the care and quality gap?
- How will you close the finance and efficiency gap?

'Local health systems' will be required to 'develop their own system wide local financial sustainability plan as part of their STP'. It is expected that these plans cover both commissioners and providers and will set out plans for 'demand moderation, allocative efficiency, provider productivity and income generation required for the NHS locally to balance its books'.

2. Transformation Footprints

The geographical area covered by the STP is called the 'transformation footprint'. Locally, this has been discussed at two systems leader's workshops covering the two CCGs, NCC, three main NHS providers and four GP 'federations/super practices'. It was been agreed that the process would be developed on a Northamptonshire Health and Social Care County basis but with links to other health economies for tertiary services and building up for the local communities on a GP Federation template. This footprint has been agreed by NHS England.

Work is now underway to develop a detailed project plan, delivery framework and governance structure to ensure submission of a system wide plan by 30th June 2016. This will require significant work and resourcing and will need to involve all health and social sector organisations along with key public, patient and voluntary sector involvement and engagement. This will build on the work undertaken through the Healthier Northamptonshire programme and will be an opportunity to refresh and re-invigorate a number of elements of that work.

Enclosure I

3. Assurance

The programme governance structure is included at appendix 1

For additional assurance the CCG has also established a STP Lay Scrutiny Group the functions which are:

- Provide the multi-organisational lay member scrutiny to the STP delivery group and STP Board
- Provide assurance that the STP plans meet the national criteria that includes full public and patient consultation
- Provide assurance that the STP plans are developed and agreed by the national timescale
- Provide assurance that all participant Boards are fully engaged in the STP process

The Operations Delivery Group meets on a fortnightly basis to ensure the STP development is progressing against the project plan. The group is represented by all health and social care partners including the GP federations.

3.1 Activity and Capacity update

The activity and capacity group had its first meeting week commencing 4th April 2016. External facilitation has been secured to provide a system wide oversight of the activity and capacity group to ensure consistency and robustness of assumptions and numbers across the system. Initial work is ongoing to establish an agreed activity baseline to model forward.

This group will need to work with all streams of the organisation and;

- Establish a clear system wide activity and capacity baseline
- Model the impact of demographic and other factors affecting activity going forward
- Identify impact of potential pathway developments and efficiencies on future activity flows
- Stress test forward assumptions to identify sensitivity of plans
- Develop a system wide capacity map to ensure alignment of activity assumptions to activity plans

The group will need to liaise closely with all other work-streams and will play a key in role in ensuring the integrity and robustness of the overall STP.

3.2 Workforce

It has been recognised that the major challenge to delivering our system priorities is having the right capacity and capability in the workforce, working in the right location. To inform our local system planning it has been decided to utilise an approach to strategic workforce planning known as SWiPe that has been developed by Whole Systems Partnership (WSP).

The framework supports local partners to bring together the anticipated changes in the composition of the local population with the planned outcomes of the proposed service transformation and to test out how this might affect the workforce required in the future. It does this by helping to source data, undertake appropriate analysis and system dynamics modelling so as to provide a strategic tool to help answer some critical questions in respect of workforce planning.

Following two initial workshops, WSP are continuing to gather and check data then collate it and populate the SWiPe tool framework in a way that reflects the strategic system redesign required and options available for achieving the required workforce capacity and capability. A final workshop will take place where WSP will demonstrate the model and test the scenarios with input from participants in both the previous workshops. WSP will produce a draft report and any supporting material for the appropriate Programme Board and WSP will present findings to STP Clinical Advisory Group Meeting.

Health Education England have produced a presentation that refers to the creation of new workforce boards to support the STP – these are fixed points. There is work to do to determine the

governance between these and the LETBs and also how the LETCs feed in. Dr Sonia Swart will be working with David Farrelly and Gerry McSorley to clarify the governance arrangements and will let us know when more information emerges. A possible outcome is that we should have one workforce group that picks up all the necessary functions and is aligned to the needs identified as part of the STP. There is a need to acknowledge that overall the HEE budget and hence the LETC funding is reduced significantly.

3.3 Information Technology

The development of the local digital roadmap (LDR) will support the delivery of the STP and is due for submission on 30.6.16. It is expected to include a 5 year vison for digitally enable transformation, a schedule for enabling capability for clinicians to be paper-free (see attached slide), universal capabilities to make best use of national datasets and information sharing agreements.

The group e-share Northants has been created. So far this has worked on information sharing agreement and understanding the requirement to develop the LDR.
To have an effective LDR will require some dedicated resource.

Some additional senior support is being sourced to support this work-stream.

3.4 Estates

Meetings will be held to establish a lead for the capital group which will comprise of Estates representatives from each organisation. Two key work streams will arise from this.

- Review existing estate strategies for all organisations to establish a system wide baseline of current estate stock and the challenges that align to keeping that fit for purpose
- Receive the outputs from the other work-streams to outline how the estate needs to be adapted, changed or created to meet the delivery of future plans
- Develop an estate disposal plan to ensure early release of savings

3.5 Clinical Oversight

The clinical oversight group will be developing a set of criteria to assess changes planned by the STP. The suggested criteria are broadly:-

- Does this meet clinical quality standards present and emerging?
- What will the overall workforce implications be?
- Does this acknowledge and address health inequalities?
- Is it clinically coherent?
- Does it support acute modernisation and out of hospital strategy, across the four pillars of the STP (urgent care, primary care, complex patients and integration)?

The group has senior medical leaders from all organisations, including the federations. This membership will be similar to the previous clinical leaders group.

This group will largely be reactive to the STP process, so there needs to be a wider engagement of clinical leaders within the health economy and it is suggested that this is done by a facilitated session, which focuses on the priorities for the health economy.

3.6 Finance

The finance group has now been established and has met twice to consider the calculation of the financial challenge and an update will be given at the STP Board meeting. The group is worked towards the initial 15th April submission and will be working as an integrated finance team to support the development of system wide solutions after this date for the final STP submission.

3.7 Communications

A communications workshop was held in April 2016 to agree the framework for communication of the STP during development process and beyond. It is anticipated that some additional resource will be required until July 2016 to support this.

4.0 The Outputs

There are three strands to the development of the STP. The update from each work-stream as at 17 May 2016 is listed at appendix 2.

The work-streams are:

- Programme management office – the focal point for overseeing the programme
- Multi-Speciality Community Provider – the focus around development of the GP Federations and their integration with other providers (most notably NHFT) to offer alternatives for urgent care provision through the development of a sustainable and vibrant primary care sector in Northamptonshire.
- Acute Hospital Transformation

4.1 Acute Hospital Transformation

This work-stream will deliver two key outputs:

1. The vision for acute hospital transformation that will form the basis of collaborative work between NGH and KGH now, and into the future

2. A review of 10 specialities at both NGH and KGH to ascertain the opportunities for collaboration including options for single, countywide services where appropriate (note: a single service does not mean a single site. It means collaboration between the Trusts but with a focus on maintaining localism)
3. The services being reviewed are:
    a. Rheumatology
    b. Orthopaedics (initially MSK services)
    c. Dermatology
    d. Cardiology
    e. Radiology
    f. Ophthalmology
    g. Pathology
    h. ENT
    i. Gynaecology
    j. Urology

Further updates will be provided to the Board as they become available.

Appendix 1


Governance Structure.docx

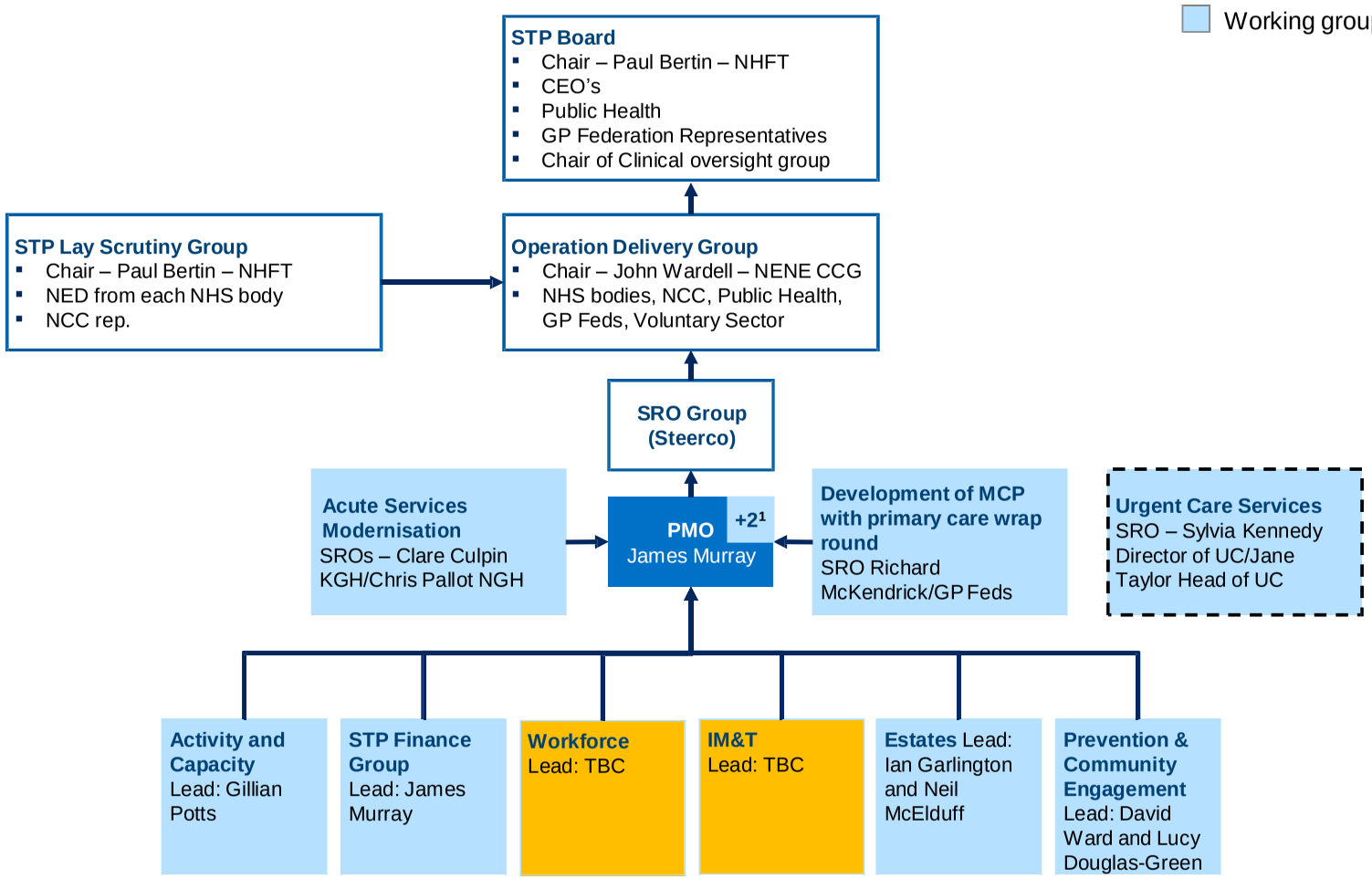
Appendix 2


Item 4- MCP Update.pptx


Item 5- Acute Services update.pptx


Item 6- PMO update.pptx

The governance structure



Northamptonshire Sustainable Transformational Plan for the Health and Social Care System
MCP Update

17th May 2016

STP Board update

Presented by Richard McKendrick

Update on Multi Specialty Community Provider (MCP)

We are building MCP models around four pathways:

1

Urgent Care

- New model for same day access to primary care

2

Complex care

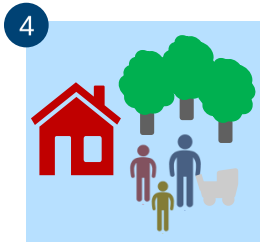
- Extensivist approach to managing people with Long-term Conditions

3

Scheduled care

- Collaboration between primary and secondary care to deliver specialist care closer to home

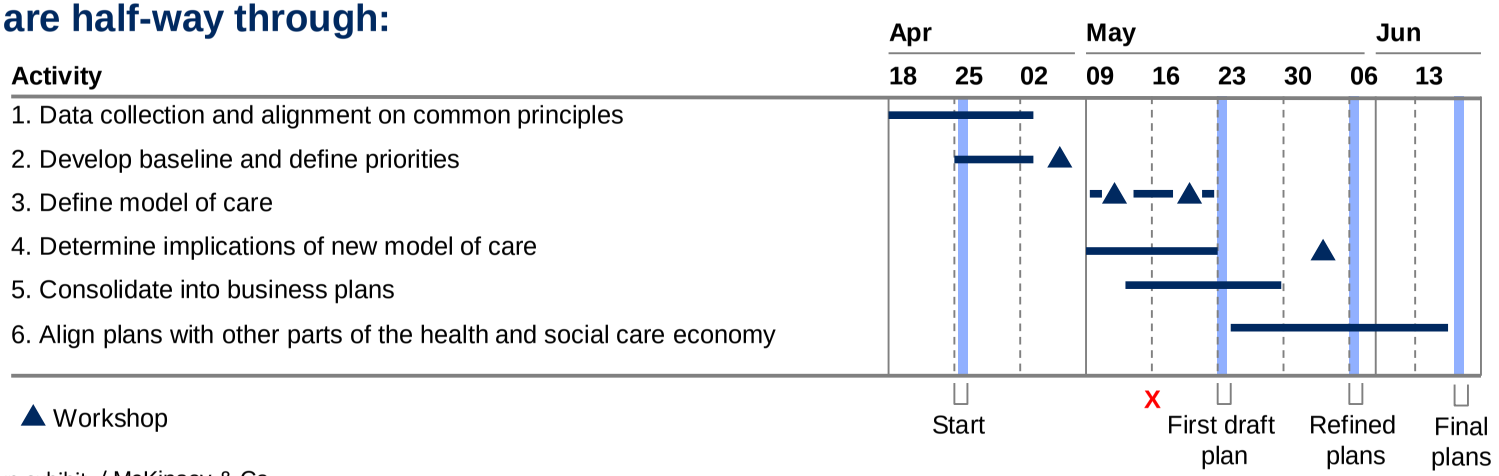
4



Prevention and wellbeing

- Asset based approach to building resilient communities

We are half-way through:



SOURCE: Own exhibit / McKinsey & Co.

Week 2 progress update – MCP workstream

Workstream owner: Richard McKendrick with support from McKinsey

✓ On track ✓ Some work needs to be done ✓ Significant concerns

Deliverables	Current status	On track?	Next steps	Completion date
Data collection and alignment on common principles	▪ Joint workshop on 4th May to align on common principles (population segmentations and prioritised interventions)	✓	▪ Access patient level data from GEM ▪ Get access to assumptions on activity data (by each type of workforce and patient group)	▪ 27th April
Develop baseline and define priorities (for each federation)	▪ Analysing data provided on Monday from GEM for patient segmentation, only accessible from onsite computer ▪ Awaiting granular workforce, estate and activity baseline data to be created	✓	▪ Collect baseline data from Giles West, Ian Garlington and Gillian Potts and split for each federation ▪ Make assumptions on workforce cost and catagorisation across primary care ▪ Develop comprehensive baseline	▪ 10th May
Define model of care (for each federation)	▪ Fully aligned on the current progress of model of care design for each Fed. ▪ Richard Smith organising logistics of model of care workshops	✓	▪ Define model of care assumptions that remain consistent across Federations ▪ Share population segmentation and baseline with Federations	▪ 20th May
Determine implications of new model of care (by Fed.)	▪ Awaiting input data from joint workshop and individual federation workshops ▪ Collecting cost assumptions	✓	▪ Richard Smith to confirm date of second workshop for each Federation ▪ Develop financial model based on model of care workshop input	▪ 23rd May
Consolidate into business plans (by Fed.)	▪ Proposed an MCP business plan structure	✓	▪ Create 5 year roadmap for each Federation ▪ Agree and iterate business plans across Federations	▪ 26th May
Align plans with other parts of the health and social care economy	▪ Progress dependent on business plans developed on 26th May	✓	▪ Align plans with other parts of the health and social care economy ▪ Make final edits to business plans	▪ 10th June

Northamptonshire Sustainable Transformational Plan for the Health and Social Care System
Hospital Transformation Update

17th May 2016

STP Board update

Presented by Clare Culpin

Update on Hospital Transformation

- We are working on the following specialities; Rheumatology, Dermatology, Radiology, Ophthalmology, Cardiology, Orthopaedics, Genealogy, ENT, pathology and Urology.

- Business Cases have been developed for MSK and Rheumatology with dermatology following in June the proposal of the cases is to have a countywide service.

- Data analysis on each of the specialties is being gathered and analysed for the STP.

- Clinical Engagement is taking place with each of the clinical leads within each of the trusts.

- Public and patient engagement has taken place with Dermatology and Rheumatology.

Week 2 progress update – Acute services

Workstream owner: Clare Culpin Chris Pallot with support from McKinsey

✓ On track ✓ Some work needs to be done ✓ Significant concerns

Deliverables	Current status	On track?	Next steps	Completion date
Launch project and understand current position	▪ Clinical collaboration group meetings attended for rheumatology (10/5) and dermatology (11/5) ▪ Drop-in gallery walk / workshop for broader clinician team logistics finalized and invite sent out for May 18/19	✓	▪ Set up shared folder for remote access to files	▪ May 13
1. Progressing Northamptonshire Clinical Collaboration through the STP	▪ Data received from Trusts; preliminary analyses conducted ▪ Interviews scheduled with 16/20 leads, interviews conducted with 11/20 leads ▪ Trust/NHS benchmarking completed for 25 metrics across 10 specialties; additional benchmarking underway at Trust level ▪ First draft of deliverables complete for elective orthpaedics, ENT, cardiology ▪ Inputs for rheumatology collaboration meeting prepared	✓	▪ Complete interviews with clinical leads ▪ Progress deliverables for remaining 6 workstreams ▪ Develop overarching storyline for acute modernization at a two-trust/county level ▪ Liaise with MCP team to understand linkages between workstreams	▪ Ongoing till May 17
2. Creating organizational alignment	▪ Meetings scheduled with McKinsey leadership and Trust CEO's ▪ Meetings scheduled with McKinsey leadership and Trust DoF's	✓	▪ NA	▪ CEO meeting: May 17 ▪ DoF meeting: May 19
3. Implementation and enablers	▪ Mapping of enablers needed for each specialty initiated ▪ Next steps / plans being finalized for each workstream in progress	✓	▪ Identify case examples of enablers for selected service lines	▪ Ongoing till May 17

Northamptonshire Sustainable Transformational Plan for the Health and Social Care System

PMO update to the STP board

17th May 2016

Contents

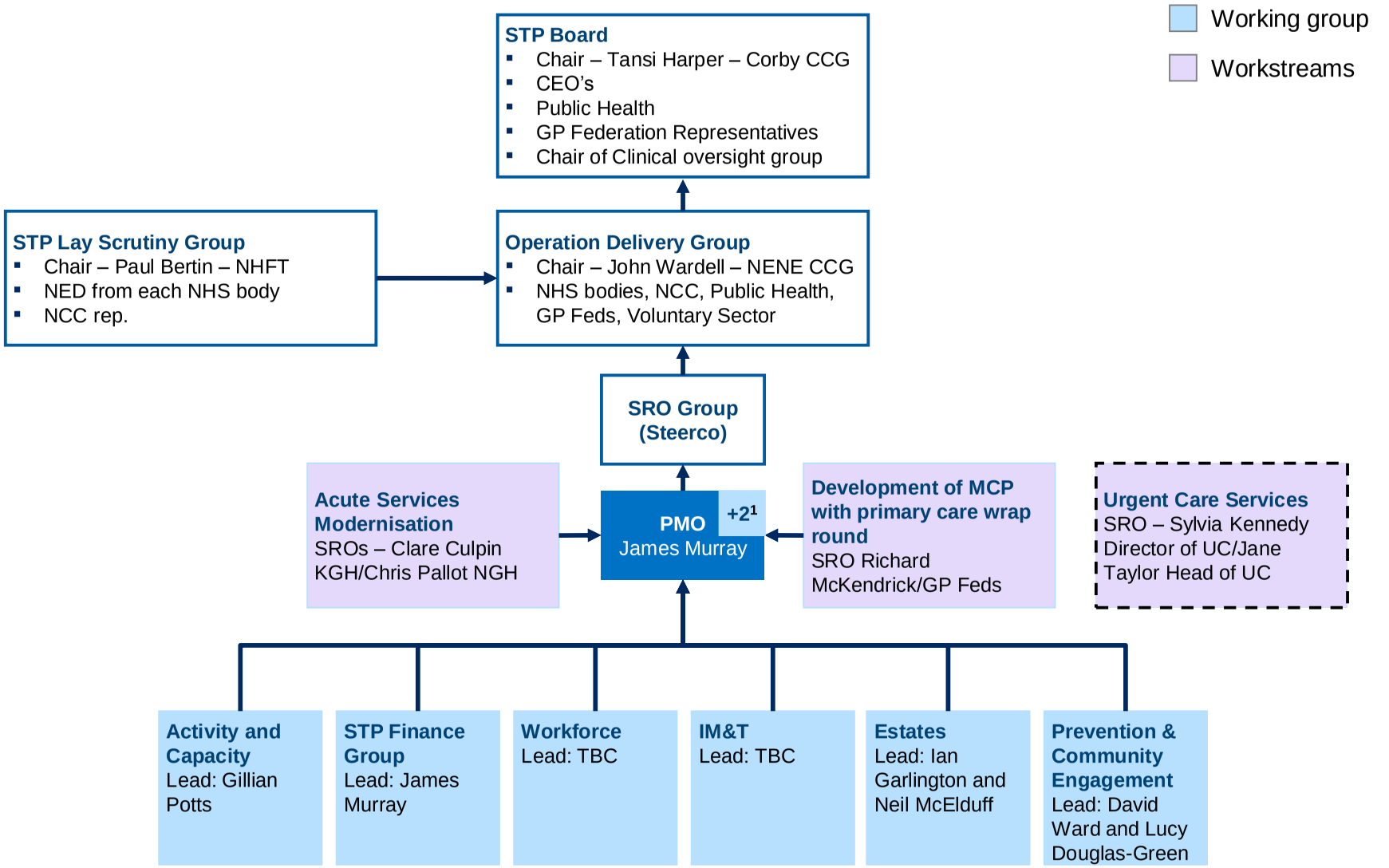
A proposed structure for the STP submission has been created based on feedback from the April submission and further NHS guidance

PRELIMINARY

Section	Description	Example content
Vision statement	▪ A comprehensive vision for how the integrated healthcare system will work in Northamptonshire in 2021 ▪ This will combine the plans of each Federation, Trust and other health bodies to set out a consistent vision across NHFT ▪ This will emphasise the patient experience as they move through the system and their care journey	▪ "To create a 7 days a week wrap around care led by GPs, where everyone will be able to access a qualified medical officer within 24hrs"
Sizing the gap	▪ A projection for the size of the health & wellbeing, care & quality, and financial & efficiency gaps in 2021 once demographic and health projections are included ▪ This will also detail the current provision, provider landscape, real estate, WTE breakdown, use of IT, and projected health priorities of the population across this time frame	▪ KPIs can be used to detail the quantitative value for current practice and benchmark this against both national standards, and an aspirational level
Transforma-tion plan and key themes/enab lers	▪ 'Programs' will be detailed to bridge the gap and reach the 2021 vision for healthcare in Northamptonshire ▪ Each 'line of action' will be composed of actionable projects that can be assigned to an SRO to lead to jointly target the three healthcare gaps ▪ Highlighting the key enablers and themes that run through as the base of all three models of care and how they achieve the 2021 vision	▪ E.g. 'Program 1' to focus on preventing L-T heart conditions – Project 1: Improve early detection – Project 2: Support at risk groups – Project 3: Self-care to through better informed choices
Impact analysis	▪ Measuring the impact of each 'line of action' on the health & wellbeing, care & quality, and financial & efficiency gaps. ▪ This will also detail the impact on CCGs, acute care, primary care and the culture and mindsets within the practices ▪ Most importantly it will also follow the patient experience and how different conditions will be supported through the health system	▪ E.g. 'Program 1' will : – Reduce the financial gap by £12m in year 1 and £35m by 2021 – Improve H&W by…. – Improve C&Q by… – The customer experience will be...
Transition funding and execution plan	▪ The operation plan over the next 5 years broken into clear actions with a defined SRO, resource allocation (financial, capital and WTE) and checkpoints of progress (milestones to be achieved) ▪ It will also detail both the list of enablers needed and what further support and funding will be required from the NHS. This includes a clear itemised application for transition funding	▪ Key milestones and KPI targets established at set points along the timeline ▪ The cadence of meetings will then be used to support each SRO in ensuring their projects are on track

SOURCE: McKinsey team analysis

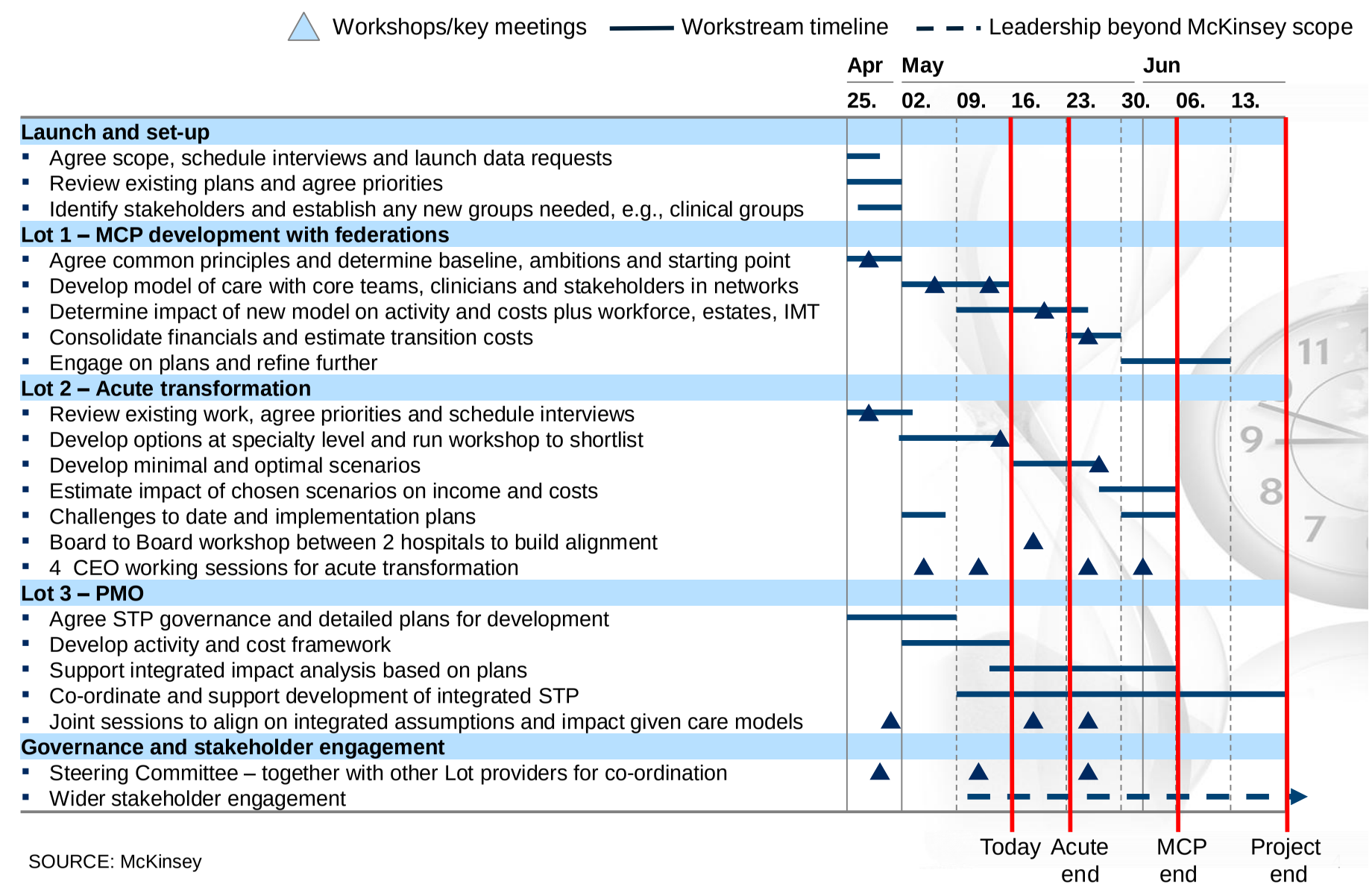
The governance structure has been adjusted to include a specific 'Urgent Care Services' workstream



1 This includes two additional advisory groups: 'communications and engagement' led by Kelly West and 'clinical oversight' led by Matthew Davis

SOURCE: Northamptonshire's Sustainability and Transformation Plan (Apr. 16)

We are moving into week four of the project's eight week timeline



SOURCE: McKinsey

Contents

Progress update – PMO workstream

Workstream owner: James Murray (with support from McKinsey)

✓ On track ✓ Some work needs to be done ✓ Significant concerns

Deliverables	Current status	On track?	Next steps	Completion date
Launch project and understand current position	▪ STP guidance reviewed and collated ▪ Proposed structure for submission has been constructed and leads assigned ▪ Cadence and foci of meetings agreed	✓	▪ Communicate proposal with the wider governing bodies to gain alignment and refine the initial structure	▪ 2nd May
Agree STP governance and reporting	▪ WG operation, meeting cadence and comms structure has been agreed ▪ A set of deliverables has been shared ▪ No group lead in place for IM&T and Workforce	✓	▪ Confirm leads for the Workforce WG ▪ Put additional support in place to support the 'IM&T' and 'Prevention' WG ▪ Align remaining groups on deliverables	▪ 6th May
Regular reporting and updates to the Steerco	▪ Communication template has been shared amongst all groups ▪ Ensure consistent use and sharing of this template	✓	▪ Create opportunities for the WG to share their findings with the wider Steerco group	▪ Ongoing until 17th June
Develop activity and finance framework	▪ The first level of the activity and finance framework has been built ▪ Template due to be sent out by NHS England over next two weeks	✓	▪ Plan for including Non-demog. growth ▪ Meet with workstream leads for their contribution to the finance document ▪ Set financial target for workstreams	▪ 27th May
Co-ordinate development of the STP	▪ Clear deliverables have been devised for the WG that support the model of care develop. and STP submission ▪ Deadlines and milestones have been shared and aligned	✓	▪ Support WG's development of output with targeted 1-2-1 working sessions ▪ Coordinate with Lot 1 and 2 to focus outputs on STP demands ▪ Align with the Urgent Care workstream	▪ Ongoing until 17th June
SteerCo meetings and engagement	▪ Comms template has been developed and shared with the key partners. ▪ Newsletter first draft will be ready to go out this week	✓	▪ Create contact email for stakeholder questions to form FAQs in 2nd newsletter ▪ Patient engagement workshop has been planned for the 26th May	▪ Ongoing until 17th June

Contents

Progress update – Prevention, community engagement and patient activation

Workstream owners: David Ward and Lucy Douglas-Green

✓ On track ✓ Some work needs to be done ✓ Significant concerns

Deliverables	Current status	On track?	Next steps	Completion date
Building a baseline for Prevention	▪ Currently building the descriptors for the current and projected landscape based around the "6 principles of engagement" ▪ Prevention section yet to be fully defined, but joint-lead now assigned	✓	▪ Meeting with Public Health to align on a baseline for prevention Friday 13th ▪ Identify regional/national best practice to benchmark	▪ 13th May ▪ 20th May (deep-dive)
Measuring the impact	▪ Identified some sources of local information	✓	▪ Need to develop a 'complete' set of measures against the elements of the current baseline and projected vision ▪ Need to test what is needed, and what works for the plan against what's available	▪ 27th May
A review of productivity opportunities	▪ Being captured within Building the landscape above piece	✓	▪ Compile document ready to be shared with the wider team	▪ 13th May
Communications	▪ Completed and shared with the working group	✓	▪ Main issue has been in understanding the format and needs of the plan and translating our vision into the given format ▪ Clear issues around understanding what the sector does, and what's commissioned	▪ 5pm each Monday
Sharing your expertise	▪ Meeting with NCC to coordinate with Public Health, Social Care and Children's services on Tue 10th	✓	▪ Increase availability for key working group meetings and STP alignment sessions ▪ Present back to the Steerco on Wed 10th	▪ As required

Progress update – Activity and capacity

Workstream owners: Gillian Potts

✓ On track ✓ Some work needs to be done ✓ Significant concerns

Deliverables	Current status	On track?	Next steps	Completion date
Building a baseline for A&C	▪ Large data gaps and requests still pending: – SSD and NHFT collecting social services and primary care data – CSU, NGH and KGH collecting non-demographic growth trends and sharing statement of capacity – Gaps in maternity data to be resolved ▪ Uploaded initial files to BOX	✓	▪ Meet with SSD to extract data and agree their contributions to capacity and trends – timescale is the worry ▪ Working session this Thursday to align on non-demographic growth calculation ▪ Align on output format for the STP submission with PMO team ▪ Work with the wider A&C team this week to support align on work development	▪ 13th May
Measuring the impact	▪ Flexibility is being built into the model to allow for easy calculation of impact once model of care inputs have been aligned	✓	▪ Need to agree: – occupancy assumptions – Non-demographic trends	▪ 27th May
Communications	▪ Communications set-up and regular feedback established to the WG. ▪ Communication with MCP in preparation for their workshop	✓	▪ Prepare presentation to present back findings to the Steerco on the 18th May	▪ 5pm each Monday
Sharing your expertise	▪ Provided patient-level data and analysis to support the MCP with their stratification of patients ▪ Will attend the Steerco on 18th May to present back initial results from activity analysis	✓	▪ May need to support the stratification analysis with the MCP workstream	▪ As required

Progress update – Estates

Workstream owners: Ian. Galington and Neil McElduff

✓ On track ✓ Some work needs to be done ✓ Significant concerns

Deliverables	Current status	On track?	Next steps	Completion date
Building a baseline for Estates	▪ Data collection baseline template and deliverables designed and agreed with PMO ▪ Template circulated for completion	✓	▪ Collect data templates this week week and follow up with outstanding requests ▪ Uploading of returns to database ▪ Analysis / report on baseline ▪ Workshop materials to be distributed	▪ 13th May ▪ 17th May (deep-dive)
Measuring the impact	▪ Preparing baseline with the foresight to make later adjustments based on the development of the model of care	✓	▪ Work with the MCP and Acute team to interpret their model of care and impart the results onto the baseline we have developed	▪ 27th May
A review of productivity opportunities	▪ Compiling ideas for the productivity and idea generation template	✓	▪ Collate those ideas onto the template so they can be shared with the wider STP team	▪ 13th May
Communications	▪ Communications set-up and regular feedback established to the WG.	✓	▪ Communicate with the MCP in preparation for their workshop with the Federations ▪ Prepare presentation to present back findings to the Steerco on the 18th May	▪ 5pm each Monday
Sharing your expertise	▪ Will attend the Steerco on 18th May to present back initial results from estates analysis	✓	▪ Make myself available for the 18th May Steerco and the MCP/Acute workstream workshops	▪ As required

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 May 2016**

Title of the Report	**Approval of Annual Report and Annual Accounts 2015/16**
Agenda item	**15**
Presenter of Report	Simon Lazarus, Director of Finance
Author(s) of Report	**Annual Report** Eva Duffy, Communications **Annual Accounts** Derek Stewart, Finance
Purpose	For Approval
Executive summary The Annual Report and Annual Accounts 2015/16 are presented for approval.	
Related strategic aim and corporate objective	All
Risk and assurance	Assurance on the delivery of the trust's strategy, objectives and statutory duties
Related Board Assurance Framework entries	All
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (**Y/**N)
Equality Impact Assessment	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 /	Statutory duties to submit annual report and accounts

regulatory requirements	

Actions required by the Trust Board

The Board is asked to:

The Board is asked to approve the Annual Report and Annual Accounts for 2015/16.

DRAFT ANNUAL REPORT 2015/16

CONTENT TO FOLLOW	WHO WILL SUPPLY
GENDER DISTRIBUTION OF SENIOR MANAGERS	Adam Cragg
REMUNERATION REPORT	TBC

CONTENTS

All NHS organisations are required to publish an annual report and financial statements at the end of each financial year. This report provides an overview of the work of Northampton General Hospital NHS Trust between 1st April 2015 and 31st March 2016.

The report is made up of three parts:

- **Performance report**
  This covers our purpose and activities and includes analysis of our performance, commentary on wider events that have shaped our business and priorities and information about some of the projects we have invested in over the year.

- **Accountability report**
  This section covers details of our structure and governance as well as information about our staff and our remuneration report

- **Financial statements**
  The final section is the publication of our annual accounts

SECTION ONE: PERFORMANCE REPORT

Chairman and Chief Executive's Introduction

Welcome to our 15/16 annual report. This report summarises some of our main achievements and challenges over the last year. It covers our finances and other important measures of our overall performance.

The ongoing challenge to deliver the best possible care for all our patients within our available resources is never an easy one. Not only did we treat more inpatient and day cases than the previous year, but we also saw a significant rise in the number of emergency admission, with patient demand, particularly for emergency service through the winter months, at an all-time high.

The achievement of the A&E four-hour target was significantly impacted by the 4% increase (4,322 patients) in the number of patients attending our emergency department during the year. Our admissions were impacted by delays in discharging our patients who no longer need acute medical care but require support in place before they can safely leave hospital. Nevertheless, across the hospital, throughout a difficult winter, our staff maintained focus on delivering safe compassionate care.

Our estates team had a busy year overseeeing a number of projects designed to improve our buildings and facilities for the benefit of our patients as well as easing pressure on our emergency department. The introduction of our enhanced ambulatory care facilities led to a notable number of patients being treated and discharged on the same day with a four-fold increase in patient capacity for that service. This means we have dedicated facilities for patients who require consultation with our emergency care specialists but aren't unwell enough to warrant attendance at A&E. Similar facilities were previously housed in the emergency department which had capacity to treat 100 patients a month; the new centre allows us to treat up to 400 patients each month.

We also opened a brand new discharge suite to help free up beds on wards and give our patients who are ready to leave hospital a comfortable place to wait while paperwork or prescriptions are processed and while they wait for their transport home. The new area, which has nursing staff, has facilities for up to 20 patients in chairs and four side rooms for patients in beds.

However, we recognise that these and other mitigating actions will not stem the rise in emergency activity, and so during the year we looked at how we could increase our bed capacity. As the financial year drew to a close, we had identified potential for a 60-bed facility located alongside our A&E department.

During the year we moved our very busy blood taking unit into new larger premises including a special waiting area for children with toys and games provided. We extended its opening hours to provide an improved service for patients. Last year we saw 63,000 patients and that's 10,000 more than the year before - so there's no doubt the upgrade was needed to make sure our patients have a good experience.

Turning to finances, despite our best efforts we ended the financial year in deficit. Caring for higher numbers of patients with increasingly complex medical and nursing needs presents enormous challenges for a hospital in one of the UK's biggest growth areas and one of our key priorities is to work with partners locally and the wider NHS economy to look for realistic and sustainable solutions. This takes place alongside our own drive to improve quality and efficiency with over 20 service improvement projects undertaken in the course of the year.

During the year we were affected by a number of national events and developments, the most significant being industrial action taken by junior doctors across the country as part of a national dispute between junior doctors and the government. Four periods of strike action took place in the time period covered by this report during which our overriding concern was to provide safe services to patients. We prepared meticulously, with many staff involved in the contingency planning process that put patient safety at the centre of our response to the situation. What the strikes and our collective response demonstrated is that we have the resources and skills and spirit to deal calmly and competently with emergency situations on an organisational scale.

We gave our support to a national campaign that aims to make the NHS the safest healthcare system in the world. The *Sign up to Safety* campaign asks NHS organisations to deliver a three-year action plan to strengthen patient safety, reduce harm for patients and save lives. The campaign emphasises the importance of listening to patients, carers and staff; and learning from successes and when things go wrong. We signed up to the campaign because it mirrors perfectly what we're aiming to achieve with our in-house patient safety academy: the delivery of harm-free care for every patient; and the championing of a culture of openness and honesty.

We were delighted to welcome Dr Kate Granger, founder of the *Hello My Name Is* ... campaign, to Northampton during the summer. Dr Granger founded the campaign when she was receiving treatment for cancer and noticed that many staff looking after her did not introduce themselves before delivering care. Her visit was an inspiration for all of us delivering care to patients and a reminder of why compassion in care is of utmost importance in building relationships.

As an employer, we took steps to bolster the support we give to our employees, with a particularly popular initiative being the presentation of a commemorative daisy pin badge to our newly-qualified nurses to welcome them to their new role. Newly qualified nurses face many challenges and it's important that they have strong support during that crucial first six months as they make the transition from student to career nurse. The badges are a way of saying thank you to our new nurses who've chosen Northampton General Hospital as the start of their nursing career. They're also a visual prompt for our other staff, patients and visitors that the nurse wearing the badge is new to practice. They'll help us to remember how daunting a new job can be and how the little gestures can make a big difference.

In a year in which we cared for more people than ever before, we had so much to celebrate and the nominations flooded in from members of the public, patients and

staff for our 2015 Best Possible Care Awards - which made shortlisting the entries a very difficult task!

We hold these awards to recognise our employees and volunteers who make an exceptional contribution to patient care – and they took place last year thanks to funding from the Northamptonshire Health Charitable Fund and sponsorship from Arup, Capsticks, Deloitte, HSB, and Simply Business. In the midst of all the discussion around pressures on NHS services, our Best Possible Care Awards are an opportunity to take stock of and celebrate the competence and commitment, the professionalism and pride, the exuberance and enthusiasm that we see every day in every ward and every department.

As well as our own awards, we were delighted that a number of our employees were recognised on the national stage for their exceptional achievements: cconsultant paediatrician Dr Andrew Williams won the WellChild award for best doctor for his "exceptional contribution" to helping sick children; Macmillan lung cancer nurse specialist Lisa Wells won a national award for leadership and innovation in cancer nursing - the Lynn Adams Award presented by the UK Oncology Nursing Society; and Shez Holmes, our Macmillan neuro-oncology clinical nurse specialist, was shortlisted for a Macmillan Professionals Excellence Award for her work supporting patients with brain tumours.

We also celebrated the fact that Brian Stone, one of our Friends of NGH volunteers, was awarded a British Empire Medal in the New Year's Honours. Brian, aged 77, was nominated for providing more than 20 years' service to a range of charities and organisations in Northampton including his invaluable work with the Friends of NGH, first as a guide and buggy driver, and now as a ward visitor.

Two events in particular during the year served as reminders of how profoundly the work we undertake affects the lives of our patients and their families.

In June, representatives of the hospital attended the opening of an art exhibition at the invitation of 23 year old University of Northampton artist Mareika Gillett. Four years earlier, Mareika Gillett lay critically ill and unconscious in A&E with a shattered pelvis, fractured spine, broken bones in every limb and shattered facial bones after a car drove through a red light and hit her as she crossed a road, just five weeks into her first year as a fine art student. Following the initial treatment to save her life, Mareika faced a daunting road to recovery involving five separate operations, specialist treatment to repair nerve damage in her arm and intensive physiotherapy as she learned to walk again. She was eventually able to return to university and complete her Fine Art Painting and Drawing Degree. Mareika exhibited her work along with other students at the University of Northampton's final degree exhibition - and invited hospital staff who had been involved in her treatment.

In December, we lost a much-admired and valued colleague when consultant obstetrician William Davies, known to us all as Roy, passed away. Roy is deeply mourned by his colleagues as somebody who loved his work and who was committed to making a difference for his patients. Roy will be remembered for his warm and compassionate care by the many parents in Northamptonshire who will be forever indebted to him for making a precious pregnancy possible. The tributes that

flowed in the wake of his death served as reminder to all of us of how privileged we are to work here – not just to treat our patients, but to care for and support them.

Finally, it would not be possible to present our year in retrospect without paying tribute to all of our staff and volunteers whose passion and commitment to the hospital, the NHS and our patients is beyond compare.

Paul Farenden, Chairman
Dr Sonia Swart, Chief Executive

An introduction to Northampton General Hospital

Who We Are

Northampton General Hospital is an acute NHS hospital trust that offers a full range of hospital services from the main hospital site close to the centre of Northampton. We also provide day case and outpatient services at Danetre Hospital in Daventry.

We have formally pledged our commitment to continuous improvements in the quality of care we provide and patient safety by strengthening our focus on corporate accountability for clinical performance. We are committed to providing the best possible care for all our patients and this is central to our strategy for the future.

What We Do

We provide general acute services for a population of 380,000 and hyper-acute stroke, vascular and renal services to 692,000 people living throughout the whole of Northamptonshire. We are an accredited cancer centre, providing services to a wider population of 880,000 who live in Northamptonshire and parts of Buckinghamshire. For one highly specialist urological treatment we serve an even wider catchment.

Our principal activity is the provision of free healthcare to eligible patients. We provide a full range of outpatients, diagnostics, inpatient and day case elective and emergency care and also a growing range of specialist treatments that distinguishes our services from many district general hospitals. We also provide a very small amount of healthcare to private patients.

Our Vision and Values

Our vision is to provide the best possible care for all of our patients. This means we deliver safe, clinically effective acute services focused entirely on the needs of the patient, their relatives and carers. These services may be delivered from our hospital sites or by our staff in the community.

Our values underpin all we do and were developed following discussion and consultation with our staff. They are:

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

For patients this means they can expect to:

- Receive the right treatment at the right time and in the right place in line with national guidelines
- Be kept safe from avoidable harm
- Be treated as individuals and have their individual needs addressed
- Be treated with compassion, respect and dignity
- Be kept fully informed and share in decision making about their care

- Have any concerns addressed as early as possible
- Be cared for in a clean and safe environment

Our Strategic Aims
Our Trust Board sets our overall strategic direction, within the context of NHS priorities, and monitors our performance against objectives. It also provides financial stewardship, clinical governance and corporate governance to ensure that we continue to provide high quality care that offers value for money.

To support delivery of these organisational priorities during 2015/16, we developed five strategic aims that are also aligned to our vision and values:

1. To focus on quality and safety
We will avoid harm, reduce mortality, and improve patient outcomes through a focus on quality outcomes, effectiveness and safety

2. To exceed our patients' expectations
We will continuously improve our patient experience and satisfaction by delivering personalised care which is valued by patients

3. To strengthen our local services
Provide a sustainable range of services delivered locally

4. To enable excellence through our people
We will develop, support and value our staff to provide our patients with quality care delivered by a highly trained and motivated workforce**.**

5. To ensure a sustainable future
To provide effective and commercially viable services for our patients, ensuring a sustainable future for NGH

Strategic Priorities
We have developed eight strategic priories to steer the delivery of our vision and strategic aims. These are**:**

- Provide resilient core hospital services
- Continue to improve urgent care services
- Collaborate and integrate with other providers to provide care closer to home
- Develop partnerships with Kettering General Hospital in response to the Challenged Health Economy work-stream
- Strengthen our hyper-acute services through working with our tertiary providers
- To become the hospital provider of choice for local GPs and patients
- To deliver excellence in the care of elective patients
- Develop our hospital as a health and wellbeing campus

Service developments
During the year we invested in and developed a range of services:

- Invested in improved seven day services across radiology, pharmacy and cardiology
- Invested in more nursing staff to increase our workforce
- Invested in further consultant appointments across ophthalmology, breast surgery and cardiology
- Integrated reablement and admission avoidance pathways e.g. heart failure, cardiac, pulmonary vascular rehabilitation

Risks and uncertainties
The current healthcare environment remains very challenging and the constrained financial environment and difficulty in recruiting a substantive workforce are our main strategic risks. However we continually focus on:

- transforming the way that our staff work and how we deliver key services to respond to changing patient needs, ensuring that we are able to respond to the demands placed on our services and the organisation
- maximising efficiency and reducing cost so that we are a high value organisation
- strengthening the way that we work with other organisations and partners, to establish partnerships and strategic alliances where this is mutually beneficial and improves the quality and efficiency of our services for patients
- We have taken every opportunity to be at the forefront of the development of new care models, working collaboratively with primary and secondary care organisations to optimise service delivery

Looking forward
We are committed to providing the following in 2016/17:

- Further investment in our workforce to include additional nursing and consultant staff. This will help us reduce the number of agency staff used across the hospital
- Integrated pathways for frail and elderly patients through new and innovative approaches
- Multi-disciplinary community clinics to include dermatology, rheumatology, and musculoskeletal services

Plans for the future
We are working in collaboration with system leaders from around the county to develop a five year Sustainability and Transformation Plan (STP) for Northamptonshire, written on a *bottom up* basis to truly reflect the needs of patients and services at a detailed level.
The aim of the plan is to align all partners in Northamptonshire to plan and deliver as one place. Some headlines for this work are:

- Recovering urgent care and cancer quality and performance issues
- Sustaining primary care
- Accelerating clinical collaboration between the acute providers
- Design of a truly integrated demand and capacity model
- Reviewing and redesigning IT provision to support clinical change

- Emergence of new integrated models of provision between multi-sector partners

The following principles have been agreed by the partners in Northamptonshire

- Delivering headroom in year one through the additional allocations for following years
- Total commitment to an open book approach
- System sustainability leading to organisational sustainability
- System management of controlled 'deficits support' by transformation
- Clear health outcomes informed by Public Health analysis
- Clear implementation plans with identified timescales, resources and benefits
- Ownership by all organisations
- Stakeholder, public and patient engagement - single standard communications
- Clear system and organisation metrics

It is clear that in order to remain as a viable organisation we will need to consider new approaches to the way in which some services are managed and run. We are committed to implementing new models of care and we will take every opportunity to be at the forefront of their development.

Working with our local community

During the period covered by this report, we published our patient experience & engagement strategy (2015-2018) which details our vision for patient experience and engagement in the hospital, and how we aim to achieve it. The strategy focusses on five key aspects:

- Ask
- Listen
- Share
- Improve
- Engage.

During the year, we made numerous improvements in response to the feedback we received from the Family & Friends Test. From herbal tea and noiseless bin lids to doctors in white coats and sleep-well packs, we listened to what our patients, staff and visitors told us and we acted on it.

We also made it easier than ever to give feedback. Now, as well as feedback from SMS text messaging and automated calls, we have a suite of postcards tailored to specific departments and wards.

We created an easy-read version of the feedback postcard to help our patients with a learning disability or dementia in giving their feedback. We designed a children's survey for our younger patients to have opportunities to give their feedback, with three different surveys available depending on the age of the child. And we've used QR codes make the survey available in 50 different languages. To help us collect all those postcards, we now have 70 postboxes right across the hospital.

As well as offering multiple methods for collection, we are also now collecting demographic information from our patients, to ensure that we are providing the best possible experience to everyone, equally.

During the year, we entered into a research agreement with University of Northampton that we hope will pave the way for academic research to be put into practice and open up new opportunities for research projects to improve health and wellbeing. We signed a Memorandum of Understanding which commits both organisations to working together on biological, medical and health related research, for the benefit of people in the county and further afield. This development paves the way for a more meaningful research alliance between our organisations and the exploration of new areas for future research.

Our staff and patients benefited from other partnerships we entered into during the year; we joined forces with Boots to change the way prescriptions are dispensed to people following an outpatient appointment. This initiative means our outpatients will have shorter waiting times for prescriptions and more convenient and accessible pharmacy services. We can reinvest our highly-skilled NHS pharmacists in ward-based work so they can concentrate their efforts on ensuring our inpatients that need the most care, get the necessary medication as quickly as possible. As well as an enhanced prescription service, the new Boots pharmacy offers hospital employees and visitors retail and over-the-counter facilities, as well as the same professional advice and support that's available in its high-street pharmacies.

Another significant partnership saw Northampton Leisure Trust (NLT) NLT take over the management of our on-site Cripps Recreation Centre; NLT now operate and manage Cripps alongside its four other leisure facilities across Northampton under the Trilogy brand. As well as a refurbished and modernised gym and fitness programmes, NLT is working with us as a strategic partner as we deliver our health and wellbeing strategy.

PERFORMANCE ANALYSIS

Performance against our strategic priorities
In 2015/16 we made progress in implementing our strategic priorities as set out in our five year clinical strategy. We:

- Developed our urgent care pathways and services
- Developed and launched our health and wellbeing strategy with a broad programme of events and actions to support the health and wellbeing of our staff and patients
- Improved our theatre and outpatient efficiencies, ensuring patients are seen and treated in a more timely way
- Worked in partnership with both University Hospitals Leicester and Kettering General Hospital to set up a South East Midlands oncology centre which will deliver a sustainable, high quality patient focused oncology service for our local population

- Started closer collaboration with Kettering General Hospital to develop countywide rheumatology and orthopaedic services across both hospitals

Achievement against key performance standards

We achieved ten out of the 14 national performance indicators as at the end of 2015/16.

Indicator	Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
A&E: Total time in A&E (month)	95%	93.70%	94.2%	89.66%	81.8%
A&E: 12 hour trolley waits	0	0	0	0	0
Diagnostic waiting times (number of patients waiting < 6weeks)	99%	100%	100%	99.98%	99.9%
Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	93%	92.0%	95.6%	96.7%	95.9%
Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	93%	87.9%	98.2%	99.8%	99.4%
Cancer: Percentage of patients treated within 62 days of referral from screening	90%	89.1%	97.6%	95.3%	93.8%
Cancer: Percentage of patients treated within 62 days of referral from hospital specialist	85%	86.7%	68.8%	83.3%	86.4%
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	85%	77.0%	78.0%	80.9%	76.5%
Cancer: Percentage of patients treated within 31 days	96%	96.7%	97.1%	96.9%	94.6%
Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	94%	95.7%	100.0%	92.3%	95.8%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	98%	99.5%	99.4%	98.4%	97.0%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	94%	99.3%	97.8%	98.6%	96.5%
RTT waiting times – Patients on incomplete pathways with a current wait time < 18 weeks	92%	95.6%	95.4%	95.4%	93.9%
RTT waiting times - number of patients waiting > 52 weeks	0	0	0	0	1

The performance was delivered in the face of a significant increase in demand for our services compared to the previous year, in part due to the benefits of our new clinically-led divisional structure which was established at the beginning of 2015 with senior clinical leaders driving improvements in performance.

The following sections provide a more detailed picture of our performance over the course of the year.

1.1 Activity

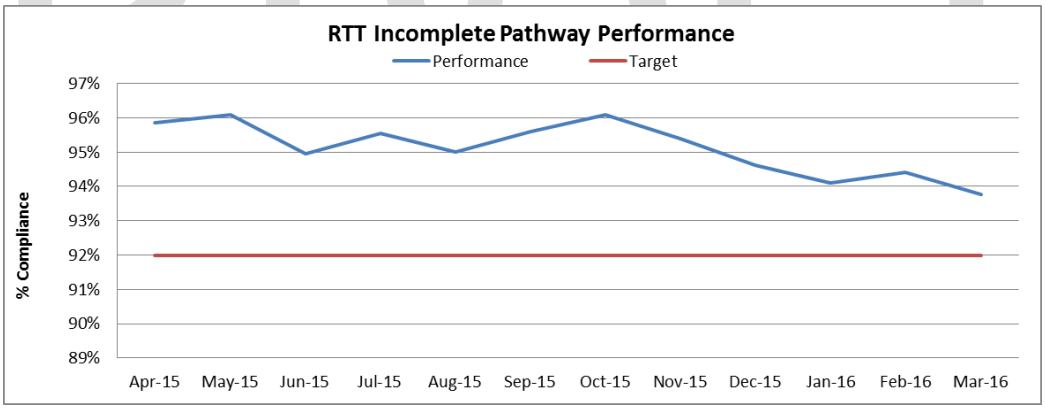
The demand on our services increased during 2015/16 when compared to the previous year. A breakdown of this activity is provided in the table below, contrasted against the previous year's activity.

Activity Comparison	2014-15	2015-16	Diff	% Diff
Non-Elective Inpatients	40,349	43,456	3,107	8%
Elective Inpatients	6,208	5,824	-384	-6%
Elective Daycases	38,346	39,610	1,264	3%
New outpatient attendances - Consultant led	80,037	83,474	3,437	4%
Follow-up outpatient attendances - Consultant led	149,977	155,562	5,585	4%
New outpatient attendances - Nurse led	38,571	42,127	3,556	9%
Follow-up outpatient attendances - Nurse led	114,953	154,412	39,459	34%
Total number of outpatient DNA's	30,350	34,770	4,420	15%
Patients seen in Accident & Emergency	109,305	114,179	4,874	4%
Number of babies born	4,685	4,726	41	1%
Average length of stay (in days)	3.55	4.36	0.81	23%

The main increase seen within the activity is shown in the rise in non-elective admissions, which has proved to be a challenge for us.

1.2 Referral to Treatment Performance

We have successfully achieved the Referral to Treatment Incomplete pathway indicator target of 92% throughout the year, maintaining an average well above this level of 95%.



At a specialty level, there were some capacity challenges in oral surgery in the first months of the year, but these have since been resolved. More recently the main area of challenge has been the trauma & orthopaedics specialty, which has been affected by the significant rise in non-elective admissions and the inability to provide capacity for some routine elective procedures.

Directly attributable to the increased acuity and the increase in non-elective inpatients activity, there were 31 patients who experienced a cancelled operation for

a non-clinical reason and who were then not rebooked within 28 days. We recognise that this is not acceptable, although should be seen in the context of the 45,403 inpatients who were treated during 2015/16.

1.3 Cancer Waiting Times

At the end of 2015/16, we had achieved six of the nine national cancer performance indicators.

Indicator	Target	Q1	Q2	Q3	Q4
Percentage of 2 week GP referral to 1st outpatient appointment	93.0%	92.0%	95.6%	96.7%	96.1%
Percentage of 2 week GP referral to 1st outpatient - breast symptoms	93.0%	87.9%	98.2%	100.0%	99.3%
Percentage of patients treated within 31 days	96.0%	96.9%	97.1%	97.1%	95.2%
Percentage of patients treated within 62 days urgent referral to treatment of all cancers	85.0%	78.6%	78.0%	82.0%	77.5%
Percentage of patients treated within 62 days of referral from screening	90.0%	89.1%	97.6%	95.4%	95.0%
Percentage of patients treated within 62 days of referral from hospital specialist	85.0%	100.0%	68.8%	75.9%	96.3%
Percentage of patients for second or subsequent treatment treated within 31 days - surgery	94.0%	100.0%	100.0%	92.5%	92.0%
Percentage of Patients for second or subsequent treatment treated within 31 days - drug	98.0%	99.5%	99.4%	98.3%	98.5%
Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	94.0%	98.8%	97.8%	99.0%	96.5%

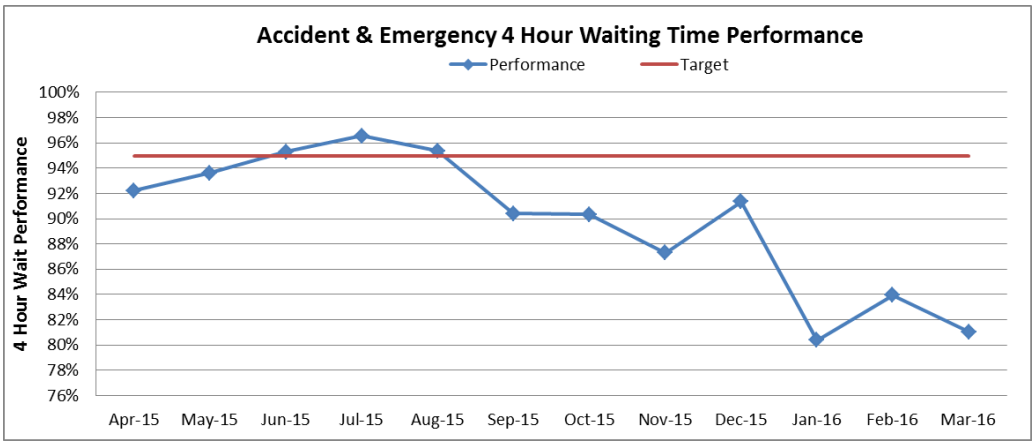
Over the year we saw a 14% increase in the two week wait cancer pathways and a rise in the number of complex cancer cases, requiring multiple diagnostic interventions and treatments.

We developed an internal cancer board to oversee performance as well as a *Breaking the Cycle* project. The focus of this initiative was on reviewing pathways and reducing waits across diagnostics, including MRI, CT and endoscopy.

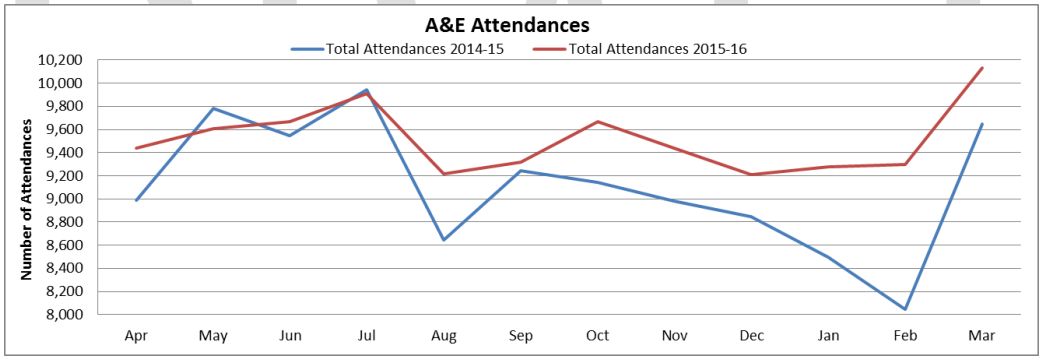
In addition, a county wide cancer improvement group has been established and is supporting us to deliver actions which will enable achievement of the cancer performance indicators during the latter part of 2016/17.

1.4 A&E 4 Hour Standard

We achieved the national target for the A&E 4-hour waiting time performance indicator during the summer of 2015. However, during the autumn and winter months performance dropped below the national standard due to an increase in A&E attendances, subsequent admissions and higher acuity of those patients requiring admission. Our ability to safely discharge patients who no longer required acute hospital care remained a challenge through 2015/16 with the numbers of delayed transfers of care (DTOC) averaging at 70 patients at any one time. The table below shows our performance for this indicator.



The achievement of the target was significantly impacted by the 4% increase (4,322 patients) in the number of patients attending A&E during 2015-16, when compared to 2014/15, with the majority of this increase seen between August 2015 and March 2016 (see the table below).



During 2016/17, we have implemented an inpatient productivity programme to seek opportunities to strengthen ward processes, early patient review and enhanced seven day working.

In addition, we are working with Northamptonshire County Council and other partner organisations to reduce the number of patients who are experiencing a delay from hospital (DTOC) to alleviate the high demand for our inpatient beds.

We are planning to increase the current acute bed base by 60 beds to be able to manage the rise in demand which is expected in the coming year.

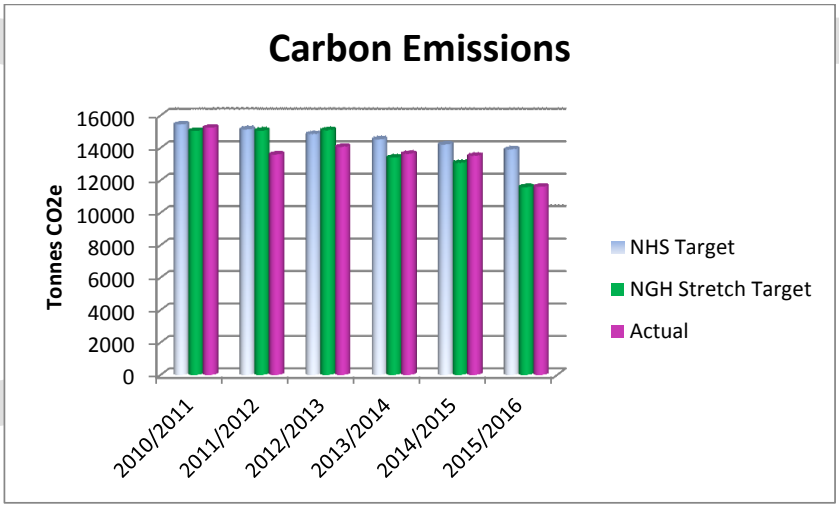
Sustainability at NGH.

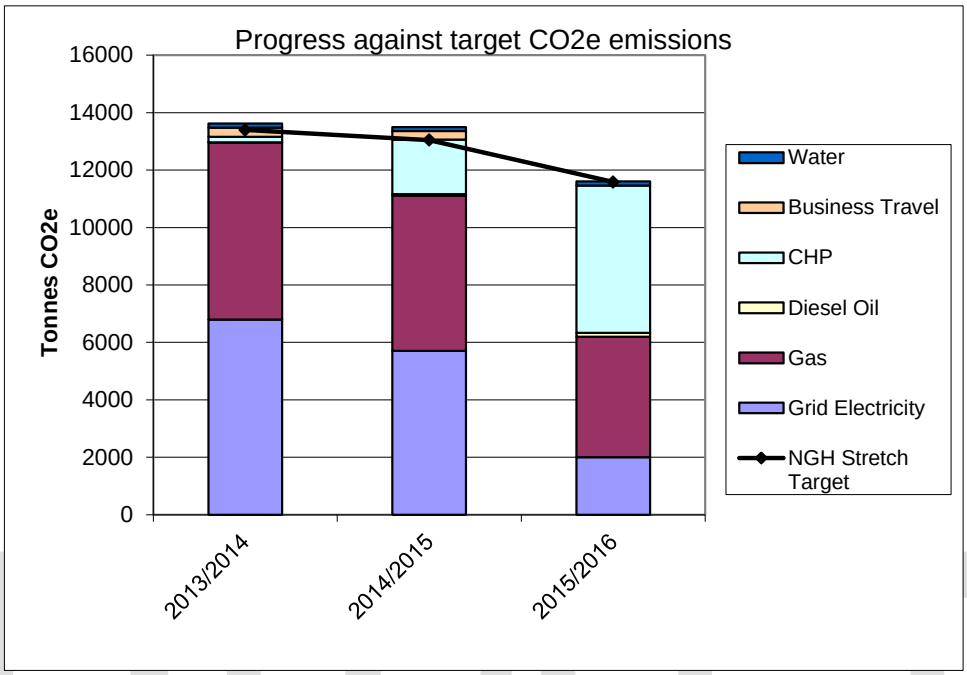
As well as achieving reaccreditation to green level in the Investors in the Environment scheme, our energy and sustainability manager was voted Large Business Green Champion. 2015 also saw the successful application by the catering department for the Bronze level in the Food for Life scheme from the Soil Association.

We were shortlisted in the HSJ Awards for improving environmental and social sustainability and were highly commended in the NHS Sustainability Day Awards food category. Further accolades came in the Northampton in Bloom awards when the Willow garden, which was redesigned for patients and wildlife, was awarded Silver Gilt.

Carbon Management Plan

2015/16 marked the end of the five-year carbon management plan which had the goal of achieving a 25% reduction in emissions from our property and travel. This was a stretch target; the NHS target was a 10% reduction in emissions. Although the biomass was not operational and the CHP engine was inactive for two months, this stretch target was only missed by approximately three per cent (assuming business mileage emissions remain constant). With a full year of both the CHP and biomass we're confident that emissions from buildings remain on target for the 34% reduction required by 2020.





	2013/2014	2014/2015	2015/2016
Consumption Data			
Gas kWh	33,538,628	29,250,909	22,683,936
Electricity kWh	14,315,605	14,611,750	15,222,263
Water m3	136,369	127,781	136464
Business Travel miles	1,079,683	977,976	**
Financial Data £			
Gas	1,140,618	1,148,238	1,276,017
Electricity	1,465,853	1,131,103	477,196
Water	278,441	268,190	263,063
Business Mileage	449,155	431,790	**
Carbon Credits	167,736	214,397	191,202

*volume used higher than expected due to change in measurement technique for remaining oil
**Data unavailable at time of printing

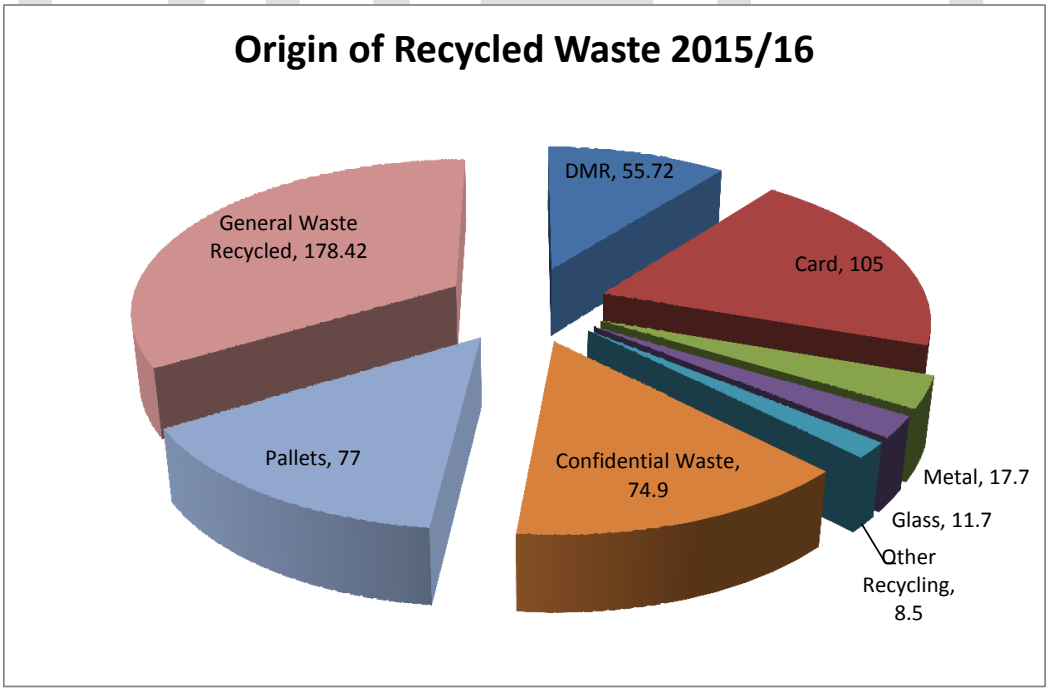
Investment
Further changes were made to our lighting, with the library and medical records departments changing to LED fitted with advanced controls to reduce lighting in low occupancy areas. These were funded through a Salix loan. At the end of the financial year, the final two transformers were replaced with more efficient equipment which should reduce energy consumption in these areas by a minimum of 3%, a saving of 0.6% of the total site demand and an additional 45 tonnes of CO_2e per year.

In the next year further lighting changes will be made, along with the start of a program to replace parts of the heating system with more efficient plate heat exchangers, both of which should be eligible for Salix funding. Further optimisation of the Building Management System (which controls all the site's heating and ventilation) is also planned.

Water Use
Water use has increased in the last financial year due to planned maintenance of all our site's water tanks and additional flushing regimes to ensure high water quality. Water meters will be fitted to crucial areas of the hospital to determine which areas are the highest users and to look for appropriate water saving measures.

Waste and Recycling
In 2015/16 we segregated 198 tonnes of recycling, including plastics, cans, metal and card. A further 178 tonnes of waste was separated by our waste management contractor and sent for recycling from their materials recovery facility. In addition we recycled 75 tonnes of confidential waste and sold 77 tonnes of pallets for reuse. As a total of our non-clinical waste we segregated 37% at NGH and a further 19% was segregated at the waste management company, making a total of 56%. Standard recycling rates for UK households are approximately 43%.

Levels of clinical waste have remained static for the last three years despite increasing patient activity. There will be a continuing drive to move waste to the most environmentally preferable option, which is likely to reduce costs further. In 2015 our average cost per tonne of waste was £189 compared with £233 in 2014, a 19% reduction.



Recycling volumes have increased following the removal of under desk bins in several departments and the start of recycling in theatres. We also recycle mobile phones and asthma inhalers. The latter part of the year has been spent optimising the clinical waste management, and raising awareness of recycling including a household small appliance amnesty in February.

The coming year will see continued efforts to improve recycling rates as well as find some waste streams from which there is the potential to gain a revenue. The majority of the remaining XRays will also be culled and the silver recycled.

Carbon footprint and procurement

We completed the first level of Defra's Procuring 4 Carbon Reduction Framework and are starting on level two. Using this framework an approximate carbon footprint has been calculated at 75,288 tonnes CO_2e, an increase of 18% on the previous year. The majority of this rise has come from increased spend on construction, medical equipment and chemicals and gases. The carbon footprint from anaesthetic gases has been calculated at 2525 tonnes CO_2e, which is approximately the same as that calculated in 2014. However, this is an estimate of the carbon footprint based on expenditure in different categories. The new inventory management system will reduce stockholding, expenditure and wastage in most areas.

Other green initiatives

During the year, we made a number of changes to menus. As well as ensuring that no harmful additives or GM foods are used, the amount of freshly prepared food was increased from less than 60% to over 90% (a minimum of 75% was required). Meat purchased complies with farm assurance standards, all eggs are free range and fish are chosen so they are not on the Marine Conservation Society's 'Fish to Avoid' list. Menus are changed quarterly to ensure that they are reflecting seasonal produce.

We replaced a kitchen macerator to dispose of food waste with two anaerobic digesters. These use enzymes to break down the food and release grey water rather than sending fats down to the drain. In addition to saving hot water, there are also substantial maintenance savings.

We took part in NHS Sustainability Day, promoting the new energy centre that has been officially operating for most of the calendar year and launching a photography competition inviting staff to send in pictures of what sustainability means to them.

In addition to talking to all new starters every month, training in how to be green now forms part of the program for all of our new healthcare assistants.

We carried out a second travel survey and as a result we purchased two new cycle shelters. The survey results were also used to inform our latest travel plan. We held three Dr Bike sessions during the year during which our local SusTrans representative carried out safety checks and services on staff bikes.

Sustainability plans for next year
The next year will see the start of a new five year Sustainability Strategy aimed at moving us beyond looking at just energy and waste and will ensure that we are more resilient to deliver our services into the next decade. In order to ensure we are targeting the right areas for investment and engagement the metering strategy will be extended to include water and heat meters.

Information technology
Reliance on ICT to improve patient care and assist with our business processes continues to grow and once again our capital programme was delivered as planned.

We continue to improve our essential IT infrastructure and this year replaced the SANs in both our data centres to accommodate the exponential growth of our IT systems. Resilience of our network has also completed with the separation of our N3 connections to the outside world and dual homing between switches internally.

The National Programme for IT contract comes to an end in 2016 and much of 2015/16 was spent on business case development and approval and procurement of a new patient administration solution to integrate with our existing electronic patient record systems. Emis was chosen as our successful bidder and as we already has their applications in accident and emergency, pharmacy and in many areas for electronic prescribing and medicines administration we look forward to a successful implementation and the benefits this will bring.

We prepared for the introduction of a new PACS system which will allow us to share radiology images with seven other NHS Trusts across the East Midlands and we have extended our commitment to our laboratory information system to allow an evaluation of options to take place.

The benefits of VitalPac have been extended to include fluid management and nutritional screening and other modules will be implemented over the coming year.

Finally – many of our clinicians are now enjoying the benefits of Single Sign On with context management which enables a joined up view of our “Best of Breed” electronic patient record.

Emergency preparedness
We are a Category 1 responder as defined by the Civil Contingencies Act (CCA, 2004) and therefore emergency preparedness, resilience and response (EPRR) is a very important element of our activity.

The CCA requires NHS organisations to operate safe patient care during emergency situations, while maintaining essential services. We therefore need to plan for, and respond to, a wide range of incidents and emergencies. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport incident.

We have a major incident plan that is tested on a regular basis. Our suite of emergency response plans are developed in collaboration with other agencies

involved in emergency planning, including Northamptonshire Police, Northamptonshire Fire and Rescue Service, East Midlands Ambulance Service, local clinical commissioning groups and Northamptonshire County Council's emergency planning team to ensure we provide a cohesive response.

During the year, we:

- Increased staff training through attendance our staff induction.
- Reviewed business continuity management and major incident plans for all areas of the hospital.
- Managed the preparation and response to industrial action.
- Enhanced the major incident alerting system across the hospital.
- Undertaken a deep dive into our Chemical, Biological, Radiological and Nuclear (CBRN) preparedness.
- Created a new CBRN storage facility, easily accessible to A&E.
- Delivered training for CBRN responders within A&E in accordance with updated guidance.
- Engaged in multi-agency exercises to test and develop the capability of the local health economy.

In the coming 12 months we will be working to:

- Engage in training and exercising of all local plans.
- Develop and deliver a hospital-wide 'live' exercise.
- Deliver training for major incident loggists.
- Continue to engage with health and other response partners to deliver the best possible response to incidents in the county.

QUALITY ACCOUNT

An annual Quality Account published by NHS healthcare providers and the independent sector describes the quality of its services and delivered to its local communities and stakeholders. The report covers patient safety, Effectiveness of treatments and patient feedback. It also highlights the key developments during 2015/16. A separate statutory report in more detail is available via NHS Choices or our website.

Our Quality Strategy

The purpose of our quality strategy is to ensure we provide the best possible care for all of our patients. We define quality as embracing three key components:

1. Patient safety
   - Eliminating avoidable harm.

2. Effectiveness of care
   - Delivery of care and treatment at the right time in the right place.

3. Patient experience
   - Compassionate care delivered by caring and committed staff

Our Quality Priorities – actions and progress in 20115/16

We agreed five core work streams demonstrating our commitment to quality following input from staff, patients, and the public:

1. Supporting patients in getting home
2. Listening to our patients
3. Investing in our staff
4. 'Sign up to Safety'
5. Improving End of Life Care

A review of 2015/16 performance includes:

- Increased throughput of patients, allowing us to treat a greater number of patients without increasing resources
- Prompt, well-coordinated discharge with reduced waiting for medication and transport
- Investigations from incidents and complaints resulting in meaningful changes where required
- Reporting and learning from errors which are then shared at learning forums
- Improved staff Family & Friends Test (FFT) results
- Improved data in relation to: appraisal; staff turnover; sickness absence; and attendance on mandatory training
- More robust identification for patients who are supported on an end-of-life pathway

Quality Priorities 2016/17

The key quality priorities that will have sustained focus for 2016/17, and beyond, are:

- Reducing harm from failure to rescue
- Reducing avoidable harm from failures in care
- To deliver patient and family centred care
- To lead and promote a reflective culture of safety and improvement
- To ensure operational processes support essential planning, delivery and record keeping
- To deliver reliable and effective care (care bundles)

We will deliver these priorities through our clinically-led divisional structure as part of our overarching programme of Changing Care at NGH supported by our Patient Safety Academy.

Progress with each of these priorities will closely monitored to ensure the best possible care for our patients. Each of these Quality Priorities will be overseen by the medical and nursing directors and reported to the Quality Governance Committee on a quarterly basis.

Building upon the work of the previous quality improvement strategy, the focus for 2016/17 aligns our visions and values with clinical services; enabling us to provide the best possible care to every patient.

Serious Incidents (SI)

Our internal governance structures, overseen by our medical director, ensure robust processes are in place to review and investigate serious incidents in which lapses in care result in patient harm. Our commissioners have oversight and scrutiny of all such investigations and the resulting reports' to ensure proportionate scrutiny, appropriate actions are taken, and key learning is shared.

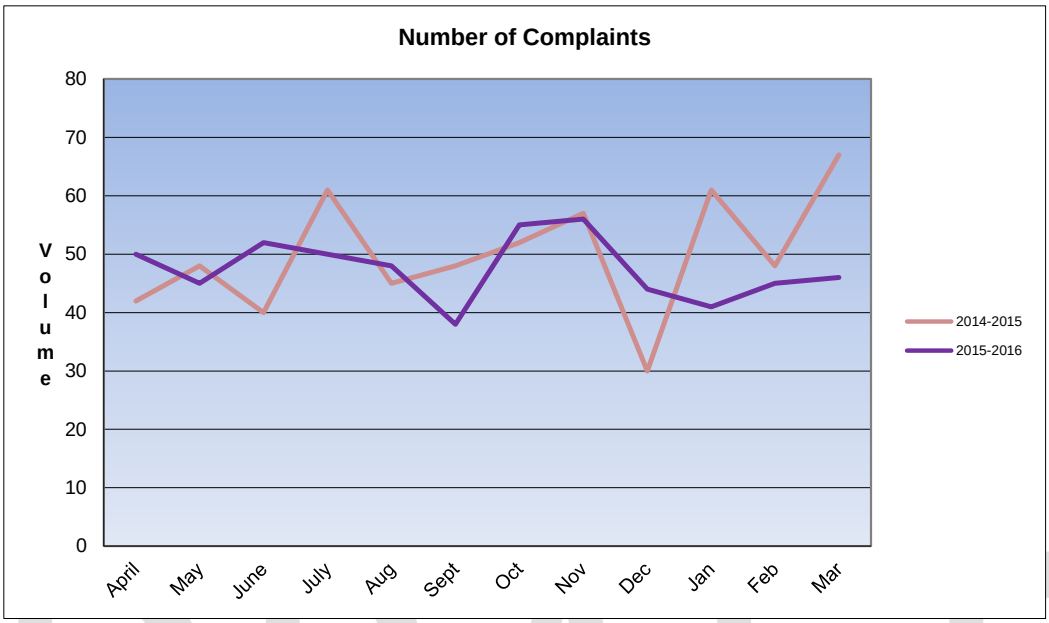
During 2015-16 we declared 19 serious incidents (SIs); this is a significant reduction in the number reported the previous year. A subset of this are incidents are defined by the Department of Health as 'Never Events'; all NHS Trusts report such incidents separately under a distinct criteria due to the serious and largely preventable nature of such incidents. We reported three never events during 2015/16 and a number of actions were implemented to further reduce the risk and possibility of recurrence.

The culture of incident reporting in NGH is continuing to mature, with the total number of incidents reported increasing annually indicating an open reporting culture and a commitment to learn and improve the quality of care we deliver.

Complaints
We received a total of 570 written complaints that were investigated through the NHS complaints procedure, compared to 599 complaints received the previous financial year.

Total no of complaints for the year	570
Average response rate (including 307 renegotiated timescales)	*90%
Total no of complaints that exceeded the renegotiated timescale	*49
Complaints that were still open at the time that the information was prepared (14th April 2016)	*94
Total patient contacts/episodes (Versus 2014/2015)	678,140 (607,659)
Percentage of complaints versus number of patient contacts/episodes (Versus 2014/2015)	0.08% (0.10%)

**Figures correct at time of collation.*



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2014-2015	42	48	40	61	45	48	52	57	30	61	48	67	599
2015-2016	50	45	52	50	48	38	55	56	44	41	45	46	570

Trend Analysis

The following table provides the top 5 themes emerging from complaints.

	2015-2016	% of Total Complaints Received
Clinical Care	228	40%
Communication	146	26%
Delays	44	8%
Discharge	41	7%
Cancellations	33	6%

SECTION TWO ACCOUNTABILITY REPORT

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money is achieved from the resources available to the trust;

- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are in place; and

- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

I confirm that, as far as I am aware, there is no relevant audit information of which the trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the trust's auditors are aware of that information.

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Signed

Dr Sonia Swart

Chief Executive

Date

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

- make judgements and estimates which are reasonable and prudent;

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

Date Dr Sonia Swart

Chief Executive

Date

Simon Lazarus

Finance Director

Annual Governance Statement 2015/2016

1. **Scope of Responsibility**

As Accountable Officer, I am responsible for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me.
I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively.

I acknowledge my responsibilities as set out in the Accountable Officer Memorandum, including in relation to the production of statutory accounts, effective management systems and regularity and propriety of expenditure.

As Chief Executive I am accountable to the Trust Board. I am also responsible, via the NHS Accounting Officer, to Parliament for the stewardship of resources within the Trust

2. **Governance framework of the organisation**

The Trust's governance framework and system of internal control is designed to manage risk to a reasonable level rather than eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- Identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives and
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically

During 2015/16 the organisation continued to align and embed improved systems of control and risk management to support a new organisational operational structure and improve risk management and assurance mechanisms.

Trust Board and Committee structure

Northampton General Hospital NHS Trust has a Board of Directors (the Board) which compromises both Executive and Non-Executive Directors and has met monthly throughout the year.
Voting members comprise the Chair and five non-Executive Directors and five Executive Directors, including the Chief Executive along with four non-voting Directors.

The role of the Board is to govern the organisation effectively and in doing so to build public and stakeholder confidence that their health and healthcare is

in safe hands and ensure the Trust is providing safe, high quality patient – centred care.

The Board holds its meetings in public bi monthly and papers are available on the Trust website. The Board regularly reviews performance against national standards and regulatory requirements and a summary of performance against these priorities is available through the Trust's Annual report. The Board places a strong emphasis on quality and safety of patient care and in addition to performance reports, regularly hears directly from patients and carers, including patient stories and ward visits.

The Trust Board approved the organisation's Quality Account in June 2015, further to review by the Quality Governance Committee. The accuracy of the Quality Account is assured through internal review and data checking processes as part of the Trust's data quality arrangements.

The Trust's External Auditors also undertook an audit of the 2015/16 Quality Account and their findings are being taken into account for the production of this year's Quality Account which is due to be agreed by the Board in June 2016.

The Board has reviewed its effectiveness against the Care Quality Commission's Well Led framework where a full gap analysis and action plan was agreed by the Trust Board. This will be reviewed again the first quarter of 2016/17.

In early 2015 the Board commenced a development programme and this has culminated in a programme to support the Board in understanding its Quality agenda and was underpinned by a two day Board Development course for the whole Board, led by AQuA, in March 2016.

Following a governance review in 2014, the organisation strengthened it governance structures during 2015 and this culminated in a committee effectiveness review presentation to the Trust Board in November 2015. As a result further amendments and improvements were recognised and these will be implemented in early 2016 to further strengthen organisational governance and assurance arrangements.

The principle committees of the Trust Board which support it in undertaking its responsibilities are:

Audit Committee
The Audit committee has overall responsibility for independently monitoring, reviewing and reporting to the Trust Board on all aspects of governance, risk management and internal control. It is supported in this role by the Quality Governance committee.

Quality Governance Committee
The Quality Governance committee monitors, reviews and reports on the quality and safety of services provided by the Trust. This includes the review

of governance, risk management and internal control systems to ensure the delivery of safe, high quality, patient centred care.

Finance Investment and Performance Committee
The Finance, Investment and Performance committee undertakes on behalf of the Trust Board objective scrutiny of the Trust's financial plans, investment policy and major investment decisions.
Additionally it is responsible for overseeing the delivery of all key performance metrics for finance and operational delivery. The committee reviews the Trust's monthly financial and operational performance and identifies key issues and risks requiring discussion or decision by the Trust Board.

Workforce Committee
The Workforce committee monitors, reviews and reports on the organisational development and workforce performance of the Trust. This includes the achievement of associated key performance indicators and advising the Trust Board on key strategic organisational and workforce initiatives.

Remuneration and Appointments Committee
The Remuneration and Appointments committee has delegated authority from the Board to appoint and remove the Chief Executive and together with the Chief Executive to appoint and remove other Directors. In addition, it sets the remuneration, allowances and other terms and conditions of office for the Trust's Executive Directors.

Charitable Funds Committee
The Charitable Funds Committee acts on behalf of the Corporate Trustee, in accordance with the Northampton General Hospital NHS Trust Standing Orders to oversee the charity's operation and to ensure that the administration of charitable funds is distinct from its exchequer funds.

Board and Subcommittee Attendance

Name	Position	Date of Commencing Appointment	Board Record of Attendance *April 2015 to Jan 2016*	Membership of Board Committees					
				Audit Committee	Quality Governance Committee	Finance Investment & Performance Committee	Workforce Committee	Remuneration and Appointments Committee	Charitable Funds Committee
Paul Farenden	Non- Executive Director, Chair	1.3.12	11/12		x	x	x	x	
Phil Zeidler	Non- Executive Director, Vice Chair	1.12.08	10/12	x		x		x	x
David Noble	Non- Executive Director	1.1.13	12/12	x	x	x		x	x
Liz Searle	Non- Executive Director	1.1.13	7/12	x	x			x	
Graham Kershaw	Non- Executive Director	1.3.13	10/12	x	x		x	x	

Name	Position	Date of Commencing Appointment	Board Record of Attendance *April 2015 to Jan 2016*	Membership of Board Committees					
				Audit Committee	Quality Governance Committee	Finance Investment & Performance Committee	Workforce Committee	Remuneration and Appointments Committee	Charitable Funds Committee
Nick Robertson*	Non- Executive Director	1.2.09	5/6	x			x	x	x
Olivia Clymer	Non- Executive Director	2.11.15	4/5	x	x		x	x	
Sonia Swart	CEO	23.9.13	12/12		x	x	x		
Debbie Needham	Chief Operating Officer/ Deputy CEO	10.4.14	11/12		x	x	x		
Catherine Thorne	Director of Corporate Development Governance and Assurance	19.1.15	11/12	Attend	x		x		
Simon Lazarus	Director of Finance	11.3.14	12/12	Attend	x	x			
Janine Brennan	Director of Workforce and Transformation	2.4.13	11/12		x	x	x		
Charles Abolins	Director of Facilities	29.11.10	12/12		x	x	x		
Chris Pallot	Director of Strategy and Partnerships	11.10.10	11/12		x	x			
Rachael Corser**	Interim Director of Nursing	5.1.15	2/3		x	x	x		
Mike Cusack	Medical Director	26.9.14	11/12		x		x		
Carolyn Fox	Director of Nursing	20.7.15	9/9		x	x	x		

**Stepped down - 30 September 2015*
***Stepped down - 20 July 2015*

3. The risk and control framework and risk assessment

As designated accountable Officer I have overall responsibility for risk management with specific responsibilities delegated to other Executive Directors and senior managers within the organisation.

Risk Management framework
The trust has a comprehensive Risk Management Strategy and Policy which has Board approval and is available to staff via the Trust's intranet pages.

These documents describe the Trust's overall risk management strategy, responsibilities for risk at each level of the organisation, the risk management process and the Trust's risk identification, evaluation and control system.

The leadership and governance framework for risk management is as follows:

- The Audit Committee meets 4-5 times annually and oversees the overall performance of the risk management system. Additionally the Trust's Board-level Quality Governance committee on a monthly basis

and monitors reviews and reports on the quality of services provided by the Trust. It provides assurance to the Audit Committee and the Trust Board that effective governance, risk management and internal control systems are in place to ensure that the Trust's services deliver safe, high quality, patient-centred care. Key risks are highlighted to and reviewed by the Trust Board both as part of its regular monitoring of performance and in the context of specific issues that may arise.

- The Trust has a Risk Group which is chaired by the Director of |Corporate Development, Governance and Assurance providing executive oversight of risk management issues. The Risk Group is responsible for ensuring the development and implementation of effective systems and processes for risk management at each level of the Trust. All new risks with a proposed score of 15 and above ('Significant') are reviewed by the Risk Group who also undertakes a monthly review of corporate directorate and Divisional / Directorate risks with a score of 12 ('High') and above and those risks with high consequence but low likelihood.
  The Risk Group reviews the Trust's corporate risk register on an ongoing basis and this is presented to the Trust Board and its sub committees on a quarterly basis.
- The Trust has a Governance team with a focus on integrated risk management – the team support the process of identification, assessment, analysis and management of risks and incidents at every level in the organisation and the aggregation of results at a corporate level.
- The Director of Corporate Development, Governance and Assurance is the Trust's Senior Information Risk Owner (SIRO). Working closely with the Medical Director as Caldicott Guardian, the SIRO is responsible for taking ownership of information risk at Board level and advising the Chief Executive accordingly.
- For each of the Trust's Divisions' the Divisional Director has lead responsibility for governance and risk issues and is responsible for coordinating risk management processes within the Divisions, including management of the Divisional risk register supported by the Divisional manager. The Divisional management groups have responsibility for monitoring, managing and where necessary escalating risks on their risk registers and significant risks are reviewed at monthly performance review meeting.

Risk management training is delivered to staff in accordance with the Trust's risk management training needs analysis. This begins at corporate induction which all staff are required to attend.

There is clear policy and guidance on the type of courses that staff need to attend and the frequency of attendance required. Attendance at mandatory risk management training courses is monitored and fed-back to Divisions

and Corporate directorates via a central monitoring database with Human Resources which allows corrective action to be taken by management teams as required aimed to improve attendance rates throughout the year.

Board Assurance Framework (BAF)

Throughout 2015/16 the organisation reviewed the processes for developing the BAF and risk management processes and recruited a Director of Corporate Development, Governance and Assurance to continue this work.

The BAF is based around the Trust's strategic objectives and is mapped to the Care Quality Commission's Fundamental Standards. It identifies the principal risks to the achievement of those objectives, the key controls in place to manage those risks and the sources of assurance about the effectiveness of those controls.

It also details any gaps in control and assurance in relation to the risks, including strategic objectives related to service delivery, workforce, finance, service transformation, and infrastructure and information systems, together with actions to address them. The actions include identifying additional resources, putting in place new systems, processes, operating procedures and monitoring arrangements, strengthening project and programme management, and effective working with partners.

The BAF is updated monthly by the Executive Director leads with a full review at the end of each quarter which is then presented to the Trust Board. In addition risks to objectives are reported to a Trust Board assurance committee for monitoring and oversight. It is also crossed referenced to the Corporate Risk Register.

The Trust's principal risks can be found listed in Appendix 1.

Internal Audit

During the year the Trust engaged TiAA Ltd as its Internal Auditors; they have integrated successfully with the Trust continuing progress in completing the internal audit programme as agreed at the start of the financial year.

Counter Fraud

Northampton General Hospital NHS Trust Local Counter Fraud service ensures an annual plan of proactive work to minimise the risk of fraud within the Trust and is fully compliant with NHS Protect Counter Fraud Standards for providers. Preventative measures include reviewing Trust policies to ensure they are fraud-proof utilising intelligence, best practice and guidance from NHS Protect.

The Trust is committed to promoting and maintaining an absolute standard of honesty and integrity, and to eliminating fraud and illegal acts committed within the Trust and detection exercises are undertaken where a known area is at high risk of fraud.

Fraud is deterred by publicising proven cases of NHS fraud and staff are encouraged to report suspicions of fraud through utilising communications, presentations and fraud awareness literature throughout the Trust's sites. The Local Counter Fraud Specialist liaises with Internal Audit in order to capture any fraud risks from internal audits undertaken within the Trust. Counter Fraud reports are presented to the Audit and Risk Committee and include details of reported suspicions of fraud in addition to actual fraud.

Stakeholder involvement in risk

Partners and stakeholders are involved in managing risks which impact on them through their involvement in and contributions to many aspects of the work of the Trust, including for example:

- **Patients and the public**
  - The work of the Trust's Patient Forum, the Patient Advice and Liaison Service and specific patient representative groups.
  - Patient membership of key Trust committees and groups.
  - The work of the local Health and Wellbeing Boards.
  - Meetings of the Trust Board held in public which include monthly Patient Stories.
  - An extensive volunteering programme across hospital departments
  - A Patient & Public Engagement Network to ensure engagement is managed effectively with people that wish to be involved given opportunities throughout the organisation.
  - A dedicated and committed group of ward audit volunteers who conduct surveys and audits on behalf of the Trust
  - The National Patient Survey Programme and the results of real time feedback through the Friends and Family Test available on wards, and through the NGH external website.
  - Representation on the Patient & Carer Experience and Engagement Group (PCEEG) from Health Watch and internal focus groups (such as BME, Dignity, end of life).
  - During the coming year the Trust will be implementing the use of a Membership Engagement Service database to further encourage active membership and engagement with the Trust.
- **Staff**
  - Strong focus on encouraging staff to raise concerns
  - Plan to appoint a Freedom to Speak Up Guardian supported by special volunteers
  - Board to Ward and "Beat the Bug" visits by Executive and non-Executive Directors.
  - Monthly Core Brief to staff by Executive team.
  - Partnership forum with staff-side representation.
  - Staff Engagement Strategy that includes specific vehicle through which staff views are sought on key matters.

- **Partners**
    - Regular performance discussions with commissioners and the Trust Development Authority.
    - Regular Board to Board meetings and discussion with the Trust Board of Kettering Hospital
    - Weekly Operations Executive Meeting comprising the Chief Executive Officers of Health and Social Care partners across the Northamptonshire County.
    - Healthier Northamptonshire - a countywide, multi partner forum for transformation delivery.
    - System Resilience Group.

Compliance matters
The Trust has an Equality and Human Rights Strategy, that was adopted in 2013 and this is due for review in April 2016.

For our workforce we have our Equality Objectives and 4 Year Equality and Diversity Plan, which linked to the outcomes of our EDS2 (Equality Delivery System) self-assessment and these are also due for review in 2016.

The Trust has undertaken and published the data required for 2015 in accordance with the NHS England Workforce Race Equality Standard (WRES). Both an annual Equality and Human Rights and Annual Equality and Human Rights Monitoring Report are published on our website along with other key equality and diversity documents.

The Trust has an Equality and Diversity Staff Group that meets on a quarterly basis and it reports into the Trust's Workforce Committee.

As an employer with staff entitled to membership of the NHS Pension scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Northampton General Hospital NHS Trust has reviewed the required risks and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. Adaptation reporting uses a risk based approach in conjunction with resilience planning founded on weather-based risks e.g. heat wave, extreme cold, drought, flood.

Details of compliance with the Care Quality Commission's Essential Standards of Quality and Safety can be found in Section 4 below.

Information Governance (IG)
Northampton General Hospital NHS Trust is committed to ensuring it manages all the information it holds and processes in an efficient, effective and secure manner through the application of robust IG policies and procedures to support the delivery of high quality patient care. The IG team also run a series of audits and checks across the organisation to ensure compliance.

The Trust has had two data security breaches during the year which have been reported to the Information Commissioners Office and details are included within section 4.

Quality Account
The Trust produces an annual Quality Account report in respect to its quality priorities and the quality of services by an NHS healthcare provider. This Quality Account is an important way that the Trust reports and demonstrates improvements to the services delivered

In addition to a review of the quality of the services the Quality Account includes specific statements relating to assurance and the Trust's performance against national standards.

The indicators within this document are subject to external audit scrutiny and the auditors are required to provide an independent assurance opinion to the organisation. During 2014/15 the Trust received an unqualified limited assurance opinion for its Quality Account.

4. Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work.
The Head of Internal Audit Opinion for 2015/16 concludes in summary that:

> Reasonable assurance can be given that there are adequate and effective management and internal control processes to manage the achievement of the organisation's objectives.

This is based on:

a) An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and

b) An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the first nine months of the financial year. This

assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

Additional areas of work that may support the opinion will be determined locally but are not required for Department of Health purposes e.g. reliance being placed upon Third Party Assurances.

c) TIAA has carried out 14 assurance reviews to date, which were designed to ascertain the extent to which the internal controls are adequate and to ensure that activities and procedures are operating to achieve the Trust's objectives. For each assurance review an assurance assessment was provided. A summary is set out below:

Assurance Assessments	Number of Reviews
Substantial Assurance	2
Reasonable Assurance	10
Limited Assurance	2
No Assurance	0

However, the full opinion does note that there are some areas where improvements can be made in design or consistency of application which may increase the effectiveness of some controls to eliminate or mitigate risks to the achievement of some of the objectives. These include the audits where 'Limited Assurance' was given in:

- **Health & Safety - Asbestos and Safe Management of Water Policies**
- **Agency Staffing**

The Trust has implemented in immediate improvements and a longer term action plan to address areas for improvement highlighted in these audits.

My review has been informed by

- Executives and managers within the organisation, who have responsibility for the development and maintenance of the system of risk management and internal control.
- Performance against national and local standards.
- The Trust's ongoing assessment of compliance with the CQC's Fundamental standards
- The findings of the comprehensive inspection of Northampton General Hospital NHS Trust by the Chief Inspector of Hospitals.
- The work of internal audit through the year. Details of the internal audit reports completed during 2015/16 and the level of assurance provided are set out in the head of internal audit opinion.

- Outcomes of the Trust's clinical audit programme.
- The results of external audits work on the Trust's annual accounts and local tailored performance management reviews.
- Patient and staff surveys and feedback and other sources of external scrutiny and accreditation including clinical peer review arrangements.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Quality Governance Committee, Risk Management Group and the Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place. Key roles have been as follows:

- The Board has played a key role in reviewing risks to the delivery of the Trust's performance objectives through monthly monitoring and discussion of the Corporate Performance Report and detailed financial and quality and safety reports, and through Board and committee reporting on progress against other strategic objectives.
- The Audit and Risk Committee has overseen the effectiveness of the risk management arrangements.
- The Risk Management Group has reviewed the Trust's risk register and the Board Assurance Framework and monitored key clinical and non-clinical risks highlighted by Trust committees and individual managers.
- Executive Directors have ensured that key risks have been highlighted and monitored within their functional areas and the necessary action taken to address them.
- Both Internal and External Audit have provided scrutiny and assurance in relation to governance and control arrangements across a wide range of the Trust's activities.

The Trust has identified the following significant control issues and the actions which have been or are being taken to address them.

Compliance with Care Quality Commission (CQC) Essential Standards of Quality and safety

Northampton General Hospital NHS Trust is registered with the Care Quality Commission (CQC) and following the CQC Chief Inspector of Hospital's Inspection in January 2014 with a follow up inspection in September 2014 The Trust received an overall rating of 'Requires Improvement'.

There are currently no outstanding warning notices for the Trust.

Data Security

During the year there were two incidents involving personal data which were reported to the Information Commissioners Office (ICO).

Incident 1

A spreadsheet containing patient information was emailed from the Trust to the CCG to indicate patient volumes in order to support a business case. The spreadsheet contained approximately 150 patient details such as Patient Name, PAS number, diagnosis, care plan.
The data required by the CCG was numbers of patient only, the CCG are not entitled to patient level information in this case. Unfortunately the patient data was not removed; the whole spreadsheet was released and sent unencrypted to the CCG.

Incident 2
A patient list which included clinical data was found in the on-site library (provided by a third party NHS organisation).

Lessons Learned – Incident 1 and 2

1. Staff made aware of the importance of certifying a recipient's rights to personal identifiable data (PID) and that recipients of any person identifiable data (PID) must have the appropriate rights to receive patient level information.
2. Remind staff that not all monitoring/regulatory bodies have the appropriate rights to patient level information, especially when the information is not for the direct care of that patient. Staff were educated that they must identify this as appropriate and seek advice from senior management or IG team when sharing.
3. Ensure awareness of the use of secure accounts for information transfer.
4. Staff must ensure any embedded document/reports are scrutinised for PID.
5. Teams or departments that send information out of the Trust regularly must have a process in place where a senior member staff or fellow colleague reviews the information before it is sent.
6. Care must be taken when physically transferring information or documents which contain PID from on location to another, onsite and offsite. All transfers must be carried out in line with Trust policies.

Incident 3
A preadmissions list containing 42 patient details was sent insecurely to a new service provider. The recipient was entitled to receive patient level information however the mode of transfer led to a breach of the DPA 1998. Investigation and learning from this incident were still underway at the time of writing this statement.

All three incidents were graded as Level 2 on the Information Governance (IG) Toolkit Incident reporting tool and the Information Governance (IG) team within the Trust put together an action plan, working closely with the ICO caseworker in order to provide significant assurance of the Trust's IG agenda.

National Performance Standards
Despite the increasing challenges with urgent care during 2015/16, the Trust has met the majority of national performance standards. However it underachieved on the standards for:

4Hr A&E standard
2015/16 was another challenging year for the Trust's urgent and emergency care pathways and our emergency department saw an additional 4,322 patients (4.3% increase), patients together with 3,730 more admissions than the previous year representing a 15.1% increase.

After a challenging start to the year, during June, July and August the acuity of patients decreased and performance was sustained above the 95% standard however this deteriorated from September onwards with the Trust seeing an increase in both acuity and activity.

These issues contributed to a high bed occupancy rate throughout autumn and winter of 2015/16 and these issues remain challenging for the Trust with additional factors of high numbers of delayed discharges, with often in excess of 15% of acute beds occupied with patients waiting for ongoing care and support outside of an acute hospital setting.

A new clinically led and managed organisational structure was put into place during 2015 and is now embedding with senior clinical leaders taking accountability for performance.

Looking forward to 2016/17 the Trust is implementing an inpatient productivity project as part of our cost efficiency and productivity programme 'Changing Care @ NGH'. This will focus on weekend discharge, ward leadership and standardising ward process supported by a new ward accreditation scheme.

The external support required to reduce the number of patients who are delayed continues to be a challenge and the likely financial cuts in adult social care will inevitably impact performance within the hospital, therefore to support this likely increase in activity there is a proposed business plan to put in place an additional 60 acute beds during winter 2016.

Cancer waiting times
The two cancer standards which were not achieved in 2015/16 were the 31 day wait standard (quarter 2) and 62 day wait standard (quarters 1-4)

During 2015/16, the Trust saw an increase of 14% in referrals to the two week wait pathways along with an increase in complex cancer cases, requiring multiple diagnostic interventions and treatments.

During 2015 the Trust developed an internal cancer board to oversee performance and a "Breaking the Cycle" project. This project has been focused on reducing waits across diagnostics, including MRI, CT and

Endoscopy with further CT, MRI and Endoscopy capacity planned for 2016. Additionally agreement was reached both Kettering General Hospital and University Hospitals Leicester in respect to patients referred after day 42 to the tertiary centre whereby the receiving hospital will be allocated the full breach.

A county wide Cancer improvement group has been established and is supporting the trust to deliver actions which will enable achievement of the cancer performance during 2016/17.

52 week RTT
One patient waited over 52 weeks for treatment which was investigated and discovered to be the result of an administrative error, further training was put in place to support the relevant staff.
.
Number of patients not treated within 28 days of any last minute cancellations for non-clinical reasons
During 2015/16 the Trust had 31 patients who breached this target which represented an increase from 2014/15. These were largely due to pressures from the urgent care pathway. All affected patients were routine elective admissions and involved clinically led decisions to treat more urgent patients.

Divisional management teams are held to account through monthly review meeting with the Executive Directors as described in the Trust's Performance Management Framework document.

Quality & accuracy of waiting List data & associated risks
During 2015/16 the Trust has undertaken a comprehensive programme to provide assurance around the data that is published and/or submitted externally. This work has been supported through the recruitment of dedicated audit staff that review and corroborate information held both electronically and on paper.

The programme of work includes audits against the accuracy and use of "clock stops" and RTT status codes. A full review of all reports used to generate figures for national returns is also part of this programme.

Audit findings are presented to the Trust's Assurance, Risk and Compliance Group and additionally any recommendations and findings are circulated to Divisional Managers across the organisation.

The trust has is re-establishing a data quality steering group with the responsibility of responding to any issues identified through audits both internally and externally. This group will also ensure that any change to national guidance is identified and implemented in a timely manner with full documentation maintained.

Current areas of risk include:

1. Non adherence to the access policy and timely input of data onto PAS. This is being mitigated by providing training to all key staff on the use of the access policy and more intensive training for small groups is currently taking place on RTT rules. Consideration is currently underway around mandatory role specific annual training.

2. Multiple systems being accessed to provide information both internally and externally, which could lead to discrepancies in the information being presented. This is being mitigated by a full assessment of internal and external data returns including information being processed through the data warehouse.

Never events
During the year Northampton General Hospital reported 3 incidents that fell under the reporting category of Never Events.

These were as follows:

- Wrong site surgery: Incorrect tooth extraction.
- Wrong site surgery: Bilateral Oophorectomy performed.
- Incorrect implant: Incorrect strength lens inserted during cataract surgery.

Immediate actions were put in place and a full root cause analysis was undertaken for each event and a comprehensive action and improvement plan implemented. This was shared with the Trust's commissioners and overseen through the Quality Governance structures of the organisation. Additionally, a thematic analysis of these three never events is to be undertaken on completion of the final root cause analysis.
All theatre clinical teams involved in the incidents will be required to attend a simulation session to reinforce lessons learnt.

During 2016/17 the Trust will be re-invigorating the organisation's Safety and Learning Forum to further improve organisational sharing and learning.

Financial Improvement Plan
Northampton General Hospital has an established programme for improving quality and efficiency. This is the Changing Care @ NGH programme which consists of projects led by clinical leaders and executive directors. In 2015/16 the programme delivered £12 million of savings.

For 2015/16 the Trust started the year with a planned deficit of £21.2 million and accepted a partial stretch target to improve the position to £20.4 million deficit. The final deficit reported prior to audit of the accounts was £20.15 million.

The Trust is continuing to work with Health Economy Partners including commissioners, other healthcare providers and local government to identify a medium term sustainability and transformation plan aimed at returning the health system to a more sustainable financial position within five years. NGH does however like many NHS providers currently face a very challenging financial environment and is anticipating a deficit of £27.4 million in 2016/17 based on the latest available information at the time of writing.

Nurse Recruitment
The national shortage of trained nurses continues to pose a significant risk to the organisation. We continue with efforts to mitigate this risk and in addition to an "Overseas Nurses" recruitment programme the Trust has moved to a twelve hour shift standardisation within nursing which has seen an improvement in shift fill rates and improved continuity of care for our patients.

In addition a revised staff retention strategy is being implemented in order to support our existing staff and reduce turnover rates.

Conclusion
With the exception of the internal control issues that I have outlined in this statement, my review confirms that Northampton General Hospital NHS Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.

Dr Sonia Swart

Chief Executive Officer
Northampton General Hospital NHS Trust

Report from the Director of Finance

Economic Outlook and Impact on the Trust

The NHS continues to experience extreme financial pressures with almost all NHS Acute Hospitals in deficit in 2015/16 with the size of deficits rising considerably compared to 2014/15.

In 2014/15 nationally NHS Providers (NHS hospitals and community and mental health Trusts) incurred a financial deficit of approximately £0.8 billion but in 2015/16 this increased to in excess of £2 billion.

The situation reflects systematic underfunding of NHS providers and we have been affected by this; our financial performance was also characterised by an increasing deficit although the rate of increase was less severe than the national position.

We continued to target improvements in quality and efficiency through our established Changing Care@ NGH programme. The provision of high quality care even in the face of extreme financial pressures is being prioritised with appropriate improvements in efficiency being planned and delivered subject to rigorous quality impact assessments.

There is some additional funding available nationally in 2016/17 and it is too soon to say what impact this will have on the NHS Provider sector. The funding settlements beyond 2016/17 are extremely tight and all the indications are that NHS Providers like NGH will continue to face very significant financial challenges going forward.

Financial Performance

We originally planned a deficit of £21.2 million in 2015/16. The Trust Development Authority (NHS Trust regulator) challenged us to improve our position to a stretch target deficit of £18.8 million which our Board responded to by agreeing a partial stretch target and revising its planned deficit to £20.4 million. The final actual deficit was £20.15 million, greater than the previous year's deficit of £16.5 million. However we were able to stay on track to deliver our revised £20.4 million plan throughout the year and although our deficit has increased, the increase is less dramatic than the national trend. In holding our deficit to £20.15 million, we had to deliver £12 million of savings through the Changing Care@ NGH programme.

We met its other financial duties to manage our capital expenditure within our capital resource limit, our borrowing within our external finance limit and paying suppliers within 30 days for more than 95% of invoices paid.

Capital Expenditure

We invested £18.1 million in 2015/16 improving our estate, medical equipment and information technology (IT) assets. In the year we made a successful application for new equipment funding of £9.4 million to finance the costs of some major medical equipment replacement including two new linear accelerators for radiotherapy cancer treatment and a new MRI scanner and CT scanner.

Charitable Funds

Northamptonshire Health Charitable Funds continued to support the our work and also made progress to moving to independent charitable status.

Risk management
We review risks against our principal objectives on a regular basis and an agreed system of internal control is in place. This is described in more detail in the Annual Governance Statement, which can be found on page xxx [**to be inserted once report layout has been completed**]

Counter-fraud policies
We take all reasonable steps to comply with the requirements set out in the code of conduct for NHS managers, and have appointed TIAA Ltd to provide an accredited counter-fraud specialist service. Their remit also includes compliance with the Bribery Act.

Charges for information
We have complied with HM Treasury's guidance on setting charges for information, as outlined in Appendix 6.3 HM Treasury's guidance 'Managing Public Money'. This includes the use of charges in relation to requests for information as in accordance with relevant legislation, including the Freedom of information Act 2000; Environmental Information Regulations 2004; Data Protection Act 1998; and the Access to Health Records Act 1990. Standard charges are published on our website together with contact information if a special request is to be made.

Compliance with the NHS Constitution
Based on the reports it receives, the Board is able to provide reasonable assurance that it is compliant with the rights and pledges within the NHS Constitution and has had regard to the NHS Constitution in carrying out its function.

Better Payment Practice Code
The Confederation of British Industry (CBI) outlines the process in relation to:

Paying suppliers on time
- Within the terms agreed at the outset of the contract
- Without attempting to change payment terms retrospectively
- Without changing practice on length of payment for smaller companies on unreasonable grounds

Giving clear guidance to suppliers
- Providing suppliers with clear and easily accessible guidance on payment procedures
- Ensuring there is a system for dealing with complaints and disputes which is communicated to suppliers
- Advising them promptly if there is any reason why an invoice will not be paid to the agreed terms

Encouraging good practice
By requesting that lead suppliers encourage adoption of the code throughout their own supply chains. The normal payment terms for an approved invoice are 30 days from invoice date. Exceptions to this may arise where there is disagreement over the

invoice or it is received with insufficient time for processing. In the exception cases payment is made as soon as possible after agreement or receipt of the invoice as relevant. Where there is a dispute over an invoice our policy is to communicate this to the supplier as soon as the difference of view is apparent and agree how to proceed towards resolution.

We are signed up to the Better Payment Practice Code

Corporate Governance: The Trust Board

Led by the chairman, Paul Farenden, our trust board comprises executive and non-executive directors who are responsible for determining our strategic direction, agreeing our policy framework and monitoring our performance. Its statutory obligations are set out in the codes of conduct and accountability, published by the Department of Health.

The trust board discharges its responsibilities through bi-monthly public board meetings and bi-monthly board of director meetings, an annual public meeting and a framework of formal subcommittees. The supporting committee structure is designed to:

- Deliver the board's collective responsibility for the exercise of our powers and performance
- Assess and manage financial and quality risk
- Ensure compliance with Department of Health guidance, relevant statutory requirements such as the Care Quality Commission requirements and contractual obligations.

The current composition of the Board is:

- Chairman
- Five non-executive directors (one of whom is vice-chairman)
- Five executive directors with voting rights
- Four executive directors

The directors do not have material interests in organisations where those organisations or related parties are likely to do business, or are possibly seeking to do business with Northampton General Hospital NHS Trust.

The directors are not aware of any relevant audit information of which the trust's auditors are unaware and they have taken all the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the trust's auditors are aware of that information.

Directors during 2015 /16 * denotes voting members of the Trust Board.

Job Title	Name	Comments
Chairman*	Paul Farenden	
Chief Executive Officer*	Sonia Swart	
Non-Executive Directors*	Phil Zeidler (vice Chair) Graham Kershaw	

Job Title	Name	Comments
	Elizabeth Searle Nicholas Robertson David Noble Olivia Clymer	 Stepped down 30th Sept 2015 Commenced November 2015
Chief Operating Officer*	Debbie Needham	
Medical Director*	Michael Cusack	
Director of Nursing*	Rachel Corser (interim) Carolyn Fox	To July 2015 From July 2015
Director of Finance*	Simon Lazarus	
Director of Facilities and Capital Development	Charles Abolins	
Director of Workforce and Transformation	Janine Brennan	
Director of Strategy and Partnerships	Chris Pallot	
Director of Corporate Development, Governance and Assurance	Catherine Thorne	

Board members

Paul Farenden, CIPFA, MBA

Chairman

Paul was appointed as Chairman on 1st March 2013 and reappointed in 2015. A local man, who was previously chief executive at the Dudley Group of Hospitals NHS Foundation Trust, Paul has some 40 years' experience in healthcare finance, management and leadership. A qualified accountant, Paul has been chief executive in three NHS Trusts over the last 20 years, where he has led large-scale organisational change. Paul's experience has provided him with an in-depth understanding of both the NHS and the wider healthcare system.

Phil Zeidler

Vice Chairman

Phil had a successful career as an entrepreneur in financial services, building a number of businesses, including the largest independent outsourced distributor of general insurance in the UK. Currently chairman of two insurance businesses, a music fund and two strategy of change consultancies, his core skills lie in strategic planning, innovation and developing strategic relationships. He is married to a consultant paediatrician.

Graham Kershaw
Non-executive director
Graham holds a first class honours degree in business from Leeds Metropolitan University and an MBA. He is a fellow of both the Chartered Institute of Secretaries and Administrators and the Chartered Institute of Personnel and Development. Graham also holds a professional marketing qualification. Graham has been a main board director of a number of major UK retail companies including Lloyds Pharmacy, Capio UK and Joshua Tetley's. He is currently managing director of Cogniscence Ltd a business providing change management and business turnaround input mainly to the public sector.

David Noble
Non-executive director
David Noble's career has been in finance covering both the public and private sectors. Most recently David has spent nine years as finance director of the equipment procurement and support sector of the Ministry of Defence, leading change programmes to improve the performance of the organisation. He chairs the audit committee.

Elizabeth Searle
Non-executive director
After qualifying as a nurse and working in cancer and palliative care, Liz Searle held posts in higher education developing palliative care courses, with Macmillan as Director of Education Development and Support, and at Sue Ryder Care as Head of Palliative Care working with their hospices.

Olivia Clymer
Non-executive director
Olivia's early career was spent with the Environment Agency, which subsequently led to roles in related areas in both the public and private sector. Her experience of the voluntary and community sector and local authority helped to develop her focus on regeneration and the challenges of social and economic disadvantage. Olivia has served as a member for the Consumer Council for Water and as a housing association board member for nine years. She is currently an associate non-executive director for Dudley and Walsall Mental Health Trust. Her experience in social care and systems transformation has informed her interest in the challenging area of sustainable healthcare provision.

Dr Sonia Swart, MA, MB, BCh, MD, FRCP, FRCPath
Chief Executive
Sonia was appointed as chief executive on 20th September 2013, having been our medical director since September 2007 and acting chief executive since July 2013. Sonia qualified from the University of Cambridge and went on to train in general medicine and clinical haematology. She worked as a consultant haematologist in North Warwickshire before joining Northampton General Hospital in 1994. Prior to becoming Medical Director, Sonia combined an active clinical role with a number of managerial activities, including head of pathology, clinical director for diagnostics and clinical lead for the foundation trust application. Sonia has made a commitment to align the trust's aims, values, objectives and corporate governance to support a clinically-led quality agenda.

Deborah Needham
Chief Operating Officer
Deborah trained as a registered general nurse in Lancashire, where she held positions in both respiratory and emergency medicine units before moving to London in 1998 as a ward sister. After graduating as a nurse, Deborah gained a diploma in respiratory medicine and nursing care and a BA (Hons) in healthcare management

Simon Lazarus
Director of Finance
Simon joined NGH in March 2014 from the Oxford University Hospitals NHS Trust where he was the deputy director of finance. Simon has held a number of senior roles in NHS hospital finance since joining the NHS in 1993. He has a special interest in improving hospital finances, financial planning and major capital projects. Simon is a chartered accountant and has a degree in natural sciences from Cambridge University. Simon started his career in the private sector working in London before joining the NHS.

Dr Michael Cusack
Medical Director
Dr. Michael Cusack, a consultant cardiologist, has joined our executive team from the end of September 2014. Mike was closely involved with reconfiguration of cardiac services across sites, led the Black Country Cardiovascular Network from 2008-2012 and has been involved in various aspects of pathway redesign. He has a longstanding interest in medical management and has been a clinical director and more recently a divisional medical director of a large surgical division at Royal Wolverhampton Hospital. His responsibility there included all surgical specialties, anaesthetics, theatres, support and maternity services in a medically-led management model.

Carolyn Fox
Director of Nursing
Carolyn began her nursing career in Sheffield and qualified as a registered nurse in 1990. She held staff nurse positions and went on to become a ward manager in respiratory medicine. Carolyn worked in London as a clinical nurse specialist before relocating to the North West. With an interest in quality, Carolyn worked as a national programme manager, NHS Quality Improvement Scotland and assistant director of nursing, Salford Royal Foundation Trust before joining Aintree University Hospital as deputy director of nursing.

Charles Abolins, FBIFM, MHCIMA
Director of Facilities and Capital Development (non-voting)
Responsible for our estates and facilities, procurement and capital development, purchasing and supply. After graduating in hospitality management from Birmingham College of Food and Tourism, Charles has held a number of facilities management posts in the NHS. Since joining NGH, Charles has been responsible for leading and implementing complex, major capital building programmes and managing a wide range of facilities support services. He is our lead for sustainability.

Janine Brennan

Director of Workforce and Transformation (non-voting)
Janine was appointed as director of workforce & transformation on 2nd April 2013, having worked previously as director of workforce and organisational development at Royal Berkshire NHS Foundation Trust. She qualified in law and human resources management and has worked in a number of acute NHS Trusts, as well as the public sector and not-for-profit organisations. Janine's special interest is in developing staff commitment and engagement in ways that lead to improvements in the care we give to patients.

Chris Pallot MSc, BA (Hons), DipHSM, DipM
Director of Strategy and Partnerships (non-voting)
Chris has worked with us since January 2010. He joined the NHS management training scheme in 1995 after graduating from university and since then has gained a postgraduate Diploma in Marketing and an MSc in Management. During his career, Chris has held previous positions at Kettering General Hospital, the NHS Modernisation Agency, Northamptonshire Heartlands PCT and NHS Northamptonshire. In previous roles he has been responsible for operational management, service improvement and commissioning & contracting. As director of strategy and partnerships, he has responsibility for strategy development, contracting, market development and clinical coding services.

Catherine Thorne
Director of Corporate Development, Governance and Assurance (non-voting)
Catherine was appointed as director of corporate development, governance and assurance in January 2015 having previously held the post of director of governance for London North West Healthcare NHS Trust. She started her career clinically within radiotherapy and oncology services, transitioning into a variety of senior NHS roles in quality assurance, service improvement and governance. Catherine acts as the board secretary in addition to responsibility for clinical governance, health and safety, and compliance, risk and legal services.

Table of Attendance 2015/16

A = Maximum number of meetings the Director could have attended

B = Number of meetings Director actually attended

	Trust Board / Board of Director Meetings		Audit Committee		Quality Governance Committee		Finance, Investment & Performance Committee		Workforce committee		Remuneration Committee	
Name	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**
Chairman	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**
Paul Farenden	12	12			12	10	12	10	11	4	3	3
Chief executive	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**
Dr Sonia Swart	12	12			12	7	12	10	11	4	3	3
Non-executive Directors	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**
Graham Kershaw	12	10	4	4	12	7			11	4	3	3
David Noble	12	12	4	4	12	7	12	11			3	3
Nicholas Robertson	6	5	2	4	6	0					2	2
Elizabeth Searle	12	7	2	2	12	9					3	2
Phil Zeidler	12	10	1	1			12	9			3	3
Olivia Clymer	5	4	1	1	5	1	12	1	5	4	1	1
Executive Directors	**A**		**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**
Deborah Needham	12	11			12	8	12	9	11	7		
Simon Lazarus	12	12	4	4	12	6	12	10				
Rachael Corser	4	2			4	1	3	3	4	0		
Carolyn Fox	9	9			9	9			9	8		
Dr Michael Cusack	12	11			12	9	4	1	11	8		

	Trust Board / Board of Director Meetings		Audit Committee		Quality Governance Committee		Finance, Investment & Performance Committee		Workforce committee		Remuneration Committee	
Chris Pallot	**12**	**11**			**12**	**5**	**12**	**10**				
Janine Brennan	**12**	**11**			**12**	**8**	**12**	**9**	**11**	**10**	**3**	**3**
Charles Abolins	**12**	**11**			**12**	**8**	**12**	**10**	**11**	**10**		
Catherine Thorne	**12**	**11**	**4**	**4**	**12**	**9**	**3**	**2**	**11**	**9**		

Board Meetings
The Board meets in public session every other month with a board of directors meeting in the intervening months. Where the board meets in public this is also followed by a second session held in private. Information regarding board meetings, including agenda and papers, is published on our website.

Audit committee
The audit committee meets around six times per year. Its purpose is to review the systems of integrated governance, risk management and internal control, to ensure that there is an effective internal audit function, to review the findings of the external auditor, to review the findings of other significant assurance functions and considers the draft annual report and financial statements before submission to the board.

Finance Investment and Performance Committee
The finance investment and performance committee meets monthly. The committee's purpose is to maintain a detailed overview of our assets and resources in relation to the achievement of financial targets and business objectives and the financial stability on behalf of the board. In addition, this committee is responsible for ensuring the delivery of all key performance metrics.

Quality Governance Committee
The quality governance committee meets monthly. The purpose of the committee is to ensure there is an effective system of integrated governance, risk management, and internal control across the clinical activities of the organisation that support the organisation's objectives of delivering the best possible outcomes of care to patients.

Workforce Committee
The workforce committee meets monthly. The purpose of the committee is to provide assurance to the trust board on organisational development and workforce performance and on the achievement of associated key performance indicators and

to make recommendations to the trust board on key strategic organisational development and workforce initiatives.

Declaration of Interests of Trust Board Members

(as at 5 January 2016)

Member	Directorships (a)	Other business (b)	Charity/ Voluntary sector (c)	Others (d)
Charles Abolins	None	None	None	None
Janine Brennan	None	None	None	Husband is an employee of Oxford University Hospitals – Director of Clinical Services
Rachael Corser Left September 2015	None	None	None	None
Dr Mike Cusack	None	None	Hon Treasurer NHS Retirement Fellowship	None
Paul Farenden	None	None	None	None
Caroline Fox Started July 2015	None	None	None	None
Graham Kershaw	None	None	None	None
Simon Lazarus	None	None	None	None
Deborah Needham	None	None	None	None
David Noble	Director, David C Noble	None	None	None

Member	Directorships (a)	Other business (b)	Charity/ Voluntary sector (c)	Others (d)
	Ltd			
Chris Pallot	None	None	Chairman, Voluntary Impact Northampton shire	None
Nick Robertson Left 30 September 2015	None	None	Trustee of 'Mental Health Matters'/Chair of Audit Committee	Governor, Northampton University (1st August 2011)
Liz Searle	None	None	Clinical Director at Keech Hospice	None
Dr Sonia Swart	None	None	None	None
Catherine Thorne	None	None	None	None
Phil Zeidler	Director Amp Channel 2 Ltd Director Dead Happy Limited Chairman EDBL Ltd Non-executive chairman, IG04 Ltd Non Executive Director of NMG Group Holdings Director of Playbrave Sports Ltd Senior Independent Director AssurOne Group Non-Executive Chairman Simply business Non-Executive Director Curium Solutions	None	None	Wife is consultant paediatrician at NGH
Olivia Clymer Commenced 1 Nov 2015	Non-Executive Director for Dudley and Walsall Mental Health Trust	None	Secretary of Sailing Club	None

Guidance to Codes:

a. Directorships, including non-executive directorships held in private companies or plcs (with the exception of those of dormant companies);

b. Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS; majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS;
c. A position of authority in a charity or voluntary body in the field of health and social care;
d. Any connection with a body that NGH may contract with or compete with (include family members)

Each director knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken "all the steps that he or she ought to have taken" to make himself/herself aware of any such information and to establish that the auditors are aware of it.

Remuneration and staff report

TO FOLLOW – REMUNERATION POLICY

TO FOLLOW – REMUNERATION POLICY

Pay Multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the Trust in the financial year 2015-16 was £225-230k (2014-15, £225-230k). This was 10.97 times (2014-15, 11.0 times) the median remuneration of the workforce, which was £21k (2014-15, £23k).

In 2015-16 and 2014-15 no employees received remuneration in excess of the highest-paid director. Remuneration ranged from £1k for part-time staff to £180k for the next highest paid director. (2014-15 £1k - £180k)

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The ratio has decreased in 2015/16 by 0.03. Nursing staff represent the largest increase in Total Average Staff Numbers. The majority of staff on Agenda for Change terms and conditions received a 1% pay increase. This has contributed to the increase in the overall median remuneration of the workforce.

Salary and Pensions report

Salary and Pension entitlements of senior managers

Remuneration

Name and Title	2015-16 Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100 £00	Performance Pay and Bonuses (bands of £5,000) £000	Long term Performance Pay and Bonuses (bands of £5,000) £000	All Pension-related Benefits (bands of £2,500) £000	Total - Salary & Benefits (bands of £5,000) £000
Paul Farenden - Chairman	20-25	25				20 - 25
Sonia Swart - Chief Executive Officer	225-230					225 - 230
Deborah Needham - Chief Operating Officer / Deputy Chief Executive Officer	125-130				22.5 - 25	150 - 155
Michael Cusack - Medical Director	180-185				17.5 - 20	195 - 200
Carolyn Fox - Director of Nursing, Midwifery & Patient Services (20 July 15 onwards)	75-80				200 - 202.5	275 - 280
Rachael Corser - Interim Director of Nursing, Midwifery & Patient Services (up to 19 July 15)	35-40				67.5 - 70	105 - 110
Simon Lazarus - Director of Finance	120-125				17.5 - 20	140 - 145
Charles Abolins - Director of Facilities & Capital Development	95-100				0	95 - 100
Janine Brennan - Director of Workforce and Transformation	110-115				5 - 7.5	120 - 125
Chris Pallot - Director of Strategy & Partnerships	95-100				15 - 17.5	110 - 115
Catherine Thorne - Director of Corporate Development, Governance & Assurance	100-105				0	100 - 105
Phil Zeidler - Non-Executive Director (Vice Chairman)	5-10	6				5 - 10
Nicholas Robertson - Non-Executive Director (up to 30 September 15)	0-5	5				0 - 5
Graham Kershaw - Non-Executive Director	5-10	14				5 - 10
David Noble - Non-Executive Director	5-10	7				5 - 10
Elizabeth Searle - Non-Executive Director	5-10	5				5 - 10
Olivia Clymer - Non-Executive Director (2 November 15 onwards)	0-5					0 - 5

Name and Title	2014-15 Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £100 £00	Performance Pay and Bonuses (bands of £5,000) £000	Long term Performance Pay and Bonuses (bands of £5,000) £000	All Pension-related Benefits (bands of £2,500) £000	Total - Salary & Benefits (bands of £5,000) £000
Paul Farenden - Chairman	20-25	19				20 - 25
Sonia Swart - Chief Executive Officer	225-230					225 - 230
Deborah Needham - Chief Operating Officer / Deputy Chief Executive Officer	125-130				227.5 - 230	355 - 340
Michael Cusack - Medical Director	90-95				240 - 242.5	330 - 335
Carolyn Fox - Director of Nursing, Midwifery & Patient Services						
Rachael Corser - Interim Director of Nursing, Midwifery & Patient Services	25-30				27.5 - 30	55 - 60
Simon Lazarus - Director of Finance	120-125				115 - 117.5	235 - 240
Charles Abolins - Director of Facilities & Capital Development	95-100				85 - 87.5	180 - 185
Janine Brennan - Director of Workforce and Transformation	110-115					110 - 115
Chris Pallot - Director of Strategy & Partnerships	95-100				5 - 7.5	105 - 110
Catherine Thorne - Director of Corporate Development, Governance & Assurance	20-25					20 - 25
Phil Zeidler - Non-Executive Director (Vice Chairman)	5-10	9				5 - 10
Nicholas Robertson - Non-Executive Director	5-10	5				5 - 10
Graham Kershaw - Non-Executive Director	5-10	6				5 - 10
David Noble - Non-Executive Director	5-10					5 - 10
Elizabeth Searle - Non-Executive Director	5-10					5 - 10
Olivia Clymer - Non-Executive Director						

Salary Notes

The following Senior Manager's 2014-15 salary represents a part year:
Michael Cusack (Sept - March)
Rachael Corser (Jan - March)
Catherine Thorne (Jan - March)

Nicholas Robertson's 2014-15 salary represents a full year

Relocation packages were paid, exempt of PAYE & NICs, in accordance with HMRC guidelines, to the following:
Michael Cusack - £3k (2014-15 £5k)
Carolyn Fox - £5k

The benefits paid to Non-Executives and Chairman above relate to travel and subsistence between home & office

All pension related benefits represent the annual increase in total pension benefits entitlement. This represents the values payable at the beginning and end of the financial year, adjusted for inflation, irrespective of whether or not the position was held for full or part year and length of NHS service. Where this value is negative a nil balance is shown

Pension Benefits

Name & Title	Real increase in pension at Pension Age (bands of £2,500)	Real increase in pension lump sum at Pension Age (bands of £2,500)	Total accrued pension at Pension Age at 31 March 2016 (bands of £5,000)	Lump sum at Pension Age related to accrued pension at 31 March 2016 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2015	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2016	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Sonia Swart - Chief Executive Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0
Deborah Needham - Chief Operating Officer / Deputy Chief Executive Officer	0 - 2.5	0	35 - 40	110 - 115	511	21	538	0
Michael Cusack - Medical Director	0 - 2.5	0	40 - 45	120 - 125	681	21	711	
Carolyn Fox - Director of Nursing, Midwifery & Patient Services (20 July 15 onwards)	5 - 7.5	15 - 17.5	25 - 30	85 - 90	297	93	453	0
Rachael Corser - Interim Director of Nursing, Midwifery & Patient Services (up to 19 July 15)	0 - 2.5	0 - 2.5	15 - 20	45 - 50	173	13	217	0
Simon Lazarus - Director of Finance	0 - 2.5	0	30 - 35	90 - 95	520	20	545	0
Charles Abolins - Director of Facilities & Capital Development	0 - 2.5	0 - 2.5	50 - 55	160 - 165	N/A	0	N/A	0
Janine Brennan - Director of Workforce and Transformation	0 - 2.5	2.5 - 5	45 - 50	135 - 140	822	27	859	
Chris Pallot - Director of Strategy & Partnerships	0 - 2.5	0	25 - 30	70 - 75	360	12	377	0
Catherine Thorne - Director of Corporate Development, Governance & Assurance	0 - 2.5	0 - 2.5	35 - 40	105 - 110	617	19	644	0

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated in accordance with the Occupational Pensions Schemes (Transfer Values) Regulations 2008.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

A rate of 1.2% Consumer Price Index (CPI) annual inflation has been used to calculate the real increases.

No lump sum is shown for senior managers who only have membership in the 2008 Section of the NHS Pension Scheme, unless they chose to move their 1995 Section benefits under Choice. No CETV is shown for pensioners, senior managers over 60 (1995 Section) or over 65 (2008 Section)

Off-Payroll Engagements

Off-Payroll Engagements Table 1
For all off-payroll engagements as of 31 March 2016, for more than £220 per day and that last longer than six months:

Narrative	Number
Number of existing engagements as of 31 March 2016	**36**
Of which, the number that have existed:	
for less than one year at the time of reporting	**32**
for between 1 and 2 years at the time of reporting	**0**
for between 2 and 3 years at the time of reporting	**0**
for between 3 and 4 years at the time of reporting	**0**
for 4 or more years at the time of reporting	**4**

Confirmation that all existing off-payroll engagements have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Off-Payroll Engagements Table 2
For all new off-payroll engagements between 1 April 2015 and 31 March 2016, for more than £220 per day and that last longer than six months:

Narrative	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	32
Number of new engagements which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	29
Number for whom assurance has been requested	32
Of which:	
assurance has been received	3
assurance has not been received	0
engagements terminated as a result of assurance not being received	0

Off-Payroll Engagements Table 3
For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2015 and 31 March 2016

Narrative	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	0
Number of individuals that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	10

Expenditure on consultancy
Details of our expenditure on consultancy can be found at Note 8 in the Annual Accounts [INSERT PAGE NUMBER FOLLOWING DESIGN AND LAYOUT PROCESS]

Exit packages
Details of exit packages can be found at Note 10.4 in the Annual Accounts INSERT PAGE NUMBER FOLLOWING DESIGN AND LAYOUT PROCESS]

Our Staff

Equality
During 2015/16, we continued to work towards the achievement of the objectives of our four year plan based on the outcomes of our Equality Delivery System (EDS2) assessment undertaken the previous year. EDS2 is about making positive differences to healthy living and working lives so that everyone counts.

The four year plan's objectives are:

Goal	Objective
1. Better Health outcomes for all	We will develop a programme of data

	collection and analysis to understand areas where there are health inequalities amongst protected groups. This will be completed in line with our quality programme and in conjunction with NHS Northamptonshire
2. Improved access and experience	We will increase engagement and involvement with representatives from protected groups. In two years we aim to achieve representation from 100% of the protected groups.
3. Empowered, engaged and well supported staff	We aim, by 2014, to improve our staff satisfaction rates as reported in the annual staff survey so that we are in the top 25% of Trusts for response to the question regarding whether staff would recommend the Trust as place to work.
4. Inclusive leadership at all levels	To develop a management and leadership strategy and programme for all staff based on the standards set out in the NHS Leadership Framework and its supporting frameworks.

The detailed action plan can be accessed via our website http://www.northamptongeneral.nhs.uk/WorkforUs/Equality,DiversityHumanRights/Equality,DiversityHumanRights.aspx

Gender distribution of staff

Directors & Non-Executives

	Count	Percentage
Female	7	46.67
Male	8	53.33
Grand Total	**15**	**100**

Senior Managers (Band 8-A and above) & Senior Medical Staff

ADDITIONAL INFORMATION TO FOLLOW

	Count	Percentage
Female	199	49.50
Male	203	50.50
Grand Total	**402**	**100**

All Employees

	Count	Percentage
Female	3866	78.95
Male	1031	21.05
Grand Total	**4897**	**100**

Staff numbers

A more detailed breakdown of our staff numbers can be found at Note 10.2 in the Annual Accounts **INSERT PAGE NUMBER FOLLOWING DESIGN AND LAYOUT PROCESS**]

Employment of People with a Disability Policy

We have an employment of people with a disability policy, the purpose of which is:

- To raise awareness of the employment of people with disabilities throughout the organisation and ensure employees are aware of our commitment towards disabled people.
- To ensure recruitment procedures are reviewed and developed to encourage applications and the employment of people with disabilities.
- To ensure that staff and potential job applicants with a disability are treated fairly and receive the same opportunities as other staff to develop with appropriate and reasonable support.
- To take all reasonable steps to ensure that the working environment does not prevent disabled people from taking up positions for which they are suitably qualified.
- To assist staff who become disabled during their employment to adapt to the disability and to continue in post wherever possible, or, if this is not possible, to be redeployed or retrained, where this is practicable.
- To ensure, where possible, any reasonable and practicable adjustments to work arrangements or the working environment are made to meet the ascertained needs of the employee.

The policy provides guidance on the employment of people with a disability, details the responsibilities of all staff groups during the recruitment and selection process of an individual who has identified they have a disability or associate with a person who has a disability and gives guidance on the management and support of a current employee who develops or has an existing disability, including reasonable adjustments.

We have made a commitment to operate under the Jobcentre Plus “two ticks” Disability Symbol.

As part of this commitment, we will:

1. Interview all disabled applicants who meet the minimum criteria for a job vacancy and consider them on their abilities.
2. Discuss with disabled employees, at any time but at least once a year, what both parties can do to make sure disabled employees can develop and use their abilities.
3. Make every effort when employees become disabled to make sure they stay in employment.
4. Take action to ensure that all employees develop the appropriate level of disability awareness needed to make these commitments work.
5. Review these commitments each year and assess what has been achieved, plan ways to improve on them and let employees and Jobcentre Plus know about progress and future plans.

The above policy is is underpinned by our Equality & Human Rights Strategy and supported with further information contained in our:

- Management of Sickness Absence Policy
- Recruitment, Selection & Retention Policy.

NHS Staff Survey

During 2015, for the first time all of our staff were surveyed for the national NHS Staff Survey, resulting in three times as many responses as the previous year, with a total of 1,442 employees returning the survey. Of the 32 key findings we had 10 statistically significant improvements, 13 stayed the same and 10 could not be compared to the previous year's survey. There were no deteriorations. The areas with improved responses included overall staff engagement and staff recommendation as a place to work or receive treatment.

During the year, we developed our organisational effectiveness strategy which sets out a long term programme of work that aims to steadily improve our performance against the survey's key findings.

This includes

- *Embedding a clinically led structure*

  Clinical directorates operate a clinically-led model, with four divisions, each with three clinical directorates. The aim is to put senior clinicians in charge of running our clinical services so that decisions are made by the clinical experts in that area and as close to the patient as possible..

- *Francis Crick Development Programme*

  We delivered the Francis Crick Programme, a leadership and management programme for senior leaders operating in the new clinically led structure. Further cohorts will be developed during 2016.

- *Improving Quality and Efficiency and Making Quality Count*

Making Quality Count is our formal programme of learning that aims to up-skill staff to enable them to drive continuous improvements in their area of work. There have been 18 MQC projects to date, with over 200 people participating in the programme; significant improvements in patient experience and efficiency have been seen with projects also delivering over £300k of financial benefit.

The improving quality and efficiency team supported 21 service improvement projects and continue to work on longer term programmes of work such as theatre productivity, inpatient productivity and outpatients productivity workstreams.

Health and Wellbeing

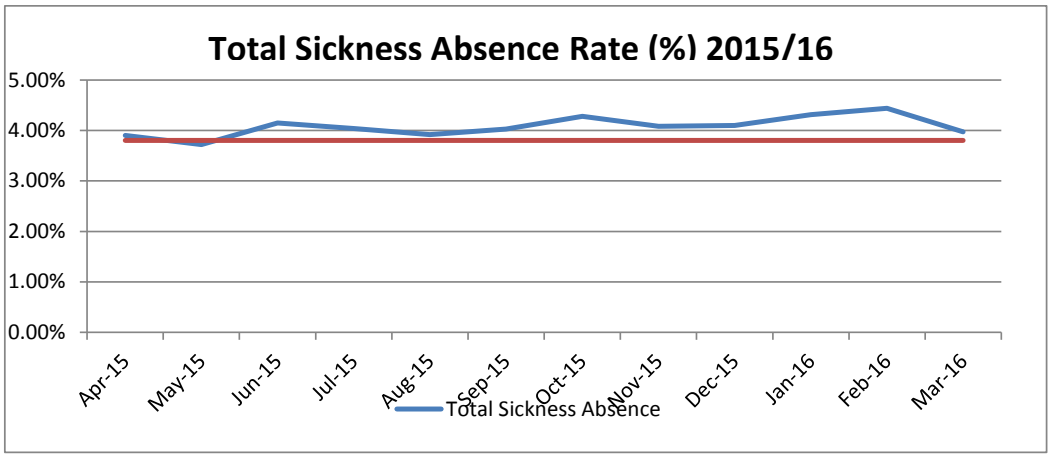
During the year we developed our first health and wellbeing strategy which affirms our commitment to playing our part in improving the health and wellbeing of not only its employees but the wider community of Northamptonshire.

An employee health survey identified support in nutrition and weight management as the main priorities for maintaining healthy active lives. We have been working with its partners Northamptonshire County Council and Northampton Leisure Trust to respond to those findings. Measures taken include the introduction of low calorie meals at our on-site restaurants, reduced payment rates at our on-site gym, a subsidised 12 week fitness and nutrition programme. We also implemented an annual programme of events for physical activity and free health checks for employees over 40. We invested in the Global Corporate Challenge to motivate employees and enhance team working. On-site physiotherapy, occupational health and stress audits are in place and available to all employees.

Sickness absence

Sickness absence rates remained above our target of 3.8% with total sickness absence average for the financial year at 4.08**%.**

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Short Term Sickness Absence	2.42%	2.16%	2.47%	2.25%	2.32%	2.63%	2.63%	2.37%	2.16%	2.83%	2.63%	2.20%
Long Term Sickness Absence	1.48%	1.56%	1.68%	1.78%	1.60%	1.41%	1.65%	1.71%	1.94%	1.49%	1.82%	1.77%
Total Sickness Absence	3.90%	3.72%	4.15%	4.04%	3.92%	4.03%	4.28%	4.08%	4.10%	4.31%	4.44%	3.97%



Learning and development
All mandatory training continued to meet CQC compliance and work started through the East Midlands streamlining group to ensure that all training is aligned to the Core Skills Training Framework or National Mandatory standards. This ensures staff who move from NHS Trust to NHS Trust have their training transferred with them so they do not spend time repeating training. This has meant that ward based staff can start work more quickly.

A new VRQ in Team Leading became available this year and was offered to staff who are aspiring to become a team leader. The course consisted of modules on: preparing to lead the team; support; development of self and the team; equality & diversity and the team; communication and the team leader and motivating the team. All new staff attend an induction programme which delivers all mandatory training subjects. During the year we introduced two inductions a month: groups are smaller so the programme is more interactive with group work, quizzes and case studies. This variety of learning activities means that we are meeting different learning styles to help embed learning.

This year we won an Employer of the Year award for our support of apprentices. We continue to offer apprentices in business administration and customer service, and this year expanded to include four-year apprenticeships in electrical engineering and mechanical engineering We also employed ten apprentices in healthcare to work on the wards to train to become healthcare assistants.

Occupational Health Service
We introduced a new electronic health questionnaire, completed online by new employees and accessed directly by the occupational health team. This new system has meant a reduction of two weeks for the management of health questionnaires.

The same system has also been developed to provide appointments by email and automatically generated appointment reminder letters, which has assisted in the move from paper based to electronic patient records.

We worked with the occupational health department of University Hospitals of Leicester to provide the Northampton Occupational Health Service with two consultant occupational physicians, reducing the waiting times for appointments.

Northampton General Hospital NHS Trust

DRAFT Annual Accounts for the period

1 April 2015 to 31 March 2016

Statement of Comprehensive Income for year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s
Gross employee benefits	10.1	**(191,283)**	(184,523)
Other operating costs	8	**(94,833)**	(101,621)
Revenue from patient care activities	5	**248,771**	242,451
Other operating revenue	6	**24,791**	27,907
Operating surplus/(deficit)		**(12,554)**	(15,786)
Investment revenue	12	**32**	27
Other gains and (losses)	13	**(83)**	2
Finance costs	14	**(440)**	(22)
Surplus/(deficit) for the financial year		**(13,045)**	(15,779)
Public dividend capital dividends payable		**(4,041)**	(4,332)
Transfers by absorption - gains		**0**	0
Transfers by absorption - (losses)		**0**	0
Net Gain/(loss) on transfers by absorption		**0**	0
Retained surplus/(deficit) for the year		**(17,086)**	(20,111)

Other Comprehensive Income

		2015-16 £000s	2014-15 £000s
Impairments and reversals taken to the revaluation reserve		**0**	0
Net gain/(loss) on revaluation of property, plant & equipment	15	**5,906**	701
Net gain/(loss) on revaluation of intangibles		**0**	0
Net gain/(loss) on revaluation of financial assets		**0**	0
Other gain /(loss) (explain in footnote below)		**0**	0
Net gain/(loss) on revaluation of available for sale financial assets		**0**	0
Net actuarial gain/(loss) on pension schemes		**0**	0
Other pension remeasurements		**0**	0
Reclassification adjustments			
On disposal of available for sale financial assets		**0**	0
Total Other Comprehensive Income		**5,906**	701
Total comprehensive income for the year		**(11,180)**	(19,410)

Financial performance for the year

Retained surplus/(deficit) for the year	**(17,086)**	(20,111)
Prior period adjustment to correct errors and other performance adjustments	**0**	0
IFRIC 12 adjustment (including IFRIC 12 impairments)	**0**	0
Impairments (excluding IFRIC 12 impairments)	**(3,315)**	3,338
Adjustments in respect of donated gov't grant asset reserve elimination	**250**	248
Adjustment re absorption accounting	**0**	0
Adjusted retained surplus/(deficit)	**(20,151)**	(16,525)

The reversal of impairment of £3,315k predominantly relates to the full site revaluation exercise undertaken as at October 2015 and is excluded from retained deficit and statutory breakeven in accordance with the DH Manual for Accounts, note 17 refers.

Donated asset net benefit of £250k (consisting of £427k donated depreciation less £177k donated additions) is excluded from retained surplus and statutory breakeven duty in accordance with the DH Manual for Accounts.

Statement of Financial Position as at 31 March 2016

	NOTE	31 March 2016 £000s	31 March 2015 £000s
Non-current assets:			
Property, plant and equipment	15	158,921	141,422
Intangible assets	16	1,270	1,828
Investment property	18	0	0
Other financial assets		0	0
Trade and other receivables	22.1	209	215
Total non-current assets		160,400	143,465
Current assets:			
Inventories	21	5,744	5,961
Trade and other receivables	22.1	16,340	11,126
Other financial assets	23	0	0
Other current assets	24	0	0
Cash and cash equivalents	25	1,602	1,114
Sub-total current assets		23,686	18,201
Non-current assets held for sale	26	375	0
Total current assets		24,061	18,201
Total assets		184,461	161,666
Current liabilities			
Trade and other payables	27	(24,345)	(17,996)
Other liabilities	28	(710)	(721)
Provisions	34	(2,802)	(1,396)
Borrowings	29	(276)	(208)
Other financial liabilities	30	0	0
DH revenue support loan	29	0	0
DH capital loan	29	(628)	(159)
Total current liabilities		(28,761)	(20,480)
Net current assets/(liabilities)		(4,700)	(2,279)
Total assets less current liabilities		155,700	141,186
Non-current liabilities			
Trade and other payables	27	0	0
Other liabilities	28	0	0
Provisions	34	(979)	(1,072)
Borrowings	29	(1,411)	(248)
Other financial liabilities	30	0	0
DH revenue support loan	29	(18,851)	0
DH capital loan	29	(7,186)	(1,431)
Total non-current liabilities		(28,427)	(2,751)
Total assets employed:		127,273	138,435
FINANCED BY:			
Public Dividend Capital		119,258	119,240
Retained earnings		(33,420)	(16,684)
Revaluation reserve		41,435	35,879
Other reserves		0	0
Total Taxpayers' Equity:		127,273	138,435

The notes on pages 76 to 113 form part of this account.

The financial statements on pages 72 to 75 were approved by the Board on 26 May 2016 and signed on its behalf by

Chief Executive: Date:

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2016

	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Other reserves £000s	Total reserves £000s
Balance at 1 April 2015	**119,240**	**(16,684)**	**35,879**	**0**	**138,435**
Changes in taxpayers' equity for 2015-16					
Retained surplus/(deficit) for the year	0	(17,086)	0	0	(17,086)
Net gain / (loss) on revaluation of property, plant, equipment	0	0	5,906	0	5,906
Net gain / (loss) on revaluation of intangible assets	0	0	0	0	0
Net gain / (loss) on revaluation of financial assets	0	0	0	0	0
Net gain / (loss) on revaluation of available for sale	0	0	0	0	0
Impairments and reversals	0	0	0	0	0
Other gains/(loss) (provide details below)	0	0	0	0	0
Transfers between reserves	0	350	(350)	0	0
Reclassification Adjustments					
Transfers between Reserves in respect of assets transferred under absorption	0	0	0	0	0
On disposal of available for sale financial assets	0	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0	0
Originating capital for Trust established in year	0	0	0	0	0
Permanent PDC received - cash	18	0	0	0	18
Permanent PDC repaid in year	0	0	0	0	0
PDC written off	0	0	0	0	0
Transfer due to change of status from Trust to Foundation Trust	0	0	0	0	0
Other movements	0	0	0	0	0
Net actuarial gain/(loss) on pension	0	0	0	0	0
Other pensions remeasurement	0	0	0	0	0
Net recognised revenue/(expense) for the year	**18**	**(16,736)**	**5,556**	**0**	**(11,162)**
Balance at 31 March 2016	**119,258**	**(33,420)**	**41,435**	**0**	**127,273**
Balance at 1 April 2014	**103,611**	**2,878**	**35,727**	**0**	**142,216**
Changes in taxpayers' equity for the year ended 31 March 2015					
Retained surplus/(deficit) for the year	0	(20,111)	0	0	(20,111)
Net gain / (loss) on revaluation of property, plant, equipment	0	0	701	0	701
Net gain / (loss) on revaluation of intangible assets	0	0	0	0	0
Net gain / (loss) on revaluation of financial assets	0	0	0	0	0
Net gain / (loss) on revaluation of assets held for sale	0	0	0	0	0
Impairments and reversals	0	0	0	0	0
Other gains / (loss)	0	0	0	0	0
Transfers between reserves	0	549	(549)	0	0
Reclassification Adjustments					
Transfers to/(from) Other Bodies within the Resource	0	0	0	0	0
Transfers between revaluation reserve & retained earnings reserve in respect of assets transferred under absorption	0	0	0	0	0
On disposal of available for sale financial assets	0	0	0	0	0
Originating capital for Trust established in year	0	0	0	0	0
New temporary and permanent PDC received - cash	26,129	0	0	0	26,129
New temporary and permanent PDC repaid in year	(10,500)	0	0	0	(10,500)
Other movements	0	0	0	0	0
Net actuarial gain/(loss) on pension	0	0	0	0	0
Other pension remeasurement	0	0	0	0	0
Net recognised revenue/(expense) for the year	**15,629**	**(19,562)**	**152**	**0**	**(3,781)**
Balance at 31 March 2015	**119,240**	**(16,684)**	**35,879**	**0**	**138,435**

Statement of Cash Flows for the Year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s
Cash Flows from Operating Activities			
Operating surplus/(deficit)		**(12,554)**	(15,786)
Depreciation and amortisation	8	**9,941**	11,407
Impairments and reversals	17	**(3,315)**	3,338
Other gains/(losses) on foreign exchange	13	**0**	0
Donated Assets received credited to revenue but non-cash	6	**(7)**	(149)
Government Granted Assets received credited to revenue but non-cash		**0**	0
Interest paid		**(381)**	0
PDC Dividend (paid)/refunded		**(3,811)**	(4,480)
Release of PFI/deferred credit		**0**	0
(Increase)/Decrease in Inventories		**217**	(825)
(Increase)/Decrease in Trade and Other Receivables		**(5,446)**	1,396
(Increase)/Decrease in Other Current Assets		**0**	0
Increase/(Decrease) in Trade and Other Payables		**3,314**	690
(Increase)/Decrease in Other Current Liabilities		**(11)**	(90)
Provisions utilised		**(687)**	(835)
Increase/(Decrease) in movement in non cash provisions		**1,978**	(430)
Net Cash Inflow/(Outflow) from Operating Activities		**(10,762)**	(5,764)
Cash Flows from Investing Activities			
Interest Received		**32**	27
(Payments) for Property, Plant and Equipment		**(13,298)**	(14,290)
(Payments) for Intangible Assets		**(398)**	(650)
(Payments) for Investments with DH		**0**	0
(Payments) for Other Financial Assets		**0**	0
(Payments) for Financial Assets (LIFT)		**0**	0
Proceeds of disposal of assets held for sale (PPE)		**0**	297
Proceeds of disposal of assets held for sale (Intangible)		**0**	0
Proceeds from Disposal of Investment with DH		**0**	0
Proceeds from Disposal of Other Financial Assets		**0**	0
Proceeds from the disposal of Financial Assets (LIFT)		**0**	0
Loans Made in Respect of LIFT		**0**	0
Loans Repaid in Respect of LIFT		**0**	0
Rental Revenue		**0**	0
Net Cash Inflow/(Outflow) from Investing Activities		**(13,664)**	(14,616)
Net Cash Inform / (outflow) before Financing		**(24,426)**	(20,380)
Cash Flows from Financing Activities			
Gross Temporary (2014/15 only) and Permanent PDC Received		**18**	26,129
Gross Temporary (2014/15 only) and Permanent PDC Repaid		**0**	(10,500)
Loans received from DH - New Capital Investment Loans	29	**6,651**	1,590
Loans received from DH - New Revenue Support Loans	29	**35,351**	0
Other Loans Received	29	**73**	118
Loans repaid to DH - Capital Investment Loans Repayment of Principal	29	**(427)**	0
Loans repaid to DH - Working Capital Loans/Revenue Support Loans	29	**(16,500)**	0
Other Loans Repaid	29	**(208)**	(288)
Cash transferred to NHS Foundation Trusts or on dissolution		**0**	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(44)**	0
Capital grants and other capital receipts (excluding donated / government granted cash receipts)		**0**	0
Net Cash Inflow/(Outflow) from Financing Activities		**24,914**	17,049
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**488**	(3,331)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**1,114**	4,445
Effect of exchange rate changes in the balance of cash held in foreign currencies		**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end	25	**1,602**	1,114

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS Trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2015-16 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.1.1 Basis of accounting – going concern

As described in the Directors' Report of the Annual Report, the current financial environment for all NHS Trusts is unprecedented. The Trust is incurred a deficit of £20.15m in 2015-16 with the recurrent nature of the financial position leading the Board to agree a deficit plan of £27.4m for the 2016/17 financial year. In so doing, the Directors have considered the impact of incurring a deficit in terms of cash flow and have included a requirement for additional cash borrowing of £27.4m in the FY16-17 NHS Improvement (NHSI) plan submission.

The Board of Directors has concluded that the Trust is able to demonstrate that it is a going concern on the following basis;

- Agreement of the 2016/17 annual plan, key assumptions and associated cashflow financing with NHS Improvement to include access a Revolving Working Capital Facility to finance the planned deficit.
- The Trust has signed service contracts with CCGs and Specialised Commissioners for 2016/17 which demonstrate the continuation of the provision of a service in the future. Contracts are agreed on the basis of fully compliant Payment by Results (PbR) contracts.
- The Department of Health and NHS Improvement will confirm to the Trust arrangements for accessing Interim Working Capital Facilities to manage operational cashflow during 2016/17 with further longer term revenue loans to be arranged to finance longer term debt. The Board will consider the conditions for accepting loans in approving each application and will take steps to develop a formal recovery plan to address the accumulated deficit in the medium term in conjunction with NHS Improvement.
- Previous guidance issued by Regulators and External Auditors that the reporting of an actual or planned deficit should not in itself trigger difficulties in respect of the concept of going concern.
- Robust arrangements are in place for the delivery of cost improvement plans supported by a revised governance and accountability framework to ensure delivery.
- For the period ended 31st March 2016, the Trust has a cumulative deficit of £29.5m (11%) for the purposes of calculating the statutory NHS breakeven duty. The Trust must therefore recover this deficit over the next financial year (or a longer period where agreed by NHSI) to avoid breaching the Statutory Breakeven duty.

In preparing the annual plan for 2016/17 the Directors have considered a range of risks to the financial position, notably the identification of a robust CIP programme in and a medium term financial recovery plan. The Board remains reasonably confident that the plan will be delivered, enabling on-going operations to continue. After making enquiries, and considering the uncertainties described above, the Directors have a reasonable expectation that the Trust will have access to adequate cash resources through the NHSI to continue in operational existence for the foreseeable future.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Movement of assets within the DH Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Charitable Funds

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact. The Trust has decided not to consolidate the charity on the basis of materiality.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.5 Critical accounting judgements and key sources of estimation uncertainty

In the application of the NHS Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.5.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the NHS Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

- Ongoing status as a going concern;
- That no major service discontinuation is anticipated;
- Selection of indices for land and building valuations;
- All lease liabilities have been identified through a review of contract documentation.

1.5.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

- Provisions - estimation provided to assess likelihood of possible financial obligations;
- Partially completed spells - estimation required regarding length of stay and case mix;
- Employee Benefits - estimate of levels of employee benefits not fully paid in year;
- Receivables - including injury cost recovery and other accounts receivable - estimation required to assess the level of where it is probable that the debt is irrecoverable

Further details of these estimations are given with each related note to the Accounts.

1.6 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay using the financial year's case-mix and tariff rules.
Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The NHS trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Income from sale of goods relates includes catering and car parking.

1.7 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following financial year.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.8 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.9 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised if:
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation
All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.
All assets are measured subsequently at fair value.
Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:
- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at fair value, with the carrying value of existing assets written off over their remaining useful lives. The Trust only indexes equipment where the asset life is greater than 5 years, using the CHAZ index, which is RPI less housing costs.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.10 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement
The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.11 Depreciation, amortisation and impairments
Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS Trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the NHS Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.

AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.12 Donated assets
Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.13 Government grants
Government grant funded assets are capitalised at their fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.14 Non-current assets held for sale
Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.15 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The NHS Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the NHS Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.16 Inventories

Drugs and consumables are valued at current replacement costs; this is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Fuel Oil is valued at the lower of cost and net realisable value, recognising that it has limited commercial value.

1.17 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the NHS Trust's cash management.

1.18 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's applicable discount rate in real terms (1.37% for employee early departure obligations).

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.19 Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at Note 34.

1.20 Non-clinical risk pooling
The NHS Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.21 Carbon Reduction Commitment Scheme (CRC)
CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.22 Contingencies
A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.23 Financial assets
Financial assets are recognised when the NHS Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss
The Trust has not identified any Financial Assets at fair value through profit and loss. Should any of these be identified in the future, further disclosures will be given.

Held to maturity investments
Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Available for sale financial assets
The Trust has not identified any Available for sale financial assets. Should any of these be identified in the future, further disclosures will be given.

1.24 Financial liabilities
Financial liabilities are recognised on the statement of financial position when the NHS Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

1.25 Value Added Tax
Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.26 Foreign currencies
The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.27 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 41 to the accounts.

1.28 Public Dividend Capital (PDC) and PDC dividend
Public dividend capital represents taxpayers' equity in the NHS Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.29 Losses and Special Payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.30 Subsidiaries
Material entities over which the NHS Trust has the power to exercise control are classified as subsidiaries and are consolidated. The NHS Trust has control when it is exposed to or has rights to variable returns through its power over another entity. The income and expenses; gains and losses; assets, liabilities and reserves; and cash flows of the subsidiary are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the NHS Trust or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

The Trust has not identified any subsidiaries. Should any of these be identified in the future, further disclosures will be provided.

From 2013-14, there is a requirement for Trust's to consolidate the results of Charitable Funds over which it considers it has the power to exercise control in accordance with IFRS10 requirements, however the Trust has decided not to consolidate on the basis of materiality. The Northamptonshire Health Charitable Fund will move to an independent status from 1 April 2016.

1.31 Associates
Material entities over which the NHS Trust has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the NHS Trust's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the NHS Trust share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the NHS Trust from the entity.

Associates that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'. The Trust has not identified any Associates. Should any of these be identified in the future, further disclosures will be provided.

1.32 Joint arrangements
Material entities over which the NHS Trust has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the Trust is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts. The Trust has not identified any joint operations. Should any of these be identified in the future, further disclosures will be provided.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method. The Trust has not identified any joint ventures. Should any of these be identified in the future, further disclosures will be provided.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.33 Accounting Standards that have been issued but have not yet been adopted

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2015-16. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 *Financial Instruments* – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 *Revenue for Contracts with Customers* - Application required for accounting periods beginning on or after 1 January 2017, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 *Leases* – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

2. Pooled budgets

The NHS Trust does not have any pooled budget arrangements.

3. Operating segments

The Trust Board considers all of its operations to be the provision of Healthcare operated as a single segment.

4. Income generation activities

The Trust has no formal registered income generation schemes.
For the purpose of reporting Catering and Non-staff car parking are treated as income generation activities.
The combined income and costs of these schemes are shown below.

Summary Table - aggregate of all schemes	**2015-16 £000s**	2014-15 £000s
Income	**2,585**	2,427
Full cost	**1,239**	1,129
Surplus/(deficit)	**1,346**	1,298

5. Revenue from patient care activities

	2015-16 £000s	2014-15 £000s
NHS Trusts	**0**	0
NHS England	**41,332**	40,637
Clinical Commissioning Groups	**204,058**	199,139
Foundation Trusts	**829**	253
Department of Health	**0**	0
NHS Other (including Public Health England and Prop Co)	**107**	0
Additional income for delivery of healthcare services	**0**	0
Non-NHS:		
Local Authorities	**0**	0
Private patients	**792**	901
Overseas patients (non-reciprocal)	**185**	203
Injury costs recovery	**1,468**	1,318
Other	**0**	0
Total Revenue from patient care activities	**248,771**	242,451

6. Other operating revenue

	2015-16 £000s	2014-15 £000s
Recoveries in respect of employee benefits	**3,021**	3,230
Patient transport services	**0**	0
Education, training and research	**11,306**	10,278
Charitable and other contributions to revenue expenditure - NHS	**0**	0
Charitable and other contributions to revenue expenditure -non- NHS	**427**	232
Receipt of donations for capital acquisitions - Charity	**177**	294
Support from DH for mergers	**0**	**0**
Receipt of Government grants for capital acquisitions	**0**	0
Non-patient care services to other bodies	**1,415**	2,077
Income generation (Other fees and charges)	**2,585**	2,427
Rental revenue from finance leases	**0**	0
Rental revenue from operating leases	**45**	28
Other revenue	**5,815**	9,341
Total Other Operating Revenue	**24,791**	27,907
Total operating revenue	**273,562**	270,358

Other revenue includes :
Pharmacy Sales £1,810k (£5,828k)
Accommodation Charges £483k (£477k)
Provision of Services to private hospitals £482k (£402k)

7. Overseas Visitors Disclosure

	2015-16 £000	2014-15 £000s
Income recognised during 2015-16 (invoiced amounts and accruals)	**185**	203
Cash payments received in-year (re receivables at 31 March 2015)	**23**	45
Cash payments received in-year (iro invoices issued 2014-15)	**35**	46
Amounts added to provision for impairment of receivables (re receivables at 31 March 2014)	**11**	42
Amounts added to provision for impairment of receivables (iro invoices issued 2014-15)	**193**	148
Amounts written off in-year (irrespective of year of recognition)	**140**	146

8. Operating expenses

	2015-16 £000s	2014-15 £000s
Services from other NHS Trusts	234	8
Services from CCGs/NHS England	0	0
Services from other NHS bodies	0	0
Services from NHS Foundation Trusts	1,260	1,224
Total Services from NHS bodies*	1,494	1,232
Purchase of healthcare from non-NHS bodies	2,901	2,842
Purchase of Social Care	0	0
Trust Chair and Non-executive Directors	54	55
Supplies and services - clinical	57,614	57,801
Supplies and services - general	3,401	3,258
Consultancy services	774	1,527
Establishment	2,998	2,936
Transport	139	218
Service charges - ON-SOFP PFIs and other service concession arrangements	0	0
Service charges - On-SOFP LIFT contracts	0	0
Total charges - Off-SOFP PFIs and other service concession arrangements	0	0
Total charges - Off-SOFP LIFT contracts	0	0
Business rates paid to local authorities	771	746
Premises	8,913	7,319
Hospitality	8	5
Insurance	215	220
Legal Fees	296	320
Impairments and Reversals of Receivables	790	618
Inventories write down	141	100
Depreciation	9,006	10,358
Amortisation	935	1,049
Impairments and reversals of property, plant and equipment	(3,315)	3,338
Impairments and reversals of intangible assets	0	0
Impairments and reversals of financial assets [by class]	0	0
Impairments and reversals of non current assets held for sale	0	0
Internal Audit Fees	141	287
Audit fees	54	72
Other auditor's remuneration	46	36
Clinical negligence	5,718	5,895
Research and development (excluding staff costs)	0	0
Education and Training	757	639
Change in Discount Rate	13	0
Other	969	750
Total Operating expenses (excluding employee benefits)	94,833	101,621

Supplies & services clinical includes value of drugs including gases of £27,757k (£29,275k)

Other auditors remuneration includes :
KPMG £46k (£36k)
- Expenses in relation to Salary Sacrifice Schemes £34k (£24k)
- Quality Accounts Audit Fee £12k (£12k)

Other expenditure includes :
Translation Services £91k (£76k)
Home Oxygen Service £126k (£132k)
Professional Subscriptions £171k (£139k)

Employee Benefits		
Employee benefits excluding Board members	189,809	183,237
Board members	1,474	1,286
Total Employee Benefits	191,283	184,523
Total Operating Expenses	286,116	286,144

*Services from NHS bodies does not include expenditure which falls into a category below

9. Operating Leases

The Trust has a variety of operating leases, the majority of which when considered on an individual basis are of non material value. These include medical equipment, leased cars, photocopiers and pathology systems.

9.1. Northampton General Hospital NHS Trust as lessee

	Other £000s	2015-16 Total £000s	2014-15 £000s
Payments recognised as an expense			
Minimum lease payments		**579**	549
Contingent rents		**0**	0
Sub-lease payments		**0**	0
Total		**579**	549
Payable:			
No later than one year	533	**533**	514
Between one and five years	602	**602**	658
After five years	0	**0**	0
Total	1,135	**1,135**	1,172
Total future sublease payments expected to be received:		0	0

9.2. Northampton General Hospital NHS Trust as lessor

An optician's shop operates on the Trust's site under an operating lease.

	2015-16 £000	2014-15 £000s
Recognised as revenue		
Rental revenue	45	28
Contingent rents	0	0
Total	**45**	28
Receivable:		
No later than one year	45	28
Between one and five years	0	0
After five years	0	0
Total	**45**	28

A nursery is situated on the hospital site, the building being originally funded by the childcare provider, with the land being leased at a peppercorn rent. At the end of the lease the building has the potential to transfer to the Trust, this is currently assumed to have a zero fair value.

10. Employee benefits and staff numbers

10.1. Employee benefits

	2015-16 Total £000s	Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure			
Salaries and wages	**163,187**	144,515	18,672
Social security costs	**11,754**	11,754	0
Employer Contributions to NHS BSA - Pensions Division	**16,333**	16,333	0
Other pension costs	**9**	9	0
Termination benefits	**0**	0	0
Total employee benefits	**191,283**	**172,611**	**18,672**
Employee costs capitalised	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**191,283**	**172,611**	**18,672**

Employee Benefits - Gross Expenditure 2014-15	Total £000s	Permanently employed £000s	Other £000s
Salaries and wages	157,138	141,107	16,031
Social security costs	11,567	11,567	0
Employer Contributions to NHS BSA - Pensions Division	15,812	15,812	0
Other pension costs	6	6	0
Termination benefits	0	0	0
TOTAL - including capitalised costs	184,523	168,492	16,031
Employee costs capitalised	0	0	0
Gross Employee Benefits excluding capitalised costs	184,523	168,492	16,031

10.2. Staff Numbers

	2015-16 Total Number	Permanently employed Number	Other Number	2014-15 Total Number
Average Staff Numbers				
Medical and dental	**529**	493	36	534
Ambulance staff	**0**	0	0	0
Administration and estates	**983**	910	73	984
Healthcare assistants and other support staff	**1,065**	875	190	1,003
Nursing, midwifery and health visiting staff	**1,411**	1,268	143	1,364
Nursing, midwifery and health visiting learners	**0**	0	0	0
Scientific, therapeutic and technical staff	**515**	480	35	509
Social Care Staff	**0**	0	0	0
Healthcare Science Staff	**148**	148	0	152
Other	**0**	0	0	0
TOTAL	**4,651**	**4,174**	**477**	4,546
Of the above - staff engaged on capital projects	**0**	0	0	0

10.3. Staff Sickness absence and ill health retirements

	2015-16 Number	2014-15 Number
Total Days Lost	38,400	40,921
Total Staff Years	4,143	4,111
Average working Days Lost	9.27	9.95

	2015-16 Number	2014-15 Number
Number of persons retired early on ill health grounds	**4**	2
	£000s	£000s
Total additional pensions liabilities accrued in the year	**135**	82

10.4. Exit Packages agreed in 2015-16

2015-16

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed.	Total number of exit packages	Total cost of exit packages	Number of Departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	0	0	0	0	0	0	0	0
£10,000-£25,000	0	0	0	0	0	0	0	0
£25,001-£50,000	0	0	0	0	0	0	0	0
£50,001-£100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

2014-15

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed.	Total number of exit packages	Total cost of exit packages	Number of Departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	0	0	0	0	0	0	0	0
£10,000-£25,000	0	0	0	0	0	0	0	0
£25,001-£50,000	0	0	0	0	0	0	0	0
£50,001-£100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

The Trust has no exit package costs in 2015/16.

10.5. Exit packages - Other Departures analysis

	2015-16 Agreements	Total value of agreements	2014-15 Agreements	Total value of agreements
	Number	£000s	Number	£000s
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval*	0	0	0	0
Total	0	0	0	0
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period

As a single exit packages can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 10.4 which will be the number of individuals.

*includes any non-contractual severance payment made following judicial mediation, and relating to non-contractual payments in lieu of notice..

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report.

The Trust has no exit package costs in 2015/16.

10.6. Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

11. Better Payment Practice Code

11.1. Measure of compliance

	2015-16 Number	2015-16 £000s	2014-15 Number	2014-15 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**97,099**	**104,056**	91,221	107,061
Total Non-NHS Trade Invoices Paid Within Target	**96,360**	**103,534**	87,753	104,787
Percentage of NHS Trade Invoices Paid Within Target	**99.24%**	**99.50%**	96.20%	97.88%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,154**	**19,783**	2,214	18,835
Total NHS Trade Invoices Paid Within Target	**2,132**	**19,746**	2,085	18,234
Percentage of NHS Trade Invoices Paid Within Target	**98.98%**	**99.81%**	94.17%	96.81%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

11.2. The Late Payment of Commercial Debts (Interest) Act 1998

	2015-16 £000s	2014-15 £000s
Amounts included in finance costs from claims made under this legislation	**3**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**3**	0

12. Investment Revenue

	2015-16 £000s	2014-15 £000s
Rental revenue		
PFI finance lease revenue (planned)	**0**	0
PFI finance lease revenue (contingent)	**0**	0
Other finance lease revenue	**0**	0
Subtotal	**0**	0
Interest revenue		
LIFT: equity dividends receivable	**0**	0
LIFT: loan interest receivable	**0**	0
Bank interest	**13**	15
Other loans and receivables	**19**	12
Impaired financial assets	**0**	0
Other financial assets	**0**	0
Subtotal	**32**	27
Total investment revenue	**32**	27

13. Other Gains and Losses

	2015-16 £000s	2014-15 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**(83)**	2
Gain/(Loss) on disposal of assets other than by sale (intangibles)	**0**	0
Gain/(Loss) on disposal of Financial Assets other then held for sale	**0**	0
Gain (Loss) on disposal of assets held for sale	**0**	0
Gain/(loss) on foreign exchange	**0**	0
Change in fair value of financial assets carried at fair value through the SoCI	**0**	0
Change in fair value of financial liabilities carried at fair value through the SoCI	**0**	0
Change in fair value of investment property	**0**	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	**0**	0
Total	**(83)**	2

14. Finance Costs

	2015-16 £000s	2014-15 £000s
Interest		
Interest on loans and overdrafts	387	0
Interest on obligations under finance leases	33	0
Interest on obligations under PFI contracts:		
- main finance cost	0	0
- contingent finance cost	0	0
Interest on obligations under LIFT contracts:		
- main finance cost	0	0
- contingent finance cost	0	0
Interest on late payment of commercial debt	3	0
Total interest expense	423	0
Other finance costs	8	11
Provisions - unwinding of discount	9	11
Total	440	22

15.1. Property, plant and equipment

2015-16	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2015	19,930	101,205	576	2,786	39,083	63	16,867	175	**180,685**
Additions of Assets Under Construction	0	0	0	6,248	0	0	0	0	**6,248**
Additions Purchased	0	4,199	0	0	3,282	5	2,450	0	**9,936**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	7	0	0	0	**7**
Additions - Purchases from Cash Donations & Government Grants	0	0	0	5	165	0	0	0	**170**
Additions Leased (including PFI/LIFT)	0	1,410	0	0	0	0	0	0	**1,410**
Reclassifications	0	2,598	0	(5,606)	2,346	0	662	0	**0**
Reclassifications as Held for Sale and reversals	0	(382)	0	0	0	0	0	0	**(382)**
Disposals other than for sale	0	0	0	0	(5,596)	0	(904)	0	**(6,500)**
Revaluation/positive indexation	(6,730)	10,410	0	0	42	0	0	0	**3,722**
Impairment/reversals charged to operating expenses	0	3,315	0	0	0	0	0	0	**3,315**
Impairments/reversals charged to reserves	0	0	0	0	0	0	0	0	**0**
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accountin	0	0	0	0	0	0	0	0	**0**
At 31 March 2016	**13,200**	**122,755**	**576**	**3,433**	**39,329**	**68**	**19,075**	**175**	**198,611**
Depreciation									
At 1 April 2015	0	0	0		28,666	47	10,435	115	**39,263**
Reclassifications	0	0	0		0	0	0	0	**0**
Reclassifications as Held for Sale and reversals	0	(7)	0		0	0	0	0	**(7)**
Disposals other than for sale	0	0	0		(5,484)	0	(904)	0	**(6,388)**
Revaluation/positive indexation	0	(2,215)	0		31	0	0	0	**(2,184)**
Impairment/reversals charged to reserves	0	0	0		0	0	0	0	**0**
Impairments/reversals charged to operating expenses	0	0	0		0	0	0	0	**0**
Charged During the Year	0	3,356	21		3,184	4	2,412	29	**9,006**
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0		0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accountin	0	0	0		0	0	0	0	**0**
At 31 March 2016	**0**	**1,134**	**21**	**0**	**26,397**	**51**	**11,943**	**144**	**39,690**
Net Book Value at 31 March 2016	**13,200**	**121,621**	**555**	**3,433**	**12,932**	**17**	**7,132**	**31**	**158,921**
Asset financing:									
Owned - Purchased	13,200	112,892	555	3,428	12,418	17	7,112	7	**149,629**
Owned - Donated	0	7,354	0	5	514	0	20	24	**7,917**
Owned - Government Granted	0	0	0	0	0	0	0	0	**0**
Held on finance lease	0	1,375	0	0	0	0	0	0	**1,375**
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2016	**13,200**	**121,621**	**555**	**3,433**	**12,932**	**17**	**7,132**	**31**	**158,921**

Cost or Valuation: Revaluation / positive indexation consists of revaluation of Land (£6,730k) and Buildings (excluding dwellings) £7,980k and indexation of Buildings (excluding dwellings) £2,430k and Plant & Machinery £42k

Depreciation: Revaluation / positive indexation consists of revaluation of Buildings (excluding dwellings) (£2,215k) and indexation of Plant & Machinery £31k

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2015	11,072	24,009	0	0	797	1	0	0	**35,879**
Movements - revaluation and indexation	(6,616)	12,497	0	0	(325)	0	0	0	**5,556**
At 31 March 2016	**4,456**	**36,506**	**0**	**0**	**472**	**1**	**0**	**0**	**41,435**

Additions to Assets Under Construction in 2015-16

Land	0
Buildings excl Dwellings	1,168
Dwellings	0
Plant & Machinery	5,080
Balance as at YTD	**6,248**

15.2. Property, plant and equipment prior-year

2014-15	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2014	20,100	106,288	586	5,174	39,745	56	14,325	391	**186,665**
Additions of Assets Under Construction	0	0	0	5,684	0	0	0	0	**5,684**
Additions Purchased	0	3,439	0	0	2,521	6	1,680	0	**7,646**
Additions - Non Cash Donations (i.e. Physical Assets)	0	0	0	0	149	0	0	0	**149**
Additions - Purchases from Cash Donations & Government Grants	0	(9)	0	79	45	0	30	0	**145**
Additions Leased (including PFI/LIFT)	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	4,404	0	(6,012)	0	0	1,583	0	**(25)**
Reclassifications as Held for Sale and Reversals	0	(308)	0	0	0	0	0	0	**(308)**
Disposals other than for sale	0	(432)	0	0	(4,200)	0	(751)	(216)	**(5,599)**
Revaluation/positive indexation	(170)	(12,177)	(10)	(1,222)	823	1	0	0	**(12,755)**
Impairments/negative indexation charged to reserves	0	0	0	0	0	0	0	0	**0**
Reversal of Impairments charged to reserves	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accountin	0	0	0	0	0	0	0	0	**0**
At 31 March 2015	**19,930**	**101,205**	**576**	**3,703**	**39,083**	**63**	**16,867**	**175**	**181,602**
Depreciation									
At 1 April 2014	0	7,204	79	0	28,675	41	9,255	298	**45,552**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale and Reversals	0	(40)	0	0	0	0	0	0	**(40)**
Disposals other than for sale	0	(425)	0	0	(4,180)	0	(751)	(216)	**(5,572)**
Revaluation/positive indexation	(1)	(14,018)	(10)	0	572	1	0	0	**(13,456)**
Impairments/negative indexation charged to operating expenses	1	4,786	0	917	1	0	0	0	**5,705**
Reversal of Impairments charged to operating expenses	0	(2,268)	(99)	0	0	0	0	0	**(2,367)**
Charged During the Year	0	4,761	30	0	3,598	5	1,931	33	**10,358**
Transfers (to)/from Other Public Sector Bodies under Absorption Accountin	0	0	0	0	0	0	0	0	**0**
At 31 March 2015	**0**	**0**	**0**	**917**	**28,666**	**47**	**10,435**	**115**	**40,180**
Net Book Value at 31 March 2015	**19,930**	**101,205**	**576**	**2,786**	**10,417**	**16**	**6,432**	**60**	**141,422**
Asset financing:									
Owned - Purchased	19,930	94,469	576	2,786	9,889	16	6,400	12	**134,078**
Owned - Donated	0	6,736	0	0	528	0	32	48	**7,344**
Owned - Government Granted	0	0	0	0	0	0	0	0	**0**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2015	**19,930**	**101,205**	**576**	**2,786**	**10,417**	**16**	**6,432**	**60**	**141,422**

15.3. (cont). Property, plant and equipment

Donated equipment to the value of £165k & preliminary building costs for the Chemotherapy Suite to the value of £5k were funded by NGH Charitable Fund. A donation of a £7k floor cleaner was gifted to the Children's Wards.

Professional valuations were carried out by the District Valuers of the Revenue and Customs Government Dept and by Cushman & Wakefield from 30 September 2015.

The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual, in so far as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury.

A site revaluation exercise was undertaken in the current financial year with an effective date of 30 September 2015 for land and buildings and this valuation has been incorporated into these accounts, the next revaluation exercise is due in April 2019.

Equipment is depreciated on current cost evenly over the estimated life of the asset.

Plant & Machinery	5 - 15 years
Transport	7 years
I.T.	5 years
Furniture & Fittings	5 years

Where the useful economic life of an asset is reduced from that initially estimated due to the revaluation of an asset for sale, depreciation is charged to bring the value of the asset to its value at the point of sale.

The gross carrying amount of fully depreciated assets still in use is £23,311k (£21,045k)

16. Intangible non-current assets

16.1. Intangible non-current assets

2015-16	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2015	399	7,966	0	0	0	8,365
Additions Purchased	0	377	0	0	0	377
Additions Internally Generated	0	0	0	0	0	0
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	0	0
Additions - Purchases from Cash Donations and Government Grants	0	0	0	0	0	0
Additions Leased (including PFI/LIFT)	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassified as Held for Sale and Reversals	0	0	0	0	0	0
Disposals other than by sale	0	(261)	0	0	0	(261)
Upward revaluation/positive indexation	0	0	0	0	0	0
Impairments/reversals charged to operating expenses	0	0	0	0	0	0
Impairments/reversals charged to reserves	0	0	0	0	0	0
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	0
At 31 March 2016	399	8,082	0	0	0	8,481
Amortisation						
At 1 April 2015	262	6,275	0	0	0	6,537
Reclassifications	0	0	0	0	0	0
Reclassified as Held for Sale and Reversals	0	0	0	0	0	0
Disposals other than by sale	0	(261)	0	0	0	(261)
Upward revaluation/positive indexation	0	0	0	0	0	0
Impairment/reversals charged to reserves	0	0	0	0	0	0
Impairments/reversals charged to operating expenses	0	0	0	0	0	0
Charged During the Year	18	917	0	0	0	935
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	0
At 31 March 2016	280	6,931	0	0	0	7,211
Net Book Value at 31 March 2016	119	1,151	0	0	0	1,270
Asset Financing: Net book value at 31 March 2016 comprises:						
Purchased	119	1,151	0	0	0	1,270
Donated	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0
Finance Leased	0	0	0	0	0	0
On-balance Sheet PFIs	0	0	0	0	0	0
Total at 31 March 2016	119	1,151	0	0	0	1,270

Revaluation reserve balance for intangible non-current assets						
						£000's
At 1 April 2015	0	0	0	0	0	0
Movements (specify)	0	0	0	0	0	0
At 31 March 2016	0	0	0	0	0	0

16.2. Intangible non-current assets prior year

2014-15

	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:						
At 1 April 2014	374	7,734	0	0	0	8,108
Additions - purchased	0	506	0	0	0	506
Additions - internally generated	0	0	0	0	0	0
Additions - donated	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0
Additions Leased (including PFI/LIFT)	0	0	0	0	0	0
Reclassifications	25	0	0	0	0	25
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	(274)	0	0	0	(274)
Upward revaluation/positive indexation	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	0
At 31 March 2015	399	7,966	0	0	0	8,365
Amortisation						
At 1 April 2014	181	5,581	0	0	0	5,762
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	(274)	0	0	0	(274)
Upward revaluation/positive indexation	0	0	0	0	0	0
Impairments charged to operating expenses	0	0	0	0	0	0
Reversal of impairments charged to operating expenses	0	0	0	0	0	0
Charged during the year	81	968	0	0	0	1,049
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	0
At 31 March 2015	262	6,275	0	0	0	6,537
Net book value at 31 March 2015	137	1,691	0	0	0	1,828
Net book value at 31 March 2015 comprises:						
Purchased						0
Donated						0
Government Granted						0
Finance Leased						0
On-balance Sheet PFIs						0
Total at 31 March 2015	0	0	0	0	0	0

16.3. Intangible non-current assets

Intangible assets, software licenses and application software development are capitalised when they are capable of being used in a Trust's activities for more than one year; they can be valued; and they have a cost of at least £5,000.

Intangible assets held for operational use are valued at historical cost and are depreciated over the estimated life of the asset on a straight line basis. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

For the purpose of determining fair value historical cost is considered to be the most accurate basis considering the nature of software evolution and development.

Intangible Assets are depreciated on current cost evenly over the estimated life of the asset, which is determined on a case by case basis between 3 and 5 years.

The gross carrying amount of fully depreciated assets still in use is £5,129k (£3,684k)

17. Analysis of impairments and reversals recognised in 2015-16

	2015-16 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	0
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	(3,315)
Total charged to Annually Managed Expenditure	(3,315)
Total Impairments of Property, Plant and Equipment changed to SoCI	(3,315)
Intangible assets impairments and reversals charged to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	0
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	0
Total Impairments of Intangibles charged to SoCI	0
Financial Assets charged to SoCI	
Loss or damage resulting from normal operations	0
Total charged to Departmental Expenditure Limit	0
Loss as a result of catastrophe	0
Other	0
Total charged to Annually Managed Expenditure	0
Total Impairments of Financial Assets charged to SoCI	0
Non-current assets held for sale - impairments and reversals charged to SoCI.	
Loss or damage resulting from normal operations	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	0
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	0
Total impairments of non-current assets held for sale charged to SoCI	0
Total Impairments charged to SoCI - DEL	0
Total Impairments charged to SoCI - AME	(3,315)
Overall Total Impairments	(3,315)
Donated and Gov Granted Assets, included above	
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	(153)
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0

17. Analysis of impairments and reversals recognised in 2015-16

	Property Plant and Equipment	Intangible Assets	Financial Assets	Non-Current Assets Held for Sale	Total
	£000s	£000s	£000s	£000s	£000s
Impairments and reversals taken to SoCI	0	0	0	0	
Loss or damage resulting from normal operations	0	0	0	0	0
Over-specification of assets	0	0	0	0	0
Abandonment of assets in the course of construction	0	0	0	0	0
Total charged to Departmental Expenditure Limit	0	0	0	0	0
	0	0	0	0	
Unforeseen obsolescence	0	0	0	0	0
Loss as a result of catastrophe	0	0	0	0	0
Other	0	0	0	0	0
Changes in market price	(3,315)	0	0	0	(3,315)
Total charged to Annually Managed Expenditure	(3,315)	0	0	0	(3,315)
Total Impairments of Property, Plant and Equipment changed to SoCI	(3,315)	0	0	0	(3,315)

Donated and Gov Granted Assets, included above	£000s
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	(153)
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0

18. Investment property

	31 March 2016	31 March 2015
	£000s	£000s
At fair value		
Balance at 1 April 2015	0	0
Additions Through Subsequent Expenditure	0	0
Other Acquisitions	0	0
Disposals	0	0
Property Reclassified as Held for Sale	0	0
Loss from Fair Value Adjustments - Impairments	0	0
Loss from Fair Value Adjustments - Reversal of Impairments	0	0
Gain from Fair Value Adjustments	0	0
Transfers to NHS Foundation Trust on authorisation as FT	0	0
Transfers (to) / from Other Public Sector Bodies under absorption accounting	0	0
Other Changes	0	0
Balance at 31 March 2016	0	0

19. Commitments

19.1. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2016	31 March 2015
	£000s	£000s
Property, plant and equipment	3,438	2,818
Intangible assets	65	19
Total	3,503	2,837

19.2. Other financial commitments

	31 March 2016	31 March 2015
	£000s	£000s
Not later than one year	0	0
Later than one year and not later than five year	0	0
Later than five years	0	0
Total	0	0

20. Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with Other Central Government Bodies	473	0	6,043	0
Balances with Local Authorities	0	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS bodies inside the Departmental Group	9,742	0	2,666	26,037
Balances with Public Corporations and Trading Funds	0	0	1	0
Balances with Bodies External to Government	6,125	209	17,249	1,411
At 31 March 2016	**16,340**	**209**	**25,959**	**27,448**
prior period:				
Balances with Other Central Government Bodies	538	0	5,482	0
Balances with Local Authorities	0	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	9	0
Balances with NHS bodies inside the Departmental Group	5,206	0	1,592	1,431
Balances with Public Corporations and Trading Funds	0	0	1	0
Balances with Bodies External to Government	5,382	215	12,000	248
At 31 March 2015	**11,126**	**215**	**19,084**	**1,679**

The increase is predominantly related to the capital and revenue support loans with the DH as outlined in note 29.

21. Inventories

	Drugs	Consumables	Work in Progress	Energy	Other	Total	Of which held at NRV
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	2,422	3,483	0	56	0	5,961	5,905
Additions	27,380	24,403	0	0	0	51,783	51,783
Inventories recognised as an expense in the period	(27,757)	(24,092)	0	(10)	0	(51,859)	(51,849)
Write-down of inventories (including losses)	(141)	0	0	0	0	(141)	(141)
Reversal of write-down previously taken to SOCI	0	0	0	0	0	0	0
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0
Balance at 31 March 2016	1,904	3,794	0	46	0	5,744	5,698

22.1. Trade and other receivables

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	31 March 2016 £000s	31 March 2015 £000s
NHS receivables - revenue	9,742	5,036	0	0
NHS receivables - capital	0	0	0	0
NHS prepayments and accrued income	0	0	0	0
Non-NHS receivables - revenue	1,250	1,426	0	0
Non-NHS receivables - capital	21	0	0	0
Non-NHS prepayments and accrued income	1,923	1,666	0	0
PDC Dividend prepaid to DH	0	170	0	0
Provision for the impairment of receivables	(834)	(1,306)	0	0
VAT	473	456	0	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	9	11	209	215
Operating lease receivables	0	0	0	0
Other receivables	3,756	3,667	0	0
Total	16,340	11,126	209	215
Total current and non current	16,549	11,341		
Included in NHS receivables are prepaid pension contributions:	0			

NHS receivables - revenue
- Estimated value of partially completed spells £1,436K (£1,604k)

Other receivables include:
- Injury Cost Recovery claims (ICR) £2,582K (£2,677k)
- Salary overpayments/other recoverable pay £546K (£499k)

The great majority of trade is with Clinical Commissioning Groups as commissioners for NHS patient care services. As Clinical Commissioning Groups are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

22.2. Receivables past their due date but not impaired

	31 March 2016 £000s	31 March 2015 £000s
By up to three months	676	1,163
By three to six months	121	352
By more than six months	45	39
Total	842	1,554

This includes £176k (£562k) relating to invoices raised to Clinical Commissioning Groups for Non Contracted Activity. data

22.3. Provision for impairment of receivables

	2015-16 £000s	2014-15 £000s
Balance at 1 April 2015	**(1,306)**	(1,223)
Amount written off during the year	**1,262**	535
Amount recovered during the year	**0**	0
(Increase)/decrease in receivables impaired	**(790)**	(618)
Transfers to NHS Foundation Trust on authorisation as FT	**0**	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	**0**	0
Balance at 31 March 2016	**(834)**	(1,306)

The Trust provides for non recovery of receivables as follows:
All Non-NHS Trade receivables over 60 days old from date of invoice unless known reason for payment delay.
16.46% (local provision) of recognised Injury Cost Recovery claims are provided for.
All salary overpayments that occurred prior to 31 March 2015, for which no recovery plan is in place, are provided for in full.

23.1. Other Financial Assets - Current

	31 March 2016 £000s	31 March 2015 £000s
Current part of loans repayable transferred from non-current assets	**0**	0
NLF deposits over 3 months	**0**	0
Closing balance 31 March	**0**	0

24. Other current assets

	31 March 2016 £000s	31 March 2015 £000s
EU Emissions Trading Scheme Allowance	**0**	0
Other Assets	**0**	0
Total	**0**	0

25. Cash and Cash Equivalents

	31 March 2016 £000s	31 March 2015 £000s
Opening balance	**1,114**	4,445
Net change in year	**488**	3,331
Closing balance	**1,602**	1,114
Made up of		
Cash with Government Banking Service	**1,543**	1,039
Commercial banks	**50**	66
Cash in hand	**9**	9
Liquid deposits with NLF	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**1,602**	1,114
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**1,602**	1,114
Third Party Assets - Bank balance (not included above)	**0**	0
Third Party Assets - Monies on deposit	**0**	0

26. Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Financial Assets	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	0	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	375	0	0	0	0	0	0	0	0	**375**
Less assets sold in the year	0	0	0	0	0	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0	**0**
Transfers to Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2016	**0**	375	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	375
Liabilities associated with assets held for sale at 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0
Balance at 1 April 2014	0	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	268	0	0	0	0	0	0	0	0	**268**
Less assets sold in the year	0	(268)	0	0	0	0	0	0	0	0	**(268)**
Less impairment of assets held for sale	0	(15)	0	0	0	0	0	0	0	0	**(15)**
Plus reversal of impairment of assets held for sale	0	15	0	0	0	0	0	0	0	0	**15**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2015	**0**	0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0
Liabilities associated with assets held for sale at 31 March 2015	0	0	0	0	0	0	0	0	0	0	0

The above £375k relates to Harborough Lodge Renal Unit which is located in Kingsthorpe within Northampton. It was identified as surplus when University Hospitals Leicester NHS Trust ceased to provide a dialysis service from here. The property has been sold in April 2016 for £585k.

27. Trade and other payables

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	31 March 2016 £000s	31 March 2015 £000s
NHS payables - revenue	978	442	0	0
NHS payables - capital	0	0	0	0
NHS accruals and deferred income	1,000	1,000	0	0
Non-NHS payables - revenue	2,390	1,288	0	0
Non-NHS payables - capital	5,192	2,157	0	0
Non-NHS accruals and deferred income	7,966	7,218	0	0
Social security costs	3,551	3,300	0	0
PDC Dividend payable to DH	60	0	0	0
Accrued Interest on DH Loans	39	0	0	0
VAT	0	0	0	0
Tax	0	0	0	0
Payments received on account	0	0	0	0
Other	3,169	2,591	0	0
Total	24,345	17,996	0	0
Total payables (current and non-current)	24,345	17,996		
Included above:				
to Buy Out the Liability for Early Retirements Over 5 Years	0	0		
number of Cases Involved (number)	0	0		
outstanding Pension Contributions at the year end	(2,347)	(2,182)		

28. Other liabilities

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	31 March 2016 £000s	31 March 2015 £000s
PFI/LIFT deferred credit	0	0	0	0
Lease incentives	0	0	0	0
Other - Employee Benefits	710	721	0	0
Total	710	721	0	0
Total other liabilities (current and non-current)	710	721		

29. Borrowings

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	31 March 2016 £000s	31 March 2015 £000s
Bank overdraft - Government Banking Service	0	0	0	0
Bank overdraft - commercial banks	0	0	0	0
Loans from Department of Health	628	159	26,037	1,431
Loans from other entities	155	208	166	248
PFI liabilities:				
Main liability	0	0	0	0
Lifecycle replacement received in advance	0	0	0	0
LIFT liabilities:				
Main liability	0	0	0	0
Lifecycle replacement received in advance	0	0	0	0
Finance lease liabilities	121	0	1,245	0
Other (describe)	0	0	0	0
Total	904	367	27,448	1,679
Total borrowings (current and non-current)	28,352	2,046		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2016		
	DH £000s	Other £000s	Total £000s
0-1 Years	628	276	904
1 - 2 Years	19,719	207	19,926
2 - 5 Years	2,605	488	3,093
Over 5 Years	3,713	716	4,429
TOTAL	26,665	1,687	28,352

The Trust has taken advantage of participating in the Energy Efficiency Loan Scheme operated by Salix Finance Ltd.
The loan is subject to zero interest and is repayable over 4 years in equal instalments.

The Trust has taken two DH capital loans to replace imaging equipment in radiology and radiotherapy

The first loan approved is £7.207 million and £6.085 million has been drawn down to date (£1.590 million in 2014/15), repayments identified a above relate to the draw down to date and not the full loan approval.
This loan is subject to an interest rate of 1.6% and is repayable over a 10 year term.

The second loan approved is £9.352 million and £2.156 million has been drawn down to date, there have been no repayments to date.
The loan is subject to an interest rate of 1.16% and is repayable over a 10 year term.

The Trust has also taken a revenue support loan of £18.851 million, this loan is subject to an interest rate of 1.5% and is due for repayment / review in February 2018.

30. Other financial liabilities

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Embedded derivatives at fair value through SoCI	**0**	0	**0**	0
Financial liabilities carried at fair value through profit and loss	**0**	0	**0**	0
Amortised cost	**0**	0	**0**	0
Total	**0**	0	**0**	0
Total other financial liabilities (current and non-current)	**0**	0		

31. Deferred income

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Opening balance at 1 April 2015	**1,777**	535	**0**	0
Deferred revenue addition	**849**	1,784	**0**	0
Transfer of deferred revenue	**(851)**	(542)	**0**	0
Current deferred income at 31 March 2016	**1,775**	1,777	**0**	0
Total deferred income (current and non-current)	**1,775**	1,777		

32. Finance lease obligations as lessee

The Trust car park decking was completed under a Finance Lease arrangement.

Amounts payable under finance leases (Buildings)	Minimum lease payments		Present value of minimum	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Within one year	**121**	0	**121**	0
Between one and five years	**529**	0	**529**	0
After five years	**716**	0	**716**	0
Less future finance charges	**0**	0	**0**	0
Minimum Lease Payments / Present value of minimum lease payments	**1,366**	0	**1,366**	0
Included in:				
Current borrowings			**121**	0
Non-current borrowings			**1,245**	0
			1,366	0

Finance leases as lessee	**31 March 2016 £000s**	31 March 2015 £000s
Future Sublease Payments Expected to be received	0	0
Contingent Rents Recognised as an Expense	0	0

33. Finance lease receivables as lessor

Northamptonshire Healthcare NHS Foundation Trust occupies Battle House under a Finance Lease arrangement.

Amounts receivable under finance leases (buildings)	**Gross investments in leases**		**Present value of minimum**	
Of minimum lease payments	**31 March 2016 £000s**	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Within one year	**9**	11	**9**	11
Between one and five years	**36**	44	**36**	44
After five years	**173**	171	**173**	171
Less future finance charges	**0**	0	**0**	0
Gross Investment in Leases / Present Value of Minimum Lease Payments	**218**	226	**218**	226
Less allowance for uncollectible lease payments:	**0**	0	0	0
Total finance lease receivable recognised in the statement of financial position	**218**	226	**218**	226
Included in:				
Current finance lease receivables			**9**	11
Non-current finance lease receivables			**209**	215
			218	226

Rental revenue	**31 March 2016**	31 March 2015
Contingent rent	**0**	0
Other	**0**	0
Total rental revenue	**0**	0

34. Provisions

	Total	Comprising: Early Departure Costs	Legal Claims	Restructuring	Continuing Care	Equal Pay (incl. Agenda for Change	Other	Redundancy
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**2,468**	0	0	0	0	0	2,468	0
Arising during the year	**2,539**	0	0	0	0	0	2,539	0
Utilised during the year	**(687)**	0	0	0	0	0	(687)	0
Reversed unused	**(561)**	0	0	0	0	0	(561)	0
Unwinding of discount	**9**	0	0	0	0	0	9	0
Change in discount rate	**13**	0	0	0	0	0	13	0
Transfers to NHS Foundation Trusts on being authorised as FT	**0**	0	0	0	0	0	0	0
Transfers (to)/from other public sector bodies under absorption accounting	**0**	0	0	0	0	0	0	0
Balance at 31 March 2016	**3,781**	**0**	**0**	**0**	**0**	**0**	**3,781**	**0**
Expected Timing of Cash Flows:								
No Later than One Year	**2,802**	0	0	0	0	0	2,802	0
Later than One Year and not later than Five Years	**868**	0	0	0	0	0	868	0
Later than Five Years	**111**	0	0	0	0	0	111	0

Amount included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2016	95,588
As at 31 March 2015	51,582

Pension provisions are based on expected lives and current levels of payment.
Provisions arising in year relate to service level agreements, injury retirement, legal and associated employment claims.

35. Contingencies

	31 March 2016 £000s	31 March 2015 £000s
Contingent liabilities		
NHS Litigation Authority legal claims	**0**	0
Employment Tribunal and other employee related litigation	**0**	0
Redundancy	**0**	0
Other	**0**	0
Net value of contingent liabilities	**0**	0
Contingent assets		
Contingent assets	**0**	0
Net value of contingent assets	**0**	0

The Trust is aware of recent legal rulings in relation to the calculation of overtime and holiday pay. At this stage it is not clear how this ruling may relate to the NHS and if so which staff groups may be affected. As such no financial value has been included in these accounts in relation to the rulings and the Trust will continue to monitor the situation pending legal advice and / or specific advice from NHS employers.

36. Financial Instruments

36.1. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the strategic health authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trusttherefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2016 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with primary care, Clinical Care Groups, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

36.2. Financial Assets

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Embedded derivatives	0	0	0	0
Receivables - NHS	0	9,742	0	**9,742**
Receivables - non-NHS	0	6,125	0	**6,125**
Cash at bank and in hand	0	1,602	0	**1,602**
Other financial assets	0	218	0	218
Total at 31 March 2016	**0**	**17,687**	**0**	**17,687**
Embedded derivatives	0	0	0	0
Receivables - NHS	0	5,036	0	5,036
Receivables - non-NHS	0	5,634	0	5,634
Cash at bank and in hand	0	1,114	0	1,114
Other financial assets	0	226	0	226
Total at 31 March 2015	0	12,010	0	12,010

36.3. Financial Liabilities

	At 'fair value through profit and loss'	Other	Total
			£000s
Embedded derivatives	0	0	**0**
NHS payables	0	978	**978**
Non-NHS payables	0	19,816	**19,816**
Other borrowings	0	26,986	**26,986**
PFI & finance lease obligations	0	1,366	**1,366**
Other financial liabilities	0	710	710
Total at 31 March 2016	**0**	**49,856**	**49,856**
Embedded derivatives	0	0	0
NHS payables	0	442	442
Non-NHS payables	0	14,254	14,254
Other borrowings	0	2,046	2,046
PFI & finance lease obligations	0	0	0
Other financial liabilities	0	721	721
Total at 31 March 2015	0	17,463	17,463

37. Events after the end of the reporting period

There are no material events after the reporting date of 31 March 2016 which effect the financial position. - TBC after Audit

38. Related party transactions

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Northampton General Hospital NHS Trust.

The Department of Health is regarded as a related party. During the year Northampton General Hospital NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. For example :

Revenue Transactions
Health Education England £10.4m (£9.9m)
Nene Clinical Commissioning Group £194.7m (£189.6m)
Corby Clinical Commissioning Group £2.6m (£2.9m)
Milton Keynes Clinical Commissioning Group £2.5m (£2.8m)
Central Midlands Commissioning Hub £32.9m (£33.1m) Previously Leic and Lincs Area Team
Central Midlands Local Office £7.7m (£7.4m) Previously Hertfordshire & South Midlands Area Team
Northamptonshire Healthcare NHS Foundation Trust £1.3m (£7.4m)

Expenditure Transactions
NHS Litigation Authority £5.9m (£6.1m)
Northamptonshire Healthcare NHS Foundation Trust £1.3m (£1.2m)
NHS Blood and Transplant £1.4m (£1.4m)

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Northampton Borough Council (Business Rates £746k (£726k)), Northamptonshire County Council (Pathology Services £150k (£151k)) and HM Revenue & Customs (Employers National Insurance contribution £11.6m (£11.6m)), National Health Service Pension Fund Scheme £15.8m (£15.8m) and NHS Business Services Authority £7.6m (£7.1m)

The Trust has also received revenue and capital payments from Northamptonshire Health Charitable fund. The corporate trustee of the Northamptonshire Health Charitable fund is the Trust Board.

Grants totalling £372k (£176k), which were received from the Charity, have been treated in the Trust's Accounts as income and have primarily contributed towards staff and patients welfare. The Charity also funded £248k (£211k) of Building Works & Medical Equipment.

The Charitable Fund produces separate Trustees Report and Accounts which are available from the Finance Department of the Trust or on the Charity Commission website www.charity-commision.gov.uk. Should you wish to learn more about the Charitable Fund's activities and current initiatives visit www.nghgreenheart.co.uk or contact the Fundraising Team on 01604 545857 or E-mail greenheart@ngh.nhs.uk

39. Losses and special payments

The total number of losses cases in 2015-16 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	349,951	427
Special payments	53,686	55
Total losses and special payments	403,637	482

The total number of losses cases in 2014-15 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	162,648	261
Special payments	115,729	53
Total losses and special payments	278,377	314

40. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

40.1. Breakeven performance

	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s
Turnover	174,041	187,379	206,926	227,805	236,260	255,481	271,295	276,894	270,358	**273,562**
Retained surplus/(deficit) for the year	156	1,834	2,100	(4,958)	1,109	(1,917)	(764)	2,103	(20,111)	**(17,086)**
Adjustment for:										
Timing/non-cash impacting distortions:										
Pre FDL(97)24 agreements	0	0	0	0	0	0	0	0	0	**0**
2007/08 PPA (relating to 1997/98 to 2006/07)	0	0	0	0	0	0	0	0	0	0
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0	0	0	0	0	0	0	0	0
Adjustments for impairments	0	0	729	7,039	0	3,453	899	(2,257)	3,338	**(3,315)**
Adjustments for impact of policy change re donated/government grants assets	0	0	0			(1,032)	264	351	248	**250**
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*	0	0	0	0	0	0	0	0	0	**0**
Absorption accounting adjustment	0	0	0	0	0	0	0	0	0	**0**
Other agreed adjustments	0	0	0	0	0	0	**0**	0	0	**0**
Break-even in-year position	**156**	**1,834**	**2,829**	**2,081**	**1,109**	**504**	**399**	**197**	**(16,525)**	**(20,151)**
Break-even cumulative position	**(1,771)**	**63**	**2,892**	**4,973**	**6,082**	**6,586**	**6,985**	**7,182**	**(9,343)**	**(29,494)**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %
Materiality test (I.e. is it equal to or less than 0.5%):										
Break-even in-year position as a percentage of turnover	0.09	0.98	1.37	0.91	0.47	0.20	0.15	0.07	-6.11	**-7.37**
Break-even cumulative position as a percentage of turnover	-1.02	0.03	1.40	2.18	2.57	2.58	2.57	2.59	-3.46	**-10.78**

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

40.2. Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

40.3. External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2015-16 £000s	2014-15 £000s
External financing limit (EFL)	**26,297**	20,413
Cash flow financing	**24,426**	20,380
Finance leases taken out in the year	**1,410**	0
Other capital receipts	**0**	0
External financing requirement	**25,836**	20,380
Under/(over) spend against EFL	**461**	33

40.4. Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2015-16 £000s	2014-15 £000s
Gross capital expenditure	**18,149**	14,131
Less: book value of assets disposed of	**(113)**	(280)
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**(177)**	(295)
Charge against the capital resource limit	**17,859**	13,556
Capital resource limit	**17,877**	13,572
(Over)/underspend against the capital resource limit	**18**	16

41. Third party assets

The Trust held cash and cash equivalents which relate to monies held by the NHS Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2016 £000s	31 March 2015 £000s
Third party assets held by the Trust	**0**	0

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 May 16**

Title of the Report	**Corporate Governance Report**
Agenda item	**16**
Presenter of Report	Catherine Thorne, Director of Corporate Development, Governance and Assurance
Author(s) of Report	Catherine Thorne, Director of Corporate Development, Governance and Assurance
Purpose	Information
Executive summary This report provides the Board with information on a range of corporate governance matters and in particular includes formal reporting on the Use of the Trust Seal pursuant to the Trust's Standing order 12.3.	
Related strategic aim and corporate objective	N/A
Risk and assurance	This report provides assurance to the Board in respect to compliance with Standing Orders and the Trust's Standards of Business Policy
Related Board Assurance Framework entries	N/A
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (Y/**N**) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (Y/**N**)

Enclosure K

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

Actions required by the Trust Board

The Trust Board is asked to:

- To note the Use of the Seal, numbers of staff declarations and new declarations of interest by Trust Board members

Northampton General Hospital NHS
NHS Trust

Public Trust Board

Corporate Governance Report
January –April 2016

Introduction

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

Use of the Trust Seal

The Trust's Standing Orders require that periodic reports are made to the Board detailing the use of the Trust's Seal. The Seal will generally be used for contracts in excess of the financial limits delegated to the Chief Executive under the Standing Financial Instructions, and for property matters, including disposals, acquisitions and leases.

The seal has been used on the following occasions during Quarter 4:

Contract between Allied Medical Ltd and The Trust for provision of PET CT services

Deed for Northamptonshire Health Charitable Fund

Land Registry form for transfer of title for Harborough Lodge Renal Unit to Dayll Developments Ltd.

Contract between the Trust and EMIS Ltd related to Patient Administration System.

Declarations of Hospitality

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

- January – April 2016: 17 declarations received

Declarations of Interest

There were no new declarations of interest.

Enclosure K

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 May 16**

Title of the Report	**Risk Management Strategy 2016 - 2019**
Agenda item	**17**
Presenter of Report	Catherine Thorne Director of Corporate Development, Governance and Assurance
Author(s) of Report	Catherine Thorne Director of Corporate Development, Governance and Assurance
Purpose	To set out the principles and framework for the management of risk in Northampton General Hospital NHS Trust.

Executive summary

The aim of this strategy is to strengthen the existing risk management framework, embedding risk management at a local level and ensuring appropriate escalation of risks through the organisation to the Board, supported by training and tools.

It is based on the principles of an *Enterprise Risk Management* (ERM). The aim of ERM is to embed risk management in the day to day running of an organisation and to understand the broad spectrum of risks facing the organisation to ensure they are appropriately managed.

The key aims of this strategy are to achieve greater local level ownership of risk, enhanced clarity regarding roles and responsibilities for risk management and strengthened governance arrangements to support the current framework and deliver a well led “Board to Ward” approach.

The strategy is supported by an implementation plan, with objectives to support the achievement of the aims of the strategy. Both strategy and implementation plan will be reviewed each year.

Implementation of the strategy will be monitored by the Trust’s

- Risk and Compliance Group and Quality Governance Committee.

Enclosure L

Related strategic aim and corporate objective	All
Risk and assurance	The strategy develops the risk management culture and structures within the organisation.
Related Board Assurance Framework entries	ALL- The risk management policy to underpin this strategy will details the process for escalation of risk to the Corporate Risk Register and BAF.
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? N Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)?/N
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	Robust risk management will support the Trust's regulatory and legal compliance visibility.

Actions required by the Trust Board

The Board is asked to:

- Approve the Risk Management Strategy and supporting implementation plan.

Northampton General Hospital NHS
NHS Trust

Risk Management Strategy and Implementation Plan 2016 - 2019

Catherine Thorne
Director of Corporate Development, Governance and Assurance

April 2016

Enclosure L

Executive Summary

We know from previous reviews that organisationally our governance frameworks and systems needed improvement, therefore

- We have moved to a clinically led structure
- We have revised our organisational committee structure
- We are improving quality governance supported by our quality improvement agenda

We recognise that there are still areas where we can strengthen our existing frameworks and risk management is an area that continually requires development to ensure all risks are appropriately identified, managed and escalated.

Executive Summary

The aim of this strategy is therefore to strengthen the existing risk management framework, embedding risk management at a local level and ensuring appropriate escalation of risks through the organisation to the Board, supported by training and tools.

It is based on the principles of an *Enterprise Risk Management* (ERM). ERM is a risk-based approach to managing an "enterprise", integrating concepts of governance, assurance, and strategic planning. The aim of ERM is to embed risk management in the day to day running of an organisation and to understand the broad spectrum of risks facing the organisation to ensure they are appropriately managed.

So, in the context of an NHS trust, ERM delivers risk management from 'ward to board'.

The key aims of this strategy are to achieve greater local level ownership of risk, enhanced clarity regarding roles and responsibilities for risk management and strengthened governance arrangements to support the current framework.

Executive Summary

The strategy is supported by an implementation plan, with objectives to support the achievement of the aims of the strategy. Both strategy and implementation plan will be reviewed each year.

Implementation of the strategy will be monitored by the

- Organisation's Risk and Compliance Group and Quality Governance Committee.

- The implementation will be in two main phases:

  - Design and developing capacity – between May 2016 and July 2016
  - Implementation – commencing from August 2016

The Risk Management Strategy

The risk management strategy has six components

The overall vision of the strategy is:

" To continually improve the maturity of the risk management framework that supports the Board in oversight and management of risks to the achievement of Trust objectives"

1. Embed risk management at all levels of the organisation

It is clear from the work undertaken by Delloitte in 2014 and feedback from the Risk Group that while the overall governance framework in the organisation is providing greater transparency with regard to risk it needs to be more variable further down in the organisation.

- One of the key aims of this strategy will be to ensure greater local ownership of risks. Whilst we have introduced risk registers at a more local level within divisions and directorate level further work is required to develop these supported by clear criteria and timeframes for escalation of risks.
- To support this greater local ownership of risks, the roles and responsibilities for risk identification, assessment, management and monitoring will be clarified to ensure clear escalation of risks between the different levels of the organisation, from 'ward to board'.
- In order to ensure that the framework is effective, we will strengthen the role and membership of the Trust's Risk and Compliance Group (RCG) so that it challenges the management of risk at clinical divisional and corporate directorate level, aggregates risks across those areas and escalates to Quality Governance Committee accordingly.
- The RCG will monitor compliance with the risk management policy by reviewing risks at divisional and directorate level, but also scrutinising the arrangements for risk management at the lower level and holding divisions to account for the effectiveness of their local arrangements.

1. Embed risk management at all levels of the organisation

Action	Lead	Timescale
Review roles within central risk team to ensure functions aligned to provide best support	Director of Corporate Development, Governance and Assurance / Deputy Director of Governance	May 2016
Amend the trust's Risk Management policy to clarify roles and responsibilities, and escalation process.	Deputy Director of Governance / Head of Governance	June 2016
Define and articulate reporting requirements at all levels and also the role of RCG to monitor effectiveness of divisional reporting - review current templates, amend risk management policy and RCG terms of reference	Director of Corporate Development, Governance and Assurance / Deputy Director of Governance	June 2016
Review the Trust web based platform for capturing risk registers to ensure robust devolvement to support local ownership of risks particularly standardised recording and reporting	Head of Governance / Risk Manager	July 2016
Commence review of local risk registers at service and directorate level and develop a transparent system for aggregation and escalation between them, the divisional risk registers and the corporate risk register and Board Assurance Framework	Head of Governance / Risk Manager	August 2016

2. Create a culture which supports risk management

A key component of an effective and mature risk management framework is having a culture of knowledge and understanding of risk management, and leadership.

This means that roles and responsibilities need to be clearly defined so that risk management is 'owned' by appropriate members of staff and that staff are encouraged to be more risk aware by promoting openness and supporting them to manage risks locally where possible.

It also means visible and effective leadership from the Board in ensuring effective systems and processes for the management and escalation of risks.

The trust has board level leadership for risk management and a clear committee structure that supports the aggregation and escalation of risk, including the Risk and Compliance Group (RCG) and Quality Governance Committee (QGC).

The Trust has already identified the need to strengthen the leadership within that framework by adding executive level risk expertise and they will chair the RCG and looking forward will look to strengthen the role of RCG in providing the Board assurance as to the effectiveness of the framework of controls and assurances, by setting up a programme of 'deep dives', ensuring that the topics on the programme reflect the risks on the BAF.

As well as structure, a mature risk management framework requires risk management to be at the heart of board level discussion. To enhance the maturity of existing conversations at board level, one of the aims of this strategy is to create a clear link between assurance, risk management, corporate governance and regulation.

Using an agreed risk appetite matrix, the Board can set out a framework within which all risk should be considered, linking objectives, business planning and risk appetite. This will also help to develop an approach that supports risk forecasting.

Feedback from the organisation following the implementation of the clinically led structure indicates that we need to ensure clearly defined accountability and responsibility within the divisional structure. This is equally important for risk management so we will ensure that roles and responsibilities for risk management are defined in the Responsibility Framework, with implementation supported by a divisional risk development and training programme.

We will also create local ownership of risk management through involvement of staff in designing the tools to manage risk and training programmes.

2. Create a culture which supports risk management

Action	Lead	Timescale
Gain Board support and approval for the strategy	Director of Corporate Development, Governance and Assurance	April 2016
Clearly define accountability and responsibility for risk within Risk management policy and develop a responsibility framework for divisions	Director of Corporate Development, Governance and Assurance / Deputy Director of Governance	June 2016
Approve revised terms of reference for RCG	Director of Corporate Development, Governance and Assurance	May 2016
Review the RCG forward planner to include regular deep dives into extreme risks linked to Corporate Risk Register and Board Assurance Framework	Director of Corporate Development, Governance and Assurance / Risk manager	June 2016

3. Provide the tools to support risk management

For an enterprise risk management system to work effectively it is important that the language used to describe risks is the same throughout the organisation and that risk registers are consistent in format.

Standardisation of the platform for risk registers also provides an efficient mechanism for escalation and de-escalation. All divisional risk registers are now on the trust platform, Datix, and this provides a single, integrated platform for risk registers.

Other 'tools' to support risk management include the introduction of some additional concepts to enhance understanding of risks, their impact and the effectiveness of controls in place:

- **Residual risk** refers to the level of risk that remains after all efforts have been made to control a risk. In assessing the effectiveness of controls and decision making regarding further treatment of a risk, it is useful to assess both the current risk and the residual risk.
- Another approach would be to identify the **'target risk'** – the reduction in the level of risk that the controls should be aiming to achieve to enable acceptance or elimination of the risk.

As part of this strategy the Board will continue to apply such concepts to the Board Assurance Framework, this should enhance the Board's understanding of and challenge as to the effectiveness of current controls.

The **proximity** of a risk indicates the anticipated timescale when the risk is likely to materialise. This could be categorised as:

- short-term (within 3 months), medium-term (3 – 12 months) or long-term (longer than 12 months). Considering the proximity, or how soon a risk may occur, can help to compare risks for decision-making and prioritisation. As part of this strategy, we will consider piloting the use of Proximity rating, with a view to including in all risk registers depending on the organisational readiness

3. Provide the tools to support risk management

Action	Lead	Timescale
Create an assurance strategy and assurance map to support Board focus on assurance	Director of Corporate Development, Governance and Assurance	July 2016
Pilot concept of risk proximity and residual risk to support risk decision making	Director of Corporate Development, Governance and Assurance	July 2016
Develop an on line suite of risk management tools and template with quick guides to support alignment of strategy and policy	Head of Governance / Risk Manager	August 2016

4. Provide the training to support risk management

In order to develop the requisite culture for effective risk management and to ensure successful implementation of this strategy, there needs to be a structured, organisation-wide training programme for staff.

Risk management training and awareness already occurs in a number of different guises.

The Board currently have regular sessions which link to risk management as part of the board development programme and risk and governance features in a number of leadership development programmes as well as ad hoc training provided.

However we recognise that in order to successfully implement this strategy we will need to develop a more structured risk management training programme to increase staff knowledge and understanding of risk management.

As well as including training in the trust's risk management processes, we will use the organisation-wide programme to help to embed a consistent language of risk management, including concepts such as controls, mitigations, assurances, residual risk and proximity.

This will enhance the quality of conversation and consistency of approach.

We will therefore review the existing training programme and training materials to ensure appropriate knowledge and skills in risk management at different levels of the organisation.

4. Provide the training to support risk management

Action	Lead	Timescale
Develop a well defined training and education programme to support staff involved in managing risk at all levels of the organisation	Deputy Director of Governance / Head of Governance / Risk Manager	June 2016
Run a risk awareness campaign to raise awareness of amended risk management policy and responsibilities. This will utilise Trust Communication channels as well as attendance at divisional and directorate governance boards	Director of Corporate Development, Governance and Assurance / Head of Governance / Communications dept.	June – September 2016
Seek to develop new mechanisms to support training programme e.g. e learning or web based video tools	Head of Governance / H&S and Risk Manager Communications dept.	July 2016
Roll out training programme	H&S and Risk Manager	August 2016

5. Embed the trust's risk appetite in decision making

Risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to accept in the pursuit of its strategic objectives.

Risk appetite is a core consideration in any enterprise risk management approach. No organisation, whether in the private, public or third sector can achieve its objectives without taking a risk. The question for the decision-makers is how much risk do they need to or are prepared to take?

The UK Corporate Governance Code states that *"the board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic decisions"*.

As well as meeting the requirements imposed by corporate governance standards, organisations are increasingly being asked to express clearly the extent of their willingness to take risk to meet their strategic objectives.

Risk appetite, correctly defined, approached and implemented, should be a fundamental business concept that makes a difference to how organisations are run.

The strategy will be to develop an approach to risk appetite that is practical and pragmatic, and that makes a difference to the quality of decision-making, so that decision-makers understand the risks in any proposal and the degree of risk to which they are permitted to expose the organisation while encouraging enterprise and innovation.

The Board has considered the proposal for a risk appetite definition at a development session to consider corporate objectives and agreed a definition as described on the following page

5. Embed the trust's risk appetite in decision making

AVERSE	Prepared to accept only the lowest level of risk, with the preference being for ultra- safe delivery options, while recognising that these will have little or no potential for reward/return	CAUTIOUS	Willing to accept some low risks, while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward / return.	MODERATE	Tending towards exposure to only modest levels of risk in order to achieve acceptable but possibly unambitious outcomes.	OPEN	Prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks	HUNGRY	Eager to seek original/ creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/ return

5. Embed the trust's risk appetite in decision making

Action	Lead	Timescale
Raise Board awareness of risk appetite and its use through Board development session regarding risk appetite and corporate objectives	Director of Corporate Development, Governance and Assurance	February – May 2016
Develop risk appetite statement for each of the Trusts corporate objectives	Director of Corporate Development, Governance and Assurance	May – June 2016
Review risk appetite statement as part of business planning process annually	Director of Corporate Development, Governance and Assurance / Director of Strategy	September – November 2016
Ensure consideration and assessment of risk and risk appetite are considered within planning process at both divisional and corporate level	Director of Corporate Development, Governance and Assurance / Director of Strategy	September – November 2016

6. Measure the impact of implementation

There is a need to measure the impact of the strategy, to measure its effectiveness in developing the maturity of the trust's risk management framework.

We will therefore review the strategy and implementation plan on an annual basis.

In order to measure the impact of implementation of this strategy, we will complete an annual risk maturity assessment, using an adaption of the *HM Treasury Risk Management Assessment Framework.*

This tool provides a flexible tool to assist in evaluating performance and progress in developing and maintaining effective risk management capability and assessing the impact on delivering effective risk handling and required/planned outcomes. It tests the framework in the following seven areas:

Capabilities

- 1. **Leadership:** do senior management and Clinical leaders support and promote risk management?
- 2. Are **people** equipped and supported to manage risk well?
- 3. Is there a clear risk **strategy** and risk **policies**?
- 4. Are there effective arrangements for managing risks with **partners**
- 5. Do the organisation's **processes** incorporate effective risk management?

Risk Handling

- 6. Are **risks handled well**?

Outcomes

- 7. Does risk management contribute to **achieving outcomes**?

By completing this an annual completion of this assessment will assess the key aims of this strategy:

- Greater local level ownership of risk
- Enhanced clarity regarding roles and responsibilities for risk management
- Strengthened governance arrangements to support the current framework

6. Measure the impact of implementation

Action	Lead	Timescale
Review purpose and terms of reference of RCG to ensure the strategy is embedded within the remit of the committee	Director of Corporate Development, Governance and Assurance	June 2016
Review divisional governance in relation to risk and ensure forms regular part of two yearly divisional governance review process	Director of Corporate Development, Governance and Assurance	August 2016
Use internal audit to evaluate implementation of the strategy	Director of Corporate Development, Governance and Assurance	March/April 2017
Consider mechanism for monitoring division for compliance with the risk management policy, including metrics to measure the effectiveness of divisional risk management processes	Director of Corporate Development, Governance and Assurance / Deputy Director of Governance	August 2016

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 May 2016**

Title of the Report	**Operational Performance Report & Scorecard**
Agenda item	**18**
Presenter of Report	Mrs Deborah Needham, Chief Operating officer / Deputy CEO
Author(s) of Report	Lead Directors & Deputies Tracey Harris, Cancer Manager Richard Wheeler, Performance Project Manager
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 and red rated has an accompanying exception report There are separate reports on cancer and urgent care.	
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)

	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

Northampton General Hospital NHS Trust Corporate Scorecard 2016-17

Caring

Indicator	Target	Trend	Feb-16	Mar-16	Apr-16
Complaints responded to within agreed timescales	=>90%	↓	75.6%	Awaiting Responses	
Friends & Family Test % of patients who would recommend: Inpatient/Daycase	95.4% (Feb 16)	↑	89.4%	89.3%	91.5%
Friends & Family Test % of patients who would recommend: A&E	84.9% (Feb 16)	↑	84.0%	84.4%	86.7%
Friends & Family Test % of patients who would recommend: Maternity - Antenatal Community	95.3% (Feb 16)	↑	100%	97.3%	100%
Friends & Family Test % of patients who would recommend: Maternity - Birth	96.3% (Feb 16)	↑	94.7%	91.4%	97.8%
Friends & Family Test % of patients who would recommend: Maternity - Postnatal Ward	93.7% (Feb 16)	↑	94.6%	95.8%	98.1%
Friends & Family Test % of patients who would recommend: Maternity - Postnatal Community	98.0% (Feb 16)	↑	97.6%	100%	99.1%
Friends & Family Test % of patients who would recommend: Outpatients	92.4% (Feb 16)	↑	91.7%	91.4%	92.1%
Mixed Sex Accommodation	0	→	0	0	0
Total deaths where a care plan is in place	=>50%	↓	62.0%	50.0%	54.0%
Transfers: Patients moved between 10pm and 7am with a risk assessment completed	=>98%	↑	94.7%	95.9%	98.3%

Effective

Indicator	Target	Trend	Feb-16	Mar-16	Apr-16
Emergency re-admissions within 30 days (elective)	None	↑	3.7%	3.6%	2.7%
Emergency re-admissions within 30 days (non - elective)	None	↑	14.9%	14.4%	13.1%
Length of stay - All	=<4.2	↓	4.93	4.34	4.65
Maternity: C Section Rates - Total	<26.2%	↓	24.2% (90)	24.6% (97)	28.8% (121)
Crude Death Rates			Not available		1.5%
Mortality: HSMR	Within expected range	↑	100	98	98
Mortality: SHMI		→	102	102	102
# NoF - Fit patients operated on within 36 hours	=>80%	↓	91.4%	96.8%	85.7%
Stroke patients spending at least 90% of their time on the stroke unit	=>80%	↑	57.1%	81.8%	75.9%
Suspected stroke patients given a CT within 1 hour of arrival	=>50%	↓	72.7%	70.4%	71.2%
% Daycase Rate		↓	88.0%	88.3%	87.2%

Safe

Indicator	Target	Trend	Feb-16	Mar-16	Apr-16
C-Diff	Ave. 1.75 per mth	↓	2	1	3
Dementia: Case finding	=>90%	↓	99.7%	97.3%	98.3%
Dementia: Initial diagnostic assessment	=>90%	→	100%	100%	100.0%
Falls per 1,000 occupied bed days	=<5.5	↓	4.7	4.1	Not Avail
Harm Free Care (Safety Thermometer)	94.08% (Mar 16)	↓	92.1%	93.3%	90.5%
MRSA	0	↑	0	1	0
Never event incidence	0	→	0	0	0
Pressure Ulcers (Hospital Acquired) - Grades 2-4	To be confirmed	↓	29	28	38
Number of Serious Incidents Requiring Investigation (SIRI) declared during the period	0	↑	3	2	2
UTI with Catheters (Safety Thermometer-Percentage new)	0.28% (Mar 16)	↓	0.32%	0.16%	0.48%
VTE Risk Assessment	=>95%	↓	96.5%	95.1%	95.7%
Transfers: Patients transferred out of hours (between 10pm and 7am)	=<60	↑	114	98	58

Footnote:

Friends and Family Test: Targets are now set against the latest national performance which is published two months retrospectively. The RAG rating is therefore only applied for the most recently published national performance.

Footnote:

S.6 & S.19 Safety Thermometer indicators: Targets are now set against the latest national performance. The RAG rating is therefore only applied for the most recently published national performance.

Responsive

Indicator	Target	Trend	Feb-16	Mar-16	Apr-16
A&E: Proportion of patients spending less than 4 hours in A&E	=>95%	↓	84.0%	81.0%	88.5%
A&E: 4hr SitRep reporting	=>95%	↑	84.5%	80.6%	87.3%
A&E: 12 hour trolley waits	0	→	0	0	0
Ambulance handovers that waited over 30 mins and less than 60 mins	0	↓	550	569	570
Ambulance handovers that waited over 60 mins	0	↑	232	374	221
Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	=>99%	↓	99.96%	99.80%	99.58%
Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	=>93%	↓	96.1%	97.2%	96.4%
Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	=>93%	↓	98.9%	99.0%	98.8%
Cancer: Percentage of patients treated within 62 days of referral from screening	=>90%	↓	100%	100.0%	90.0%
Cancer: Percentage of patients treated within 62 days of referral from hospital specialist	=>85%	↓	100%	93.8%	77.8%
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	=>85%	↓	82.3%	79.4%	71.3%
Cancer: Percentage of patients treated within 31 days	=>96%	↓	94.9%	95.5%	94.8%
Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	=>94%	↓	92.3%	100%	80.0%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	=>98%	↓	98.5%	100%	85.7%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	=>94%	↓	95.2%	99%	95.8%
Operations: Urgent Operations cancelled for a second time	0	→	0	0	0
Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	0	↑	11	2	6
RTT waiting times incomplete pathways	=>92%	↑	94.1%	93.6%	94.7%
RTT over 52 weeks	0	→	0	0	0
Delayed transfer of care	=<23	↓	80	105	112

Well Led

Indicator	Target	Trend	Feb-16	Mar-16	Apr-16
Friends & Family: % of staff that would recommend the trust as a place of work	N/Applic	↓	42.8%		Not applic.
Data quality of Trust returns to HSCIC (SUS)	=>90%	→	93.3%	93.3%	93.3%
Turnover Rate	=<8%	↑	11.19%	10.80%	10.58%
Sickness rate	=<3.8%	↑	4.44%	3.97%	4.11%
Staff: Trust level vacancy rate - All	=<7%	↓	7.4%	7.3%	9.98%
Staff: Trust level vacancy rate - Medical Staff	=<7%	↓	10.21%	10.87%	13.29%
Staff: Trust level vacancy rate - Registered Nursing Staff	=<7%	↓	11.13%	11.36%	11.60%
Staff: Trust level vacancy rate - Other Staff	=<7%	↓	8.92%	8.44%	10.79%
Staff: Temporary costs & overtime as a % of total pay bill	None	↑	12.6%	16.4%	14.1%
Percentage of staff with annual appraisal	=>85%	↑	80.2%	81.9%	82.71%
Percentage of all trust staff with mandatory training compliance	=>85%	↑	83.9%	84.5%	85.13%
Percentage of all trust staff with role specific training compliance	=>85%	↓	73.4%	74.0%	73.70%
Medical Job Planning	100%	↑	81.0%	81.0%	91.0%

Finance

Indicator	Target	Trend	Feb-16	Mar-16	Apr-16
Surplus / Deficit	0 Fav		(262) Adv	189 Fav	(311) Adv
Income	0 Fav		(377) Adv	409 Fav	(290) Adv
Pay	0 Fav		(54) Adv	(551) Adv	(629) Adv
Non Pay	0 Fav		(301) Adv	(173) Adv	631 Fav
Bank & Agency / Pay %	7.5%		8.1%	9.1%	9.2%
CIP Performance	0 Fav		(58) Adv	126 Fav	Not Avail
Waivers			8	6	12
Waivers which have breached			6	9	3

KEY	
↑	Improving performance over 3 month period
↓	Reducing performance over 3 month period
→	Stable performance delivery over 3 month period

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.

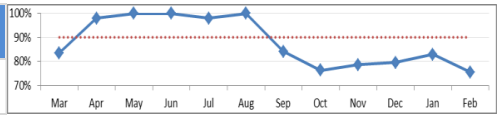
Northampton General Hospital NHS
NHS Trust

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.	April 2016

Performance and Trajectory:

Indicator	Target	Trend	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Complaints responded to within agreed timescales	=>90%	↓	100.0%	100.0%	98%	100%	84%	76%	79.0%	80.0%	83%	75.6%	Awaiting Responses	



Driver for underperformance:	Actions to address the underperformance:
• Reporting on February's figures now they have been validated • 45 complaints received in February of which 11 cases exceeded timescale • Late or incomplete responses received from the Divisions + backlog of complaints built up in the Complaints dept. • Trust on escalation for significant incidents requiring staff to be operational. • Staffing issues within Complaints Department as substantive person on Maternity leave. • Post vacant for 6 weeks. Person now in training. • Therefore unable to meet internal and external timescales.	• Followed up with senior staff and other key staff identified. • Part time temporary complaints officer employed to help with backlog of work as of May 2016. • Not expected to achieve target until June 2016's data reported in Aug 2016

Lead Clinician:	Lead Manager:	Lead Director:
Dr Mike Cusack	Lisa Cooper, Head of Complaints	Carolyn Fox, Director of Nursing

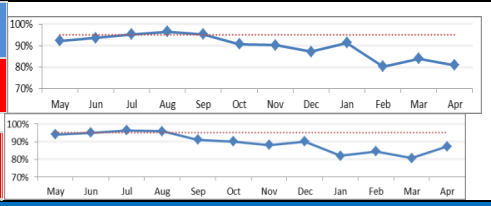
Northampton General Hospital NHS
NHS Trust

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 / 4hr SitRep Reporting	Externally mandated	Finance, Investment and Performance Committee	April 2016

Performance and Trajectory:

Indicator	Target	Trend	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
A&E: Proportion of patients spending less than 4 hours in A&E	=>95%	↓	93.6%	95.3%	96.6%	95.4%	90.7%	90.4%	87.3%	91.4%	80.4%	84.0%	81.0%	88.5%
A&E: 4hr SitRep reporting	=>95%	↑	94.1%	95.1%	96.4%	95.8%	91.0%	90.1%	88.1%	90.1%	82.1%	84.5%	80.6%	87.3%



Driver for underperformance:	Actions to address the underperformance:
• Radiology delays – loss of a room • Continued issues with air tube to pathology • Inpatient Capacity & Flow • Inflow – peaks of patient attendance late afternoon/early evening causing first assessment breaches • Dr Vacancy in A&E WTE 15.67 – continued issues within medical staffing for temporary locums. • IC24 gaps in GP & Nurse coverage	• Discussions with radiology and escalation at time of delay • Ordering new A&E red pods to highlight arrival in pathology contingency planning when tube out of order. • New urgent care ward build SOP under construction • FIT Stop work commenced – to improve pressures in ED & patient flow • IC24 contract performance meeting held – action plan in place • Review of Co-ordinator/ NIC role (incorporating deep dive objectives) • A&E escalation policy completed awaiting comments.

Lead Clinician:	Lead Manager:	Lead Director:
Dr Jon Timperly	Sue McLeod, Divisional Manager	Debbie Needham, Chief Operating Officer

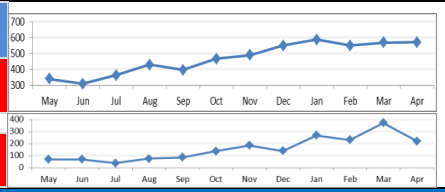
Northampton General Hospital NHS
NHS Trust

Scorecard - Exception Report

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

Performance and Trajectory:

Indicator	Target	Trend	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Ambulance handovers that waited over 30 mins and less than 60 mins	0	↓	339	308	362	429	395	466	490	550	587	550	569	570
Ambulance handovers that waited over 60 mins	0	↑	67	68	37	74	85	136	185	139	268	232	374	221



Driver for underperformance:	Actions to address the underperformance:
• A&E fit stop capacity • Batching of ambulances • Peak patient inflow to A&E • More than one entry point through Fit Stop **IT & Handover Screens:** • Ambulances not appearing • Crews not completing • No Delay - Pick option removed	**FIT Stop:** • Increased bays • Holding area for ambulance to stop corridor queues • NIC moved to ambulance entrance • New booking in point for crews • All ambulances to be streamed Ambulance handover action plan.xlsx

Lead Clinician:	Lead Manager:	Lead Director:
Dr Jon Timperly	Sue McLeod, Divisional Manager	Debbie Needham, Chief Operating Officer

Northampton General Hospital NHS
NHS Trust

Scorecard - Exception Report

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

Performance and Trajectory:

Indicator	Target	Trend	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Cancer: Percentage of patients treated within 62 days of referral from hospital specialist	=>85%	↓	100%	100%	75%	50%	75.0%	40.0%	100.0%	0%	100%	100%	93.8%	77.8%
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	=>85%	↓	85.1%	77.1%	71.9%	78.5%	80.6%	87.0%	80.6%	77.0%	69.4%	82.3%	79.4%	71.3%
Cancer: Percentage of patients treated within 31 days	=>96%	↓	99.2%	96.7%	96.0%	97.2%	98.2%	94.8%	96.3%	100%	94.7%	94.9%	95.5%	94.8%
Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	=>94%	↓	100%	100%	100%	100%	100%	85.7%	91.7%	100%	90.0%	92.3%	100%	80.0%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	=>98%	↓	100%	98.8%	100%	100%	98.5%	100%	95.6%	98%	98%	98.5%	100%	85.7%

Driver for underperformance:	Actions to address the underperformance:
• Patient delays: - delay to investigations, • Late referral • Many investigations:-patients requiring investigations at 2 hospitals. • Medical reasons: - DVT / other medical delays • Administration: - late referral to tertiary hospital, medical record availability, biopsy results • Capacity: - H&N	• Weekly meetings between Radiology and Cancer Services • Agreement of H&N pathway with KGH • Agreement of new 2ww slots for Gynae patients from June 2016 • 2ww criteria to be released on the Choose & Book Directory of Services from 16th May • Monitor urology and H&N pathways • Monitor endoscopy capacity

Lead Clinician:	Lead Manager:	Lead Director:
Dr C Elwell	Matt Tucker, Divisional Manager	Debbie Needham, COO

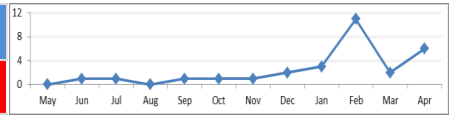
Northampton General Hospital NHS
NHS Trust

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Externally mandated	Finance, Investment and Performance Committee	April 2016

Performance and Trajectory:

Indicator	Target	Trend	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	0	↑	0	1	1	0	1	1	1	2	3	11	2	6



Driver for underperformance:

- **Medical Division:**
- Cardiology: Northampton Heart Centre has been open for escalation during the month of April 2016. Change in practice in relation to reporting cardiology diagnostics by information team. Long waits now in cardiology for all diagnostics in cardiology longest wait being 16 weeks.
- **Surgical Division**
- T&O: Patient was scheduled within 28 days, however due to emergency's pressures and an increase of Trauma patients requiring urgent surgery it was necessary to convert the Elective list to a trauma list which led to this patient breaching their 28 day target.
- Vascular Surgery: The patient was initially cancelled on the day due to emergency pressures and insufficient beds available. Patient was then relisted for the 13/04 but was cancelled the day before for a more urgent case. Patient was then offered the 18/04 but was cancelled on the day due to insufficient Theatre time. Patient received their operation on the 19/04.
- Oral Surgery: Patient was initially cancelled on the day due to emergency pressures and insufficient bed capacity. The patient was rebooked for the 28/04 within breach but was cancelled by

Actions to address the underperformance:

- **Medical Division:**
  Trajectory has been developed for recovery plan
  Deputy Chief Executive and Medical Director have amended escalation policy which excludes use of NHC for escalation purposes

- **Surgical Division**
  Where possible patients are cancelled the day before their admission to prevent the occurrence of 28 day breaches. All priority three patients are reviewed the day before admission and cancelled when the Trust is reporting Red escalation. The service aims to re-date patients within 7 days of the patient's cancellation. Where this is not possible this will be escalated to the Divisional Manager and then the DCOO / COO. Performance against this target is monitored at the weekly performance meeting.

the consultant due to a more urgent cancer case. 2 other patients where both cancelled on the day due to insufficient bed availability. Both patients were rescheduled for the 24th April but the lists were cancelled as a consequence of the Junior Drs strike.		
Lead Clinician:	**Lead Manager:**	**Lead Director:**
Mr Mike Wilkinson	Alison Pirfo, Deputy Chief Operating Officer (Interim)	Debbie Needham, Chief Operating Office

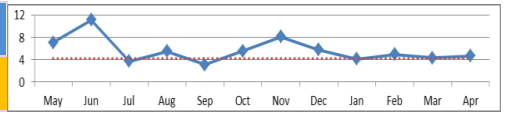
Northampton General Hospital NHS
NHS Trust

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Length of Stay	Internally set	Finance, Investment and Performance Committee	April 2016

Performance and Trajectory:

Indicator	Target	Trend	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Length of stay - All	=<4.2	↓	7.1	11.1	3.7	5.5	3.1	5.6	8.1	5.78	4.13	4.93	4.34	4.65



Driver for underperformance:	Actions to address the underperformance:
• The number of DTOC's has increased in April 16. This is due to the increase in the cohort of patients who require ongoing support, and earlier identification of this cohort of patients through recent deep dive exercises to support flow and preparation for the Junior Doctors strikes. • 3.86% increase in admissions from November 15 – April 16, compared to the same period the year before.	• Continued work continues via in patient's productivity operational steering group: the teams will focus on supporting a solid patient handover to ensure key information and messages are communicated effectively to reduce delays, duplication and LOS. • Focus continues on board rounds, and weekend discharges • Outlier senior decision maker (doctor) appointed to review all outliers • New In reach Model implemented within Medicine on 1st April 2016, this is beginning to show significant benefits

Lead Clinician:	Lead Manager:	Lead Director:
Dr Lyndsey Brawn	Sue McLeod, Divisional Manager	Debbie Needham, Chief Operating Officer

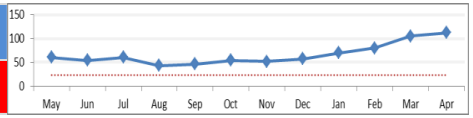
Northampton General Hospital NHS
NHS Trust

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Delayed Transfers of Care	Externally mandated	Finance, Investment and Performance Committee	April 2016

Performance:

Indicator	Target	Trend	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Delayed transfer of care	=<23	↓	60.2	54.0	60.8	43	46	54	52	58	70	80	105	112



Driver for underperformance:	Actions to address the underperformance:
• Large delays in community pick up for Discharge to Assess. There has been some drift in the process and also a focus on the proposed Integrated Discharge HUB. • Numbers of patients being referred as complex have been increasing over March. It is thought the deep dives and daily tracking in preparation for BH and Strike days have contributed. The overall number of clinically stable patients has not increased. • Waits for the Angela Grace pathway have also increased. The service throughput is only delivering at 50% of prediction. 10 additional beds have been opened. NCC does not now assess, the NHFT Mental Health service's do.	• DTA meetings are to re-established in May to ensure the project has a re-focus. • The top 20 meeting to be re-focused to address complex issues. DR to attend 2 board rounds per week with discharge co-ordinators to gain a sense check of the process. • The CCG are requested to chair weekly tracking at Angela Grace to promote better throughput. NGH have assigned a Discharge co-ordinator to support the transition over to NHFT and the choice policy has been implemented.

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Dione Rogers, Head of Capacity and Patient Flow	Debbie Needham, Chief Operating Officer

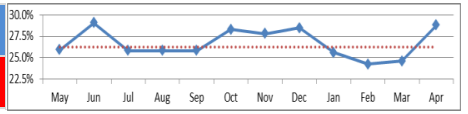
Northampton General Hospital NHS
NHS Trust

Scorecard - Exception Report

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

Performance and Trajectory:

Indicator	Target	Trend	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Maternity: C Section Rates - Total	<26.2%	↓	27.7% (106)	25.9% (101)	29.1% (118)	25.8% (110)	25.8% (98)	25.8% (113)	28.3% (110)	27.8% (110)	28.5% (107)	25.6% (94)	24.2% (90)	24.6% (97)	28.8% (121)



Driver for underperformance:	Actions to address the underperformance:
• Natural fluctuation. • Shift in activity: 2 bank holidays End of March lead to a low number in March and a high in April (6 – 8 procedures).	• This measure is not a performance measure in the conventional sense as it is highly dependent on patient factors. Interventions are complex. • Discussion with Consultant Obstetrician team what was different in April compared to Jan – Mar. • Review in departments governance meeting.

Lead Clinician:	Lead Manager:	Lead Director:
Owen Cooper, Consultant And Clinical Director	Rose McKee, Service Manager	Dr Mike Cusack, Medical Director

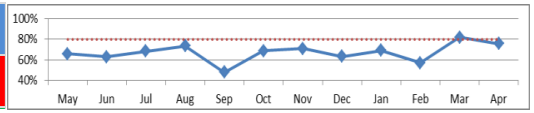
Northampton General Hospital NHS
NHS Trust

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.	April 2016

Performance and Trajectory:

Indicator	Target	Trend	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Stroke patients spending at least 90% of their time on the stroke unit	=>80%	↑	87.0%	65.9%	63.0%	68.6%	73.7%	48.0%	68.6%	70.8%	63.5%	69.2%	57.1%	81.8%	75.9%



• Driver for underperformance:	Actions to address the underperformance:
• The last 2 months show the best performance in 2 consecutive months that we have achieved to date. • The drivers for underperformance remain the same as previous months: - Patients with a short length of stay (<48 hours) not accessing a stroke bed. - Medical patients in stroke beds (Eleanor and Holcot) - Excessive wait for complex care packages, in patients that need ongoing stroke rehabilitation and consequently cannot be transferred off the Stroke Unit.	• These remain the same as for previous months and are ongoing. We admit an average of 80 stroke patients/month and until we can truly ring fence stroke beds and operate with the expectation of maintaining 2 empty stroke beds at all times, we will not consistently achieve this target. • On May 19th we are moving Holcot Ward to Allebone Ward to place all of our Stroke Service in the same area. This will give a net gain of 1 bed but we hope will enable us to improve flow of stroke patients through our beds. • A teleconference was held with the CCG and NHFT in March to discuss the location of the Community Stroke beds. An agreement was reached that all 12 beds should be located on the Isebrook site. This could improve our use of this resource but it is unclear when it will happen.

Lead Clinician:	Lead Manager:	Lead Director:
Dr Lyndsey Brawn/ Dr Melanie Blake	Sue McLeod, Divisional Manager	Dr Mike Cusack, Medical Director

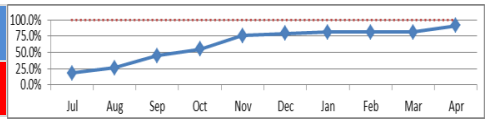
Northampton General Hospital NHS
NHS Trust

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Medical Job Planning	Internally set	Workforce Committee	April 2016

Performance and Trajectory:

Indicator	Target	Trend	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Medical Job Planning	100%	↑	Not avail.		18.0%	26.0%	45.0%	55.0%	76.0%	79.0%	81.0%	81.0%	81.0%	91.0%



Driver for underperformance:	Actions to address the underperformance:
• . Job planning not performing against agreed trajectory.	• Consultants who had not engaged in the process or signed off their job plan have been sent a letter informing them of the agreed activity and commencement date.

Lead Clinician:	Lead Manager:	Lead Director:
Dr Win Zaw, Job Plan Clinical Lead	Sue Jacobs, Project Manager	Dr Mike Cusack, Medical Director

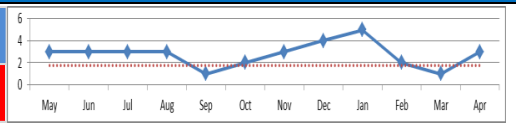
Northampton General Hospital NHS
NHS Trust

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Clostridium difficile Infection Trust attributable (post 3 days)	Externally Mandated	Quality Governance Committee.	April 2016

Performance:

Indicator	Target	Trend	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
C-Diff	Ave. 1.75 per mth	↓	1	3	3	3	3	1	2	3	4	5	2	1	3



Driver for underperformance:

- Patient safety, to protect patients from acquiring a hospital acquired infection
- CDI patient case number 1, this patient was an elective admission to the Head and Neck ward for surgery and was prescribed antibiotics post operatively.
- CDI patient case number 2, this patient was a medical outlier who was a failed discharge. The patient was prescribed antibiotics for bronchopneumonia and suspected urinary tract infection.
- CDI patient case number 3, this patient was previously *Clostridium difficile* antigen positive and taking Proton Pump Inhibitors (PPI) so therefore was at increased risk of becoming *Clostridium difficile* toxin A and B positive.

Actions to address the underperformance:

- There is a CDI action plan for 2016-2017. The Trust is also taking part in a NHS improvement collaborative, which is currently focusing on 3 wards Willow, Collingtree and Allebone ward. Many tests of change are being undertaken and the key focus for the first 30 days is prompt faecal sampling for patients who are symptomatic with diarrhoea.

Lead Clinician:	Lead Manager:	Lead Director:
Dr Minas Minassian, Divisional Director Clinical Support Services	Wendy Foster, Matron for Infection Prevention	Carolyn Fox, Director of Nursing

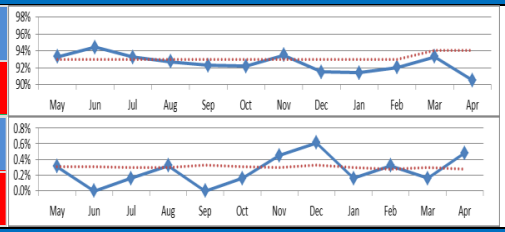
Northampton General Hospital NHS
NHS Trust

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Safety Thermometer Indicators	Externally mandated	Quality Governance Committee.	April 2016

Performance and Trajectory:

Indicator	Target	Trend	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Harm Free Care (Safety Thermometer)	94.08% (Mar 16)	↓	93.3%	94.4%	93.3%	92.7%	92.3%	92.2%	93.5%	91.5%	91.4%	92.1%	93.3%	90.5%
`	Target	Trend	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
UTI with Catheters (Safety Thermometer-Percentage new)	0.28% (Mar 16)	↓	0.31%	0.00%	0.16%	0.32%	0.00%	0.16%	0.45%	0.61%	0.16%	0.32%	0.16%	0.48%



Driver for underperformance:	Actions to address the underperformance:
• Hospital acquired Pressure Ulcers above national target • Catheter related UTI rose in April to 3 patients • Falls with harm increased to 3 in April	• Pressure Ulcer collaborative underway with third event held this month. Ward areas presented their PDSA tests of change with the emphasis on shared learning for practice that affects change. • Share & Learn meetings continue with improved engagement to understand the problems being encountered • Root cause analysis for the 3 UTI's are underway, common themes will be shared at the Infection Prevention operational group and sub-committee • Root cause analysis is undertaken for all falls with harm with shared learning cascaded through the falls sub committee

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Fiona Barnes, Deputy Director of Nursing	Carolyn Fox, Director of Nursing

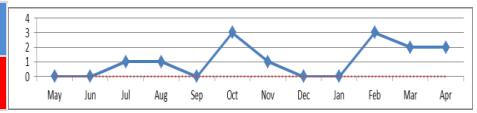
Northampton General Hospital NHS
NHS Trust

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Number of Serious Incidents Requiring Investigation (SIRI) declared during the period	Externally mandated	Quality Governance Committee.	April 2016

Performance and Trajectory:

Indicator	Target	Trend	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Number of Serious Incidents Requiring Investigation (SIRI) declared during the period	0	↑	0	0	1	1	0	3	1	0	0	3	2	2



Driver for underperformance:

- **Theatres (2015/9477 Retained vaginal block)** Patient undergoing laparoscopic hysterectomy. Normal practice is to insert bung into vagina to reduce amount of gas leaking. Pack usually removed at end of procedure. On this occasion this pack was not removed and was noticed by patient at a later date. Current practice was that this bung is not part of conventional theatre check at end of procedure and therefore the fact that it remained in patient was an oversight.
- **Urology (2015/9316 Surgical Error/nephrectomy)** Massively obese patient. Potential challenges and complications recognised and discussed pre op with patient. Very challenging laparoscopic nephrectomy – complex anatomy difficult to establish given the size of the patient. Inadvertent clipping of contralateral renal artery during operation. Recognised postop. Appropriate investigations carried out and management plan considered. Unable to rescue kidney so patient now in renal failure. Has been discharged home.

Actions to address the underperformance:

- **Theatres (2015/9477 Retained vaginal block)** Immediate change of material used for block. Now use swabs in glove (as opposed to gloves in glove). Number used dependant on patient size. Will use a number other than 5 so that there are always some swabs remaining on trolley. Pack now recorded on Swab Board and counted as part of swab counts. Immediate review of all procedures across all theatres to check if similar practice elsewhere. This has prompted change in Main and Eyes. Incident discussed and ideas shared at Theatre Managers meeting 29/4/2016. Two observations of surgeon operating by Matron. Findings reported to new Theatre Manager for ongoing monitoring. 6/5/2016 Organisational Development session with Gynae staff on values and behaviours.
- **Urology (2015/9316 Surgical Error/nephrectomy)** Debrief carried out after event. Surgeon has written an initial report. SUI investigation in progress. Written statements received from everyone involved. Interviews of key individuals commence week of 9 May. Awaiting final report to ascertain actions and learning to be addressed.

Lead Clinician:	Lead Manager:	Lead Director:
Mr Rob Hicks / Mr Owen Cooper	Fay Gordon, Divisional Manager	Dr Mike Cusack, Medical Director

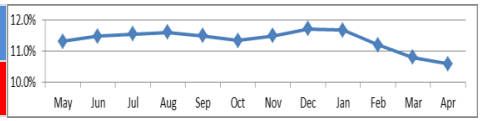
Northampton General Hospital NHS
NHS Trust

Scorecard - Exception Report

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

Performance:

Indicator	Target	Trend	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Turnover Rate	=<8%	↑	11.3%	11.5%	11.5%	11.6%	11.48%	11.33%	11.48%	11.70%	11.66%	11.19%	10.80%	10.58%



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 programmes	• Recruitment to a dedicated retention post holder • Review of exit interviews • 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, Head Of Resourcing And Employment Services	Janine Brennan, Director of H.R.

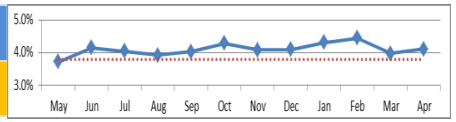
Northampton General Hospital NHS
NHS Trust

Scorecard - Exception Report

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

Performance:

Indicator	Target	Trend	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Sickness rate	=<3.8%	↑	4.4%	4.2%	4.0%	3.9%	4.03%	4.28%	4.08%	4.10%	4.31%	4.44%	3.97%	4.11%



Driver for underperformance:	Actions to address the underperformance:
• Short term absence – 2.42% and long term absence is 1.69% • Short term absence is the driver in April 2016 for the percentage increase from March 16. • 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	• Staff reaching the Trust's staff sickness absence policy triggers are being met with formally • Support through referrals to Occupational Health • Rigorous management in line with Management of Sickness Absence policy • Return to work audits • Trust wide Sickness Absence Management training sessions to be delivered by the third quarter • A number of short term and long term dismissal meetings for ill health capability are taking place on a regular basis • Monthly 1-1 meetings with Managers are taking place to support timely sickness management

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Andrea Chown, Deputy Director of H.R.	Janine Brennan, Director of H.R.

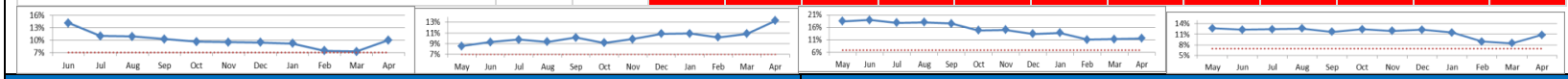
Northampton General Hospital NHS
NHS Trust

Scorecard - Exception Report

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

Performance:

Indicator	Target	Trend	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Staff: Trust level vacancy rate - All	=<7%	↓	11.1%	14.1%	11.0%	10.9%	10.3%	9.7%	9.5%	9.5%	9.2%	7.4%	7.3%	9.98%
Staff: Trust level vacancy rate - Medical Staff	=<7%	↓	8.6%	9.3%	9.8%	9.4%	10.14%	9.18%	9.88%	10.86%	10.90%	10.21%	10.87%	13.29%
Staff: Trust level vacancy rate - Registered Nursing Staff	=<7%	↓	18.4%	19.0%	17.9%	18.1%	17.58%	14.82%	15.01%	13.42%	13.87%	11.13%	11.36%	11.60%
Staff: Trust level vacancy rate - Other Staff	=<7%	↓	12.7%	12.3%	12.5%	12.6%	11.69%	12.41%	11.95%	12.29%	11.46%	8.92%	8.44%	10.79%



Driver for underperformance:

- There is a national shortage of nursing staff along with a shortage within other professional allied specialities
- Potential 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

Actions to address the underperformance:

- 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	Adam Cragg, Head Of Resourcing And Employment Services	Janine Brennan, Director of H.R.

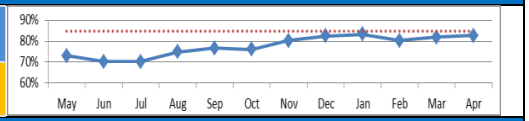
Northampton General Hospital NHS
NHS Trust

Scorecard - Exception Report

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

Performance:

Indicator	Target	Trend	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Percentage of staff with annual appraisal	=>85%	↑	73.1%	70.3%	70.3%	74.8%	76.7%	76.1%	80.4%	82.5%	83.3%	80.2%	81.9%	82.71%



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 82.71%. • 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.

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Adam Cragg, Head Of Resourcing And Employment Services	Janine Brennan, Director of H.R.

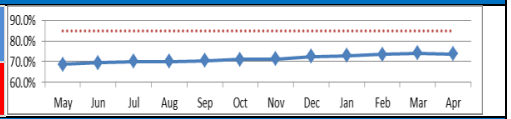
Northampton General Hospital NHS
NHS Trust

Scorecard - Exception Report

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

Performance:

Indicator	Target	Trend	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Percentage of all trust staff with role specific training compliance	=>85%	↓	68.7%	69.5%	70.1%	70.1%	70.5%	71.2%	71.3%	72.5%	73.0%	73.4%	74.0%	73.70%



Driver for underperformance:	Actions to address the underperformance:
• Mandatory Training Review in 2013 reduced the number of subjects of which many of those that were originally mandatory are now Role Specific Essential Training. • The target to be achieved by March 2015 is 85% as per the Quality Schedule set by the CCG; however this is not a national mandate	• Scoping of RSET against job roles and positions has been completed and uploaded into system to ensure accuracy of reporting. There has been additional work on Safeguarding Children Level 2 & 3 which expects an increase in % of compliance. • Following 1:1 sessions with Ward Managers, the L&D Manager is providing further support through training them in understanding the reports to use them to monitor individual training and forecasting. • Additional scoping work has commenced on Blood Training which has resulted in more staff requiring this training. • Blood Training has changed from a 3 year refresher to a 2 year which therefore has an increase in staff going out of date.

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Adam Cragg, Head Of Resourcing And Employment Services	Janine Brennan, Director of H.R.

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 May 2016**

Title of the Report	**Report from the Finance Investment and Performance Committee**
Agenda item	**19**
Presenter of Report	Phil Zeidler, Non-Executive Director and Chair of Finance Investment and Performance Committee
Author(s) of Report	Phil Zeidler, Non-Executive Director and Chair of Finance Investment and Performance Committee
Purpose	For Assurance

Executive summary

This report from the Chair of the Finance Investment and Performance Committee provides an update to the Trust Board on activities undertaken during the month of April.

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

Enclosure N

Actions required by the Trust Board

The Trust Board is asked to note the report.

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: 26 May 2016

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

Executive Summary

The Committee met on *20 April 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)*
• The FY16-17 Plan • Changing care@NGH • Agency Cap • Operation Performance Report • 16-17 contract update	

Key areas of discussion arising from items appearing on the agenda

- The 16/17 plan was for a material increase in the Trusts deficit
- Several of the opportunities in the 15/16 changing care programme were not fully realised
- It was recognised that performance had improved significantly after a very difficult period, but it was unclear whether this could be sustained
- Plans for the all out Junior doctors strikes were discussed
- Concerns were raised around the BCF and delivery of reducing DTOCS
- Discussed a risk of entering arbitration regarding the contract due to various unresolved issues including a requirement to deliver more episodes of care than we have capacity for.

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

- Changing care team to review the undelivered 15/16 schemes and report back on lessons learnt
- Final plans for doctors strike to be circulated
- Trust plans regarding contract to be circulated to Board

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

- 16/17 contract dispute to be raised at Board

Legal implications/	The above report provides assurance in relation to CQC

Enclosure N

regulatory requirements	Regulations and BAF entries as detailed above.
Action required by the Board	

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 May 2016**

Title of the Report	**Report from the Quality Governance Committee**
Agenda item	**20**
Presenter of Report	Liz Searle, Non-Executive Director and Chair of Quality Governance Committee
Author(s) of Report	Liz Searle, Non-Executive Director and Chair of Quality Governance Committee
Purpose	For Assurance
Executive summary This report from the Chair of the Quality Governance Committee (QGC) provides an update to the Trust Board on activities undertaken during the month of April. A verbal update from the May meeting will be presented.	
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 O

Actions required by the Trust Board

The Trust Board is asked to note the report.

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: *26th May 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 *22/04/2016* 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)*
• Quality Account • Medicines Optimisation Strategy • Organ Donation Report • Update on the Data Quality Strategy • Claims and Litigation Report • Duty of Candour Report	

Key areas of discussion arising from items appearing on the agenda

- ECLIPSS – new framework
- Corporate Scorecard for Quality – will be presented differently in future Committee meetings
- Run charts included to present pressure ulcer data which indicated an improvement in numbers
- Medical Directors report – the possibility of a potential never event
- Health & Safety report – a review of the data is needed to ensure it contains a wider stretch of data, also the possibility of triangulating the data with the Workforce Committee to be explored. Two new members of staff have been employed which will help coordinate this process.

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

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

Legal implications/	The above report provides assurance in relation to CQC

Enclosure O

regulatory requirements	Regulations and BAF entries as detailed above.
Action required by the Board	

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 May 2016**

Title of the Report	**Report from the Workforce Committee**
Agenda item	**21**
Presenter of Report	Graham Kershaw, Non-Executive Director and Chair of Workforce Committee
Author(s) of Report	Graham Kershaw, Non-Executive Director and Chair of Workforce Committee
Purpose	For Assurance
Executive summary This report from the Chair of the Workforce Committee provides an update to the Trust Board on activities undertaken during the month of April.	
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)

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

Northampton General Hospital NHS
NHS Trust

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: ***26 May 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 20/04/2016* 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)*
Proposed Junior Doctor contract and potential implementation Nurse recruitment and retention strategies/action plans. Workforce performance Safe nurse staffing	

Key areas of discussion arising from items appearing on the agenda

The committee had a comprehensive presentation from the Director of Workforce on the Junior Doctor revised contract and the issue of implementing this. This included the appointment of a Guardian and the challenges faced by the Trust in for example organising shifts and rotas. This is clearly going to be a challenge to implement successfully and the financial implications still need to be assessed.
Recruitment of nurses is challenging, more recruitment activity is now taking place in India and the Philippines. A retention strategy and action plan has been introduced which will address this key issue.
On safer nurse staffing daytime nurse fill rates are at just over 90%.

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

See key areas of discussion above.

An update was requested on the Francis Crick programme and organisational development.
The workforce committee also requested a review of appraisal effectiveness to be undertaken in the near future following introduction of the revised appraisal system.

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

Non other than the new Junior Doctor contract 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	

Report To	**TRUST PUBLIC BOARD**
Date of Meeting	**26 May 2016**

Title of the Report	**Report from the Audit Committee**
Agenda item	**22**
Presenter of Report	David Noble Non-Executive Director and Chair of Audit Committee
Author(s) of Report	David Noble Non-Executive Director and Chair of Audit Committee
Purpose	For Assurance
Executive summary This report from the Chair of the Audit Committee provides an update to the Trust Board on activities undertaken during the month of March – April.	
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 - All
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (Y/**N**) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (Y/**N**)
Legal implications / regulatory requirements	Statutory and governance duties

Enclosure Q

Actions required by the Trust Board

The Board is asked to note the report.

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: 26 May 2016

Title	**Audit Committee Exception Report**
Chair	**David Noble**
Author (s)	**David Noble**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met o*n 24/03/2016* 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)*
Board Assurance Framework and Risk Register External Audit Progress Report Internal Audit Progress Report, Draft Plan and Opinion Local Fraud Progress Report Annual Governance Statement Annual Report and Accounts Progress Report	

Key areas of discussion arising from items appearing on the agenda

The Committee were informed of potential breach of the Audit remit regarding the Quality Account Audit. We are awaiting advice from regulators and have put in place contingency plan.
The Committee agreed that it would be useful to have a Board level Discussion on risk appetite. This is particularly relevant as the Trust is still carrying significant risk post mitigation.
Internal Audit Reports with Limited Assurance were discussed in detail, namely audits relating to Nurse Agency Staffing and Health and Safety. In both cases the responsible executives satisfied the Committee that all the actions agreed in the reports had been effectively followed up.
The Internal Audit report gave a Reasonable Assurance opinion overall. The Committee concurred with this assessment.
The requirement for a Schedule of Delegated Responsibilities to complement the Corporate Governance Manual was discussed and agreed
Commitment required from TDA/NHSI regarding Going Concern assurances.
The Committee heard that good progress was being made on the preparation of the Annual Report and Accounts.

Any key actions agreed / decisions taken to be notified to the Board
See key areas of discussion above.

Initiate Board discussion on risk appetite.

Enclosure Q

Any issues of risk or gap in control or assurance for escalation to the Board None.	
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 None.	

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 May 2016**

Title of the Report	**Report from the Hospital Management Team Workshop Meeting held on 3rd May 2016**
Agenda item	**23**
Presenter of Report	Dr Sonia Swart, Chief Executive Officer
Author(s) of Report	Deborah Needham, Chief Operating Officer/Deputy CEO
Purpose	For Information & Assurance
Executive summary This report provides an update to the Trust Board on activities undertaken at the Hospital Management Team meeting held in May 2016.	
Related strategic aim and corporate objective	Strategic Aims - All
Risk and assurance	Risks assessment provided within the report.
Related Board Assurance Framework entries	BAF 1.2, 1.5, 1.7, 2.1, 4.1, 4.2, 5.1,
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
Legal implications / regulatory requirements	Statutory and governance duties
Actions required by the Trust Board The Trust Board is asked to note the report.	

Enclosure R

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: 26th May 2016

Title	**HMT Exception Report**
Chair	**Dr Sonia Swart**
Author (s)	**Mrs Deborah Needham**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met on 3rd May 2016 as a HMT workshop 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**
Trust Board highlights - Urgent care pressures - Patient safety awards - Financial position including STP Divisional performance 7 day working – case note review STP update GDSU business case	1.1, 1.2, 2.2, 3.1, 3.2,

Key areas of discussion arising from items appearing on the agenda

Divisions presented their top 3 areas of concern & challenge, the themes discussed were broadly similar to those discussed at the subcommittees of the Board:

- R&D – consultant dedicated time required.
- EMRAD implementation.
- Urgent care pressures and performance including the new model for acute medicine, the introduction of a SpR specifically for medical patients on surgical wards, a new administrator role for junior doctors within medicine and actions being taken to improve ambulance handover times.
- Cancer performance and specifically the increase in urology referrals due to the "blood in pee campaign", an additional locum is in place to help manage demand.
- RTT ongoing performance and the backlog of patients in orthopaedics, the division are planning additional capacity to resolve. The backlog in Gynaecology has started to reduce.
- The recent SI in Gynaecology and the use of the NPSA decision tree.

7 day working – Case note review

Dr Bisset presented the findings from a recent audit against the 7 day working findings. Further work is required from divisions to both validate the information and take action to address the gaps. The Divisional Directors are planning to discuss this at their next team meeting.

STP update

Mr Pallot & Mr Lazarus gave a verbal update on the STP including introduction and timescales, the working groups, governance and support from McKinsey's in developing the plan.

Enclosure R

Any key actions agreed / decisions taken to be notified to the Board GDSU business case Mr VonWidekind outlined a business case which had been developed as part of the annual planning round. This was brought back to HMT for further discussion given the delay in the implementation of additional beds for Winter. The case outlines the need to carry out some building work in GDSU and will create a dedicated day case area for women as well as provide an additional 8 beds for Spencer ward. The case was agreed.	
Any issues of risk or gap in control or assurance for escalation to the Board All areas of risk regarding quality and performance are covered in Trust Board reports and detailed on the risk register	
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 note the contents of the report.	

Northampton General Hospital NHS
NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 26 May 2016
09:30 in the Board Room at Northampton General Hospital

Time		Agenda Item	Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2.	Declarations of Interest	Note	Mr P Farenden	**Verbal**
	3.	Minutes of meeting 31 March 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.**
10:05	**CLINICAL QUALITY AND SAFETY**				
	8.	Medical Director's Report	Assurance	Dr M Cusack	**D.**
	9.	Director of Nursing and Midwifery Report	Assurance	Ms C Fox	**E.**
	10.	Midwifery Learning Disability Group Presentation	Receive	Ms C Fox	**Presentation.**
	11.	Approval of Quality Account	Assurance	Dr M Cusack	**F.**
10:25	**OPERATIONAL ASSURANCE**				
	12.	Finance Report	Assurance	Mr S Lazarus	**G.**
	13.	Workforce Performance Report	Assurance	Mrs J Brennan	**H.**
10:45	**STRATEGY**				
	14.	Sustainability and Transformation Plan Update	Assurance	Mr C Pallot	**I.**
10:55	**GOVERNANCE**				
	15.	Approval of Annual Report and Annual Accounts 2015/16	Decision	Mr S Lazarus	**J.**
	16.	Corporate Governance Report	Assurance	Mrs C Thorne	**K.**
	17.	Approval of Risk Management Strategy	Decision	Mrs C Thorne	**L.**

Time	Agenda Item		Action	Presented by	Enclosure
11:00	**FOR INFORMATION**				
	18.	Integrated Performance Report	Assurance	Mrs D Needham	**M.**
11:15	**COMMITTEE REPORTS**				
	19.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler	**N.**
	20.	Highlight Report from Quality Governance Committee	Assurance	Mrs L Searle	**O.**
	21.	Highlight Report from Workforce Committee	Assurance	Mr G Kershaw	**P.**
	22.	Highlight Report from Audit Committee	Assurance	Mr D Noble	**Q.**
	23.	Highlight Report from Hospital Management Team	Assurance	Dr S Swart	**R.**
11:45	**24.**	**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 28 July 2016 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).