Northampton General Hospital NHS
NHS Trust

Public Trust Board

Thursday 26 January 2017

09:30

Board Room
Northampton General Hospital

Northampton General Hospital NHS
NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 26 January 2017
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 Zeidler	**Verbal**
	2.	Declarations of Interest	Note	Mr P Zeidler	**Verbal**
	3.	Minutes of meeting 24 November 2016	Decision	Mr P Zeidler	**A.**
	4.	Matters Arising and Action Log	Note	Mr P Zeidler	**B.**
	5.	Patient Story	Receive	Executive Director	**Verbal**
	6.	Chairman's Report	Receive	Mr P Zeidler	**Verbal**
	7.	Chief Executive's Report	Receive	Dr S Swart	**C.**
10:00	**CLINICAL QUALITY AND SAFETY**				
	8.	Medical Director's Report	Assurance	Dr M Cusack	**D.**
	9.	Director of Nursing and Midwifery Report	Assurance	Ms C Fox	**E.**
10:25	**OPERATIONAL ASSURANCE**				
	10.	Finance Report	Assurance	Mr S Lazarus	**F.**
	11.	Workforce Performance Report	Assurance	Mrs J Brennan	**G.**
10:50	**STRATEGY**				
	12.	Clinical Collaboration & STP Update	Assurance	Mr C Pallot	**H.**
11:05	**FOR INFORMATION**				
	13.	Integrated Performance Report	Assurance	Mrs D Needham	**I.**
	14.	Resilience Annual Report	Assurance	Mrs D Needham	**J.**
11:15	**GOVERNANCE**				
	15.	Corporate Governance Report	Assurance	Ms C Thorne	**K.**
	16.	Approval of subcommittee Terms of Reference	Assurance	Ms C Thorne	**L.**
11:30	**COMMITTEE REPORTS**				

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

DATE OF NEXT MEETING

The next meeting of the Trust Board will be held at 09:30 on Thursday 30 March 2017 in the Board Room at Northampton General Hospital.

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

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

Northampton General Hospital NHS
NHS Trust

Minutes of the Public Trust Board

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

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

TB 16/17 070 Introductions and Apologies

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

Apologies were received from Ms O Clymer and Ms C Fox.

TB 16/17 071 Declarations of Interest

No new Declarations of Interest were noted.

TB 16/17 072 Minutes of the meeting 29 September 2016

The minutes of the Trust Board meeting held on 29 September 2016 were presented for approval.

The Board resolved to **APPROVE** the minutes of the 29 September 2016 as a true and accurate record of proceedings subject to typographical errors.

TB 16/17 073 Matters Arising and Action Log 29 September 2016

The Matters Arising and Action Log from the 29 September 2016 were considered.

Action Log Item 66:
Dr Cusack advised that the information was now included within the Medical Directors report.

Action Log Item 67:
Mrs Brennan stated that there is an automated generated reminder email service that sends out reminders for outpatient appointments. Ms Brennan confirmed that the option of a telephone reminder service is being explored.

The Board **NOTED** the Action Log and Matters Arising from the 29 September 2016.

TB 16/17 074 Patient Story

Mr Abolins presented the Patient Story.

Mr Abolins shared with the Board a compliment letter received from the Chief Executive at Carlsberg following the recent gas leak at the Organisation following which the Trust treated 30 plus members of their staff. The Chief Executive of Carlsberg expressed his gratitude to the Trust and the staff who treated their employees. He noted that the staff at NGH were inspirational and showed a great level of professionalism. He would like to pass on thanks on behalf of all staff at Carlsberg and if the Trust needs Carlsberg's support in the future, to not hesitate to ask.

Mr Abolins advised the Board that a letter of thanks had also been received on behalf of Northampton Fire Service and NCC.

The Board **NOTED** the Patient Story.

TB 16/17 075 **Chairman's Report**

Mr Farenden presented the Chairman's Report.

Mr Farenden advised that he had revisited a ward that when he had originally visited the ward had appeared to be struggling under operational pressures. The ward support had improved considerably and the staffs were complimentary to the support that it was receiving.

Mr Farenden commented that he appreciates the fantastic work and effort by staff to ensure patient safety and the highest quality of patient care.

Mr Farenden stated that he recently attended a Health & Wellbeing Board and noted that the presentations were inspirational. The concordat of support to ex-military personnel and their family was very moving. It was also encouraging to see the support given to mental health. Mr Farenden advised that the values demonstrated at the Health & Wellbeing Board needed to be displayed by the Health Economy in the manner that the Healthy Economy responds to challenges.

Mr Farenden shared with the Board that the recommendation to appointment 2 Non-Executives to the Trust Board had been passed to NHSI for approval. Mr Farenden confirmed he would update the Board once feedback has been received from NHSI.

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

TB 16/17 076 **Chief Executive's Report**

Dr Swart presented the Chief Executive's Report.

Dr Swart advised that she had recently attended the HSJ Awards where the Trust had been nominated for its staff engagement work. Even though the Trust did not win, Dr Swart found the event uplifting. Dr Swart commented on the standing ovation that was given to EU staff at the HSJ Awards and that this was important to note.

Dr Swart praised the use of external communications which has encouraged people to come and work for the Organisation.

Dr Swart stated that urgent care pressures are still the main challenge for the Trust. The last 6 weeks has been extremely difficult with an increase in respiratory illnesses and an overall increase in sick patients in comparison to November 2015. Dr Swart advised that Mrs Needham has led a huge programme of work of help reduce these pressures.

Dr Swart commented that the Trust needs to focus on what matters most. It is critical that patients receive the most appropriate treatment and are asked the right

questions. Dr Swart and Mrs Needham are working on the implementation of a safety barometer.

Dr Swart shared the importance of ensuring 95% of observations happen on time and that patients are escalated appropriately. It is essential to make use of the A&E Board and the Trusts partners in Social Care.

Dr Swart stated that the Safety Survey as part of the AQUA programme had done very well in A&E and that this needs to be built on. Dr Swart has recently received 3 compliments from patients who had been admitted to A&E and who had felt safe.

Dr Swart advised that the Sustainability Transformation Plan (STP) for the County had not been published due the Trusts impression that the plan was embargoed. Following recent correspondence it is noted that the plan will be made public shortly. A formal communication plan will be launched to ensure the staffs are fully aware and understand the STP. Dr Swart stated that key messages of the STP are moving care into the community, the stabilisation of acute services and bringing in partners to work in a collaborative way. Cancer services will feature in the plans with a focus on improving diagnosis and treatment.

Dr Swart reported that the NHSI Single Oversight Framework categorised Trusts into 4 segments with the Trust put into segment 3. These means that the Trust will continue to have a lot of mandated support and continued high level of scrutiny. Dr Swart commented that 80 out of 137 Trusts are placed in segment 3 or 4.

Dr Swart shared with the Board that a planned programme of events will include listening and learning events for staff and patients. The plan is noted to be extensive.

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

TB 16/17 077 **Medical Director's Report**

Dr Cusack presented the Medical Director's Report.

Dr Cusack advised that actions were in place to address the pressures within the urgent care pathway. The Trust has and continues to undertake substantial work in order to mitigate the risks to patients posed by the urgent care pressures. Dr Cusack noted pressures have increased in the recent weeks due to an increase in acuity.

Dr Cusack reported that there are still difficulties in securing sufficient Nursing and Medical Staff. There is work being done on the recruitment of medical staff.

Dr Cusack drew the Board to page 25 of the report pack which now includes the definition of 'Serious Incident' which was revised by NHS England at the beginning of 2015/16. Since the last report to the Board, during the reporting period 1/9/2016 – 31/10/2016 there has been 1 new Serious Incident has been reported onto STEIS. This relates to a patient who was admitted to the Trust with a Grade 4 pressure ulcer which is under review. The outcome of this review will be presented to the Quality Governance Committee.

Dr Cusack commented that learning from the 10 Serious Incidents reported to date in 2016/17 has been shared with clinical teams and staff through their local governance forums/groups. The Governance Team have facilitated Trust wide quarterly events where learning from serious incidents is shared which are open to all of the multidisciplinary team. Dr Cusack stated that the most recent event took place in September focusing on Never Events that had occurred within the Trust and also a Board to Ward on Theatre Safety.

Dr Cusack advised that the HSMR for the year to July 2016 remains with the 'as

expected' range. The revised SHMI for the period April 2015 to March 2016 is also within the 'as expected'.

Dr Cusack delivered an update on the expectation for Trusts to introduce the role of Medical Examiner. The timescale for this is not yet clear however Dr Cusack believed that the role would be introduced in 2017 and he will provide the Board with an update when more information is available.

Dr Cusack drew the Board to page 29 of the report pack which details the Trust's progress on the 2016/17 CQUINs. The CQUIN requirement to deliver flu vaccine to 75% of frontline clinical staff is currently at 74.1%. Dr Cusack noted that there are risks with the compliance of the Quarter 4 CQUINs for Sepsis and Antimicrobial Resistance and Stewardship. Dr Cusack believed that the 2 year CQUINs for 2017/19 are to carry on the same themes for Sepsis and Antimicrobial Resistance and Stewardship.

Dr Cusack reported on Sepsis performance which is on page 31 of the report pack. The Trust performance in ensuring that there is timely screening of patients with suspected sepsis is shown on the graph on page 31 of the report pack. Dr Cusack is confident that the quarter 4 target will be reached. The quarter 4 CQUIN also includes a drug review required within 72 hours. The ongoing work is detailed on page 32 of the report pack.

Mr Farenden noted that the SI group meet weekly and asked whether the importance of the group is received by all given the current operational pressures. Dr Cusack stated that the shift in definition of SI's has changed the focus of the group to a review of harm group. SI's involving moderate harm or severe harm is always discussed at the group. There number of SI investigators has reduced however the SI investigators now come from a more skilled pool of staff. Dr Cusack advised that reporting can be done by in a concise manner and also as a full SI report. A concise report allows learning from the SI to be more relevant and prompt. Dr Cusack noted that it is a challenge however to cascade the information. Ms Thorne stated that the Mortality Review Group compliments the SI Group.

Mr Zeidler asked whether Dr Cusack has confidence that all SI's are reported. Dr Cusack advised that the Governance Team submit a report to the Quality Governance Committee that has a breakdown of all incidents and grades of harm. There is a high level of reporting with a low rate of harm reported. Ms Thorne commented that the introduction of anonymous Datix reporting may also improve incident reporting. Dr Cusack stated that automatic feedback is given to the reporter where in the past there were issues with this function.

Mrs Needham shared with the Board that a report on maintaining safety and managing patient flow through Winter will be presented at Decembers Quality Governance Committee.

Dr Swart commented that the Trust needs a more comprehensive action for the reporting on Sepsis and that this has become a national issue. The plan needs to be built into the process as normal to ensure that it is sustainable.

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

TB 16/17 078 **Director of Nursing and Midwifery Care Report**

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

Ms Barnes advised that in October 2016 NGH achieved 98.6% harm free care (new harms). The Trust has achieved 93.14% of harm free care in October. Broken down into the four categories this equated to: 0 falls with harm, 0 venous

thromboembolism, (VTE), 2 Catheter related urinary tract infections (CRUTI) and 7 'new' pressure ulcers.

Ms Barnes noted there was a positive decrease in number of patients harmed from pressure ulcers and it is important that the Trust maintains this reduction.

Ms Barnes reported that from a national perspective it is required that the Trust will need to report on gram-negative bacteraemia next year. The Trust already reports on this monthly and it is likely that the whole Health Economy will have a trajectory.

Ms Barnes stated that there has been a reduction in severe and moderate falls. The Falls Prevention Lead commenced in post in October.

Ms Barnes advised that Safeguarding Children Level 3 training compliance has seen a decrease over the past three months. This has been raised through the Divisions and that weekly safeguarding level 3 sessions will be provided.

Ms Barnes reported that in relation to safe staffing the Overall fill rate for October 2016 was 103%, compared to 102% in September and 105% in August. The combined fill rate during the day was 99%, compared with 98% in September. Ms Barnes drew the Board to page 48 of the report pack which summarises the Care Hours per Patient Day (CHPPD) metric.

Ms Barnes commented that the development of a 'Model Hospital' has continued to provide hospitals with detailed guidance as to what 'good' looks like. Currently the N&M Dashboard has limited data available to review. Therefore no further data has been presented on the 'Model Hospital' dashboard in December.

Mr Zeidler queried the summer seasonal variation peak in Safeguarding referral activity detailed on page 45 of the report pack. Ms Barnes clarified that summer seasonal peaks is a nationally recognised peak due to children being at home more due to the summer holidays.

Mr Zeidler questioned the value of the CHPPD metric. Dr Swart stated that this was discussed at the Workforce Committee. The Trust will comply with the metric and will see if it can gather any meaningful information from the data. Mr Zeidler could see the use of the metric as a comparative measure.

Mr Noble asked for clarity as to why there would be more HCA's planned then nursing. Ms Barnes confirmed that this would due to enhanced observation of care requirements.

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

TB 16/17 079 **Segmentation of Trusts**

Dr Swart presented the Segmentation of Trusts Report.

Dr Swart updated the Board on what the Segmentation of Trusts will mean for NGH. The Trust will received mandated support for specific concerns. The Trust will also be regularly monitored on finance and performance. The CQC will assess how the Trust uses its resources.

Dr Swart stated that the Well-Led Framework focuses on Quality Improvement. The Trust has signed up to receive Quality Improvement information from HSJ and the Trust has launched its QI statement.

Dr Swart commented that further work will be needed to improve the Trusts 'requires improvement' rating to good rating in next year's CQC inspection.

Mr Farenden queried whether the Trusts finance performance could pull the rating back down. Dr Swart clarified that it is about value not just cost. The Trust is on track to deliver its plan and this gives the Trust financial credibility. Dr Swart stated that the Trust has low reference costs. There are things within the Trusts gift and these must be worked on whilst maintaining a high level of safety to the Trusts patients.

Mr Zeidler asked for an update on the Trusts reference costs. Dr Swart advised that these were at 92 and that the reference costs are falling further. Mr Farenden commented that the Trust does not receive recognition for its good reference costs.

The Board **NOTED** the Infection Segmentation of Trusts Report.

TB 16/17 080 **Finance Report**

Mr Lazarus presented the Finance Report.

Mr Lazarus advised that the overall I&E position is a deficit of £7.689m, £0.02m favourable to the year to date plan. This position is measured against the revised I&E control total agreed with NHSI for FY16-17. Mr Lazarus reported that the £7.7m deficit after 7 months equates to £1.1m per month which over the FY16-17 would equal £13.2m. Mr Lazarus commented that there has been an increase in cost reduction over the first 5 months with a potential 20% increase over Winter. Due to the increase over Winter, the Finance Committee cannot be assured that the Trust will meet its financial target.

The Board **NOTED** the Finance Report.

TB 16/17 081 **Workforce Performance Report**

Mrs Brennan presented the Workforce Performance Report.

Mrs Brennan advised that Substantive Workforce Capacity has increased by in October 2016. The Annual Trust turnover decreased by 0.07% to 9.86% in October which is above the Trust target of 8%. The reduction in registered nurses is an ongoing struggled. Mrs Brennan stated that Registered Nursing & Midwifery vacancy rate decreased.

Mrs Brennan commented that in month sickness absence had increased by 0.17% to 3.93% which is above the Trust target of 3.8%, however the Trust is still lower than the national average. The increase could be linked to seasonal variation.

Mrs Brennan reported that the current rate of Appraisals recorded for October 2016 has decreased and Mrs Brennan commented that due to the decrease this will be monitored. Mandatory Training compliance and Role Specific Essential Training compliance increased in October. Mrs Brennan advised that Medicine and Surgery have had their own trajectories set and that these will be monitored in performance review meetings.

Mrs Brennan stated that within October 2016 there have amendments to 4 policies and these are listed on page 83 of the report pack.

Mrs Brennan delivered the Board an update on the phase 2 of the Francis Crick programme. The programme will aimed at new Clinical Directors, Matrons and Managers. The programme content is reinforced for the learner by the addition of action learning sets. Mrs Brennan advised that the Trust is working with the Institute of Leadership and Management (ILM) to accredit the programme to a recognised qualification.

Mrs Brannan advised that Flu Vaccination compliance is at 74.1%.

Mr Farenden stated that the training figures appear quite resilient and wondered whether this could be sustained. Mrs Brennan confirmed that high training compliance had been sustained for a long period of time and believed that contributory to the sustainment is that the Divisions are now able to recognise the importance of training. Mr Farenden queried whether Mrs Brennan is satisfied with the focus and commitment given to training by the Divisions. Mrs Brennan confirmed that she was. It is important to note that 3 years ago training compliance was at 30%.

Mr Farenden commented that there now appeared to be a strong cultural message forming. Dr Swart stated that the Francis Crick Programme was a big cultural programme and has helped staff to think in a different way whilst adapting to the current environment.

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

TB 16/17 082 STP and Clinical Collaboration Update

Mr Pallot presented the Board with a STP and Clinical Collaboration Update.

Mr Pallot advised that on 8 December 16 the STP will be released to the public.

Mr Pallot noted that early feedback is that the STP will need to be revisited as the control totals for each organisation will have to be met each year both individually and collectively as well as over the 5-year life of the STP.

Mr Pallot stressed the importance of understanding the impact of each scheme on the Trusts activity plan which is being negotiated as part of the contract process.

Mr Pallot shared the positive news that the Collaboration Steering Board with KGH has supported the Dermatology case, with one amendment being requested which is the inclusion of additional quality metrics and links to national guidelines where they exist. It has been agreed that members of the steering board will attend the CCG Finance Committee next week to discuss the Dermatology and Rheumatology case (due for implementation April 2017).

Mr Pallot noted that resource is still an issue and which is even more pressing as there is likely to be a request to bring forward workstream delivery. Work is now underway for on Cardiology and Pathology. The next 5 workstreams have been identified and but further work will need to be undertaken with the PMO at the CCG to resource them.

Dr Swart discussed the dermatology case further. Dr Swart commented that the service will be delivered in the community and it has not been set up to stabilise Trust income but to provide a positive patient pathway, excellent outcomes and a contribution to the STP. It will be important to the GP's current work and will help set up a good clinical governance framework. The business case will ensure everyone can deliver the right care in a standardised way.

Dr Swart stated that the Trust needs to support the dermatology case as a package and that it will be good for both patients and clinical staff. Dr Swart commented that she is excited to see the benefits the service will provide.

Mr Farenden shared his concern on the timeframe given to the other workstreams considering the enormous financial challenge. Mr Farenden questioned whether the work was being done at the right pace. Mr Pallot advised that there is a high level of enthusiasm from senior clinicians in the service to deliver the agreed outcomes. The dermatology business case will receive a significant financial contribution to the STP and Mr Pallot noted that this is a positive message.

Mr Farenden queried whether the contract and financial discussions of the STP are synchronised. Mr Pallot stated that the discussions are based on the unmitigated activity plans which are the basis on which the Trust has accepted its control total. Only those mitigations will be accepted where appropriate levels of detail can be shared with the Trust that provides a basis for costs to be removed as the schemes are delivered.

Mr Pallot reported that the focus of the discussions is much more on the system, alongside the interests of the organisation. On 5 December 16 the Trust will need to decide on whether it enters mediation. The contract needs to be signed by the 23 December 16.

Mr Zeidler noted that there was significant focus on the Changing Care @NGH scheme for next year and asked whether there was any further clarity on the STP schemes. Mr Pallot commented that there is no further information on the STP schemes to advise the Board.

Dr Swart advised that she has had conversations with the Accountable Officer at NHS Nene CCG and there is agreement that progress is needed on agreeing the STP finances. A clearer understanding is also required on activity is translated.

Mr Pallot hoped that early feedback would be given week commencing 28 November 16 following submission of the plan today (24 November 16).

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

TB 16/17 083 **Integrated Performance Report**

Mrs Needham presented the Integrated Performance Report.

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

Mrs Needham reported that the Trust had met its diagnostic and RTT targets and thanked the Divisions for their hard work.

Mrs Needham noted that progress was being made in Cancer and she is confident that the Trust will be able to deliver on target by the end of January.

Mrs Needham commented that she was proud of our staff despite the ongoing challenge with Urgent care and the daily pressures in ensuring flow through the organisation is optimised . Mrs Needham's noted that the biggest concern presently is the morale & resilience of staff.

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

TB 16/17 088 **Highlight Report from Finance Investment and Performance Committee**

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

The Board were provided a verbal update on what had been discussed at the Finance Investment and Performance Committee meeting held on 16 November 2016. The report covered any issues of significance, interest and associated actions that were required and had been agreed to be taken forward by the Committee.

Mr Zeidler advised of the key points –

- There were discussions on the STP and the impact of the Changing Care

programme.
- Self-certification for Agency staff which was a significant focus of the Changing Care Group.

Mr Zeidler would like the Board to be aware that the Finance Investment and Performance Committee are keeping a focus on the key points discussed.

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

TB 16/17 089 **Highlight Report from Quality Governance Committee**

Mr Farenden presented the Highlight Report from the Quality Governance Committee.

The Board were provided a verbal update what had been discussed at the Quality Governance Committee meeting held on 18 November 2016. The report covered any issues of significance, interest and associated actions that were required and had been agreed to be taken forward by the Committee.

Mr Farenden advised of the key points –
- The End of Life and Palliative Care Team have been merged into 1 team.
- The Clinical Audit Team will now sit under Governance.

Dr Swart reported that the approach to Quality Improvement run rates would be explored in a different way. Dr Swart commented that the Quality Improvement work is highly important as it enables the Board to ask the right questions and it is the way forward.

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

TB 16/17 090 **Highlight Report from Workforce Committee**

Mr Kershaw presented the Highlight Report from the Workforce Committee.

The Board were provided a verbal update on what had been discussed at the Workforce Committee meeting held on 16 November 2016. The report covered any issues of significance, interest and associated actions that were required and had been agreed to be taken forward by the Committee.

Mr Kershaw advised of the key points –
- The Workforce Retention and Recruitment Strategy is a key focus to the Committee.
- The Workforce Performance Report included information on QI improvements and the Francis Crick training programme phase 2.
- The Medical Education report needs to give the Committee further assurance that adequate progress is being made.

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

TB 16/17 091 **Highlight Report from Hospital Management Team**

Dr Swart advised the Board that Novembers Hospital Management Team meeting was cancelled as the Trust was on black alert.

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

TB 16/17 092 **Any Other Business**

Mrs Needham informed the Board that the Trust will be appealing its quarter 2 cancer performance trajectories.

Mrs S Watts encouraged the Board to attend the Long Service Awards.

Date of next meeting: Thursday 26 January 2017 at 09:30 in the Board Room at Northampton General Hospital.

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

Public Trust Board Action Log							Last update	03/01/2017
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								

Northampton General Hospital NHS
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**26 January 2017**

Title of the Report	**Chief Executive's Report**
Agenda item	***7***
Presenter of the Report	Dr Sonia Swart, Chief Executive
Author(s) of Report	Sally-Anne Watts, Head of Communications
Purpose	For information and assurance
Executive summary The report highlights key business and service issues for Northampton General Hospital NHS Trust in recent weeks.	
Related strategic aim and corporate objective	N/A
Risk and assurance	N/A
Related Board Assurance Framework entries	N/A
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	None
Actions required by the Trust Board The Trust Board is asked to note the contents of the report	

Enclosure C

Northampton General Hospital NHS
NHS Trust

Public Trust Board
26 January 2017

Chief Executive's Report

1. Our 2017 challenge

During the first three months of the year we have a challenging number of issues to address so that we can continue to safely deliver urgent care and, at the same time, comply with centrally-mandated regimes and programmes of work.

It is important to remember that, although the A&E situation is high on the agenda in the minds of the government, the media, the public and internally because of the pressures it causes, there are many other national programmes of work which are equally important and we need to ensure we keep all of these in mind so that we can serve our population in the best way. The system plans in development will pick some of this up but increasingly there is a need for system plans to include all the programmes of work needed to deliver the national cancer strategy, 7 day working, and the national plans for mental health and maternity – just as examples. A great deal of elective work has been postponed in recent months and we must find a way of ensuring that we can protect critical elective services for our patients. If we are to be successful it is important that we identify the key issues and focus on our core values.

Our first challenge is to develop and deliver a series of listening and learning events for our staff at all levels. We will have a variety of types of format for these, such as informal events, workshops and question time events.

We will also be refreshing our clinical strategy and our strategy for development of the hospital site. Both strategies will be developed and shared with staff and service users.

Our quality improvement strategy has now been agreed and will be formally launched during February. Our aim is to ensure this is linked with improved communication about the work that is underway along with clearer alignment with the overall strategy which includes our leadership and developing people strategy.

In the face of the challenges we must remember that culture change and transformation and real change take time, especially when there are many external pressures. We are not there yet, but we have made progress. That is why we must stick to our plans and make them work.

A number of our change projects are delivering results. We have been recognised nationally for the work we are doing and received a number of prestigious awards. I am confident that 2017 will continue in a similar vein.

Many things that have been important at NGH during recent years are now being echoed in others that are receiving a national mandate. Some of the important points that are coming through include the following recommendations, all of which are in accord with our aim of providing the best possible care and our core values:

- Make quality and quality improvement the strategy. This is what we are trying to do at NGH. To train staff in quality improvement and urge everyone to help improve care. That aligns with our view that each and every member of staff has two duties, one to deliver care and one to improve it. This will help recreate a sense of involvement and vocation.

- Nurture a culture of compassion and inclusion and move away from blame and fear. I believe this needs to start with a rebalance of inspections and targets and will require a new approach from the centre which they are now formally acknowledging but internally we need to ensure we don't just transmit the target culture.

- Change the balance of power to ensure our staff lead the changes that are needed. Clinical leadership and management are important components of this structure and we must keep our attention on this.

- Develop staff, nurture talent and make leadership inclusive. Our internal programmes of development for senior managers are a start.

- Greater focus on bringing joy into work and promoting wellbeing for our staff. I believe this is the most important and most difficult thing for us to achieve and during 2017 we will find ways of celebrating all the good things and keep our sense of purpose going.

- Consider how to align all the efforts of our organisation around what matters most. This is critical so that everyone understands their part in helping us achieve the overall aims we have set ourselves.

At a time of unprecedented demand for NHS services, with the inevitable pressure that this places on our staff, I have been heartened by a number of positive efforts made by our staff to bring joy into the workplace. This hospital achieves incredible things every day and working through the current pressures and keeping our patients safe is an achievement in itself.

2. Long service awards

Both the chairman and I were delighted to host our long service awards festive tea just before Christmas. This was a relaxed and friendly occasion when we, along with other board members, were able to meet and talk with several members of staff who have given NGH more than 25 years' continuous service.

Many of those who attended commented on how special the occasion was and they had welcomed the chance to celebrate their commitment in a less formal way. Based on their feedback we will be adopting a similar approach for our next long service awards celebration.

3. Member engagement

We recruited several thousand members as part of our NHS foundation trust application and for some time I have been aware that we have not been as effective in communicating with them as we might be.

In 2016 Membership Engagement Services (MES) were appointed to provide us with a database management system, which includes a monthly review of members to identify any who have moved or passed away. This new database now provides with a platform on which to rebuild our member engagement, which began with our first event on 26th January.

Within days of announcing the event to our members more than 50 had signed up to attend our first ‘Quality Conversation’, many of whom expressed their pleasure at being invited. I am confident that we can build on the success of this event and take our membership engagement forward now in a more meaningful way than we have previously.

Dr Sonia Swart
Chief Executive

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 January 2017**

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

Executive summary

One new Serious Incidents has been reported during the period 1/11/2016 – 31/12/2016 which relates to Delay in the Diagnosis of a Type B Thoracic Dissection. A further Serious Incident (Grade 4 pressure ulcer) remains active. Where appropriate, immediate actions have been agreed at the SI Group to mitigate against recurrence. No Serious Incident reports have been submitted to the CCG for closure during the reporting period.

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

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

An update is provided on the Trust roll-out of electronic prescribing.

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
January 2017

Medical Director's Report

1. Clinical Risks

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

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

1.1 Pressure On Urgent Care Pathway

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

The Trust has and continues to undertake substantial work in order to mitigate the risk to patients posed by the urgent care pressures. This is coordinated through the Urgent Care Working Group led by the Chief Operating Officer with representation from each of the clinical Divisions. Significant progress has been made through this group across a broad range of actions including the on-going roll out of the SAFER Bundle.

1.2 Difficulties in Securing Sufficient Nursing & Medical Staff

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

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

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

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

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

The potential impacts of these issues are also described in items BAF 1.4, BAF 1.5, BAF 4.1 and BAF 4.2 within the Board Assurance Framework.

2. Summary Serious Incident Profile

The Trust is committed to identifying, reporting and investigating serious incidents, and ensuring that learning is shared across the organisation and actions taken to reduce the risk of recurrence. The Trust is determined, where at all possible, to prevent the occurrence of serious incidents by taking a proactive approach to the reporting and management of risk to ensure safe care is provided to patients, through the promotion of a positive reporting and investigation culture.

A report on Serious Incidents (SI) is presented to the Committee on a monthly basis to provide assurance that incidents are being managed, investigated and acted upon appropriately and that action plans are developed from the Root Cause Analysis investigations.

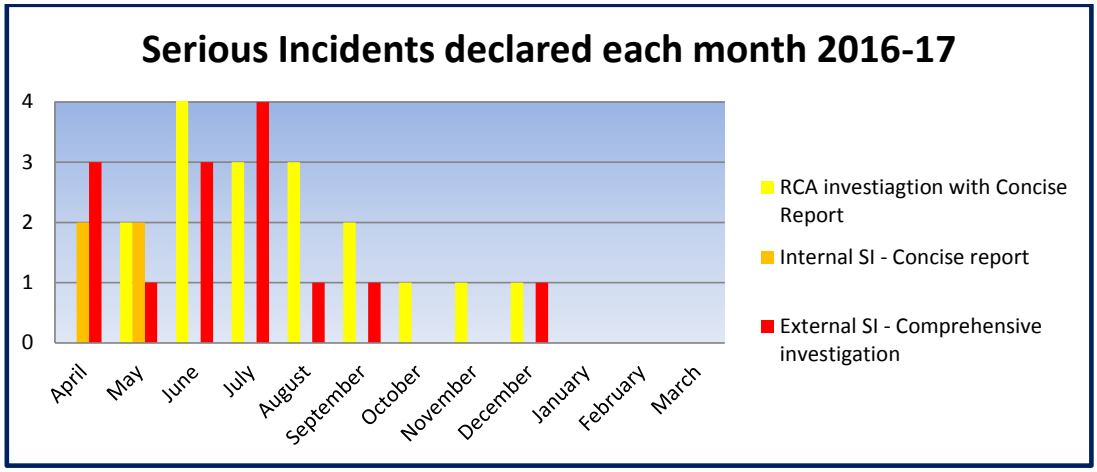
This element of the report paper focuses on those incidents determined to be Serious Incidents following the guidance from the NHS England's 'Serious Incident Framework" published in March 2015 which requires reporting externally via STEIS.

The patient safety incidents that do not fulfil the criteria for reporting onto STEIS but where there are thought to have been omissions or concerns over the care the patient received, are now declared as a "Concise Investigation". This allows for a thorough root cause analysis investigation and provision of a concise report outlining the investigation and findings.

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

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

The following graph demonstrates the number of declared Concise Reports that have a comprehensive root cause analysis and the External Serious Incidents that have been reported onto STEIS between 1st April 2016 and 31st March 2017:



2.1 Never Events

There were no incidents in November or December that met the criteria of a Never Event.

2.2 New Serious Incidents

Since the last report to the Board, during the reporting period 1/11/2016 – 31/12/2016 1 new Serious Incident has been reported onto STEIS:

2016/32625 Delay in the Diagnosis of a Type B Thoracic Dissection

One other Serious Incident remains active:

2016/24735 Grade 4 Pressure Ulcer

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).

Within **2016/17**, 11 Serious Incidents have been reported under the following categories:

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

- Maternity/Obstetric incident
- Pressure ulcer

2.3 Open Serious Incidents

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

STEIS/Datix Ref.	STEIS Criteria / SI Brief Detail	Directorate	Location
2016/24735 W-67503	Grade 4 Pressure Ulcer	Outpatients, Elderly & Stroke	Victoria Ward

2.4 Serious Incidents Submitted for Closure

During the reporting period there were no serious incident reports submitted to Nene and Corby Clinical Commissioning Group (CCG) for closure.

The systematic investigation of Serious Incidents results in important lessons being learned and improvements identified and implemented. These improvements support the embedding of an effective safety culture, thus allowing the delivery of high quality, safe patient care.

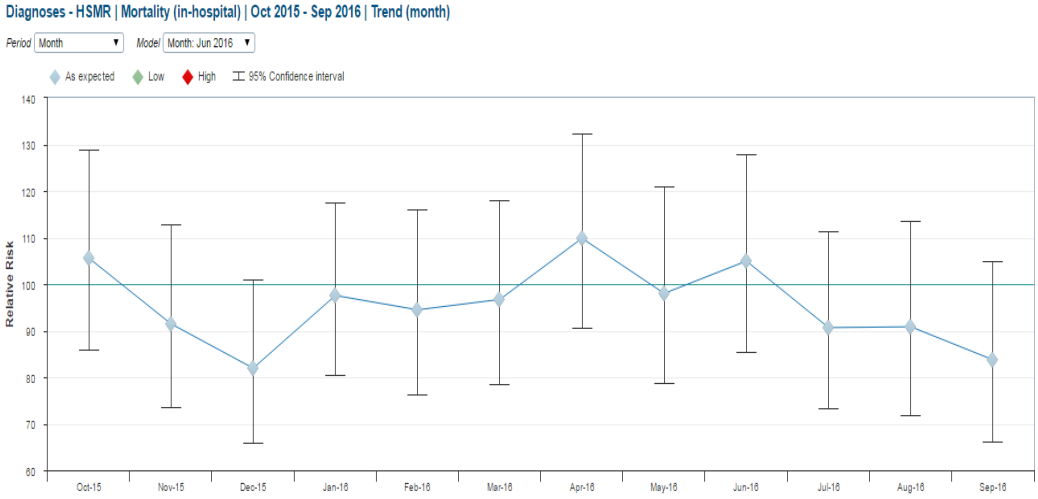
The lessons learned from serious incident investigations, are shared with clinical teams and staff through their local governance forums/groups. These are also shared with staff across the Trust where lessons apply more widely through the publication of safety alerts, bulletins and discussion at team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

The Governance Team also facilitate Trust wide 'Dare to Share' Learning Events quarterly where learning from serious incidents is shared. These events are open to all of the multidisciplinary team and have been well attended. The next is scheduled to take place on 20/1/17.

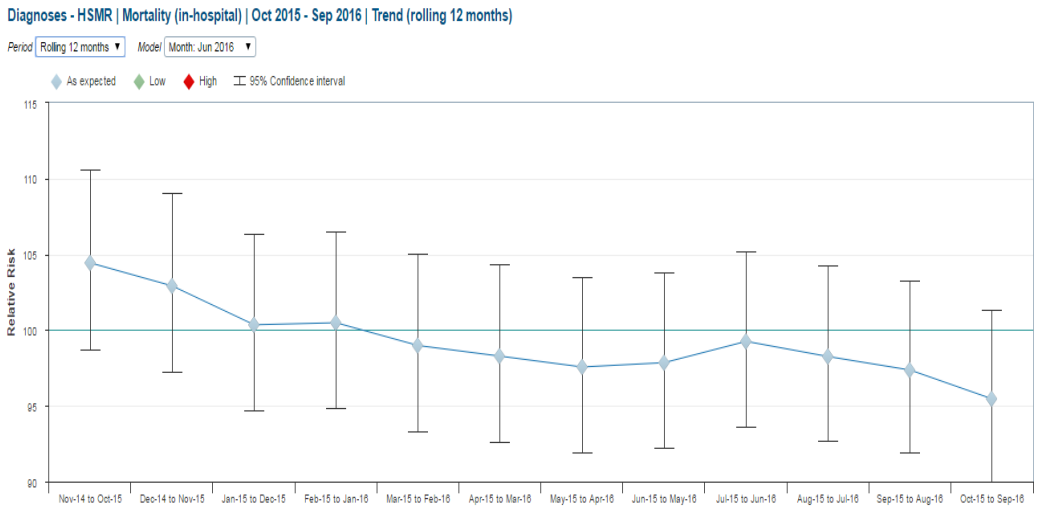
The findings from Serious Incident reports are shared with the patient and/or family by the Governance Team in line with Trust's Duty of Candour.

3. Mortality Monitoring

The HSMR for the year to September 2016 remains with the 'as expected' range at **95.5**. The variation in HSMR during the 12 months to September 2016 is shown in the graph below:

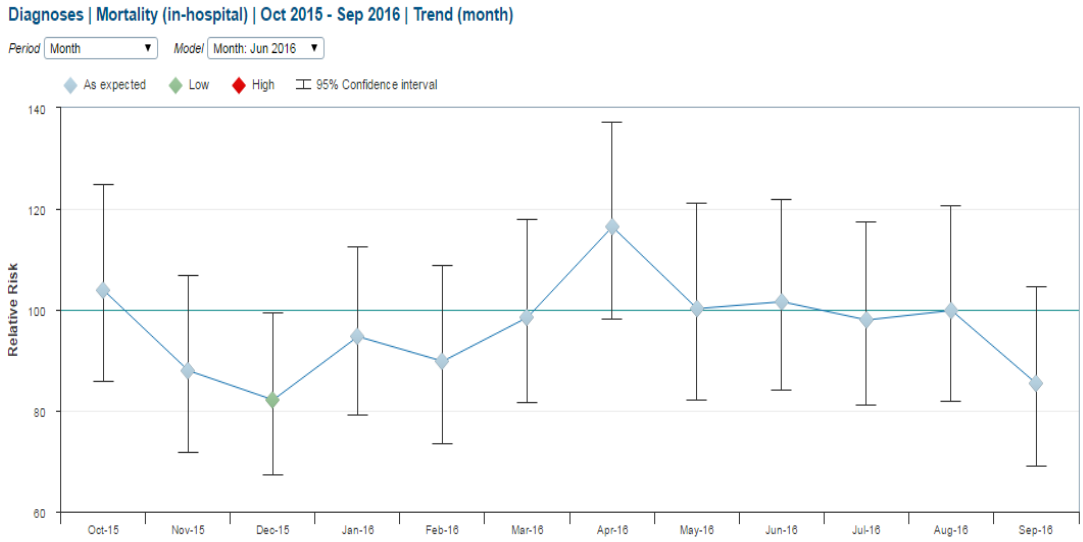


Longer term variation in HSMR represented by the 'rolling years' for Nov'14/Oct'15 to Oct'15/Sept'16 is shown below:



Between July and September the monthly SMR has remained less than 100 and this is reflected in the recent reduction in the 'rolling' HSMR over a similar timeframe.

The SMR for the All Diagnoses Metric for the rolling year to September 2016 was also 'as expected' (SMR=**96.5**). Monthly variation in the SMR for All Diagnoses is shown below:



The recently revised SHMI for the period July 2015 to June 2016 is within the 'as expected' range at **94.8**. The all diagnosis metric approximates to the SHMI which also includes patients who die within 30 days of hospital discharge. The variation within the All Diagnosis SMR metric described above suggests that SHMI will continue to remain within the 'as expected' range.

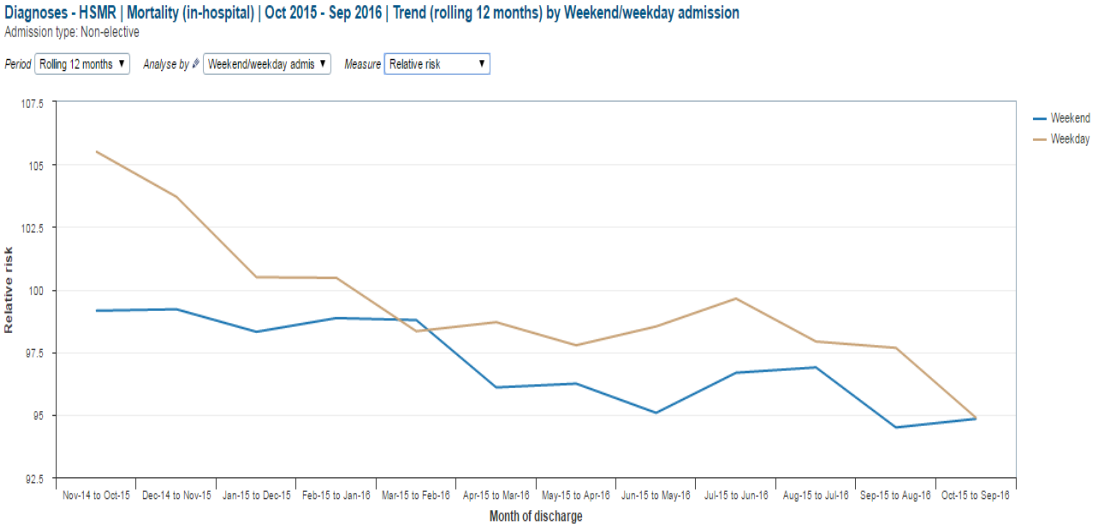
The Trust SHMI value relative to that of our peers is shown in the table below:

SHMI - Published (With Over Dispersion): (Jul 15 - Jun 16)

	Provider	Denominato	Obs	Exp	Obs-Exp	SHMI	Low	High
RC1	Bedford Hospital NHS Trust	32,967	1,218	1,161	57	104.87	88.77	112.65
RWH	East And North Hertfordshire NHS Trust	68,652	2,337	2,193	144	106.54	89.37	111.90
RNQ	Kettering General Hospital NHS Foundation Trust	49,299	1,565	1,459	106	107.29	89.02	112.33
RC9	Luton And Dunstable University Hospital NHS Foundation Tr	71,693	1,646	1,534	112	107.29	89.07	112.27
RD8	Milton Keynes Hospital NHS Foundation Trust	41,145	1,187	1,150	37	103.22	88.76	112.67
RNS	Northampton General Hospital NHS Trust	69,275	1,756	1,852	-96	94.82	89.24	112.06
RWD	United Lincolnshire Hospitals NHS Trust	84,291	3,455	3,139	316	110.07	89.58	111.63
RWE	University Hospitals Of Leicester NHS Trust	151,571	4,506	4,483	23	100.51	89.73	111.44
RWG	West Hertfordshire Hospitals NHS Trust	61,406	1,865	2,097	-232	88.92	89.34	111.94

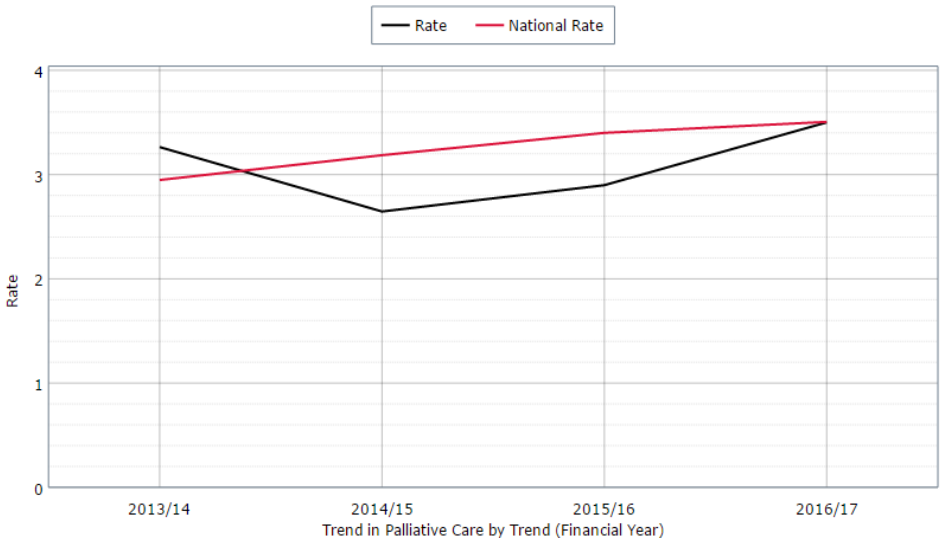
3.1 Weekend Effects

The HSMR for emergency admissions to the Trust on weekdays (**94.9**) and weekends (**94.8**) remains in the 'as expected' range. The variation in these measures over time is shown here:

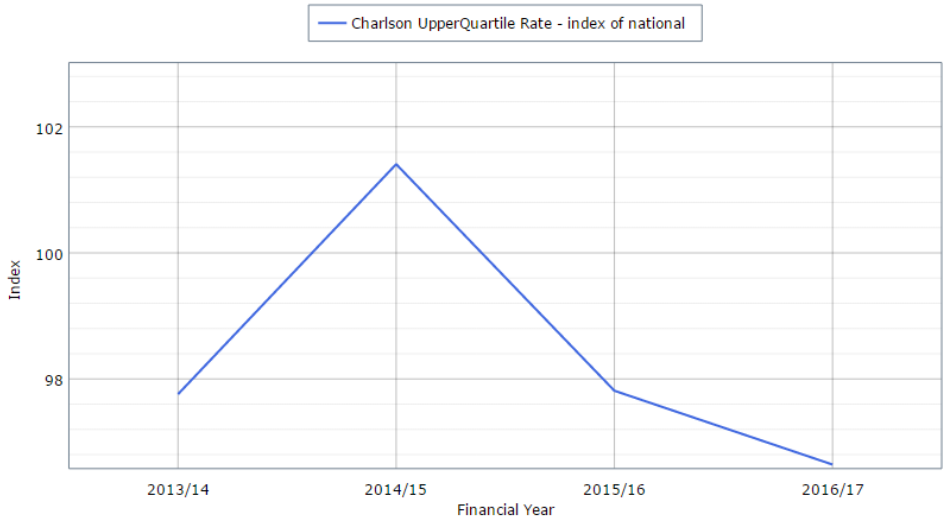


3.2 Coding Trends

The Trust has a palliative care coding rate for 2016/17 of 3.50% which now approximates closely to the national rate of 3.51%:



The NGH rate of Charlson co-morbidity upper quartile reporting (24.2%) remains lower than the national rate (25.0%) but has increased since the last report to the Board (23.8% reported in December):



4. Quality Schedule

The draft NHS Standard Contract requires that the Trust to report against certain quality indicators on a periodic basis. The quality requirements are set out in Schedule 4 of the Contract and are split into seven sections. Within these sections are the Local Quality Requirements (LQR) and Commissioning for Quality and Innovation (CQUIN).

4.1 Local Quality Requirements

These are agreed locally with the Commissioner and are derived from a variety of sources, such as:

- Nationally approved quality requirements derived from NICE standards
- The core set of quality indicators for mandatory reporting in Quality Accounts
- Previous years' NHS standard contracts
- Local indicators

The Local Quality Requirements for 2017 to 2019 (two years) have been agreed and are outlined here:

Quality Requirement	**Threshold 2017-19**
End of Life care	To support delivery of person-centred End of Life Care through integration within and between providers of healthcare along the pathway.
Patient Safety	1)National Information 2) Incidents 3) Policy 4) Discharge Information 5) Outpatient Letters

	6) Mortality & Morbidity 7) Cancer Patients with a long waiting time
Learning	1) The provider will demonstrate a learning culture from ward to board. 2) Review action taken towards implementation of NICE technical appraisal guidance, within three months of publication. Review action taken towards implementation of all other NICE guidance and Quality Standards that are judged to be appropriate to the Trust as a provider of acute care 3) Evidence of learning from concerns about patient care raised by GPs and/or trust
Quality care for Patients with a Learning Disability	Implementation of actions from the Learning Disability 'Better Healthcare Plan'
Patient Experience	1)Evidence that patient experience is of equal importance as clinical quality and patient safety 2) Evidence of learning from complaints and PALs enquiries 3) Evidence of learning from National and regional surveys
Nutrition and Hydration	1) 95% of patients have a completed MUST score within 24 hours 2) 95% of eligible patients have an individualised care plan
WHO surgical checklist	All patients undergoing a surgical procedure to have all stages of the WHO checklist completed
National Early Warning Score (NEWS)	Report on the percentage of patients that have NEWS undertaken within required time period and percentage of patients whose NEWS triggers need for review who are reviewed.
Safeguarding Children	Implementation of Early Help Assessment (EHA) Section 11 Audit /Audits and Agreed Assurance Framework Learning Supervision
Safeguarding Adults	Safeguarding Alerts Dashboard Quality Monitoring Visits SAAF Safeguarding Alerts Dashboard Quality Monitoring Visits Learning Supervision Appropriate use of Mental Capacity Act (2005) Assessments and Deprivation of Liberty Safeguards Training

Workforce	a) Assurance provided that 85% of all staff (including Drs & AHP) have received appraisals, mandatory and essential to role training b) Provider is compliant with the expectations in relation to nursing and midwifery and care staffing and capability as laid out in '*How to ensure the right People with the right skills are in the right place at the right time'.*
VTE	As per Service Condition 22, the following will be required and monitored: 1. All patients receive VTE prevention in line with the NICE Quality standards. 2. Root cause analysis will be undertaken on all cases of hospital associated thrombosis.
Pressure Tissue Damage	2016/17 data to be used to set baseline of numbers of hospital acquired grade 2/3/4. Trust to agree ongoing improvement for the year in April 2017 (to be repeated for 2017/18) To continue to participate in countywide work to prevent pressure tissue damage.
Service Specifications	Assurance that all service specifications included in the 2017/19 contract are being implemented.
Quality Assurance regarding any trust sub-contracted services	Assurance that all services sub-contracted by the trust have been fully quality monitored with any areas of concern investigated

4.2 CQUIN

The income associated with CQUINs for NGH in 2016/17 is approximately £4.7 million**.** The framework aims to embed quality within commissioner-provider discussions and to create a culture of continuous quality improvement for the benefit of the patients we serve, with stretching goals agreed in contracts on an annual basis.

2016/17

The CQUIN submission for Q2 was met with the outcomes shown below:

			NGH
CQUIN Goal		**Description**	**Q2**
Staff Health and Wellbeing		a Introduction of health and wellbeing initiatives – Option B	
		b Healthy food for staff, visitors and patients	
		c Flu vaccinations for front line clinical staff	
Sepsis	a Emergency dept.	ai Screening	achieved
		aii Treatment and three day review	achieved
	b Acute Inpatient	bi Screening	achieved
		bii Treatment and three day review	achieved

Antimicrobial resistance and antimicrobial review	a Reduction in antibiotic consumption per 1000 admissions	achieved (no payment attached this quarter)
	b Empiric review of antibiotic prescriptions	achieved
End of life pathways	Identification of causes of patients not dying at their PPD and actions for improvement.	achieved
Dementia Discharge summaries	Patients of any age who have a known diagnosis or are identified as having a dementia have a discharge summary that is shared with GP	achieved
Dementia John's Campaign	Supporting carers and family members of people with dementia to be welcomed by hospitals	achieved
AKI	Focuses on AKI diagnosis and treatment in hospital and the plan of care to monitor kidney function after discharge	achieved
Delayed Transfers of care	Supporting Improvements across the local system to make improvements in patient flow and discharge	achieved

The Q3 submission of Trust data will be prior to 31 January 2017 and all milestones for this period are on track.

The Q4 submission is due on 28 April 2017 and a risk to delivery of 5% of the total CQUIN value or £280,835.65 has been identified. This is related to the following areas:

- **Q4 – Sepsis CQUIN.** Q4 target of 90% for the early identification, accurate assessment and appropriate treatment of sepsis. It should be noted that there is a partial payment for part B of the CQUIN (acute inpatient setting).

- **Q4 - Antimicrobial Resistance and Stewardship CQUIN – Reduction in antibiotic consumption.** This CQUIN is split into four parts with the risk being centred on three reductions (the total reduction of antibiotic consumption, total reduction of carbapenems and total reduction of piperacillin-tazobactam). The Trust antibiotic guidelines have continued to follow the best available evidence and take account of local antimicrobial resistances.

2017/19

The finalised CQUINs for 2017 to 2019 (two year CQUINs) have now been agreed and are:

National CQUINs
1a. Improvement of staff health and wellbeing
1b. Healthy food for NHS staff, visitors and patients
1c. Improving the uptake of flu vaccinations for frontline clinical staff within Providers.
2a. Timely identification of patients with sepsis in emergency departments and acute inpatient settings

2b. Timely treatment of sepsis in emergency departments and acute inpatient settings
2c. Assessment of clinical **antibiotic review** between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.
2d. Reduction in antibiotic consumption per 1,000 admissions
4. Improving services for people with mental health needs who present to A&E.
6. Offering advice and Guidance (A&G)
7. NHS e-Referrals CQUIN
8. Supporting Proactive and Safe Discharge – Acute Providers
9. Preventing ill health by risky behaviours – alcohol and tobacco
Specialised CQUINs
IM3. Multi-system auto-immune rheumatic diseases MDT clinics, data collection and policy compliance
GE3. Hospital Pharmacy Transformation and Medicines Optimisation
Public Health CQUIN
1. Clinical Engagement

Each of these CQUINs has been assessed in terms of quality of care for patients, deliverability and financial consequences of non-delivery. This is tracked through the monthly CQUIN Progress Group to ensure timely identification and escalation of any risks or concerns.

5. Electronic Prescribing Update (EPMA)

There remains partial usage of Electronic Prescribing and Medicines Administration (EPMA) in medical in-patient areas. It is not yet available in the Emergency Department for patients waiting for an in-patient bed as it is dependent upon the patient being admitted on the iPM PAS system.

Due to the clinical risk of split paper and EPMA systems, during November 2016 the EPMA project team supported medical wards (*excluding* Assessment Units and Dryden Ward) to increase usage to 100% EPMA. Following this, conversion of all paper charts to EPMA was mandated.

5.2 Enabling EPMA in the Emergency Department

The key to the further roll-out and sustainability of EPMA in the Trust is its introduction into ED where the majority of in-patients are admitted. An interface between the Symphony system in ED and EPMA has been developed by EMIS and is now being tested. When activated, this will allow EPMA prescribing to commence at the point of the Decision to Admit in the Emergency Department, and for these prescriptions to carry through to the inpatient

admission. This will remove the requirement for ward doctors to convert paper charts to EPMA, and it will bring all medical wards up to 100% EPMA usage.

Plans have been developed to 'go-live' with this system in the ED and Assessment Units, for patients referred to the medical specialties.

The planning for the go-live in ED includes arrangements for nine non-medical wards that have medical outliers. This is because medical patients will occasionally be admitted directly to non-medical wards, and would otherwise result in the need to printing off and converting EPMA charts onto paper.

The go-live for ED / assessment wards / medical outliers is planned to take place on 20 February 2017.

5.3 EPMA for Surgical patients

The go-live of EPMA across the remainder of surgery will follow as soon as the system has been established for medical patients. Further preparation is underway in surgery including additional training of users, and mapping processes in theatres to ensure EPMA is supported there.

6. Next Steps

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

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

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

Title of Meeting	**PUBLIC TRUST BOARD**
Date of Meeting	**26 January 2017**

Title of the Report	**Director of Nursing & Midwifery Report**
Agenda item	**9**
Presenter of Report	Carolyn Fox, Director of Nursing, Midwifery & Patient Services
Author(s) of Report	Fiona Barnes, Deputy Director of Nursing Debbie Shanahan, Associate Director of Nursing Senior Nursing & Midwifery Team
Purpose	Assurance & Information

Executive Summary

This report provides an update and progress on a number of clinical projects and improvement strategies that the Nursing & Midwifery senior team are working on. An abridged version of this report, providing an overview of the key quality standards, will become available on the Trusts website as part of the Monthly Open & Honest Care Report.

Key points from this report:

- Safety Thermometer - The Trust achieved 98.6% harm free care (new harms) an improvement from the previous month.
- Pressure ulcers incidence - 20 patients were harmed in December. This shows an increase in the number of patients harmed.
- Infection Prevention - there were 2 patients identified with Clostridium Difficile Infection,1 MRSA bacteraemia, 1 MSSA bacteraemia and 5 patients identified with E.coli bacteraemia.
- There were 4 moderate harm falls in December; all cases are being fully investigated.
- Friends and Family Test (FFT) – The results illustrate that there has been 8 consecutive months of improvement above the mean line. This shows good progress and indicates significant improvements in satisfaction being achieved.
- There is an update from Safeguarding, Midwifery Services, the Nursing and Midwifery Dashboard and Enhanced Observation Collaborative.
- Safe Staffing, the overall fill rate for December 2016 was 103%

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

Enclosure E

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.

Public Trust Board
26 January 2017

Director of Nursing & Midwifery Report

1. Introduction

The Director of Nursing & Midwifery Report presents highlights from projects during the month of December 2016. 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

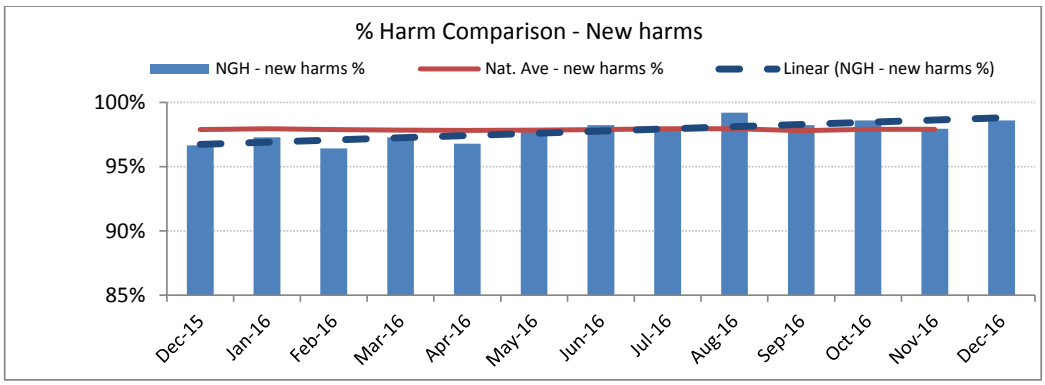
As part of the 'Promoting good practice for safer care' work stream of the National Maternity Transformation Programme, the midwifery team submitted two bids for external funding in December 2016.

The first bid was the NHS Health Education England's Maternity Safety Training Fund. The funding is intended to support maternity services in developing and maintaining high standards of leadership, teamwork, communication, clinical skills and a culture of safety whilst reducing maternal and foetal harm. The Trust was successful in securing £55,549 and maternity services have decided to focus on human factors training.

The second bid was the Department of Health's, Maternity and Neonatal Safety Innovation Fund 2016-17. The panel judged almost 100 applications, the Trust was one of 25 Trusts to receive £10,820, to fund an innovative new midwife led ultrasound scan clinic for women who smoke during pregnancy. This initiative will link with the maternity specific Sign up to Safety improvement pledge.

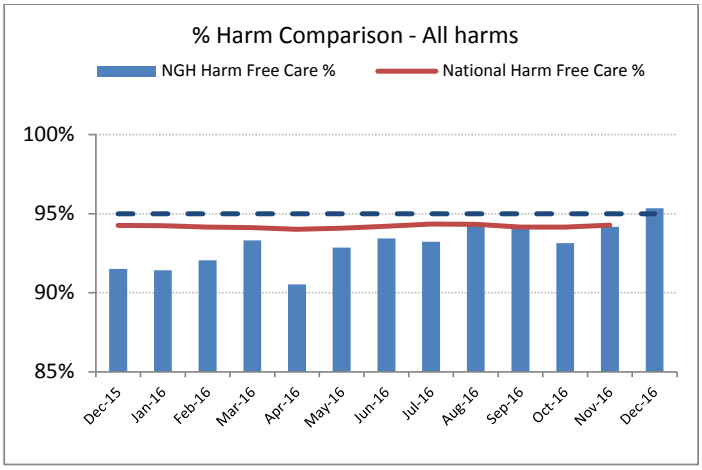
3. Safety Thermometer

The graph below demonstrates the percentage of all new harms attributed to the Trust. In December 2016 the Trust achieved 98.6% harm free care (new harms). This is an improvement of 0.06% to the previous month. Please see (Appendix 1) for the definition of safety thermometer.



The graph below illustrates the Trust has achieved 95% of harm free care in December a significant improvement of 1.82% compared to the previous months data. Broken down into

the four categories this equated to: 3 falls, 0 venous thromboembolism (VTE), 0 Catheter related urinary tract infections (CRUTI) and 6 'new' pressure ulcers.

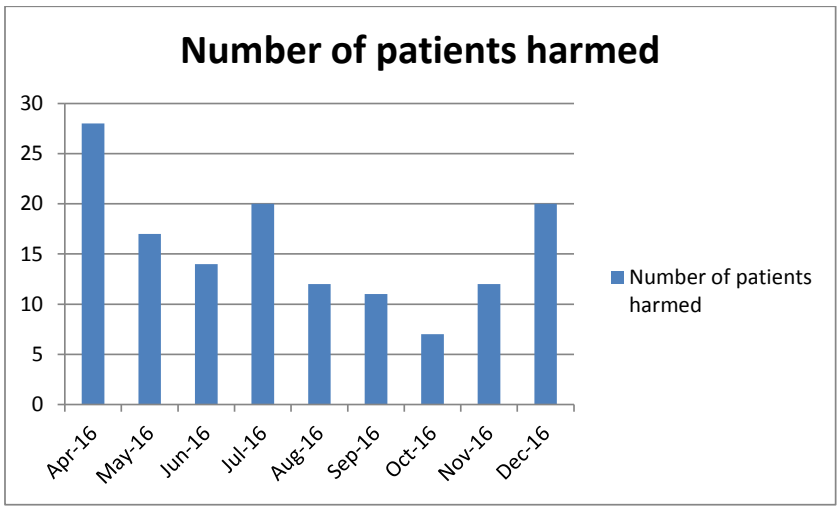


4. Pressure Ulcer Incidence

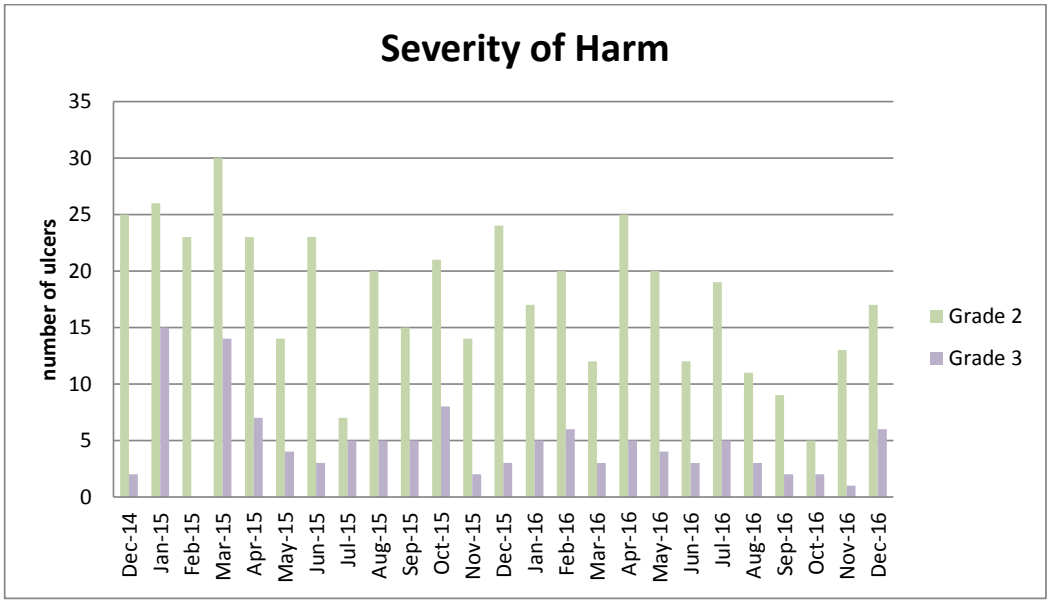
In December 2016, the Tissue Viability Team (TVT) received a total of 417 datix incident reports relating to pressure damage. This is a 25% increase on the previous month and is reflective of the acuity of the Trust. Of these the TVT assessed/validated 310 (75%) on the wards and the remainder were validated from photographs.

As previously reported, suspected Deep Tissue Injuries (sDTI's) are not included in the data presented below. In addition to this the pressure damage that occurred to patients under the care of Northampton General Hospital (NGH) in either Avery or Angela Grace Care Homes will be reported separately moving forward.

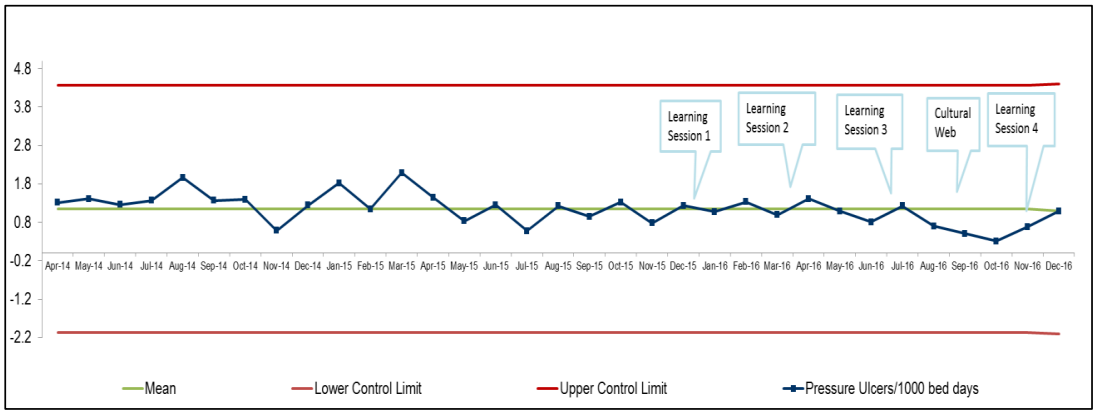
The graph below shows the number of patients harmed whilst in the care of the Trust. In December 2016, 20 patients were harmed; this is an increase of 8 patients from the previous month.



The graph below illustrates the severity of harm to a patient in developing either a Grade 2 or 3 pressure ulcer.



Pressure Ulcers per 1000 bed days



The chart above shows the number of pressure ulcers/1000 bed days in relation to hospital acquired pressure ulcers with 4 clear data points below the mean line in August, September, October and November. In December 2016, the incidence has been calculated at 1.09, the Trusts 5th data point just below the mean line. To determine whether changes made as part of the Trust wide Pressure Ulcer Collaborative have led to a statistically significant improvement one would expect at least 8 data points below the mean line.

Pressure Ulcer Prevention December Update

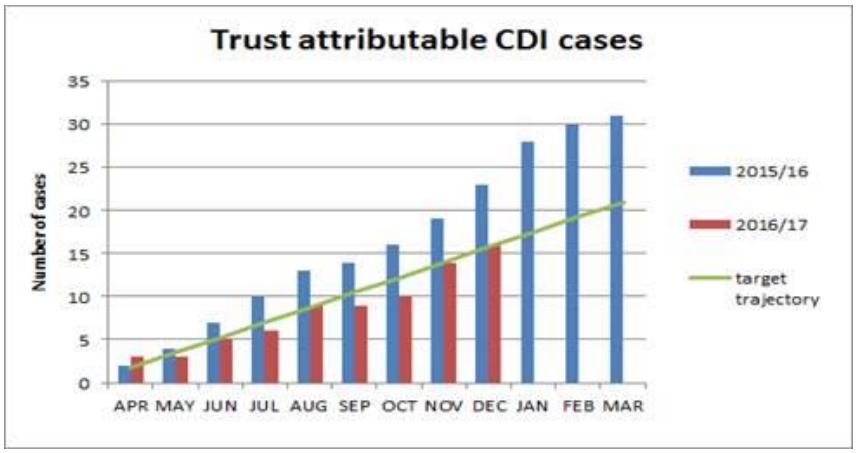
- The 90 day Rapid Pressure Ulcer Prevention Turnaround Project has been running since 2nd November 2016 with involvement from Becket, Cedar, Hawthorn and Knightley. During December the 4 wards continued with the improvements they have made, however the Trust was under extreme pressure due the high acuity
- December saw an increase in heel pressure damage, 70% of all ulcers validated occurred on the heel. The Moving and Handling team have been invited to future Validation meetings in response to this increase
- In future the Clinical Quality Effectiveness Group (CQEG) reports will include moisture lesions as a separate harm. Moisture lesions account for over 60% of all validated skin damage
- The TVT in conjunction with Quality Assurance and Improvement Matrons carried out a SSKIN Compliance Audit across all general inpatient wards, the result will be fed back

to the Pressure Ulcer Steering Group. This was postponed from December as the meeting had to be cancelled due to unforeseen circumstances. Based on the audit results, training needs analysis will be undertaken and targeted training will be provided

- TVT will be meeting the Lead Nurse for Specialist Palliative Care and End of Life to address repositioning of patients who are at the end of life raised at the Share and Learn meetings

5. Infection Prevention and Control

Clostridium difficile Infection (CDI)



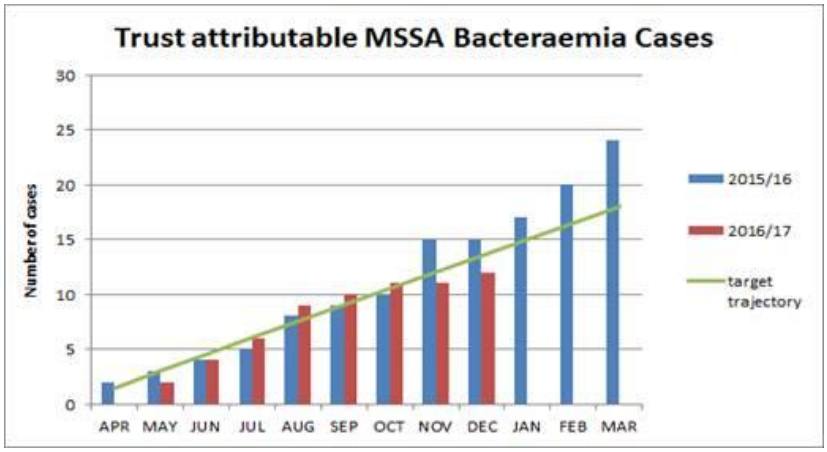
The graph above shows the cumulative total of the number of patients with Trust apportioned CDI, to date there has been 16 patients. In December 2016 there were 2 patients identified as Clostridium difficile toxin A and B, post infection reviews (PIR) are in progress.

MRSA Bacteraemia

For December there has been 1 Trust attributable MRSA bacteraemia, a PIR is in progress.

MSSA Bacteraemia

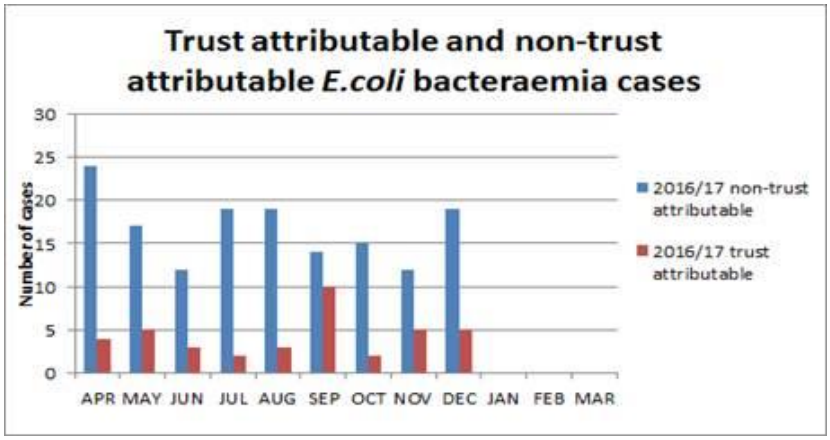
There is no national target set for MSSA bacteraemia however due to updated guidance from Public Health England (PHE) and a change in formula, the out turn for MSSA bacteraemia for 2015/2016 is 24 cases. The Infection Prevention forward plan has set a revised ambition of no more than 18 cases for 2016/2017. The graph below demonstrates for December there is 1 Trust attributable case and to date there have been 13 patients with MSSA bacteraemia, the Infection Prevention Team continue to work on the Trusts MSSA reduction plan.



Escherichia coli (*E.coli*) Bacteraemia

Currently, there is no national target set for *E.coli* bacteraemia, however the Department of Health due to the national increase relating to Gram-negative bacteremia are reviewing this for 2017-2018. PHE have advised not to set a Trust reduction target as work to reduce the number of patients with *E.coli* bacteremia will be a Whole Health Economy (WHE) approach, led by the local Clinical Commissioning Group (CCG).

The graph below demonstrates that during December 2016 there were 25 patients who were identified as having *E.coli* bacteraemia in the Trust, 20 of those patients were admitted in to the Trust with an *E.coli* bacteraemia and 5 patients had Trust attributable *E.coli* bacteraemia.



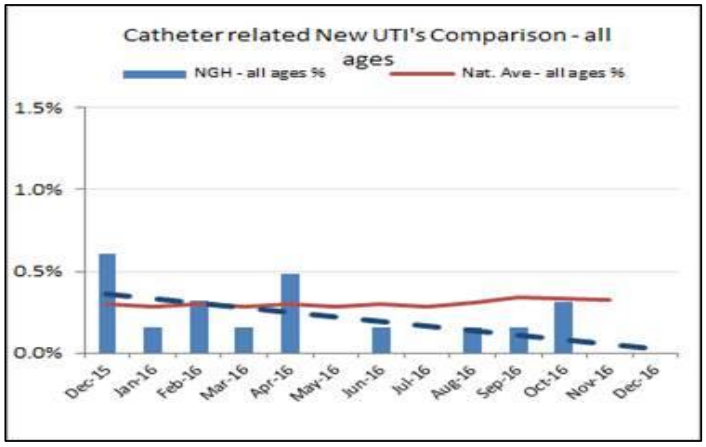
The table below shows the breakdown of source and number of trust attributable *E.coli* bacteraemia cases for December 2016:

Source of Infection December 2016	
Probable Urosepsis	2
Hepatobiliary	2
Neutropenic sepsis	1

Enclosure E

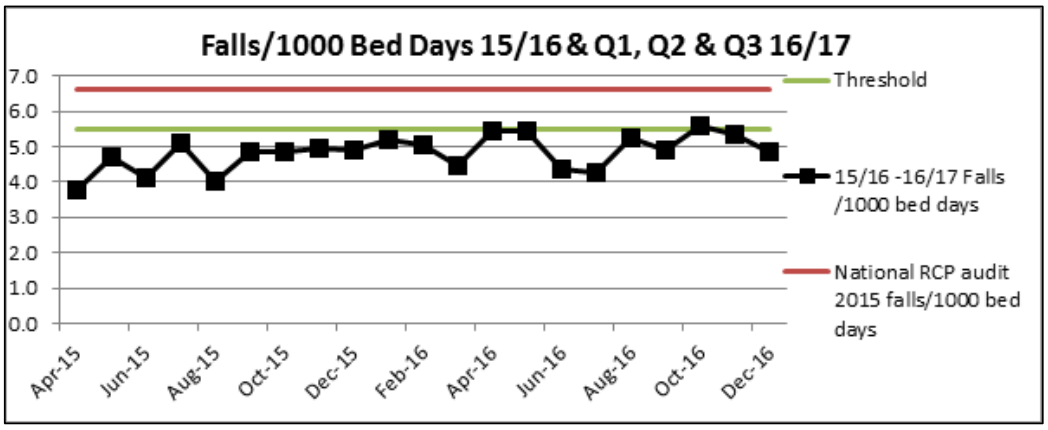
Catheter Related Urinary Tract Infections (CRUTI)

In December 2016 there were no CRUTI's in accordance with the safety thermometer. The graph below shows that for December 2016, NGH remained below the National Average for CRUTI's.



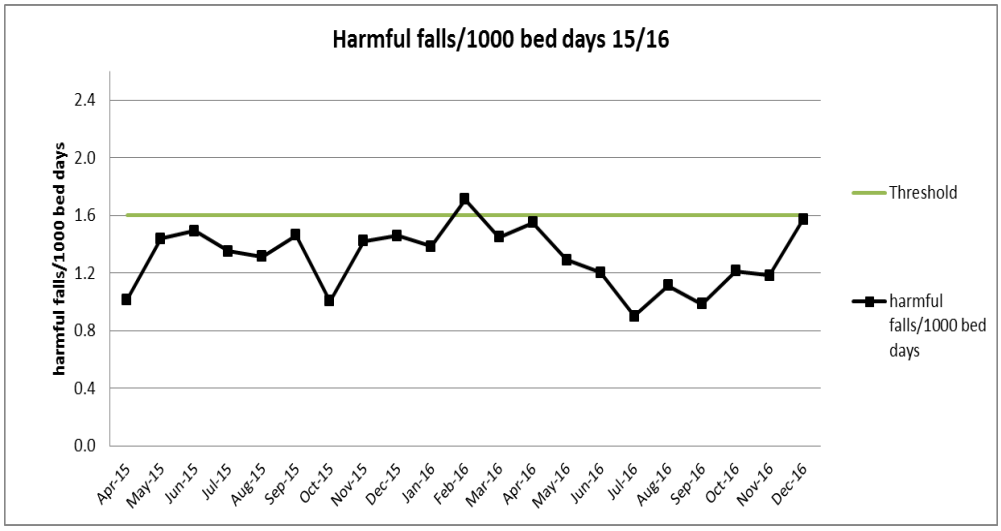
6. Falls Prevention

The Trust's Falls/1000 bed days are below the national average 6.63/1000 bed days and the internally set trust target of 5.5/1000 bed days. There was a reduction in the number of falls/1000 bed days of 0.46 in December compared to the previous month.



Harmful Falls/1000 bed days including Low, Moderate, Severe and Catastrophic

Although during December 2016, falls/1000 bed days reduced, the number of harmful falls/1000 bed days has shown an increase. The Trust has an internally set target of 1.6 harmful falls/1000 bed days. During December 1.57 harmful falls/1000 bed days were recorded, this remains just under the internally set target but is an increase of 0.39 harmful falls/1000 bed days compared to November. The recording of harmful falls in this data represents low, moderate, severe and catastrophic harm.



Falls resulting in moderate, severe or catastrophic harm
Moderate, severe and catastrophic falls/1000 bed days have increased through December 2016 by 0.09 compared to November. The Trust recorded 0.18 moderate, severe, catastrophic falls/1000 bed days. This remains just under the national threshold of 0.19.

In December 2016 there has been 4 moderate falls reported compared to 1 moderate and 1 severe fall in November 2016. All the falls are being reviewed and investigated.

7. Nursing and Midwifery Dashboards

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

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

The QCI for December 2016 shows the following:

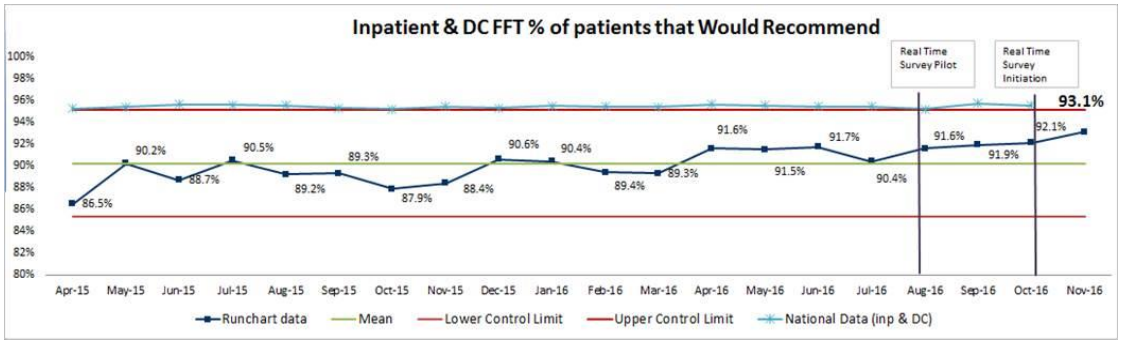
- Privacy and Dignity has seen the most improvement for the 4th consecutive month. Work is on-going within the Divisions to sustain the improvement
- Compliance with falls assessments and care planning has decreased again this month to 83%, Holcot and Collingtree Wards require improvement, the ward sisters and Matrons for the 2 wards are aware and actions are in place to improve the assessment. The general wards continue to monitor compliance and implement suggestions from the Falls Group
- Surgical Division has seen an improvement to their QCI data. There are 3 red areas compared to 5 in the previous month, (Head and Neck Ward have not input any data at time of writing the report). Ward Sisters, Matrons and the Associate Director of Nursing (ADN) are aware and actions are in place to improve outcomes
- Medical Division has seen a reduction to their QCI data. There are only 10 reds across the Division compared to 2 in the previous month. Ward Sisters, Matrons and the ADN are aware and actions are in place to improve outcomes
- Women's Children's and Oncology Division, has seen an improvement and Talbot Butler has sustained the improvement to the QCI data for the 3rd consecutive month. (Spencer Ward unfortunately has not inputted any data at time of writing the report). Gosset has achieved an improvement all green areas. Maternity on all three areas

need to improve the patient experience. Ward Sisters, Matrons and the ADN/M are aware and actions are in place to improve outcomes

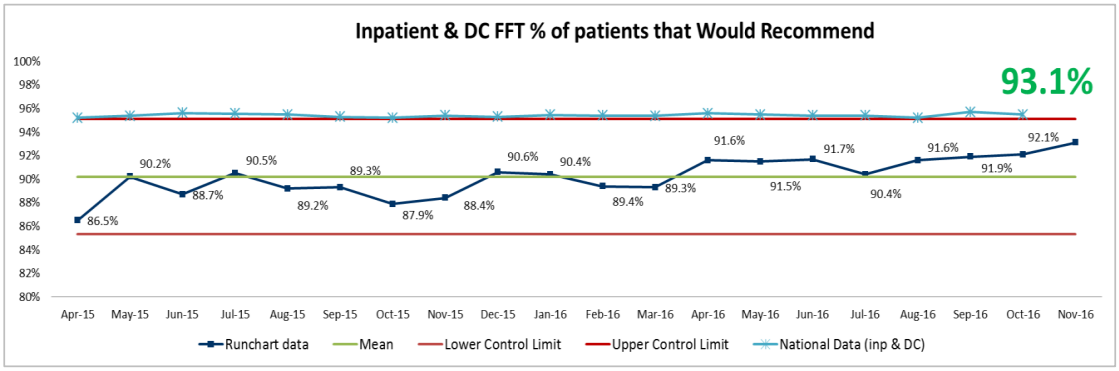
- First impressions and 15 steps, for the general wards are at 77% showing a decrease or 2 consecutive months. Work is ongoing to improve the clutter and general appearances of the general wards, through the IPC, 'Going for Gold' Declutter initiative.

8. Friends & Family Test (FFT)

FFT Overview- % Would Recommend Run Charts



- Trust wide results for the amount of patients that would recommend the services provided reached their eighth consecutive month above the mean line. In February the run charts will be rebased to show how much progress the hospital has made in regards to satisfaction rates.



- The Inpatient & Day Case results are showing consistent progress and indicate significant improvements in the levels of satisfaction being achieved within the Trust. November saw the Trust obtain the highest levels of satisfaction within Inpatient and Day Case areas to date. This has led to the Trust obtaining 8 data points above the mean line. The mean will be rebased in February to show progress.

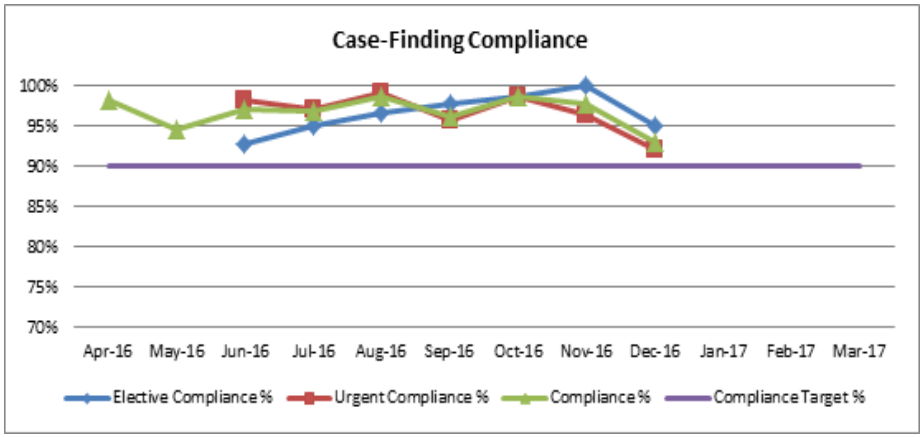
9. Dementia CQUINS

The Clinical Commissioning Group has confirmed achievement of both John's Campaign and Discharge Summaries milestones for Q2 as part of the CQUIN schedule. Accordingly, the risk register entries have been reduced to reflect the lessened risk of non-achievement. The Q3 submission is scheduled for the end of January 2017 and as can be seen through this, and previous reports for the quarter, achievement of the Q3 milestone is anticipated.

Discharge Summaries

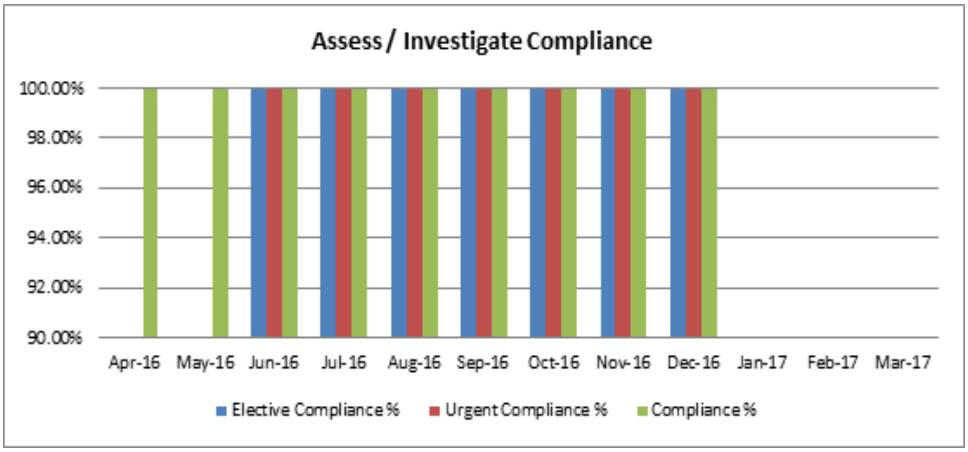
The 2016/17 dementia CQUIN, in contrast to previous years, includes patients admitted via the non-urgent (elective) pathway. Planning for the collection of this data was undertaken during Q1 and the subsequent split in compliance figure was reportable from Q2.

The overall compliance target remains at 90%, which has been achieved for each element of the CQUIN, as illustrated in the three graphs below.

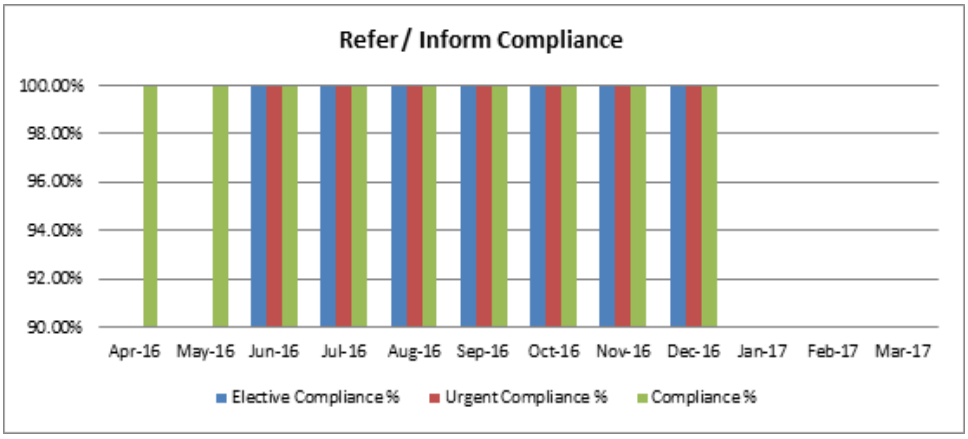


The elective and non-elective areas both remain above the 90% threshold for compliance; the total Trust compliance for December is 93.1%. There has been a slight decrease (though still above the threshold) in compliance, particularly during December, however this is anticipated given the increased patient acuity at this time of year. This represents 23 patients out of a total cohort of 331 patients.

The graph below demonstrates continued 100% compliance for both Elective and Urgent Compliance for Assess and Investigate



The graph below demonstrates continued 100% compliance for both Elective and Urgent Compliance for Refer and Inform Compliance.

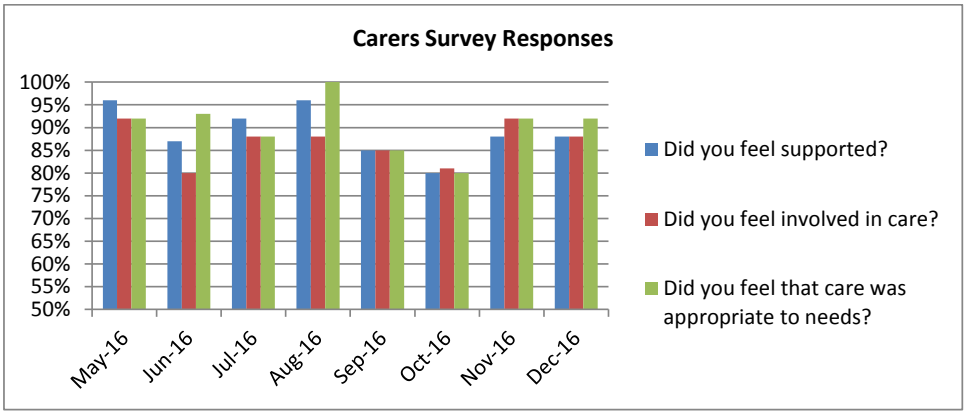


John's Campaign

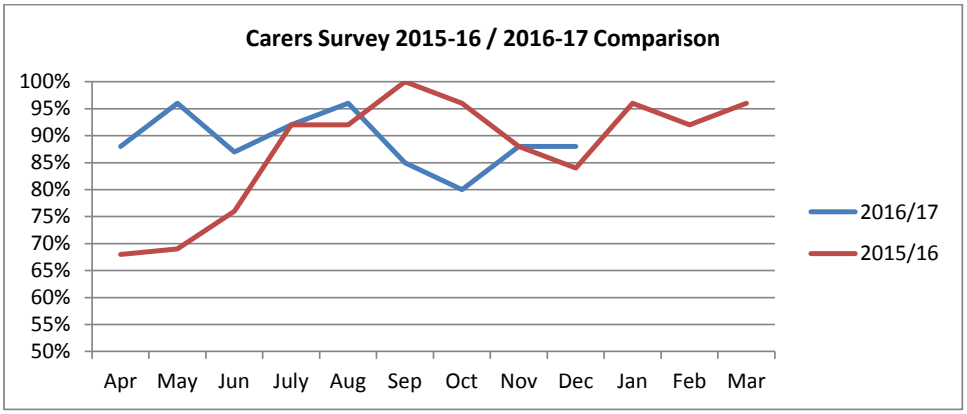
John's campaign roll out continues, with a further six wards now online. Anecdotal feedback has been positive and the formal feedback exercise *(as part of the CQUIN compliance)* will take place in Q4.

Carers Survey

Whilst no longer part of the CQUIN, the Dementia Liaison Service continues to seek the views of carers in order to make continues improvement to care provided, the key responses for this are shown in graphs below *(n=25).* There has been a slight decrease in 2 questions, did you feel supported? and did you feel involved in care? compared to last month. The modifications to the survey discussed in the last report, to gather further qualitative responses have been implemented and this will begin to be reported in January 2017.

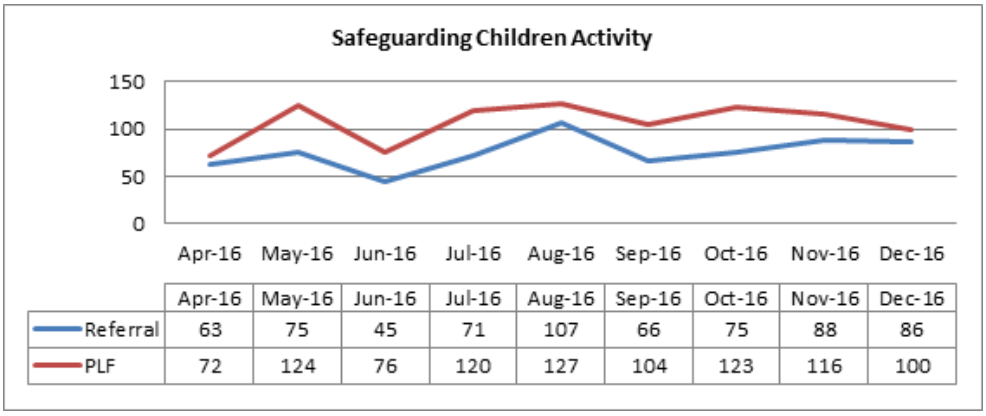


The carer's survey has been iterative, however the consistent question "do you feel supported" has been present since the survey was initiated as part of preceding years' CQUINs. The graph below shows the variation between 2015/16 and 2016/17 to date.



As previously reported, the improvement in results has maintained since the downturn at the start of the quarter.

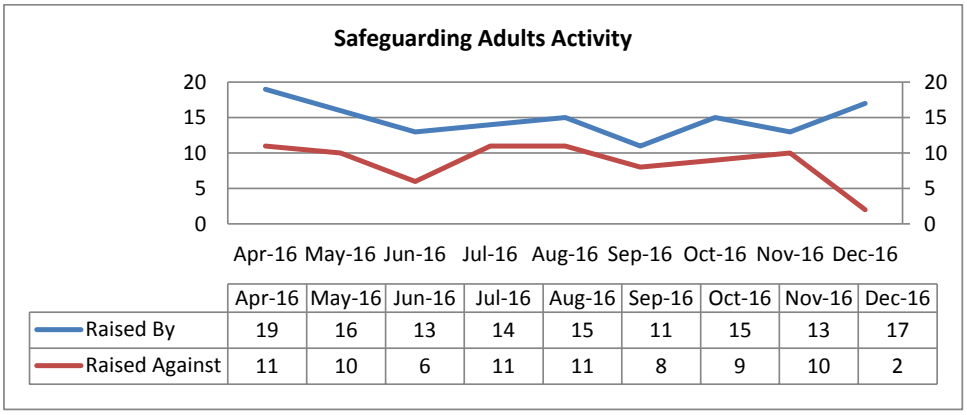
Safeguarding Referral Activity



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Referral	63	75	45	71	107	66	75	88	86
PLF	72	124	76	120	127	104	123	116	100

Safeguarding Children referral activity has remained constant from November to December. There is the potential for seasonal increase in January as the schools return; however this is not anticipated to be outside normal variation as illustrated in the graph above.

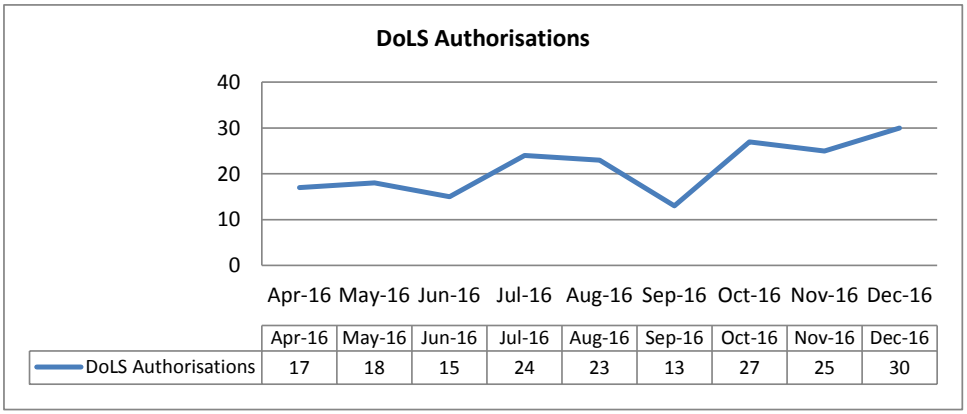
Safeguarding Adults activity as shown in the graph below remains relatively static in relation to referrals made by the organisation i.e. cases of concern identified. The number of referrals received where the organisation is cited as having caused harm is consistently reducing over time, with a significant reduction being seen in December. This trend is closely monitored through the Safeguarding Assurance Group.



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Raised By	19	16	13	14	15	11	15	13	17
Raised Against	11	10	6	11	11	8	9	10	2

Enclosure E

Deprivation of Liberty Safeguards (DoLS)



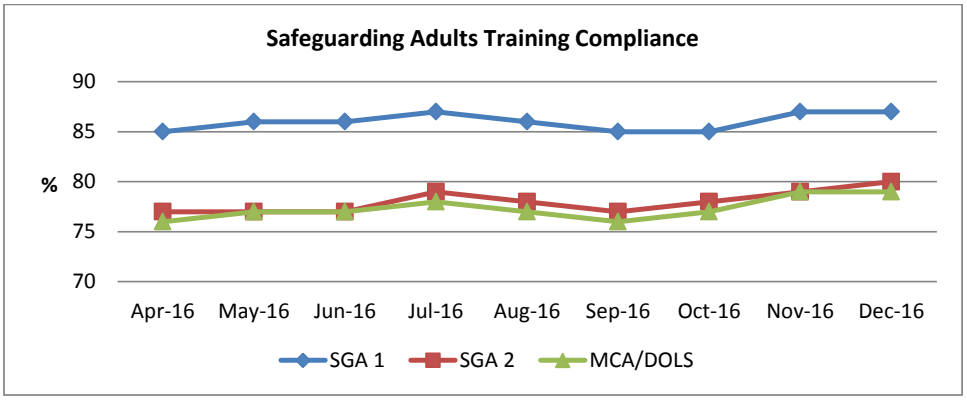
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
DoLS Authorisations	17	18	15	24	23	13	27	25	30

DoLS referrals in December have seen a slight rise, restoring referral rates to circa 30 per month, which is the average for the Trust. All DoLS applications continue to be scrutinised on an individual basis by the safeguarding team to ensure that care is delivered in the least restrictive manner possible.

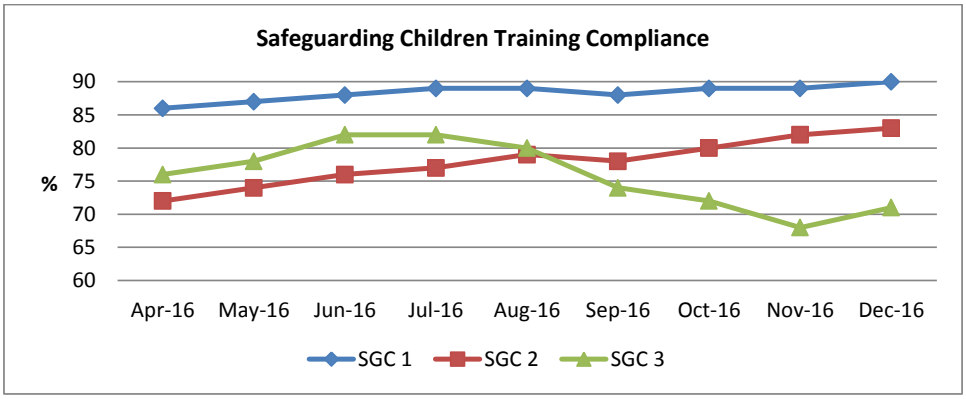
The Law Commission have deferred the publication of their report into the review of the DoLS legislation from December 2016 to March 2017; it is not expected that this will disrupt the legislative timetable with new DoLS legislation anticipated in 2019.

Safeguarding Training Compliance

Safe garding adult compliance for SGA 1 and MCA/DoLS has stayed static this month with a slight increase in SGA2 training as demonstrated in the graph below.



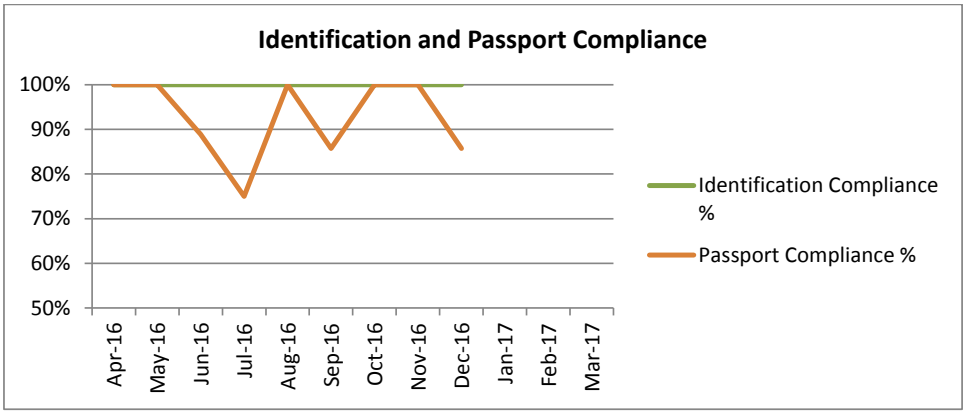
The drop in safeguarding children training compliance is reversing, with extra access and targetted communication being successful in effecting an improvement. This work will continue in January and February to recover the postion as shown in the following graphs.



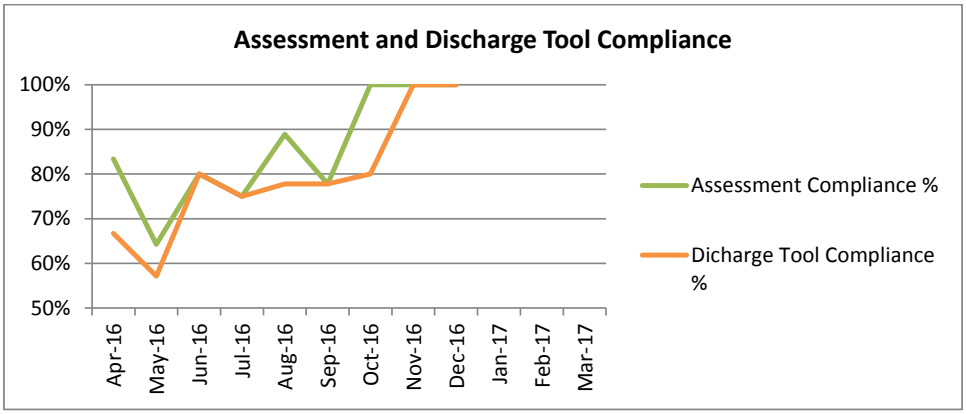
Learning Disability

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

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



The graph above shows passport compliance has dipped slightly in December, with one person not receiving a hospital passport within the first 24hrs of admission.



The improvement in compliance with the assessment and discharge tools has continued, compliance for the whole quarter is at 100% as demonstrated in the graph above. This particular element has presented challenges previously and this improvement is welcomed.

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

10. Enhanced Observations of Care

The Enhanced Observations Collaborative commenced in June 2016 the first seven wards, identified based on highest additional staffing use ('specials'), and a supplementary wave of three wards coming online ten weeks later. The collaborative completed work in November, with full roll out across the additional wards in January. A full report is available in Appendix 6.

11. Safe Staffing

Overall fill rate for December 2016 was 103% in November & October which was the same. Combined fill rate during the day was 100%, compared with 100% in December, 99% in November. The combined night fill rate was 107% compared with 108% in December. RN fill rate during the day was 95% and for the night 96%. Please see appendix 7.

12. TIAA - Comparator Review of Agency Nurse Utilisation 2016/17

The objective of the review was to identify where there were opportunities to share information which may assist in financial savings in the engagement of agency nursing staff. The review compared the usage of agency nursing staff at a number of Trusts and was designed to help identify issues and share opportunities for improvement and good practices.

The review was carried out between August and October 2016 and was part of the planned internal audit work for 2016/17. This is the first of this type of cross-participating Trusts review. No assurance assessment is provided within the report as the principal purpose of the review was to establish areas of potential opportunities for cost efficiency savings. NGH was selected as one of 10 provider trusts (6 Foundation Trusts and 4 NHS Trusts) to participate in the review.

Whilst it is understood that the report is an advisory report, areas of operational good practice were identified across the participating Trusts. From the Trust perspective, there were some key findings from the report for nursing agency utilisation; however, due to the length of time taken to produce the report, all recommended actions had already been addressed.

13 Safer Nursing Care Tool audit

Twice a year the general wards across the Trust undertake the Safer Nursing Care Tool (SNCT) audit. This audit was completed in October 2016. However, due to the new multipliers and poor validation of the data there are a number of anomalies that make the data unreliable. If the SNCT audit is not superseded by the Care Hours Per Patient Day benchmarking in the Spring 2017, then a robust and validated SNCT audit will be undertaken.

14 Recommendations

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

Appendix 1

Safety Thermometer Definition

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

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

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

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

Appendix 2

Nursing and Midwifery Dashboard Description

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

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

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

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

- Effective
- Safe
- Well led
- Caring

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

Appendix 3

Dec-2016	Medicine															Surgery								
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Allebone	Becket	Benham	Brampton	Collingtree	Compton	Creaton	Dryden	EAU	Eleanor	Finedon	Knightley	Holcot	Victoria	Talbot Butler	Rowan	Willow	Head & Neck	Spencer	Abington	Cedar	Althorp	Hawthorn	General Wards
Falls/Safety Assessment	100.%	87.%	93.%	93.%	47.%	97.%	97.%	100.%	97.%	100.%	100.%	90.%	70.%	97.%	87.%	100.%	100.%			97.%	83.%	93.%	82.%	83.%
Pressure Prevention Assessment	100.%	100.%	97.%	100.%	83.%	100.%	97.%	97.%	97.%	100.%	97.%	89.%	89.%	97.%	74.%	96.%	95.%			94.%	83.%	100.%	100.%	86.%
Nutritional Assessment	100.%	97.%	100.%	97.%	87.%	100.%	93.%	100.%	87.%	100.%	100.%	100.%	83.%	97.%	97.%	100.%	100.%			97.%	90.%	100.%	89.%	87.%
Patient Observation and Escalations	100.%	100.%	100.%	95.%	100.%	95.%	100.%	95.%	94.%	100.%	100.%	95.%	95.%	88.%	100.%	94.%	90.%			100.%	95.%	100.%	100.%	89.%
Pain Management	100.%	100.%	100.%	100.%	100.%	93.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	93.%	100.%	100.%	100.%			100.%	100.%	100.%	100.%	91.%
Nursing & Midwifery Documentation - Quality of Entry	98.%	95.%	100.%	90.%	70.%	95.%	90.%	97.%	96.%	100.%	97.%	95.%	93.%	98.%	92.%	88.%	100.%			98.%	92.%	100.%	100.%	86.%
Medication Assessment	100.%	80.%	100.%	100.%	80.%	100.%	100.%	100.%	96.%	100.%	100.%	96.%	100.%	100.%	88.%	100.%	100.%			96.%	100.%	100.%	94.%	88.%
Patient Experience - Protected Mealtimes (PMT) Observations	100.%	100.%	100.%	100.%	83.%	100.%	100.%	100.%	83.%	100.%	100.%	100.%	83.%	100.%	100.%	100.%	100.%			100.%	100.%	83.%	83.%	88.%
Patient Experience - Care Rounds Observe patient records	100.%	100.%	100.%	91.%	100.%	91.%	100.%	100.%	100.%	100.%	100.%	100.%	91.%	67.%	100.%	82.%	100.%			100.%	100.%	100.%	100.%	88.%
Patient Experience - Environment	100.%	100.%	100.%	100.%	60.%	100.%	100.%	80.%	100.%	100.%	100.%	100.%	80.%	80.%	100.%	80.%	100.%			100.%	100.%	100.%	60.%	84.%
Patient Experience - Privacy and Dignity	98.%	96.%	90.%	97.%	99.%	94.%	96.%	93.%	87.%	95.%	99.%	94.%	99.%	88.%	92.%	92.%	97.%			98.%	96.%	100.%	67.%	85.%
Patient Safety and Quality	100.%	86.%	100.%	100.%	90.%	92.%	100.%	95.%	100.%	100.%	90.%	95.%	90.%	100.%	85.%	83.%	91.%			86.%	81.%	90.%	100.%	85.%
Leadership & Staffing observations	96.%	96.%	94.%	95.%	94.%	95.%	100.%	96.%	98.%	100.%	96.%	96.%	96.%	100.%	92.%	95.%	100.%			83.%	92.%	96.%	97.%	87.%
EOL	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%			100.%	100.%	100.%	100.%	91.%
SOVA/LD/Cognitive Impairment	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%			100.%	100.%	100.%	100.%	91.%
First Impressions/15 Steps	94.%	77.%	71.%	100.%	71.%	100.%	94.%	89.%	77.%	86.%	89.%	80.%	51.%	80.%	86.%	86.%	83.%			91.%	94.%	97.%	80.%	77.%
Safety Thermometer – Percentage of Harm Free Care	92.86%	100.00%	93.10%	93.10%	100.00%	77.78%	100.00%	100.00%	84.85%	83.33%	100.00%	85.71%	93.10%	100.00%	96.43%	100.00%	92.59%	100.00%	100.00%	89.29%	96.67%	100.00%	96.55%	90.00%
Pressure Ulcers – Grade 2 incidence hosp acquired, (Previous Month)																								
Pressure Ulcers – Grade 3 incidence hosp acquired, (Previous Month)																								
Pressure Ulcers – Grade 4 incidence hosp acquired, (Previous Month)																								
Pressure Ulcers -sDTI's incidence hosp acquired																								
Falls (Moderate, Major & Catastrophic)	1	0	1	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	4
HAI – MRSA Bact	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
HAI – C Diff	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	2
Patient Overdue Observations frequency - <7%	5%	8%	7%	12%	11%	8%	6%	5%	8%	7%	19%	11%	6%	8%	5%	8%	6%	8%	9%	5%	7%	6%	6%	21%
Caring																								
Complaints – Nursing and Midwifery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	2
Number of PALS concerns relating to nursing care on the wards	0	2	1	0	5	0	0	1	0	0	2	1	2	1	1	0	1	2	1	0	1	0	0	21
Friends Family Test % Recommended	95.0%	86.4%	80.0%	87.5%	86.1%	100.0%	96.0%	92.1%	82.9%	100.0%	100.0%	50.0%	71.4%	50.0%	95.0%	86.1%	91.4%	97.6%	86.7%	91.0%	100.0%	98.6%	95.3%	87.8%
Well Led																								
Staff Nurse Staffing - Registered Staff (day & night combined)	95%	94%	97%	101%	97%	98%	98%	92%	44%	99%	93%	97%	97%	103%	79%	98%	99%	92%	100%	96%	102%	98%	97%	94%
Staff Nurse Staffing - Support Worker (day & night combined)	144%	100%	172%	126%	110%	158%	123%	101%	156%	116%	139%	114%	161%	158%	134%	123%	112%	112%	161%	108%	132%	96%	161%	131%
Staffing related datix	0	0	0	1	0	0	0	1	0	0	1	1	0	0	0	1	0	0	0	0	0	0	0	5

Enclosure E

Appendix 4

Dec 16

Quality Care Indicators - Nurse & Midwifery	MATERNITY			
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Balmoral	Robert Watson	MOW	Sturtridge
Quality & Safety				
Postnatal Safety Assessment (Q)	Nil	96%	100%	Nil
SOVA/LD (Q)	Nil	Nil	Nil	Nil
Patient Observation Chart (Q)	Nil	Nil	100%	100%
Medication Assessment (Q)	Nil	100%	100%	100%
Environment Observations (Q)	Nil	96%	100%	100%
HAI – MRSA Bact	0	0	0	0
HAI – C Diff	0	0	0	0
Drug Administration Incident				
Emergency Equipment – Checked Daily (Q)	Nil	100%	0%	100%
Patient Quality Boards (Q)	Nil	100%	100%	100%
Controlled Drug Checked (Q)	Nil	0%	100%	100%
Patient Experience				
Complaints – Nursing and Midwifery	0	0		0
Call Bells responses (Q)	Nil	Nil	Nil	100%
Patient Experience (Q)	Nil	79%	75%	69%
Patient Safety and Quality (Q)	Nil	83%	50%	100%
Leadership & Staffing (Q)	Nil	Nil	100%	100%
Management				
Staffing related datix	0	2	0	0
Monthly Ward meetings (Q)	Nil	100%	100%	100%
Saftey and Quality (Q)	Nil	Nil	100%	100%
Leadership & Staffing (Q)	Nil	100%	100%	100%

Ward Overall Results
0
0

Appendix 5

Dec 16	PAEDIATRICS		
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Disney	Paddington	Gosset
Quality & Safety			
Falls/Safety Assessment (Q)	69%	93%	nil
Pressure Prevention Assessment (Q)	100%	67%	100%
Child Observations [documentation] (Q)	100%	93%	100%
Safeguarding [documentation] (Q)	87%	100%	100%
Nutrition Assessment [documentation] (Q)	100%	88%	100%
Medication Assessment (Q)	95%	100%	100%
Pressure Ulcers – Grade 2 incidence hosp acquired			
Pressure Ulcers – Grade 3 incidence hosp acquired			
Pressure Ulcers – Grade 4 incidence hosp acquired			
Pressure Ulcers - sDTI's incidence hosp acquired			
Safety Thermometer – Percentage of Harm Free Care	100.00%	100.00%	100.00%
Falls (Moderate, Major & Catastrophic)	0	0	0
HAI – MRSA Bact	0	0	0
HAI – C Diff	0	0	0
Patient Overdue Observations frequency - <7%	100%	100%	
Drug Administration Incident			
Patient Experience			
Friends Family Test % Recommended	91.8%	96.0%	
Complaints – Nursing and Midwifery	0	0	0
Number of PALS concerns relating to nursing care on the wards	1	0	0
Call Bells responses (Q)	100%	100%	100%
Patient Saftey & Quality Environment Observations Observe patient records (Q)	100%	100%	86%
Privacy and Dignity (Q)	97%	97%	nil
Management			
Staffing related datix	1	0	0
Monthly Ward meetings (Q)	95%	100%	100%
Safety and Quality ask 5 staff (Q)	80%	100%	100%
Leadership & Staffing observations (Q)	100%	100%	100%

Ward Overall Results
0
1

Enclosure E

Appendix 6

Nursing Productivity: Enhanced Observations of Care Update

1.0 Introduction

1.1 This paper presents an update to the Committee of the work undertaken as part of the Changing Care Workstream: Enhanced Observations of Care. The Enhanced Care project has been delivered via a Quality Improvement methodology; using Breakthrough Series Model[1].

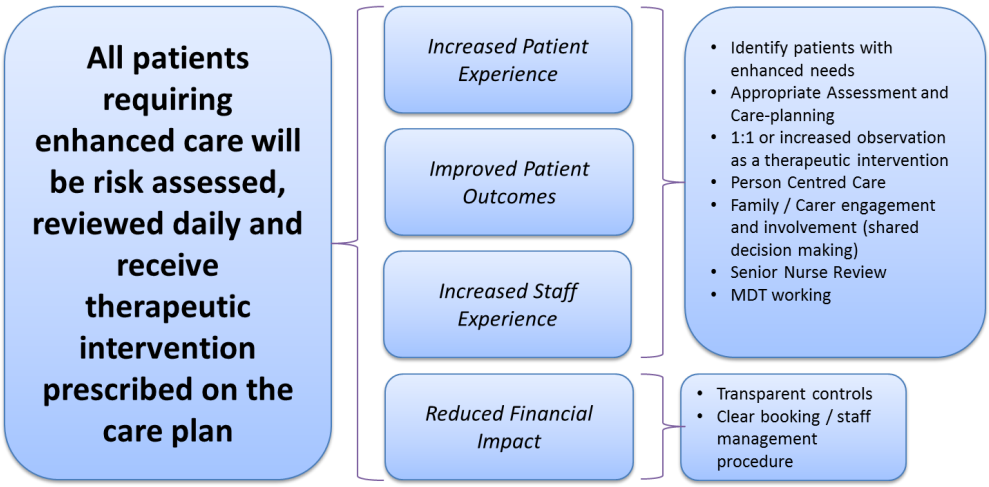
1.2 "Enhanced Care" is the description used to describe the range of interventions used to support those patients who, for a number of reasons, require a level of interactive care that is beyond the expected afforded by the established staffing level.

1.3 There is a perception within the NHS that enhanced care is synonymous with increased numbers of nursing (most often unregistered), staff. The Collaborative, using PDSA cycles of change, has demonstrated that this perception is, if not entirely without factual basis, not the panacea of service delivery for those with additional care needs.

2.0 The Collaborative Approach

2.1 The Collaborative comprises two waves of wards – the first seven wards, identified based on highest additional staffing use ('specials') commencing in June, and a supplementary wave of three wards coming online ten weeks later.

2.2 The Collaborative developed a driver diagram; describing the aim and primary and secondary drivers for the project; shown below. As a result of this aim, four key areas which the Collaborative identified as essential in order to effect change were prioritised: uniform assessment, in-process scrutiny, meaningful activity interventions and robust booking controls.



3.0 Impact on Patients

1

3.1 The single biggest change to practice resulting in a direct impact to patient care has been the development and use of a uniform risk assessment process. Unlike previous iterations of this document, the risk assessment developed through the Collaborative does not serve a primary function of obtaining extra staffing resource.

3.2 The risk assessment and subsequent process of review and validation ensures that each patient's need is assessed on an individual basis and a plan / prescription of care developed that reflects that need.

3.3 As part of the QI methodology, the wards developed tests of change in order to deliver care in new and different ways – that was tailored to the needs of the patients (based on the risk assessment).

3.4 Examples of these tests of change include:

- Bay Tagging – having a continued physical nursing[2] presence in the bay, resulting in short, intentional interventions with patients. This has the effect of reducing anxiety, relieving boredom and developing rapport.

- Individualised and Group activity – utilising other professionals (such as OT) to engage patients in other activities which, in addition to having direct therapeutic impact; address other challenges in relation to illness presentation.

- Family and Carer involvement – the wards in the Collaborative where John's Campaign is being rolled out utilised families and carers to highlight particular times and patterns to distress or presentation that supported the staff in pre-empting challenging scenarios.

- Distraction Interventions – the single biggest manifestation of behaviours that challenge services is finding engaging activity for patients to undertake; tests of change using activity boxes and other techniques (for example; twiddlemuffs) were utilised to support patients.

3.5 The risk assessment intuitively guides staff to ensure that all necessary interventions have been put in place prior to considering the need for additional staff; for example in relation to patients who are at risk of falls, the assessment directs staff to ensure that the appropriate falls interventions have been undertaken.

3.6 The inclusion of Senior Nurse Review of the risk assessment, irrespective of the suggested outcome, has resulted in an additional layer of scrutiny to the risk assessment process, coupled with the introduction of a senior and experienced clinician to the decision making process.

3.7 The Collaborative has developed a change package to support the use of appropriate enhanced care across the Hospital. The package includes:

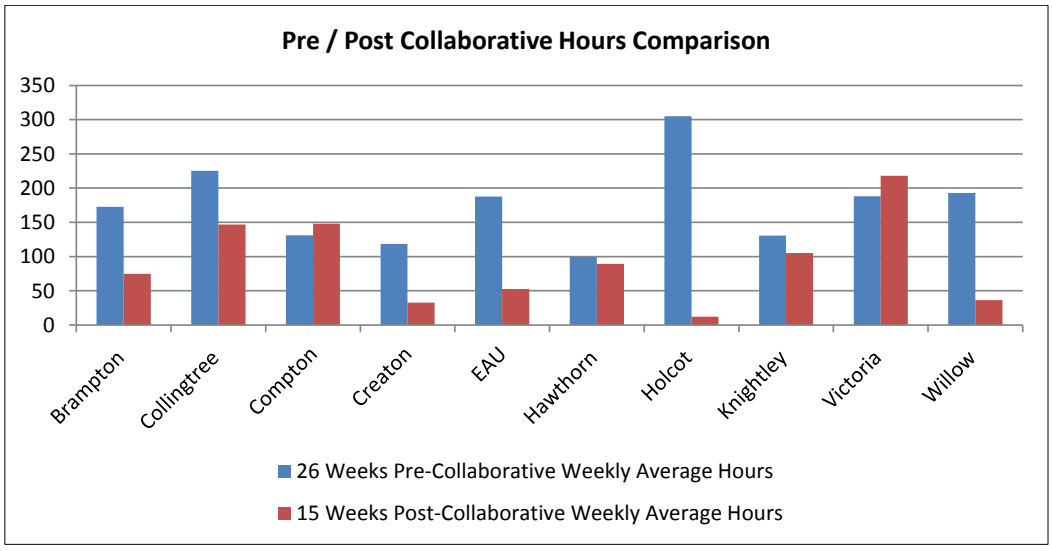
- Risk Assessment and Monitoring Tool;
- Prescription of Care and Five Day Evaluation;
- Increased Observation;
- Senior Nurse Review.

[2] Both registered and unregistered staff

4.0 Financial Impact

4.1 In order to gauge the financial impact of the project; the use of hours and the distinction between bank and agency usage has been monitored on a weekly basis throughout the Collaborative. The original seven wards invited to join the Collaborative were identified on the basis that they were, at the time, the most intense users of "enhanced observation" shifts; in terms of hours worked. This methodology was replicated for the second wave wards.

4.2 To support the analysis, a 26week average hourly usage was calculated for each ward prior to the start of the Collaborative as a baseline figure. The graph below shows the pre-collaborative averages in comparison to the average usage during the collaborative:



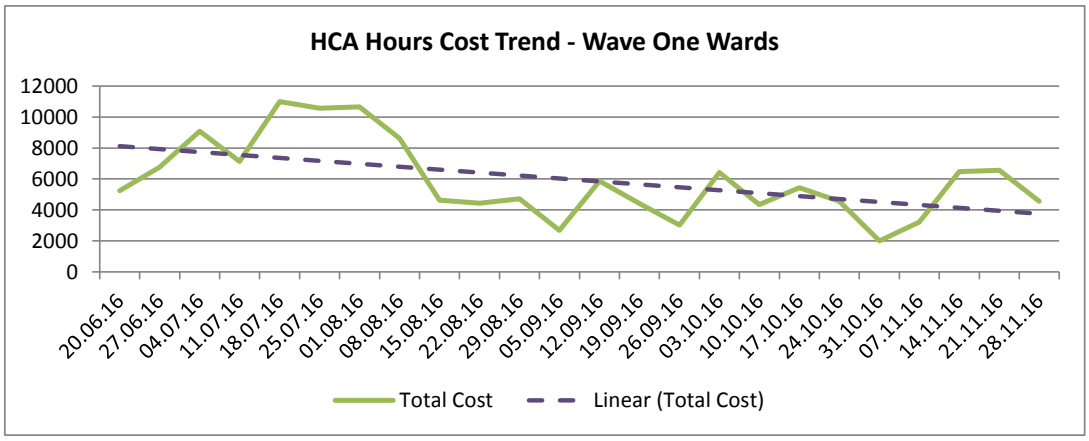
4.3 As can be seen, significant improvements have been made in relation to the use of enhanced observations. Overall, this equates to an approximate reduction of an average of 836hours per week compared to the average weekly use prior to the start of the Collaborative.

4.4 Not all wards were successful in reducing the usage of additional shifts for patients with enhanced needs; due to environmental or particular acuity factors. The use of risk assessment and the introduction of the Senior Review provides assurance however, that all of these shifts are required in order to meet patient need.

4.5 Prior to the collaborative starting, the 26week average spend on additional enhanced care shifts for the wards involved was ~£25k. The reduction in hours used as a consequence of the collaborative work has been mirrored in the reduced average weekly cost of ~£13k.

4.6 The data collected during the project also shows a marked decrease in the use of agency staff, synergising with the associated productivity workstreams regarding bank recruitment, average weekly spend on agency staff during the collaborative has reduced by just under two thirds; from ~£14.8k to ~£6.4k.

4.7 As the graph below shows, the use of additional hours for enhanced care has reduced significantly as a result of the controls implemented, creating an increasing cost reduction.



4.8 There has been variation in reduction of hours (and therefore cost), in particular over the past two weeks (w/c 14.11.16 & w/c 21.11.16). This is an expected change due to increased clinical pressures impacting on skill mix in specialty areas. The model of assessment and review introduced through the Collaborative however, has meant that this is recognised and responded to in a constructive way, as is illustrated by a reduction in hours after each peak.

5.0 Next Steps

5.1 Using the Change Package to support scale up and spread, the collaborative will 'roll out' the use of the risk assessment and associated care bundle through a 'buddy' system (those ward sisters involved will support colleagues in neighbouring wards), with support from the project lead.

5.2 During Q4, the Collaborative membership will audit compliance against the use of the change package, in real time, over a five day period. This will test the embeddedness and provide comparison data to identify areas of success or where further attention is required.

5.3 The majority of the patients who are assessed as requiring enhanced care have a cognitive difficulty. The work undertaken by the Dementia and Learning Disability Steering Groups in identifying and supporting meaningful activity and distraction intervention will ensure that there are more opportunities and resources available to staff to support patients with these particular needs, thus further reducing the need for additional staff.

6.0 Recommendation

6.1 The Committee are asked to **note** the content of this report and **support** the continued activity in this area.

Northampton General Hospital NHS
NHS Trust

Ward Staffing Fill Rate Indicator (Nursing, Midwifery & Care Staff) — December2016

Ward name	Day: Registered midwives/nurses — Total monthly planned staff hours	Day: Registered midwives/nurses — Total monthly actual staff hours	Day: Care Staff — Total monthly planned staff hours	Day: Care Staff — Total monthly actual staff hours	Night: Registered midwives/nurses — Total monthly planned staff hours	Night: Registered midwives/nurses — Total monthly actual staff hours	Night: Care Staff — Total monthly planned staff hours	Night: Care Staff — Total monthly actual staff hours	Day: Average fill rate - registered nurses /midwives (%)	Day: Average fill rate - care staff (%)	Night: Average fill rate - registered nurses / midwives (%)	Night: Average fill rate - care staff (%)	Care Hours Per Patient Day (CHPPD): Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall	Actions/Comments	Red Flag
									Key: Below 80% Shift Fill Rate Target; 80% and Above Shift Fill Rate Target									
Abington	1,602.50	1,499.17	1,412.50	1,446.50	1,068.00	1,070.75	1,062.00	1,216.00	93.6%	102.4%	100.3%	114.5%	843	3.0	3.2	6.2		
Allebone	1,625.50	1,518.75	1,068.50	1,331.50	1,426.00	1,391.50	713.00	1,225.75	93.4%	124.6%	97.6%	171.9%	861	3.4	3.0	6.4		
Althorp	955.50	932.00	649.25	574.50	713.00	701.50	437.00	470.75	97.5%	88.5%	98.4%	107.7%	290	5.6	3.6	9.2		
Becket	2,031.50	1,943.17	1,401.75	1,332.58	1,771.00	1,638.45	713.00	773.75	95.7%	95.1%	92.5%	108.5%	804	4.5	2.6	7.1		
Benham	1,782.25	1,699.25	891.25	1,344.75	1,426.00	1,427.50	713.00	1,414.50	95.3%	150.9%	100.1%	198.4%	792	3.9	3.5	7.4		
MATERNITY COMBINED UNIT: Sturtridge, MOW, Balmoral & Birth Centre	7204.5	7006.7	3805.3	3200.8	6544.6	6279.1	3070.3	2296.1	97.3%	84.1%	95.9%	74.8%	1105	12.0	5.0	17.0	Shortfall of MSWs due to vacancy and maternity leave. Active recruitment ongoing. Staffing and acuity reviewed daily and staff redeployed to maintain safety . Day shifts prioritised as increased activity and women require more support	
Brampton	1,416.00	1,433.00	1,054.00	1,067.75	1,058.00	1,059.00	713.00	1,161.50	101.2%	101.3%	100.1%	162.9%	887	2.8	2.5	5.3		
Cedar	1,609.00	1,653.25	1,748.75	2,125.75	1,068.58	1,068.75	1,069.50	1,585.25	102.8%	121.6%	100.0%	148.2%	898	3.0	4.1	7.2		
Collingtree	2,357.00	2,261.25	1,788.00	1,871.75	1,782.50	1,752.50	713.00	883.48	95.9%	104.7%	98.3%	123.9%	1220	3.3	2.3	5.5		
Compton	1,068.75	1,035.50	730.50	1,040.50	713.00	712.50	356.50	677.25	96.9%	142.4%	99.9%	190.0%	556	3.1	3.1	6.2		
Creaton	1,705.00	1,651.00	1,672.25	1,827.75	1,069.50	1,069.50	713.00	1,096.00	96.8%	109.3%	100.0%	153.7%	860	3.2	3.4	6.6		
CHILD HEALTH COMBINED: Disney, Gosset & Paddington	7341.4	6875.9	2328.8	2105.8	5865.0	5295.1	1155.3	1102.0	93.7%	90.4%	90.3%	95.4%	1055	11.5	3.0	14.6	short fall of 25% of planned staffing due to sickness	staff priotised all care and escalated appropiately. Reprspective meeting held withCD lead consultant Matron and Sister. Escaltion plan devised.
Dryden	2,131.75	1,811.25	966.50	939.00	1,423.50	1,469.50	713.00	759.00	85.0%	97.2%	103.2%	106.5%	775	4.2	2.2	6.4		
EAU	2,130.00	2,123.75	1,016.75	1,642.00	1,782.50	1,796.50	1,069.00	1,604.00	99.7%	161.5%	100.8%	150.0%	905	4.3	3.6	7.9		
Eleanor	1,050.50	1,028.50	711.00	820.50	713.00	713.00	713.00	828.00	97.9%	115.4%	100.0%	116.1%	346	5.0	4.8	9.8		
Finedon	2,139.00	1,911.00	600.25	688.00	1,069.50	1,067.75	356.50	638.75	89.3%	114.6%	99.8%	179.2%	492	6.1	2.7	8.8		
Hawthorn	1,959.95	1,955.58	1,066.00	1,103.00	1,426.00	1,394.42	966.00	1,079.50	99.8%	103.5%	97.8%	111.7%	841	4.0	2.6	6.6		
Head & Neck	1,054.70	1,017.70	707.50	630.00	908.50	784.25	356.50	558.75	96.5%	89.0%	86.3%	156.7%	393	4.6	3.0	7.6		
Holcot	1,418.25	1,344.42	1,426.00	1,708.50	1,069.50	1,069.75	713.00	1,729.37	94.8%	119.8%	100.0%	242.5%	874	2.8	3.9	6.7		
ITU	5,989.50	5,533.08	651.75	587.00	4,577.00	4,246.50	621.00	573.75	92.4%	90.1%	92.8%	92.4%	363	26.9	3.2	30.1		
Knightley	711.75	696.25	867.45	925.70	1,069.50	1,023.50	356.50	471.08	97.8%	106.7%	95.7%	132.1%	649	2.6	2.2	4.8		
Rowan	1,965.00	1,954.92	1,069.00	1,225.75	1,782.50	1,731.92	713.00	971.00	99.5%	114.7%	97.2%	136.2%	879	4.2	2.5	6.7	2 x Other Staffing issues 1 x Delay or omisson of regular checks - Personal needs	1.Patient was assessed as requiring 1:1 observation for high risk of falls, this shift was unfilled, the correct escalation was followed which was unable to be resolved. Patient monitored post fall appropriately, no harm occurred. 2. Incident currently under investigation. The patient was not a high risk of falls, not confused or requiring enhanced care. Staff prioritised all care, escalated appropriately. Night practitioner highlighted the elevated number of DNA's and short term sickness throughout the Trust, no further assistance available. Extra HCA returned to own ward due to increase dependency on own ward (5 admissions in 2 hours). One patient sustained harm post fall during this period (W-70991) during this shift
Spencer	923.25	918.75	584.98	800.07	713.00	720.75	356.50	711.25	99.5%	136.8%	101.1%	199.5%	398	4.1	3.8	7.9		
Talbot Butler	2,588.25	2,099.17	1,410.50	1,481.42	1,414.50	1,065.33	701.50	1,341.00	81.1%	105.0%	75.3%	191.2%	826	3.8	3.4	7.2	The numbers of HCA increased on night duty increased to support patient care due to RN ongoing recruitment. Staffing monitored daily by the Matron and reallocation as required.	
Victoria	1,169.25	1,230.50	693.90	893.75	713.00	713.00	330.50	721.50	105.2%	128.8%	100.0%	218.3%	557	3.5	2.9	6.4		
Willow	2,313.50	2,347.67	1,068.50	1,124.92	2,139.00	2,049.25	713.00	865.50	101.5%	105.3%	95.8%	121.4%	859	5.1	2.3	7.4		

Enclosure E

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 January 2017**

Title of the Report	Financial Position - November (FY16-17)
Agenda item	10
Sponsoring Director	Simon Lazarus, DoF
Author(s) of Report	Bola Agboola, Interim Deputy DoF
Purpose	To report the financial position for the period ended December 2016/17.

Executive summary

This report sets out the financial position of the Trust for the period ended 31st December. The overall I&E position is a deficit of £10.5m, £25k better than YTD plan. This is after factoring in the impact of the £0.5m loss of STF performance-related funding.

Key points:

- STF funding of £6.8m is included in the reported position but excludes £0.5m funding for Cancer and A&E targets which are below required trajectories.
- Income and activity are based on our best estimate, in order to fit in with the reporting timescale this month. The final income position will be reported verbally to the Board.
- Agency spend is beginning to show a downward trend, for the third month in a row, although Pay expenditure YTD remains significantly adverse to plan at £6.0m.
- Agency expenditure is exceeding the authorised cap by £2.4m (24%) YTD.
- The Trust continues to score "3" against the new NHSI "Finance and use of Resources" metrics.

Related strategic aim and corporate objective	Financial Sustainability
Risk and assurance	The recurrent deficit and I&E plan position for FY16-17 signal another challenging financial year ahead and the requirement to develop a medium term financial strategy to deliver financial balance in the medium term.
Related Board Assurance Framework entries	BAF 3.1 (Sustainability); 5.1 (Financial Control); 5.2 (CIP delivery); 5.3 (Capital Programme).
Equality Impact Assessment	N/A

Enclosure F

Legal implications / regulatory requirements	NHS Statutory Financial Duties
Actions required by the Board: The Board is asked to note the financial position for the period ended December 2016/17 and to consider the actions required to ensure that the control total of £15.1m is delivered.	

Northampton General Hospital NHS
NHS Trust

Financial Position

Month 9 (December)
FY 2016/17

Report to:

Trust Board

January 2017

Enclosure F

1. Overview

	RAG	This Month Dec	Last Month Nov	Change
Statutory Financial Duties				
3 year Cumulative I&E Breakeven duty (£000's)	✗	(40,006)	(38,454)	(1,552)
Achieving EFL (£000's)	✓	21,278	21,278	0
Capital Cost Absorption Duty (%)	✓	3.5%	3.5%	0
Achieving the Capital Resource Limit (£000's)	✓	13,898	14,750	(852)
Financial Sustainability Risk Rating	✓	3	3	(0)
I&E Position				
Actual in Month Position (£000's)	✗	(1,552)	(1,275)	(277)
Forecast in Month Position (£000's)	✗	(1,867)	(963)	(904)
STF Plan		7,275	6,467	808
STF Actual	✗	6,810	6,063	747
Actual Year to Date Position (£000's)	✗	(10,515)	(8,963)	(1,552)
Forecast End of Year I&E Position (£000's)	✗	(15,129)	(15,129)	0
EBITDA %	✗	-0.2%	0.0%	-0.2%
Income				
MRET Penalty - YTD (£000's)	✗	(3,523)	(3,015)	(508)
Readmissions YTD - Gross (£000's)	✗	(2,561)	(2,288)	(273)
Contract Fines & Data Challenges (£000's)	✗	(141)	(140)	(1)
Elective variance to plan (£000's)	✓	(322)	(420)	98
Daycase variance to plan (£000's)	✓	221	(144)	366
Non-Elective variance to plan (£000's)	✓	3,341	3,460	(119)
Outpatients variance to plan (£000's)	✓	1,885	1,714	171
Operating Costs				
Pay Expenditure (£000's)	✓	16,602	16,739	136
Agency Staff Costs (£000's)	✓	1,186	1,269	83
Agency Staff Cap (£000's)		1,047	1,067	20
Non-Pay - Clinical (£000's)	✓	4,713	5,023	310
Non-Pay - Other (£000's)	✓	3,051	3,393	342
Cost Improvement Schemes				
Year to Date Actual (£000's)	✗	8,913	8,029	884
Year to Date Plan (£0o0's)		9,179	7,683	1,496
Forecast Delivery (£000's)	✗	11,521	11,656	(135)
Annual CIP Target (£'000s)		12,900	12,900	0
Capital				
Year to date expenditure (£'000s)		8,208	7,358	
% of annual plan Committed	✓	92%	80%	12%
Annual Capital Expenditure Plan (£000's)	✓	13,898	14,750	(852)
Cash				
In month movement (£000's)	✗	(1,594)	491	(2,085)
In Year movement (£000's)	✓	961	2,555	(1,594)
New PDC / Temporary borrowing (£000's)	✓	12,964	12,714	250
Debtors Balance > 90 days (£000's)	✗	1,030	1,058	28
Creditors % > 90 days	✓	0%	0%	0%
Cumulative BPPC - by volume (%)	✓	99.2%	99.2%	0.1%

Key issues for this report

This report sets out the financial position of the Trust for the period ended 31st December. The overall I&E position YTD is a deficit of £10.5m, which is £25k better than plan. This is after factoring in the impact of the £0.5m loss of STF performance-related funding.

Income

- Income continues to outperform plan and accounts for a favourable variance of £1.7m. If the loss of STF funding is excluded, income over-performance is £2.2m.
- Activity and Income for December have been calculated based on our best estimates, due to the tight reporting timescales. The final calculation will be done mid-month and any significant variances will be reported verbally to the Board.

Pay

- Pay YTD is an adverse variance of £6.0m (Nov £5.4m) although there is a slight improvement over prior month spend.
- Agency expenditure is exceeding the authorised cap YTD by £2.5 m (24%) but continues to show a downward trend.

Non-pay & Reserves

- Non-pay year to date is a favourable variance of £0.9m, again a slight improvement on last month, mainly due to medicines.
- Unspent reserves of £2.6m (Nov £2.2m) contributes to reducing the adverse Pay variance .

Liquidity

- The year to date position includes STF funding of £6.8m on the basis that the Trust continued to meet the performance criteria, with the exception of Cancer (Aug, Sep, Oct and Nov) and A&E (Q3).
- The Trust continues to access Deficit funding (Dec - £10.5m) and STF funding and manage its operational cashflow and commitments as they fall due.
- Of the Short-term IRWCSF funding received to date, £12.4m has been converted to long-term loans, based on the treatment dictated by the M9 Monitoring forms and subsequent confirmation from NHSI.

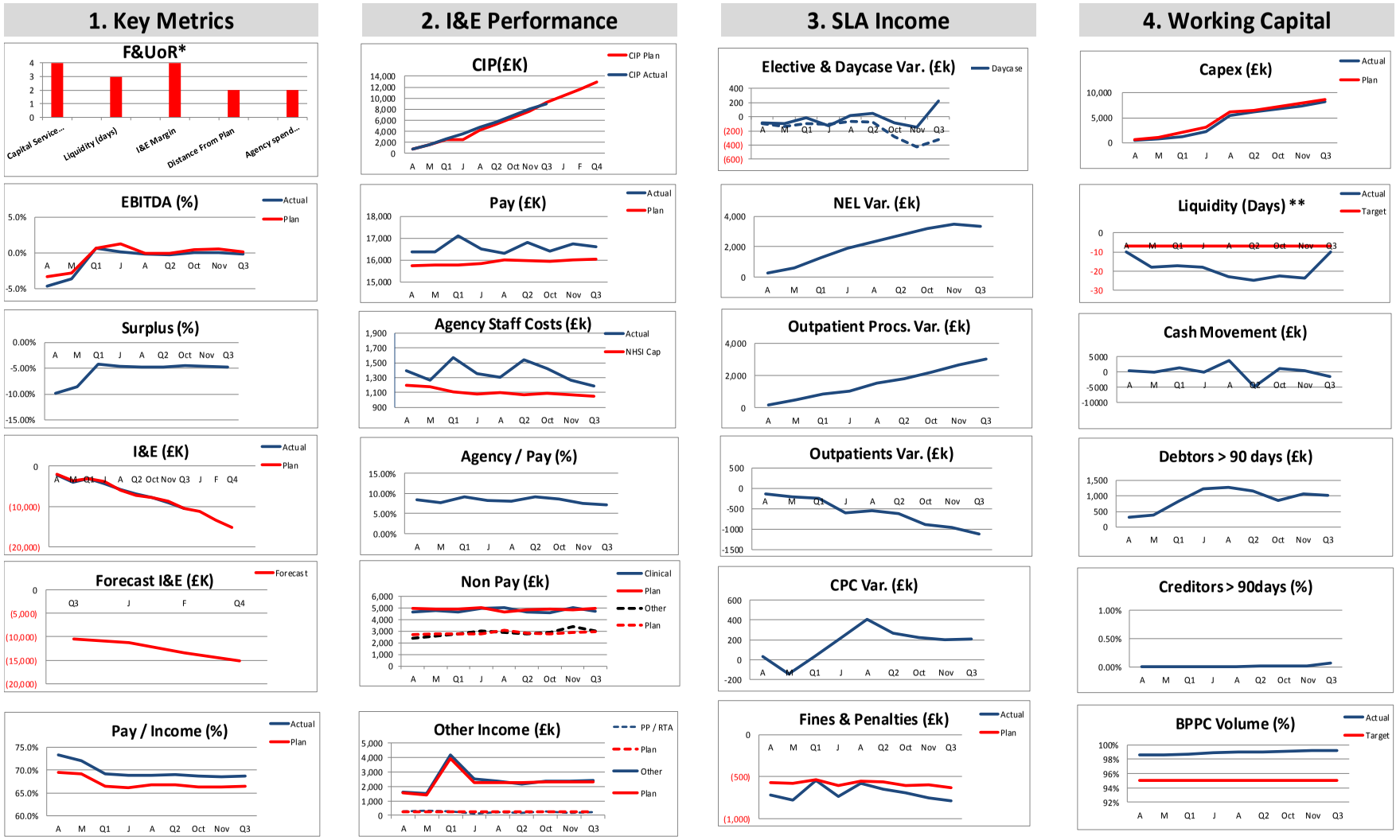
General

- NHSI rating - The Trust continues to score "3" against the NHSI "Finance and use of resources" metrics.
- CRL –Capital Resource limit has reduced by £0.9m due to slippage in some capital schemes.

Forecast

- Although the Trust is on plan year to date, the high-level forecast shows it must continue to put in place necessary financial measures to ensure it stays on track as well as manage the forward risks associated with delivering safe care in an increasingly challenging environment.

2. KPI & Trend Analysis



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

*** The liquidity gap is supported by access to Revolving Working Capital Funding and STF Funding*

3.0 Income and Expenditure Position

I&E Summary	Actual FY15-16	Annual Plan	YTD plan	YTD Actual	Variance to Plan	Dec 16	Nov 16
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	246,152	256,996	193,159	194,018	859	21,387	22,233
Other Clinical Income	2,444	2,686	2,010	2,032	22	198	177
Other Income	20,872	27,573	20,625	21,403	779	2,424	2,376
Total Income	269,468	287,256	215,794	217,454	1,660	24,008	24,786
Pay Costs	(187,327)	(191,127)	(143,216)	(149,194)	(5,978)	(16,602)	(16,739)
Non-Pay Costs	(88,196)	(92,784)	(69,548)	(68,608)	941	(7,763)	(8,136)
CIPs		(0)	0	0	0	0	0
Reserves/ Non-Rec		(3,336)	(2,584)	0	2,584	0	0
Total Costs	(275,523)	(287,247)	(215,348)	(217,802)	(2,454)	(24,366)	(24,875)
EBITDA	(6,055)	9	445	(348)	(794)	(357)	(88)
Depreciation	(9,941)	(10,365)	(7,774)	(7,179)	595	(815)	(815)
Amortisation	(9)	(9)	(7)	(7)	0	(1)	(1)
Impairments	3,315	1,590	1,252	(1,918)	(3,170)	0	0
Net Interest	(355)	(1,239)	(688)	(487)	201	(71)	(68)
Dividend	(4,041)	(3,501)	(2,626)	(2,537)	89	(262)	(284)
Surplus / (Deficit)	(17,086)	(13,515)	(9,397)	(12,475)	(3,078)	(1,507)	(1,257)
NHS Breakeven duty adjs:							
Donated Assets	250	(24)	109	42	(67)	(45)	(18)
NCA Impairments	(3,315)	(1,590)	(1,252)	1,918	3,170	0	0
I&E Position (breakeven duty)	(20,151)	(15,129)	(10,540)	(10,515)	25	(1,552)	(1,275)

I&E Performance

- The YTD financial performance for December is a normalised deficit of £10.5m, £25k better than plan. The in-month position improved and is £0.3m better than plan, and therefore contributes to the YTD position picking up from last month's YTD results.
- SLA income from Commissioners is £0.9m fav. to plan and continues to exclude provision for access fines in accordance with the conditions of the STF regime and standard contract.
- Other income is a variance of £0.8m fav. mainly due to charitable funds contribution to expenditure and release of 2015/16 maternity provision.
- STF funding of £6.8m for the year to date (£0.5m adv. to plan) is included within Other income of £21.4m.
- Pay expenditure £5.98m (4.1%) adverse to plan driven by high costs of medical agency and other clinical agency staff. Agency costs are continuing to show a gradual decline for the third consecutive month.
- Non-Pay costs £0.9m favourable to plan; mainly due to lower clinical non-pay spend in medicines and surgical appliances.
- Depreciation continues to remain favourable to plan by £0.6m following completion of Q2 additions to the capital asset register and reassessment of in year phasing of charges.

Key Issues

SLA Income (figures in brackets = last month variance)

- The YTD SLA income position of £194m includes £6.2m provision for potential fines and penalties and over-performs plan (on a net basis) by £0.9m (£0.7m).
- The favourable position results from increased Non elective activity, Daycases and Outpatient procedures, (better than plan), compensating for the reduction in Elective activity.
- Activity and income have been calculated on best estimates and will be refined later in the month, with any significant variances reported to the Board verbally.
- The reported position includes provision for data challenges and contract reconciliation issues.

Other Income

- Other income continues to show a favourable variance of £0.8m (£0.7m fav.) mainly due to charitable funds contribution to expenditure and release of 2015/16 maternity provision.
- Other clinical income is a net favourable variance of £22k (£50k), made up of Private Patient income £186k fav and RTA income £164k adv. to plan.

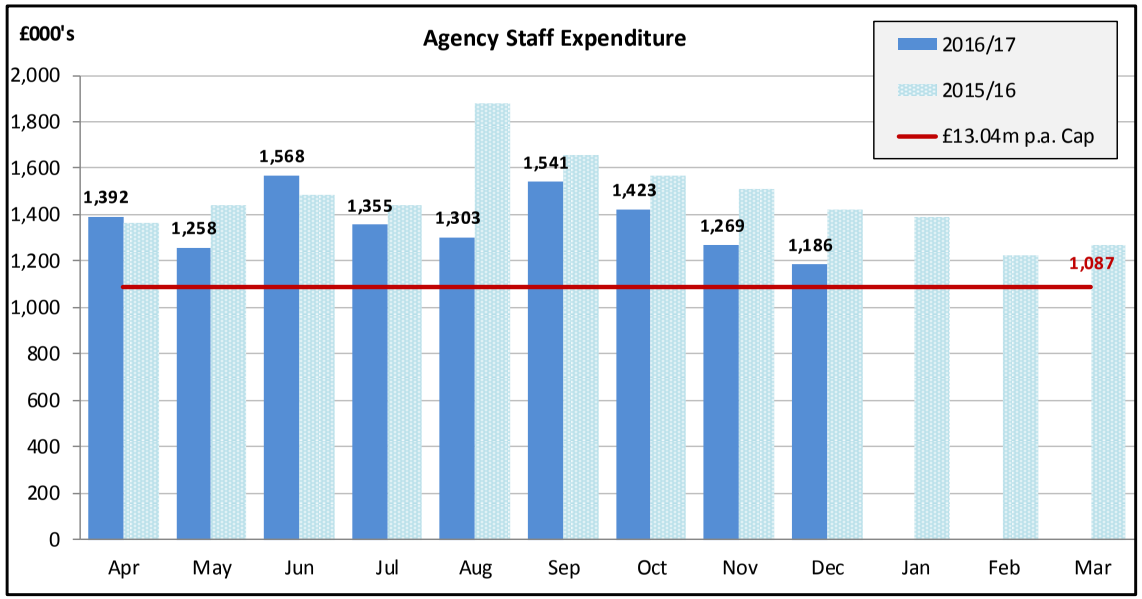
Pay

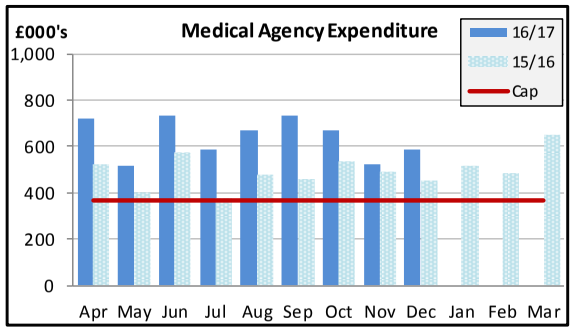
- Included within Pay is Agency costs YTD of £12.3m versus full year agency cap of £13.04m. However we are continuing to see a gradual decline in agency spend for the third consecutive month and believe a large contributor to this downward trend are the measures the Trust is putting in place to reduce agency spend.

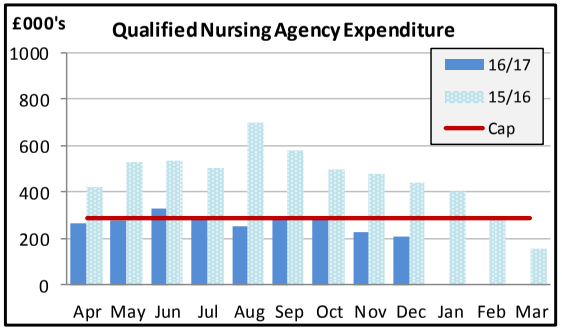
Non-Pay

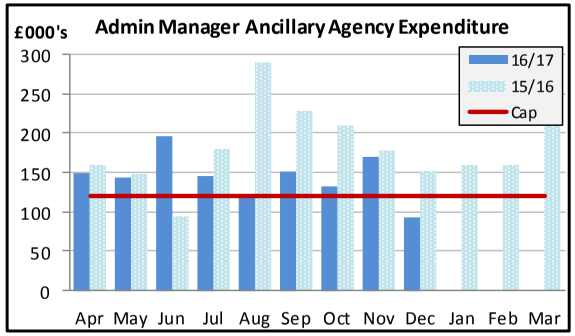
- Non-pay spend continues to show a favourable variance to plan of £0.9m, which is a slightly improved performance over M8 (£0.8).

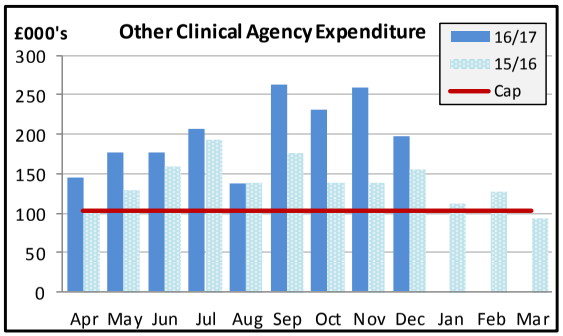
3.1 Agency Staff Expenditure





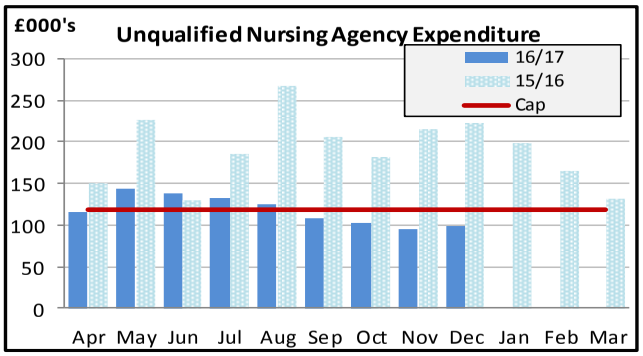






Key Issues

- NHS Improvement issued an expenditure limit of £13.04m for the financial year 2016/17, equivalent to a 26% reduction year-on-year across all staff groups.
- The Trust total expenditure for agency staff in 2015/16 was £17.6m.
- Applying the £13.04m annual limit equally across the year gives a £1.1m per month cap to keep within.
- **At the end of December the Trust is £2.5m behind this cap.**
- However Agency Expenditure continues to show a reduction for a third successive month. The £1.186m spend figure for December is the lowest reported monthly figure since Nov-14.
- Agency Medical Staff expenditure constitutes 47% of the Trust total agency spend of £12.3m to date. December spend is 9% below the average month in 16/17.
- Agency Other Clinical Staff expenditure has seen a reduction this month particularly in Pathology scientists.
- Nursing agency spend has now dropped to under 5% of the total amount spent on the nursing staff group.



4.0 SLA Income by Point of Delivery

		Activity			Finance £000's	
Point of Delivery	Plan	Actual	Variance	Plan	Actual	Variance
AandE	90,268	88,116	(2,152)	10,521	10,118	(403)
Block / CPC	2,102,661	2,177,530	74,869	42,197	42,405	208
CQUIN	-	-		4,115	3,538	(578)
Day Cases	26,102	30,492	4,390	18,341	18,562	221
Elective	4,361	4,153	(208)	12,190	11,868	(322)
Elective XBDs	1,590	1,702	112	372	389	17
Excluded Devices	1,246	1,501	255	1,332	1,423	91
Excluded Medicines	-	331	331	16,362	16,200	(162)
Non-Elective	32,589	34,936	2,347	51,871	55,212	3,341
Non-Elective XBDs	27,852	29,124	1,272	6,073	6,327	254
Outpatient First	43,120	41,373	(1,747)	7,134	6,867	(267)
Outpatient Follow UP	138,567	124,542	(14,025)	13,821	12,964	(857)
Outpt Procedures	75,746	92,607	16,861	13,633	16,642	3,008
Other Central SLA Income				(345)	(2,272)	(1,928)
CIPs				763		(763)
Total SLA Income (before fines and penaties)	**2,544,102**	**2,626,407**	**82,305**	**198,380**	**200,242**	**1,863**

Fines & Penatlies				
Contract Penalties	2WW	-	(5)	(5)
Contract Penalties	31 Day	-	(12)	(12)
Contract Penalties	62 Day	-	(52)	(52)
Contract Penalties	Cancelled Operations	-	(72)	(72)
Readmissions	Readmissions	(2,115)	(2,561)	(446)
MRET	MRET	(3,105)	(3,523)	(418)
Sub-Total Fines & Penalties		**(5,220)**	**(6,225)**	**(1,004)**
Grand Total SLA Income		**193,159**	**194,018**	**858**
NHSI STF Funding		**7,275**	**6,810**	**(465)**

Key issues

Summary
£859k favourable to plan

Total SLA Income showing £859k favourable position to plan, reduced to £394k including STF support.

CQUIN
£578k adverse to plan

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

Admitted patient income
£3,511k favourable to plan

Because of the timescales, this month the income is a high level estimate, based on volumes of non-processed activity. Activity for December has therefore not been split between Day Cases, and Elective and Non-Elective activity. The full income processing is always repeated mid-month for the final figures to be sent to the Commissioners, and therefore when this has been done, if there is a significant difference against this estimate, we can adjust as appropriate.

Outpatients
£1,885k ahead of plan

The net position on outpatients is also an estimated over-performance, again based on non-processed data.

AandE

A&E is £403k below plan.

Fines & Penalties
£1,004k adverse to plan

Non-elective activity has forged ahead, with many more patients than expected returning within 30days. The December position is again an estimate, based on the proportion of MRET and Readmissions within the figures for the year to date.

4.1 STF Funding

I&E £k	Plan	YTD Plan	Actual	Var
Pre STF	(24,829)	(17,815)	(17,325)	490
STF	9,700	7,275	6,810	(465)
Post STF	(15,129)	(10,540)	(10,515)	25

FY16-17 STF criteria and weighting

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

Key issues

- The Trust performed above plan by £490k before considering lost income from STF trajectories not met. When this loss of £465k is taken into account, the Trust still managed to do better than plan by £25k
- The trajectories not met were for Cancer (Aug+Sep+Oct+Nov) and A&E (Q3) culminating in a loss of £465k.
- The Trust has put in an appeal for Cancer for Q2 and remains hopeful for a positive outcome. In addition, the Trust will be putting in an appeal for Cancer (Oct+Nov) and A&E (Q3).
- The STF funding accounted for is subject to reconciliation of the STF trajectories delivery.

5. Statement of Financial Position

TRUST SUMMARY BALANCE SHEET MONTH 9 2016/17	Balance at 31-Mar-16	Current Month			Forecast end of year	
		Opening Balance	Closing Balance	Movement	Closing Balance	Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	160,399	160,399	160,399	0	160,399	0
IN YEAR REVALUATIONS	0	(6,234)	(6,236)	(2)	(4,225)	(4,225)
IN YEAR MOVEMENTS	0	7,856	8,778	922	18,222	18,222
LESS DEPRECIATION	0	(6,364)	(7,179)	(815)	(9,929)	(9,929)
NET BOOK VALUE	160,399	155,657	155,762	105	164,467	4,068
CURRENT ASSETS						
INVENTORIES	5,744	6,210	6,505	295	5,494	(250)
TRADE & OTHER RECEIVABLES	16,341	22,049	22,608	559	17,035	694
NON CURRENT ASSETS FOR SALE	375	0	0	0	0	(375)
CASH	1,602	4,157	2,563	(1,594)	1,500	(102)
TOTAL CURRENT ASSETS	24,062	32,416	31,676	(740)	24,029	(33)
CURRENT LIABILITIES						
TRADE & OTHER PAYABLES	24,347	28,492	29,243	751	25,126	779
FINANCE LEASE PAYABLE under 1 year	121	121	121	0	124	3
SHORT TERM LOANS	783	13,486	1,059	(12,427)	1,782	999
STAFF BENEFITS ACCRUAL	710	767	767	0	750	40
PROVISIONS	2,802	2,286	2,166	(120)	2,503	(299)
TOTAL CURRENT LIABILITIES	28,763	45,152	33,356	(11,796)	30,285	1,522
NET CURRENT ASSETS / (LIABILITIES)	(4,701)	(12,736)	(1,680)	11,056	(6,256)	(1,555)
TOTAL ASSETS LESS CURRENT LIABILITIES	155,698	142,921	154,082	11,161	158,211	2,513
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year	1,245	1,167	1,157	(10)	1,039	(206)
LOANS over 1 year	26,203	28,785	41,462	12,677	47,802	21,599
PROVISIONS over 1 year	979	979	979	0	226	(753)
NON CURRENT LIABILITIES	28,427	30,931	43,598	12,667	49,067	20,640
TOTAL ASSETS EMPLOYED	127,271	111,990	110,484	(1,506)	109,144	(18,127)
FINANCED BY						
PDC CAPITAL	119,258	119,258	119,258	0	119,258	0
PDC TEMPORARY BORROWING	0	0	0	0	0	0
REVALUATION RESERVE	41,435	37,118	37,118	0	38,437	(2,998)
I & E ACCOUNT	(33,422)	(44,386)	(45,892)	(1,506)	(48,551)	(15,129)
FINANCING TOTAL	127,271	111,990	110,484	(1,506)	109,144	(18,127)

Key Movements

The key movements from last month are:

Non Current Assets

•Increase in depreciation of £815k offset by capital expenditure additions of £922k, as per the Capital expenditure report.

Current assets

•Inventory - £295k - Increase in Inventory-holding levels to recognise the time lag to reorder items over the bank holiday.

•Trade & Other Receivables - £559k – Mainly due to amounts invoiced in excess of accrued income in relation to Q2 over-performance.

•Cash - £1,594k, mainly to do with DH Interim working capital loan repayment. This was in addition to other cash movement arising from normal trading transactions.

Current Liabilities

•Trade & Other Payables - £751k - increase due to accruals and capital expenditure invoices.

•Short-term loans - £12,427k – Conversion of short-term to long-term revolving working capital loans, as dictated by the M9 Monitoring forms. We have checked with NHSI who confirmed that this should be the case.

•Provisions - £120k – release of 2015/16 CEA payments provisions relating to permanent medical staff back pay.

Non Current Liabilities

•Long-term loans - £12,677k – increase mainly to do with the conversion of revolving working capital short-term loans as explained above.

6. Capital Expenditure

Capital Scheme	Plan 2016/17 £000's	M9 Plan £000's	M9 Spend £000's	Under (-) / Over £000's	Plan Achieved %	Actual Committed £000's	Plan Achieved %
Replacement Imaging Equipment (Loan - Tranche 1)	0	0	-8	-8	0%	-8	0%
Replacement Imaging Equipment (Loan - Tranche 2)	3,951	2,445	2,452	7	62%	3,585	91%
Additional Imaging Equipment (Loan)	693	693	705	12	102%	741	107%
Replacement NPfIT Systems	1,407	823	827	3	59%	1,285	91%
Stock / Inventory System (Loan)	382	192	189	-3	49%	331	87%
A&E / Orthopaedics	500	500	456	-44	91%	500	100%
Contingency	-77	0	0	0	0%	0	0%
Medical Equipment Sub Commiittee	938	588	567	-21	60%	575	61%
Estates Sub Committee	3,219	2,314	2,122	-192	66%	3,130	97%
IT Sub Committee	3,101	1,618	1,350	-268	44%	2,796	90%
60 Bedded Ward	0	0	0	0	0%	0	0%
Other	859	122	119	-2	14%	901	105%
Total - Capital Plan	**14,973**	**9,295**	**8,778**	**-517**	**59%**	**13,836**	**92%**
Less Charitable Fund Donations	-700	-195	-195	0	28%	-685	98%
Less NBV of Disposals	-375	-375	-375	0	100%	-375	100%
Total - CRL	**13,898**	**8,725**	**8,208**	**-517**	**59%**	**12,776**	**92%**

Funding Resources	
Internally Generated Depreciation	9,704
Finance Lease - 60 Bedded Ward	0
Capital Loans - Imaging Equipment Tranche 1	0
Capital Loans - Replacement Imaging Tranche 2	3,951
Capital Loans - Additional Imaging Equipment	693
Capital Loans - Stock / Inventory System	400
Capital Loan - Repayment	-694
Other Loans - Repayment	-156
Total - Available CRL Resource	**13,898**
Uncommitted Plan	**0**

Key Issues

- Further slippage has been encountered on the PAS scheme of £148k as the project milestone has slipped till April 2017. This reduces the 2016/17 plan over commitment to £77k. However as this resource will be reprovided in 2017/18 this will result in an additional pressure in the new year plan.
- In relation to the radiology replacement schemes funded by the capital loan, Room F will not complete till May 2017 with slippage of £0.3m, the new build associated with the MRI won't now commence till the new financial year with further slippage of £0.6m. The additional £0.9m has been included in the revised plan submission to NHSI in December.
- The above slippage accounts for the revised CRL to £13,898k (M8 £14,750k)
- Orders have now been placed for Room D, F and the CT scanner equipment and the enabling costs associated with these are being finalised with Estates.
- Fluoroscopy Room equipment has been ordered and the enabling costs associated with these are being finalised with Estates.
- The MRI scanner, equipment order has been placed and the building works are being finalised between Estates and Philips.
- There is a meeting with Genesis, the chosen supplier of the inventory management system and ABS, the financial ledger provider to develop the interfaces between the system. However it is likely that the system will now go live in the new financial year.
- The current full year depreciation forecast is £9,704k (M8 £9,929k).

7. Receivables, Payables and BPPC Compliance

Narrative	Total at December £000's	0 to 30 Days £000's	31 to 60 Days £000's	61 to 90 Days £000's	Over 90 Days £000's
Receivables Non NHS	1,361	364	337	82	579
Receivables NHS	13,202	11,920	684	148	451
Total Receivables	**14,564**	**12,283**	**1,021**	**229**	**1,030**
Payables Non NHS	(7,258)	(7,235)	(10)	(7)	(7)
Payables NHS	(3,595)	(3,581)	(14)	0	0
Total Payables	**(10,853)**	**(10,816)**	**(23)**	**(7)**	**(7)**

Narrative	Total at November £000's	0 to 30 Days £000's	31 to 60 Days £000's	61 to 90 Days £000's	Over 90 Days £000's
Receivables Non NHS	1,442	605	145	144	547
Receivables NHS	12,636	11,639	263	222	511
Total Receivables	**14,078**	**12,245**	**409**	**366**	**1,058**
Payables Non NHS	(8,535)	(8,525)	(7)	(2)	(2)
Payables NHS	(2,649)	(2,649)	0	0	0
Total Payables	**(11,184)**	**(11,174)**	**(7)**	**(2)**	**(2)**

Receivables and Payables

- SLA commissioner monthly invoices were paid on time, with the exception of Leicester City CCG. This account is no longer in credit balance following the issue of Qtr 2 over-performance invoices.
- Qtr 2 Over & Underperformance invoices/credit notes have been issued in December. With the exception of Leicester City CCG, all Qtr 1 invoices have now been paid.
- Continued focus on reducing age profile of non current debt.
- Non-NHS over 90 day debt includes Overseas visitor accounts of £277k, of which £88k are paying in instalments and a high proportion of the balance passed to debt collection agency to recover. Other significant balances include BMI Three Shires £159k and Alliance Medical £38k .
- NHS over 90 day debt predominantly relates to NCA's £442k (£445k) of which £416k is due from Kettering General.

Narrative	June 2016	Sept 2016	Oct 2016	Nov 2016	Dec 2016	Cumulative 2016/17
NHS Creditors						
No.of Bills Paid Within Target	196	171	162	188	149	1,567
No.of Bills Paid Within Period	197	193	162	189	150	1,606
Percentage Paid Within Target	**99.49%**	**88.60%**	**100.00%**	**99.47%**	**99.33%**	**97.57%**
Value of Bills Paid Within Target (£000's)	1,761	1,726	1,780	1,937	1,761	16,225
Value of Bills Paid Within Period (£000's)	1,762	1,738	1,780	1,938	1,765	16,291
Percentage Paid Within Target	**99.98%**	**99.31%**	**100.00%**	**99.94%**	**99.81%**	**99.59%**
Non NHS Creditors						
No.of Bills Paid Within Target	8,782	8,226	7,405	9,174	7,572	70,507
No.of Bills Paid Within Period	8,883	8,277	7,423	9,217	7,595	71,032
Percentage Paid Within Target	**98.86%**	**99.38%**	**99.76%**	**99.53%**	**99.70%**	**99.26%**
Value of Bills Paid Within Target (£000's)	9,350	8,988	8,848	11,002	8,693	79,075
Value of Bills Paid Within Period (£000's)	9,405	9,005	8,869	11,036	8,705	79,530
Percentage Paid Within Target	**99.42%**	**99.81%**	**99.76%**	**99.69%**	**99.86%**	**99.43%**
Total						
No.of Bills Paid Within Target	8,978	8,397	7,567	9,362	7,721	72,074
No.of Bills Paid Within Period	9,080	8,470	7,585	9,406	7,745	72,638
Percentage Paid Within Target	**98.88%**	**99.14%**	**99.76%**	**99.53%**	**99.69%**	**99.22%**
Value of Bills Paid Within Target (£000's)	11,112	10,714	10,629	12,939	10,454	95,299
Value of Bills Paid Within Period (£000's)	11,167	10,744	10,649	12,974	10,470	95,821
Percentage Paid Within Target	**99.51%**	**99.73%**	**99.80%**	**99.73%**	**99.85%**	**99.46%**

Better Payment Practice Code

- The BPPC performance has been achieved for all targets in December, and cumulative position for year to date.

8. Cashflow

MONTHLY CASHFLOW	Annual £000s	ACTUAL APR £000s	MAY £000s	JUN £000s	JUL £000s	AUG £000s	SEP £000s	OCT £000s	NOV £000s	DEC £000s	FORECAST JAN £000s	FEB £000s	MAR £000s	FORECAST 17/18 APR £000s	MAY £000s	JUN £000s
RECEIPTS																
SLA Base Payments	246,947	19,343	21,547	20,808	19,889	21,204	20,616	20,582	20,589	20,565	20,630	20,587	20,587	20,587	20,587	23,591
STF Funding	9,275	0	0	0	0	2,425	0	0	1,698	647	0	2,081	2,425	0	0	0
SLA Performance/ Other CCG Investment	2,004	0	0	0	0	0	0	-15	757	43	11	1,208	0	0	0	0
Health Education Payments (SIFT etc)	9,861	798	785	858	821	828	845	821	737	854	871	821	821	817	817	817
Other NHS Income	16,079	1,419	652	2,850	914	1,679	1,074	962	1,043	949	1,617	1,072	1,849	1,500	1,500	1,500
PP / Other (Specific > £250k)	4,154	473	0	764	567	273	476	0	962	393	246	0	0	0	0	0
PP / Other	10,692	1,046	691	711	817	783	907	684	894	805	954	1,200	1,200	1,200	1,200	1,200
Salix Capital Loan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC - Capital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Capital Loan	5,044	0	0	0	0	0	0	2,771	232	0	0	859	1,182	0	314	855
Revenue Support Loan	15,129	0	0	0	0	0	0	0	0	0	0	0	15,129	0	0	0
Revolving Working Capital Facility - deficit funding	0	2,038	1,554	2,120	1,724	-1,496	1,259	510	963	1,867	743	2,188	-13,469	3,116	2,224	1,762
Revolving Working Capital Facility - STF funding	9,700	0	0	0	0	4,042	808	808	809	808	808	808	808	436	436	436
Interest Receivable	32	3	4	5	2	3	2	2	2	2	2	2	2	2	2	2
Sale of Assets	585	585	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL RECEIPTS	**329,502**	**25,706**	**25,232**	**28,117**	**24,734**	**29,741**	**25,987**	**27,126**	**28,685**	**26,932**	**25,882**	**30,827**	**30,535**	**27,658**	**27,080**	**30,163**
PAYMENTS																
Salaries and wages	183,122	15,154	15,035	15,518	15,288	15,180	15,086	15,199	15,253	15,660	15,200	15,200	15,350	15,711	15,711	15,701
Trade Creditors	93,838	6,686	7,882	8,802	7,280	7,288	8,533	7,319	10,001	7,927	5,396	10,303	6,421	9,142	7,782	10,874
NHS Creditors	19,814	1,565	2,063	1,762	1,763	2,030	1,647	1,778	1,940	1,763	1,322	1,000	1,180	2,120	2,120	2,120
Capital Expenditure	18,009	1,864	300	620	404	1,215	705	1,575	1,030	743	4,998	1,710	2,844	664	1,468	1,468
PDC Dividend	3,472	0	0	0	0	0	1,856	0	0	0	0	0	1,616	0	0	0
Repayment of RWC Facility - STF funding	9,700	0	0	0	0	0	2,425	0	0	2,425	0	2,425	2,425	0	0	0
Repayment of Loans (Principal & Interest)	1,464	0	0	0	0	154	460	0	0	0	0	189	661	0	0	0
Repayment of Salix loan	155	12	0	0	0	0	85	21	0	0	0	0	38	21	0	0
TOTAL PAYMENTS	**329,574**	**25,280**	**25,281**	**26,702**	**24,735**	**25,867**	**30,797**	**25,892**	**28,224**	**28,518**	**26,916**	**30,827**	**30,535**	**27,658**	**27,081**	**30,163**
Actual month balance	-72	425	-49	1,415	-1	3,874	-4,811	1,234	461	-1,586	-1,035	0	0	0	-1	0
Cash in transit & Cash in hand adjustment	-29	-24	14	15	12	-20	48	-69	30	-7	-29	-1	1	-1	1	0
Balance brought forward	1,602	1,602	2,003	1,968	3,398	3,409	7,263	2,501	3,666	4,157	2,564	1,500	1,500	1,500	1,500	1,500
Balance carried forward	**1,500**	**2,003**	**1,968**	**3,398**	**3,409**	**7,263**	**2,501**	**3,666**	**4,157**	**2,564**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**

Key Issues

- Qtr 2 Over-performance invoices and credit notes have been raised. These are forecast to be paid in January & February.
- The Performance target element of the STF funding for Quarter 2 (£647k) was received in December. The respective Quarter 2 borrowing was repaid to the DH (£2,425k) in December.
- The Trust has drawn down a further £2.7m of Temporary Borrowing (3.5% Interim Revolving Working Capital Support Facility) in December. Further Temporary Borrowing (IRWCSF) of £1.6m has been approved for draw down in January.
- Salary Payments were £388k higher than forecast in December. This was partially due to Clinical Excellence Awards payments being made to Consultants.
- Capital Expenditure in December was £743k, £55k more than forecast. Invoices relating to the Radiology Replacement Schemes, for which Capital Loan was drawn down in Qtr 3 (£3.0m) have been received and are forecast to be paid in January.
- It is anticipated, due to the high value of Capital creditors to be paid in January, that cash available for NHS & Trade Creditors will be restricted in the short term. Following further drawn down of Capital & Working Capital Loans in February, it is forecast that invoices not paid within 30 days in January will be paid once the loans are received.

9. Conclusions and Recommendations

Conclusion:

- The Trust has performed £25k better than plan in the period ended December 2016. If the STF performance funding loss of £465k is recovered, the Trust would be £490k better than plan.
- The Trust is yet to receive feedback on its appeal for Q2 Cancer funding and will be putting in an appeal for both Cancer and A&E Q3 funding.
- There remains a range of risks to delivery of the £15.1m control total which need to be addressed. The high level forecast position (provided under separate cover) highlights some of these risks. It is important that the Trust continues to focus on addressing the current areas of risk and overspend.
- Elective income has fallen behind plan due to increased NEL demand and capacity pressures with increased risk forecast for the winter period.
- There have been improvements in Pay spend, in particular agency spend, which we believe is a result of the actions the Trust is taking to control agency spend, including CEO sign off and Exec scrutiny over agency spend.
- Non-recurrent CIP delivery is expected to be c.£2.9m based on latest estimates which suggests pressure on future years' budgets. In addition there is a forward risk in terms of high risk schemes yet to be delivered.

Recommendations & actions

- Focus is maintained on managing the risks to the financial position and continued reduction of the Pay overspend.
- Divisions that are not meeting their financial targets continue to be subject to the approved performance management framework and develop action plans to improve financial performance for the remainder of the financial year.
- Monitor the Winter plan to ensure it remains in line with forecast and focus on supporting plans around protecting the elective bed base and outsourcing of elective work to the private sector.
- Continue to focus on the financial controls around agency spend including the oversight and sign-off provided by Execs in managing agency spend and promoting substantive recruitment drive.
- An appeal is put in for Q3 in relation to Cancer and A&E, in addition to putting in measures to ensure delivery of Q4 trajectories.

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 January 2017**

Title of the Report	**Workforce Performance Report**
Agenda item	**11**
Presenter of Report	Janine Brennan, Director of Workforce & Transformation
Author(s) of Report	Adam Cragg, Head of Resourcing & Employment Services
Purpose	This report provides an overview of key workforce issues
Executive summary • The Key Performance Indicators show a decrease in sickness absence. • Increase in Mandatory Training and Role Specific Essential Training and compliance for Appraisals. • Improving Quality & Efficiency update.	
Related strategic aim and corporate objective	Enable excellence through our people
Risk and assurance	Workforce risks are identified and placed on the Risk register as appropriate.
Related Board Assurance Framework entries	BAF – 2.1, 2.2 and 2.3
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (Y/N) No

	Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (Y/N) No
Legal implications / regulatory requirements	No

Actions required by the Board:

The Board is asked to Note the report.

Public Trust Board

Thursday 26th January 2017

Workforce Performance Report

1. Introduction

This report identifies the key themes emerging from December 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 decreased by 10.87 FTE in December 2016 to 4307.40 FTE. The Trust's substantive workforce is at 90.24% of the Budgeted Workforce Establishment of 4773 .13 FTE.

The Annual Trust turnover figure decreased by 0.41% to 9.27% in December, which is above the Trust target of 8%. Turnover within Nursing & Midwifery decreased by 0.5% to 6.57%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust. Turnover also decreased in Admin and Clerical, Allied Health Professionals and Healthcare Scientists, Estates & Ancillary, Additional Clinical Services and Medical & Dental. Turnover increased in Add Prof Sci & Technicians.

Medical Division: turnover increased by 0.34% to 7.45%

Surgical Division: turnover decreased by 0.04% to 8.45%

Women, Children & Oncology Division: turnover decreased by 0.02% to 9.21%

Clinical Support Services Division: turnover decreased by 0.85% to 10.06%

Support Services: turnover decreased by 1.18% to 11.98%

The vacancy rates for Allied Health Professionals, Healthcare Scientists, Additional Clinical Services and Admin & Clerical staff groups all increased in December 2016. Registered Nursing & Midwifery vacancy rate also increased from 10.19% to 10.98% .Additional Professional Scientific & Technical, Estates & Ancillary and Medical & Dental staff groups all decreased in December

In month sickness absence decreased by 0.03% to 3.75% which is below the Trust target of 3.8%. Clinical Support Services, Support Services and Surgery Divisions were the only ones below the trust target. In total 13 directorate level organisations were below the trust target rate.

Improving Quality & Efficiency Update

MOPD outpatients – Improving the administration & booking processes

- Design phase completed, actions prioritised.
- Standard Operating Procedure drafted for bureau.
- Bureau changes agreed by team manager.
- KPIs agreed.

Medical Staffing – Improving the Junior Doctor Process

- Project charter completed and signed off.
- Action plan completed.
- KANO commenced with stakeholders.
- Process map completed subject to team agreement.

Preoperative Assessment Stream ASA1 patients

- Project charter and plan completed.
- Staff briefed on the project.
- Visits to other Trusts identified and complete.
- Future state process map complete.

Surgical Productivity – Improving operational efficiency and utilisation in DSU

- Supported the Head & Neck and General Surgery booking teams to implement 6/4/2
- Implemented visual management to highlight opportunities in the booking process.
- Engaged the anaesthetists in the 6/4/2 planning process.
- Supported the DSU theatre team to improve the organisation of the day and introduce 'planning today for tomorrow'.
- Helped the team define their personal and operating standards and roles and responsibilities.
- Documented the standards and Standard Operating Procedure for 6/4/2.

Outpatient Productivity – Improving the booking process in outpatients – trial areas, Urology, ENT, MOPD (as above)

- Visual management utilised in ENT.
- ENT team meeting to agree team structure.
- Visual management training underway in Urology.
- Urology project team design session has prioritised actions.

- Flow chart from Medical Secretaries to Clinic Coordinators completed.

Nurse Recruitment & Retention

- The overseas recruitment campaign continues and between October 2016 and December 2016 a total of 9 overseas recruits arrived from the following countries:

  5 - India
  3 – Philippines
  1 – Romania

- Between October 2016 and December 2016, 25 interviews took place with overseas candidates.

- Between October 2016 and December 2016 a total of 22 offers were made to overseas nurses, 15 of which were accepted. 3 candidates were unsuccessful at interview stage.

- Between October & December 2016 overall (domestic and overseas) nursing capacity increased through new recruits and increases in hours by 41.43 WTE.

- Over the same period nursing capacity decreased through leavers and decreases in hours by 48.80 WTE.

- Between October & December 2016 nursing capacity therefore saw a net decrease of 7.37 WTE. This is in contrast the previous quarter which saw a net increase in nursing capacity of 26.23 WTE, however the data for Oct – December 2015 is broadly consistent with the same period for 2016.

- As at January 2017, total nursing vacancies for core and specialist areas is 133.18 WTE.

Brand Northamptonshire

- In conjunction with Kettering General Hospital, Northampton Healthcare Foundation Trust, St. Andrews and the University of Northampton a collaborative exercise to invest in the development of a Northamptonshire Brand has been undertaken in order to attract healthcare professionals and students wishing to become healthcare professionals to Northamptonshire. This collaborative investment has resulted in the production of a microsite and various organisation specific marketing materials which are aimed at enhancing each organisation's ability to attract staff and students to Northamptonshire in response to the national staffing shortages.

- Following the successful submission of a Business Case, LWAB money has been obtained to launch this branding and microsite in the following ways

1) Utilisation of two, core media (BMJ & RCN Bulletin) to reach Doctors and Nurses.

2) Utilisation of 'The Guardian' to reach a general health audience via behavioural targeting, showing advertising only to site visitors who are actively engaged in health-related editorial and relevant professional networks.

3) Utilisation of options for targeting people while visiting non-health or recruitment sites via programmatic targeting, driving traffic to the collaboratively developed microsite via Google SEM.

4) Utilisation of social media to build an audience long-term.

Nurse Retention

- No overseas nurses have left between October and December 2016.
- Quarter three saw a high leavers rate of domestic nurses, peaking in December at 18.47 WTE, however the figures over the three months is broadly consistent with the same period last year.
- The position of Nurse Retention Manager is out to advert for a second occasion due to being unable to recruit a candidate of the required calibre in December 2016. Interviews for the role are scheduled to take place on 8 February 2017.

2.2 Capability

Appraisals, Mandatory Training and Role Specific Essential Training

The current rate of Appraisals recorded for December 2016 is 82.01%; this is an increase of 1.12% from last month's figure of 80.89%.

Mandatory Training compliance increased in December from 85.79% to 86.41% which maintains the position above the Trust target of 85%.

Role Specific Essential Training compliance increased in December to 78.14% from last month's figure of 77.19%.

Assessment of Risk

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

Recommendations/Resolutions Required

The Committee is asked to note the report.

Next Steps

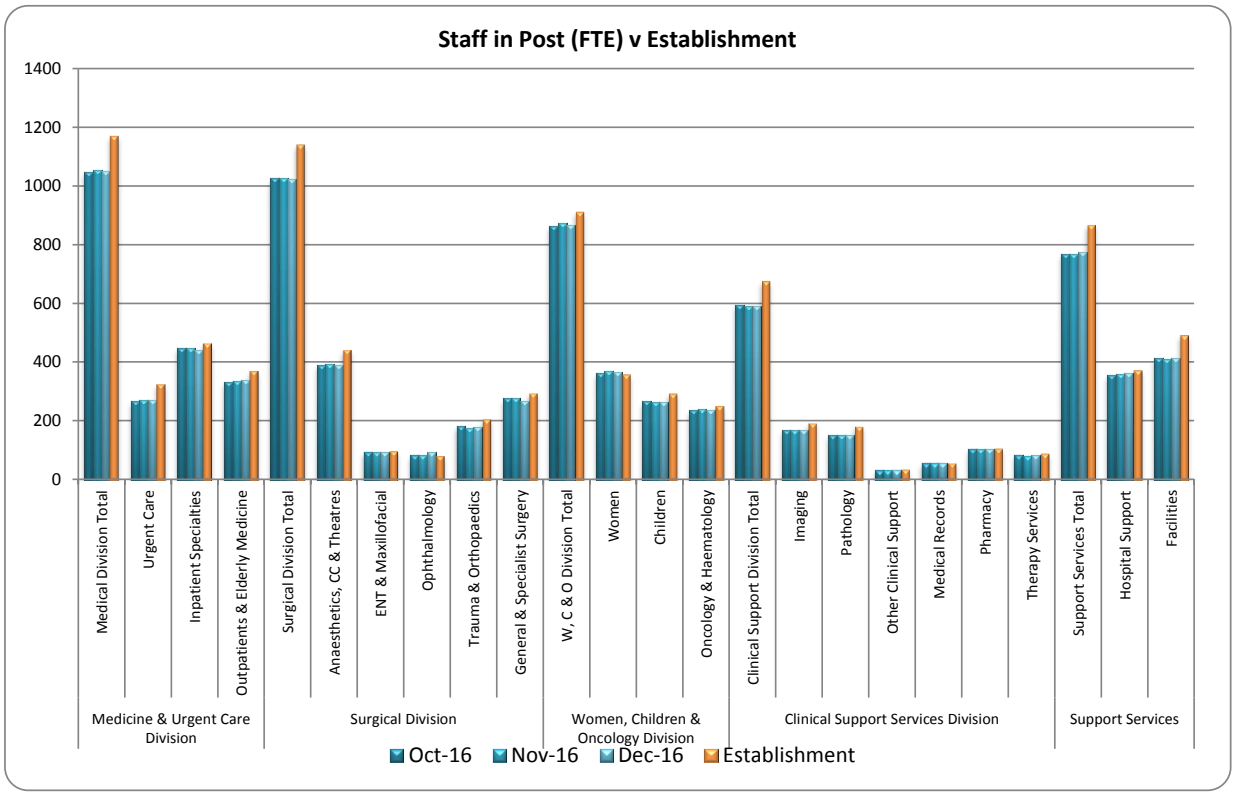
Key workforce performance indicators are subject to regular monitoring and appropriate action is taken as required.

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

CAPACITY
Staff in Post

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

Staff in Post (FTE)		Oct-16		Nov-16		Dec-16	Establishment	
Medicine & Urgent Care Division	Medical Division Total	1048.76	↑	1055.77	↓	1050.19	1170.95	89.69%
	Urgent Care	267.78	↑	270.74	↓	269.30	327.94	82.12%
	Inpatient Specialties	447.60	↑	447.68	↓	441.10	467.19	94.42%
	Outpatients & Elderly Medicine	332.38	↑	336.35	↑	338.79	372.82	90.87%
Surgical Division	Surgical Division Total	1025.19	↓	1024.93	↓	1023.41	1141.79	89.63%
	Anaesthetics, CC & Theatres	389.07	↑	392.69	↓	391.19	444.41	88.02%
	ENT & Maxillofacial	94.36	↓	91.82	↑	92.87	100.59	92.33%
	Ophthalmology	81.37	↓	81.30	↑	91.23	84.21	108.34%
	Trauma & Orthopaedics	180.29	↓	175.72	↑	178.32	208.96	85.34%
	General & Specialist Surgery	275.30	↑	278.60	↓	265.00	297.82	88.98%
Women, Children & Oncology Division	W, C & O Division Total	864.17	↑	872.62	↓	866.70	913.52	94.87%
	Women	361.96	↑	368.66	↓	363.85	360.91	100.81%
	Children	264.89	↓	264.55	↓	263.84	295.89	89.17%
	Oncology & Haematology	236.38	↑	237.48	↓	237.08	253.87	93.39%
Clinical Support Services Division	Clinical Support Division Total	593.83	↓	589.18	↑	591.95	677.65	87.35%
	Imaging	166.92	↑	167.32	↑	167.50	195.77	85.56%
	Pathology	150.72	↓	149.71	↑	149.72	184.35	81.22%
	Other Clinical Support	32.72	↓	32.32	↑	32.92	37.93	86.79%
	Medical Records	55.76	↑	55.76	↓	54.49	59.33	91.84%
	Pharmacy	104.15	↑	104.20	↑	105.06	108.93	96.45%
	Therapy Services	83.57	↓	79.86	↑	82.26	91.34	90.06%
Support Services	Support Services Total	768.34	↓	766.43	↑	775.15	868.67	89.23%
	Hospital Support	354.15	↑	357.69	↑	361.39	374.96	96.38%
	Facilities	414.19	↓	408.74	↑	413.76	493.71	83.81%
Trust Total		4303.29	↑	4318.27	↓	4307.40	4773.13	90.24%



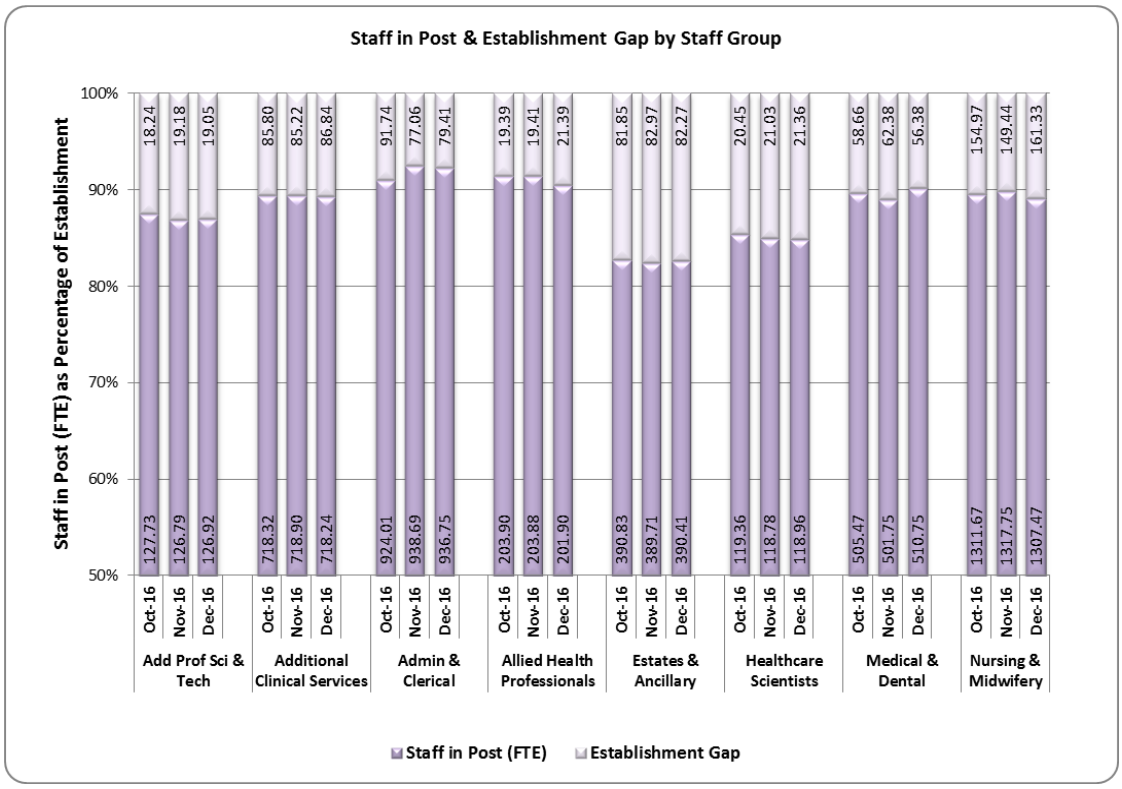
Workforce Committee: Capacity, Capability and Culture Report - December 2016

CAPACITY
Staff Group (FTE v Est)

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

Staff Group Vacancy Rate (Contracted FTE v Establishment)

Staff Group	Oct-16	Nov-16	Dec-16
Add Prof Sci & Tech	12.49%	13.14%	13.05%
Additional Clinical Services	10.67%	10.60%	10.78%
Admin & Clerical	9.03%	7.59%	7.82%
Allied Health Professionals	8.68%	8.69%	9.58%
Estates & Ancillary	17.32%	17.55%	17.41%
Healthcare Scientists	14.63%	15.04%	15.28%
Medical & Dental	10.39%	11.06%	9.99%
Nursing & Midwifery	10.57%	10.19%	10.98%



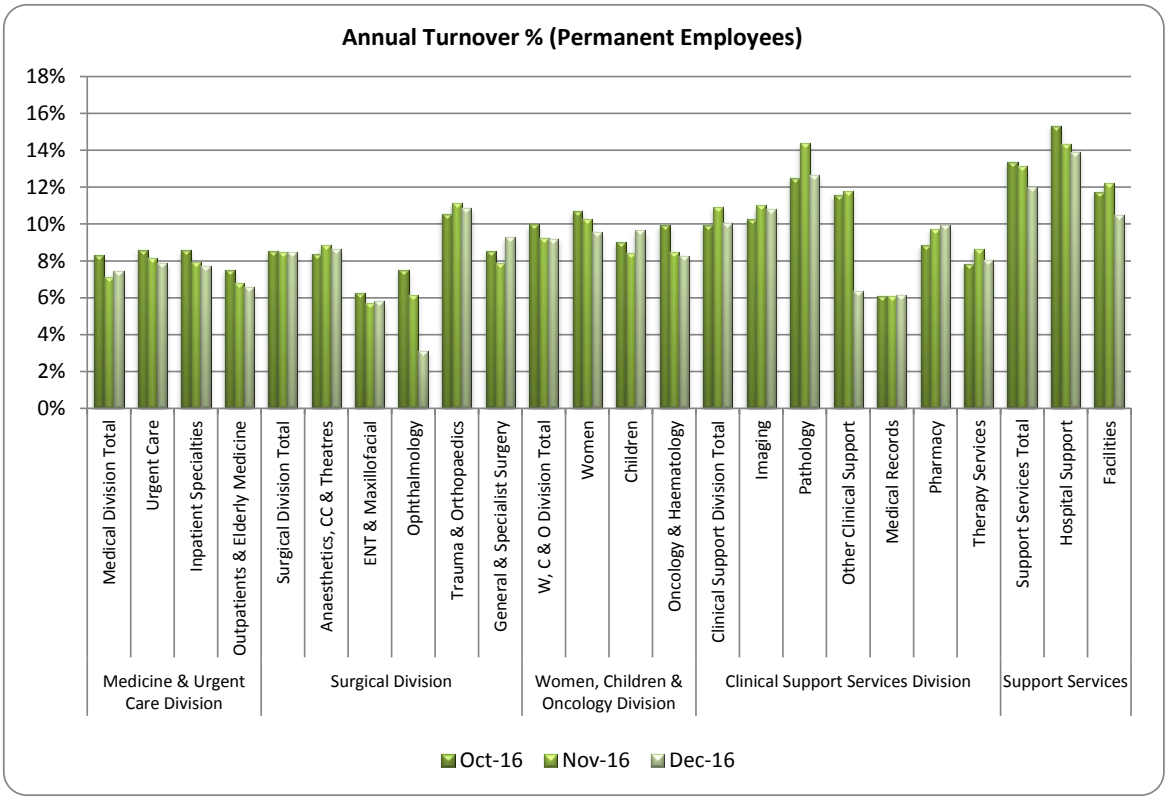
Workforce Committee: Capacity, Capability and Culture Report - December 2016

CAPACITY
Annual Turnover

Figures refer to the year ending in the month stated

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

Annual Turnover (Permanent Staff)		Oct-16	Nov-16		Dec-16	
Medicine & Urgent Care Division	Medical Division Total	8.32%	↘	7.11%	↗	7.45%
	Urgent Care	8.57%	↘	8.16%	↘	7.85%
	Inpatient Specialties	8.58%	↘	7.91%	↘	7.68%
	Outpatients & Elderly Medicine	7.49%	↘	6.81%	↘	6.56%
Surgical Division	Surgical Division Total	8.51%	↘	8.49%	↘	8.45%
	Anaesthetics, CC & Theatres	8.38%	↗	8.83%	↘	8.61%
	ENT & Maxillofacial	6.27%	↘	5.71%	↗	5.80%
	Ophthalmology	7.52%	↘	6.12%	↘	3.11%
	Trauma & Orthopaedics	10.56%	↗	11.15%	↘	10.86%
	General & Specialist Surgery	8.51%	↘	7.89%	↗	9.27%
Women, Children & Oncology Division	W, C & O Division Total	10.00%	↘	9.23%	↘	9.21%
	Women	10.69%	↘	10.27%	↘	9.55%
	Children	9.01%	↘	8.42%	↗	9.64%
	Oncology & Haematology	9.92%	↘	8.48%	↘	8.27%
Clinical Support Services Division	Clinical Support Division Total	9.92%	↗	10.91%	↘	10.06%
	Imaging	10.24%	↗	11.00%	↘	10.79%
	Pathology	12.50%	↗	14.41%	↘	12.67%
	Other Clinical Support	11.56%	↗	11.76%	↘	6.35%
	Medical Records	6.11%	↘	6.09%	↗	6.15%
	Pharmacy	8.84%	↗	9.74%	↗	9.93%
	Therapy Services	7.84%	↗	8.63%	↘	8.02%
Support Services	Support Services Total	13.35%	↘	13.16%	↘	11.98%
	Hospital Support	15.34%	↘	14.33%	↘	13.92%
	Facilities	11.75%	↗	12.22%	↘	10.47%
Trust Total		9.86%	↘	9.68%	↘	9.27%



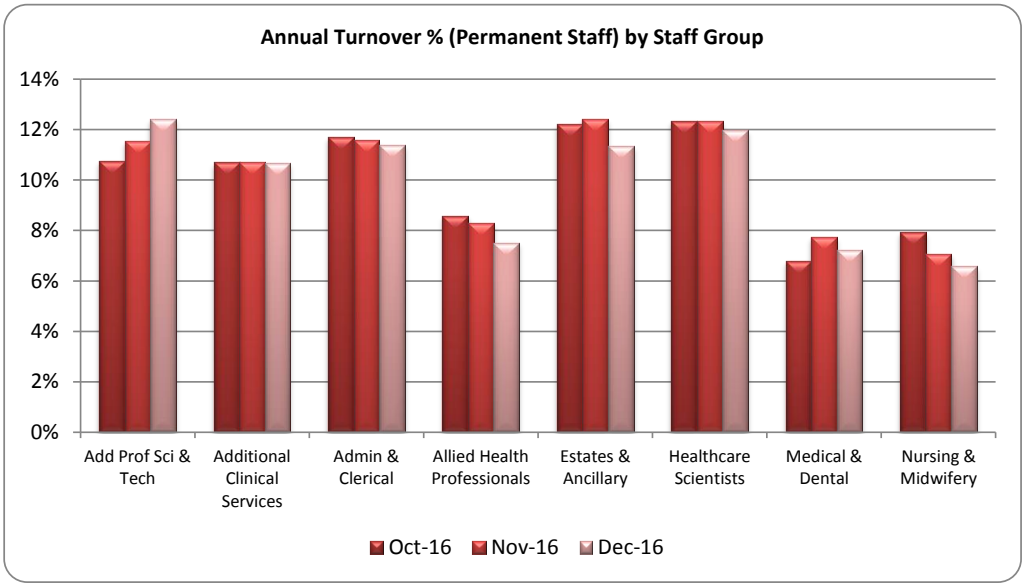
Workforce Committee: Capacity, Capability and Culture Report - December 2016

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	Oct-16	Nov-16		Dec-16	
Add Prof Sci & Tech	10.74%	↗	11.55%	↗	12.41%
Additional Clinical Services	10.69%	↗	10.70%	↘	10.68%
Admin & Clerical	11.71%	↘	11.57%	↘	11.39%
Allied Health Professionals	8.58%	↘	8.29%	↘	7.52%
Estates & Ancillary	12.21%	↗	12.42%	↘	11.33%
Healthcare Scientists	12.35%	↘	12.32%	↘	11.98%
Medical & Dental	6.79%	↗	7.73%	↘	7.21%
Nursing & Midwifery	7.92%	↘	7.07%	↘	6.57%



Capacity: Substantive Workforce Capacity decreased by 10.87 FTE in December 2016 to 4307.40 FTE. The Trust's substantive workforce is at 90.24% of the Budgeted Workforce Establishment of 4773 .13 FTE.

Staff Turnover: Annual Trust turnover decreased by 0.41% to 9.27% in December which is above the Trust target of 8%. Turnover within Nursing & Midwifery decreased by 0.5% to 6.57%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust. Turnover also decreased in Admin and Clerical, Allied Health Professionals and Healthcare Scientists, Estates & Ancillary , Additional Clinical Services and Medical & Dental . Turnover increased in Add Prof Sci & Technicians .

Medical Division: turnover increased by 0.34% to 7.45%
Surgical Division: turnover decreased by 0.04% to 8.45%
Women, Children & Oncology Division: turnover decreased by 0.02% to 9.21%
Clinical Support Services Division: turnover decreased by 0.85% to 10.06%
Support Services: turnover decreased by 1.18% to 11.98%

Staff Vacancies: The vacancy rates for Allied Health Professionals, Healthcare Scientists, Additional Clinical Services and Admin & Clerical staff groups all increased in December 2016. Registered Nursing & Midwifery vacancy rate also increased from 10.19% to 10.98% .Additional Professional Scientific & Technical, Estates & Ancillary and Medical & Dental staff groups all decreased in December

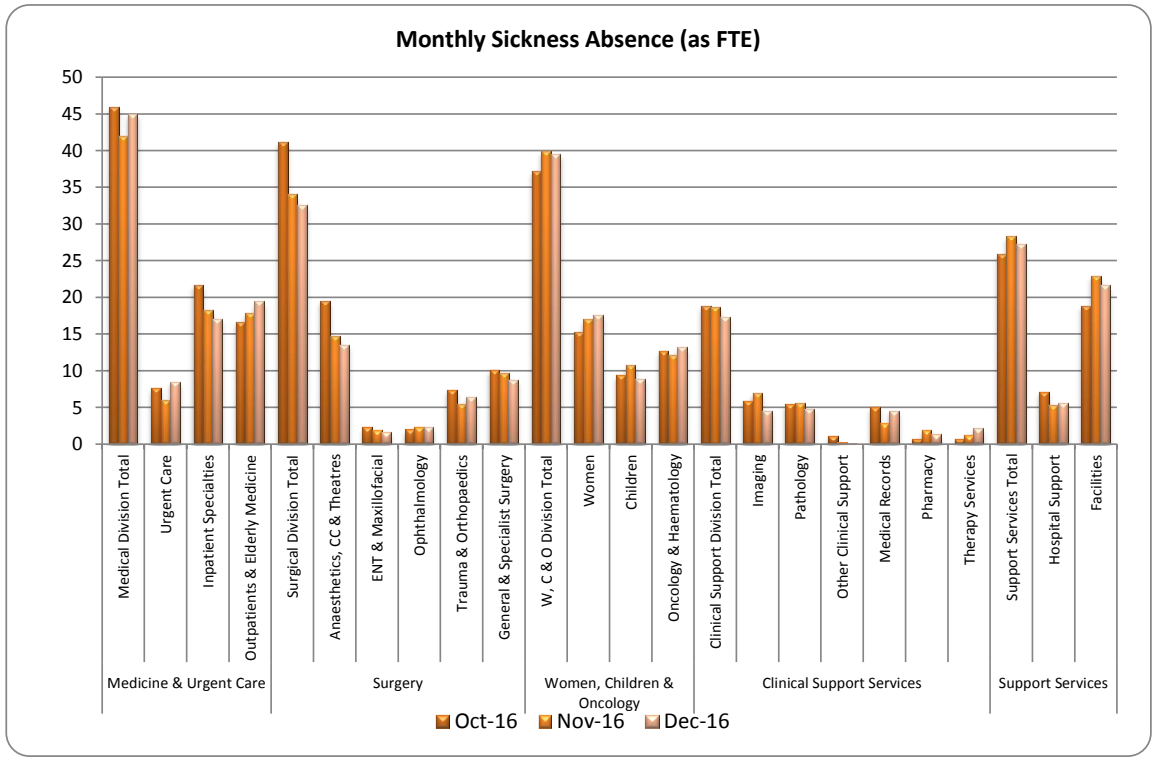
Sickness Absence: In month sickness absence decreased by 0.03% to 3.75% which is below the Trust target of 3.8%. Clinical Support Services , Support Services and Surgery Divisions were the only ones below the trust target. In total 13 directorate level organisations were below the trust target rate.

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

CAPACITY
In-Month Sickness

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

Monthly Sickness (as FTE)		Oct-16	Nov-16	Dec-16	Dec-16	Short Term	Long Term
Medicine & Urgent Care	Medical Division Total	45.94	42.02	44.95	4.28%	2.63%	1.65%
	Urgent Care	7.58	5.98	8.46	3.14%	1.39%	1.75%
	Inpatient Specialties	21.66	18.22	17.07	3.87%	2.65%	1.22%
	Outpatients & Elderly Medicine	16.65	17.86	19.41	5.73%	3.58%	2.15%
Surgery	Surgical Division Total	41.21	34.03	32.54	3.18%	2.17%	1.01%
	Anaesthetics, CC & Theatres	19.49	14.69	13.46	3.44%	1.90%	1.55%
	ENT & Maxillofacial	2.35	1.90	1.63	1.75%	0.67%	1.08%
	Ophthalmology	1.97	2.34	2.25	2.47%	2.47%	0.00%
	Trauma & Orthopaedics	7.36	5.46	6.42	3.60%	2.86%	0.74%
	General & Specialist Surgery	10.10	9.70	8.75	3.30%	2.56%	0.75%
Women, Children & Oncology	W, C & O Division Total	37.25	39.88	39.52	4.56%	2.72%	1.85%
	Women	15.27	16.96	17.54	4.82%	3.21%	1.61%
	Children	9.35	10.79	8.84	3.35%	2.15%	1.20%
	Oncology & Haematology	12.67	12.09	13.13	5.54%	2.59%	2.95%
Clinical Support Services	Clinical Support Division Total	18.77	18.68	17.34	2.93%	1.69%	1.23%
	Imaging	5.89	6.98	4.56	2.72%	2.24%	0.48%
	Pathology	5.38	5.58	4.81	3.21%	1.71%	1.50%
	Other Clinical Support	1.15	0.24	0.10	0.31%	0.31%	0.00%
	Medical Records	4.98	2.79	4.46	8.19%	4.05%	4.13%
	Pharmacy	0.71	1.95	1.29	1.23%	1.23%	0.00%
	Therapy Services	0.70	1.21	2.11	2.57%	0.14%	2.43%
Support Services	Support Services Total	25.89	28.28	27.29	3.52%	2.60%	0.92%
	Hospital Support	7.05	5.29	5.64	1.56%	1.38%	0.18%
	Facilities	18.85	22.89	21.60	5.22%	3.66%	1.56%
Trust Total	*As FTE*	169.12	163.23	161.53			
	As percentage	3.93%	3.78%		3.75%	2.40%	1.35%



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

CAPABILITY
Training & Appraisal Rates

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

Mandatory Training Compliance Rate	Directorate	Oct-16	Nov-16	Dec-16
Medicine & Urgent Care Division	Medical Division Total	81.20%	82.48%	82.82%
	Urgent Care	80.57%	81.23%	82.20%
	Inpatient Specialties	79.60%	80.82%	80.99%
	Outpatients & Elderly Medicine	83.70%	85.54%	85.56%
Surgical Division	Surgical Division Total	84.69%	86.08%	86.32%
	Anaesthetics, CC & Theatres	82.73%	84.68%	84.99%
	ENT & Maxillofacial	78.56%	79.63%	79.29%
	Ophthalmology	86.98%	88.42%	87.77%
	Trauma & Orthopaedics	86.26%	86.56%	87.54%
	General & Specialist Surgery	87.79%	89.10%	89.36%
Women, Children & Oncology Division	W, C & O Division Total	87.89%	87.72%	88.65%
	Women	85.52%	85.68%	87.43%
	Children	90.16%	89.81%	90.55%
	Oncology & Haematology	89.08%	88.75%	88.50%
Clinical Support Services Division	Clinical Support Division Total	88.06%	88.31%	88.67%
	Imaging	83.98%	85.17%	84.82%
	Pathology	88.36%	88.09%	90.56%
	Other Clinical Support	88.36%	87.57%	89.68%
	Medical Records	92.02%	90.14%	89.53%
	Pharmacy	92.27%	91.90%	92.52%
	Therapy Services	87.35%	89.51%	87.08%
Support Services	Support Services Total	86.41%	85.55%	86.90%
	Hospital Support	88.14%	88.38%	90.44%
	Facilities	85.08%	83.37%	84.15%
Trust Total		**85.31%**	**85.79%**	**86.41%**

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

CAPABILITY
Training & Appraisal Rates

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

Role Specific Training Compliance Rate	Directorate	Oct-16	Nov-16	Dec-16
Medicine & Urgent Care Division	Medical Division Total	74.93%	75.05%	75.60%
	Urgent Care	73.00%	73.65%	74.91%
	Inpatient Specialties	73.61%	73.55%	72.95%
	Outpatients & Elderly Medicine	78.82%	78.55%	79.87%
Surgical Division	Surgical Division Total	75.84%	78.20%	79.54%
	Anaesthetics, CC & Theatres	73.18%	75.54%	76.40%
	ENT & Maxillofacial	63.76%	65.54%	68.68%
	Ophthalmology	76.68%	77.73%	80.17%
	Trauma & Orthopaedics	78.24%	80.61%	82.09%
	General & Specialist Surgery	81.15%	83.83%	85.25%
Women, Children & Oncology Division	W, C & O Division Total	80.67%	80.36%	81.71%
	Women	76.17%	76.73%	78.59%
	Children	86.14%	85.18%	86.56%
	Oncology & Haematology	84.46%	82.86%	82.53%
Clinical Support Services Division	Clinical Support Division Total	76.74%	76.56%	76.64%
	Imaging	72.64%	71.43%	73.59%
	Pathology	57.78%	58.66%	59.03%
	Other Clinical Support	74.65%	74.13%	80.71%
	Medical Records	98.59%	97.18%	97.10%
	Pharmacy	88.07%	89.00%	86.73%
	Therapy Services	90.05%	90.48%	87.05%
Support Services	Support Services Total	69.80%	70.10%	70.90%
	Hospital Support	71.18%	71.81%	74.06%
	Facilities	68.09%	67.94%	67.02%
Trust Total		**76.59%**	**77.19%**	**78.14%**

Capability

Appraisals
The current rate of Appraisals recorded for December 2016 is 82.01%; this is an increase of 1.12% from last month's figure of 80.89%.

Mandatory Training and Role Specific Essential Training
Mandatory Training compliance increased in December from 85.79% to 86.41% which maintains the position above the Trust target of 85%.

Role Specific Essential Training compliance increased in December to 78.14% from last month's figure of 77.19%.

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 - December 2016

CAPABILITY
Training & Appraisal Rates

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

Appraisal Compliance Rate	Directorate	Oct-16	Nov-16	Dec-16
Medicine & Urgent Care Division	Medical Division Total	76.68%	77.34%	77.95%
	Urgent Care	79.77%	79.85%	81.51%
	Inpatient Specialties	76.41%	76.34%	73.33%
	Outpatients & Elderly Medicine	74.77%	76.79%	80.95%
Surgical Division	Surgical Division Total	86.77%	85.68%	87.01%
	Anaesthetics, CC & Theatres	80.06%	83.01%	85.39%
	ENT & Maxillofacial	72.50%	72.73%	79.22%
	Ophthalmology	93.33%	89.61%	86.08%
	Trauma & Orthopaedics	91.07%	89.16%	89.22%
	General & Specialist Surgery	96.22%	89.80%	90.83%
Women, Children & Oncology Division	W, C & O Division Total	85.31%	85.19%	86.39%
	Women	79.60%	78.59%	81.82%
	Children	90.49%	90.67%	89.81%
	Oncology & Haematology	89.18%	90.27%	90.72%
Clinical Support Services Division	Clinical Support Division Total	82.33%	80.83%	80.40%
	Imaging	72.83%	70.06%	74.01%
	Pathology	84.47%	83.85%	82.61%
	Other Clinical Support	53.85%	52.63%	52.63%
	Medical Records	91.55%	88.73%	88.41%
	Pharmacy	95.58%	93.04%	91.38%
	Therapy Services	85.11%	86.67%	80.43%
Support Services	Support Services Total	78.61%	75.46%	78.06%
	Hospital Support	77.35%	74.27%	77.78%
	Facilities	79.55%	76.35%	78.27%
Trust Total		**81.86%**	**80.89%**	**82.01%**

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 January 2017**

Title of the Report	**Sustainability and Transformation Plan Update**
Agenda item	12
Sponsoring Director	Chris Pallot, Director of Strategy & Partnerships
Author(s) of Report	Chris Pallot, Director of Strategy & Partnerships
Purpose	To provide an update on the STP Programme in Northamptonshire.

Executive summary

This report is presented to the Board to update on progress that is being made with the STP and consists of two attachments.

The first is provided at **Appendix 1** and is the public document and introduces the STP that was released in December 2016. This provides the Board members with the same level of detail that has been reported across the STP footprint.

The second document is provided at **Appendix 2** and is the most recent programme update submitted by the Scheduled Care work stream to the Programme Management Office at the CCG.

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? All
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks
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) 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/Committee

The Board is asked to note the update.

Enclosure H

Appendix 1

Programme Highlight Report

Financial Target	£11.4m	Overall delivery status	Green

Programme name	Scheduled Care	
Programme stage	2. Programme planning	
Reporting period (from – to)	12/12/2016	11/01/2017
Date of report	11/01/2017	
Senior Responsible Owner	Chris Pallot	
CEO Sponsor	David Sissling	

Programme objectives

Co-creation and implementation of shared integrated services with redesign of acute service provision and development of new service delivery models, for ten specialties initially' that are integrated across the county and involve a range of partners pertinent to the redesign of each clinical service

Progress summary for this period

The overall milestone planner was reviewed and updated at the Collaboration Operational Delivery Group on the 11th January and individual specialty milestone plans are reviewed and updated at the work group meetings.

Key progress made in this period;

- Workforce modelling workshop completed for Dermatology
- Appointment of NGH consultant Rheumatologist-KGH consultant out to advert in January
- Detailed implementation planning for both Rheumatology and Dermatology to enable go live from beginning of April 17
- GP engagement workshop help for Dermatology with good attendance from interested GPs indicating there will be capacity to deliver the new integrated community model
- IT workshops held in Dermatology and MSK to support implementation
- Cardiology PID completed and agreement to develop countywide MRI solution
- Ongoing development of a single county wide Cardiology Business Unit

Appendix 1

1. Programme Status			
	Overall status		Commentary on progress, status and any actions
	Last period	This period	
Specialty Summary Updates	Green	Green	**Rheumatology** • Referral proformas in development as at 05/01/17 and to be shared with clinical team in January once initial draft complete • Discussions underway regarding Licences to Attend/Honorary Contracts between both Trusts. Consistent approach to be confirmed in January. • KGH Consultant post application closes 8th January. Interviews confirmed for end of January 2017. Workforce modelling and IT pathway planning scheduled for 17th January. **Orthopaedics** • Finance and IT groups have met to confirm models • Clinical Network Leads met to review progress of standardised pathways by Specialty and understand activity assumptions • ESPs have identified the future triage process and assumptions to allow the future pathway to be mapped and workforce requirements identified **Dermatology** • Meeting identified existing capacity and expertise in primary care to deliver the community clinics in 2017/18 • Nurses agreed conditions to treat in Community Clinics: Patients prescribed Systemic medication, Chronic disease Management and SOS patients • Workforce modelling completed with Core Group **Cardiology** • Draft PID agreed with clinicians. Awaiting CSB sign off on 31st Jan • KGH beginning to send sub-cutaneous ICDs to NGH following clinical discussions • Both teams have reviewed the NICE 'Do Not Do' list – an online resource to assist doctors to identify areas of waste in their clinical areas. Both teams report compliance with the recommendations made in the cardiac conditions and pathways. • In discussion about resolving Cardiac MRI capacity and delivery model, including cost effectiveness of ongoing delivery • Agreement by the two departments to work towards combining finances under a single budget. Scope and any phasing will need to be defined and agreed by the CSB • Clinical time will need to be released to undertake the work required. • Agreement to look at combined MDTs but will require video teleconferencing set up. KGH IT currently scoping and costing this. **Pathology** • Meeting to examine managed service contracts, stock/consumables and equipment as areas of early collaboration and savings opportunities Friday 13th Jan • NHS Improvement dashboards received by both Trusts, reviewed and feedback provided to the central team. Awaiting revised dashboards to analyse baseline positions. • Researching models of wider integration and pros/cons of each. This will allow local understanding and agreement of the long-term vision for the two departments. Expected completion end Jan 2017 • Agreement to complete reference range data collection as previously agreed. **Ophthalmology** • Clinical meeting planned between CCG , NGH and KGH for mid-February

Appendix 1

			Other Specialties – ENT, Urology, Gynae, Radiology Programme management resource not currently available to progress these specialties.

2. Programme Status			
	Overall status		
PROGRESS	Previous	Current	
Governance	Green	Amber	• Business case for Dermatology completed submitted to CSB and CCG Finance Committee-awaiting confirmation of STP governance processes
Dependencies	Green	Green	• Cardiology features in Urgent & Emergency Care, Complex Care as well as the Scheduled Care STP work programme. Relationships are to be established across the 3 STP work programmes to ensure all plans and actions to deliver those plans, are aligned and complimentary across the specialty • Rheumatology cases shall require a joined up workforce plan with Orthopaedics, particularly with regards to the following services to ensure sound planning:- Early Arthritis Clinic, Osteoarthritis and "general" MSK cases
Non-Financial impact	Green	Green	• Closer working relationships between KGH and NGH clinical teams becoming evident in specialties
Financial Impact	Green	Amber	• A financial model for the overall work programme and specialties within it has been developed and applied to Dermatology. The finances within the Orthopaedics and Rheumatology business cases will now be reviewed and reworked using the same model however the timescale for this is dependent on available capacity within the Finance teams.
Critical Resource Requirement	**Green**	**Amber**	• Resources required in enabling support services such as Finance, HR and IT to support development and delivery of business cases. • Capacity required for clinical teams to focus on service redesign
Enablers	**Green**	**Green**	• Links to the LDR programme have been strengthened with IM & T presence at the monthly Operational Delivery Group where it was agreed that the 3 specialties where new models have been developed will each hold an IM & T session to map the proposed pathways from an IT perspective to ensure the LDR programme is sighted on requirements and timescales from the Scheduled Care programme. • Appropriate Estates to be identified to deliver both the clinical assessment and Call Handling Service functions of the new Orthopaedic pathway
Risk	**Green**	**Green**	• Risk Registers have now been developed for each of the specialties currently in progress. A programme wide register, building on Specialty level content is being developed.

Red – Significant impact on programme
Amber - Marginal effect on programme
Green – No significant impact on programme

Appendix 1

3. Key Milestones

Milestones since last report	Met/Not Met	Remedial Actions (if not met)	Notes / Comments
Revised financial models for Orthopaedics and Rheumatology using new financial model template to be undertaken	Not Met	Completion date revised due to lack of dedicated resource to support the work stream. Revised timescale-by mid-January 17 for Rheumatology, end of Feb for MSK	
Completion of PID for Cardiology	Met	PID reviewed by teams-and submitted to CSB on 31st January	
Dermatology-Activity to be analysed to inform community clinic development	Met		
Dermatology-Meeting with GPs to determine local competency, skills and capacity	Met		
Orthopaedics – Cost and activity assumptions to be factored into refreshed model	Not met	Timescale for completion of revised MSK business case set back to mid Feb to enable greater engagement with NHFT	
Cardiology Demand modelling for service complete	Ongoing		

Upcoming Milestones (next 4 weeks)	Due Date	Notes / Comments
Cardiology-Capacity, activity, demand modelling complete for outpatients	Jan 17	
Cardiology-Efficiency map for cath labs	Jan 17	
Cardiology-Cardiac MRI solution (short and medium term) agreed	Jan 17	
Cardiology-Draft Business Plan	Feb 17	
Cardiology Capacity, activity, demand modelling complete for outpatients	Jan 17	
Pathology-Harmonisation of test repertoires and reference ranges: provide expected date of completion	Jan 17	
Pathology-County-wide guidelines: list shared guidelines, identify work in progress and timescales for completion	Jan 17	
Rheumatology IT meeting between the clinical leads and Deputy Directors of IT to agree IT standards and agree requirements and solutions in advance of the LDR strategy	Jan 17	
Rheumatology to undertake -referral testing of patients between both Trusts to support countywide triage.	End Jan 17	
Rheumatology-Completion of revised referral proformas	Jan 17	
Rheumatology DOS set up and setting up of training dates for consultants to undertake testing of the system	End Jan 17	
Dermatology Business Case STP Approval	Feb 17	STP Governance process to be confirmed

Appendix 1

Dermatology IT pathway to be mapped to understand the viability of utilising a single PAS	Jan 17	Paper to be submitted to CSM on 31st Jan 17
Dermatology Governance Arrangements to be agreed	Jan 17	
Dermatology-Job descriptions to be reviewed in line with the delivering Community Clinics	Jan 17	
Dermatology Confirm Clinic locations and GPs identified to deliver the specified number of clinics in 2017/18	Jan17	
MSK-Map current pathway to include activity numbers	Feb 17	Revised timescales agreed
MSK-Draft 'As is' Financial Model	Feb 17	Revised timescales agreed
MSK-Clinical Pathways to be finalised	Feb 17	Revised timescales agreed
MSK- IT Options Appraisal	Feb 17	Revised timescales agreed

Northamptonshire County Council

NHS

Northamptonshire's Sustainability and Transformation Plan 2016-2021

How We Will Support Local People To Flourish

Enclosure H

Contents

Welcome

I am delighted to introduce Northamptonshire's Sustainability and Transformation Plan (STP), setting out how health and social care locally will develop over the next five years.

This plan sits alongside the county's Health & Wellbeing Strategy, *Supporting Northamptonshire to Flourish*, and builds upon previous work to shape services in a joined up way. It describes how health and social care can be improved to bring real benefits to individuals and communities.

We have developed our plan through an unprecedented level of commitment between local partners across health and social care and the voluntary sector. Members of the public have also been involved.

When we succeed in delivering our plan, we will see people staying in good health for longer, with better care and more of it provided closer to home. This is an exciting opportunity. We want the people of Northamptonshire to help us get it right.

John Wardell,
Senior Responsible Officer,
Northamptonshire STP Programme

1. What is this plan?

Every part of England is working on a local Sustainability and Transformation Plan (STP), setting out how health and social care will evolve over the next five years.

This is a summary of the STP for Northamptonshire. It is very much work in progress and a lot more detail will follow in the months and years to come. But it is being published now so that local people can know what is planned for our area.

The vision of our county's Health and Wellbeing Strategy, ***Supporting Northamptonshire to Flourish***, is to:

"Improve the health and wellbeing of all people in Northamptonshire and reduce health inequalities by enabling people to help themselves"

We also want to provide more choice for people by increasing their options in the community support they can get closer to home.

In doing these things, we will address at a local level the three top priorities facing the NHS across the country:

1. **Health and wellbeing:** By promoting healthier lifestyles, we can improve people's quality of life and reduce the pressure on our health and social care services.
2. **Care and quality:** We want to ensure that needs are met by services of consistently high quality.
3. **Funding and efficiency:** Efficient use of our limited resources is essential if our services are to remain effective, affordable and able to provide up-to-date treatments.

This plan has been developed with a range of professionals from health and social care, including doctors, nurses and social care workers. Many frontline clinicians have been helping over a period of years to shape plans and get us to the point we're at now. There will be more opportunities to contribute as proposals for specific areas of care take shape.

2. Why do we need this plan?

Every day, thousands of people across Northamptonshire receive high quality care from skilled and dedicated professionals. But we know we can do better.

This plan is about ensuring that services can meet the needs of local people in the future. To achieve this, there needs to be change.

Without change, we will not be able to deal with the significant challenges we are now facing:

- **Population change.** Northamptonshire's population is growing and getting older. More people have complex needs and the demand for care services is increasing.
- **Health and wellbeing.** Many of our citizens could be healthier. There are also big inequalities in health within the county, including differences in cancer rates and how long people can expect to live. We need to support people to make positive lifestyle choices such as not smoking, having a good diet and exercising.
- **Access.** People can find it hard to see a GP when they want, and sometimes choose to be treated in our Accident and Emergency departments when local services could help them to manage their care differently.
- **Operational pressure.** It is difficult to deal with the sheer number of people requiring health and social care, which is putting a severe strain on services. Some people are in hospital longer than they need to be, which is not good for them or the service.
- **Mental health.** We want to help people to stay well emotionally, while ensuring that those who need support can access the right mental health services in the most appropriate way.
- **Standards.** There are important expectations on national standards, such as waiting time targets and service guidelines. Quality standards are getting more stringent and providers of care will need to work together to meet them adequately.
- **Staff shortages.** It is difficult to recruit enough health and social care professionals. Not having enough staff or the right skills increases cost, creates stress and hampers our ability to provide high quality care.
- **Integration.** Services could be more joined up to create a better experience for people.
- **Money.** Health and social care budgets are challenging to manage. We have to work differently, to be able to meet the future needs of Northamptonshire people within the resources available.

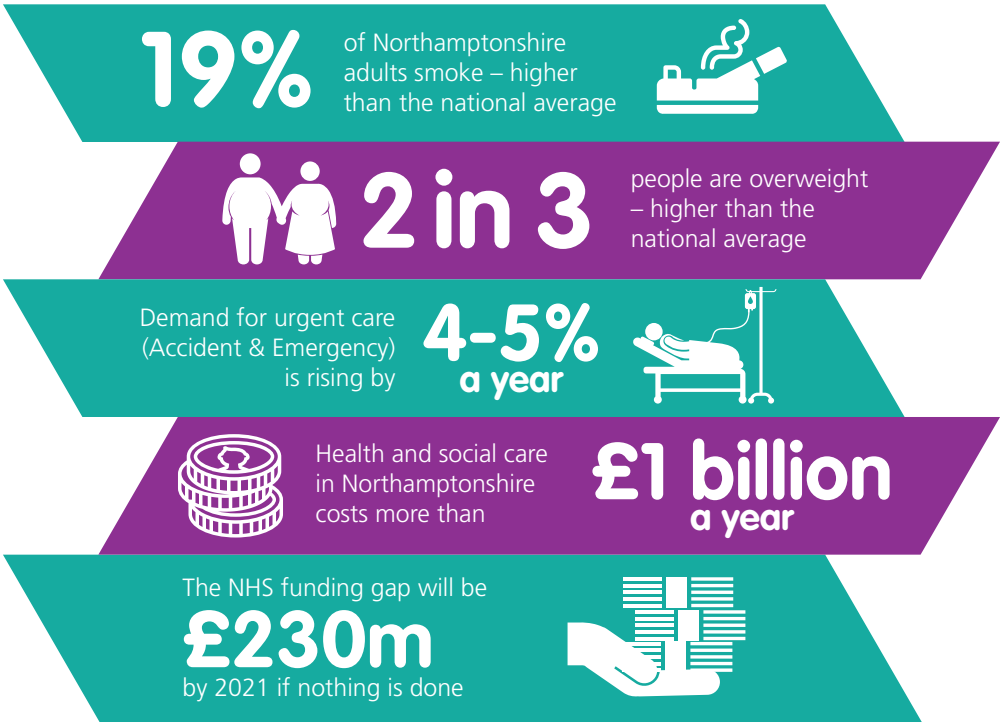
Increasingly, we have a system which relies heavily on people being cared for in a hospital setting, fails to provide the best type of care in some cases, is expensive and is becoming increasingly unsustainable.

By changing how services are delivered, we can improve care, help people live healthier lives AND make better use of our resources. That is what this plan aims to achieve.

The pressures by numbers

Northamptonshire's NHS is currently running a deficit of £41million.

If nothing is done to address the challenges listed on the previous page, we estimate the local NHS gap could rise to somewhere in the region of £230million by 2020/21.



Without service change, by 2021 Northamptonshire will:

3. What will this plan achieve?

Addressing the challenges we face creates big opportunities to improve. The aim of this plan is to shape health and social care for Northamptonshire which is fit for the 21st century, supports a healthier population, meets all the needs of local people – and becomes affordable.

It will result in a very different way of providing care for our county:

- **A focus on prevention first** – supporting people to stay healthy and live independently.
- **A "whole person" approach** – taking into account all care needs, both physical and mental, where services are focused on the individual, not the organisation providing them.
- **The right care, in the right place and at the right time** – safe care in the most appropriate setting; fast access to services wherever people live.
- **Reduced reliance on hospitals** – high quality specialist services available when needed, supported by a system which enables people to move back home quickly.
- **Integration** – more joined-up services, delivered in the community by GPs and other professionals working in one system; stronger collaboration between specialists in our main hospitals in Northampton and Kettering.
- **Voluntary support** – greater involvement of voluntary and community groups in helping people to stay well.
- **Viable hospitals** – ensuring that our district hospitals can continue to provide high quality acute and specialist services.
- **Sustainability in general practice** – GP practices joining together to provide a wider range of services for their population.
- **Working differently** – staff will be supported to work in new ways and across mixed teams in one Northamptonshire system.

There will also need to be a focus on value for money, to ensure that services are financially sustainable:

- Significant investment will be needed in new technology to create a more streamlined system.
- Providers of services will be helped to work differently – with a major emphasis on operating across organisational boundaries county-wide, to provide consistently high quality care. New community-based organisations will also be created, capable of delivering the full range of out of hospital services.
- A major review will assess how all health and social care buildings are used.
- NHS organisations will be expected to make year-on-year savings and to streamline services. This may involve stopping some services where they don't significantly improve outcomes for patients, and offering others in different ways.

All these issues will be considered as we develop our plans. We know that change is not easy and we are likely to face some difficult decisions along the way.

4. What will care look like?

We intend to transform four key strands of care:

- Urgent care (such as emergency services)
- Complex care (for people with multiple needs)
- Scheduled care (such as planned operations and outpatient clinics)
- The prevention of ill health

Our plans will improve Northamptonshire's care system and make it more efficient.

This means providing the right care for people without going to hospital if that isn't necessary – and also ensuring that our hospitals can provide consistently high-quality specialist services when they are needed.

There are wider groups of people and aspects of health, where we will meet national standards, prevent ill health and provide accessible personalised care:

- Respiratory
- Cardiovascular
- Cancer
- Maternity
- Children and young people
- Mental health
- Learning disabilities

Introducing Madeline

54-year-old Madeline has lung disease, is overweight and also drinks heavily to help her cope. She has been into hospital several times. Madeline recently lost her part-time job and has become withdrawn and socially isolated. We are using her story to illustrate how changes set out in this plan will improve things for patients.

Enclosure H

Urgent Care

The aim is to ensure people get the right care, first time – based on services closer to home. This will help to reduce A&E attendance, emergency admissions and the length of time people have to stay in hospital. This should result in greater patient satisfaction and a better quality of life.

For urgent but non-life threatening care needs, highly responsive services will be provided outside hospital or as close to home as possible.

For more serious or life threatening emergency needs, people will be treated in centres with high expertise, delivering the best possible outcomes – enabling as many patients as possible to return safely to their own homes.

Through this plan, there will be:

- **Rapid access** to GPs and community services such as physiotherapy, working together around the clock to provide support on the day people need it, so avoiding hospital care. Care homes will get more support to meet the needs of those they look after.
- **More joined-up community care**, including more services which allow people to leave hospital quickly. This will involve greater use of technology to monitor people at home and access to community support groups (for example, for those with eating disorders or alcohol issues).
- **Co-ordinated urgent response when required.** The joint working of NHS 111, carers and social care will be key to arranging the most appropriate service for their needs – so avoiding unnecessary visits to A&E.
- **Efficient emergency care**, with people streamed in A&E to direct them to the right place. GPs and the ambulance service will have direct access to services to avoid A&E attendance. The flow in hospitals will be managed better, with consistent standards seven days a week. New models of care will be introduced, and some services may be changed so they work better for patients and are more efficient.

What it will be like for Madeline

Madeline has tried to manage her lung condition but it's got worse and she's having trouble breathing. The centre co-ordinating her care is automatically alerted and works with the ambulance crew to consider what to do. Options include additional intensive support at home or a short time in a local health bed. This time, Madeline is admitted to the local acute hospital so she can be assessed. When she arrives, hospital staff know all about her as they have access to the information on their computer networks. Just 24 hours later, they liaise with Madeline's GP and care team to prepare for her discharge. The team have arranged for someone to look after her pet, and will provide a volunteer to take her home and check her house is warm enough, with food to eat. The volunteer will also work alongside the community care team for the first week Madeline is home, to ensure things run smoothly.

Complex Care

An increasing number of people have a range of long-term health conditions, such as a mental illness, diabetes, or heart failure. Their care is complex. Such people are often frail, vulnerable and potentially in need of a lot of support from both health and social care. Complex care can also be needed by some people who have been in an accident.

The aim is to ensure that the care system identifies those considered to be most at risk and has the right services in place to keep them well. This gives people a better quality of life by keeping them independent and avoiding deteriorations in health so they don't have to be admitted to hospital.

For those identified as at risk, there will be:

- **Proactive care** targeted at those who most need it. Each of these individuals will have a personalised care plan in which they and their families have had a say, and support from integrated teams of health and social care professionals.
- **Intermediate care** for people recovering from an acute hospital stay – either at home or in a local bed. Different professionals working together will provide rehabilitation and other support for up to six weeks, to help patients return to their home (adapted if necessary) or to avoid unnecessary admission to hospital in the first place.

- **Specialist care**, re-designed to meet the needs of people with complex physical and mental health issues. Services will provide adequate access to specialist input with care that is safe, compassionate and person-centred.

What it will be like for Madeline

Madeline has been identified as at risk of becoming increasingly dependent on services. Her GP puts her in touch with her local care team who do a full assessment. She is allocated someone who will make regular visits and help her get the support she needs. Madeline is helped to join the local community clinic, which is run by people with respiratory conditions. It provides social engagement, education and access to professional advice in an informal setting. The group also has its own psychosocial therapist. As the group gives her greater confidence, Madeline also joins the Breathe Easy Choir to exercise her lungs and through it finds new friendship and support. She has monitoring equipment at home which alerts her care team, should any of her readings stray from the norm.

Scheduled Care

Not all care is given in response to an urgent need. While it may require input from a specialist, a lot of care is routine. The aim is to ensure that these services are consistently of high quality, operate efficiently and can be easily accessed by those who need them.

Through this plan, there will be:

- **Re-designed care** in ten different specialties, to create single streamlined county-wide services operating across organisations, with less duplication.
- **Closer collaboration** between medical teams at both our main hospitals and in other settings.
- **More specialist clinics in community settings**, so people don't always have to travel to hospital for outpatient appointments.

Work is already well advanced in orthopaedics, rheumatology and dermatology, and is also underway in cardiology and pathology. A similar approach is planned for ophthalmology, radiology, ENT (ear, nose and throat), gynaecology and urology.

What it will be like for Madeline

Madeline has had moderate eczema since she was young. She manages the condition with support from her GP, but occasionally it gets worse. When this happens there's a risk of dehydration and infection, so Madeline is immediately referred by her GP to a dermatology clinic. Such clinics are delivered by a mixed team in a convenient location on a bus route only a few miles from Madeline's home. This means she can go to appointments cheaply and with minimum disruption to her life. When she attends, Madeline is assessed and seen by a specialist nurse, a GP with a special interest in dermatology or her consultant, so that she gets the most appropriate and consistent care for her condition. If she was eligible, Madeline could be taken to clinic by the Non-Emergency Patient Transport Service. If not, she would be directed to her local Voluntary Car Scheme.

Prevention and Community Engagement

We already have some great working going on in the county to support people to manage their wellbeing. Through our plan, there will be a growing focus on staying well – helping people to make positive lifestyle choices, giving them the confidence to manage their health, and plugging them into the many local community and voluntary support networks which already exist.

The aim is to create a healthier Northamptonshire population, improve the quality of people's lives and ease the demand for care services.

Through this plan, there will be:

- Prevention of ill health – both county-wide through information campaigns and at a personal level, through direct intervention by health and social care professionals.
- Effective prevention services, such as screening and immunisation programmes and support to make healthier lifestyle choices such as stopping smoking.
- Voluntary organisations with the right capacity to provide care services, building resilient and engaged communities.

- Social prescribing – people being directed to community support to improve population health and wellbeing.
- Individuals or their carers educated and empowered to be proactive in managing their own wellbeing.

What it will be like for Madeline

Through social prescribing Madeline can access six counselling sessions to help avoid depression or anxiety. She will also have three sessions with the local Citizens' Advice Bureau to deal with debt which has grown since she lost her job. Addressing the debt worries will allow Madeline to attend a prescribed six-week support group with the local community drug and alcohol support centre, to deal with her increasing dependency on alcohol as a coping mechanism. Then she will have contact with a local volunteer centre to start some supported volunteering, to increase her skills and help her get back into work.

5. What happens next?

This is a long term plan for health and social care in Northamptonshire, alongside our Health and Wellbeing Strategy *Supporting Northamptonshire to Flourish*. It sets out key principles and the direction of travel, but much of the detail is still being finalised. The plan will evolve over time and there is a clear determination to deliver real change during the next five years – starting now.

Health and social care will continue to work with local people, doctors and other professionals to develop individual service changes in detail. You will see a different approach in how we:

- Engage with and support you to live well and stay healthy
- Use services differently so that you can manage your own health where you can, and access the right care when you need to
- Support you to remain at home for as long as possible when you are ill
- Use and share information better to support your care

This is truly a "one Northamptonshire plan". As it moves forward, a wide range of partnerships will grow to make it a reality – with health and social care staff, local councils, communities and groups.

There will be opportunities for people to contribute and comment as this work progresses. It is important to stress that any major changes to services will have to go through formal consultation before they could happen.

You can contact us by:
Emailing northamptonshirestp@nhs.net

Writing to:
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Summerhouse Road, Moulton Park, Northampton NN3 6BF

The signatories to this plan are:

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Sonia Swart
Chief Executive, Northampton General Hospital NHS Trust

David Sissling
Chief Executive, Kettering General Hospital NHS Foundation Trust

Clare Culpin
Acting Chief Executive, Kettering General Hospital NHS Foundation Trust

Angela Hillery
Chief Executive, Northamptonshire Healthcare NHS Foundation Trust

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Chief Executive Office, Lakeside Healthcare Group

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Chief Executive Officer, General Practice Alliance Ltd

Andrew Elphick
Chief Executive Officer, Principal Medical

Nicki Price
Director, 3Sixty

Jane Carr
Chief Executive, Voluntary Impact Northamptonshire (working on behalf of the county's community and voluntary sector)

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 January 2017**

Title of the Report	**Operational Performance Report**
Agenda item	**13**
Presenter of Report	Deborah Needham Chief Operating Officer / Deputy Chief Executive
Author(s) of Report	Lead Directors & Deputies Cancer – Sandra Neale A/E – Paul Saunders
Purpose	For Information & Assurance

Executive summary

The paper is presented to provide information and assurance to the committee on all national and local performance targets via the integrated scorecard.

Each of the indicators which is Amber/red rated has an accompanying exception report

Related strategic aim and corporate objective	Focus on quality & safety
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks N Risk of not delivering performance standards Associated fines Patient experience Reputation
Related Board Assurance Framework entries	BAF – 1.2, 3.1
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (N)

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

Actions required by the Board

The Board is asked to:

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

Corporate Scorecard

2016/17 Accountability Framework for NHS Trust Boards
December Performance

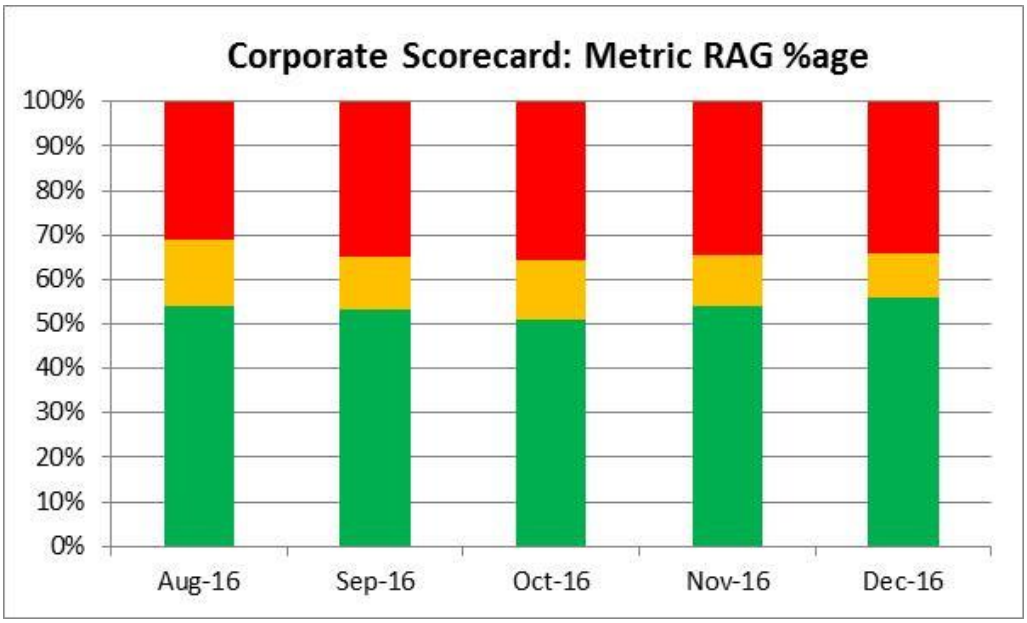
The corporate scorecard provides a holistic and integrated set of metrics closely aligned between NHS Improvement and the CQC oversight measures used for identification and intervention.

1. Performance Summary

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

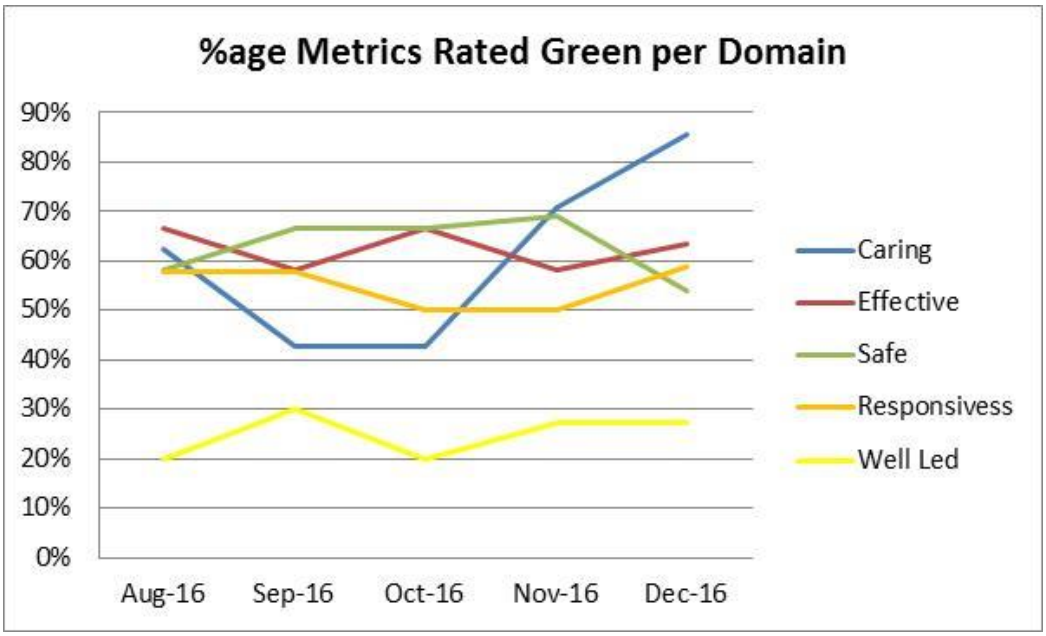
December Corporate Indicators: RAG Performance

SOF Theme	Prev Domain	Number				Percentage		
		Red	Amber	Green	Total	Red	Amber	Green
Quality of Care	Caring	1	0	6	7	14%	0%	86%
	Effective	2	2	7	11	18%	18%	64%
	Safe	4	2	7	13	31%	15%	54%
Operational Performance	Responsive	7	0	10	17	41%	0%	59%
Leadership & Improvement	Well Led	6	2	3	11	55%	18%	27%
	Total	21	6	32	59	34%	10%	56%



The biggest area of continued improvement has been in the caring domain – in December only one metric (F&F for IP/DC) was not rated green...

The graph below illustrates the proportion of metrics in each domain rated as green over the last 5 months.



2. Sustainable Transformation Funding (STF) Performance Metrics

Performance Assessment

2 of the 5 key metric trajectories were met in December; performance was below agreed trajectories for A&E 4hr and for the Cancer 62 days target.

STF Funding Key Metrics: Performance Against Trajectories

		2016/17											
		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
A&E 4hr (95%)	Trajectory	88%	84%	85%	87%	86%	90%	90%	88%	87%	88%	89%	91%
	Actual	88.5%	89.2%	94.6%	91.1%	92.2%	89.3%	85.4%	84.1%	83.3%			
Diagnotiscs (99%)	Trajectory	99.9	99.1	99.1	99.1	99.1	99.1	99.1	99.1	99.1	99.1	99.1	99.1
	Actual	99.9%	99.9%	99.0%	99.9%	99.8%	99.5%	99.9%	99.4%	99.1%			
RTT (92%)	Trajectory	92.0	92.0	92.0	92.0	92.0	92.0	92.0	92.0	92.0	92.0	92.0	92.0
	Actual	94.7%	94.5%	94.5%	94.7%	94.0%	92.4%	92.1%	92.1%	92.5%			
RTT 52wks+ (0)	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	0	0	0	0	0	0	0	0	0			
Cancer 62 days (85%)	Trajectory	75.0	77.2	77.6	78.7	79.5	85.0	85.0	85.0	85.0	85.0	85.0	85.0
	Actual	70.9%	76.5%	81.7%	80.0%	76.9%	71.5%	81.6%	80.8%	84.8%			

2016/17 Trajectory

We are required to provide an updated 3 month forward view of our key performance trajectories to NHS Improvement. The following shows the details submitted

NHSI Midlands & East Forward Forecasts Template				
Trust Name:	**Northampton General Hospital NHS Trust**			
		Dec-16	**Jan-17**	**Feb-17**
Indicator	**Standard**	**%**	**%**	**%**
Diagnostics	**1.0%**	0.9%	0.9%	1.0%
2ww %	**93.0%**	97.0%	96.4%	96.1%
2ww Breast %	**93.0%**	100.0%	100.0%	100.0%
31 Day %	**96.0%**	97.1%	96.6%	96.4%
31 Day Radiotherapy %	**94.0%**	97.7%	95.1%	97.6%
31 Day Surgery %	**94.0%**	100.0%	100.0%	100.0%
31 Day Drug %	**98.0%**	98.5%	98.2%	98.5%
62 Day %	**85.0%**	85.4%	85.1%	85.0%
62 Day Screening %	**90.0%**	92.3%	90.0%	91.7%
RTT - Incomplete %	**92.0%**	92.1%	92.1%	92.1%
52+ week waits	**0**	-	-	-

2017/18 STF Trajectories

As part of the final contract submission to NHS I on 22/12/16 we included the following performance trajectories for 2017/18.

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
A&E 4hr (95%)	84%	84%	84%	85%	86%	85%	85%	85%	85%	86%	87%	88%
Diagnotiscs (99%)	99.1	99.1	99.1	99.1	99.1	99.1	99.1	99.1	99.1	99.1	99.1	99.1
RTT (92%)	92.0	92.0	92.0	92.0	92.0	92.0	92.0	92.0	92.0	92.0	92.0	92.0
RTT 52wks+ (0)	0	0	0	0	0	0	0	0	0	0	0	0
Cancer 62 days (85%)	85.0	85.0	85.0	85.0	85.0	85.0	85.0	85.0	85.0	85.0	85.0	85.0
(#%) = National target in brackets												

We are expecting a challenge on the A&E trajectory as it shows deterioration in expected performance from March to April, and it also does not show achievement of the national target of 95%.

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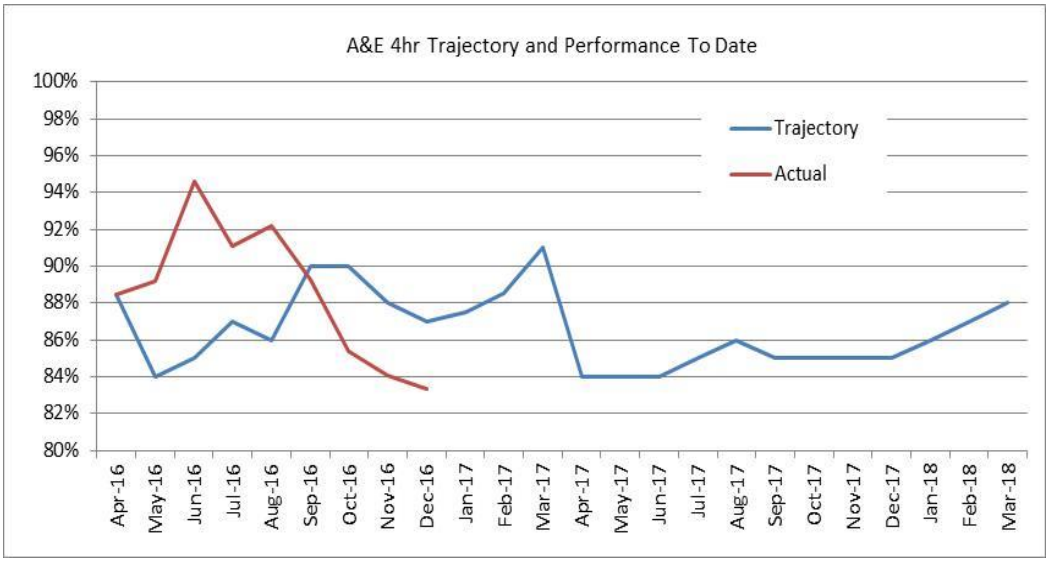
A&E 4hr Trajectory and Performance To Date
100%
98%
96%
94%
92%
90%
88%
86%
84%
82%
80%
Trajectory
Actual
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
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Feb-18
Mar-18

Northampton General Hospital NHS Trust Corporate Dashboard 2016-17

Corporate Scorecard

	Indicator	Target	OCT-16	NOV-16	DEC-16
Quality of Care: Caring	Complaints responded to within agreed timescales	>=90%	93.0%		
	Friends & Family Test % of patients who would recommend: A&E	>=86%	85.3%	87.0%	87.4%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	>=95.5%	92.1%	93.0%	92.9%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	>=96.1%	99.2%	99.0%	98.8%
	Friends & Family Test % of patients who would recommend: Outpatients	>=92.8%	91.7%	92.6%	93.2%
	Mixed Sex Accommodation	=0	8	0	0
	Total deaths where a care plan is in place	>=50%	54.0%	66.2%	56.8%

	Indicator	Target	OCT-16	NOV-16	DEC-16
Operational Performance	A&E: Proportion of patients spending less than 4 hours in A&E	>=95%	84.8%	83.3%	83.2%
	Ambulance handovers that waited over 30 mins and less than 60 mins	<=25	229	220	247
	Ambulance handovers that waited over 60 mins	<=10	47	21	36
	Average Ambulance handover times	=15 mins	00:17	00:16	00:17
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	>=93%	97.3%	96.4%	97.7%
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	>=93%	91.3%	96.0%	94.9%
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	>=98%	100.0%	100.0%	100.0%
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	>=94%	97.4%	97.6%	97.9%
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	>=94%	100.0%	81.8%	90.0%
	Cancer: Percentage of patients treated within 31 days	>=96%	96.8%	96.4%	98.5%
	Cancer: Percentage of patients treated within 62 days of referral from hospital specialist	>=85%	77.7%	83.3%	100.0%
	Cancer: Percentage of patients treated within 62 days of referral from screening	>=90%	100.0%	96.7%	100.0%
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	>=85%	81.6%	81.6%	84.8%
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	>=99.1%	99.9%	99.4%	99.1%
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	=0	0	0	2
	RTT over 52 weeks	=0	0	0	0
	RTT waiting times incomplete pathways	>=92%	92.3%	92.1%	92.5%

	Indicator	Target	OCT-16	NOV-16	DEC-16
Quality of Care: Effective	Crude Death Rates	1	1.2%	1.1%	1.6%
	Emergency re-admissions within 30 days (elective)	<=3.5%	3.7%	3.9%	2.7%
	Emergency re-admissions within 30 days (non-elective)	<=12%	16.6%	14.8%	12.5%
	Length of stay - All	<=4.2	4.5	4.6	5.2
	Maternity: C Section Rates - Total	<26.2%	26.3%	27.5%	28.4%
	Mortality: HSMR	100	98	97	95
	Mortality: SHMI	100	94	94	94
	# NoF - Fit patients operated on within 36 hours	>=80%	96.0%	48.5%	93.9%
	Stranded patients >75yrs (LOS > 7 DAYS)	<=45%	51.4%	55.5%	55.6%
	Stroke patients spending at least 90% of their time on the stroke unit	>=80%	78.7%	87.5%	81.8%
	Suspected stroke patients given a CT within 1 hour of arrival	>=50%	68.7%	74.2%	70.5%

	Indicator	Target	OCT-16	NOV-16	DEC-16
Finance and Use of Resources	CIP Performance	=0	(1,551) Adv	(2,717) Adv	266 Fav
	Waivers	=0	3	5	4
	Waivers which have breached	=0	2	1	6

	Indicator	Target	OCT-16	NOV-16	DEC-16
Winter Pressures	A&E Trolley waits 8hrs 1 min to 12hrs (DTA to admission)	=0	95	87	83
	% being triaged in less than 20 mins	>=95%	69.1%	71.5%	70.9%
	Number of ambulances (Total)		3,507	3,376	2,824
	Operations cancelled due to bed pressures	=0	16	48	27
	Patients who need to be readmitted if transport arrives too late	=0	0	0	0

	Indicator	Target	OCT-16	NOV-16	DEC-16
Quality of Care: Safe	C-Diff	<=1.75	1	4	2
	Delayed transfer of care	=23	75	67	45
	Dementia: Case finding	>=90%	98.5%	96.3%	92.0%
	Dementia: Initial diagnostic assessment	>=90%	100.0%	100.0%	100.0%
	Falls per 1000 occupied bed days	<=5.5	4.3	4.1	4.8
	Harm Free Care (Safety Thermometer)	>=94.2%	93.1%	94.1%	95.3%
	MRSA	=0	0	0	1
	Never event incidence	=0	0	0	0
	Number of Serious Incidents Requiring Investigation (SIRI) declared during the period	=0	0	0	1
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	>=98%	100.0%	87.1%	96.8%
	Transfers: Patients transferred out of hours (between 10pm and 7am)	<=60	75	70	94
	UTI with Catheters (Safety Thermometer-Percentage new)	<=0.3%	0.3%	0%	0%
	VTE Risk Assessment	>=95%	96.3%	96.1%	93.9%

	Indicator	Target	OCT-16	NOV-16	DEC-16
Leadership & Improvement Capability	Data quality of Trust returns to HSCIC (SUS)	>=95%	95.5%	95.5%	95.5%
	Medical Job Planning	>=90%	0%	4.3%	52.2%
	Percentage of all trust staff with mandatory training compliance	>=85%	85.3%	85.7%	86.4%
	Percentage of all trust staff with role specific training compliance	>=85%	76.5%	77.1%	78.1%
	Percentage of staff with annual appraisal	>=85%	81.8%	80.8%	82.0%
	Sickness Rate	<=3.8%	4.0%	3.7%	3.7%
	Staff: Trust level vacancy rate - All	<=7%	10.9%	10.6%	10.9%
	Staff: Trust level vacancy rate - Medical Staff	<=7%	10.3%	11.0%	9.9%
	Staff: Trust level vacancy rate - Other Staff	<=7%	11.3%	10.8%	11.0%
	Staff: Trust level vacancy rate - Registered Nursing Staff	<=7%	10.5%	10.1%	10.9%
	Turnover Rate	<=8%	9.8%	9.6%	9.2%

Run Date: 12/01/2017 12:46 Corporate Scorecard Run by: JohnsonCJ

Northampton General Hospital NHS Trust

Corporate Scorecard

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

The corporate scorecard provides a holistic and integrated set of metrics closely aligned between NHS Improvement and the CQC oversight measures used for identification and intervention.

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

The arrows within this report are used to identify the changes within the last 3 months reported, with exception reports provided for all measures which are Red, Amber or seen to be deteriorating over this period even if they are scored as green or grey (no target); identify possible issues before they become problems.

Each indicator which is highlighted as red has an accompanying exception report highlighting the reasons for underperformance, actions to improve performance and trajectory for the reminder of the year.

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
A&E: A&E Performance	Externally mandated	Finance, Investment & Performance Committee	December 2016

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
A&E: Proportion of patients spending less than 4 hours in A&E	>=95%	87.3%	90.0%	94.6%	90.5%	92.2%	89.1%	84.8%	83.3%	83.2%
A&E Trolley waits 8hrs 1 min to 12hrs (DTA to admission)	=0							95	87	83

Driver for underperformance:	Actions to address the underperformance:
• December achieved 83.2%: against an agreed NHSI trajectory 88% • Delays in 1st Assessment • Specialty waits • Bed capacity • Vacancies within medical staffing equating to 22 WTE across all of the grades • Increased acuity is still well above baseline and in upper quartile, this has increased throughout December, currently acuity is the highest on record.	• Improve the streaming of patients suitable to access GP services and ambulatory care. Weekend Opening of Ambulatory Care Centre (7 day working) • Improve 1st assessment of attenders in ED. Implementation of revised escalation triggers to begin 12th December • 1st assessment delay action plan in place. • Daily Meetings in place to review delays in 1st assessment • Escalation policy being reviewed • Escalation of specialty delays to site team out of hours, NIC to contact specialty consultant. • Ensure senior clinical decision makers available during core hours and periods of increased activity. Explore the opportunity of seven day working for senior decision makers • Review the use of “Pull model” implemented for speciality areas in Medicine. Stroke Model successful and need replicating across Medicine • Review and Monitor - IC24 contract performance against agreed action plan and the inability to fill GP shifts. Review alternative models to ensure greater GP support for “assessment closer to front door”. Notice served to IC24, model being reviewed for ED to

	implement. • "Confirm and Challenge" to be established regarding "zero length of stay patients" • Improve bed availability and flow before midday. • Identify the opportunity to provide short stay assessment on EAU and Benham • Current vacancies are out to advert and active recruitment is ongoing, 1 WTE Consultant recruited for ED and will start 16th January. • Discharge co-ordinator working at the front door to offer social support. • ICT trial to be implemented extending hours until midnight 5 days per week. • 2x SPR 1600-0200hrs in ED to support senior decision making.

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

Scorecard - Exception Report

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

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Ambulance handovers that waited over 30 mins and less than 60 mins	<=25	570	547	405	275	239	151	229	220	247
Ambulance handovers that waited over 60 mins	<=10	221	253	130	47	15	11	47	21	36
Average Ambulance handover times	=15 mins	00:25	00:27	00:22	00:14	00:16	00:14	00:17	00:16	00:17

Driver for underperformance:

- Ambulance attendances have increased against previous month.
- Acuity remains high across the Trust, and has increased significantly throughout December; currently Trust acuity is the highest on record.
- Bed capacity

Actions to address the underperformance:

- RGN to staff corridor in times of increased activity, thus releasing crews, winter funding requested to staff corridor 24hours, 7 days a week.
- Early escalation to EMAS silver to request HALO should the need arise.
- Discussion with EMAS Regional Operations Manager (ROM) to ensure admission avoidance MDT message is put out to crews, and to make aware of Trust pressures.
- FIT NIC to assess early and refer patients through to minors/GP from ambulance crews if appropriate.
- FIT NIC to assess the patients that arrive via ambulance and ensure only those that require trolleys are bedded, those that do not will be placed in FIT waiting area.
- Two FIT bays (F9, F10) designated for ambulance off load and handover.
- Communications to all ED staff to reiterate the importance of using ambulance handover screen.

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Stranded patients >75yrs (LOS > 7 DAYS)	Internally set	Finance, Investment and Performance Committee	January 2017

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Stranded patients >75yrs (LOS > 7 DAYS)	<=45%		52.4%	53.8%	51.8%	50.8%	56.4%	51.4%	55.5%	55.6%

Driver for underperformance:	Actions to address the underperformance:
• High numbers of Delayed Transfers of Care (DTOC) resulting in high numbers of 'stranded' patients across Northamptonshire • Pathway for Dementia patients to Angela Grace beds is no longer in place. Reduced Delirium diagnoses with inpatients but only small part-time team. Very high numbers of complex discharge patients. • Variation in discharge process – lack of empowerment and decision making, repeated assessment, process not starting until patient medically fit • Reliance on beds; Insufficient capacity within the home support services • Lack of home support increases demand on bedded solutions resulting in inappropriate placements and increased LOS • Increasing costs of residential care. This is resulting in families being very reluctant to move patients out promptly	• SAFER bundle implementation within the trust continues, with recently Red to Green, although high pressure affecting normal planned working pathway. Aims to ensure all patients have a senior review daily. Trust lead Chris Field is 3 months into post and roll out despite pressured climate continues • Executively chaired top delays meetings to review the longest staying patients in the trust continue weekly. Consultant and ward manager will present case to exec led panel for support and challenge in progressing the patient's pathway. Some excellent weeks achieved additionally some very poor. Pressure around staff attendance increased. • Training organised across wards by Discharge team around Trust Discharge Policy to reduce internal delays further. • Training on details and methods of Deep dives on wards aided by Red to Green but continuing input needed.

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Externally mandated	Finance, Investment and Performance Committee	December 2016

Performance and Trajectory:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	=0	6	4	2	0	2	2	0	0	2

Driver for underperformance:	Actions to address the underperformance:
• **Gynaecology:** 2 routine patients were cancelled on the day due to urgent care pressures.	• **Gynaecology:**

Lead Clinician:	Lead Manager:	Lead Director:
Mr C VonWidekind	Sandra Neale	Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Length of stay - All	Internally set	Finance, Investment and Performance Committee	December 2016

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Length of stay - All	<=4.2	3.6	2.8	4.4	4.4	4.3	4.8	4.5	4.6	5.2

Driver for underperformance:	Actions to address the underperformance:
• High numbers of Delayed Transfers of Care (DTOC) in December resulting in high numbers of 'stranded' patients across Northamptonshire • Pathway for Dementia patients to Angela Grace beds is no longer in place. High Delirium diagnoses with inpatients and very high numbers of complex discharge patients • Variation in discharge process – lack of empowerment and decision making, repeated assessment, process not starting until patient medically fit • Reliance on beds; Insufficient capacity within the home support services • Lack of home support increases demand on bedded solutions resulting in inappropriate placements and increased LOS • Increasing costs of residential care. This is resulting in families being very reluctant to move patients out promptly • Much increased acuity of patient admissions in December (esp Respiratory)	• SAFER bundle implemented within the trust, with recently Red to Green. Aims to ensure all patients have a senior review daily. Trust lead Chris Field is in post and roll out continues • Executively chaired top delays meetings to review the longest staying patients in the trust continue weekly. Consultant and ward manager will present case to exec led panel for support and challenge in progressing the patients pathway 54 lonbest staying patients discharged with 8700 bed day accumulated • Training organised across wards by Discharge team around Trust Discharge Policy to reduce internal delays further. • Training on details and methods of Deep dives on wards aided by Red to Green • 'Perfect Week' put in place last week of December and first week of January to help drive flow and discharge through the hospital

Lead Clinician:	Lead Manager:	Lead Director:
Lyndsey Brawn/Mike Wilkinson	Carl Holland	Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Transfers: Patients transferred out of hours	Internally set	Finance, Investment and Performance Committee	December 2016

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Transfers: Patients moved between 10pm and 7am with a risk assessment completed	>=98%	98.3%	70.0%	98.4%	98.5%	100%	96%	100.0%	87.1%	96.8%
Transfers: Patients transferred out of hours (between 10pm and 7am)	<=60	58	83	61	67	44	45	75	70	94

Driver for underperformance:	Actions to address the underperformance:
• Two new staff in post. We have identified they require some further training about what moves require a risk assessment. Actioned this week. • Still one site manager short. • High pressures within the trust increasing the amount of moves and use of escalation areas. On Black escalation for a high proportion of the time in December. This is resulting in outlying medical patients after hours increasing the number of out of outs moves.	• Site manager role now recruited to. • Bank set up for site management team, have not recruited any new staff as yet. • New staff given a further session on moves requiring risk assessments. • Request the review of the escalation areas at a higher level i.e. medical bed base.

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Medical Job Planning	Externally mandated	Quality Governance Committee.	December 2016

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Medical Job Planning	>=90%	Not applicable until Sept 2016						0%	4.3%	52.2%

Driver for underperformance:

- Job planning not performing against timeframe of Trust trajectory

Actions to address the underperformance:

- Task and finish group established chaired by Medical Director
- Divisional Director/Clinical Director to provide Directorate exception report
- Job plans that remain unsigned following first meeting of task and finish group, consultant to be given 3 month notice period that the plan that is live on the Trust Allocate system will come into effect. Job plans unsigned at over 12 PA to be reduced to 12 PA and consultant notified accordingly.

Division	Directorate	Target	Sep-16	Oct-16	Nov-16	Dec-16
M&UC	Urgent Care	>=90%	0%	0%	0%	20%
	Inpatient	>=90%	0%	0%	0%	20%
	Outpatient	>=90%	0%	0%	0%	24%
Surgery	A&CC	>=90%	0%	0%	0%	84%
	Head & Neck	>=90%	0%	0%	0%	52%
	T&O	>=90%	0%	0%	0%	92%
	General & Specialist	>=90%	0%	0%	0%	50%
WCOH	Women's	>=90%	0%	0%	0%	93%
	Children's	>=90%	0%	0%	41%	87%
	Oncology/Haem	>=90%	0%	0%	0%	18%
C.Support	Imaging	>=90%	0%	0%	0%	20%
	Pathology	>=90%	0%	0%	0%	60%

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

Scorecard - Exception Report

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

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Percentage of staff with annual appraisal	>=85%	82.7%	83.0%	83.0%	80.4%	81.4%	83.5%	81.8%	80.8%	82.0%

Driver for underperformance:	Actions to address the underperformance:
• The Trust set a target of 85% compliance for appraisals in line with the CCG's expectation. The CQC requirement was for an improvement, which we have made with compliance ratings increasing from 41% in March 2014 to 80.89% in November. • Whilst we have not achieved our target we have undoubtedly improved. There is no national target; the only benchmark data available is that contained within the national staff survey whereby the trust achieved 87% against a national average of 85%.	• Continue to embed appraisal process into all areas, providing 1:1 support through regular monthly meetings with some directorates or as requested. • All Divisional Directors and Divisional Managers will be reminded to have as one of their objectives that at least 85% of their staff must have an in-date Appraisal.

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

Scorecard - Exception Report

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

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Percentage of all trust staff with role specific training compliance	>=85%	73.7%	75.2%	76.1%	77.0%	76.4%	75.1%	76.5%	77.1%	78.1%

Driver for under performance:	Actions to address the underperformance:
• Mandatory Training Review in 2013 reduced the number of subjects of which many of those that were originally Mandatory are now Role Specific Essential Training. • The target to be achieved by March 2015 is 85% as per the Quality Schedule set by the CCG; however this is not a national mandate	• Further work is being carried out on Blood Training by reviewing the positions that require this. • Work is still being carried out on Slips, Trips and Falls, following the analysis of the Role Specific Training requirements for Medical and Dental staff. This will bring Medical and Dental staff in line with their colleagues. • Work continues in aligning Role Specific subjects to positions, after managers have queried whether their staff require the training

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

Scorecard - Exception Report

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

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Turnover Rate	<=8%	10.6%	10.1%	10.0%	9.8%	9.6%	9.9%	9.8%	9.6%	9.2%

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

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

Scorecard - Exception Report

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

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Staff: Trust level vacancy rate - All	<=7%	10.0%	9.8%	9.8%	11.1%	11.9%	11.1%	10.9%	10.6%	10.9%
Staff: Trust level vacancy rate - Medical Staff	=<7%	13.3%	11.8%	11.7%	11.6%	12.90%	10.00%	10.3%	11.0%	9.9%
Staff: Trust level vacancy rate - Other Staff	=<7%	10.8%	10.6%	10.8%	10.6%	11.50%	11.10%	11.3%	10.8%	11.0%
Staff: Trust level vacancy rate - Registered Nursing Staff	=<7%	11.6%	11.4%	11.2%	12.2%	12.10%	11.50%	10.5%	10.1%	10.9%

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

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

Scorecard - Exception Report

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

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Maternity: C Section Rates - Total	<26.2%	28.8%	25.2%	27.0%	27.8%	29.6%	28.1%	26.3%	27.5%	28.4%

Driver for underperformance:	Actions to address the underperformance:
• Average national Caesarean section rate has risen to 27.1% (NHS Digital statistics) • Average East Midlands caesarean section rate has risen to 27.5%	• Continue to monitor caesarean section rate for any upward trends • All elective and emergency caesarean section cases are reviewed to ensure appropriate decision making • Continue work on normalising birth

Lead Clinician:	Lead Manager:	Lead Director:
Mr Owen Cooper	Sandra Neale	Dr Mike Cusack

Scorecard - Exception Report

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

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Friends & Family Test % of patients who would recommend: Inpatient/Daycase	>=95.5%	91.5%	91.5%	91.7%	90.5%	91.5%	91.8%	92.1%	93.0%	92.9%

Driver for underperformance:	Actions to address the underperformance:
• It is evident when reviewing the data set across the past 9 months that despite underperformance there is a continued upward trajectory, this is particularly evident within Inpatient and Day cases where we see a month on month improvement and have done for a number of months consecutively. • December saw the FFT Inpatient & Day Case results continue at the same levels of November, despite the pressures seen within the organization.	• Many actions are being undertaken to address performance all of which are evidently having an effect, particularly within Inpatient and Day Case areas. • Particular focus has been given to the areas where the Trust underperformed within the Inpatient survey. It is expected that this will further improve the results from the FFT and it is believed this is already becoming evident. • Two further local surveys are currently being initiated enabling wards to be able to identify specific areas where they are performing well and whether further improvements need to be made. The Right time results are in the process of being analysed and will provide further detail on patient satisfaction within certain areas. • Patient Experience now has a number of volunteers helping with card collections and data entry meaning data sets are becoming increasingly more representative of our population.

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Cancer Access Targets	Externally Mandated	Finance, Investment and Performance Committee	January 2017 CWT validated performance for November 2016

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	>=94%	88.9%	100%	88.9%	100%	63.6%	83.3%	100.0%	81.8%	90.0%
Cancer: Percentage of patients treated within 62 days of referral from hospital specialist	>=85%	81.8%	58.3%	100%	77.7%	90.0%	76.9%	77.7%	83.3%	100.0%
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	>=85%	70.9%	76.5%	81.8%	80.0%	76.9%	71.5%	81.6%	81.6%	84.8%

Driver for underperformance:	Actions to address the underperformance:
62 Day Standard –17 breaches –81.6% The Trust reached 81.6 % of the standard in November in line with its trajectory. 6 tumour sites breached the standard with 17 breaches in total. 9.5 breaches were from legacy patients and a concerted effort has been made to treat these patients, particularly in Head & Neck. 92 treatments were achieved overall in November versus 77 for the month of October • Urology-5.5 breaches Urology has sustained its reduction in breaches this month. 4 patients only just failed to meet the standard and with further improvement work ongoing this is anticipated to reduce in future months: 1 patient was as a result of a clinical decision to delay surgery for consultant availability post op. 1 patient initiated delays to two appointments. 1 patient had some delay to investigations and declined treatment within target.	A Trust-wide Cancer Recovery Programme with measurable tumour site, and support service action plans continue to be refined, with exception reporting against the Trust trajectory to the Cancer Board monthly Progress this month: • A new RAG rated tracking tool now implemented and welcomed by tumour sites • All pathways reviewed and signed off • Cancer Services team co-ordinators completed first module of "Understanding Cancer" e-learning • New RCA template implemented • Observation study of Cancer Services team roles/remit to inform possible re-structure • Regular meetings with lead Cancer Nurse now in place to improve links with CNS team • Positive meeting with all partners to establish robust working

1 patient had delays due to patient choice, specialist MDT referral and cancelled OPA. 1 patient was a legacy patient treated and had delays to subsequent investigations pending results of biopsies. The final patient was a shared breach delayed as initial result showed benign requiring further investigation and then onward referral to the treating provider. • <u>Colorectal – 1 breach</u> Colorectal has sustained its improvement again this month from 3 to 1 breach. This patient was a legacy patient and initiated significant delays to their pathway through patient choice around appointments • <u>Head and Neck – 5 breaches</u> This tumour site has seen an increase in breaches this month as focus has been on treating a number of legacy patients with improvements expected next month. 4 patients were received from tertiary providers , 1 had delay at MDT due to investigations being available and required a PEG, dental and dietician support prior to treatment 2 required a PEG and 1 of these required a RIG as PEG failed and the final patient required additional imaging prior to treatment commencing 1 patient had diagnostic reporting delays 1 patient had multiple diagnostics and required complex planning for radiotherapy 1 patient's diagnosis was delayed for medical reasons due to fitness, this was followed by delays to surgery due to availability of surgeon and theatre as patient had co-morbidities. • <u>Haematology – 2 breaches inc 1 rare</u> 1 patient was a legacy patient treated which initiated from the head & neck pathway and was an inpatient which contributed to the delays as well as delays to an investigation being reported. 1 patient breached the standard by a week with a number of discussions between Breast and Haematology until acceptance	practices to support IPT Operational Focus continues on: • Ratification of the Trust Access and Operational Policy • Securing a lead Cancer Clinician • Implementing the MDT review and observational assessment. • Implementing the new e-learning programme trust-wide • Further monitoring tools being refined to enable focus on pathway constraints. • Rollout consultant upgrade revised process after initial trial in Skin site • Establish trust breach panel • Define Cancer Services Team role/responsibilities • Review of 104+ waiters • Development of SOP's for Cancer Services Team

and treatment by Haem. • Lung – 2.5 breaches All 3 patients were legacy patients treated with complex pathways, 1 of which initiated in the Head & Neck pathway and was transferred to a tertiary provider for treatment and 1 patient that was required to cease medication for an investigation which added delay. • Gynaecology – 1 breach 1 patient was referred from a tertiary centre at day 51 and had some delay to treatment commencing and was a shared breach. 1 patient was referred from a tertiary centre but was unfit for surgery which attributed to the delay **Subsequent Surgery – 2 breaches – 81.8%** The trust failed to reach the standard due to the small number of patients in this cohort. 1 patient was delayed for medical reasons. **Consultant Upgrade – only reported locally – 1 breach – 83.3%** The trust failed to reach the standard due to the small number of patients in this cohort but has shown improvement since last month.	

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
MRSA Incidents *(Post 48hrs)*	Externally Mandated	Quality Governance Committee	December 2016

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
MRSA	=0	0	0	0	0	0	0	0	0	1

Driver for underperformance:	Actions to address the underperformance:
• There is a zero tolerance approach to MRSA bacteraemia. Our trajectory for April 2016 –March 2017 is 0 post 48 hours MRSA bacteramias.	• A post infection review (PIR) is due to take place on this patient, this will take place with the CCG. Following the initial review of this patient, there is a strong possibility that this MRSA bacteraemia will be what is termed as third party and therefore will not be attributed to the Trust. So therefore following the PIR review with the CCG on Tuesday 17/1/2017. This may not be counted.

Lead Clinician:	Lead Manager:	Lead Director:
Dr Minassian	Wendy Foster	Carolyn Fox

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Clostridium difficile Infection Trust attributable (post 3 days)	Externally Mandated	Quality Governance Committee	December 2016

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
C-Diff	<=1.75	3	0	2	1	3	0	1	4	2

Driver for underperformance:	Actions to address the underperformance:
• The trust trajectory for April 2016 – March 2017 is 21 cases of *Clostridium difficile* infection (post 3 days) at the end of December there had been 16 patients with *Clostridium difficile* infections (CDI) post 3 days.	• All post infection reviews (PIR) on these patients are sent to the CCG, who decide if there has been any lapse in care. 10 patients PIRs have been reviewed and there have been no lapses in care for these patients. The other cases are awaiting review. • The infection prevention team will continue to work and move forward the *Clostridium difficile* infection reduction plan.

Lead Clinician:	Lead Manager:	Lead Director:
Dr Minassian	Wendy Foster	Carolyn Fox

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Operations: Operations cancelled due to bed pressures	Internally set	Finance, Investment and Performance Committee	December 2016

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Operations cancelled due to bed pressures	=0							16	48	27

Driver for underperformance:	Actions to address the underperformance:
• Bed occupancy at >100% • In excess of 70 medical patients outlying into surgical beds • Very tight ITU capacity so electives being cancelled • Highest Acuity seen in hospital at present with high very sick patients • High numbers of Delayed Transfers of Care (DTOC) in December resulting in high numbers of 'stranded' patients across Northamptonshire • Lack of home support increases demand on bedded solutions resulting in inappropriate placements and increased LOS • Increasing costs of residential care. This is resulting in families being very reluctant to move patients out promptly • Theatre staffing issues with circa 30WTE theatre staff vacancies resulting in cancellation for theatre lists as they cannot be staffed	• SAFER bundle implemented within the trust, with recently Red to Green. Aims to ensure all patients have a senior review daily. Trust lead Chris Field is in post and roll out continues • Executively chaired top delays meetings to review the longest staying patients in the trust continue weekly. Consultant and ward manager will present case to exec led panel for support and challenge in progressing the patients pathway 54 longest staying patients discharged with 8700 bed day accumulated • Training organised across wards by Discharge team around Trust Discharge Policy to reduce internal delays further. • Training on details and methods of Deep dives on wards aided by Red to Green • 'Perfect Week' put in place last week of December and first week of January to help drive flow and discharge through the hospital • Highly focussed recruitment plan agreed in Theatres

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Number of Serious Incidents Requiring Investigation (SIRI) declared during the period	Externally mandated	Quality Governance Committee	December 2016

Performance and Trajectory:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Number of Serious Incidents Requiring Investigation (SIRI) declared during the period	=0	2	1	3	2	1	1	0	0	1

Driver for underperformance:	Actions to address the underperformance:
• **A delay in diagnosing a patient with a Type B aortic dissection in the Emergency Department.** • Patient attended the ED initially on the 26.11.16 with epigastric pain and chest pain, his ECG and troponin were NAD. Nitrites in urine and a WCC of 17.9. Patient wanted to go home, had an EWS on discharge. • Patient returned to NGH on 03.12.16 at 0600hrs, he was pale and clammy and had difference in right and left sided BPs. His pain score was 8/10. • An ACP saw the patient and had a scan performed by a locum MG or saw aorta 3.3cm and advised no further action needed. The ACP discussed the patient with another ED MG and the patient was admitted in view of this mildly deranged renal function. No CXR was performed. • A CT aortogram on 04.12.16 identified a dissecting thoracic aneurysm from the left subclavian to 3cm under the diaphragm, with a large left pleural collection. The patient died.	• Incident brought to the attention of the staff who initially assessed the patient and other staff to raise awareness • Triage is only to be carried out once the Nurse has seen the patient • Datix W-70172 completed. • Early management Report and IAF completed • ED consultant part of investigation • Declared as SI now being investigated

Lead Clinician:	Lead Manager:	Lead Director:
Dr. Mike Pearce	Paul Saunders	Dr. Mike Cusack

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 January 2017**

Title of the Report	**Emergency Preparedness, Resilience & Response Annual Report**
Agenda item	**14**
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) BAF 1
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**)

Actions required by the Board:

The Board is asked to:

- Note the contents of this paper.
- Discuss and appropriately challenge the contents of this report.
- Identify areas where additional assurance is required.

Northampton General Hospital NHS
NHS Trust

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 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. Overview of EPRR

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.

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.

Evacuation Planning

A draft Evacuation Plan has been created, however its completion is reliant on partner input detailing locations for patients to be transferred to. The Trust is currently liaising with

partner agencies such as the local authority and transport providers in order to move this forward. This is due for completion by March 2017.

CBRN

Kettering General Hospital are currently unable to provide a CBRN/HAZMAT response. The date for resolution is January 31st and the LHRP are monitoring progress. A MoU between KGH and NGH remains in place to ensure there is a response capability in the county whilst KGH obtain the required equipment in order to undertake decontamination

The MoU advises that NGH will provide its resources to conduct wet decontamination of persons presenting with, or where it is suspected that they have been caustically contaminated. KGH will retain responsibility for dealing with presenters who can be dealt with using the dry, Initial Operational Response (IOR).

CBRN powered respiratory protective suit (PRPS) procurement

The Trust's PRPS suits are due to expire in March 2018, having reached the maximum re-certification period of 10 years. A national procurement programme is underway to ensure NHS CBRN capability is maintained. This programme will replace expired PRPS suits on a like for like basis. The CCG have requested clarification from NHS England surrounding the potential options. A business case will be produced once further details are received.

3. Governance

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.

Audits

The TIAA undertook an audit of training within the resilience function in July 2016. Following detailed testing, the overall assessment was of Reasonable Assurance, with no urgent action points highlighted. Four important action points related to the completion of the resilience training matrix, inclusion of the resilience risk register, lessons identified from planned exercises and failure to attend training to be monitored through the Resilience Planning Group. These items are being addressed through the Resilience Planning, Risk and Assurance, Risk and Compliance Groups.

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

4. Core Standards Submission 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: (2015 comparison is shown in brackets)

Northampton General Hospital NHS
NHS Trust

Theme	Number of Criteria	Compliance Level		% of Overall Compliance
Governance	4	Fully	4	100% (100%)
		Partial	-	
		Non-Compliant	-	
Duty to assess risk	3	Fully	3	100% (66.6%)
		Partial	-	
		Non-Compliant	-	
Duty to maintain plans – emergency plans and business continuity plans	20	Fully	15	75% (60%)
		Partial	5	
		Non-Compliant	-	
Command and Control (C2)	7	Fully	4	57% (43%)
		Partial	3	
		Non-Compliant	-	
Duty to communicate with the public	2	Fully	2	100% (100%)
		Partial	-	
		Non-Compliant	-	
Information Sharing – mandatory requirements	1	Fully	1	100% (100%)
		Partial	-	
		Non-Compliant	-	
Co-operation	5	Fully	5	100% (100%)
		Partial	-	
		Non-Compliant	-	
Training and Exercising	4	Fully	1	25% (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 84% (up on 65% 2015 and 60% 2014) 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 maintain plans – emergency plans and business continuity plans: An area that has seen an improvement over the past 12 months is the level of Business Continuity planning carried out within the Trust. A large piece of work has taken place this year following the introduction of new templates to meet the ISO 22301 standard now employed by the NHS. All areas have undertaken a Business Impact Analysis and have a robust Business Continuity Response Plan in place. Many of these, however, still require ratification by the appropriate departmental governance committees and will subsequently require a programme of training and exercising.

The following table highlights the plans, policies and procedures relating to the resilience function and their subsequent renewal date.

	Policy	Review Date
NGH-683	Major Incident Corporate Plan	June 2017
NGH-420	Business Continuity Management	June 2017
NGH-761	Corporate Business Continuity Response Plan	June 2017
-	Departmental Business Continuity Response Plans	Awaiting ratification
NGH-389	Emergency Preparedness and Resilience	June 2017
NGH-614	Adverse Weather	October 2017
NGH-793	Heatwave	June 2017
NGH-880	CBRN/HAZMAT	June 2017
NGH-926	Command, Control & Communication (C3)	June 2017
NGH-762	Pandemic Influenza	June 2017
NGH-792	Major Incident - Control Room	June 2017

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. An on-call manager Major Incident training session was undertaken on 1st December 2016. Attendance at Local Resilience Forum (LRF) run strategic and tactical leadership training is encouraged for individuals expected to fulfil these roles. Presentation materials from these courses are used as a basis for in-house delivered training sessions.

Training and Exercising: This area remains partially compliant and 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 Head of Resilience now attends Trust induction for new starters, providing an overview of the resilience function, and raising awareness of the various policies and procedures. The Trust has worked with EMAS to deliver CBRN training in order to support the response required to a potential incident.

Despite numerous training sessions being organised, there remains an issue surrounding lack of attendance, this is evident within the table below: The sessions below are predominantly aimed at operational managers and clinical staff who are required onsite during periods of severe pressure.

Training session	Invited	Accepted	Attended
Acute CBRN/Initial Operational Response (IOR) Train the Trainer Course (Day 1) 31st May 2016, Francis Crick House	5	5	5
Acute PRPS/Decontamination Train the Trainer Course (Day 2) 24th October 2016, Lecture Theatre, Cripps PGMC	Open to any front line staff.		5
On-call Managers Workshop 1st December 2016, Boardroom, NGH	27	18	18
Strategic/Tactical Leadership Training 12th April 2016, St. Andrews	39	3	2
Joint working and joint decisions in a multi-provider setting, 19th, Surgical Training Room, NGH	38	4	1
Initial Operation Response/CBRN 30th November – 23rd December 2015, A&E Seminar Room, NGH	Numerous 'drop in sessions' over multiple days.		54
Exercise Adder 12th September 2016, Wootton Hall	51	15	6
Exercise Cygnus 17th October 2016, Francis Crick House	2	2	2

The assurance panel agreed that Substantially Compliant was justified. The report highlighting the Panel's findings is attached for awareness. **APPENDIX 2**

5. Testing and Exercising

During 2016, the Trust was involved in a number of external multi-agency exercises.

Whenever possible, the Trust strives to ensure that testing is held in a multi-agency context in order 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.

Exercise Adder – 12/09/2015:

Exercise Adder was a counter terrorism exercise led by the Local Resilience Forum (LRF) with participation from Nene and Corby CCG, NGH, KGH, NHFT and EMAS. Attended by the Chief Operating Officer, Head of Resilience and colleagues from ED, a number of recommendations prompted minor amendments to the relevant Trust plans.

Exercise Cygnus – 17-19/10/2016:

Exercise Cygnus was a national exercise designed to test the Strategic level of each LRF and the national response via COBRA of a pandemic Influenza. In addition the

national element of the exercise we took the opportunity to test the Health and Social Care Economy response to a pandemic via the Health Economy Tactical Coordination Group (HETCG). All participants to the HETCG were provided with a 'soft start' to the exercise by injects being provided on a weekly basis for 3 weeks prior to Monday 17th October.

The debrief report is attached for awareness. **APPENDIX 3**

6. Live Events

During 2016, NGH experienced a number of live incidents. These are detailed below:

Industrial Action

Since December 2015, junior doctors have taken part in a number of periods 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.

Water leak in ED: 21/09/2016

At approximately 03:45 on the morning of the 21st September, a mains water pipe from the sprinkler system had ruptured near the entrance to FIT area, resulting in a flood within the new FIT waiting room. This also triggered the fire alarms for the area. The A&E consultant was called, along with the site manager and operator. Estates were in attendance and 'Aquavacs' and extra domestics were requested to attend. The water supply was quickly isolated so the flow of water was slowing down.

Fortunately there were only four patients in majors and half of these were discharged home. Two patients within Resuscitation were moved to Benham and EAU. Important electrical equipment was moved out of the FIT area for safety and placed into majors cubicles.

A plan was quickly made to ensure continuation of care for walk in patients and life threatening emergencies. The Ambulatory Care area was opened up and used as a

temporary reception/FIT area. The back entrance to resus was opened to allow easy access for ambulances, and staff were relocated.

Fortunately only a few patients were booked into the department.

The timely action of ED and estates staff to deal with immediate flooding ensured the safety of patients and equipment and continuation of care for emergency patients.

A debrief has been conducted and the debrief report will be circulated following completion.

A tabletop exercise is being planned with A&E colleagues in order to test the department's business continuity plan.

Carlsberg Chemical Incident: 9-11/11/2016

The Trust responded to a Chemical Incident at the Carlsberg Brewery plant between Wednesday 9th and Friday 11th November. 32 casualties were transported to NGH over the 3 days. A multi-agency debrief was undertaken on the 16th December.

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 recent 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 2017.

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.

The Trust should be undertaking a more detailed and comprehensive training and exercising programme; however, this requires resourcing.

APPENDIX 1

Northampton General Hospital-Trus

APPENDIX 2

EPRR Core Standards letter - NG

APPENDIX 3

cygnus debrief_RJ 21-11-16.docx

Internal Audit

tiaa

Northampton General Hospital NHS Trust

Review of Resilience Responsibilities

2016/17

July 2016

FINAL

Enclosure J

Executive Summary

OVERALL ASSURANCE ASSESSMENT

KEY FINDINGS

- **Although work is in progress there is a need to complete the Emergency Planning and Preparedness annual training and exercising plan, and training matrix, at the earliest opportunity and to also set a timescale for completion.**
- **Training opportunities identified following real life incidents should be used to inform the training and exercising plan.**
- **Although there is regular discussion of incidents at the Resilience Planning Group meetings there appears to be a more limited review of risks – the risk resister should therefore be included as a standing agenda item to promote these discussions.**
- **Improvement is required to ensure that actions agreed through the Resilience Planning Group are formally fed back and consistently minuted.**
- **Follow-up of 2015/16 Internal Audit Report Resilience Responsibilities highlighted that three recommendations are implemented and two are in progress.**

SCOPE

The review focused on training provided and covered the Training Strategy and Policy; training needs analysis, training plans, mock exercises undertaken; learning from real life business interruption episodes (where applicable) and processes to address training requirements identified from action plans from post incident reports, and Management information and assurance to the Board.

The review also followed-up on the 2015/16 Internal Audit report 'Review of Resilience Responsibilities Arrangements' issued in November 2015 to assess the progress made with implementing the recommendations.

The review was not intended to provide any guarantee over the appropriateness of training undertaken or the arrangements to respond to the multitude of un-planned events which may impact upon the Trust's activities.

ACTION POINTS

Urgent	Important	Routine	Operational
0	4	2	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)
1	Directed	Review of minutes of the Resilience Planning Group for meetings held between March and December 2015 identified that training and exercising is a standing agenda item where issues relating to training are raised as discussed. One action noted in the March 2015 minutes was to produce and distribute a full training and exercising matrix, although a timescale for completion was not recorded. A similar action point was also raised in August 2015, which was to draft a yearly training plan to ensure preparedness and compliance with the Emergency Planning and Preparedness Policy. While it is acknowledged that work on the training plan has started, there is a need to complete the training and exercising plan and the training matrix at the earliest opportunity.	The training and exercising plan and training matrix be competed at the earliest opportunity. To facilitate this a formal deadline be set which is monitored through the Resilience Planning Group.	2	*Agreed. Training and exercising plan and training matrix to be completed in line with EPRR Core Standards 2016/17 process*	*01/09/2016*	*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)
2	Directed	To manage resilience risks a Resilience risk register is in place which is maintained through the Datix system. Review of Resilience Planning Group minutes for the period March 2015 to December 2015 highlight that there is regular discussion of incidents but appears to be a more limited review of risks. The Resilience Planning Group minutes for March and May 2015 confirm that the risk register was discussed at these meetings and a further action point raised that "*JM is still to formulate the risk register into the required number of risks and forward to the teams*." While it was stated that the required action has been taken and the risk register has been reviewed and shared, there is no evidence to support that the updated risk register has been reviewed at subsequent Resilience Planning Group meetings.	The Resilience risk register be included as a standing agenda item at the Resilience Planning Group to ensure appropriate sharing of risks and scrutiny of mitigating actions.	2	*Agreed. In-depth review of risks at future Resilience Planning Group meetings to ensure appropriate sharing of risks and scrutiny of mitigating actions.*	*26/07/2016*	*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)
4	Directed	The Trust has been fully involved in several planned multi-agency exercises which take place on a periodic basis. While evidence was seen to support that feedback and analysis of the exercise outcomes have been reported to the Board, analysis and lessons learned have not been reported to the Resilience Planning Group.	Feedback and analysis from planned exercises be formally reported to the Resilience Planning Group in order that lessons learned can be shared and implemented.	2	*Agreed. Feedback and analysis from planned exercises will be formally reported to the Resilience Planning Group.*	*26/07/2016*	*Head of Resilience & Business Continuity*
5	Compliance	Systems are in place for the Head of Resilience to distribute details of external training courses to appropriate staff. However, it was stated that uptake of training has been poor. There is a policy requirement that "*All members of the Resilience Planning Group will be responsible for ensuring staff within their respective areas are aware of the training available and encourage attendance on recommended courses*" however, there is no formal process to report the failure to attend suggested training via the Resilience Planning Group.	Failures to attend suggested training or training required as part of the completed training matrix, and the reasons for doing so, be reported via the Resilience Planning Group for review and to determine the implications on the Trust.	2	*Agreed. Training matrix to be reviewed at future Resilience Planning Group meetings. Continued non-compliance to be escalated.*	*26/07/2016*	*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)
		When fully completed, the training matrix will provide the benchmark against which training non-compliance can be gauged and reported against.					
3	Directed	It was noted that agreed actions in relation to risks and training are not being followed up in subsequent meetings of the Resilience Planning Group. The governance processes could be improved by ensuring that there are clear deadlines for agreed actions and that the progress of actions is actively monitored, and recorded in the Resilience Planning Group's minutes.	Governance processes be improved to ensure that deadlines are set for all Resilience Planning Group actions and the progress of actions is actively monitored, and recorded in the minutes.	3	*Agreed. Action log to be reviewed to ensure deadlines are set, progress is monitored, ensuring actions are not lost to follow up.*	*26/07/2016*	*Head of Resilience & Business Continuity*
6	Compliance	Evidence was available to support that real life incidents are shared and discussed at the Resilience Planning Group. Review of minutes confirmed that actions are determined on the basis of incident outcomes but the opportunities for further training was not clear.	All real life incidents be assessed for training opportunities, which can then be used to populate the training and exercising plan.	3	*Agreed. To be taken forward as best practice.*	*01/07/2016*	*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	Consideration be given to providing new staff with key details regarding emergency preparedness and major incident planning to back up discussions held as part of the induction training session.	*Handout advising staff of key details to be provided to new starters at Trust induction.*

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 May 2016 as part of the planned internal audit work for 2016/17. 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 is legally required to plan for, and respond to, potential incidents and emergencies that could affect health or patient care.

4. The Civil Contingencies Act (2004) establishes a clear set of roles and responsibilities for those involved in emergency preparedness and response. Training staff to respond to significant incidents and emergencies is of fundamental importance. NHS organisations are familiar to responding to routine, everyday challenges by following usual business practices; yet very few respond to significant incident or emergencies on a frequent basis. If staff are to respond to an emergency in a safe and effective manner they require the tools and skills to do so in line with the role to which they are assigned to.

5. The review specifically focused upon training provided and cover the following:

- Training Strategy / Policies and procedures
- Training Needs Analysis
- Training plans, including objectives and outcomes and cycle of training plans
- Mock exercises undertaken
- Learning from real life business interruption episodes (where applicable) and processes to address training requirements identified from action plans from post incident reports
- Management information and assurance to the Board

6. The review also followed-up on the 2015/16 Internal Audit report ‘Review of Resilience Responsibilities Arrangements’ issued in November 2015 to assess the progress made with implementing the recommendations.

7. The scope of this audit was limited to the areas identified above. Detailed testing was undertaken on a sample basis only. The review was not intended to provide any guarantee over the appropriateness of training undertaken or the arrangements to respond to the multitude of un-planned events which may impact upon the Trust's activities.

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. Under the Civil Contingencies Act (2004) all providers of NHS funded care must show that they can effectively respond to emergencies and business continuity incidents while maintaining services to patients. This work is referred to in the health service as 'emergency preparedness, resilience and response' (EPRR).

DISCLAIMER

10. 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

11. The definitions of the assurance assessments are:

Substantial Assurance	Based upon the issues identified there is a robust series of suitably designed internal controls in place upon which the organisation relies to manage the risks to the continuous and effective achievement of the objectives of the process, and which at the time of our review were being consistently applied.
Reasonable Assurance	Based upon the issues identified there is a series of internal controls in place, however these could be strengthened to facilitate the organisation's management of risks to the continuous and effective achievement of the objectives of the process. Improvements are required to enhance the controls to mitigate these risks.
Limited Assurance	Based upon the issues identified the controls in place are insufficient to ensure that 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 to mitigate these risks.
No Assurance	Based upon the issues identified there is a fundamental breakdown or absence of core internal controls such that the organisation cannot rely upon them to manage risk to the continuous and effective achievement of the objectives of the process. Immediate action is required to improve the controls required to mitigate these risks.

ACKNOWLEDGEMENT

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

RELEASE OF REPORT

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

Date draft report issued:	17th June 2016
Date management responses received:	1st July 2016
Date final report issued:	4th July 2016

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

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

14.1 The 2015/16 Internal Audit report 'Review of Resilience Responsibilities Arrangements' provided the Trust with reasonable assurance. The report made two important and three routine recommendations which were due to be implemented by the end of November 2015. Follow-up undertaken as part of this audit confirmed that the two important recommendations and one routine recommendation have been implemented. Work is in progress to implement the remaining two routine recommendations. Completion of the remaining outstanding recommendations will be monitored through the routine follow-up of recommendations process.

14.2 The Trust has a current Emergency Preparedness and Resilience Policy (NGH PO 389) in place which is due for review in November 2016. Review of the policy confirms that the content references the requirements of the Civil Contingencies Act 2004. There is also a master list of other associated policies which has been developed by the Head of Resilience and Business Continuity.

14.3 A governance structure is in place which ensures that there is oversight and review of resilience training at both operational level through the Resilience Planning Group and the Assurance, Risk and Compliance Group, and strategically through the Trust Board. An annual report was provided to the Trust Board in March 2016. The report identified training and exercising as a key area for development for 2016/17.

14.4 Review of the terms of reference for the Resilience Planning Group confirms that there are specific duties which relate to training:

1. Ensuring that the Trust has a robust and tested Major Incident Plan in place and that staff have been trained in their roles; and
2. Ensuring that staff are trained to an appropriate level with respect to role and function in an emergency situation. At the time of the audit the Trust major incident plan was in draft awaiting ratification.

14.5 Review of minutes of the Resilience Planning Group for meetings held between March and December 2015 was undertaken to assess the evidence to support that there is compliance with the Group's duties relating to training. It was noted that training and exercising is a standing agenda item where issues relating to training are raised as discussed. One action noted in the March 2015 minutes was to produce and distribute a full training and exercising matrix, although a timescale for completion was not recorded. A similar action point was also raised in August 2015, which was to draft a yearly training plan to ensure preparedness and compliance with the Emergency Preparedness and Resilience Policy. While it is acknowledged that work on the training and exercising plan has started, there is a need to complete the training and exercising plan and the training matrix at the earliest opportunity. To facilitate this a formal deadline for completion of this work stream needs to be determined. Issues were noted relating to the follow-up of actions and monitoring deadlines through the Resilience Planning Group. Recommendation three suggests improvements to the governance process.

Recommendation: 1	Priority: 2
The training and exercising plan and training matrix be completed at the earliest opportunity. To facilitate this a formal deadline be set which is monitored through the Resilience Planning Group.	

14.6 The terms of reference of the Resilience Planning Group also include a specific duty relating to management of risks "*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*". A recent review of the Resilience Planning Group terms of reference assessed the appropriateness of membership and divisional representation.

14.7 To manage resilience risks a Resilience Risk register is in place which is maintained through the Datix system. Review of Resilience Planning Group minutes for the period March 2015 to December 2015 highlight that there is regular discussion of incidents but appears to be a more limited review of risks. The Resilience Planning Group minutes for March and May 2015 confirm that the risk register was discussed at these meetings and a further action point raised that "*JM is still to formulate the risk register into the required number of risks and forward to the teams*." While it was stated that the required action has been taken and the risk register has been reviewed and shared, there is no evidence to support that the updated risk register has been reviewed at subsequent Resilience Planning Group meetings.

Recommendation: 2	Priority: 2
The Resilience risk register be included as a standing agenda item at the Resilience Planning Group to ensure appropriate sharing of risks and scrutiny of mitigating actions.	

14.8 It was noted that agreed actions in relation to risks and training are not being followed up in subsequent meetings of the Resilience and Planning Group. The governance processes could be improved by ensuring that there are clear deadlines for agreed actions and that the progress of actions is actively monitored and recorded in the Resilience Planning Group's minutes.

Recommendation: 3	Priority: 3
Governance processes be improved to ensure that deadlines are set for all Resilience Planning Group actions and the progress of actions is actively monitored, and recorded in the minutes.	

14.9 The Trust has been fully involved in several planned multi-agency exercises which take place on a periodic basis. While evidence was seen to support that feedback and analysis of the exercise outcomes have been reported to the Board, analysis and lessons learned have not been reported to the Resilience Planning Group.

Recommendation: 4	Priority: 2
Feedback and analysis from planned exercises be formally reported to the Resilience Planning Group in order that lessons learned can be shared and implemented.	

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

14.10 Review of training material and attendance records confirms that the Head of Resilience has provided some internal training, for instance in January 2016 all appropriate on-call Directors attended a session on strategic planning, and Protective PPI training sessions were held in December 2015 for staff in the Emergency Department. Additionally during the year, ad-hoc training has been provided to the leads responsible for producing business continuity plans. However, the absence of a formalised training and exercising plan undermines systems in place as there is no method to ensure that internal training being delivered has been approved as appropriate to need. The need for completion of the training and exercising plan and training matrix has been raised in Recommendation 1.

14.11 Systems are in place for the Head of Resilience to distribute details of external training courses to appropriate staff. However, it was stated that uptake of training has been poor. There is a policy requirement that "*All members of the Resilience Planning Group will be responsible for ensuring staff within their respective areas are aware of the training available and encourage attendance on recommended courses*" however, there is no formal process to report the failure to attend suggested training via the Resilience Planning Group. When fully completed the training matrix will provide the benchmark against which training non-compliance can be gauged and reported against.

Recommendation: 5	Priority: 2
Failures to attend suggested training or training required as part of the completed training matrix, and the reasons for doing so, be reported via the Resilience Planning Group for review and to determine the implications on the Trust.	

14.12 Evidence was available to support that real life incidents are shared and discussed at the Resilience Planning Group. Review of minutes confirmed that actions are determined on the basis of incident outcomes but the opportunities for further training was not clear.

Recommendation: 6	Priority: 3
All real life incidents be assessed for training opportunities, which can then be used to populate the training and exercising plan.	

14.13 Specific policy requirements for training are described in Section 8.2 of the Emergency Preparedness and Resilience Policy. Review identified that the Trust is not fully compliant with statements in Section 8.2 of the policy. The main area of weakness being the lack of a formalised Emergency Preparedness and Resilience training plan, which should encompass internal, external and training provision via multi-agency partners. The need for the training and exercising plan to be completed at the earliest opportunity has been raised in Recommendation 1.

14.14 Resilience awareness training is provided to new starters through the Trust Induction programme. A "speed training" session is held for all staff on induction, during which major incident and business continuity planning is discussed. Currently, new starters are not provided with any training materials as part of this training.

Operational Effectiveness Matter: 1
Consideration be given to providing new staff with key details regarding emergency preparedness and major incident planning to back up discussions held as part of the induction training session.

Sent via email

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8 December 2016

Dear Sonia

Re: EPRR Core Standards Assurance Meeting

Thank you for your submission of the self-assessment against the EPRR core standards and for participating in the NHS Core Standards for EPRR Assurance meeting held on Wednesday 21st September 2016. The purpose of the assurance meeting was to discuss your Core Standards submission in an open and facilitative forum, in order to set priorities moving forward. The Core Standards Panel will then make recommendations to the Local Health Resilience Partnership (LHRP) and in turn, the Local Resilience Forum (LRF) in response to your submission.

We were pleased to acknowledge the areas of good practice in relation to the development of divisional business continuity plans and raising the profile of EPRR.

Core Standards
The Trust Board is well sighted on EPRR and resilience in general and has received communications and gold command training. However, there remains reluctance among staff to attend off-site training. The training and exercise plan is an ongoing rolling plan, with a log being maintained centrally for on-call staff training. The Trust stated that it is overdue a live exercise and plans are in place to address this.

Divisional business continuity plans are now in place, with an overarching update of the trust-wide plan now required. This is to be in place by January 2017.

You are working with Kettering General Hospital to develop a county-wide whole site evacuation plan, with a deadline of March 2017. A draft plan is in place, but is reliant on partner input as to where patients would be transferred to. The Trust needs to liaise with further agencies such as local authority and transport providers in order to move this forward. NHS England has provided you with a copy of the UHL Evacuation plan as an example.

Your VIP / high profile patients plan has been drafted, but needs to be ratified. With regard to the consort element of the plan, the panel encouraged you to treat this separately and continue with ratifying the VIP part of the plan.

There are a number of plans that are under review, however, they are in line with the expected review process and therefore core standard 9 was assessed as fully compliant.

With regard to core standard 14 (debrief process), 19 (Sit-reps) and 20 (access to 24h specialist CBRN adviser), the panel established that whilst you have adequate processes in place, these processes are not currently documented in the appropriate plans. The Trust is encouraged to address this so that these core standards may be assessed as fully compliant.

CBRN/HAZMAT
There is a task and finish group in A&E that meets weekly to complete CBRN / Hazmat risk assessments. This is an ongoing process and therefore core standard 40 was assessed as fully compliant.

There are schedules in place to test decontamination equipment and you are working with the Estates department with regard to the installation of showers. Equipment testing is an ongoing process and so once schedules are documented in the appropriate plans, core standards 45, 46 and 47 will be fully compliant.

Business Continuity Deep Dive
This was also covered under the Core Standard section of the meeting. Critical functions are to be identified following the recently completed departmental BIAs and these will be incorporated into the Trust-wide business continuity plan. The Trust is reminded of the importance of key sub-contractors having robust business continuity plans in place to prevent any impact on service delivery.

Any Other Issues
You were encouraged to increase the uptake of seasonal flu vaccinations among Trust employees and informed the panel of the introduction of a “free meal when having a vaccination” campaign. Back-office staff are also being focussed on and campaign teams will visit wards, departments and meetings to encourage uptake. The employee voucher scheme is being launched w/c 26th September.

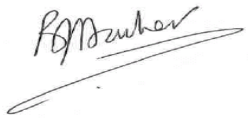
Summary
In your EPRR Core Standards self-assessment, you have rated your overall level of compliance as substantial. Following the assurance meeting and review of your submission, whilst the panel reassessed a number of the core standards as fully compliant, we agree with your EPRR Core Standards Assurance rating of: **SUBSTANTIAL**.

Key priorities / actions

- Encourage staff to attend appropriate off-site training and undertake a live exercise
- Documentation of processes in appropriate plans
- Development of Evacuation plan
- Increase uptake of staff seasonal flu vaccination

We would like to thank you for your time and for your efforts in developing and embedding the EPRR agenda within the Trust.

Yours sincerely



Trish Thompson
Locality Director (Central)
Midlands and East (Central Midlands)

pp. Prof Akeem Ali
Director of Public Health
Northamptonshire County Council

Cc: Kevin Robotham, Head of EPRR, NHS England
Sara Watson, Operations & Delivery Coordinator, NHS England
Richard Jarvis, Urgent Care Planning & EPRR Manager, Nene CCG

High quality care for all, now and for future generations

Corby Clinical Commissioning Group

Nene Clinical Commissioning Group

Exercise Cygnus

Health Economy Tactical Coordinating Group

Debrief

Contents

Executive Summary

Exercise Cygnus was a nationally led exercise designed to test a Strategic Coordinating Group (SCG) response to a pandemic influenza. The exercise was coordinated by Public Health England, NHS England and DCLG. The debrief for the SCG is being led by the Local Resilience Forum. This document has been developed to review the NHS response via the Health Economy Tactical Coordinating Group (HETCG).

The exercise was built around a novel influenza virus (Swan Flu) with modelling detailing the impact on both the NHS and the wider community, including social care and excess death (these were the two main aims for the national exercise). From 3 weeks prior to the exercise, using the modelling provided, we were able to provide participants with weekly updates on the international, national and local picture. This included numbers of deaths, anti-viral authorisations and any impact on schools and other infrastructure.

The HETCG was well controlled by the chair and ensured that everyone who wanted to speak were given the opportunity to do so which allowed for a collaborative approach to managing the scenario. Post exercise feedback suggests that the HETCG was too large and consideration should be given to slimming this down to a more manageable size. The evaluator also felt that those in the room were unsure if they were Tactical or Strategic Commanders. Some organisations brought their tactical experts (EPRR Managers). It was felt that they didn't add any support to their strategic commander.

The evaluator couldn't distinguish whether this was because they felt they had nothing to add or felt they couldn't interject.

Due to the artificiality of the exercise, where we would have already had a number of planning meetings, the HETCG was disjointed in so much as we were trying to look forward to the next few weeks but participants wanted to give an overview of what they would have done to this point. The exercise team tried to prevent this by asking participants to complete a questionnaire during the week prior to the HETCG to give them the opportunity to review what their response would have been. This was only completed by the CCG (including Primary Care), NHFT, Voluntary Impact Northampton and NHS 111. During the debrief, there was a comment made that the exercise team should have given participants the opportunity to reflect in this way. Some of the participants felt the exercise start time was confusing. Initially the start time was in the morning but this was put back to the afternoon. This was communicated and the new time was consistent in the joining instructions for the exercise sent out 2 weeks before the exercise started.

During the debrief it was identified that the exercise became disjointed due to the interjection of a thousand deceased in Northamptonshire in the next 3 weeks into the scenario midway through the exercise. This was outside of the scope for a HETCG. The aim of this was to try to move the discussion into identifying issues for consideration of the SCG.

It was noted by the exercise facilitator and the exercise evaluator that there was little, if any, reference made by the participants to the relevant plans (Pandemic Flu, surge and escalation etc.).

Introduction

Exercise Cygnus was a national exercise that had been designed to test the national and local response to an influenza pandemic. Participants included, at a national level, Government Ministers who will be based in the Cabinet Office Briefing Room (COBR). Locally the Local Resilience Forum and the Local Health Resilience Partnership tested the Strategic Coordinating Group, Tactical Coordinating Group, the Health Economy Tactical Coordinating Group and the Communications Group.

Northants LRF Aims and objectives

Aim:

- To test Northamptonshire's preparedness for an Influenza Pandemic

Objectives:

- Assess effectiveness of the Northamptonshire Pandemic Influenza Plan and highlight areas for improvement
- Validate the assumptions in the Northamptonshire Mortuary Plan

Scenario

The scenario for the exercise was a novel influenza virus (identified as Swan Flu for the purposes of the exercise). The index cases were identified in Thailand with the first cases in the UK identified in travellers returning from Thailand.

The exercise facilitator provided a comprehensive overview of the emerging situation, which included presentations and a video clip.

Exercise Format

The participants were provided with weekly briefings, which included detail on the international, national and local situation emerging over the course of time. This was provided to enable each participant to attend the HETCG with the same level of knowledge of the current situation locally and to have used this information to work through, with colleagues from within their own organisation, where they would expect the impacts to have been felt and the planning they would have undertaken to this point. Each organisation was invited to complete a questionnaire and submit this prior to the HETCG. The aim of this was to allow each organisation to review their own response to date and also the response of other organisations as the plan was to share these prior to the HETCG. The planning team didn't receive enough response back to make this a worthwhile activity. Each participant attended a HETCG with some supported by their organisations Emergency/Resilience Officer.

Participating Organisations

- NHS Nene & NHS Corby Clinical Commissioning Groups
- Kettering General Hospital
- Northampton General Hospital
- Northamptonshire Health Foundation Trust
- East Midlands Ambulance Service
- Northamptonshire County Council Adult Social Care
- NSL Non-Emergency Patients Transport Service
- IC24 Out of Hours primary Care Service
- NHS 111
- Northamptonshire Emergency Response Corp
- Public Health England
- Corby Urgent Care Centre
- Primary Care

Exercise Evaluation

Evaluator reports - The HETCG was assigned an evaluator to evaluate their performance against criteria based on the exercise objectives.

Participant debrief - A debrief was undertaken involving all organisations. Each organisation undertook their own debrief to feed into the wider debrief.
Material produced during the exercise - Information and answers produced by the participants for the exercise was saved and has been viewed in the evaluation process.

Evaluator assessment

The following is the feedback received from the evaluator for the HETCG:

Observations:

The facilitator gave a comprehensive overview of the emerging situation, which included presentations and a video clip, setting the scene for those in attendance. Playing a key role through the HETCG, interjecting and bringing the chair back to the salient points. As the tactical expert in the room, highlighting relevant plans and referencing to the battle rhythm, and highlighting the requirement to upward feed to the SCG.

The HETCG was chaired by the AEO, who controlled the meeting well, given the number of organisations present. Ensuring that everyone was aware of the gravity of the situation, then focusing in to those organisations who would need the support of the HETCG. Chair ensured all who wanted to speak were able to do so, and it felt like a collaborative atmosphere which allowed those who wanted to speak to do so even if they were unsure on their footing. This type of approach allows people to feel their way through these meetings, especially if it is their first.

From my observations, the meeting was too large, unsure if those in attendance fully understood that the meeting was Health TCG (Tactical) also not sure that the room understood whether those sat around the table were Strategic Commanders or Tactical commanders? The relationship should be providers send strategic commanders who act in the TCG as Strategic, then ask their own organisational tactical commanders to produce the plans, those around the table appeared to be both.

Some organisations brought their tactical experts (EP's) however these individuals did not appear to add any support to their strategic commander, I could not tell if this was because they felt they had nothing to add, or felt they could not interject.

Plans

I was not aware of anyone referencing the Surge and Escalation plan; as a starter for 10 this document helps everyone to agree the position, and what steps can be done and by whom.
I was not aware of anyone really referencing back to the agreed flu plan, the plan would set the scene for collaborative working.
There was no reference to a LHRP mutual aid agreement.

Lessons Learnt

- Northants has a large LA, with multiple councils and boroughs, there did not appear to be one voice or a collective chair for the LA.
- The HETCG was very large, with some providers providing input, but consideration to be given as to whether their input would have been better suited to a subgroup or working group.
- Richard while facilitating well, I believe would have added more value at the table next to AEO, which would happen in reality.
- Provider EP's should play a more supporting role, to be explored at the LHRP operational group
- The HETCG appeared to be more of a feedback group, and less of the tactical planning that was required
- There did not appear to be clear requests for support of clarification to the SRG
-

Summary

- The meeting was well chaired, and no different to the challenges all AEO's have when holding a HETCG
- Excellent engagement at very senior level

Lessons Identified

1. The HETCG needs to focus more on looking forward rather than reviewing where they've been or the current position;
2. Review the membership of the HETCG and ensure that it is able to function efficiently. Consider using sub-groups that then report into the wider group;
3. The Chair of the HETCG should support NHSE at the SCG;
4. Participants in exercises should ensure that they have read all pre-exercise documentation and material and complete any required documentation.
5. The ideas developed at both the HETCG and SCG should be explored further and if viable built into the Pandemic Plan as options available to support the Health and Social Care Economy in this type of scenario. This should be undertaken by the Health Resilience Working Group.

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 January 2017**

Title of the Report	**Corporate Governance Report**
Agenda item	**15**
Presenter of Report	Catherine Thorne, Director of Corporate Development, Governance and Assurance
Author(s) of Report	Catherine Thorne, Director of Corporate Development, Governance and Assurance
Purpose	Information
Executive summary This report provides the Board with information on a range of corporate governance matters and in particular includes formal reporting on the Use of the Trust Seal pursuant to the Trust's Standing order 12.3.	
Related strategic aim and corporate objective	N/A
Risk and assurance	This report provides assurance to the Board in respect to compliance with Standing Orders and the Trust's Standards of Business Policy
Related Board Assurance Framework entries	N/A
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (/**N**) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (/**N**)

Enclosure K

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

Actions required by the Trust Board

The Trust Board is asked to:

- To note the Use of the Seal, numbers of staff declarations and new declarations of interest by Trust Board members

Northampton General Hospital NHS
NHS Trust

Public Trust Board

Corporate Governance Report
October – Dec 2016 (Q3)

Introduction

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

Use of the Trust Seal

The Trust's Standing Orders require that periodic reports are made to the Board detailing the use of the Trust's Seal. The Seal will generally be used for contracts in excess of the financial limits delegated to the Chief Executive under the Standing Financial Instructions, and for property matters, including disposals, acquisitions and leases.

The seal has been not been used during Quarter 3

Declarations of Hospitality

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

During Q3 all senior staff (Band 8C and above or equivalent) and Consultant staff have been required to make specific declarations in line with the Trust's updated Standing Financial Instructions.

- Oct – Dec 2016: 49 declarations received
  (this includes declarations from departments where lunch has been provided during an educational session and may involve a group of staff but is counted as a single declaration))

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

Enclosure K

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26 January 2017**

Title of the Report	**Board Subcommittee Review of Terms of Reference**
Agenda item	**16**
Presenter of Report	Catherine Thorne, Director of Corporate Development, Governance and Assurance
Author(s) of Report	Catherine Thorne, Director of Corporate Development, Governance and Assurance
Purpose	Approval

Executive summary

This report provides the Trust Board with an update in respect to the Terms of Reference for each of the Board subcommittees Terms of Reference review.
Amendments have been suggested as follows and the Board is asked to approve the changes

Finance, Investment and Performance Committee :

- Strengthen duties in respect to Benefits Realisation
- Alter reporting for IT directly to the Committee
- Change TDA to NHSI

Workforce Committee:

- Update responsibilities in respect to oversight of Freedom to Speak Up work and report
- Specify oversight of workforce risk register

Quality Governance committee

- Include Deputy Director of QI in list of attendees

Audit Committee

- Specify attendance of all Chairs of Trust Board subcommittees

Related strategic aim and corporate objective	All
Risk and assurance	Annual review of Terms of reference is a duty for all Trust Board subcommittees and is in line with best corporate governance practice.
Related Board Assurance Framework entries	AA

Enclosure L

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	Annual review of Terms of reference is a duty for all Trust Board subcommittees and is in line with best corporate governance practice

Actions required by the Trust Board

The Trust Board is asked to:

- Approve the Terms of reference attached

Northampton General Hospital NHS
NHS Trust

FINANCE, INVESTMENT & PERFORMANCE COMMITTEE

TERMS OF REFERENCE

Membership	• Non-Executive Director (Chair) • Two other Non-Executive Directors • Chief Executive • Director of Finance • Chief Operating Officer • Director of Workforce and Transformation • Director of Strategy and Partnerships • Director of Facilities and Capital Planning • Director of Nursing, Midwifery and Patient Services • Director Corporate Development Governance and Assurance • Divisional Directors x 4
Quorum	• Six members including a minimum of two Non-Executive Directors
In Attendance	• Deputy Director of Finance • Head of Programme Management Office • Head of Communications • Board and Committee Secretary • Associate Directors of Finance (as required)
Frequency of Meetings	• Monthly
Accountability and Reporting	• Accountable to the Trust Board • Report to the Trust Board after each meeting • Minutes available to all Trust Board members on request • Annual report to the Trust Board on actions taken to comply with terms of reference
Date of Approval by Trust Board	• January 2017
Review Date	• 12 months review

Enclosure L

Northampton General Hospital NHS
NHS Trust

FINANCE, INVESTMENT AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. Constitution

The Trust hereby resolves to establish a Committee of the Trust Board to be known as the Finance, Investment and Performance Committee (the Committee).

The principle aim of the Committee is to maintain a detailed overview of the Trust's assets and resources in relation to the achievement of financial targets and business objectives and the financial stability of the Trust. In addition, this committee is responsible for ensuring the delivery of all key performance metrics. This will include:-

- overseeing the development and maintenance of the Trust's medium and long term financial strategy;
- reviewing and monitoring the delivery of the annual financial plan and its link to operational performance and quality;
- reviewing and monitoring operational performance;
- overseeing financial risk evaluation, measurement and management scrutiny and oversight of the capital programme;
- ensure the finance function is fit for purpose and , key financial policies and objectives align with Trusts objectives
- consider and make recommendations regarding the self-declarations for the Trust in respect to the compliance with the oversight and escalation process to the Trust Development Agency (TDA)
- consideration of major investment decisions
- consideration of material transactions and governance issues

2. Membership

The Chair of the Committee and non-executive members shall be appointed by the Trust Board. The Trust Board should satisfy itself that at least one non-executive member of the Committee has recent and relevant financial experience.

In the absence of the Chair appointed by the Trust Board, one of the Non-Executive Directors will be elected by those present to Chair the meeting.

3. Quorum, Frequency of meetings and required frequency of attendance

No business shall be transacted unless six members of the Committee are present. This must include not less than two non-executive Board members.

In the event that the Director of Finance is not available, the Deputy Director of Finance must attend.

The Committee will normally meet monthly, but not less than quarterly. Members of the Committee are required to attend a minimum of 80% of the meetings held each financial year and not be absent for two consecutive meetings without the permission of the chair of the committee.

4. In attendance

In addition to the agreed membership, other Board members shall have the right to attend. Other directors and officers of the Trust may be asked to attend at the request of the Chair. Only the Committee Chair and relevant members are entitled to be present at a meeting of the Committee, but others may attend by invitation of the Chair.

5. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference and to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee can also recommend the provision of expert advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

6. Duties

Financial Strategy

- To consider the financial strategy, ensuring that the financial objectives are consistent with the strategic direction and quality priorities.
- To review the long term financial model (LTFM) and seek assurance that the LTFM and IBP are aligned together with the wider health economy plans.
- To oversee the development and management of the rolling capital programme including scrutiny of the prioritisation process, forecasting and remedial action, and report to the Board accordingly
- To provide assurance on the robustness of the Annual Planning Process
- To review key medium term planning assumptions
- To review NHSI/Monitor/LAT /CCG/NHS England, etc. publications around financial and operating environment and their link to planning assumptions and models
- To ensure that the financial forecast and associated recovery plans are robust and are delivered

Monitoring Performance

- Monitor the divisional and overall Trust achievement of the financial strategy, and financial targets, associated activity targets and how these relate to the performance of the trust in non-financial domains such as patient safety and effectiveness.
- To review the Trusts short and medium term financial performance of the Transformation Programme, including any mitigation plans for the identified risks and provide assurance to the Trust Board that appropriate action is being taken.
- Developing high level metrics to focus the Committee on areas where corrective action may need to be developed and monitoring agreed actions
- Monitor the Trust KPIs and associated actions, the performance scorecard, and activity and financial performance.
- Monitor the outcomes of the quarterly performance reviews and the associated remedial actions agreed
- To monitor and scrutinise the Trust procurement plan, ensuring it drives value for money across purchasing and supplies
- To scrutinise financial and non-financial performance, trends, projections and underlying data on a monthly basis so that assurance can be sought around any action plans that address emerging patterns in finance or activity.
- To scrutinise the trust transformation programme including trends, projections and underlying data on a monthly basis so that assurance can be sought around any action plans that address emerging patterns in delivery.

- To consider the annual reference costs and review profitability analyses using service line reporting.
- Provide oversight of the Trust Charitable Funds Group and associated plans.
- To review the annual accounts, any going concerns and the statement of internal governance prior to Audit Committee and Board approval

Financial Risk Management

- To review financial risk and advise the Board accordingly
- Review and evaluation of key financial risks and associated mitigating actions
- Development of risk management process around the evaluated risks linking to Board Assurance Framework providing assurance around active financial risk management

Business Case consideration, Capital and Service Investment Programme management

- To perform a preliminary review of proposed major investments.
- To establish the overall controls which govern business case investments and to receive assurances on the approvals process for Business Cases approved by the Hospital Management Team and making recommendations to the Trust Board when the level of approval exceeds the limits set in the Trust Scheme of Delegation.
- Provided it is quorate, the Committee may approve (or recommend approval) of individual business cases up to the value of £1m (lifecycle). Business cases in excess of £1m (lifecycle) must be approved by the Trust Board.
- To ensure that robust processes are followed, evaluating, scrutinising and monitoring investments so that benefits realisation can be confirmed in line with the Trust's Capital Investment Policy.
- To ensure any matters in respect to benefits realisation issues which may have a quality impact are referred to the Quality Governance committee for oversight
- To ensure testing of all relevant options for larger business cases prior to detailed workup
- To focus on financial metrics within cases e.g. payback periods, rate of return etc.

Other Matters

- To examine the fitness for purpose of the finance function compared to the scale of the financial challenge.
- To seek assurance of financial governance arrangements
- To consider ad hoc financial issues that arise and associated actions
- In conjunction with the Audit Committee, periodically consider changes required to Trust Standing Financial Instructions due to structural change within the Trust, developments in the wider statutory/regulatory framework.
- To oversee arrangements for outsourced financial functions and shared financial services.
- To consider such other matters and take such other decisions of a generally financial nature as the Board shall delegate to it.

7. Accountability and Reporting arrangements

The minutes of the Committee meetings shall be formally recorded by the Board and Committee Secretary. Copies of the minutes of Committee meetings shall be available to all Trust Board members on request.

The Committee Chair shall prepare a report on to the Trust Board after each meeting of the Committee. The Chair of the Committee shall draw to the attention of the Trust Board any issues

that require disclosure to the full trust Board, or require executive action whilst the Board are considering the information including within the monthly finance, performance and improving quality and efficiency reports.

8. Sub-committees and reporting arrangements

The Committee shall have the power to establish sub-committees for the purpose of addressing specific tasks or areas of responsibility. In accordance with the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee unless expressly authorised by the Trust Board.

The terms of reference, including the reporting procedures of any sub-committees must be approved by the committee and regularly reviewed.

9. Administration

The Finance, Investment and Performance Committee shall be supported administratively by the Board and Committee Secretary whose duties in this respect will include:

- Agreement of the agenda for Committee meetings with the Chair;
- Collation of reports and papers for Committee meetings;
- Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward;
- Advising the Committee on pertinent matters.

10. Requirement for review

These terms of reference will be formally reviewed by the Committee at least annually.

11. FOI Reminder

The minutes (or sub-sections) of the Board, unless deemed exempt under the Freedom of Information Act 2000, shall be made available to the public, through the meeting papers.

Workforce and Organisational Development Committee

TERMS OF REFERENCE

Membership	• Non-Executive Director (Chair) • One other Non-Executive Director • Chief Executive • Director of Workforce and Transformation • Director of Nursing, Midwifery and Patient Services • Medical Director • Chief Operating Officer • Director of Facilities and Capital Development • Divisional Directors (4)
Quorum	• Six Members with at least one Non-Executive Directors
In Attendance	• Board and Committee Secretary • Head of Communications
Frequency of Meetings	• Monthly
Accountability and Reporting	• Accountable to Trust Board • Summary report to Trust Board after each meeting by Chair • Minutes available to all group members • Annual report to Trust Board on actions taken to comply with terms of reference
Date of Approval by Trust Board	• Jan 2017
Review Date	12 months

Workforce and Organisational Development Committee
Terms of Reference

1. Constitution

The Trust Board hereby resolves to establish a Committee of the Trust Board to be known as the Workforce and Organisational Development Committee (The Committee). Its principal aims are;

- To provide assurance to the Trust Board on organisational development and workforce performance and on the achievement of associated key performance indicators.
- To make recommendations to the Trust board on key strategic organisational development and workforce initiatives.

The Committee has no executive powers other than those specifically delegated in these terms of reference.

2. Membership

The Chair and non-executive members of the committee shall be appointed by the Trust Board. In the absence of the Chair, one of the non-executive directors will be elected to Chair the meeting.

3. Quorum, Frequency of Meetings and Required Frequency of Attendance

No business shall be transacted unless six members of the Committee are present. This must include not less than one non-executive Board member.

The committee will meet monthly, but not less than quarterly. Members of the Committee are required to attend a minimum of 80% of the meetings held each financial year and not be absent for two consecutive meetings.

4. In Attendance

In addition to the agreed membership, other Board members shall have the right to attend. Other directors and officers of the Trust may be asked to attend at the request of the Chair. Only the Committee Chair and relevant members are entitled to be present at a meeting of the Committee, but others may attend by invitation of the Chair of the Committee.

5. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference and to seek any information it requires from directors/managers of the trust.

6. Duties

- To agree targets for workforce and organisational development and monitor the Trust's performance against those targets
- Receive reports from Divisional Directors on performance against their Divisional workforce and organisational development KPI's

- Consider workforce and organisational development strategies and make recommendations to the Trust board on the proposed strategies

- Receive reports on key matters including: employee relations, occupational health, workforce, medical staffing, organisational development and learning and development

- Consider reports and proposals arising from staff feedback, including staff surveys and Staff Friends and Family tests.

- Review workforce risks on the Corporate Risk Register (CRR) at each meeting and ensure alignment with the Board Assurance Framework (BAF).

- Receive reports and proposals from the Communications department in relation to internal staff communications systems and processes.

- To receive reports from the Freedom to Speak up Guardian and refer matters related to safety to the Quality Governance committee for oversight where appropriate

7. Accountability and Reporting Arrangements

The minutes of the Committee meetings shall be formally recorded by the Board and Committee Secretary. Copies of the minutes of Committee meetings shall be available to all Trust Board members on request.

The Committee Chair shall prepare a summary report on to the Trust Board after each meeting of the Committee. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full trust Board, or require executive action whilst the Board are considering the information including within the monthly reports.

8. Sub Groups and Reporting Arrangements

The Committee will establish suitable subgroups for the purpose of addressing specific tasks or areas of responsibility and these will be reviewed by the committee as required.

9. Administration

The Workforce and Organisational Development Committee shall be supported administratively by the Board and Committee Secretary whose duties in this respect will include:

- Agreement of the agenda for Committee meetings with the Chair and Director of Workforce and Transformation;

- Collation of reports and papers for Committee meetings;

- Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward;

- Advising the Committee on pertinent matters.

10. Requirement for review

These terms of reference will be formally reviewed by the Committee at least annually.

11. FOI Reminder

The minutes (or sub-sections) of the Board, unless deemed exempt under the Freedom of Information Act 2000, shall be made available to the public, through the meeting paper.

Northampton General Hospital NHS
NHS Trust

QUALITY GOVERNANCE COMMITTEE

Terms of Reference

Membership	• Non-Executive Director (Chair) • One other Non-Executive Director • Chief Executive • Director of Nursing, Midwifery and Patient Services • Medical Director • Chief Operating Officer • Director of Workforce and Transformation • Director of Finance • Director of Strategy and Partnerships • Director of Facilities and Capital Development • Director of Corporate Development, Governance and Assurance • Divisional Clinical Directors (4) • Deputy Director for Quality Improvement
Quorum	• Seven Members with at least one Non-Executive Directors (including the Chair)
In Attendance	• Deputy Director of Nursing • Head of Communications • Board and Committee Secretary
Frequency of Meetings	• Monthly
Accountability and Reporting	• Accountable to the Trust Board • Summary report to the Trust Board after each meeting from Chair • Minutes available to all Trust Board members on request • Annual report to the Trust Board on actions taken to comply with terms of reference
Date of Approval by Trust Board	Jan 2017
Review Date	• 12 months review

Enclosure L

QUALITY GOVERNANCE COMMITTEE (QGC)

TERMS OF REFERENCE

1. Constitution

The Trust hereby resolves to establish a Committee of the Trust Board to be known as the Quality Governance Committee (the Committee). The purpose of the Committee is to ensure there is an effective system of integrated governance, risk management, and internal control across the clinical activities of the organisation that support the organisation's objectives of delivering the best possible outcomes of care to patients.

2. Membership

The Chair, Non-Executive and Executive members of the Committee shall be appointed by the Trust Board. The Trust Board should satisfy itself that the Chair of the Committee has recent and relevant clinical experience.

The membership includes Director of Workforce and Transformation, Director of Strategy and Partnerships, Director of Facilities and Capital Development and the Director of Corporate Development, Governance and Assurance. The four Divisional Clinical Directors are also members of this Committee.

3. Quorum, Frequency of meetings and required frequency of attendance

No business shall be transacted unless seven members of the Committee are present. This must include not less than one Non-Executive Board members including the Chair.

The committee will meet monthly. Members of the Committee are required to attend a minimum of 80% of the meetings held each financial year and not be absent for two consecutive meetings.

4. In attendance

In addition to the agreed membership, other Board members shall have the right to attend. Other directors and officers of the Trust may be asked to attend at the request of the Chair. Only the Committee Chair and relevant members are entitled to be present at a meeting of the Committee, but others may attend by invitation of the Chair of the Committee.

5. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference and to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee can also recommend the provision of expert advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

6. Duties

The Committee has three reporting domain sub-groups;

1. The Assurance, Risk, and Compliance Group. (Chaired by the Director of Corporate Development, Governance and Risk).
2. The Patient and Carer Experience Group. (Chaired by the Director of Nursing, Midwifery and Patient Services).
3. Clinical Quality and Effectiveness Group (CQEG) (Chaired by the Medical Director).

Through each of the Chairs of the three sub-groups, the Committee will receive assurance from the Chair of the sub-group on;

6.1 Policy, Planning and Strategy

- The Committee will oversee the planning and development of quality and governance activities in the Trust.
- The Committee will ensure that the Trust's strategy for quality and governance is being delivered, and ensure the robust development of the Trust's quality and governance plans.
- The Committee will encourage and foster greater awareness of quality and governance throughout the organisation at all levels.
- The Committee will ensure the development and ratification of new clinical, quality and governance policies via the Trust's Procedural Document Group. This group will report to the Committee through CQEG.
- The Committee will oversee the development of the Quality Accounts and oversee the monitoring and reporting process.

6.2 Monitoring and Delivery

- The Committee will report and provide assurance to the Trust Board through the Chair of the Committee on the quality of healthcare provided by the Trust.

- The Committee will gain assurance from the Chairs of each of the three reporting domain groups. Each domain group represents an aggregated group of further sub-groups.

- The Committee will monitor the system and process for capturing and responding to service user and carer feedback through the Chair of the Patient and Carer Experience sub-group.

- The Committee will monitor the system and process for capturing and responding to the effectiveness and outcomes of care provided to patients through the Chair of the CQEG sub-group.

- The Committee will monitor the system and process in place in respect to CQUIN delivery through the Chair of the CQEG sub-group.

- The Committee will monitor health and safety management systems and processes throughout the organisation, through the Chair of the Assurance Risk and Compliance sub-group.

- The three domain sub-groups will each provide a highlight report to QGC provided in advance of the meeting to be presented by the Chair of the group. The reporting domain groups represent an aggregated group of further meeting groups as identified in ***Appendix 1*****.**

- The report by each Chair will include the key findings and issues discussed within the domain group that was agreed to be escalated at QGC for information or consideration.
- Where delivery becomes sub-optimal the focus of assurance for the Committee will be in options to be considered, the turnaround solutions and actions the Divisions have agreed at

HMT to progress together with timeframes for delivery. The operational delivery and accountability of the Divisions is through HMT.

- Through the membership of QGC, the Committee will receive assurance directly from Divisional Clinical Directors of the delivery and commitment to deliver high quality, effective outcomes for patients within a robust governance framework.

- The Committee will monitor the system and processes in place in relation to compliance with the CQC and other relevant regulatory compliance standards, through the Assurance, Risk and Compliance sub-group.

- Receive and challenge the annual reports from each of the domain reporting groups. In addition annual reports in respect to Safeguarding Adults and Children, Infection control, NICE compliance etc.

6.3 Risk Management

- Review quality risks on the Corporate Risk Register (CRR) at each meeting and ensure alignment with the Board Assurance Framework (BAF).

- The Committee will seek assurance over the arrangements within the Trust for managing high clinical and non-clinical risks, together with the robustness of associated mitigating actions.

6.4 Other Matters

The Committee will also set the specification and ensure the development of the components of quality and governance through each of the three reporting sub-groups. This to include;

- Clinical effectiveness and evidence based practice
- Training and development and continuous professional development
- Staff skills and competencies
- Professional reviews and appraisals
- Clinical audit outcomes
- Patient complaints, clinical and non-clinical claims
- NICE guidelines
- Serious Incidents.

7. Accountability and Reporting arrangements

The minutes of the Committee meetings shall be formally recorded by the Director of Corporate Development, Governance and Assurance and Committee Secretary. Copies of the minutes of Committee meetings shall be available to all Trust Board members.

The Committee Chair shall prepare a summary report on to the Trust Board after each meeting of the Committee. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require escalation to the full Trust Board.

8. Sub-committees and reporting arrangements

The Committee shall have the power to establish sub-committees for the purpose of addressing specific tasks or areas of responsibility. In accordance with the Trust's Standing Orders, the

Committee may not delegate powers to a sub-committee unless expressly authorised by the Trust Board.

The terms of reference, including the reporting procedures of any sub-committees must be approved by the Committee and reviewed.

The Quality Governance Committee has three reporting sub-groups each with their own Terms of Reference. In addition, the business cycles of each of these groups are aligned with the Business Cycle of the QGC.

1. The Assurance, Risk, and Compliance Group. (Chaired by the Director of Corporate Development, Governance and Risk).
2. The Patient and Carer Experience Group. (Chaired by the Director of Nursing, Midwifery and Patient Services).
3. Clinical Quality and Effectiveness Group (CQEG) (Chaired by the Medical Director).

9. Administration

The Quality Governance Committee shall be supported administratively by the Director of Corporate Development, Governance and Assurance and Committee Secretary whose duties in this respect will include:

- Agreement of the agenda for Committee meetings with the Chair;
- Collation of reports and papers for Committee meetings;
- Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward;
- Advising the Committee on pertinent matters
- Agreeing the reporting cycle of the Committee with the Chair of the Committee and the Director of Corporate Development, Governance and Assurance that is aligned with the business cycle of the Trust Board.

10. Requirement for review

These terms of reference will be formally reviewed by the Committee at least annually.

11. FOI Reminder

The minutes (or sub-sections) of the Board, unless deemed exempt under the Freedom of Information Act 2000, shall be made available to the public, through the meeting papers.

AUDIT COMMITTEE

TERMS OF REFERENCE

Membership	• Non-Executive Directors (Chair) • Two Non-Executive Directors • NED Chairs of each of the Trust Board subcommittees
Quorum	• Three Non-Executive Directors
In Attendance	• Director of Finance • Director of Corporate Development Governance and Assurance • Deputy Director of Finance • Head of Financial Services • External Audit • Internal Audit • Local Counter Fraud • CEO to present Annual Governance Statement, draft internal audit plan and the annual accounts. • Other Executive Directors as requested to present key papers • Executive Board Secretary
Frequency of Meetings	• At least four meetings per year
Accountability and Reporting	• Accountable to the Trust Board • Highlight report to the Trust Board by Chair of Committee after each meeting • Minutes available to all Trust Board members Annual report to the Trust Board on actions taken to comply with terms of reference
Date of Approval by Trust Board	• January 2017
Review Date	• 12 months review

Northampton General Hospital NHS
NHS Trust

AUDIT COMMITTEE

TERMS OF REFERENCE

1. Constitution

The Trust hereby resolves to establish a Committee of the Trust Board to be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference.

2. Membership

The Committee shall be appointed by the Board from amongst the non-executive directors of the Trust and shall consist of not less than three members. The Trust Board should satisfy itself that at least one member of the Committee has recent and relevant financial experience.

One of the members will be appointed chair of the Committee by the Board. In the absence of the Chair appointed by the Trust Board, once of the non-executive directors will be elected by those present to Chair the meeting.

The Chairman of the Trust shall not be a member of the Committee.

3. Quorum, Frequency of meetings and required frequency of attendance

No business shall be transacted unless three members of the Committee are present.

Meetings shall be held not less than four times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

Members of the Committee should attend regularly and should not be absent for more than two consecutive meetings.

4. In attendance

The Director of Finance and appropriate internal and external audit representatives shall normally attend meetings.

The counter fraud specialist will attend a minimum of two committees a year.

The Accountable Officer should be invited to attend meetings and should discuss at least annually with the audit committee the process for assurance that supports the governance statement. He or she should also attend when the Committee considers the draft annual governance statement and the annual report and accounts.

Other executive directors/managers should be invited to attend, particularly when the Committee is discussing areas of risk management or operation that are the responsibility of that director/manager.

Representatives from other organisations (e.g. NHS Protect) and other individuals may be invited to attend on occasion.

The Board and Committee Secretary shall be secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and committee members.

At least once a year, the Committee should meet privately with the external and internal auditors.

5. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference and to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

6. Duties

6.1 Integrated Governance, Risk Management and Internal Control

The committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical) that supports the achievement of the organisation's objectives.

In particular, the committee will review the adequacy and effectiveness of:

- All risk and control-related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other independent assurance, prior to submission to the Board
- The underlying assurance processes that indicate the degree of the achievement of the organisations objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications
- The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State Directions and as required by NHS Protect.

In carrying out this work the committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key committees so that it understands processes and linkages.

6.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets the *Public Sector Internal Audit Standards, 2013* and provides appropriate independent assurance to the Audit Committee, Chief Executive and Trust Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service and the costs involved
- Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework.
- Considering the major findings of Internal Audit work (and management's response) and ensuring co-ordination between the Internal and External Auditors to optimise audit resources
- Ensuring that the Internal Audit function is adequately resources and has appropriate standing within the organisation
- Monitoring the effectiveness of internal audit and carrying out an annual review.

6.3 External Audit

The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the Board when appropriate)
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
- Reviewing all external audit reports, including the report to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services

6.4 Other Assurance Functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (for example, the Care Quality Commission, NHS Litigation Authority, etc.) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies, etc.)

The Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. In particular, the committee will work in close liaison with the Quality Governance Committee and the Finance, Investment and Performance Committee and will meet formally with these committees at least twice per year.

In reviewing the work of the Quality Governance Committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

6.5 Counter fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Protect's standards and shall review the outcomes of work in these areas.

6.6 Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit) as they may be appropriate to the overall arrangements.

6.7 Financial Reporting

The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Audit Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- Letter of representation
- Explanations for significant variances

6.8 Whistleblowing

The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

7. Accountability and Reporting arrangements

The Committee shall report to the Board on how it discharges its responsibilities.

The minutes of the Committee's meetings shall be formally recorded by the Board and Committee Secretary and submitted to the Board. The Chair of the Committee, via a formal highlight report, shall draw the attention of the Board any issues that require disclosure to the Board or require executive action.

The Committee will report to the Board at least annually on its work in support of the annual governance statement, specifically commenting on:

- The fitness for purpose of the assurance framework
- The completeness and 'embeddedness' of risk management in the organisation
- The integration of governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business
- The robustness of the processes behind the quality account.

This annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

8. Sub-committees and reporting arrangements

The Committee shall have the power to establish sub-committees for the purpose of addressing specific tasks or areas of responsibility. In accordance with the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee unless expressly authorised by the Trust Board.

The terms of reference, including the reporting procedures of any sub-committees must be approved by the committee and regularly reviewed.

9. Administration

The Committee shall be supported administratively by the Board and Committee Secretary – his or her duties in this respect will include:

- Agreement of agendas with the Chair and attendees
- Preparation, collation and circulation of papers in good time
- Ensuring that those invited to each meeting attend
- Taking minutes and helping the Chair to prepare reports to the Board
- Keeping a record of matters arising and issues to be carried forward
- Arranging meetings for the Chair – for example with the internal/external auditors or local counter fraud specialists
- Maintaining records of members' appointments and renewal dates etc
- Advising the Committee on pertinent issues/areas of interest/policy developments
- Ensuring that action points are taken forward between meetings
- Ensuring that Committee members receive the development training they need

10. Requirement for review

These terms of reference will be formally reviewed by the Committee at least annually.

11. FOI Reminder

The minutes (or sub-sections) of the Board, unless deemed exempt under the Freedom of Information Act 2000, shall be made available to the public, through the meeting papers.

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: 26 January 2017

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

Executive Summary

The Committee met on 14 December 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)*
• Finance Forecast Progress • Changing care@NGH • Operation Performance Report • Christmas/New Year planning • Contract update	

Key areas of discussion arising from items appearing on the agenda

- The Trust continues to track to its financial plan despite very significant challenges
- Changing care programme still indicated as on track, combines carter initiatives, but still nothing included from the STP.
- A&E performance is under increasing pressure due to significantly heightened acuity, and no reduction in DTOCS. Cancer performance is improving.
- There remain substantial commitments for the acute providers to reduce costs in the STP that still have no detail and are considered a significant risk.

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

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

- The contract will now deal with STP schemes by contract variations, but the lack of clarity regarding the deliverability of the required reduction in acute activity is putting the whole system affordability at risk.
- The increasing non-elective activity over plan continues to put quality of care and A&E targets at risk.

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

- The Board should request urgent clarification of the various cost reduction schemes built into the STP that will impact the Trust.

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: *26 January 2017*

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

Executive Summary

The Committee met on *16 December 16* 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)*
• Corporate Scorecard for Quality • Report on Maternity Quality Governance including C-Section Rate • Quality Improvement Story – 10 minutes conversation • Theatres Update • Keeping Patients Safe Over Winter • Report from the Assurance and Compliance Group Chair	

Key areas of discussion arising from items appearing on the agenda

- Corporate Scorecard for Quality – Job planning poor compliance
- Report on Maternity Quality Governance including C-Section Rate – The Committee is not assured by the report and a number of actions came from the report.
- Theatres Update – Improvement of morale and the group has set up an action plan with an update to the Committee in March/April 2017.
- Keeping Patients Safe Over Winter – an addition of a metric to count the number of times a patient moves was requested.
- Report from the Assurance and Compliance Group Chair – concerns raised on low risk register ratings for Cancer & Oncology.

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

- ToR approved

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

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board

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

Executive Summary

The Committee met o*n 14/12/2016* 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)*
Nursing Associate Role Update People Strategy Update Workforce performance Safe nurse staffing Raising Concerns & Freedom to Speak Up	

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

DoN updated on Nursing Associate role. Approximately 18 to 22 candidates starting employment at the end of Jan 2017.

A detailed presentation was made on the People strategy by the senior HR team. The committee noted that significant progress was being in a number of areas with high activity being seen.

Workforce performance highlights included a decrease in sickness absence, and exceeding the flu vaccine target of 75%. An improvement in staff survey returns had also been achieved.

Ms Thorne presented on Freedom to Speak up and activity over last 3 months.

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

See the detail contained within the above sections.

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

Non other than referred to above

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

Enclosure O

Action required by the Board

Note report

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: ***26 January 2017***

Title	**Audit Committee Exception Report**
Chair	**David Noble**
Author (s)	**David Noble**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met on *16 December 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:

- External Audit report
- Internal Audit report
- Counter Fraud report
- Waivers, Losses and Special Payments, Salary overpayments
- Benefits realisation update

Board Assurance Framework entries *(also cross-referenced to CQC standards)*

Key areas of discussion arising from items appearing on the agenda

The Audit Committee received updates from Internal and External Auditors, including Counter Fraud in the context of the Risk Register and the Board Assurance Framework. The Committee reviewed progress against plans, which was generally good; follow up of audit recommendations which continues to be patchy and requires executive action; specific audits including three internal audits which have been given limited assurance (see below); and potential conflict of interest of our external auditors (see below).

The Committee reviewed in some detail waivers, losses and salary overpayments and concluded that some progress appears to being made on waivers but no progress is being made on salary overpayments which at least until system solutions are implemented requires a much greater degree of management input.

The Committee considered the Board Assurance Framework and the Risk Register and requested that the STP risk be raised. The Committee found that the BAF and risk register were sound and had continued to be managed effectively.

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

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

KPMG reported that under new NAO rules they would have a conflict of interest were they continue to provide certain payroll services in the next financial year. The Finance Director was well aware of

this and reported that was putting in place a contingency plan to recompete some of the payroll services work which required Audit Committee concurrence and Board Approval. The Audit Committee concurred with this approach.

The Committee noted that three (out of four) Internal Audit Reports had been given Limited Assurance. There was a discussion regarding whether this was the result of an increased focus on identifying areas for audit where there was the greatest risk, which the Audit Committee and Board has encouraged. There was an agreement that this was at the very least a contributing factor.

The report on stock noted that there were issues relating to the control of obsolete stock and were concerned that this could potentially have a significant quality impact.

The report on Contractors highlighted weaknesses in controls which could potentially result in safety issues

The report on prescribing highlighted a lack of compliance.

All the above are being followed up by subcommittees of the Board to establish the extent of the risk identified in each case.

The Board should note the position on salary overpayments and follow up of internal audit recommendations and encourage action through the executive team.

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

Northampton General Hospital NHS
NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 26 January 2017
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 Zeidler	**Verbal**
	2.	Declarations of Interest	Note	Mr P Zeidler	**Verbal**
	3.	Minutes of meeting 24 November 2016	Decision	Mr P Zeidler	**A.**
	4.	Matters Arising and Action Log	Note	Mr P Zeidler	**B.**
	5.	Patient Story	Receive	Executive Director	**Verbal**
	6.	Chairman's Report	Receive	Mr P Zeidler	**Verbal**
	7.	Chief Executive's Report	Receive	Dr S Swart	**C.**
10:00	**CLINICAL QUALITY AND SAFETY**				
	8.	Medical Director's Report	Assurance	Dr M Cusack	**D.**
	9.	Director of Nursing and Midwifery Report	Assurance	Ms C Fox	**E.**
10:25	**OPERATIONAL ASSURANCE**				
	10.	Finance Report	Assurance	Mr S Lazarus	**F.**
	11.	Workforce Performance Report	Assurance	Mrs J Brennan	**G.**
10:50	**STRATEGY**				
	12.	Clinical Collaboration & STP Update	Assurance	Mr C Pallot	**H.**
11:05	**FOR INFORMATION**				
	13.	Integrated Performance Report	Assurance	Mrs D Needham	**I.**
	14.	Resilience Annual Report	Assurance	Mrs D Needham	**J.**
11:15	**GOVERNANCE**				
	15.	Corporate Governance Report	Assurance	Ms C Thorne	**K.**
	16.	Approval of subcommittee Terms of Reference	Assurance	Ms C Thorne	**L.**
11:30	**COMMITTEE REPORTS**				

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

DATE OF NEXT MEETING

The next meeting of the Trust Board will be held at 09:30 on Thursday 30 March 2017 in the Board Room at Northampton General Hospital.

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

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