Northampton General Hospital NHS
NHS Trust

Public Trust Board

Thursday 30 March 2017

09:30

Board Room
Northampton General Hospital

Northampton General Hospital
NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 30 March 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 Zeidler	**Verbal**
	2.	Declarations of Interest	Note	Mr Zeidler	**Verbal**
	3.	Minutes of meeting 26 January 2017	Decision	Mr Zeidler	**A.**
	4.	Matters Arising and Action Log	Note	Mr Zeidler	**B.**
	5.	Patient Story	Receive	Executive Director	**Verbal**
	6.	Chairman's Report	Receive	Mr 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.**
	12.	Staff Survey Results 2016	Assurance	Mrs J Brennan	**H.**
11:05	**FOR INFORMATION**				
	13.	Integrated Performance Report	Assurance	Mrs D Needham	**I.**
11:15	**GOVERNANCE**				
	14.	Update to Quality Governance and Workforce Terms of Reference	Decision	Ms C Thorne	**J.**
	15.	Care Quality Commission Inspection	Receive	Ms C Thorne	**K.**
11:30	**ANNUAL REPORTS**				
	16.	Health & Wellbeing Annual Report	Receive	Mr C Abolins	**L.**
11:45	**COMMITTEE REPORTS**				
	17.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler	**M.**

Time	Agenda Item		Action	Presented by	Enclosure
	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 Hospital Management Team	Assurance	Dr S Swart	**P**
12:00	**21.**	**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 25 May 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 26 January 2017 at 09:30 in the Board Room at Northampton General Hospital

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

TB 16/17 070 Introductions and Apologies

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

Apologies for absence were recorded from Mr P Farenden and Dr M Cusack.

TB 16/17 071 Declarations of Interest

No new Declarations of Interest were noted.

TB 16/17 072 Minutes of the meeting 24 November 2016

The minutes of the Trust Board meeting held on 24 November 2016 were presented for approval.

The Board resolved to **APPROVE** the minutes of the 24 November 2016 as a true and accurate record of proceedings.

TB 16/17 073 Matters Arising and Action Log 24 November 2016

The Matters Arising and Action Log from the 24 November 2016 were considered.

The Board **NOTED** the Action Log and Matters Arising from the 24 November 2016.

TB 16/17 074 Patient Story

Mrs Needham presented the Patient Story.

Mrs Needham shared with the Board a compliment letter received by the Chief Executive's office. Mrs Needham noted that the letter was pertinent following the current winter pressures the NHS is under and illustrates how all the healthcare systems work together.

An inpatient complimented the professional and rapid caring treatment they had recently received. The patient commented that they had experienced a 'first class experience of care' and that the 'NHS is a wonderful institution'. The patient highlighted that they had been born in the 1920s and there was no NHS until 1948. She believed the NHS to be a now a world renowned service.

The patient then described her illness and their admission to NGH. On 30 December 2016 the patient's son rang 111 following which the out of hours service prescribed 6 hours of antibiotics. After a period of a few days a doctor conducted a home visit and noted that the patient was very poorly, with an admission to hospital required as the patients 02 levels were too low. The patient commented that although the A&E waiting room was packed, they were booked in within 10 to 15 minutes and taken to Ambulatory Care. The nursing staffs were very professional and kept the patient in to ensure that they were well enough to go home. The patient was seen by a 'busy' junior doctor who conducted additional tests and throat swab.

The patient advised that following the swab it was confirmed that she had a virus and the medical team had to make the decision whether to admit, or to send her home. Due to the hospital being on black alert the patient was sent home and asked to report back the following morning.

The patient stated that the next morning she was greeted by the same sister and the patient was very impressed that the sister remembered her.

The patient would like to thank all the wonderful staff and is extremely proud of their efforts.

Mr Zeidler commented that this clearly displayed a brilliant episode of care.

The Board **NOTED** the Patient Story.

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

Mr Zeidler presented the Chairman's Report.

Mr Zeidler advised that he had recently done his infection prevention control ward rounds and had nothing of concern to report.

Mr Zeidler commented that he had attended the STP scrutiny group last week and stated that this would be discussed later in Private Board.

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 noted the very pressured difficult period that the Trust is currently experiencing and complimented the resilience of the staff in this time.

Dr Swart drew the Board back to the Patient Story and highlighted the significance of the patient using all the appropriate services and the correct interventions were put in place that prevented the need for the patient to be admitted.

Dr Swart reported that A&E is still high on the agenda in addition to the STP plans. In relation to the STP plans, the Trust needs to fully understand what the mandated improvements are and what business as normal is.

Dr Swart advised that the Trust will be refreshing its clinical strategy and the strategy for development of the hospital site.

Dr Swart commented that listening and learning events have started with a yearlong rolling programme devised. Dr Swart attended a listening event and noted the importance of being connected to the front line staff.

Dr Swart stated that the Chairman and she hosted the Trust's long service awards festive tea. It was noted that attendees had welcomed the chance to celebrate their commitment in a less formal way.

Dr Swart advised that the Trust's Quality Improvement Strategy has now been agreed and will be formally launched during February. It is important to be aware that the Trust is doing its best to ensure the all staff are feeling valued.

Dr Swart commented that the Trust had been placed on black alert regularly over the recent period. She stated that it was a real achievement to walk into resus and see the tone and language being used by staff, despite the pressures, as positive.

Dr Swart discussed the need to become more effective with member engagement. The Trust is looking to rebuild its member engagement with the first event 'Quality Conversations – Winter Warmers' to be held on the 26 January 2016. The event will seek the views of the members with an aim to develop patient partners.

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

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

Dr Bisset presented the Medical Director's Report.

Dr Bisset noted the increased pressures in the urgent care system, with an increase in demand exceeding capacity. Despite these pressures there has been no detrimental effect to the quality of care.

Dr Bisset advised that there has been no increase in SI's. Since the last report to the Board 1 new Serious Incident has been reported. This was a delay in the diagnosis of a patient in A&E.

Dr Bisset confirmed that mortality is as expected and that the Trust is not suffering from any weekend effects.

Dr Bisset drew the Committee to page 25 of the report pack which detailed the Quality Schedule. Following on from the Quality Schedule was an update on CQUINs and the Trust has achieved quarter 3 CQUINs. There will be an increased level of work required if the Trust is to meet its Quarter 4 CQUIN for Sepsis. In relation to the CQUIN for Antimicrobial Resistance, tazocine is in short supply and alternatives in IV are being explored. There is likely to be a delay in the delivery of this antibiotic.

Dr Bisset reported that EPMA will continue to roll out with a planned introduction into A&E next month.

Dr Bisset stated that the Review of Harm Group continues to meet on a weekly basis where the group is able to identify areas of harm.

Ms Fox advised that the reduction of tazocine has been discussed at the Infection Control Steering Group where representatives from Pharmacy and Public Health England attended. There appeared to be no short term solution identified and Ms Fox noted that impact it will have on Trust Policies. Dr Swart suggested that an expectation report is created to help mitigate the risk.

Mrs Needham queried CQUIN 7 on page 29 of the report pack 'NHS e-Referrals'. Mrs Needham stated that this is a risk to the Trust and will affect how the Trust currently works when receiving referrals then booking appointments. The Trust is cited on the risk and a plan is in place.

Mr Pallot reported on the secondary impact that if an acute patient is not referred electronically, then the Trust will forfeit payment.

Mr Noble queried how the local CQUINs are controlled. Mr Pallot stated that some CQUINs are specified nationally.

Mrs Needham commented that the Trust does not have the electronic booking system implemented Trust wide.

Mr Zeidler asked for an electronic prescribing update and for clarity on the key benefits of the system. Mrs Needham confirmed that electronic prescribing is safer for the patient due a reduction in prescription errors as medication can only be prescribed at the correct dosage. The system will also improve communications with primary care. Dr Bisset noted that another important function of the system as that the tracking of medications will also be easier.

Mr J Archard-Jones queried whether there was an EPMA user group. Mrs Needham confirmed that a user group had been set up. The key issues with the implementation of EMPA have been cultural, technical and staffing. Mrs Needham commented that an incremental approach is needed to ensure all risks are overcome, notably the duplication of paperwork.

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

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

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

Ms Fox advised that 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 Trust was successful in both of their bids securing £55,549 from NHS Health Education England's Maternity Safety Training Fund to improve human factors training and £10,820 from the Department of Health's, Maternity & Neonatal Safety Innovation Fund to fund an innovative new midwife led ultrasound scan clinic for women who smoke during pregnancy.

Ms Fox reported that in relation to the Safety Thermometer in December 2016 the Trust achieved 98.6% harm free care (new harms) and 95% of harm free care.

Ms Fox stated that in December 2016, 20 patients were harmed from Pressure Ulcers and that this is an increase of 8 patients from the previous month. Ms Fox assured that Board that the Trust has returned to pre-December incident rates in January. A root cause analysis has been completed and the key issue noted was the low use of slide sheets that has been shared with the Moving and Handling team.

Ms Fox commented that for December there has been 1 third party attributed MRSA bacteraemia and a PIR is in progress.

Ms Fox advised that the cumulative total of the number of patients with Trust apportioned CDI is 17 patients against an annual trajectory of 21. At the same stage last year there were 23 patients. All cases are subject to scrutiny by the CCG to see there was a lapse in care. Ms Fox confirmed that year to date, there has been none

at NGH.

Ms Fox drew the Board to page 40 of the report pack which detailed the Friends & Family Test (FFT). There has been an improvement with the 93.1% of patients reporting that they would recommend the Trust. Ms Fox highlighted the positive message that despite the pressures the Trust is under, patients would still recommend the Trust to their friends and family.

Ms Fox noted that positive fill rate for nurse staffing which are included within the Ward Staffing Fill Rate Indicator.

Ms Fox drew the Board to page 46 of the report pack to discuss the TIAA - Comparator Review of Agency Nurse Utilisation 2016/17. The Trust was noted to be safe and will look at aligning the fill rate template with national policy.

Dr Swart commented that nurse staffing is still challenging and the focus on this needs to be continued.

Mr Noble highlighted that there have been no pressure ulcer incidents reported at Angela Grace and Avery, therefore queried how is the care governed with the 2 providers. Ms Fox stated that there is a close working relationship in place with a formalised contact and regular meetings. Mrs Needham confirmed that the Trust receives a comprehensive monthly report from both providers which includes all quality indicators expected from wards within NGH.

Mr Pallot commented that there is a legally binding contract in place with a quality schedule included, as well as a sub-contract to provide oversight.

Mr Zeidler queried whether Angela Grace and Avery are treated any different to the wards at NGH. Ms Fox assured the Board that the wards report in the same way and follow the same procedures.

Dr Swart stated that patients are admitted into those beds so a focus can be given on discharging the patients home due the reduce need of medical input. The patients would experience a different model of care whilst still receiving consultant input. It was important that the Board noted that the staffs on these wards are not directly employed by the Trust.

Mr Archard-Jones queried whether there was any shifts in the hospital that ran on whole agency or/and bank staff. Ms Fox assured Mr Archard-Jones that this does not happen. There are twice daily huddles and forward planning to address any staffing issues prior to them happening. The site team manage the ward staffing at the weekend. Ms Fox stated that the Trust believes that bank staffs are Trust staff.

Mr Zeidler asked for clarity for the General Wards column on page 49 of the report pack. Ms Fox confirmed she would explore this and report back at the next Trust Board.

Action: Ms Fox

Dr Swart requested that Ms Fox updated on the Board on what had been done to improve Patient Experience at the Trust which is translated in the positive FFT run charts. Ms Fox explained that patient experience does not focus solely on the national survey. The Trust identified that happy staff equals happy patients and the patient experience groups focuses on this.

Ms Fox stated that a new piece of patient experience work will include a member of the nursing team visiting an allocated ward and interviewing 15 patients. The ward will then receive feedback from this survey within 24 hours. The importance of driving

the information back to the front line staff quickly is imperative.

Ms Fox commented that November 2016 saw the first Right Time survey results. There were approximately 600 patients contacted per month to report back on their experience. There will be similar questions included within the Real Time survey. The Real Time survey will include involvement from the Communication Team and Nursing Informatics Team, working together to deliver a unique approach.

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

TB 16/17 079 **Finance Report**

Mr Lazarus presented the Finance Report.

Mr Lazarus advised that 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.

Mr Lazarus drew the Board to page 65 of the report pack which detailed the current position regarding STF funding. 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). Mr Lazarus commented that it is important to note that the Trust has not assumed that the appeals will be successful.

Mr Lazarus updated the Board on Agency Staff Expenditure. 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. Despite the reduction at the end of December the Trust is £2.5m behind the cap set by NHSI.

Mr Lazarus reported that the actions the Trust is taking to control agency spend including CEO sign off and Executive scrutiny over agency spend will hope to continue to see a reduction. There creation of an enhanced bank for doctors is being explored. Dr Swart noted that success of the nursing bank and concurred that the same approach is needed for medical staff.

Mrs Brennan confirmed that the possibility of setting up a medical bank is being discussed. Firstly the rate needs to be determined with investigation as to what the varying amounts Trust pays, what other providers pay and what the Doctors would expect to be paid. A survey is being developed to send to staff to gather their opinions on what would encourage them to work on an NGH medical bank to establish other drivers in addition to pay.

Dr Swart stated that the reduction of medical agency staff is a national must do and the creation of a medical bank is critical to this. A short, medium and long term strategic approach is needed.

Mrs Needham advised that Board that the Quarter 2 appeal for Cancer had not been successful and has been accounted for within the finances. She has not heard on the outcome for the Quarter 3 appeal for A&E and Cancer.

Mr Zeidler noted that he is encouraged to see at month 9 that the Trust is still on plan.

The Board **NOTED** the Finance Report.

TB 16/17 080 **Workforce Performance Report**

Mrs Brennan presented the Workforce Performance Report.

Mrs Brennan advised that Substantive Workforce Capacity decreased in December 2016. The Annual Trust turnover figure decreased in December and remains above the Trust target.

Mrs Brennan reported that sickness absence decreased which is positive given the time of year.

Mrs Brennan drew the Board to page 74 of the report pack which details the Improving Quality and Efficiency Update. Some of the projects listed are also included in the Making Quality Count Programme. Mrs Brennan explained that the Making Quality Count Programme focuses on service development. The programme included building on staff's capability and applying learning into projects that would improve their service. There has been 200 staff through the programme.

Mrs Brennan noted that only 1 European nurse was recruited between October and December 2016. Mrs Brennan expressed her concern that this may be the start of the impact from Brexit. The highest number of overseas nurses was recruited from India which also appeared to be of the highest quality in terms of oversea nursing. Mrs Brennan stated a total of 22 offers were made to overseas nurses out of 25 interviewswhich indicated a high offer rate.

Mrs Brennan commented that between October and December 2016 nursing capacity saw a net decrease. As at January 2017, total nursing vacancies for core and specialist areas is 133.18 WTE.

Mrs Brennan advised that a marketing campaign was needed to launch Brand Northamptonshire. Following the successful submission of a Business Case, LWAB money has been obtained to launch this branding and the microsite. Mrs Brennan confirmed that a meeting has been scheduled to discuss the launch of the Brand.

Mrs Brennan reported that in relation to nurse retention, no overseas nurses have left between October and December 2016. The Trust need to focus their efforts the existing workforce whereas until recently the key focus had been on the overseas nurses. 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 in February 2017.

Mrs Brennan stated that capability key performance indicators has improved in all areas.

Mr Kershaw noted that the considerable amount of time spent on nurse recruitment and retention d during what had been a challenging year. The future charging of tuition fees could further impact recruitment.

Ms Fox shared with the Board that the Nursing Associate roles are now to be regulated. There will be 18 staff starting the training programme shortly.

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

TB 16/17 081 **Clinical Collaboration & STP Update**

Mr Pallot presented the Clinical Collaboration & STP Update.

Mr Pallot advised that the Dermatology and Rheumatology clinical collaboration schemes will start in April 2017. For the 2 schemes final approval from the CCG is required and also a binding agreement with KGH on who will lead on a speciality basis. Mr Pallot confirmed that the Cardiology clinical collaboration scheme is also

near implementation with discussions being had on a single unit proposal.

Mr Pallot stated that there other work streams within Urgent and Complex Care are still being quantified.

Mr Archard-Jones queried whether due to unavailability of the current CEO Sponsor would this cause an issue. Mr Pallot confirmed that Dr Swart would now be covering this role.

Mr Zeidler commented that it is encouraging to see the clinical collaboration programme with KGH. Mr Zeidler queried whether there was any further information available on the urgent care and complex care schemes. Mr Pallot stated that the PMO for these schemes has not finalised the information.

Dr Swart noted that importance that the schemes will help deliver the same care in the community. Dr Swart believed that it is imperative that these schemes are followed through over the next few months and that Trust is very committed to making the schemes work.

Mr Pallot advised that the schemes need to be quantified by February 17. The Trust must not assume that the schemes will show a reduction in costs. Mr Pallot commented that a good level of engagement has been had from senior clinicians in relation to the schemes.

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

TB 16/17 082 **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 noted the slight improvement across in the scorecard this month.

Mrs Needham reported that the Trust has met the performance targets in cancer, Diagnostics and RTT for December. This is the first month that the 62 day cancer target has been achieved. The 18 week RTT is good with the exception of Trauma and Orthopaedics. MDSU and Althorp are now open.

Mrs Needham stated that planned elective orthopaedic patients had been transferred out, totalling an approximate of 100 patients whilst day case patients are still being treated on site.

Mrs Needham shared with the Board that the Trust was able to reduce its bed occupancy to 90% on Christmas Eve. In January DTOC has increased to 78.

Mrs Needham advised that there was a dramatic increase in acuity for December with acuity figures currently the highest on record for NGH. Due to an increase in respiratory illness the Trust was on black alert 8 times in December. It is double the normal numbers and has continued into January. Mrs Needham noted that the Trust is experiencing similar issues to other hospitals.

Mrs Needham commented that the Urgent Care Group continue to meet with a focus now on SAFER, Red to Green and professional standards on all the wards. A closer look at frailty and simple/complex discharge processes will be overseen by herself and Ms Fox.

Mrs Needham stated that the Winter Schemes that had recently been delayed were now progressing well.

Mrs Needham advised that job planning is likely to see a significant improvement in compliance on the next scorecard.

Mrs Needham reported on the recent DTOC system meeting. The team that supported the visit was from varying levels of performing hospital. Mrs Needham believed that the Trust did not learn anything new. The team agreed that the Trusts action plan is correct and will feed this back to the regulators.

Ms Clymer queried whether there were any improvements on the working relationships with NCC and Social Care. Mrs Needham stated that following recent personnel changes at NCC, working relationships have improved and the outlook is positive at an operational level.

Mr Noble questioned that if the Trust is able to get DTOC down when it is imperative to do, how can this be made sustainable and how can the Trust learn from what it done well. Mrs Needham commented that Christmas Eve is always an exception. Patients push to go home and different risks are taken. There is an urgent care plan in place and this plan needs to be progressed. Mrs Needham confirmed that she would bring detailed information on SAFER and Red to Green to Februarys Board of Directors.

Action: Mrs Needham

Mrs Needham shared with the Board on how proud she was of the staff and the organisation. It was also important to note that back office and admin staff were also involved.

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

TB 16/17 083 Resilience Annual Report

Mrs Needham presented the Resilience Annual Report.

Mrs Needham drew the Board to page 136 of the report pack which detailed the role and responsibility of the Resilience Planning Group. The group meets bi-monthly and has representation from both the Clinical and Corporate Directorates.

Mrs Needham advised that NHS England submitted an assessment on the Trust meeting the Core Standards. The Trust made the decision to declare an overall rating of Substantially Compliant on the basis of the self-assessment process carried out by the Trust which NHS England agreed with.

Mrs Needham stated that on page 139 of the report pack there is narrative on where the Trust is partially compliant and how this is to be ratified. There was concern noted with training and this will be a focus going forward.

Mrs Needham commented that the On-call Managers Workshop held on the 01 December 2016 had full attendance.

Mrs Needham detailed the live events the Trust had faced on page 141 of the report pack. The key events to note were the Junior Doctor Industrial Action and the Carlsberg Chemical Incident.

Mrs Needham noted that the next steps forward required a more detailed and comprehensive training and exercising programme.

Mr Noble thanked Mrs Needham for the excellent report and believed the report to be of high importance. Mr Noble urged the Trust Board to support staff in attending required training. Mr Noble expressed his concern that only 1 person attended the

Joint Working and Joint Decisions in a multi-provider setting.

Mr Archard-Jones queried whether the Trust has a business continuity plan in relation to cyber security. Mrs Needham confirmed that the Trust has a robust data back-up system and is well prepared in case of a cyber-attack.

The Board **NOTED** the Resilience Annual Report.

TB 16/17 084 **Corporate Governance Report**

Ms Thorne presented the Corporate Governance Report.

Ms Thorne advised that the Trust seal has been not been used during Quarter 3. There have been increase to 49 declarations of hospitality received following actions taken to request that all senior staff Band 8c and above, and Consultants were to make specific declarations with the Trust's updated Standing Financial Instructions.

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

TB 16/17 085 **Approval of subcommittee Terms of Reference**

Ms Thorne presented the Approval of subcommittee Terms of Reference for approval.

The Board **APPROVED** the subcommittee Terms of Reference.

TB 16/17 086 **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 18 January 2017. 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 –

- A review of the IT workload which was useful.
- A paper on Benefits Realisation which is to develop over time.
- A period of time was spent on the Changing Care Report and the request for assurance that the plan for the next year is to be realistic.

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

TB 16/17 087 **Highlight Report from Quality Governance Committee**

Ms Clymer presented the Highlight Report from Quality Governance Committee.

The Board were provided a verbal update on what had been discussed at the Quality Governance Committee meeting held on 20 January 2017. The report covered any issues of significance, interest and associated actions that were required and had been agreed to be taken forward by the Committee.

Ms Clymer advised of the key points –

- Issues noted with the different data collection methods for VTE data.
- CQC compliance report.
- The commencement of a new Palliative Care Consultant.
- The death of a dementia patient at another hospital and the learning from this.
- Tissue donation at NGH was noted to be the biggest in the County.

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

TB 16/17 088 **Highlight Report from Workforce Committee**

Mr Kershaw presented the Highlight Report from Workforce Committee

The Board were provided a verbal update on what had been discussed at the Workforce Committee meeting held on 18 January 2017. 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 –

- A detailed review was given on Medical Education.
- Nursing recruitment and retention, this has also been discussed at the Board.

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

TB 16/17 089 **Highlight Report from Audit Committee**

Mr Noble presented the Highlight Report from Audit Committee.

Mr Noble commented the highlighted report was the same to verbal update he had given at Decembers Board of Directors. Mr Noble wanted to reinforce the importance that despite internal audit giving limited assurance in 3 out of 4 areas, this was positive as it showed that the Trust was focusing Internal Audit onto the right areas.

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

TB 16/17 090 **Highlight Report from Hospital Management Team**

Dr Swart delivered the Highlight Report from Hospital Management Team.

The Board were provided a verbal update on what had been discussed at the Hospital Management Team meeting held on 23 January 2017. The report covered any issues of significance, interest and associated actions that were required and had been agreed to be taken forward by the Committee.

Dr Swart stated that the Divisions were challenged on their top 3 areas of risk and delivered an update to the other Divisions. There was a workshop held on the Quality Improvement Strategy and the New Medical Model for when approval is potentially given for the new 60 bedded unit.

Dr Swart advised that Mrs Needham updated the HMT on the progress of the Winter Schemes.

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

TB 16/17 091 **Any Other Business**

There was no other business to discuss.

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

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

Public Trust Board Action Log							Last update	17/03/2017
Ref	**Date of meeting**	**Minute Number**	**Paper**	**Action Required**	**Responsible**	**Due date**	**Status**	**Updates**
Actions - Slippage								
NONE								
Actions - Current meeting								
69	Jan-17	TB 16/17 078	Director of Nursing and Midwifery Care Report	Mr Zeidler asked for clarity for the General Wards column on page 49 of the report pack. Ms Fox confirmed she would explore this and report back at the next Trust Board.	Ms Fox	Mar-17	On agenda	Update to be given in **DoN Report**
70	Jan-17	TB 16/17 082	Integrated Performance Report	Mrs Needham confirmed that she would bring detailed information on SAFER and Red to Green to Februarys Board of Directors.	Mrs Needham	Feb-17	On agenda	Confirmation given that this was discussed at **Feb BoD**
Actions - Future meetings								
NONE								

Northampton General Hospital NHS
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**30 March 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
30 March 2017

Chief Executive's Report

1. **CQC Inspection**

During the first weeks of February we saw unprecedented levels of demand for our urgent care services. More than 300 people each day were attending our emergency department and many of them required hospital admission. During this period there was a relentless focus throughout the hospital on ensuring we maintained patient flow and could admit the patients who needed our care and prioritise the sickest patients so minimise risks to patient safety

All of this happened at the same time as we were undergoing an inspection by the Care Quality Commission. The inspection impacted on all of us, whether to a greater or lesser degree, yet everyone continued to maintain their focus on keeping our patients safe and providing the best possible care.

On behalf of the board I have thanked staff, many of whom worked way beyond the reasonable call of duty, for their outstanding effort, commitment and professionalism.

Many staff took the time to attend one of three focus groups held by the CQC and some also took the opportunity to speak with Inspectors individually. I have been told that the feeling of positivity, confidence and pride from our staff in what they do and what they have achieved was overwhelming. I am aware that we don't offer enough chances to our staff to talk about all the great things we do and I was pleased they were provided with this opportunity. Certainly it has given us food for thought about how we might provide other opportunities like this for our staff so we can share and learn from our experiences.

2. **Winter pressures**

At the time of our CQC inspection three years ago urgent care dominated the hospital in an unhelpful way. It still does, but there are aspects of urgent care that have improved greatly and which justifiably are a source of pride for our clinical and managerial teams. . Equally important is that fact that our approach to urgent care illustrates our approach to challenges generally where we all understand the need to make quality improvement and safety the biggest priority and the aligning principle for our programmes of work.

A&E is the barometer of the hospital and a walk through the department helps keep us grounded in how things are. As we notice improvements and reflect on how they have been achieved it is important to remember that the changes in the department were not made by importing a manager or senior clinician or by enforcing central edicts – rather they are the result of our preferred approach to managing improvement and change.

There were and are three important components which run through our thinking generally:

Firstly – there has been a persistent and dogged effort from the teams on the ground who have been supported and encouraged by managers and leaders at all levels. Patient safety maintains a key thread as a core value for the Trust.

I feel very strongly about this and I know for this to work everyone has to speak that language. So, for example rather than asking about targets we must ask different questions: Is your department safe? Do you know who your sickest patients are? Are they getting the right treatment? These are the right questions for our emergency department (ED) and for the rest of the hospital.

Secondly – we have managed to create a culture in ED where people listen from both sides. Clinicians and managers hold the mirror, share perspective, build trust and follow through. Everyone owns the same agenda to solve problems, making the diagnosis and prescribing the solution, testing it and starting again. This is quality improvement in action. It applies in ED and to the rest of the hospital.

Thirdly – we have spread the ownership of the urgent care issue. This is about moving urgent care from being considered as an A&E issue to a place where this is a whole hospital issue and then to a place where it is recognised as a wider health and social care economy challenge. We have made progress in all of these areas but there is more to do.

Walking through A and E now it feels very different from a few years ago – whether viewed through the lens of a patient , a relative , a member of the clinical team , a manager or a senior executive or indeed the CQC. There is a positivity and can do attitude which is obvious even when the department is very busy.

The department has been redesigned and greatly improved while business as usual carried on (quite a feat in itself). There is a better focus on the very young and the very old, safety rounds, rapid assessment, GP streaming, new roles and - most critically - a change from 'we can't do any more' to people talking about the next change, the next development.

I feel a sense of pride from the staff in A&E. It is calmer, more ordered, with fewer complaints and more compliments and palpably happier staff with lots of smiles. The safety culture work across the East Midlands shone a light on how far things have come, with NGH leading the pack by some way and others coming to us for advice and guidance. More improvements are on their way; there is better understanding and a greater ownership of issues with a real desire to make things better.

There is clearly more to do around the urgent care pathway and there is a significant amount of work already underway. However, we are convinced that the same approach, consistently applied, will get us there. At the same time we are always thinking about future solutions to take us to a better place.

We continue to plan for a bedded assessment unit in front of A&E, and are working on a plan for developing GP services on site, better ambulatory care, more liaison with community services at the front door as well as continuing to develop new processes to improve flow throughout the hospital. Again much has already been done and huge efforts have been made.

A key challenge for us all is to address the delays in discharging patients. There are many issues, including the need to communicate all aspects of discharge more effectively. This needs to be addressed both within NGH and beyond in terms of ensuring community support to enable safe discharge. I continue to have conversations with our partners to facilitate the development of services for patients who don't need to be in hospital. Despite our efforts over the past three years this is a key area which needs more work.

3. Staff survey

The results of the staff survey are primarily intended for use by NHS organisations to help them review and improve staff experience. The Care Quality Commission uses the results from the survey to monitor ongoing compliance with essential standards of quality and safety. The survey also supports accountability of the Secretary of State for Health to Parliament for delivery of the NHS Constitution.

This is a survey that matters a great deal and to have a year-on-year improvement means more than a single good result. It is survey which reflects on everyone who works here, and improvements when they occur are always due to a whole variety of factors that signify cultural shift.

Our aims in the last few years have been around making sure that the overall aims and values we believe in are supported as coherently and consistently as possible by a range of programmes, initiatives and processes, all of which are focussed on ensuring we support people to be able to contribute to the quality and the quality improvement agenda.

This is very much still work in progress, but it is starting to have an effect. We can see this in things like the board's support for a different approach, ownership of the quality agenda across the executive team, the clinically-led structure and a finance programme focussed on changing care and making things better, not cost-cutting.

Our organisational development programmes supported by our human resources teams help teams understand how best to work together and our quality improvement focus is steadily increasing with the development of the QI Hub. More recently our ward accreditation scheme and the work that has started towards building towards Pathway to Excellence is the beginning of a re-energisation of the nursing workorce.

Developing staff to understand how they can make improvements in quality and safety and efficiency is the premise behind our Making Quality Count programme and the necessary leadership development to support our clinically led structure has its basis in the Francis Crick programme and our nurse leadership programmes. The threads through this have been deliberately supported by our increasingly critical communications department. Many of these things have had a slow but steady lead-in time and it is only after some years and a few changes along the way that the benefits really start to show. Quite simply the idea is that we all come to work to provide the best care that we can. The development of our people is be based around how we can ensure everyone understands not only this, but also one other and how we can support one other to always deliver and improve care whilst setting our aspirations high.

This year's staff survey shows some significant improvements. Even more important is the fact that for every year since 2013 there has been a slight improvement – and the most significant one is for the 2016 results. This year we are in the top 5 most improved acute hospitals with respect to staff survey results. We still have quite a way to go as overall we are still just above average but we have made big strides so we know our approach is working. Clearly we need to stick with it and, of course, make sure we address areas where we still need to improve.

A couple of headlines are particular importance are:

- In 2016… 61% our staff recommended NGH as a place to work (up from 49% in 2012 and from 55% in 2015) – this is a better result than, for example, from some well-known outstanding organisations
- In 2016…. 68% of our staff recommended NGH as a place to be treated (up from 50% in 2012 and up from 60% in 2015)

The overall engagement score represents our staff's perceived ability to contribute to improvements at work, their willingness to recommend the organisation as a place to work or receive treatment, and the extent to which they feel motivated and engaged with their work. Overall our score has gradually risen significantly this year. For the first time we also now are in the top 20% of trusts for staff motivation at work.

There are quite a number of other positive areas too and the overall survey will form part of the assessment that the CQC and others will make about us.

There are still areas where we are doing badly and or have deteriorated. Even though there are fewer of these than before there are two that stand out – one is that far too many staff are reporting experiencing bullying, with too few reporting this and there are negative comments about flexible working. We will be looking very hard at these areas and working with our staff to improve matters.

4. **Staff engagement**

One of the biggest challenges at NGH is how best to communicate with the nearly 5000 people who work here in a way that is both meaningful and interesting, and helps us move towards our aim of ensuring that everyone understands their own role, feels valued for it and able to contribute to the wider agenda of the hospital in some way.

The first initiative aimed at improving understanding is a series of regular lunchtime listen and learn/question time-style events where a topic will be introduced by a member of the executive team and staff are invited to submit questions to be answered by a panel chosen by the executive. We would anticipate that our divisional directors will be invited to be part of the panel as appropriate and various members of the executive team will join the panel as appropriate in addition to any other experts chosen by the lead executive.

We are also starting a series of 'get to know you' tea and cake sessions where we are asking divisions to invite a range of 30 staff from across their area to a session where they can meet both executives and members of the divisional team. Our aim is to provide an opportunity for people to meet and talk so they can better understand one another's roles and share experiences. This idea flows from the success of the long service award tea party earlier this year.

Overall I am hopeful that events such as this will help us build understanding across the hospital and develop even further the spirit of #teamNGH.

Like the rest of the NHS, we are experiencing a range of significant challenges. Despite these a huge amount of excellent work is done by teams throughout the hospital. The more we can learn about what is going on and the more we can understand things from the perspective of others, the more likely we are to be able to improve things for our patients and ourselves.

5. **NGH Website**

Over the past year the communications team has been working with colleagues in IT and teams across the trust to completely redesign and refresh our NGH website.

The work is almost complete and the new website, based on best practice in design, content, functionality and accessibility, will be live in the first week of April.

Development of the new website has been based on the evidence we have gathered from visitors to the existing site. A key element has been to ensure the new is mobile responsive as the majority of visits to our site take place via a mobile device.

A major focus has been on developing new content for the recruitment pages. The communications team has held focus groups with colleagues across the organisation to develop and strengthen our USP as an employer, our supportive #teamNGH environment.

6. Awards

Three patient experience projects were successfully shortlisted at the Patient Experience National Network Association awards ceremony with NGH winning an award for the work on Staff Engagement with the project entitled 'Staff Experience – Compliments Collation A recipe for Success'.

NGH also won the award for work with patients with learning disabilities – this is the results of some excellent work in this area over some years now. This reflects a sustained effort to ensure that we make the best use of learning from compliments as well as from complaints**.**

NGH has been shortlisted for two HSJ Patient Safety Awards. One for the work on 'Dare to Share', which is about learning from serious incidents and one in the category of Quality Lead of the Year category - for our leadership focus on Quality Improvement. The results will be announced at this year's HSJ Patient Safety Awards in Manchester on 4th July. In addition we have also submitted a number of patient safety posters for the Patient Safety Congress which takes place in Manchester on 4th-5th July.

NGH had had an excellent programme of work focussing on sustainability and we are only one of 39 Provider Trusts who have recently been awarded 'Excellence in Sustainability Reporting' as recommended by the Sustainable Development Unit .

Overall over the last 2 months there has been a real sense that some of the programmes of work set out in recent years are starting to gain traction and have a real impact, leading to a sense of the culture of Team NGH . Further work is needed but there are certainly signs that the work in progress is starting to make a difference.

Dr Sonia Swart
Chief Executive

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30 March 2017**

Title of the Report	**Medical Director's Report**
Agenda item	**8**
Sponsoring Director	Dr Michael Cusack, Medical Director
Author(s) of Report	Dr Michael Cusack, Medical Director Dr Amanda Bisset, Associate Medical Director Mrs Louise Simms-Ward, Clinical Governance Manager
Purpose	Assurance

Executive summary

Three new Serious Incidents were reported during the period 1/01/2017 – 28/02/2017 which relate to an in-patient fall resulting in a fractured elbow, a missed scaphoid fracture and influenza. A further Serious Incident (Type-A Aortic Dissection/ED) 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 and VTE.

Related strategic aim and corporate objective	Be a provider of quality care for all our patients
Risk and Assurance	Risks to patient safety if the Trust does not robustly investigate and identify any remedial actions required in the event of a Significant Incident or mortality alert.
Related Board Assurance Framework entries	BAF 1.4, BAF 1.5, BAF 4.1 and BAF 4.2
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/

	policy will not promote equality of opportunity for all or promote good relations between different groups? (Y/**N**) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(Y/**N**)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper

Actions required by the Trust Board

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

Northampton General Hospital NHS
NHS Trust

Public Trust Board
March 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 and 'Red to Green'.

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, a key part of which seeks to enhance recruitment of medical staff in particular. It is recognised 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 emerged at relatively short notice it was not possible to fully mitigate the impact of this on service provision. These have improved with targeted recruitment in these areas

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. Serious Incidents

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.

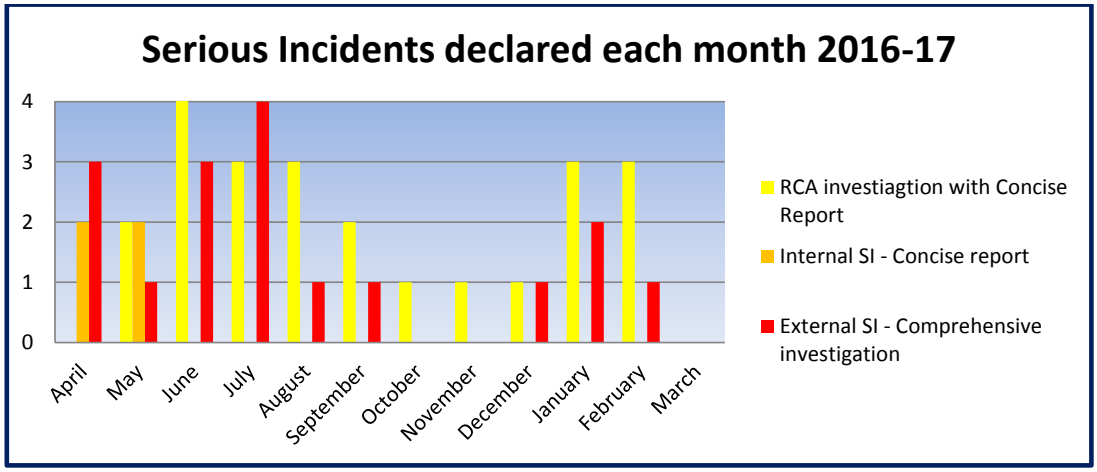
The patient safety incidents that do not fulfil the criteria for reporting onto STEIS but where there are thought to have been omissions or concerns over the care the patient received, are now declared as a "Concise Investigation". This allows for a thorough root cause analysis investigation and provision 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	13
Never Events	2	2	1	0	1	3	1

There were no incidents in January or February that met the criteria of a Never Event.

The following graph shows 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 New Serious Incident

Since the last report to the Board, during the reporting period 1/01/2017 – 28/02/2017 three new Serious Incidents were reported onto STEIS.

2017/5530	In-patient Fall (#Elbow)	Discharge Lounge
2017/1071	Missed Scaphoid Fracture	Urgent Care
2017/1745	Influenza	Inpatient Specialities

2.2 Open Serious Incidents

The serious incident at 28th February 2017 which remains **open** and under investigation is listed below:

STEIS/Datix Ref.	STEIS Criteria / SI Brief Detail	Directorate	Location
2016/32625	Delay in diagnosis	Urgent Care	Emergency Department

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**, 14 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
- HCAI/Infection control incident

2.3 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.

2.4 Learning from Serious Incidents

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 a quarterly Trust wide 'Dare to Share' Learning Event where learning from serious incidents is shared. This event is open to all of the multidisciplinary team. The last Dare to Share took place in January where a Serious Incident relating to the use on non-invasive ventilation (NIV) was discussed and the new Trust NIV guidelines were launched. There was a second discussion on Health and Safety focussing on the safe use of sharps which had been highlighted in an incident.

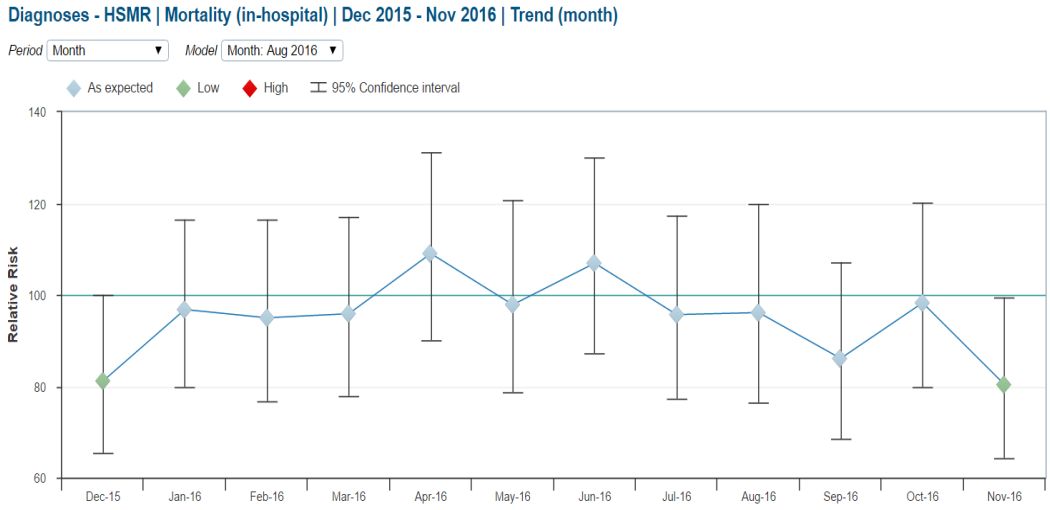
The next Dare to Share will take place on March 31st which will include a presentation on MRSA bacteraemia and a complex incident related to the use of DOLS and MCA/MHA.

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.

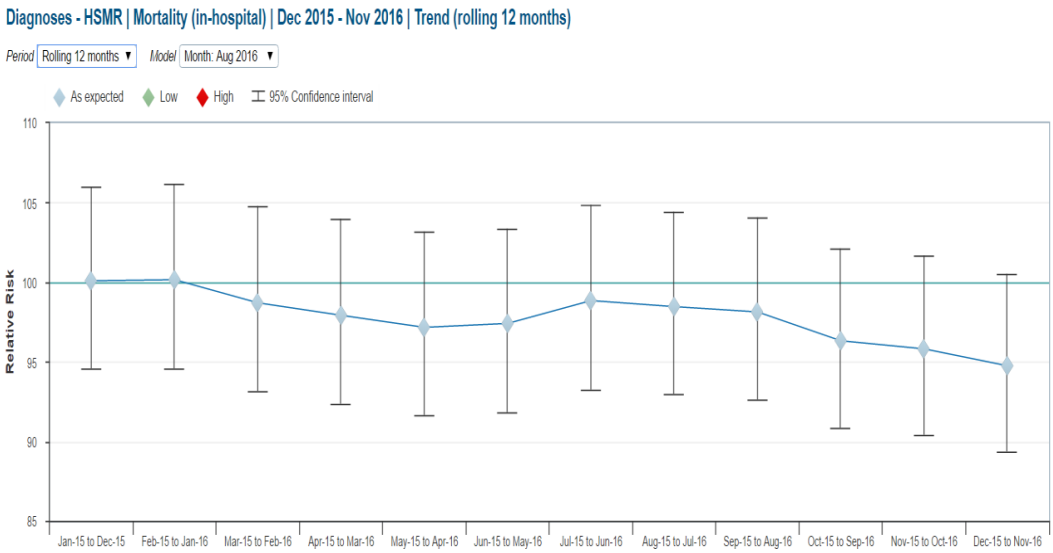
The Trust also provides assurance to the CCG that actions have been implemented following closure of a Serious Incident and this is achieved through the quarterly Serious Incident Assurance Meeting (SIAM) with the Commissioners.

3. Mortality Monitoring

The HSMR for the year to November 2016 remains within the 'as expected' range at **94.7**. The SMR for the month of November was 'better than expected' (**80.3**). The monthly variation in HSMR during the year to November 2016 is shown below:

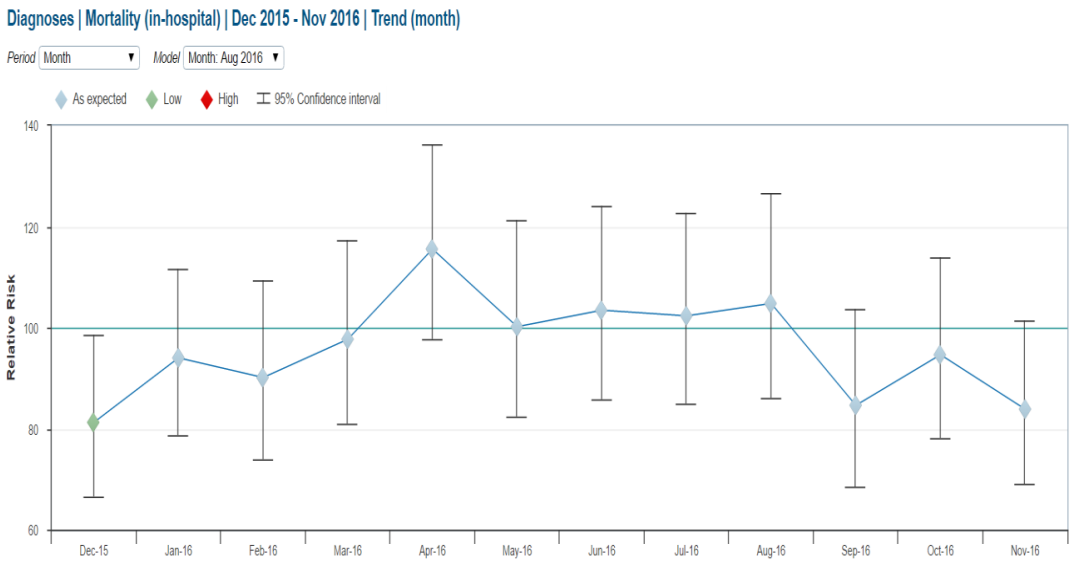


Longer term variation in HSMR represented by the 'rolling years' for Jan'15/Dec'15 to Dec'15/Nov'16 is shown below. Each data point in the following graphic represents the HSMR during the preceding 12 month period which continues a downward trajectory:

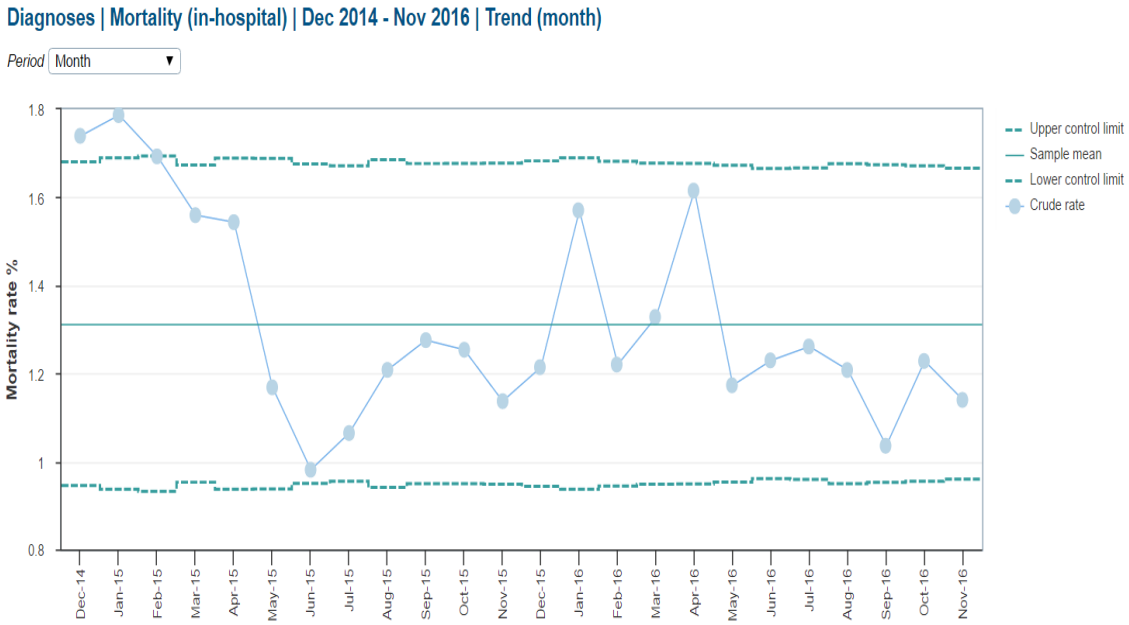


Since July '16 the monthly SMR has remained below a 100 and this is reflected in the reduction in the 'rolling' HSMR over this timeframe.

The SMR for the All Diagnoses Metric for the rolling year to November 2016 was also 'as expected' (SMR=**95.8**). Monthly variation in the SMR for All Diagnoses is shown below:



The current Trust crude mortality rate for the 'all diagnosis' basket is 1.3% (Midlands & East Peer group rate is 1.5%). The variation in crude mortality within the 'all diagnosis' basket during the last 24 months is shown below:



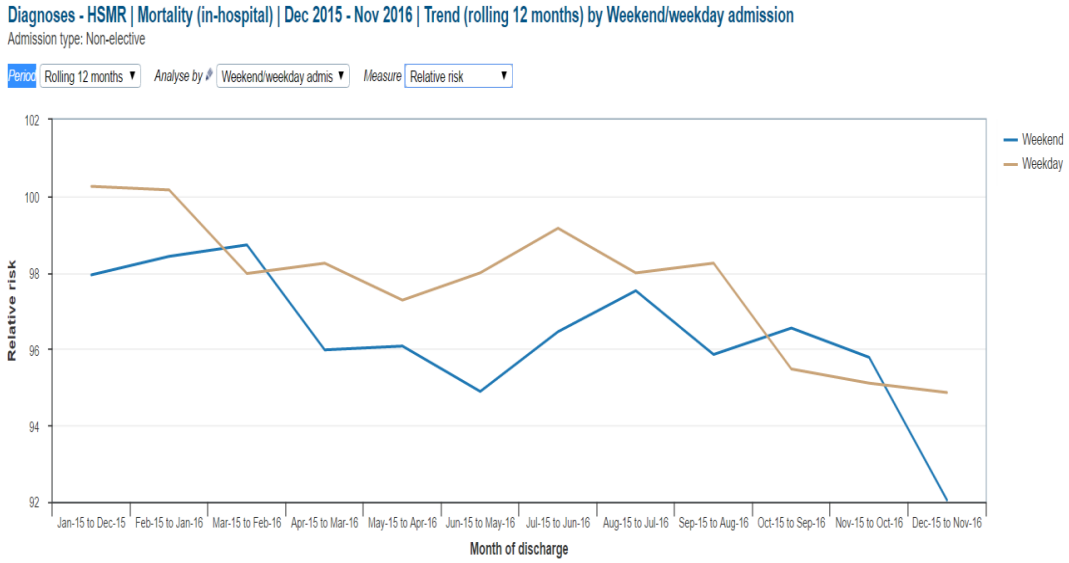
Following seasonal increases in crude mortality between January and April 2016, the crude mortality has remained below the long-term mean during the following months. The crude data presented here is consistent with that for SMR shown above.

The recently revised SHMI for the period October 2015 to September 2016 remains within the 'as expected' range at **95**. 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.

3.1 Weekday/Weekend Effects

The HSMR for emergency admissions to the Trust on weekdays (**94.9**) and weekends (**92.1**) remains in the 'as expected' range. The variation in these measures over time is shown below. As with the overall HSMR, this has exhibited a downward trajectory in recent months:



4. CQUINs

The CQUIN framework was introduced in April 2009 as a national framework for locally agreed quality improvement schemes. It enables commissioners to reward excellence by linking a proportion of each English healthcare provider's income to the achievement of local quality improvement goals.

The income linked to CQUINs for NGH in 2016/17 was approximately **£4.7 million** and is used by the Trust as part of its budget setting process. 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.

The CQUIN submission for Q3 was met with an expectation that all milestones have been achieved. We have received written confirmation from the specialised commissioners indicating that all Q3 specialised CQUIN milestones have been met.

Appendix 1 shows the CQUINs for 2016/17 rated for the current risk to delivery of the Q4 milestones. The current risk assessment suggests that 5% of the total CQUIN value or £280,835.65 may not be delivered. These are related to the following CQUINs:

- Sepsis ED: Treatment & day 3 review – The percentage of patients who present with severe sepsis, Red Flag Sepsis or septic shock and were administered with intravenous

antibiotics within the appropriate timeframe and have an empiric review within three days of the prescribing of antibiotics.

- Sepsis Acute Inpatient: Screening - The percentage of patients who met the criteria for sepsis screening and were screened for sepsis.

- Sepsis Acute Inpatient: Treatment & day 3 review – The percentage of patients who present with severe sepsis, Red Flag Sepsis or septic shock and were administered intravenous antibiotics within the appropriate timeframe and had an empiric review within three days of the prescribing of antibiotics.

- Antimicrobial Resistance and Stewardship: Reduction in consumption
    - Total antibiotic consumption per 1,000 admissions
    - Total consumption of carbapenem per 1,000 admissions
    - Total consumption of piperacillin-tazobactam per 1,000 admissions

- Antimicrobial Resistance and Stewardship: Empiric Review – To perform an empiric review for at least 90% antibiotic prescriptions reviewed within 72 hours.

It is acknowledged nationally that the targets for Q4 are challenging and may result in the milestones not being achieved.

4.1 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)

The key to the sustainability of EPMA in the Trust will be 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 which allows e-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.

After further training of clinical staff the system successfully went 'live' in the ED and Assessment Units (for patients referred to Medicine) 27th February 2017. Across the Division of Medicine more than 95% of patients are now on the EPMA system.

5.2 EPMA for Surgical patients

Preparation is underway to roll-out EPMA in Surgery. As before, this will include additional training for users and direct support from the project team. The system will initially be used in Trauma and Orthopaedics prior to a larger scale roll-out across the Surgical Division.

6. VTE

In the initial feedback following their inspection, the CQC identified VTE risk assessment as an area of concern. A comprehensive action plan has been put in place to address the issues that had arisen as the Trust moved to electronic capture of VTE compliance data using the Vitalpac system. The action plan which is monitored regularly by the Executive Team has been completed and point prevalence data has shown a high rate of compliance with VTE risk assessment.

7. 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.

APPENDIX 1 – CQUIN RAG STATUS

RAG rating to delivery:
Black Highlight no milestone / Green highlight -should be fully delivered / Amber highlight -should be partially delivered / Red highlight -risk to any delivery / Blue highlight - actual achievement // *indicates potential partial payments

Local – 1.25% of the contract value =		£2,442,049.10					
CQUIN Name	**Overall %**	**Overall Value**	**Quarter**	**Quarter**	**Quarter Value**	**RAG rating to delivery**	**Estimated £ Achievement**
End of Life	0.25	£488,409.82	1	20%	£97,681.96		£97,681.96
			2	20%	£97,681.96		£97,681.96
			3	20%	£97,681.96		£97,681.96
			4	40%	£195,363.93		£195,363.93
Dementia Discharge Summaries	0.25	£488,409.82	1	25%	£122,102.45		£122,102.45
			2	25%	£122,102.45		£122,102.45
			3	25%	£122,102.45		£122,102.45
			4	25%	£122,102.45		£122,102.45
Dementia Johns Campaign	0.25	£488,409.82	1	0%	£0.00		
			2	50%	£244,204.91		£244,204.91
			3	25%	£122,102.45		£122,102.45
			4	25%	£122,102.45		£122,102.45
AKI	0.25	£488,409.82	1*	25%	£122,102.45		£122,102.45
			2*	25%	£122,102.45		£122,102.45
			3*	25%	£122,102.45		£122,102.45
			4*	25%	£122,102.45		£122,102.45
Delayed Transfer of Care	0.25	£488,409.82	1	25%	£122,102.45		£122,102.45
			2	25%	£122,102.45		£122,102.45
			3	25%	£122,102.45		£122,102.45
			4	25%	£122,102.45		£122,102.45
				Totals	**£2,442,049.10**		**£2,442,049.10**

APPENDIX 1 – CQUIN RAG STATUS

National – 1.25% of the contract value = £		£2,442,049.10					
CQUIN Name	**Overall %**	**Overall Value**	**Quarter**	**Quarter %**	**Quarter Value**	**RAG rating to delivery***	**Estimated £ Achievement**
NHS Staff & Wellbeing 1a initiatives	0.25	£488,409.82	1	20%	£97,681.96		£97,681.96
			2	0%	£0.00		
			3	0%	£0.00		
			4	80%	£390,727.86		£390,727.86
NHS Staff & Wellbeing 1b health food	0.25	£488,409.82	1	20%	£97,681.96		£97,681.96
			2	0%	£0.00		
			3	0%	£0.00		
			4*	80%	£390,727.86		£390,727.86
NHS Staff & Wellbeing 1c flu vaccinations	0.25	£488,409.82	1	0%	£0.00		
			2	0%	£0.00		
			3	0%	£0.00		
			4*	100%	£488,409.82		£488,409.82
Sepsis ED - Screening	0.125	£244,204.91	1*	10%	£24,420.49		£24,420.49
			2	10%	£24,420.49		£24,420.49
			3	10%	£24,420.49		£24,420.49
			4	10%	£24,420.49		£24,420.49
Sepsis ED - Treatment & day 3 review			1	15%	£36,630.74		£36,630.74
			2	15%	£36,630.74		£36,630.74
			3	15%	£36,630.74		£36,630.74
			4	15%	£36,630.74	Expected 5%	£12,210.25
Sepsis Acute Inpatient - Screening	0.125	£244,204.91	1	10%	£24,420.49		£24,420.49
			2	10%	£24,420.49		£24,420.49
			3	10%	£24,420.49		£24,420.49
			4*	10%	£24,420.49	Expected 5%	£12,210.25
Sepsis Acute Inpatient - Treatment & day			1	15%	£36,630.74		£36,630.74

APPENDIX 1 – CQUIN RAG STATUS

3 review			2	15%	£36,630.74		£36,630.74
			3	15%	£36,630.74		£36,630.74
			4*	15%	£36,630.74	Expected 5%	£12,210.25
Antimicrobial Resistance and Stewardship - Reduction in consumption	0.2	£390,727.86	1	0%	£0.00		
			2	0%	£0.00		
			3	0%	£0.00		
			4	100%	£390,727.86	Expected 50%	£195,363.93
Antimicrobial Resistance and Stewardship - Empiric Review	0.05	£97,681.96	1	25%	£24,420.49		£24,420.49
			2	25%	£24,420.49		£24,420.49
			3	25%	£24,420.49		£24,420.49
			4	25%	£24,420.49		£0.00
				Totals	**£2,442,049.10**		**£2,161,213.45**

Specialist – % of the contract value =		**£418,224.00**					
CQUIN Name	**Overall %**	**Overall Value**	**Quarter**	**Quarter %**	**Quarter Value**	**RAG rating to delivery***	**Estimated £ Achievement**
2 year follow up	0.3	£139,408.00	1	0%	£0.00		
			2	20%	£27,881.60		£27,881.60
			3	40%	£55,763.20		£55,763.20
			4	40%	£55,763.20		£55,763.20
Hypothermia in pre term babies	0.3	£139,408.00	1	0%	£0.00		
			2	25%	£34,852.00		£34,852.00
			3	25%	£34,852.00		£34,852.00
			4	50%	£69,704.00		£67,704.00
Rheumatology	0.3	£139,408.00	1	0%	£0.00		
			2	25%	£34,852.00		£34,852.00
			3	25%	£34,852.00		£34,852.00
			4	50%	£69,704.00		£69,704.00
				Totals	**£418,224**		**£418,224**

Northampton General Hospital NHS
NHS Trust

Title of Meeting	**PUBLIC TRUST BOARD**
Date of Meeting	**30 March 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
March 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

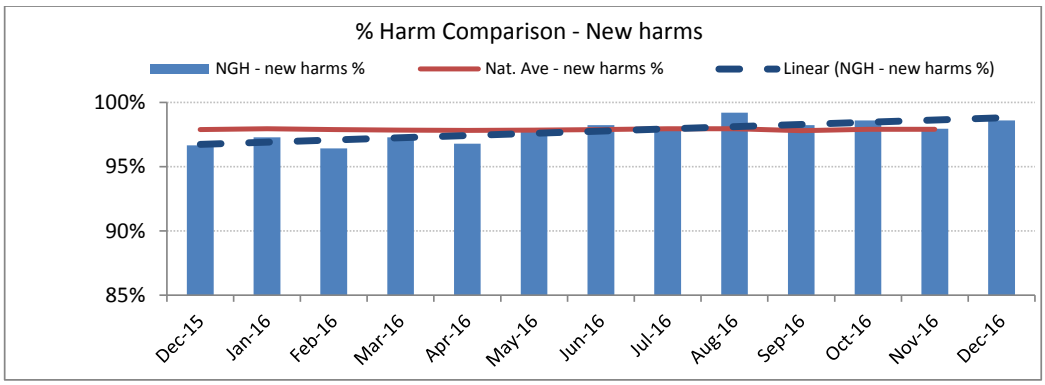
As part of the 'Promoting good practice for safer care' work stream of the National Maternity Transformation Programme, the midwifery team submitted two bids for external funding in December 2016.

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.

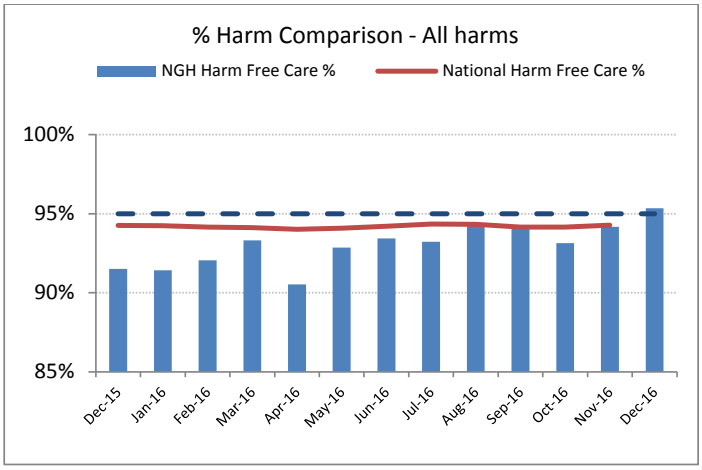
3. Safety Thermometer

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.

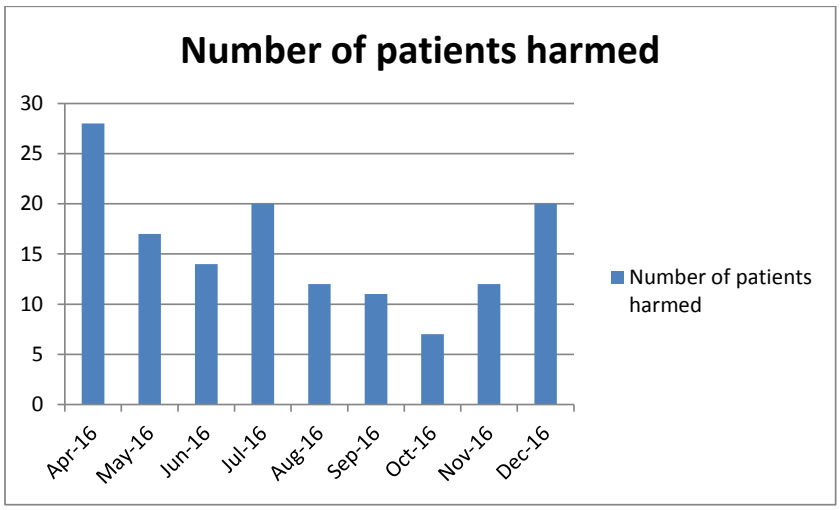


4. Pressure Ulcer Incidence

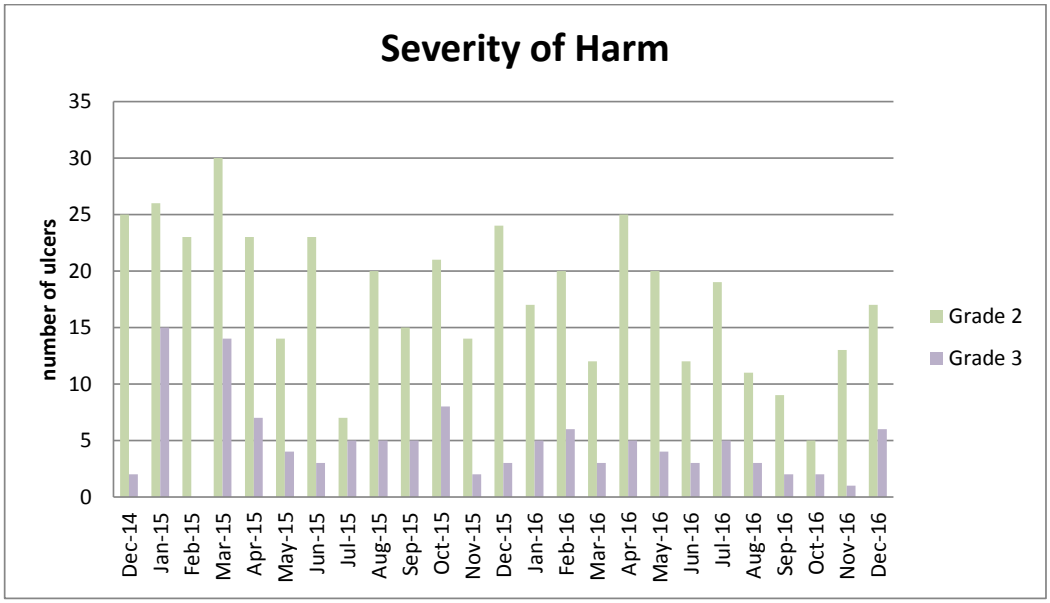
In December 2016, the Tissue Viability Team (TVT) received a total of 417 datix incident reports relating to pressure damage. This is a 25% increase on the previous month and is reflective of the acuity of the Trust. Of these the TVT assessed/validated 310 (75%) on the wards and the remainder were validated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

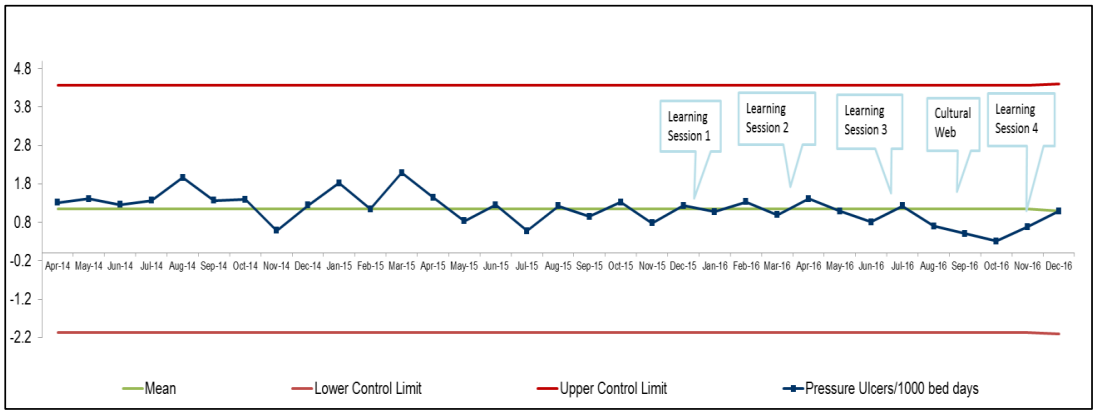
The graph below shows the number of patients harmed whilst in the care of the Trust. In December 2016, 20 patients were harmed; this is an increase of 8 patients from the previous month.



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

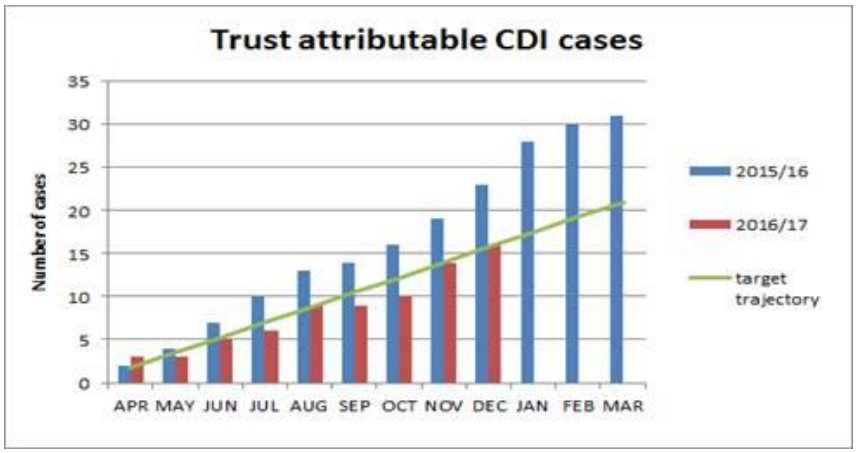
- The 90 day Rapid Pressure Ulcer Prevention Turnaround Project has been running since 2nd November 2016 with involvement from Becket, Cedar, Hawthorn and Knightley. During December the 4 wards continued with the improvements they have made, however the Trust was under extreme pressure due the high acuity
- 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)



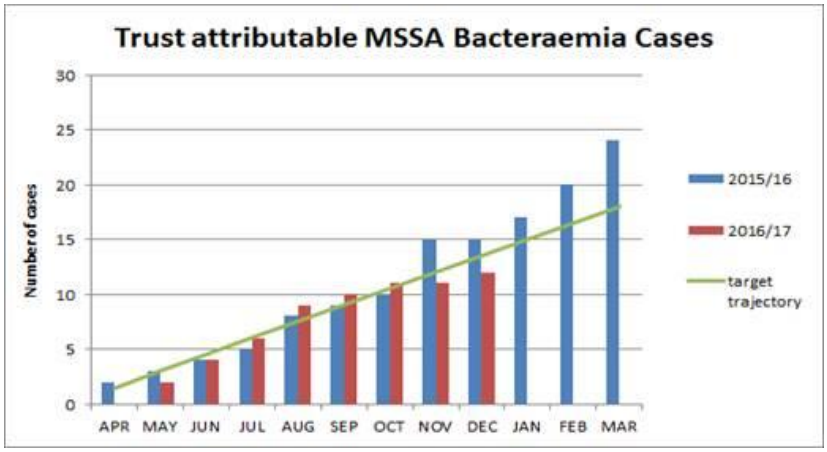
The graph above shows the cumulative total of the number of patients with Trust apportioned CDI, to date there has been 16 patients. In December 2016 there were 2 patients identified as Clostridium difficile toxin A and B, post infection reviews (PIR) are in progress.

MRSA Bacteraemia

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

MSSA Bacteraemia

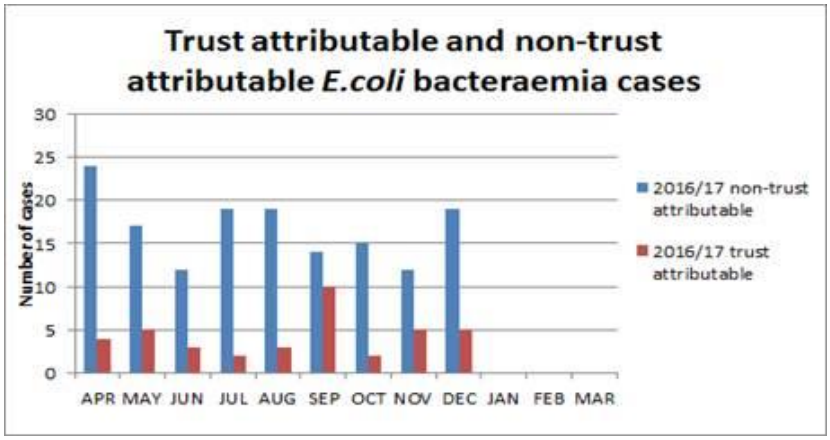
There is no national target set for MSSA bacteraemia however due to updated guidance from Public Health England (PHE) and a change in formula, the out turn for MSSA bacteraemia for 2015/2016 is 24 cases. The Infection Prevention forward plan has set a revised ambition of no more than 18 cases for 2016/2017. 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.



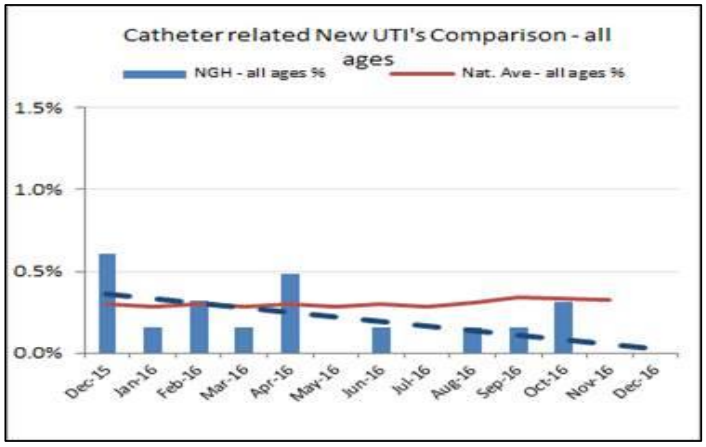
The table below shows the breakdown of source and number of trust attributable *E.coli* bacteraemia cases for December 2016:

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

Enclosure E

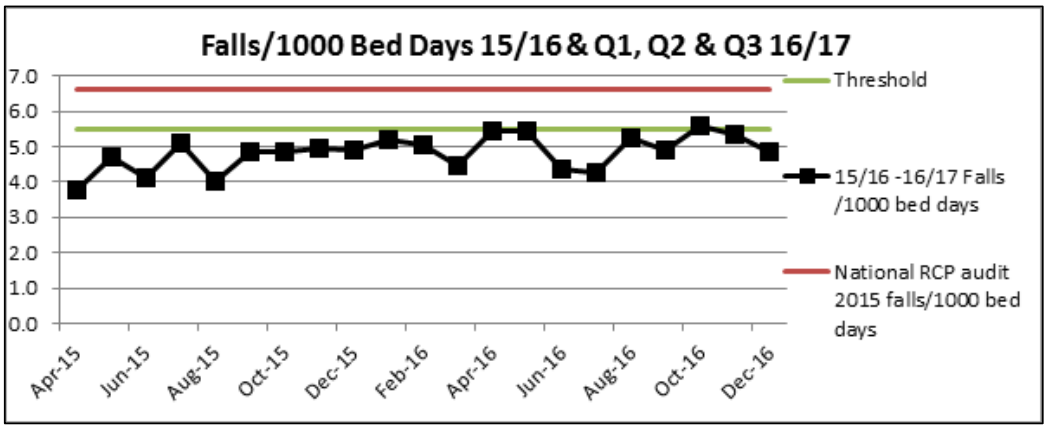
Catheter Related Urinary Tract Infections (CRUTI)

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.



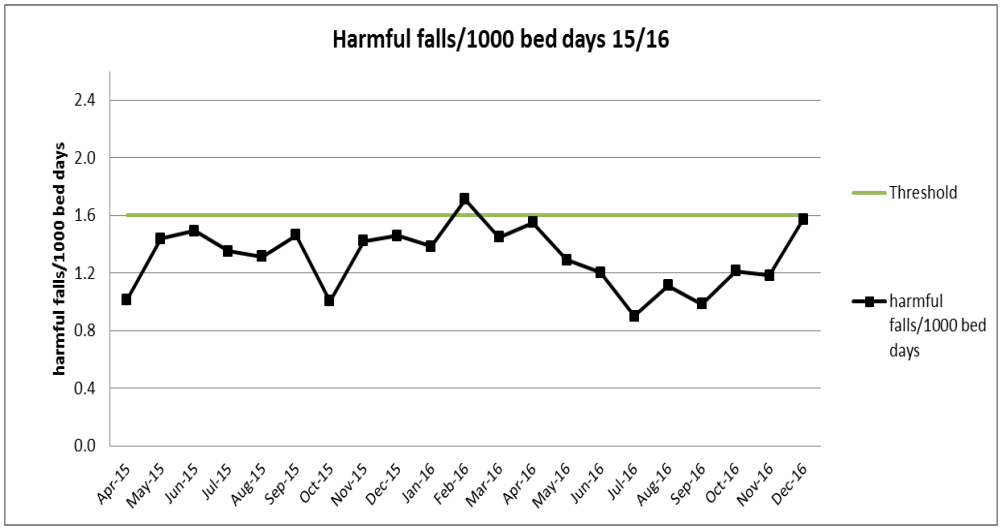
6. Falls Prevention

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:

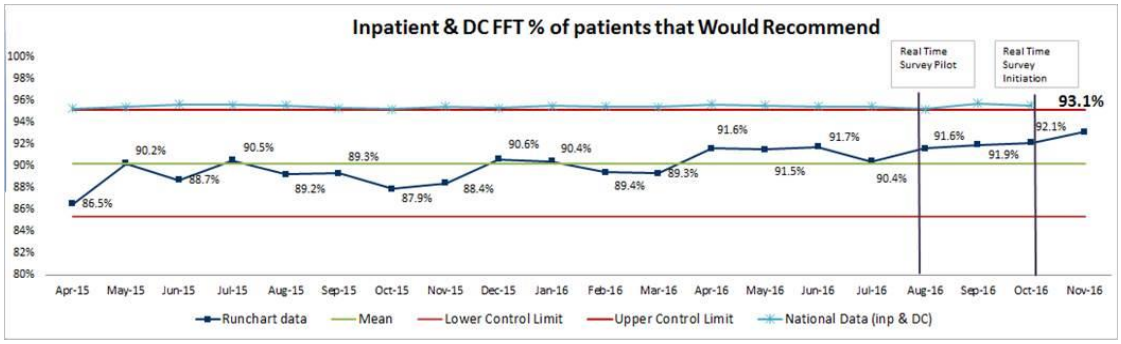
- Privacy and Dignity has seen the most improvement for the 4th consecutive month. Work is on-going within the Divisions to sustain the improvement
- Compliance with falls assessments and care planning has decreased again this month to 83%, Holcot and Collingtree Wards require improvement, the ward sisters 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

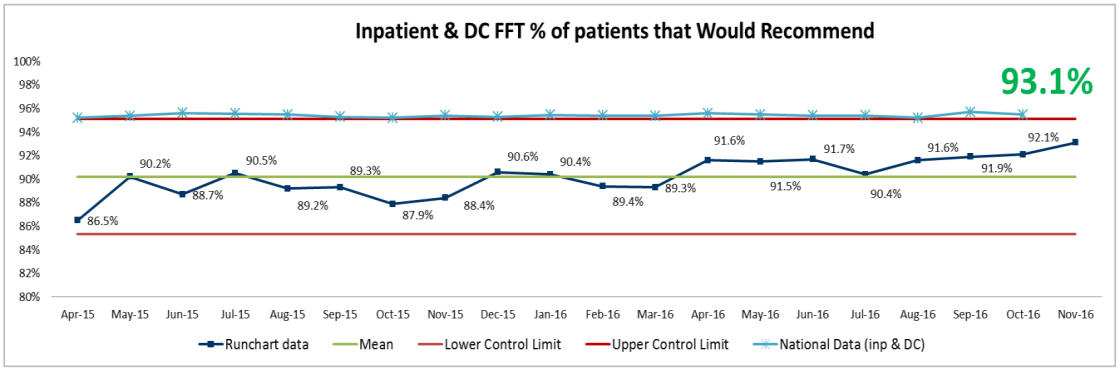
- First impressions and 15 steps, for the general wards are at 77% showing a decrease or 2 consecutive months. Work is ongoing to improve the clutter and general appearances of the general wards, through the IPC, 'Going for Gold' Declutter initiative.

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.

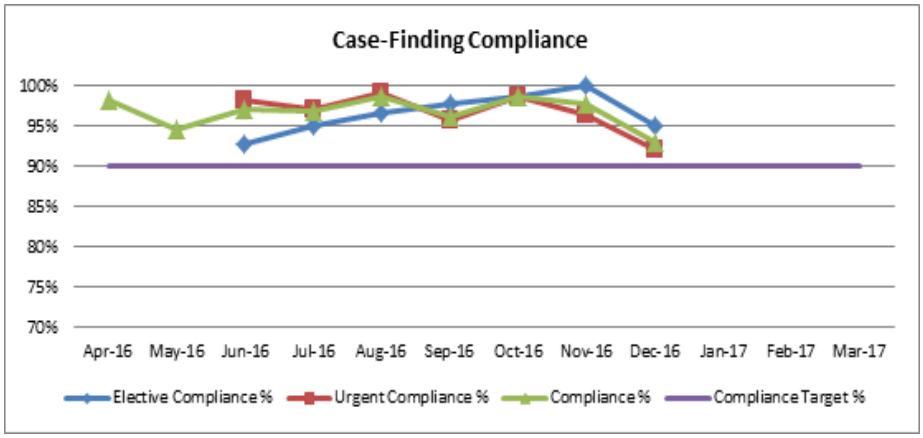
9. Dementia CQUINS

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

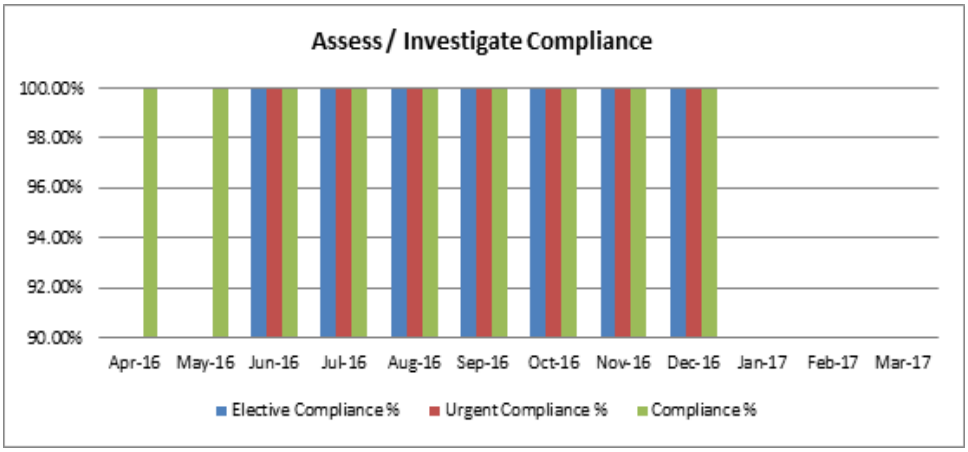
The 2016/17 dementia CQUIN, in contrast to previous years, includes patients admitted via the non-urgent (elective) pathway. Planning for the collection of this data was undertaken during Q1 and the subsequent split in compliance figure was reportable from Q2.

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

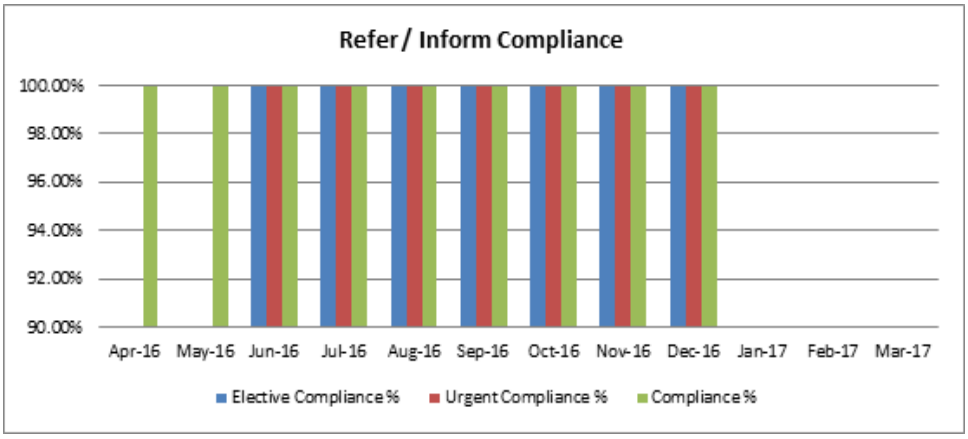


The elective and non-elective areas both remain above the 90% threshold for compliance; the total Trust compliance for December is 93.1%. There has been a slight decrease (though still above the threshold) in compliance, particularly during December, however this is anticipated given the increased patient 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.

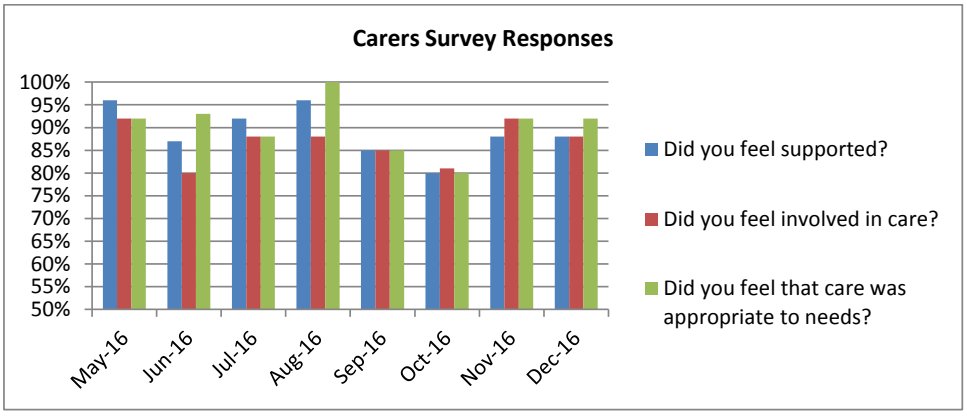


John's Campaign

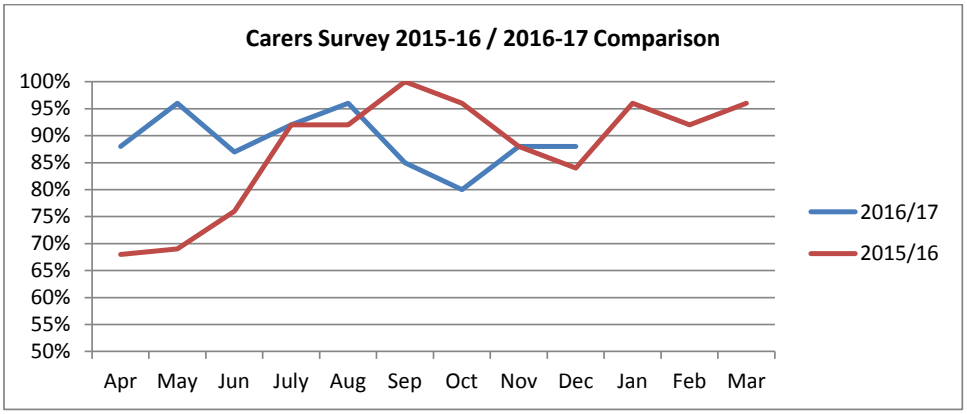
John's campaign roll out continues, with a further six wards now online. Anecdotal feedback has been positive and the formal feedback exercise *(as part of the CQUIN compliance)* will take place in Q4.

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.

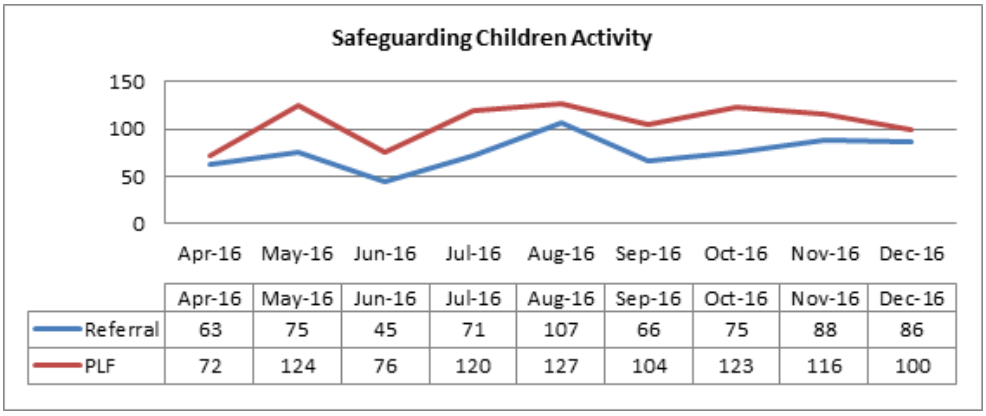


The carer's survey has been iterative, however the consistent question "do you feel supported" has been present since the survey was initiated as part of preceding years' CQUINs. The graph below shows the variation between 2015/16 and 2016/17 to date.



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

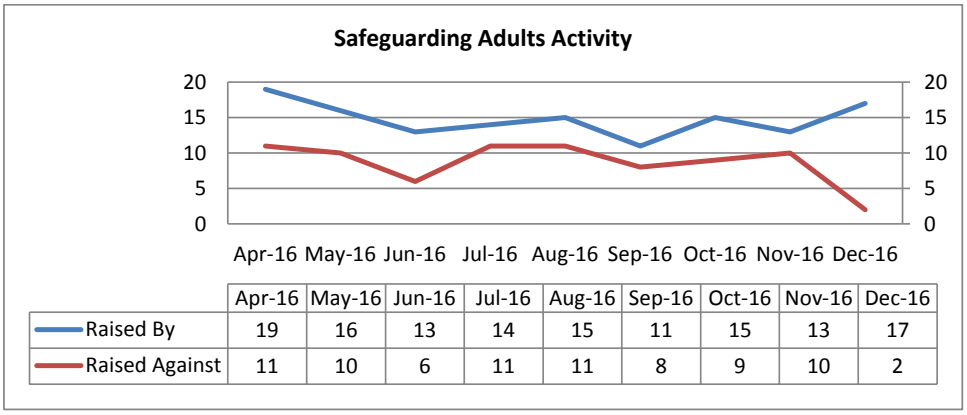
Safeguarding Referral Activity



	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.

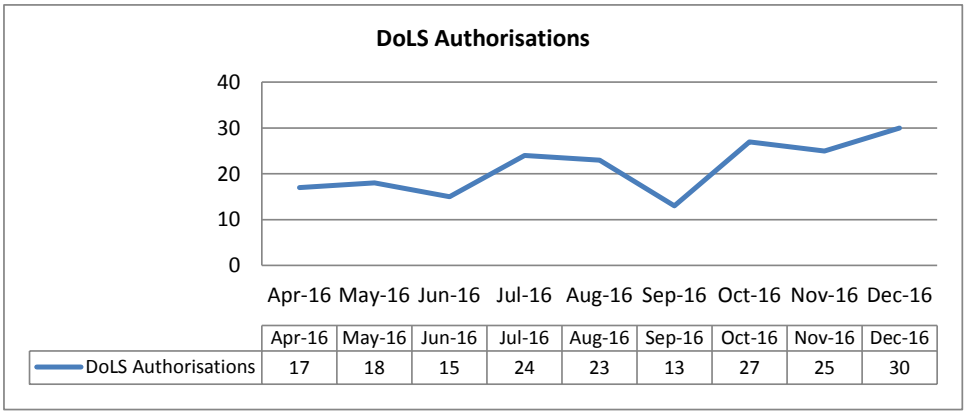
Safeguarding Adults activity as shown in the graph below remains relatively static in relation to referrals made by the organisation i.e. cases of concern identified. The number of referrals received where the organisation is cited as having caused harm is consistently reducing over time, with a significant 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)



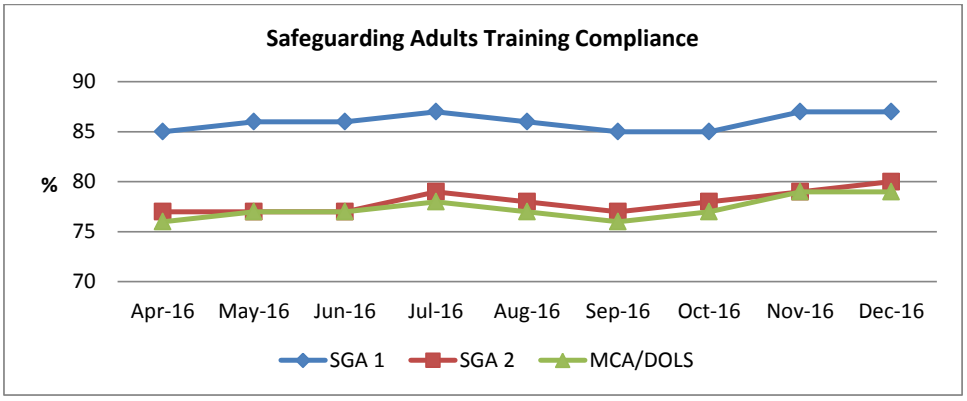
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
DoLS Authorisations	17	18	15	24	23	13	27	25	30

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.

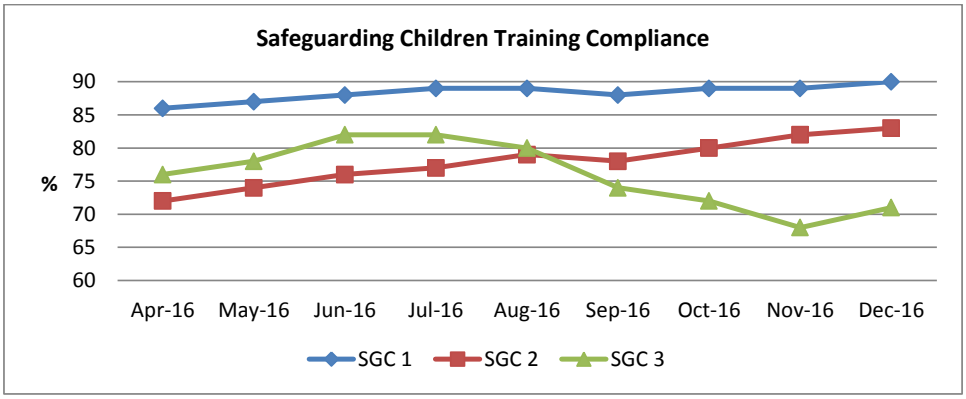
The Law Commission have deferred the publication of their report into the review of the DoLS legislation from December 2016 to March 2017; it is not expected that this will disrupt the legislative timetable with new DoLS legislation anticipated in 2019.

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.



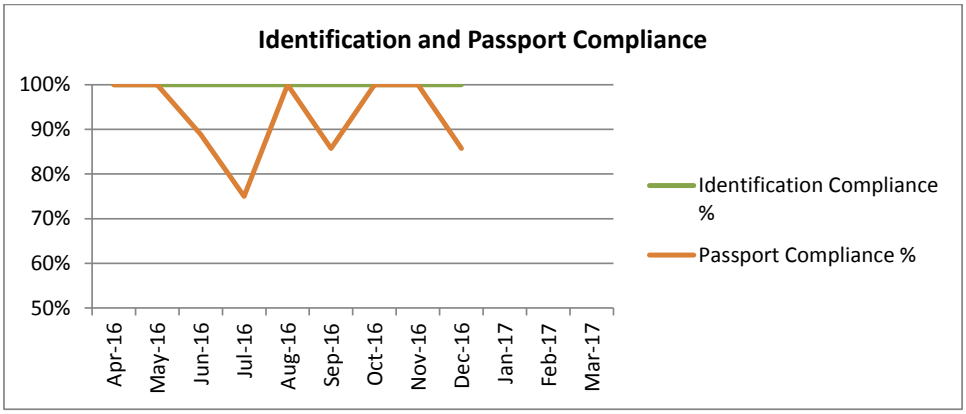
The drop in safeguarding children training compliance is reversing, with extra access and targetted communication being successful in effecting an improvement. This work will continue in January and February to recover the postion as shown in the following graphs.



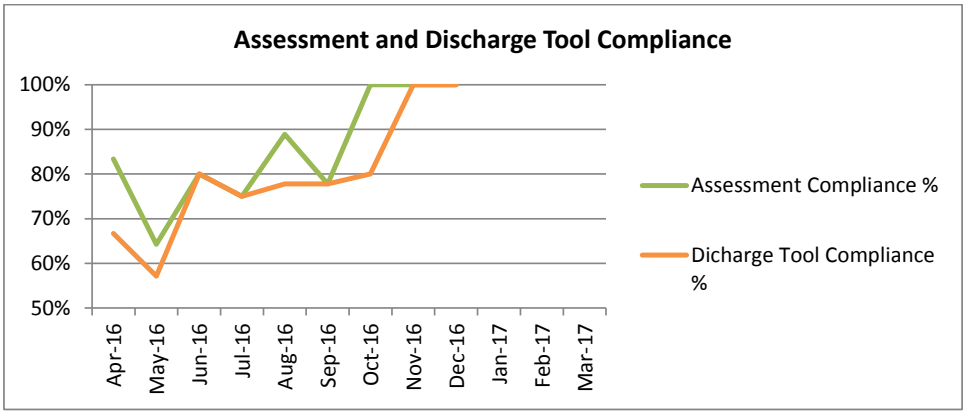
Learning Disability

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].

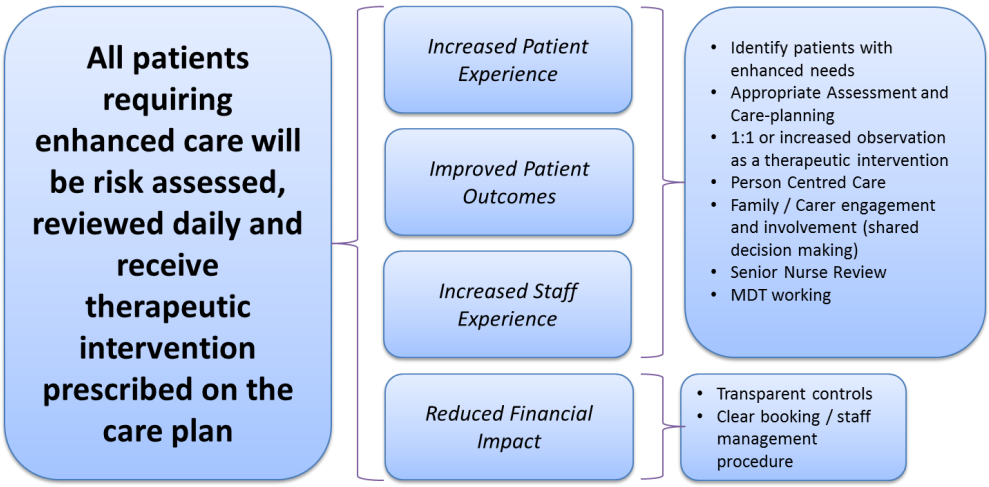
1.2 "Enhanced Care" is the description used to describe the range of interventions used to support those patients who, for a number of reasons, require a level of interactive care that is beyond the expected afforded by the established staffing level.

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:

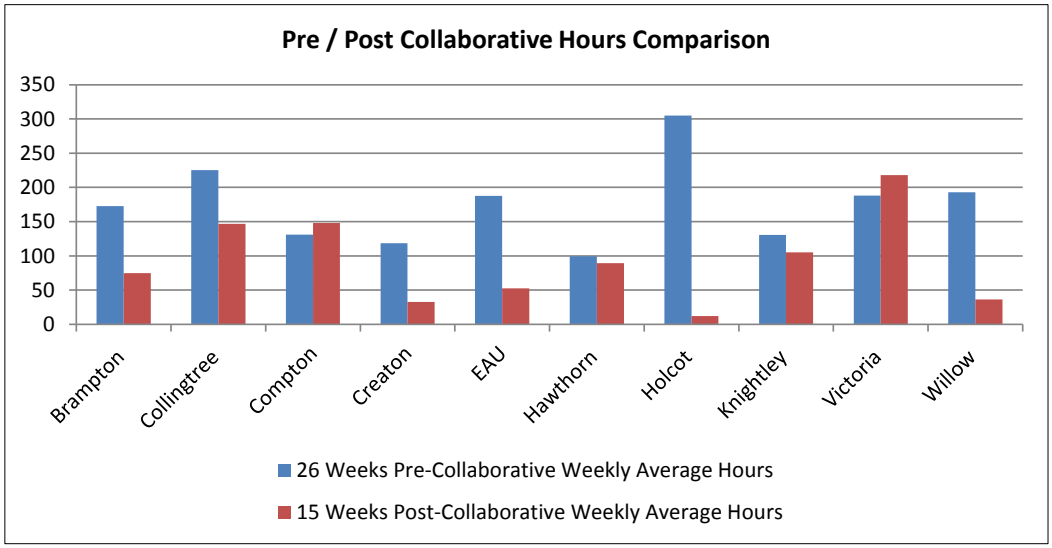
- Risk Assessment and Monitoring Tool;
- Prescription of Care and Five Day Evaluation;
- Increased Observation;
- Senior Nurse Review.

4.0 <u>Financial Impact</u>

[2] Both registered and unregistered staff

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:



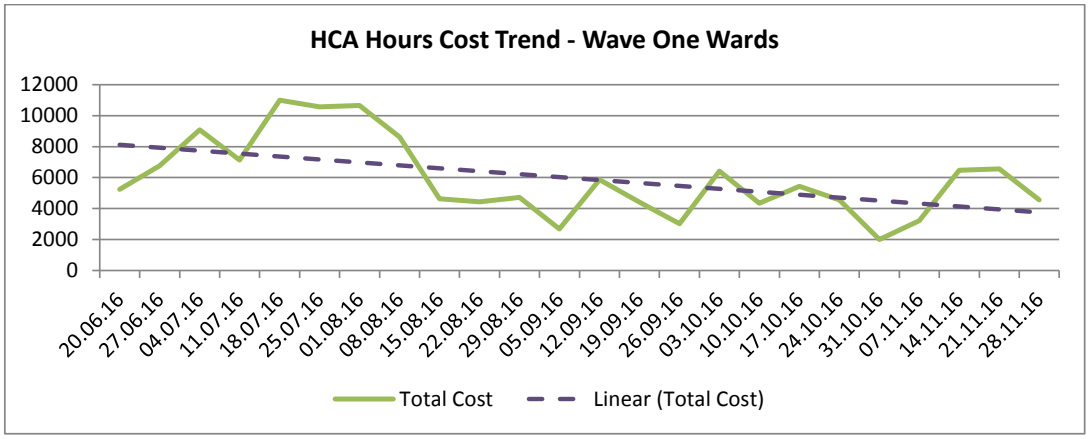
4.3 As can be seen, significant improvements have been made in relation to the use of enhanced observations. Overall, this equates to an approximate reduction of an average of 836hours per week compared to the average weekly use prior to the start of the Collaborative.

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		Day: Care Staff		Night: Registered midwives/nurses		Night: Care Staff		Day: Average fill rate - registered nurses /midwives (%)	Day: Average fill rate - care staff (%)	Night: Average fill rate - registered nurses / midwives (%)	Night: Average fill rate - care staff (%)	Care Hours Per Patient Day (CHPPD): Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall	Actions/Comments	Red Flag
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours										
Abington	1,602.50	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		

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

Enclosure E

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30 March 2017**

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

Executive summary

This report sets out the financial position of the Trust for the period ended 28th February 2017. The overall I&E YTD position is a deficit of £13.4m, £23k better than plan.

Key points:

- Income and Non-pay have continued to show a favourable variance but has been offset by adverse variance on Pay.
- STF funding of £8.4m is included in the reported position but excludes £0.4m funding for Cancer & A&E targets that were below required trajectories.
- The Trust continues to score "3" against the new NHSI "Finance and use of Resources" metrics.
- The Trust is on track to deliver its plan for the year and estimates the final position to be about £0.3m better than plan due to the STF incentive funding.

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

Enclosure F

Actions required by the Board

The Board is asked to note the financial position for the period ended February 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 11 (February)
FY 2016/17

Report to:

Trust Board

March 2017

Enclosure F

1. Overview

	RAG	This Month Feb	Last Month Jan	Change
Statutory Financial Duties				
3 year Cumulative I&E Breakeven duty (£000's)	✗	(42,819)	(40,687)	(2,131)
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)	✓	13,560	13,580	(19)
Financial Sustainability Risk Rating	✓	3	3	(0)
I&E Position				
Actual in Month Position (£000's)	✗	(2,131)	(681)	(1,450)
Plan in Month Position (£000's)		(2,187)	(743)	(1,444)
STF Plan		8,892	8,083	808
STF Actual	✗	8,447	7,780	667
Actual Year to Date Position (£000's)	✓	(13,447)	(11,267)	(2,180)
Forecast End of Year I&E Position (£000's)	✓	(14,846)	(15,129)	283
EBITDA %	✗	-0.3%	0.1%	-0.4%
Income				
MRET Penalty - YTD (£000's)	✗	(4,405)	(3,987)	(418)
Readmissions YTD - Gross (£000's)	✗	(3,131)	(2,899)	(232)
Contract Fines & Data Challenges (£000's)	✗	(176)	(152)	(24)
Elective variance to plan (£000's)	✗	(987)	(36)	(951)
Daycase variance to plan (£000's)	✓	63	(100)	163
Non-Elective variance to plan (£000's)	✓	4,315	4,076	239
Outpatients variance to plan (£000's)	✓	2,456	2,276	180
Operating Costs				
Pay Expenditure (£000's)	✗	16,617	16,673	56
Agency Staff Costs (£000's)	✗	1,211	1,053	(158)
Agency Staff Cap (£000's)		1,038	1,047	9
Non-Pay - Clinical (£000's)	✗	5,062	4,723	(339)
Non-Pay - Other (£000's)	✗	3,549	3,063	(486)
Cost Improvement Schemes				
Year to Date Actual (£000's)	✗	11,246	10,126	1,120
Year to Date Plan (£0o0's)		11,623	10,384	1,239
Forecast Delivery (£000's)	✗	12,233	11,948	285
Annual CIP Target (£'000s)		12,900	12,900	0
Capital				
Year to date expenditure (£'000s)	✗	10,125	9,157	
% of annual plan Committed	✓	95%	97%	-2%
Annual Capital Expenditure Plan (£000's)	✓	13,560	13,580	(19)
Cash				
In month movement (£000's)	✓	2,347	(820)	3,167
In Year movement (£000's)	✓	2,488	141	2,347
New PDC / borrowing (£000's)		13,469	14,515	(1,046)
Debtors Balance > 90 days (£000's)	✗	1,017	1,015	(3)
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 month ended February 2017. The overall I&E position YTD is a deficit of £13.4m, which is £23k better than plan.

Income

- Income continues to outperform plan and is £3.4m favourable in February.
- SLA income continues to outperform plan and accounts for a net favourable variance of £2.2m, mainly due to over performance on non-elective and outpatient income.
- Other income is better than plan by £1.3m.

Pay

- Pay YTD continues to be an adverse variance of £7.4m (Jan £6.9m).
- The Trust needs to continue in its efforts towards reducing agency spend particularly medical agency and other clinical agency.

Non-pay

- Non-pay year to date is an adverse variance of £0.1m, mainly due to pathology outsourcing accruals being brought up to date and provision for P11D tax liability.

Capital

- The Trust has achieved a committed capital spend of 95% of its plan and is working with divisions to ensure that the various schemes are completed by year-end.

Liquidity

- The year to date position includes STF funding of £8.4m on the basis that the Trust continued to meet the performance criteria, with the exception of Cancer (Aug, Sep, Oct, Nov, Jan & Feb) and A&E (Jan & Feb).
- The Trust continued to access Deficit funding (Feb - £13.5m) and STF funding and manage its operational cashflow and commitments as they fall due.

General

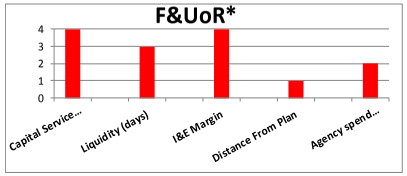
- NHSI rating - The Trust continues to score “3” against the NHSI “Finance and use of resources” metrics.

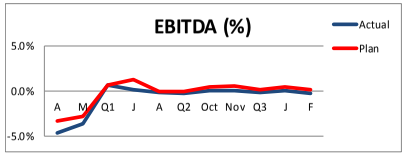
Forecast

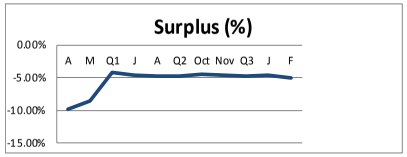
- The Trust is forecasting to deliver its plan of £15.1m and estimating a slight over-performance of around £0.3m due to the NHSI STF incentive scheme.

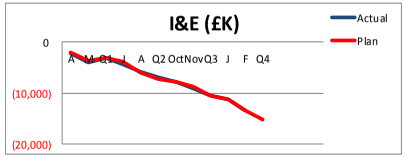
2. KPI & Trend Analysis

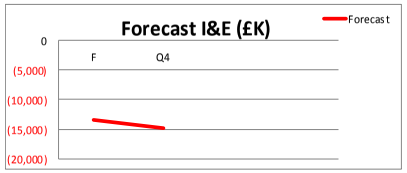
1. Key Metrics

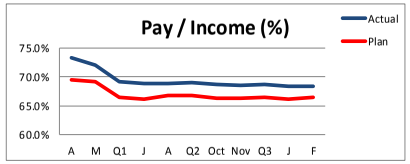




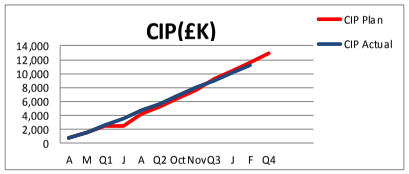


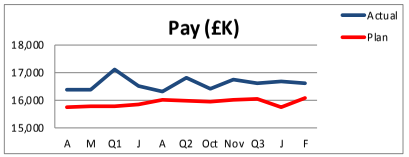


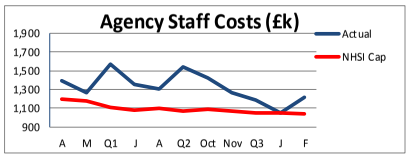


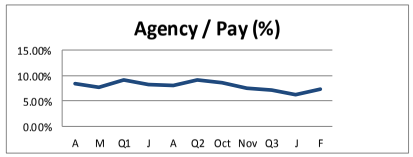


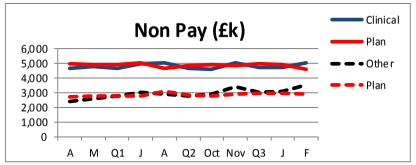
2. I&E Performance

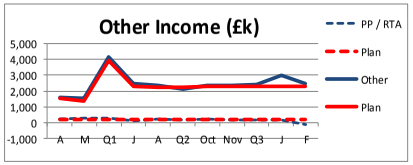




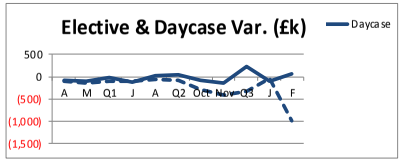


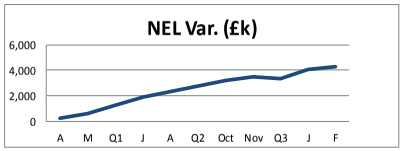


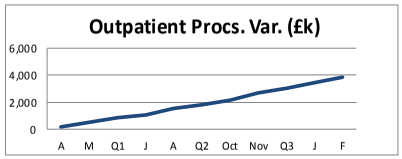


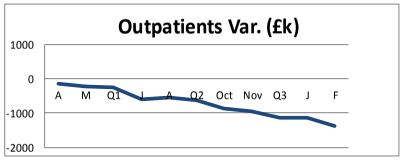


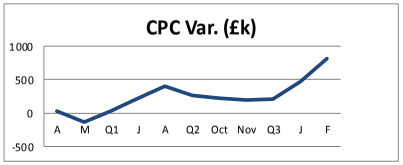
3. SLA Income

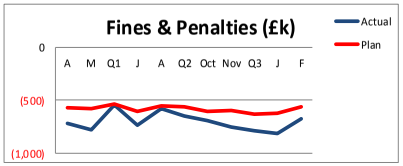




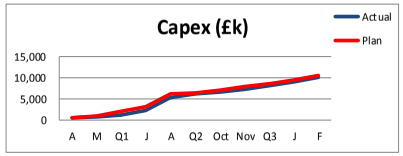


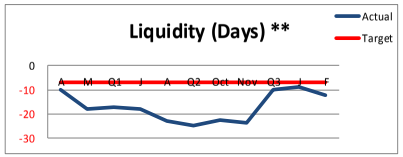


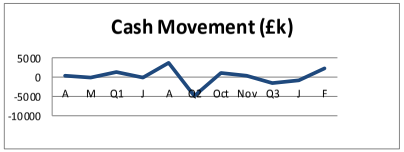


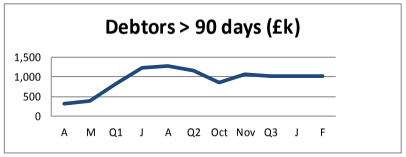


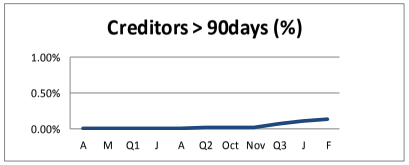
4. Working Capital

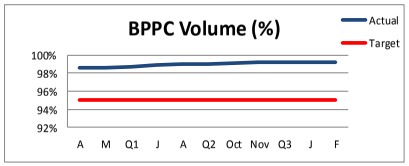












** F&UoP = Finance and Use of Resources metrics*

*** 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	Feb 17	Jan 17
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	246,152	256,996	235,589	237,762	2,173	21,889	21,775
Other Clinical Income	2,444	2,686	2,461	2,128	(333)	(91)	187
Other Income	20,872	27,573	25,256	26,833	1,577	2,496	3,014
Total Income	269,468	287,256	263,306	266,723	3,417	24,294	24,976
Pay Costs	(187,327)	(191,127)	(175,039)	(182,484)	(7,446)	(16,617)	(16,673)
Non-Pay Costs	(88,196)	(92,784)	(84,929)	(85,005)	(76)	(8,611)	(7,786)
CIPs		(0)	0	0	0	0	0
Reserves/ Non-Rec		(3,336)	(3,016)	0	3,016	0	0
Total Costs	(275,523)	(287,247)	(262,984)	(267,490)	(4,505)	(25,228)	(24,460)
EBITDA	(6,055)	9	322	(766)	(1,088)	(934)	516
Depreciation	(9,941)	(10,365)	(9,501)	(8,862)	639	(842)	(842)
Amortisation	(9)	(9)	(8)	(8)	0	(1)	(1)
Impairments	3,315	1,590	1,590	(1,732)	(3,322)	266	(80)
Net Interest	(355)	(1,239)	(1,028)	(621)	407	(60)	(74)
Dividend	(4,041)	(3,501)	(3,209)	(3,022)	187	(250)	(236)
Surplus / (Deficit)	(17,086)	(13,515)	(11,835)	(15,012)	(3,177)	(1,820)	(717)
NHS Breakeven duty adjs:							
Donated Assets	250	(24)	(45)	(167)	(122)	(45)	(45)
NCA Impairments	(3,315)	(1,590)	(1,590)	1,732	3,322	(266)	80
I&E Position (breakeven duty)	(20,151)	(15,129)	(13,470)	(13,447)	23	(2,131)	(681)

I&E Performance – In-month

Income

- SLA income for February of £21.9m (Jan: £21.8m) continues to make positive contribution to the YTD position mainly driven by increased Non elective activity, Daycases and Outpatient procedures.
- The reported position includes provision for data challenges and contract reconciliation issues, which has been reviewed and adjusted to reflect latest estimates. This has resulted in a write-back of £0.8m.
- Other income £2.5m (Jan: £3.0m) is in line with plan, although lower than prior month as January included a catch-up accrual to the recognise A&E STF funding .

Pay

- Pay costs is about £0.5m above plan in-month, but £0.1m better than last month. The Trust is continuing to put in necessary measures to reduce agency spend.

Non-Pay

- Non-Pay in-month movement of £0.8m in comparison to last month was due to £0.4m catch up accruals re pathology outsourcing in addition to £0.3m provision for P11D potential tax charge.

Key Issues

Income

- The YTD financial performance for February is a normalised deficit of £13.4m, £23k better than plan.
- SLA income from Commissioners is £2.2m fav. to plan mainly due to over-performance on non-elective and outpatient procedures. In addition, provision held relating to prior year data challenges was released in-month.
- Other income is a variance of £1.6m fav. mainly due to additional income from external parties usage of the Trust's facilities and the release of income provisions in Q1.
- STF funding of £8.4m for the year to date (£0.4m adv. to plan) is included within Other income of £26.8m.

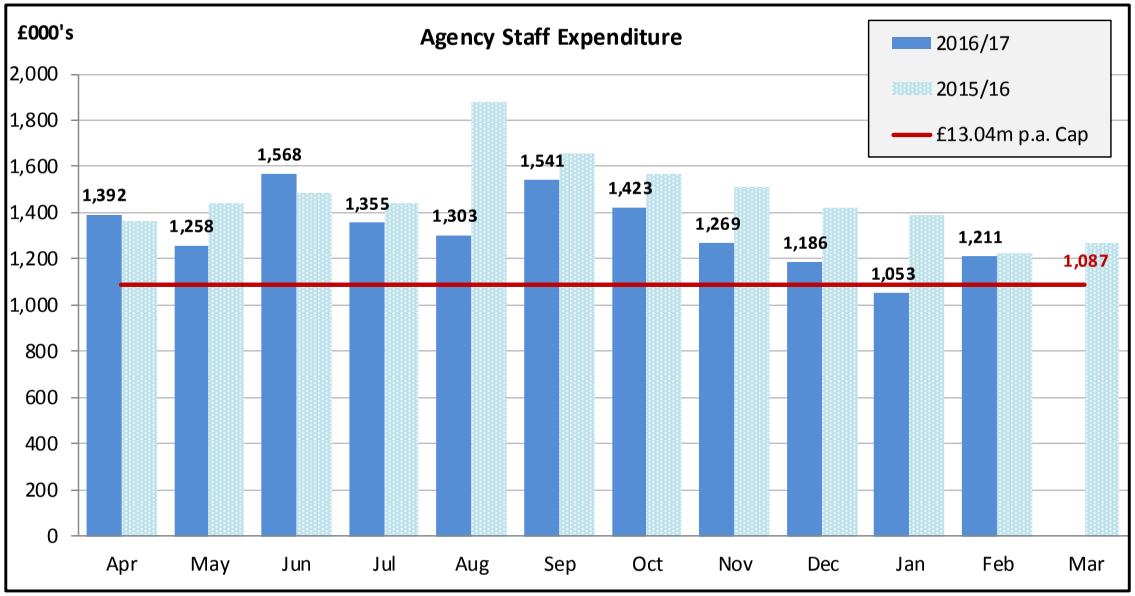
Pay

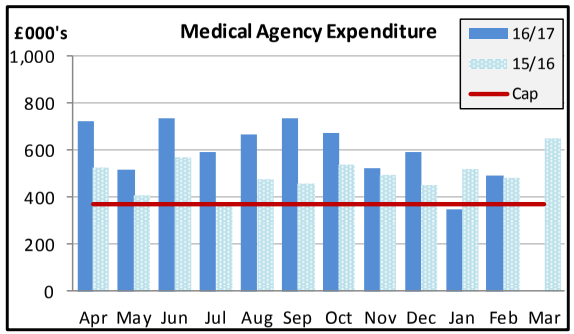
- Pay expenditure £7.4m (4.2%) adverse to plan driven by high costs of medical agency and other clinical agency staff.
- Agency costs are continuing to show a decline and represent a YTD reduction of 11% compared to spend in 15/16.

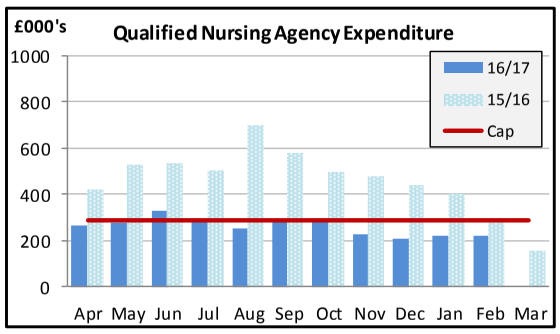
Non-Pay

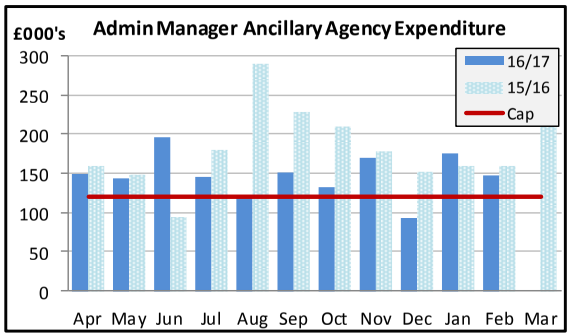
- Non-Pay costs £0.1m adverse to plan mainly due to £0.4m catch up accruals re pathology outsourcing in addition to £0.3m provision for P11D potential tax charge.
- Depreciation remains favourable to plan by £0.6m following asset capitalisation and a reassessment of in year phasing of charges.

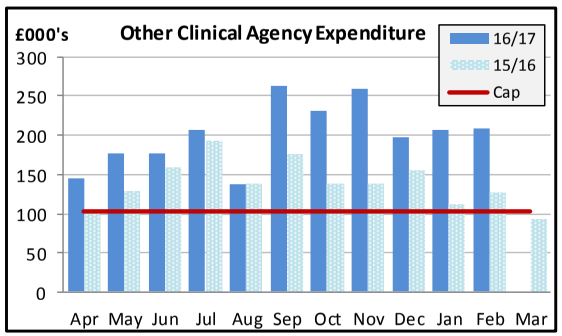
3.1 Agency Staff Expenditure





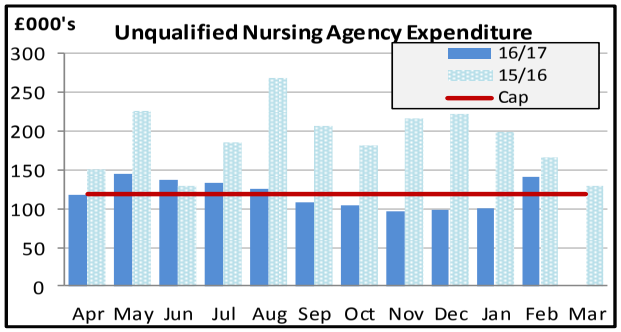






Key Issues

- The Trust's agency cap limit issued by NHSI for 16/17 was £13.04m (c. £1.1m per month). This is a 26% reduction when compared to agency expenditure in 2015/16 of £17.6m.
- At the end of February the Trust is £2.6m behind this cap.
- Agency Expenditure has increased marginally to £1.2m in February, still lower than the first half of 16/17, and lower than YTD average.
- Agency Medical Staff expenditure has increased from the January low, but continues to show a downward trend on earlier in the year.
- Agency Other Clinical Staff has increased significantly compared to 15/16. Therapies, Imaging, Theatres, Pathology and Cardiology continue to present a pressure on the agency cap.
- Temporary Nursing cover demand has increased in the last couple of months, with Bank covering a substantial proportion. Some of this demand is being fulfilled by agency with a peak in unqualified cover in February.



4. SLA Income

Point of Delivery	Activity Plan	Activity Actual	Activity Variance	Finance £000's Plan	Finance £000's Actual	Finance £000's Variance
AandE	109,757	106,006	(3,751)	12,792	12,181	(611)
Block / CPC	2,507,491	2,663,240	155,749	51,354	52,171	817
CQUIN	-	-	0	4,156	4,148	(8)
Day Cases	31,552	36,880	5,328	22,276	22,340	63
Elective	5,255	4,817	(438)	14,666	13,679	(987)
Elective XBDs	1,913	1,976	63	448	452	5
Excluded Devices	1,513	1,701	188	1,618	1,794	175
Excluded Medicines	-	425	425	19,873	19,853	(20)
Non-Elective	39,980	42,746	2,766	63,645	67,960	4,315
Non-Elective XBDs	34,178	37,095	2,917	7,452	8,063	611
Outpatient First	52,556	50,351	(2,205)	8,695	8,349	(346)
Outpatient Follow UP	178,775	166,992	(11,783)	16,845	15,816	(1,030)
Outpt Procedures	124,174	150,356	26,182	16,617	20,448	3,831
Other Central SLA Income			0	452	(1,780)	(2,232)
CIPs			0	1,106	0	(1,106)
Reserves / Contingency						0
Total SLA Income (before	**3,087,144**	**3,262,585**	**175,440**	**241,995**	**245,474**	**3,478**
Fines & Penalties						
Contract Penalties	2WW			-	(7)	(7)
Contract Penalties	31 Day			-	(17)	(17)
Contract Penalties	62 Day			-	(72)	(72)
Contract Penalties	A&E			-	-	0
Contract Penalties	Cancelled Operations			-	(71)	(71)
Contract Penalties	CDIFF			-	-	0
Contract Penalties	MRSA			-	(10)	(10)
Contract Penalties	RTT - Incomplete			-	-	0
Readmissions	Readmissions			(2,596)	(3,131)	(535)
MRET	MRET			(3,811)	(4,405)	(594)
Sub-Total Fines & Penalties				**(6,406)**	**(7,712)**	**(1,305)**
Grand Total SLA Income				**235,589**	**237,762**	**2,174**
NHSI Central support				**8,892**	**8,447**	**(445)**

Key issues

Summary
£2,174k favourable to plan

SLA Income shows an overall position that is £2,174k favourable to plan.
Following 3 months of estimated reporting. We have been able to update the point of delivery (POD) view to reflect actual activity year to date. This will still be subject to the usual coding changes during the month.

CQUIN
£8k adverse to plan

CQUIN income now recognises schemes achieved up to and including Q3, but with estimates for Q4.

Admitted patient income
£4,007k favourable to plan

Elective activity is showing the impact of capacity pressure and is £987k below plan. However the decline in activity is compensated for by continued increase in Non-elective activity. NEL remains high, at 7% above activity and financial plans.

Daycase activity includes same-day Chemo/Radiotherapy although the income is classified within 'Block/CPC'. The activity accounts for over 4,450 of the activity variance.

Outpatients
£2,456k favourable to plan

The net position on outpatients is an over-performance of £2,546k and is consistent with recent months.

A&E

A&E is £611k below plan.

Fines & Penalties
£1,305k adverse to plan

MRET and readmissions are higher than plan as a result of the increase experienced with non-elective activity.

4.1 High-level Commissioner Position

Commissioner	Finance £000's Annual Plan	YTD Plan	Actual	Variance
Nene CCG	202,873	186,036	184,734	(1,302)
Corby CCG	2,702	2,422	2,276	(146)
Bedfordshire CCG	673	617	626	9
East Leicestershire & Rutland CCG	626	565	609	44
Leicester City CCG	43	49	72	23
West Leicestershire CCG	91	63	85	21
Milton Keynes CCG	2,609	2,388	2,830	442
SCG & Cancer Drug Fund	33,893	31,522	33,520	1,998
SCG - Not in Contract Value (inc. Hep C)	1,134	825	963	138
Herts & South Midlands LAT	7,552	6,926	6,800	(126)
NCA	3,624	3,454	3,726	272
Central (Contingency, Central provisions, CIP & adj)	788	722	1,520	798
Total SLA Income	**256,608**	**235,589**	**237,762**	**2,174**

Nene Contract
£1,302k adverse to plan

Non-elective and Outpatient activity continue to outperform plan. However the impact of A&E variance and elective pressures continue to drive an adverse variance.

Specialised Commissioner & Cancer Drug Fund
£1,998k favourable to plan

Over performance against radiotherapy of £0.8m due to improved casemix as a result of the new linacc machine as well as additional fractions more than plan. £1m variance relates to increase in NEL and Outpatient activity.

4.2 STF Funding

I&E £k	Plan	YTD Plan	Actual	Var
Pre STF	(24,829)	(22,362)	(21,894)	467
STF	9,700	8,892	8,447	(445)
Post STF	(15,129)	(13,470)	(13,447)	23

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 £467k before considering lost income from STF trajectories not met. When this loss is taken into account, the Trust still performed better than plan by £23k.
- The Trust continues to meet both the finance and RTT criteria, however the A&E and Cancer trajectories were not met in February.
- We remain hopeful for a successful outcome of the Q3 (Oct+Nov) cancer appeal.
- As a result of the Trust forecasting to do better than plan for the full year in its pre-STF forecast, it is expecting to accrue additional STF incentive at year-end of around £0.3m.
- The STF income accrued is subject to reconciliation of the STF trajectories delivery.

5. Statement of Financial Position

TRUST SUMMARY BALANCE SHEET MONTH 11 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	(6,652)	(5,555)	1,097	(5,565)	(5,565)
IN YEAR MOVEMENTS	0	9,868	10,956	1,088	14,603	14,603
LESS DEPRECIATION	0	(8,021)	(8,862)	(841)	(9,704)	(9,704)
NET BOOK VALUE	160,399	155,594	156,938	1,344	159,733	(666)
CURRENT ASSETS						
INVENTORIES	5,744	6,090	5,873	(217)	5,700	(44)
RECEIVABLES						
TRADE & OTHER RECEIVABLES	16,341	24,874	22,608	(2,266)	18,326	1,985
NON CURRENT ASSETS FOR SALE	375	0	0	0	0	(375)
CASH	1,602	1,743	4,090	2,347	1,500	(102)
TOTAL CURRENT ASSETS	24,062	32,707	32,571	(136)	25,526	1,464
CURRENT LIABILITIES						
TRADE & OTHER PAYABLES	24,347	29,476	28,679	(797)	22,487	(1,860)
FINANCE LEASE PAYABLE under 1 year	121	121	121	0	124	3
SHORT TERM LOANS	783	1,059	5,100	4,041	6,331	5,548
STAFF BENEFITS ACCRUAL	710	767	767	0	750	40
PROVISIONS	2,802	2,307	1,980	(327)	2,503	(299)
TOTAL CURRENT LIABILITIES	28,763	33,730	36,647	2,917	32,195	3,432
NET CURRENT ASSETS / (LIABILITIES)	(4,701)	(1,023)	(4,076)	(3,053)	(6,669)	(1,968)
TOTAL ASSETS LESS CURRENT LIABILITIES	155,698	154,571	152,862	(1,709)	153,064	(2,634)
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year	1,245	1,147	1,137	(10)	1,039	(206)
LOANS over 1 year	26,203	43,014	42,303	(711)	44,492	18,289
PROVISIONS over 1 year	979	979	979	0	226	(753)
NON CURRENT LIABILITIES	28,427	45,140	44,419	(721)	45,757	17,330
TOTAL ASSETS EMPLOYED	127,271	109,431	108,443	(988)	107,307	(19,964)
FINANCED BY						
PDC CAPITAL	119,258	119,258	119,258	0	119,258	0
REVALUATION RESERVE	41,435	36,561	37,393	832	37,393	(4,042)
I & E ACCOUNT	(33,422)	(46,388)	(48,208)	(1,820)	(49,344)	(15,922)
FINANCING TOTAL	127,271	109,431	108,443	(988)	107,307	(19,964)

Key Movements

The key movements from last month are:

Non Current Assets

•Increase in depreciation of £841k offset by capital expenditure additions of £1,088k, as per the Capital expenditure report. Revised building indices have been provided and applied resulting in a increase in valuation of £1,097k.

Current assets

•Inventory - £217k - Decrease in Inventory-holding levels due to usage, mainly pharmacy stocks.

•Trade & Other Receivables – Decrease of £2,266k due to increased collection of outstanding debts (£1,307k reduction in outstanding NHS invoices) and £685k reduction in NHS Litigation prepayment.

•Cash - £2,347k increase in comparison to last month. The Trust continues to put in place necessary cash management measures to ensure that payments are made as and when due and that collections are chased and received in time.

Current Liabilities

•Trade & Other Payables - £797k - decrease in outstanding Trade Creditor invoices offset by an increase in accruals.

• Short-term loan - £4,041k – this relates to the STF element of DH Loan.

•Provisions - £327k Decrease – Provisions have been reviewed and those no longer considered necessary have been released, including SLA contract provisions (£797k). This position is offset by new provisions for potential P11D PAYE liability (£320k).

Non Current Liabilities

•Long-term loans - £711k – Draw down of DH Uncommitted Revenue Support Loan in relation to deficit & STF funding (£2,995k) and reclassification of STF element to Short Term Loan (£4,041k).

Financed By

- Revaluation Reserve - £832k movement relates to revised building indices
- I & E Account - £1,820k – M11 deficit before adjustment for impairment and donated assets.

6. Capital Expenditure

Capital Scheme	Plan 2016/17 £000's	M11 Plan £000's	M11 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)	3,633	2,445	2,392	-53	66%	3,547	98%
Additional Imaging Equipment (Loan)	693	704	701	-3	101%	701	101%
Replacement NPfIT Systems	1,249	921	1,082	161	87%	1,091	87%
Stock / Inventory System (Loan)	400	299	299	0	75%	387	97%
A&E / Orthopaedics	500	500	496	-4	99%	501	100%
Contingency	44	0	0	0	0%	0	0%
Medical Equipment Sub Commiittee	1,005	756	745	-11	74%	1,005	100%
Estates Sub Committee	3,159	2,455	2,266	-189	72%	2,851	90%
IT Sub Committee	3,101	2,755	2,521	-234	81%	3,095	100%
60 Bedded Ward	0	0	0	0	0%	0	0%
Other	819	508	461	-47	56%	776	95%
Total - Capital Plan	**14,603**	**11,343**	**10,956**	**-387**	**75%**	**13,945**	**95%**
Less Charitable Fund Donations	-668	-458	-456	2	68%	-694	104%
Less NBV of Disposals	-375	-375	-375	0	100%	-375	100%
Total - CRL	**13,560**	**10,510**	**10,125**	**-385**	**75%**	**12,876**	**95%**

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	3,614
Capital Loans - Additional Imaging Equipment	693
Capital Loans - Stock / Inventory System	400
Capital Loan - Repayment	-694
Other Loans - Repayment	-157
Total - Available CRL Resource	**13,560**
Uncommitted Plan	**0**

Key Issues

- The year to date position is an underspend of £385k against plan (75%).
- In order to achieve the capital plan for the year, the Trust needs to complete £3.6mk worth of capital schemes in M12, of which £1.2m relates to Fluoroscopy and CT.
- The PICC line service has found a temporary new home. As a result both the works associated with Fluoroscopy Room and CT have commenced and the majority of the works will be completed & equipment delivered on site by 31st March.
- We remain positive that the Trust will achieve this target in M12. The finance team is working pro-actively with each of the Sub Committees to ensure that all commitments are correct & receipted by 31 March 2017.
- The inventory management system is now planned to go live in mid-May following a reschedule of the go-live of the financial ledger upgrade.
- The current full year depreciation forecast unchanged from M10, £9,704k.

7. Receivables, Payables and BPPC Compliance

Narrative	Total at February £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	1,362	589	285	71	418
Receivables NHS	13,339	12,068	499	172	600
Total Receivables	**14,701**	**12,657**	**784**	**243**	**1,017**
Payables Non NHS	(6,104)	(6,061)	(24)	(7)	(11)
Payables NHS	(2,952)	(2,951)	(1)	0	0
Total Payables	**(9,056)**	**(9,013)**	**(25)**	**(7)**	**(11)**

Narrative	Total at January £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	1,432	683	144	149	457
Receivables NHS	15,038	13,484	286	710	558
Total Receivables	**16,470**	**14,167**	**430**	**858**	**1,015**
Payables Non NHS	(7,098)	(5,296)	(1,782)	(9)	(12)
Payables NHS	(4,180)	(4,180)	0	0	0
Total Payables	**(11,278)**	**(9,475)**	**(1,782)**	**(9)**	**(12)**

Receivables and Payables

- There is continued focus on collecting outstanding debts and resolving any associated queries.
- Qtr 2 over & underperformance invoices/credit notes issued to Milton Keynes CCG & Central Midlands Region Local Office remain outstanding.
- Qtr 3 & Qtr 4 over & underperformance is being accrued, along with anticipated STF funding. Qtr 3 performance invoices have been issued in March.
- Non-NHS over 90 day debt includes Overseas visitor accounts of £309k, of which £102k are paying in instalments and a high proportion of the balance passed to debt collection agency to recover.
- NHS over 90 day debt predominantly relates to NCA's £583k (Jan: £511k), of which £527k is due from Kettering General.
- NHS 61-90 days debt includes £119k Qtr 2 over-performance SLA income due from Milton Keynes CCG .

Better Payment Compliance Code - 2016/17

Narrative	June 2016	Sept 2016	Dec 2016	Feb 2017	Cumulative 2016/17
NHS Creditors					
No.of Bills Paid Within Target	196	171	149	138	1,874
No.of Bills Paid Within Period	197	193	150	140	1,916
Percentage Paid Within Target	**99.49%**	**88.60%**	**99.33%**	**98.57%**	**97.81%**
Value of Bills Paid Within Target (£000's)	1,761	1,726	1,761	863	19,237
Value of Bills Paid Within Period (£000's)	1,762	1,738	1,765	866	19,316
Percentage Paid Within Target	**99.98%**	**99.31%**	**99.81%**	**99.64%**	**99.59%**
Non NHS Creditors					
No.of Bills Paid Within Target	8,782	8,226	7,572	5,664	82,694
No.of Bills Paid Within Period	8,883	8,277	7,595	5,759	83,349
Percentage Paid Within Target	**98.86%**	**99.38%**	**99.70%**	**98.35%**	**99.21%**
Value of Bills Paid Within Target (£000's)	9,350	8,988	8,693	6,211	94,944
Value of Bills Paid Within Period (£000's)	9,405	9,005	8,705	8,063	97,280
Percentage Paid Within Target	**99.42%**	**99.81%**	**99.86%**	**77.04%**	**97.60%**
Total					
No.of Bills Paid Within Target	8,978	8,397	7,721	5,802	84,568
No.of Bills Paid Within Period	9,080	8,470	7,745	5,899	85,265
Percentage Paid Within Target	**98.88%**	**99.14%**	**99.69%**	**98.36%**	**99.18%**
Value of Bills Paid Within Target (£000's)	11,112	10,714	10,454	7,074	114,181
Value of Bills Paid Within Period (£000's)	11,167	10,744	10,470	8,929	116,596
Percentage Paid Within Target	**99.51%**	**99.73%**	**99.85%**	**79.23%**	**97.93%**

Better Payment Practice Code

- The BPPC performance wasn't achieved for all targets in February due to the late payment of a NHS Supply Chain invoice relating to a replacement linear accelerator of £1.7m as a result of low cash balance at the end of January.

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	JAN £000s	FEB £000s	FORECAST MAR £000s	FORECAST 17/18 APR £000s	MAY £000s	JUN £000s
RECEIPTS																
SLA Base Payments	246,945	19,343	21,547	20,808	19,889	21,204	20,616	20,582	20,589	20,565	20,628	20,587	20,587	22,508	21,499	22,508
STF Funding	4,769	0	0	0	0	2,425	0	0	1,698	647	0	0	0	0	4,769	0
SLA Performance/ Other CCG Investment	2,446	0	0	0	0	0	0	-15	757	43	1,552	8	101	1,707	0	0
Health Education Payments (SIFT etc)	10,158	798	785	858	821	828	845	821	737	854	871	885	1,055	817	817	817
Other NHS Income	15,936	1,419	652	2,850	914	1,679	1,074	962	1,043	949	599	2,401	1,395	1,500	1,500	1,500
PP / Other (Specific > £250k)	4,789	473	0	764	567	273	476	0	962	393	246	284	351	0	0	0
PP / Other	10,232	1,046	691	711	817	783	907	684	894	805	1,131	863	900	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	4,707	0	0	0	0	0	0	2,771	232	0	0	335	1,369	0	0	314
Revenue Support Loan	14,515	0	0	0	0	0	0	0	0	0	0	14,515	0	0	0	0
Revolving Working Capital Facility - deficit funding	15,129	2,038	1,554	2,120	1,724	-1,496	1,259	510	963	1,867	743	2,187	1,660	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	809	436	436	436
Interest Receivable	31	3	4	5	2	3	2	2	2	2	2	1	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	**339,942**	**25,706**	**25,232**	**28,117**	**24,734**	**29,741**	**25,987**	**27,126**	**28,685**	**26,932**	**26,580**	**42,874**	**28,230**	**31,286**	**32,447**	**28,539**
PAYMENTS																
Salaries and wages	184,374	15,154	15,035	15,518	15,288	15,180	15,086	15,199	15,253	15,660	15,574	15,661	15,768	15,911	15,711	15,701
Trade Creditors	94,118	6,686	7,882	8,802	7,280	7,288	8,533	7,319	10,001	7,927	6,889	6,626	8,884	11,509	8,930	9,603
NHS Creditors	19,389	1,565	2,063	1,762	1,763	2,030	1,647	1,778	1,940	1,763	1,432	846	800	2,320	2,120	2,120
Capital Expenditure	17,857	1,864	300	620	404	1,215	705	1,575	1,030	743	3,493	2,698	3,209	1,525	837	1,115
PDC Dividend	3,387	0	0	0	0	0	1,856	0	0	0	0	0	1,531	0	0	0
Repayment of RWC Facility - STF funding	19,365	0	0	0	0	0	2,425	0	0	2,425	0	14,515	0	0	4,850	0
Repayment of Loans (Principal & Interest)	1,368	0	0	0	0	154	460	0	0	0	0	169	585	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	**340,013**	**25,280**	**25,281**	**26,702**	**24,735**	**25,867**	**30,797**	**25,892**	**28,224**	**28,518**	**27,388**	**40,515**	**30,815**	**31,286**	**32,448**	**28,539**
Actual month balance	-72	425	-49	1,415	-1	3,874	-4,811	1,234	461	-1,586	-808	2,359	-2,585	0	-1	0
Cash in transit & Cash in hand adjustment	-30	-24	14	15	12	-20	48	-69	30	-7	-12	-13	-5	0	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	1,744	4,090	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**	**1,744**	**4,090**	**1,500**	**1,500**	**1,500**	**1,500**

Key Issues

- Quarter 3 Over/Under-performance invoices & credit notes have been issued in March with payments forecast to be received in April . The remaining Quarter 2 payments are now forecast to be received in March.
- NHS England are still to advise when payment in respect of Quarter 3 & 4 STF Funding will be made. Payment is forecast to be received in May. Payment relating to performance targets which have been appealed is excluded from the forecast. All borrowing relating to STF Funding is required to be repaid once payment is received from NHS England.
- The Trust has drawn down £3.0m against the new 1.5% Uncommitted Interim Revenue Support Facility (ISUCL) in February. A further draw down of £2.5m has been approved for March. The £14.5m Interim Working Capital Support drawn down to date has been converted to an Interim Revenue Support Facility in February. This has an interest rate of 1.5%.
- Capital Loan of £0.3m has been drawn down in February with a further £1.4m approved for draw down in March.
- It is anticipated that cash available for trade creditors may be restricted in March. Capital Expenditure invoices, for which Loan Funding has been received, will be prioritised. Direct Debit payments will also be collected by DH in March in relation to PDC Dividend & Loan repayments.

9. Conclusion

Key Points:

- The Trust has performed £23k better than plan in the period ended February 2017.
- There has been improvement in Pay spend, but more improvement is required. The Trust must continue to follow through on measures to curb agency spend, including such measures as CEO sign off and Exec scrutiny over agency spend.
- Elective income has fallen behind plan due to increased NEL demand and capacity pressures. The underperformance on electives has been managed by increasing outsourcing as well as increasing Daycase activity.
- STF support of £8.4m has been included in the YTD position. The outcome of the Q3 cancer appeal is yet to be known but we remain hopeful for a successful outcome.
- The Trust is on track to deliver its plan for the year.
- The risks to the position still remain and the Trust must maintain the financial discipline it has exercised in order to ensure it stays on track.

Report To	**Public Trust Board**
Date of Meeting	**30 March 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 an increase in contracted workforce employed by the Trust and no change in the sickness absence rate since January 2017. • Decrease in compliance rate for Mandatory Training and Appraisals and an increase in compliance for Role Specific Essential Training. • Position relating to number of in month changes for employee relations cases. • Exception Reports for Staff Turnover, Staff Role Specific Training, Mandatory Training, Staff Appraisals, Sickness Absence and Vacancy Rates.	
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

30 March 2017

Workforce Performance Report

1. Introduction

This report identifies the key themes emerging from February 2017 performance and identifies trends against Trust targets. It also sets out current key workforce updates.

2. Workforce Report

2.1 Capacity

Substantive Workforce Capacity increased by 3.88 FTE in February 2017 to 4319.77 FTE. The Trust's substantive workforce is at 90.50% of the Budgeted Workforce Establishment of 4772.94 FTE.

Annual Trust turnover increased by 0.25% to 9.70% in February which is above the Trust target of 8%. Turnover within Nursing & Midwifery decreased by 0.15% to 6.48%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust. Turnover also increased in Add Prof Sci & Technicians, Additional Clinical Services, Administrative & Clerical, Allied Health Professionals, Healthcare Scientists and Estates & Ancillary. Turnover decreased in Nursing & Midwifery.

Medical Division: turnover decreased by 0.01% to 7.33%

Surgical Division: turnover increased by 0.40% to 9.26%

Women, Children & Oncology Division: turnover decreased by 0.35% to 8.72%

Clinical Support Services Division: turnover increased by 1.18% to 11.87%

Support Services: turnover increased by 0.40% to 12.65%

The vacancy rates for Additional Professional Scientific & Technical, Additional Clinical Services, Healthcare Scientists and Medical & Dental staff groups all increased in February 2017. Registered Nursing & Midwifery vacancy rate decreased this month from 11.14% to 10.55%, there has also been a decrease in Administrative & Clerical, Allied Health Professionals and Estates & Ancillary staff groups in February.

Sickness absence for February 2017 remains the same as last month at 4.14% which is above the Trust target of 3.8%. Clinical Support Services and Support Services were the only Divisions below the trust target. In total 9 directorate level organisations were below the trust target rate in February 2017.

2.2 Capability

Appraisals, Mandatory Training and Role Specific Essential Training

The current rate of Appraisals recorded for February 2017 is 84.40%; this is a decrease of 1.96% from last month's figure of 85.36%.

Mandatory Training compliance decreased in February from 86.90% to 83.35% which is lower than the Trust target of 85%. This is the first time that mandatory training compliance has fallen below Trust target since March 2016.

Role Specific Essential Training compliance increased in February to 79.74% from last month's figure of 79.04%.

3. Assessment of Risk

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

4. Recommendations/Resolutions Required

The Trust Board is asked to note the report.

5. Next Steps

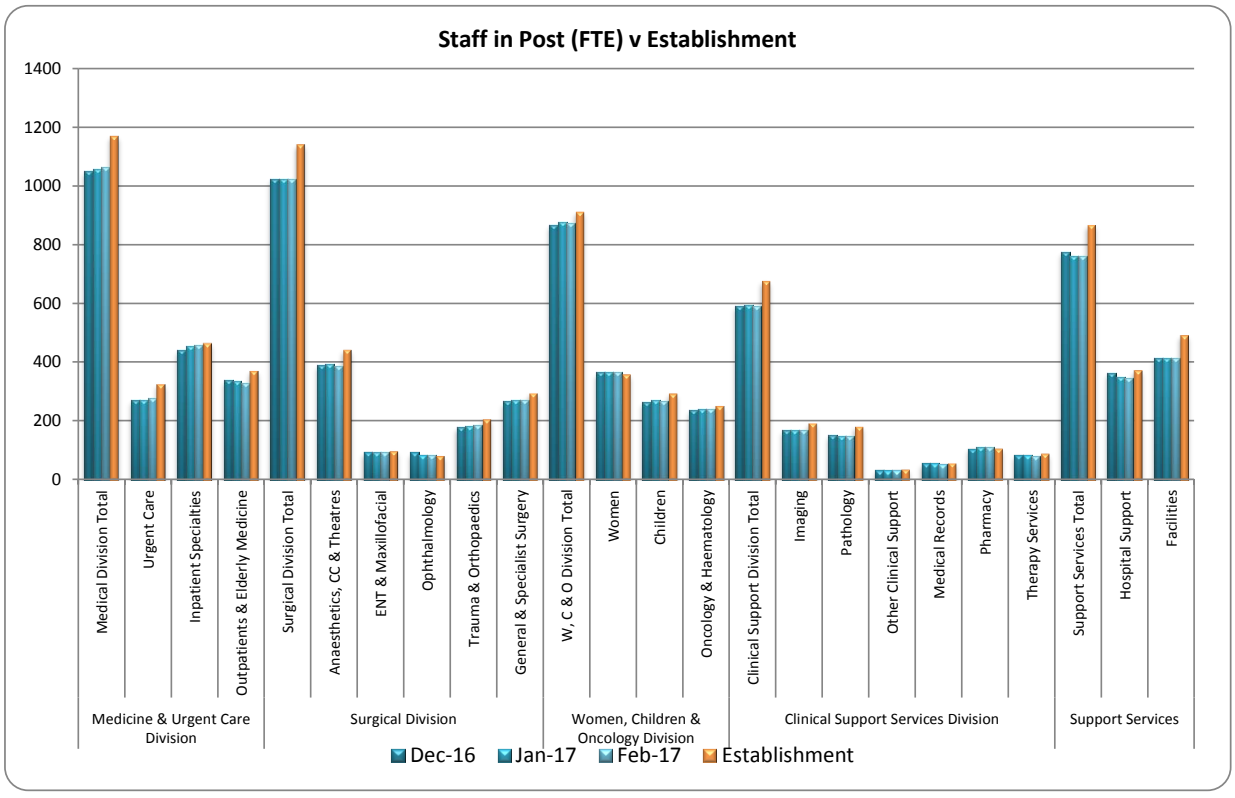
Key workforce performance indicators are subject to regular monitoring and appropriate action is taken as required.

Workforce Committee: Capacity, Capability and Culture Report - February 2017

CAPACITY
Staff in Post

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

Staff in Post (FTE)		Dec-16		Jan-17		Feb-17	Establishment	
Medicine & Urgent Care Division	Medical Division Total	1050.19	↑	1059.18	↑	1063.13	1170.00	90.87%
	Urgent Care	269.30	↑	269.39	↑	275.19	327.94	83.91%
	Inpatient Specialties	441.10	↑	452.65	↑	458.04	467.19	98.04%
	Outpatients & Elderly Medicine	338.79	↓	336.14	↓	328.89	372.82	88.22%
Surgical Division	Surgical Division Total	1023.41	↓	1022.87	↑	1024.01	1141.79	89.68%
	Anaesthetics, CC & Theatres	391.19	↑	391.72	↓	386.27	444.41	86.92%
	ENT & Maxillofacial	92.87	↓	91.47	↑	91.89	100.59	91.35%
	Ophthalmology	91.23	↓	83.31	↑	84.04	84.21	99.80%
	Trauma & Orthopaedics	178.32	↑	181.02	↑	184.94	208.96	88.51%
	General & Specialist Surgery	265.00	↑	270.56	↑	272.06	297.82	91.35%
Women, Children & Oncology Division	W, C & O Division Total	866.70	↑	876.22	↓	875.04	913.52	95.79%
	Women	363.85	↑	365.49	↑	365.51	360.91	101.28%
	Children	263.84	↑	268.60	↓	266.84	295.89	90.18%
	Oncology & Haematology	237.08	↑	240.20	↑	240.75	253.87	94.83%
Clinical Support Services Division	Clinical Support Division Total	591.95	↑	592.90	↓	588.75	677.65	86.88%
	Imaging	167.50	↓	167.41	↓	166.69	195.77	85.15%
	Pathology	149.72	↓	148.89	↓	148.89	184.35	80.76%
	Other Clinical Support	32.92	↓	31.12	↑	32.42	37.93	85.48%
	Medical Records	54.49	↓	53.76	↓	51.23	59.33	86.34%
	Pharmacy	105.06	↑	110.06	↓	109.86	108.93	100.85%
	Therapy Services	82.26	↓	81.66	↓	79.66	91.34	87.22%
Support Services	Support Services Total	775.15	↓	760.71	↑	760.84	868.67	87.59%
	Hospital Support	361.39	↓	347.74	↓	346.32	374.96	92.36%
	Facilities	413.76	↓	412.98	↑	414.52	493.71	83.96%
Trust Total		4307.40	↑	4315.89	↑	4319.77	4772.94	90.51%



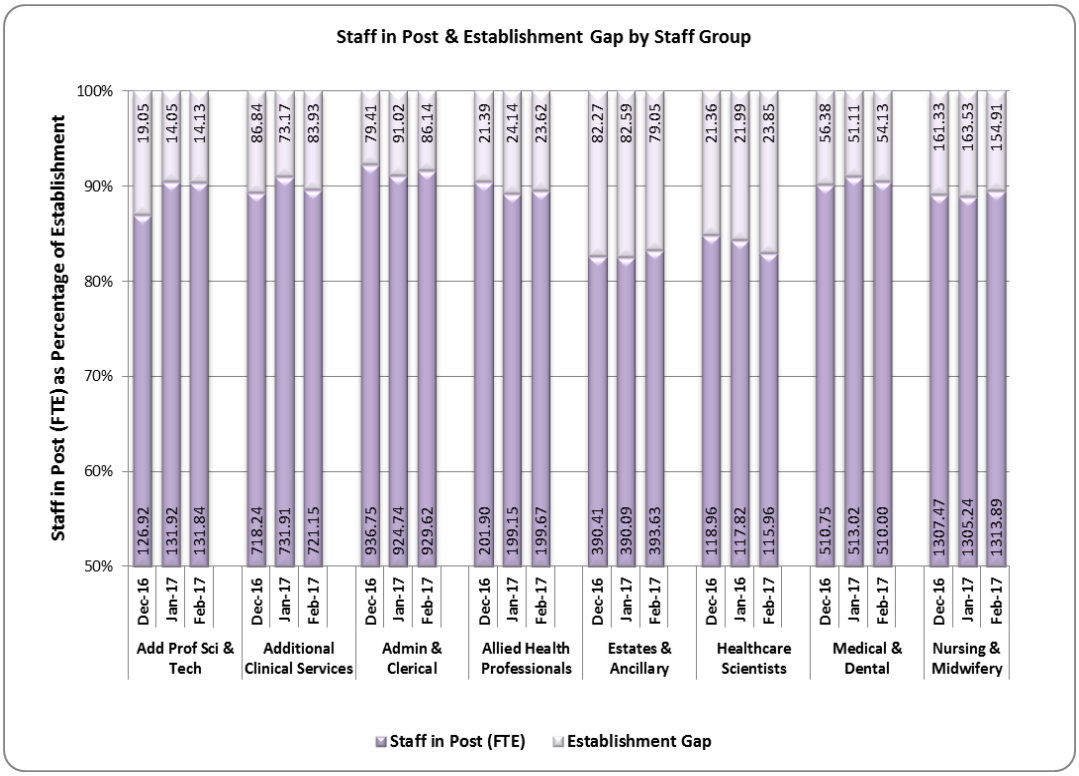
Workforce Committee: Capacity, Capability and Culture Report - February 2017

CAPACITY
Staff Group (FTE v Est)

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

Staff Group Vacancy Rate (Contracted FTE v Establishment)

Staff Group	Dec-16	Jan-17	Feb-17
Add Prof Sci & Tech	13.05%	9.63%	9.68%
Additional Clinical Services	10.78%	9.09%	10.43%
Admin & Clerical	7.82%	8.96%	8.48%
Allied Health Professionals	9.58%	10.81%	10.58%
Estates & Ancillary	17.41%	17.47%	16.72%
Healthcare Scientists	15.28%	15.73%	17.06%
Medical & Dental	9.99%	9.06%	9.59%
Nursing & Midwifery	10.98%	11.14%	10.55%



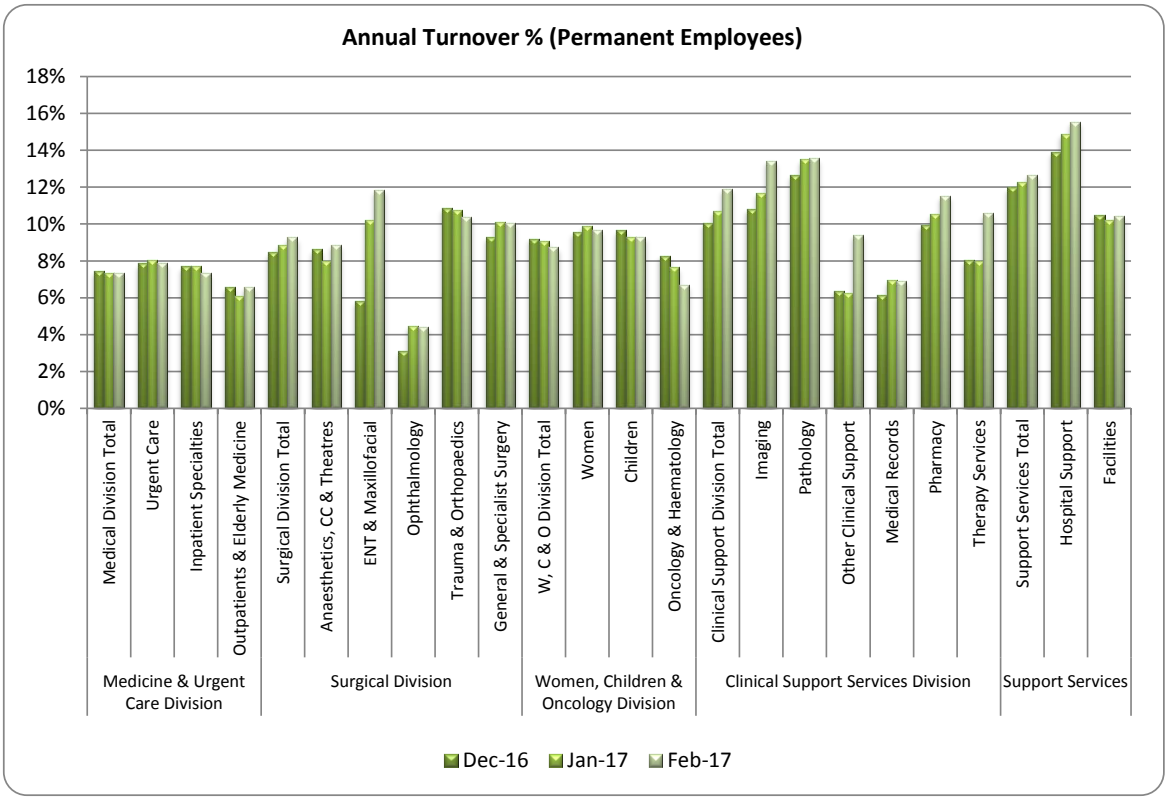
Workforce Committee: Capacity, Capability and Culture Report - February 2017

CAPACITY
Annual Turnover

Figures refer to the year ending in the month stated

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

Annual Turnover (Permanent Staff)		Dec-16	Jan-17	Feb-17
Medicine & Urgent Care Division	Medical Division Total	7.45%	7.34%	7.33%
	Urgent Care	7.85%	8.02%	7.87%
	Inpatient Specialties	7.68%	7.68%	7.36%
	Outpatients & Elderly Medicine	6.56%	6.08%	6.56%
Surgical Division	Surgical Division Total	8.45%	8.86%	9.26%
	Anaesthetics, CC & Theatres	8.61%	8.00%	8.86%
	ENT & Maxillofacial	5.80%	10.23%	11.84%
	Ophthalmology	3.11%	4.45%	4.41%
	Trauma & Orthopaedics	10.86%	10.73%	10.35%
	General & Specialist Surgery	9.27%	10.11%	10.06%
Women, Children & Oncology Division	W, C & O Division Total	9.21%	9.07%	8.72%
	Women	9.55%	9.87%	9.64%
	Children	9.64%	9.29%	9.28%
	Oncology & Haematology	8.27%	7.64%	6.67%
Clinical Support Services Division	Clinical Support Division Total	10.06%	10.69%	11.87%
	Imaging	10.79%	11.69%	13.41%
	Pathology	12.67%	13.50%	13.54%
	Other Clinical Support	6.35%	6.26%	9.38%
	Medical Records	6.15%	6.93%	6.89%
	Pharmacy	9.93%	10.52%	11.52%
	Therapy Services	8.02%	7.99%	10.57%
Support Services	Support Services Total	11.98%	12.25%	12.65%
	Hospital Support	13.92%	14.89%	15.51%
	Facilities	10.47%	10.22%	10.43%
Trust Total		9.27%	9.45%	9.70%



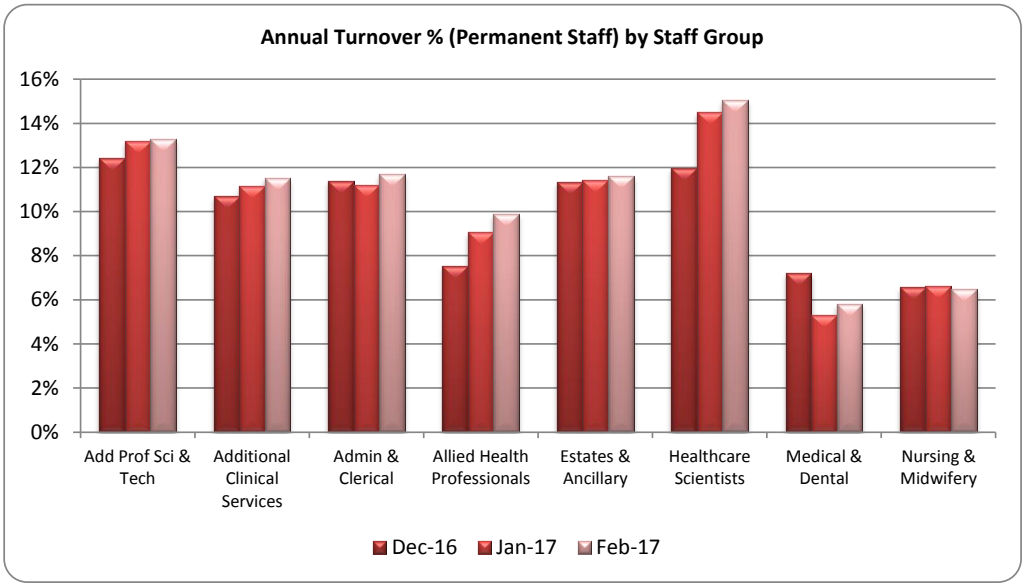
Workforce Committee: Capacity, Capability and Culture Report - February 2017

CAPACITY
Turnover by Staff Group

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

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

Staff Group	Dec-16	Jan-17		Feb-17	
Add Prof Sci & Tech	12.41%	↗	13.19%	↗	13.30%
Additional Clinical Services	10.68%	↗	11.16%	↗	11.53%
Admin & Clerical	11.39%	↘	11.17%	↗	11.69%
Allied Health Professionals	7.52%	↗	9.08%	↗	9.88%
Estates & Ancillary	11.33%	↗	11.41%	↗	11.61%
Healthcare Scientists	11.98%	↗	14.51%	↗	15.04%
Medical & Dental	7.21%	↘	5.30%	↗	5.80%
Nursing & Midwifery	6.57%	↗	6.63%	↘	6.48%



Capacity: Substantive Workforce Capacity increased by 3.88 FTE in February 2017 to 4319.77 FTE. The Trust's substantive workforce is at 90.50% of the Budgeted Workforce Establishment of 4772.94 FTE.

Staff Turnover: Annual Trust turnover increase by 0.25% to 9.70% in February which is above the Trust target of 8%. Turnover within Nursing & Midwifery decreased by 0.15% to 6.48%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust. Turnover also increased in Add Prof Sci & Technicians, Additional Clinical Services , Administrative & Clerical, Allied Health Professionals , Healthcare Scientists and Estates & Ancillary . Turnover decreased in Nursing & Midwifery.

Medical Division: turnover decreased by 0.01% to 7.33%
Surgical Division: turnover increased by 0.40% to 9.26%
Women, Children & Oncology Division: turnover decreased by 0.35% to 8.72%
Clinical Support Services Division: turnover increased by 1.18% to 11.87%
Support Services: turnover increased by 0.40% to 12.65%

Staff Vacancies: The vacancy rates for Additional Professional Scientific & Technical, Additional Clinical Services, Healthcare Scientists and Medical & Dental staff groups all increased in February 2017. Registered Nursing & Midwifery vacancy rate decreased this month from 11.14% to 10.55% , there has also been a decrease in Administrative & Clerical, Allied Health Professionals and Estates & Ancillary staff groups in February.

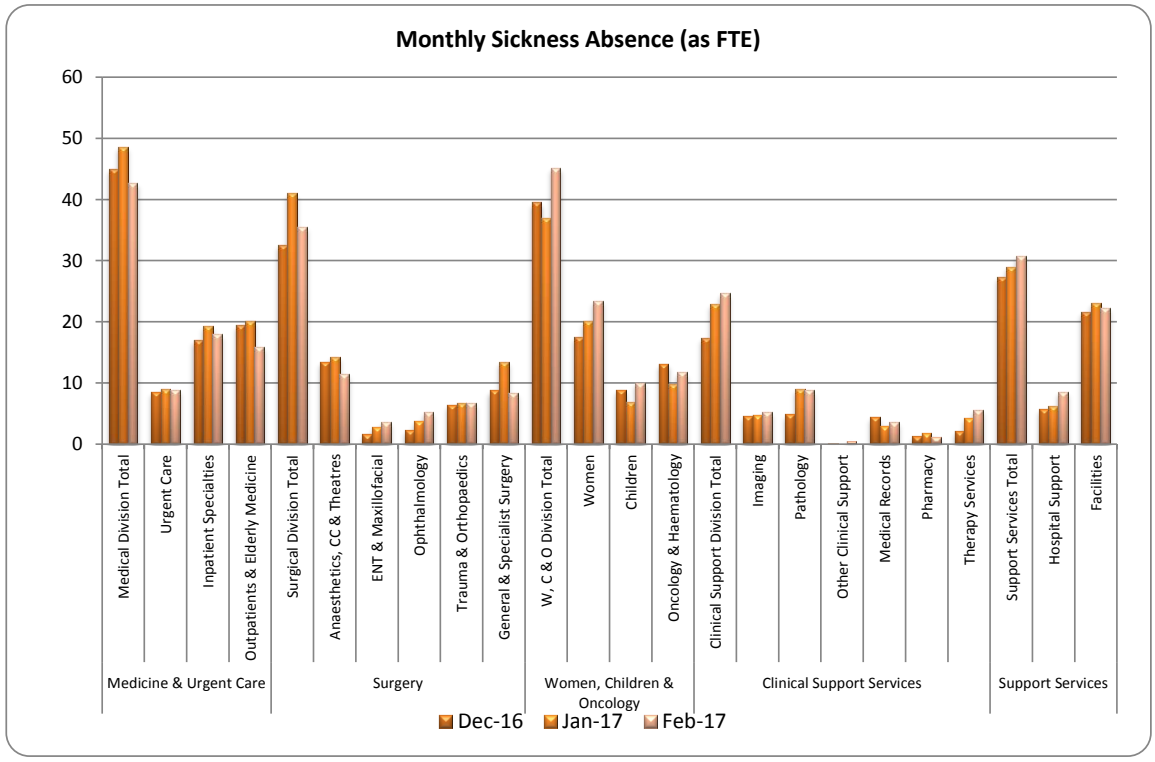
Sickness Absence: Sickness absence for February 2017 remains the same as last month at 4.14% which is above the Trust target of 3.8%. Clinical Support Services and Support Services were the only Divisions below the trust target. In total 9 directorate level organisations were below the trust target rate in February 2017.

Workforce Committee: Capacity, Capability and Culture Report - February 2017

CAPACITY
In-Month Sickness

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

Monthly Sickness (as FTE)		Dec-16	Jan-17	Feb-17	Feb-17	Short Term	Long Term
Medicine & Urgent Care	Medical Division Total	44.95	48.59	42.63	4.01%	2.83%	1.18%
	Urgent Care	8.46	8.92	8.83	3.21%	2.48%	0.73%
	Inpatient Specialties	17.07	19.33	17.91	3.91%	2.34%	1.57%
	Outpatients & Elderly Medicine	19.41	20.13	15.82	4.81%	3.80%	1.01%
Surgery	Surgical Division Total	32.54	40.96	35.53	3.47%	2.27%	1.20%
	Anaesthetics, CC & Theatres	13.46	14.25	11.47	2.97%	1.93%	1.03%
	ENT & Maxillofacial	1.63	2.78	3.57	3.88%	2.28%	1.60%
	Ophthalmology	2.25	3.84	5.17	6.15%	3.86%	2.29%
	Trauma & Orthopaedics	6.42	6.77	6.69	3.62%	2.18%	1.45%
	General & Specialist Surgery	8.75	13.39	8.35	3.07%	2.30%	0.77%
Women, Children & Oncology	W, C & O Division Total	39.52	36.93	45.15	5.16%	3.44%	1.71%
	Women	17.54	20.18	23.43	6.41%	4.29%	2.12%
	Children	8.84	6.86	9.98	3.74%	3.22%	0.53%
	Oncology & Haematology	13.13	9.85	11.70	4.86%	2.44%	2.42%
Clinical Support Services	Clinical Support Division Total	17.34	22.84	24.61	4.18%	2.85%	1.33%
	Imaging	4.56	4.77	5.20	3.12%	2.28%	0.84%
	Pathology	4.81	8.95	8.74	5.87%	2.58%	3.29%
	Other Clinical Support	0.10	0.03	0.46	1.41%	1.41%	0.00%
	Medical Records	4.46	2.99	3.54	6.92%	3.95%	2.97%
	Pharmacy	1.29	1.81	1.12	1.02%	1.02%	0.00%
	Therapy Services	2.11	4.19	5.52	6.93%	6.93%	0.00%
Support Services	Support Services Total	27.29	28.99	30.74	4.04%	2.31%	1.73%
	Hospital Support	5.64	6.13	8.52	2.46%	1.71%	0.74%
	Facilities	21.60	23.05	22.26	5.37%	2.82%	2.56%
Trust Total	*As FTE*	161.53	178.84	178.84			
	As percentage	3.75%	4.14%		4.14%	2.73%	1.41%



Workforce Committee: Capacity, Capability and Culture Report - February 2017

CAPABILITY
Training & Appraisal Rates

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

Mandatory Training Compliance Rate	Directorate	Dec-16	Jan-16	Feb-17
Medicine & Urgent Care Division	Medical Division Total	82.82%	85.02%	81.43%
	Urgent Care	82.20%	84.49%	79.84%
	Inpatient Specialties	80.99%	83.38%	80.49%
	Outpatients & Elderly Medicine	85.56%	87.51%	83.94%
Surgical Division	Surgical Division Total	86.32%	86.37%	81.31%
	Anaesthetics, CC & Theatres	84.99%	84.65%	79.24%
	ENT & Maxillofacial	79.29%	81.60%	75.26%
	Ophthalmology	87.77%	85.01%	79.59%
	Trauma & Orthopaedics	87.54%	88.56%	85.22%
	General & Specialist Surgery	89.36%	89.40%	84.19%
Women, Children & Oncology Division	W, C & O Division Total	88.65%	88.82%	86.45%
	Women	87.43%	87.85%	84.98%
	Children	90.55%	90.32%	89.63%
	Oncology & Haematology	88.50%	88.87%	85.32%
Clinical Support Services Division	Clinical Support Division Total	88.67%	88.52%	86.07%
	Imaging	84.82%	83.85%	82.16%
	Pathology	90.56%	90.51%	86.99%
	Other Clinical Support	89.68%	91.06%	88.63%
	Medical Records	89.53%	91.50%	84.62%
	Pharmacy	92.52%	90.27%	90.20%
	Therapy Services	87.08%	88.93%	86.67%
Support Services	Support Services Total	86.90%	86.58%	82.86%
	Hospital Support	90.44%	89.51%	87.33%
	Facilities	84.15%	84.35%	79.46%
Trust Total		**86.41%**	**86.90%**	**83.35%**

Workforce Committee: Capacity, Capability and Culture Report - February 2017

CAPABILITY
Training & Appraisal Rates

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

Role Specific Training Compliance Rate	Directorate	Dec-16	Jan-17	Feb-17
Medicine & Urgent Care Division	Medical Division Total	75.60%	77.56%	77.69%
	Urgent Care	74.91%	77.39%	77.17%
	Inpatient Specialties	72.95%	75.00%	75.09%
	Outpatients & Elderly Medicine	79.87%	81.28%	81.81%
Surgical Division	Surgical Division Total	79.54%	80.06%	79.94%
	Anaesthetics, CC & Theatres	76.40%	76.38%	76.56%
	ENT & Maxillofacial	68.68%	69.81%	71.04%
	Ophthalmology	80.17%	79.14%	76.41%
	Trauma & Orthopaedics	82.09%	83.46%	83.63%
	General & Specialist Surgery	85.25%	86.11%	85.62%
Women, Children & Oncology Division	W, C & O Division Total	81.71%	82.63%	82.89%
	Women	78.59%	79.66%	81.18%
	Children	86.56%	88.11%	87.79%
	Oncology & Haematology	82.53%	81.98%	79.82%
Clinical Support Services Division	Clinical Support Division Total	76.64%	75.50%	81.29%
	Imaging	73.59%	75.54%	77.25%
	Pathology	59.03%	58.18%	84.18%
	Other Clinical Support	80.71%	87.05%	80.13%
	Medical Records	97.10%	97.06%	95.38%
	Pharmacy	86.73%	80.89%	82.83%
	Therapy Services	87.05%	83.19%	83.33%
Support Services	Support Services Total	70.90%	71.08%	72.68%
	Hospital Support	74.06%	75.03%	77.81%
	Facilities	67.02%	66.41%	66.77%
Trust Total		**78.14%**	**79.04%**	**79.74%**

Capability

Appraisals
The current rate of Appraisals recorded for February 2017 is 83.40%; this is an decrease of 1.96% from last month's figure of 85.36%.

Mandatory Training and Role Specific Essential Training
Mandatory Training compliance decreased in February from 86.90% to 83.35% which is lower than the Trust target of 85%.

Role Specific Essential Training compliance increased in February to 79.74% from last month's figure of 79.04%.

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 - February 2017

CAPABILITY
Training & Appraisal Rates

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

Appraisal Compliance Rate	Directorate	Dec-16	Jan-17	Feb-17
Medicine & Urgent Care Division	Medical Division Total	77.95%	83.13%	82.61%
	Urgent Care	81.51%	89.66%	89.55%
	Inpatient Specialties	73.33%	77.59%	79.00%
	Outpatients & Elderly Medicine	80.95%	85.20%	81.82%
Surgical Division	Surgical Division Total	87.01%	89.27%	86.81%
	Anaesthetics, CC & Theatres	85.39%	84.51%	84.00%
	ENT & Maxillofacial	79.22%	82.67%	89.04%
	Ophthalmology	86.08%	87.50%	75.64%
	Trauma & Orthopaedics	89.22%	95.21%	92.49%
	General & Specialist Surgery	90.83%	94.56%	89.84%
Women, Children & Oncology Division	W, C & O Division Total	86.39%	90.25%	87.61%
	Women	81.82%	88.16%	84.60%
	Children	89.81%	91.70%	91.73%
	Oncology & Haematology	90.72%	92.47%	88.48%
Clinical Support Services Division	Clinical Support Division Total	80.40%	82.47%	79.91%
	Imaging	74.01%	83.91%	77.27%
	Pathology	82.61%	81.01%	86.16%
	Other Clinical Support	52.63%	75.68%	70.00%
	Medical Records	88.41%	735.53%	69.23%
	Pharmacy	91.38%	94.69%	86.61%
	Therapy Services	80.43%	76.40%	76.67%
Support Services	Support Services Total	78.06%	80.69%	78.84%
	Hospital Support	77.78%	79.89%	78.05%
	Facilities	78.27%	81.30%	79.44%
Trust Total		**82.01%**	**85.36%**	**84.40%**

Northampton General Hospital NHS
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**30 March 2017**

Title of the Report	National Staff Survey Results 2016
Agenda item	***12***
Presenter of the Report	Janine Brennan, Director of Workforce and Transformation
Author(s) of Report	Janine Brennan, Director of Workforce and Transformation
Purpose	For Information
Executive summary: The paper provides an overview of the survey results for 2016 and progress against our Organisational Effectiveness Strategy	
Related strategic aim and corporate objective	Enable Excellence through our people
Risk and assurance	
Related Board Assurance Framework entries	2.3
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? No Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? No
Legal implications / regulatory requirements	Staff survey results are considered as a key part of CQC ratings.
Actions required by the Trust Board The Trust Board is asked to note the report.	

Enclosure H

Northampton General Hospital NHS
NHS Trust

Trust Board March 2017
National Staff Survey Results 2016

1. Introduction

The national staff survey was undertaken between October and December 2016. This report contains the key headlines.

2. Overview

A total of 1,624 members of staff returned the survey, constituting a 35% response rate, compared to a 32% response rate in 2015.

Of the 32 key findings the Trust has four in the top 20%, when compared to other Acute Trusts; an improvement from last year.

Of the 32 key findings the Trust had 2 in the lowest (worse) 20% when compared to other Acute Trusts, an improvement from last year which stood at 9 key findings in this category.

The Trust had 12 statistically significant improvements since 2015 which includes staff engagement and staff recommendation as a place to work or receive treatment.

The attached report sets out in detail the key findings together with work undertaken through, inter alia, our Organisational Effectiveness Strategy that was designed to address the underlying cultural and organisational issues that influence staff perceptions about the trust, their work environment and their role.

3. Assessment of Risk

The staff survey results are indicators used by the CQC as part of their regulatory role. In 2014 we changed our approach to move away from a more traditional year on year action plans. Instead we've developed our Organisational Effectiveness Strategy, a long term programme of work that aims to steadily improve our performance against the reports key findings.

4. Recommendations

The Trust Board is asked to note the report.

5. Next Steps

Work continues on all key themes underpinning the relevant strategies and the overall Organisational Effectiveness strategy. A specific focus on bullying harassment to enable us to respond to the issues raised around this in the survey is under development.

Northampton General Hospital NHS
NHS Trust

National NHS 2016 Staff Survey Results

1.0 Summary

The NGH approach is to address the underlying root causes, working towards a fundamental shift in culture, where everyone is focussed on quality improvement, effective leadership and meaningful staff engagement to sustainably improve staff satisfaction at work. The staff survey contains the best results achieved by the Trust since its introduction in 2005.

2.0 NGH Results

There are 32 Key Findings (relevant to the acute sector) this year and there has been a marked improvement. In 2015 we had 9 key findings in the bottom 20% in the country (a reduction of 50% from 2014); in 2016 we have 2, a further reduction of 78%.
We have increased our results in the top 20% of the country from 1 key finding in 2015 to 4 in 2016 – a 300% increase. NGH is one of the top 5 most improved acute Trusts in the 2016 survey.

Of the 32 key findings the Trust has four in the top 20%, when compared to other Acute Trusts; an improvement from last year. These include:

- Staff Motivation at Work
- Effective Team Working
- % appraised in last 12 months
- Quality of non-mandatory training, learning or development

Of the 32 key findings the Trust had 2 in the lowest (worse) 20% when compared to other Acute Trusts an improvement from last year, which stood at 9 key findings. The bottom 2 were:

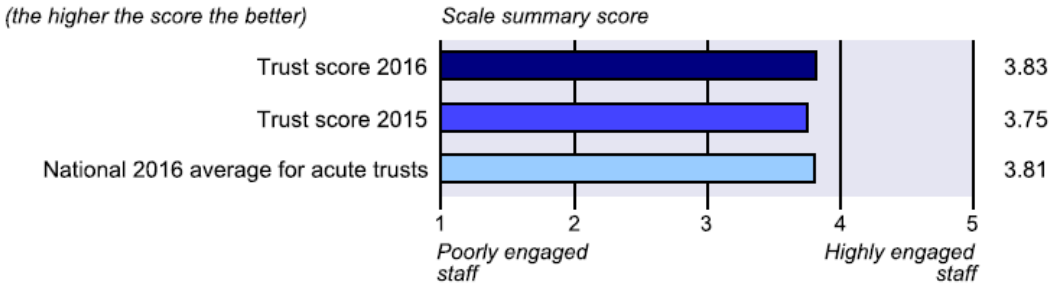
- % satisfied with the opportunities for flexible working patterns (no change from last year)
- % reporting most recent experience of harassment, bullying or abuse (there was no statistically significant change in the response score however this was below average last year, so has deteriorated compared to others).

Within those overall 32 areas, there are 11 results (12 in total) that have statistically significant improvement that include:

- Staff reporting good communication between senior management and staff
- Quality of non-mandatory training, learning or development
- Fairness and effectiveness of procedures for reporting errors, near misses and incidents
- Staff confidence and security in reporting unsafe clinical practice
- Organisation and management interests on health and well being
- Staff recommendation as a place to work or receive treatment
- Staff satisfaction with level of responsibility and involvement
- Staff satisfaction with resourcing and support
- Recognition and value of staff by managers and the organisation
- Support from immediate mangers
- Staff satisfaction with the quality of work they are able to deliver.

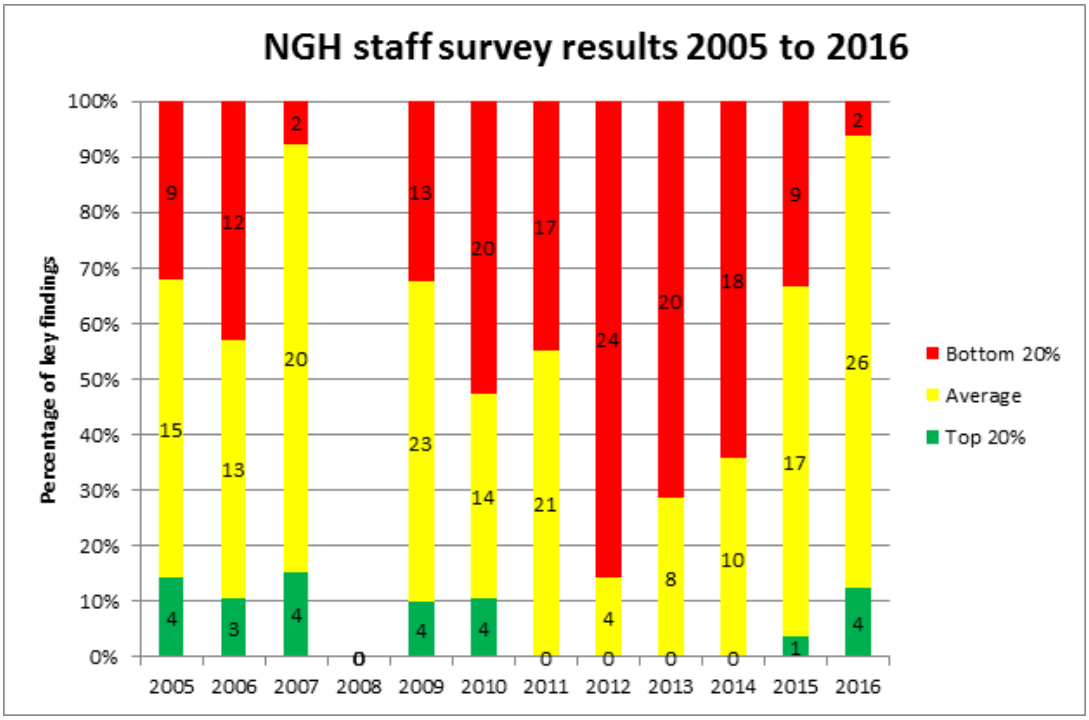
In addition our overall staff engagement score (which is a combined score rather than an individual key finding increased from 3.75 (out of 5) to 3.83 – a statistically significant improvement.

OVERALL STAFF ENGAGEMENT



Trend Analysis

The following graph shows the overall picture is now continuing towards an increasingly upward trend.



In summary results shows below the significant reduction in the number in the bottom 20% and an increase of the number in the top 20%.

Overall there have been improvements across all areas when you compare the trust to the others as follows:

	Lowest (worst) 20%	Below average	Average	Above average	Top 20%
2015	9	15	5	2	1
2016	2	4	14	8	4
Percentage Improvement	78%	74%	200%	300%	300%

Drivers that could be linked to the improvements in the survey

- Further work to embed the Trust values
- Further support for the Quality Improvement agenda including the Quality Improvement Hub and county wide and regional programmes of work
- Further work to improve the Clinically led structure which is now starting to embed
- Team development through 'Rainbow Risk and Back in the Box' workshops
- Increased focus on learning and development to include the Francis Crick Leadership programme and the band 7 development programme
- Focus on re-energising and raising the profile of nursing led by the Director of Nursing, Midwifery and Patient services.
- Continued support for the Trust communications programme of work
- Support for further staff listening events and engagement events
- Further development of the Health and Well Being Strategy
- Further development of the feedback loop for compliments and feedback from patients in real time for wards

Significant issues at and around the time of the survey collection, which may have had an adverse impact

- Hospital capacity and increasing activity/acuity of patients
- Junior Doctor industrial action
- Medical and Nurse staffing levels.

3.0 Addressing the Underlying Issues; Organisational Effectiveness Strategy

We maintain our view that to work on the development of a sustained, coherent and integrated approach to address the underlying organisational and cultural issues will deliver long term sustainable results. The Trust has set out initially to clarify the overall aim of the Trust introducing Best Possible Care and the Trust Values and bringing them to life over the years. A key priority from the start was to align all efforts around the quality agenda in its broadest sense. This includes a relentless focus on patient safety and key quality outcome issues from all operational, clinical and managerial staff underpinned by key programmes of work. This work has been in progress for some time but some of the key initiatives have gained significant traction over the last 2 years.

The approach has been led and modelled by Board members in a variety of ways including leading by example and focus as well as ensuring that supporting strategies are developed. The entire executive team has supported the relentless focus on the quality agenda in terms of the approach they take on a day to day basis.

This approach was originally captured in the Trust's Organisational Effectiveness Strategy: **Connecting for Quality, Committed to Excellence.** This led on from the Trust's focus on strategies for patient safety and quality improvement based but took this much further by focussing on the development of staff around Quality Improvement. The overall aim is supported also by a variety of other components including the Quality Improvement Strategy , the approach to Changing Care @ NGH , the Communications Strategy , the

approach to the safety focus of urgent care programmes particularly safety in A&E , Board Development programmes , a number of leadership programmes, programmes of work to increase team and personal awareness led by the organisational development team, the patient experience feedback programmes and the Dare to Share events set up for staff to learn from serious incidents .

Relevant Programmes of work and initiatives

Employee Engagement Strategy

Our organisational effectiveness strategy was primarily focussed around improving staff engagement - but with a purpose – to enthuse and engage staff in continuously finding ways to improve their service and thus increase their job satisfaction, wellbeing and ability to contribute to the overall ability of the trust to 'deliver best possible care'. Hence all our staff at NGH have 2 jobs: delivering care and improving care. Since launching our flagship employee engagement strategy in 2014, over 1500 employees have taken part in the journey to making NGH a great place to work. The Employee Engagement strategy was designed to facilitate cultural transformation to deliver improved sustainable staff engagement for high performance working, building capability and commitment at all levels of the organisation through:

a) Encouraging self-awareness and positive behaviours aligned to the Trust values to improve work including a model of working with teams and individuals built around **Interact** (understanding personality types and styles of communication)
b) Increasing collaborative working built around I**ntegrate** (understanding how team cultures develop)
c) Promoting opportunities to empower and enable the execution of **innovation** (designing the journey to excellence for your service).

The following themes are all aligned to deliver this over-riding common purpose and have been introduced since 2013, which is when our staff survey results started to show year on year improvement.

Communications initiatives to strengthen engagement and build on the quality alignment theme

The communications team have greatly improved the scope and content of communications across the Trust and meet regularly with the CEO to ensure alignment of all messages. Some of the initiatives include:

- Screensavers targeted to support specific initiatives such as red to green which have been shared internationally
- Features in Insight to raise awareness with a wider audience, including leading articles on urgent care, sepsis, care of the elderly, and features on spotlight wards and departments
- Health and wellbeing intranet pages and resources, clear branding of all health and wellbeing communications activity, including a number of high-profile events in the cybercafé to help raise awareness of events and opportunities for improving health and wellbeing, and more lately an animated film to help raise awareness
- Use of the NGH plus app to extend the information we share via Insight and bring stories to life
- Best Possible Care Awards (supported by the organisational development team)
- First-ever social media conference for staff
- Award-winning recruitment campaign
- Supporting new listen and learn and topical tea events, building on last year's compass check
- Helping improve patient experience through support of newly launched bedside book club
- Social media campaigns to support targeted recruitment activity, sepsis, discharge, service developments, and infection prevention to name but a few

Theme: Making Quality Count

Developing staff around continuous improvement methodologies

Since 2014, the Making Quality Count programme has run a number of successful programmes. The 6 month development programme equips teams with a common methodology (D5) and tool kit for local service improvement. The teams access the expertise of the Improving Quality and Efficiency team (IQET) and typically look to deliver against a range of measures including: quality, patient safety, efficiency, productivity and staff engagement. 3 projects have recently concluded and the next phase is due to commence.
The IQE Team also work on the ground with teams to redesign their services and processes using the D5 methodology

Developing clinical staff around quality improvement designed around key quality and safety issues

The hospital has built on work done in this area over the last 8 years and is now recognised on an international platform for the improvement initiatives our clinicians and managers have delivered. The work originally was developed in order to improve the safety culture at NGH and many initiatives continue to be based around key safety issues including the very successful work around the safety culture in A&E. To support and strengthen the delivery of the Quality improvement ambition the Trust has a multidisciplinary and multitalented Quality Improvement (QI) Team and a designated resourced QI Hub.
The QI team support doctors-in-training in a variety of forums and capacities, from QI undergraduate training as an a student selected module entitled "Aspiring to Excellence", a Junior Doctor Safety Board and Registrar leadership and development programmes entitled "Delivering Excellence". The QI projects delivered throughout the above programmes have been accepted for presentation at the International Forum on Quality and Safety in Healthcare – NGH had the largest QI contingent at this prestigious safety conference

Theme: Managing for Quality and Leading for Excellence

Francis Crick Development Programme

The Francis Crick Programme is a Leadership and Management Programme for senior leaders operating in the new clinically led structure. Phase 1 is to complete in April and phase 2 commenced in February 2017.

This programme aims to emphasise the key issues in leadership in today's NHS and also brings the clinical and managerial leaders together as they learn. A key premise of this is that the quality, finance and operational agendas are owned by all leaders and managers and indeed by all members of staff.

Other Key Leadership programmes

The QI teams support for doctors in training includes a leadership component and the Registrar programme has been extended to include leadership programme across the STP for Specialist trainees in both acute and general practice. Further leadership development has been set up for nurses including the RCN leadership programme and for newly appointed consultants

Theme: Developing a culture of Excellence

Organisational Values

Staff were involved in developing a set of Trust values as follows:

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

Actions are being undertaken to embed these including embedding them in our policies, living our values every day (LOVE) and Values in Practice (VIP) interventions.

Inspiring Nurses to give of their best

A new nursing strategy has been launched and NGH has signed up to be the first UK Trust to aspire to an accreditation programme entitled Pathway to Excellence. The Trust supports the view that high quality nursing is the bedrock of good clinical care.

Theme: Enabling Quality

The clinically led structure

Clinical directorates operate a clinically-led model, with four divisions, each with three clinical directorates. The model's aims are to create more devolved decision making and greater synergy between medical, clinical and managerial staff. The model is now embedding and we believe is part of the driver for the improvements particularly those around management and leadership, responsibility and involvement.

Theme: Changing for the better

Change without migraines

A change management model that helps managers and leaders lead staff through change has been adopted and leaders have been introduced to the model and received training in the model as part of the Francis Crick programme.

Theme: Rewarding Excellence

Best Possible Care Awards

The introduction of the annual Best Possible Care awards led by the communications team and the organisational development teams have been a resounding success and are gaining in momentum and popularity every year. These set out to recognise and show value to our staff for their actions in committing to excellence.

Feedback on Compliments

The various mechanisms for feeding results back to front line staff have been improved. This is in line with a clear need to link the staff experience and the patient experience and ensure that staff feel valued for the work they do.

Encouraging support for National Awards

There has been active encouragement for staff to put colleagues forward for healthcare awards with some significant success including increasing numbers of shortlisted initiatives and some outright winners**.**

Assisting staff to submit articles and posters for publication

In the light of the importance of recognising and celebrating successes the QI team offer support for publication in a healthcare journals, or presentation at national or international healthcare conferences for QI projects

Theme: Supporting Staff Health and Wellbeing

There is an active Health and Wellbeing programme which is being led and supported by lead directors and by a small cohort of enthusiastic staff including the communications department and key individuals from HR and Facilities. Further funding has now been agreed to extend the programme and the already successful nutrition and fitness programmes and being extended to include a focus on mental health. The need to link the health and wellbeing of staff to initiatives to keep the public healthy has been accepted

Theme: Focus on Improving Quality in order to provide more cost effective healthcare

The NGH Changing Care @ NGH programme sets out to focus on getting the quality and efficiency of services right with the aim of release resources through that process. This is different from a traditional CIP programme and this focus will continue as evidence based national programmes of work such as the Carter report and Getting it Right First Time are used to focus efforts on the most important issues.

Theme: Operational Focus on Quality
The NGH approach to urgent care in particular and the challenges this presents to delivery of care are all framed around the need for patient's safety. The daily safety huddles , the approach to staffing issues , the approach to patient moves and the prioritising of issues in the daily operational rhythm all come back to the same questions: are the patients safe and are they getting the treatment they need. This operational focus is led by the Chief Operating Officer and supported by operational and clinical staff alike.

Theme: Overall Trust Strategy
The Trust overall strategy is conveyed in the Clinical Strategy which sets out plans for services in the coming years. This refers to all the underpinning strategies as a support and also explicitly sets out to drive the estate and workforce requirements based on the shape of clinical services. This is currently being refreshed and used as a tool for further engagement.

4.0 2016 National Staff survey results by key findings

The table below indicates how the aspects of the organisational effectiveness strategy are underway that impact on a number of key findings aiming for a positive impact on improving results in future surveys.

⇧ shows a positive trend compared to 2015

Blank shows either no change and or cannot be compared

⇩ shows a negative trend compared to 2015

Statistically significant changes are highlighted in yellow and top 20% and bottom 20% in Green and red respectively.

KEY FINDING	STATEMENT	TRUST SCORE	+/- Trend	Work completed and in progress
	STAFF PLEDGE 1: TO PROVIDE ALL STAFF WITH CLEAR ROLES, RESPONSIBILITIES AND REWARDING JOBS			
1	Staff recommendation of the organisation as a place to work or receive treatment	**3.74 out of 5**	⇧	People Strategy Best Possible Care Awards Employee Engagement Strategy (EES) • Street talk • Interact -Rainbow Risk • Integrate- Boxes Staff Friends & family Test SFFT Trust values - VIP Nurse Recruitment Strategy Ward assessment and accreditation Nurse Retention Strategy Making Quality count development programme Induction for Overseas nurses Quality Improvement

2	Staff feeling satisfied with the quality of work and patient care they are able to deliver	**3.97 out of 5**	⇧	Making Quality Count (MQC) continuous improvement development programme Nurse Recruitment Strategy VIP
3	% of staff agreeing their role makes a difference to patients	**90%**		Patient Friends and family test MQC
4	Staff motivation at work	**3.99 out of 5**	⇧	EES • Interact -Rainbow Risk • Integrate- Boxes • Street talk Ward manager development programme Francis Crick leadership development Programme People Strategy Trust values – all Best possible Care Awards Nurse Retention Strategy Developmental coaching, team and 1:1
5	Recognition and value of staff by managers and the organisation	**3.44 out of 5**	⇧	Trust values Best Possible Care awards NGH leadership module
8	Staff satisfaction with level of responsibility and involvement	**3.93 out of 5**	⇧	EES • Interact -Rainbow Risk • Integrate- Boxes Clinically led structure Ward accreditation and assessment
9	Effective team working	**3.81 out of 5**	⇧	EES • Interact (Rainbow Risk) • Integrate (Boxes) Trust values (we respect and support each other): LOVE Developmental team coaching Clinically led structure
14	Staff satisfaction with resourcing and support	**3.33 out of 5**	⇧	Nurse Retention Strategy Nurse Recruitment Strategy
	STAFF PLEDGE 2: TO PROVIDE ALL STAFF WITH PERSONAL DEVELOPMENT, ACCESS TO APPROPRIATE EDUCATION AND TRAINING FOR THEIR JOBS AND LINE MANAGEMENT SUPPORT TO ENABLE THEM TO FULFIL THEIR POTENTIAL			
10	Support from immediate managers	**3.70 out of 5**	⇧	NGH Leadership model Ward manager leadership programme Francis Crick programme Band 6 and Band 7 development Matron Action Learning
11	% of staff appraised in the last 12 months	**91%**	⇧	Appraisal Policy Divisional & corporate dashboard – well led framework Street Talk – Appraisals
12	Quality of appraisals	**3.09 out of 5**	⇧	Appraisal Policy Ward manager leadership programme
13	Quality of non-mandatory training, learning or development	**4.11 out of 5**	⇧	Trust and Local Induction (policy reviewed 2015) Band 6 and Band 7 development Francis Crick Programme

				Consultant Foundation Programme Specific education and training programmes for clinical staff e.g. medical education, Practice Development etc.
	STAFF PLEDGE 3: TO PROVIDE SUPPORT AND OPPORTUNITIES FOR STAFF TO MAINTAIN THEIR HEALTH, WELL-BEING AND SAFETY			
15	% satisfied with the opportunities for flexible working patterns	**46%**	⇧	Nursing Shift standardisation project Flexible Working policy
16	% working extra hours	**71%**	⇧	Nurse Recruitment strategy Nursing Shift standardisation project
17	% of staff suffering work related stress	**37%**	⇧	Stress Management Policy Health & Well-being strategy Occupational Health service Nurse Recruitment Strategy Nurse retention Strategy MQC Francis Crick (resilience)
18	% of staff feeling pressure in the last three months to attend work when feeling unwell	**55%**	⇧	Management of Sickness Absence Policy Nurse Recruitment Leadership development programmes
19	Organisation and management interest in and action on health and wellbeing	**3.58 out of 5**	⇧	Stress Management Policy Health & Well-being strategy Occupational Health service Domestic Abuse Support for staff policy
22	% of staff experiencing physical violence from patients, relatives or the public in the last 12 months	**16%**	⇧	Protecting Staff Against Violence, Aggression and Harassing Situations From Patients and Members of the Public Policy (due for review) Conflict Resolution Training
23	% of staff experiencing physical violence from staff in last 12 months	**2%**		Disciplinary Policy Conflict Resolution Training Trust values – Respect and support
24	% staff /colleagues reporting most recent experience of violence	**67%**	⇧	Datix Francis response (Freedom to Speak Up)
25	% experiencing harassment, bullying or abuse from public in last 12 months	**31%**	⇩	Francis response (Freedom to Speak Up) Protecting Staff Against Violence, Aggression and Harassing Conflict Resolution training
26	% experiencing harassment, bullying or abuse from staff in last 12 months	**26%**	⇧	EES • Interact - Rainbow Risk and boxes Induction training Bullying, Harassment & Victimisation Policy (reviewed 2015)
27	% reporting most recent experience of harassment, bullying or abuse	**26%**	⇩	Bullying, Harassment & Victimisation Policy (reviewed 2015) Freedom to Speak up
	STAFF PLEDGE 4: TO ENGAGE STAFF IN DECISIONS THAT AFFECT THEM, THE SERVICES THEY PROVIDE AND EMPOWER THEM TO PUT FORWARD WAYS TO DELIVER BETTER AND SAFER SERVICES			
6	% reporting good communication between senior management	**34%**	⇧	NGH leadership model Francis Crick programme

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	and staff			Communications strategy Core brief Team Huddles New clinically led Structure CEO Blog Executive visibility e.g. Board to Ward
7	% able to contribute towards improvements at work	**71%**	↑	EES: Street talk Making Quality Count programme Ward assessment and accreditation
	ADDITIONAL THEMES: EQUALITY AND DIVERSITY			
20	% experiencing discrimination at work in the last 12 months.	**11%**	↓	EES: Interact - Rainbow Risk Equality & Diversity Staff Group Equality & Human Rights Strategy 2013 – 2016
21	% believing the Trust provides equal opportunities for career progression or promotion	**86%**	↑	Recruitment, Selection and Retention Policy Equality & Human Rights Strategy People Strategy Nurse Retention Strategy
	ADDITIONAL THEMES: ERRORS AND INCIDENTS			
28	% of staff witnessing potentially harmful errors, near misses or incidents in the last month	**31%**	↑	Datix
29	% of staff reporting errors, near misses or incidents witnessed in the last month	**91%**	↑	Raising Concerns at Work (Whistleblowing) Policy Quality Improvement initiatives
30	Fairness and effectiveness of incident reporting procedures	**3.71 out of 5**	↑	Raising Concerns at Work (Whistleblowing) Policy Datix
31	Staff confidence and security in reporting unsafe clinical practice	**3.63 out of 5**	↑	Francis response (Freedom to Speak Up) recommendations Raising Concerns at Work (Whistleblowing) Policy
32	Effective use of patient / service user feedback	**3.72 out of 5**	↑	Patient FFT Patient surveys Real time, right time feedback process

Our top 5 scores are:

- Quality of Mandatory training (which was revised in 2014/15)
- Percentage staff appraised in the last 12 months (top 20%)
- Staff motivation at work (top 20%)
- Effective team working (top 20%)
- Percentage of staff experiencing violence from staff in the last 12 months

Our bottom 5 scores are:

- Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse (bottom 20%)
- Percentage of staff with opportunities for flexible working patterns (bottom 20%)
- Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months

- Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last 12 months.

5.0 Local Survey Responses

For a number of years we have included local questions in the national survey built around our trust values and our leadership model. These are set out as an appendix. In summary we have improved on all our questions against the trust values and the trust leadership model with the exception of two where there was no change. An analysis of these, together with questions from the main survey that are pertinent to our values and leadership shows us there is still work to do on:

Values: *We reflect, we learn, we improve* and *We respect and support each other.*

Leadership model: *Motivating staff at work, building Trust* (employees trust their manager), and *toleration of poor performance*.

6.0 Next steps

Work continues to ensure that all our strategies are aligned and that we are implementing key elements of all our key strategies that impact on the way the hospital works and the way our staff feel about working here. This includes the core business of the organisation, the focus on quality and quality improvement, the focus on re-energising the nursing workforce as well as Organisational Effectiveness strategy and our People Strategy. In the light of current workforce issues in the NHS the need to focus particularly on workforce capacity (recruitment and retention), capability and culture within the overarching trust strategy is essential if we are to be able to deliver best possible care. Further work is being developed in many key areas.

Given the results on bullying and harassment we will be focussing more effort on addressing this to support our trust value of *'we respect and support each other'*. We will approach this from two perspectives; firstly to support to staff by understanding their concerns through engaging directly with staff; developing our mental well-being & Resilience policy and providing resilience training as part of our health & well-being strategy and secondly to send clear communications and have robust policies that make it clear that any form of bullying or harassment is unacceptable and will be dealt with.

Our results on flexible working are also of concern, although our score has not changed from the previous year despite the introduction of standardised shifts in nursing. This will be investigated further.

Further work on overall staff engagement including developing new ways of obtaining feedback through 2 way communications will be through the introduction of our new Listen and Learn events.

Janine Brennan
March 2017

Northampton General Hospital NHS
NHS Trust

Key Findings from the 2016 Staff Survey	2015/16 Trust Trend		2016 Score	2015 Score	2014 Score	2013 Score
TRUST LEADERSHIP MODEL						
My manager informs me about what's happening in my Trust	▲	Committed to excellence	66%	63%	67%	61%
My manager sets high standards for the quality of service we provide	▲	Committed to excellence	74%	70%	74%	66%
My manager is committed to improving team performance	▲	Committed to excellence	71%	68%	66%	64%
My manager recognises and acknowledges good performance	▲	Committed to excellence	64%	44%	37%	36%
My manager does not tolerate poor performance	▲	Committed to excellence	61%	45%	43%	47%
My manager encourages me to develop new and better ways of working	N/A	Committed to excellence	63%			
My manager finds ways to encourage and motivate me to do the best I can at work	▲	Motivation	53%	49%	47%	46%
My manager helps me feel like a valued member of the team	▲	Motivation	61%	59%	56%	53%
My manager trusts me to do my job	▲	Trust	85%	76%	79%	76%
My manager is trusted by me to do the right thing	▲	Trust	72%	66%	62%	58%
My manager shows respect for others	No change	We respect & support each other	71%	71%	65%	63%
My manager challenges inappropriate behaviour from others regardless of who they are	No change	We respect & support each other	62%	62%	53%	53%
TRUST VALUES						
I am proud to work at NGH	▲	Aspire to excellence	70%	62%	58%	66%
I trust the organisation to do the best thing for patients	▲	We put patient safety above all	72%	65%	59%	63%
I trust the organisation to do the best thing for staff	▲	We put patient safety above all	47%	37%	34%	39%
Most staff put patient safety above all else	N/A	We put patient safety above all	86%			
Most staff treat other staff with respect and support each other	N/A	We respect & support each other	77%			

Green shading indicates areas where staff experience has improved; red shading indicates where staff experience has deteriorated; amber shading indicates where staff experience is unchanged from the previous year

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30 March 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

Northampton General Hospital NHS Trust Corporate Dashboard 2016-17

Corporate Scorecard

	Indicator	Target	DEC-16	JAN-17	FEB-17
Quality of Care: Caring	Complaints responded to within agreed timescales	>=90%	96.7%		
	Friends & Family Test % of patients who would recommend: A&E	>=86.1%	87.4%	88.4%	86.7%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	>=95.7%	92.9%	94.0%	92.7%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	>=96.6%	98.8%	97.9%	98.6%
	Friends & Family Test % of patients who would recommend: Outpatients	>=93.1%	93.2%	93.0%	93.7%
	Mixed Sex Accommodation	=0	0	0	0
	Total deaths where a care plan is in place	>=50%	56.8%	60.5%	57.9%

	Indicator	Target	DEC-16	JAN-17	FEB-17
Operational Performance	A&E: Proportion of patients spending less than 4 hours in A&E	>=95%	83.2%	81.3%	78.1%
	Ambulance handovers that waited over 30 mins and less than 60 mins	<=25	247	263	293
	Ambulance handovers that waited over 60 mins	<=10	36	58	60
	Average Ambulance handover times	=15 mins	00:17	00:18	00:19
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	>=93%	97.7%	96.1%	98.2%
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	>=93%	95.0%	95.5%	96.0%
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	>=98%	98.3%	98.4%	92.1%
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	>=94%	100.0%	93.0%	95.9%
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	>=94%	100.0%	88.2%	100.0%
	Cancer: Percentage of patients treated within 31 days	>=96%	98.0%	97.4%	98.1%
	Cancer: Percentage of patients treated within 62 days of referral from hospital specialist	>=85%	100.0%	100.0%	70.0%
	Cancer: Percentage of patients treated within 62 days of referral from screening	>=90%	100.0%	100.0%	90.4%
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	>=85%	85.9%	80.4%	78.1%
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	>=99.1%	98.5%	99.4%	99.6%
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	=0	2	2	1
	RTT over 52 weeks	=0	0	0	0
	RTT waiting times incomplete pathways	>=92%	92.5%	92.3%	92.5%

	Indicator	Target	DEC-16	JAN-17	FEB-17
Quality of Care: Effective	Crude Death Rates	1	1.6%	1.7%	1.4%
	Emergency re-admissions within 30 days (elective)	<=3.5%	3.0%	2.8%	2.7%
	Emergency re-admissions within 30 days (non-elective)	<=12%	15.3%	14.2%	12.2%
	Length of stay - All	<=4.2	5.2	4.5	5.3
	Maternity: C Section Rates - Total	<26.2%	28.4%	24.5%	25.0%
	Mortality: HSMR	100	95	95	95
	Mortality: SHMI	100	95	95	95
	# NoF - Fit patients operated on within 36 hours	>=80%	93.9%	63.1%	86.3%
	Stranded patients >75yrs (LOS > 7 DAYS)	<=45%	55.6%	52.6%	56.2%
	Stroke patients spending at least 90% of their time on the stroke unit	>=80%	81.8%	79.5%	84.6%
	Suspected stroke patients given a CT within 1 hour of arrival	>=50%	70.5%	82.7%	81.0%

	Indicator	Target	DEC-16	JAN-17	FEB-17
Finance and Use of Resources	Bank & Agency / Pay %	<=7.5%	14.3%	14.1%	14.0%
	CIP Performance	>=0	(266) Adv	(258) Adv	(377) Adv
	Income	>=0	1,660 Fav	2,254 Fav	3,417 Fav
	Non Pay	>=0	941 Fav	1,026 Fav	(76) Adv
	Pay	>=0	(5,978) Adv	(6,916) Adv	(7,446) Adv
	Surplus / Deficit	>=0	7,885 Fav	9,429 Fav	10,965 Fav
	Waivers	=0	4	6	2
	Waivers which have breached	=0	6	3	2

	Indicator	Target	DEC-16	JAN-17	FEB-17
Winter Pressures	A&E Trolley waits 8hrs 1 min to 12hrs (DTA to admission)	=0	83	214	237
	% being triaged in less than 20 mins	>=95%	70.9%	68.8%	64.0%
	Number of ambulances (Total)		2,824	2,719	2,440
	Operations cancelled due to bed pressures	=0	27	28	38
	Patients who need to be readmitted if transport arrives too late	=0	0	0	2

	Indicator	Target	DEC-16	JAN-17	FEB-17
Quality of Care: Safe	C-Diff	<=1.75	2	1	1
	Delayed transfer of care	=23	45	50	46
	Dementia: Case finding	>=90%	92.0%	96.9%	94.5%
	Dementia: Initial diagnostic assessment	>=90%	100.0%	100.0%	100.0%
	Falls per 1000 occupied bed days	<=5.5	4.8	4.1	4.8
	Harm Free Care (Safety Thermometer)	>=94%	95.3%	93.2%	94.3%
	MRSA	=0	0	0	0
	Never event incidence	=0	0	0	0
	Number of Serious Incidents Requiring Investigation (SIRI) declared during the period	=0	1	2	1
	UTI with Catheters (Safety Thermometer-Percentage new)	<=0.2%	0%	0.1%	0%
	VTE Risk Assessment	>=95%	95.2%	95.7%	94.4%
	Ward Moves (>2)	=0	142	122	124
	Ward Moves (>2) Context	=0%	3.9%	3.7%	3.9%

	Indicator	Target	DEC-16	JAN-17	FEB-17
Leadership & Improvement Capability	Data quality of Trust returns to HSCIC (SUS)	>=90%	95.5%	93.3%	93.3%
	Medical Job Planning	>=90%	52.2%	66.3%	74.3%
	Percentage of all trust staff with mandatory training compliance	>=85%	86.4%	86.8%	83.3%
	Percentage of all trust staff with role specific training compliance	>=85%	78.1%	79.0%	79.7%
	Percentage of staff with annual appraisal	>=85%	82.0%	85.3%	84.4%
	Sickness Rate	<=3.8%	3.7%	4.0%	4.0%
	Staff: Trust level vacancy rate - All	<=7%	10.9%	10.7%	10.7%
	Staff: Trust level vacancy rate - Medical Staff	<=7%	9.9%	9.0%	9.5%
	Staff: Trust level vacancy rate - Other Staff	<=7%	11.0%	10.9%	11.0%
	Staff: Trust level vacancy rate - Registered Nursing Staff	<=7%	10.9%	11.1%	10.5%
	Turnover Rate	<=8%	9.2%	9.4%	9.7%

Run Date: 16/03/2017 14:11 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	Directorate Management Board	February 2017

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
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%	81.3%	78.1%
A&E Trolley waits 8hrs 1 min to 12hrs (DTA to admission)	=0	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail	95	87	83	214	237
% being triaged in less than 20 mins	>=95%	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail	69.1%	71.5%	70.9%	68.8%	64.0%

Driver for underperformance:

- Specialty waits
- Bed capacity
- Vacancies within medical staffing equating to 21 WTE across all of the grades
- Increased acuity is still well above baseline and in upper quartile, currently acuity is the 3rd highest on record.
- Capacity within department
- Increased attendances

Actions to address the underperformance:

- 1st assessment delay action plan in place, reduction seen in 1st assessment breaches
- Daily Meetings in place to review delays in 1st assessment, minute meeting held weekly
- Weekly meetings held with Clinical Lead and Clinical Director to review breaches.
- Weekly meetings to commence 10th March chaired by COO to discuss speciality breaches with Divisional Directors.
- 2x SPR 1600-0200hrs in ED to support senior decision making.
- ICT trial to be implemented extending hours until midnight 5 days per week.
- Early escalation to speciality teams should patients be waiting more than 30minutes for review.
- Escalation of multiple ambulance attendances to manager, matron and EMAS
- Current vacancies are out to advert and active recruitment is ongoing.
- Review of PCSS pathways with ‘go live’ date 1st April 2017

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	Directorate Management Board	February 2017

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Ambulance handovers that waited over 30 mins and less than 60 mins	<=25	570	547	405	275	239	151	229	220	247	263	293
Ambulance handovers that waited over 60 mins	<=10	221	253	130	47	15	11	47	21	36	58	60
Average Ambulance handover times	=15 mins	00:25	00:27	00:22	00:14	00:16	00:14	00:17	00:16	00:17	00:18	00:19

Driver for underperformance:

- Ambulance attendances have increased
- Acuity remains high across the Trust, although we have seen reduction; acuity still remains the 3rd highest on record for the Trust.
- Bed capacity
- Multiple ambulance arrivals in quick succession

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.
- Two FIT bays (F9, F10) designated for ambulance off load and handover.
- 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.
- Explore options to use ACC pathways so crews can directly refer into ACC.
- Clinical guidance being written to support crews remotely with GP advice between 0800-2300hrs.
- In absence of HALO crews to be requested to double up.

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:
Delayed Transfers of Care	Externally mandated	Finance, Investment and Performance Committee	February 2017

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Delayed transfer of care	=23	65	63	80	59	83	90	75	67	45	50

Driver for underperformance:	Actions to address the underperformance:
• The system has seen a large rise in acutely unwell patients leading to a rise in patients requiring support. Changes to social care structure and processes. Large delays in placements. • Not enough long term care packages. • Large delays in patient awaiting for low level care packages (Discharge to Assess)	• Use of CHS brokerage for self-funding patients • Olympus care looking to provide a bridging service for care packages. Due in March 2017. • The trust has agreed to invest money in Domiciliary care. • Social worker funded by the trust for the front door/Dickens unit cover. • Use of Dickens therapy unit for reduce demand on care in community. • Overnight care model in place. • New Discharge Team leader in post. Induction almost completed. . • Daily tracking with the SPA commenced. • Stranded patient reviews with senior level engagement. • Review of the Delirium and Dementia Team performance. Paper written and sent to the COO meeting and Outflow for review. • Challenge made to MH colleagues regarding delirium best practice and escalation. • “”Button pushed” on use of interim beds by CEO NGH. 15 patients moved out of the trust to external beds. • Conversations started with CHC regarding long delays in assessments and NH places.

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:
Stranded patients >75yrs (LOS > 7 DAYS)	Internally set	Finance, Investment and Performance Committee	February 2017

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Stranded patients >75yrs (LOS > 7 DAYS)	<=45%		52.4%	53.8%	51.8%	50.8%	56.4%	51.4%	55.5%	55.6%	52.6%	56.2%

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 • Significant restructure in Social care • Lack of home support increases demand on bedded solutions resulting in inappropriate placements and increased LOS • Increasing costs of residential care leaving vacancies in region. This is resulting in families being very reluctant to move patients out promptly	• SAFER bundle implemented within the trust and embedding continues. Red to Green implemented aims to ensure all patients have a senior review daily. Despite pressured climate progress being made. • 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. Good weeks achieved becoming more consistent. Staff attendance increased. • Training continues organised across wards by Discharge team around Trust Discharge Policy to reduce internal delays further. • New Discharge Team Manager now in post • Inpatient Tracking refocus • Interim placements used at times with delayed safe discharge exit plans

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:
Patients who need to be readmitted if transport arrives too late	Internally set	Finance, Investment and Performance Committee	February 2017

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Patients who need to be readmitted if transport arrives too late	=0	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail	0	0	0	0	2

Driver for underperformance:	Actions to address the underperformance:
• Two patients re-bedded due to transport and other delays that were experienced on Monday 27th February	• NSL admit it was the fault of their controller and some staff re-training has and will be taking place.

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:
Ward Moves > 2	Internally set	Finance, Investment and Performance Committee	February 2017

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Ward Moves (>2)		Not applicable until Nov 2016							124	142	122	124
Ward Moves (>2) Context									3.8%	3.9%	3.7%	3.9%

Driver for underperformance:	Actions to address the underperformance:
• Clarify the number of moves that needs to be monitored. For some patients there are three moves as normal. ED to Assessment area to base ward to Discharge suite Avery or Dickens Unit • The use of escalation areas puts this figure higher however we are using these areas to keep patients safe and patients off the ED corridor • Clarify how the movement for a clinical reason will be measured. • Number of moves will be higher now that the trust has purchased a number of 'step down' beds at both Avery and Dickens • Not enough beds in system and high DTOCS • High bed occupancy driving the use of escalation areas. • DETOC numbers / Discharge pathways meaning use of interim beds requires more moves.	• Patients moved to accommodate infection control precautions. High use due to Flu outbreak in January. • GDCU and Althorp ward closed at the end of Feb to medical outliers this will reduce the number of patient moves • Number of medical outliers has reduced from >100 over winter to <50 as we move into March • Further embedding of Red / Green days to drive down LOS will enable patients to get to the most appropriate ward first time • Pull model in Medicine to be strengthened to ensure the 'right patients are pulled to the 'right ward'

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

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	February 2017

Performance and Trajectory:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Operations cancelled due to bed pressures	=0	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail	16	48	27	28	38

Driver for underperformance:

- **ENT: x 3**
- **General Surgery: x 15**
- **Gastroentrology x 1**
- **Gynaecology: x 2**
- **Plastics x 2**
- **Trauma & Orthopaedics: x 6**
- **Urology: x 9**

- Escalation pressures at a high level during February. 14 days on Black escalation status with 12 on Red escalation and 2 on Amber. The current escalation policy requires any priority 2 and 3 elective surgeries to be considered to be cancelled due to the emergency demand. The number of Outliers was at times approx 100 medical patients in surgical beds. Althorp Ward was included in this having been converted to Medicine throughout this month. Acuity was also high with critical care instigating the surge plan when demand required this. Patients who required critical care intervention post-surgery were cancelled for safety reasons.

Actions to address the underperformance:

- The Site management team and divisions have worked together to reduce outliers and close Althorp to 60.
- Medicine have continued to use conference calls to wards on a daily basis to ensure the daily number of discharges are met to ensure there is enough capacity on medicine reducing the need to Outlie.

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:
Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Externally mandated	Finance, Investment and Performance Committee	February 2017

Performance and Trajectory:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
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	2	1

Driver for underperformance:	Actions to address the underperformance:
• ENT: Patient was initially cancelled on the 11th Jan 2017 due to bed pressures. Patient was rescheduled for the 8th February but was cancelled on the day due unforeseen complication with another patient which consequently led to the list overrunning. Patient was then given a TCI for the 8th March but cancelled again due to a clinically urgent case.	• Where appropriate all 28 day cancellation are requested to be 1st on the list. • All 28 day patients are highlighted and discussed at the daily theatre huddle. • All patients at risk of being cancelled now have to be discussed with the Theatre manager before being cancelled. The purpose of this is to see if a plan can be put into place to prevent the breach. This is a new process which has been implemented as part of the Changing care surgical productivity Programme in order to reduce the number of cancellations on the day.

Lead Clinician:	Lead Manager:	Lead Director:
Mike Wilkinson	Fay Gordon	Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Cancer Access Targets	Externally Mandated	Finance, Investment and Performance Committee	February 2017 - Validated January 17 performance

Performance:

Jan 17 – Validated And Feb 17 – Unvalidated Perfromance

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	>=98%	100%	98.8%	100%	98.1%	97.8%	98.6%	100.0%	100.0%	98.3%	98.4%	92.1%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	>=94%	96.2%	94.4%	93.1%	95.6%	93.0%	100.0%	97.4%	97.6%	100.0%	93.0%	95.9%
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%	100.0%	88.2%	100.0%
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%	100.0%	70.0%
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%	85.9%	80.4%	78.1%

Driver for underperformance:

The Trust has met 6 out of the 9 Cancer Waiting Time Standards in January 2017 which was not unexpected and mirrors national performance this was due to the seasonal difficulties the Trust faced, with reduced decision making at MDT's over the holiday period, patient initiated delays and winter capacity issues:

Subsequent Treatments:
The Trust met 1 out of the 3 subsequent treatment standards for January which was Drug treatments reaching 98.5% against a standard of 98%. Subsequent surgery treatments reached 88.2% against a standard of 94%; this standard was failed due to 2 breaches in Skin in a small cohort of patients. Subsequent radiotherapy treatments reached 93.1% against a standard of 94%; this was largely due to patient initiated delays over the holiday period. (slight variation due to rounding up vs down internal reporting)

Actions to address the underperformance:

Achievements this period

- Consultation on Access and Operational Policy complete, ratification within the next month
- First Trust Breach panel met
- Observational Study of all MDT's complete with recommendations
- Positive meeting with PHE to improve COSD reporting, presentation to Clinicians at Cancer Board, followed up with training sessions on reporting expectations by site.
- Planning underway for Internal Validation to support tumour site self declarations in June

Operational Focus for next period

The Cancer Services Team have completed over a number of months an improvement programme introducing a number of monitoring tools and revised working practices with a clear escalation process through weekly performance meetings and beyond, which are attended by each site in order to effectively monitor patients through their pathway in a timely

62 Day First Treatments: 7 tumour sites breached the standard in January reaching 80.5% against a standard of 85%. slight variation due to rounding up vs down internal reporting). Colorectal in particular have seen an increase on the number of breaches against the past 2 months performance although 3 of the 5 breaches were complex and were discussed across two tumour sites. • <u>Urology-3.5 breaches</u> 1 patient had multiple investigations which had delays to reporting, this combined with delayed MDT decision making over Christmas led to the patient breaching. 1 patient was treated a week over the breach date due to histopathology reporting delays and TRUS being performed before MRI.1 patient had a complex pathway with DNA's, a period as an inpatient, referral to a tertiary provider, surgery scheduled and subsequently changed to hormones. 1 patient had delays due to OPA capacity but delayed progress through the pathway due to considering treatment options. • <u>Colorectal – 5 breaches</u> 2 patients had complex pathways being discussed between 2 sites with multiple investigations. 1 patient had delays due to recovery period from an investigation to treatment commencing.1 patient was discussed at 2 site MDT's due to a histology report indicating previous history which was incorrect, this caused delays. 1 patient had delays due to fitness issues and capacity issues in HDU once they were fit contributed to the delay. • <u>Head and Neck – 2.5 breaches</u> 1 patient was a late tertiary referral at day 78. 1 patient delayed their initial investigations by 47 days, 1 patient had some delays to initial investigations but had a complex diagnostic pathway with an initial unknown primary. • <u>Haematology – 1.5 breaches</u> 1 patient was a late tertiary referral at day 55 but had some radiology delays from a reporting and discussion at MDT perspective.1 patient was discussed at 2 sites MDT's and had multiple investigations as initial investigations were inconclusive.	manner. The final stage to support all tumour sites will be a consultation with Cancer Services staff over the next two months to ensure the team roles and responsibilities are fit for purpose. Ongoing efforts to sustain December's performance will be accountable to the monthly Cancer Board where each tumour site will be required to report on their individual action plans to sustain improvements and reduce Trust breaches. Action plans will incorporate recommendations from the MDT observational study in order to improve the effectiveness of these weekly meetings.

• Upper GI –3 breaches 1 patient initiated delays to treatment over the Christmas period and only breached by a week as a result. 1 patient breached by 2 days as a result of requiring an echocardiogram. 1 patient initiated delays to the start of the pathway with investigations, as well as being claustrophobic which led to further delays and had numerous discussions at specialist MDT meetings before being transferred for treatment to a tertiary provider,1 patient had a period as an inpatient which led to delays to treatment commencing. • Gynaecology – 0.5 breach Patient was received from a tertiary referral with an expectation for surgery, some delay due to radiology capacity, MDT discussion deemed not fit for surgery, alternative treatment had to be discussed and scheduled. • Lung -0.5 breach Patient was discussed between 2 tumour sites and had a complex Diagnostic pathway. • Sarcoma 0.5 Patient was received at day 68 from a tertiary provider and then went on to a trial which required being randomised before treatment could commence.	

Lead Clinician:	Lead Manager:	Lead Director:
Position currently vacant	Stephanie Buckley / Sandra Neale	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	February 2017

Performance and Trajectory:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Number of Serious Incidents Requiring Investigation (SIRI) declared during the period	=0	2	1	3	2	1	1	0	0	1	2	1

Driver for underperformance:	Actions to address the underperformance:
• Patient fell in the discharge suite resulting in a fracture. Bed brakes were not on when patient leaded against it.	• Datix investigation. Nurse involved spoken with and has been asked to write up a reflection. • Daily checks put in place to see that all beds are at the lowest level and brakes on. • Training with staff re falls risks. • Checks on arrival to the suite to include falls risk and mobility levels. • Raised at ward meetings (huddle in suite) • IAF report completed. • Lessons learned completed by the Unit Manager. Patient did not use her frame to walk. Staff reiterated to use equipment recommended.

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:
Friends and Family Test % - Inpatient/Daycase	Externally mandated	Quality Governance Committee	February 2017

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Friends & Family Test % of patients who would recommend: Inpatient/Daycase	>=95.4%	91.5%	91.5%	91.7%	90.5%	91.5%	91.8%	92.1%	93.0%	92.9%	94.0%	92.7%

Driver for underperformance:	Actions to address the underperformance:
• It is evident when reviewing the data set across the past 11 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. • January saw the FFT Inpatient & Day Case results reach their highest levels to date of 94.1% satisfaction. • This depreciated slightly in February, however this was normal variation.	• Many actions are being undertaken to address performance all of which are evidently having an effect, particularly within Inpatient and Day Case areas. • Two further local survey have now commenced with ward specific data produced and circulated. This has provided areas with specific improvement areas to focus on. • 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:
Medical Job Planning	Externally mandated	Quality Governance Committee.	February 2017

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Medical Job Planning	>=90%	Not applicable until Sept 2016						0%	4.3%	51.5%	66.3%	74.3%

Driver for underperformance:

- Job planning not performing against timeframe of Trust trajectory

Actions to address the underperformance:

- First meeting of the Task and Finish Group chaired by Medical Director took place 07.03.17
- Divisional Director to provide Directorate exception report.
- Divisional Directors progress with Clinical Directors re non completion of job plans.

Division	Directorate	Target	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb 17
M&UC	Urgent Care	>=90%	0%	0%	0%	20%	20%	70%
	Inpatient	>=90%	0%	0%	0%	20%	20%	20%
	Outpatient	>=90%	0%	0%	0%	24%	33%	42%
Surgery	A&CC	>=90%	0%	0%	0%	84%	95%	95%
	Head & Neck	>=90%	0%	0%	0%	52%	92%	92%
	T&O	>=90%	0%	0%	0%	92%	92%	92%
	General & Specialist	>=90%	0%	0%	0%	50%	60%	72%
WCOH	Women's	>=90%	0%	0%	0%	93%	100%	100%
	Children's	>=90%	0%	0%	41%	87%	87%	87%
	Oncology/Haem	>=90%	0%	0%	0%	18%	18%	40%
C. Support	Imaging	>=90%	0%	0%	0%	20%	33%	54%
	Pathology	>=90%	0%	0%	0%	60%	100%	100%

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Staff Sickness Rate	Internally set	Workforce Committee	Feb 2017

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Sickness Rate	<=3.8%	4.1%	4.0%	4.2%	4.0%	3.9%	3.8%	4.0%	3.7%	3.7%	4.0%	4.0%

Driver for underperformance:	Actions to address the underperformance:
• Short term absence – 2.89% and long term absence is 1.24% • Short term absence remains the driver • The illnesses being reported are self-limiting which are all being managed in line with the Trust's trigger points • The staff survey also highlighted that staff put themselves under pressure to attend work • Seasonal increases at this time of year	Staff reaching the Trust's staff sickness absence policy triggers are being met with formally In relation to actively managing sickness absence levels health and wellbeing has been embedded into 1:1 meetings with line managers with the focus being on early interventions The HR Advisors are now promoting First for Wellbeing through sickness absence meetings and they are receiving positive comments from affected employees about this service The Health and Well Being Strategy is progressing well and currently there is a focus on providing training on mental health awareness

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Staff Annual Appraisal Rate	Internally set	Workforce Committee	February 2017

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
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%	85.3%	84.4%

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	February 2017

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
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%	79.0%	79.7%

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:
Mandatory Training Compliance	Internally set	Workforce Committee	February 2017

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Percentage of all trust staff with mandatory training compliance	>=85%	85.1%	85.9%	86.2%	86.6%	85.8%	85.0%	85.3%	85.7%	86.4%	86.8%	83.3%

Driver for under performance:	Actions to address the underperformance:
• Target of compliance has increased to 85% as per the Quality Schedule set by the CCG; however this is not a national mandate • An awareness leaflet for Equality & Diversity was given to all staff in February 2014, this meant that majority of staff went out of date with Equality & Diversity in February 2017.	• Prior to February reports were produced detailing the staff going out of date with Equality & Diversity. Reminders were given to managers and emails sent to make staff and managers aware. Staff were asked to complete Equality & Diversity prior to February, which many did. Since February, further information has been issued to raise awareness of staff being out of date.

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	February 2017

Performance:

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
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%	10.7%	10.7%
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%	9.0%	9.7%
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%	10.9%	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%	11.1%	10.5%

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

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

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30 March 2017**

Title of the Report	**Revised Terms of Reference – Quality Governance and Workforce committees**
Agenda item	**14**
Presenter of Report	Catherine Thorne Director of Corporate Development, Governance and Assurance
Author(s) of Report	Catherine Thorne Director of Corporate Development, Governance and Assurance
Purpose	The Board is asked to approve amendments to the Terms of reference
Executive summary The Quality Governance and Workforce committee terms of reference have been amended to reflect that the Corporate Risk register is reviewed quarterly by each committee	
Related strategic aim and corporate objective	Objectives related to Quality Governance and Workforce
Risk and assurance	The terms of reference have been updated to reflect oversight of risk quarterly
Related Board Assurance Framework entries	BAF 1 and 2
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (/N) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (/N)
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote 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 Board is asked to:

- Approve amendments to the Terms of reference

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

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) quarterly 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.

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) quarterly 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.

Report To	**Public Trust Board**
Date of Meeting	**30 March 2017**

Title of the Report	**Care Quality Commission (CQC) Inspection - February 2017**
Agenda item	**15**
Presenter of the Report	Catherine Thorne, Director of Corporate Development, Governance and Assurance
Author(s) of Report	Catherine Thorne, Director of Corporate Development, Governance and Assurance
Purpose	This paper is presented to inform the Board of the recent CQC inspection and actions to date
Executive summary The Trust underwent an announced, focussed inspection in February 2017. Initial feedback has been received and where appropriate challenged in terms of factual accuracy. An initial improvement plan is in place and will be merged into any further improvement plan once the formal report has been received.	
Related strategic aim and corporate objective	ALL
Risk and assurance	The Trust is required to register under the CQVC regulatory framework and failures to meet Essential and Fundamental standards can lead to regulatory action against the Trust by the CQC.
Related Board Assurance Framework entries	ALL
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)?Y/N)
Legal implications / regulatory requirements	The requirements of the CQC regulatory framework form part of the Health and Social Care act.

Enclosure K

Actions required by the Trust Board

The Trust Board is asked to:

- Note the inspection and actions to date.

Care Quality Commission

Inspection February 2017

1. Introduction

The Care Quality Commission (CQC) is the independent regulator of health care services in England.

Northampton General Hospital is governed by the regulatory framework set by the Care Quality Commission (CQC) which has a statutory duty to assess the performance of healthcare organisations. The CQC requires that hospital trusts are registered with the CQC and therefore licensed to provide health services.

The CQC provides assurance to the public and commissioners about the quality of care through a system of monitoring a trust's performance across a broad range of areas to ensure it meets Fundamental and essential standards.

The CQC assessors and inspectors frequently review all available information and intelligence they hold about a hospital, and depending on what this tells them, they may choose to inspect a hospital to ensure standards are being maintained.

Being able to demonstrate compliance with CQC and other external reviews is important to demonstrate the safety and quality of the services provided to patients.

2. NGH CQC Inspection 2017

A focused, short-notice, announced CQC inspection of the trust took place on 7-9 February 2017. The inspection team focused on four core services medicine, surgery, end of life care and urgent care. There was also a review of the well-led domain at trust level.

There was significant work completed across the trust to submit the information for the Provider Information Return (PIR) on time; an estimated 200 documents were sent. Following the inspection, the trust has as of 28 February 2017, received an additional 54 data requests. The majority of these have been submitted by the agreed deadlines.

The Trust has received initial feedback together with a follow up letter to confirm the initial findings and verbal feedback. The Trust has responded to the letter and corrected and challenged some inaccuracies.

In addition an initial improvement plan has been developed in response to the immediate concerns raised at the end of the inspection. This is being monitored by the weekly Executive team meeting and all actions are on track to meet the deadline completion dates. Once the full report is received any further actions will be merged into the action plan and it will form part of a formal improvement plan that will be overseen by the Quality Governance committee.

Report To	**Public Trust Board**
Date of Meeting	**30 March 2017**

Title of the Report	**Health and Wellbeing Annual Report**
Agenda item	**16**
Presenter of Report	Charles Abolins, Director of Facilities and Capital Development
Author of Report	Charles Abolins, Director of Facilities and Capital Development Anne-Marie Dunkley, PA to Director of Facilities and Deputy Director of Facilities
Purpose	For assurance/information

Executive summary

The Trust has established a structure over the past 18 months within which health and wellbeing activities are developed and managed. The effects of these activities are monitored and will inform the health and wellbeing programme going forward.

As an employer it is important to recognise that wellbeing is a worthwhile investment, with healthy behaviours leading to increased productivity and ultimately a happier workforce, which in turn results in enhanced recruitment retention and attendance at work.

Evidence suggests that happy, engaged staff leads to improved patient care, so it is fundamental that we ensure that staff continue to be engaged, valued and supported to improve their health and wellbeing.

Related strategic aim and corporate objective	Enable excellence through our people
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks (No)
Related Board Assurance Framework entries	BAF 3.3
Equality Analysis	Is there potential for, or evidence that, the proposed

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

Actions required by the Board

The Board is asked to:

- Note the progress to date of health and wellbeing initiatives

Northampton General Hospital
NHS Trust

Public Trust Board
30 March 2017
Health and Wellbeing Annual Report

1. Introduction and Background

Following approval of the Clinical Services Strategy, a Health and Wellbeing Steering Group was formed to drive forward the recommendation contained within the Clinical Services Strategy, namely that the Trust should aspire to becoming a health and wellbeing campus.

Established in July 2015, the steering group is chaired and jointly led by the Director of Facilities and Capital Development and the Director of Workforce and Transformation. The steering group meet on a monthly basis and comprises of staff representatives from across the Trust, clinicians, RCN representative and external stakeholders as appropriate.

The group is responsible for developing the Trusts Health and Wellbeing Strategy which was approved by the Board in November 2015 and subsequently launched in April 2016.

2. Health and Wellbeing Survey 2017

Assessing our employees attitudes, perceptions, activity levels and interests was fundamental to determining the Health and Wellbeing Strategy as well as developing a tailored annual health and wellbeing programme. In September 2015 a health and wellbeing survey, developed in conjunction with Public Health Action Support Team (PHAST) was circulated to all staff, electronically and in paper format.

The survey results determined the next steps NGH needed to take to improve access to activities and advice, and has shaped the annual programme improve our staff's overall health and wellbeing.

A repeat survey has since been carried out in February/March 2017, with 761 responses received.

The survey is currently being analysed, however two interesting prelimary results indicate that:

- 83.4% of staff are aware of the positive action the Trust is taking towards health and wellbeing
- 25.4% of staff feel that their line manager could do more to support their health and wellbeing

Once the analysis has been completed the Health and Wellbeing Steering Group will determine what further action will need to be undertaken to improve the programme, to meet the needs of the staff.

3. Annual Programme of Activities

The annual programme of activities was developed and launched jointly with the Health and Wellbeing Strategy in April 2016.

Enclosure L

Activities undertaken during 2016/17:

- 12 week nutrition and fitness programme in partnership with Trilogy held in February 2016, June 2016 and January 2017
- Participation in Global Corporate Challenge
- Participation in Northamptonshire Sport Business Games
- Finalist in Northamptonshire Sport Active Workplace of the Year award
- Weekly dance classes, health walks and choir practice
- Specialised awareness events e.g. Nutrition and Hydration Week and Dry January
- Mindfulness, stress management and sleep management programmes throughout October, November and December 2016 with additional dates throughout March 2017
- Over 40's health checks
- Smoking cessation including promotion of National No Smoking Day 2017
- A range of under 500 calories meals developed and a new deli bar introduced, offering a range of healthy eating options in the restaurant
- Two healthy options vending machines installed across the Trust
- Weight Watchers meetings exclusive to NGH staff

4. Time to Change Pledge

As part of our Health and Wellbeing strategy NGH identified that one of the key areas of employee support that we needed to focus on was mental wellbeing so this year, alongside our physical activity agenda, we will be doing more to tackle stigma and discrimination.

We have been working with Time to Change which is a national campaign run by charities Mind and Rethink Mental Illness and was launched in 2007. They work with schools and workplaces on mental wellbeing and are integral to helping improve how we all think and act about mental health. Since they launched, 473 organisations have signed the Time to Change Employer Pledge, demonstrating their commitment to addressing stigma and discrimination in the workplace. On 3 February 2017 we signed the Pledge to demonstrate our commitment:

Our pledge is to create a culture where our staff feel they can openly discuss and manage their mental wellbeing. We will raise awareness of the importance of mental health and wellbeing at work and provide the resources and tools our staff need to help them lead healthy lives, cope with the daily pressures, have positive relationships and achieve their full potential. We will be enhancing our resources to support all staff through our Health and Wellbeing Steering group.

5. Staff Communications

The key to an effective wellbeing programme is employee engagement. This has been achieved by raising awareness through promotional activity of what is available. Several health and wellbeing promotional events across the Trust have been held throughout the year and provided opportunities for staff to learn more about the Trusts plans to improve and invest in their health and wellbeing.

Health and wellbeing is also promoted through display boards located in key areas across the site, containing the latest news and events, a slot in the weekly staff bulletin and also through Trust monthly core briefings for senior managers to take to local team briefings. A mix of electronic communications and face to face communication is used as not all staff groups have access to computers.

A Health and Wellbeing wall located at the South Entrance is a prominent visual containing key pledges to patients, staff, visitors and the wider community taken from within the Health and Wellbeing Strategy. There is also the facility to view the new health and wellbeing animation by downloading the NGH Plus app and scanning the target image. The animation brings to life the health and wellbeing initiatives available to staff and provides an innovative way of communicating this.

Dedicated health and wellbeing intranet pages have been developed containing a range of information for staff including; latest news and events, NGH active programme, physical wellbeing, emotional wellbeing and lifestyle information. These pages are updated on a regular basis.

In addition to the specialised health and wellbeing awareness events mentioned above, Trust health and wellbeing initiatives have been promoted at the following events:

- International Nurses Day 2016
- Nursing and Midwifery Conference 2016
- Nursing Strategy Launch 2016

6. External Communications

During 2016 the Trust was invited to present its health and wellbeing journey at:

- Healthy Workplace Conference 2016, Northampton University
- NHS Employers National Health and Wellbeing Leads Conference, London

7. Health and Wellbeing CQUIN

The new CQUIN introduced in 2016 has 3 parts, focussing on health and wellbeing, food services and improving uptake of flu vaccinations with a value of £488,410 per CQUIN. An implementation plan for the Trusts health and wellbeing CQUIN was developed and submitted to CCG in July 2016.

The next health and wellbeing report to CCG is due on 31st March 2017 and will evidence that the criteria for achievement have been met.

- **2016/17 Health and Wellbeing CQUIN Requirement**

The Health & Wellbeing CQUIN introduced in 2016 encourages providers to improve their role as an employer in looking after employees' health and wellbeing. Providers were expected to develop a plan to cover the following three areas:

a) Introducing a range of **physical activity schemes** for staff. Providers would be expected to offer physical activity schemes with an emphasis on promoting active travel, building physical activity into working hours and reducing sedentary behaviour.

b) Improving **access to physiotherapy services** for staff. A fast track physiotherapy service for staff suffering from musculoskeletal (MSK) issues to ensure staff who are referred via GPs or Occupational Health can access it in a timely manner without delay

c) Introducing a range of **mental health initiatives** for staff. Providers would be expected to offer support to staff such as, but not restricted to; stress management courses, line management training, mindfulness courses, counselling.

A key indicator agreed with the CCG is that at least **10%** of our staff should have taken up some of the health and wellbeing initiatives on offer. To date **1355** staff have participated in a health and wellbeing initiative which equates to approximately **27%**.

As can be seen from this annual report, significant activity has been undertaken within the Trust to ensure this CQUIN is achieved. A comprehensive portfolio of evidence has been developed which will be reviewed by CCG in April/May 2017.

For 2017/18, the focus of this element of the CQUIN will shift from the introduction of schemes to measuring the impact that staff perceive from the changes, via improvements to the health and wellbeing questions within the NHS staff survey.

- **2016/17 Healthy Food for NHS Staff, Visitors and Patients**

Providers were expected to achieve a step change in the health of food offered on their premises.

a) The banning of price promotions on sugary drinks and foods high in fat, sugar and salt (HFSS).
b) The banning of advertisement on NHS premises of sugary drinks and foods high in fat, sugar and salt.
c) The banning of sugary drinks and foods high in fat, sugar and salt.
d) Ensuring healthy options are available at any point including for those staff working night shifts.

Data was supplied to CCG at Quarter 1 setting out volumes of sugar sweetened beverages sold. The changes will be monitored in the Quarter 4 submission. All indications are that step change has been achieved which will provide a baseline which will be measured in 2017/18 and 2018/19.

The 2016/17 requirements have been achieved and the evidence portfolio will be available for review by CCG in April/May 2017.

- **2016/17 Improving the Uptake of Flu Vaccinations for Front Line Staff Within Providers**

The key indicator for the third part of this CQUIN was achieving an uptake of flu vaccinations for frontline clinical staff of **75%**. Progress has been reported to the Board up to December 2016. This indicator has been fully achieved with an overall figure of **78.8%**.

8. Plans for the Coming Year

- Determine the annual programme from April 2017 taking account of results from the recent health and wellbeing survey

- Establish mental wellbeing training programme for managers

- Introduce other mental wellbeing resources for staff to access based on learning derived from current initiatives
- Health and wellbeing section to be incorporated into the NGH induction programme
- Create induction cards for new starters
- Enhance staff engagement / communications further using latest technology

9. Conclusion

As can be seen from the foregoing, much has been achieved over the past year. The health and wellbeing agenda continues to grow and relying on the good will of one or two key staff to keep this initiative live, in addition to them doing their day job is just not a sustainable way forward. The aim is to make health and wellbeing within the Trust, part of normal business.

However to do this effectively now requires a dedicated resource in the form of a Health and Wellbeing Co-ordinator.

Recently a bid was submitted to the Charities Committee to pump prime the funding of a Health and Wellbeing Co-ordinator for a period of 12 months, after which time the Trust will pick up the funding. Once staff Health and Wellbeing has become more embedded, there is also significant opportunity to focus on the patients needs for Health and Wellbeing support as part of the prevention agenda.

It is really pleasing to report that a positive response has just been received from the Charities Committee who have recognised the value of this work to the organisation and have agreed to fund this position.

There are few Trusts that have developed staff Health and Wellbeing to the extent of NGH. NGH is seen as a model of good practice and with the resources now being made available, this will ensure NGH continues to build on the excellent work that has already started.

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: *30 March 2017*

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

Executive Summary

The Committee met on *15 February 2017* to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:	**Board Assurance Framework entries** *(also cross-referenced to CQC standards)*
Current financial performance Forecast outturn Changing Care @ NGH SLR Risk Register/BAF	

Key areas of discussion arising from items appearing on the agenda

Level of confidence around the current position and the forecast outturn.
Recurrent and non-recurrent CIPS
Achievement of Agency Cap
Reference costs
A & E in conjunction with DTOCs

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

Structured questions to highlight risks with the BAF
IT Glossary of acronyms required for future meetings

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

N/A

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

N/A

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: *30th March 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 *17th February 2017* 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)*
• Complaints report • Incidents report • EPMA •	

Key areas of discussion arising from items appearing on the agenda

- HSMR – positive regional position
- CDiff positive figures
- FFT – positive figures and triangulation of data with real time surveys
- Radiology – systematic approach
- EPMA and VTE/Vitalpac – good progress being made
- Changes to Midwifery supervision due to be announced in the Spring
- Lessons learned from complaints and incidents
- Pressure ulcers

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

- Maternity Quality Governance Report, including Dashboards to be presented at March QGC.

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

- VTE
- CQC
- EPMA

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: Thursday 30th March 2017

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

Executive Summary

The Committee met o*n 15/02/2017* 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)*
Workforce performance Medical revalidation and appraisal Consultant job planning Nursing Associate role Safe nurse staffing	

Key areas of discussion arising from items appearing on the agenda

Workforce performance highlights included an increase in contracted workforce and in compliance for Mandatory Training, Role Specific Training and Appraisals. There had also been an increase in sickness absence, the Committee were also updated on the Junior Doctor contract and Time to Change pledge.

Dr Cusack summarised the status of medical appraisal and revalidation which included an update on revalidation activities and changes to process implemented over the last quarter. The report submitted provided assurance that effective governance was in place to support medical revalidation.

Dr Cusack presented a report on Consultant job planning including Consultant job plan status and the process for the 2017/18 cycle. It was agreed that a further update would be made to the committee on this subject in 6 months' time.

The Director of Nursing gave a detailed report on the progress being made and the programme for the training of the Nursing Associate, how this will be developed and how the role will operate within NGH. The Committee noted the excellent progress being made with this.

The DoN went on to present an update on Safe Nurse staffing and action taken to ensure that the trust is compliant with the TIAA review of Nurse staffing guidelines were the Trust had an assurance level of reasonable and with CHPPD were the Trust was cost effective. The committee also noted that the Trust had an overall fill rate in January of 106%.

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.
Action required by the Board Note report.	

Northampton General Hospital NHS
NHS Trust

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: 30 March 2017

Title	**HMT Exception Report**
Chair	**Mrs Deborah Needham**
Author (s)	**Mrs Deborah Needham**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met on 7th March 2017 *as* a workshop to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:	**Board Assurance Framework entries**
1. Highlight report 2. Divisional updates 3. Update on: - Clinical & estate strategy - Rheumatology & Dermatology business cases	1.1, 1.2, 2.2, 3.1, 3.2,

Key areas of discussion arising from items appearing on the agenda

Divisional updates

Divisions presented their current concerns and actions being taken and any other divisional updates:

Within the last month the only division to have had a performance review was CSS.

Medicine & Urgent Care

a. AE performance
b. Medical patients in surgical beds
c. Falls
d. Recruitment to key consultant roles
e. Mandatory training

Surgery

a. RTT ongoing - Orthopaedics
b. Role specific mandatory training - BLS
c. Cancer performance

Women's ,Childrens, Oncology, Haematology and Cancer

a. Improving Cancer performance
b. SEMOC
c. GDSU refurbishment/capacity changes

Clinical Support services

a. Radiology capacity review – being undertaken within the next 6 weeks, followed by a meeting with MD & COO – **action currently unassured**.
b. Job planning – sign off within pathology required – plan assured
c. RST/Appraisal – Plan to increase performance assured

d. Medical records strategy – Task & finish group being put into place, proposal to move further records into storage via medical records group and further use of documentum proposed – plan assured.

Clinical & Estate strategy – information and discussion
A presentation was provided (also presented at BOD in Feb 17) on the process to review the clinical & estate strategy

Dermatology & Rheumatology Business cases – information and discussion
A presentation was provided on the new medical model, governance and finance for the collaboration between NGH and KGH for both dermatology and rheumatology. (Business cases previously presented to the Board)

Verbal report – information only
A summary briefing was provided by the Deputy CEO on:

a. Recent CQC visit
   Further information requests
   Actions taken
   Timescales for the report
   Positive informal feedback
b. Feedback from the March 2017 progress review meeting with NHSI
c. Requirement to improve A&E performance
d. Offer of support from regulators for urgent care and theatre utilisation
e. Progress on 60 bedded business case

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

Further workshop to be arranged to engage directorates/divisions with the clinical strategy review.

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

All areas of risk regarding quality and performance are covered in Trust Board reports and detailed on the risk register including the gap in capacity for radiology.

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

Action required by the Board

To note the contents of the report.

Northampton General Hospital
NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 30 March 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 Zeidler	**Verbal**
	2.	Declarations of Interest	Note	Mr Zeidler	**Verbal**
	3.	Minutes of meeting 26 January 2017	Decision	Mr Zeidler	**A.**
	4.	Matters Arising and Action Log	Note	Mr Zeidler	**B.**
	5.	Patient Story	Receive	Executive Director	**Verbal**
	6.	Chairman's Report	Receive	Mr 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.**
	12.	Staff Survey Results 2016	Assurance	Mrs J Brennan	**H.**
11:05	**FOR INFORMATION**				
	13.	Integrated Performance Report	Assurance	Mrs D Needham	**I.**
11:15	**GOVERNANCE**				
	14.	Update to Quality Governance and Workforce Terms of Reference	Decision	Ms C Thorne	**J.**
	15.	Care Quality Commission Inspection	Receive	Ms C Thorne	**K.**
11:30	**ANNUAL REPORTS**				
	16.	Health & Wellbeing Annual Report	Receive	Mr C Abolins	**L.**
11:45	**COMMITTEE REPORTS**				
	17.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler	**M.**

Time	Agenda Item		Action	Presented by	Enclosure
	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 Hospital Management Team	Assurance	Dr S Swart	**P**
12:00	**21.**	**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 25 May 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).