Northampton General Hospital NHS
NHS Trust

Public Trust Board

Thursday 31 March 2016

09:30

Board Room
Northampton General Hospital

Northampton General Hospital NHS
NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 31 March 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 28 January 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.**
10:25	**OPERATIONAL ASSURANCE**				
	10.	Finance Report	Assurance	Mr S Lazarus	**F.**
	11.	Workforce Performance Report	Assurance	Mrs J Brennan	**G.**
10:45	**STRATEGY**				
	12.	Clinical Collaboration & Healthier Northants Update	Assurance	Mr C Pallot	**H.**
10:55	**GOVERNANCE**				
	13.	Emergency Preparedness Annual Report	Assurance	Mrs D Needham	**I.**
11:00	**FOR INFORMATION**				
	14.	Integrated Performance Report	Assurance	Mrs D Needham	**J.**
	15.	Staff Survey	Assurance	Mrs J Brennan	**K**
11:15	**COMMITTEE REPORTS**				
	16.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler	**L**

Time	Agenda Item		Action	Presented by	Enclosure
	17.	Highlight Report from Quality Governance Committee	Assurance	Mrs L Searle	**M.**
	18.	Highlight Report from Workforce Committee	Assurance	Mr G Kershaw	**N.**
	19.	Highlight Report from Audit Committee	Assurance	Mr D Noble	**Verbal**
	20	Highlight Report from Hospital Management Team	Assurance	Dr S Swart	**O.**
11:45	**21.**	**ANY OTHER BUSINESS**		Mr P Farenden	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Trust Board will be held at 09:30 on Thursday 26 May 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 28 January 2016 at 09:30 in the Board Room at Northampton General Hospital

Present		
	Mr P Zeidler	Non-Executive Director (Chair)
	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
	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		
	Mr C Abolins	Director of Facilities and Capital Development
	Mrs J Brennan	Director of Workforce and Transformation
	Mrs S McKenzie	Executive Board Secretary
	Mr C Pallot	Director of Strategy and Partnerships
	Ms C Thorne	Director of Corporate Development Governance & Assurance
	Mrs S Watts	Head of Communications
Apologies		
	Mr P Farenden	Chairman
	Mrs L Searle	Non-Executive Director

TB 15/16 095 Introductions and Apologies

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

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

TB 15/16 096 Declarations of Interest

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

TB 15/16 097 Minutes of the meeting 26 November 2015

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

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

TB 15/16 098 Matters Arising and Action Log 26 November 2015

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

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

Action: Mrs McKenzie

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

TB 15/16 099 Patient Story

Ms Fox reported that following a number of changes to the Friends and Family Test (FFT) a relaunch had been undertaken in December. As part of the relaunch a short video was created of the '12 days of FFT', which detailed 10 changes that had been made as a result of patient feedback. The video was then played to the Board members after which they offered their thanks to the Communications team and the Head of Patient Experience and Engagement.

The Board **NOTED** the Patient Story.

TB 15/16 100 **Chief Executive's Report**

Dr Swart presented the Chief Executive's Report.

Dr Swart reported on the five year planning guidance and that Northampton General Hospital (NGH) was required to produce an individual operational plan for 2016/17. The initial draft must be submitted by 8 February 2016.The implications of the planning guidance for both NGH and the wider health and social care community are being assessed and will be built into the planning and commissioning framework for 2016/17.

She commented that all Trust boards had also received a joint letter from Jim Mackey and Mike Richards asking them to consider finance and quality on an equal footing in their planning decisions and had also now received individual letters from NHS Improvement indicating their proposed share of transformation funding with a number of conditions including a specified control total and a range of improvements in performance, transformation and sustainability. Trusts were required to confirm acceptance of the offer with conditions by 8 February 2016.

Dr Swart reported that the Trust's plans for the junior doctors' strike were robust and were implemented effectively by staff. Regular Silver and Gold command meetings, supported by safety huddles and team meetings, ensured that any issues were identified and addressed without delay. Team NGH rose to the challenge of keeping patients safe and now confident that the learning from this event would be taken forward to further enhance and develop our resilience plans.

The Board noted that a Memorandum of Understanding with the University of Northampton had been signed to develop closer links with the University to pave the way for academic research to be put into practice and open up new opportunities for research projects to improve health and wellbeing.

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

TB 15/16 101 **Medical Director's Report**

Dr Cusack presented the Medical Director's Report.

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

He reported that three Never Events had been discussed at the Quality Governance Committee and each case was under investigation. He confirmed that a report on the findings would be presented to the Quality Governance Committee.

For the rolling year ending in September 2015 there remained no statistical difference between the standardised mortality rates for weekend and weekday admissions. The Trust had received a letter from NHS England advising of the intention to introduce a standardised methodology for reviewing all deaths occurring in hospital through a structured analysis of patient records with the aim of identifying themes for improvement both nationally and within organisations. NHS England (NHSE) had commissioned Healthcare Quality Improvement Partnership (HQIP) to manage procurement of development of a standardised methodology and training roll out to all NHS trusts in England. It was anticipated that a supplier would be in place by January 2016, with a pilot expected to start in Q1 2016/17.

Dr Cusack provided an update on the NGH Quality Improvement Day and informed the Board that the Junior Doctor Safety Board 2015/2016 (JDSB) had been formed following the new intake of Junior Doctors in August 2015. This year the JDSB had been offered to both FY1 & FY2 doctors in training. There were currently 20 members who had chosen a project and were being supported through the process by mentors having received introductory QI & Safety Science taster sessions.

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

TB 15/16 102 Director of Nursing and Midwifery Care Report

Ms Fox presented the Director of Nursing and Midwifery Report.

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

The Board were informed that the first QA visit for the Antenatal & Newborn Screening programme in NGH conducted by Midlands and East screening quality assurance service on behalf of Public Health England took place on 14 January 2016. QA visits were in progress around the country as a national initiative. Evidence submitted so far had been described as very good particularly for Ultrasound, Newborn Hearing Screen and Child Health Records. The notes audit was described as being of a high standard and a full written report would be available within 8 weeks.

Ms Fox reported that in December the number of reported pressure ulcers was 31, eight of which were reported as grade 3 or a deep tissue injury. She commented that a deep dive would take place and results would be available at the end of March.

The Board were informed that there had been 23 cases of C.diff apportioned to the Trust, 4 cases in December. All Root Cause Analysis (RCA) were sent to the CCG to identify any lapses in care and to date, out of the 23 cases, 17 RCAs had been sent to the CCG. 17 cases had been reviewed and there was 1 lapse in care identified. She commented that the Trust was working very closely with Public Health England.

Ms Fox reported that this month there had been 2 in-patient falls that caused at least 'moderate' harm. Two patients had a fall resulting in a fractured neck of femur, both were currently under investigation. Ms Clymer enquired on the type of falls and Ms Fox responded that she would report back to the Board once the investigation had been completed.

The Board noted that themes shown in the report on the Friends and Family Test and Ms Fox reported that there had been a delay in the roll out of the new process.

In the month of December, 50% of patients who died at NGH had an individualised plan of care. Although the target of 50% had been achieved, the figure had fallen from last month. She reported that the End of Life Care Team from the George Elliot would be visiting to review the Trust's processes.

Ms Fox commented that Safe Nursing Staffing had been discussed in detail at the Workforce Committee and Mr Kershaw commented on the improvement of the report.

Mr Zeidler commented that he was very impressed with the positive areas and news which should be recognised. Ms Fox commented that she would feed this back to the team.

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

TB 15/16 103 Finance Report

Mr Lazarus presented the Finance Report.

Mr Lazarus reported that the Finance Report had been discussed in detail at the January Finance Investment and Performance Committee meeting.

Mr Lazarus reported that the I&E position for the period ended December (M9) showed a deficit of £16.6m, £0.16m favourable to plan. Pay costs remained at a run rate of £15.7m in December, although enhancements for December would be reported and paid in January. He reported that the Department of Health had approved the capital loan of £9.352m in support of replacement imaging equipment, expansion of imaging capacity and the development of inventory systems and a further loan for £18.851m Interim Revenue Support had also been approved. The recorded level of RN agency fell to 9% in December but remained above the TDA required ceiling of 8%. He informed the Board that there remained a risk in delivering the year end control total deficit which needed to be managed in Q4 through a formal action plan.

The Board **NOTED** the Finance Report.

TB 15/16 104 Workforce Performance Report

Mrs Brennan presented the Workforce Performance Report.

Mrs Brennan reported that the Workforce Performance Report had been discussed in detail at the January Workforce Committee meeting. She informed the Board that annual Trust turnover had increased to 11.70% in December which was above the Trust target of 8%. Substantive Workforce Capacity had decreased by 35.65 FTE in December 2015 to 4168.57 FTE. In-month sickness absence had increased very slightly by 0.02% from November's rate of 4.08%, to 4.10%, which was above the Trust target of 3.8%.

She commented that the current rate of Appraisals recorded for December 2015 was 82.52% and this was an increase of more than 2% from last month's figure of 80.37%. Mandatory Training compliance also increased between November and December from 82.88% to 84.21% and was approaching the Trust target of 85%. Role Specific Essential Training compliance also increased in December to 72.51%; whilst this was still less than the Trust target it continued the improving trend seen each month since March 2015.

Mrs Brennan provided an overview of mandatory and role specific essential training processes and systems which included determining what subjects were included, reports provided and future plans.

With regard to the Junior Doctors Strike action she assured the Board that robust plans were put in place which included consultant and other senior medical staff covering both emergency and non-emergency work, although a number of procedures were cancelled in advance, in order to mitigate the risk of compromising patient care. The teams worked extremely hard and as a result there were no major incidents and work progressed smoothly.

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

TB 15/16 105 Clinical Collaboration and Healthier Northants Update

Mr Pallot presented the Clinical Collaboration and Healthier Northants Update.

Mr Pallot provided a detailed update to the Board on the current position of the Healthier Northamptonshire programme as at 7 December 2015 and was similar to that presented to both Clinical Commissioning Group (CCGs) Governing Bodies and Kettering General Hospital Board to ensure the same information was shared. He commented that both the Healthier Northamptonshire Implementation Steering Group and the Integrated Care Closer to Home (ICCtH) Board were cancelled due to low attendance over the festive season in December and hence the briefness of the update. Mr Zeidler commented that the cancellation of these meetings over the Christmas period demonstrated a lack of focus and drive. Dr Swart responded that the meetings were not cancelled due to the festive season.

Mr Pallot reported that further to the tripartite escalation meeting on 23 September 2015 the Health and Social Care partners had agreed that the programme would be refreshed and refocused to ensure delivery of the Integrated Care Closer to Home strategy, development of primary care at scale, and further integration (physical, social and mental health). Agreement to provide a strong focus on acute quality priorities and all of these refinements needed to be agreed and embedded to ensure a sustainable system plan.

The Board were informed that a workshop was held on Monday 9 November 2015, to start to develop the milestone plan required for the system regulators. There were 3 breakout sessions for each of the programme areas whereby all partner organisations started to develop an outlined milestone plan for Integrated Care Closer to Home, Clinical Collaboration, Collaborative Resource Management and Finance. Since the workshop Health and Social Care partners have further developed the original document. The milestone plan with financial high level modelling has been submitted to the Regulators on 30 November 2015.

Mr Pallot provided an update on Clinical Collaboration which currently included 6 specialties which are Rheumatology, Orthopaedics, Ophthalmology, Radiology, Cardiology and Dermatology. All the specialities were at different stages of implementation; therefore an overarching clinical collaboration implementation framework had been developed and implemented to ensure there was a consistency in both the approach and pace of delivery. The Clinical Collaboration Steering Board had been expanded to include GP representation. The key focus was to produce business cases that supported the changes in each specialty with rheumatology and orthopaedics being the first.

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

TB 15/16 106 Corporate Governance Quarterly Report

Ms Thorne presented the Corporate Governance Quarterly Report.

Ms Thorne provided the Board with information on a range of corporate governance matters and in particular included formal reporting on the use of the Trust Seal pursuant to the Trust's Standing order 12.3. She commented that the Trust's Standing Orders required that periodic reports were made to the Board detailing the use of the Trust's Seal. She reported that during September to December 2015 the Seal had not been used.

She commented that following regular staff reminders the Board noted that during September to December 2015 there had been 32 declarations received. It was also noted that there were 2 new declarations of interest by Trust Board members.

Olivia Clymer commenced as a newly appointed Non-Executive Director on 1 November 2015 and had declared the following interests:

- Non-Executive Director for Dudley and Walsall Mental Health Trust
- Secretary to a Sailing Club

Chris Pallot has made an update to declarations:

- Chairman of Voluntary Impact Northamptonshire

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

TB 15/16 107 TDA Self-Certification Report

Ms Thorne presented the TDA Self-Certification Report.

Ms Thorne reported that in accordance with the Accountability Framework, the Trust had been required to complete two self-certifications in relation to the Foundation Trust application process. Draft copies of Monitor Licensing Requirements and Trust Board Statements self-certifications for December 2015 were discussed and approved.

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

TB 15/16 108 NHS Preparedness for a Major Incident

Mrs Needham presented the NHS Preparedness for a Major Incident.

Mrs Needham reported that following the recent attacks in Paris, NHS England (NHSE) had requested the support of national agencies in continuing to ensure that the NHS remained in a position to respond appropriately to any threat. NHSE commented that the threat assessment to the UK from international terrorism in the UK remained at 'Severe'.

The Trust was therefore requested to provide assurance surrounding the following 4 key areas:

1. You have reviewed and tested your cascade systems to ensure that they can activate support from all staff groups, including doctors in training posts, in a timely manner including in the event of a loss to the primary communications system;

2. You have arrangements in place to ensure that staff can still gain access to sites in circumstances where there may be disruption to the transport infrastructure, including public transport where appropriate, in an emergency;

3. Plans are in place to significantly increase critical care capacity and capability over a protracted period of time in response to an incident, including where patients may need to be supported for a period of time prior to transfer for definitive care;

4. You have given due consideration as to how the Trust can gain specialist advice in relation to the management of a significant number of patients with traumatic blast and ballistic injuries.

Mrs Needham drew the Board's attention to the 4th key area and commented that specialist advice would normally be sought from tertiary centres if needed and that the Trust proposes to undertake an exercise in order to test the management of a significant number of patients with traumatic blast injuries using multi agencies. She commented that next a joint operations table top exercise across fire, police and health would take place.

The Board **NOTED** the NHS Preparedness for a Major Incident.

TB 15/16 109 Integrated Performance Report and Corporate Scorecard

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.

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

TB 15/16 110 Highlight Report from the Finance Investment and Performance Committee

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

The Board were provided an update on activities undertaken during the month of December and discussed at the Finance Investment and Performance Committee meeting held on 16 December 2015. The report covered any issues of significance, interest and associated actions that were required and had been agreed to be taken forward by the Committee.

Mr Zeidler gave a verbal update from the meeting which took place on 20 January 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 arising from items appearing on the agenda were:

- Draft 16/17 plan had been significantly impacted by transformation and sustainability funding offer which requires us to delivery £19.2m deficit on a like for like basis.
- 16/17 CIP plan being developed with Divisional Directors ensuring savings were recurring
- Operating environment continues to be deeply challenging, staff were exhausted. Additional 60 beds this year were seen as essential to break the cycle.
- Conditions on revenue support were very onerous.

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

TB 15/16 111 Highlight Report the Quality Governance Committee

Mr Kershaw 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 18 December 2015. The report covered any issues of significance, interest and associated actions that were required and had been agreed to be taken forward by the Committee.

Mr Kershaw gave a verbal update from the meeting which took place on 22 January 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.

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

- Improvement in back log of Ophthalmology patients
- Mortality as expected but more focus on biliary tract
- Non-compliance of one standard in audit of C-Section standard to be reviewed at the March Committee
- 31 pressure ulcers and 26 patients with C-Diff. A deep dive on all to commence
- Gap analysis on end of life Nice guidance underway
- 3 Never Events reported

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

TB 15/16 112 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 20 January 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:

Overseas recruitment had been a challenge with 89 nurses commencing work against a target of 177. Problems were being experienced with NMC registration and English language testing results. The Trust had vacancies for 147 nurses against a forecast of 177 out of an establishment of 1024 wte.

Workforce performance and scorecard highlights were increased sickness levels in November and increased compliance with Mandatory training, Appraisals and role specific training.

The Director of Nursing had reviewed and updated the nurse safe staff report. Bank and Agency usage decreased in December and there was considerable focus on reducing nurse agency usage in line with national initiatives.

The Committee approved the Setting & Reviewing Nurse/Midwifery Staff and Establishments – Standard Operating Procedure. The Committee received an update from the Equality and Diversity Group (Staff) and the Equality and Diversity Annual Report.

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

TB 15/16 113 Highlight Report from the Audit Committee

Mr Noble presented the Report from the Audit Committee.

The Board were provided an update on activities undertaken during the month of December and discussed at the Audit Committee meeting held on 18 December 2015. The report covered any issues of significance, interest and associated actions that were required and had been agreed to be taken forward by the Committee. He informed the Board that key areas of discussion arising from items appearing on the agenda were:

The Audit Committee discussed the effectiveness of the Board Assurance Framework noting that many of the risks were red post mitigation.

The External Auditors, KPMG reported good progress and clear plans for the Audit, but raised a concern that there were changes afoot with National Audit Office now giving Audit guidance and a continuing lack of clarity regarding Quality Account guidance. This risk associated with this lack of certainty is judged to be low.

Internal Audit reported good progress against the plan with only one audit receiving limited assurance on Health and Safety related to Legionella and Asbestos. This is being followed up by the Quality Committee.

The Committee reviewed the proposed Internal Audit Charter which would be recommended for approval by the next quorate Audit Committee.

The Local Counter Fraud Progress Report identified a continuing threat of fraud and a continuing need for diligence. The Committee agreed that in view of the threat there should be a small rebalancing of resources between Counter Fraud and Internal Audit.

The Committee discussed the new arrangements for appointment of auditors which come into place for 2017/18.

The Committee reviewed the register of waivers, losses and special payments report and salary overpayments report.

The Committee reviewed an early draft of the proposed Corporate Governance Policies and supported with the direction of travel which was to put all the policies together in a consistent and sustainable format.

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

TB 15/16 114 **Highlight Report from the Hospital Management Team**

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

Dr Swart reported that the meeting of HMT took place on 19 January 2016 were the Divisional Directors gave an update on key areas of focus following their monthly performance meetings and specifically addressed the key challenges and any areas where help was required.

She reported that HMT received an updates on the Research and Development Strategy, Business Cases and 7 day Working.

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

TB 15/16 115 **Any Other Business**

There were no items of any other business.

Date of next meeting: Thursday 31 March 2016 at 09:30 in the Board Room at Northampton General Hospital.

Mr P Zeidler called the meeting to a close at 11:20

Public Trust Board Action Log							Last update	24/03/2016
Ref	**Date of meeting**	**Minute Number**	**Paper**	**Action Required**	**Responsible**	**Due date**	**Status**	**Updates**
Actions - Slippage								
NONE								
Actions - Current meeting								
NONE								
Actions - Future meetings								
NONE								

Enclosure B

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**31 March 2016**

Title of the Report	**Chief Executive's Report**
Agenda item	**7**
Presenter of Report	Dr Sonia Swart, Chief Executive
Author(s) of Report	Sally-Anne Watts, Head of Communications Sonia Swart , Chief Executive
Purpose	Information and assurance
Executive summary The report highlights key business and service issues for Northampton General Hospital NHS Trust in recent weeks.	
Related strategic aim and corporate objective	N/A
Risk and assurance	N/A
Related Board Assurance Framework entries	N/A
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups) (N)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper (N)

Enclosure C

Actions required by the Trust Board

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

Public Trust Board
31 March 2016
Chief Executive's Report

1. Improving quality at NGH

Don Berwick, a senior fellow at the Institute for Healthcare Improvements who has been advising the NHS, recently gave his perspective to an audience of Chairs, CEOs and senior officials in the NHS. His recommendations for hospitals are sensible and we can certainly adopt them at NGH as far as we are able.

We are urged to:

- **Make quality and quality improvement the strategy**. The board will be aware that this is our aim at NGH. We are training staff in quality improvement as we are aware that every member of staff has two duties, one to deliver care and the other to improve it.

  For the past couple of years our aim has been to develop our staff's ability to use tools to improve quality. The principle of our Safety Academy, where we are training increasing numbers of staff in safety science and have clinically-led programmes of work to improve safety and quality remain. This work is now augmented by our improving quality and efficiency team, our organisational development team and our Changing Care @NGH programme. At the same time we ensure the focus of the executive team continues to be on quality and quality improvement as an aligning principle.

- **Rebalance inspections and targets.** Don Berwick's view is that 'target thinking dis-incentivises quality improvement, absorbs excessive amounts of time, stifles invention and innovation and builds a cycle of feat into management.' Any rebalancing of inspection and targets would require a new approach. However, it is clear that there is a need for assurance and for organisations to keep learning.

- **Change the balance of power** to ensure our staff lead the changes that are needed. We are encouraging staff at all levels to take contribute and take part in our quality improvement programmes as we know their insight and involvement is essential.

- **Standardise** thing where possible, making things easier for staff (adopting human factors science), but not forgetting that standardised procedures will have to be customised for the patient.

- **Patient-centred care** that is provided as close as possible to patients rather than moving them around, as this is more effective and more efficient.

- **Financial support** for the front line.

- Focus more on **bringing joy into work and on promoting wellbeing for staff.** We recognise the importance of our staff being able to say they enjoy their work, and for them to thrive and help us to improve. However, we also know that this is hard to achieve and making improvements at all in the current environment is testament to the hard work many of our teams are doing.

At NGH we are doing all we can to foster an environment where our staff are understand that things do have to change and are empowered to lead and make these changes and have enough time and space to do this. This is not an easy task or one which can be done quickly but setting out the aspiration to align us all in a common aim is the start of a very important process of cultural change

Having recently spent two days with Boards from Leicester and Nottingham, and shared perspectives as part of our board development programme, I was pleased to note how far our Board has come in supporting the quality improvement agenda. We know there is

more to do in terms of how this is communicated, shared and supported, but we are definitely on the right track in terms of how we benchmark against best practice. We need to do more to ensure that all our programmes of work are aligned and to ensure that we can clearly measure the benefit of any improvement work but it was clear that in some areas we have done significantly more than most other hospitals

One of these areas is the work we have done with our junior doctors and medical students to involve them in quality improvement and patient safety through improvements projects and audits. At a recent foundation doctor recruitment event in Leicester we had superb comments as part of an excellent 'campaign pitch' which came from some of our foundation doctors themselves commenting in a video put together under the direction of Jane Bradley and the communications team. Giving these doctors in training the opportunities to be involved in improvement has resulted in successful posters and presentations at conferences locally, nationally and internationally. This is credit to them and to the safety and improvement teams that have supported this under the direction of the medical director's office, Jane Bradley and our improvement lead, Dr Philip Pearson. We are also now involving our student nurses in improvement.

It is through these kinds of projects that we can start signalling the Boards appetite for supporting a culture of learning and the aspiration for continuous quality improvement.

It is disappointing that, as a hospital that has developed a first class learning from error programme through our simulation suite, as a hospital that has supported audit programmes for doctors in training, and as one of our trainees has had a successful application to present a poster on involving trainees in learning from error, that we still managed to find our way into a bottom league position in the national ranking of hospitals who learn from error. This relates to a few questions on the staff survey related to reporting incidents and knowing how they have been dealt with. Clearly there is a communication problem in this respect, which reflects the fact that, although lots of 'fabulous stuff' is going on, coupled with a huge amount of work around serious incidents, not everyone knows what happens when incidents are reported and we will be working on that.

Another area where we have demonstrably been attempting to link clinical governance with improvement relates to the way we use data from Dr Foster and other sources to target areas where we need to improve outcomes. It is worth remembering for example that there are several areas where we now have good and much improved outcomes as a result of some really good work from our clinical teams – fractured neck of femur, vascular surgery and colorectal surgery. I was reminded of this when we said goodbye to Dr Natasha Robinson at the end of February, and had cause to reflect back on her significant contribution to NGH. It is important to continue this meticulous approach to the use of data to help us to know where to target improvement

2. Junior doctors' strike action

As ever our staff have continued to do their best in difficult circumstances with the focus on ensuring patient safety requiring more emphasis than ever. Despite increased pressure team NGH remained enthusiastic and committed to keeping our patients safe. The strike brought closer working between nurses, consultants, pharmacists and other support staff. There is always something we can learn from a crisis and what we learn helps improve our plans going forward.

As a wider point, it is essential that we engage with and support our junior doctors as this is a group of critically important staff – these are our consultants of tomorrow and this is where we will find the energy that needs to be harnessed for the future. We need to invest in ways of moulding a sense of professionalism and understanding that gives our young doctors a real sense of the privilege of being able to work in healthcare and the responsibility that brings. I am pleased that at NGH we have programmes for our junior doctors to involve them in quality improvement and leadership, and we are also developing similar programmes for our student nurses. At the same time we are continuing to invest in the more traditional educational activities and we must keep our attention on this. Good

care and good training go hand in hand and the best way to reinvigorate our staff is to involve them in these activities.

One of our key concerns as a board should be how we continue to support a workforce under great pressure. The whole workforce has felt the discomfort of conflict resulting from this industrial relations dispute and this is the time for us to relentlessly focus on staff development in its widest sense and on fostering a sense of respect and support across the organisation and involve our partners in the health and social care economy and our patients.

3. **Local media**
I recently spent time talking with Nick Spoors from the Northampton Chronicle and Echo as part of our quarterly catch-ups. He is very supportive of NGH and is keen to understand the pressures we face, the impact these have on our patients and our staff and, importantly, our plans to address these pressures.

We spent some time discussing the wider issues affecting healthcare locally and nationally as well our proposed business case to provide 60 additional beds and what this would mean for us and our patients. Nick was particularly interested in the work we are doing to recruit our own bank staff and the benefits this brings for staff and patients.

4. **Annual general meeting**
Our annual general meeting will be held on Saturday 17th September 2016 at Cripps Postgraduate Education Centre, 10.00am – 12 noon. We are re-engaging with our members and I hope that they will come along to find out more about the changes and improvements we have made, as well as opportunities for them to become involved. We are keen to develop a large volunteering workforce and are convinced that this will bring benefits for our patients, our staff and our whole community.

5. **Best possible care awards**
Last year's Best Possible Care Awards at The Park Inn were a resounding success with everyone who attended. This year's event will be held on 30th September and it is our intention to increase the number of staff who can attend by seeking additional sponsorship. Our own charity is supporting the event, but we are keen to identify opportunities for local businesses to become involved, and to find ways in which we can work with them for mutual benefit in the year ahead.

We plan to host a 'get to know' evening in the coming months, hosted by our board members, when we will be able to discuss how we can promote and develop more effective ongoing relationships with local business leaders.

6. The NHS financial challenges continue to escalate and the imperative to develop better and more efficient systems of integrated care that maximise modern technology and are centred on patient needs have never been stronger. The national mandate to develop plans for our Health and Social Care Economy that extend over the next 5 years and clearly set out what needs to be achieved by when is a welcome one. Given the slow progress of various programmes of work that have been taking place across our system in recent years , ensuring this new agreed programme is adequately supported is key. We hope that the new programme will build on existing work and will ensure the enablers in terms of Information Technology, Estate and workforce are addressed in a sensible, deliverable well-structured programme and we are certainly committed to supporting that.

Any such programme must focus firstly on improving the quality of care for patients and in that regard addressing the urgent care challenge is essential. Our urgent care pressures remain significant and are impacting on all our services and hence on all our patients. The last 3 months have brought the most difficult bed pressures that we have ever experienced and with that we are even more determined to develop a clear vision for the future of clinical services at NGH. The creation of additional bed capacity is now of the upmost importance if we are to be able to deliver our commitment to our patients.

Dr Sonia Swart
Chief Executive

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**March 2016**

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

Executive summary

Four new Serious Incidents (including a Never Event) have been reported during the reporting period 01/01/2016 – 29/02/2016 which remain open and under investigation. Immediate actions have been put into place to mitigate the risk of the never event re-occurring. There have been twelve serious incidents which have been reported since 01/04/2015. Two External Serious Incident reports have been submitted to the CCG for closure. Seven inquests have been held where the Trust were requested to provide reports and at some, staff requested to attend.

Dr Foster data showed overall mortality expressed as the HSMR, Crude Mortality and SHMI to have remained within the 'as expected' range. The palliative care coding rate remains below the national average and it is noted that there is considerable work is underway in relation to the end of life patient pathway within the Trust which seeks to address this shortfall. NGH will be hosting the countywide mortality meeting in May 2016 and details of this event are provided. 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 once the analysis of the findings is complete.

An update on the Quality Improvement Strategy is described along with information on the Maternal Sign Up To Safety Campaign.

Related strategic aim and corporate objective	Be a provider of quality care for all our patients
Risk and Assurance	Risks to patient safety if the Trust does not robustly investigate and identify any remedial actions required in the event of a Significant Incident or mortality alert.
Related Board Assurance Framework entries	BAF 1.4, BAF 1.5, BAF 4.1 and BAF 4.2
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (Y/**N**)

	Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(Y/**N**)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper

Actions required by the Trust Board

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

Northampton General Hospital NHS
NHS Trust

Public Trust Board
March 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
694	Insufficient nursing staff on both the neonatal unit and the paediatric wards.	12	15	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
Serious Incidents	27	55	78	115	93	9
Never Events	2	2	1	0	1	3

The Never Events in 2015/16 relate to:

I. Wrong site surgery – removal of the incorrect tooth

This is currently being investigated however immediate actions have been introduced which include:

- Review of the process used in Oxford to reduce the risk of dental Never Events. The Oxford team have introduced an extra check into the surgical process and NGH is reviewing if this could be implemented here.
- An oral map has been developed which will be fixed to the patient drapes/garments which clearly describes procedure to be undertaken.
- An additional check to ensure that the procedure described in the written clinical notes matches that contained in the clinic letters and the operation list
- A requirement that the clinician taking consent is present at the operating procedure.

II. Wrong site surgery – removal of ovaries

This is currently under investigation. Again immediate actions have been agreed which include:

- Discussion of the incident with all surgical teams highlighting the need for absolute vigilance prior to and during surgery to ensure that the patient is aware of, and has been consented for the correct procedure.
- Reinforcement that surgeons/operators must ensure that the surgical team fully understands what procedure is to take place and re-checks this at the ‘time-out’.
- Discussions/reinforcement with Theatre Teams at Safety Huddles.
- Use of operating theatre whiteboard to document planned procedure which is cross-checked at the WHO Time-Out and referenced throughout the surgery.
- Where appropriate the surgeon will re-confirm the operative plan with the team prior to irreversible step or ligating of a vascular pedicle – ‘Mini Time Out’.

III. Incorrect lens insertion

This again is currently under investigation. Immediate actions were introduced which include:

- Review of process for implant selection. Agreement across surgery that when implant selected/taken the operation will halt to permit focus on this key stage - 'Mini Time Out'.
- Discussions/reinforcement with Theatre Team regarding necessity for adherence to SOP.
- Debriefing carried out by ward manager to staff involved.

More broadly within theatres there the OD and IQET teams are providing support. Simulation suite scenarios are being developed to further imbed the use of the WHO Checklist and will incorporate the learning from these incidents. Each of the theatres team will be allocated time in the suite to run through these scenarios. The Clinical Audit team are undertaking a monthly audit of WHO Checklist utilisation which will expand to review the quality of its use. The Board to Ward Visits have also focused on WHO Checklist and NATSSIPs.

2.1 New Serious Incidents

Since the last report to the Board (during the reporting period 1/1/2016 – 29/2/2015) 4 new Serious Incidents (one of which is the Never Event - removal of ovaries) 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 12 Serious Incidents have been reported year to date under the following categories:

- Slips/Trips/Falls
- Unexpected Deterioration
- Death following pulmonary embolism
- Infection Control issue
- Medication incident
- Maternity – baby born with low Apgars
- Wrong site surgery
- Delay in treatment/referral to specialist team

2.2 Open Serious Incidents

The serious incidents at 29th February 2016 which remain open and under investigation are listed below:

Date of Incident	SI Brief Detail	Status	Directorate/Division
30 Sep 2015	Tooth Extraction **(Never Event)**	Active	Surgery Division

24 Dec 2015	Wrong site surgery **(Never Event)**	Active	Womens's
12 Jan 2016	Wrong Lens Inserted during Cataract Surgery **(Never Event)**	Active	Surgery Divison
06 Dec 2015	Digit amputation	Active	Urgent Care/T&O
03 Feb 2016	Fall - Dislocation	Active	Surgery Division
05 Jan 2016	Fall - Parenchymal Haemorrhage	Active	Medicine & Urgent Care

2.3 Serious Incidents Submitted for Closure

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

Maternity – baby born with low Apgar Score
Recommendations/Actions:
CTG guidelines should be updated to include in what circumstances an obstetrician has to carry out a full physical assessment and document a plan of care in the records.
Update guideline to ensure the requirement for clear multi-disciplinary communication especially during emergencies needs to be reiterated and improve.
Support to be provided to juniors during Consultant Labour Ward Sessions
Consultant on-call should be informed regarding all the relevant information when called for an emergency.
Consider use of SBAR method of Labour ward management and prioritisation should be regularly included and considered in the junior doctors teaching sessions and case presentations.
Use of case presentation in junior doctors teaching sessions - Include scenario in skills drills training

Cardiac arrest whilst on telemetry
Recommendations/Actions:
A multiple agency approach (Resuscitation, Practice Development and Training and Development) needs to be placed on rolling support for the ward – this should use the 'Bay working system
Report to be shared with the chair of Medical Devices Sub Committee (MDSC) in order to support the capital expenditure on a updated monitoring system
Development of a policy for telemetry - Completed policy to be made available and read by all staff using telemetry
Formal programme for Telemetry Training to be developed and to be provided to all staff who use telemetry on the ward
Training packages to be reviewed / developed and implemented
Monitor the number of senior Dryden staff used to staff and coordinate the Heart Centre through Cardiac Service Meeting.

2.4 Inquests

H M Coroner convened 7 Inquests during the reporting period which involved Trust staff either preparing statements or giving evidence at the hearing. The conclusions of the Inquests were 3 narrative conclusions,2 Natural Causes, 1 alcohol and drug related and 1 industrial diseases.

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

Learning was identified from two of the inquests as outlined below:

- Ownership of sample testing and who is responsible for the results.
- Introduction of spinal pathway to facilitate referrals
- Staff Education re management of patients with psychiatric and physical health comorbidity
- Staff Education re spinal precautions with possible spinal injury and procedures for requesting imaging out-of-hours
- Staff Education – Orthopaedic team re lack of escalation of patient with high EWS

3. Mortality Monitoring

The HSMR for the year to October 2015 remains with the 'as expected' range at **100.1** (reduced from **101.3** in October 2015). The overall 12 month trend is downward as described in the report to the committee in February.

The SHMI data which records deaths which occur both in hospital and within 30 days of discharge for the year to June 2015 was reported to the committee in February and is within the 'as expected' range at **101.9**.

The crude mortality in February was lower than the comparable period in 2014/15. Though the acuity of patients admitted to the assessment areas remains high this may reflect a relative reduction in the number of patients presenting with respiratory disease resulting from influenza infection in 2015/16.

3.1 Palliative Care Coding

The NGH palliative care coding rate remains below the national average (3.3%) at 2.7% of HSMR in-patient spells 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.

3.1 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 on-going national audits, national mortality review and their recent review of sepsis management in the UK.

3.2 Trust wide mortality case note review

The 7th Trust wide mortality case note review was completed earlier this month. This review has focused on low-risk and post-operative patients. The outcome of the review will be presented within the Trust once the analysis of the finding has been completed.

It is anticipated that the format of these reviews will change moving forward in line with the national requirements for Trusts to undertake a review of all deaths which occur within hospital.

4.0 Safety Academy Update

4.1 Quality Improvement Strategy

Following on from the Board Development work, the Quality Improvement Strategy is being developed and is currently in draft format. It has been developed with input from staff through focus groups and lessons learnt from complaints, serious incidents and asking our staff what quality means for them.

The aims of the strategy are to ensure that patients and service users of NGH receive safe, effective services with a positive patient experience.

We have used the aims within the 'Sign Up To Safety' campaign as a framework for the strategy which emphasises the importance of listening to patients, their carers and our staff, learning from successes as well as when things go wrong. We have focussed on areas where we know we can make improvements, and continue to build on the work that has already begun. We signed up to the campaign because it mirrors what we are aiming to achieve with our in-house Patient Safety and Quality Improvement programmes. This is the delivery of harm-free care for every patient and the championing of a culture of openness and honesty - meeting the expectations and demands of our patients while at the same time improving quality.

The Quality Improvement Strategy highlights the importance of developing capability by providing training on an on-going basis, commensurate with the role of the individual.

4.2 Maternity Sign Up to Safety Campaign

NGH has been 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 "Preventing Avoidable Harm in Maternity Care" capital fund is part of a new commitment by the government to support midwives and obstetricians to reduce the rate of stillbirths,

neonatal and maternal deaths and intrapartum brain injuries in babies by 50% by 2030 thereby making England one of the safest places to have a baby. This initiative will be included within the current NGH Sign up to Safety Campaign.

4.3 Foundation doctor recruitment event in Leicester

NGH received a very positive response and comments as part of a 'campaign pitch' to encourage future FY1`s who had been allocated to the LNR Deanery to choose NGH as a first choice placement.

Current FY1 and FY2s spoke freely with candidates commenting on their experiences as a junior doctor at NGH and their training, the support received and the experience of making service changes using Quality Improvement methodology as part of the Junior Doctor Safety Board.

The work undertaken by our junior medical staff in improving systems and processes within the hospital has been shortlisted for presentation at conferences both nationally and internationally.

4.4 Collaboration with University of Northampton

The Quality Improvement team and Northampton University are jointly supporting a practice improvement project to improve the access to mental health services in adult secondary care through implementation of screening tool on our assessment units. This builds on the on-going collaborative work between the two organisations.

5. 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.

Report To	**TRUST BOARD**
Date of Meeting	**March 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 – the Trust achieved 92.35% 'harm free care' in January a reduction from December's position.
- In February the number of reported pressure ulcers was 31. These will be validated in March at the Share and Learn Meeting.
- There has been 2 C. Difficile case reported in February, 0 MRSA Bacteraemia,
- In February there have been 2 in-patient falls that have caused severe harm and are currently under investigation.
- FFT in February– Inpatients 89.4%, OPD 91.7%, Emergency Dept. 84% and Maternity 95.5% 'would' recommend
- 62% of Patients at the End of Life this month had an individualised plan of care in place
- Overall fill rate has slightly decreased in February with a combined fill rate of 101% throughout the month, a 1% decrease from the previous month.

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

Actions required by the Board

The 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
March 2016

Director of Nursing & Midwifery Report

1. Introduction

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

Working together to halve stillbirths and neonatal deaths
The following two initiatives are part of the new commitment by the Government to support Midwives and Obstetricians to reduce the rate of stillbirths, neonatal, maternal deaths and intrapartum brain injuries in babies by 50% by 2030 and make England one of the safest places to have a baby.

Preventing Avoidable Harm in Maternity Care Capital Fund
The Trust were successful in securing partial funding (£18,000) 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.

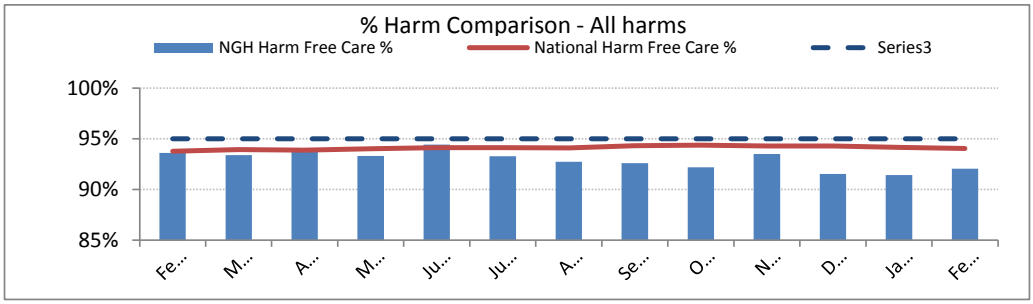
The varied benefits of this pathway include reducing harm, improving the quality of care and improving overall outcomes for the baby, mother and her family. The pathway will be included as a maternity specific improvement project in the Trust's Sign up to Safety Campaign.

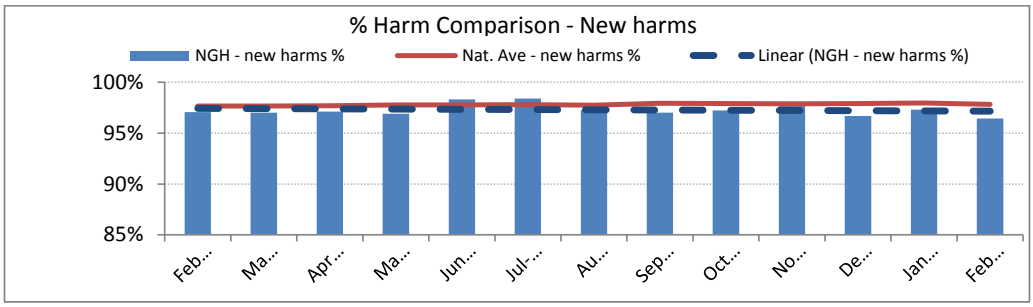
Health Education England – Patient Safety Education and Training Group
In support of the Government's ambition, HEE have set up a group to agree a suite of standardised training programmes around obstetric emergencies and developing a culture of safety. There is an opportunity for 5 maternity units in the Midlands and East to be an early adopter of the programme with an initial fund of £10,000 available for each maternity unit and further money available around implementation of the agreed suite of training programmes, once standards have been agreed and commissioned. NGH maternity services have been successful in our application to be an early adopter site.

Safeguarding Children Level 3 Training
One of the priorities for Maternity was to increase our Level 3 Safeguarding Children training compliance to over 85% by the end of March 2016; we have already managed to raise the level to 87.2% as of the end of February. Work continues to sustain this improvement.

All staff	**87.2%**
Midwives	92.7%
Maternity Support Workers	71.4%
Maternity Assistant Practitioners	100%
Consultants	90%

3. Safety Thermometer





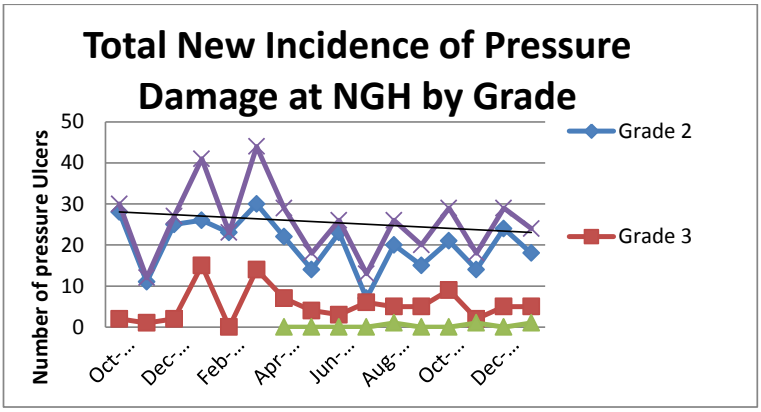
In February 2016 NGH achieved 92.05% harm free care, with 3.57% of patients on the day recorded in the category of 'new' harm (sustained during whilst they were in our care). Broken down into the four categories this equated to: 0 falls with harm, 0 VTE, 1 CRUTI and 16 'new' pressure ulcers.

Maternity Safety Thermometer – How safe do women think our service is?
The NHS Maternity Safety Thermometer has now been fully released. NGH piloted it during Quarter 3 and it is being fully implemented from February 2016. It records the proportion of mothers who have experienced harm free care. It measures harm from –

- Maternal infection
- Perineal trauma
- Postpartum haemorrhage
- Term babies Apgar score
- Term baby treatment

In addition to the measures listed above, it requires the auditor to ask all postnatal women 4 questions which will assess their perception of how safe they think the service is. The maternity services therefore feel this would be valuable information to collate in order to help inform further improvements in the care we provide to women and their families.

4. Pressure Ulcer Incidence

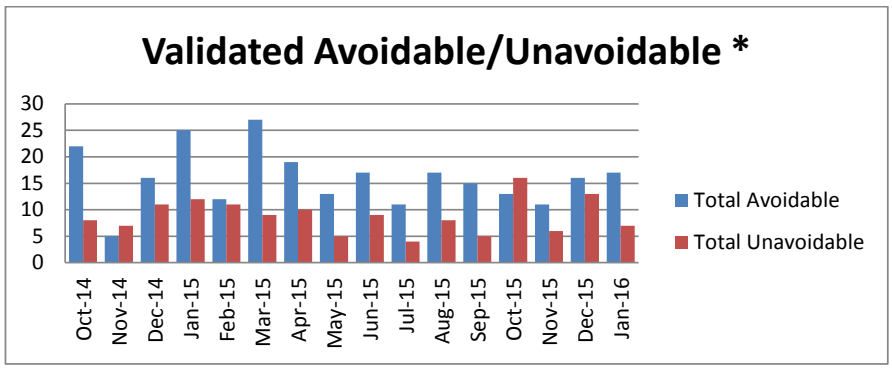


In February 2016 and pre Share & Learn meeting there have been a total of 31 pressure ulcers which developed whilst the patient was in our care.

Classification	Number
Grade 2	23
Grade 3 & unclassified Grade 3	5
sDTI's	3
Grade 4	0

The Share and Learn Meetings took place on 22nd and 26th February, a further meeting was arranged as pressures on the ward prevented 13 cases from being discussed. This additional meeting on 7th March had to be postponed and is rescheduled for 17th March. Prior to this meeting the confirmed numbers of hospital acquired pressures ulcers for January was 24, a reduction of 31% from previous report (Nursing & Midwifery Care Report February 2016).

Classification	Number	
Grade 2	18	7 identified lapses in care (Avoidable) & learning. 9 awaiting Share & Learn Forum
Grade 3 & unclassified Grade 3	5	2 identified lapses in care (Avoidable) 3 awaiting Share & Learn Forum.
sDTI	1	
Grade 4	0	



* *this data is subject to change following rescheduled Share &Learn Meeting.*

Enclosure E

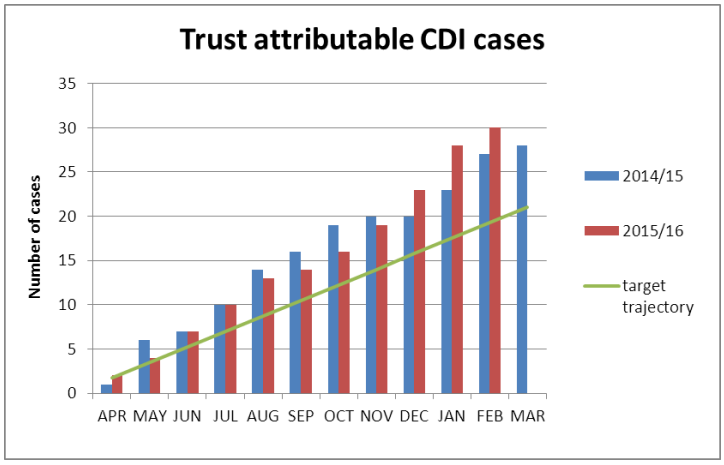
The graph above shows the number of validated avoidable and unavoidable pressure ulcers for the month of January 2016.

Pressure Ulcer Collaborative
Learning Session Two took place on 9th February 2016, and focused on device related pressure ulcers. Despite pressures on the wards attendance was excellent, with representation from 95% of adult inpatient areas.

At the previous Learning session, staff said that a mirror would be beneficial in skin assessments, in particular the heels, the Collaborative team listened and presented mirrors, funded by charitable funds to all those in attendance. Mirrors were distributed to all wards in the following days.

5. Health Care Associated Infections (HCAIs)

Clostridium difficile Infection
Clostridium difficile infection (Trust apportioned)



The graph above shows that there have been 30 cases of C.diff apportioned to the Trust. 2 cases in February 2016. All Root Cause Analysis (RCA) are sent to the CCG to identify any lapses in care. To date 22 cases have been reviewed by the CCG and there was 1 lapse in care identified.

The Trust strives to prevent any patient developing a Healthcare Associated Infection (HAI) such as CDI whilst in its care. The ceiling for Trust attributable *C.diff* cases for April 2015- March 2016 is 21. The IPT have reviewed each case and have identified initial themes for the 30 cases of Clostridium difficile infection (CDI) to date. This information will be provided as an addendum to April's CQEG report.

CDI patients from April –March 1st 2016

The table below demonstrates the remaining Trust apportioned cases that are awaiting review.

CDI Cases April – February 2nd	CDI cases no lapse in care to date	CDI cases lapses in care	CDI cases awaiting review
30	22	1	8

Beat the Bug Update
The quality visits continue with 5 wards visited in February. Many visits were cancelled due to organisational capacity. The wards reviewed were Cedar, Abington, Becket and Collingtree and Critical Care. In March we will aim to undertake more quality visits.

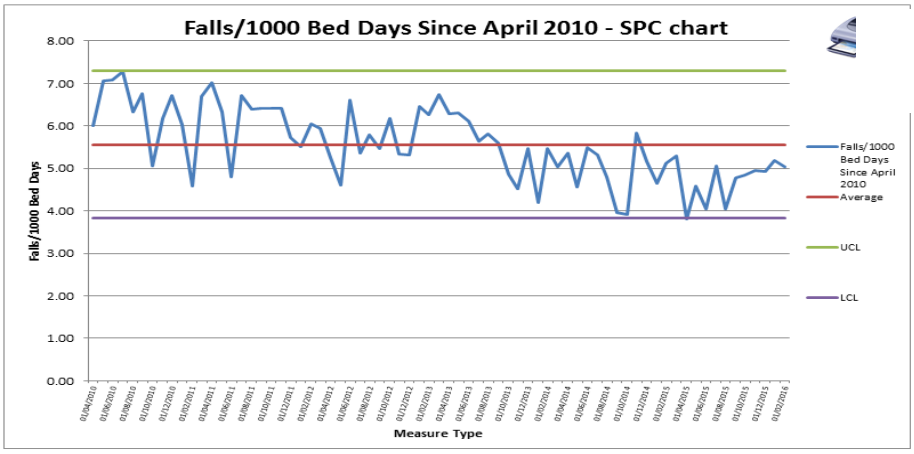
Positive findings were:
- Floors clean and dust free
- Bays were free from unpleasant odours
- All items in the isolation rooms are clean and dust free
- The tops of cupboards and floors in the treatment room were clean and dust free including behind the doors

Areas for Improvement were:
- Curtains were not visibly clean, all hooks in place, no tears and dated and signed
- Not all patient equipment was found to be cleaned
- When patient equipment was found to be cleaned it was not all signed to denote this

All of the above findings were fed back to the ward managers verbally and through a written report. All findings are followed up by the Infection Prevention Team on their weekly visits to the ward.

6. Falls Prevention

Maximum of 5.5 falls/1000 bed days (internally set target)



Although the statistical process chart above shows a sustained reduction in falls/1000 bed days Since April 2010; the rate appears to be rising over the last few months. It is thought that this may be due to sustained winter bed pressures with a rising acuity of patients. The Trust's Falls/1000 bed days is below the national average and the (internally set) target.

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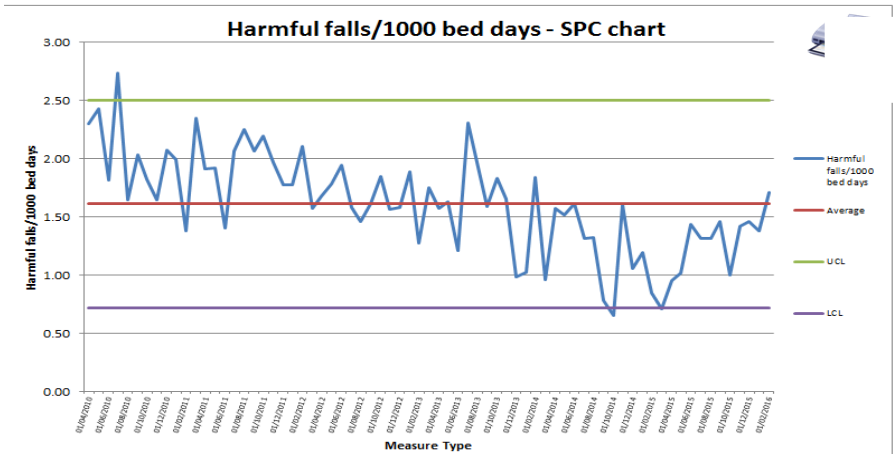
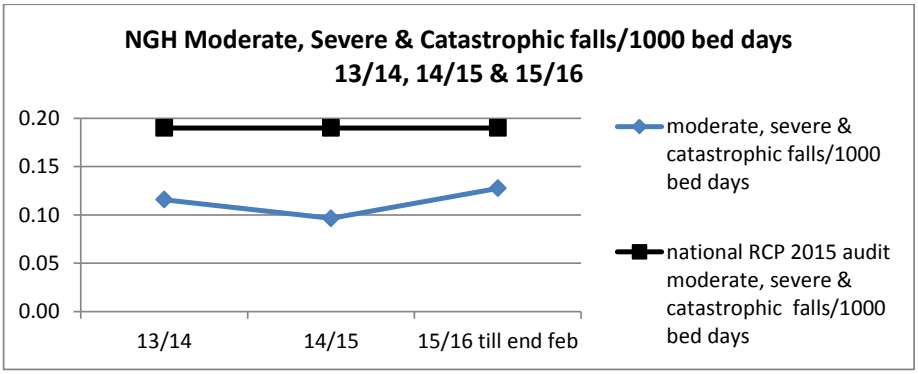
Maximum of 1.6 harmful falls/1000 bed days (internally set target).

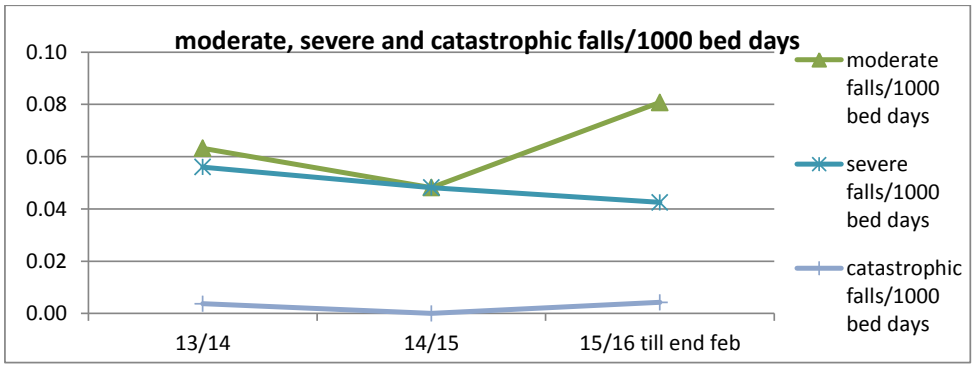


Although the statistical process chart above shows a sustained reduction in falls/1000 bed days Since April 2010; the rate appears to be rising over the last few months. It is thought that this may be due to sustained winter bed pressures with a rising acuity of patients. The Trust's Falls/1000 bed days is below the national average and the (internally set) target.

Falls resulting in moderate, severe or catastrophic



The graph above shows the falls/1000 bed days in relation to falls resulting in moderate, severe or catastrophic harm. This graph shows that the trust is below the national average. However, the rate is higher than it has been for the last two years. Further analysis shows an increase in incidents graded as moderate. These will be reviewed and reported on in the near future.



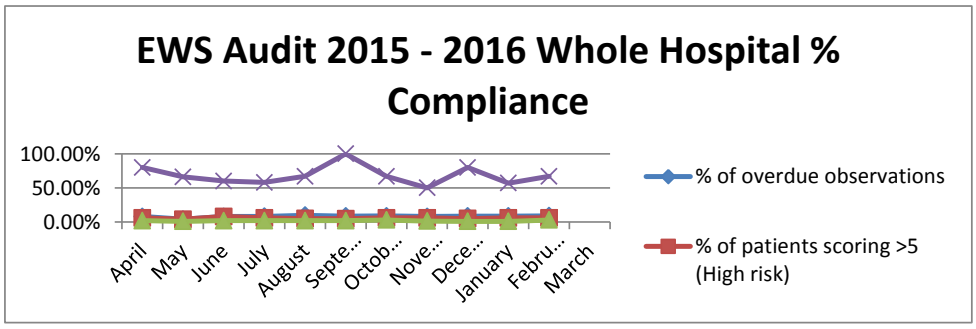
Severity of injury	Number of falls last month
Moderate	0
Severe	2
Death	1

This month we reported 3 in-patient falls that caused at least 'moderate' harm. Two falls resulting in severe harm; both falls resulting in a fractured neck of femur (hip). One fall has been graded as catastrophic whilst it is investigated as to whether the head injury caused the fall or was caused by the fall. This will be reported on in the near future with further detail.

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 to be piloted in April 2016
- Support/training to wards RAG rated red in completion of the falls risk assessment and/or care plan

7. EWS Compliance



February saw a significant improvement in compliance with the number of patients deemed at risk due to a raised EWS with a plan in place – 67% compared to 57% in the month of January. This month has seen an improvement in the number of DNACPR forms not signed by a nurse. This has decreased from 13 last month to 16 this month.
Overdue observations has improved this month at 9.01% against an upper limit target of 7%. The wards that are consistently above target have been asked to update their Associate Directors of Nursing to how they will improve this position in the coming month. Action plans are being put into place for those areas that are consistently above the target.

Enclosure E

8. Friends & Family Test

Period: January 2016 Department / Ward	Latest Nat. % Recommended (Nov 2015)	NGH % Recommended	Latest Nat. % Not Recommended (Nov 2015)	NGH % Not Recommended	No. of eligibles	Target Response Rate	Response Rate
TRUST TOTAL	N/Applic	90.8%	N/Applic	4.2%	38645	N/Applic	22.6%
Inpatient Total	95.4%	86.4%	1.5%	7.0%	2860	30.0%	24.4%
Day Case total	95.4%	93.1%	1.5%	3.1%	3514	15%	28.9%
Inpatient & Daycase Total	95.4%	90.4%	1.5%	4.7%	6374	N/Applic	26.9%
Accident & Emergency Total	86.9%	85.8%	7.0%	7.9%	6709	20%	19.7%
All Outpatient Departments	92.0%	91.6%	3.2%	3.3%	24238	15%	21.5%
ANTENATAL	95.7%	98.5%	1.5%	1.5%	317	30%	21.5%
Birth	95.3%	97.5%	1.4%	0.5%	370	30%	54.3%
Postnatal Ward	93.9%	96.9%	1.7%	2.4%	354	30%	35.9%
POSTNATAL COMMUNITY	97.7%	100.0%	0.8%	0.0%	283	30%	21.9%

January Feedback Comments

- In total 399 negative comments were received through the FFT for January.
- Across all areas, the most common negative themes were Waiting Times, Communication and Care. These continue to be high each month.
- Working groups have been established to improve Waiting times in Outpatient services.
- A deep-dive into the issues around Communication is planned for 2016/2017.

NHS England FFT Awards- NGH Shortlisted

NGH has been selected as a finalist in a national awards scheme about the way patient and staff feedback is used to improve healthcare services. The FFT Awards 2016 were set up to recognise NHS providers who are going the extra mile in their work to listen to patients and staff. There are five categories and NGH has made the shortlist for two categories; Best FFT Accessibility Initiative category and Best FFT initiative in any other NHS-funded service.

The entry submitted for Best FFT Initiative was for the 12 days of FFT which was carried out over Christmas. 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 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. In addition to this a Compliments Christmas Tree was erected displaying positive comments from the FFT.

For the Best FFT Accessibility Initiative category the hospital submitted the many different ways in which the FFT is collected to ensure that the hospital is inclusive. This includes the SMS/IVM which is standard throughout all services, but also the suite of bespoke postcards, online children's survey, the multi-language surveys, bespoke LD Survey, and the use of Technology in Radiology- and potentially in midwifery moving forward.

The winners will be announced at a national feedback and insight conference, organised by NHS England, on 17th March and will be attended by our Head of Patient Experience & Engagement.

9. Dementia

Dementia CQUIN

The current compliance against the Dementia CQUIN Indicators is shown below:

Indicator	Target	Trend	Dec-15	Jan-16	Feb-16
Dementia: Case finding	**90%**		91.7%	90.6%	99.7%
Dementia: Initial diagnostic assessment	**90%**		100.0%	100.0%	100.0%
Dementia: Referral for specialist diagnosis/follow-up	**90%**		**89.5%**	100.0%	100.0%
Dementia: Plan of Care	**90%**			100.0%	100.0%

Figure One: Indicator 3a Metrics February 2016

Validation of the January data for the "I" element *(Plan of Care)* took place with the CCG in February. This was successful, with the CCG agreeing with the approach taken and the data collected. This model will therefore be used moving forward. Moving forward, the management of this element will be refined and developed to enhance the capability to provide supportive, individually focussed information.
In February 2016, only one individual was not identified for case finding (99.7%), the most successful achievement of the CQUIN indicators to date. There are no unanticipated risks moving forward to year-end and it is anticipated that the **3a indicator will be met** for the quarter and the year end at March 2016.

Indicator 3b, Staff Training, has been a raised risk for the CQUIN completion for the past quarter. This risk is now mitigated following successful implementation of a remedial plan and training compliance is at the CQUIN target, **meeting the requirement for indicator 3b**. The current position at time of reporting is 91%, this will continue to increase throughout March, putting the Trust in a positive figure moving into the new financial year.

Numerator	Denominator	Compliance
668	736	91%

Figure Two: Indicator 3b Compliance Data February 2016

Compliance with the Carer's Survey is shown below:

Indicator	Target	Trend	Dec-15	Jan-16	Feb-16
% CQUIN Compliance	**90%**		100.0%	100.0%	100.0%
Numerator Value	**25 / month**		25	25	25

Figure Three: Indicator 3c Compliance February 2016

In addition to the carers' compliance data, the following narrative responses have been received *(not part of CQUIN monitoring).* The data represents the direct positive / negative response questions.

Question		Dec 15	Jan 16	Feb 16
Q1	Do you feel supported?	84%	96%	92%
Q2	Are you involved in assessing the patient's needs?	88%	96%	92%
Q3	Have the specific needs regarding dementia been met?	80%	92%	92%
Q4	Are you involved in ongoing care and treatment planning?	76%	96%	88%
Q5	Are you involved in discharge planning?	80%	94%	80%
Q6	Do you know what will happen next?	78%	88%	86%
Q10	Do you need further support whilst in hospital?	40%	16%	12%
Q11	Have you received the information leaflet?	100%	100%	100%
Q12	Do you know where to get further info and support?	100%	100%	100%

Figure Four: Indicator 3c Supplementary Data February 2016

Safeguarding Children

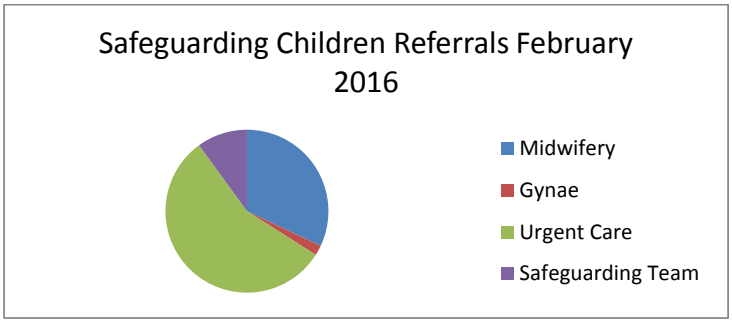


Figure Five: Safeguarding Children Referrals February 2016

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.

Children Looked After and Safeguarding CQC Action Plan Progress
A full health economy peer review of the CQC action plan took place on 1st February 2016, co-ordinated by NGH. The outcome of this will be fed into the Health Strategic Safeguarding Forum which retains oversight of the whole economy plan and the Trust's Safeguarding Governance Group.

Adult Safeguarding

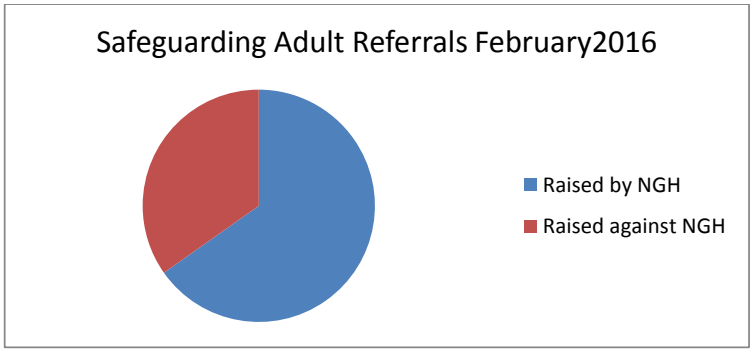


Figure Six: Adult Safeguarding February January 2016

The majority of referrals for adult safeguarding concerns (15) are generated from the Urgent Care directorate and relate to neglect or Acts of Omission; most often in relation to care delivered in registered care services.

For the referrals made ***against*** NGH (8), these are currenlty being investigated in line with the Multi-Agency procedures, the majority of concerns raised relate to discharge arrangements.

Lessons Learned
On completion of an investigation relating to the assessment unit, a patient safety concern regarding patient's own medication was identified. This has been highlighted to the Division of Medicine and the Site Team for further review.

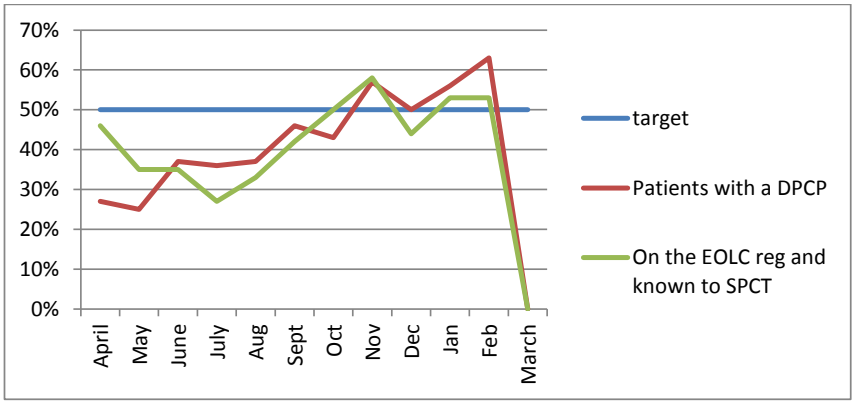
Deprivation of Liberty Safeguards
The Trust granted **22 urgent authorisations** under DOLS in the January 2016. The bias between the Divisions remains, as expected, towards Medicine, with only two of the DOLS required in Surgery.

Local Multi-Agency Activity
The Ofsted inspection of Children's Services and the Local Safeguarding Children Board has been completed. NGH contributed as a partner agency to the case mapping and tracking exercise undertaken by inspectors, providing case audits of involvement and contribution to safeguarding planning. All of the audits were evaluated as "meets good" or "exceeds good". The partnership is now awaiting the final report from Ofsted in relation to the improvement notice.

10. End of Life Care

The use of the Dying Person Care Plan (DPCP) for patients thought to be in the last hours/days of life

In February, 62% of patients who died at NGH had an individualised plan of care. There has been a consistent improvement in the last 3 months (see figure 1). The Specialist Palliative and End of Life Care Team (EOL/SPCT) will continue to support teams in care planning for patients and their family if the patient's details are brought to the daily patient safety huddle or if the wards ring directly to the EOL/SPCT.



- Percentage of patients who died at NGH with an individual plan of care and patients who were on the End of Life Care register.

The target of 50% has been achieved for the month of February, for numbers of dying patients with a care plan in place. The National Care of the Dying Audit Round 5 results will be published on March 31st and it is anticipated that this will demonstrate the improvement required. One important aspect which will receive some focus is the completion of the 4 hourly assessments of patients for symptom management and comfort.

The trust has completed a baseline assessment after the publication of the NICE guidance for Adults in the Last Days of Life (2015). The trust was 97% compliant and the Dying Person Care

Plan is in the process of being reviewed by the End of Life team and Specialist Palliative Carer Team (EOL/SPCT)

The AMBER Care Bundle
The AMBER Care Bundle has been introduced on the following wards:

- Knightley
- Holcot
- Eleanor
- Talbot Butler
- Becket
- Creaton
- Allebone

The Creaton comparative audit data is in the process of being analysed and Allebone's comparative audit will be completed at the end of March.

Talbot Butler and Becket comparative audit has demonstrated improvement in the service.

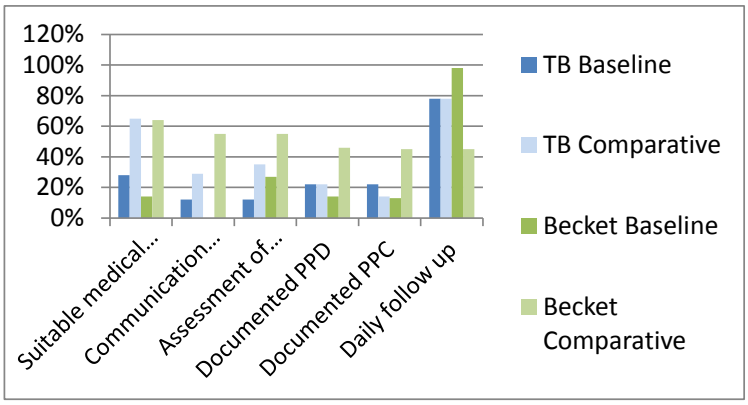


Figure 3 – Data from Talbot Butler and Becket comparative audit showing improvement in practice

11. Safe Nurse Staffing

It is an ongoing requirement of NHS England that all NHS Trust Boards receive a monthly report relating to nurse staffing levels. This report provides an overview of the staffing levels in January 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 February 2016 was 101%, compared to 102% in January and 100% in December. Combined fill rate during the day was 98% compared with 99% in January. The night fill rate has stayed the same as January at 106%. RN fill rate during the day was 93% and for the night 95%. Please see appendix 1.

February 2015 safe staffing

A summary of the ward analysis for staffing is included at the end of the report. There is an update from the Divisions for each ward that is below 80% 'fill-rate' explaining the actions to maintain patient safety. The narrative from the Divisional teams includes any 'harm events' that have been recorded through the incident system (Datix) against wards below 80% 'fill-rate'.

As reported previously, the Board should be reassured that staffing is reviewed by a senior nurse at the twice daily safety Huddles Monday to Friday, and daily at a weekend. Any wards where staffing is at a minimum level or due to increases in acuity and dependency there is a

need for additional staff above planned numbers, movement of staff is made and risk assessed.

Safe Staffing data compared with region

On a monthly basis NHS England report on Safe Staffing data from each Trust throughout the region. The collated data from NHS England is shared a number of months 'behind' our own local data. In February NHS England noted that in December 2015:

Northampton General Hospital's fill rates for registered staff have stabilised following recent improvements and stand at 90.74% (day) and 94.075 (night). This is the 4th consecutive month this figure has improved after being below 90% for several months prior to November 2015, appendix 2.

Since December 2015 the Trust has continued to improve, with fill rates improving in January and stabilising in February as previously discussed, appendix 3.

12. 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 - Ward Staffing Fill Rate Indicator (Nursing, Midwifery & Care Staff) **FEBRUARY 2016**

Ward name	Day				Night				Day		Night		Actions/Comments	Red Flag
	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Key: Below 80% Shift Fill Rate Target / 80% and Above Shift Fill Rate Target					
Abington	1410.75	1332.25	1322	1357	1035	989	989	1127	94.4%	102.6%	95.6%	114.0%		
Allebone	1574	1632.75	1575.5	1594.75	1334	1105.5	664.25	1158.75	103.7%	101.2%	82.9%	174.4%		
Althorp	820.5	880.25	661.75	690.5	621	586.5	333.5	494.5	107.3%	104.3%	94.4%	148.3%		
Becket	1909	1728.55	1330	1421.25	1667.5	1552.5	667	822	90.5%	106.9%	93.1%	123.2%		
Benham	1665.95	1599.7	839.5	768	1334	1449	667	764.75	96.0%	91.5%	108.6%	114.7%		
MATERNITY COMBINED UNIT: Sturtridge, MOW, Balmoral & Birth Centre	7240	6283.73	3982.5	3250.34	6318.5	5409.61	2822.33	2213.21	86.8%	81.6%	85.6%	78.4%	Continued MSW recruitment staff reallocted to ensure safe skill mix-monitored by the Matron and Maternity Operational Manager on a shift by shift basis	No red flags
Brampton	1333.5	1324.25	995.75	1437	1334	1276.5	667	1294.5	99.3%	144.3%	95.7%	194.1%		
Cedar	1463.6	1644.1	1623	2157.92	1127	1115.75	1000.5	1536.25	112.3%	133.0%	99.0%	153.5%		
Collingtree	2236.25	1934.62	1661.75	2124.5	1667.5	1633	667	1160.92	86.5%	127.8%	97.9%	174.1%		
Compton	969.75	974	693	1038.03	667	677.25	333.5	667	100.4%	149.8%	101.5%	200.0%		
Creaton	1566	1559.25	1298	1537.5	1046.5	1038.75	655.5	1086.58	99.6%	118.5%	99.3%	165.8%		
CHILD HEALTH COMBINED: Disney, Gosset & Paddington	6960.46	5924.59	2622.7	1733.95	4955	4692.5	989	733	85.1%	66.1%	94.7%	74.1%	RN fill rates continue to increase ,recruitment ongoing and continued HCA recruitment. Monitored by Matron on a shift by shift basis to ensure safe skill mix	No red flags
Dryden	1936.92	1784.08	905.5	850	1330.25	1334	667	794.5	92.1%	93.9%	100.3%	119.1%		
EAU	1999.5	2024.75	1001.25	1291.05	1667.5	1662.75	989	1352.33	101.3%	128.9%	99.7%	136.7%		
Eleanor	1001	1084	661.75	694.5	667	675.25	667	772.75	108.3%	104.9%	101.2%	115.9%		
Finedon	1976.65	1738.25	469.5	465.75	1000.5	1000.5	333.5	460	87.9%	99.2%	100.0%	137.9%		
Hawthorn	1830.23	1759.96	994.25	1071.67	1333.25	1313.25	908.5	1018.75	96.2%	107.8%	98.5%	112.1%		
Head & Neck	1000.5	1028.5	653.75	527.25	828	724.5	333.5	379.5	102.8%	80.7%	87.5%	113.8%		
Holcot	1480.75	1287.25	989.75	1415.25	1322.5	1299	667	1147.75	86.9%	143.0%	98.2%	172.1%		
ITU	5316.25	4603.05	834.25	607.25	3979	4125.03	667	540.5	86.6%	72.8%	103.7%	81.0%	No detrimental effect to patient care as critical care patients receive 1:1 nursing from RN's. Assessment undertaken on a daily basis regarding acuity and dependancy, if required alternative support practitioners aligned to critical care assist.	No red flags
Knightley	990.17	931.58	822.25	1084.25	1000.5	941.25	333.5	712.58	94.1%	131.9%	94.1%	213.7%		
Rowan	1834.25	1870.73	1000.5	1024.33	1667.5	1614.5	667	678.5	102.0%	102.4%	96.8%	101.7%		
Spencer	897	902.5	536	697.42	666.25	684.5	333.5	528.75	100.6%	130.1%	102.7%	158.5%		
Talbot Butler	2061.1	1932.75	1302.5	1000.83	1334	999.75	667	977.5	93.8%	76.8%	74.9%	146.6%	RN vancany plus maternity leave,LTS and STS.Staffing monitored by Matron on a shift by shift basis and staffing reallocation as required. Number of HCA on night shifts increased to support patient care and maintain safety. HCA day shifts were supported by supernummery RN.	4 red flags due to 'less than 25% of planned RN on shift'- no harm
Victoria	808.75	798.05	678.5	968.25	667	667	333.5	966	98.7%	142.7%	100.0%	289.7%		
Willow	2159.25	2069.84	1000.5	1592.25	2000.5	1877.25	667	1246.67	95.9%	159.1%	93.8%	186.9%		

Enclosure E

Appendix 2 – Regional Safer Staffing Data

Daytime Fill Rates - Registered Midwives/Nurses									
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Bedford Hospital NHS Trust	97.17%	94.12%	95.15%	94.39%	94.52%	95.56%	91.36%	95.30%	92.08%
East and North Hertfordshire NHS Trust	98.68%	96.69%	96.58%	94.48%	94.50%	95.95%	98.51%	99.42%	98.90%
Hertfordshire Community NHS Trust	95.56%	98.88%	98.48%	101.07%	101.95%	103.92%	106.02%	104.04%	108.92%
Hertfordshire Partnership NHS Foundation Trust	102.45%	100.70%	103.40%	97.17%	96.13%	96.43%	101.69%	102.92%	101.69%
Kettering General Hospital NHS Foundation Trust	95.40%	95.87%	95.93%	90.89%	96.01%	96.28%	96.66%	95.93%	95.84%
Luton and Dunstable Hospital NHS Foundation Trust	94.98%	94.46%	93.77%	93.56%	90.52%	90.93%	89.55%	92.12%	94.07%
Milton Keynes Hospital NHS Foundation Trust	96.85%	97.34%	100.27%	98.40%	91.47%	91.07%	93.52%	90.48%	92.12%
Northampton General Hospital NHS Trust	79.46%	79.35%	78.96%	79.25%	78.53%	84.67%	87.11%	90.37%	90.74%
Northamptonshire Healthcare NHS Foundation Trust	91.63%	97.00%	98.68%	93.34%	90.86%	95.01%	96.23%	100.24%	99.46%
West Hertfordshire Hospitals NHS Trust	92.76%	95.55%	93.66%	92.15%	84.16%	83.56%	93.11%	90.60%	92.00%
Lincolnshire Community Health Services NHS Trust	91.35%	88.55%	91.75%	88.42%	88.31%	89.88%	88.04%	94.42%	93.53%
Leicestershire Partnership NHS Trust	107.24%	108.99%	100.79%	100.91%	101.24%	104.31%	104.63%	106.24%	104.01%
Lincolnshire Partnership NHS Foundation Trust	115.66%	112.54%	114.01%	101.93%	105.17%	111.67%	107.97%	108.41%	114.25%
United Lincolnshire Hospitals NHS Trust	85.87%	82.66%	87.50%	88.33%	88.50%	89.14%	93.40%	92.30%	90.31%
University Hospitals of Leicester NHS Trust	93.64%	90.32%	91.19%	90.32%	90.16%	90.51%	91.42%	87.19%	90.98%

Night-time Fill Rates - Registered Midwives/Nurses									
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Bedford Hospital NHS Trust	104.68%	99.94%	99.43%	102.32%	99.04%	99.63%	99.17%	98.87%	101.24%
East and North Hertfordshire NHS Trust	97.31%	98.49%	98.77%	98.43%	97.81%	99.92%	101.17%	101.67%	98.87%
Hertfordshire Community NHS Trust	95.96%	99.76%	100.20%	98.99%	99.31%	102.12%	100.79%	100.62%	104.53%
Hertfordshire Partnership NHS Foundation Trust	100.09%	100.72%	102.65%	98.50%	97.68%	99.61%	99.35%	102.22%	100.03%
Kettering General Hospital NHS Foundation Trust	97.44%	99.76%	96.57%	93.52%	97.91%	98.93%	96.82%	98.38%	98.11%
Luton and Dunstable Hospital NHS Foundation Trust	99.28%	98.75%	98.09%	99.95%	96.65%	96.93%	95.76%	97.62%	97.32%
Milton Keynes Hospital NHS Foundation Trust	113.17%	115.43%	114.15%	110.59%	104.13%	101.75%	103.41%	103.64%	103.69%
Northampton General Hospital NHS Trust	86.36%	88.83%	82.43%	93.21%	91.38%	95.74%	94.53%	93.48%	94.07%
Northamptonshire Healthcare NHS Foundation Trust	98.87%	101.36%	101.11%	100.53%	101.42%	103.42%	106.80%	105.09%	104.57%
West Hertfordshire Hospitals NHS Trust	97.90%	99.42%	98.72%	97.98%	96.22%	96.90%	98.03%	98.51%	97.48%
Lincolnshire Community Health Services NHS Trust	88.72%	97.72%	89.35%	88.47%	89.14%	92.30%	92.94%	95.47%	94.09%
Leicestershire Partnership NHS Trust	98.24%	100.91%	95.47%	96.03%	97.87%	99.12%	102.25%	101.15%	102.73%
Lincolnshire Partnership NHS Foundation Trust	99.63%	101.91%	106.84%	100.94%	93.36%	96.32%	99.00%	98.76%	104.21%
United Lincolnshire Hospitals NHS Trust	91.33%	93.53%	94.39%	96.97%	96.60%	96.83%	99.63%	99.66%	97.06%
University Hospitals of Leicester NHS Trust	98.92%	95.97%	96.21%	94.29%	94.31%	94.91%	96.10%	91.42%	94.79%

Overall Fill Rates									
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Bedford Hospital NHS Trust	102.62%	99.90%	98.32%	99.56%	99.60%	100.97%	96.33%	97.41%	97.91%
East and North Hertfordshire NHS Trust	105.74%	103.43%	104.47%	102.88%	102.07%	102.08%	103.75%	105.22%	104.49%
Hertfordshire Community NHS Trust	102.29%	112.42%	111.31%	111.18%	113.28%	120.10%	119.84%	120.77%	129.76%
Hertfordshire Partnership NHS Foundation Trust	107.13%	108.91%	106.33%	108.60%	107.82%	106.92%	108.74%	110.82%	108.08%
Kettering General Hospital NHS Foundation Trust	99.46%	101.88%	100.23%	94.17%	96.97%	96.98%	97.46%	99.16%	98.91%
Luton and Dunstable Hospital NHS Foundation Trust	96.16%	95.81%	95.84%	96.37%	94.65%	94.66%	93.55%	94.33%	95.47%
Milton Keynes Hospital NHS Foundation Trust	102.78%	104.90%	105.46%	105.09%	98.80%	96.25%	99.18%	97.08%	97.77%
Northampton General Hospital NHS Trust	91.43%	91.03%	89.80%	93.94%	92.70%	97.35%	96.79%	98.80%	100.15%
Northamptonshire Healthcare NHS Foundation Trust	101.11%	102.75%	105.16%	102.57%	103.66%	104.98%	106.53%	106.37%	102.91%
West Hertfordshire Hospitals NHS Trust	97.25%	100.21%	99.06%	97.33%	95.43%	97.61%	100.35%	98.03%	98.20%
Lincolnshire Community Health Services NHS Trust	95.64%	95.80%	92.84%	93.28%	93.47%	94.49%	93.36%	94.44%	95.88%
Leicestershire Partnership NHS Trust	145.06%	144.54%	136.03%	136.82%	139.05%	140.48%	145.94%	146.65%	145.13%
Lincolnshire Partnership NHS Foundation Trust	100.55%	99.54%	103.66%	100.58%	97.51%	99.69%	99.65%	99.48%	103.28%
United Lincolnshire Hospitals NHS Trust	94.21%	93.62%	96.77%	98.59%	97.70%	96.77%	100.45%	99.83%	97.19%
University Hospitals of Leicester NHS Trust	96.39%	92.75%	93.76%	92.62%	92.46%	93.13%	94.04%	90.67%	93.29%

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

Appendix 3 – Safer Staffing Northampton Fill Rates

October 2015	Safe Staffing Report Overall Fill Rates October 2015			
	DAY		NIGHT	
	RN	HCA	RN	HCA
Total Fill Rate	87%	100%	95%	134%
Combined Fill Rate	92%		106%	
Total Combined	97%			

November 2015	Safe Staffing Report Overall Fill Rates November 2015			
	DAY		NIGHT	
	RN	HCA	RN	HCA
Total Fill Rate	90%	102%	93%	139%
Combined Fill Rate	94%		107%	
Total Combined	99%			

December 2015	Safe Staffing Report Overall Fill Rates December 2015			
	DAY		NIGHT	
	RN	HCA	RN	HCA
Total Fill Rate	91%	107%	94%	133%
Combined Fill Rate	97%		106%	
Total Combined	100%			

January 2016	Safe Staffing Report Overall Fill Rates January 2016			
	DAY		NIGHT	
	RN	HCA	RN	HCA
Total Fill Rate	94%	107%	95%	132%
Combined Fill Rate	99%		106%	
Total Combined	102%			

February 2016	Safe Staffing Report Overall Fill Rates February 2016			
	DAY		NIGHT	
	RN	HCA	RN	HCA
Total Fill Rate	93%	106%	95%	132%
Combined Fill Rate	98%		106%	
Total Combined	101%			

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

Information displayed using the NHS England East Midlands RAG originally launched with the Safe Staffing data

Northampton General Hospital NHS
NHS Trust

Report To	**TRUST BOARD**
Date of Meeting	**31st March, 2016**
Title of the Report	Financial Position Month 11
Agenda item	10
Sponsoring Director	Simon Lazarus, DoF
Author(s) of Report	Andrew Foster, Deputy DoF.
Purpose	To report the financial position for the period ended February 2015/16.

Executive summary

The I&E position for the period ended February (M11) is a deficit of £20.2m, £0.2m favourable to plan. Elective activity and associated income fell sharply again in February but the impact was offset by lower levels of non-pay expenditure and further reductions in the overall level of agency expenditure. Delivery of the required £20.4m deficit control total remains achievable although the forecast I&E position continues to highlight risk and remains extremely tight. Key to this is delivery of the Urgent Care CQUIN in March. A range of year end actions and accounting estimates have to be made in March before the final position can be determined and these are set out under separate cover.

Related strategic aim and corporate objective	Develop IBP which meets financial and operational targets.
Risk and assurance	The recurrent deficit and I&E plan position for FY15-16 signal another challenging financial year ahead and the requirement to develop a medium term financial strategy to deliver financial balance in the medium term.
Related Board Assurance Framework entries	BAF 3.1 (Sustainability); 5.1 (Financial Control); 5.2 (CIP delivery); 5.3 (Capital Programme).
Equality Impact Assessment	N/A
Legal implications / regulatory requirements	NHS Statutory Financial Duties

Actions required by the Committee

The Board is asked to note the report and recommendations in support of delivering the required TDA stretch target of £20.4m by the financial year end.

Enclosure F

Northampton General Hospital NHS
NHS Trust

Financial Position
Month 11 FY 2015/16

Report to
Trust Board
March 2016

Enclosure F

1. Overview

	RAG	This Month Feb 16	Last Month Jan 16	Change
Statutory Financial Duties				
3 year Cumulative I&E Breakeven duty (£000's)	▼	(29,526)	(27,429)	(2,096)
Achieving EFL (£000's)	▲	25,999	26,296	297
Capital Cost Absorption Duty (%)	◆	3.5%	3.5%	0
Achieving the Capital Resource Limit (£000's)	◆	17,681	17,876	(195)
Financial Sustainability Risk Rating	▼	1.0	2.0	(1.0)
I&E Position				
Actual in Month Position (£000's)	▼	(2,096)	(1,476)	(620)
Forecast in Month Position (£000's)	◆	(1,838)	(1,756)	(82)
Actual Year to Date Position (£000's)	▼	(20,182)	(18,085)	(2,097)
Forecast Year to Date Position (£000's)	▼	(20,364)	(18,526)	(1,838)
Forecast End of Year I&E Position (£000's)	▲	(20,436)	(21,037)	601
EBITDA %	◆	-3.0%	-2.8%	-0.2%
Income				
NENE CCG Variance to plan - YTD (£000's)	▼	(1,823)	(1,151)	(673)
MRET Penalty - Gross (£000's)	▼	(3,449)	(3,122)	(327)
Readmissions Penalty - Gross (£000's)	▼	(2,589)	(2,348)	(242)
Contract Fines & Data Challenges (£000's)	▼	(802)	(659)	(143)
Elective variance to plan (£000's)	▼	(2,625)	(2,067)	(558)
Daycase variance to plan (£000's)	▲	639	572	66
Non-Elective variance to plan (£000's)	▲	1,877	1,518	359
Outpatients variance to plan (£000's)	▽	2,023	2,090	(66)
Operating Costs				
Pay Expenditure (£000's)	▲	15,505	15,642	137
Agency Staff Costs (£000's)	▲	1,226	1,389	163
Agency Staff Cost (%)	▲	7.9%	8.9%	1.0%
RN Agency % (Ceiling 8%)	▲	6.1%	8.3%	2.2%
Non-Pay - Clinical (£000's)	▲	4,354	4,527	173
Non-Pay - Other (£000's)	▽	2,716	2,593	(123)
Cost Improvement Schemes				
Year to Date Actual (£000's)	▲	10,693	9,742	951
Year to Date Plan (£0o0's)	▲	10,405	9,166	1,239
Forecast Delivery (£000's)	▽	11,919	12,038	(119)
Annual CIP Target (£'000s)		12,125	12,125	0
Capital				
Year to date expenditure (£'000s)	◆	13,027	11,963	1,064
% of annual plan Committed	▲	102%	92%	9.2%
Annual Capital Expenditure Plan (£000's)	▲	17,681	17,663	18
Cash				
In month movement (£000's)	▲	3,547	(4,424)	7,971
In Year movement (£000's)	▲	3,769	222	3,547
New PDC / Temporary borrowing (£000's)	▲	18,200	16,500	1,700
Debtors Balance > 90 days (£000's)	▲	468	688	220
Creditors % > 90 days	◆	0%	0%	0%
Cumulative BPPC - by volume (%)	◆	99.2%	99.2%	0.0%

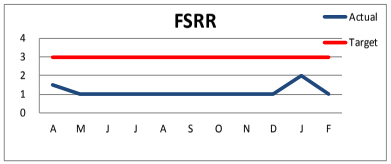
Key issues for this report

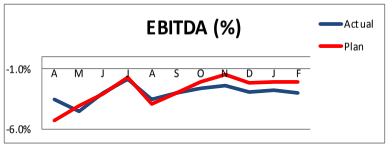
The I&E position for the period ended February (M11) is a deficit of £20.2m, £0.2m favourable to plan. Elective activity and associated income fell sharply again in February but the impact was offset by lower levels of non-pay expenditure and further reductions n the overall level of agency expenditure. Delivery of the required £20.4m deficit control total remains achievable although the forecast I&E position continues to highlight risk and remains extremely tight. A range of year end actions and estimates have to be made in March before the final position can be determined.

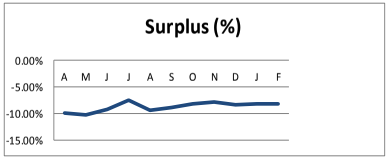
- The I&E position is measured against the revised year end stretch target of £20.4m (improvement of £0.8m to original plan).
- The adverse variance for elective and daycase income worsened by a further £0.5m in February.
- Delivery of the required control total remains subject to a range of operational risks, end of year accounting adjustments, some of which cannot be measured until the year end (e.g. Stock and WIP).
- The Trust has been unable to progress to agree a year end settlement with NENE CCG and this now looks unlikely to be achieved before the end of the contract year.
- The cumulative breakeven duty target for recovery now stands at £29.5m.
- A significant number of capital schemes remain outstanding in the final month of the financial year. The Trust must ensure it delivers the planned capital resource limit by the year end. The planned sale of Harborough Lodge remains subject to contract and if not delivered by 31/3 will mean the expected profit on sale (£0.2m) cannot be recorded in the current financial year. Further the Trust will not be able to count the capital proceeds (£0.6m) as a source of capital funding in year as planned giving rise to a risk of exceeding the CRL if not managed.
- The Trust is still awaiting formal approval of the PAS FBC but has now learnt that the capital loan application submitted in January was rejected by the TDA.
- Despite previous concerns, operational cashflow has remained positive overall during February and early March with all creditor demand being met on a timely basis.
- The Trust has received late notification of an additional £18k of DH PDC capital funding to purchase equipment to support Midwifery services .

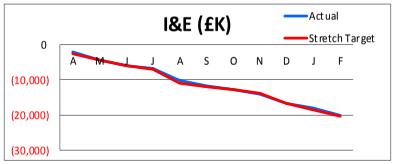
2. Financial Performance KPI Trend Analysis

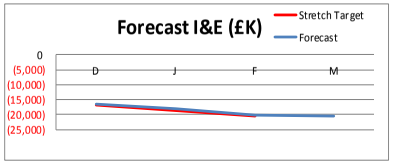
1. Key Metrics

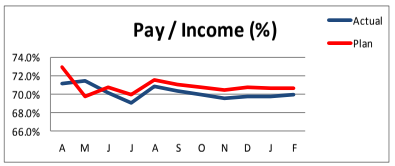




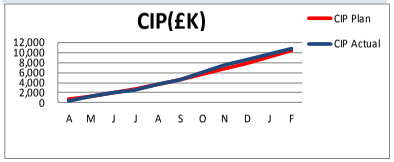


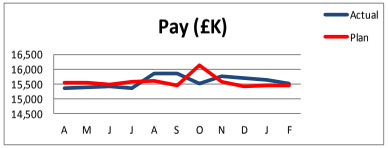


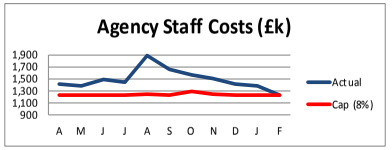


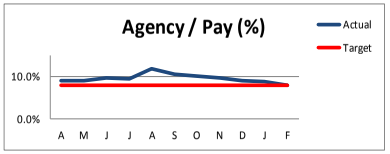


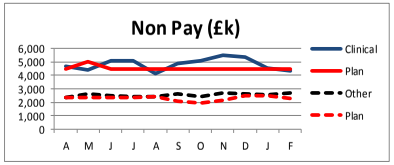
2. I&E Performance

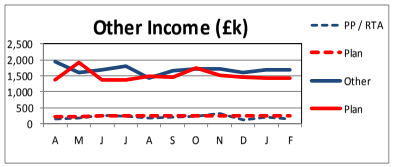




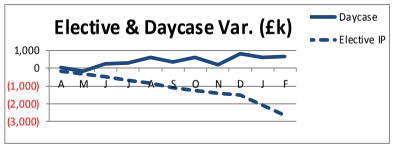


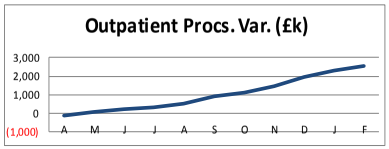


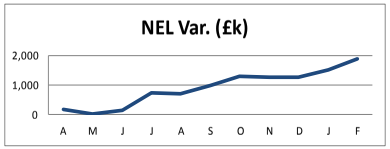


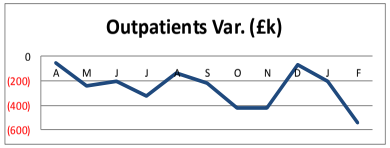


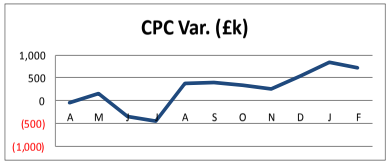
3. SLA Income

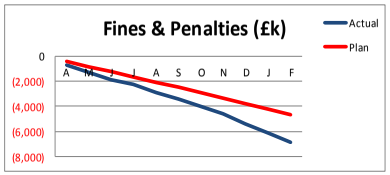




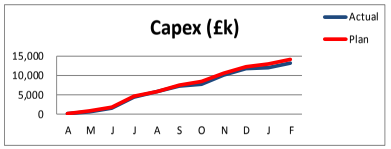


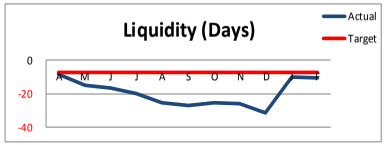


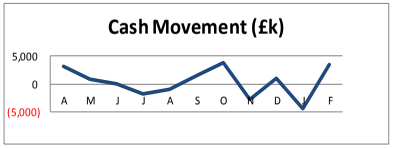


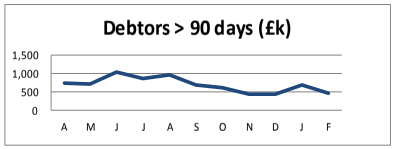


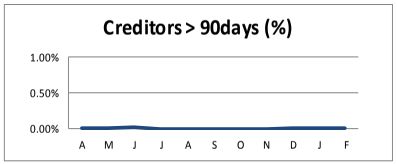
4. Working Capital

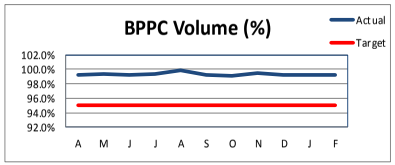












3. Income and Expenditure Position

I&E Summary	Actual FY14-15	Annual Plan	YTD plan	YTD Actual	Variance to Plan	Feb 16	Jan 16
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	239,776	245,555	223,388	224,378	989	19,727	20,472
Other Clinical Income	2,422	2,904	2,662	2,203	(459)	131	197
Other Income	23,810	17,998	16,509	18,500	1,991	1,692	1,689
Total Income	266,007	266,457	242,560	245,081	2,521	21,550	22,358
Pay Costs	(180,225)	(186,691)	(171,236)	(171,342)	(106)	(15,505)	(15,642)
Non-Pay Costs	(86,832)	(81,849)	(74,932)	(81,000)	(6,068)	(7,070)	(7,119)
CIPs		0	0	0	(0)	0	0
Reserves/ Non-Rec		(1,710)	(1,520)	0	1,520	0	0
Total Costs	(267,057)	(270,250)	(247,688)	(252,342)	(4,654)	(22,575)	(22,761)
EBITDA	(1,050)	(3,794)	(5,128)	(7,261)	(2,133)	(1,024)	(403)
Depreciation	(11,407)	(11,947)	(10,926)	(9,210)	1,717	(730)	(730)
Amortisation	(11)	(16)	(15)	(15)	0	(1)	(1)
Impairments	(3,338)	0	0	3,329	3,329	0	1,063
Net Interest	27	(516)	(501)	(302)	198	(14)	(51)
Dividend	(4,332)	(4,316)	(3,956)	(3,686)	270	(368)	(327)
Surplus / (Deficit)	(20,111)	(20,588)	(20,526)	(17,144)	3,382	(2,138)	(449)
NHS Breakeven duty adjs:							
Donated Assets	248	155	162	291	129	42	35
NCA Impairments	3,338	0	0	(3,329)	(3,329)	0	(1,063)
I&E Position (breakeven duty)	(16,525)	(20,433)	(20,364)	(20,183)	181	(2,096)	(1,476)

I&E Performance

- Financial performance for the period ended February 2015/16 is a normalised deficit of £20.183m, £181k fav. to the planned deficit of £20.364m for the same period.
- Pay expenditure run rate reduced marginally month on month, with a similar reduction in agency staff costs reported.
- SLA income was significantly below plan in February led by a sharp fall in elective activity. Overall, SLA income is £0.989m fav. to plan overall (last month £1.51m fav). Within this position Tariff excluded medicines income is £2.7m fav. to plan and excluded devices £0.6m fav. to plan.
- Pay expenditure is £106k adv. (£52k adv.) to plan with Non-Pay expenditure £6.068m (£5.767m) adv. to plan.
- 11 months of the planned contingency reserve have been allocated for the year to date (£1.5m fav).
- Run Rate forecast (unmitigated) is for a deficit of £20.4m subject to risk (see Stretch Target report).
- The in year deprecation charge is £1.7m fav. to plan reflecting the revised Modern Equivalent Asset basis of asset valuation and asset lives adopted in October. Additional revenue works costs of £113k have been incurred in February which can no longer be capitalised under the MEA basis.

Key issues

SLA Income

- Underling position is £3.1m fav.to plan offset by requirement to make provision for potential fines and penalties of £6.8m for the YTD.
- EL IP activity £2.6m (16%) below plan for year to date. (Last month £2.0m or 14%)
- Daycase activity £639k (3%) above plan for the year to date. (Last month £572k (3%) above plan).
- NEL activity 1% above plan for period to date giving rise to MRET penalty exposure. NEL excess bed day income 20% above plan (Last month 20%).
- CCG continue to include debtor balance for 50% of the FY14-15 income settlement (£0.9m) in the agreement of balances exercise. This has been disputed by the Trust and is not included in the reported position.
- CQUIN £1.5m adv. to plan pending delivery of revised Urgent Care CQUIN in Q4.

Other Income

- Private Patient income £372k adverse to plan. (Last month £326k adv.).
- RTA income £87k adv. to plan. (Last month £22k adv.).
- Income / Other Generation £1.991m fav. to plan led by external drug sales and recharges to Charitable funds and additional education income.

Pay

- Total agency staffing costs 10% (£16.4m) of the total pay bill for the period to February (see Appendix 1).
- RN Agency 6.1% (8.3%) of RN pay in February (ceiling 8%).
- Medical staff ADH costs £131k in January (last month £85k).
- Nursing pay expenditure £1.41m (2.1%) fav. to plan overall (last month £1.29m fav.).

Non-Pay

- Drugs £3.2m adv. to plan due to high level of Excluded medicines offset by additional income from Commissioners and unplanned external drug sales to NHFT earlier in year.
- Prosthesis £503k fav. to plan. (£408k fav).
- Energy £694k (was £618k) fav. to plan.
- Consultancy Fees £528k adv. to plan.
- Office equipment £164k (£167k) adv.to plan.
- Building and engineering £426k adv. to plan.

3.1 Run Rate Income & Expenditure Forecast (M11+1)

	Outturn 2014/15 £000's	Original Plan 2015/16 £000's	Month 1 £000's Apr	Month 2 £000's May	Month 3 £000's Jun	Month 4 £000's Jul	Month 5 £000's Aug	Month 6 £000's Sep	Month 7 £000's Oct	Month 8 £000's Nov	Month 9 £000's Dec	Month 10 £000's Jan	Month 11 £000's Feb	Month 12 £000's Mar	EOY Forecast £000's 2015-16
SLA Clinical Income	239,776	245,555	19,481	19,669	20,848	21,205	18,603	21,387	20,951	21,652	20,382	20,472	19,727	21,279	**245,658**
Other Clinical Income	2,422	2,904	147	185	251	232	170	201	241	320	129	197	131	195	**2,399**
Other Income	23,810	17,998	1,966	1,588	1,682	1,798	1,419	1,662	1,699	1,715	1,590	1,689	1,692	1,675	**20,176**
Total Income	**266,007**	**266,457**	**21,594**	**21,442**	**22,782**	**23,236**	**20,192**	**23,250**	**22,891**	**23,688**	**22,101**	**22,359**	**21,550**	**23,149**	268,233
Pay Costs	(180,225)	(186,691)	(15,343)	(15,395)	(15,414)	(15,369)	(15,850)	(15,849)	(15,520)	(15,753)	(15,702)	(15,642)	(15,505)	(15,700)	**(187,042)**
Non-Pay Costs	(86,832)	(81,849)	(7,012)	(7,024)	(7,614)	(7,495)	(6,591)	(7,511)	(7,506)	(8,124)	(7,933)	(7,120)	(7,070)	(7,700)	**(88,700)**
Reserves		(1,710)													
Total Costs	**(267,057)**	**(270,250)**	**(22,355)**	**(22,419)**	**(23,028)**	**(22,865)**	**(22,440)**	**(23,360)**	**(23,026)**	**(23,877)**	**(23,635)**	**(22,761)**	**(22,575)**	**(23,400)**	(275,741)
EBITDA	**(1,050)**	**(3,794)**	**(762)**	**(978)**	**(246)**	**371**	**(2,249)**	**(110)**	**(135)**	**(189)**	**(1,534)**	**(402)**	**(1,024)**	**(251)**	(7,509)
Depreciation	(11,407)	(11,947)	(1,038)	(1,003)	(1,021)	(616)	(941)	(941)	(730)	(730)	(730)	(730)	(730)	(730)	**(9,941)**
Amortisation	(11)	(16)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	**(16)**
Impairments	(3,338)								2,267			1,063			**3,329**
Net Interest	27	(516)	(6)	(14)	(14)	(15)	(18)	(25)	(45)	(45)	(55)	(55)	(14)	(14)	**(319)**
Dividend	(4,332)	(4,316)	(364)	(356)	(360)	(360)	(360)	(360)	(125)	(377)	(332)	(327)	(368)	(368)	**(4,055)**
Surplus / (Deficit)	**(20,111)**	**(20,588)**	**(2,170)**	**(2,351)**	**(1,642)**	**(621)**	**(3,569)**	**(1,437)**	**1,230**	**(1,343)**	**(2,653)**	**(452)**	**(2,138)**	**(1,365)**	**(18,511)**
Breakeven Assessment:															
Donated Asset adjustment	248	268	42	42	42	(12)	(20)	42	2	42	32	32	42	42	332
Impairments	3,338								(2,267)			(1,063)			(3,329)
I&E Position (month)			**(2,128)**	**(2,309)**	**(1,599)**	**(632)**	**(3,589)**	**(1,394)**	**(1,035)**	**(1,300)**	**(2,621)**	**(1,482)**	**(2,096)**	**(1,322)**	**(21,508)**
I&E Position (Cum)	**(16,525)**	**(20,320)**	**(2,128)**	**(4,437)**	**(6,036)**	**(6,669)**	**(10,258)**	**(11,652)**	**(12,687)**	**(13,987)**	**(16,608)**	**(18,090)**	**(20,186)**	**(21,508)**	

Key Issues

- Run Rate forecast gives rise to indicative I&E deficit of £21.5m by the financial year end (£1.1m adverse to the required control total of £20.4m).
- Income quoted in March remains subject to additional elective activity risk and excludes the outstanding Urgent Care CQUIN (£1.1m see over).
- Potential risks not included in the run rate forecast (e.g. excess Winter Pressures).
- SLA income assumption reduced by £600k (M10-11) primarily due to elective income losses and additional fines & penalties in February.
- Run rate forecast excludes a range of year end accounting adjustments for items such as WIP, Stock and provisions.

Key Metrics	YTD £000's	EOY £000's
Run Rate Forecast	(20,186)	(21,508)
Revised Plan (£800k stretch)	(20,364)	(20,433)
Original Plan	(21,213)	(21,217)

Average Run Rates:	YTD	YTG
Income	22,280	23,149
Pay	(15,577)	(15,700)
Non-Pay	(7,364)	(7,700)
I&E	(1,835)	(1,322)

3.2 Risks & Opportunities

	Ref	Plan / FYE £000's	Best Case £000's	Most Likely £000's	Worst Case £000's	Comments
I&E Surplus / (Deficit) YTD	1		-20,186	-20,186	-20,186	Position to Month 10
Baseline I&E Forecast YTG	2		-1,322	-1,322	-1,322	Run-rate forecast position for months 11-12
Baseline Forecast I&E EOY	**A**		**-21,508**	**-21,508**	**-21,508**	
Income Risks						
CCG clawback of 50% of FY14-15 settlement	3				-870	CCG have issued invoice to the Trust in FY15-16
New Fines, Penalties & Challenges	4			-70	-100	Ongoing high risk of increasing A&E and RTT penalties
Elective Cancellations (Strike/Winter)	5		-300	-500	-600	Impact of winter pressures / stike action - March
Sub-Total Income Risks	**B**		**-300**	**-570**	**-1,570**	
Expenditure Risks						
Winter Pressures - Planned	6			-50	-100	Additional Winter schemes approved by Executive Team
Winter Pressures - Unplanned	7			-100	-150	Estimated winter 'drag' on variable and premium costs
Capitalisation of Works / Fees	8		-100	-150	-200	Impact of MEA valuation £113k transferred from Capital to revenue in M11.
Outsourcing of Elective Activity to meet RTT	9			-75	-100	Pressure to meet Endoscopy 2ww.
Interest Payable on new Loan approvals	10					Loan repayments and interest now confirmed with NTDA.
Payroll Contrtact Exit	11		-62	-62	-62	Cost of implementing weekly payroll / exiting Equiniti contract (ex. VAT)
IT Projects (Stock / PAS Implementation)	12			-30	-50	Project management and initialisation
Site Strategy / 60 Beds	13			-75	-100	Feasibility / Planning Fees
CEA Awards 15-16 (above budget of £120k)	14				-80	Assumes £200k cost for FY15-16 awards to be backdated to April 15
BMI Uncoded activity	15		-100	-140	-210	Unrecorded activity billed by BMI in Feb. 5% interest charge levied by BMI.
New ET / NHSLA provsions required	16			-100	-200	Increase in employment / NHSLA provsions TBC.
Sub-Total Expenditure Risks	**C**		**-262**	**-782**	**-1,252**	
Opportunities:						
NENE / SCG CCG Income Settlement	17		410			BC assumes contract settlement of £194.5m with NENE CCG
Delivery of Urgent Care CQUIN	18		1,070	1,070	100	Achievement of Urgent Care CQUIN to be measured / agreed with CCG in March.
WIP movement March	19		300		-300	ML assumes WIP movement is neutral. Risk to Maternity WIP.
Stock movement	20		200		-200	ML assumes no material adverse stock movement at year end.
Nurse Shift Standardisation	21			30		Savings being offset by Pay Protection of £20-£30k pcm.
Agency Controls	22		100	50		£1m TDA stretch Target required H2
LETB Income	23		91	91	91	£91k contribution to rotational trainees excess travel costs
Review of Provsions	24		400	370	300	Based on Q3 provisions review. Assumes no new provision required.
Defrerred income release	25		300	200	200	Review of deferred income required in M12.
Review of year end accruals	26		300			Review of year end expenditure accruals
Book profit on Asset Sales	27		200			Sale of Harborough Lodge remains subject to contract (15/3).
AML PET CT Income	28		28	28	28	Commercial agreement completed. Non-Rec costs to be billed.
Sub-Total Opportunities	**D**		**3,399**	**1,839**	**219**	
Risk Adjusted I&E Position	**A+B+C+D**		**-18,671**	**-21,021**	**-24,111**	
Stretch Target - Trust			**-20,417**	**-20,417**	**-20,417**	
Additional Mitigations Required / FRP			**1,746**	**-604**	**-3,694**	

Key Issues

- Table opposite seeks to identify the main drivers of potential changes to the run rate forecast in March and in preparing the year end accounts for the FY15-16 Financial Year.
- Risks and opportunities have been modelled based on current estimates and are subject to further refinement and quantification as part of the annual accounts process.
- Significant risk of elective activity reducing again in March due to winter pressures.
- Most Likely case fails to deliver £20.4m target without further mitigating actions being identified and delivered.
- Risk in relation to asset disposal which remains subject to contract (15/3).
- No year end settlement has yet been reached with NENE CCG meaning the contract will run its course for FY15-16.
- Requirement to measure and agree delivery of Urgent Care CQUIN ion March (previously assumed to be part of a year end settlement).

4. SLA Income

Point of Delivery		Activity Plan	Activity Actual	Activity Variance	Finance £000's Plan	Finance £000's Actual	Finance £000's Variance
AandE		105,778	104,041	(1,737)	11,597	11,645	48
Block / CPC		2,350,137	2,532,098	181,961	50,868	51,580	712
CQUIN		-	-		5,086	3,504	(1,582)
Day Cases		33,881	35,373	1,492	20,506	21,145	639
Elective		6,051	5,036	(1,016)	16,193	13,568	(2,625)
Elective XBDs		1,976	1,994	18	448	470	23
Excluded Devices		83	1,624	1,541	1,108	1,770	662
Excluded Medicines		-	15	15	15,990	18,737	2,747
Non-Elective		38,342	39,685	1,343	61,243	61,923	680
Non-Elective XBDs		27,872	33,209	5,337	5,974	7,171	1,197
Outpatient First		58,863	52,253	(6,610)	9,108	8,572	(536)
Outpatient Follow UP		183,244	181,601	(1,643)	16,902	16,894	(8)
Outpt Procedures		106,618	124,982	18,364	14,011	16,578	2,567
Other Central SLA Income					(2,189)	(2,338)	(150)
CIPs					1,192		(1,192)
Total SLA Income (before fines		**2,912,847**	**3,111,911**	**199,064**	**228,037**	**231,218**	**3,181**
Fines & Penatlies							
Contract Penalties	2WW				-	(7)	(7)
Contract Penalties	31 Day				-	-	-
Contract Penalties	62 Day				-	(81)	(81)
Contract Penalties	A&E				-	(561)	(561)
Contract Penalties	Cancelled Operations				-	(24)	(24)
Contract Penalties	CDIFF				-	-	-
Contract Penalties	MRSA				-	(10)	(10)
Contract Penalties	RTT - Incomplete				-	(120)	(120)
MRET	MRET				(2,365)	(3,449)	(1,084)
Readmissions	Readmissions				(2,284)	(2,589)	(306)
Sub-Total Fines & Penalties					**(4,648)**	**(6,841)**	**(2,192)**
Grand Total SLA Income					**223,388**	**224,378**	**990**

Key issues

Summary
£990k favourable to plan

CQUIN
£1,582k adverse to plan

Day Case & Elective Inpatients
£1,986k adverse to plan

Outpatients
£2,023k ahead of plan

Fines & Penalties
£2,192k adverse to plan

Total SLA Income showing £990k favourable position to plan; c.£3.4m relates to excluded items with a direct cost impact and therefore the underlying position is c.£2.5m adverse. This is a movement of c.£600k adverse from the previous month driven by a decrease in elective and outpatient activity due to urgent care demand impacting on capacity issues and the junior doctor strike.

The CQUIN has been reconciled up to the end of Q2. The variance relates to the urgent care CQUIN which doesn't have any partial payments and the achievement will be determined in Q4 and therefore this variance may be significantly reduced.

This remains a significant risk area for the Trust and a further adverse movement in month 12 would make the Trust control total unachievable as there is no current year end agreement with Nene CCG and payment is dependent upon activity.

Outpatient procedures are ahead of plan; some of this has been challenged as unauthorised coding and counting changes where improvements in coding have been made outside of the policies and timelines and remains as a central adjustment. Ophthalmology is the area with the most over performance.

As non-elective activity and bed days continue to over perform, there is a corresponding increase in MRET and readmissions. There are contractual penalties for missing the A&E 4 hour transit time (£561k), breaching the 62 day cancer pathway (£81k) and RTT (£120k).

5. Statement of Financial Position

	Balance at 31-Mar-15	Current Month			Forecast end of year	
		Opening Balance	Closing Balance	Movement	Closing Balance	Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	143,465	143,465	143,465		143,465	
IN YEAR REVALUATIONS		9,542	9,541	(1)	8,748	8,748
IN YEAR MOVEMENTS		11,438	12,503	1,065	18,325	18,325
LESS DEPRECIATION		(8,480)	(9,210)	(730)	(9,940)	(9,940)
NET BOOK VALUE	**143,465**	**155,965**	**156,299**	**334**	**160,598**	**17,133**
CURRENT ASSETS						
INVENTORIES	5,961	4,855	5,060	205	5,500	(461)
RECEIVABLES						
NHS RECEIVABLES	5,036	8,348	7,722	(626)	5,500	464
OTHER TRADE RECEIVABLES	1,437	1,315	1,188	(127)	1,500	63
RECEIVABLES IMPAIRMENTS PROVISION	(455)	(206)	(206)		(350)	105
CAPITAL RECEIVABLES						
NON NHS OTHER RECEIVABLES	216	474	389	(85)	250	34
COMPENSATION RECEIVABLES (RTA)	2,677	2,622	2,612	(10)	2,750	73
SALARY OVERPAYMENTS	499	591	596	5	610	111
SALARY SACRIFICE SCHEMES	427	509	485	(24)	485	58
OTHER RECEIVABLES	474	503	384	(119)	524	50
IRRECOVERABLE PROVISION	(851)	(851)	(851)		(875)	(24)
PREPAYMENTS	1,666	3,580	2,711	(869)	1,800	134
SUB TOTAL	11,126	16,885	15,030	(1,855)	12,194	1,068
NON CURRENT ASSETS FOR SALE		375	375			
CASH	1,114	1,336	4,883	3,547	1,500	386
CURRENT ASSETS	**18,201**	**23,451**	**25,348**	**1,897**	**19,194**	**993**
CURRENT LIABILITIES						
NHS PAYABLES	442	1,740	2,146	406	500	58
TRADE PAYABLES REVENUE	1,289	2,673	2,842	169	4,629	3,340
TRADE PAYABLES FIXED ASSETS	2,157	2,715	2,620	(95)	5,013	2,856
TAX AND NI OWED	3,301	3,418	3,390	(28)	3,500	199
NHS PENSIONS AGENCY	2,182	2,267	2,233	(34)	2,300	118
OTHER PAYABLES	407	347	333	(14)	400	(7)
SHORT TERM LOANS - DH (CAPITAL)	159	526	526		839	680
SHORT TERM LOANS - DH (REVENUE)						
SHORT TERM LOANS - NON DH	208	188	188		158	(50)
ACCRUALS	6,441	7,486	8,593	1,107	5,600	(841)
RECEIPTS IN ADVANCE	1,777	1,904	2,117	213	1,500	(277)
PDC DIVIDEND DUE		1,367	1,752	385		
STAFF BENEFITS ACCRUAL	721	721	721		650	(71)
PROVISIONS	1,396	751	740	(11)	510	(886)
CURRENT LIABILITIES	**20,480**	**26,103**	**28,201**	**2,098**	**25,599**	**5,119**
NET CURRENT ASSETS / (LIABILITIES)	**(2,279)**	**(2,652)**	**(2,853)**	**(201)**	**(6,405)**	**(4,126)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**141,186**	**153,313**	**153,446**	**133**	**154,193**	**13,007**
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year		1,385	1,376	(9)	1,369	1,369
LOANS over 1 year DH (CAPITAL)	1,431	4,867	5,447	580	6,975	5,544
LOANS over 1 year DH (REVENUE)		16,500	18,200	1,700	18,851	18,851
LOANS over 1 year NON DH	248	147	147		181	(67)
PROVISIONS over 1 year	1,072	1,081	1,081		991	(81)
NON CURRENT LIABILITIES	**2,751**	**23,980**	**26,251**	**2,271**	**28,367**	**25,616**
TOTAL ASSETS EMPLOYED	**138,435**	**129,333**	**127,195**	**(2,138)**	**125,826**	**(12,609)**
FINANCED BY						
PDC CAPITAL	119,240	119,240	119,240		119,258	18
PDC TEMPORARY BORROWING						
REVALUATION RESERVE	35,879	41,445	41,445		41,445	5,566
I & E ACCOUNT BALANCE	(16,684)	(16,347)	(16,347)		(16,347)	337
I & E CURRENT YEAR		(15,005)	(17,143)	(2,138)	(18,530)	(18,530)
FINANCING TOTAL	**138,435**	**129,333**	**127,195**	**(2,138)**	**125,826**	**(12,609)**

Key Movements

Non Current Assets

•Increase of £0.3m – additions exceed depreciation in month.

Current assets

•Increase in Inventories of £0.2m.
•Decrease in NHS Receivables £0.6m.
•Increase in Cash of £3.5m.
•Decrease in Prepayments of £0.9m.
•Decrease in Non NHS Other Receivables £0.1m.
•Decrease in Other Receivables £0.1m.

Current Liabilities

•Increase in NHS payables of £0.5m.
•Increase in Trade Creditors of £0.2m.
•Decrease in Trade Payables (Fixed Assets) £0.1m.
•Increase in accruals of £1.1m.
•Increase in receipts in advance of £0.2m.
•Increase in PDC Dividends Due of £0.4m.

Non Current Liabilities

•Increase of Capital Loans (repayable over more than 1 year) of £0.6m.
•Increase of Revenue Support Loan (repayable over more than 1 year) of £1.7m.

Financing

•Increased I&E deficit in month of £2.1m.

N.B. As a result of the reversal of the impairment due to the revaluation exercise, the EOY I&E forecast is shown as a deficit of £18.5m, however this is normalised position to £20.4m for purposes of calculating the NHS break even duty. Revenue Loan Support is restricted to £18.9m and the TDA have confirmed the Trust can fully access this funding in year. The revolving working facility is being replaced by a short term loan with a lower interest rate of 1.5% (was 3.5%) in February, this has been approved by the Trust Board and the DH.

6. Capital Expenditure

Capital Scheme	Plan 2015/16 £000's	M11 Plan £000's	M11 Spend £000's	Under (-) / Over £000's	Plan Achieved %	Actual Committed £000's	Plan Achieved %	To Achieve Plan £000's	Plan O/S %
Linacc corridor	0	0	0	0	0%	0	0%	0	0%
Replacement Imaging Equipment - Tranche 1	4,495	4,435	4,409	-26	98%	4,430	99%	86	2%
Replacement Imaging Equipment - Tranche 2	2,156	0	0	0	0%	2,106	98%	2,156	100%
Additional Imaging Equipment	0	0	0	0	0%	0	0%	0	0%
Replacement NPfIT Systems	305	192	176	-16	58%	107	35%	129	42%
Stock / Inventory System - Loan	0	0	0	0	0%	0	0%	0	0%
A&E / Orthopaedics	1,100	980	968	-12	88%	973	88%	132	12%
Contingency	0	0	0	0	0%	0	0%	0	0%
Medical Equipment Sub Committee	2,204	1,518	1,512	-6	69%	2,036	92%	692	31%
Estates Sub Committee	3,698	3,042	2,113	-928	57%	3,859	104%	1,585	43%
IT Sub Committee	2,666	2,272	2,267	-5	85%	2,850	107%	399	15%
Car Park Decking	1,410	1,410	1,410	0	100%	1,410	100%	0	0%
Other	291	445	439	-6	151%	449	154%	-148	-51%
Total - Capital Plan	**18,325**	**14,293**	**13,294**	**-999**	**73%**	**18,220**	**99%**	**5,031**	**27%**
Less Charitable Fund Donations	-175	-177	-172	5	98%	-172	98%	-3	2%
Less NBV of Disposals	-469	-94	-94	0	20%	-94	20%	-375	80%
Total - CRL	**17,681**	**14,022**	**13,027**	**-994**	**74%**	**17,954**	**102%**	**4,654**	**26%**

Funding Resources	£000's
Internally Generated Depreciation	9,940
Maternity PDC Allocation	18
SALIX	90
Finance Lease - Car Park Decking	1,410
Capital Loans - Imaging Equipment (Approved)	4,495
Capital Loans - Replacement Imaging Equipment	2,156
Capital Loans - Additional Imaging Equipment	0
Capital Loans - NPfIT Systems	0
Capital Loans - Stock / Inventory System	0
Capital Loan - Repayment	-427
Total - Available CRL Resource	**17,682**
Uncommitted Plan	**0**

Key Issues

- The Linear Accelerator corridor works have now completed and linear accelerator machine is now operational.
- The MRI scanner within the approved replacement imaging equipment approved capital loan and is now likely to slip to 2016/17 with revised forecast of £4,495k in year.
- The capital loan submission has now been approved by the DH for £9.352m which includes two linear accelerator replacements, second MRI scanner, third CT scanner, CT scanner replacement, three x-ray room replacements and an inventory system . This is at a lower level for 2015/16 following review with Radiology and Radiotherapy. The second linear accelerator replacement is due for delivery mid-March and the remaining items will be purchased in 2016/17.
- The A&E / Orthopaedics scheme continues in the new financial year with completion of Ambulatory Care in October and Emergency Observation Area now planned to complete by December. The next elements of the works will now commence in the new financial year.
- Full year depreciation forecast is currently £9,940k (was £9,940k in M10).
- The car park decking which is subject to a 10 year finance lease is now fully operational.
- The second linear accelerator is due for delivery on 12 March, this is £2.2m of remaining plan.
- All capital sub groups are now working to deliver the forecast plan as outlined above , which is being monitored on a weekly basis with the Finance team.
- The sale of Harborough Lodge remains subject to contract meaning a significant source of capital funding remains outstanding. Contingency plans to manage the risk of any CRL overspend are being put in place.

7. Receivables, Payables and BPPC Compliance

February	Total at	0 to 30 Days	31 to 60 Days	61 to 90 Days	Over 90 Days
	£000's	£000's	£000's	£000's	£000's
Receivables Non NHS	1,188	443	420	49	276
Receivables NHS	6,153	5,356	439	166	192
Total Receivables	**7,341**	**5,799**	**859**	**215**	**468**
Payables Non NHS	(5,463)	(5,368)	(94)	(0)	(0)
Payables NHS	(2,146)	(2,144)	(2)		
Total Payables	**(7,609)**	**(7,512)**	**(96)**	**(0)**	**(0)**

January	Total at	0 to 30 Days	31 to 60 Days	61 to 90 Days	Over 90 Days
	£000's	£000's	£000's	£000's	£000's
Receivables Non NHS	1,315	877	145	42	251
Receivables NHS	6,779	5,744	539	59	437
Total Receivables	**8,094**	**6,621**	**684**	**101**	**688**
Payables Non NHS	(5,389)	(5,389)			
Payables NHS	(1,740)	(1,740)			
Total Payables	**(7,129)**	**(7,129)**			

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 £221k of which £83k are paying in instalments and a high proportion of the balance passed to debt collection agency to recover and Private Patients £44k.
- NHS over 90 day debt predominantly relates to NCA's £103k, Oxford University Hospitals NHS Trust £41k and University Hospitals of Leicester NHS Trust £34k.
- 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 with a further year end review scheduled.

Narrative	June 2015	Sept 2015	Dec 2015	Feb 2015	Cumulative 2015/16
NHS Creditors					
No.of Bills Paid Within Target	150	263	232	153	1,889
No.of Bills Paid Within Period	156	264	233	155	1,911
Percentage Paid Within Target	**96.15%**	**99.62%**	**99.57%**	**98.71%**	**98.85%**
Value of Bills Paid Within Target (£000's)	1,831	2,086	1,909	636	18,725
Value of Bills Paid Within Period (£000's)	1,841	2,088	1,909	647	18,762
Percentage Paid Within Target	**99.47%**	**99.90%**	**100.01%**	**98.32%**	**99.81%**
Non NHS Creditors					
No.of Bills Paid Within Target	6,581	9,236	9,568	7,343	86,642
No.of Bills Paid Within Period	6,629	9,415	9,589	7,399	87,336
Percentage Paid Within Target	**99.28%**	**98.10%**	**99.78%**	**99.24%**	**99.21%**
Value of Bills Paid Within Target (£000's)	6,507	9,312	10,044	7,227	91,586
Value of Bills Paid Within Period (£000's)	6,529	9,381	10,053	7,287	92,091
Percentage Paid Within Target	**99.67%**	**99.26%**	**99.91%**	**99.17%**	**99.45%**
Total					
No.of Bills Paid Within Target	6,731	9,499	9,800	7,496	88,531
No.of Bills Paid Within Period	6,785	9,679	9,822	7,554	89,247
Percentage Paid Within Target	**99.20%**	**98.14%**	**99.78%**	**99.23%**	**99.20%**
Value of Bills Paid Within Target (£000's)	8,338	11,398	11,953	7,862	110,312
Value of Bills Paid Within Period (£000's)	8,370	11,470	11,962	7,934	110,853
Percentage Paid Within Target	**99.62%**	**99.37%**	**99.93%**	**99.10%**	**99.51%**

BPPC Compliance

- The BPPC performance has been maintained in the new financial year with all targets achieved in year to date by volume and value with the payments team continuing to achieve processing within the targets once approved.

- Of the 58 invoices (£72k) that were paid late in January, 38 invoices (£53k) related to agency invoices.

8. Cashflow

MONTHLY CASHFLOW	Annual £000s	APR £000s	JUN £000s	SEP £000s	DEC £000s	JAN £000s	FEB £000s	MAR £000s	APR £000s	MAY £000s	JUN £000s
		ACTUAL						FORECAST			
RECEIPTS											
SLA Base Payments	235,528	19,508	20,342	19,622	22,104	17,078	19,644	19,609	21,158	21,158	21,158
SLA Performance/ Other CCG Investment	86										
DH - Quarterly Funding											2,425
Health Education Payments (SIFT etc)	9,956	759	802	1,878	815	792	838	821	808	808	808
Other NHS Income	13,272	1,084	441	2,169	1,638	763	1,557	1,721	1,072	1,072	1,072
PP / Other (Specific > £250k)	3,572	396		353	324	426	442	324			
PP / Other	11,808	1,104	1,011	965	798	916	1,119	850	1,200	1,200	1,200
Salix Capital Loan	90							90			
PDC - Capital	18							18			
Capital Loan	6,651					397	580	2,156			
Revenue Support Loan	18,851						18,200	651			
Revolving Working Capital Facility	16,500	3,500		4,500	1,700				1,700	1,500	
Interest Receivable	32	6	3	2	3	2	2	2	3	2	2
Sale of Assets	585							585			
TOTAL RECEIPTS	**316,950**	**26,356**	**22,600**	**29,491**	**27,382**	**20,373**	**42,383**	**26,827**	**25,941**	**25,740**	**26,665**
PAYMENTS											
Salaries and wages	171,328	13,999	14,194	14,136	14,442	14,414	14,479	14,573	14,900	15,000	15,000
Trade Creditors	92,303	7,259	6,122	7,874	8,899	8,171	5,886	9,573	7,429	7,845	8,361
NHS Creditors	17,879	1,491	1,841	2,088	1,909	1,401	647	1,100	1,800	1,800	1,800
Capital Expenditure	13,711	490	431	1,567	1,149	833	1,321	2,472	1,800	1,095	1,504
PDC Dividend	3,811			1,988				1,823			
Repayment of Loans (Principal & Interest)	17,275			219			16,500	555			
Repayment of Salix loan	208			111				85	12		
TOTAL PAYMENTS	**316,515**	**23,238**	**22,588**	**27,984**	**26,399**	**24,819**	**38,833**	**30,181**	**25,941**	**25,740**	**26,665**
Actual month balance	436	3,118	12	1,508	984	-4,446	3,550	-3,354			
Cash in transit & Cash in hand adjustment	-49	-20	-2	-38	-27	22	-3	-28			
Balance brought forward	1,114	1,114	5,072	2,304	4,804	5,760	1,336	4,883	1,500	1,500	1,500
Balance carried forward	**1,500**	**4,212**	**5,083**	**3,774**	**5,760**	**1,336**	**4,883**	**1,500**	**1,500**	**1,500**	**1,500**

Key Issues

- The Trust has utilised £18.2m of the £18.9m DH approved Revenue Support Loan primarily to repay the Revolving Working Capital Support Facility (RWCSF) drawn down earlier in the year of £16.5m. In effect the interim facility has now been transferred to the short term loan with a lower rate of interest of 1.5% and a funding period from mid-month to mid-month. The remaining £0.7m of the revenue support loan will be drawn down in March
- The carried forward cash balance at the end of February was £4.9m.
- £0.6m of the approved capital loan funding was utilised in February with a further £2.1m to be drawn in March in relation to the second linear accelerator.
- The 16/17 plan submitted to the TDA incorporates Temporary Borrowing of £9.5m (subject to receiving £9.7m of transformation funding). £3.2m of this is forecast for Q1.
- The cash flow incorporates the sale of Harborough Lodge in March following approval by Trust Board to accept an offer of £585k.

9. Conclusions and Recommendations

Conclusion:

- The Trust has continued to perform favourably to plan with further progress demonstrated in relation to the reduction of Agency expenditure.
- The cumulative deficit of £20.2m at the end of February adds additional pressure into delivery of the position for March which must reverse recent trend of month on month trading deficits if the £20.4m deficit control total is to be delivered.
- In line with recent TDA guidance, a year end management plan is in place which aims to mitigate risks to delivery of the £20.4m deficit control total.
- There has been no tangible progress in agreeing a year end settlement with NENE CCG and as such the contractual position will now run its course for the remainder of the financial year giving rise to potential increased risk in relation to assumed levels of SLA income in the forecast and action plan.
- The position in relation to achieving the Urgent Care CQUIN is now pivotal to delivering the financial position and the Trust will need to demonstrate delivery to the CCG to secure the outstanding income at the year end (£1.1m).
- The loan application to fund the replacement PAS system was rejected by the TDA in February due to national capital funding constraints. As a result revision of the FY6-17 capital programme is now required with an increased reliance on lease financing to offset the shortfall in available DH capital funding.
- The sale of Harborough Lodge is progressing but may not complete by the financial year end giving rise to revenue and capital resource risk at the year end.
- Cash flow has been successfully managed in March but has been temporarily boosted by lower than planned level of capex.
- The overall I&E position remains tight with clear risks evident in terms of delivery of the £20.4m planned deficit by year end. A number of accounting estimates cannot be fully quantified until the financial year end.

Recommendations & actions

1. Implementation of actions to deliver required target and ongoing review of the detailed I&E forecast to deliver the I&E control total at the financial year end.
2. Ensure delivery of the Urgent Care CQUIN can be clearly demonstrated and associated income shortfall is agreed with Commissioners.
3. Develop mitigation plan in the event that sales of Harborough Lodge does not complete by 31/3.
4. Continue to exercise controls and measures to ensure agency expenditure for registered Nurses does not exceed the expected 8% ceiling in Q4 (subject to maintaining safe staffing levels).
5. Review 5 year capital plan in light of rejected ITFF capital loan application for the replacement PAS system.
6. Monitor cashflow and agree trajectory for new financial year with TDA.

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 11	Total Agency YTD Mth 11	Total Agency YTD Mth 10	Total Agency YTD Mth 9	Total Agency YTD Mth 8	Average Month 2014/15
General Surgery	330	73	502	232	-	7	1	7	-	9%	1,151	1,110	1,040	969	91
Anaesthesia & Critical Care	5	36	824	32	-	10	28	37	7	5%	980	920	858	786	78
Trauma & Orthopaedics	(2)	409	625	158	-	-	6	40	-	15%	1,236	1,145	1,078	946	77
Ent & Maxfax	249	243	44	39	-	-	-	110	-	14%	685	637	555	479	28
Ophthalmology	36	86	0	-	81	1	-	2	-	6%	207	173	142	115	6
Surgical Care Management	-	-	-	-	1	-	-	-	-	0%	1	1	1	1	4
Surgical Division	**618**	**847**	**1,996**	**461**	**82**	**18**	**35**	**195**	**7**	**9%**	**4,260**	**3,986**	**3,673**	**3,296**	**284**
Inpatient Specialties	420	325	1,082	719	-	28	20	103	35	16%	2,733	2,483	2,278	2,017	279
Outpatient & Elderly Medicine	497	70	283	458	-	-	113	-	-	10%	1,422	1,254	1,060	938	36
Urgent Care	212	1,572	1,430	322	-	2	-	-	-	26%	3,538	3,320	3,014	2,709	256
Medical Care Management	-	-	-	-	(3)	-	-	-	-	(1%)	(3)	(3)	(3)	(3)	17
General Medicine Division	**1,129**	**1,968**	**2,795**	**1,500**	**(3)**	**30**	**134**	**103**	**35**	**17%**	**7,689**	**7,054**	**6,349**	**5,660**	**587**
Child Health	(2)	33	357	33	-	0	5	4	-	4%	431	409	396	364	50
Obstetrics & Gynae	-	3	93	85	-	-	-	1	-	1%	183	168	151	135	14
Oncology/Clin Haematology	87	157	124	75	-	5	-	-	-	5%	448	405	338	296	90
WC&O Division	**85**	**193**	**574**	**193**	**-**	**5**	**5**	**5**	**-**	**3%**	**1,061**	**981**	**885**	**795**	**153**
Pathology	40	-	-	-	-	5	-	761	-	13%	806	760	694	642	19
Imaging	363	-	-	-	-	-	38	-	-	6%	400	369	333	313	23
Research	-	-	-	-	-	-	-	-	-	0%	-	-	-	-	-
Pharmacy	-	-	-	-	-	-	95	-	-	3%	95	83	82	59	35
Therapy Services	-	-	0	-	-	-	152	-	-	6%	152	143	125	105	31
Clinical Support Division	**402**	**-**	**0**	**-**	**-**	**5**	**285**	**761**	**-**	**7%**	**1,454**	**1,355**	**1,234**	**1,120**	**108**
Clinical Divisions	**2,234**	**3,008**	**5,366**	**2,154**	**79**	**58**	**459**	**1,064**	**42**	**10%**	**14,464**	**13,376**	**12,142**	**10,871**	**1,133**
Hospital Support	43	-	20	4	345	136	53	-	-	5%	599	543	488	454	53
Facilities	-	-	-	-	-	14	-	1	1,290	13%	1,305	1,222	1,123	1,009	92
Support Services	**43**	**-**	**20**	**4**	**345**	**150**	**53**	**1**	**1,290**	**8%**	**1,904**	**1,765**	**1,611**	**1,463**	**145**
Trust Total	**2,277**	**3,008**	**5,385**	**2,158**	**424**	**208**	**512**	**1,065**	**1,332**	**10%**	**16,368**	**15,142**	**13,753**	**12,334**	**1,278**
										Discrete Monthly Spend	**1,226**	**1,389**	**1,418**	**1,508**	**1,278**

Key Issues

- **At Month 11** £16.4m (£1.49m/mth average) has been spent on agency costs (£1.28m/mth average in 14/15).
- **Medical locum agency costs** was an average £481k in February. The Trust has spent £5.3m on agency, against a vacancy of £5.1m on medical staff in 16/17. This agency expenditure is 7% more than in 14/15.
- **Nursing (RN & HCA) agency costs** have reduced to £459k in February, with £293k of this on RNs. This places NGH with an agency expenditure of 7.8% of the total RN expenditure for the 3 months Dec-Feb, suggesting the Trust will manage the 8% RN expenditure target for Q4.

Appendix 2: Financial Sustainability Risk Rating

Criteria	M11	Score	Weight	Weighted Score
Capital Service capacity (times)	-0.35	1	25.00%	0.25
Liquidity (days)	-11	1	25.00%	0.25
I&E Margin	-8.2%	1	25.00%	0.25
Variance on I&E Margin as % of Income	0.1%	4	25.00%	1.00
Overall Score				1

New Financial Sustainability Rating Issued

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

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

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

Monitor Guidance (extract)

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

Northampton General Hospital NHS
NHS Trust

Report To	**Trust Board**
Date of Meeting	**March 2016**

Title of the Report	**Workforce Performance Report**
Agenda item	**11**
Presenter of Report	Janine Brennan, Director of Workforce & Transformation
Author(s) of Report	Sandra Wright, Assistant Director of Workforce Development Joanne Wilby, Workforce Planning & Information 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 January. • Increase in compliance rate for Role Specific Essential Training and a fall in compliance for Mandatory Training and Appraisals. • Position relating to number of in month changes for employee relations cases.	
Related strategic aim and corporate objective	Enable excellence through our people
Risk and assurance	Workforce risks are identified and placed on the Risk register as appropriate.
Related Board Assurance Framework entries	BAF – 4.1, 4.2 and 4.3
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (Y/N) No Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (Y/N) No
Legal implications / regulatory requirements	No

Actions required by the Board

The Board is asked to Note the report.

Northampton General Hospital NHS
NHS Trust

23 March 2016

Workforce Performance Report

1. Introduction

This report identifies the key themes emerging from February 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 78.89 FTE in February 2016 to 4255.95 FTE. The Trust's substantive workforce is at 92.56% of the Budgeted Workforce Establishment of 4597.97 FTE.

Annual Trust turnover decreased by almost 0.5% to 11.19% in February, which is above the Trust target of 8%. Turnover within Nursing & Midwifery increased by 0.07% to 12.21%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust. Turnover decreased in all other staff groups.

In month sickness absence increased by 0.13% to 4.44% which is above the Trust target of 3.8%. All Divisions were above the target rate in February with the exception of Support Services.

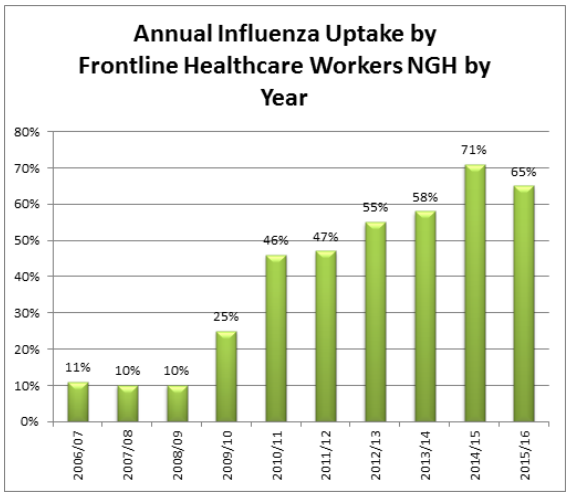
Flu Vaccination Campaign

The total for this year's uptake was 65.2%.

This was achieved with 4 weeks of daily clinics in the Cyber Café and 4 weeks' department visits and hospital walk rounds (there were a total of130 departmental visits during the campaign). There were additional visits to specific areas due to a rise in H1N1 Flu cases in January/February.

Planning for the flu clinics for 16/17 is currently underway.

The Department of Health flu survey data should be published in April/May 2016 to show how we fared regionally and nationally for the level of uptake.



2.2 Capability

Appraisals, Mandatory and Role Specific Essential Training

The current rate of Appraisals recorded for February 2016 is 80.23%; this decrease of 3.06% from last month's figure of 83.29% may in part be attributable to the large number of new starters on 29 February who will not yet have their initial new starter appraisal recorded.

Mandatory Training compliance decreased very slightly in February to 83.93% but remains close to the Trust target of 85%.

Only the Inpatient Specialties (Medicine) Directorate and ENT & Maxillofacial Directorate have a Mandatory Training compliance rate below 80%; in total 12 directorate level organisations are over 85%.

Role Specific Essential Training compliance increased further in February to 73.43%, continuing the improvement seen for several months.

2.3 Culture

Suspensions
The total number of suspensions in February was four, which remains the same as January 2016; there was no in-month change. 3 suspensions remain open within the Medicine Division, with an on-going suspension within Corporate Services (Facilities). Neither Surgery Division nor the Women, Children, Oncology and Haematology Division have any staff currently suspended.

Grievances
The total number of formal grievances across the Trust has increased in February to four from three, with a new grievance opening in Surgery. This new case, plus an ongoing grievance means Surgery have two cases. One grievance remains open within Women's Children's Oncology and Haematology; one remains open in Medicine but is at the appeal stage and there are no grievances in Corporate Services.

Bullying and Harassment

There are a total of three bullying and harassment cases within the Trust. February 2016 has seen some in-month changes relating to bullying and harassment cases. Medicine has seen one case closed, but a new case open, totalling two cases. There continues to be one ongoing case within Surgery. There are no cases within the other divisions and Corporate Services.

Whistleblowing
In total, there are 6 whistleblowing cases within the Trust. There are three new whistleblowing cases in February 2016; one in Corporate and two enquiries have opened within the Surgery Division, these are within General Surgery Directorate and the Anaesthetics, Critical Care and Theatres Directorate. In addition to the new cases in Surgery, there is an existing whistleblowing enquiry that opened in December 2015 in Trauma and Orthopaedics and the internal enquiry and audit has commenced. Surgery has a total of 3 whistleblowing enquiries. The whistleblowing case within Clinical Support Services which opened in September 2015 remains open and the internal enquiry is continuing. The existing Corporate whistleblowing case is ongoing and an enquiry has commenced for the new case.

Division	Type	Type of enquiry	Outcome

Corporate Services	Patient Safety	Internal Enquiry	Opened January 2016 and an internal enquiry continues with the majority of staff being interviewed.
Clinical Support Services	Patient Safety	Internal Enquiry	Opened September 2015. Email correspondence regarding recruitment of locums. Internal enquiry continuing.
Surgery Division / Trauma and Orthopaedics	Patient Safety	Internal Enquiry	Opened December 2015. In the process of gathering documentation in order to carry out an audit for the internal enquiry.
Surgery Division/ General Surgery	Fraud	Internal Enquiry	Opened February 2016.
Surgery Division/ Anaesthetics, Critical Care & Theatres	Fraud	Internal Enquiry	Opened February 2016.
Corporate	Disregard for legislation (recruitment processes)	Internal Enquiry	Opened February 2016. Internal enquiry commenced.

2.4 Policy Changes

The policies listed below have had minor amendments made that have been ratified in February and they are now on the intranet:

- Management of Sickness Absence Policy – inclusion of reference to Domestic Abuse Support for Staff Policy
- Probationary Period – inclusion of reference to Care Certificate, Secondment Policy and clarity on paperwork to be sent to an employee when inviting them to a final review meeting.

3. Assessment of Risk

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

4. Recommendations/Resolutions Required

The Board is asked to note the report.

5. Next Steps

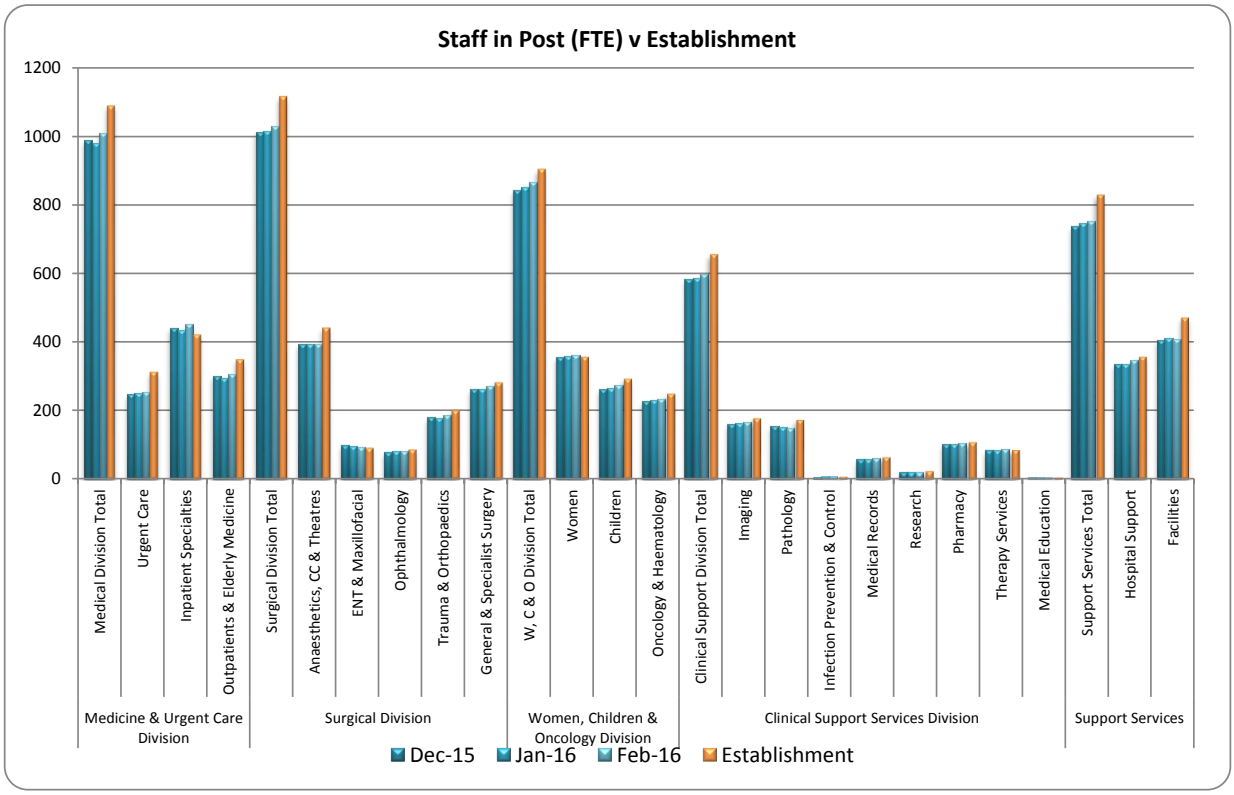
Key workforce performance indicators are subject to regular monitoring and appropriate action is taken as required.

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

CAPACITY
Staff in Post

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

Staff in Post (FTE)		Dec-15	Jan-16	Feb-16	Establishment	
Medicine & Urgent Care Division	Medical Division Total	989.85	979.28	1009.89	1089.89	92.66%
	Urgent Care	248.50	249.61	252.34	314.24	80.30%
	Inpatient Specialties	441.04	435.21	450.69	422.54	106.66%
	Outpatients & Elderly Medicine	299.30	293.46	305.85	350.73	87.20%
Surgical Division	Surgical Division Total	1013.58	1015.39	1029.26	1116.79	92.16%
	Anaesthetics, CC & Theatres	393.84	393.07	393.26	442.59	88.85%
	ENT & Maxillofacial	97.21	94.41	92.60	93.03	99.54%
	Ophthalmology	76.91	81.33	81.82	88.16	92.81%
	Trauma & Orthopaedics	178.36	177.81	184.20	202.47	90.98%
	General & Specialist Surgery	261.45	262.97	271.59	283.44	95.82%
Women, Children & Oncology Division	W, C & O Division Total	843.59	851.10	866.94	904.57	95.84%
	Women	355.31	356.40	360.99	358.18	100.78%
	Children	260.56	263.67	272.32	293.48	92.79%
	Oncology & Haematology	226.72	230.02	231.77	250.17	92.65%
Clinical Support Services Division	Clinical Support Division Total	582.44	585.20	596.84	656.68	90.89%
	Imaging	158.93	160.53	166.20	179.23	92.73%
	Pathology	154.28	151.28	149.12	173.73	85.83%
	Infection Prevention & Control	5.08	6.08	7.01	9.00	77.89%
	Medical Records	55.37	57.24	60.44	65.25	92.63%
	Research	19.74	19.74	19.74	25.12	78.58%
	Pharmacy	100.68	101.68	102.68	109.43	93.83%
	Therapy Services	82.16	82.45	85.45	86.93	98.30%
	Medical Education	4.20	4.20	4.20	6.45	65.12%
Support Services	Support Services Total	739.12	746.10	753.02	830.04	90.72%
	Hospital Support	335.29	336.05	345.43	357.85	96.53%
	Facilities	403.83	410.06	407.59	472.19	86.32%
Trust Total		4168.57	4177.06	4255.95	4597.97	92.56%



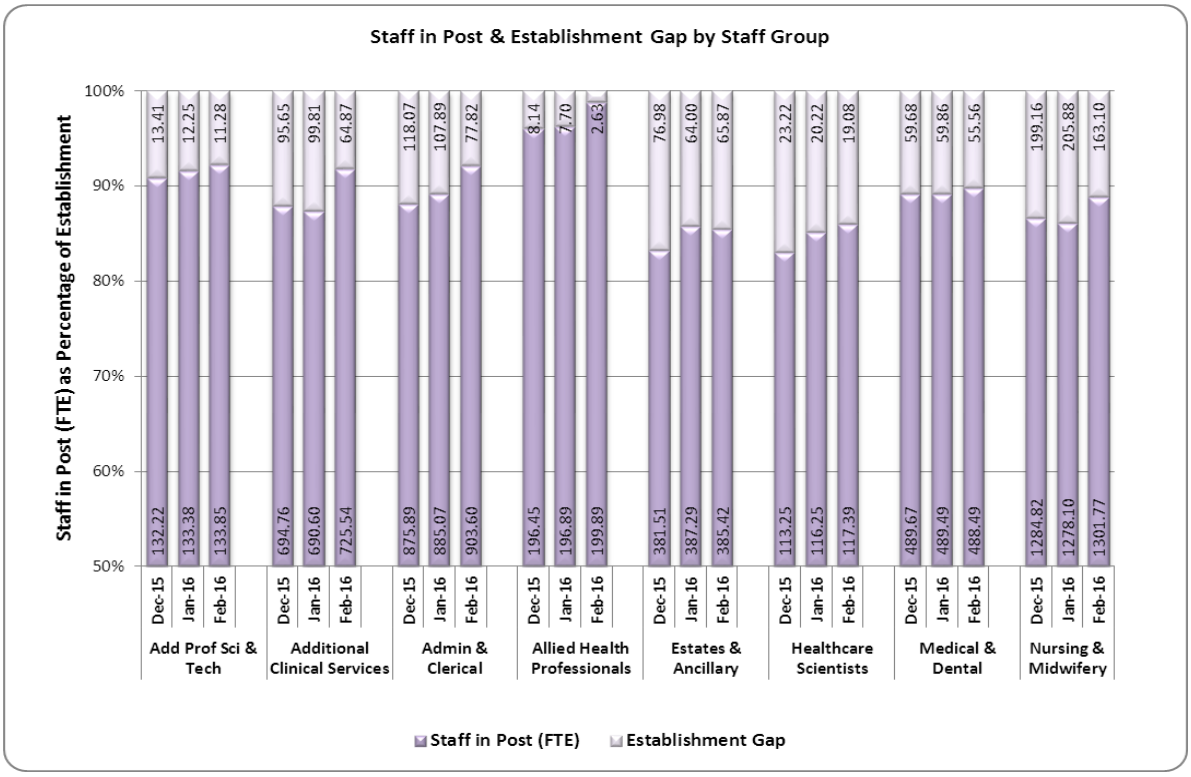
Workforce Committee: Capacity, Capability and Culture Report - January 2016

CAPACITY
Staff Group (FTE v Est)

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

Staff Group Vacancy Rate (Contracted FTE v Establishment)

Staff Group	Dec-15	Jan-16	Feb-16
Add Prof Sci & Tech	9.21%	8.41%	7.77%
Additional Clinical Services	12.10%	12.63%	8.21%
Admin & Clerical	11.88%	10.87%	7.93%
Allied Health Professionals	3.98%	3.76%	1.30%
Estates & Ancillary	16.79%	14.18%	14.60%
Healthcare Scientists	17.01%	14.82%	13.98%
Medical & Dental	10.86%	10.90%	10.21%
Nursing & Midwifery	13.42%	13.87%	11.13%



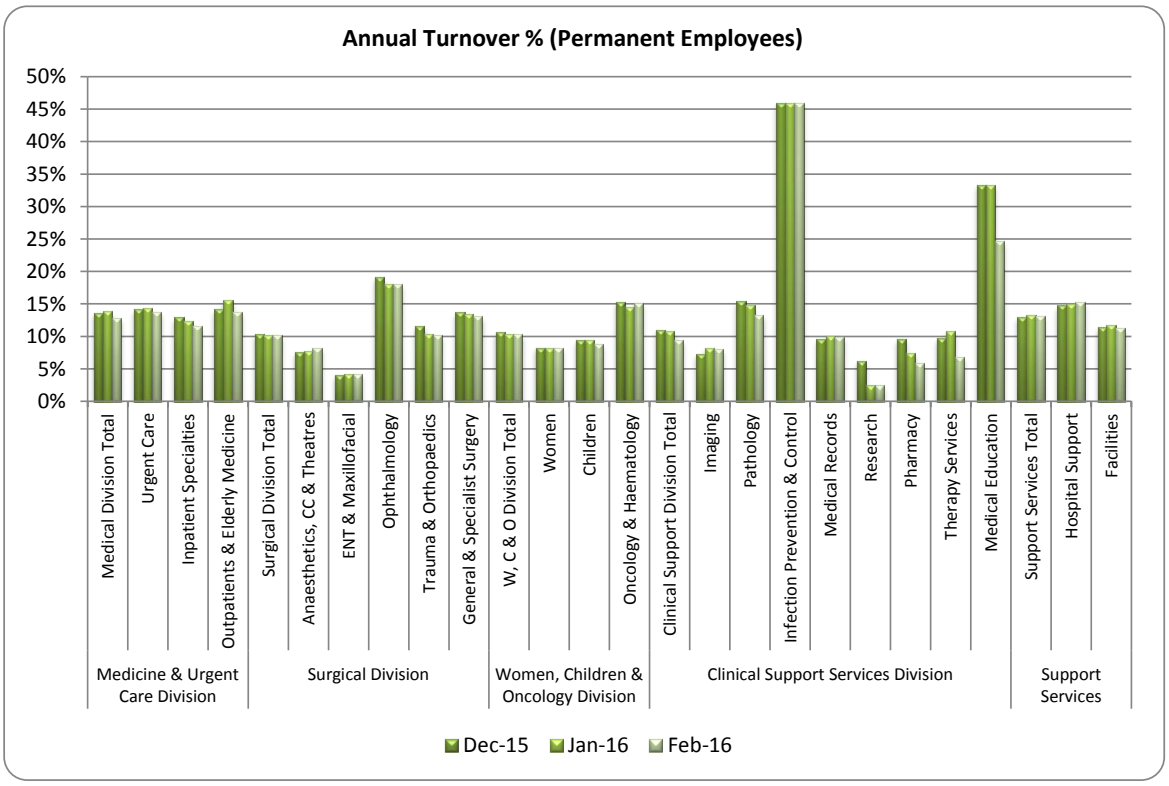
Workforce Committee: Capacity, Capability and Culture Report - January 2016

CAPACITY
Annual Turnover

Figures refer to the year ending in the month stated

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

Annual Turnover (Permanent Staff)		Dec-15	Jan-16		Feb-16	
Medicine & Urgent Care Division	Medical Division Total	13.58%	↗	13.80%	↘	12.76%
	Urgent Care	14.21%	↗	14.36%	↘	13.75%
	Inpatient Specialties	12.90%	↘	12.36%	↘	11.63%
	Outpatients & Elderly Medicine	14.14%	↗	15.53%	↘	13.71%
Surgical Division	Surgical Division Total	10.37%	↘	10.12%	↗	10.14%
	Anaesthetics, CC & Theatres	7.59%	↗	7.79%	↗	8.18%
	ENT & Maxillofacial	4.09%	↗	4.17%	↗	4.17%
	Ophthalmology	19.16%	↘	18.01%	↘	17.99%
	Trauma & Orthopaedics	11.58%	↘	10.34%	↘	10.14%
	General & Specialist Surgery	13.66%	↘	13.45%	↘	13.01%
Women, Children & Oncology Division	W, C & O Division Total	10.61%	↘	10.35%	↘	10.26%
	Women	8.26%	↘	8.14%	↘	8.13%
	Children	9.45%	↘	9.44%	↘	8.78%
	Oncology & Haematology	15.29%	↘	14.57%	↗	15.06%
Clinical Support Services Division	Clinical Support Division Total	10.97%	↘	10.75%	↘	9.41%
	Imaging	7.33%	↗	8.21%	↘	8.08%
	Pathology	15.44%	↘	14.82%	↘	13.22%
	Infection Prevention & Control	45.87%	↗	45.87%	↗	45.87%
	Medical Records	9.50%	↗	10.07%	↘	9.87%
	Research	6.15%	↘	2.42%	↗	2.42%
	Pharmacy	9.61%	↘	7.42%	↘	5.84%
	Therapy Services	9.69%	↗	10.78%	↘	6.81%
	Medical Education	33.33%	↗	33.33%	↘	24.59%
Support Services	Support Services Total	12.93%	↗	13.24%	↘	13.09%
	Hospital Support	14.72%	↗	14.96%	↗	15.23%
	Facilities	11.43%	↗	11.78%	↘	11.26%
Trust Total		11.70%	↘	11.66%	↘	11.19%



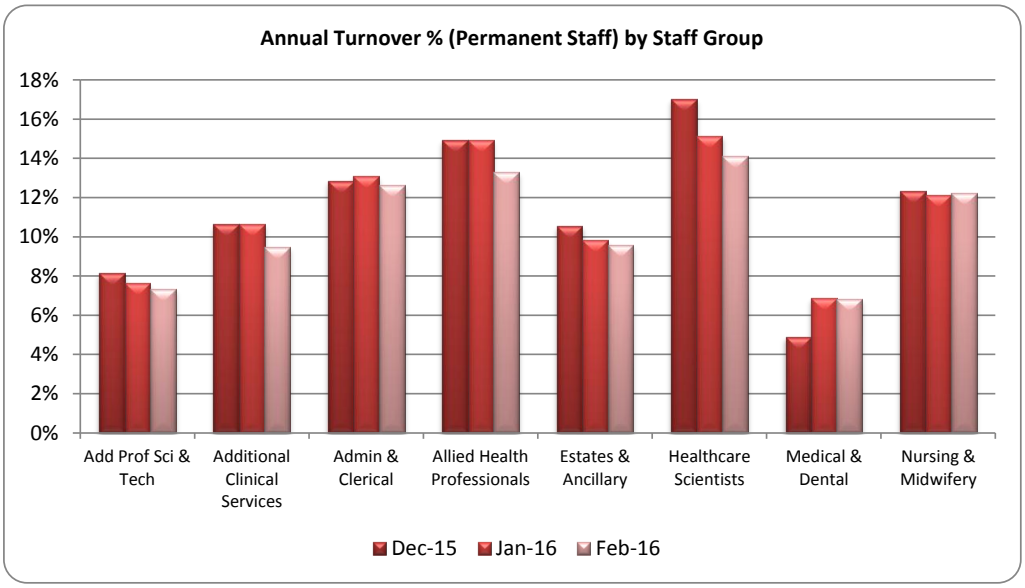
Workforce Committee: Capacity, Capability and Culture Report - January 2016

CAPACITY
Turnover by Staff Group

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

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

Staff Group	Dec-15		Jan-16		Feb-16
Add Prof Sci & Tech	8.16%	↘	7.66%	↘	7.31%
Additional Clinical Services	10.62%	↗	10.63%	↘	9.47%
Admin & Clerical	12.84%	↗	13.07%	↘	12.61%
Allied Health Professionals	14.94%	↗	14.95%	↘	13.29%
Estates & Ancillary	10.55%	↘	9.85%	↘	9.57%
Healthcare Scientists	17.00%	↘	15.12%	↘	14.10%
Medical & Dental	4.89%	↗	6.89%	↘	6.84%
Nursing & Midwifery	12.32%	↘	12.14%	↗	12.21%



Capacity: Substantive Workforce Capacity increased by 78.89 FTE in February 2016 to 4255.95 FTE. The Trust's substantive workforce is at 92.56% of the Budgeted Workforce Establishment of 4597.97 FTE.

Staff Turnover: Annual Trust turnover decreased by almost 0.5% to 11.19% in February which is above the Trust target of 8%. Turnover within Nursing & Midwifery increased by 0.07% to 12.21%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust. Turnover decreased in all other staff groups.

Medical Division: turnover decreased to 12.76%.
Surgical Division: turnover increased by just 0.02% to 10.14%
Women, Children & Oncology Division: turnover decreased by 0.09% to 10.26%
Clinical Support Services Division: turnover fell by 1.34% to below 10% (9.41%)
Support Services: turnover fell from 13.24% to 13.09% for the year ending February 2016.

Staff Vacancies: The vacancy rate within Additional Clinical Services staff group decreased significantly in February from 12.63% to 8.21% . The Registered Nursing & Midwifery vacancy rate also fell from 13.87% to 11.13%. The vacancy rate in all other staff groups also fell with the exception of Estates and Ancillary which rose from 14.18% to 14.60%.

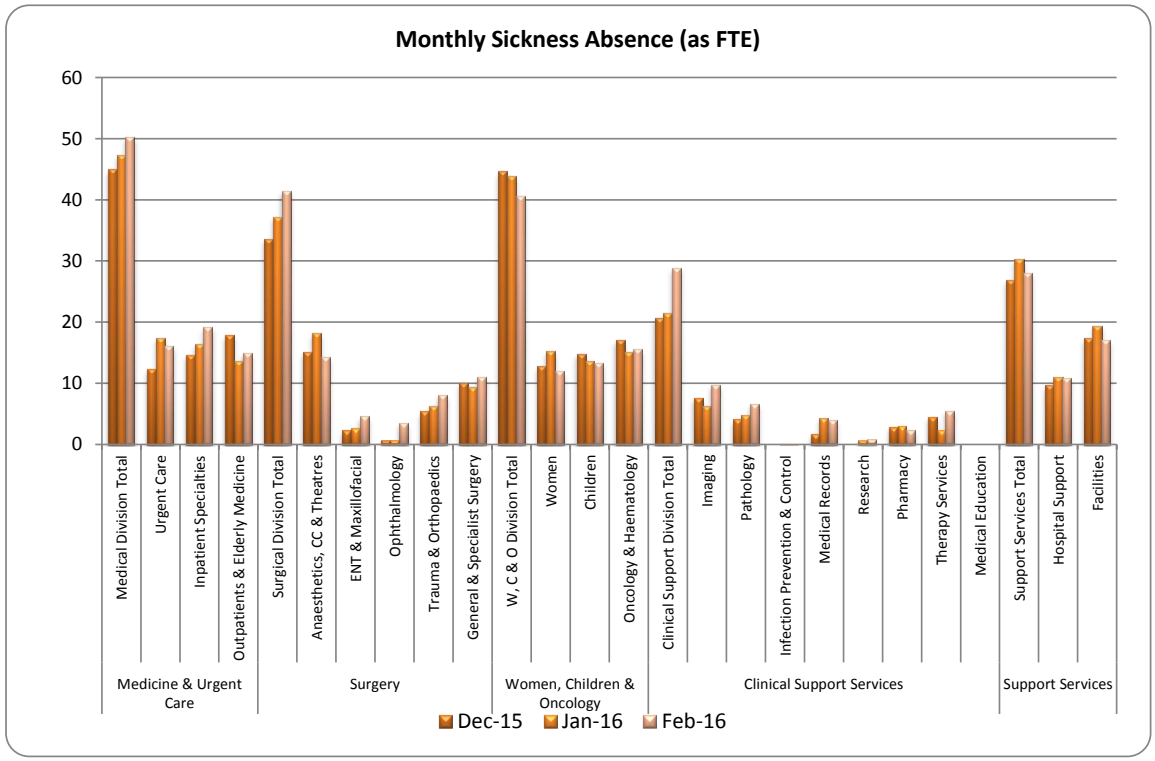
Sickness Absence: In month sickness absence increased by 0.13% to 4.44% which is above the Trust target of 3.8%. All Divisions were above the target rate in February with the exception of Support Services.

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

CAPACITY
In-Month Sickness

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

Monthly Sickness (as FTE)		Dec-15	Jan-16	Feb-16	Feb-16	Short Term	Long Term
Medicine & Urgent Care	Medical Division Total	44.94	47.30	50.19	4.97%	3.08%	1.89%
	Urgent Care	12.38	17.37	16.05	6.36%	2.86%	3.50%
	Inpatient Specialties	14.55	16.41	19.20	4.26%	2.68%	1.58%
	Outpatients & Elderly Medicine	17.93	13.56	14.93	4.88%	3.88%	1.00%
Surgery	Surgical Division Total	33.55	37.16	41.38	4.02%	2.40%	1.62%
	Anaesthetics, CC & Theatres	15.16	18.20	14.24	3.62%	1.96%	1.66%
	ENT & Maxillofacial	2.29	2.58	4.53	4.89%	3.29%	1.60%
	Ophthalmology	0.67	0.75	3.51	4.29%	3.77%	0.52%
	Trauma & Orthopaedics	5.35	6.31	8.09	4.39%	1.44%	2.96%
	General & Specialist Surgery	10.09	9.34	11.08	4.08%	3.03%	1.05%
Women, Children & Oncology	W, C & O Division Total	44.63	43.92	40.66	4.69%	2.41%	2.28%
	Women	12.83	15.22	11.91	3.30%	2.77%	0.53%
	Children	14.83	13.58	13.32	4.89%	2.14%	2.75%
	Oncology & Haematology	17.07	15.16	15.51	6.69%	2.17%	4.51%
Clinical Support Services	Clinical Support Division Total	20.68	21.48	28.83	4.83%	2.59%	2.24%
	Imaging	7.50	6.23	9.77	5.88%	1.91%	3.97%
	Pathology	4.04	4.80	6.52	4.37%	1.88%	2.49%
	Infection Prevention & Control	0.00	0.10	0.07	1.05%	1.05%	0.00%
	Medical Records	1.76	4.29	3.97	6.57%	4.33%	2.24%
	Research	0.00	0.69	0.79	4.00%	1.43%	2.57%
	Pharmacy	2.85	3.07	2.30	2.24%	2.24%	0.00%
	Therapy Services	4.45	2.35	5.40	6.32%	4.96%	1.37%
	Medical Education	0.00	0.00	0.00	0.00%	0.00%	0.00%
Support Services	Support Services Total	26.90	30.29	28.01	3.72%	2.60%	1.11%
	Hospital Support	9.62	10.96	10.88	3.15%	1.76%	1.39%
	Facilities	17.32	19.35	17.08	4.19%	3.31%	0.88%
Trust Total	*As FTE*	170.91	180.03	188.96			
	As percentage	4.10%	4.31%		4.44%	2.63%	1.82%



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

CAPABILITY
Training & Appraisal Rates

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

Mandatory Training Compliance Rate	Directorate	Dec-15	Jan-16	Feb-16
Medicine & Urgent Care Division	Medical Division Total	81.75%	81.92%	80.89%
	Urgent Care	84.85%	84.73%	83.33%
	Inpatient Specialties	78.35%	79.17%	78.30%
	Outpatients & Elderly Medicine	84.07%	83.51%	82.57%
Surgical Division	Surgical Division Total	83.67%	84.03%	84.12%
	Anaesthetics, CC & Theatres	84.16%	85.47%	85.46%
	ENT & Maxillofacial	76.39%	78.49%	78.09%
	Ophthalmology	89.13%	87.50%	88.55%
	Trauma & Orthopaedics	82.31%	82.48%	81.08%
	General & Specialist Surgery	84.76%	83.70%	84.73%
Women, Children & Oncology Division	W, C & O Division Total	85.68%	84.90%	84.91%
	Women	83.63%	84.21%	85.41%
	Children	89.53%	87.69%	85.91%
	Oncology & Haematology	84.53%	82.68%	82.74%
Clinical Support Services Division	Clinical Support Division Total	88.92%	87.45%	86.72%
	Imaging	88.95%	88.27%	85.90%
	Pathology	85.88%	81.44%	80.74%
	Infection Prevention & Control	85.19%	88.89%	87.50%
	Medical Records	86.15%	83.72%	87.39%
	Research	87.24%	90.53%	88.07%
	Pharmacy	93.20%	93.07%	93.97%
	Therapy Services	91.28%	90.66%	87.97%
	Medical Education	100.00%	100.00%	100.00%
Support Services	Support Services Total	82.72%	82.84%	84.21%
	Hospital Support	86.90%	86.68%	84.77%
	Facilities	79.66%	80.04%	83.78%
Trust Total		**84.21%**	**83.99%**	**83.93%**

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

CAPABILITY
Training & Appraisal Rates

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

Role Specific Training Compliance Rate	Directorate	Dec-15	Jan-16	Feb-16
Medicine & Urgent Care Division	Medical Division Total	68.90%	69.12%	68.93%
	Urgent Care	70.24%	69.93%	70.20%
	Inpatient Specialties	65.21%	65.55%	64.73%
	Outpatients & Elderly Medicine	73.12%	73.65%	73.83%
Surgical Division	Surgical Division Total	72.43%	73.19%	73.03%
	Anaesthetics, CC & Theatres	72.92%	74.37%	76.01%
	ENT & Maxillofacial	67.17%	67.38%	64.70%
	Ophthalmology	75.43%	75.92%	71.75%
	Trauma & Orthopaedics	70.84%	71.71%	70.32%
	General & Specialist Surgery	73.82%	73.68%	73.47%
Women, Children & Oncology Division	W, C & O Division Total	73.04%	73.70%	76.52%
	Women	68.55%	70.28%	75.28%
	Children	78.02%	77.83%	78.22%
	Oncology & Haematology	76.72%	75.83%	76.86%
Clinical Support Services Division	Clinical Support Division Total	86.17%	84.91%	83.55%
	Imaging	87.17%	84.95%	80.83%
	Pathology	72.61%	71.48%	76.58%
	Infection Prevention & Control	70.00%	76.19%	78.00%
	Medical Records	95.65%	91.55%	89.19%
	Research	72.94%	71.76%	71.43%
	Pharmacy	89.97%	86.60%	87.42%
	Therapy Services	91.75%	92.26%	90.03%
	Medical Education	100.00%	100.00%	100.00%
Support Services	Support Services Total	68.60%	70.31%	69.58%
	Hospital Support	70.84%	71.43%	69.25%
	Facilities	65.92%	68.98%	70.04%
Trust Total		**72.51%**	**72.99%**	**73.43%**

Capability

Appraisals
The current rate of Appraisals recorded for February 2016 is 80.23%; this decrease of 3.06% from last month's figure of 83.29% may in large part be attributable to the large number of new starters on 29 February who will not yet have their initial new starter appraisal recorded.

Mandatory Training and Role Specific Essential Training
Mandatory Training compliance decreased very slightly in February to 83.93% but remains close to the Trust target of 85%.

Role Specific Essential Training compliance increased further in February to 73.43%, continuing the improvement seen for several months.

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.

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

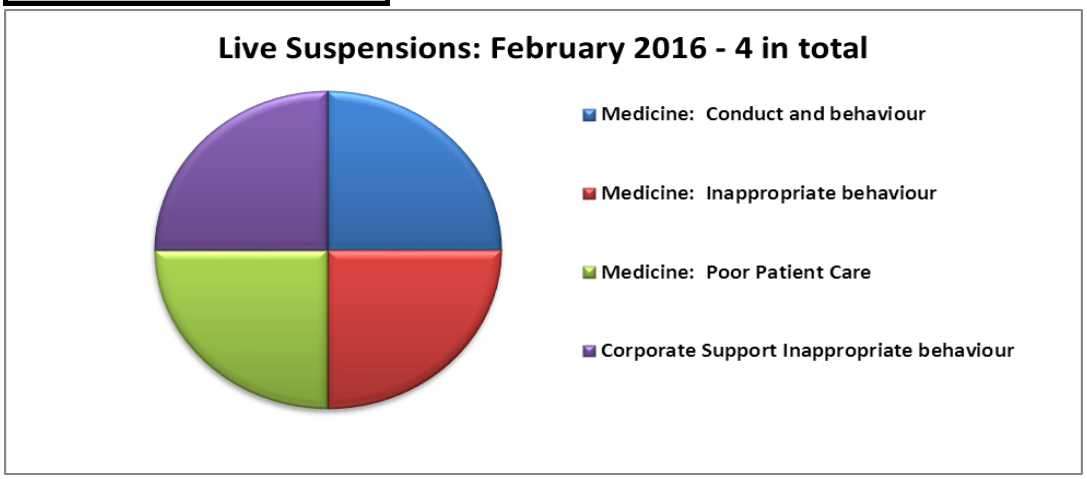
CAPABILITY
Training & Appraisal Rates

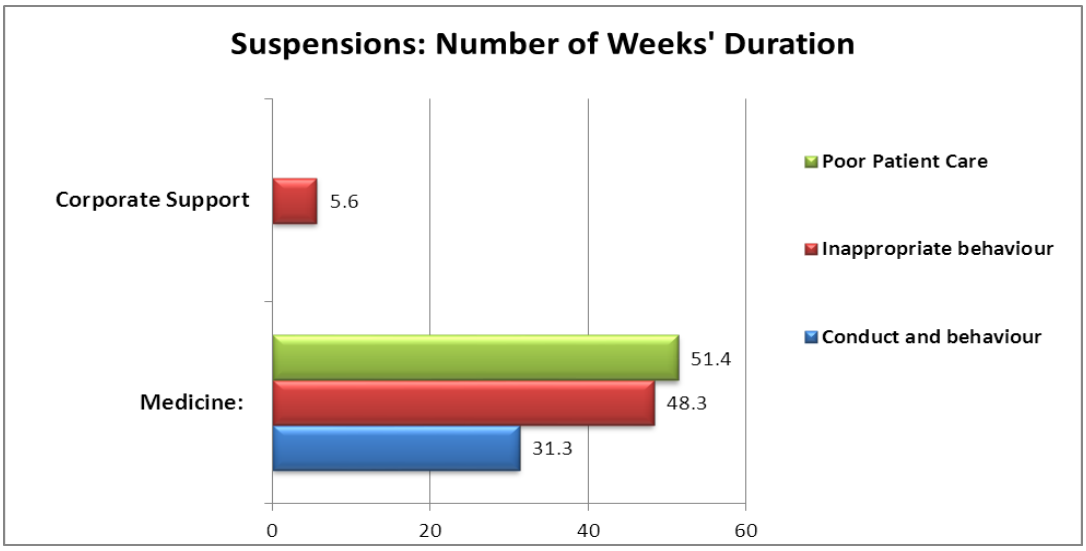
Training & Appraisal RAG Rates:		
< 80%	80 - 84.9%	> 85%

Appraisal Compliance Rate	Directorate	Dec-15	Jan-16	Feb-16
Medicine & Urgent Care Division	Medical Division Total	80.08%	83.76%	80.85%
	Urgent Care	89.07%	91.53%	89.33%
	Inpatient Specialties	74.29%	79.41%	75.57%
	Outpatients & Elderly Medicine	80.39%	83.06%	80.88%
Surgical Division	Surgical Division Total	89.96%	91.10%	89.33%
	Anaesthetics, CC & Theatres	87.50%	90.44%	88.28%
	ENT & Maxillofacial	88.24%	86.25%	85.90%
	Ophthalmology	84.72%	90.54%	90.54%
	Trauma & Orthopaedics	97.66%	95.91%	92.00%
	General & Specialist Surgery	90.16%	90.28%	89.45%
Women, Children & Oncology Division	W, C & O Division Total	86.94%	87.03%	82.73%
	Women	84.65%	87.56%	80.10%
	Children	87.26%	86.74%	84.13%
	Oncology & Haematology	90.95%	86.81%	85.96%
Clinical Support Services Division	Clinical Support Division Total	86.14%	85.78%	83.00%
	Imaging	83.13%	76.79%	72.99%
	Pathology	85.00%	91.14%	92.31%
	Infection Prevention & Control	66.67%	42.86%	50.00%
	Medical Records	91.30%	91.55%	77.03%
	Research	84.00%	88.00%	80.00%
	Pharmacy	92.24%	91.45%	94.07%
	Therapy Services	84.95%	82.98%	80.41%
	Medical Education	100.00%	100.00%	100.00%
Support Services	Support Services Total	69.76%	68.69%	65.05%
	Hospital Support	70.83%	70.88%	68.00%
	Facilities	68.99%	67.12%	62.87%
Trust Total		**82.52%**	**83.29%**	**80.23%**

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

CULTURE
Suspensions & Grievances

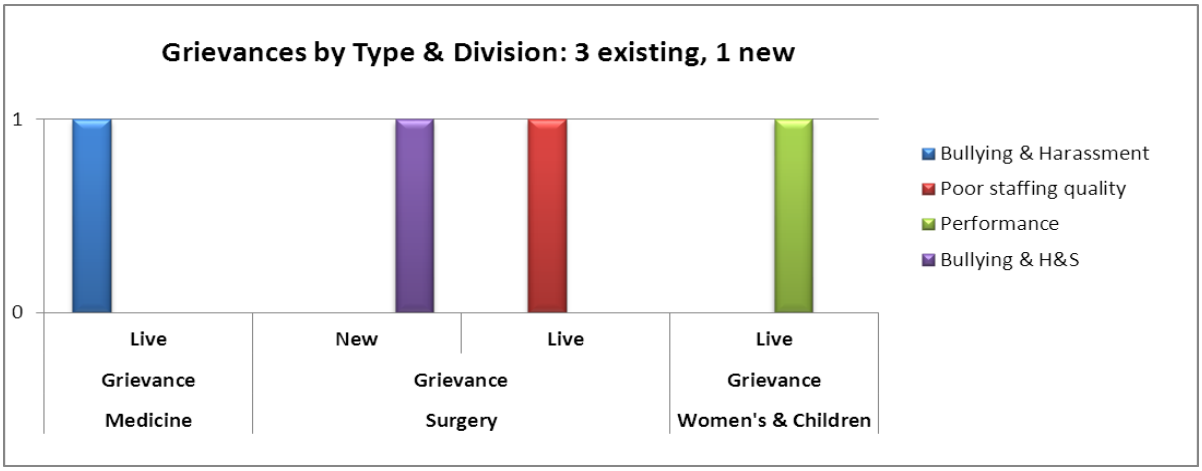




Suspensions

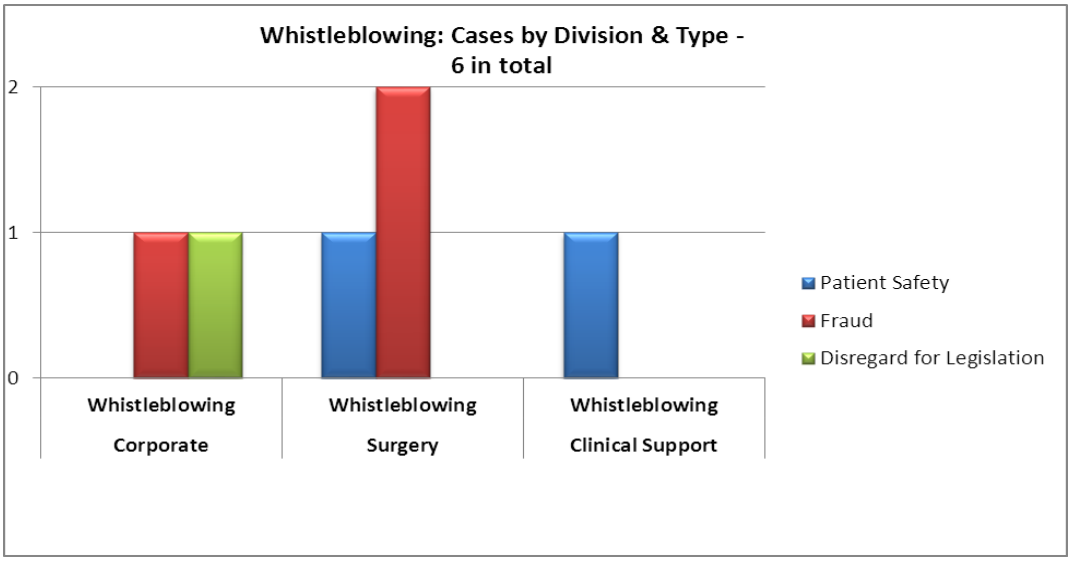
The total number of suspensions in February was four, which remains the same as January 2016; there was no in-month change. 3 suspensions remain open within the Medicine Division, with an on-going suspension within Corporate Services (Facilities). Neither Surgery nor Women's, Children's, Oncology and Haematology have any staff currently suspended.

CULTURE
Suspensions & Grievances



Grievances
Definition: Grievances are concerns, problems or complaints raised by an employee with management in relation to their working conditions or relationships with colleagues.

The total number of formal grievances across the Trust has increased in February to four from three, with a new grievance opening in Surgery. This new case, plus an ongoing grievance means Surgery have two cases. One grievance remains open within Women's Children's Oncology and Haematology; one remains open in Medicine

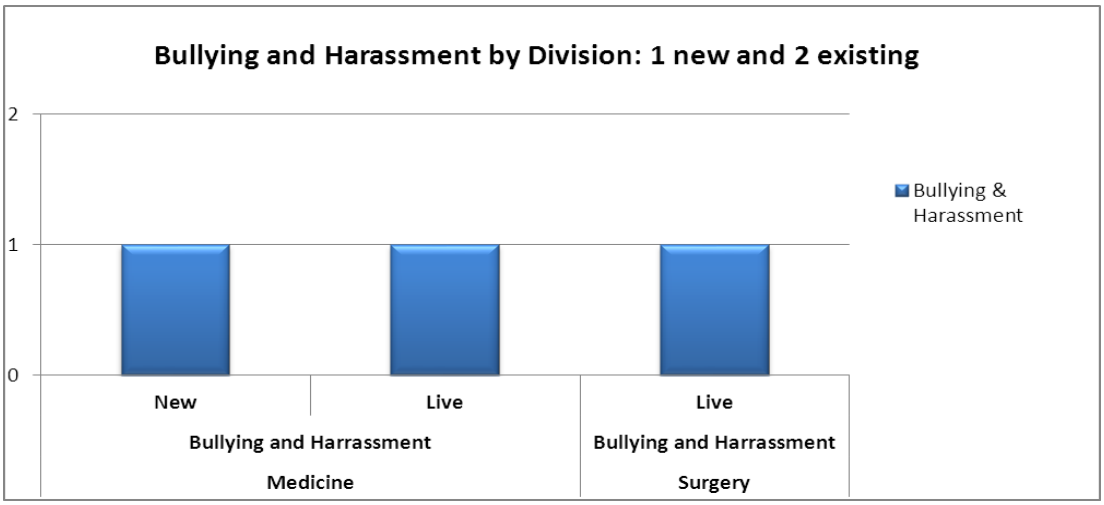


Whistleblowing:
Definition: When an employee raises a genuine concern they have with their employer about malpractice, patient safety, financial impropriety or any other serious risks they consider to be in the public interest.

In total, there are 6 whistleblowing cases within the Trust. There are three new whistleblowing cases in February 2016; one in Corporate and two enquiries have opened within the Surgery Division, these are within General Surgery Directorate and the Anaesthetics, Critical Care and Theatres Directorate. In addition to the new cases in Surgery, there is an existing whistleblowing enquiry that opened in December 2015 in Trauma and Orthopaedics and the internal inquiry and audit has commenced. Surgery have a total of 3 whistleblowing enquiries. The whistleblowing case within Clinical Support Services which opened in September 2015 remains open and the internal enquiry is continuing. The existing Corporate whistleblowing case is still ongoing and an enquiry has commenced for the new case.

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

CULTURE
Suspensions & Grievances



Bullying & Harassment

Definitions:

Bullying
Bullying may be characterised as offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means that undermine, humiliate, denigrate or injure the recipient.

Harassment
Harassment as defined in the Equality Act 2010 is unwanted conduct related to a relevant protected characteristic, which has the purpose or effect of violating an individual's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for that individual.

There are a total of three bullying and harassment cases within the Trust. February 2016 has seen some in-month changes relating to bullying and harassment cases. Medicine has seen one case closed, but a new case open, totalling two cases. There continues to be one ongoing case within Surgery. There are no cases within the other divisions or Corporate Services.

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**31 March 2016**

Title of the Report	Clinical Collaboration & Healthier Northamptonshire Update
Agenda item	**12**
Presenter of Report	Chris Pallot, Director of Strategy & Partnerships
Author(s) of Report	Chris Pallot, Director of Strategy & Partnerships
Purpose	To provide and update on the Healthier Northamptonshire programme
Executive summary The purpose of this paper is to brief the Board on the current position of the Healthier Northamptonshire programme.	
Related strategic aim and corporate objective	
Risk and assurance	No
Related Board Assurance Framework entries	2.2
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (N) 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

Enclosure H

	good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper: No
Actions required by the Trust Board The Board is asked to note the update.	

Healthier Northamptonshire and Clinical Collaboration with Kettering General Hospital

Progress Update

1. Introduction

This paper provides a summary of progress to date with the delivery of the Healthier Northamptonshire and Clinical Collaboration Programmes.

The section on Healthier Northamptonshire is identical to that presented at the CCG Governing Bodies. The clinical collaboration aspect has been present to the KGH Trust Management Committee.

2. Healthier Northamptonshire

In light of the Delivering the Forward View NHS planning guidance 2016/17 – 2020/21 the Healthier Northamptonshire Programme is being aligned and refocused to ensure that it is fit for purpose and is geared to meet the national requirements.

The NHS Planning Guidance 2016/2017 – 2021/21, issued on 22nd December 2015 sets out a new approach to ensure that health and social care organisations work together to produce local transformational plans that make delivery of the Five Year Forward View a reality – delivering the triple aim – better health, transformed quality of care delivery and sustainable finances. Guidance states that NHS organisations should produce two separate but interconnected plans.

1. A local health and care system Sustainability and Transformation Plan (STP), covering the period October 2016 to March 2021 – this will ensure acceleration on the implementation of the Forward View and
2. A plan by organisations for 2016/17, which will need to reflect the emerging Sustainability and Transformation Plan. This will be regarded as year one of the five year Sustainability and Transformation Plan. These will need to be agreed by the NHS England and the NHS Improvement Board and based on local contracts that must be signed by March 2016.

The full Sustainability and Transformation Plan must be submitted by the end of June 2016.

There is a great deal of work to do and the focus of the Implementation Steering Group discussions on 5th January was around how the Healthier Northamptonshire programme will be reconfigured to deliver the place-based plan that is needed for the system. There was agreement that the implementation of the planning guidance will require a redefinition of the challenge and different approaches as there will be fundamental shifts in the way services are planned.

System Leaders met on the 27th January and agreed the geographical scope of the Sustainable Transformation Plan to be Northamptonshire, whilst recognising the need to reflect the differential needs of the GP federations and Super practice to be central to this process. This proposal has been submitted to NHS England.

It is recognised a successful Sustainability and Transformation Plan will depend on having an open, engaging and iterative process that involves clinicians, patients, carers, citizens and local community partners involved the independent and voluntary sectors and local government through health and well-being boards.

We are waiting for further guidance to be to be issued this month but planning has begun to develop the programme of work required and how this will be managed.

This represents an opportunity for the Health Economy to build on with what has been done to date and develop a fully integrated plan across all organisations with the potential to access central transformation funds.

3. Clinical Collaboration

This work commenced as part of the Healthier Northamptonshire Programme the overarching objective being to "prove the concept" that the two Trusts could work in partnership. This was approved by the two Trust Boards, clinical commissioners and the regulators in 2014 through the proof of concept document that has now been developed further.

The clinical services identified for the first cohort to clinically collaborate were:

- Rheumatology
- Orthopaedics
- Radiology
- Ophthalmology

In addition, in view of the work already commenced on joint working, cardiology was also included. Furthermore, work to review dermatology services has been in progress for some time, led by the clinical commissioners and therefore this service has been included in the clinical collaboration programme in order to complete and implement draft proposals.

3.1 Existing partnership working

The clinical collaboration programme builds on existing joint working between KGH and NGH. Examples are listed below:

- Stroke Pathway
- Vascular Pathway
- Interventional radiology
- Ear, Nose and Throat
- Ophthalmology
- Cardiology
- Clinical Oncology

Our existing shared services have tended to be using the lead provider model and currently there is no consistent approach to monitoring patient outcomes, experience or shared governance. It is believed that this needs to evolve as our partnership grows, where services become truly unified then it makes sense to standardise other processes around them.

3.2 Progress to date

There has been good engagement from the clinicians for many of the work programmes. In some there is a need to be clear on expectations with regard to the work that is needed and to support delivery of the new models of care.

Below is a brief summary of progress made for each of the services.

Rheumatology

- A business development proposal is now complete and has been submitted to the commissioners.
- The working group remains in place and is committed to support the development of the detailed implementation plan.

Orthopaedics

- A business development proposal is now complete and has been submitted to the commissioners.
- A strategy meeting between the two organisations has been organised for executive leads scheduled for 10th March to discuss further development of this work.

Radiology

- Joint countywide direct ultrasound referral criteria finalised.
- GP clinical engagement forums in both the north and south of county have been organised
- New countywide direct ultrasound referral criteria disseminated to GP practices for full implementation by April 2016.
- GP clinical engagement forum dates being scheduled in May for feedback following implementation of guidance.
- Plans for further service alignments have been discussed at a joint meeting with the commissioners held in February
- Full referral data set awaited from Corby CCG to enable identification of anticipated avoided activity from implementation of aligned ultrasound guidance.

Ophthalmology

- Progress has been slow in terms of implementing any changes and there has been difficulty in establishing an agreed shared model. Discussions with other partners in the GP Federations have presented additional opportunities for collaboration that are soon to be fully explored.

Cardiology

- There have been a number of meetings resulting in the development of proposed shared pathways. However, in order to establish a consistent foundations for these pathways across Northamptonshire KGH and NGH put forward a service development bid to the CCG to establish heart failure services out of hospital. Whilst NGH had their bid approved and are now working to implement, KGH did not. There have been several meetings and conversations with the commissioners to conclude this. We are now proposing to develop the model to proceed pending the decision by the CCG

Dermatology

- A proposed shared service model has been further refined
- Awaiting full commissioner activity data set to inform activity modelling
- The working group continue to meet regularly and has a membership across acute and primary care
- A clinical subject matter expert contribution to core work stream established
- Action plan progressing to support business proposal development
- There is a GP engagement workshop planned for 23rd March with good intended attendance so far.
- Patient engagement forums are planned for 20 and 27 April 2016

3.3 Governance

The two Chief Executives jointly chair the Clinical Collaboration Steering Board (CCSB) which meets monthly. The agenda for this group has been the implementation of the Healthier Northamptonshire (HN) Clinical Collaborative programme.

Board to Board meetings have been held and there is clear commitment to continue to progress collaboration between the two organisations.

A memorandum of understanding is in place alongside an Information Sharing Agreement.

There is a Task & Finish group developing a shared governance framework to take account of the management, monitoring and assurance required for quality, regulation and workforce. It is anticipated this will be presented in April 2016.

A proposal financial and contractual framework has been drafted by the Finance Directors. This will be presented at the next CCSB for approval.

Trust legal advisors have supported the development of a proposal for the Business Model to support Clinical Collaboration taking into consideration KGH being a FT and NGH being a NHS Trust. It is likely that we will progress with a federation model because it is believed this is the easiest model to adopt that will facilitate delivery of the change that we need to make.

In order to strengthen relationships, operational management and clinical leadership of this work, it is recommended that a version of a joint HMT be established to meet every 6 weeks. This will enable both organisations to consider in more detail joint working across all existing and new pathways to ensure a consistent approach is taken for the whole portfolio and have some direct influence on pace. The views of HMT would be welcome in this regard but one of the key challenges we face is building mutual trust and support that go alongside the programmes of work that we need to deliver.

3.4 Commissioning

The Commissioners are engaged in this work but this is an area that needs to be strengthened to supporting delivery of the agreed pathways. GP Commissioners are involved in the service development groups and are influencing the creation of new shared models, including out of hospital aspects of patient pathways delivered by other partners.

The Commissioners recently announced the introduction of a new Planned Care Board that would consider clinical collaboration as well as other issues. This Board is yet to meet and there is concern that the approach to planned care may impact on the delivery of the Clinical Collaboration programme by taking a different approach. The CCG has however agreed to providing resource to the acute trusts to support clinical collaboration.

3.5 Communication and Engagement

There has been good engagement between clinicians and the multidisciplinary team for each of the services.

A number of engagement events for patients and GP's have been held which has influenced the service redesign.

Communication of the HN Programme has been coordinated by the HN Team at the CCG and has been limited. Whilst both KGH and NGH have continued to brief their teams and boards a joint statement and communication has yet to be commenced which is currently drafted for approval.

3.6 Conclusion

Some important foundations have been established as part of this programme, which provides both organisations with the opportunity to progress implementation with pace.

Next steps:

- Understand commissioner's position and plans going forward
- Establish joint 'HMT'
- Allocate resources to implement proposed models
- Communicate the scope and intent of Clinical Collaboration in order to assess opportunities at scale.

3.7 Recommendation

The Board is asked to note this update.

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**31st March 2016**

Title of the Report	**Emergency Preparedness, Resilience & Response Annual Report**
Agenda item	**13**
Presenter of the Report	Deborah Needham – Chief Operating Officer, Deputy Chief Executive
Author(s) of Report	Jeremy Meadows – Head of Resilience and Business Continuity
Purpose	For assurance/information/awareness.

Executive summary

As an acute provider of NHS Funded Care, the Trust is required to evidence appropriate planning and response mechanisms for a wide range of emergencies and business continuity incidents. These requirements are set out by the Civil Contingencies Act (CCA, 2004) and NHS England's Emergency Preparedness, Resilience and Response (EPRR) Framework 2015.

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

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? Strategic aim 1 – focus on quality and safety
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks (**Y**)
Related Board Assurance Framework entries	BAF – please enter BAF number(s)
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**)

Enclosure I

	Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? (**N**)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper (**N**)

Actions required by the Group

The Group is asked to:

- To note the contents of this paper.

NHS Preparedness for a Major Incident

1. Introduction

This paper provides a report on the Trust's emergency preparedness in order to meet the requirements of the Civil Contingencies Act (CCA, 2004) and the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework 2015.

Emergency Preparedness, Resilience and Response is key to ensuring that the Trust is able to respond to a variety of incidents whilst continuing to provide its essential services. The Civil Contingencies Act outlines a clear set of roles and responsibilities for those involved in emergency preparedness and response at the local level. As a category one responder, the Trust is subject to the following civil protection duties:

- Assess the risk of emergencies occurring and use this to inform contingency planning
- Put in place emergency plans.
- Put in place business continuity management arrangements.
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency.
- Share information with other local responders to enhance co-ordination.
- Co-operate with other local responders to enhance co-ordination and efficiency.

The Civil Contingencies Act places a legal duty on responders to undertake risk assessments and publish risks in a Community Risk Register. The purpose of the Community Risk Register is to reassure the community that the risk of potential hazards has been assessed, and that preparation arrangements are undertaken and response plans exist. Those risks currently identified on Northamptonshire's Local Resilience Forum Community Risk Register with a rating of very high include:

- Influenza-type disease
- Fuel shortages
- Countywide Loss of Electricity
- Local accident involving transport of hazardous materials.

The EPRR activities at Northampton General Hospital are made up of two distinct but closely linked work streams:

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

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

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

The Trust has a suite of plans to deal with Major Incidents and Business Continuity issues. These conform to the CCA (2004) and current NHS-wide guidance. All plans have been developed in consultation with regional stakeholders to ensure cohesion with their plans.
The purpose of this annual report is to provide the organisation with an update on the delivery of EPRR activities within the Trust during 2015/16, providing assurance that the Trust is meeting its statutory EPRR duties. This report provides an overview of the plans that have been reviewed, the multi-agency partnership that the Trust has been involved in, and the training and exercises that

Trust staff have participated in. This report also gives a summary of instances in which the Trust has had to respond to extraordinary circumstances.

2. Planning

2.1 Planning Priorities

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

- Major Incident Planning, Training and Exercising
- Chemical, Biological, Radiological incident preparedness, Training and Exercising.
- Business Continuity development and training

2.2 Resilience Planning Group

The Trust has a Resilience Planning Group that meets bi-monthly. All standing members of the group are required to attend 4 of the 6 meetings held each financial year and not be absent for two consecutive meetings without the permission of the chair of the group.

The group includes representation from all areas within the Trust and other Directors and Officers of the Trust may be asked to attend at the request of the Chair. External partner agencies will be invited if there are specific agenda items that require multi-health partner involvement.

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

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

- Ensuring that the Trust is compliant with the requirements of the Civil Contingencies Act 2004.
- Ensuring that the Trust can satisfy the requirements of external standards, legislation and statutory requirements.
- Ensuring that the Trust is engaged at a strategic, tactical and operational level with National, Regional and local health and multi-agency resilience agendas specifically: Local Health Resilience Partnership, Northamptonshire Local Resilience Forum and its sub-groups.
- Ensuring appropriate Trust input via operational and resilience routes into multi-agency plans, procedures and policies.
- Ensuring that the Trust has a robust and tested Major Incident Plan in place and that staff have been trained in their roles.
- Ensuring that the Trust has a range of emergency plans in place to respond to specific emergency situations such as Pandemic Influenza, Communicable Disease Outbreaks, Mass Casualty and CBRN.
- Ensuring that staff are trained to an appropriate level with respect to role and function in an emergency situation.
- Ensuring that the Trust and all of its Directorates have robust Business Continuity Management Plans in place which would enable the continued delivery of key services even whilst responding to an emergency.
- Ensuring that all Divisions are involved in the emergency planning and resilience agenda and that updates, potential risks and new initiatives are shared with respective management teams.
- To provide a forum to exchange information, and promote good practice in emergency planning across the Trust.

3. Core Standards Submission 2015 – 2016.

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

- Fully compliant
- Partially compliant
- Non-compliant

The following table provides an overview of the Trust's position against the Core Standards which is described through a series of 46 criteria:

Theme	Number of Criteria	Compliance Level		% of Overall Compliance
Governance	4	Fully	4	100%
		Partial	-	
		Non-Compliant	-	
Duty to assess risk	3	Fully	2	66.6%
		Partial	1	
		Non-Compliant	-	
Duty to maintain plans – emergency plans and business continuity plans	20	Fully	12	60%
		Partial	8	
		Non-Compliant	-	
Command and Control (C2)	7	Fully	3	43%
		Partial	4	
		Non-Compliant	-	
Duty to communicate with the public	2	Fully	2	100%
		Partial	-	
		Non-Compliant	-	
Information Sharing – mandatory requirements	1	Fully	1	100%
		Partial	-	
		Non-Compliant	-	
Co-operation	5	Fully	5	100%
		Partial	-	
		Non-Compliant	-	
Training and Exercising	4	Fully	1	25%
		Partial	3	
		Non-Compliant	-	

On the basis of the self-assessment process carried out by the Trust, the decision was made to declare an overall rating of substantially compliant which is an acceptable position with 65% (up on 60% 2014-15) of all criteria being fully compliant. The definitions of full, substantial, partial and non-compliance are included below for awareness.

Compliance Level	Evaluation and Testing Conclusion
Full	The plans and work programme in place appropriately address all the core standards that the organisation is expected to achieve.
Substantial	The plans and work programme in place do not appropriately address one or more the core standard that the organisation is expected to achieve.
Partial	The plans and work programme in place do not adequately address multiple core standard that the organisation is expected to achieve.
Non-compliant	The plans and work programme in place do not appropriately address several core standard that the organisation is expected to achieve.

There are 4 main areas that are partially compliant with a brief overview of each area below:

Duty to assess risk: Within this section, the key area which remains partially compliant is the process to ensure that the risk assessments are shared with relevant partners. Whilst internal sharing takes place via the Resilience Planning Group on a bi-monthly basis, there is a requirement for the Trust to adopt a clear process to share information with the Northampton health economy and with other relevant agencies.

Duty to maintain plans – emergency plans and business continuity plans: The main area that remains partially compliant is the level of Business Continuity Planning carried out within the Trust. A large piece of work has taken place this year through the introduction of new templates to meet the ISO 22301:2012 standard now employed by the NHS, and ensuring all areas have undertaken a Business Impact Analysis and have a robust Business Continuity Response Plan in place. Many of these, however, require ratification by the appropriate departmental governance committees and will subsequently require a programme of training and exercising.

As part of the yearly update requirements, all other plans are being reviewed and updated to take into account the latest guidance.
Command and Control (C2): The main area that remains partially compliant is ensuring all staff fulfilling incident management roles have received appropriate training and are maintaining an appropriate CPD portfolio. Director and senior management training requires aligning to the National Occupational Standards for major incidents and business continuity planning. Training plans are being developed to address this shortfall, and training will follow a rolling 12 month cycle.

Training and Exercising: This area remains partially compliant as the Trust is currently reviewing and updating all of the training and exercising requirements to ensure appropriate level of training for all staff at all levels within the Trust. The Trust will work with EMAS to provide training in order to support the response required to a HAZMAT or CBRN incident.

The assurance panel agreed that substantially compliant was justified. A full report into their findings is expected and will be shared in due course.

4. Audits

The TIAA undertook an audit of the resilience function in September 2015. Following detailed testing, the overall assessment was of reasonable assurance, with no urgent action points highlighted. The two important action points related to the Terms of Reference for the Resilience Planning Group and the number of outstanding Business Continuity Plans. Both items have been addressed through the Resilience Planning, and Assurance, Risk and Compliance Groups.

The Review of Resilience Responsibilities Arrangements report is attached for awareness.
Appendix 1.

5. Policy

5.1 Major Incident Policy

This policy details the Trust's action in the event of an external major incident (e.g., an air disaster, rail crash, flooding, or a terrorist attack). Such an event will require the hospital to employ a different method of working in order to manage the situation. The policy is supplemented with unit-level plans that detail the actions required of individual units to ensure that the corporate plan is achieved.

5.2 Business Continuity Management Policy

Business Continuity Management is a management process that helps to manage the risks to the smooth running of an organisation or delivery of a service, ensuring that the business can continue in the event of a disruption. These risks can be from an external environment (e.g., power failures or severe weather) or from within an organisation (e.g., systems failures or loss of key staff). A business continuity event is any incident requiring the implementation of special arrangements within an NHS organisation in order to maintain or restore services. For NHS organisations, there may be a long 'tail' to an emergency event, e.g., loss of facilities provision of services to patients injured or affected in the event, etc.

The policy is comprised of a corporate-level policy and supported by service-level plans. These service level plans detail what would be required for the service to continue; which less-critical services or functions could be suspended and for how long in order to maintain critical services; which other services are required for that service to function; and which services rely on that service being operational.

6. Testing and Exercising

During 2015/16, the Trust has been, and is due to be involved in a number of external multi-agency exercises.

Whenever possible, the Trust strives to ensure that our testing is held in a multi-agency context. This is to provide familiarisation with other organisations and to assist with benchmarking our response with our partners. Exercises provide invaluable insight into the operationalisation of our plans and important information regarding the areas of the plans that require further development.

6.1 Exercise Harris

In October 2014, the Trust ran Exercise Harris, a live exercise to test the hospitals internal and external interoperability with players from Northamptonshire Healthcare Economy. The objectives were;

- To validate individual provider and commissioner response plans for an incident in Northamptonshire.
- To assess the interoperability of each provider and commissioner during an incident within Northamptonshire.

A debrief was undertaken, the report is attached for information **Appendix 2.**

6.2 Pandemic Influenza Exercise – 07/08/2015

The Head of Resilience attended a Local Resilience Forum (LRF) run Exercise Birdsong on the 7th October with colleagues from Site Management and Infection Control in order to test the Trust's Pandemic Influenza Plan and to comply with the 'Deep Dive' section of this years Core Standards. Learning from this exercise prompted minor amendments to the Trust's Pandemic Influenza Plan.

6.3 Exercise Cygnus

Exercise Cygnus is a national Pandemic Influenza Exercise being led by PHE and the Department for Communities and Local Government (DCLG). Northamptonshire LRF have agreed to be part of the exercise and have agreed to run a Strategic Coordinating Group. The NHS will be represented by Gold Commanders from the CCG and NHS England.

To support this element of the exercise and recognising the severe impact a pandemic would have on the health and social care economy, the CCG intend to run a Health Economy Tactical Coordinating Group exercise to test the management of a potential influx of patients. Exercise Cygnus was scheduled for 26th and 27th April, however this has been postponed until the autumn due to the proposed Junior Doctors Industrial Action.

6.4 Live Events

During 2015/16, NGH experienced a number of live incidents. These are detailed below:

- **Ebola:**

Ebola virus disease (EVD) is a Category 4 viral haemorrhagic fever (VHF). A fast evolving outbreak of EVD in West Africa was first reported in March 2014. Despite the expectation that the outbreak would be brought under control, at the end of May 2014 there was a surge in the number of new cases and the outbreak spread in previously unaffected areas.

As a result of the emerging threat, guidance was circulated internally and staff were instructed to remain vigilant for travellers who had visited the areas affected by VHF and developed unexplained illness.

In August 2014, the World Health Organisation declared the outbreak a public health emergency of international concern under the International Health Regulations (2005). National operation guidance was cascaded to Senior Clinicians.

The Trust established an Ebola Preparedness Working Group chaired by the Deputy Chief Operating Officer. Reporting to the Risk Group, the group oversaw coordination and management of operational readiness in anticipation of suspected or confirmed EVD cases attending NGH, together with learning from workshops, training, exercises and best practice.

Occupational Health advice and guidance was developed for healthcare workers called upon to work with patients with VHF in any setting and healthcare workers and students returning from countries affected.

The Head of Resilience developed an overarching Ebola Preparedness Summary and VHF Management Procedure in consultation with the Ebola Preparedness Working Group and approved by the Executive Team. The document formed part of the EPRR Framework and supports NGH to be as well prepared as possible to safely deal with patients presenting with a high index of suspicion or confirmed EVD in NGH.

All key areas identified within the planning process (Accident & Emergency, Paediatrics and Critical Care) underwent a rigorous process of training and exercising to ensure that they were ready to respond to any potential situation.

EVD plans and procedures were thoroughly tested, following a live drill and the attendance of a suspected patient in January 2015. The patient was a returning health care worker, however, although a low possibility required sampling and testing. The patient tested negative for EVD.

The World Health Organisation has declared the end of the outbreak in Liberia and says all known chains of transmission have been stopped in West Africa.

The Ebola Preparedness Working Group has since been disbanded and any issues are raised at the Infection Prevention Sub-Committee.

- **Symphony Outage**

The Symphony System is used in the Emergency Department, Emergency Assessment Unit, Benham Ward, Eye Casualty, the Operations Centre, and is accessed by staff throughout the Trust.

The Symphony System started experiencing intermittent problems on Wednesday 4th March, rendering it unusable anywhere from 30 seconds to 10 minutes. The Trust's Information Technology Department were notified and contacted Ascribe, the supplier of Symphony.

The issue appeared to be resolved, however, over the next few days the issue continued intermittently. This behaviour deemed it very difficult to diagnose the root cause of the issue.

Tuesday 10th March: The problem was becoming more frequent. The head of Resilience liaised with the Deputy Director of Information Technology on the actions being taken to find a resolution. At this stage, it was agreed the issue was not local, i.e. not resolvable by NGH. Ascribe eliminated possible causes but were still having difficulty identifying the root of the issue.

Thursday 12th March: After extensive investigation, there were several factors causing the system to run slow and freeze, date and time logs on site confirmed these. Acsribe then focused on resolving the issue.

To update staff on the issue, all Clinical and Nursing Managers were asked to attend the Huddle at 14:30.

The Symphony System was taken down for a number of hours, at which point Business Continuity Plans were instigated, this involved departments taking screenshots from Symphony and recording patient activity manually.

Symphony was later bought back online, and staff undertook phased data entry to minimise any further loss of information. The application has remained fully functional and a report detailing the full route cause was requested by Information Technology. Early indication suggested problems with messaging and data tables being overloaded causing the system to freeze.

The issues contributed to a large number of breaches for the week 9th – 15th March.

- **Brackmills**

On 30th September NGH ED received a telephone call from EMAS informing of seven people who had been found in the back of a lorry in Brackmills Industrial Estate complaining of chest pains and cough. The patients were unable to speak English so their country of origin was not known, therefore Ebola could not be ruled out. Due to the possibility of the Trust declaring a significant incident, ED was cleared due to the potential for a large number of casualties. Additional staff were called in and those in attendance donned PPE as per the Ebola algorithm.

Patients were still being held at the scene, however PHE colleagues were now in attendance to advise EMAS. The EMAS Hazardous Area Response Team were also at the scene, querying MERS. Samples were taken at the scene by PHE.

There was suggestion that there were more patients within the lorry, in a poorer condition and therefore unable to make themselves known. This later proved to be incorrect. One patient was received in ED later that evening and was treated by staff in full Ebola PPE. They were discharged the following day. The MERS flowchart has since been circulated to ED.

- **Industrial Action**

Since December 2015, Junior Doctors have taken part in a number of days of national industrial action in a long-running dispute with the Government over pay and conditions. Extensive contingency planning was undertaken in order to provide the safe continuation of all essential services. To provide a coordinated response and escalation of any unexpected event or operational pressures, Hospital Control Teams (Silver and Gold Commands) were established for each period of industrial action. Membership of the group included Senior Operational Directors, Divisional Managers, Human Resources, Communications, Facilities and Resilience.

The Trust engaged with the Trade Unions to identify and agree the definition of emergency cover within the Trust to secure safe emergency care to patients throughout the periods of industrial action.

Whilst it was necessary to re-schedule some non-urgent activity, due to successful engagement with Trade Unions and contingency planning, disruption to patient care was kept to a minimum and all patients were kept safe during all periods of industrial action.

The debrief report following January's period of action is attached for awareness. **Appendix 3.**

- **Debriefing from Live Events and Exercises**

Following live events and exercises, debriefs are undertaken in order to capture learning points. Lessons identified from live events and exercises are subsequently incorporated into major incident plans and business continuity plans, and also shared with partner organisations.

7. Recommendations

The Board is asked to note the contents of this paper and the assurance that it provides to support the ongoing work of the Resilience Planning Group and Trust's resilience function.

8. Next steps

The Emergency Planning and Business Continuity Programme has undergone a complete transformation over the past 5 years and has drastically improved the Trust's capabilities to plan for and respond to a Major Incident or failure in business continuity.

The areas highlighted as partially compliant will determine the Emergency Planning and Business Continuity Work Plan for 2016. The key areas that will be prioritised within the next 12 months will be CBRN, Major and Internal Significant Incident Planning and Training & Exercising.

The past year has seen good developments in the Trust's resilience arrangements; however, more work is required at the service level to achieve full resilience.

INTERNAL AUDIT

tiaa

Northampton General Hospital NHS Trust

Review of Resilience Responsibilities Arrangements

2015/16

FINAL

November 2015

Enclosure I

Review of Resilience Responsibilities Arrangements

Executive Summary

OVERALL ASSURANCE ASSESSMENT

KEY FINDINGS

- **Local engagement at the Resilience Planning Group (RPG) requires improvement.**
- **Business Continuity Plans (BCPs) are not all completed, despite extension of the Trust's deadline and local follow-up action being taken. Responsibilities may need re-assigning, or resource released from non-urgent activities to enable prompt completion.**
- **BCPs were not being signed-off by the responsible Director in accordance with Trust Policy.**
- **BCPs do not consistently demonstrate consultation with relevant staff.**
- **Final plans had not been uploaded to the intranet. Out of date versions were available which may cause confusion.**

SCOPE

The Chief Operating Officer requested this review focuses on compliance with ensuring: emergency response plans (Major Incident plans); and robust Business Continuity Management arrangements are in place; and that monitoring and reporting mechanisms used to provide assurance to any delegated group or directly to the Board were reviewed. Findings were compared with NHS England Core Standards for EPRR, where appropriate.

Detailed testing was undertaken on a sample basis only and the review does not provide any guarantee over the appropriateness of the arrangements to respond to the multitude of un-planned events which may impact upon its activities. The review did not undertake to perform any 'test' of plans in place and did not include a detailed review of all NHS England Core Standards for EPRR, pandemic influenza, Hazardous materials (HAZMAT) and Chemical, Biological, Radiological and Nuclear (CBRN) response.

ACTION POINTS

Urgent	Important	Routine	Operational
0	2	3	1

Management Action Plan - Priority 1, 2 and 3 Recommendations

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
2	Compliance	The Resilience Planning Group Terms of Reference (TOR) require attendance from all Clinical Directorates and a minimum 40% of members for a meeting to be quorate (approx. 10 members); however only eight representatives attended in August 2015. Testing also identified that representatives from the Human Resources and IT departments have not attended the past three consecutive meetings. Regular non-attendance is not currently managed. Lack of engagement may compromise local resilience arrangements.	The quoracy and management of regular non-attendance (e.g. escalation to senior management and identifying suitable deputies) be reviewed by the Resilience Planning Group	2	*Agreed. RPG to review TOR, including the number of members required and whether divisional representation is acceptable to retain quorum and implementation of process to escalate non-attendance to senior management.*	*25/11/2015*	*Head of Resilience & Business Continuity*
3	Compliance	At the time of the review five Business Continuity Plans remained outstanding, despite extension of the Trust's deadline and local follow-up action	Management be requested to account for outstanding Business Continuity Plans at the next RPG. Prompt resolution may require local	2	*Agreed. This will be taken forward at the next RPG meeting.*	*25/11/2015*	*Head of Resilience & Business Continuity*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
		being taken. Non-completion of BCPs has been acknowledged by the Trust as an ongoing concern and the Trust's deadline has now been extended to December 2015. This has also been recorded as a red rated risk on the Resilience Risk Register, and Corporate Risk Register (Risk OP773, Datix system).	management to re-assign this to other leads, or release of resource from other, non-urgent activities.				
1	Directed	A BCP monitoring list is maintained centrally which records the current status, relevant lead and whether further support is required. This document does have limitations as the dates of plans are not included and it was noted that it has been added to during the year to reflect further departments that needed a BCP. Separate records were also being maintained to capture and update details of leads, contact numbers, Business Impact Analysis and BCP status and dates of training and exercising. Using a more comprehensive, consolidated master schedule would be more efficient and provide more robust monitoring and	One master schedule be used to record and monitor key BCP information.	3	*Agreed. One overall record will be used.*	*31/10/2015*	*Head of Resilience & Business Continuity*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
		assurance at a glance. A template is available which has been used in the past, and is pre-populated with areas therefore also mitigates against the risk of plans not being completed where needed.					
4	Compliance	NHS Core Standards 'evidence of assurance' includes the ability to provide evidence of an approval process for EPRR plans and documents. Section 7.4.5 of the Trust's Business Continuity Management policy requires BCPs to be agreed by the responsible Director; however this was not taking place. Review by local governing groups is stated within the Trust's EPRR self-assessment; however, this it is understood that arrangements are not in place for all areas. Evidence of local group approval had not been provided for the draft plans sampled. Of the two BCPs in final form, the Pharmacy BCPs had been agreed by	BCPs be signed-off by the responsible Director in accordance with Trust Policy, or alternative delegated authority be implemented	3	*Trust requirements for the approval of BCPs will be discussed at the RPG.*	*24/11/2015*	*Head of Resilience & Business Continuity*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
		the Senior Pharmacy Management group. The former Head of Resilience quality checked the Oncology, Haematology and Cancer Services BCP.					
5	Compliance	A list of contributors to plans is evidence of assurance for NHS Core Standards. The section for contributors to be recorded on the front of Trust BCPs is not being completed, therefore it is not clear if relevant staff have been consulted with for appropriate input and review.	BCP contributors be recorded on plans to demonstrate consultation with relevant staff.	3	*Agreed. BCPs which do not state contributors will be identified at the draft review stage and queried with leads.*	*31/10/2015*	*Head of Resilience & Business Continuity*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Operational Effectiveness Matters

Ref	Risk Area	Item	Management Comments
1	Compliance	Final plans be uploaded onto the intranet and out of dates versions removed to avoid confusion.	*Head of Resilience & Business Continuity:* *Agreed. Plans will be uploaded following approval.*

ADVISORY NOTE

Operational Effectiveness Matters need to be considered as part of management review of procedures, rather than on a one-by-one basis

Detailed Findings

INTRODUCTION

1. This review was carried out in October 2015 as part of the planned internal audit work for 2015/16. Based on the work carried out an overall assessment of the overall adequacy of the arrangements to mitigate the key control risk areas is provided in the Executive Summary.

KEY FINDINGS & ACTION POINTS

2. The key control and operational practice findings that need to be addressed in order to strengthen the control environment are set out in the Management and Operational Effectiveness Action Plans. Recommendations for improvements should be assessed for their full impact before they are implemented.

SCOPE AND LIMITATIONS OF THE REVIEW

3. The Trust has specific responsibilities under the Civil Contingencies Act and EPRR requirements as a Category 1 responder. The Chief Operating Officer has requested that this review focuses on compliance with the following civil protection duties at Corporate and Departmental level:

   - Having emergency response plans in place (Major Incident plans); and
   - Having robust Business Continuity Management arrangements in place.

4. The audit also reviewed the monitoring and reporting mechanisms used to provide assurance to any delegated group or directly to the Board. Findings were compared with NHS England Core Standards for EPRR where appropriate

5. The scope of this audit was limited to the areas identified above and detailed testing was undertaken on a sample basis only.

6. The review is not intended to provide any guarantee over the appropriateness of the arrangements to respond to the multitude of un-planned events which may impact upon its activities. TIAA did not undertake to perform any 'test' of plans in place.

7. This audit does not include a detailed review of all NHS England Core Standards for EPRR, pandemic influenza, Hazardous materials (HAZMAT) and Chemical, Biological, Radiological and Nuclear (CBRN) response.

8. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan.

MATERIALITY

9. The Trust is legally required to plan for, and respond to, potential incidents and emergencies that could affect health or patient care.

10. The Civil Contingencies Act (2004) establishes a clear set of roles and responsibilities for those involved in emergency preparedness and response. NHS organisations are required to demonstrate that they can manage incidents (Major Incident Planning) whilst maintaining service resilience (Business Continuity).

11. This programme of work is referred to in the health community as Emergency Preparedness, Resilience and Response (EPRR) Arrangements. EPRR form some of the changes to the health system in England made by the Health and Social Care Act (2012).

DISCLAIMER

12. The matters raised in this report are only those that came to the attention of the auditor during the course of the internal audit review and are not necessarily a comprehensive statement of all the weaknesses that exist or all the improvements that might be made. This report has been prepared solely for management's use and must not be recited or referred to in whole or in part to third parties without our prior written consent. No responsibility to any third party is accepted as the report has not been prepared, and is not intended, for any other purpose. TIAA neither owes nor accepts any duty of care to any other party who may receive this report and specifically disclaims any liability for loss, damage or expense of whatsoever nature, which is caused by their reliance on our report.

RISK AREA ASSURANCE ASSESSMENTS

13. The definitions of the assurance assessments are:

Substantial Assurance	Based upon our findings there is a robust series of suitably designed internal controls in place upon which the organisation relies to manage the risk of failure of the continuous and effective achievement of the objectives of the process, which at the time of our review were being consistently applied.
Reasonable Assurance	Based upon our findings there is a series of controls in place, however there are potential risks that they may not be sufficient to ensure that the individual objectives of the process are achieved in a continuous and effective manner. Improvements are required to enhance the adequacy and effectiveness of the controls to mitigate these risks.
Limited Assurance	Based upon our findings the controls in place are not sufficient to ensure that the organisation can rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Significant improvements are required to improve the adequacy and effectiveness of the controls.
No Assurance	Based upon our findings there is a fundamental breakdown or absence of core internal controls such that the organisation cannot rely upon them to manage the risks to the continuous and effective achievement the objectives of the process. Immediate action is required to improve the adequacy and effectiveness of controls.

ACKNOWLEDGEMENT

14. We would like to thank staff for their co-operation and assistance during the course of our work.

RELEASE OF REPORT

15. The table (Figure 1) below sets out the history of this report.

Figure 1 - Report History

Date draft report issued:	26th October 2015
Date management responses received:	9th November 2015
Date final report issued:	9th November 2015

16. The following matters were identified in reviewing the Key Risk Control Objective:

Directed Risk: Failure to direct the process through approved policy & procedures.

16.1 Overarching Emergency Preparedness and Resilience and Business Continuity Management policies are in place and were identified to be current. Responsibilities for key roles and general duties for all staff are outlined within policies. The Trust's Accountable Emergency Officer is the Chief Operating Officer overall responsibility delegated on behalf of the Chief Executive for all Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Management.

16.2 Supporting policies for specific topics have been developed that are managed and monitored via a register and revisions to out of date policies for Command Control and Communications and the Control Room to reflect the changes (from Human Resources back to the Operations Centre) were due for completion by November 2015. Policies are circulated to peers for comment in relation to where a joint local response to an event may be required. The Human Resources department is responsible for the Managing Industrial Action procedure, and it was identified that this contains links to the activation of Business Continuity Plans.

16.3 It was confirmed that a self-assessment against NHS England Core Standards for EPRR has been completed and an assurance report was provided to the Trust Board in September 2015. Overall compliance has improved since last year from 60% to 65% and it was noted that there were no non-compliances. Actions have been identified to address partially compliant areas and were progressing within timescales. Priority was being given to key areas such as internal planning, training and exercising. Full compliance with EPRR Core Standards is expected by September 2016.

16.4 The annual EPRR assurance process between the Trust and NHS England was taking place during the audit (October 2015) with an annual report to the Board to follow.

16.5 It was identified that the Trust has a local resilience risk register in place which is in accordance with NHS England Core Standards for EPRR duties. This is maintained by the Head of Resilience & Business Continuity who also attends the Trust Risk Committee. Risk register entries and scoring were recently revised to ensure they are relevant (October 2015).

16.6 A monitoring and reporting structure for EPRR is in place. The Trust has established a delegated governing forum, the Resilience Planning Group (RPG) which meets on a bi-monthly basis to oversee Trust arrangements. This is chaired by the Deputy Chief Operating Officer and reports to the Assurance, Risk and Compliance Group, Quality Governance Committee, and in turn to the Trust Board. Terms of Reference for the RPG were updated and approved by the Assurance, Risk and Compliance Group in June 2015.

16.7 A Local Health Resilience Partnership is also attended by the Accountable Emergency Officer. This group includes other local responders and partner agencies and is setup to share information, enhance co-ordination and efficiency. A shared electronic space 'Resilience Direct' was being adopted to make information, such as updated policies and plans, available within the local health economy and to other relevant agencies.

16.8 A Corporate Business Continuity Response Plan is in place and Trust policy requires supporting local plans for certain key activities (emergency, elective, maternity, diagnostic and support services and Therapeutic Services). It was noted that further prioritisation via the identification of critical services was being progressed by the Head of Resilience & Business Continuity.

16.9 All completed Business Continuity Plans (BCPs) require quality control review by the Head of Resilience & Business Continuity and example BCP guidance has been circulated to leads. A BCP monitoring list is maintained centrally which records the current status, relevant lead and whether further support is required. However, this document does have limitations as the dates of plans are not included and it was noted that it has been added to during the year to reflect further departments that needed a BCP.

16.10 Separate records were also being maintained to capture and update details of leads, contact numbers, Business Impact Analysis and BCP status and dates of training and exercising. Using a more comprehensive, consolidated master schedule would be more efficient and provide more robust monitoring and assurance at a glance. A template is available which has been used in the past, and is pre-populated with areas therefore also mitigates against the risk of plans not being completed where needed.

Recommendation: 1	Priority: 3
One master schedule be used to record and monitor key information.	

16.11 A new Trust-wide Major Incident Plan was in draft at the time of the audit, for review by the Procedural Document Group by November 2015 (NGH-PL-683). This has been re-written in order to have one overall plan with appended action cards for key Trust-wide roles. The existing Trust policy requirement for detailed Major Incident (MI) plans for A&E and Theatres is now superseded. It was also noted that the separate A&E MI plan that was updated and reported to the RPG in July 2015 is being consolidated within and Theatres arrangements have been appended.

16.12 Plan completion is monitored by the RPG and a process for escalating outstanding plans to the Deputy Chief Operating Officer is in place.

16.13 Training requirements are outlined within Trust policies. Resilience training has recently been included within the Trust's induction arrangements. A stand is manned by the Head of Resilience & Business Continuity that attendees visit, following recent streamlining of the Trust's statutory and mandatory training programme.

Compliance Risk: Failure to comply with approved policy and procedure leads to potential losses.

16.14 It was confirmed that RPG meetings took place in May and August 2015 (the July meeting was postponed) during 2015/16 to date. Terms of Reference (TOR) require bi-monthly meetings to take place and members to attend from all Clinical Directorates. A minimum of 40% attendance is required for a meeting to be quorate (10 members); however only eight representatives attended in August 2015. Discussions with the Head of Resilience & Business Continuity highlighted that TOR need revising to allow for overall Divisional level representation instead, which is acceptable subject to mechanisms to feedback to Directorates.

16.15 Testing on RPG attendance also identified that representatives from the Human Resources and IT departments have not attended the past three consecutive meetings. It was identified that regular non-attendance is not currently managed. Lack of engagement may compromise the adequacy of local resilience arrangements.

Recommendation: 2	Priority: 2
The quoracy and management of regular non-attendance (e.g. escalation to senior management and identifying suitable deputies) be reviewed by the Resilience Planning Group	

16.16 The Trust's BCP log covers plans at Corporate and departmental level. Records are risk rated to demonstrate whether plans are in place and up to date (R/A/G). The completion of BCPs has been monitored at each RPG meeting this year; however it was noted the effectiveness of monitoring has been undermined due to no attendance by certain departments (e.g. IT).

16.17 An extension to the final deadline for completing outstanding BCPs was granted by the Deputy Chief Operating Officer, moving this from May to 14th September 2015. Escalation of outstanding plans and follow-up by the Deputy Chief Operating Officer was evident during the course of the year (evidenced for May and July 2015). Follow-up has involved notifications to Senior Management, e.g. Deputy Directors, Divisional and Directorate Managers. Progress was being made and documents had been provided from three areas during the audit. Five BCPs remained outstanding for the following reasons as at 20th October 2015:

1. Radiology (escalated to Divisional Manager, lead to complete by end October 2015).
2. General Surgery (escalated to Divisional Manager, being reviewed by Directorate Manager).
3. Head & Neck (delayed due to operational pressures, may need to be reassigned).
4. I.T (no response or evidence provided, although plans understood to be in place during discussions earlier in the year, escalated to COO, also no departmental attendance at the RPG (see Recommendation 2 above)).
5. Nuclear Medicine (escalated to Divisional Manager, Service Manager delegated to more appropriate local lead, guidance provided).

16.18 Non-completion of BCPs has been acknowledged by the Trust as an ongoing concern. The Trust's deadline is now December 2015. This has also been recorded as a red rated risk on the Resilience Risk Register, and Corporate Risk Register (Risk OP773, Datix system).

Recommendation: 3	Priority: 2
Management be requested to account for outstanding Business Continuity Plans at the next RPG. Prompt resolution may require local management to re-assign this to other leads, or release of resource from other, non-urgent activities.	

16.19 Review of the intranet identified an out of date Corporate BCP and a MI plan for Theatres dated 2010. Current plans have not been uploaded yet. The Head of Resilience & Business Continuity was to see if the Corporate BCP is still required, or can be merged into the general BCM policy.

Operational Effectiveness Matter: 1
The intranet be updated with final plans and out of dates versions removed to avoid confusion.

16.20 Audit testing highlighted that only two updated BCPs were at final stage as at 8th October 2015 (Pharmacy and Oncology, Haematology and Cancer Services) and a further 14 draft plans have been submitted for checking. A sample of five Business Impact Assessments and associated BCPs were selected for audit testing (the two final versions and three randomly selected drafts for Therapies, Corporate and Nursing Services and Trauma and Orthopaedics). Review against key policy requirements with the Head of Resilience & Business Continuity confirmed these were reasonably documented, adhered to the Trust's template, and details were provided in required fields, such as leads and maximum tolerable periods of disruption. Priorities had been assessed, with mitigations and actions identified for further resilience. Minor areas for improvement identified on draft plans were being taken forward by the Head of Resilience as part of the local quality review process.

16.21 NHS Core Standards evidence of assurance includes *'the ability to provide evidence of an approval process for EPRR plans and documents*'. Section 7.4.5 of the Trust's Business Continuity Management policy requires BCPs to be agreed by the responsible Director; however this was not taking place. Review by local governing groups is stated within the Trust's EPRR self-assessment; however, it is understood that arrangements are not in place for all areas. Evidence of local group approval had not been provided for the draft plans sampled. Of the two BCPs in final form, the Pharmacy BCPs had been agreed by the Senior Pharmacy Management group. The former Head of Resilience quality checked the Oncology, Haematology and Cancer Services BCP.

Recommendation: 4	Priority: 3
BCPs be signed-off by the responsible Director in accordance with Trust Policy, or alternative delegated authority be implemented.	

16.22 A list of contributors to plans is also evidence of assurance for NHS Core Standards. The section for contributors to be recorded on the front of Trust BCPs was not being completed consistently, therefore it is not clear if relevant staff have been consulted with for appropriate input and review.

Recommendation: 5	Priority: 3
BCP contributors be recorded on plans to demonstrate consultation with relevant staff.	

16.23 It is important that key staff have received training, particularly for any new Executives or Senior Managers on the on-call rota (compulsory policy requirement). Trust Executives last attended 'Gold' level training provided by the CCG during sessions held in September and October 2015. Annual Strategic and Tactical senior manager training by the Local Resilience Forum is being scheduled, potentially after winter pressures. A local annual session for Executives is also scheduled for December 2015. The Head of Resilience & Business Continuity is made aware of new starters and updates contacts lists on a regular basis. Attendance lists are also maintained for the exercising of plans (evident for the last live exercise, 'Harris' in September 2014). It was noted that an annual table-top exercising was also being scheduled for spring 2016.

16.24 Bespoke guidance and informal training is provided in response to needs. Policies are circulated to managers to raise awareness regarding arising issues, such as adverse weather. Records of training provided are held on file.

Exercise Harris:
Northamptonshire Health Economy Major Incident Exercise

POST EXERCISE REPORT

October 2014

Author – Exercise Planning Team

Richard Jarvis CCG
Luke Martin NGH
Lissa Savage CCG
Mark Pape NHFT
Warren Owens KGH
Garry Mawby EMAS

Contents

Richard Jarvis CCG Lissa Savage CCG Warren Owens KGH
Luke Martin NGH Mark Pape NHFT Garry Mawby EMAS

Glossary

KGH	Kettering General Hospital Foundation Trust
NGH	Northampton General Hospital
NHFT	Northamptonshire Healthcare Foundation Trust
CCG	Clinical Commissioning Group
EMAS	East Midlands Ambulance Service
LHRP	Local Health Resilience Partnership
EPRR	Emergency Preparedness Resilience Response
HALO	Hospital Ambulance Liaison Officer
SitRep	Situation Report
ICC	Incident Coordination Centre
IMT	Incident Management Team
HCG	Health Coordinating Group
SCG	Strategic Coordinating Group

Richard Jarvis CCG
Luke Martin NGH
Lissa Savage CCG
Mark Pape NHFT
Warren Owens KGH
Garry Mawby EMAS

Purpose

This report sets out the background, conclusions and proposed recommendations from Exercise Harris. The intended audience for this report is Exercise Harris participants, planning team, executive team, emergency planners and responders. The aim is to provide an opportunity to discuss and implement the lessons identified from Exercise Harris. The document has been written by the Exercise Harris Planning Team. This document includes all recommendations from the exercise and will be presented to LHRP for their response.

Introduction

Exercise Harris was a half day 'live' exercise on October 3rd 2014 involving the Northamptonshire Health Economy using principles aligned to international best practice in Disaster Medicine. This is achieved by using a simulation system for testing, practising and developing a whole system medical response to major incidents. This system has been successfully used in the majority of English First-Responding hospitals i.e. EMERGO train exercise.

In order for the Acute Trusts to comply with the NHS Framework for EPRR (2013) they are required to run a live exercise every 3 years, as both trusts were coming to this cycle date it was agreed by LHRP that a county wide exercise should be undertaken.

The Exercise was 'live' for Northampton General Hospital (NGH), Kettering General Hospital (KGH) and NHS Nene CCG and NHS Corby CCG; Northamptonshire Healthcare Foundation Trust (NHFT) and East Midlands Ambulance Service (EMAS) played a scripted role. The players were required to cooperate, communicate and take decisions based on the resources available to them. In addition, the decisions taken had consequences for the situation of other participants.

The exercise ran in real-time and was modelled against the hospital(s) services profile. The exercise tested operational response, casualty management, hospital management and included aspects such as capacity creation and patient discharge. The exercise allowed for control rooms to be set up and feed into one another.

Exercise Aim

The aim of Exercise Harris was to enable both Acute Trusts to test their internal and external interoperability through a live exercise for the Acute Trust's and scripted play from Northamptosnhire Healthcare Economy. The objectives were;

- To validate individual provider and commissioner Response Plans for an incident in Northamptonshire.

- To assess the interoperability of each provider and commissioner during an incident within Northamptonshire.

Within this there were internal organisational specific Aims and Objectives

NHS Corby & NHS Nene Clinical Commissioning Group

- To test the activation and response processes of the Incident Coordination Centre and it's interaction between Strategic, Tactical and Operational Command Groups.
- To assess the Clinical Commissioning Group's role during a Major Incident and it's interactions with the Health Community within Northamptonshire.

Northampton General Hospital

- To exercise a limited Tactical and the A&E, Medicine Bed Holding and Surgical Operational teams within the Trust.
- To exercise interoperability between the Trust and Health Economy partners during a Major Incident Response.
- Additionally NGH wished to add to the exercise scenario: a VIP was travelling in the car that was involved in the collision. Operation Consort will be activated and exercised.

Kettering General Hospital

- To exercise Strategic, Tactical and Accident & Emergency teams along with a composite rest of hospital team
- To exercise interoperability between the Trust and Health Economy partners during a Major Incident Response.

Northamptonshire Healthcare NHS Foundation Trust

- To exercise a limited discharge function within each Acute Trust.

Exercise Scenario

The scenario presented to the participants at the start of the exercise was as follows

- Time now is 08:50 on Friday 3rd October
- A road traffic accident between two coaches on the A43 near Sywell Aerodrome has been reported. EMAS are on route to the scene and have placed a number of Acute Hospitals on Major Incident Standby (incl. NGH & KGH).

- Little information available at the moment
- A & E are aware

Shortly afterwards a METHANE was circulated to participants containing additional information that indicated approximately 60 casualties.

Exercise Planning Structure

The exercise planning team consisted of:

- Lissa Savage – NHS Nene & NHS Corby CCG's
- Luke Martin – Interim Head of Reslilience, Northampton General Hospital (NGH)
- Warren Owens – Resilience and Business Continuity Manager, Kettering General Hospital Foundation Trust (KGH)
- Mark Pape – Emergency Planning and Resilience Manager, Northamptonshire Health Foundation Trust (NHFT)
- Garry Mawby – Emergency Planning Manager, East Midlands Ambulance Service (EMAS)

Initially the scenario was to be based around two Lancaster Bombers colliding above Sywell Airfield, but this was quickly changed as this would not generate the number of casualties needed to create an effective exercise. The scenario was changed to a collision between two coaches on the A43 outside of Sywell Airfield. This location would enable casualties to be transported to both NGH and KGH. This scenario would also enable a realistic casualty list to be developed.

The Planning team agreed to meet weekly and meetings were to be focused on actions to be completed and exercise scenario / scoping document development. There were issues with the commitment to the meetings leading to confusion over exercise scenario and time lines of actions which meant planning time was lost. The planning team, in the early stages, did not function due to internal conflicts of opinion and how the exercise and scenario should develop, This was leading to planning meetings been poorly attended which led to a difficult working environment. Due to this the exercise Manager took the decision to narrow down the planning group to ensure that the meetings were more focussed on the LHRP action to run a live exercise for both NGH and KGH. Once the scenario had been agreed and work had begun on agreeing the casualty lists the planning team reverted back to its original formation.

The options for the location of the exercise were use of the training facilities in the Hydra Suite, Northamptonshire Fire and Rescue Service or organisations run the exercise using their Incident Coordinating Centres (ICC). The planning group decided to use the individual ICC as this would assist with allowing participants to experience using the facilities identified within their Incident Response Plans.

It was decided that the exercise would start from 'major incident declared' this enabling exercise play to start immediately as it was felt that if the exercise started from major incident standby there would be a lot of waiting around for the participants, in particular the Acute Trust Gold group and CCG IMT. With the exercise starting at major incident declared it allowed for the participants to hit the ground running and begin play immediately. This was felt to be the ideal scenario as it would avoid loss of engagement from players with the natural peaks and troughs which are encountered during incident response. It was agreed that no details of the exercise would be released prior to October 3rd.

For the basis of the exercise both Acute Trusts used the bed state of October 3rd 2013 as a baseline for current activity. It was agreed in the exercise scoping document that the exercise would only be cancelled / rescheduled in the event of one or both of the acutes declaring Black escalation status on October 2nd or the morning of October 3rd. It was also made clear that organisations should be ensuring their staffing is adequate to ensure day to day pressures can be dealt with whilst the exercise was in play. The decision to cancel or postpone the exercise could only be taken by joint discussion between the exercise director and the COOs from each Acute Trust.

Exercise Evaluation

The exercise was evaluated from direct observation of participants by experienced staff at each location during exercise play. The list of evaluators was scrutinised by the planning group to ensure that the appropriate people went to each location. This provided peer level review of the exercise and organisations. The evaluator's feedback has provided a basis for the development of the final exercise report.

Learning and outcomes from the exercise

The evaluators all agreed that the exercise aims and objectives were met. Those who took part identified some key areas of learning. This section looks specifically at what they identified during the exercise supported by the evidence captured during the exercise evaluation including debriefs held with participants.

For the purpose of this report the key learning points have been split into the following categories:

- Planning Group
- Command & Control
- Communication
- Resources
- Roles

- Partnership working

Exercise Summary

The feedback on the day and subsequently via the written responses was generally positive. It was accepted that both Acute Trust and the CCG had met the aims and objectives of the exercise, however there was a feeling communicated at both Trusts that the pressure created by the incident could have been increased to provide more challenging scenarios.

Based on the exercise it was agreed that the Major Incident Plans at both Acute Trusts and the Incident Response Plan at the CCG provides an effective basis for the efficient response to an incident. It was noted at KGH that the response to the scenario via both the Command and Control structure and A&E was controlled and effective with decisions being made in a timely manner and based on the unfolding scenario, something which has not been seen in previous exercises with the Trust. It was felt through the feedback received that the exercise was realistic with participants "forgetting it was an exercise' and becoming immersed in the scenario". Overall the exercise provided a great platform for roles to be tested and exercised in particularly the Loggist role, as this was the role which was highlighted as requiring further training from all organisations involved in the exercise.

NGH Deviation from Exercise Scope

There were issues during the exercise of deviation from the agreed exercise scope causing confusion and impacting on timings. These included requests from outside of the exercise scope which caused problems during the exercise. For example a HALO was requested which was outside of the scope of the exercise or discussed on the MEL. However a HALO would be requested as part of the major incident response for the Trust, so whilst not explicitly detailed in the Scoping Document or MEL, requesting a HALO followed the process for major incident response, this can be identified as a key learning point for future exercises to ensure that EMAS are fully prepared for a HALO request during the exercise.

The addition of the VIP at NGH caused issues and bled into the exercise play. It was made clear throughout the planning of the exercise that VIP's would not be tested. NGH wished to test their Operation Consort Plans so it was agreed that this would be done outside the remit of the exercise to avoid confusion. Unfortunately Operation Consort plans were allowed to bleed into the main exercise by the exercise staff at NGH. As it was out of scope this required resources and time spent on something which was not to be tested. It was noted by evaluators at NGH that the inclusion of Operation Consort led to injects appearing which felt like they had been created at the time rather than in a planned, considered manner, however the inclusion of the VIP was always a part of the NGH specific planning for the exercise so was planned and prepared in advance of the exercise play, the confusion was due to it bleeding into main exercise play. The inclusion of the VIP has provided some valuable learning points for NGH to implement in further exercises and proved a valuable inclusion for the Trust.

Organisational Issues identified during exercise play

NGH

- Management and leadership of the teams were confused.The evaluating team noted that there was a period of time at the beginning where Medicine had nobody overseeing them and Surgery appeared to be lacking leadership.
- Feedback suggests that the staff were excellent and knew their field well, however the teams appeared disjointed – departments were unclear of who wards belonged to which led to patients being handed over to Surgery when they were Medical.
- Feedback suggests that Exercise Harris was a series of independent exercises taking part at the same time as opposed to a joint up coordinated exercise.
- It was noted that NGH were experiencing internal pressure on the day of the exercise so the decision was made internally to scale back the participation to ensure the ability of the trust to manage the operational issues beingexperienced.
    - As a result of this action there was a reduction in operational players within the Medicine & Surgery groups and led to the amalgamation of certain teams which would normally operate independently; Surgery, Critical Care and Theatres, these services were joint up for the purpose of the exercise due to pressures internally leading to reduction of players.
- Outside of exercise scope NGH added in a full tactical team which oversaw the running of the exercise from the Trust's Incident Coordination Centre providing additional expertise to the exercise allowing for internal review of that level of Command and Control which resulted in valuable lessons identified for the Trust. To this end there were some operational issues identified by evaluatorswhich have been fed back internally and incorporated into the Trusts Major Incident planning and response capabilities.

KGH

- It was observed during exercise play and noted in the post exercise hot debrief that the communications between NGH and KGH were extremely limited during exercise play. It was identified that there needs to be much closer working between the two Acute Trusts; regular communications and planning need to be taking place between the Trusts to ensure the most effective response to any incident is provided to patients. (See point 6 for CCG issues identified)
- A future exercise in conjunction with NGH should be planned and run to involve all levels of Command and Control and to test the inter-trust communication and multi-health response.

- There was a lack of full understanding of the Major Incident Plan and its more detailed contents causing challenges to arise, which had the Major Incident Advisor role not been able to address could have resulted in a response markedly different to that set out in the plan. It has been identified that it is essential for the Trust to develop a rolling training programme to maintain a working knowledge of the plan and individual roles in its delivery. The greatest concern highlighted at both Acute Trusts and CCG focussed on communication and Command and Control across the wider health economy. There was no communication with KGH Gold Command by the CCG and only 2 calls into the Hospital Control Team. This resulted in KGH operating in a vacuum with no real understanding of a communication strategy, county wide response and multi-agency priorities.

- A centralised SitRep template is required so providers are able to deliver information to the HCG/CCG in a standardised and agreed format.

CCG

- There was a lack of equipment such a spider phone, laptops, flip chart etc in the CCG ICC These items were missed and hindered the progress and flow in the ICC.
- There was an issue with staff not remaining in the ICC during telephone conversations meaning other IMT staff were not privy to this information which impacted on the situational awareness.
- There appeared to be little attention paid to the Action Cards and the Incident Response Plan during the exercise.
- An issue arose with contact telephone numbers for providers which caused problems with contacting partners and arranging teleconferences etc.
- The 'newness' of the IMT roles in the CCG created problems and highlighted further training requirements, whilst this was an element of the exercise that didn't go well it had provided some valuable feedback for the CCG to implement in further training sessions with IMT staff, in particularly the Loggist and ICC Manager role.
- It was observed during exercise play and noted in the post exercise hot debrief that there was ineffieicencies of overall Command and Control, the CCG failing to convene a HCG as this would be where communication between the two acutes would take place.

- An issue was with the exercise beginning at 'major incident declared' was raised as this felt to be 'un-realistic' and prevented certain areas of incident response not being exercised. It was felt that had the exercise began with 'major incident declared' as it would do in a live incident staff would have been better prepared to deal with the incident and the exercise would have flowed easier, it was also felt that if this was to happen some of the pit falls that were identified may not have occurred as there would have been time to iron out the issues in the build-up prior to 'major incident declared'.

Executive Summary of recommendations

This Executive Summary of recommendations provides an overview of the main learning points identified during the Exercise and the de-brief process. Many of the learning points are generic although some are more specific relating to particular organisations which once resolved will benefit the wider health economy. There is no criticism of any individual organisation / person within this report and its findings should be viewed as a constructive development activity and a way to develop a robust training and exercising action plan.

- **Planning Group**
    - The planning group contributed to the production of a practical exercise, however there was disruption caused by the addition of elements outside of scope of the exercise thus prolonging the planning schedule to the point of almost non-delivery.
    - Specifically exercise planning is the opportunity to develop a robust exercise and have a detailed walk through for how the exercise will run on the day to ensure that all potential pinch points are resolved ahead of the exercise, due to disruption to planning meetings, lack of attendance, conflicting information and the addition of out of scope elements the planning group was hindered and prolonged the planning

Recommendation Ensure that all further exercise planning is structured. The planning group members, meetings and frequency of meetings are confirmed at the beginning and ALL to adhere to the schedule. Planning meetings to be action focussed allowing for time to thoroughly run through the exercise to tease out any issues.

- **Command and Control of a County Wide Health Major Incident**
    - It was apparent during the exercise that there were issues re: command and control, particularly between Acute Trusts and the CCG – no knowledge within Trust as to the actions being taken across the health economy

** Recommendation ** Ensure that Command and control is tested and exercised more frequently pan county response, yearly multi health exercise to test command and Control systems.

- **Communications issues**
    - It became clear during the exercise that communication was a key issue – the use of certain communication tools (mobile phones instead of spider phones) made it difficult for messages to be understood clearly – poor reception.
    - Communication and engagement between organisations particularly the CCG and Acute Trusts where there was a lack of liaising with each other meant the exercise didn't feel 'joint' in that respect;
    - There was no standard SitRep template making it unclear what information was expected from the CCG when requested.

Recommendation Ensure that ICCs are equipped with the relevant equipment's, phones, spider phones etc. to avoid bad reception issues.

Recommendation Ensure that a standard generic health SitRep Template is developed and shared across the health economy for use in a major incident.

Recommendation More frequent multi health exercises to test the communication internally and across the health economy

** Recommendation** Undertake a Health Coordinating Group Exercise

- **Resources for major incident response**
    - Lack of adequate resources was a theme across the exercise debriefs, the CCG in particular require resources for their ICC to be fit for purpose.

Recommendation Ensure that each organisation has adequate resources in ICC(s) and A&E etc.

- **Clarity on staff roles during a major incident – in particularly the role of the loggist**.
    - It was clear during the exercise and from the de-briefs that the roles of staff were ambiguous and unclear at some stages.
    - The role of the loggist was raised across both Acute Trusts and the CCG which has identified that further training is needed.

Recommendation Further internal training on major incident roles within the Acute Trusts and CCG ensuring that internal exercising is taking place to ensure that the roles are liaising and working together effectively – clarity on responsibility and accountability.

Recommendation Further training on the role of the Loggist – clarity on what is expected of that role and how the role works in incident response – internal training and exercising to ensure those trained are both competent and confident in the role.

Recommendation Ensure all actions cards are explicit and detail ALL critical actions that must be undertaken by the individual role.

- **Involvement of all partners**
    - It was noted during the exercise that certain key 'players' were missing from the exercise and exercise planning, notably NSL.

Recommendation to ensure that all pan health exercises in future involve ALL health partners including NSL, NCC Health & Social Care and NHS 111.

Conclusion

In conclusion Exercise Harris provided an ideal platform for Incident Management Response roles to be tested in their setting using a realistic scenario with real patient figures from the previous year. The exercise has given some valuable lessons identified to push through in further training and exercising for all partners, alongside with valuable lessons for implementation county wide.

All lessons identified and recommendations from this report and the internal reports undertaken from partners will be implemented into an action plan. The LHRP will oversee this action plan ensuring that all actions are undertaken. The CCG will gain assurance from the Acute Trusts that all Major Incident Plans are robust and training and exercising timetables are adhered to.

Appendix A

Key:	✓	= Completed/On-track	⏳	= On-going/On track	✗	= Not completed/Off plan	

Action No.	Action	Responsibility	Deadline	Completed	Comments
1	All further exercises to have a robust and clear planning strategy which is structured and agreed by all partners at the initial exercise planning stage.	*LHRP Sub-Group*			
2	Command & Control to be tested and exercised more frequently for a pan county response, as a minimum yearly multi health agency exercise to test Command & Control systems	*Richard Jarvis*			
3	Frequent multi health exercises to test internal and across health economy communication.	*LHRP Sub-Group*			
4	All organisations have the adequate / appropriate equipment needed for incident response in ICC(s) and A&E. • Lockable storage unit housing relevant plans & action cards, Loggist books. • Flipcharts – pens – whiteboard markers • Maps • Spider phone • Laptop(s) • List of providers • Medical equipment	*Richard Jarvis* *Luke Martin* *Jamie Tomalin* *Mark Pape*			
5	Create a standard generic SitRep for use by all partners in the event of an incident, this to be shared across the health economy, utilising the existing NHS standard SitRep including specific information request sections.	*LHRP Sub-Group*			

6	Arrange a Health Coordinating Group Exercise to test the communications through HCG to SCG	LHRP Sub-Group			
7	Further internal training on major incident roles within the Acute Trusts and CCG ensuring that internal exercising is taking place to confirm that the roles are liaising and working together effectively – clarity on responsibility and accountability.	*Richard Jarvis* *Luke Martin* *Jamie Tomalin* *Mark Pape*			
8	Clarity on the Loggist role and responsibilities during incident response, internal training across the health economy.	*Richard Jarvis* *Luke Martin* *Jamie Tomalin* *Mark Pape*			
9	Ensure that Action Cards in Major Incident Plans are explicit and detail ALL critical actions that must be undertaken by the individual role.	*Richard Jarvis* *Luke Martin* *Jamie Tomalin* *Mark Pape*			
10	All further pan health exercises involve all health partners including NSL, NCC Health & Social Care and NHS 111	*LHRP Sub-Group*			
Items will remain <u>at the top of the action list</u> until completed					

Appendix B

Northampton General Hospital NHS Trust

Exercise Harris Debrief Report

Luke Martin

Interim Head of Resilience

Northampton General Hospital

Executive Summary

The Civil Contingencies Act 2004 requires organisations to exercise their emergency response arrangements and to train their staff in operating those arrangements. In line with the NHS England Emergency Preparedness Framework 2013 Northampton General Hospital in conjunction with Kettering General Hospital were tasked to organise and run a live exercise to validate individual provider plans and interoperability between partners.

As part of this, there was a Command Post Exercise run by NHS Nene & NHS Corby Clinical Commissioning Group to exercise the Incident Coordination Centre and Incident Management Team and their interfaces with Northampton General Hospital.

The scenario used was a multi-coach road traffic collision during peak rush hour on the A43 between Kettering & Northampton near to Sywell Aerodrome and Hardwick Wood. An additional element for Northampton General was to test the activation plans for Operation Consort to validate planning assumptions within the Emergency Department and Trust wide for the response plans being developed.

On the day of the exercise the Trust was under significant internal pressures. To ensure safety in the hospital the exercise continued, with a scaled down attendance to ensure that where possible the objectives of the exercise were still able to be achieved.

Richard Jarvis CCG
Lissa Savage CCG
Warren Owens KGH
Luke Martin NGH
Mark Pape NHFT
Garry Mawby EMAS

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Background

The Trust was experiencing significant internal pressure on the day that the exercise was due to run, therefore the decision was made to scale back the participation where possible to ensure an appropriate mix of exercise participation and maximise the ability of the Trust to manage the operational issues being experienced at the time.

As a result, this did lead to a reduction in operational players within the Medicine and Surgery groups and the amalgamation of certain teams that would normally operate as their own independent entities. Alongside this, whilst out of scope for the exercise, there was a full Tactical team in Operation that oversaw the running of the exercise from the Trust's Incident Coordination Centre that provided additional expertise to the exercise and allowed an internal review of that level of Command and Control which resulted in some useful lessons learnt and suggestions for improvement.

As a result, there were some operational issues that will have been identified by the evaluators and whilst these lessons learnt will be taken into consideration and incorporated into the ongoing review of the Trust's Major Incident plans and response capabilities; there is an acceptance that the attendance within Medicine and Surgery for a live incident would be significantly higher.

Exercise Objectives

There were three organisational objectives that were to be tested as part of the live table-top exercise:

- To exercise the A&E, Medicine Bed Holding and Surgical Operational teams within the Trust.
- To exercise interoperability between the Trust and Health Economy partners during a Major Incident Response.
- To test planning assumptions currently made for Operation Consort through an addition to the exercise scenario involving a VIP was travelling in the car that was involved in the collision.

Each of these objectives were established as a result of key needs resulting from the ongoing review of internal plans and the increased interoperability requirement for all internal teams within the Trust moving forwards; along with interoperability for all Health Partners and associated Category 1 responders within the Northamptonshire Health Economy.

As Northampton General Hospital had recently fully exercised Tactical and Strategic Teams during the recent industrial action, guidance was received from NHS England and NHS Nene Clinical Commissioning Group that these teams did not need to be exercised for this exercise.

Exercise Evaluation

Direct observation of participants at Northampton General Hospital during the exercise was used by experienced staff from partner agencies to provide a peer level review of the Trust's response plans in line with the stated objectives above.

The evaluator's feedback will form the basis of the exercise report, along with key points from the evaluation forms that have been received from the exercise participants.

Performance Evaluation

Trust wide

The Trust wide performance was evaluated by the following external subject matter experts:

- Pip Tomalin, Interim Head of EPRR, NHS England (Hertfordshire & South Midlands) Area Team
- Garry Mawby, Emergency Planning Manager, East Midlands Ambulance Service
- Julia Yates, Emergency Planner, Northamptonshire Police
- Nathan Steele, Joint Operations Team Sergeant, Northamptonshire Police

Learning Points & Key Issues

There was a noticeable lack of command and control arrangements in place, primarily due to the absence of a Strategic (Gold) Command & Control team. The Incident Coordination Centre was not evaluated as part of this exercise.

Due to the scenario lacking in appropriate realism there was a degree of dis-engagement by Accident & Emergency staff and an inappropriate attitude towards the exercise by a small number of staff.

It was identified that consideration should be given to making the patient triage more realistic for future exercises through the use trauma dolls to allow staff to practice clinical skills to obtain the patient-specific information, as this would provide a more appropriate level of realism.

The numbers and types of casualty were appropriate for the overarching scenario. However the Accident & Emergency staff managed to triage patients faster than they would in real time which may not have provided sufficient challenge.

Inclusion of Operation Consort appears to have been a late addition to the scenario. Initially this provided some useful challenge and learning opportunities; however, as time progressed, the value and reality of such a situation diminished.

To ensure effective testing of arrangements, all participating organisations should ensure resourcing and exercising at the same levels to ensure a realistic exercise.

During the hot debrief after the exercise comments made indicated that whilst departments did refer to and used their plans appropriately there were a number of areas to be addressed, these areas need to be incorporated into the Trust's Resilience Work plan.

As noted above, inter-organisation communication was extremely limited. Calls to exercise control for ambulance input from all levels were received but were few in number. Comments received regarding difficulties contacting participating organisations suggest that significant improvement is required.

Accident & Emergency

The Accident & Emergency Department were evaluated by Andy Kelly, Head of EPRR (Leicestershire & Lincolnshire Area), NHS England Area Team

Learning Points and Key Issues

- It was not clear that the Nurse Coordinator had a clear overview of nursing resource requirements as they were tied to a location and phone. If they were more mobile and went around with the Lead Consultant they would have a better view of what was going on and be able to plan ahead better.

- There is a lot of structure in the plan that relates to timing of meetings. Accident & Emergency may need to be more flexible in these timings, so such a structure may not actually help.

- When the Lead Consultant left to go to a Silver meeting, they took the Loggist with them. There was no handover to another member of staff, and no log to record a new Lead Consultant in.

- There are some practicalities to work though on what the Loggist actually does, and ensuring a constant clear leadership within the Department

- The input of patient details on Symphony seemed to be an issue; however this may be an exercise artefact but needs further analysis.

Medicine & Surgery Divisions

The Medicine & Surgery directorates were evaluated by Mark Gregory, Head Commissioning for Corby Clinical Commissioning Group.

Learning Points and Key Issues

The Silver level meeting was late starting primarily as a result of the A&E team attending the meeting late, these kept key personnel away from their respective teams for longer than was required.

There were duplicated messages being passed from teams into the Tactical team leading to confusion. At the outset there was one manager overseeing everything in Medicine, this caused challenges when attending Silver level meetings

Surgery appeared to be lacking in overall leadership, there were some excellent staff/individuals who clearly knew their field, however at times the team felt disjointed. Departments seemed unclear of who wards belonged to which led to patients being handed over to Surgery when in fact they were for Medicine.

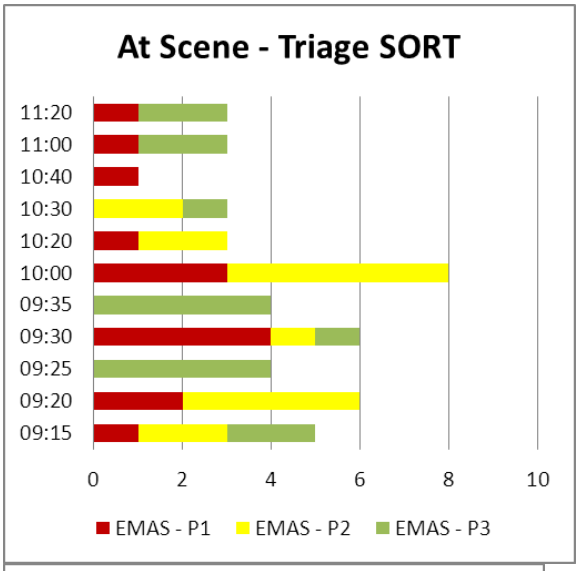
Casualty Regulation

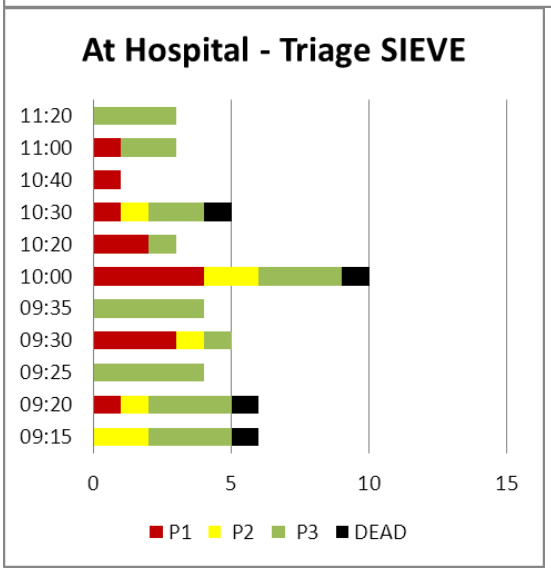
All patients included in the exercise were modelled around actual patient data provided from one of the Public Health England "Off the Shelf Exercises" and the symptoms manipulated to reflect the scenario developed during the planning process.

Whilst balancing the need for an appropriate level of Triage, with the forthcoming changes being proposed to manage patients from a major incident to ensure that the have the best possible care in the right place and at the right time, this will be an area

that will need to be reviewed over the forthcoming 12 to 18 months as things change within the wider health economy within Northamptonshire.

In the charts below there is a comparison between the Ambulance Service Triage Sort Criteria and the Triage Sieve applied by the Emergency Department upon handover.





From the data provided above there is a clear difference in the criteria applied at scene by the Ambulance Service and the criteria applied at the point of arrival within the Accident & Emergency Department by the Triage team within Accident & Emergency.

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Luke Martin NGH Mark Pape NHFT Garry Mawby EMAS

Whilst there is a need to balance speed versus the need for a rapid clinical assessment, there is a danger that patients who have a chance of survival may be triaged inappropriately because of lack of understanding of the triage processes used pre-hospital.

Triage Sieve & Triage Sort

Triage sieve is performed in the field by ambulance officers who first arrive at an incident. The priority in a triage sieve is to locate, triage and tag each casualty. The goal is to spend less than sixty seconds on any one casualty. During the triage sieve, only immediate life-saving treatment is provided (generally limited to clearing the airway or performing an airway manoeuvre).

Triage sort is performed by Senior Paramedics or Doctors with pre-hospital triage training at the triage gate, prior to treatment. In some cases, casualties with minor injuries may be directed away from the Casualty Clearing Point to a different area where they can receive first-aid, be interviewed by police or other investigators, and receive counselling.

Conclusions & Recommendations:

Accident & Emergency

As all patients that will come from scene will already have gone through both a Triage SIEVE and a Triage SORT process, the recommendation is that Accident & Emergency revisits the training and awareness regarding casualty triage and that the system used at the front door to Triage is reviewed in conjunction with East Midlands Ambulance Service to ensure a more joined up and smoother approach to the reception and management of patients at the front door.

The Accident & Emergency Department plan needs to be reviewed, ensuring that the plan is structured to allow for closer working between the nurse coordinator and the doctor in charge during the incident as there was no clear link between these two critical roles.

The evaluator's recommendation was that the Trust completes a separate Operation Consort exercise within Accident & Emergency to enable full validation and exercising of the plans. As the operation consort plan is still under development this will be picked up as part of the on-going work with Northamptonshire Police.

Further training needs to be undertaken with the Site Management Team and Accident and Emergency to clarify the major incident declaration process and how this is then represented within Symphony. Training was offered pre-exercise by the Clinical Systems team; however this was not taken advantage of by the required staff.

Medicine & Surgery

There was a lack of clarity about how patients were moving from Accident and Emergency into the specific wards within Medicine and Surgery during the exercise, this led to numerous patients being passed through to Medicine and Surgery halfway through the exercise. The links between all areas of the Trust should be reviewed to ensure that this does not happen during a live incident.

Overall it was felt that that the exercise ran as smoothly as it could have given the pressures within the wider trust. Staff seemed to thrive in their roles and coped with the ever changing circumstances as they rose, however the command and control structure needs to be reviewed to ensure maximum efficiency and appropriate senior manager availability for live incidents and future exercises.

Overall Conclusions

It was observed during the exercise and noted in the post-exercise hot debrief that communication between Northampton General Hospital and Kettering General Hospital during the exercise was extremely limited. There needs to be closer working and regular communications and updates to be taking place between the Acute Trusts to ensure the most effective response is provided to patients.

It was recommended that in conjunction with Kettering General a future exercise is planned and run to involve all levels of command and control and to test inter-trust communication and a multi-health response to ensure that an appropriate response will be provided in the event on a real incident occurring.

To ensure effective testing of arrangements, the Trust should also ensure appropriate resourcing and exercising at the same levels as other Health Economy partners for all future exercises.

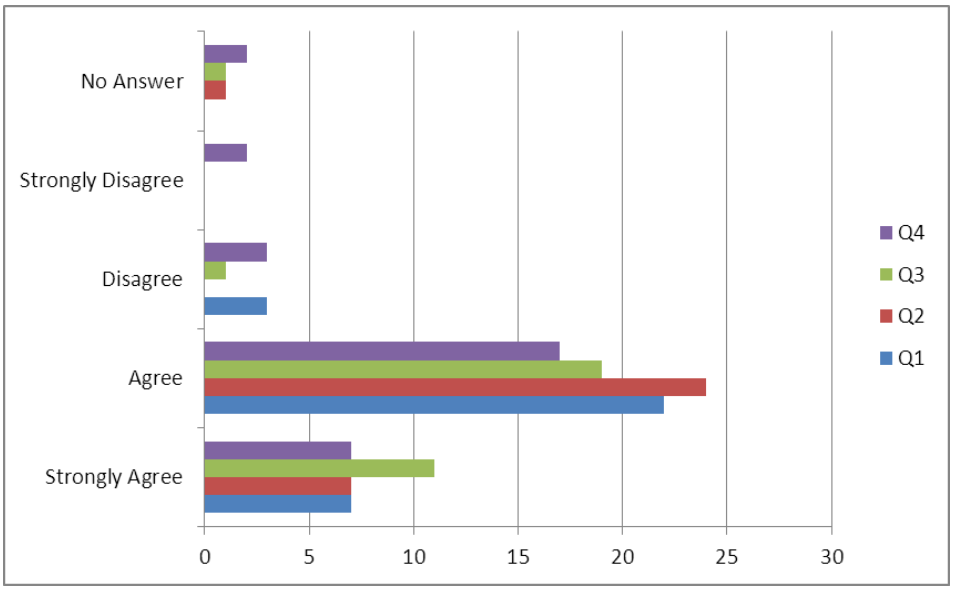
Participant Feedback

All participants were asked to rate the exercise based on four questions using the criteria of Strongly Agree; Agree; Disagree or Strongly Disagree. A total of 33 replies were received back from the 45 participants in the exercise.

From the chart below the overall response from the internal self-assessment from those participants who replied was that the exercise had an overall positive outcome with the main themes that needed improvement being highlighted as reviewing current plans and updating them; ICT and Telephony issues; lack of command and control input (this was due to the constraints on the Trust due to the Operational requirements) and the need to clarify the requirements of Operation Consort and EMAS transfers.

The questions that were used for the internal participant self-evaluation of the exercise were as follows:

- Question 1: Do you think that the exercise achieved the stated aim given in the exercise briefing?
- Question 2: Do you think that the scenario allowed for "live play" and generated good discussions?
- Question 3: Do you think that the exercise generated important issues and identified useful lessons and learning points?
- Question 4: Do you think that the exercise allowed your team to identify improvements to your major incident plan and how you would operate during a live incident?



Action Plan

As a result of the exercise, the learning points identified will be carried forward and incorporated into the Trust's Resilience Work Plan and have formed part of the Trust's Core Standards Self-Assessment criteria submitted to NHS England for 2014-2015.

Each area will receive support from the Emergency Planning and Business Continuity Team within the Trust to ensure that all plans are reviewed and updated and any necessary additions or amendments are made in line with current best practice.

As the Trust is currently undergoing a change in the management structure, moving towards being a clinically lead organisation, the Command & Control arrangements are currently undergoing review and consultation with the new structure due to be implemented in the first quarter of 2015.

Planning is currently at the early stages for a combined exercise across both Acute Providers in conjunction with other Health Economy partners, with a potential date for the exercise in quarter 3 2016.

Appendix C

Exercise Harris:
Northants Health Economy Major Incident Exercise

KGH POST EXERCISE REPORT

October 2014

Richard Jarvis CCG
Luke Martin NGH
Lissa Savage CCG
Mark Pape NHFT
Warren Owens KGH
Garry Mawby EMAS

Contents

Richard Jarvis CCG Lissa Savage CCG Warren Owens KGH
Luke Martin NGH Mark Pape NHFT Garry Mawby EMAS

Introduction

In order to validate the revised KGH Major Incident Plan, and also bring the Trust into compliance with its statutory duty to conduct a live exercise of its Major Incident Plan every 3 years the Trust, along with Northampton General Hospital (NGH), Northamptonshire Healthcare Foundation Trust (NHFT), EMAS and the Urgent Care Team from Nene CCG undertook Exercise Harris on Friday October 3rd 2014.

Exercise Harris was a 'live' exercise of the revised Trust Major Incident Plan utilising the Emergo Train System (ETS) which is widely used across acute Trusts in the UK.

Exercise Harris ran in real-time and was modelled against the hospital's services profile. The event tested operational response, casualty management, hospital management and includes aspects such as capacity creation and patient discharge.

ETS is a simulation system for testing, practising and developing a whole system medical response to major incidents. The system has been successfully used in the majority of English First-Responding hospitals. The players were required to cooperate, communicate and take decisions based on the resources available to them. In addition, the decisions taken had consequences for the situation of other participants.

This report relates to the KGH element of the exercise which focussed on the following aspects of a major incident response

- Internal Command & Control structure
- A & E response
- Capacity creation & patient discharge processes
- Communication links with local health economy partners

A formal feedback system to capture both the satisfactory outcomes from the exercise and areas for improvement was put in place.

This Post-exercise report will be circulated to Strategic Resilience Group, Trust Management Committee and Trust Board along with the wider exercise report incorporating input from other 'players'.

Exercise Aim

To validate the revised KGH Major Incident Plan, ensuring it is fit for purpose

Exercise Objectives

Generic objectives of an Emergo exercise are to enable attendees to

- Understand the need for clear communication.
- Appreciate the need for cooperation between all responding agencies and hospital departments.
- Understand the constraints imposed by limited resources in the immediate aftermath of an incident.
- Be aware of the consequences of decisions made in stressful situations.
- Recognise and understand the logistical difficulties of major incident management.

KGH's specific objectives for the exercise were

- **To evaluate the effectiveness of the KGH Major Incident Plan with specific focus on**:-
  - Major Incident Command & Control arrangements with particular focus on the Hospital Control Team and the Strategic Command
  - KGH's ability to manage staffing and capacity requirements to enable the receipt of major incident related casualties
  - Arrangements for the discharging of patients in order to create capacity
  - Identifying changes / improvements required to the Major Incident Plan and Action cards
    - Identifying any required roles not considered in the current plan

- **To identify immediate and on-going Major Incident related training, exercising and communication requirements for KGH staff**

Exercise Outline

The exercise took place between 08:30hrs and 13:00hrs on Friday 3rd October in PWEC (Prince of Wales Education Centre) and the Glebe House Meeting Rooms. A total of 4 rooms were used during the exercise along with the Lecture Theatre. These represented

- A&E
- Hospital Control Team Office (Major Incident Room)
- Strategic Command
- Discharge Process

The exercise was run in real time. No details of the exercise scenario were released prior to the exercise.

For the purpose of the exercise actual hospital bed states, clinically stable numbers, theatre activity and staffing figures as on 3rd October 2013 were used as a baseline.

KGH exercise players were expected to assume the Major Incident role allocated to them and make decisions based on the unfolding scenario that would enable the Trust to respond effectively to the challenges presented. The Trust's Major Incident Plan was to form the basis of the response.

There was debrief session at the end of the exercise to capture key lessons identified by each department and identify improvements to the hospital's Major Incident Plan. The exercise was not designed to test any individual's abilities within their own profession, indeed for many participants it acted as a training session; it was designed to help the hospital to identify the strengths and weaknesses of the plan and to enable a positive but critical review of it.

Exercise Scenario

The scenario presented to the participants at the start of the exercise was as follows

- Time now is 08:50 on Friday 3rd October
- A road traffic accident between two coaches on the A43 near Sywell Aerodrome has been reported. EMAS are on route to the scene and have placed a number of Acute Hospitals on Major Incident Standby (incl. KGH).
- Little information available at the moment
- A & E are aware

Shortly afterwards a METHANE was circulated to participants containing additional information that indicated approximately 60 casualties. The METHANE form can be found at appendix B

Debriefing Process

All involved in the exercise were asked to provide feedback on the exercise including what they felt were satisfactory outcomes and any areas for improvement. This took the form of a 'hot debrief' immediately after the exercise with a further opportunity to provide feedback via email submission of an evaluation form in the week following the exercise.

Using the Feedback forms, this Post Exercise Report highlights the satisfactory outcomes and areas identified for improvement (sections 9 & 10).

A summary of the actions to be taken forward are listed in section 11.

Exercise Summary

The feedback both on the day and subsequently via written responses was generally positive. It was accepted that the objectives for the Trust had largely been met although there was a general feeling communicated that the pressure created by the incident could have been increased to provide more challenging scenarios for those involved (although it was pointed out that not all major incidents are a major as the title suggests!). Based on the exercise it was agreed that the Major Incident Plan provides an effective basis for the Trust response to a major incident.

The response to the scenario via both the Command & Control structure and A & E was controlled and effective with decisions being made in a timely manner and based on the unfolding scenario, something not seen in previous exercises within the Trust. As expected the lack of full understanding of the plan and its more detailed contents provided challenges which, had they not been addressed by the presence of the Major Incident Advisor role, could have resulted in a response markedly different to that set out in the plan. It is therefore essential that the Trust develops a rolling training programme to maintain a working knowledge of the plan and individuals roles in its delivery.

There are a number of issues for the Trust to address as the continuous improvement of the MIP proceeds over the coming period. These are set out in this document.

Of greater concern to those present was the element of the exercise focussed on communication and command & control across the wider local health economy. There was no communication with KGH Gold Command and only 2 calls into the Hospital Control Team. This resulted in the Trust operating in a vacuum with no understanding of communication strategy, county wide response and multi-agency priorities. In addition, the lack of an agreed SitRep template would have made it difficult for the CCG to identify the impact on providers and the process for swift discharge of clinically stable patients to enable capacity to be created for those involved in a major incident was not exercised. It must be a priority for the local health economy that these issues are addressed as a matter of urgency and a further exercise developed and run to confirm the identified gaps have been addressed satisfactorily.

What went well? - Satisfactory outcomes

A & E

- Good level of staffing available to respond at short notice
- Staff involved in the exercise had a good understanding of the situation
- It was clear that the team had a good understanding of how to manage the emergency department and maintain patient safety.
- There was very good control of the department

Gold Command

- Prompt setting of aims and objectives of the response
- Clear and timely decisions made with focus on planning from the day of the incident (Friday) until the Monday
- Left the operational management of the response to the Hospital Control Team
- Maintained a strategic focus with view on longer term issues and impacts
- An early message cascaded to the organisation (in addition to the telephone/text cascade) that we had declared a major incident as per action card
- There was a frank discussion around some of the possible issues arising around capacity in comms and its impact on operations

Hospital Control Team

- Controlled response to declaration of MI. Elective and Outpatient activity monitored on going with view to cancellation if situation required it rather than a blanket 'cancel everything'
- Incident Advisor role effectively signposted team around the MI Plan
- Clear and timely decisions made
- Discussions led to the identification of issues that may impact the Trust in a major incident i.e. sourcing additional Switchboard staff, lack of staff with permissions to update KNet & website
- The incident felt calm and there was not a feeling of panic

Other

- Information/communication between ED/Silver and Gold improved throughout the duration of the exercise
- Control and command structure set up well
- All people present took the exercise seriously and went through the different aspects of their roles. The exercise encouraged discussion around the plan from all groups. Flaws in processes seemed to be highlighted.

What didn't go so well? - Areas for improvement

A & E

- There are no whiteboards available to A & E on which they would record major incident patients arrival, CAs card ref number and triage category
- The lack of an EMAS HALO or contact from EMAS made it very difficult for A & E to have a picture of what they should expect in terms of patients arriving from the scene.
- Insufficient information made available re capacity status / bed availability (this may be a symptom of the exercise itself but demonstrates the importance of timely and accurate information). Further allocation of Site Manager to the department to ensure bed state etc. updated may be necessary as well as allocation of porters or other resource to facilitate transfers
- At times the team lost track of some patients largely due to no dedicated tracker being present
- Nurse and Doctor in charge were not explaining what they were doing. They clearly could deal with incident but did not explain to either the observers or other staff the rational for actions
- Comms between ED and Silver was poor.
- Level of uncertainty about what to do with deceased from incident
- The plan clearly needs to be rehearsed within ED to ensure that it is coherent and understood by the team.
- There was no info on a visitor reception area where minors who had been treated could be discharged to.

- There was poor tracking of patients from the incident so this could not be fed back for comms purposes

Gold Command

- No clear decisions made re issuing of external Comms. Lack of clarity if responsibility sat with Trust or CCG
- No contact from the CCG so lack of visibility of wider response
- Use of the meeting structure contained within the Gold Command action cards may have speeded up Gold's response

Hospital Control Team

- The control room was very noisy with conversations going on whilst some team members were taking telephone calls with situation updates
- The Control Room didn't establish a whiteboard capturing agreed actions, owners and timescales which meant there was no 'single version of events' for the team to follow
- The Hospital Control Team didn't follow the standard meeting agenda documented on the action cards which meant some key points / issues were not discussed
- A & E were requesting information direct from the Hospital Control Team. This may have been a symptom of not having a full Bronze Command involved in the exercise but it may also indicate an ineffectiveness in the flow of information between different functions
- There was no control of access to the Control Room
- A need was identified for a documented process for accessing security staff to support a major incident response 'in hours'
- With no loggist present, records were not retained of greed actions and their rationale
- No clarity of the aims and objectives established for the Trust by Gold Command
- Did anyone use the MIP?

Other Internal

- Use of the action cards was limited which could result in key actions being missed / delayed
- It was agreed that the proposed location for the KGH Control Room was inappropriate and it was agreed an alternative location should be sought (ITU Seminar Room was proposed as the preferred location)
- Lack of clarity in the MIP regarding the proposed location of the discharge lounge to be established within the Treatment Centre and the process for establishing and operating it
- The Command & Control 'battle rhythm' documented in the MIP was not utilised effectively
- The codes required to access Trust issue BlackBerry's was not communicated to staff issued with phones
- The telephone numbers issued at the start of the exercise were not utilised
- Lack of common understanding of the MIP with regards to use of locations
    - all admitted MI patients to be cohorted on Clifford
    - 'Friends & Family' reception area (PWEC)
    - Discharge Lounge within the Treatment Centre
- Access to major incident tabards etc. needs to be considered and? this should be in locked cabinet in site office
- Could have been more people present to give a more realistic feel to timescales and escalations. Lack of bleep holders caused a problem with the management of the situation. Could do with all front line staff to work things through as in reality this could cause extra confusion that needs to be dealt with.

- Action card currently says Comms is to establish a focal point for patient/relative communications. Ownership should be reviewed with Comms now just one person within the Trust and reassigned to operational staff.
- Wider access required to list of Key Communications Contacts (in the event of Comms lead not being available). Info is included in On Call packs but the exercise indicated there is limited awareness across the Execs.
- There is also a need to update any old Comms contact lists as this is something which is ever changing – e.g. all of the old police numbers no longer work.
- Consider the development of a Comms Checklist which identifies key questions for Gold & Silver to answer and therefore prompt Comms messages e.g. visiting cancelled, outpatient appointments cancelled business as usual etc.
- Limited / no use of social messaging included in the plan.

Other External

- There was very little communication between KGG and the CCG during the exercise which raises questions regarding to Command and Control structures and processes in a pan county response. KGH Gold Command reported no calls from the CCG and the Hospital Control Team had 2 calls. As a result there was no understanding within the Trust as to the actions being taken across the Health Economy
- Communications with the CCG very difficult due to poor reception via mobile telephones
- Requests for support from NGH were received directly rather than via the CCG Command & Control function
- There was no Command & Control teleconference upon which all partners were present (nor was there any attempt to establish one)
- There was no standard Sit Rep template to provide update information internally and externally. As a result it wasn't clear what information was expected by the CCG when they did contact the Hospital Control Team
- Comms contacts with the new Health Co-ordinating Group need to be clarified and exercised. KGH Comms Lead has not been involved in any training or exercising of these arrangements nor does he have any contact numbers for use in an MI.
- The exercise failed to effectively test the ability of external partners to support early discharge of patients to create capacity within the acute trusts

Recommended Actions

Issue	Action	Owner	Priority	Timescale
Countywide Response Command & Control	Provide feedback to County Debrief with key points including Effective command & control structure and battle rhythm to be developed Review MI training for CCG On Call Directors & Managers Develop and utilise common SitRep template for use in an MI Comms responsibility & coordination Recommendation of dedicated Health Economy Command & Control exercise to be developed and run as a matter of urgency.	Head of Capacity & Resilience	H	October 2014
A & E staff training & awareness	Arrange further MI training for all A & E staff. Training to include Patient tracking process Information flow / management Comms from EMAS & Internal Command & Control MI admission & discharge processes	R & BC Mgr and Urgent Care Lead	H	Q4 & on-going
A & E staff training & awareness	Develop and run more frequent MI exercises for A & E staff (include in training sessions)	R & BC Mgr and Urgent Care Lead	H	Q4
Management of deceased in A & E	Update plan to include overview of process for management of deceased in A & E	R & BC Mgr with Urgent Care and Mortuary Leads	H	Q3
Safeguarding processes in A & E	Update plan to include overview of required arrangements to ensure safeguarding is maintained	R & BC Mgr with Urgent Care and Safeguarding Leads	H	Q3
Dedicated Capacity Tracker role	Develop action card & role for dedicated A & E Capacity Tracker / Lead in a major incident	R & BC Mgr and Urgent Care Lead	L	Q4
MI Resources	Identify resources required to enable delivery of an MI response and source subject to approval Dedicated A & E supplies required with lockable & portable container with all other resources to be centrally located (Ops Room?)	R & BC Mgr and Urgent Care Lead	H	Q3
MI Control Room	Identify and equip fit for purpose MI Control Room (s) Develop MI Control Room SOP & add to MI Plan. SOP to include control of access, phone lines in and out,	R & BC Manager	H	Q3
Loggist Role	Review number of trained loggists within the Trust and ensure sufficient numbers of staff are trained to provide cover in the	R & BC Manager	M	Q4

	event of an MI			
MIP Content	Review list of proposed objectives for response (Gold) and remove any not relevant for KGH / Acute Trust Review / revise Section 2 of MIP to include summary of locations to be used and their purpose. Link to relevant page of full MIP	R & BC Manager	L M	Q4 Q3
Staff training & awareness (non A & E)	Develop more frequent 'live' exercises or multiple smaller exercises to ensure all roles are trained and exercised Develop annual Command & Control training / exercises to improve meeting structures and battle rhythm	R & BC Manager	M	Q4 & on-going
Comms	Review Comms action card and reassign tasks where appropriate (limited Comms resource within the Trust to be taken into account)	R & BC Manager and Comms Lead	L	Q4
Comms	Review and update Comms Contact List on a regular basis to ensure it remains accurate	R & BC Manager and Comms Lead	H	Q3
Comms	Develop Comms checklist (or similar) of key questions; the response to which will inform internal and external Comms e.g. cancellation of all outpatient clinics	R & BC Manager and Comms Lead	M	Q4
Comms	Ensure Trust issue mobiles for use in an MI have stickers showing 'lock code' on reverse	R & BC Manager	L	Q4
Comms	Develop capability to ensure KNet and Trust website can be updated on 24/7 basis Requires increase in the number of staff with update privileges and training	Comms Lead	H	Q3
Comms	Include reference to use of social messaging in MIP and relevant action cards	R & BC Manager and Comms Lead	L	Q4

Appendix a – Exercise participants

Major Incident Role	Attendee
Medical Controller	Manjula Natarajan
Clinical Operations Lead	Eamonn O'Brien
Capacity & Patient Flow Controller and Major Incident Advisor	Simon Beesley
ED Commander	David Bowden
ED Consultant - Triage Doctor	
Consultant / Middle Grade (P1)	
Consultant / Middle Grade (P2)	
Consultant / Middle Grade (P3)	
ED Nurse In Charge	Mandy Blackman / Sandra Iwanoff
ED Tracker	David Ward
ED Senior Receptionist	Linda Simms / Emma Lilley
ED Nurse (P1)	Sarah Clarke
ED Nurse (P2)	
ED Nurse (P3)	
ED Nurse	Natalie Rodgers
ED Triage Nurse	
HR (Tactical / Operational)	Kathryn Large
Strategic Commander	David Sissling
Media & Comms Lead	Dave Tomney
Executive Directors	Andrew Chilton
Executive Directors	Clare Culpin
Executive Directors	Mark Smith
Executive Directors	Kish Sidhu
Executive Directors	David Sissling
Executive Directors	Alan Gurney
Hospital Controller	Imran Devji
Nursing Controller	Leanne Hackshall
Operations Controller	Chris Hodgson

Appendix B: Exercise METHANE

Major Incident Declaration Form		
This form should be completed by anyone receiving information regarding a major incident affecting KGH. *Always check through the form to make sure that you have completed all fields. If information is not available then N/A should be entered in that field.*		
Date: 3rd October 2014	**Time: 09:00**	**Name: EMAS**
Details of person calling Name: Barry Organisation: EMAS Department: Control Room Contact details: 999		
M	**Major Incident Declared Y**	**Major Incident Stand-by ☐**
E	Exact Location of Incident: **A43 at Hardwick Cross Roads**	
T	Type: **Road Traffic Collision, involving multiple vehicles; two coaches and one car** Incident time: Chemical (CBRN)? **No**	
H	Hazards: **Casualties trapped with fuel spillage**	
A	Access and Egress: **Access via A43 north and south bound – but no through traffic**	
N	Number and Nature of casualties: **Currently Unconfirmed, initial assessment approx 60+ casualties**	
E	Emergency Services on site and if further services required: **Police, Fire, Ambulance and Helimed on scene**	
Other receiving hospitals: UHCW, UHL, Peterborough, NGH	MERIT Team Required? Yes	

Appendix D

Exercise Harris

Northamptonshire Health Economy Exercise

NHS Nene CCG & NHS Corby CCG Post Exercise Report

October 2014

Richard Jarvis CCG Lissa Savage CCG Warren Owens KGH
Luke Martin NGH Mark Pape NHFT Garry Mawby EMAS

Introduction

In order to validate the newly ratified Incident Response Plan, Incident Coordination Centre and associated roles, NHS Nene and NHS Corby CCG(s) along with Northampton General Hospital, Kettering General Hospital, Northamptonshire Healthcare Foundation Trust and East Midlands Ambulance Service undertook a half day 'live' exercise on October 3rd 2014.

As NGH and KGH were both due to run a live exercise to ensure their compliance with their statutory duty to product a live exercise the decision was made at LHRP to run a Northamptonshire Health Economy live exercise, to test and validate all providers Incident Response / Major Incident Plans.

The Exercise provided the Health Economy the opportunity to test communication between the CCG ICC and the ICC of the two Acute Trusts.

Exercise Aims & Objectives:

Aim

- To enable both Acute Trusts to test their internal and external interoperability through a live exercise for the Acute Trust's within Northamptonshire.

Objectives:

- To validate individual provider and commissioner Response Plans for an incident in Northamptonshire.
- To assess the interoperability of each provider and commissioner during an incident within Northamptonshire.

CCG Specific objectives

- To test the activation and response processes of the Incident Coordination Centre and it's interaction between Strategic, Tactical and Operational Command Groups.
- To assess the Clinical Commissioning Group's role during a Major Incident and it's interactions with the Health Community within Northamptonshire.

The exercise scenario was developed to achieve the objectives of each organisation. The scenario was two coaches involved in a head on collision on the A43 near Sywell Aerodrome. This allowed the planning team to introduce casualties of all ages into the scenario. The location being in the middle of each of the Acute Trusts was deliberate to aid casualty sorting.

Evaluation of the Exercise

Evaluation of the Incident Response Plan, the Use of the ICC, the role of the Loggist and the role of the CCG was undertaken whilst the Exercise was running by Carole Dehghani (CD), Accountable Officer, Corby Clinical Commissioning Group. There was no evaluation of individuals participating in the exercise.

Each participant was asked to complete a self-evaluation form after CD completed a hot debrief at the end of the exercise. The following specific questions were asked with responses:

	Exercise Content	Strongly Agree	Agree	Disagree	Strongly Disagree
1.	The Exercise achieved the stated aim (given in the exercise briefing)	1	111111		
2.	The Scenario allowed for 'live play' and generated good discussions	11	11111		
3.	The exercise generated important issues and identified useful lessons and learning points	111111	1		

The participants were then asked to complete further questions.

What went well?

- Although this was an exercise it really seemed real and there were some fraught times
- Was good experience for putting loggist training into action
- Gave the loggist an idea of how the on-call director and manager roles would be in an incident and how the loggist fits into this
- Demonstrated the speed at which things happen
- Briefing was comprehensive
- Hot debrief was useful
- Roles were clearly defined an undertaken professionally
- Relationships in the ICC were strong
- Participants well versed on incident and their role

What didn't go well?

- Lack of spider phone
- Loggists weren't fully confident/ aware of their ability to challenge the room
- On-Call manager and Director going outside the room for conversations and failing to brief the Loggist
- Once incident underway there was little referral to the action cards
- Difficult to get information from the Acute Hospital
- Incident Coordination Centre Manager should be based outside

- Demonstrates need for the Information Hub and appropriate training provided to staff who will fulfil this role
- Telephony an issue
- Confusion over contact numbers for providers

Learning identified:

- Need to have a resource box available with:
  - Flip chart
  - Map of Northamptonshire and surrounding area
  - Pens, blue tack etc.
  - Telephones – including spider phone for conference calls
  - Laptop – for sitrep reports
  - List of providers
  - Templates for agenda's for meeting, conference calls, sitrep forms
- Continuous training for individual roles e.g. Loggists, Director, Incident Coordination Centre Manager
- Develop an aide-memoire for Director On-Call
- Can Loggists be involved in the daily Urgent Conference call to get used to capacity related issues
- Use the output from this exercise to develop further training for Loggists

Conclusion

The exercise was designed to test the Incident Response Plan and the Incident Coordination Centre and enable the CCG to recognise where further development of the plan is required. The exercise was successful in this respect. There will more formal debriefs held and a report provided with timeframes included to resolve the lessons identified.

Appendix A

Key:	✓	= Completed/On-track	⌛	= On-going/On track	✗	= Not completed/Off plan	

Action No.	Action	Responsibility	Deadline	Completed	Comments
1	Inclusion of a resource box into the ICC • Flip charts and pens • Whiteboard pens • Stationary – blue tac, staples, rulers, pens etc. • Provider contact details • Maps • Provider plans • Templates for Agendas – Teleconferences – HCG etc.	*Richard Jarvis* *Lissa Savage*	January 2015		
2	Lap top(s) in the ICC for the Incident Director Manager – potentially ICC Manager	*Richard Jarvis* *Lissa Savage*	April 2015		
3	Spider phone in the ICC	*Richard Jarvis* *Lissa Savage*	January 2015		
4	Robust and comprehensive Training Schedule for all IMT roles	*Richard Jarvis*	January 2015		

		Lissa Savage			
5	Develop Aide Memoir for On-Call Manager / Director	*Richard Jarvis* *Lissa Savage*	December 2014	⌛	Awaiting to go to Exec Meeting
6	Develop further mini exercises for Loggists to ensure they are confident and competent in their role – aware of their roles and responsibilities during incident response.	*Richard Jarvis* *Lissa Savage*	*January 2015*	⌛	Awaiting to go to Exec Meeting
7	Ensure further internal exercise for ICC with the inclusion of the Info Hub	*Richard Jarvis* *Lissa Savage*	*January 2015*		
8	Ensure ICC is functional and fully equipped	*Richard Jarvis* *Lissa Savage*	*April 2015*		
Items will remain <u>at the top of the action list</u> until completed					

Appendix E

EXERCISE HARRIS

SCOPING DOCUMENT

Health Community Exercise
3rd October 2014

VERSION	ORIGINATOR	AMENDMENTS	DISTRIBUTION	DATE
1.0	Luke Martin Interim Head of Resilience Northampton General Hospital	Document Creation	Planning Team	
1.1	Luke Martin Interim Head of Resilience Northampton General Hospital	Remove EMERGO Updates to Scenario	Planning Team	
1.2	Luke Martin Interim Head of Resilience Northampton General Hospital	Updates to Scenario	Planning Team	
2.0	Luke Martin Interim Head of Resilience Northampton General Hospital	Document rewrite due to organisational changes	Planning Team	
2.1	Luke Martin Interim Head of Resilience Northampton General Hospital	Updates following comments from KGH	Planning Team	
2.2	Lissa Savage Emergency Planning Officer NHS Nene / NHS Corby CCG	Updates following meeting Changes to scenario	Planning Team	August 21st 2014
2.3	Lissa Savage Emergency Planning Officer NHS Nene / NHS Corby CCG	Updates following Planning meeting	Planning Team	September 15th 2014
2.4	Lissa Savage Emergency Planning Officer NHS Nene / NHS Corby CCG	Updates following Planning meeting	Planning Team	September 17tth 2014

CONTENTS

PURPOSE

The purpose of this document is to establish the requirements for Exercise Harris, a multi Health Agency exercise. Once reviewed and signed off this document will form the overview of the exercise requirements, scope, approach and governance.

The document sets out the proposal for the response exercise, covering key elements including aim and objectives, exercise development and delivery timeframe.

BACKGROUND

The Civil Contingencies Act 2004 requires organisations to exercise their emergency response arrangements and to train their staff in operating those arrangements.

In line with the NHS England Emergency Preparedness Framework 2013 Northampton General Hospital and Kettering General Hospital are required to run a live exercise every three years.

As part of this, there will also be a Command Post Exercise for the NHS Nene / NHS Corby Clinical Commissioning Group to exercise the Incident Coordination Centre and Incident Management Team.

AIM AND OBJECTIVES FOR EXERCISE HARRIS

Aim

- To enable both Acute Trusts to test their internal and external interoperability through a live exercise for the Acute Trust's within Northamptonshire.

Objectives:

- To validate individual provider and commissioner Response Plans for an incident in Northamptonshire.
- To assess the interoperability of each provider and commissioner during an incident within Northamptonshire.

ORGANISATIONAL SPECIFIC OBJECTIVES:

The following organisational specific objectives will be exercised during the exercise.

NHS Corby & NHS Nene Clinical Commissioning Group

- To test the activation and response processes of the Incident Coordination Centre and it's interaction between Strategic, Tactical and Operational Command Groups.
- To assess the Clinical Commissioning Group's role during a Major Incident and it's interactions with the Health Community within Northamptonshire.

Northampton General Hospital

- To exercise a limited Tactical and the A&E, Medicine Bed Holding and Surgical Operational teams within the Trust.
- To exercise interoperability between the Trust and Health Economy partners during a Major Incident Response.
- Add on to the exercise scenario: a VIP was travelling in the car that was involved in the collision. Operation Consort will be activated and exercised.

Kettering General Hospital

- To exercise Strategic, Tactical and Accident & Emergency teams along with a composite rest of hospital team
- To exercise interoperability between the Trust and Health Economy partners during a Major Incident Response.

Northamptonshire Healthcare NHS Foundation Trust

- To exercise a limited discharge function within each Acute Trust.

EXERCISE SCENARIO

At 07:30hrs today (October 3rd 2014), two coaches travelling North and South bound collided during peak rush hour on the A43 between Kettering & Northampton near to Sywell Aerodrome and Hardwick Wood. One of the coaches was carrying a mixture of children and adults; the second coach was carrying adults of mixed ages, late teens to elderly, this was a tour group going to Skegness. A car carrying two adults was involved in the incident. Both coaches have rolled as a result of the collision; early reports are that the majority of passengers on the coach were not wearing seatbelts.

- A number of priority 1 casualties have been flown to the nearest Major Trauma Unit at University Hospital Coventry & Warwickshire. The remaining P1 casualties will be sent to both Northampton & Kettering General.
- Priority 2 casualties will be sent to Kettering General and Northampton General Hospitals.
- Priority 3 casualties will be assessed / treated on scene and sent to the most appropriate facility, the acutes should expect to receive a number of Priority 3s.

EXERCISE CANCELLATION

NB: The exercise will be cancelled if one or both of the acutes declare **Black** escalation status on October 2nd / October 3rd. However organisations should be looking at staffing levels to ensure that they are appropriately staffed to deal with normal day to day pressures whilst playing in the exercise.

When reporting a real emergency the term 'No Duff' should be used to signify that the incident *is not* part of exercise play. EXCON will then inform the other participating organisations so that the emergency can be dealt with unimpeded. In the event of a real incident the exercise will be cancelled.

The decision to cancel / postpone the exercise will be taken on the day of the exercise by joint discussion between the exercise director and COOs from the Acute Trusts.

EXERCISE SCOPE

The exercise will be a command post exercise (CPX) for the NHS Nene & NHS Corby CCG Incident Coordination Centre and a "live exercise" for Northampton General Hospital (NGH) and Kettering General Hospital (KGHFT).

The CCG ICC will be based at NHS Nene CCG, Francis Crick House as per the CCG Incident Response Plan.

Input from National and Regional level will be simulated by exercise control with appropriate subject matter experts.

Internal Communications at each organisation will be informed of the exercise and invited to observe.

OUT OF SCOPE

The following aspects will be outside the scope of this exercise:

- Management of the incident site.
- The time and assets (logistics) required to transport casualties and patients.
- Live exercise play (unless participating partners wish to use the exercise to drive other activities outside the parameters of the exercise).
- External Media will not be invited to report on the Exercise except for the purposes detailed in the media strategy.
- Any organisational specific aims **will not bleed into the exercise** – information to and from other organisations should be simulated. **NO** information that is not in the agreed scope and MEL should be fed to other organisations (acute / CCG etc.)

ASSUMPTIONS

All exercise assumptions will be based on organisations current plans and policies.

TIMING AND LOCATION OF EXERCISE

The exercise will take place on the 03/10/2014 from 08:30 hours until 13:00 hours.

EXCON will be based at Northampton General Hospital Classroom 6 room 1. Access to Exercise locations will be required on the day before STARTEX to set up for the exercise. A timeline for the day for Directing Staff is at **Appendix A**. (Inject timings are contained in a separate Master Events List).

KEY REFERENCES

The Facilitators will be provided with a copy of the relevant plans for the respective organisations they are embedded with for the duration of the exercise.

All participants should already have received training within their own organisations prior to the exercise.

EXERCISE PLANNING

The timeline and key tasks for the exercise planning are at **Appendix B.**

Exercise Planning Team

The planning team will comprise the following representatives:

NHS Corby / NHS Nene Clinical Commissioning Group	Lissa Savage
Northampton General Hospital NHS Trust	Luke Martin
Kettering General Hospital NHS Foundation Trust	Warren Owens
Northamptonshire Healthcare NHS Foundation Trust	Mark Pape
East Midlands Ambulance Service	Garry Mawby

The planning team is collectively responsible for the planning, design and delivery of the exercise, including writing the scenario and injects, and will meet regularly as agreed in the exercise schedule.

EXERCISE STRUCTURE

The structure is based on the normal command and control structures at tactical and strategic level in the respective organisational plans.

The exercise structure is at **Appendix C**.

Exercise Design

This exercise will be run as a Command Post Exercise (CPX) at the CCG ICC and as a live exercise for both Acute Trusts at Operational level.

All aspects will be controlled by Exercise Control (EXCON) through Evaluators and Facilitators at each Acute and CCG

Players will be expected to respond to the exercise as they would a real incident.

Players are not to question the scenario.

Injects will be delivered to players by the exercise facilitator at each location. The injects will be paper based and the exercise facilitator will follow the strict timelines of the MEL.

EVALUATION

An evaluation sub-group will be established consisting of the exercise Evaluators and headed by Richard Jarvis from NHS Nene CCG to develop and deliver the evaluation of the exercise.

The exercise evaluation process will be as follows:

- All evaluators will record any issues, best practice, lessons identified and any other learning points they observe.
- Participants and evaluators will complete a feedback form and will participate in a hot debrief at the end of the exercise.
- Individual stakeholder organisations will conduct formal debriefs within one week of the Exercise, convened by members of the planning team.
- A formal evaluator/planner structured debrief will be convened by the Exercise Director within 28 days of the completion of the Exercise. This will take place via a teleconference on October 31st.
- A draft report will be produced for consultation with the core planning group and stakeholders within 30 working days of the exercise and a full report will follow to the LHRP Executive Board within 40 working days after the exercise.
- The exercise report will take the form of an action table which will be submitted to the LHRP Executive Board and then forwarded to all organisations.

What we are evaluating.

- The exercise stated aims and objectives the evaluation will consider the effectiveness of the following;
- The Strategic response to the incident in Northamptonshire
- The Tactical response to the incident
- The affected site's plans and their integration to and support of the Health Community strategic plans.
- The successful outcomes of coordinated interaction between all participants at all levels and the seamless integration of individual organization's plans with other responding agencies.

Method of evaluation

Direct observation of participants at both locations by evaluators drawn from the planning team members and experienced staff from partner agencies. Also the compulsory completion of participant feedback sheets from participants. The exercise evaluators will only evaluate against the objectives of the exercise. Information from the feedback sheets will be collated by the evaluators for use in the event debriefs and the production of the final exercise report.

Each agency can evaluate their own performances through internal debriefs and taking account of the overall exercise evaluation report. Individual agencies should be able to evaluate their specific plans and performances against their set objectives through the success or otherwise of the exercise. The evaluators will be able to assist by providing feedback within the evaluation process based on objective reporting of exercise outcomes. Information on the feedback sheets that is of relevance to any particular agency will be passed on for that agency to use as they think fit.

Process

The evaluation process will be published in pre-exercise briefing documents to ensure transparency.

Immediate feedback sheets will be provided to participants on the day, completion of these is mandatory for all players.

Evaluators will gather evidence using the agreed procedures during the exercise.

Individual agency debriefs will be held in accordance with the attached timetable and any issues relating to other organizations provided to the evaluation team by the relevant debriefing staff.

Evaluation Sub group report final exercise report on behalf of the planning team, submit to them for approval and then publish final report.

The evaluation team will NOT do any work on separate internal agency debriefing other than including setting a deadline for return of relevant information for use in the main event debrief from those internal debriefs.

COMMUNICATIONS

There will be no invitation to prompt media reporting on the exercise.
There is no planned proactive external media strategy. If approached by any media to comment on the exercise the agreed line to take is as follows:

- The Health Community within Northamptonshire as part of their duties under the Civil Contingencies Act (2004) will be conducting a table-top exercise named "Harris" on the 3rd October2014.

- The 'play' will not be real as this is a table-top exercise. The exercise will involve several agencies who will be testing Critical and Major Incident Strategies.

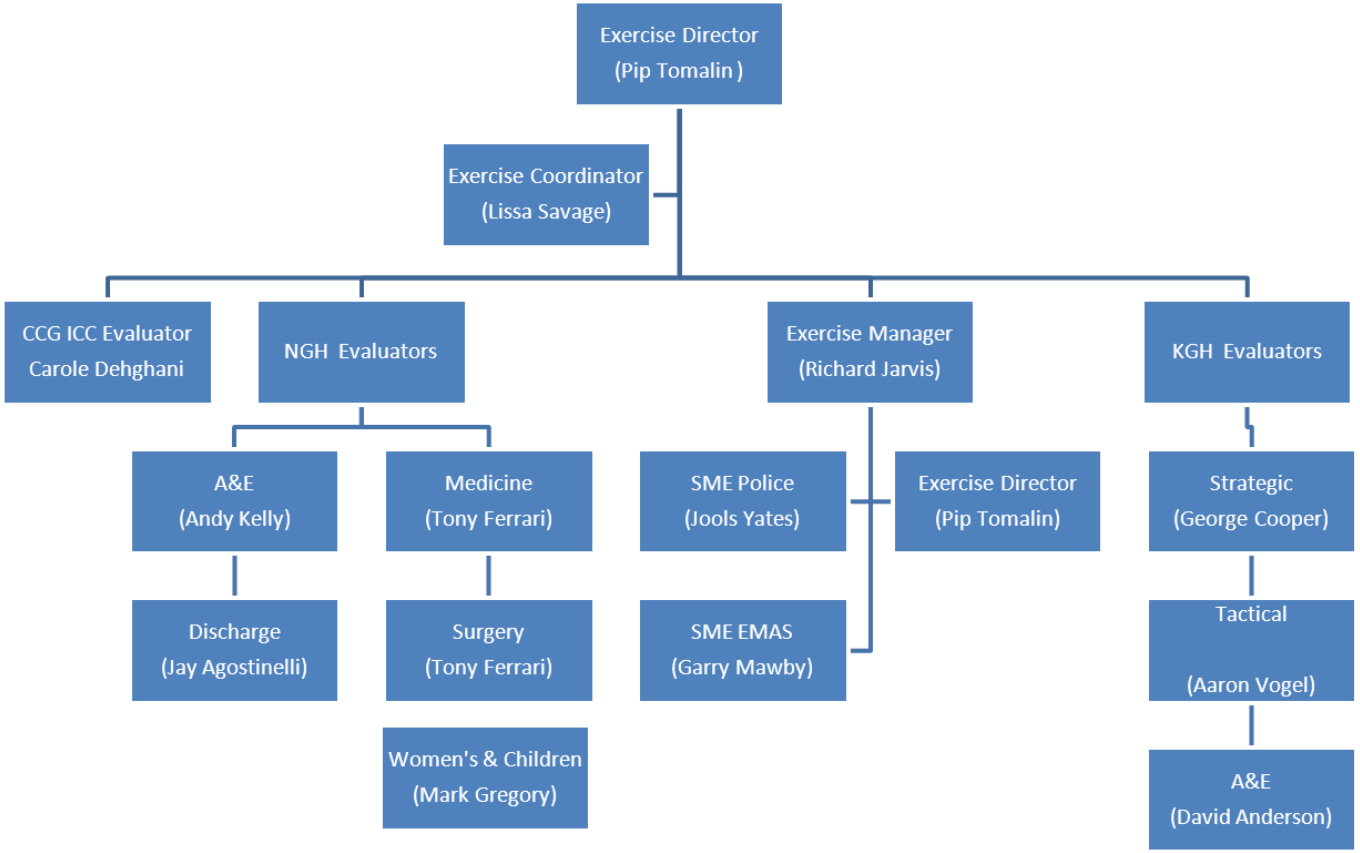
- All internal communication teams are briefed and aware of the exercise.

The spokesman for the exercise is Pip Tomalin from Hertfordshire and South Midlands Area Team; any media enquiries should be forwarded to him.

DOCUMENT MANAGEMENT

All exercise documents will be held centrally by the Planning Group under version change control arrangements. Suggestions for amendment should be submitted to the undersigned in writing, preferably in electronic format, via: lissa.savage@neneccg.nhs.uk

DIRECTING STAFF ORGANOGRAM



DIRECTING STAFF ROLES

Exercise Director

Oversees the delivery of the exercise. Based at Exercise Control.

Exercise Manager

Is from the planning team and is responsible for the conduct and delivery of the exercise.

SMEs

SMEs have been recruited to participate in the exercise by the simulate stakeholder functions for the exercise and provide specialist knowledge where required.

Exercise Coordinator

Manages the MEL and Scoping Document, ensures the injects are delivered on time, any queries are passed to the Excon Manager.

Facilitator

A Facilitator has been identified for each exercise location. They are the point of contact for the participants and evaluators, at that location. They are also responsible for all logistics in their location.

In outline Facilitators will:

- Ensure the exercise administration and logistics run smoothly at their locations.
- Be the first point of contact for participants to report technical and exercise issues.
- Be the first point of contact for Evaluators.
- Ensure evaluation sheets are completed and submitted.

Evaluation Lead

Develops an evaluation strategy in conjunction with the planning team and provides a framework which the evaluators can use to assess the exercise. At the end of the exercise pulling all the evaluation documentation together to provide a report.

Evaluators

Trained exercise evaluators will evaluate the exercises against the defined objectives as appropriate using standard documentation. They will conduct hot de-briefs of participants immediately after ENDEX. They are also responsible for issuing and collecting participant feedback forms. This will also be used to inform a final report for each exercise.

APPENDIX A: EXERCISE TIMINGS – TIMELINE

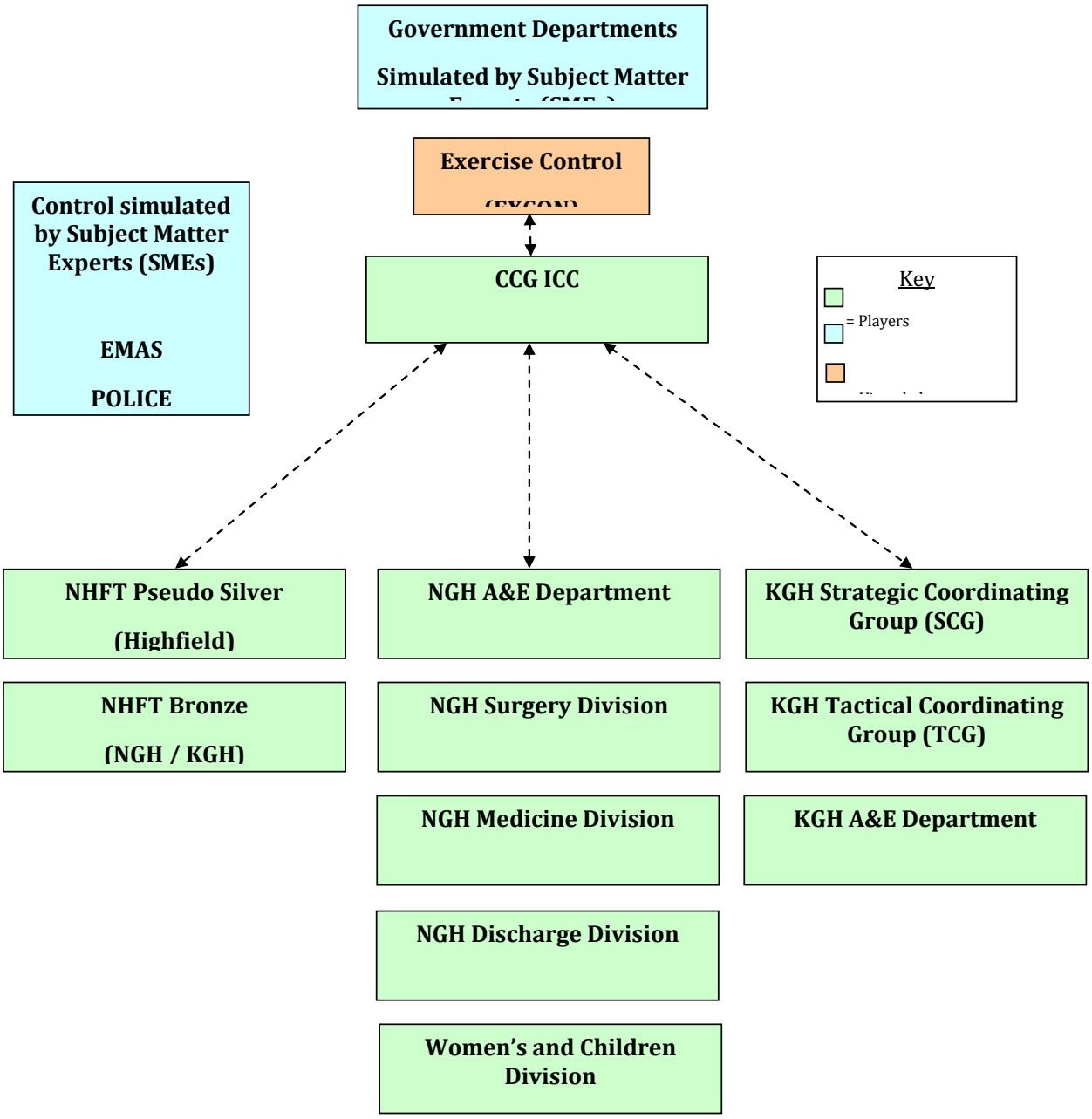
	Time	Activity	Controller action required	Responsible
	(a)	(b)	(c)	
			02 October 2014	
	16:00	Final exercise directory sent out	Check receipt	
			03 October 2014	
	08:00	EXCON open		
	08:00	EXCON Live		
	08:00	Final Communications Tests	Contact EXCON and confirm comms	
	08:30	Briefings	Participants, Evaluators, Observers	
	09:00	STARTEX	Follow MEL manage exercise play	
	13:00	Endex Participant debrief	Close down locations Under direction of exercise director via reps at each location	

APPENDIX B: EXERCISE TIMELINE – KEY TASKS

Action	Responsible	Progress	Comments
Set up planning group	All CCG Secretariat	Complete	Group to meet as a collective at FCH
Agree level / frequency of meetings	CCG	Complete	Weekly meetings agreed by group To occur every Thursday
Agree Exercise Scenario	All	Complete	Ex Scenario evolved from Air crash to RTC
Agree level of exercise - casualty numbers	All	Complete	Group agreed this should not meet mass casualty level scenario changes to reflect this in a realistic manner
Agree casualty list	EMAS / Acutes	Complete	EMAS have worked through the casualty cards giving timeframes along with priority status
Develop Exercise Scoping Document	Lissa Savage	Complete	Luke developed the scoping document Lissa taken over with amendments
Agree Players for exercise Agree roles & responsibilities	All	On-Going	
Develop MEL	All	On-Going	
Arrange appropriate training Individual & Joint	All	On-Going	Organisations are working to ensure that internal training is complete CCG and AT are delivering joint Gold Level Training
Agree exercise facilitators and evaluators	All	Complete	A group of people have been identified and approached to ensure they are available on the day of the exercise - agreement and confirmation from all
Agree exercise structure - level of free play	All	Complete	
Select evaluation team leader	Exercise Manager	Complete	Pip Tomalin will be evaluator group lead

Agree level of involvement NHFt will have in the Ex Simulated Silver vs actual Silver	NHFT & Acutes	Complete	KGH will be using historical data and have been working with NHFT to script replies for requests etc. NGH will be using live on the day data - work is to be undertaken between NHFT & NGH to see how this will work and how NHFT Silver will feed into the exercise.
Brief Participants and conduct Exercise	All		
Observe assigned objectives	Evaluators		

APPENDIX C EXERCISE STRUCTURE



APPENDIX PLAYERS ROLES & RESPONSIBILITIES

ExCon

Name	Organisation	Role
Garry Mawby	EMAS	Subject Matter Expert
Jools Yates	Northants Police	Subject Matter Expert
Pip Tomalin	NHS England	Exercise Director
Richard Jarvis	NHS Nene / Corby CCG	Exercise Manager

CCG

Name	Role
	Incident Director
Vicky Hughes	Incident Manager
Gary Coles	Incident Coordination Centre Manager
Number of recently trained loggists	Loggist

KGH

Name	Role
Manjula Natarajan	Medical Controller
Eamonn O'Brien	• Capacity & Patient flow controller • Discharge Lounge Manager • MI Discharge Lounge Manager • Hospital discharge facilitator
David Bowden	• ED Commander • ED Consultant – Triage Doctor
Simona Bratu	• Consultant / Middle Grade (P1) • Consultant / Middle Grade (P2) • Consultant / Middle Grade (P3)
Mandy Blackman / Sandra Iwanoff	ED Nurse In Charge
David Ward	ED Tracker
Linda Simms / Emma Lilley	ED Senior Receptionist

Sarah Clarke	• ED Nurse (P1) • ED Nurse (P2) • ED Nurse (P3)
Natalie Rodgers	• ED Nurse • ED Triage Nurse
Jo Keach	Urgent Care Lead
Charles Marson	HR (Tactical / Operational)
David Sissling	Strategic Commander
Dave Tomney	Media & Comms Lead
• Andrew Chilton • Clare Culpin • Mark Smith • Kish Sidhu • David Sissling • Alan Gurney	Executive Directors
Imran Devji	Hospital Controller
Leanne Hackshall	Nursing Controller
Chris Hodgson	Operational Controller
Major Incident Advisor	Warren Owens

NGH

Name	Role
Sue McLeod	General Manager
Hayley Stewart	PA to Sue McLeod
Lorraine Warden	Service Manager
Pat Miller	Matron
Christine Mallon	Team Leader
Liz Shaw	Team Leader, General Surgery
Mr Rob Hicks	Clinical Director
Sandra Neale	Service Manager Head & Neck
Laura Wilkinson	Team Leader Head & Neck
Kelly Kidsley	Matron Head & Neck
Helen Kerry	Acting Service Manager Trauma & Orthopaedic

Lindsey Woodbridge	Service Manager Trauma & Orthopaedic
Claire Sambridge	Matron Trauma & Orthopaedic
Emma Gittings	Team Leader Trauma & Orthopaedic
Claire Hourican	Secretary Trauma & Orthopaedic
Julie Kelly	Service Manager Theatres, Anaesthetics & Critical Care
Dulcie Checketts	Administrations Manager Theatres, Anaesthetics & Critical Care
Jo Dilley	Matron Theatres, Anaesthetics & Critical Care
Kate Broad	Interim Matron Theatres
Dr Chris Leng	Clinical Director Anaesthetics & Critical Care
Ian Beatty	Service Manager Ophthalmology
Belle Glithero	Secretary
Rebecca Brown	Deputy Chief Operating Officer
Tim Meade	NEPT Manager / Associate Resilience Manager
Darryl North	Radiology
Liz Aldridge	Therapies
Alison Jones	Clinical Site Manager
Emma Duff	Pharmacy Rep
James Rogers	Service Manager Oncology
Jackie Perkins	Discharge Facilitator
David Coyle	Service Manager
Julie Mason-Wright	General Manager
Suzanne Lee	Service Manager
Jason King	A&E Matron
Helen Lidbetter	Matron
Sara Magson	Matron
Cindy Crawford	Matron
TBC	Portering & Security
TBC	Loggist
TBC	A&E Consultant x2
TBC	Doctor x2
TBC	Nurse x4

Industrial Action Debrief Report

12th January 2016

Junior Doctors went out on strike on Tuesday 12th January in a long-running dispute with the Government over pay and conditions. Upon notification of junior doctor's intentions to strike, the Trust instigated its Command and Control structure in the form of Silver and Gold planning group meetings which took place daily from 6th January up to and including to the day of action, with an Incident Coordination Centre established throughout the 24-hour walkout in order to monitor and escalate any issues to Gold.

All areas were risk assessed with key mitigations added to the divisional Industrial Action Resilience plans. These plans fed into the overarching corporate plan which also contained various appendices, including guidance from the BMA, a timetable of the day, contact numbers and key documents. This was circulated to members of Silver and Gold groups.

The following provides an overview of the work undertaken by NGH prior to the proposed industrial action on the 12th January.

- Full cancellation of non-urgent outpatient's appointments.
- Cancellation of electives in advance of the action.
- Retained emergency operations and urgent cancer surgery.
- The Trust met with the BMA in order to agree emergency duties to be covered by junior doctors.
- It was agreed with the BMA that there would be full support for ED, Ambulatory care and assessment areas. It was also agreed that junior doctors would provide support in the event of an external major incident.
- Patients were informed of cancelled appointments in advance of the action. In the event that the industrial action was cancelled, patients were advised to attend appointments as originally planned.
- Full command and control structure in place
- All areas created an industrial action resilience plan which fed into the overarching corporate document. Plans included pre and post period.
- Work was undertaken to maximise flow on the 10th and 11th in order to clear the hospital and to ensure good capacity for the 12th.
- Work to ensure additional GP support from IC24.
- There was Trust representation at all of the system wide HCG Teleconferences prior to the industrial action.
- It was agreed that teleconferences did not take over the day, in order to allow senior staff to be around the hospital.
- All staff were made aware of work being undertaken via the addition of messages onto 'The Street'.
- Skill gap matrix was completed in order to identify training needs.
- All non-essential meetings and training were cancelled.

- No new annual leave to be approved for the strike period, any pre-standing leave to be honoured.

Four procedure teams were established in order to assist colleagues during the period of action, these included IT support, outreach service, phlebotomy/pharmacy and a procedure group.

The details of these teams were printed and circulated to all areas prior to the industrial action and was added to the screensaver to be viewable by all staff with access to Trust PC's.

I.T. created a special Industrial Action assistance hotline in order to assist with access to clinical systems, smartcards and passwords. Consultant colleagues were required to ensure access to ICE.

A strong clinical site team was in place for the duration of the strike, with the clinical on-call manager staying onsite overnight.

There was some anxiety surrounding patients going to the Discharge Suite without EDN's this was quickly rectified. There were also concerns that EDN's were completed by Consultants for patients moving to the Discharge Suite. A mechanism was put into place and IT and pharmacy were in attendance to provide support.

The Trust quickly returned to normal the following morning, thanks to the work undertaken to ensure adequate cover for the duration of the action.

What went well?

Nil clinical incidents.

Well planned by all divisions.

Excellent clinical engagement.

Discussions with the BMA gave clarity for the Trust and junior doctors as to what emergency care meant.

As the dates of the action were known in advance, new patients we not added to lists, meaning fewer cancellations.

The Trust communicated to patients early and frequently, resulting in very few complaints from patients via switchboard and on social media.

There was good feedback received regarding pharmacists providing assistance on the wards.

Pickets were well behaved.

There were more junior doctors than expected in oncology.

What can be improved on in the future?

Data surrounding number of cancelled appointments to be provided to the communications team sooner, in order to ensure media enquiries are answered in a timely manner.

Not all consultants had access to the electronic prescribing tool, all areas with EPMR to ensure access by the 26th.

A patient was moved from EAU, a place of safety with junior doctors, to Beckett ward, without junior doctors. It has since been agreed to keep acute patients as close to ED as possible, if required.

Increase cover for ICC during the next event.

A member of staff queried who the consultant was for their ward. It transpired that the ward had been informed however this member of staff was not aware.

Greater spread of senior management to be made available later in the day.

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**31 March 2016**

Title of the Report	**Integrated Performance Report and Corporate Scorecard**
Agenda item	**14**
Presenter(s) of Report	Deborah Needham, Chief Operating Officer/Deputy CEO Dr Michael Cusack, Medical Director Carolyn Fox, Director of Nursing, Midwifery and Patient Services Janine Brennan, Director of Workforce and Transformation
Author(s) of Report	Deborah Needham, Chief Operating Officer/Deputy CEO Dr Michael Cusack, Medical Director Carolyn Fox, Director of Nursing, Midwifery and Patient Services Janine Brennan, Director of Workforce and Transformation
Purpose	The paper is presented for discussion and assurance

Executive summary

This revised Integrated Performance Report and Corporate Scorecard provides a holistic and integrated set of metrics closely aligned between the TDA, Monitor and the CQC oversight measures used for identification and intervention. The Scorecard and Exception reports have been discussed in detail at the Finance Investment and Performance Committee, Workforce Committee and Quality Governance Committee.

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

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

Related strategic aim and corporate objective	Be a provider of quality care for all our patients
Risk and assurance	Risk of not delivering Urgent care and 62 day performance standards Potential Financial fines for performance below standard Reputation risk for Performance below standard Potential poor patient experience
Related Board Assurance Framework entries	BAF - All
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (Y/N) No Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (Y/N) No
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper (Y/**N**)

Actions required by the Trust Board

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

Northampton General Hospital NHS Trust

Trust Board Corporate Scorecard

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

Delivering for patients:
2015/16 Accountability Framework for NHS trust boards

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

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

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

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

Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Escalation Areas Open	Report period:	February 2016

Driver for underperformance:	Actions to address the underperformance:
• Improved performance against the previous month despite continued pressures. • The volume of admissions with high acuity continues. • Flow through the Emergency Care Pathway is limited, causing the inability to move patients in a timely manner to an appropriate ward. • Subsequently, escalation areas will be utilised when necessary to ensure the safe care of patients. • Delayed transfers of care remain high • Overall capacity does not meet demand	• Daily Command and Control and internal significant incidents declared when necessary to manage the activity • Divisional manager overview of all medical patients each day (Dragons den method) • Daily manager / matron in charge of flow within medicine • Escalation areas open when authorised by COO or CEO
Forecast date (month) for *meeting the standard*	Forecast performance for next reporting period:
Q2 2016/17	Used as necessary
Lead for recovery:	Lead Director:
Alison Pirfo	Deborah Needham

Historical Target Performance

Indicators		Target	Trend	Dec-15	Jan-16	Feb-16
WP.1	Escalation Areas Open	0	↑	399	687	422

Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Patient Ward Moves (between 9pm & 8am) NEL ONLY	Report period:	February 2016

Driver for underperformance:	Actions to address the underperformance:
• Improved performance from previous month despite increased pressures • The volume of admissions with high acuity continues. • Discharges on the base wards are not happening early enough in the day to ensure flow from the Urgent Care departments • The Trust has also experienced issues with NSL patient transport resulting in transfer of patients from the discharge lounge to the main wards (re-bedding) • Delayed transfers of care remain high • Overall capacity does not meet demand	• Daily Command and Control and internal significant incidents declared to manage the activity and expedite discharges • The challenges with NSL are being managed through the CCG with NGH involvement • Divisional manager overview of all medical patients each day (Dragons den method) • Daily manager / matron in charge of flow within medicine
Forecast date (month) for *meeting the standard*	Forecast performance for next reporting period:
June 2016	Mar 16 - <70
Lead for recovery:	Lead Director:
Alison Pirfo	Deborah Needham

Historical Target Performance

Indicators		Target	Trend	Dec-15	Jan-16	Feb-16
WP.2	Patient Ward Moves (between 9pm & 8am) - NEL ONLY	**To be agreed**	↑	**70**	**91**	**71**

Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Cancelled Operation Numbers (Clinical and Non-clinical)	Report period:	February 2016

Driver for underperformance:	Actions to address the underperformance:
• Operations have been cancelled due to continued use of escalation areas throughout February • In severe escalation (RED) all non-urgent patients are cancelled to ensure safety for emergency patients • Operations are routinely cancelled when lists over run • Staff availability within theatres due to vacancy and sickness has a direct effect on cancellations	• The theatres productivity work stream has been relaunched and has 6 projects to increase productivity within the surgical division • Daily Command and Control in place to manage the activity and expedite discharges
Forecast date (month) for *meeting the standard*	Forecast performance for next reporting period:
Standard to be confirmed	<400
Lead for recovery:	Lead Director:
Fay Gordon / Alison Pirfo	Deborah Needham

Historical Target Performance

Indicators		Target	Trend	Dec-15	Jan-16	Feb-16
WP.3	Cancelled Operation Numbers (Clinical & Non Clinical)	**To be agreed**	↑	**260**	**415**	**301**

Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Patient who need to be readmitted if transport arrives too late	Report period:	February 2016
Driver for underperformance:		Actions to address the underperformance:	
• Reduced performance on previous month • NSL were unable to deliver transport for patients within the allotted time. • The Trust deemed that the delayed arrival time of the transport was too late for patient to be moved so patients were re-bedded.		• This issue with NSL continues to be managed with the CCG who are in discussions with NSL and reviewing contracts and their performance • NSL have received an improvement notice • The Trust must ensure wards are booking transport at appropriate times • NGH have requested a copy of the action plan which has been agreed between NSL and Nene CCG	
Forecast date (month) for *meeting the standard*		Forecast performance for next reporting period:	
April 2016		>10	
Lead for recovery:		Lead Director:	
Alison Pirfo		Deborah Needham	

Historical Target Performance

Indicators		Target	Trend	Dec-15	Jan-16	Feb-16
WP.4	Patient who need to be readmitted if transport arrives too late	**To be agreed**	↑	**22**	**5**	**13**

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	A&E Trolley waits 8hrs 1min to 12hrs – (DTA to admission)	Report period:	February 2016

Driver for underperformance:	Actions to address the underperformance:
• Significant improvement in performance against previous month despite urgent care pressures • The trust continues to see a prolonged period of high admissions with high acuity • Discharges on the base wards not early enough in the day to facilitate flow, this leads to exit block in ED • Long delays for speciality review on occasion • Long waits for initial first assessment due to increased attenders	• Command and control is in place and internal significant incidents declared to manage the activity and expedite discharges • Additional Consultant support within EAU being appointed • Divisional manager overview of all medical patients each day (Dragons den method) • Daily manager / matron in charge of flow within medicine • Escalation areas in use as required
Forecast date (month) for *meeting the standard*	Forecast performance for next reporting period:
April 2016	<120
Lead for recovery:	Lead Director:
Sue McLeod / Lyndsey Brawn	Deborah Needham

Historical Target Performance

Indicators		Target	Trend	Dec-15	Jan-16	Feb-16
WP.5	A&E Trolley waits 8hrs 1 min to 12hrs (DTA to admission)	**To be agreed**	↑	**21**	**132**	**52**

Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Proportion of patients spending less than 4 hours in A&E	Report period:	February 2016

Driver for underperformance:	Actions to address the underperformance:
• The number of attendances to ED has increased since December and remains higher for the 7th consecutive month against the previous year. • The number of admissions through ED has increased compared to the month before, and acuity has remained high. • Flow through the Emergency Care Pathway has been challenging, leading to a high number of 1st Assessment Breaches speciality review breaches, especially for the medical teams, and bed breaches. • DTOC remains high • **Full exception report submitted to F&P committee**	• Daily Command and Control in place to manage the activity • The Inpatient Productivity theme of the Changing Care @ NGH programme has been launched to reduce ALOS, increase discharges pre 12 noon, and increase the number of discharges over the weekend • The new Ambulatory Care Centre continues to see a month on month increase in the numbers of patients seen within the unit to reduce admissions and the discharge suite is used to create flow earlier in the day • **Full exception report submitted to F&P committee**
Forecast date (month) for *meeting the standard*	Forecast performance for next reporting period:
July 2016	<90%
Lead for recovery:	Lead Director:
Sue McLeod / Lyndsey Brawn	Deborah Needham

Historical Target Performance

Indicator		Target	Trend	Dec-15	Jan-16	Feb-16
R.1	A&E: Proportion of patients spending less than 4 hours in A&E	=>95%	↓	91.4%	80.4%	84.0%

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Discharge: Number of medically fit patients awaiting discharge (average daily)	Report period:	February 2016

Driver for underperformance:	Actions to address the underperformance:
• Increase in attendances and admissions generally and especially in the frail elderly • Increase in acuity leading to longer LOS and greater, more complex discharge requirements.	• Additional Discharge Assistants appointed to support the wards and discharge teams • Additional support from CRT on Creaton/Brampton in place • Daily review of top 20 across the system • Divisional manager daily oversight • Additional 10 beds in place at Angela Grace
Forecast date (month) for *meeting the standard*	**Forecast performance for next reporting period:**
Unknown due to lack of system progress	<100
Lead for recovery:	**Lead Director:**
Alison Pirfo	Deborah Needham

Historical Target Performance

Indicator		Target	Trend	Dec-15	Jan-16	Feb-16
R.5	Discharge: Number of medically fit patients awaiting discharge (average daily)	=<50	↑	122	108	115

Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Cancer Access Targets	Report period:	February 2016

Driver for underperformance:	Actions to address the underperformance:
• **Reporting on January data** • **62 day standard January** • Patient delays: - DNA, thinking time, the want to start treatment after Christmas, delay to investigations, delay to OPA • Late referrals • Many investigations:-patients requiring investigations at 2 hospitals, investigations for 2 primaries • MRI:- Break down impacted on urology patient pathway who had to have TRUS before MRI • Medical reasons: - cardiac / other medical delays • Strike: - one patients TCI was moved due to potential strike • **31 day First Treatment** • Seven patients breached due to medical reasons, patient DNA, patient choice to delay treatment until after Christmas and the unforeseen leave within ENT which impacted on two Head & Neck patients. • **Full report is being submitted to F&P**	• Continuation of meetings between radiology and cancer services • Escalation of delays in urology typing • A review of the Cancer Recovery Plan and engagement with the Divisional Managers • A meeting was held between KGH and NGH H&N Departments including Cancer Services to discuss recruitment to a consultant post and the future cancer service and pathway between Trusts. • Transfer the work of the Urology MDT Coordinator to another Coordinator due to long-term sickness. • Continued work with the CCG to agree the 2ww criteria and process for requesting a test • **Full report is being submitted to F&P**

Forecast date (month) for meeting the standard	Forecast performance for next reporting period:
February 2017	75%
Lead for recovery:	**Lead Director:**
Directorate Managers/Tracey Harris	Deborah Needham

Historical Target Performance

Indicator		Target	Trend	Dec-15	Jan-16	Feb-16
R.9	Cancer: Percentage of patients treated within 62 days of referral from hospital specialist	=>85%	↑	0%	100%	100%
R.10	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	=>85%	↑	77.0%	69.4%	80.0%
R.11	Cancer: Percentage of patients treated within 31 days	=>96%	↓	100%	94.7%	95.1%
R.12	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	=>94%	↑	100%	90.0%	100%

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Report period:	February 2016

Driver for underperformance:	Actions to address the underperformance:
• T&O had 10 breaches in February due emergency pressures and the need to use Althorp ward as escalation an area. Unfortunately the patients were not cancelled until their admission day. • Plastics surgery had 1 breach. The patient was cancelled on the day due to a lack of beds. Every effort was made to re-date the patient within the 28 days but this was not possible due to other clinical priorities and only one consultant being able to undertake this particular procedure. • Oral Surgery had 2 breaches. Both of these patients were cancelled on the day due to the unavailability of beds. Every effort was made to re-date the patients with 28 days but this was not possible due to a high clinical case load of cancer patients which took priority. Other consultants were asked to accommodate these patients but as above they could not accommodate as their lists were already full with Cancer cases which were clinical priorities.	• Where possible patients will be cancelled the day before their admission to prevent this occurring. • 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.
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
Q3 16/17	8
Lead for recovery:	**Lead Director:**
Fay Gordon / Dr Mike Wilkinson	Deborah Needham

Historical Target Performance

Indicator		Target	Trend	Dec-15	Jan-16	Feb-16
R.16	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	0	↓	2	3	13

Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Delayed transfer of care	Report period:	February 2016

Driver for underperformance:	Actions to address the underperformance:
• Capacity of external Health and Social teams remains challenging • Availability of Dom Care providers to relieve CRT • Larger number of patient being admitted with complex discharge needs placing more demand on services • Delays within the DTA pathway due to Start	• Additional Discharge Assistants appointed to support wards and discharge teams • Additional support from CRT on Brampton/Creaton wards • 2nd & 3rd Tier Dom Care providers coming on board to help relieve START, who in turn can relieve CRT • 'Top 20' review daily • Twice weekly tracking meetings • Daily overawe from head of capacity • 10 additional beds at Angela Grace
Forecast date (month) for *meeting the standard*	**Forecast performance for next reporting period:**
Target measure will be reviewed in the next month. Target should be 3.5% of bed base	<60
Lead for recovery:	**Lead Director:**
Alison Pirfo	Deborah Needham

Historical Target Performance

Indicator		Target	Trend	Dec-15	Jan-16	Feb-16
R.21	Delayed transfer of care	18	↑	58	70	80

Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Length of Stay	Report period:	February 2016

Driver for underperformance:	Actions to address the underperformance:
• Trustwide LOS has increased following the number of admissions with high acuity specifically respiratory illness • The denominator for EL LOS has changed as 'simpler' surgery has been cancelled and more complex and serious cases undertaken, which in turn will lengthen LOS.	• The Inpatient Productivity theme of the Changing Care @ NGH programme has been launched to reduce ALOS, increase discharges pre 12 noon, and increase the number of discharges over the weekend • Immediate focus on the weekend discharge process to facilitate flow • The theatres productivity work stream has been relaunched and has 6 projects to increase productivity within the surgical division • Greater utilisation of the new Ambulatory Care Centre to reduce NEL admissions • 'Top 20' review throughout winter period
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
June 2016	No change
Lead for recovery:	**Lead Director:**
Lyndsey Brawn/ Mike Wilkinson Sue McLeod / Fay Gordon	Deborah Needham

Historical Target Performance

Indicator		Target	Trend	Dec-15	Jan-16	Feb-16
E.3	Length of stay - All	=<4.2	↑	5.78	4.13	4.93
E.51	Length of stay - All (Excl. Compton, Blenheim & Cliftonville wards)	=<4.2	↓	3.82	3.8	4.25
E.4	Length of stay - Elective	=<2.7	↑	3.93	3.12	3.27
E.52	Length of stay - Elective (Excl. Compton, Blenheim & Cliftonville wards)	=<2.7	↑	3.8	3.02	3.08
E.5	Length of stay - Non Elective	=<4.7	↓	6.54	4.94	6.05
E.53	Length of stay - Non Elective (Excl. Compton, Blenheim & Cliftonville wards)	=<4.7	↓	4.3	4.51	5.29

Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Stroke patients spending at least 90% of their time on the stroke unit	Report period:	February 2016

Driver for underperformance:	Actions to address the underperformance:
• Performance has decreased in month 1. Patients with a short length of stay not accessing a stroke bed. 2. Medical patients in stroke beds. 3. Beds on Holcot blocked by patients waiting excess length of time for complex care packages (in excess of 5 weeks in some cases) • Poor performance is due to the high bed occupancy within the Trust due to urgent care pressures	• Remain the same as for previous months and are ongoing. • We admitted 75 stroke patients in February. • Continue to reduce ALOS with a view to ring fencing 2 stroke beds
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
Unable to predict as not achievable in current setting	60%
Lead for recovery:	**Lead Director:**
Dr M Blake/ Dr L Brawn	Dr M Cusack

Historical Target Performance

Indicator		Target	Trend	Dec-15	Jan-16	Feb-16
E.19	Stroke patients spending at least 90% of their time on the stroke unit	=>80%	↓	63.5%	69.2%	57.1%

Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	% weekend discharges against week day discharges	Report period:	February 2016

Driver for underperformance:	Actions to address the underperformance:
• Slight reduction on previous months performance, but continued improvement against pre December figures. • Acute patients requiring Consultant input at weekend.	• Weekend discharge Immediate focus of Inpatient Productivity work stream and is reviewed weekly • New process in place where patients are being identified on Friday, Saturday and Sunday for discharge • Weekend stickers used in notes to prompt teams to ensure medical plan available and focus on discharge • Week by week monitoring of performance • Discharge teams in over weekend to support processes and discharges
Forecast date (month) for *meeting the standard*	Forecast performance for next reporting period:
March 16	65%
Lead for recovery:	Lead Director:
Sue McLeod / Lyndsey Brawn	Deborah Needham

Historical Target Performance

Indicator		Target	Trend	Dec-15	Jan-16	Feb-16
E.47	% Weekend Discharges against Week Day Discharges	=>80%	↑	47.6%	63.5%	60.8%

Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Staff Turnover Rate	Report period:	February 2016

Driver for underperformance:

Staff Group	Jan-16	Feb-16
Add Prof Sci & Tech	7.66%	7.31%
Additional Clinical Services	10.63%	9.47%
Admin & Clerical	13.07%	12.61%
Allied Health Professionals	14.95%	13.29%
Estates & Ancillary	9.85%	9.57%
Healthcare Scientists	15.12%	14.10%
Medical & Dental	6.89%	6.84%
Nursing & Midwifery	12.14%	12.21%

- **Staff Turnover:** Annual Trust turnover decreased by almost 0.5% to 11.19% in February which is above the Trust target of 8%. Turnover within Nursing & Midwifery increased by 0.07% to 12.21%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust.
- Turnover decreased in all other staff groups.
- Medical Division: turnover decreased to 12.76%.
- Surgical Division: turnover increased by just 0.02% to 10.14%
- Women, Children & Oncology Division: turnover decreased by 0.09% to 10.26%
- Clinical Support Services Division: turnover fell by 1.34% to below 10% (9.41%)
- Support Services: turnover fell from 13.24% to 13.09% for the year ending February 2016.

Actions to address the underperformance:

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

Forecast date (month) for meeting the standard	Forecast performance for next reporting period:
October 2016	11.10%
Lead for recovery:	**Lead Director:**
Andrea Chown	Janine Brennan

Historical Target Performance

Indicator		Target	Trend	Dec-15	Jan-16	Feb-16
W.3	Turnover Rate	=<8%	↑	11.70%	11.66%	11.19%

Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Staff Sickness Rates	Report period:	February 2016

Driver for underperformance:	Actions to address the underperformance:

Monthly Sickness (as FTE)		Jan-16	Feb-16
	Medical Division	4.83%	4.97%
	Surgical Division	3.66%	4.02%
	W, C & O Division	5.16%	4.69%
	Clinical Support Division	3.67%	4.83%
	Hospital Support	3.26%	3.15%
	Facilities	4.72%	4.19%
Trust Total			
	As percentage	4.31%	4.44%

- **Sickness Absence:** In month sickness absence increased by 0.13% to 4.44% which is above the Trust target of 3.8%. All Divisions were above the target rate in February with the exception of Support Services.

- In all divisions monthly meetings are held between Managers and HR to discuss the sickness absence figures. The HR Advisor arranges and attends long term and short term meetings. All figures are presented to the Divisional Management Team meetings including return to work percentages. The HR Business partners challenge the managers.
- In the Medicine division the percentage of sickness absence is particularly high in Urgent Care although there is no underlying trend.
- In Women's and Children's, Oncology and Haematology sickness absence has reduced since December but there continues to be high levels in Oncology due to anxiety and stress. The HR Business has raised this at the most recent Directorate Management Board and asked the managers to consider any actions that they could take to reduce anxiety within the workplace.

Forecast date (month) for meeting the standard	Forecast performance for next reporting period:
August 2016	4.40%
Lead for recovery:	**Lead Director:**
Andrea Chown	Janine Brennan

Historical Target Performance

Indicator		Target	Trend	Dec-15	Jan-16	Feb-16
W.4	Sickness rate	=<3.8%	↓	4.10%	4.31%	4.44%

Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Staff Vacancy Rates	Report period:	February 2016

Driver for underperformance:	Actions to address the underperformance:

Staff Group	Jan-16	Feb-16
Add Prof Sci & Tech	8.41%	7.77%
Additional Clinical Services	12.63%	8.21%
Admin & Clerical	10.87%	7.93%
Allied Health Professionals	3.76%	1.30%
Estates & Ancillary	14.18%	14.60%
Healthcare Scientists	14.82%	13.98%
Medical & Dental	10.90%	10.21%
Nursing & Midwifery	13.87%	11.13%

- **Staff Vacancies:** The vacancy rate within Additional Clinical Services staff group decreased significantly in February from 12.63% to 8.21%. The Registered Nursing & Midwifery vacancy rate also fell from 13.87% to 11.13%. The vacancy rate in all other staff groups also fell with the exception of Estates and Ancillary which rose from 14.18% to 14.60%.

- Proactive Recruitment campaign within nursing – this includes overseas recruitment and local specific recruitment events.
- 110 International nurses have commenced employment between January 2015 and February 2016 with a number still to commence from the overseas recruitment programme.
- A pilot of Clinical Apprentices commenced in September & January.
- Some vacancies within Additional Prof Scientific & Technical are being held pending new equipment which may necessitate a skill mix review.
- New roles are being developed within Estates & Ancillary including Technical Apprentices

Forecast date (month) for meeting the standard	Forecast performance for next reporting period:
February 2016	All vacancies – 7.4%
Lead for recovery:	**Lead Director:**
Andrea Chown	Janine Brennan

Historical Target Performance

Indicator		Target	Trend	Dec-15	Jan-16	Feb-16
W.5	Staff: Trust level vacancy rate - All	=<7%	↑	9.5%	9.2%	7.4%
W.5	Staff: Trust level vacancy rate - Medical Staff	=<7%	↑	10.86%	10.90%	10.21%
W.5	Staff: Trust level vacancy rate - Registered Nursing Staff	=<7%	↑	13.42%	13.87%	11.13%
W.5	Staff: Trust level vacancy rate - Other Staff	=<7%	↑	12.29%	11.46%	8.92%

Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Staff Training – Role Specific	Report period:	February 2016

Driver for underperformance:	Actions to address the underperformance:
• Mandatory Training Review in 2013 reduced the number of subjects of which many of those that were originally Mandatory are now Role Specific Essential Training. • The target to be achieved by March 2015 is 85% as per the Quality Schedule set by the CCG; however this is not a national mandate	• Scoping of RSET against job roles and positions has been completed and uploaded into system to ensure accuracy of reporting. There has been further refinement, in particular to Blood Training which expects an increase in % of compliance. • Following 1:1 sessions with Ward Managers, the L&D Manager is providing further support through training them in understanding the reports to use them to monitor individual training and forecasting. • L&D continue to focus on areas of low % of compliance and provide awareness to relevant Directors, Divisional Managers, Service Managers, Matrons and Ward Sisters. • New Appraisal process encouraging uptake of Mandatory training & RSET by requiring staff to have in-date training in order to incrementally progress.
Forecast date (month) for meeting the standard	Forecast performance for next reporting period:
October 2016	73.8%
Lead for recovery:	Lead Director:
Sandra Wright	Janine Brennan

Historical Target Performance

Indicator		Target	Trend	Dec-15	Jan-16	Feb-16
W.12	Percentage of all trust staff with role specific training compliance	=>85%	↑	72.5%	73.0%	73.4%

Northampton General Hospital NHS
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Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Medical Job Planning	Report period:	February 2016

Driver for underperformance:	Actions to address the underperformance:
• Job planning not performing against agreed trajectory.	• Divisional Directors held to account by Exec leads to ensure sign off progression with immediate action. • Consultants who have 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.
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
As per Divisional plans	100%
Lead for recovery:	**Lead Director:**
Sue Jacobs	Dr Mike Cusack

Historical Target Performance

Indicator		Target	Trend	Dec-15	Jan-16	Feb-16
W.15	Medical Job Planning	100%	↑	79.0%	81.0%	81.0%

Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	C-Diff Incidents	Report period:	February 2016

Driver for underperformance:	Actions to address the underperformance:
• 2 Trust apportioned cases of *Clostridium difficile* infection (CDI) for February 2016.	• All CDI patients have a Root Cause Analysis (RCA) undertaken on them and these are sent to the CCG. All actions identified form the RCA's are followed up and completed.
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
March 2016	1
Lead for recovery:	**Lead Director:**
Wendy Foster	Carolyn Fox

Historical Target Performance

Indicator		Target	Trend	Dec-15	Jan-16	Feb-16
S.1	C-Diff	Ave. 1.75 per mth	↑	4	5	2

Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Safety Thermometer Performance	Report period:	February 2016

Driver for underperformance:	Actions to address the underperformance:
• Hospital acquired Pressure Ulcers above national target	• Pressure Ulcer collaborative underway with second event in February • Share & Learn meetings up and running, themes and analysis being shared Trust wide • Continued training & assessment sessions for PUP champions and ward staff
Forecast date (month) for meeting the standard	**Forecast performance for next reporting period:**
Unable to predict as variables not all within Trusts sphere of influence	
Lead for recovery:	**Lead Director:**
Ward Sisters/Charge Nurse Sub Groups	Carolyn Fox

Historical Target Performance

Indicator		Target	Trend	Dec-15	Jan-16	Feb-16
S.6	Harm Free Care (Safety Thermometer)	**94.05% (Feb 16)**	↑	**91.5%**	**91.4%**	**92.1%**

Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Transfers: Patients transferred out of hours	Report period:	February 2016

Driver for underperformance:	Actions to address the underperformance:
• Improved performance from previous month despite pressures • The volume of admissions with high acuity continues, which is reducing bed occupancy. • Discharges on the base wards are not happening early enough in the day to ensure flow from the Urgent Care departments	• Daily Command and Control in place to manage the activity and expedite discharges • The Inpatient Productivity theme of the Changing Care @ NGH programme has been launched and is identifying areas which need strengthening within the inpatient pathway
Forecast date (month) for *meeting the standard*	**Forecast performance for next reporting period:**
July 16	<100
Lead for recovery:	**Lead Director:**
Alison Pirfo	Deborah Needham

Historical Target Performance

Indicator		Target	Trend	Dec-15	Jan-16	Feb-16
S.21	Transfers: Patients transferred out of hours	0	↑	106	127	114

Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Percentage of patients cared for outside of specialty	Report period:	February 2016

Driver for underperformance:	Actions to address the underperformance:
• Improved performance against previous month. • Demand on medical team remains unprecedented. • Flow through the Trust has been compromised and to ensure safety, patients are moved to an available bed. • Capacity gap for medical beds	• Improving the clinical review for outlying patients • RAP (Recovery Action Plan) launched with focus on board/ward rounds and weekend discharges to help reduce outliers
Forecast date (month) for *meeting the standard*	Forecast performance for next reporting period:
March 16	20%
Lead for recovery:	Lead Director:
Sue McLeod / Dr Lyndsey Brawn	Deborah Needham

Historical Target Performance

Indicator		Target	Trend	Dec-15	Jan-16	Feb-16
S.22	Percentage of patients cared for outside of specialty	<10%	↓	15.0%	22.0%	21.0%

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Percentage of discharges before midday	Report period:	February 2016

Driver for underperformance:	Actions to address the underperformance:
• Static performance • Discharge decisions and actions not being completed early enough in the day, such as EDN, TTO	• Ward observations completed to review the true issues restricting discharges before 12 noon, from which the implementation of agreed changes will be launched • Greater Utilisation of the Discharge Suite earlier in the day • Improved Board/Ward rounds
Forecast date (month) for *meeting the standard*	**Forecast performance for next reporting period:**
March 16	22%
Lead for recovery:	**Lead Director:**
Sue McLeod / Lyndsey Brawn Fay Gordon / Mike Wilkinson	Deborah Needham

Historical Target Performance

Indicator		Target	Trend	Dec-15	Jan-16	Feb-16
S.23	Percentage of discharges before midday.	>25%	↑	19.7%	20.2%	20.1%

Northampton General Hospital NHS
NHS Trust

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Number of cancelled operations due to bed availability	Report period:	February 2016

Driver for underperformance:	Actions to address the underperformance:
• Improved performance against previous month, mainly as operations were cancelled in advance of the day. • Operations have been cancelled due to greater use of escalation areas throughout February • In severe escalation (RED) all non-urgent patients are cancelled to ensure safety for emergency patients	• The Trust is making changes throughout the Emergency Care Pathway to improve flow earlier in the day, high level actions include: • The Inpatient Productivity theme of the Changing Care @ NGH programme has been re-launched to improve efficiencies and flow through the Trust
Forecast date (month) for *meeting the standard*	Forecast performance for next reporting period:
Q3 2016	120
Lead for recovery:	Lead Director:
Alison Pirfo	Deborah Needham

Historical Target Performance

Indicator		Target	Trend	Dec-15	Jan-16	Feb-16
S.24	Number of cancelled operations due to bed availability	0	↑	31	173	94

Trust Board Corporate Scorecard
Exception Report

Target underperformed:	Number of Serious Incidents Requiring Investigation (SIRI) declared during the period	Report period:	February 2016

Driver for underperformance:	Actions to address the underperformance:
• **T&0** - Digit amputation • The patient attended A&E with an injured finger, A&E sorted an orthopaedic opinion which was completed and the patient remained under the care of A&E with instructions to return to their clinic the next day for IV antibiotics, which took place. The patient was previously known to the Plastics team – out of hours if A&E were concerned the pathway is to refer to Leicester. • **T&O** - Abington – fall dislocation • This patient attended A&E, fell in A&E but not x-rayed. Went to theatre and during the recovery period noted on x-ray to have sustained a dislocation. On initial assessment it appeared that not all aspects of the falls assessment and care planning protocol were followed. • **Medicine** - Collingtree – fall parenchymal haemorrhage • The patient had an unwitnessed fall at 04.40 on 05/01/16. The nursing staff noted that the patient was unresponsive and appeared cyanosed. The nursing staff put out a peri-arrest call as per protocol. The patient did not lose cardiac output at any time. The patient was assessed as being at risk of falls and the Falls care plan was in place. It had been updated at 0055 0n 04/01/16. The patient was not directly observable from the nursing station, but was previously independently mobilising safely with a zimmer frame.The patient was reviewed by the FY1 at 0950. Noted to be “less responsive” and that she “couldn’t keep her eyes open”. The Dr documented that anticoagulants were to be withheld and that the nursing staff were to inform the medics if there was a change in GCS which she had assessed as 14/15. The Doctor requested the CT head scan at 1024. It was not documented as “urgent”. The patient was taken for a CT scan of her head at 1623. There is no	• **T&0** - Digit amputation • This patient was treated through A&E and is currently under investigation recommendations and learning will be disseminated once the investigation is concluded – however this is not a T&O SI which the governance team are reassigning. This particular incident may be an external Serious Incident. • **T&O** - Abington – fall dislocation • Initial investigation undertaken and sent through to SI group. Falls expert included within the investigation as there is a variance in opinion as to when the dislocation occurred. • **Medicine** - Collingtree – fall parenchymal haemorrhage • Medical staff to review if the CT head should have been done urgently when the patient became more drowsy. This action will be discussed at the next governance meeting. Serious incident investigation ongoing- awaiting outcome.

documented reason for the delay in obtaining the CT scan. This showed a parenchymal haemorrhage	
Forecast date (month) for meeting the standard	Forecast performance for next reporting period:
NA	1
Lead for recovery:	Lead Director:
Fay Gordon / Sue McLeod	Dr Mike Cusack

Historical Target Performance

Indicator		Target	Trend	Dec-15	Jan-16	Feb-16
S.17	Number of Serious Incidents Requiring Investigation (SIRI) declared during the period	0	↓	0	0	3

Northampton General Hospital NHS Trust Quality Scorecard 2015-16

Caring

	Indicator	Target	Trend	Dec-15	Jan-16	Feb-16
C.1	Written complaints rate	None	↓	44	41	48
C.2	Complaints responded to within agreed timescales	=>90%		80.0%	Awaiting validation	
C.3	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	95.45% (Jan 16)	↓	90.6%	90.4%	89.3%
C.4	Friends & Family Test % of patients who would recommend: A&E	86.3% (Jan 16)	↑	86.7%	85.8%	89.3%
C.13	Friends & Family Test % of patients who would recommend: Maternity - Antenatal Community	95.9% (Jan 16)	↑	91.2%	98.5%	100%
C.14	Friends & Family Test % of patients who would recommend: Maternity - Birth	96.6% (Jan 16)	↓	96.4%	97.5%	94.7%
C.15	Friends & Family Test % of patients who would recommend: Maternity - Postnatal Ward	96.9% (Jan 16)	↓	97.1%	96.9%	94.6%
C.16	Friends & Family Test % of patients who would recommend: Maternity - Postnatal Community	100% (Jan 16)	↓	100%	100%	97.6%
C.6	Friends & Family Test % of patients who would recommend: Outpatients	92.4% (Jan 16)	↓	92.0%	91.6%	91.7%
C.7	Mixed Sex Accommodation	0	→	0	0	0
C.8	Total deaths where a care plan is in place	=>50%	↑	50.0%	56.0%	62.0%
C.9	Transfers: Patients moved with a risk assessment completed	100%	↓	96.2%	96.1%	94.7%

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.

Winter Pressures

	Indicators	Target	Trend	Dec-15	Jan-16	Feb-16
WP.1	Escalation Areas Open	0	↑	399	687	422
WP.2	Patient Ward Moves (between 9pm & 8am) - NEL ONLY	To be agreed	↑	70	91	71
WP.3	Cancelled Operation Numbers (Clinical & Non Clinical)	To be agreed	↑	260	415	301
WP.4	Patient who need to be readmitted if transport arrives too late	To be agreed	↑	22	5	13
WP.5	A&E Trolley waits 8hrs 1 min to 12hrs (DTA to admission)	To be agreed	↑	21	132	52

Effective

	Indicator	Target	Trend	Dec-15	Jan-16	Feb-16
E.1	Emergency re-admissions within 30 days (adult elective)	None	↑	4.5%	2.9%	3.4%
E.2	Emergency re-admissions within 30 days (adult non - elective)	None	↑	14.1%	14.2%	11.4%
E.3	Length of stay - All	=<4.2	↑	5.78	4.13	4.93
E.51	Length of stay - All (Excl. Compton, Blenheim & Cliftonville wards)	=<4.2	↓	3.82	3.8	4.25
E.4	Length of stay - Elective	=<2.7	↑	3.93	3.12	3.27
E.52	Length of stay - Elective (Excl. Compton, Blenheim & Cliftonville wards)	=<2.7	↑	3.8	3.02	3.08
E.5	Length of stay - Non Elective	=<4.7	↓	6.54	4.94	6.05
E.53	Length of stay - Non Elective (Excl. Compton, Blenheim & Cliftonville wards)	=<4.7	↓	4.3	4.51	5.29
E.6	Maternity: C Section Rates - Total	<26.2%	↑	28.5% (107)	25.6% (94)	24.2% (90)
E.7	Maternity: C Section Rates - Emergency	<13.0%	↑	13.6% (51)	13.9% (51)	12.9% (48)
E.8	Maternity: C Section Rates - Elective	<13.2%	↑	14.9% (56)	11.7% (43)	11.3% (42)
E.10	Mortality: SHMI	Within expected range	→	102	102	102
E.11	Mortality: HSMR		↑	103	101	100
E.12	Mortality: HSMR - Weekend		↓	99	97	101
E.13	Mortality: HSMR - Week day		↑	104	102	101
E.14	Mortality: Low risk conditions		↑	74	78	75
E.15	Mortality: Maternal Deaths	0	→	0	0	0
E.16	NICE Technology Appraisal Guidance compliance	=>80%	↓	Not Avail	98.3%	96.7%
E.17	Patients cared for in an escalation area (occ bed days)	0	↑	399	687	422
E.18	# NoF - Fit patients operated on within 36 hours	=>80%	↓	88.9%	95.5%	91.4%
E.19	Stroke patients spending at least 90% of their time on the stroke unit	=>80%	↓	63.5%	69.2%	57.1%
E.20	Suspected stroke patients given a CT within 1 hour of arrival	=>50%	↑	68.7%	65.8%	72.7%
E.47	% Weekend Discharges against Week Day Discharges	=>80%	↑	47.6%	63.5%	60.8%
E.54	% Daycase Rate		↓	87.7%	88.7%	88.0%

Safe

	Indicator	Target	Trend	Dec-15	Jan-16	Feb-16
S.1	C-Diff	Ave. 1.75 per mth	↑	4	5	2
S.38	C-Diff incidents apportioned to NGH care			Awaiting review response		
S.2	Dementia: Case finding	=>90%	↑	91.7%	90.6%	99.7%
S.3	Dementia: Initial diagnostic assessment	=>90%	→	100%	100%	100%
S.4	Dementia: Referral for specialist diagnosis/follow-up	=>90%	↑	89.5%	100%	100%
S.36	Falls per 1,000 occupied bed days	=<5.5	↑	4.8	5.2	4.7
S.6	Harm Free Care (Safety Thermometer)	94.05% (Feb 16)	↑	91.5%	91.4%	92.1%
S.7	Medical Notes: Availability for clinics	=>99%	↑	99.4%	98.7%	99.1%
S.11	Medication incidents that cause significant harm	0	→	0	0	0
S.12	MRSA	0	→	0	0	0
S.13	Never event incidence	0	↑	2	1	0
S.14	Pressure Ulcers: Avoidable grade 4	0	→	0	0	0
S.15	Pressure Ulcers: Avoidable grade 3	Max 3.4 p/mth	↓	1	3	4
S.16	Pressure Ulcers: Avoidable grade 2	Max 12.3 p/mth	↓	10	13	13
S.17	Number of Serious Incidents Requiring Investigation (SIRI) declared during the period	0	↓	0	0	3
S.18	Overdue CAS alerts	0	→	0	0	0
S.19	UTI with Catheters (Safety Thermometer-Percentage new)	0.32% (Feb 16)	↑	0.61%	0.16%	0.32%
S.20	VTE Risk Assessment	=>95%	↑	95.6%	95.7%	96.3%
S.21	Transfers: Patients transferred out of hours	0	↑	106	127	114
S.22	Percentage of patients cared for outside of specialty	<10%	↓	15.0%	22.0%	21.0%
S.23	Percentage of discharges before midday.	>25%	↑	19.7%	20.2%	20.1%
S.24	Number of cancelled operations due to bed availability	0	↑	31	173	94
S.32	TTO's sent by Taxi	0	→	0	0	0

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	Dec-15	Jan-16	Feb-16
R.1	A&E: Proportion of patients spending less than 4 hours in A&E	=>95%	↓	91.4%	80.4%	84.0%
R.2	A&E: 4hr SitRep reporting	=>95%	↓	90.1%	82.1%	84.5%
R.3	A&E: 12 hour trolley waits	0	→	0	0	0
R.4	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	=>99%	→	99.95%	99.97%	99.96%
R.5	Discharge: Number of medically fit patients awaiting discharge (average daily)	=<50	↑	122	108	115
R.6	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	=>93%	↑	95.7%	95.2%	95.8%
R.7	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	=>93%	↓	100%	100%	98.9%
R.8	Cancer: Percentage of patients treated within 62 days of referral from screening	=>90%	↑	97.0%	94.1%	100%
R.9	Cancer: Percentage of patients treated within 62 days of referral from hospital specialist	=>85%	↑	0%	100%	100%
R.10	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	=>85%	↑	77.0%	69.4%	80.0%
R.11	Cancer: Percentage of patients treated within 31 days	=>96%	↓	100%	94.7%	95.1%
R.12	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	=>94%	↑	100%	90.0%	100%
R.13	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	=>98%	↓	98%	98%	90.9%
R.14	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	=>94%	↑	100%	96.4%	98.4%
R.15	Operations: Urgent Operations cancelled for a second time	0	→	0	0	0
R.16	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	0	↓	2	3	13
R.17	RTT for admitted pathways: Percentage within 18 weeks	=>90%	↓	85.5%	87.6%	82.3%
R.18	RTT for non- admitted pathways: Percentage within 18 weeks	=>95%	↓	94.6%	93.1%	93.5%
R.19	RTT waiting times incomplete pathways	=>92%	↓	94.3%	94.1%	94.1%
R.20	RTT over 52 weeks	0	↑	0	1	0
R.21	Delayed transfer of care	0	↓	58	70	80

Well Led

	Indicator	Target	Trend	Dec-15	Jan-16	Feb-16
W.1	Friends & Family: % of staff that would recommend the trust as a place of work	N/Applic		55.0%	Not applic.	
W.2	Data quality of Trust returns to HSCIC (SUS)	=>90%	→	93.3%	93.3%	93.3%
W.3	Turnover Rate	=<8%	↑	11.70%	11.66%	11.19%
W.4	Sickness rate	=<3.8%	↓	4.10%	4.31%	4.44%
W.5	Staff: Trust level vacancy rate - All	=<7%	↑	9.5%	9.2%	7.4%
W.5	Staff: Trust level vacancy rate - Medical Staff	=<7%	↑	10.86%	10.90%	10.21%
W.5	Staff: Trust level vacancy rate - Registered Nursing Staff	=<7%	↑	13.42%	13.87%	11.13%
W.5	Staff: Trust level vacancy rate - Other Staff	=<7%	↑	12.29%	11.46%	8.92%
W.9	Staff: Temporary costs & overtime as a % of total pay bill	None	↑	13.3%	13.1%	12.6%
W.10	Percentage of staff with annual appraisal	=>85%	↓	82.5%	83.3%	80.2%
W.11	Percentage of all trust staff with mandatory training compliance	=>85%	↓	84.2%	84.0%	83.9%
W.12	Percentage of all trust staff with role specific training compliance	=>85%	↑	72.5%	73.0%	73.4%
W.15	Medical Job Planning	100%	↑	79.0%	81.0%	81.0%

Finance

	Indicator	Target	Trend	Dec-15	Jan-16	Feb-16
F.1	Surplus / Deficit	0 Fav		332 Fav	1,344 Fav	(262) Adv
F.2	Income	0 Fav		1,117 Fav	161 Fav	(377) Adv
F.3	Pay	0 Fav		(271) Adv	(199) Adv	(54) Adv
F.4	Non Pay	0 Fav		(979) Adv	(154) Adv	(301) Adv
F.5	Bank & Agency / Pay %	7.5%		8.5%	8.0%	8.1%
F.6	CIP Performance	0 Fav		(27) Adv	(27) Adv	(58) Adv
F.7	Waivers			7	4	7
F.8	Waivers which have breached			6	7	6

Section	Red Rated	Amber Rated	Green Rated	None	Total
Caring	1	0	2	9	12
Winter Pressures	1	0	0	4	5
Effective	8	1	12	3	24
Safe	8	2	12	1	23
Responsive	10	0	11	0	21
Well-Led	7	3	1	2	13
Finance	7	0	0	1	8
Total	42	6	38	20	106

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

Report To	**Trust Board**
Date of Meeting	**March 2016**

Title of the Report	National Staff Survey Results 2015
Agenda item	**15**
Presenter of the Report	Janine Brennan, Director of Workforce and Transformation
Author(s) of Report	Ian Gregory, Assistant Director Organisational Development & IQE
Purpose	For Information
Executive summary: The paper provides an overview of the survey results for 2015 and our actions to respond	
Related strategic aim and corporate objective	Enable Excellence through our people
Risk and assurance	
Related Board Assurance Framework entries	4.3
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? No Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? No
Legal implications / regulatory requirements	Staff survey results are considered as a key part of CQC ratings.
Actions required by the Board The Board is asked to note the report.	

Enclosure K

March 2016
National Staff Survey Results 2015

1. Introduction

The national staff survey was undertaken between October and December 2015. This report contains the key headlines.

2. Overview

A total of 1,442 members of staff returned the survey, constituting a 32% response rate. For the first time, all staff were surveyed instead of a sample of 850, this has resulted in a drop in our response rate, which was expected, however the numbers of staff who responded has more than tripled from the 394 in 2014.

Of the 32 key findings the Trust has one in the top 20%, for the first time since 2010 (staff appraised in the last 12 months), when compared to other Acute Trusts. The Trust had 10 statistically significant improvements since 2014. These included overall staff engagement and staff recommendation as a place to work or receive treatment.

The attached report sets out in detail the key findings together with the continued progress through our Organisational Effectiveness Strategy that was designed to address the underlying cultural and organisational issues that influence staff perceptions about the trust, their work environment and their role.

3. Assessment of Risk

The staff survey results are indicators used by the CQC as part of their regulatory role. In 2014 we changed our approach to move away from a more traditional year on year action plans. Instead we've developed our Organisational Effectiveness Strategy, a long term programme of work that aims to steadily improve our performance against the reports key findings.

4. Recommendations

The Board is asked to note the report.

5. Next Steps

Work continues on all key themes underpinning the Organisational Effectiveness strategy.

National NHS 2014 Staff Survey Results

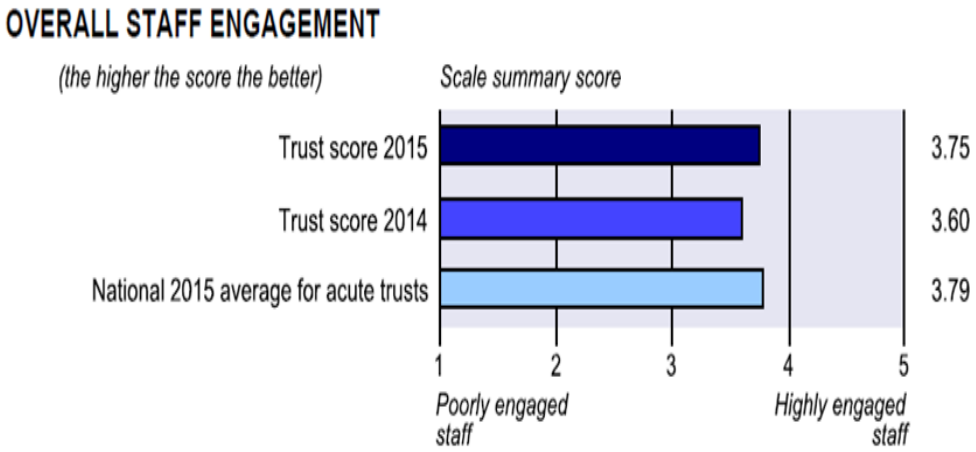
1.0 Summary

The NGH approach is to address the underlying root causes, working towards a fundamental shift in culture, where everyone is focussed on quality, continuous improvement and meaningful staff engagement to sustainably improve staff satisfaction at work.

All staff were invited to participate, with a response rate of 32%, we had 1,442 survey returns, up from 394 in 2014. Nationally, the response rate for Acute Trusts was 41%. By Occupation Group the highest responders were Admin & Clerical followed by Adult/General nurses. By Directorate the highest responses were received from Women, Children & Oncology Division. The Trust's 2015 Overall Staff Engagement score is virtually the same as the average for the sector (Trust 3.75, sector 3.79).

2.0 NGH Results

There are 32 Key Findings (relevant to acute sector) this year and there has been a marked improvement. In 2014 we had 18 key findings in the bottom 20%, in 2015 we have 9. Within those overall 32 areas, 10 results have improved, 13 have stayed the same and 10 could not be compared to the previous year's survey.



Drivers that could be linked to the improvements in the survey

- A focus on appraisal compliance
- Patient Safety Academy continue to work on learning from incidents
- Mandatory training compliance has seen further improvements
- Stability within the Executive team
- Team development through 'Rainbow Risk and Back in the Box' workshops (1,500)
- 8 modules of the Francis Crick Leadership programme delivered

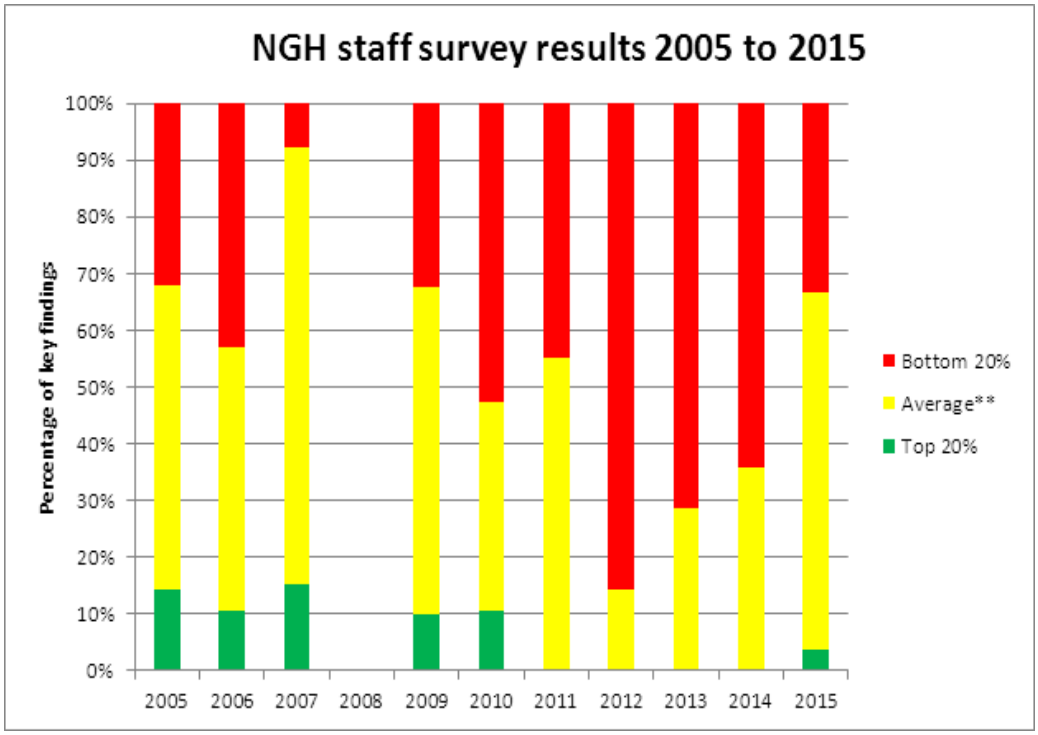
Significant issues at and around the time of the survey collection, which may have had an adverse impact

Enclosure K

- Junior Doctor contract negotiations
- Shift standardisation
- Doctor and Nurse staffing levels
- National pay constraints
- Hospital capacity and increasing activity/acuity of patients

Trend Analysis

The following graph shows the overall picture is now moving towards an increasingly upward trend.



3.0 Addressing the Underlying Issues

We maintain our stance to work on the development of a sustained, coherent and integrated approach to address the underlying organisational and cultural issues. The Trust's Organisational Effectiveness Strategy: **Connecting for Quality, Committed to Excellence** is the driver for this and work continues on a number of key aspects of this including:

- **The clinically led structure**

Clinical directorates operate a clinically-led model, with four divisions, each with three clinical directorates. The model's aims are to create more devolved decision making and greater synergy between medical, clinical and managerial staff.

- **Developing a culture of excellence**

Staff were involved in developing a new set of Trust values as follows:

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

Actions are being undertaken to embed these both in the staff journey, including values based recruitment, but also in the patient's journey.

In 2015 we adopted a 'values in Practice' OD intervention that was adopted in 2 areas where difficulties were being experienced and has been the subject of a Street Talk session. It has been agreed that this intervention will continue to be applied in the appropriate circumstances.

- **Francis Crick Development Programme**

The Francis Crick Programme is a Leadership and Management Programme for senior leaders operating in the new clinically led structure. 8 of the 15 modules have been run and will continue through 2016. Further cohorts will be developed during 2016.

- **Employee Engagement Strategy**

Since launching the employee engagement strategy in 2014, over 1000 employees have taken part in the journey making NGH a great place to work, for everyone through attendance and involvement in our workshops and events. The strategy was designed to facilitate cultural transformation to deliver improved sustainable staff engagement for high performance working, building capability and commitment at all levels of the organisation through:

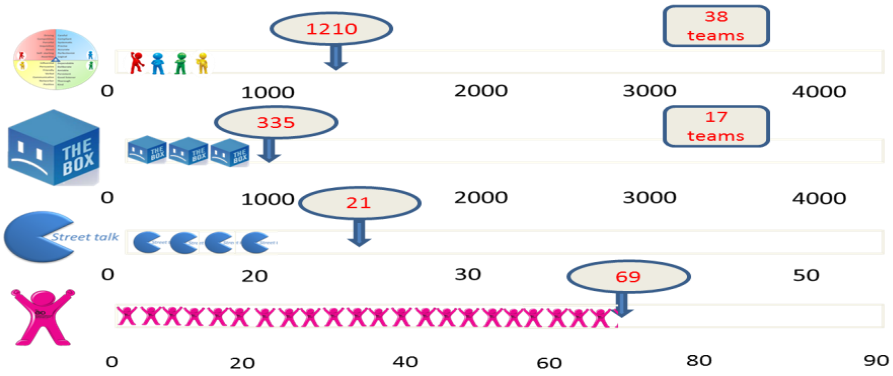
a) Encouraging self-awareness, emotional intelligence and positive behaviours aligned to the Trust values to improve work based interaction
b) Creating personal ownership and responsibility for NGH's priorities to achieve improved integration and increased collaborative working
c) Promoting platforms and opportunities to empower and enable the execution of innovation across all levels of NGH.

The strategy includes Street talk which has created greater alignment between staff and the Trust (3 events Trust wide and 22 local events) including a model of working with teams and individuals built around **Interact** (understanding personality types and styles of communication) I**ntegrate** (understanding how team cultures develop)– i**nnovate** model (designing the journey to excellence for your service).

- **Organisational Development Department**

Since 2014, the OD team has driven our Organisational Effectiveness Strategy through 7 themes. The highlight for some for those are:

Enclosure K



- **Communications and Culture**

Just over 1200 staff have been through our Rainbow Risk programme, and 335 through our Back in the box workshop. 4 Trust wide 'Street Talk' events have been held with a further 21 local events. We now have a network of 69 volunteer DoOD's, a supported network of key individuals from across NGH who actively support the staff engagement agenda.

- **Making Quality Count**

Since 2014, the Making Quality Count programme has run 28 successful projects. The 6 month development programme equips teams with a common methodology and tool kit for local service improvement. The teams access the expertise of the Improving Quality and Efficiency team (IQET) and typically look to deliver against a range of measures including: quality, patient safety, efficiency, productivity and staff engagement. 4 new projects have already commenced in 2016.

- **Staff family and friends (SFFT)**

Quarterly surveys have been used since 2014. They have allowed us to target a smaller audience and hear feedback and respond to comments in a more meaningful way. We will continue to complete the SFFT, working with areas of low recommendation to understand what it would take to increase our employee's recommendation of NGH as a place for treatment and as a place to work.

2015 National Staff survey results by key findings

The table below indicates the specific pieces of work that are underway that have been actioned to address each of the key findings aiming for a positive impact on improving results in future surveys.

↑ shows a statistically positive trend compared to 2014

Blank shows either no significant change and or cannot be compared

↓ shows a statistically negative trend compared to 2014

KEY FINDING	STATEMENT	TRUST SCORE	+/- Trend	Work completed and in progress
	STAFF PLEDGE 1: TO PROVIDE ALL STAFF WITH CLEAR ROLES, RESPONSIBILITIES AND REWARDING JOBS			
1	Staff recommendation of the organisation as a place to work or receive treatment	**3.63 out of 5**	⇧	People Strategy Organisational Effectiveness Strategy (rewarding Excellence) EES • Street talk • Interact -Rainbow Risk • Integrate- Boxes • Innovate – journey to excellence Staff FFT DoODs Trust values – all Nurse Recruitment Strategy Nurse Retention Strategy Making Quality count Induction for Overseas nurses Values based recruitment
2	Staff feeling satisfied with the quality of work and patient care they are able to deliver	**3.68 out of 5**		Employee Engagement Strategy (EES) • Street Talk • Innovate-journey to excellence Making Quality Count (MQC) continuous improvement development programme Nurse Recruitment Strategy Safety Academy
3	% of staff agreeing their role makes a difference to patients	**90%**		Patient Friends and family test MQC
4	Staff motivation at work	**3.93 out of 5**		EES • Interact -Rainbow Risk • Integrate- Boxes • Innovate – journey to excellence • Street talk Ward manager programme Francis Crick Programme People Strategy Trust values – all Best possible Care Awards Nurse Retention Strategy Developmental coaching, team and 1:1
5	Recognition and value of staff by managers and the organisation	**3.35 out of 5**		Trust values Best Possible Care awards NGH leadership module
8	Staff satisfaction with level of responsibility and involvement	**3.88 out of 5**		EES • Interact -Rainbow Risk • Integrate- Boxes • Innovate – journey to excellence
9	Effective team working	**3.75 out of 5**		EES • Interact (Rainbow Risk) • Integrate (Boxes) • Innovate (Journey to Excellence) Trust values (we respect and support each other) Developmental team coaching

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14	Staff satisfaction with resourcing and support	**3.21 out of 5**		Nurse Retention Strategy Nurse Recruitment Strategy
	STAFF PLEDGE 2: TO PROVIDE ALL STAFF WITH PERSONAL DEVELOPMENT, ACCESS TO APPROPRIATE EDUCATION AND TRAINING FOR THEIR JOBS AND LINE MANAGEMENT SUPPORT TO ENABLE THEM TO FULFIL THEIR POTENTIAL			
10	Support from immediate managers	**3.62 out of 5**	⇧	NGH Leadership model Ward manager leadership programme Francis Crick programme Band 6 and Band 7 development Matron Action Learning
11	% of staff appraised in the last 12 months	**91%**	⇧	Appraisal Policy (due for review 2016) Street Talk – Appraisals
12	Quality of appraisals	**2.99 out of 5**		Appraisal Policy (due for review 2016) Appraisal Training Ward manager leadership programme
13	Quality of non-mandatory training, learning or development	**4.02 out of 5**		Trust and Local Induction (policy reviewed 2015) Mandatory Training (policy reviewed 2014) Role specific training Band 6 and Band 7 development Francis Crick Programme Consultants Programme Specific education and training programmes for clinical staff e.g. medical education, Practice Development etc. People Strategy
	STAFF PLEDGE 3: TO PROVIDE SUPPORT AND OPPORTUNITIES FOR STAFF TO MAINTAIN THEIR HEALTH, WELL-BEING AND SAFETY			
15	% satisfied with the opportunities for flexible working patterns	**44%**		Nursing Shift standardisation project
16	% working extra hours	**73%**		Nurse Recruitment strategy Nursing Shift standardisation project People Strategy
17	% of staff suffering work related stress	**39%**		Stress Management Policy Health & Well-being Occupational Health service People Strategy Nurse Recruitment Strategy Nurse retention Strategy
18	% of staff feeling pressure in the last three months to attend work when feeling unwell	**58%**	⇧	Management of Sickness Absence Policy Nurse Recruitment
19	Organisation and management interest in and action on health and wellbeing	**3.41 out of 5**		Stress Management Policy Health & Well-being Occupational Health service Domestic Abuse Support for staff policy
22	% of staff experiencing physical violence from	**17%**		Protecting Staff Against Violence, Aggression and Harassing Situations From Patients and Members of the Public Policy (due for review)

	patients, relatives or the public in the last 12 months			Conflict Resolution Training
23	% of staff experiencing physical violence from staff in last 12 months	**2%**	⇧	Disciplinary Policy Conflict Resolution Training Trust values – Respect and support
24	% staff /colleagues reporting most recent experience of violence	**52%**		Safety Academy Datix Francis response (Freedom to Speak Up)
25	% experiencing harassment, bullying or abuse from public in last 12 months	**31%**	⇧	Francis response (Freedom to Speak Up) recommendations Protecting Staff Against Violence, Aggression and Harassing Situations From Patients and Members of the Public Policy
26	% experiencing harassment, bullying or abuse from staff in last 12 months	**29%**		EES • Interact - Rainbow Risk Bullying, Harassment & Victimisation Policy (reviewed 2015)
27	% reporting most recent experience of harassment, bullying or abuse	**35%**		Safety Academy Datix Raising Concerns at Work (Whistleblowing) Policy
	STAFF PLEDGE 4: TO ENGAGE STAFF IN DECISIONS THAT AFFECT THEM, THE SERVICES THEY PROVIDE AND EMPOWER THEM TO PUT FORWARD WAYS TO DELIVER BETTER AND SAFER SERVICES			
6	% reporting good communication between senior management and staff	**28%**		NGH leadership model Francis Crick programme Communications strategy Core brief Intranet development All staff going onto email Team Huddles New clinically led Structure Team Huddles CEO Blog Executive visibility e.g. Board to Ward
7	% able to contribute towards improvements at work	**68%**		EES • Street talk • Innovate – journey to excellence Making Quality Count programme
	ADDITIONAL THEMES: EQUALITY AND DIVERSITY			
20	% experiencing discrimination at work in the last 12 months.	**9%**	⇧	EES • Interact - Rainbow Risk Equality & Diversity Staff Group Equality & Human Rights Strategy 2013 – 2016
21	% believing the Trust provides equal opportunities for career progression or	**84%**		Recruitment, Selection and Retention Policy Equality & Human Rights Strategy People Strategy Nurse Retention Strategy

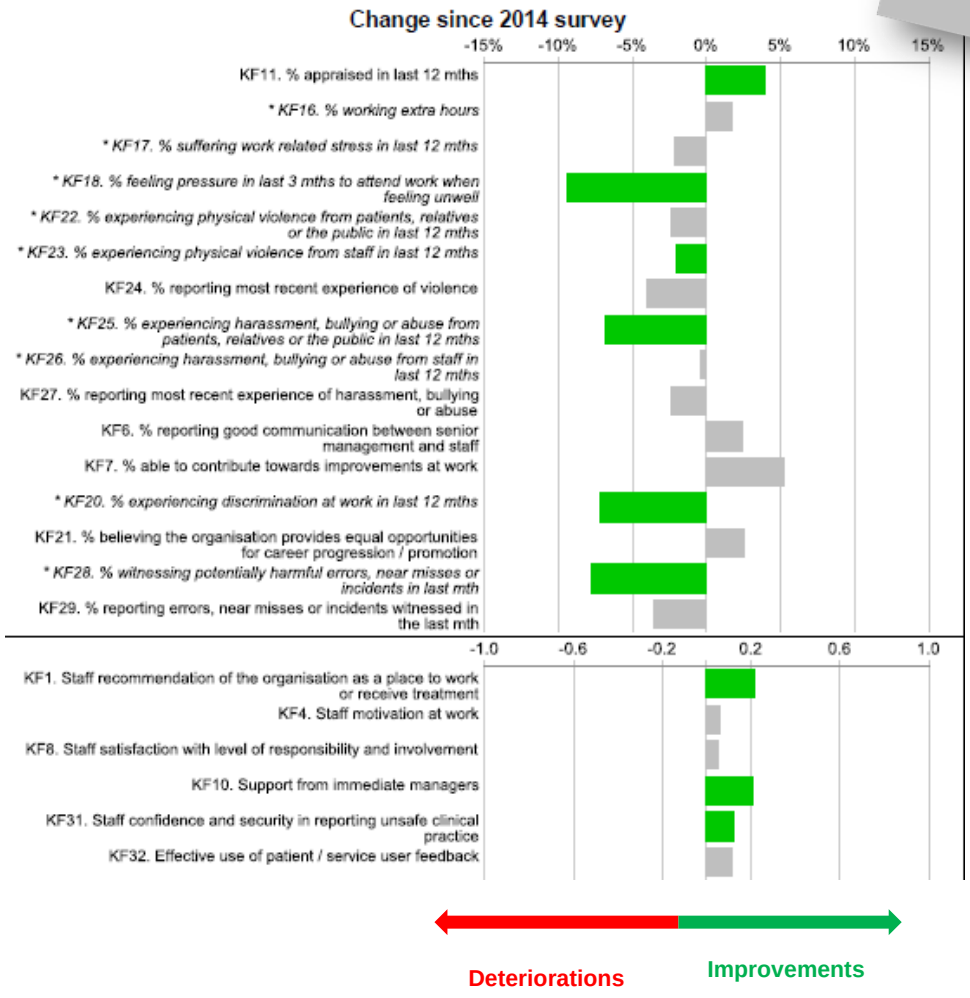
	promotion			
	ADDITIONAL THEMES: ERRORS AND INCIDENTS			
28	% of staff witnessing potentially harmful errors, near misses or incidents in the last month	**34%**	⇧	Safety Academy Datix
29	% of staff reporting errors, near misses or incidents witnessed in the last month	**88%**		Raising Concerns at Work (Whistleblowing) Policy Safety Academy
30	Fairness and effectiveness of incident reporting procedures	**3.60 out of 5**		Raising Concerns at Work (Whistleblowing) Policy Safety Academy Datix
31	Staff confidence and security in reporting unsafe clinical practice	**3.55 out of 5**	⇧	Francis response (Freedom to Speak Up) recommendations Raising Concerns at Work (Whistleblowing) Policy Safety Academy
32	Effective use of patient / service user feedback	**3.65 out of 5**		Patient FFT EES • Innovate – journey to excellence Street talk

Key –
EES – Employee Engagement Strategy
OES – Organisation Effectiveness Strategy
PFFT – Patient Friends and Family Test
SFFT – Staff Friends and Family Test

Appendix 1

Extract taken from National NHS Staff Survey RNS Full Report to highlight improvements and deteriorations by key findings since 2015

Change since 2014 Survey for Northampton General Hospital



Enclosure K

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

Title of the Report	**Report from the Finance Investment and Performance Committee**
Agenda item	**16**
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 February.	
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 L

Actions required by the Trust Board

The Trust Board is asked to note the report.

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: 31 March 2016

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

Executive Summary

The Committee met on *17 February 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)*
Month 10 Report Changing Care Report Update on Agency Cap Update on Pharmacy Stock Control Addressing the capacity gap by Increasing the adult bed base Business Case Board Assurance Framework	

Key areas of discussion arising from items appearing on the agenda

Additional beds
Conversion of non-recurrent CIP to recurrent
52 week wait breach – further report to be presented to Quality Governance Committee
Assurances provided on Pharmacy Stock
Trajectories on key performance indicators

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

Business case re 60 beds to be approved the Board

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

Board Assurance Framework

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

Action required by the Board

Enclosure L

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**March 2016**

Title of the Report	**Report from the Quality Governance Committee**
Agenda item	**17**
Presenter of Report	Liz Searle, Non-Executive Director and Chair of Quality Governance Committee
Author(s) of Report	Paul Farenden, Chairman
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 February A verbal update from the March 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

Actions required by the Trust Board

The Trust Board is asked to note the report.

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: 31 March 2016

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

Executive Summary

The Committee met on *19 February 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)*
Ophthalmology Report Surgical Never Events Complaints/Patient Feedback	

Key areas of discussion arising from items appearing on the agenda

WHO Surgical Safety Checklist
Patient Safety in escalation bed areas
Noted Level 7 Safeguarding Improvement

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

Paper offering assurance regarding patient safety in escalation bed areas will come to the March committee meeting

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

Not at this time

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	**March 2016**

Title of the Report	**Report from the Workforce Committee**
Agenda item	**18**
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 February

Related strategic aim and corporate objective	Strategic Aim 3,4 and 5
Risk and assurance	Risks assessment provided within the report.
Related Board Assurance Framework entries	BAF 4.1, 4.2, 4.3
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (Y/N) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (Y/N)

Enclosure N

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

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: 31 March 2016

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

Executive Summary

The Committee met on *17 February 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)*
Risks around medical staffing and recruitment Length of time to deal with suspensions Staff Survey – positive results Significant improvement in safe staffing	

Key areas of discussion arising from items appearing on the agenda

Revalidation Report no longer required on the Workforce Agenda
Medical Agency Staffing report to be moved to Finance Committee

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

Board Assurance Framework changes/amendments

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

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

Action required by the Board

Enclosure N

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**March 2016**

Title of the Report	**Report from the Hospital Management Team Workshop Meeting held on 15th March 2016**
Agenda item	
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 March 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 O

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: 31st March 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 as a workshop on *15th March 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**
Divisional Updates Clinical collaboration update on progress Fit for purpose changing care work stream update Communications workshop	1.1, 1.2, 2.2, 3.1, 3.2,

Key areas of discussion arising from items appearing on the agenda

Dr Swart provided an overview of the urgent care pressures and recent meeting held with 30 acute hospitals regarding poor A&E performance and the current financial position including the offer of *management* support from NHS Improvement.

Divisions presented their top 3 areas of challenge and actions being taken from their monthly performance meetings, the themes discussed were broadly similar to those discussed at the subcommittees of the Board:

a. Urgent care pressures including ALOS
b. Mandatory training
c. Theatre utilisation
d. Job planning
e. Cancer 62 day target
f. Medical staffing and recruitment
g. Delivery of CIP for 16/17

The committee received an update on the business cases which had been submitted to the CCG of which two had been approved and the remainder had been rejected. A clinical discussion is now required between NGH and Nene CCG with regard to those cases which were rejected.

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

The meeting received a paper and update on the clinical collaboration between NGH and KGH, this was with respect to progress made in rheumatology, orthopaedics, radiology and ophthalmology, along with the other 7 existing speciality partnerships. Members of HMT confirmed their wish to continue the collaboration work and move forward with a joint HMT type forum.

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

Enclosure O

All areas of risk regarding quality and performance are covered in Trust Board reports	
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 31 March 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 28 January 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.**
10:25	**OPERATIONAL ASSURANCE**				
	10.	Finance Report	Assurance	Mr S Lazarus	**F.**
	11.	Workforce Performance Report	Assurance	Mrs J Brennan	**G.**
10:45	**STRATEGY**				
	12.	Clinical Collaboration & Healthier Northants Update	Assurance	Mr C Pallot	**H.**
10:55	**GOVERNANCE**				
	13.	Emergency Preparedness Annual Report	Assurance	Mrs D Needham	**I.**
11:00	**FOR INFORMATION**				
	14.	Integrated Performance Report	Assurance	Mrs D Needham	**J.**
	15.	Staff Survey	Assurance	Mrs J Brennan	**K**
11:15	**COMMITTEE REPORTS**				
	16.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler	**L**

Time	Agenda Item		Action	Presented by	Enclosure
	17.	Highlight Report from Quality Governance Committee	Assurance	Mrs L Searle	**M.**
	18.	Highlight Report from Workforce Committee	Assurance	Mr G Kershaw	**N.**
	19.	Highlight Report from Audit Committee	Assurance	Mr D Noble	**Verbal**
	20	Highlight Report from Hospital Management Team	Assurance	Dr S Swart	**O.**
11:45	**21.**	**ANY OTHER BUSINESS**		Mr P Farenden	**Verbal**

DATE OF NEXT MEETING

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