UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Public Trust Board

Thursday 26 September 2019

09:30

Board Room
Northampton General Hospital

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

AGENDA

NHS
Northampton General Hospital
NHS Trust

PUBLIC TRUST BOARD

Thursday 26 September 2019
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 A Burns	**Verbal**
	2.	Declarations of Interest	Note	Mr A Burns	**Verbal**
	3.	Minutes of meeting 26 July 2019	Decision	Mr A Burns	**A.**
	4.	Matters Arising and Action Log	Note	Mr A Burns	**B.**
	6.	Patient Story	Receive	Executive Director	**Verbal.**
	7.	Chairman's Report	Receive	Mr A Burns	**Verbal**
	8.	Chief Executive's Report	Receive	Dr S Swart	**C.**
10:15	**CLINICAL QUALITY AND SAFETY**				
	9.	Medical Director's Report including • Learning from Deaths Update • GMC Survey Results Update	Assurance	Mr M Metcalfe	**D.**
	10.	Director of Nursing and Midwifery Report	Assurance	Ms S Oke	**E.**
	11.	Patient Experience Survey Update	Assurance	Ms S Oke	**F.**
10:40	**OPERATIONAL ASSURANCE**				
	12.	Month 05 Finance Report	Assurance	Mr P Bradley	**G.**
	13.	Operational Performance Report	Assurance	Mrs D Needham	**H**
	14.	Workforce Performance Report	Assurance	Mrs J Brennan	**I.**
11:10	**FOR INFORMATION & GOVERNANCE**				
	15.	Fire Safety Annual Report	Assurance	Mr S Finn	**J.**
	16.	Fire Safety Board Compliance Statement	Assurance	Mr S Finn	**K.**
	17	Corporate Governance Report	Assurance	Ms C Campbell	**L.**
	18.	Brexit Update	Assurance	Mrs D Needham	**M.**
	19.	EPRR Self-Assessment Assurance Report	Assurance	Mrs D Needham	**N.**
11:40	**COMMITTEE REPORTS**				
	20.	Highlight Report from Finance and Performance Committee	Assurance	Mr D Moore	**O.**

Time	Agenda Item		Action	Presented by	Enclosure
	21.	Highlight Report from Quality Governance Committee	Assurance	Mr J Archard-Jones & Prof T Robinson	**P.**
	22.	Highlight Report from Workforce Committee	Assurance	Ms A Gill	**Q.**
	23.	Highlight Report from HMT	Assurance	Dr S Swart	**R.**
11:50	**24.**	**ANY OTHER BUSINESS**		Mr A Burns	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held at 09:30 on 28 November 2019 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).

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Minutes of the Public Trust Board

Friday 26 July 2019 at 09:30 in the Board Room at Northampton General Hospital

Present		
	Mr A Burns	Chairman
	Dr S Swart	Chief Executive Officer
	Mr P Bradley	Director of Finance
	Ms A Gill	Non-Executive Director
	Ms S Oke	Director of Nursing, Midwifery & Patient Services
	Mr M Metcalfe	Medical Director
	Mr D Moore	Non-Executive Director
	Mr D Noble	Non-Executive Director
In Attendance		
	Ms C Campbell	Director of Corporate Development Governance and Assurance
	Mrs J Brennan	Director of Workforce and Transformation
	Miss K Palmer	Executive Board Secretary
	Mr O Cooper	Divisional Director - Women's Children's Oncology and Haematology
	Mr K Spellman	Deputy Director of Strategy & Partnerships
	Mr T Sanders	Joint CEO Northamptonshire CCGs (Agenda Item 5)
Apologies		
	Dr E Heap	Associate Non-Executive Director
	Mrs D Needham	Chief Operating Officer & Deputy Chief Executive
	Ms J Houghton	Non-Executive Director
	Mr J Archard-Jones	Non-Executive Director
	Mr C Pallot	Director of Strategy & Partnerships
	Mr S Finn	Director of Facilities and Capital Development

TB 19/20 025 Introductions and Apologies

Mr Burns welcomed those present to the meeting of the July Public Trust Board.

Apologies for absence were recorded from those listed above.

Mr Burns introduced Mr T Sanders (Joint CEO Northamptonshire CCGs) to the Trust Board. He would be delivering a presentation on the Northamptonshire CCGs Transition Programme.

TB 19/20 026 Declarations of Interest

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

TB 19/20 027 Minutes of meeting 30 May 2019

The minutes of the Trust Board meeting held on 30 May 2019 were presented for approval subject to amendments requested by Mr D Noble.

The Board resolved to **APPROVE** the minutes of the Minutes of meeting 30 May 2019.

TB 19/20 028 Matters Arising and Action Log 30 May 2019

Action Log Item 94

Mrs Brennan commented that the workforce plan had been referenced in the People Strategy. A full report would be coming to the **October** Board.

The Board **NOTED** the Action Log and Matters Arising from the 30 May 2019.

TB 19/20 029 CCG Transition Programme

Mr T Sanders introduced himself to the Board.

Mr Sanders advised that he would be sharing with the Board the reasons behind the Northamptonshire CCGs Transition Programme and what needed to be different moving forward.

Mr Sanders explained that the proposal was to create a new single countywide CCG to drive required changes more efficiently and effectively.

Mr Sanders commented that he had been recruited 18 months previous. In the time that had passed he had already established full joint/ in common meetings and was now looking at creating a Single Executive Director Team.

Mr Sanders hoped that the format for the single CCG would be presented to NHSE end of August/early September 2019.

Mr Sanders stated that this would be creating something new and different. It was also consistent with national policies. This was a real opportunity to change how commissioning is run in the county. The CCG needed to be clinically led in the wider sense. Mr Sanders remarked that it was a multi-year approach. If something doesn't change the population of Northamptonshire would be impacted.

Mr Burns asked the Board to present questions to Mr Sanders.

Mr Moore noted that this was a logical decision. He asked how the 5 year STP plan would fit.

Mr Bradley believed that this made sense. He asked how could the CCG link up better with the council and what could be done differently to change pathways to improve the quality of care for the patients. He noted the opportunities to be gained from working with the PCN's.

Ms Gill remarked that this was an exciting opportunity and she queried what capabilities are needed to make this work. Mr Noble expanded on this question and asked whether previous behaviours would be addressed.

Mr Sanders noted that changes in behaviours would make a difference. There needed to be an open relationship and a huge amount of effort would be focused on this area.

Mr Sanders advised that a long term plan would not be able to be created in the next few weeks prior to submission to NHSE. Instead there would be work done looking at what direction the county was travelling in and what to get behind. Also how to drive efficiency.

Mr Sanders reported that he had attended the Primary Care Network meeting. The attendees had shown an equal measure of both excitement and terror. The CCG had made clear that moving forward it was less about individual surgeries but more about groups of surgeries.

Mr Sanders remarked that in relation to capabilities there was a slide in the report

that showed this.

Dr Swart stated that this new partnership work would be an equally led partnership where providers are trusted to go and deliver things. All providers needed to participate and add value.

Mr Burns commented that it would take a few years to perhaps unlearn some behaviours. He believed that the two Trust's could actively work as the acute centres for the unitries. The two Trust's would need to work sensibly together for one overall pot of money and not two separate pots. Mr Burns noted that NGH was full supportive of the plans. He asked for an update in **18 months (January 2021).**

The Board **NOTED** the CCG Transition Programme and **APPROVED** the merger of the two CCG's.

TB 19/20 030 Chairman's Report

Mr Burns delivered the Chairman's Report to the Board.

Mr Burns informed the Board of the appointment of Professor T Robinson as an Associate NED. He will be chairing the August Quality Governance Committee and will eventually take over as Chair.

Mr Burns advised that the September overnight Board development session was being organised. There would be extensive discussions on how the Board and Committees could work better.

Mr Burns stated that recruitment was ongoing for the Independent Executive Chair for the HCP.

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

TB 19/20 031 Patient Story

Ms Oke introduced Ms L Bale who delivered her patient story to the Board.

Ms L Bale had a nursing background. She had trained and worked at NGH. Ms Bale commented that she was proud to have worked at NGH as it was the first in the UK to have done many things.

Ms Bale's story started on 6 March 2018 when she had been diagnosed with breast cancer. She had a number of surgeries over the preceding months. When she was a day case patient she had found it both very physically and emotionally traumatic.

Ms Bale had 18 weeks of chemotherapy and explained that she had not been aware of the degree of the side-effects beforehand. She was admitted to hospital on four out of the 6 cycles. Ms Bale had also found Radiotherapy very exhausting.

Ms Bale shared with the Board her ideas for the future moving forward. She noted that compassion was simple deliver and cheap. The recovery nurse holding her hand had given her comfort. The busy nurse who had given her time to talk and reassure her. She had felt like an individual and not a patient. Ms Bale gave an example of the time when she had felt nauseous. The nurse had made her a hot chocolate and toast with marmite.

Ms Bale commented on her experience as a cancer day patient. She felt that these patients needed holistic care. In the past it used to be the nurse who took the dressing down however now there is nobody there to do this.

Ms Bale believed that in regards to aftercare more pain relief should be offered.

Ms Bale stated that she still needed reassurance. There needed to be more acknowledgment of the side effects of breast cancer and its treatment. It has changed the quality of her life. She believed information being given in different formats would be beneficial to the patients.

Ms Bale remarked that she was really committed to help and would like to introduce 'Compassion Ambassadors'. She thought that these would be a huge benefit to the Trust. Ms Bale would also like to educate nurses in the future.

Dr Swart commented that it had been a privilege to meet Ms L Bale. She agreed that compassion did not cost and staff should take this approach. Dr Swart stated that all areas of good practice would be highlighted back to the teams involved.

Ms Gill stated that it was very brave and courageous for Ms Bale to come and talk to the Board. Her story was very powerful. Ms Gill thought the 'Compassion Ambassadors' were a brilliant idea and she was happy to support this.

Mr Burns thanked Ms Bale for sharing her patient story. The Trust would deliver 'Compassion Ambassadors'. He had found it powerful seeing the "world through the other end of the telescope".

Ms Oke confirmed that she would be responsible at taking the 'Compassion Ambassadors' forward.

Ms Spellman remarked that in regards to psychological support the cancer transformation fund was looking at how it could employ additional support across the county in this regard.

The Board **NOTED** the Patient Story.

TB 19/20 032 Chief Executive's Report

Dr Swart presented the Chief Executive's Report.

Dr Swart discussed the recent unannounced CQC inspection. The straight forward issues had already been addressed and the more difficult ones were being looked into. She expected to receive the letter in relation to the well-led inspection within the next few days.

Dr Swart commented on the different A&E performance standards that had been piloted at a few Trust's across the country. There had been some controversy on these however these were meant to be more clinically appropriate.

Dr Swart stated that the Trust had been asked to pilot a new RTT target and cancer standards. She believed that this was positive and could provide the Trust with useful information.

Dr Swart advised that the People Strategy had adopted a fresh approach. The Trust was embarking on a trust-wide engagement exercise with our staff to develop our people strategy. The engagement sessions would be led by senior managers from across NGH, supported by a group of skilled facilitators. The iterative feedback would confirm and shape our priorities and commitments, and determine our short and medium-term objectives within our people strategy. Mrs Brennan confirmed she would circulate the dates of the engagement events to the Non-Executive Directors.

Action: Mrs Brennan

Dr Swart remarked that the Trust had recently welcomed the Barnes family, the American creators of the DAISY foundation, to NGH for a second time to help celebrate the achievements of our DAISY Award honourees.

Dr Swart informed the Board that the Best Possible Care Awards were scheduled for 27 September 2019. She hoped Board members would attend and Mr Burns concurred with this.

Mr Moore noted that it was interesting that the Trust had been picked to pilot the new target for RTT. He remarked though at times patients were not clear on what a target meant and targets can become confusing. Dr Swart agreed that there should be clear communication given to patients on the new RTT target. Miss Gill queried the length of the pilot and Dr Swart had not yet been informed of this.

Mr Burns commented that KGH had piloted the new A&E target. It would be beneficial to take learning from both Trusts and compare the learning from them.

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

TB 19/20 033 **Medical Director's Report including Learning from Deaths Update & GMC Survey Results**

Mr Metcalfe presented the Medical Director's Report.

Mr Metcalfe drew the Board to page 46 of the report pack and the update on Thrombosis. He, the Chief Pharmacist and the Chief Information Officer and other colleagues from NGH have met with representatives of the supplier of EPMA. The discussion had explored the range of product issues and support experienced. Mr Metcalfe stated that he had received little assurance that these issues would be resolved. There has been another meeting scheduled for 07 August 2019 to discuss a potential way forward. Mr Metcalfe asked the Board to give authority to the Quality Governance Committee that following the meeting whether to proceed with this supplier or look for a different one. The Board **DELEGATED** authority to the Quality Governance Committee.

Mr Metcalfe advised that in regards to the Learning From Deaths Update there had been an increase in mortality screening rates. There had been eight medical examiners and one medical examiner officer appointed. The Medical Examiner System would go live from September 2019.

Mr Metcalfe delivered an update on the GMC survey. He informed the Board that he would be presenting a fuller report to the Workforce Committee and then back to the Board. He noted the results to be poor and disappointing. There had been no substantive change in the number of red flags and the Trust had scored in the bottom 20% of acute Trusts. Mr Metcalfe remarked that there had been many changes within the Medical Education team recently.

Mr Metcalfe reported that himself and the Director of HR had visited Derby Hospital to explore the ways in which that hospital recruited and their medical rotations. There is a large amount of work needed to develop a cohesive medical recruitment strategy.

Mr Metcalfe referred back to Medical Education and the GMC survey results. He believed that the results from Oncology were slightly skewed due to the deanery pulling out the trainees from this department. There would be an internal governance and medical education review on Oncology and this would report to the Workforce Committee in **September.** Mr Burns requested that an update also came to the **September Trust Board**. He suggested that the Head of Medical Education and a

Junior Doctor to be involved in this presentation.

Action: Mr Metcalfe

Ms Gill commented that she had attended the Medical Education Committee. One of the key areas of discussion had been on the workload.

Dr Swart remarked that she had received a letter from HEEM who had noted the positive work put in place to support Oncology. It was reported that HEEM were attending the September Workforce Committee.

Mrs Brennan stated that the BMA had agreed a new Junior Doctor contract. The HR Team would need to look at the rotas.

Mr Cooper commented that there were quick fixes in relation to behaviour from some of the Consultants towards Junior Doctors. The Trust relied heavily upon the Junior Doctors to provide cover at times.

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

TB 19/20 034 Director of Nursing and Midwifery Report

Ms Oke presented the Director of Nursing and Midwifery Report and advised that it had been discussed in detail at the Quality Governance Committee.

Ms Oke drew the Board to page 92 of the report pack and the section which detailed In-patient 2018 Survey Highlights. The Trust overall inpatient experience scoring had been 7.9/10. When reviewing the overall scores for the Emergency Department, the Trust scored 8.5 and when compared with other Trusts, this was 'about the same'. There was no category in which the Trust was scored as 'worse than'.

Ms Oke stated that in three of the categories there was one question where we scored 'worse' than other Trusts. These were; Expectations after operation, Doctors not answering questions in a way that patients could understand and Noise from other patients at night. The Trust improved on 2 questions categorised as the 'worst than' from the 2017 survey. The 2019 survey would be sent to be patients that had been an in-patient in July 2019.

Ms Oke discussed safeguarding activity with the Board. The safeguarding concerns at Angela Grace had been discussed at the Quality Governance Committee. There has been daily feedback to the Director of Nursing and further meetings have taken place with the investigating team and Avery management. There had been no further concerns that had been raised since the last Quality Governance Committee.

Ms Oke shared a Maternity Update with the Board. In regards to the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme, the Trust must submit their completed Board declaration form to NHS Resolution by Thursday 15 August 2019. Ms Oke confirmed that the Quality Governance Committee had supported the sign off and had asked that the Board delegated approval the Executive Team. The Board **agreed delegated approval** to the Executive Team.

Mr Noble remarked on noise at night. He believed that packs had been introduced to address this however at speaking to a patient recently this patient had advised that they had not been given one of these packs. Ms Oke was surprised at this and Ms Campbell confirmed that she had seen packs on the wards.

Mr Moore asked what the financial incentive was behind the CNST scheme. He was informed that this was £300k.

Mr Moore queried the two wards at Avery. These were confirmed to be Blenheim and Cliftonville. The beds on Cliftonville were due to be removed due to concerns previously discussed on this ward. Ms Spellman advised that notice had been served for September. The Trust was in the process of procuring 24 beds and the Trust was out to the care homes as an interim measure.

Dr Swart remarked that this needed to be resolved before winter. This was being discussed by Mrs Needham and the CEO group.

Mr Burns asked for an update on this to the **November** Board.

Action: Ms Oke

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

TB 19/20 035 Maternity Bi-Annual Staffing Review

Ms Oke presented the Maternity Bi-Annual Staffing Review.

Ms Oke advised that the reviewed was required under the CNST Maternity Incentive Scheme V2 Safety action 5. She stated that the first part of the report covered the national papers and how midwifery staffing should be set.

Ms Oke commented that the Birthrate Plus establishment recommended a Midwife to Birth ratio of 1:27. The Trust has a 1:32 however this ratio can change weekly. The Trust currently has a 9.82 wte midwife deficit to provide care for existing models. The development of business case is underway to cover implementation of required models of care.

Ms Oke drew the Board to page 112 of the report and the self-assessment against NQB (2018) Board recommendations in determining staffing requirements for maternity services. There was a gap noted in Maternity safety training requirements.

Mr Noble remarked on the training gap within the self-assessment. He asked for the further mitigations to address this. Ms Oke explained that the team was going through the self-assessment and a piece of work was underway to look at the training requirements for midwives going forward.

Mr Burns referred the Board to the Public Trust Board report pack. He recognised the workload that fell to the Executive Team at submitting reports for inclusion in the pack. He suggested that the Non-Executive Team looked at ways in which the workload could be reduced and to establish the best way to build up the agenda. This included the creation of an integrated report.

Dr Swart believed that there needed to be a discussion on this as some elements of the Public Board pack were mandatory. Mr Burns reminded the Board that when a requirement refers to ‘reporting to the Board’ it does not always mean the Trust Board and can go to one of the Committees of the Board. Mr Burns welcomed this discussion at the upcoming Board Development day.

Mr Moore concurred with Mr Burns and questioned whether 329 pages to a Public Trust Board were excessive.

Mr Burns remarked that he needed to make decisions on what was best for the Board as Chair. Mr Moore suggested looking at examples of other Trust Board’s public Board papers. Mr Burns asked Ms Campbell to look at arranging dates with the Committees Chairs to discuss further.

Action: Ms Campbell

The Board **NOTED** the Maternity Bi-Annual Staffing Review.

TB 19/20 036 Month 03 Finance Report

Mr Bradley presented the Month 03 Finance Report.

Mr Bradley advised that the month 3 results were better than the previous two. The Trust had a pre-PSF overspend against plaint of £1.27m, which was an £51k improvement. It had lost PSF and FRF of £2.53m, which left the month 3 position at £3.75m adverse. Mr Bradley informed the Board that the Trust had it confirmed in writing that PSF/FRF was recoverable at any time of the year up to month 12.

Mr Bradly reported that he, Dr Swart and the Deputy Director of Finance had a conference call with the regional Finance Director.

Mr Bradley commented that divisional escalation meetings continued and the preliminary results will feed into the recovery plan which was discussed at the Finance and Performance Committee.

Mr Bradley drew the Board to the pay costs referred to on page 126 of the report pack. Once unplanned pay savings of £1.93m had been removed there is almost £2.8m overspent. A considerable amount of the pay overspend sat in the Medical Division (£2.06m) and £391k in Womens.

Mr Bradley stated that agency spend was £1.28m in month versus the plan of £934k with above planned spend on senior medical staff and both qualified and unqualified nursing staff. Some of this would be due to the continued use of the escalation wards but that doesn't account for all of it. It was noted that pay spend required greater control if the Trust is to meet the financial plan this year and areas to reduce pay spend are included in the Divisional recovery plans.

Mr Bradley informed the Board that non-pay was £149k adverse in month (mainly due to the phasing of a CIP related to Angela Grace). There was £493k underspent year to date before excluded drugs and medicines.

Mr Bradley advised that clinical income had improved over the month 2 position and was now £955k above plan. However elective and outpatient income remained below plan and needed to recover over the summer period.

Mr Bradley commented that the Trust had seen a slight recovery in June but there is much more work needed to reduce the pay spend and meet the elective and outpatient plan. As the Trust now worked within a system the over performance of the Nene contract of £924k will be seen as an issue to be worked on to recover.

Mr Bradley reported that on capital the Northamptonshire health economy reduction required £1.24m (3.7%) and not the 20% expected. An agreement had been reached that between the three providers this would be split equally which totalled £416k each. At the last Capital Committee it was agreed to take this reduction from the ward decant budget due to the fact that spending had been curtailed this year due to the escalation ward remaining open.

Mr Bradley discussed the call with the regulators with the Board. The call with the regulators covered the year to date financial position, risks, system risks, address worries from a financial perspective, the actions the Trust was taking and the recovery plan. Mr Bradley explained to the regulators the drivers of the deficit and the escalation and overspending cost centres process. The Trust discussed the impact on the system of non-elective activity being 7.4% above plan at NGH whereas this activity was well below plan at KGH. This led to a discussion about setting up a system-wide discussion in August to discuss the overall state of finances

in Northamptonshire. The regulators did not add anything additional to the actions the Trust already had in place.

Mr Burns remarked that the Trust had a good record in relation to financial stewardship and where does it go from here to maintain this. Mr Bradley believed that elective and outpatient figures needed to be sorted. The level of sickness for medical staff and nursing was greater than budgeted. Due to this there was a larger number of additional HCA's on the escalation wards.

Mr Bradley stated that the financial escalation meetings had showed progress. He commented that month 3 performance had improved on the previous months and hoped that this would continue.

Mr Cooper advised that changes to pensions had likely been a reason why consultants were more reluctant to take on additional work. Mr Metcalfe concurred and noted this to also be a patient safety risk. The Trust needed to provide appropriate pension advice and support in principle the remuneration of additional hours if the consultant was not in the pension scheme. He had been informed that KGH had done something similar. Mrs Brennan confirmed that NGH was looking at policies from other Trusts and would be pulling together a proposal.

Mr Burns remarked that this was complicated and hoped that an update would come to both the Workforce Committee and Finance & Performance Committee in due course.

Mr Moore updated the Board on the discussions at the Finance & Performance Committee in regards to recovery plans. This Committee was holding budget holders more to account. It had been mentioned that escalation beds were still open and a ring-fenced Orthopaedic ward had low level of patients at the weekend.

The Board **NOTED** the Month 03 Finance Report.

TB 19/20 037 Operational Performance Report

Mr Cooper presented the Operational Performance Report.

Mr Cooper advised that A&E performance had improved. The Trust was still below the national average however above the local average.

Mr Cooper reported that attendees were up, the biggest increase was seen in over 75's with the Age Band 86-90 years having an increase of 31% when comparing the data over the 3 month period (2018/19 vs 2019/20). It was noted that NHS 111 Referrals had seen a 25% increase as well as Arrivals by Ambulance seeing a 13% increase.

Mr Cooper commented that work is ongoing with Transformation-Nous to look at process and culture within A&E. Transformation-Nous had also looked at discharge and effective board rounds.

Mr Cooper informed the Board that RTT performance had improved.

Mr Cooper stated that the issue with the number of unappointed follow up appointments had been discussed in detail at the Quality Governance Committee.

Mr Cooper advised that in regards to cancer 2ww, 2ww breast and 62 days had improved. In May the Trust had been above the national average for 2ww for May.

Mr Cooper delivered a Urology update. It was noted that Radical prostatectomy waits

are over 13 weeks at UHL. The service had written to 8 patients (in legacy) to offer them the opportunity to have their treatment at University College London Hospital. There had been only one patient who had accepted the offer.

Ms Gill queried the increased 111 calls. Mr Cooper clarified that work was ongoing to establish what had caused this increase.

Mr Burns remarked that the Operational Performance Report did not advise if the Trust performance against the targets could be considered as normal in line with the rest of the country. It would be meaningful if the data was put into context.

Mr Noble asked if there were opportunities for other cancer pathways to use University College London Hospital. Dr Swart explained that different cancer sites presented with different issues. She suggested that this was something the cancer group could look at. Mrs Spellman expanded to describe the work with KGH on developing the lung cancer pathways.

Ms Gill referred the Board to page 163 of the report pack 'Percentage of discharges before midday'. This had dropped below the lower limit line. Mr Cooper stated that this was quite a complex metric and it would be better to look at the overall picture of discharge over a day.

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

TB 19/20 038 Workforce Performance Report including People Strategy Update

Mrs Brennan presented the Workforce Performance Report.

Mrs Brennan advised that the Workforce Performance Report had taken on a refreshed format and one aspect of this was that the graphs showed the data across a longer period of time.

Mrs Brennan reported that due to the main reason for sickness absence still being anxiety/stress the Trust had recruited two mental health professionals to support the staff.

Mrs Brennan commented that in relation to recruitment there were 600 applications in process due to the recent nurses and volunteer's recruitment drive.

Mrs Brennan stated that work was being undertaken with Therapies on the OT/Physio Apprenticeship which is available from September 2019.

Mrs Brennan advised that two role specific training programmes had recently been approved. These were on Dementia and Insulin Safety.

Mrs Brennan referred the Board to page 178 of the report pack. The education and training team were not getting the number through for organisational development interventions. There is work underway to understand why.

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

<u>People Strategy</u>

Mrs Brennan stated that following discussions at the June Board of Directors an updated overview of the People Strategy was included. She had added in the expected outcomes.

Mrs Brennan drew the Board to appendix 1 which listed the development/

reward/staff support currently in place.

Mrs Brennan reported that the engagement must be driven by the leadership team. She noted that in relation to rewards a lot come at a cost and at current there is no budget for engagement.

Dr Swart suggested compiling a list of what irritated staff and what staff thought could be done to resolve the items on this list.

Mr Burns believed asking staff what type of rewards that appreciate to also be a good step forward. Mr Burns requested an update to the **October** Board.

Action: Mrs Brennan

The Board **NOTED** the People Strategy Update.

TB 19/20 039 Equality & Diversity Workforce Annual Report 2018/2019

Mrs Brennan presented the Equality & Diversity Workforce Annual Report 2018/2019.

Mrs Brennan noted the importance of the formation of the BAME (Black, Asian and Minority Ethnic) staff Group. The first BAME group had launched week commencing 22 July 2019.

Mrs Brennan commented that the Trust was certified as a Disability Confident Employer. During 2019/2020 we will be looking at working towards attaining the next level of certification, which was a Disability Confident Leader.

Mrs Brennan advised that there was an update on the Staff Survey 2018 Equality & Diversity Results on page 230 of the report pack. On page 232 of the report pack the health and wellbeing initiatives were listed.

Mr Burns queried when the Equality & Diversity Workforce Annual Report 2018/2019 would be published and he was informed after the Trust Board.

The Board **NOTED** the Equality & Diversity Workforce Annual Report 2018/2019.

TB 19/20 040 Equality & Diversity Workforce Monitoring Report 2018/2019

Mrs Brennan presented the Equality & Diversity Workforce Monitoring Report 2018/2019.

Mrs Brennan commented that information regarding the BAME cohort of staff in relation to job banding would be explored further.

Mrs Brennan noted that there was a conflict in the Disability data as the Trust records showed 3% of the staff base and the staff survey had shown 20% of staff identifying themselves to have a disability.

Mr Burns asked what the opinion was of the Workforce Committee in relation to the data and information in the reports. Ms Gill advised that the findings should be reflected in the People Strategy as a priority, what was the remit of BAME staff group and for further information on Diversity by Design.

Mr Noble commented that there was a lack of statistical analysis in the report. He also referred to the use of the text ‘adjustments made’ in relation to disabilities. Mrs Brennan explained that adjustments are made when staff declare a disability however staff did not always declare this. Mr Noble believed that work should be done on how to encourage staff to declare a disability. Ms Gill suggested the creation

of a staff disability group.

The Board **NOTED** the Equality & Diversity Workforce Monitoring Report 2018/2019.

TB 19/20 041 Equality & Diversity Workforce Progress Report for Staff

The Board **NOTED** the Equality & Diversity Workforce Progress Report for Staff.

The Board **APPROVED** the Equality & Diversity Workforce Annual Report 2018/2019, the Equality & Diversity Workforce Monitoring Report 2018/2019 and the Equality & Diversity Workforce Progress Report for Staff.

TB 19/20 042 Board Assurance Framework

Ms Campbell presented the Board Assurance Framework (BAF).

Ms Campbell advised that the BAF had been presented to all the Board Committees.

Ms Campbell referred the Board to page 292 of the report pack which detailed the changes to BAF during quarter 1. The Initial Risk score dates have been updated to reflect the score at the end of Q4 2018/19. The changes to the BAF had been coloured red in the document. She had also created a summary sheet shown in the report as appendix 1.

Ms Campbell stated that there would be an annual review on the BAF at the **October** Board development.

The Board **NOTED** the Board Assurance Framework.

TB 19/20 043 Update Paper - Violence & Aggression Review Group (VARG)

Ms Oke presented the Update Paper - Violence & Aggression Review Group (VARG).

Ms Oke commented that there had been concerns over the increased number of violence and aggression incidents across the Trust over the past 12 months. The top 3 areas for these Datix were Emergency Department, Collingtree and Nye Bevan. The Violence and Aggression Review Group (VARG) is meeting bi-weekly.

Ms Oke advised that the current projects being undertaken by the VARG are listed on pages 317-318 of the report pack.

Mr Burns remarked that staff should not being subject to this.

The Board **NOTED** the Update Paper - Violence & Aggression Review Group (VARG).

TB 19/20 044 Highlight Report from Finance and Performance Committee

Mr Moore reported that at the recent Finance and Performance Committee it had been noted the shortfall identified in the CIP programmes. This is of concern and would be looked at carefully.

Mr Moore stated that it had been positive that the loss to capital had not been as much as expected.

Mr Moore advised that Transformation-Nous had presented to the Committee.

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

TB 19/20 045 Highlight Report from Quality Governance Committee

Mr Moore commented on the increased levels of aggression towards staff which had been reported in the Health & Safety Highlight Report.

Mr Moore stated that the Gosport Analysis report had been presented and the Trust was adopting the recommendations.

Mr Moore remarked that the Committee had received a paper on Unappointed Follow Ups.

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

TB 19/20 046 Highlight Report from Workforce Committee

Ms Gill advised that a discussion had been had on midwifery capacity following presentation of the CRR.

Ms Gill commented that the Committee had learnt that the Divisions were responsible for their own recruitment adverts therefore a common template was being created.

Ms Gill remarked that following a recent visit to Derby from the Director of HR and the Medical Director, learning from this visit would be built into the medical recruitment pipeline.

Ms Gill advised that the GMC survey results had been mentioned and a follow up report had been requested by the Committee to the August meeting.

Ms Gill stated that the Nurse Overseas Recruitment Business Case had been supported by the Committee.

Ms Gill reported that the Freedom to Speak Up Quarter 1 report had been presented.

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

TB 19/20 047 Highlight Report from Audit Committee

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

TB 19/20 048 Highlight Report from HMT

The Board **NOTED** the Highlight Report from HMT.

TB 19/20 049 Any Other Business

There was no other business to discuss.

Date of next Public Board meeting: Thursday 26 September 2019 at 09:30 in the Board Room at Northampton General Hospital.

Mr A Burns called the meeting to a close at 12:30pm

Public Trust Board Action Log **Last update** **13/09/2019**

Item No	Month of meeting	Minute Number	Paper	Action Required	Responsible	Due date	Status	Updates
Actions - Slippage								
Actions - Current meeting								
110	Jul-19	TB 19/20 032	People Strategy	Mrs Brennan confirmed she would circulate the dates of the engagement events to the Non-Executive Directors	Mrs Brennan	Sep-19	On Agenda	**Update Matters Arising**
111	Jul-19	TB 19/20 033	Medical Director's Report	There would be an internal governance and medical education review on Oncology and this would report to the Workforce Committee in September. Mr Burns requested that an update also came to the September Trust Board. He suggested that the Head of Medical Education and a Junior Doctor to be involved in this presentation	Mr Metcalfe	Sep-19	On Agenda	
113	Jul-19	TB 19/20 035	Board Papers	Mr Burns remarked that he needed to make decisions on what was best for the Board as Chair. Mr Moore suggested looking at examples of other Trust Board's public Board papers. Mr Burns asked Ms Campbell to look at arranging dates with the Committees Chairs to discuss further.	Ms Campbell	Sep-19	On Agenda	
Actions - Future meetings								
94	Jan-19	TB 17/18 206	Chief Executive's Report	Mrs Brennan commented that the workforce plan was under development and this was split into 5 workstreams. The plan would be shared in March with the detail received by the Autumn. An update would be brought to the Trust Board when circulated.	Mrs Brennan	Oct-19	On Track	**Update from May Board - Mrs Brennan updated the Board and informed them that the National Workforce plan had still not been released. Once it had been she would update the Board.** **Update from **July** Board - Mrs Brennan commented that the workforce plan had been referenced in the People Strategy. A full report would be coming to the October Board.**
112	Jul-19	TB 19/20 034	Director of Nursing and Midwifery Report	Mr Burns asked for an update on this to the November Board - CNST Update,	Ms Oke	Nov-19	On Track	
114	Jul-19	TB 19/20 038	People Strategy Update	Mr Burns believed asking staff what type of rewards that appreciate to also be a good step forward. Mr Burns requested an update to the October Board.	Mrs Brennan	Oct-19	On Track	
103	Mar-18	TB 18/19 249	Paediatric Nurse in Paediatric ED	Mr Burns asked for a future report on registered Paediatric Nurse in Paediatric ED.	Ms Oke	TBC	TBC	
109	May-19	TB 19/20 017	Health and Safety Annual Report	Mr Burns referred the Board back the increased number of incidents of aggression towards staff from patients. He asked what can practically be done to address this. Mr Burns requested an update at a Public Trust Board	Mr Finn	TBC	TBC	

Report To	**Public Trust Board**
Date of Meeting	**26 September 2019**

Title of the Report	**Chief Executive's Report**
Agenda item	***8***
Presenter of the Report	Dr Sonia Swart, Chief Executive
Author(s) of Report	Dr Sonia Swart, Chief Executive and Sally-Anne Watts, Associate Director 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	

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Public Trust Board
26 September 2019

Chief Executive's Report

1. Capital Investment in the NHS

On 30 August NHS Providers launched a national campaign calling on the government to help rebuild the NHS.

The aim of the campaign is to highlight the need for a properly-funded and well-designed system of capital funding to allow NHS trusts to invest in the buildings and technology projects organisations need in order to help create a 21st century health service.

Whilst the prime minister's commitment to allow the NHS to spend an additional £1.8bn capital funding, the scale of the challenge is great and the campaign seeks to highlight that the announcement can only be considered as a starting point.

No projects in Northamptonshire were identified as receiving support from the additional funding. This was disappointing for both us and colleagues at Kettering General Hospital NHS Foundation Trust.

Population growth in Northamptonshire has been 30% over the last 30 years, which is significantly higher than the national average of 16%. This population growth is impacting on both hospitals and we are concerned that, without significant capital investment, patients will be at risk and our ability to attract and retain staff will also be affected. Facilities at both hospitals are stretched and the need for an urgent care hub in the north of the county has been identified as the main priority for local investment.

Here at NGH we have a very high percentage of old estate (some of which is more than 200 years old) and, whilst we try to do as much as possible to maintain the site, backlog maintenance continues to be an issue. The legacy of older buildings to the east of our site means that only around 37% of our buildings are in good or satisfactory condition. The older buildings are functionally unsuitable and costly to maintain, representing a disproportionate amount of our backlog maintenance liability.

Ten years ago we developed a long term capital plan for the site which has been held back due to lack of clarity around capital investment.

We know the older parts of the estate need replacing and we have plans to do this in a sequential way over the coming years. However, our current level of capital investment is 2.95%. Turnover for 2919/20 was £349million, against which we had a capital plan of £10.3million. Improving our productivity and efficiency levels becomes increasingly more difficult to achieve when we are providing services in outdated facilities which are not located centrally on the site and we don't receive adequate capital investment.

Despite the capital constraints, Board members will be aware that we have made every effort to find alternative sources of funding, including a long-term loan to develop our Nye Bevan emergency assessment unit and also working with external partners to redevelop our main entrance and medical records facilities and provide staff accommodation.

Without access to significant capital funding we will be unable to move forward with our plans, which include relocation of our paediatric and women's services.

I recently met with Andrew Lewer MP as he was concerned that no funding had been announced for this hospital and wanted to understand more about what this meant for NGH. Following our discussions he spent some time looking at our paediatric emergency, assessment and inpatient facilities and talking to staff. He was able to see for himself the cramped conditions within our paediatric emergency area, something that has already been raised by the CQC in relation to quality standards.

I have also written to our local MPs to alert them to the campaign which is being spearheaded by NHS Providers and seeking their support. I have taken the opportunity to make them aware that we are seeing more and more children attending our children's emergency area - and there is no indication that this is likely to reduce with 26,121 children attending in 2018 compared to 23,913 in 2016, and in the first eight months of 2019 we have already seen 18,081 children attend our paediatric emergency department. We are looking at ways of working differently with community providers, but it is still likely that we will need a significant facility on site.

Our paediatric assessment unit, which operates on a referral only basis, has also seen a steady rise in demand over the past three years, from 4318 referrals in 2016 to 6137 in 2018 and 3715 in the first eight months of the year.

I have advised our MPs that, whilst limited, short-term investment in paediatric emergency facilities will bring about immediate relief for that service, it will not address the longer-term issues of decreasing productivity and efficiency and increased risk to patient safety that will accumulate as we struggle to provide 21st century healthcare in 19th and 20th century buildings.

Andrew Lewer, MP has indicated his support for the campaign and specifically for investment at NGH. Andrea Leadsom, MP has also indicated her interest and her team are arranging for me to meet with our local MPs in Westminster very soon.

We are also involved in developing a long term strategic estates plan for both actual hospital sites and for the wider health and social care economy.

2. Clinically-led review of NHS cancer standards

Board members will be aware that NGH is one of 12 NHS trusts currently taking part in testing updates and upgrades to NHS access standards as part of the clinical review of standards, led by Professor Stephen Powis, NHS National Medical Director.

The aim of the review is to determine whether updating and improving the targets currently in use could better support frontline staff to deliver the highest quality care for patients and save more lives, taking into account advances in clinical practice and what patients say matters most to them.

The interim report published by Professor Powis in March included a proposal to measure cancer services on whether they can give people with suspected cancer a diagnosis within 28 days of being referred, rather than simply whether they see a specialist within 14 days, which is the current two week wait standard. It is believed this simplified and modernised alternative will be more understandable and meaningful to people with suspected cancer and their families, support best clinical practice and help to diagnose more cancers earlier.

In addition to taking part in the review of access standards, we have also agreed to be involved in testing the proposition in relation to cancer standards in collaboration with NHS England and NHS Improvement.

The interim performance threshold for NGH during phase 1 of the testing is set at 63%, although we will continue to be performance managed against the national 62-day 85% threshold during the test period.

Our patients' right to see a specialist within two weeks will continue to apply throughout the testing period and our focus throughout the trial will remain firmly on delivering safe, high quality, clinically appropriate patient care and experience. Staff will be expected to continue to work in line with current best practice and protocols.

Once testing is complete the NHS nationally will collate and analyse the data to track results, with the learning from NGH and elsewhere informing any final recommendations from the review later in the year.

3. Our Staff

During the summer we saw record attendances to A and E and record numbers of admissions. Given the pressure this puts on people it is important that we remember some of the great things and take a moment to welcome our new staff with energy and positivity.

At the start of August we welcomed our new foundation doctors and the following week we welcomed 140 new doctors in training at various levels. Our corporate teams from HR, IT, resuscitation, quality improvement, occupational health and others supported by our education teams did their best to make sure we welcomed and looked after these doctors on their first days and I am sure this will continue in all our wards and departments.

It is always a pleasure for me to give our new doctors a personal welcome and to be joined in this by our medical director and director of medical education. Every year we try to learn from the various experiences and do something a little better. This year was the first year we introduced our health and well-being packs, an initiative led by Anne-Marie Dunkley who is our health and well-being lead. It was a great idea and she is quite right – it is a scary time for doctors who move around the country to new hospitals, often starting new roles with some trepidation.

I have also been struck recently by the very positive efforts we are making to welcome our new nurses from India. They have spoken to me very positively about how they have been welcomed and supported and how proud they are to be here. As we will increasingly need to go out internationally to recruit nurses we all need to remember how important the welcome and care we give to them is.

August and September has seen us undertaking a summer of engagement with staff at all levels as we seek their views about our people strategy. The appreciative listening that is a key part of this work needs very much to flow into ideas on the immediate things that need to feel different for all the people who work so hard to deliver, improve and support high quality care for our patients. Having led a couple of these sessions so far, with more in the diary, I am convinced that this personal engagement with staff at all levels will be an essential component of our improved offer to our workforce and felt particularly privileged to share my story with our Black and Ethnic Minority Group.

4. Maggie's Centre

Towards the end of July the formal planning application was submitted for our Maggie's Centre and we hope to hear more news about the development very soon. This has been in the planning stage for quite some time now and the fact that we can go out for planning means that fundraising is going well. This beautiful building will host a range of services to help people affected by cancer cope with the impact this has on them. We were recently asked for a comment relating to the value of this building and this was included in its entirety.

'A Maggie's Centre at NGH would be a fantastic asset for Northamptonshire. It will be a symbol of hope for those living with and beyond cancer and those affected by it. As more and more families are touched by cancer and as more and more complex treatments are available many people are faced with confusing choices.

The holistic healing environment and services provided at a Maggie's Centre offers a chance for patients and their families to connect with what matters most to them in a way that allows them to value and enjoy each day of the life they have, whether it is a shorter or longer one.

People who treat cancer also need the chance to reflect and reconnect with the privilege of healthcare whilst they continue to work in a pressurised environment that risks squeezing the compassion out of them. Maggie's Centres offer a new kind of hope for cancer patients and for the people treating them.'

Dr Sonia Swart
Chief Executive

Report To	**Public Trust Board**
Date of Meeting	**26 September 2019**

Title of the Report	**Medical Directors Report**
Agenda item	**9**
Presenter of Report	Matt Metcalfe, Medical Director
Author(s) of Report	Matt Metcalfe, Medical Director
Purpose	The paper is presented to provide information to the board to form a discussion relating to medical quality and safety.

Executive summary

The paper is presented to provide information to the board to form a discussion relating to medical quality and safety.

Each of the indicators on the integrated scorecard (Appendix 1) for which the Medical Director is the executive lead and which are non-compliant have an accompanying exception report (Appendix 2) and these have been discussed in detail in the appropriate subcommittees. Within the body of the report are listed those corporate risks relating to the corporate medical portfolio. Where information is available benchmarking is included.

Within this month's report, the main areas of focus for discussion are;

a. VTE assessment
b. East Midlands Clinical Senate Reviews

Related strategic aim and corporate objective	1
Risk and assurance	There is a potential risk to the organisation if risks are not identified in a timely manner and effective mitigation actions taken

	that the staff and patients in the organisation may experience foreseeable harm and the Trust could be exposed to reputational damage and prosecution.
Related Board Assurance Framework entries	BAF – ALL
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (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	

Actions required by the Board

The board is asked to receive this report.

UNIVERSITY OF LEICESTER
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Medical Director's Report

September 2019

1. Introduction

The purpose of this report is to reflect faithfully upon the quality and safety of the clinical services afforded to our patients against our vision of delivering best possible care for all our patients. This report should therefore be taken in conjunction with the director of nursing and midwifery report to the board. For ease of access the report is structured;

ii. in relation to the principle risks to delivery where these are rated "extreme" and pertain to the corporate medical portfolio (>14)
iii. review of harm, incidents and thematic
iv. mortality and the management of outlier alerts
v. related topics from the medical director's portfolio largely reflecting the reporting cycle of CQEG and QGC, this month;
   a. VTE assessment
   b. East Midlands Clinical Senate Reviews

2. Risk

The principle risks to delivering high quality and timely patient care rated 15 and over are listed below. The mitigation of these is described in the corporate risk register and associated reports.

CRR ID	Description	Rating (Initial)	Rating (Current)	Corporate Committee
1967	Risk to patient safety when EAB is understaffed, and staff untrained to use equipment and identify rapidly deteriorating patients.	15	20	Quality Governance
1902	Shortage of staff able to provide assessment of physical, cognitive, and emotional function at diagnosis and every stage of follow-up for patients with brain tumours is likely to result in impaired recovery and	20	20	Quality Governance

	quality of life for these patients and NGH Trust being non-compliant with NICE guidance for best practice.			
1867	Risk that an unborn or new-born baby or vulnerable woman/family may not be identified or managed as per local safeguarding procedures due to external issues and factors with the Local Authority provision for Children's social care. Significant number of women and families with complex safeguarding needs Considerable slippage with the management of the very high risk cases. Thresholds are considerably raised.	20	20	Quality Governance
1665	Quality, Reputational and potential risk to CQC rating as the established / budgeted midwifery staffing numbers are insufficient to meet the national recommended midwife to birth ratio of 1:27 (currently 1:30.7)	20	20	Workforce
1373	Lack of access to clinical areas to carry out statutory Estates works Unable to carry out electrical testing under full loading conditions so unable to give assurance that it would work.	20	20	Quality Governance
966	Vulnerable children & adults are not afforded appropriate protection due to failures to remain compliant with necessary legislative and regulatory standards, both as an independent agency and part of a multi-agency	6	20	Quality Governance

	partnership. Concerns raised regarding children services:			
2070	We currently have 2 vacancies for Consultant Orthodontists.	16	16	Quality Governance and Workforce
2051	Lack of diabetes transition service Only 5 out of 12 transition clinics held last year	16	16	Quality Governance
2020	There is a risk that patients are not being managed through their RTT pathway which could result in harm due to inaccurate closure of pathway and potential fine	16	16	Finance and Performance
2006	Failure of the CCG to commission adequate activity to meet the needs of the population or to effectively plan and implement demand management in partnership with providers leading to an inability of the Trust to deliver safe, effective and responsive services	20	16	Finance and Performance
1962	Safety, Quality and reputational risk associated with increased number of maternity unit closures and escalations due to insufficient capacity (particularly on labour Ward) to accommodate the increasing levels of birth activity and the fluctuations and peaks of high activity	20	16	Quality Governance
1911	Difficultly demonstrating full compliance with the Saving Babies Lives care bundle due to the level of audit required for NHSE Deep Dive.	20	16	Quality Governance
1879	There is a risk to patient safety due to the inability to provide a dedicated Obstetric Triage area	16	16	Quality Governance

	leading to potential delays in time critical review / intervention for mothers and babies.			
1782	Unable to fully demonstrate full compliance with NICE guidelines NG89 in terms of VTE risk assessment, reporting and management. VitalPAC system (a standalone VTE assessment therein) is not linked to clerking or prescribing of prophylaxis management.	16	16	Quality Governance
1598	Low levels of fully chemotherapy trained nursing staff continue then there will be delays in providing treatments to cancer patients on the ward and if nurses are not suitably trained there is potential for omissions of care to take place.	12	16	Quality Governance
2044	The Trust is not yet compliant with safety alert EFA/2018/005. The Trust does not yet have a robust process that has identified which clinical areas require a ligature point risk assessment using the toolkit advised within the alert.	15	15	Quality Governance
1955	Lack of support / guidance in training to support staff in assessing and managing deteriorating patients across the Trust.	20	15	Quality Governance
1844	Removal of training grade doctors risks loss of significant clinical capacity compromising care quality and ability to deliver service level agreement.	20	15	Workforce
1682	Inadequate numbers of nurses in paeds ED to safely care for all the	9	15	Workforce

	patients.			
1553	Risk that a failure to close off safety alerts as per expected timescales and policy.	15	15	Quality Governance
1478	Noncompliance with documentation of mental capacity assessments when completing DNACPR orders.	15	15	Quality Governance
1411	Medical records not being received at the locations in a timely manner. Records are not received within time for the clinics, therefore full clinical information not available for clinicians which could lead to harm.	9	15	Quality Governance
1348	If high vacancy levels continue for medical staff, there will be delays seeing patients and a risk that care quality will be compromised.	9	15	Quality Governance
368	Risk of reduced patient safety when demand exceeds capacity within the ED and the Trust, resulting in a risk of delayed diagnosis and delayed escalation.	20	15	Quality Governance

3. Harm

The process by which harm and potential harm is identified at the trust has been well described in previous reports to the board and QGC. In this section the following are set out;

i. The number of serious incidents (requiring STEIS escalation) and the number `of Never events in 2018/19, with previous years under the current framework for comparison.
ii. The number of new serious incidents requiring full root cause analysis (RCA) and moderate harm incidents requiring “concise” RCA since the last trust board. Summary information for new Serious Investigations initiated and submitted to the CCG are provided.
iii. Key thematic issues relating to avoidable patient harm.

3.i Run rate of clinical SI and Never Event investigations

	16/17	17/18	18/19	19/20
Serious Incidents	13	18	34	16
Never Events	1	3	1	1

3.ii New SI and moderate investigations

There were 10 serious incidents reported on STEIS during July and August 2019. These are on track to report by their deadlines. 2 SI reports were submitted to the CCG for closure. The learning and actions arising have been shared through morbidity and mortality meetings, divisional governance meetings, CQEG and QGC.

21 moderate harm incidents were identified, and these are subject to concise RCA investigations.

3.iii Thematic issues

No new themes have been identified from incidents since January. The previously recognised themes of delayed recognition of the deteriorating patient, with associated recurring issues around diabetic control, fluid management, safeguarding and escalation/end of life care continue to be addressed holistically through the deteriorating patient operating group. The roll out through inpatient areas has been confirmed. Issues relating to the failure to act upon investion results are being addressed through work led by the associate medical director for medicines and mortality. A cluster of falls with with significant harm were noted in August. No common causal link was noted, however delays in imaging were common to several, and a new pathway for falls requiring imaging has been agreed between imaging, trauma and medicine.

4. Mortality

The rolling 12 month HSMR to January 2019 for the trust remains within the “expected” range at 102. Diagnosis and procedure specific outlying SMRs are investigated and managed in the usual process of trust reviews.

The medical examiners officer will be in post by the beginning of October, and the medical examiner function will commence in November.

The East Midlands Clinical Senate review of the cardiology service made some recommendations in relation to addressing the congestive cardiac failure SMR, although this is not currently a statistical outlier.

5. Thrombosis

The trust secured enhanced engagement with our ePMA supplier, and through a process of daily virtual workshops and weekly senior oversight have achieved the release of the upgraded product to clinical testing. The implementation is now in the gift of the trust, and IT clinical systems have committed to clinical go live in November 209 for the assessment forcing function.

6. East Midlands Clinical Senate Reviews

The trust invited reviews of breast cancer pathways and the cardiology service which took place in July and August respectively. The reports have been approved by the senate council and shared with the relevant services. The recommendations will be incorporated into work programmes, integrated with those arising from other external sources – eg GIRFT and NCEPOD.

Northampton General Hospital NHS
NHS Trust

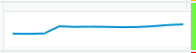
Corporate Scorecard 2019/2020 AUG

Domain	Indicator	Executive Owner	Target	Target Set By	Direction of Travel	Trend	SEP-18	OCT-18	NOV-18	DEC-18	JAN-19	FEB-19	MAR-19	APR-19	MAY-19	JUN-19	JUL-19	AUG-19
Caring	Complaints responded to within agreed timescales	Sheran Oke	>=90%		↓		100.0%	97.3%	97.4%	98.0%	100.0%	100.0%	100.0%	97.7%	96.1%	94.5%	83.7%	72.7%
	Friends & Family Test % of patients who would recommend: A&E	Sheran Oke	>=86.4%	Nat	↓		87.3%	86.4%	88.1%	85.9%	85.1%	80.9%	83.3%	85.3%	86.8%	86.0%	82.1%	81.9%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	Sheran Oke	>=95.7%	Nat	↓		91.9%	92.4%	94.0%	92.6%	92.7%	93.5%	92.8%	92.7%	93.8%	93.9%	93.6%	92.6%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	Sheran Oke	>=96.8%	Nat	↑		100.0%	100.0%	96.6%	100.0%	99.4%	98.6%	99.3%	99.3%	98.6%	99.0%	97.7%	98.6%
	Friends & Family Test % of patients who would recommend: Outpatients	Sheran Oke	>=93.8%	Nat	↑		92.7%	92.3%	93.8%	93.5%	93.5%	93.6%	93.3%	93.3%	93.6%	94.7%	93.1%	93.8%
	Mixed Sex Accommodation	Sheran Oke	=0	Nat	→		0	0	0	0	4	2	0	0	0	0	0	0
	Compliments	Sheran Oke	>=5	NGH	↑			4,288	4,335	3,541	4,269	3,639	4,007	3,647	3,697	3,595	4,363	4,367
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	Debbie Needham	>=90.1%	Nat	↓		88.9%	86.7%	85.9%	83.3%	78.5%	79.0%	80.2%	79.0%	83.9%	85.5%	83.6%	78.4%
	Average Ambulance handover times	Debbie Needham	<=15 mins		→		00:14	00:14	00:14	00:14	00:31	00:14	00:16	00:17	00:13	00:19	00:18	00:18
	Ambulance handovers that waited over 30 mins and less than 60 mins	Debbie Needham	<=25		↓		118	174	142	299	330	400	420	343	203	69	84	219
	Ambulance handovers that waited over 60 mins	Debbie Needham	<=10		↓		15	17	19	30	49	33	22	13	11	15	9	13
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Debbie Needham	=0		↑		2	3	3	4	5	4	4	11	1	4	3	1
	Delayed transfer of care	Debbie Needham	=23	NGH	↓		36	10	10	24	12	11	20	31	34	21	32	47
	Average Monthly DTOCs	Debbie Needham	<=23	NGH	↓		34	27	15	20	20	17	29	41	41	32	30	37
	Average Monthly Health DTOCs	Debbie Needham	<=7	NGH	↓		25	25	13	16	17	13	20	30	33	23	19	25
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	Debbie Needham	>=93%	Nat	↑		75.2%	94.0%	88.5%	86.1%	73.7%	81.9%	73.3%	70.5%	91.0%	85.7%	95.5%	
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	Debbie Needham	>=93%	Nat	↑		85.7%	91.0%	40.2%	35.4%	60.2%	69.3%	66.4%	27.2%	42.1%	54.0%	96.8%	
	Cancer: Percentage of patients treated within 31 days	Debbie Needham	>=96%	Nat	↑		94.7%	97.5%	94.8%	96.5%	92.1%	94.1%	94.4%	94.5%	96.4%	95.5%	96.1%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	Debbie Needham	>=98%	Nat	↑		96.7%	100.0%	100.0%	100.0%	98.9%	100.0%	94.6%	100.0%	99.0%	98.5%	98.7%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	Debbie Needham	>=94%	Nat	↑		95.6%	95.7%	96.6%	94.8%	97.9%	97.9%	95.0%	96.1%	97.7%	91.5%	98.2%	
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	Debbie Needham	>=94%	Nat	↑		88.8%	86.6%	93.7%	93.7%	80.0%	100.0%	86.6%	90.0%	100.0%	90.9%	94.1%	

Enclosure D

Northampton General Hospital NHS
NHS Trust

Corporate Scorecard 2019/2020 AUG

	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	Debbie Needham	>=85%	Nat	↓		81.4%	85.4%	76.0%	80.0%	71.1%	74.0%	70.6%	70.0%	69.8%	77.5%	75.2%	
	Cancer: Percentage of patients treated within 62 days of referral from screening	Debbie Needham	>=90%	Nat	↑		100.0%	83.8%	100.0%	81.8%	90.4%	100.0%	100.0%	90.0%	95.8%	66.6%	100.0%	
	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	Debbie Needham	>=85%	Nat	↓		79.0%	85.7%	83.6%	89.1%	84.0%	80.0%	92.5%	80.5%	88.2%	88.5%	47.5%	
	RTT waiting times incomplete pathways	Debbie Needham	>=92%	Nat	→		80.3%	81.5%	82.1%	81.5%	81.6%	80.7%	80.0%	79.0%	80.6%	82.5%	82.5%	No Longer Reported
	RTT over 52 weeks	Debbie Needham	=0	Nat	→		0	0	0	0	1	3	1	0	1	0	0	
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	Debbie Needham	>=99.1%	Nat	↑		99.9%	99.8%	99.9%	99.7%	100.0%	99.4%	99.3%	96.8%	96.4%	94.1%	93.7%	95.9%
	Stroke patients spending at least 90% of their time on the stroke unit	Debbie Needham	>=80%		↓		92.7%	94.8%	95.6%	100.0%	79.6%	66.2%	75.4%	96.6%	93.7%	74.5%	83.3%	64.2%
	Suspected stroke patients given a CT within 1 hour of arrival	Debbie Needham	>=50%		↓		95.0%	97.9%	95.0%	95.3%	89.3%	82.4%	92.3%	98.1%	90.6%	90.9%	91.8%	85.7%
	Unappointed Follow Ups	Debbie Needham	=0	NGH	↓						8,608	8,723	9,957	10,119	10,363	10,385	9,670	9,801
Well Led	Bank & Agency / Pay %	Janine Brennan	<=7.5%	NGH	↓		12.4%	12.4%	12.3%	12.3%	12.4%	12.4%	12.6%	12.7%	13.2%	15.2%	15.7%	15.9%
	Sickness Rate	Janine Brennan	<=3.8%	NGH	↓		4.2%	4.0%	4.0%	4.4%	4.9%	4.7%	4.0%	4.2%	4.2%	4.5%	4.3%	4.6%
	Staff: Trust level vacancy rate - All	Janine Brennan	<=9%	NGH	→		11.1%	10.4%	10.3%	12.5%	11.8%	11.0%	11.2%	12.3%	12.0%	12.1%	12.1%	12.1%
	Staff: Trust level vacancy rate - Medical Staff	Janine Brennan	<=9%	NGH	↑		9.4%	8.8%	9.0%	9.9%	9.1%	2.4%	3.2%	6.8%	7.2%	7.5%	7.9%	5.9%
	Staff: Trust level vacancy rate - Registered Nursing Staff	Janine Brennan	<=9%	NGH	↓		7.4%	7.3%	7.5%	11.5%	11.2%	11.3%	11.2%	11.0%	11.1%	11.5%	12.2%	12.6%
	Staff: Trust level vacancy rate - Other Staff	Janine Brennan	<=9%	NGH	↓		13.7%	12.8%	12.1%	13.5%	12.7%	12.5%	12.8%	14.0%	13.5%	13.4%	13.0%	13.2%
	Turnover Rate	Janine Brennan	<=10%	NGH	↓		7.8%	7.7%	7.8%	8.3%	8.2%	8.9%	8.4%	8.4%	8.6%	8.6%	8.8%	8.9%
	Percentage of all trust staff with mandatory training compliance	Janine Brennan	>=85%	NGH			88.6%	87.8%	88.2%	88.5%	88.7%	88.5%	88.6%	89.2%	89.4%	89.4%	No data submitted	88.8%
	Percentage of all trust staff with mandatory refresher fire training compliance	Janine Brennan	>=85%	NGH					81.9%	82.8%	82.0%	81.9%	82.7%	83.6%	84.4%	84.5%	No data submitted	84.8%
	Percentage of all trust staff with role specific training compliance	Janine Brennan	>=85%	NGH			82.1%	81.9%	82.5%	83.0%	83.2%	83.7%	83.8%	83.8%	84.1%	84.4%	No data submitted	83.7%
	Percentage of staff with annual appraisal	Janine Brennan	>=85%	NGH			84.5%	83.1%	83.5%	81.6%	83.6%	84.5%	86.4%	84.5%	84.7%	85.0%	No data submitted	83.3%
	Job plans progressed to stage 2 sign-off	Matt Metcalfe	>=90%	NGH	↓		12.5%	15.1%	27.5%	24.2%	28.6%	30.9%	37.8%	37.1%	46.4%	44.1%	53.6%	53.2%
	Income YTD (£000's)	Phil Bradley	>=0	NGH	↑		(2,627) Adv	(3,337) Adv	(2,957) Adv	(3,550) Adv	(3,093) Adv	(3,256) Adv	(2,887) Adv	(985) Adv	(1,358) Adv	(600) Adv	(1,333) Adv	(1,309) Adv
	Surplus / Deficit YTD (£000's)	Phil Bradley	>=0	NGH	↓		392 Fav	57 Fav	97 Fav	(432) Adv	(460) Adv	(761) Adv	(2,512) Adv	(1,477) Adv	(2,949) Adv	(3,321) Adv	(5,036) Adv	(6,228) Adv
	Pay YTD (£000's)	Phil Bradley	>=0	NGH	↓		(2,967) Adv	(3,221) Adv	(3,277) Adv	(3,165) Adv	(3,614) Adv	(3,901) Adv	(4,623) Adv	(1,021) Adv	(1,978) Adv	(2,786) Adv	(3,599) Adv	(4,270) Adv

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	Non Pay YTD (£000's)	Phil Bradley	>=0	NGH			3,819 Fav	4,246 Fav	4,204 Fav	4,612 Fav	5,088 Fav	5,232 Fav	5,437 Fav	407 Fav	474 Fav	67 Fav	217 Fav	4 Fav
	Salary Overpayments - Number YTD	Phil Bradley	=0	NGH			128	153	167	195	209	230	266	55	34	57	72	92
	Salary Overpayments - Value YTD (£000's)	Phil Bradley	=0	NGH			260.9	313.1	340.9	371.9	392.3	454.4	509.2	156.6	86.4	156.8	183.8	232.3
	CIP Performance YTD (£000's)	Phil Bradley	>=0	NGH			1,833 Fav	1,704 Fav	1,821 Fav	1,554 Fav	2,030 Fav	1,458 Fav	1,458 Fav	246 Fav	686 Fav	1,147 Fav	570 Fav	No data submitted
	CIP Performance - Recurrent	Phil Bradley	-	NGH						64.5%	65.9%	65.5%	69.0%	39.0%	39.9%	42.2%	43.1%	No data submitted
	CIP Performance - Non Recurrent	Phil Bradley	-	NGH						39.1%	40.4%	41.0%	41.0%	42.8%	38.7%	39.6%	41.7%	No data submitted
	Maverick Transactions	Phil Bradley	=0	NGH						15	21	21	19	18	18	22	27	19
	Waivers which have breached	Phil Bradley	=0	NGH						1	0	0	0	4	1	2	1	2
Effective	Stranded Patients (ave.) as % of bed base	Debbie Needham	<=40%	NGH			57.6%	54.1%	54.4%	54.7%	58.0%	57.0%	55.3%	60.4%	62.0%	59.6%	55.6%	57.9%
	Super Stranded Patients (ave.) as % of bed base	Debbie Needham	<=25%	NGH			26.1%	23.7%	23.1%	23.1%	23.8%	21.6%	22.0%	27.9%	29.6%	26.3%	23.6%	25.3%
	Length of stay - All	Debbie Needham	<=4.2	NGH			4.4	4.6	4.4	4.2	4.8	4.7	4.8	4.3	4.7	4.4	4.6	4.4
	Percentage of discharges before midday	Debbie Needham	>25%	NGH			17.8%	18.6%	17.4%	19.1%	18.3%	17.2%	18.2%	17.4%	16.8%	16.3%	16.7%	16.9%
	Readmissions within 30 days of previous reporting month	Matt Metcalfe	<=12%												7.7%	15.1%	8.0%	13.0%
	# NoF - Fit patients operated on within 36 hours	Matt Metcalfe	>=80%				77.1%	84.6%	82.7%	100.0%	86.4%	81.8%	90.9%	83.3%	92.0%	83.7%	90.4%	85.1%
	Maternity: C Section Rates	Matt Metcalfe	<29%				28.9%	31.4%	31.3%	32.1%	32.3%	27.2%	36.0%	28.1%	33.3%	27.1%	30.6%	28.7%
	Mortality: HSMR	Matt Metcalfe	100	Nat			104	106	106	106	105	106	104	103	104	105	0	102
	Mortality: SHMI	Matt Metcalfe	100	Nat			100	100	104	104	104	104	104	104	100	100	100	99
	Patient Ward Moves Overnight (22:00 - 06:59)		=0											738	817	830	851	334
	% Daycase Rate		>=80%											81.2%	82.6%	83.0%	81.1%	83.5%
	Failed Daycases as a % of Planned Daycases		-											1.8%	2.6%	2.6%	2.6%	2.4%
Safe	Transfers: Patients transferred out of hours (between 10pm and 7am)	Debbie Needham	<=60	NGH			47	66	36	35	53	51	35	35	35	17	No data submitted	22
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	Debbie Needham	>=98%	NGH			95.7%	96.9%	97.2%	91.4%	98.1%	96.0%	100.0%	100.0%	100.0%	100.0%	No data submitted	100.0%
	Never event incidence	Matt Metcalfe	=0	NGH			0	1	0	0	0	0	0	0	0	0	1	0
	Number of Serious Incidents (SI's) declared during the period	Matt Metcalfe	0				3	0	0	3	7	1	0	0	2	3	7	2

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	VTE Risk Assessment	Matt Metcalfe	>=95%				95.7%	95.7%	95.4%	95.3%	95.9%	95.0%	95.1%	95.4%	95.4%	95.1%	95.1%	92.5%
	MRSA > 2 Days	Sheran Oke	=0	Nat			0	0	0	0	0	0	0	0	0	0	0	0
	HOHA and COHA (C-Diff > 2 Days)	Sheran Oke	<=4	Nat			2	0	0	1	0	0	0	2	3	1	3	3
	MSSA > 2 Days	Sheran Oke	<=1.1	NGH			0	2	1	0	1	2	0	5	4	1	1	1
	New Harms	Sheran Oke	<=2%	NGH				2.11%	0.67%	0.99%	0.62%	0.15%	1.71%	1.59%	1.89%	1.44%	2.16%	1.19%
	Appointed Fire Wardens	Stuart Finn	>=85%	Nat						85.6%	88.1%	90.7%	91.2%	91.2%	91.2%	91.2%	No data submitted	95.6%
	Fire Drill Compliance	Stuart Finn	>=85%	Nat						62.0%	59.7%	56.7%	57.2%	53.0%	43.2%	41.2%	No data submitted	55.9%
	Fire Evacuation Plan	Stuart Finn	>=85%	Nat						89.2%	89.2%	67.5%	72.6%	70.6%	68.5%	66.4%	No data submitted	51.0%

No data submitted — Data not provided

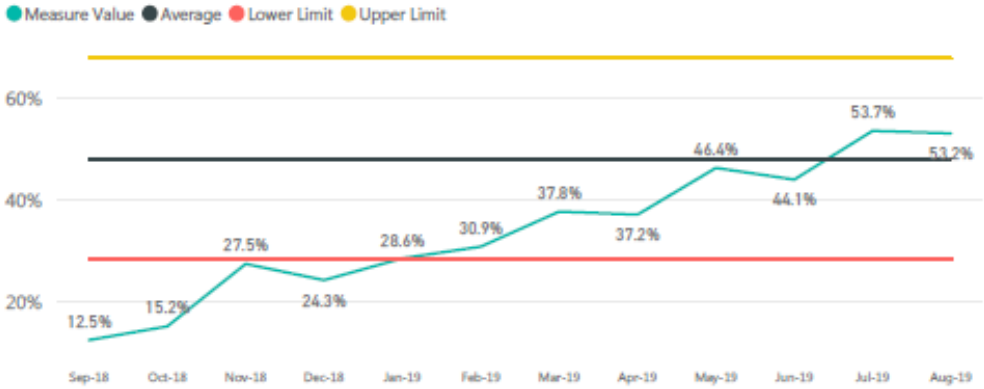
No data - pre KPI implementation

Job plans progressed to stage 2 sign-off

August 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
90.0 %	53.2 %	↓	Matt Metcalfe

Performance vs Target



Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
12.5 %	15.2 %	27.5 %	24.3 %	28.6 %	30.9 %	37.8 %	37.2 %	46.4 %	44.1 %	53.7 %	53.2 %

What is driving under performance?

Data was rebased during September 2018 to reflect compliance in all divisions which includes job plans reviewed in the rolling 12 month period and progressed to second stage sign off. Initial delays within the Medicine Division negatively impacted on other Divisions progress, however progress was made over the year with compliance improving significantly. As Divisions commence the job planning process the compliance declines as new job plans are entered (rolling year). This month both Urgent Care and Trauma and Orthopaedics have entered new job plans to be reviewed, reducing compliance. New Consultants joining the Trust that require job plans can also negatively impact on compliance.

Actions completed in the past month to achieve recovery

Regular Executive Consistency Committee (ECC) meetings continue to take place. Further improvement within the Surgery Division, Outpatients, Paediatrics, Oncology and Haematology is acknowledged this month as new job plans are being agreed. Despite compliance being below target, an ongoing improvement of job plans complying with 12 PAs or less continues (from 48 plans above 12PAs to 7 plans above 12PAs – an 85% improvement). Of the 7 outstanding job plans, 5 job plans are currently in discussion, with the remaining 2 yet to be reviewed. New job plans have now been entered onto the system for 91% of Consultants, and of these 70% have reached partial sign off.

Exception report written by

SmillieE

Timeframe for recovery

April 2020

Assurance Committee

Quality Governance Committee

Next steps

Executive Consistency Committee meetings will continue for the Divisions. Support continues from the QI team to ensure progress is maintained and that the changes to Job Plans are reflected in pay. Any job plans awaiting second stage sign off are being notified to the departments to ensure timely progression and expedited to the MD when necessary.

NGH Mortality Dashboard Q1 2019/20

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	Monitoring & Screening			1st and 2nd Stage Review		Consideration for Investigation	
Data for the Rolling Year to June 19	Total number of adult inpatient deaths	Total number of adult deaths in ED	Percentage of all deaths screened by Mortality Screening Team	Number of 1st Structured Judgement Reviews completed in directorate/ specialty morbidity and mortality meetings ot Trust wide reviews	Total number of deaths referred for 2nd stage review at Trust Wide Challenge Meetings	Number of deaths considered more likely than not to be due to a problem in care and referred to Review of Harm Group	Review of Harm Group Decision Serious Incident (SI) Comprehensive Investigation (CI) No Investigation (NI)
Q2 18/19	276	36	64%	76	7	1	1 NI
Q3 18/19	308	33	92%	68	9	2	1 SI / 1 NI
Q4 18/19	384	37	91%	66	5	2	1 SI / 1 NI
April	123	14	93%	20 of 43	2	0	0
May	127	7	96%	13 of 31	0	0	0
June	100	13	70%	5 of 22	2	0	0
Total Q1 19/20	**350**	**34**	**88%**	**38 of 96**	**4**	**0**	0

Vulnerable Adults

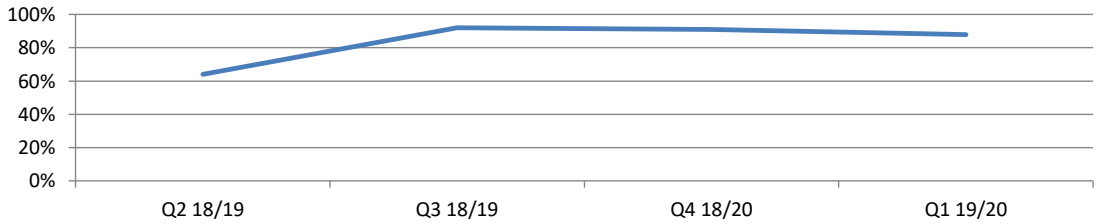
Patients with a learning disability

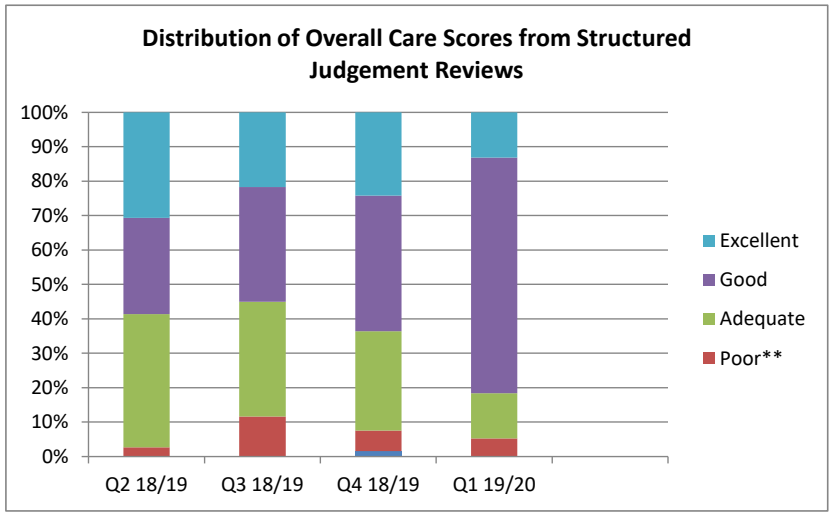
In Q1 2019-20, 2 patients with a learning disability died at the Trust. Both have been reviewed at the Vulnerable Adults M&M, 1 was felt to have received good care, the other poor care. This death was already subject to a Comprehensive Investigation.

Patients with a significant mental health diagnosis

In Q1 2019-20 4 patients with a significant mental health diagnosis died at the Trust. 3 have been reviewed at the Vulnerable Adults M&M, and were felt to have good or adequate care. 1 case will be reviewed at the next

Percentage of Deaths Screened by Mortality Screening Team





**Trigger for 2nd stage review

Compliance with request for completion of Structured Judgement Reviews has declined in Q1 2019-20, work is underway to follow up with all requests and escalate non-compliance.

Mortality Screening rates have been at >90% of all deaths since December 2018, a slight decline was seen in Q1 2019-20 to 88%, work is underway to retrospectively screen those deaths missed.

Medical Director's Risk Register

An entry on the risk register has been created for mortality metrics. HSMR is currently as expected and any change can now be reflected using the risk register (monitored by Mortality Review Group)

Planning to introduce the Medical Examiner System continued in Q1. Recruitment for Medical Examiners and a Medical Examiner Officer was well under the way by the end of the quarter with appointments due to be finalised in July .

Learning from Screening, and Structured Judgement Reviews

In Q1 2019/20, Mortality Review Group focused on the 4 work streams launched in response to the findings of Trust wide Mortality Case Note Review 12.
Sepsis mortality for the rolling year continued to fall and became "as expected" during Q1. An appropriate pathway for challenging a diagnosis of sepsis in the notes was agreed and monitoring pathways discussed.
The Quality Improvement project to launch **frailty** scoring across the Trust began in Q1. The Care of the Elderly Morbidity and Mortality meeting also specifically reviewed cases with a focus on ensuring all co-morbidities had been noted, documented and managed appropriately. A process was put in place to ensure all emergency readmissions and any patients who are being frequently admitted are highlighted to the team. Dr Foster are also supporting NGH to look in closer detail at the risk adjustment for frail elderly patients and how data can be used to identify patients with frailty.
The project to review **delivery of palliative care to patients with secondary malignancy** highlighted the need for an audit of time to ERCP in patients with known or suspected HPB malignancy. The completed audit identified a need to set specific internal standards for time to ERCP and a possible need for an increase in capacity which will be explored.
iBox went live with a field to record working diagnosis as part of the **clinical care/ documentation/ coding interface work stream.** Local communications were used to increase awareness and spot checks on Esther White Ward showed that >90% of patients had a working diagnosis recorded. From June 2019 this has been rolled out across the Trust.

Dr Foster data for the management of patients with congestive heart failure continued to show a higher than expected mortality rate in Q1

The cardiology lead has formed a task and finish group to review this data in conjunction with data from mortality case note review, National Heart Failure Audit, National Confidential Enquiry into the management of Heart Failure, staffing levels and referral pathways.

An initial audit of the information and data surrounding the alert showed that 13% of patients with a primary code of CHF did not have diagnostic features of heart failure although the documentation in the notes did support the choice of clinical code. Not all patients with HF were reviewed or cared for by a cardiology team and this is an area of service provision that needs to be addressed.

Report To	**Board Report**
Date of Meeting	**26 September 2019**

Title of the Report	**Nursing & Midwifery Care Report**
Agenda item	**10**
Presenter of Report	Sheran Oke, Director of Nursing, Midwifery & Patient Services
Author(s) of Report	Natalie Green – Interim Deputy Director of Nursing
Purpose	Assurance & Information

Executive Summary

The paper references areas within the Trust scorecard relating to Caring and the nursing related aspects of the Safe domain:

- Complaints and Compliments: 59 formal complaints and 4,203 compliments
- Pressure Ulcer Prevention; 22 patients developed a total of 25 pressure ulcers new to the trust. There were 13 Category 2 pressure ulcers, there were 9 Deep Tissue Injuries, 2 patients developed Unstageable pressure ulcers and 1 category 4 was declared and under investigation
- Maternity Safety Thermometer: 'harm' free care as 75% which is above the national aggregate of 74.7%
- The report also contains an update on Midwifery CNST incentive scheme, Safeguarding, , Assessment and Accreditation, End of Life, and Nursing, Midwifery Quality Care Indicator Dashboards.
- The Nursing Assessment and Accreditation panel recommends that Becket and Head and Neck Ward are assigned Best Possible Care status

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? Quality & Safety. We will avoid harm, reduce mortality, and improve patient outcomes through a focus on quality outcomes, effectiveness and safety
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks 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 – please enter BAF number(s) 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) If yes please give details and describe the current or planned activities to address the impact. 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) If yes please give details and describe the current or planned activities to address the impact.
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper? No

The Board is asked to:

- Discuss and where appropriate challenge the content of this report and to support the work moving forward

- 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

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Trust Board
September 2019

Nursing & Midwifery Care Report

1.0 Introduction

The Nursing & Midwifery (N&M) Care Report highlights key issues from the Divisions, audits and projects during the month of August 2019. 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.

2.0 Trust Scorecard –Summary

The Nursing and Midwifery Care Report relates to our patients and includes the data that is presented in the Trust scorecard under the domains of Caring and those pertinent to Nursing and Midwifery in the Safe domain.

2.1 Quality of Care:

2.1.1 Complaints and Compliments

Patient care is at the centre of what we do as an organisation and we are committed to improving their experience. Whilst we receive a significant amount of positive feedback, there were 4203 compliments in August; we also receive feedback when things have not gone so well. As a Trust we recognise that complaints and concerns are an opportunity to learn and improve.

August:
We received 59 formal complaints and achieved a 74% response rate (target is 90% or above) – the complaints team have now recruited and are training news members which will enable recovery of the response rate compliance. We aim that the Trust will of recovered the position by December.

Themes:
The main categories are:

- Care x 23 (15 x medical / 6 x nursing / 2 x other)
- Communication x 17 (9 x medical / 6 x other / 2 x nursing)
- Delays x 0

Our aim is that every complaint is responded to within the agreed timeframe and that any learning that comes from the findings is agreed and owned within the Directorate. These are logged through the Datix system; evidence of that learning is logged and provided as evidence of a responsive and well led process.

Patient Experience Updates

- **Surveys** - WCO Division are reviewing the results of the 2018 Childrens & Young People national survey (national release is September) plans are being devised for the areas that require improvement, this will be shared at the next Patient and Carers Experience and Engagement Group.
- **Right Time Survey Forum** - A Right Time Forum involving Ward Managers and Matrons took place in August. This forum was an opportunity for wards/areas to share best practice/ideas/improvements with each other and to discuss how to improve upon poor performing responses. In subsequent forums, the

focus will be on changes that can be made, trialled and improvements measured (PDSA cycles). From the meeting, the areas decided they would like to look at the discharge section first.

- **Listening Events** – The Patient Experience Team are continuing to carry out listening events on the children's wards by speaking with the relatives/carers of the patients. These events have proved to provide some valuable feedback so far. Alongside this, the team are also visiting Carer's Café listening events and collecting feedback.
- **Patient Experience Champions** – This group is gradually expanding and now has 25 members Trustwide. Each champion is helping to improve the patient experience and increase response and recommendation rates in their individual area and liaising regularly with their Shared Decision Making Councils.

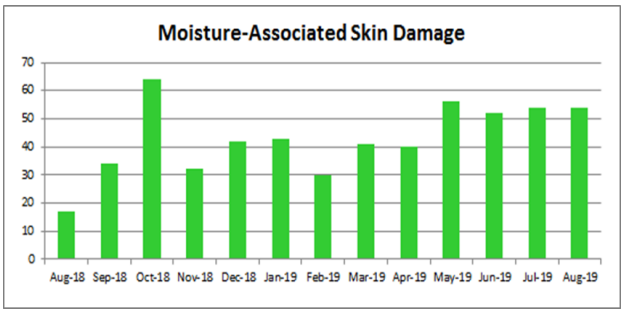
2.2 Safe

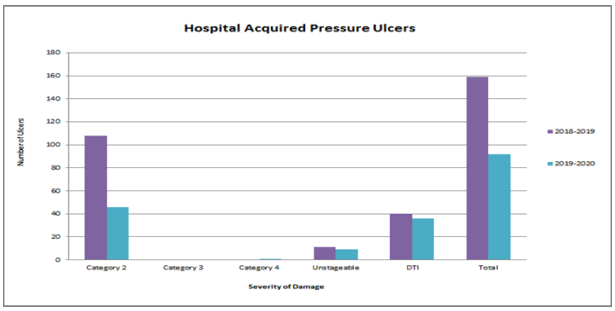
2.2.1 Pressure Ulcers

In August, following validation, 23 patients developed 25 pressure ulcers whilst in our care and 88 patients were admitted with 111 pressure ulcer harms.
Of the hospital acquired:

Category 2	13
Category 3	0
Category 4	1
DTI/unstageable	9

Of the 9 patients who developed DTIs/unstageable, 2 passed away within two weeks of the Datix report being made.





In August, the number of pressure ulcers per 1000 bed days was 1.1; this is an increase on the previous month. The increase in reporting might have contributed to the increase this will be monitored by the TV team. The team continues to be focused on supporting the wards in reducing pressure ulcers, this is proving to be challenging due to staff being unable to attend training, or share and learn due to vacancy pressures and reduced capacity within the TV team. New methods of support and cascade training are being looked at; the TV team are providing increased support to Hawthorn with the development of the category 4. The concise report is currently being undertaken and will be reviewed by the Director of Nursing and at ROHG.
Four members of the Trust attended the first day of the NHS Improvement PU collaborative recently, project work will now commence focussing on specific areas (one of which will be the number of heel related tissue damage) baseline data and change projects are being planned.

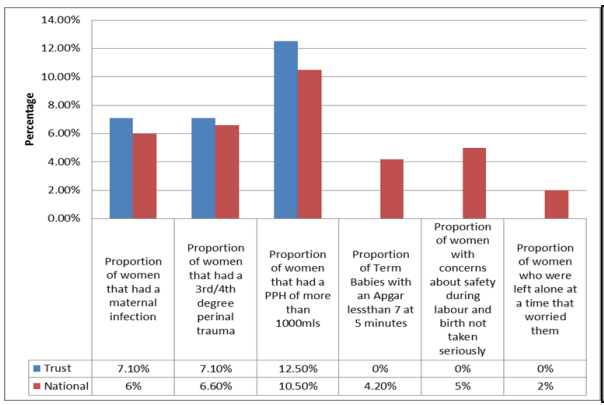
2.2.2 Safety Thermometer

In August the Trust achieved 93.9% 'All Harms Free Care' against the national average of 93.8% and for our new harms free rate 98.8% against a national average of 97.8%

2.2.3 Maternity Safety Thermometer

The Maternity Safety Thermometer enables a point prevalence calculation of the proportion of women and babies who received harm free care 'in month'.

The percentage of women and babies who received overall 'harm' free care in August was 75% which is slightly above the national aggregate of 74.7%. Those who received harm free physical care were 75% compared to 80.1% nationally. The following chart shows the breakdown of harms this month.



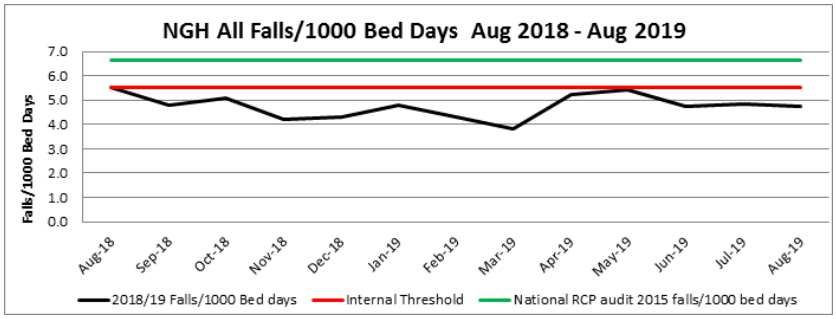
Harm free psychological harm was 100% for the fourth consecutive month, with all women surveyed saying that they felt safe compared to 93% nationally. None of the women surveyed reported that they were left alone at a time that worried them and none felt that their concerns about safety during labour and birth were not taken seriously.

2.2.4 Falls in August

Falls/1000 bed days

The rate per 1000 bed days is 4.73.There were 106 inpatient falls in total, 78 inpatient falls resulted in no harm to the patient and 21 low harm falls. There was an increase in moderate, severe and catastrophic falls of 0.31 falls/1000 bed days compared to July. In total there was 3 inpatient incident recorded as moderate harm, 3 inpatient incidents recorded as severe harm and 1 inpatient incident recorded as catastrophic harm.

All incidents have and are being investigated with the reports reviewed at the Review of Harm Group, currently no themes have been identified all findings are shared at a local level and are being taken to directorate governance meetings for further dissemination



2.2.5 Infection Prevention Update

Whilst the reporting of Meticillin-Sensitive *Staphylococcus* aureus (MSSA) bloodstream infection (BSI) to Public Health England (PHE) is mandatory, no national targets have been set for this organism. At the trust 12 patients have developed a hospital onset MSSA to date for 2019/20, against an internal challenge of 13. This upward trend in incidence is reflected by the East Midlands and national data.

The IPC Team have analysed the post infection reviews and the factors that have caused these patients to develop a MSSA BSI, and have developed and commenced work on an MSSA reduction plan. This has a strong focus on reducing the risk of infection to patients from cannulas, central venous access devices and wounds in particular as these were the three main sources of the MSSA BSIs.

The Trust has an external ceiling of no more than 40 patients develop a *Clostridium difficile* infection in 2019/2020 (CDI) Hospital Onset Healthcare Associate Infections (HOHA) and Community Onset Healthcare Associated Infections (COHA). In August 2 patients developed a HOHA and 1 patient developed a COHA

3.0 Nursing and Midwifery Dashboards

The Nursing and Midwifery Quality Dashboards provide triangulated data utilising quality outcome measures, 15 steps methodology, patient experience and workforce informatics.

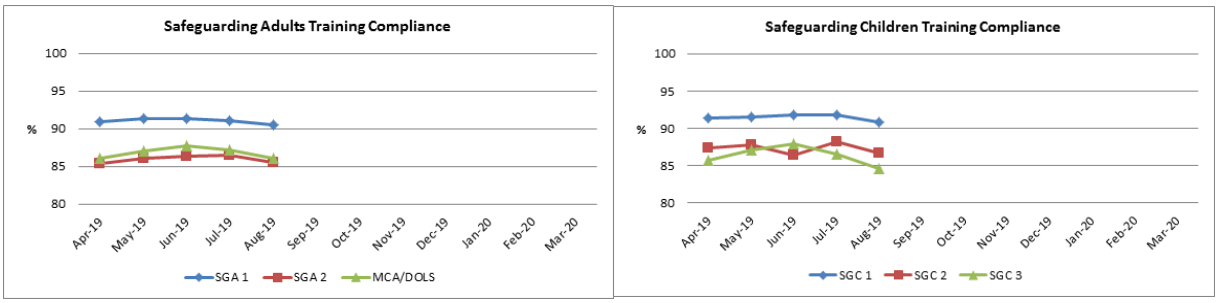
Exception Overview of the Nursing & Midwifery Dashboard
In August there was an improvement with 10 reds across the quality indicator questions, 8 in medicine, 2 in surgery and 0 in Womens, Children's, Oncology and Haematology

- One red was on Hawthorn due to an incomplete care rounds documentation, which the Matron dealt with at the time of audit
- Head & Neck had 1 red which was for first impressions, cluttered environment, the Matron and band 6 dealt with the issues at the time
- Willow had improved from last month with 0 red and 7 amber, the band 7's and 6's have addressed the issues at their ward meeting
- 2 red were on Eleanor due to interruptions at protected mealtimes and 1st impression due to clutter – the Matron and band 7 addressed these with the MDT
- 1 red and 6 ambers was on Victoria due to being unable to record late observations and the ambers within the patient experience, environment sections – the new band 7 is working through the standards and making steady improvements
- There was an data inputting error for two sections on Brampton, Compton and Holcot – the ADN for medicine will discuss this with the Matron of the area
- 2 red and 2 ambers were on Holcot, the recent change in leadership has highlighted a few problems the Matron is working with the band 7 regarding expectations and standard measures

There are five areas that are receiving increased surveillance due to triangulation of QCI, outcome measures, patient experience and Assessment & Accreditation are: Benham, Compton, Holcot, Talbot Butler and Hawthorn – these areas recognised and monitored by the ADN's through to the Deputy and Director of Nursing and Midwifery.

4.0 Safeguarding

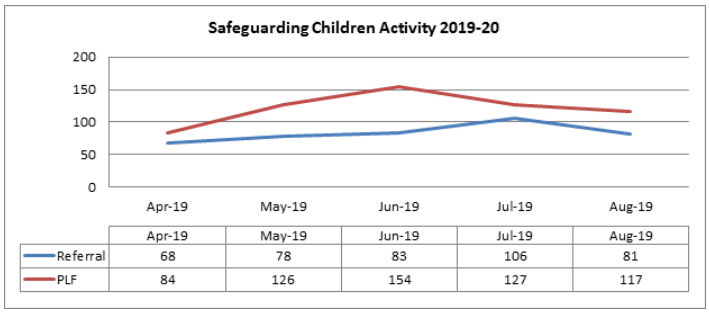
Safeguarding Training Compliance
The training compliance rate of 85% is set as part of the quality schedule set by the Clinical Commissioning Group (CCG) for all safeguarding training. Safeguarding training continues to be compliant in all areas apart from a slight dip to 84.6% in safeguarding children level 3 as illustrated in the graphs below:



As previously reported a remedial plan is in place for Prevent training. Good progress has been maintained and the Trust has exceeded its initial compliance of 50% of all Trust staff reaching level 3 training by the end of this year. Currently compliance is 84% (2165 staff members have received training out of 2574) and full compliance is expected by the end of the year.

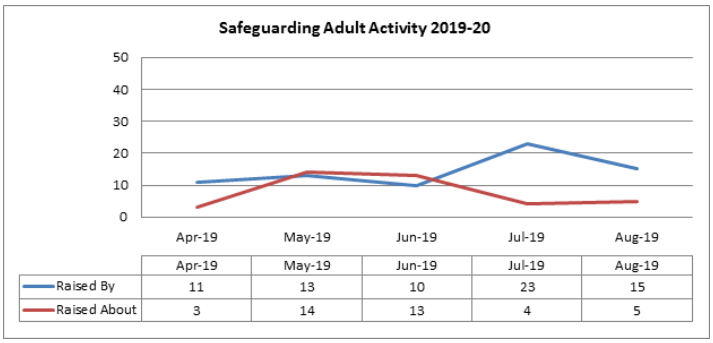
Safeguarding Children and Adult Referrals

The chart below validates the number of referrals made by the Trust in the reporting period for children and young people, at risk of, or suffering significant harm. This includes the number of Paediatric Liaison Forms (PLF's) processed. There has been an decrease in referrals made to the Multi-Agency Safeguarding Hub (MASH) and a slight decrease in PLF's during the reporting period which is an unusual trend due to being the school summer holidays.



	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Referral	68	78	83	106	81
PLF	84	126	154	127	117

In terms of safeguarding adults' referral activity, there has been a decrease in the number of safeguarding allegations raised by the Trust and no significant change in reporting in safeguarding allegations made about the Trust as highlighted in the following graph:

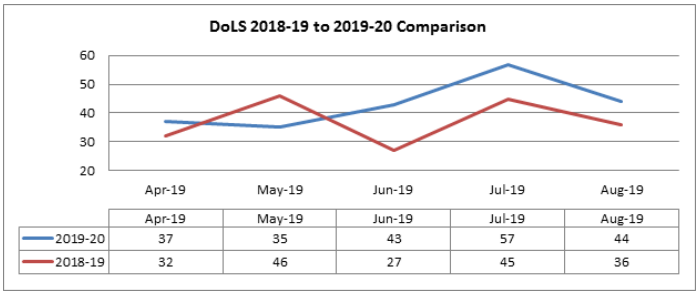


	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Raised By	11	13	10	23	15
Raised About	3	14	13	4	5

Information received by Northamptonshire County Council has been received in a timelier manner than previous months, although it is difficult to evaluate how accurate the statistics are. This will be monitored over the coming months to ensure that the statistics do portray an accurate picture and continues to be captured on the Nursing and Patient Services risk register.

The themes around allegations made about the Trust continue to be unsafe/poorly planned discharge with the lack of communication with families and external agencies.

Deprivation of Liberty Safeguards (DoLS)



	Apr-19	May-19	Jun-19	Jul-19	Aug-19
2019-20	37	35	43	57	44
2018-19	32	46	27	45	36

DoLS applications for authorisations to Northamptonshire County Council (NCC) under the statutory framework have decreased during the reporting period. This is not of statistical concern when compared to previous months.

Task and finish groups for the Liberty Protection Safeguards (LPS) continue to meet across the county on a regular basis. LPS will replace DoLS in October 2020. Unfortunately the code of practice has not been

published and therefore this new legislation is difficult to translate into practice. A briefing paper will be presented to the Executive Team in September.

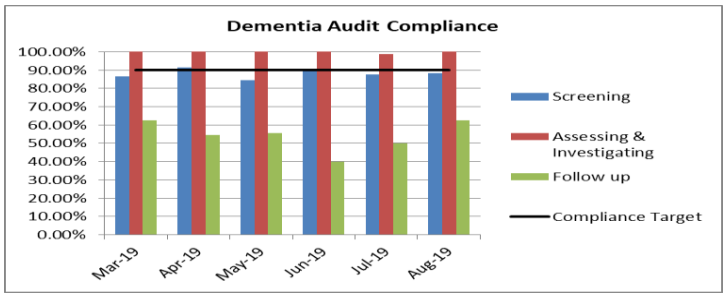
Safeguarding Assurance Activity
The safeguarding team continue to experience gaps/ omissions within children's services as highlighted in the Ofsted report and continue to escalation concerns when the perceived correct threshold of intervention is not made.

Following the publication of Working Together to Safeguard Children (2018), children's serious case reviews have been replaced by child safeguarding practice reviews. Four reviews have been commissioned by the Safeguarding Children Partnership. The Trust had contact with three of the families.

Two safeguarding adult reviews (SAR's) have been completed and presented to the Northamptonshire Safeguarding Adult's Board (NSAB). The full report of one of the reviews will not be published due to family members still living within the county. There is internal learning for the Trust around the application of the Mental Capacity Act within clinical practice. Action plans are in place to ensure that learning is embedded into the organisation.

There are three Domestic Homicide Reviews (DHR's) that are ongoing, which focus on the north of the county. Therefore there was no family contact with the Trust.

Dementia Activity
Dementia screening data continues to be collected monthly for sharing with NHS England as illustrated below:



Part one of the audit, screening,is slightly under compliance during the reporting period which was contributed to the changeover of medical staff.

There has been an improvement in compliance with part three of the audit; the Dementia Liaison Nurse is working with the Deputy Director of Patient Safety and Quality Improvement to ensure that this issue is addressed by medical staff.

5.0 Maternity Update

Maternity Safety Highlight Report
The following tables show the progress made against two of the national drivers around maternity safety, the CNST Maternity Incentive Scheme (Maternity Safety Actions) and the Saving Babies Lives Care Bundle (SBLCB).

CNST Incentive Scheme – Maternity Safety Actions
NHS Resolution is operating a second year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.

The Board Declaration Form declaring compliance with all 10 maternity safety actions has been signed by the CEO as delegated authortiy and was submitted to NHS Resolution on 14 August 2019.

Maternity Safety Actions			SBLCB V1		
1	Perinatal Review Tool		1	Reducing Smoking in pregnancy	
2	MSDS		2	Risk assessment and surveillance for fetal growth restriction	
3	ATAIN		3	Raising awareness of reduced fetal movement	
4	Medical Workforce		4	Effective fetal monitoring during labour	
5	Midwifery Workforce		**SBLCB V2**		
6	Saving Babies Lives Care Bundle (SBLCB)		1	Reducing Smoking in pregnancy	
7	Patient Feedback		2	Risk assessment and surveillance for fetal growth restriction	
8	Multi-professional Training		3	Raising awareness of reduced fetal movement	
9	Safety Champions		4	Effective fetal monitoring during labour	
10	Early Notification Scheme (ENS)		5	Reducing the number of preterm births	

Key	
Complete	The Trust has completed the activity within the specified timeframe
On Track	The Trust is currently on track to deliver within the specified timeframe
At Risk	The Trust is currently at risk of not being able to deliver within the specified timeframe
Will not be met	The Trust will not deliver within specified timeframe

National Benchmarking / Outlier Reports

There a two main external reports that allow the Trust to benchmark performance and outcomes nationally as well as within the region, highlighting opportunities for continuous improvement. The following table shows the latest reported data and how the maternity services compares to the national mean rates.

National Benchmarking / Outlier Reports			
Metric	**Trust Rate**	**National Mean Rate**	**Source / Year**
PPH > 1500 mls	4.3%	2.8%	NMPA (2017)
Induction of Labour	28.1%	29.3%	NMPA (2017)
SGA babies	46.1%	55.3%	NMPA (2017)
CS Rates	26.2%	25.9%	NMPA (2017)
3rd / 4th degree tears	3.4%	3.7%	NMPA (2017)
Term babies Apgar < 7 @ 5 mins	0.6%	1.2%	NMPA (2017)
Stillbirth	5.4	5.9	MBRRACE (2018)

Current Outlier status

- The second NMPA report is due to be published on 12th September 2019. The report will cover births between 1st April 2016 – 31st March 2017
- The Trust have again received notification of potential outlier status for PPH > 1500 mls with a PPH rate of 4.2% against a national mean of 2.9%
- Following the publication of the first NMPA report, the Trust commenced a quality improvement programme which has been supported by NHS Improvement as part of the Maternal & Neonatal Health Safety Collaborative. The quality improvement initiatives were not fully implemented until April 2018 and therefore we would not expect to realise the full impact of this work until that date.
- A report and assurance with reference to the NMPA report is to be made to the Quality Governance Committee in September

6.0 Safe Staffing

Overall fill rate for August was RN 97%, HCA 107% with a combined of 92%. CHPPD for adult wards was RN 4, Nursing Associate 0.1 and HCA 3.3 giving a combined CHPPD of 7.4.

Currently vacancies across the Divisions (including Maternity) for the Inpatient areas are approximately 129wte. with a 'felt' vacancy (which includes long term sick, vacancy and maternity leave) being nearer 200wte. Acuity and Dependency of our patients and extra capacity remaining open has created additional pressure on resource and the requirement of increased temporary staff usage.

There were 77 staffing related Datix incidents during August compared with 46 in July and 59 in June. Following a full review by the Associate Directors of Nursing & Midwifery 9 datix were categorised under the red flag definition, with 7 on Quinton Ward and 2 on Benham Ward. There was one patient who had an unwitnessed fall on Benham Ward during a shift when the staffing level was reduced.

7.0 End of Life

The Specialist Palliative Care Team has seen 130 new referrals, a 25% increase in referrals to August 2018.

A case for senior nurses to discuss and sign DNACPR forms is to be taken to the Nursing and Midwifery Board. Compliance with MCA has continued to improve since introduction of the new countywide form; however there remain gaps in practice. The DNACPR and MCA QI group have produced guidelines for medical colleagues to aid compliance.

A Palliative Care conference is planned for May 2020 during Dying Matters Week.

8.0 Assessment & Accreditation

During August, with the support of PPD 2 days per week, assessments recommenced. One ward and 2 Outpatient areas were undertaken in August. Becket and Head & Neck ward went to their Best Possible care panels during July the panel are recommending that both areas receive Best Possible Care status.

9.0 Nursing and Midwifery Recognition Events

During August Trust nurses and midwives have been:

- Shortlisted for 4 Nursing Times Awards
- Confirmed one submission will be presented at 2020 Pathway to Excellence® Conference USA and one poster displayed
- 3 Cavell stars presented and 3 DAISY honourees

During September:

- 5 staff were selected to represent NGH in partnership with Cavell at the House of Lords
- 1 Cavell Star presented
- 2 poster presentations made at the national Infection Prevention Control Conference

10.0 Recommendation

The Board is asked to note the content of the report, support the mitigating actions required to address the risks presented and continue to provide appropriate challenge and support and are requested to support Becket and Head & Neck being designated as Best Possible care wards.

Northampton General Hospital NHS
NHS Trust

Corporate Scorecard 2019/2020 AUG

Domain	Indicator	Executive Owner	Target	Target Set By	Direction of Travel	Trend	SEP-18	OCT-18	NOV-18	DEC-18	JAN-19	FEB-19	MAR-19	APR-19	MAY-19	JUN-19	JUL-19	AUG-19
Caring	Complaints responded to within agreed timescales	Sheran Oke	>=90%		↓		100.0%	97.3%	97.4%	98.0%	100.0%	100.0%	100.0%	97.7%	96.1%	94.5%	83.7%	72.7%
	Friends & Family Test % of patients who would recommend: A&E	Sheran Oke	>=86.4%	Nat	↓		87.3%	86.4%	88.1%	85.9%	85.1%	80.9%	83.3%	85.3%	86.8%	86.0%	82.1%	81.9%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	Sheran Oke	>=95.7%	Nat	↓		91.9%	92.4%	94.0%	92.6%	92.7%	93.5%	92.8%	92.7%	93.8%	93.9%	93.6%	92.6%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	Sheran Oke	>=96.8%	Nat	↑		100.0%	100.0%	96.6%	100.0%	99.4%	98.6%	99.3%	99.3%	98.6%	99.0%	97.7%	98.6%
	Friends & Family Test % of patients who would recommend: Outpatients	Sheran Oke	>=93.8%	Nat	↑		92.7%	92.3%	93.8%	93.5%	93.5%	93.6%	93.3%	93.3%	93.6%	94.7%	93.1%	93.8%
	Mixed Sex Accommodation	Sheran Oke	=0	Nat	→		0	0	0	0	4	2	0	0	0	0	0	0
	Compliments	Sheran Oke	>=5	NGH	↑			4,288	4,335	3,541	4,269	3,639	4,007	3,647	3,697	3,595	4,363	4,367
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	Debbie Needham	>=90.1%	Nat	↓		88.9%	86.7%	85.9%	83.3%	78.5%	79.0%	80.2%	79.0%	83.9%	85.5%	83.6%	78.4%
	Average Ambulance handover times	Debbie Needham	<=15 mins		→		00:14	00:14	00:14	00:14	00:31	00:14	00:16	00:17	00:13	00:19	00:18	00:18
	Ambulance handovers that waited over 30 mins and less than 60 mins	Debbie Needham	<=25		↓		118	174	142	299	330	400	420	343	203	69	84	219
	Ambulance handovers that waited over 60 mins	Debbie Needham	<=10		↓		15	17	19	30	49	33	22	13	11	15	9	13
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Debbie Needham	=0		↑		2	3	3	4	5	4	4	11	1	4	3	1
	Delayed transfer of care	Debbie Needham	=23	NGH	↓		36	10	10	24	12	11	20	31	34	21	32	47
	Average Monthly DTOCs	Debbie Needham	<=23	NGH	↓		34	27	15	20	20	17	29	41	41	32	30	37
	Average Monthly Health DTOCs	Debbie Needham	<=7	NGH	↓		25	25	13	16	17	13	20	30	33	23	19	25
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	Debbie Needham	>=93%	Nat	↑		75.2%	94.0%	88.5%	86.1%	73.7%	81.9%	73.3%	70.5%	91.0%	85.7%	95.5%	
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	Debbie Needham	>=93%	Nat	↑		85.7%	91.0%	40.2%	35.4%	60.2%	69.3%	66.4%	27.2%	42.1%	54.0%	96.8%	
	Cancer: Percentage of patients treated within 31 days	Debbie Needham	>=96%	Nat	↑		94.7%	97.5%	94.8%	96.5%	92.1%	94.1%	94.4%	94.5%	96.4%	95.5%	96.1%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	Debbie Needham	>=98%	Nat	↑		96.7%	100.0%	100.0%	100.0%	98.9%	100.0%	94.6%	100.0%	99.0%	98.5%	98.7%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	Debbie Needham	>=94%	Nat	↑		95.6%	95.7%	96.6%	94.8%	97.9%	97.9%	95.0%	96.1%	97.7%	91.5%	98.2%	
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	Debbie Needham	>=94%	Nat	↑		88.8%	86.6%	93.7%	93.7%	80.0%	100.0%	86.6%	90.0%	100.0%	90.9%	94.1%	

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	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	Debbie Needham	>=85%	Nat	↓		81.4%	85.4%	76.0%	80.0%	71.1%	74.0%	70.6%	70.0%	69.8%	77.5%	75.2%	
	Cancer: Percentage of patients treated within 62 days of referral from screening	Debbie Needham	>=90%	Nat	↑		100.0%	83.8%	100.0%	81.8%	90.4%	100.0%	100.0%	90.0%	95.8%	66.6%	100.0%	
	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	Debbie Needham	>=85%	Nat	↓		79.0%	85.7%	83.6%	89.1%	84.0%	80.0%	92.5%	80.5%	88.2%	88.5%	47.5%	
	RTT waiting times incomplete pathways	Debbie Needham	>=92%	Nat	→		80.3%	81.5%	82.1%	81.5%	81.6%	80.7%	80.0%	79.0%	80.6%	82.5%	82.5%	No Longer Reported
	RTT over 52 weeks	Debbie Needham	=0	Nat	→		0	0	0	0	1	3	1	0	1	0	0	
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	Debbie Needham	>=99.1%	Nat	↑		99.9%	99.8%	99.9%	99.7%	100.0%	99.4%	99.3%	96.8%	96.4%	94.1%	93.7%	95.9%
	Stroke patients spending at least 90% of their time on the stroke unit	Debbie Needham	>=80%		↓		92.7%	94.8%	95.6%	100.0%	79.6%	66.2%	75.4%	96.6%	93.7%	74.5%	83.3%	64.2%
	Suspected stroke patients given a CT within 1 hour of arrival	Debbie Needham	>=50%		↓		95.0%	97.9%	95.0%	95.3%	89.3%	82.4%	92.3%	98.1%	90.6%	90.9%	91.8%	85.7%
	Unappointed Follow Ups	Debbie Needham	=0	NGH	↓						8,608	8,723	9,957	10,119	10,363	10,385	9,670	9,801
Well Led	Bank & Agency / Pay %	Janine Brennan	<=7.5%	NGH	↓		12.4%	12.4%	12.3%	12.3%	12.4%	12.4%	12.6%	12.7%	13.2%	15.2%	15.7%	15.9%
	Sickness Rate	Janine Brennan	<=3.8%	NGH	↓		4.2%	4.0%	4.0%	4.4%	4.9%	4.7%	4.0%	4.2%	4.2%	4.5%	4.3%	4.6%
	Staff: Trust level vacancy rate - All	Janine Brennan	<=9%	NGH	→		11.1%	10.4%	10.3%	12.5%	11.8%	11.0%	11.2%	12.3%	12.0%	12.1%	12.1%	12.1%
	Staff: Trust level vacancy rate - Medical Staff	Janine Brennan	<=9%	NGH	↑		9.4%	8.8%	9.0%	9.9%	9.1%	2.4%	3.2%	6.8%	7.2%	7.5%	7.9%	5.9%
	Staff: Trust level vacancy rate - Registered Nursing Staff	Janine Brennan	<=9%	NGH	↓		7.4%	7.3%	7.5%	11.5%	11.2%	11.3%	11.2%	11.0%	11.1%	11.5%	12.2%	12.6%
	Staff: Trust level vacancy rate - Other Staff	Janine Brennan	<=9%	NGH	↓		13.7%	12.8%	12.1%	13.5%	12.7%	12.5%	12.8%	14.0%	13.5%	13.4%	13.0%	13.2%
	Turnover Rate	Janine Brennan	<=10%	NGH	↓		7.8%	7.7%	7.8%	8.3%	8.2%	8.9%	8.4%	8.4%	8.6%	8.6%	8.8%	8.9%
	Percentage of all trust staff with mandatory training compliance	Janine Brennan	>=85%	NGH			88.6%	87.8%	88.2%	88.5%	88.7%	88.5%	88.6%	89.2%	89.4%	89.4%	No data submitted	88.8%
	Percentage of all trust staff with mandatory refresher fire training compliance	Janine Brennan	>=85%	NGH					81.9%	82.8%	82.0%	81.9%	82.7%	83.6%	84.4%	84.5%	No data submitted	84.8%
	Percentage of all trust staff with role specific training compliance	Janine Brennan	>=85%	NGH			82.1%	81.9%	82.5%	83.0%	83.2%	83.7%	83.8%	83.8%	84.1%	84.4%	No data submitted	83.7%
	Percentage of staff with annual appraisal	Janine Brennan	>=85%	NGH			84.5%	83.1%	83.5%	81.6%	83.6%	84.5%	86.4%	84.5%	84.7%	85.0%	No data submitted	83.3%
	Job plans progressed to stage 2 sign-off	Matt Metcalfe	>=90%	NGH	↓		12.5%	15.1%	27.5%	24.2%	28.6%	30.9%	37.8%	37.1%	46.4%	44.1%	53.6%	53.2%
	Income YTD (£000's)	Phil Bradley	>=0	NGH	↑		(2,627) Adv	(3,337) Adv	(2,957) Adv	(3,550) Adv	(3,093) Adv	(3,256) Adv	(2,887) Adv	(985) Adv	(1,358) Adv	(600) Adv	(1,333) Adv	(1,309) Adv
	Surplus / Deficit YTD (£000's)	Phil Bradley	>=0	NGH	↓		392 Fav	57 Fav	97 Fav	(432) Adv	(460) Adv	(761) Adv	(2,512) Adv	(1,477) Adv	(2,949) Adv	(3,321) Adv	(5,036) Adv	(6,228) Adv
	Pay YTD (£000's)	Phil Bradley	>=0	NGH	↓		(2,967) Adv	(3,221) Adv	(3,277) Adv	(3,165) Adv	(3,614) Adv	(3,901) Adv	(4,623) Adv	(1,021) Adv	(1,978) Adv	(2,786) Adv	(3,599) Adv	(4,270) Adv

Northampton General Hospital NHS
NHS Trust

Corporate Scorecard 2019/2020 AUG

	Non Pay YTD (£000's)	Phil Bradley	>=0	NGH			3,819 Fav	4,246 Fav	4,204 Fav	4,612 Fav	5,088 Fav	5,232 Fav	5,437 Fav	407 Fav	474 Fav	67 Fav	217 Fav	4 Fav
	Salary Overpayments - Number YTD	Phil Bradley	=0	NGH			128	153	167	195	209	230	266	55	34	57	72	92
	Salary Overpayments - Value YTD (£000's)	Phil Bradley	=0	NGH			260.9	313.1	340.9	371.9	392.3	454.4	509.2	156.6	86.4	156.8	183.8	232.3
	CIP Performance YTD (£000's)	Phil Bradley	>=0	NGH			1,833 Fav	1,704 Fav	1,821 Fav	1,554 Fav	2,030 Fav	1,458 Fav	1,458 Fav	246 Fav	686 Fav	1,147 Fav	570 Fav	No data submitted
	CIP Performance - Recurrent	Phil Bradley	-	NGH						64.5%	65.9%	65.5%	69.0%	39.0%	39.9%	42.2%	43.1%	No data submitted
	CIP Performance - Non Recurrent	Phil Bradley	-	NGH						39.1%	40.4%	41.0%	41.0%	42.8%	38.7%	39.6%	41.7%	No data submitted
	Maverick Transactions	Phil Bradley	=0	NGH						15	21	21	19	18	18	22	27	19
	Waivers which have breached	Phil Bradley	=0	NGH						1	0	0	0	4	1	2	1	2
Effective	Stranded Patients (ave.) as % of bed base	Debbie Needham	<=40%	NGH			57.6%	54.1%	54.4%	54.7%	58.0%	57.0%	55.3%	60.4%	62.0%	59.6%	55.6%	57.9%
	Super Stranded Patients (ave.) as % of bed base	Debbie Needham	<=25%	NGH			26.1%	23.7%	23.1%	23.1%	23.8%	21.6%	22.0%	27.9%	29.6%	26.3%	23.6%	25.3%
	Length of stay - All	Debbie Needham	<=4.2	NGH			4.4	4.6	4.4	4.2	4.8	4.7	4.8	4.3	4.7	4.4	4.6	4.4
	Percentage of discharges before midday	Debbie Needham	>25%	NGH			17.8%	18.6%	17.4%	19.1%	18.3%	17.2%	18.2%	17.4%	16.8%	16.3%	16.7%	16.9%
	Readmissions within 30 days of previous reporting month	Matt Metcalfe	<=12%												7.7%	15.1%	8.0%	13.0%
	# NoF - Fit patients operated on within 36 hours	Matt Metcalfe	>=80%				77.1%	84.6%	82.7%	100.0%	86.4%	81.8%	90.9%	83.3%	92.0%	83.7%	90.4%	85.1%
	Maternity: C Section Rates	Matt Metcalfe	<29%				28.9%	31.4%	31.3%	32.1%	32.3%	27.2%	36.0%	28.1%	33.3%	27.1%	30.6%	28.7%
	Mortality: HSMR	Matt Metcalfe	100	Nat			104	106	106	106	105	106	104	103	104	105	0	102
	Mortality: SHMI	Matt Metcalfe	100	Nat			100	100	104	104	104	104	104	104	100	100	100	99
	Patient Ward Moves Overnight (22:00 - 06:59)		=0											738	817	830	851	334
	% Daycase Rate		>=80%											81.2%	82.6%	83.0%	81.1%	83.5%
	Failed Daycases as a % of Planned Daycases		-											1.8%	2.6%	2.6%	2.6%	2.4%
Safe	Transfers: Patients transferred out of hours (between 10pm and 7am)	Debbie Needham	<=60	NGH			47	66	36	35	53	51	35	35	35	17	No data submitted	22
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	Debbie Needham	>=98%	NGH			95.7%	96.9%	97.2%	91.4%	98.1%	96.0%	100.0%	100.0%	100.0%	100.0%	No data submitted	100.0%
	Never event incidence	Matt Metcalfe	=0	NGH			0	1	0	0	0	0	0	0	0	0	1	0
	Number of Serious Incidents (SI's) declared during the period	Matt Metcalfe	0				3	0	0	3	7	1	0	0	2	3	7	2

Northampton General Hospital NHS
NHS Trust

Corporate Scorecard 2019/2020 AUG

	VTE Risk Assessment	Matt Metcalfe	>=95%				95.7%	95.7%	95.4%	95.3%	95.9%	95.0%	95.1%	95.4%	95.4%	95.1%	95.1%	92.5%
	MRSA > 2 Days	Sheran Oke	=0	Nat			0	0	0	0	0	0	0	0	0	0	0	0
	HOHA and COHA (C-Diff > 2 Days)	Sheran Oke	<=4	Nat			2	0	0	1	0	0	0	2	3	1	3	3
	MSSA > 2 Days	Sheran Oke	<=1.1	NGH			0	2	1	0	1	2	0	5	4	1	1	1
	New Harms	Sheran Oke	<=2%	NGH				2.11%	0.67%	0.99%	0.62%	0.15%	1.71%	1.59%	1.89%	1.44%	2.16%	1.19%
	Appointed Fire Wardens	Stuart Finn	>=85%	Nat						85.6%	88.1%	90.7%	91.2%	91.2%	91.2%	91.2%	No data submitted	95.6%
	Fire Drill Compliance	Stuart Finn	>=85%	Nat						62.0%	59.7%	56.7%	57.2%	53.0%	43.2%	41.2%	No data submitted	55.9%
	Fire Evacuation Plan	Stuart Finn	>=85%	Nat						89.2%	89.2%	67.5%	72.6%	70.6%	68.5%	66.4%	No data submitted	51.0%

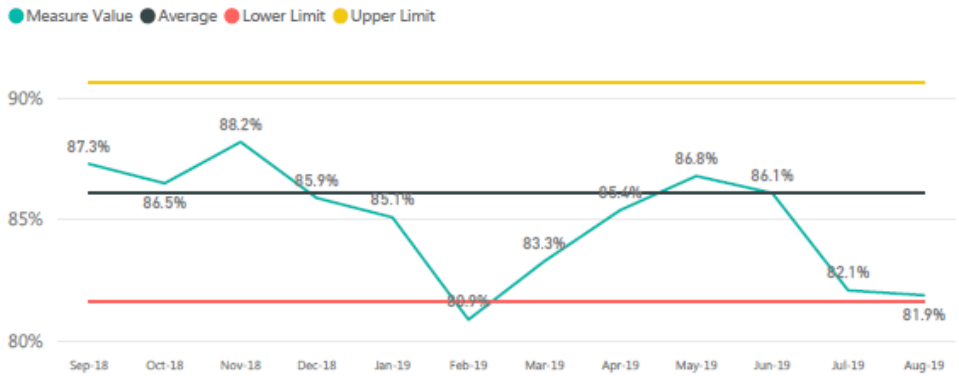
No data submitted — Data not provided

No data - pre KPI implementation

Friends & Family Test % of patients who would recommend: A&E

	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
August 2019	86.4 %	81.9 %	↓	Sheran Oke

Performance vs Target



Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
87.3 %	86.5 %	88.2 %	85.9 %	85.1 %	80.9 %	83.3 %	85.4 %	86.8 %	86.1 %	82.1 %	81.9 %

What is driving under performance?

During August the reduction in recommend rates for ED and ACC from the comments received was due to the delays and wait times

Actions completed in the past month to achieve recovery

ED staff keep patients informed of delays and wait times, safety rounds are conducted in periods of high attendance and explanations given Work continues across the organisation to improve flow and attain discharges to enable appropriate allocation of patient to bed. The assessment unit has 6 trolley assessment bays open during the majority of August to assist with reducing delays and reducing capacity issues in ED

Exception report written by

GreenNA

Timeframe for recovery

December 2019

Assurance Committee

Quality Governance Committee

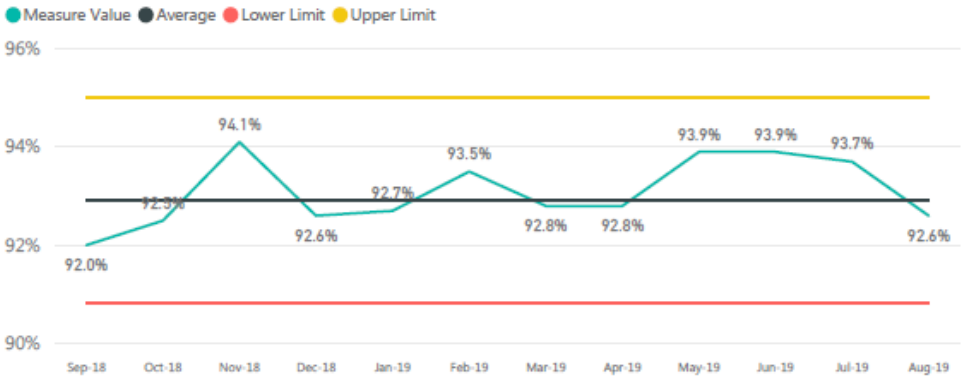
Next steps

Continue with improved communication explaining the current situation with patients Continue the focus on the 3 work streams reviewing organisation wide processes to assist timely discharge Utilise the assessment trolleys in Nye Bevan to their full effectiveness

Friends & Family Test % of patients who would recommend: Inpatient/Daycase

August 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	95.7 %	92.6 %	↓	Sheran Oke

Performance vs Target



Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
92.0 %	92.5 %	94.1 %	92.6 %	92.7 %	93.5 %	92.8 %	92.8 %	93.9 %	93.9 %	93.7 %	92.6 %

What is driving under performance?

The negative themes from the comments given via FFT have predominantly focussed on delays, cancellations and a generalised one word comment of either care or communication

Actions completed in the past month to achieve recovery

The first right time focus group was held, actions were taken and plans for the group going forward were decided. The patient experience champions for areas have been communicating their ideas and projects for improvement - focussed areas have been how to give feedback, discharge process and expectations. Patient experience survey results were presented at PCEEG and will be disseminated to the Divisions

Exception report written by

GreenNA

Timeframe for recovery

December 2019

Assurance Committee

Quality Governance Committee

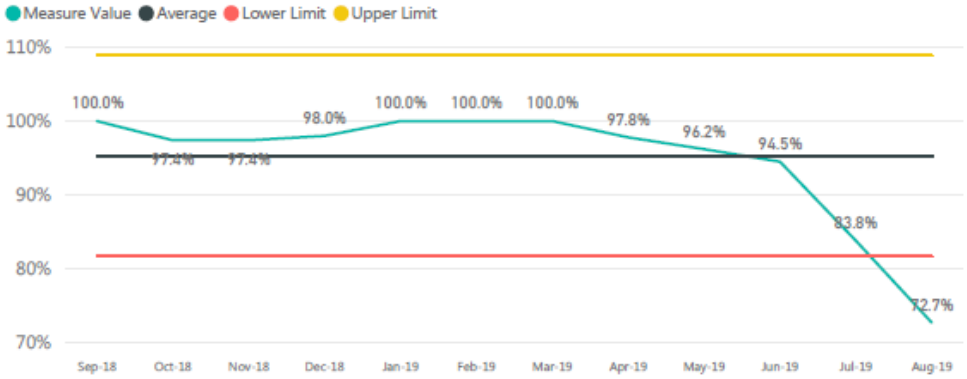
Next steps

Action plans from Patient Experience and from Divisions to improve on survey and FFT results Continue to maintain response rates Patient Experience lead returns to post

Complaints responded to within agreed timescales

August 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	90.0 %	72.7 %	↓	Sheran Oke

Performance vs Target



Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
100.0 %	97.4 %	97.4 %	98.0 %	100.0 %	100.0 %	100.0 %	97.8 %	96.2 %	94.5 %	83.8 %	72.7 %

What is driving under performance?

Sickness and then death of Complaints Officer (B5) Internal promotion (to Governance) of another Complaints Officer (B5) Unable to secure bank/agency cover for vacancies Annual leave of other staff members Restructure – providing additional support to PALS / Bereavement with workload and recruitment following retirement of Head of Service

Actions completed in the past month to achieve recovery

1 x Complaints Officer (B5) in post from 24.06.19 – 2 months in to 4-5 month training 1 x Complaints Officer (B5) replaced through secondment for 6 months (in post from the 16.09.19 – internal to Complaints team – administrator - so has had to be temporarily replaced through the bank) Recently secured additional support through an agency (individual is a band 6 and therefore is working part time to maintain budget) 1 x B3 administrator in post from the bank undergoing training at present ready for new Officer to move across in to her post

Exception report written by

CooperL1

Timeframe for recovery

November 2019

Assurance Committee

Quality Governance Committee

Next steps

As detailed in the actions completed this remains ongoing at present to ensure improvement in performance moving forwards.

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Report To	**Trust Board**
Date of Meeting	**26 September 2019**

Title of the Report	**NGH Inpatient Survey Results 2018**
Agenda item	**11**
Presenter of Report	Sheran Oke, Director of Nursing
Author(s) of Report	Natalie Green, Interim Deputy Director of Nursing
Purpose	For Assurance

Executive summary

- The overall response rate for NGH was **42%** with inpatient experience scoring **7.9/10.** This is a slight improvement when compared with **41%** in 2017.
- Overall, 11 categories were scored '**about the same**' as other Trusts participating in the survey.
- In three of the categories there was one question in each where we scored '**worse'** than other Trusts:

  1) Expectations after operation – Patients being told how they could expect to feel after operation or procedure .
  2) Doctors – Doctors answering questions in a way that patients could understand.
  3) Hospital and Ward – Noise from other patients at night.

- The question relating to being offered a choice of food had improved compared to 2017.
- Overall views of care and services showed a slight decrease in 2018 with a score of **3.2** compared with **4.2** in 2017.
- The overall experience of inpatient services received a score of **7.9**. This score was similar when compared with 2017.

Related strategic aim and corporate objective	Focus on Quality and Safety
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks The report aims to provide assurance to the Trust regarding the quality of nursing and midwifery care being delivered
Related Board Assurance Framework entries	**Principal Risk 1** – Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. **Principal Risk 2 –** Failure to deliver patient focussed care may lead to reputational risk and poor patient experience.
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) If yes please give details and describe the current or planned activities to address the impact. 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) If yes please give details and describe the current or planned activities to address the impact.
Legal implications / regulatory requirements	None

The Board is asked to:

- Discuss and where appropriate challenge the content of this report and to support the work moving forward.

NGH Inpatient Survey Results

Inpatient Survey 2018 - Overview

To improve the quality of services that the NHS delivers, it is important to understand what people care and think about their care and treatment. One way of doing this is by asking people who have recently used health services to tell us about their experiences.

This survey looked at the experiences of 76,668 people who were discharged from an NHS acute hospital in July 2018.

Between August 2018 and January 2019, a questionnaire was sent to 1,250 recent inpatients.

Responses were received from 496 patients at Northampton General Hospital NHS Trust (42%). The national response rate was 45%

This report summarises how Northampton General Hospital scored for each evaluative question in the survey, compared with other trusts that took part.

About the scores

Most questions are grouped under the section in which they appear in the questionnaire.

We asked people to answer questions about different aspects of their care and treatment. Based on their responses, we gave each NHS trust a **score out of 10** for each question (the higher the score the better).

Each trust also received a rating of '**Better**', '**About the same**' or '**Worse**'.

Better: the trust is better for that particular question compared to most other trusts that took part in the survey.

About the same: the trust is performing about the same for that particular question as most other trusts that took part in the survey.

Worse: the trust did not perform as well for that particular question compared to most other trusts that took part in the survey.

Emergency Department

- When reviewing the overall scores for the Emergency Department, the Trust scored **8.5.** When compared with other Trusts, this was 'about the same'. The results were very similar in 2017**.**

- The question relating to privacy (when being examined or treated) in A&E scored **9.1.** This is an improvement when compared with **8.7** in 2017.

- The question relating to information given about the patients' condition or treatment scored **7.9**. This was a slight decrease compared with **8.5** in 2017.

Waiting Lists and Planned Admissions

- Overall, the trust scored **8.7**. When compared with other trusts, this was 'about the same'. The results were the same in 2017.

Waiting to get to a bed on a ward

- When reviewing the results for patients who were waiting for a bed, the trust scored **7.6**. This was 'about the same' when compared with other trusts and a similar score achieved in 2017.

The Hospital & Ward

- The overall results received for Hospital and ward were **7.5** and 'were about the same' when compared with other trusts. The results were the same when compared with 2017.

- The scores received for the two questions relating to choice of food and assistance from staff at meal times have improved from 'worse' than other trusts in 2017 to 'about the same' in 2018.

- Noise at night from other patients was rated the '**worse**' when compared with other trusts. This was the same for 2017.

Questions	Score out of 10	Rating
Single sex accommodation	9.3	About the same
Changing wards at night	6.0	About the same
Noise at night from other patients	5.4	**Worse**
Noise at night from staff	7.8	About the same
Cleanliness of rooms or wards	8.9	About the same
Help to wash and keep clean	8.0	About the same
Taking own medication when needed	6.9	About the same
Quality of food	5.2	About the same
Choice of food	8.3	About the same
Help with eating	6.5	About the same
Having enough to drink	9.1	About the same
Being well looked after	9.1	About the same

Doctors

- The overall results received for Doctors scored **8.2** and were 'about the same' when compared with other trusts. The scores had slightly dropped in 2018 when compared with **8.6** in 2017.

- The trust was rated '**worse**' than other trusts in relation to the doctors answering questions in a way that that patients could understand.

Nurses

- The overall results received for Nurses was **8.0** and were 'about the same' when compared with other trusts. When compared with 2017, the results were very similar.

Care & Treatment

- The overall results received for Care and Treatment were **7.8** and were 'about the same' as other trusts. When compared with 2017, the results were similar.

- There were 11 questions under this category. The questions that received the lowest scores are reflected in the table below. Both questions have decreased slightly when compared with 2017.

Questions	Score out of 10	Rating
Talking about worries and fears	4.8	About the Same
Emotional support from hospital staff	6.7	About the Same

Operations & Procedures

- The overall results received for Operations & Procedures were **7.8** and were 'about the same' as other trusts. When compared with 2017, the results were similar.

- The trust was rated 'worse' than other trusts in relation to expectations of what to expect after an operation or procedure.

Questions	Score out of 10	Rating
Answers to questions in a way patients could understand	8.8	About the same
Expectations explained after the operation or procedure	6.9	**Worse**
After the operation	7.5	About the same

Leaving Hospital

- The overall results received for Leaving Hospital were **6.7** and were 'about the same' as other trusts. This score was similar with the results from 2017.

- There were 17 questions in total under this category. The questions that received the lowest scores were related to explaining to patients how to take their medication once at home and danger signals.

Questions	Score out of 10	Rating
Medication side effects – being told about side effects and what to watch out for (those given medicines to take home.	4.1	About the same
Danger signals – being told about any danger signals to watch for after going home.	5.1	About the same

Overall views of care and services

- The overall results received for views of care and services scored **3.2** and were 'about the same' as other trusts. This score has slightly decreased in ratings when compared with 2017 at **4.3**.

- There were 4 questions under this category.

Questions	Score out of 10	Rating
Respect and dignity.	8.8	About the same
Being offered to take part in research.	1.1	About the same
Patients being asked to provide their views about the quality of their care, during their hospital stay.	1.3	About the same
Information about complaints – being given any information explaining how to complain to the hospital about care received.	1.4	About the same

Overall experience

The overall view of inpatient services achieved a score of 7.9/10 and is 'about the same' as other trusts. The ratings were similar when compared with 2017.

Action Points

Patient Experience Team

Right Time Forum – This forum will be used as an opportunity to review the most recent Right Time Survey results for the individual areas to discuss best practice, areas for improvement and explores ideas on how everyone can improve their Right Time Survey results moving forward.

Noise at night from other patients

- Understand further the causative factors.
- Utilising patient experience champions for operational ideas.
- Liaising with the areas that have the 'sound ear' and closely monitor the results.
- Consider submitting a trust wide charity bid for more 'sound ears' to be distributed to areas.

How to make a complaint – the Patient Advice & Liaison Service will be running a PALS Awareness day in the Cyber Café for staff and patients /relatives. The aim of the awareness day is to promote the PALS service to make staff and visitors aware of their services and try to encourage local resolution where possible.

Divisional actions

Dissemination – the ADNs are sharing the results presentation at their Divisional meetings and cascading results through the Directorates and local areas/wards.

Communication – two points within the 'worse' category are how we, particularly doctors, communicate with our patients about their treatment – one in particular about what to expect after a procedure. The Divisions are required to action these points through the CDs and training days.

Right Time results – the Right Time Survey questions mirror those that require improvement in the annual survey, the right time forum will give a focus however these results need to be shared widely in the Divisions and actioned – results and improvements to be presented at PCEEG.

Limitations of Findings

Due to the significant time between the data collection (July 2018) and the publication of the results (June 2019), the findings can be considered as somewhat limited in their usefulness. However, the results do provide us with a marker and a set of indicators about the quality of services which we provide.

Recommendation – Trust Board are asked to note the findings of the report and to note action points which are highlighted.

Report To	**TRUST BOARD**
Date of Meeting	**25th September 2019**

Title of the Report	Financial Position - Month 5 (FY2019-20)
Agenda item	12
Sponsoring Director	Phil Bradley, Director of Finance
Author(s) of Report	Bola Agboola, Deputy Director of Finance
Purpose	To report the financial position for the month ended August 2019.

Executive summary

This report sets out the Trust's financial position for the month ended 31 August 2019 and shows a pre-PSF & FRF deficit of £12,709k compared to plan deficit of £10,816k, resulting in an adverse variance to plan of £1,893k.

As the Trust has not achieved the year to date financial plan, we have not accrued for the finance-related PSF and FRF of £4,782k therefore the overall variance to plan is £6,675k. However, the missed PSF/FRF can be recovered when the Trust gets back to plan.

The Trust nearly met the plan in-month, short of £59k; the performance is as a result of increased activity/income which is offset by continuing pay overspends on temporary staff, partly in response to the increased activity but also to cover vacancies, sickness and enhanced observation for patients. Agency expenditure is a record spend in August of £1,588k.

The Divisions have come up with schemes for the Trust financial recovery plan which is being monitored and reviewed on a regular basis to ensure that the Trust is able to return to financial balance

Related strategic aim and corporate objective	Financial Sustainability
Risk and assurance	The recurrent deficit and I&E plan position for FY19-20 signals another challenging financial year and the requirement to maintain the financial discipline required to deliver the agreed control total.
Related Board Assurance Framework entries	BAF 3.1 (Sustainability); 5.1 (Financial Control); 5.2 (CIP delivery); 5.3 (Capital Programme).
Equality Impact Assessment	N/A
Legal implications / regulatory requirements	NHS Statutory Financial Duties

Actions required by the Board

The Board is asked to note the financial position for the month ended August 2019 and to review the performance against plan.

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Financial Position

Month 5 (August 2019)
FY 2019/20

Report to:

Trust Board

September 2019

Content

1. Director of Finance Message

The Trust's financial position in month 5 is a YTD deficit variance of £1,893k, mainly due to Pay overspends.

No accrual is included for PSF and FRF funding as these are related to meeting the financial plan, therefore resulting in an overall adverse variance to plan of £6,675k.

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As the Trust has not achieved the year to date financial plan, we have not accrued for the finance-related PSF and FRF of £4,782k therefore the overall variance to plan is £6,675k. However, the missed PSF/FRF can be recovered when the Trust gets back to plan.

The Trust nearly met the plan in-month, short of £59k; the performance is as a result of increased activity/income which is offset by continuing pay overspends on temporary staff, partly in response to the increased activity but also to cover vacancies, sickness and enhanced observation for patients. Agency expenditure is a record spend in August of £1,588k.

The winter and escalation ward reserves of £1,225k are almost fully spent and only £490k remains of the contingency reserve, as the operational pressures continue across the Trust. This will likely be a big challenge for winter.

The Divisions have come up with schemes for the Trust financial recovery plan which is being monitored and reviewed on a regular basis to ensure that the Trust is able to return to financial balance.

CIP delivery is £5,407k year to date which is £570k better than plan although about 60% of this is delivered through non-recurrent unplanned pay savings. The challenge for the Trust continues to be to find sufficient recurrent schemes to deliver the CIPs target.

Capital spend is £1,709k at month 5 which is below plan by £192k but is expected to recover during the course of the year.

Cash balance at the end of month 5 is £2,076k and continues to be tightly managed. The impact of not meeting the financial plan and of the missed PSF/FRF funding continues to cause cashflow difficulties and may get worse if the position does not improve. We will continue to manage the cash position carefully.

Next Steps

We continue to monitor the Divisional Financial Recovery Plans alongside other centrally managed measures including measures to support a reduction of temporary staff spend. This is reported separately under the Forecast paper.

Table 1: Income and Expenditure Summary

I&E Summary	Annual Plan	In-Month			Year to Date			Recent Months: Actual	
		Plan	Actual	Variance	Plan	Actual	Variance	Jun-19	May-19
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	301,676	24,694	25,476	782	125,260	127,124	1,864	25,360	25,688
Other Clinical Income	24,986	1,800	699	(1,101)	8,159	3,771	(4,388)	1,058	685
Other Income	22,150	1,900	2,243	343	9,281	10,496	1,215	2,047	2,130
Total Income	348,813	28,395	28,418	24	142,700	141,391	(1,309)	28,465	28,503
Pay Costs	(236,256)	(19,712)	(20,384)	(671)	(97,156)	(101,426)	(4,270)	(20,199)	(20,319)
Non-Pay Costs	(102,827)	(8,669)	(8,881)	(213)	(43,686)	(43,682)	4	(8,954)	(8,772)
Unallocated CIPs	5,435	72		(72)	(254)		254		
Reserves / Non-Rec	(529)	249		(249)	837		(837)		
Total Costs	(334,177)	(28,059)	(29,265)	(1,206)	(140,258)	(145,108)	(4,850)	(29,153)	(29,091)
EBITDA	14,635	335	(846)	(1,182)	2,442	(3,716)	(6,159)	(688)	(588)
Depreciation	(12,355)	(1,022)	(1,022)	(0)	(5,088)	(5,088)	(0)	(1,015)	(1,015)
Amortisation	(7)	(1)	(1)	0	(3)	(3)	0	(1)	(1)
Impairments									
Net Interest	(1,356)	(113)	(111)	2	(541)	(549)	(8)	(108)	(110)
Dividend	(1,174)	(98)	(110)	(12)	(489)	(550)	(61)	(133)	(98)
Surplus / (Deficit)	(257)	(898)	(2,090)	(1,192)	(3,679)	(9,907)	(6,228)	(1,945)	(1,811)
NHS Breakeven duty adjs:									
Donated Assets	257	22	10	(12)	110	84	(26)	15	15
2018/19 PSF adjustment						(421)	(421)	(421)	
NCA Impairments									
Surplus / (Deficit) - Normalised	0	(876)	(2,080)	(1,204)	(3,569)	(10,244)	(6,675)	(2,351)	(1,796)

Table 2: I&E Analysis (Pre & Post PSF)

I&E	Plan	YTD Plan	Actual YTD	Var
	£'k	£'k	£'k	£'k
Pre PSF, FRF, MRET	(22,799)	(10,816)	(12,709)	(1,893)
PSF + FRF: Finance	16,881	4,782		(4,782)
MRET	5,918	2,465	2,465	
Post PSF + FRF	0	(3,569)	(10,244)	(6,675)

Table 3: Pre-PSF I&E Performance

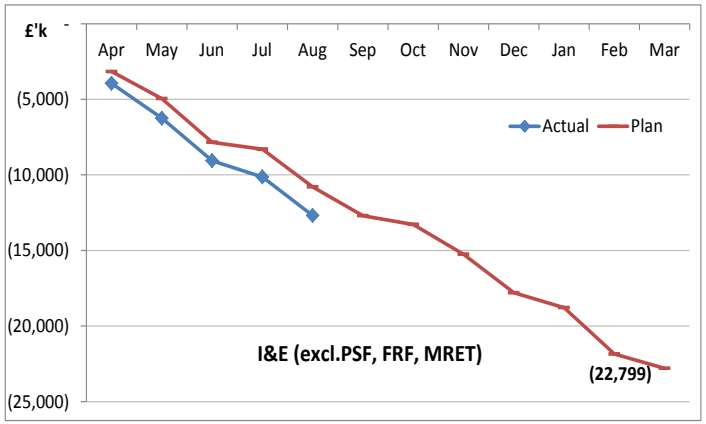
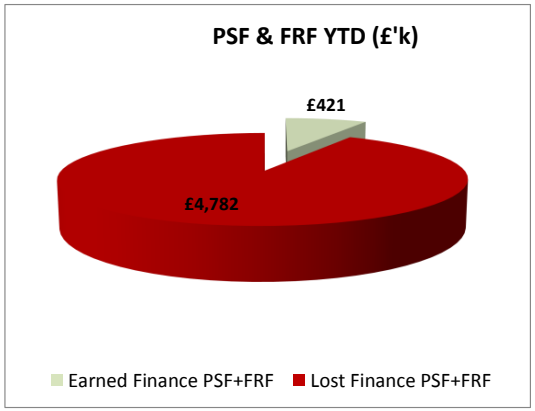


Table 4: PSF YTD Performance

£421k earned PSF relates to 2018/19 bonus PSF allocated to the Trust in current year.



2.1 Clinical Income By Commissioner (YTD)

Nene Contract - £2,205k over performance
The Month 5 position on the Nene contract is £2,205k over plan. This is due to over-performance in NEL activity (£2,411k). Planned activity is under (-£55k) as is Critical Care which is now £516k under contract.

Specialised Commissioning - £366k over performance
Excluded medicines are £132k over plan at the end of Month 5. This is offset by under-performance in Radiotherapy (-£237k), which dipped slightly after a strong performance in July. Gynae elective activity is over plan at Month 5 by £219k, following increased surgical activity on Gynae cancer. With Neo-natal Critical Care remaining at £174k over plan following periods of July at capacity.

Other - £814k under performance
This includes Year-to-date CIP targets (£633k) and RTT (£1,610k), offset by over-performing NCA's (+£737k) and WIP (£390k).
CDF (Cancer Drugs Fund) and Hep C drugs are also over plan by £437k.

Table 5: SLA Clinical Income by Commissioner

Commissioner	Finance £000's YTD Plan	Actual	Variance
Nene CCG	99,626	101,831	2,205
Corby CCG	1,388	1,358	(30)
Bedfordshire CCG	387	430	43
East Leicestershire & Rutland CCG	334	347	13
Leicester City CCG	59	38	(20)
West Leicestershire CCG	34	38	4
Milton Keynes CCG	1,050	1,188	138
Specialised Commissioning	15,329	15,695	366
Secondary Dental	3,005	2,966	(39)
NCA / Central / Other	4,048	3,234	(814)
Total SLA Income	**125,260**	**127,124**	**1,864**

2.2. Other Income

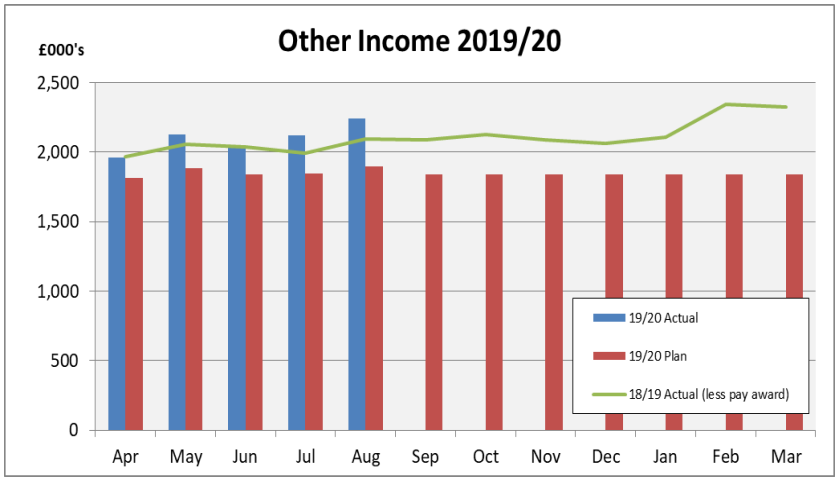
Other Income is £0.34m favourable to plan in month 5; £1.2m favourable to year to date plan

- **Other Income £126k favourable to plan in month 5; £419k favourable to year to date plan** continued trend of higher than plan occupational health income (£69k favourable in month) and nuclear medicine (£9k favourable in month). Additional income received in relation to organisational development (£28k) offsetting relevant costs. £17k of apprenticeship levy funding also received above plan in Month 5 increasing from previous months, again offset by costs.

- **Charitable Funds Donations £49k favourable to plan in month 5; £153k favourable to year to date plan** funds received in month related to revenue and capital purchases including 3D Brachytherapy Printer and Bladder Scanners.

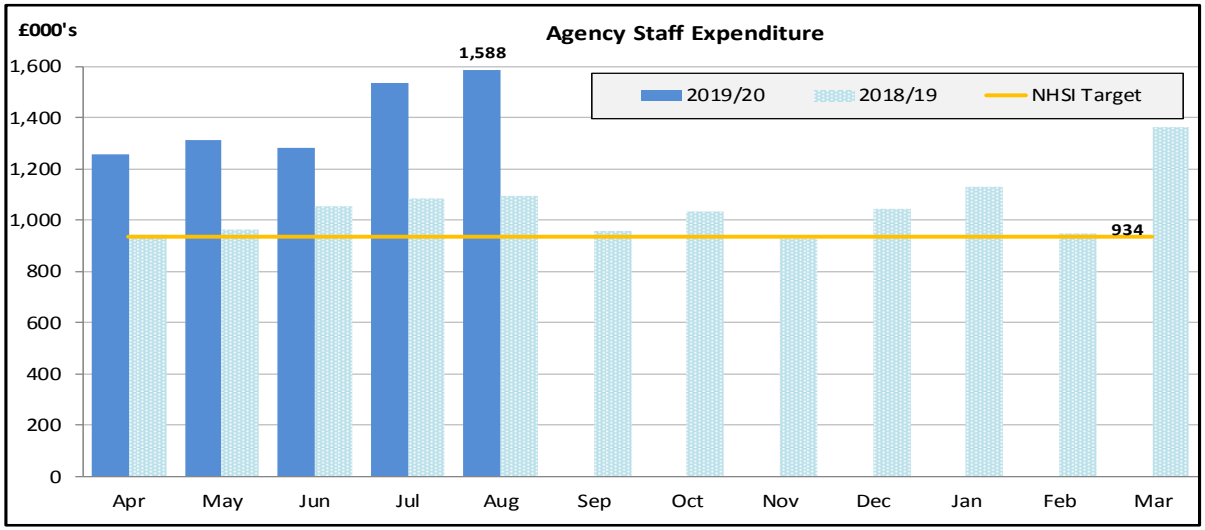
- **Catering Income £44k favourable to plan in month 5; £187k favourable to year to date plan** continued over-performance against income targets for food sales in Café Royale, Cliftonville Restaurant and CRIPPs catering.

Table 6 : Other Income Trend

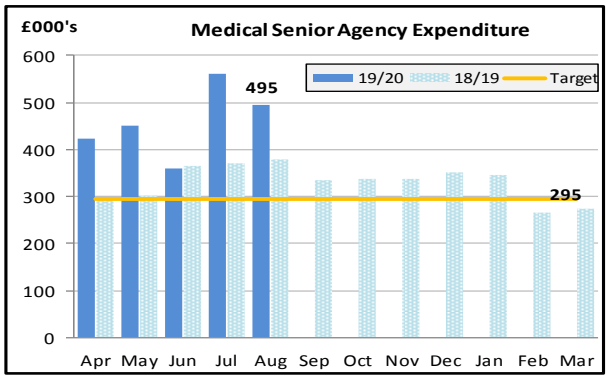


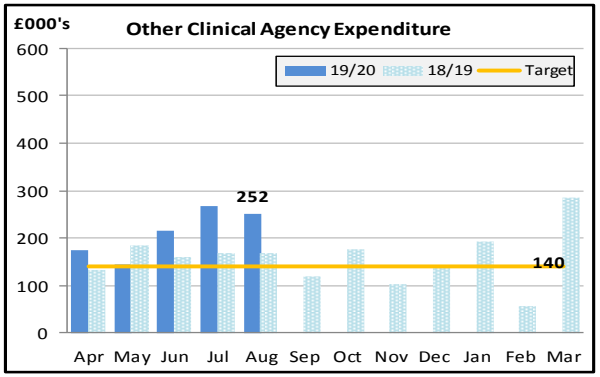
3. Pay: Agency Spend

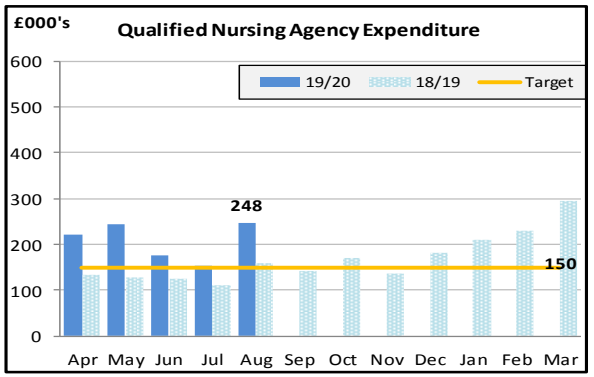
Table 7: Agency Spend

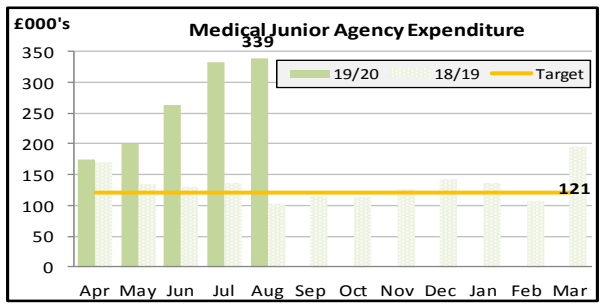


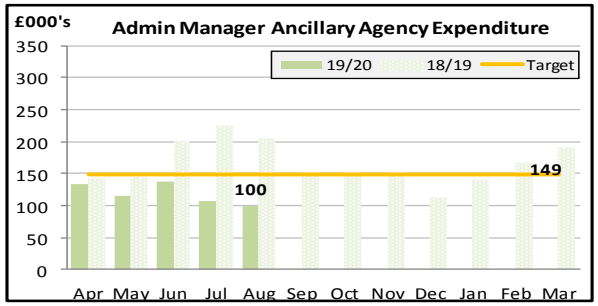
- NHS Improvement issued an expenditure limit of £11.208m for the financial year 2019/20.
- This £934k per month target is equivalent to an 10.6% improvement upon the 18/19 expenditure level. The graphs below apply this reduction equally to all staff groups.
- August 2019 surpassed the highest ever month of July 2019.
- Agency usage to cover vacancies, sickness across medical and nursing staff. There was a seasonal increase in demand for RN cover during the holiday month.

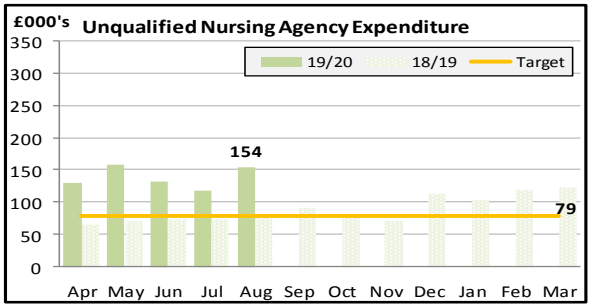












4. Non-Pay

Non Pay expenditure for month 5 is £0.2m adverse in month, on plan year to date.

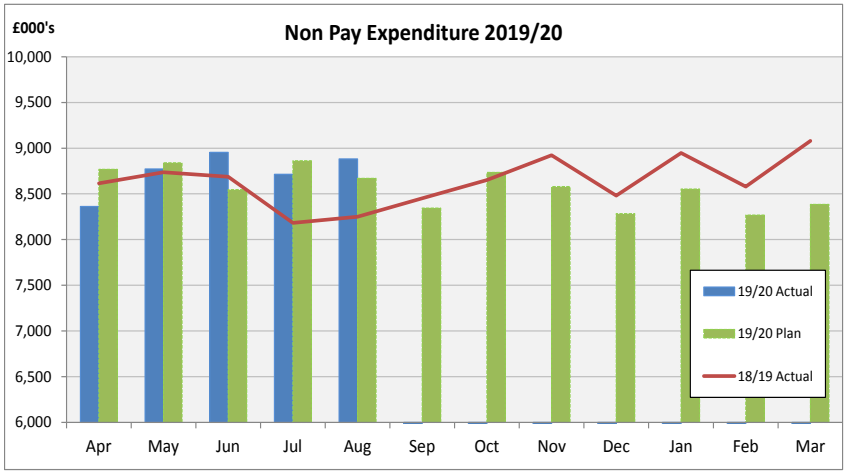
Excluding pass-through drugs and devices costs, the in month non-pay variance is £82k adverse to plan with key variances including:

- £80k Prosthesis; includes some re-coding, but is part of an orthopaedic theatre expenditure that is up 16% on 18/19. Given activity is up 10%, a further understanding is being sought for the disproportionate increase.
- £48k Training; includes £30k of nurse training costs recovered through Other Income. There is also some charitable funds covered training here.
- £37k Energy & Utilities; continues to overspend in spite of the additional Inflationary budget increases that have been applied; this position is being investigated.
- £36k Communications; a higher month for reported Postage, which is up year on year 8% and is also being looked into.

Favourable variances offsetting above favourable variances in month include:

- £113k Medicines bringing the Trust to a £206k Fav year-to-date. CIP efficiencies have been identified high level and require further breakdown to reduce the medicines budget in the relevant directorates.
- £41k Travel; in line with recent years the amount spent has decreased against the historic levels, especially in junior medical travel claims.

Table 8: Non-Pay Trend



5. CIPs

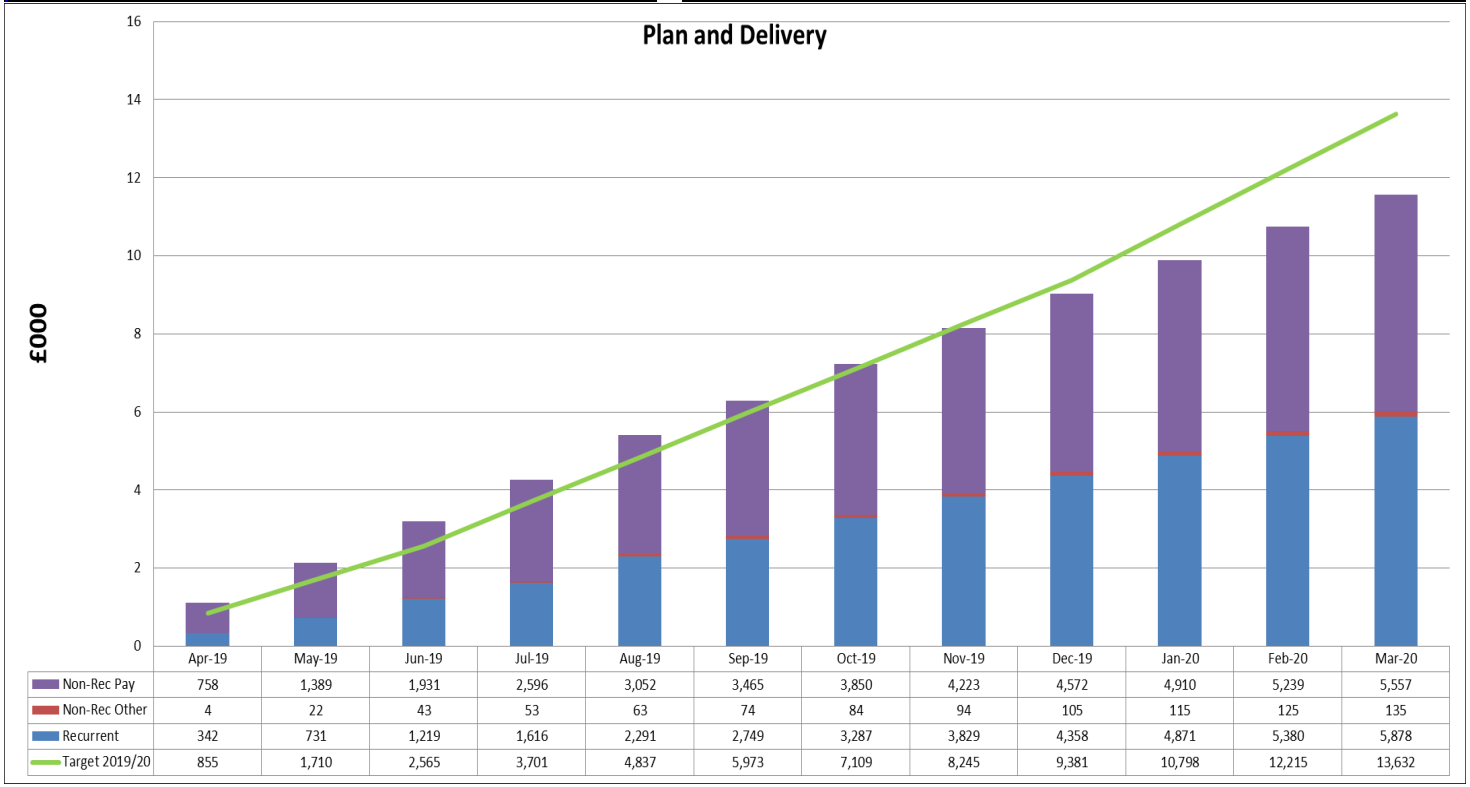
Table 9: CIPs Trend

YTD Delivery £000's

Division	Plan	Rec	N/R	Pay Under	Actual Total	Variance vs plan
SURGICAL DIVISION	1,297	326	0	563	888	-409
MEDICAL DIVISION	1,317	1,165	28	555	1,748	431
WCOH DIVISION	807	38	12	536	586	-221
CSS DIVISION	748	387	10	831	1,228	480
HOSPITAL SUPPORT	378	143	12	567	722	344
FACILITIES	290	233	2	0	235	-56
CENTRAL	0	0	0	0	0	0
Trust Total	**4,837**	**2,291**	**63**	**3,052**	**5,407**	**570**

Delivery £000's

Division	Plan	Rec	N/R	Pay Under	Total	Risk Adj LTF	Variance
SURGICAL DIVISION	3,656	1,052	0	1,107	2,159	1,857	-1,799
MEDICAL DIVISION	3,711	2,783	66	1,097	3,945	3,921	210
WCOH DIVISION	2,275	322	12	1,087	1,421	1,307	-968
CSS DIVISION	2,108	766	25	1,642	2,432	2,374	266
HOSPITAL SUPPORT	1,064	397	28	625	1,050	1,009	-55
FACILITIES	818	558	5	0	563	563	-255
CENTRAL	0	0	0	0	0	0	0
Trust Total	**13,632**	**5,878**	**135**	**5,557**	**11,571**	**11,032**	**-2,600**



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Non-Rec Pay	758	1,389	1,931	2,596	3,052	3,465	3,850	4,223	4,572	4,910	5,239	5,557
Non-Rec Other	4	22	43	53	63	74	84	94	105	115	125	135
Recurrent	342	731	1,219	1,616	2,291	2,749	3,287	3,829	4,358	4,871	5,380	5,878
Target 2019/20	855	1,710	2,565	3,701	4,837	5,973	7,109	8,245	9,381	10,798	12,215	13,632

The month 5 2019/20 risk adjusted LTF is currently £11.032m against a target of £13.632m. This represents a negative variance of £2.600m.

Of the £11.571m forecast delivery £5.557m (49%) of schemes are non-recurrent. This is predominantly £5.557m vacancies and pay underspend. If this can become recurrent it will mitigate I&E risks otherwise it poses a risk to the 2020/21 financial position.

Cumulative delivery at month 5 totalled £5.407m against a year to date plan of £4.837m. This represents a favourable variance to plan of £570k, which is mainly due to £3.059m Non- Recurrent pay general underspend across all divisions.

Financial escalation meetings are being held every fortnight to recover the financial position and to review Cost Improvement Programme schemes.

6. Statement of Financial Position

The key movements from opening movements are:

Non Current Assets

- M5 movements include the capital additions of £626k which includes £124k of Endoscopy Scopes.
- Depreciation charge is as planned £1,021k.

Current assets

- Inventories - £50k. Increase in Pharmacy stockholding (£82k) is offset by decrease Heart Centre (£92k), Pathology (£37k) & Gynae Endoscopy excluded devices (£2k).
- Trade & Other Receivables – £777k made up of : Increases in Income accruals (£215k), NHS Receivables (£300k), Trade Receivables (£61k), VAT reclaim (£41k), Other receivables (£104k), Compensation Recovery (RTC & PI Claims) (£31k), Salary Overpayments (£32k), Salary Sacrifice (£34k). Decrease in Prepayments (£42k).
- Cash – Decrease of £8,434k.

Current Liabilities

- Trade & Other Payables - £2,990k made up of: Decreases in NHS Payables (£354k), Trade Payables (£949k), Tax, NI & Pension Creditor (£161k), Other Payables (£394k), Accruals (£795k) & Receipts in Advance (£456k). Increase in PDC Dividend (£112k)
- Short Term Loans - £137k. Decreases in Revenue Loan interest payable (£106k) & Capital Loan interest payables (£30k).

•Non Current Liabilities

- Finance Lease Payable - £97k. Nye Bevan £85k, Car Park £12k.
- Loans over 1 year - £2,790k. Repayment of Revenue Loan £2,252k, Repayment of Capital Loan £537k

Financed By

- I & E Account - £2,090k deficit in month.

Table 10: SOFP

TRUST SUMMARY BALANCE SHEET MONTH 5 2019/20	Balance at 31-Mar-19 £000	Current Month Opening Balance £000	Current Month Closing Balance £000	Current Month Movement £000	Forecast end of year Closing Balance £000	Forecast end of year Movement £000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	162,168	162,168	162,168	0	162,168	0
IN YEAR REVALUATIONS	0	465	465	0	553	553
IN YEAR MOVEMENTS	0	1,125	1,751	626	8,962	8,962
LESS DEPRECIATION	0	(4,067)	(5,088)	(1,021)	(12,355)	(12,355)
NET BOOK VALUE	162,168	159,691	159,296	(395)	159,328	(2,840)
CURRENT ASSETS						
INVENTORIES	5,338	5,101	5,051	(50)	5,238	(100)
TRADE & OTHER RECEIVABLES	23,892	19,831	20,608	777	27,319	3,427
NON CURRENT ASSETS FOR SALE	0	0	0	0	0	0
CASH	1,553	10,510	2,076	(8,434)	1,500	(53)
TOTAL CURRENT ASSETS	30,783	35,442	27,735	(7,707)	34,057	3,274
CURRENT LIABILITIES						
TRADE & OTHER PAYABLES	23,806	28,441	25,451	(2,990)	20,639	(3,167)
FINANCE LEASE PAYABLE under 1 year	1,109	1,125	1,129	4	1,157	48
SHORT TERM LOANS	41,016	41,162	41,025	(137)	61,240	20,224
STAFF BENEFITS ACCRUAL	723	723	723	0	650	(73)
PROVISIONS under 1 year	731	657	655	(2)	350	(381)
TOTAL CURRENT LIABILITIES	67,385	72,108	68,983	(3,125)	84,036	16,651
NET CURRENT ASSETS / (LIABILITIES)	(36,602)	(36,666)	(41,248)	(4,582)	(49,979)	(13,377)
TOTAL ASSETS LESS CURRENT LIABILITIES	125,566	123,025	118,048	(4,977)	109,349	(16,217)
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year	10,686	10,304	10,207	(97)	9,529	(1,157)
LOANS over 1 year	53,693	58,886	56,096	(2,790)	38,124	(15,569)
PROVISIONS over 1 year	189	189	189	0	150	(39)
NON CURRENT LIABILITIES	64,568	69,379	66,492	(2,887)	47,803	(16,765)
TOTAL ASSETS EMPLOYED	60,998	53,646	51,556	(2,090)	61,546	548
FINANCED BY						
PDC CAPITAL	120,538	120,538	120,538	0	120,538	0
REVALUATION RESERVE	31,277	31,742	31,742	0	31,661	384
I & E ACCOUNT	(90,817)	(98,634)	(100,724)	(2,090)	(90,653)	164
FINANCING TOTAL	60,998	53,646	51,556	(2,090)	61,546	548

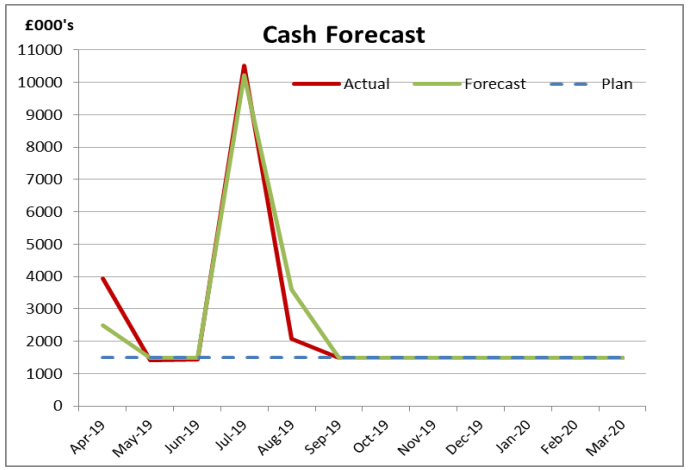
6.1 Cashflow

Table 11: Cashflow

MONTHLY CASHFLOW	ANNUAL TOTAL 2019/20 £000s	ACTUAL 19/20 APR £000s	MAY £000s	JUN £000s	JUL £000s	AUG £000s	FORECAST 19/20 SEP £000s	OCT £000s	NOV £000s	DEC £000s	JAN £000s	FEB £000s	MAR £000s
RECEIPTS													
SLA Base Payments	292,993	24,288	23,924	24,994	24,724	24,371	24,395	24,383	24,383	24,383	24,383	24,383	24,383
Provider Sustainability Fund (PSF) 18/19	8,480	0	0	0	8,480	0	0	0	0	0	0	0	0
Provider Sustainability Fund (PSF/FRF) 19/20	0	0	0	0	0	0	0	0	0	0	0	0	0
Marginal Rate Emergency Tariff (MRET)	5,918	1,480	0	0	1,480	0	0	1,480	0	0	1,478	0	0
SLA Performance (relating to 17/18 activity)	71	0	0	71	0	0	0	0	0	0	0	0	0
SLA Performance (relating to 18/19 activity)	-1,550	0	0	-1,439	0	0	0	21	405	0	-537	0	0
Health Education Payments	9,077	775	775	767	737	704	704	731	777	777	777	777	777
Other NHS Income	12,403	1,025	790	1,711	914	963	1,000	1,000	1,000	1,000	1,000	1,000	1,000
PP / Other (Specific > £250k)	5,244	1,261	423	291	241	506	547	350	325	325	325	325	325
PP / Other	11,688	1,113	986	855	938	797	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Salix Capital Loan	25	0	0	25	0	0	0	0	0	0	0	0	0
PDC - Capital	0	0	0	0	0	0	0	0	0	0	0	0	0
Uncommitted Revenue Loan - Deficit funding 18/19	1,644	0	0	1,644	0	0	0	0	0	0	0	0	0
Uncommitted Revenue Loan - Deficit funding 19/20	4,800	1,695	0	0	976	0	1,164	0	0	360	0	605	0
Uncommitted Revenue Loan - PSF/FRF	16,879	844	0	844	1,125	0	1,125	3,657	1,688	1,688	1,969	1,969	1,970
Interest Receivable	95	10	8	8	8	11	7	7	7	7	7	7	7
TOTAL RECEIPTS	**367,766**	**32,491**	**26,907**	**29,770**	**39,623**	**27,352**	**29,942**	**32,629**	**29,584**	**29,540**	**30,402**	**30,066**	**29,462**
PAYMENTS													
Salaries and wages	225,849	18,633	18,786	18,820	18,820	19,064	18,772	19,105	18,705	18,705	19,030	18,705	18,705
Trade Creditors	97,882	6,068	8,154	8,764	9,529	11,257	8,055	8,893	7,680	7,996	6,687	8,086	6,713
NHS Creditors	20,584	2,160	2,105	1,767	1,722	1,818	1,802	1,902	1,902	1,902	1,902	800	800
Capital Expenditure	9,859	1,250	325	329	356	567	745	995	1,040	879	1,117	1,675	581
PDC Dividend	1,260	0	0	0	0	0	599	0	0	0	0	0	661
Repayment of Revenue Loan - Deficit Funding 19/20	4,800	0	0	0	0	0	0	1,602	210	0	1,473	0	1,515
Repayment of Revenue Loan - PSF 18/19	4,182	1,930	0	0	0	2,252	0	0	0	0	0	0	0
Repayment of Revenue Loan - PSF/FRF 19/20	0	0	0	0	0	0	0	0	0	0	0	0	0
Repayment of Loans (Principal & Interest)	3,253	58	47	49	171	795	491	63	46	55	192	799	486
Repayment of Salix loan	101	29	0	0	0	0	0	69	0	2	0	0	0
TOTAL PAYMENTS	**367,771**	**30,128**	**29,416**	**29,729**	**30,598**	**35,754**	**30,465**	**32,629**	**29,584**	**29,540**	**30,402**	**30,065**	**29,461**
Actual month balance	-5	2,363	-2,510	41	9,025	-8,402	-523	0	1	-1	0	0	0
Cash in transit & Cash in hand adjustment	-48	29	-23	-13	45	-32	-53	0	0	0	0	0	0
Balance brought forward	1,553	1,553	3,946	1,413	1,441	10,510	2,076	1,500	1,500	1,500	1,500	1,500	1,500
Balance carried forward	**1,500**	**3,946**	**1,413**	**1,441**	**10,510**	**2,076**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**

- Closing cash balance at the end of August was £2,076k.
- Due to the current uncertainty of the Trust being eligible to receive Qtr 1 & 2 PSF & FRF funding & the timing of any receipt from NHS England, the receipt and corresponding repayment of Revenue Loan drawn down in lieu, has been removed from the forecast. Uncommitted Revenue Loan will continue to be drawn down until PSF/FRF funding is received or alternative arrangements are agreed with NHS Improvement.

Table 12: Cash forecast



6.2 Capital

Capital Scheme	Plan 2019/20 £000's	M5 Plan £000's	Cum M5 Spend £000's	Under (-) / Over £000's	Plan Achieved %	M5 Commit + Spend £000's	Plan Achieved %
Medical Equipment - MESC Block	688	284	284	0	41%	284	41%
Medical Equipment - Charitable Funds	84	29	29	0	34%	29	34%
IT - iLab	474	0	4	4	1%	4	1%
Information Technology	2,214	630	467	(163)	21%	827	37%
Information Technology - Charitable Funds	13	13	13	0	103%	13	103%
Estates - Backlog	1,788	420	413	(7)	23%	1,300	73%
Estates - Statutory	1,119	136	96	(40)	9%	470	42%
Estates - Non Maintenance	372	138	161	23	43%	367	99%
Estates - Ward Refurbishment	1,334	79	68	(11)	5%	101	8%
Estates - Charitable Funds, Talbot Butler	3	3	3	0	93%	3	93%
Endoscopy Washers	70	70	68	(2)	97%	70	100%
Endoscopy Scopes	124	124	124	0	100%	124	100%
Other - inc. Gamma Camera 2 & Breast Screening Mobile + Static	654	20	23	3	3%	24	4%
SALIX	25	0	1	1	3%	523	2091%
Total - Capital Plan	**8,962**	**1,946**	**1,754**	**(192)**	**20%**	**4,138**	**46%**
Less Charitable Fund Donations	(100)	(45)	(45)	0	45%	(45)	45%
Less NBV of Disposals	0	0	0	0	0%	0	0%
Total - CRL	**8,862**	**1,901**	**1,709**	**(192)**	**19%**	**4,093**	**46%**

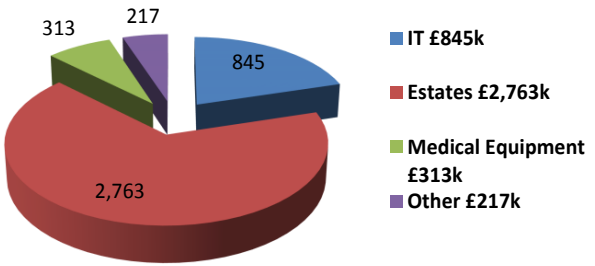
Table 13: Capital

Funding Resources	
Internally Generated Depreciation	12,355
Salix	25
Capital Loan - Repayment	(1,835)
Capital Element - Finance Lease (Assessment Unit)	(978)
Capital Element of Finance Lease (Car Park)	(139)
Other Loans - Repayment (SALIX)	(150)
STP 20% Capital Control Cut	**(416)**
Total - Available CRL Resource	**8,862**
Uncommitted Plan	**0**

Key Points

- At M5, commitments and spend totalled £4.1m which is 47% of the overall capital plan.
- The Trust is still waiting a CRL addition for the Salix loan of £606k for replacement of the calorifiers as detailed in M4's report.
- IT Capital have identified £526k of iLab slippage in to next financial year. This has been allocated to the central capital funds.
- In M5 there was an urgent capital request of £124k for insourcing of Endoscopy this was funded from central capital funds.

M5 Capital spend & commitments 2019/20



6.3 Receivables and Payables

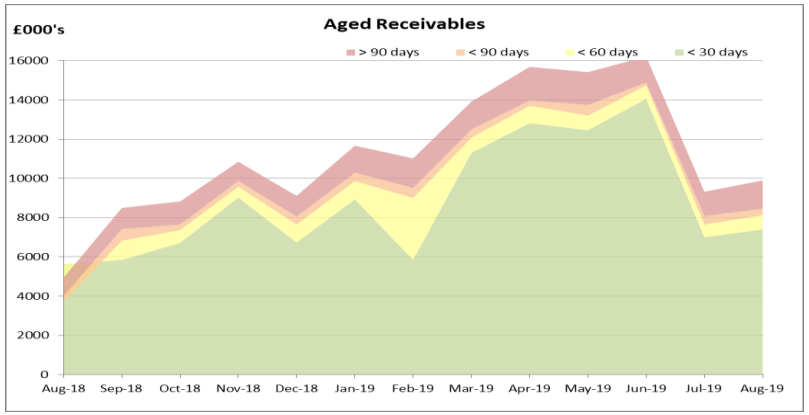
- NHS Receivables – Accruals are included within the 0 to 30 Days Receivables balance.
- NHS over 90 day debt include s Kettering General Hospital FT £156k, University Hospitals of Leicester NHS Trust £52k, NHS Property Services £82k, Central Midlands Region £56k and £207k NCA's.
- Creditor payments to Kettering General are being held until the outstanding Sales Ledger invoices are settled. The Creditor Balance is included in Over 90 days NHS Payables.
- Non-NHS over 90 day debt includes overseas visitor accounts of £559k, of which £186k are paying in instalments & a further £324k have been referred to debt collection & private patients accounts of £60k. Salary overpayments invoiced over 90 days are £176k.
- Contract Underperformance with Commissioners is included within the 0 to 30 Days Payables NHS balance.

Table 14: Receivables and Payables

Narrative	Total at Aug-19 £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	1,700	428	266	192	814
Receivables NHS	8,197	6,970	464	139	624
Total Receivables	**9,897**	**7,398**	**731**	**331**	**1,437**
Payables Non NHS	(4,482)	(4,480)	0	(1)	0
Payables NHS	(2,128)	(2,111)	(1)	0	(16)
Total Payables	**(6,609)**	**(6,592)**	**(1)**	**(1)**	**(16)**

Narrative	Total at Jul-19 £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	1,639	463	287	91	797
Receivables NHS	7,682	6,539	363	336	443
Total Receivables	**9,321**	**7,003**	**651**	**428**	**1,240**
Payables Non NHS	(5,423)	(5,421)	(2)	0	0
Payables NHS	(2,482)	(2,466)	0	(16)	0
Total Payables	**(7,905)**	**(7,887)**	**(2)**	**(16)**	**0**

Table 15: Aged Receivables



6.4 Better Payment Practice Code

Targets in all areas were met for August. The cumulative position for the 19/20 year has now recovered to be just over target.

Table 16: BPPC

Better Payment Compliance Code - 2019/20						
Narrative	April 2019	May 2019	June 2019	July 2019	August 2019	Cumulative 2019/20
NHS Creditors						
No.of Bills Paid Within Target	175	165	145	148	188	821
No.of Bills Paid Within Period	183	165	150	148	188	834
Percentage Paid Within Target	**95.63%**	**100.00%**	**96.67%**	**100.00%**	**100.00%**	**98.44%**
Value of Bills Paid Within Target (£000's)	1,919	2,082	1,643	1,718	1,818	9,181
Value of Bills Paid Within Period (£000's)	1,927	2,082	1,756	1,718	1,818	9,302
Percentage Paid Within Target	**99.58%**	**100.00%**	**93.57%**	**100.00%**	**100.00%**	**98.70%**
Non NHS Creditors						
No.of Bills Paid Within Target	5,046	7,430	6,513	6,666	7,801	33,456
No.of Bills Paid Within Period	5,065	7,475	6,642	6,695	7,863	33,740
Percentage Paid Within Target	**99.62%**	**99.40%**	**98.06%**	**99.57%**	**99.21%**	**99.16%**
Value of Bills Paid Within Target (£000's)	7,484	8,330	7,019	9,563	11,833	44,228
Value of Bills Paid Within Period (£000's)	7,490	8,430	9,006	9,642	11,868	46,435
Percentage Paid Within Target	**99.92%**	**98.82%**	**77.93%**	**99.18%**	**99.70%**	**95.25%**
Total						
No.of Bills Paid Within Target	5,221	7,595	6,658	6,814	7,989	34,277
No.of Bills Paid Within Period	5,248	7,640	6,792	6,843	8,051	34,574
Percentage Paid Within Target	**99.49%**	**99.41%**	**98.03%**	**99.58%**	**99.23%**	**99.14%**
Value of Bills Paid Within Target (£000's)	9,403	10,413	8,662	11,281	13,651	53,409
Value of Bills Paid Within Period (£000's)	9,417	10,512	10,762	11,360	13,686	55,737
Percentage Paid Within Target	**99.85%**	**99.05%**	**80.49%**	**99.30%**	**99.74%**	**95.82%**

7. Single Oversight Framework (SOF)

The Trust continues to score 3.8 against the Single oversight framework which includes scoring for "finance and use of resources". The deterioration is as a result of not meeting the control total and also the high agency spend.

Table 17: SOF

Criteria	Score	Weight	Weighted Score
Capital Service capacity (times)	4	20.00%	0.80
Liquidity (days)	4	20.00%	0.80
I&E Margin	4	20.00%	0.80
Distance From Plan	4	20.00%	0.80
Agency spend (distance from cap)	3	20.00%	0.60
Overall Score			3.8

Finance and use of resources metrics

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

Note: brackets indicate negative numbers

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

8. Risks

Risk Analysis - I&E Only	£'m
As below excluding CIPs and non-recurrent funding	4.4

Table 18

Title		Risk	Risk score	Existing Controls	Mitigated Impact (£'m)	Exec Lead
I&E Risks						
Income	Income Mitigations	Nene CCG are proposing additional mitigations which would pose a risk to the Trust's financial position. In addition the new national requirement for certain procedures to have "Prior Approval" may impact on the Trust income	20	Continued discussions and negotiations with the STP partners; Improve processes to ensure approvals are maximised	0.3	DoS/DoF
	Unrealised Activity	Invest to save business cases may not deliver the full income assumptions	16	Continue to monitor via the Benefit Realisation report to FIPC and hold Divisional directors to account	0.5	Divisional Directors
	STP Partners	Cost pressures within the Northamptonshire STP may impact investments and result in operational pressure thereby impacting the ability to deliver planned activity. In addition closure of the Angela Grace / Avery beds may create further operational pressures	20	Working in close alignment with the STP partners Develop a robust operational plan for its implementation	0.9	DoS/DoF
Pay	Winter funding	Internal winter funded schemes may continue thereby reducing the funds available for 2019/20 winter	16	COO & Deputy COO have oversight of the avaialble budget and approve spend	0.5	COO
	Cost Pressures	Unfunded existing cost pressures pose a risk to the financial position. For example, Nursing Bank premium, additional temporary medical staff used in the Medicine Division to cover A&E and Assessment wards	20	Monitoring through Perfromance meetings and FIPC Reporting	1.5	DoF/Execs
	Agency staffing	Risk of continued dependence on agency staffing due to workforce vacancies, sickness	16	Targeted recruitment drive and continued monitoring of usage via existing channels	0.8	DoHR
CIP	CIP Delivery	Trust's ability to deliver £13.6m CIP target recurrently	20	Should be achievable non-recurrently via Pay underspends, but would create a challenge for 2020-21; Monitoring via the PMO, Changing Care Steering Group and FIPC	6.0	DoF
Non-recurrent Funding	PSF,FRF funding	The Trust may not deliver the required conditions to access the financial PSF & FRF funding.	20	Management of operational and financial targets; Realistic plans set for Divisions.	16.9	DoF
Non-I&E Risks						
	Capital	The availability of funding to meet the Trust's capital requirements as well as the Trust's ability to fully maximise spend against the capital plan.	15	A realistic capital plan was set for 2019-20; Use of lease financing where possible; Management of slippage; Maximization of external funding, Charitable funds and ad-hoc bid processes.	0.5	DoF
	Cashflow	Cashflow difficulties may mean that the Trust is not able to meet its debt obligations as and when due	15	Continue to utilise DH's cash funding structures including regular cashflow submissions; management of debtors and creditors; receipt of non-recurrent funding	2.0	DoF
Overarching Risk						
	Financial planning for a Sustainable Future	Trust is unable to return to financial balance in the medium term and may not be able to meet the required control total set by Regulators for FY19-20.	20	Board approved realistic plan for 2019-20; To be monitored via FIPC monthly; Monthly financial assurance meetings with NHSI		DoF/Execs

Report To	**Public Trust Board**
Date of Meeting	**27 September 2019**

Title of the Report	**Operational Performance Report**
Agenda item	**13**
Presenter of Report	Mrs D Needham (COO/DCEO)
Author(s) of Report	Mrs D Needham
Purpose	For information / discussion / assurance

Executive summary

The paper is presented to provide information to the board to form a discussion relating to the national performance targets.

Each of the indicators on the integrated scorecard (Appendix 1) which are red rated have an accompanying exception report (Appendix 2) and these have been discussed in detail at Finance, Investment & Performance committee.

Within this month's report, the main areas of focus for discussion are:

- Urgent care
  Remains below the national standard and has deteriorated from previous month
- RTT
  New reporting guidance in place
  FU backlog reducing and being managed through the weekly performance meeting
- Cancer
  62 days remains significantly below the national standard

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? 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 Assurance only

Related Board Assurance Framework entries	BAF – please enter BAF number(s) 1.1, 1.2, 3.1, 3.2, 3.3
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? (N) If yes please give details and describe the current or planned activities to address the impact. 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) If yes please give details and describe the current or planned activities to address the impact.
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper – No

Actions required by the Trust Board

The committee is asked to:

1. Note the report
2. Discuss the areas outlined as exceptions within the report

Operational Performance Report – September 2019

1. Introduction

The operational performance report is presented to provide information to the board to aid a discussion relating to the national operational performance targets.

The integrated scorecard can be found in *appendix one*. Areas rated as red have an accompanying exception report which has been provided by the manager and clinician responsible for delivery, the exceptions for operational performance can be found in *appendix two*.

All exception reports are discussed at the subcommittees of the board, for operational performance this is finance, investment & performance committee.

The main areas of focus in this report relating to national performance include RTT, Cancer & the urgent care four hour standard.

2. Summary performance

The performance trajectories below were agreed as part of the operational plan for 2019/20 with NHSI.

Rolling Year

Accident & Emergency - Performance % (95% Standard)	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Planned Performance	90.1%	90.3%	90.3%	90.3%	90.3%	90.3%	90.3%	95.0%	83.6%	84.6%	88.4%	89.0%	90.0%
Actual Performance	91.5%	88.9%	86.8%	85.9%	83.4%	78.6%	79.1%	80.3%	79.0%	83.9%	85.6%	83.7%	78.7%

Cancer Waiting Times - 62 Day GP Referral	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Planned Performance	88.3%	89.1%	89.6%	85.8%	86.4%	87.1%	86.9%	88.5%	79.2%	79.0%	78.8%	79.4%	81.6%
Actual Performance	80.8%	81.5%	85.4%	76.0%	80.0%	71.2%	74.0%	70.7%	70.0%	69.8%	77.5%	75.2%	

RTT Incompletes - Performance % (92% Standard)	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Planned Performance	90.0%	90.8%	91.5%	92.1%	92.2%	92.6%	93.1%	93.3%	84.0%	84.3%	85.0%	87.0%	90.4%
Actual Performance	79.9%	80.3%	81.5%	82.2%	81.5%	81.7%	80.8%	80.0%	79.1%	80.7%	82.5%	82.5%	

Please note:
Validated data for Cancer is not yet available for the reporting period
The final RTT position for August 2019 is expected to be available in mid September 2019

3. Key areas of performance

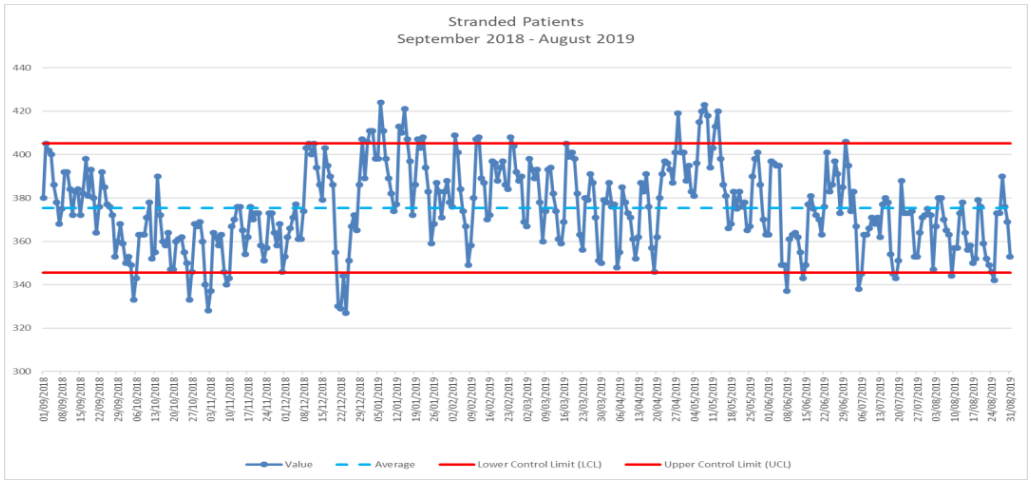
3a. Urgent care - A&E

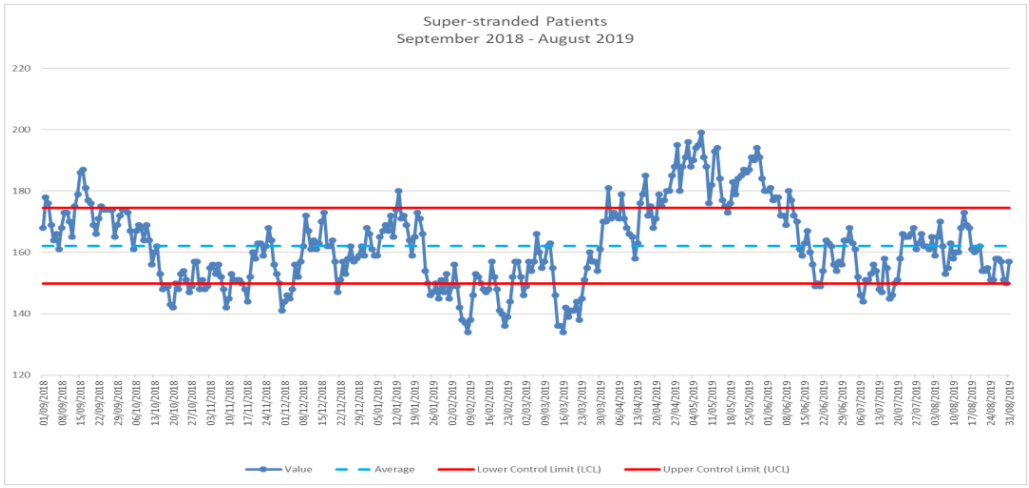
Four hour A&E performance decreased In August 2019 to 78.7%, this is a 5% decrease from July 2019.

During August the number of DTOC Increased to 47 which is above the target and contributing to the decrease in A&E performance along with a 5.8% increase in attendees to A&E and emergency admissions 8% above plan. The bed base has also reduced in August 2019 by 22 beds (planned closure of Cliftonville ward).

We have seen a shift in time of arrival with many patients presenting out of office hours and on average an increase 15% increase on patients conyeved by ambulance of which aproximately 30% do not require A&E treatment.

Both stranded & superstranded numbers of patients remain high, superstanded patient numbers are consistent with medically fit patients waiting for pathways 1,2, or 3 in the community.





The national and midlands benchmarking:
Midlands – 83.3%
National – 86.3%

The transformation work being led by the DoN, MD and COO continues with 3 work streams now in place. The HEAT programme meets bi-weekly and is attended by all project leads. The overall aim of the programme is to improve the A&E 4hr transit target.

1. A&E, ACC & Assessment – Lead: Mr M Metcalfe
Aim – To improve early assessment and prevent admission

2. Discharge – Lead: Mrs S. Oke
Aim – Reduce LOS

3. Site & weekend working – Lead: Mrs D Needham
Aim – Improve prediction, planning & weekend discharge

Risk

1. Reduced capacity for Complex discharge – resulting in longer lengths of stay, increased stranded & super stranded patients in acute beds. Potential for increased harm due to patients decompensating.

2. Staff motivation to test & introduce sustained change during a challenging period with increased activity and high operational escalation levels (OPEL).

3b. RTT – 18 weeks

As the trust is now a test field site for the new RTT standard, national reporting has ceased for this standard.

There are no patients currently waiting over 52 weeks at NGH.

The target average wait (mean) is expected to be 8.5 weeks from referral although this has not yet been set. The current average at NGH is 11 weeks.

The field-testing of the Elective Care Clinical Review of Standards commenced on the 1st August 2019 and will run for an initial period of four months. At the conclusion of the four-month field test period a decision will be required regarding the potential continuation of the field test throughout the winter. NGH is one of 12 sites chosen to test the standard.

3c. Unappointed follow up appointments

The number of outpatients waiting for a follow up appointment for greater than their planned date has increased slightly during August. The areas with high numbers of patients waiting are in H&N especially ophthalmology, cardiology, & urology.

Each directorate has a recovery plan which is monitored at the weekly performance meeting.

The increased numbers are due to the summer holiday with a reduction in clinics being undertaken as planned.

Actions being taken:

Action plans have been developed by specialties not achieving the standard, which includes additional clinics, Virtual clinics, weekend and evening activity, outsourcing and insourcing and the use of locums where possible

- Weekly performance meetings in place for all Directorates chaired by the Deputy COO where directorates will be held to account for their performance against trajectory
- PTL meetings are in place in all Divisions weekly
- Harm reviews are in place

Risks:

The limiting factor for achievement is lack of capacity. Overtime is being offered and on occasion additional capacity in place. Virtual clinics are helping to reduce the backlog. The main risk being insufficient capacity to meet demand and staff burnout due to undertaking additional workload. Many consultant staff remain reluctant to undertake additional work at present due to the pension tax issues.

3d. Cancer

Cancer performance has improved in August With 2ww Breast Symptoms & 2ww now meeting the national target.

62 day performance remains a challenge and under national target

The main causes for the underperformance remain:

- Patient initiated delays
- Late tertiary referrals
- No capacity at a tertiary provider mainly UHL for lung and urology
- Complex pathways

Validated July 2019 cancer performance figures:

	Total Treatments	Number of Patients Within Target	Number of Patients Over Target	Performance	Operating Standard
2ww Referral	1274	1217	57	95.5%	93%
2ww Breast Symptoms	125	121	4	96.8%	93%
31 Day First Treatment	207	199	8	96.1%	96%
62 Day combined with 31 Day Rare Treatments - Actual Total	137.5	103.5	34	75.3%	85%
Subsequent Surgery Treatments	17	16	1	94.1%	94%
Subsequent Drug Treatments	80	79	1	98.8%	98%
Subsequent Radiotherapy Treatments	113	111	2	98.2%	94%
62 Day Screening	5.5	5.5	0	100.0%	90%
62 Day Consultant Upgrade	20	9.5	10.5	47.5%	85%

July 2019 - National benchmarking

2ww – national 90.9%, Midlands – 88.6% (NGH – 95.5%)

2ww Breast – national 82.4%, Midlands 65.4% (NGH – 96.8%)

62 days – national 77.6%, Midlands – 73.7% (NGH – 75.3%)

Individual tumour site performance is shown below:

Cancer Site	Confirmed Total Treatments	Confirmed Total Breaches	Confirmed Performance
Breast	20	3	**85.0%**
Colorectal	8	4	**50.0%**
Gynaecology	15	0.5	**96.7%**
Haematology	12	5	**58.3%**
Head & Neck	6	4	**33.3%**
Lung	5.5	2.5	**54.5%**
Other	3	0	**100.0%**
Skin	28	1	**96.4%**
Upper GI	8.5	3.5	**58.8%**
Urology	31.5	10.5	**66.7%**
Total	**137.5**	**34**	**75.3%**

Patients waiting in excess of 62 days on their pathway as of the 05/09/19 is 56 as highlighted below showing a decrease on the previous month.

The daily PTL meetings chaired by the Chief Operating Officer continue and discuss all patients on a 62 day pathway including 2ww, screening and consultant upgrades from day 27 upwards on their pathway.

Tumour Site As at 05.08.2019	Without a Cancer Diagnosis	With a Cancer Diagnosis	Total number patients whose breach date has already passed	Tumour Site As at 05.09.2019	Without a Cancer Diagnosis	With a Cancer Diagnosis	Total number patients whose breach date has already passed
Brain	0	0	**0**	**Brain**	0	0	**0**
Breast	0	1	**1**	**Breast**	3	2	**5**
Colorectal	7	4	**11**	**Colorectal**	12	3	**15**
CUP	1	0	**1**	**CUP**	0	0	**0**
Gynaecology	1	5	**6**	**Gynaecology**	3	3	**6**
Haematology	1	1	**2**	**Haematology**	0	0	**0**
Head and Neck	1	4	**5**	**Head and Neck**	3	11	**14**
Lung	4	3	**7**	**Lung**	5	1	**6**
Other	0	0	**0**	**Other**	0	0	**0**
Paediatric	0	0	**0**	**Paediatric**	0	0	**0**

Sarcoma	2	0	**2**	**Sarcoma**	1	0	**1**
Skin	4	1	**5**	**Skin**	1	3	**4**
Upper GI	0	3	**3**	**Upper GI**	0	0	**0**
Urology	7	9	**16**	**Urology**	4	1	**5**
Grand Total	**28**	**31**	**59**	**Grand Total**	**32**	**24**	**56**

Actions being taken:

The Clinical Director for cancer will have dedicated time in his job plan from the 01/11/19

The work towards the National Optimal Lung Pathway continues with ongoing weekly meetings still focusing on the front end of the pathway including the 2WW referral and radiology aspects. The potential challenges to the delivery remain in the consultant vacancies, new equipment and estates space. A transformation project manager commenced in post on the 02/09/19.

A Joint Urology/Oncology clinic is starting on the 10th September which will directly refer to UHL for Radical Prostatectomies.

The team have seen an increase in poor referrals of patients into the sarcoma service. Some come with very little information and some clearly don't hit all the criteria. When these have been challenged back to GP's there is largely no improvement, attendance at GP locality boards to undertake an educational event is being considered.

Clinical lead planning with the team for straight to Test Colonoscopy

CT Colons are now booking into October and seem to be being requested more, this is impacting on patient pathways; additional capacity is being investigated outside NGH.

A meeting is being arranged between NGH and KGH to discuss the Screening Patients and capacity issues which are currently affecting patient experience and performance.

Review of harm
At the 104 day breach panel, 14 of the 21 patients treated in month were discussed and no harm was noted. The remainder of patients will be discussed at the next meeting.

4. Board recommendation:
The Board is asked to receive and discuss the report

Northampton General Hospital NHS
NHS Trust

Corporate Scorecard 2019/2020 AUG

Domain	Indicator	Executive Owner	Target	Target Set By	Direction of Travel	Trend	SEP-18	OCT-18	NOV-18	DEC-18	JAN-19	FEB-19	MAR-19	APR-19	MAY-19	JUN-19	JUL-19	AUG-19
Caring	Complaints responded to within agreed timescales	Sheran Oke	>=90%		↓		100.0%	97.3%	97.4%	98.0%	100.0%	100.0%	100.0%	97.7%	96.1%	94.5%	83.7%	72.7%
	Friends & Family Test % of patients who would recommend: A&E	Sheran Oke	>=86.4%	Nat	↓		87.3%	86.4%	88.1%	85.9%	85.1%	80.9%	83.3%	85.3%	86.8%	86.0%	82.1%	81.9%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	Sheran Oke	>=95.7%	Nat	↓		91.9%	92.4%	94.0%	92.6%	92.7%	93.5%	92.8%	92.7%	93.8%	93.9%	93.6%	92.6%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	Sheran Oke	>=96.8%	Nat	↑		100.0%	100.0%	96.6%	100.0%	99.4%	98.6%	99.3%	99.3%	98.6%	99.0%	97.7%	98.6%
	Friends & Family Test % of patients who would recommend: Outpatients	Sheran Oke	>=93.8%	Nat	↑		92.7%	92.3%	93.8%	93.5%	93.5%	93.6%	93.3%	93.3%	93.6%	94.7%	93.1%	93.8%
	Mixed Sex Accommodation	Sheran Oke	=0	Nat	→		0	0	0	0	4	2	0	0	0	0	0	0
	Compliments	Sheran Oke	>=5	NGH	↑			4,288	4,335	3,541	4,269	3,639	4,007	3,647	3,697	3,595	4,363	4,367
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	Debbie Needham	>=90.1%	Nat	↓		88.9%	86.7%	85.9%	83.3%	78.5%	79.0%	80.2%	79.0%	83.9%	85.5%	83.6%	78.4%
	Average Ambulance handover times	Debbie Needham	<=15 mins		→		00:14	00:14	00:14	00:14	00:31	00:14	00:16	00:17	00:13	00:19	00:18	00:18
	Ambulance handovers that waited over 30 mins and less than 60 mins	Debbie Needham	<=25		↓		118	174	142	299	330	400	420	343	203	69	84	219
	Ambulance handovers that waited over 60 mins	Debbie Needham	<=10		↓		15	17	19	30	49	33	22	13	11	15	9	13
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Debbie Needham	=0		↑		2	3	3	4	5	4	4	11	1	4	3	1
	Delayed transfer of care	Debbie Needham	=23	NGH	↓		36	10	10	24	12	11	20	31	34	21	32	47
	Average Monthly DTOCs	Debbie Needham	<=23	NGH	↓		34	27	15	20	20	17	29	41	41	32	30	37
	Average Monthly Health DTOCs	Debbie Needham	<=7	NGH	↓		25	25	13	16	17	13	20	30	33	23	19	25
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	Debbie Needham	>=93%	Nat	↑		75.2%	94.0%	88.5%	86.1%	73.7%	81.9%	73.3%	70.5%	91.0%	85.7%	95.5%	
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	Debbie Needham	>=93%	Nat	↑		85.7%	91.0%	40.2%	35.4%	60.2%	69.3%	66.4%	27.2%	42.1%	54.0%	96.8%	
	Cancer: Percentage of patients treated within 31 days	Debbie Needham	>=96%	Nat	↑		94.7%	97.5%	94.8%	96.5%	92.1%	94.1%	94.4%	94.5%	96.4%	95.5%	96.1%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	Debbie Needham	>=98%	Nat	↑		96.7%	100.0%	100.0%	100.0%	98.9%	100.0%	94.6%	100.0%	99.0%	98.5%	98.7%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	Debbie Needham	>=94%	Nat	↑		95.6%	95.7%	96.6%	94.8%	97.9%	97.9%	95.0%	96.1%	97.7%	91.5%	98.2%	
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	Debbie Needham	>=94%	Nat	↑		88.8%	86.6%	93.7%	93.7%	80.0%	100.0%	86.6%	90.0%	100.0%	90.9%	94.1%	

Northampton General Hospital NHS
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Corporate Scorecard 2019/2020 AUG

	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	Debbie Needham	>=85%	Nat			81.4%	85.4%	76.0%	80.0%	71.1%	74.0%	70.6%	70.0%	69.8%	77.5%	75.2%	
	Cancer: Percentage of patients treated within 62 days of referral from screening	Debbie Needham	>=90%	Nat			100.0%	83.8%	100.0%	81.8%	90.4%	100.0%	100.0%	90.0%	95.8%	66.6%	100.0%	
	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	Debbie Needham	>=85%	Nat			79.0%	85.7%	83.6%	89.1%	84.0%	80.0%	92.5%	80.5%	88.2%	88.5%	47.5%	
	RTT waiting times incomplete pathways	Debbie Needham	>=92%	Nat			80.3%	81.5%	82.1%	81.5%	81.6%	80.7%	80.0%	79.0%	80.6%	82.5%	82.5%	No Longer Reported
	RTT over 52 weeks	Debbie Needham	=0	Nat			0	0	0	0	1	3	1	0	1	0	0	
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	Debbie Needham	>=99.1%	Nat			99.9%	99.8%	99.9%	99.7%	100.0%	99.4%	99.3%	96.8%	96.4%	94.1%	93.7%	95.9%
	Stroke patients spending at least 90% of their time on the stroke unit	Debbie Needham	>=80%				92.7%	94.8%	95.6%	100.0%	79.6%	66.2%	75.4%	96.6%	93.7%	74.5%	83.3%	64.2%
	Suspected stroke patients given a CT within 1 hour of arrival	Debbie Needham	>=50%				95.0%	97.9%	95.0%	95.3%	89.3%	82.4%	92.3%	98.1%	90.6%	90.9%	91.8%	85.7%
	Unappointed Follow Ups	Debbie Needham	=0	NGH							8,608	8,723	9,957	10,119	10,363	10,385	9,670	9,801
Well Led	Bank & Agency / Pay %	Janine Brennan	<=7.5%	NGH			12.4%	12.4%	12.3%	12.3%	12.4%	12.4%	12.6%	12.7%	13.2%	15.2%	15.7%	15.9%
	Sickness Rate	Janine Brennan	<=3.8%	NGH			4.2%	4.0%	4.0%	4.4%	4.9%	4.7%	4.0%	4.2%	4.2%	4.5%	4.3%	4.6%
	Staff: Trust level vacancy rate - All	Janine Brennan	<=9%	NGH			11.1%	10.4%	10.3%	12.5%	11.8%	11.0%	11.2%	12.3%	12.0%	12.1%	12.1%	12.1%
	Staff: Trust level vacancy rate - Medical Staff	Janine Brennan	<=9%	NGH			9.4%	8.8%	9.0%	9.9%	9.1%	2.4%	3.2%	6.8%	7.2%	7.5%	7.9%	5.9%
	Staff: Trust level vacancy rate - Registered Nursing Staff	Janine Brennan	<=9%	NGH			7.4%	7.3%	7.5%	11.5%	11.2%	11.3%	11.2%	11.0%	11.1%	11.5%	12.2%	12.6%
	Staff: Trust level vacancy rate - Other Staff	Janine Brennan	<=9%	NGH			13.7%	12.8%	12.1%	13.5%	12.7%	12.5%	12.8%	14.0%	13.5%	13.4%	13.0%	13.2%
	Turnover Rate	Janine Brennan	<=10%	NGH			7.8%	7.7%	7.8%	8.3%	8.2%	8.9%	8.4%	8.4%	8.6%	8.6%	8.8%	8.9%
	Percentage of all trust staff with mandatory training compliance	Janine Brennan	>=85%	NGH			88.6%	87.8%	88.2%	88.5%	88.7%	88.5%	88.6%	89.2%	89.4%	89.4%	No data submitted	88.8%
	Percentage of all trust staff with mandatory refresher fire training compliance	Janine Brennan	>=85%	NGH					81.9%	82.8%	82.0%	81.9%	82.7%	83.6%	84.4%	84.5%	No data submitted	84.8%
	Percentage of all trust staff with role specific training compliance	Janine Brennan	>=85%	NGH			82.1%	81.9%	82.5%	83.0%	83.2%	83.7%	83.8%	83.8%	84.1%	84.4%	No data submitted	83.7%
	Percentage of staff with annual appraisal	Janine Brennan	>=85%	NGH			84.5%	83.1%	83.5%	81.6%	83.6%	84.5%	86.4%	84.5%	84.7%	85.0%	No data submitted	83.3%
	Job plans progressed to stage 2 sign-off	Matt Metcalfe	>=90%	NGH			12.5%	15.1%	27.5%	24.2%	28.6%	30.9%	37.8%	37.1%	46.4%	44.1%	53.6%	53.2%
	Income YTD (£000's)	Phil Bradley	>=0	NGH			(2,627) Adv	(3,337) Adv	(2,957) Adv	(3,550) Adv	(3,093) Adv	(3,256) Adv	(2,887) Adv	(985) Adv	(1,358) Adv	(600) Adv	(1,333) Adv	(1,309) Adv
	Surplus / Deficit YTD (£000's)	Phil Bradley	>=0	NGH			392 Fav	57 Fav	97 Fav	(432) Adv	(460) Adv	(761) Adv	(2,512) Adv	(1,477) Adv	(2,949) Adv	(3,321) Adv	(5,036) Adv	(6,228) Adv
	Pay YTD (£000's)	Phil Bradley	>=0	NGH			(2,967) Adv	(3,221) Adv	(3,277) Adv	(3,165) Adv	(3,614) Adv	(3,901) Adv	(4,623) Adv	(1,021) Adv	(1,978) Adv	(2,786) Adv	(3,599) Adv	(4,270) Adv

Northampton General Hospital NHS
NHS Trust

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	Non Pay YTD (£000's)	Phil Bradley	>=0	NGH			3,819 Fav	4,246 Fav	4,204 Fav	4,612 Fav	5,088 Fav	5,232 Fav	5,437 Fav	407 Fav	474 Fav	67 Fav	217 Fav	4 Fav
	Salary Overpayments - Number YTD	Phil Bradley	=0	NGH			128	153	167	195	209	230	266	55	34	57	72	92
	Salary Overpayments - Value YTD (£000's)	Phil Bradley	=0	NGH			260.9	313.1	340.9	371.9	392.3	454.4	509.2	156.6	86.4	156.8	183.8	232.3
	CIP Performance YTD (£000's)	Phil Bradley	>=0	NGH			1,833 Fav	1,704 Fav	1,821 Fav	1,554 Fav	2,030 Fav	1,458 Fav	1,458 Fav	246 Fav	686 Fav	1,147 Fav	570 Fav	No data submitted
	CIP Performance - Recurrent	Phil Bradley	-	NGH						64.5%	65.9%	65.5%	69.0%	39.0%	39.9%	42.2%	43.1%	No data submitted
	CIP Performance - Non Recurrent	Phil Bradley	-	NGH						39.1%	40.4%	41.0%	41.0%	42.8%	38.7%	39.6%	41.7%	No data submitted
	Maverick Transactions	Phil Bradley	=0	NGH						15	21	21	19	18	18	22	27	19
	Waivers which have breached	Phil Bradley	=0	NGH						1	0	0	0	4	1	2	1	2
Effective	Stranded Patients (ave.) as % of bed base	Debbie Needham	<=40%	NGH			57.6%	54.1%	54.4%	54.7%	58.0%	57.0%	55.3%	60.4%	62.0%	59.6%	55.6%	57.9%
	Super Stranded Patients (ave.) as % of bed base	Debbie Needham	<=25%	NGH			26.1%	23.7%	23.1%	23.1%	23.8%	21.6%	22.0%	27.9%	29.6%	26.3%	23.6%	25.3%
	Length of stay - All	Debbie Needham	<=4.2	NGH			4.4	4.6	4.4	4.2	4.8	4.7	4.8	4.3	4.7	4.4	4.6	4.4
	Percentage of discharges before midday	Debbie Needham	>25%	NGH			17.8%	18.6%	17.4%	19.1%	18.3%	17.2%	18.2%	17.4%	16.8%	16.3%	16.7%	16.9%
	Readmissions within 30 days of previous reporting month	Matt Metcalfe	<=12%												7.7%	15.1%	8.0%	13.0%
	# NoF - Fit patients operated on within 36 hours	Matt Metcalfe	>=80%				77.1%	84.6%	82.7%	100.0%	86.4%	81.8%	90.9%	83.3%	92.0%	83.7%	90.4%	85.1%
	Maternity: C Section Rates	Matt Metcalfe	<29%				28.9%	31.4%	31.3%	32.1%	32.3%	27.2%	36.0%	28.1%	33.3%	27.1%	30.6%	28.7%
	Mortality: HSMR	Matt Metcalfe	100	Nat			104	106	106	106	105	106	104	103	104	105	0	102
	Mortality: SHMI	Matt Metcalfe	100	Nat			100	100	104	104	104	104	104	104	100	100	100	99
	Patient Ward Moves Overnight (22:00 - 06:59)		=0											738	817	830	851	334
	% Daycase Rate		>=80%											81.2%	82.6%	83.0%	81.1%	83.5%
	Failed Daycases as a % of Planned Daycases		-											1.8%	2.6%	2.6%	2.6%	2.4%
Safe	Transfers: Patients transferred out of hours (between 10pm and 7am)	Debbie Needham	<=60	NGH			47	66	36	35	53	51	35	35	35	17	No data submitted	22
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	Debbie Needham	>=98%	NGH			95.7%	96.9%	97.2%	91.4%	98.1%	96.0%	100.0%	100.0%	100.0%	100.0%	No data submitted	100.0%
	Never event incidence	Matt Metcalfe	=0	NGH			0	1	0	0	0	0	0	0	0	0	1	0
	Number of Serious Incidents (SI's) declared during the period	Matt Metcalfe	0				3	0	0	3	7	1	0	0	2	3	7	2

Northampton General Hospital NHS
NHS Trust

Corporate Scorecard 2019/2020 AUG

	VTE Risk Assessment	Matt Metcalfe	>=95%			95.7%	95.7%	95.4%	95.3%	95.9%	95.0%	95.1%	95.4%	95.4%	95.1%	95.1%	92.5%
	MRSA > 2 Days	Sheran Oke	=0	Nat		0	0	0	0	0	0	0	0	0	0	0	0
	HOHA and COHA (C-Diff > 2 Days)	Sheran Oke	<=4	Nat		2	0	0	1	0	0	0	2	3	1	3	3
	MSSA > 2 Days	Sheran Oke	<=1.1	NGH		0	2	1	0	1	2	0	5	4	1	1	1
	New Harms	Sheran Oke	<=2%	NGH			2.11%	0.67%	0.99%	0.62%	0.15%	1.71%	1.59%	1.89%	1.44%	2.16%	1.19%
	Appointed Fire Wardens	Stuart Finn	>=85%	Nat					85.6%	88.1%	90.7%	91.2%	91.2%	91.2%	91.2%	No data submitted	95.6%
	Fire Drill Compliance	Stuart Finn	>=85%	Nat					62.0%	59.7%	56.7%	57.2%	53.0%	43.2%	41.2%	No data submitted	55.9%
	Fire Evacuation Plan	Stuart Finn	>=85%	Nat					89.2%	89.2%	67.5%	72.6%	70.6%	68.5%	66.4%	No data submitted	51.0%

No data submitted — Data not provided

No data - pre KPI implementation

Northampton General Hospital NHS
NHS Trust

Northampton General Hospital NHS Trust

Corporate Scorecard

Delivering for patients:

2019/20
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.

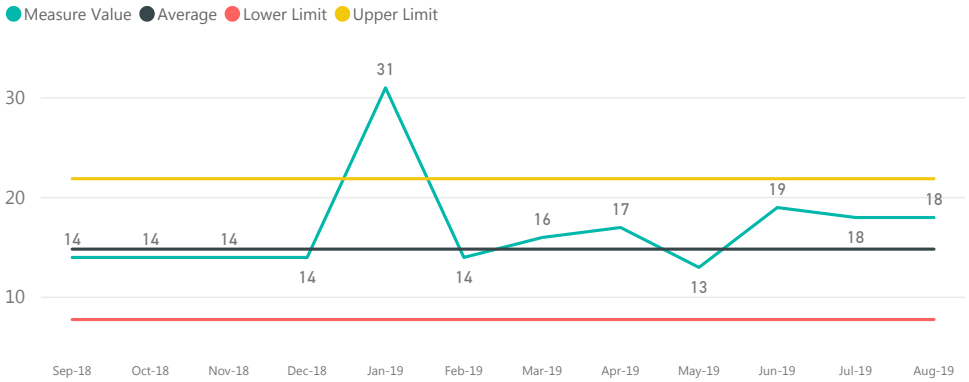
The domains identified within are: Caring, Responsiveness, Effective, Well Led, Safe and Finance, many items within each area were provided within the TDA Framework with a further number of in-house metrics identified from our previous quality scorecard which were considered important to continue monitoring.

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

Average Ambulance handover times

August 2019	Target	Actual	Direction of Travel	Accountable Executive
	00:15	00:18	⇔	Debbie Needham

Performance vs Target



Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
00:14	00:14	00:14	00:14	00:31	00:14	00:16	00:17	00:13	00:19	00:18	00:18

What is driving under performance?

The average handover of 18 minutes is sustained against last months. Despite not reaching the target of <15 minutes the Emergency Department is affected by the internal flow constraints of the organisation. This results in a cluttered department with minimal space available to off load within the required timeframe. Batching of ambulances continues to be an issue, EMAS and collaboration working to see how to address this, alongside enhanced communication regarding County wide demands, to allow NGH to be aware.

Actions completed in the past month to achieve recovery

Internal escalation process working well. Internal flow and a constrained department means off load average remains slightly elevated.

Timeframe for recovery

October 2019

Next steps

EMAS to visit site to understand NGH constraints and impact of Ambulance arrivals - how we can collaborate to improve. To discuss large volume of 'Tech' only crews which elevated conveyance rates

Exception report written by

LoasbyJ

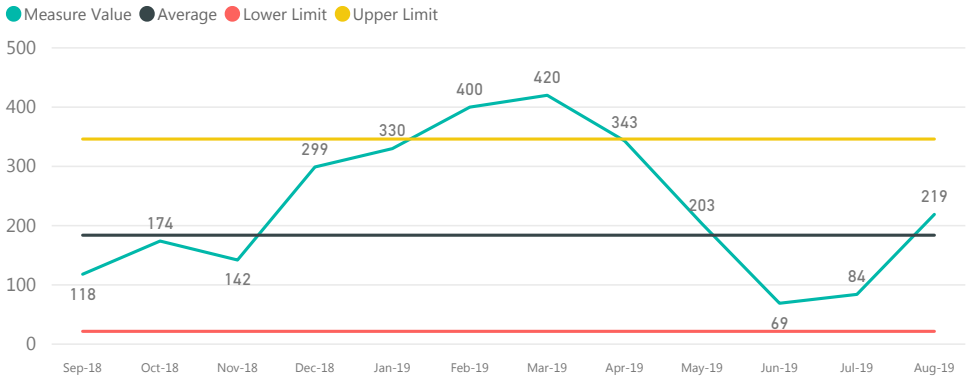
Assurance Committee

Directorate Management Board

Ambulance handovers that waited over 30 mins and less than 60 mins

August 2019	Target	Actual	Direction of Travel	Accountable Executive
	25	219	↓	Debbie Needham

Performance vs Target



Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
118	174	142	299	330	400	420	343	203	69	84	219

What is driving under performance?

Increase in volume of ambulances waiting longer than 30 minutes and less than 60 minutes. Main driver for this is the internal flow constraints and demand across the organisation. Previous months saw a significant reduction on the overall number. August has been a challenging and demanding month for the organisation. With sustained activity the department has become regularly space constrained, leading to increase in ambulance waiting longer than 30 minutes.

Actions completed in the past month to achieve recovery

Quality manager from EMAS visiting in September to understand issues from NGH perspective.

Timeframe for recovery

September 2019

Next steps

Continue to highlight other pathways to be accessed and not just conveyance to ED - collaborative with EMAS and KGH.

Exception report written by

LoasbyJ

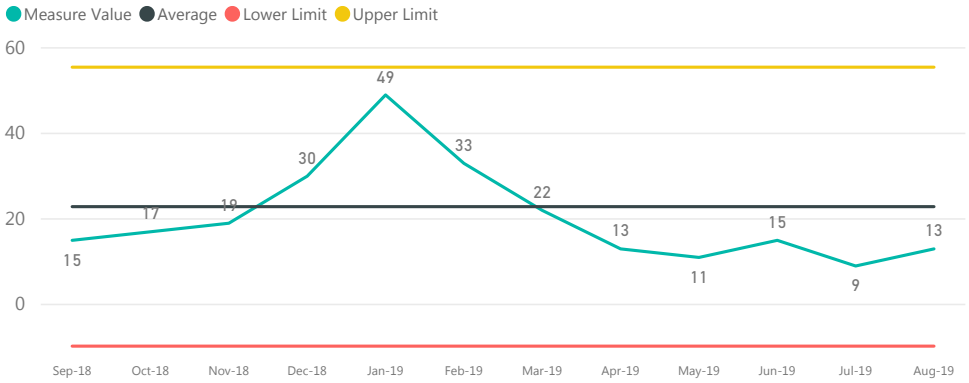
Assurance Committee

Directorate Management Board

Ambulance handovers that waited over 60 mins

August 2019	Target	Actual	Direction of Travel	Accountable Executive
	10	13	↓	Debbie Needham

Performance vs Target



Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
15	17	19	30	49	33	22	13	11	15	9	13

What is driving under performance?

An increase of 4 from previous month (13 for month). The increase in ambulance delays whilst disappointing to note the increase, is as a result of a internal flow within the organisation and inability to offload ambulances within the required timeframe. Ambulance batching and clearing has been a reoccurring constraint. This has been highlighted to and escalated to EMAS, alongside the number of 'Tech' only crews.

Actions completed in the past month to achieve recovery

Escalation of ambulance delays - internal escalation process followed.

Timeframe for recovery

September 2019

Next steps

Collaboration with EMAS / KGH to decrease conveyance rates to secondary care.
Implementation of dashboard for Ambulance - IBOX

Exception report written by

LoasbyJ

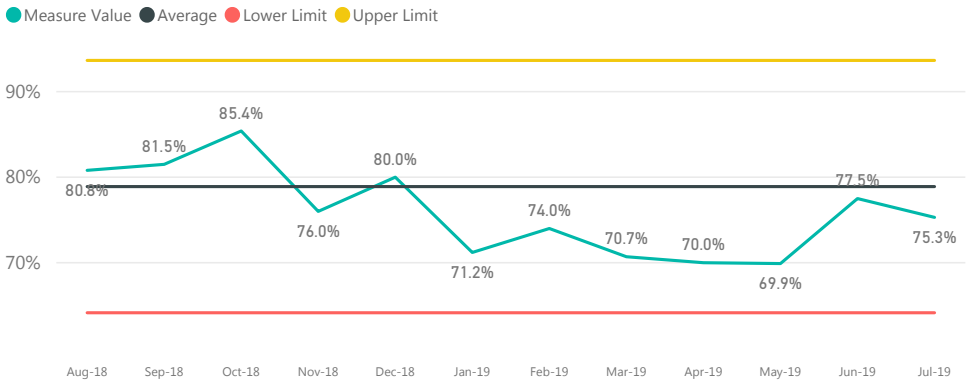
Assurance Committee

Directorate Management Board

Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers

July 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	85.0 %	75.3 %	↓	Debbie Needham

Performance vs Target



Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
80.8 %	81.5 %	85.4 %	76.0 %	80.0 %	71.2 %	74.0 %	70.7 %	70.0 %	69.9 %	77.5 %	75.3 %

What is driving under performance?

The Trust has reached 75.3% against the 85% required for 62 day performance.. Breast, Skin and Gynaecology all achieved the 62 day standard for July. The Trust undertook 137.5 treatments which is unprecedented, however 34 of these breached the standard, again the highest number the Trust have ever seen leading to the performance of 75.3%. It should be noted however that the 62 day performance is now on an upward trajectory from the beginning of this year.

Actions completed in the past month to achieve recovery

Daily ptl meeting now focuses on day 31 in the pathway services asked to complete narrative on what they need to deliver cancer to feed into cancer management team paper to the executive board Urology and Lung progressing with national pathway improvements. Colorectal exploring expanding straight to test further. Audit underway in 2ww office to survey patients referred on pathway and understand conversations had with GP to understand patient engagement issues and feedback to the CCG

Exception report written by

BuckleyS

Next steps

Finalise and share job description with all tumour site leads in order to highlight role expectations and secure buy in. Further develop paper to executive board Continue with national pathway re-designs Rollout cancer dashboard finalise cancer strategy

Timeframe for recovery

November 2019

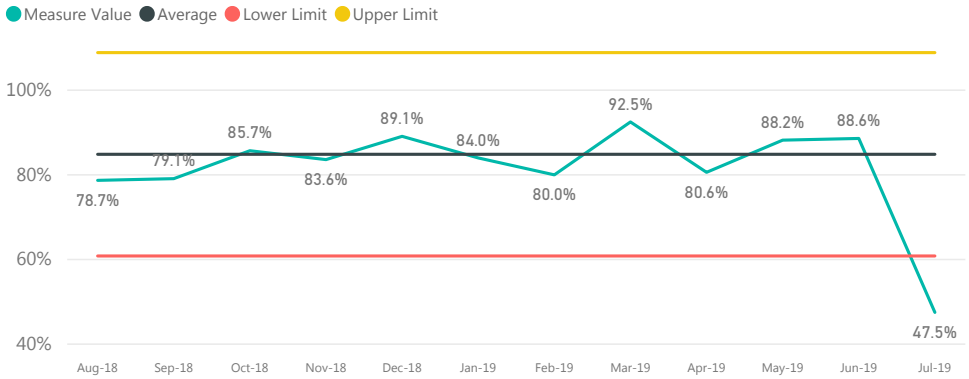
Assurance Committee

Finance Investment and Performance Committee

Cancer: Percentage of patients treated within 62 days of Consultant Upgrade

July 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	85.0 %	47.5 %	↓	Debbie Needham

Performance vs Target



Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
78.7 %	79.1 %	85.7 %	83.6 %	89.1 %	84.0 %	80.0 %	92.5 %	80.6 %	88.2 %	88.6 %	47.5 %

What is driving under performance?

The did not achieve the 62 day consultant upgrade standard in July reaching 47.5% against the local standard of 85%, this is not reported nationally. 9.5 breaches in total. 7 in Lung, themes include patient fitness, patient delays, turnaround times at UHL for tumour marker results awaited from UHL and diagnostic waits. 1 in haematology referred from breast due to patient choice and fitness, 1 in Upper GI due to patient choice and 1 in gynaecology due to fitness.

Actions completed in the past month to achieve recovery

Continued work on the National Optimal Lung pathway as the bulk of the breaches sit within this speciality and should be resolved with these intended improvements

Exception report written by

BuckleyS

Timeframe for recovery

September 2019

Assurance Committee

Finance Investment and Performance Committee

Next steps

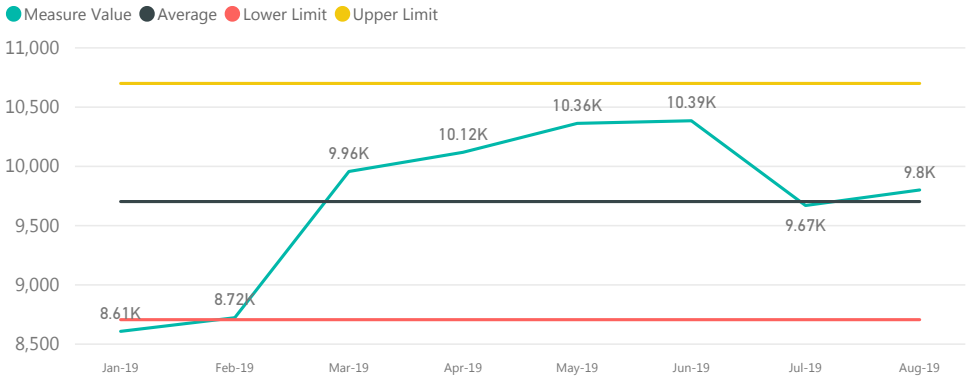
The work on the national optimal lung cancer pathway should improve performance for lung patients which includes repatriating histology from UHL to NGH and reducing diagnostic waits. Patient choice and fitness issues will always be challenging but should fall into the 15% allowance within the target if the issues we can control are resolved by pathway changes.

Unappointed Follow Ups

August 2019

Target	Actual	Direction of Travel	Accountable Executive
0	9801	↓	Debbie Needham

Performance vs Target



Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
8608	8723	9957	10119	10363	10385	9670	9801

What is driving under performance?

• 4 specialties (Cardiology, ENT, Ophthalmology and Urology) have the largest issues with un-appointed follow ups totalling 4,186 patients >10 weeks • Whilst have seen a reduction of almost 500 patients compared to Junes figures the number has increased in August • The largest fall is in the longest waiters due to the risk stratification tool being utilised by specialties • Ophthalmology is a recognised national problem with issues of follow up capacity and this issues is being managed via the CCG for both NGH and KGH

Actions completed in the past month to achieve recovery

• All 4 above specialties have provided rectification plans to resolve the issue and this was presented to QGC in July • Patients all risk stratified to a standard protocol across Northamptonshire and additional capacity bought on line to have patients reviewed. Any evidence of harm identified from the appointment is captured and reported to the review of harm group and the CCG • All areas to continue to validate their waiting lists to remove data issues • Additional capacity including virtual clinics esp in ENT developed to support the process • Admin shortages during the school summer holidays have been reported by directorates • The ongoing pension situation with Consultant staff has been little take up of additional activity to reduce the numbers of patients waiting

Timeframe for recovery

December 2019

Next steps

As per above this is a significant piece of work that will take 4-5 months to be resolved with extra admin and clinical support required during this time

Exception report written by

HollandC1

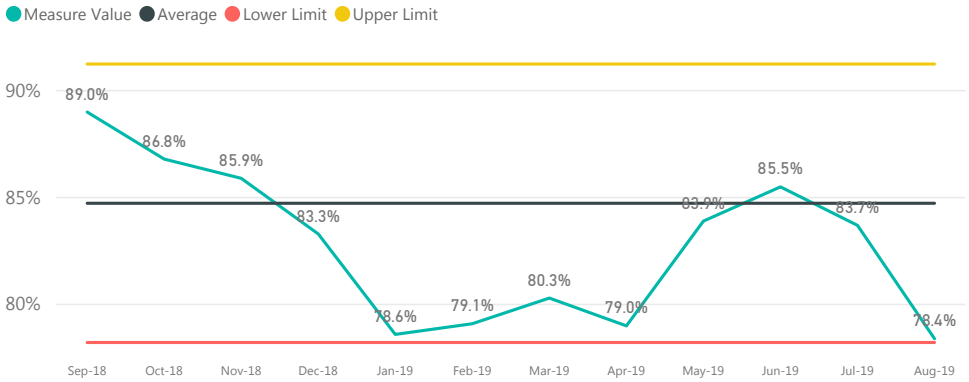
Assurance Committee

Finance Investment and Performance Committee

A&E: Proportion of patients spending less than 4 hours in A&E

August 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	90.1 %	78.4 %	↓	Debbie Needham

Performance vs Target



Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
89.0 %	86.8 %	85.9 %	83.3 %	78.6 %	79.1 %	80.3 %	79.0 %	83.9 %	85.5 %	83.7 %	78.4 %

What is driving under performance?

The month of August saw the percentage of achievement decrease to 78.4% against the 4 hour standard - this is subject to re-validation. August was a challenging month for internal capacity due to the demands on the hospital for patients requiring inpatient admittance, thus having an adverse effect on the Emergency Department leading to regular constraints with the throughput of patients. The month of August saw the changeover in Medical workforce and a welcome to new international Doctors into the Emergency Department. This changeover and new Doctors meant an increased reliance on supporting of clinical decisions by the Consultants, which at times lead to unavoidable delays. This was represented across many specialities and not unique to the Emergency department. Although department rotas were fully staffed, the skill mix and induction process led to demands on substantive staff.

Actions completed in the past month to achieve recovery

Emergency Department new starters have completed induction and now settled into working environment, which will lead to an increase in ability to see patients, as processes and documentation is now familiar. This has been achieved ahead of time as recruitment was anticipated not to be optimised until late August. Medical workforce rota has been reviewed and optimised with current staffing establishment. Demands for Mental Health support and review to be discussed and for plans out be developed to improve alongside NHFT.

Exception report written by

LoasbyJ

Timeframe for recovery

September 2019

Assurance Committee

Finance Investment and Performance Committee

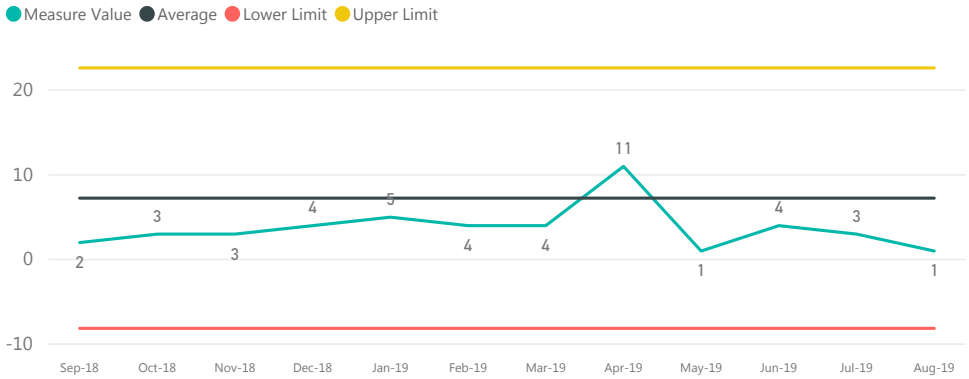
Next steps

Development of training and supporting overseas appointments within the department. Collaboration with EMAS to highlight community pathways available and use of ACC to reduce conveyance rates to the Emergency Department. Rapid transfer and identification of patients suitable for Nye Bevan to decongest Emergency Department. ACC/SEDC - Long term development plan in progress of being developed to support reduction of patients attending ED. Continue the support of Streaming and Majors Lite projects.

Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons

August 2019	Target	Actual	Direction of Travel	Accountable Executive
	0	1	↑	Debbie Needham

Performance vs Target



Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
2	3	3	4	5	4	4	11	1	4	3	1

What is driving under performance?

1 ophthalmology patient not treated within 28 days of original cancellation. Specialist lens required was not available on the original date (company had said it would be) and was not available for following 6 weeks.

Actions completed in the past month to achieve recovery

Team reviewed whether they should only book operation dates when specialist lenses receipted. The previous 10 lenses ordered all arrived as specified. Therefore team felt this was potentially a one-off incident and as the mitigation would delay treatment for all specialist lens orders it should not be implemented.

Timeframe for recovery

September 2019

Next steps

No additional steps

Exception report written by

TuckerMR

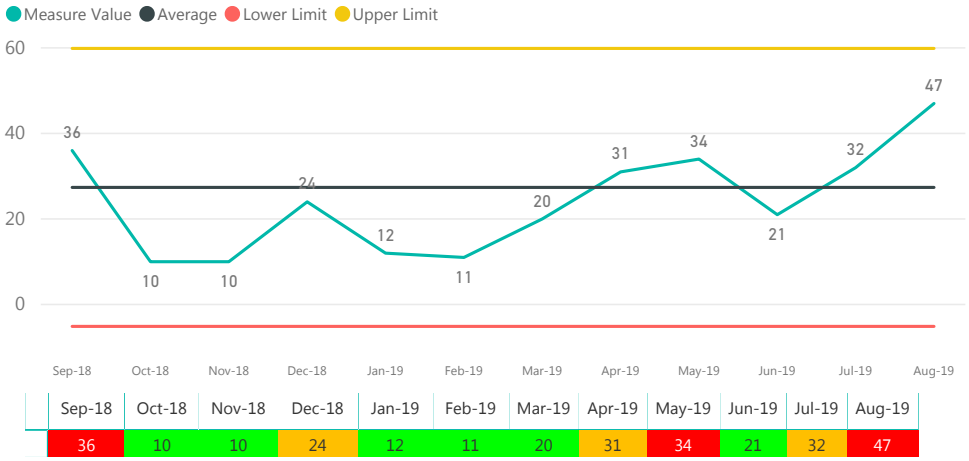
Assurance Committee

Finance Investment and Performance Committee

Delayed transfer of care

August 2019	Target	Actual	Direction of Travel	Accountable Executive
	23	47	↓	Debbie Needham

Performance vs Target



Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
36	10	10	24	12	11	20	31	34	21	32	47

What is driving under performance?

Decline in supported discharges Not enough interim placements to support Trusted Assessor Discharge Pathway Delays in early submission of PDNA's from Wards PDNA's requiring checking Increase in patient requiring CRT/DTA with limited capacity to support Lack of urgency with supported discharges Lack of urgency from Wards progressing discharge High numbers of Stranded patients More Discharge staff required Patients being treated for unrelated conditions being referred to other specialities General risk averseness, holding patients longer than required

Actions completed in the past month to achieve recovery

Transformation Nous currently working with the Trust to look at discharges and processes New work streams being launched to address internal concerns including: • Joint working • Supported discharges Recruitment of Housing officer, Discharge Coordinators currently completing further competencies to support Ward Staff IBOX being rolled out to provide an accurate DTOC recording system, Stranded Review Meetings being relaunched to support NHSI/E and provide a Patient Tracker Patients waiting DTR with CRT are being considered for SSC or Southfield's with both external managements Social Services supporting twice weekly Tracking Meetings to support flow and identify any delays

Timeframe for recovery

September 2019

Exception report written by

CrockettG

Assurance Committee

Finance Investment and Performance Committee

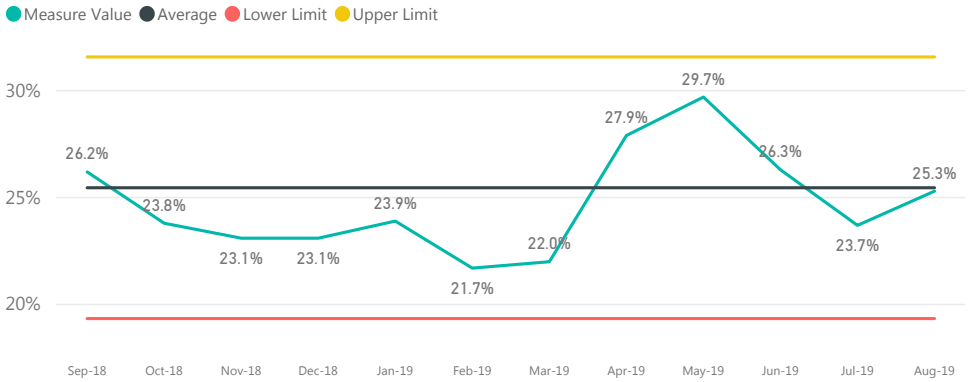
Next steps

Launch of Project Teams/Work Streams based on information gathered form Transformational Nous Continue to recruit Discharge Coordinators Request continued support from ICT to help review patients on Rehab lists Await commencement of new Housing Officer and Age UK to be appointed Further work on Stranded Meetings, devise a SOP

Super Stranded Patients (ave.) as % of bed base

August 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	25.0 %	25.3 %	↓	Debbie Needham

Performance vs Target



Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
26.2 %	23.8 %	23.1 %	23.1 %	23.9 %	21.7 %	22.0 %	27.9 %	29.7 %	26.3 %	23.7 %	25.3 %

What is driving under performance?

Increased numbers of stroke, NOF and high acuity will directly impact on the number of stranded patients and super stranded as they are dependent on community support for discharge

Actions completed in the past month to achieve recovery

Increased scrutiny around do patients have active treatment plan who is actioning it. Ward staff come directly to site and highlight any delays and issues, daily assurances sought that patients have had a senior decision maker review.

Exception report written by

CrockettG

Timeframe for recovery

September 2019

Assurance Committee

Finance Investment and Performance Committee

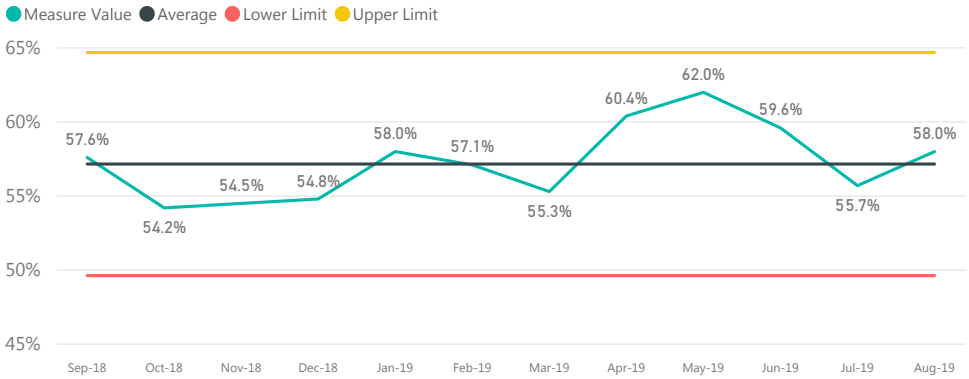
Next steps

As part of the HEAT programme the stranded has a specific focus and plan of work to reduce the number of patients between 7-20 days. also as per above - a trajectory to reduce this number is being set

Stranded Patients (ave.) as % of bed base

August 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	40.0 %	58.0 %	↓	Debbie Needham

Performance vs Target



Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
57.6 %	54.2 %	54.5 %	54.8 %	58.0 %	57.1 %	55.3 %	60.4 %	62.0 %	59.6 %	55.7 %	58.0 %

What is driving under performance?

Increased numbers of stroke, NOF and high acuity will directly impact on the number of stranded patients and super stranded as they are dependent on community support for discharge

Actions completed in the past month to achieve recovery

Increased scrutiny around do patients have active treatment plan who is actioning it. Ward staff come directly to site and highlight any delays and issues, daily assurances sought that patients have had a senior decision maker review.

Exception report written by

CrockettG

Timeframe for recovery

September 2019

Assurance Committee

Finance Investment and Performance Committee

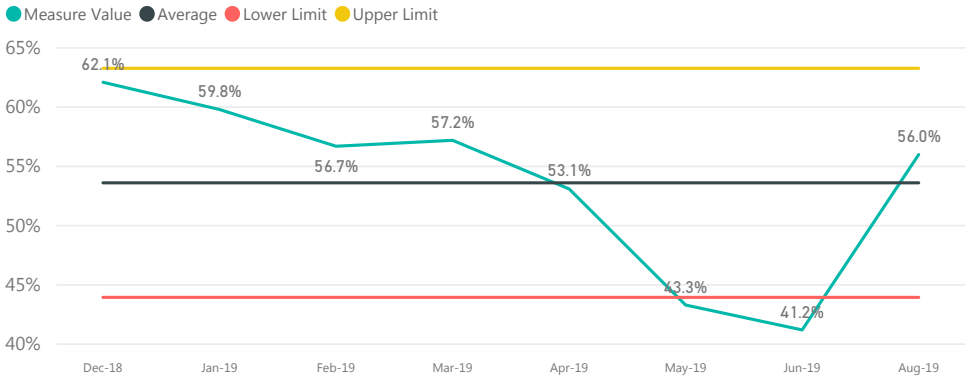
Next steps

As part of the HEAT programme the stranded has a specific focus and plan of work to reduce the number of patients between 7-20 days. also as per above - a trajectory to reduce this number is being set

Fire Drill Compliance

August 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	85.0 %	56.0 %	↑	Stuart Finn

Performance vs Target



Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Aug-19
62.1 %	59.8 %	56.7 %	57.2 %	53.1 %	43.3 %	41.2 %	56.0 %

What is driving under performance?

Previously, Fire activations were recorded as Fire Drills, however with the issues around fire safety and a new Fire Safety Team, we have reviewed what we consider to be a fire drill and the way we record their results. With a change in emphasis that means a fire drill is just that and a clear focus on safety and quality of delivery, there has been a drop in completed drills, however the quality of our support has been extensive and we are not just completing a tick box exercise. We do believe that the number of drills has bottomed out as there has been 15% increase in completed drills over the last 2 months.

Actions completed in the past month to achieve recovery

Additional support from the Fire Safety Team. We have positively encouraged departments to contact us where we can give additional support and provide training and assist them with their fire drills. This is done by direct contact, Fire Refreshers, Inductions and other training sessions such as ROK

Exception report written by

StewartJ

Timeframe for recovery

September 2019

Assurance Committee

Finance Investment and Performance Committee

Next steps

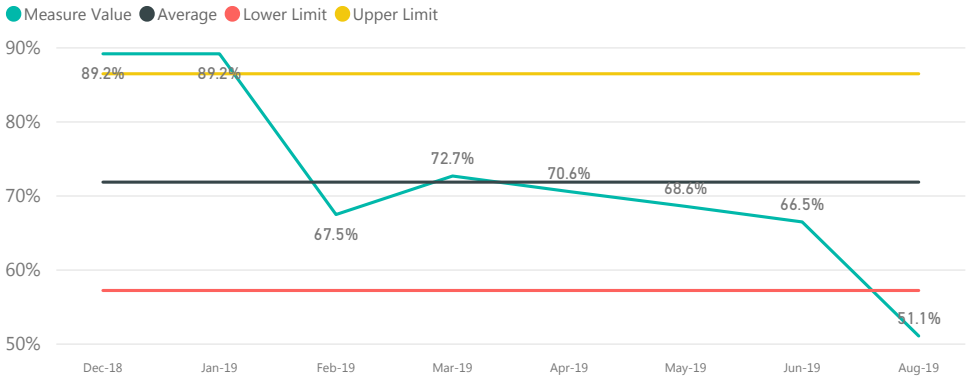
Continue to encourage departments to contact us to enable our theme of quality with support. Continue to encourage Divisional and Department Managers to take a pro-active approach to fire safety and Fire Drills in particular.

Fire Evacuation Plan

August 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
85.0 %	51.1 %	↑	Stuart Finn

Performance vs Target



Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Aug-19
89.2 %	89.2 %	67.5 %	72.7 %	70.6 %	68.6 %	66.5 %	51.1 %

What is driving under performance?

The way in which we record the review of Fire Evacuation Drills has changed over the last 3 months following the setup of a new Fire Safety Team. The database in which we record statistical information has changed and provides a very accurate snapshot at any time. With a change in emphasis in our training strategy this year to provide high quality information and support to departments in helping them with their fire safety obligations. It is worrying that the number of Evacuation Drills being reviewed continues to fall.

Actions completed in the past month to achieve recovery

The Fire Safety Team will continue to offer support to all departments if they are unsure or unfamiliar with Fire Evacuation Plans. We will continue to positively encourage departments to contact us where we can give additional support and provide training and assist them with their evacuation plans. This is done by direct contact, Fire Refreshers, Inductions and other training sessions such as ROK

Exception report written by

StewartJ

Timeframe for recovery

January 2020

Assurance Committee

Finance Investment and Performance Committee

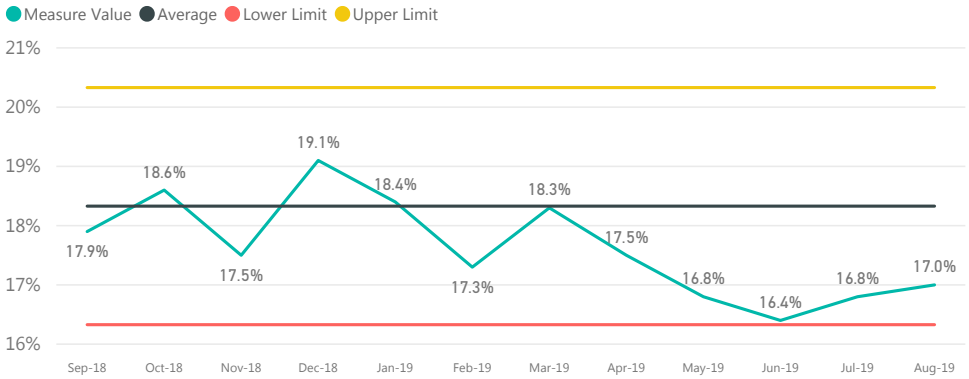
Next steps

Continue to encourage Divisional and Department Managers to take a pro-active approach to fire safety and Fire Evacuation Plans in particular. To get this area of compliance back to >85% this will need buy in from all managers.

Percentage of discharges before midday

August 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	25.0 %	17.0 %	↑	Debbie Needham

Performance vs Target



Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
17.9 %	18.6 %	17.5 %	19.1 %	18.4 %	17.3 %	18.3 %	17.5 %	16.8 %	16.4 %	16.8 %	17.0 %

What is driving under performance?

this has remained stable on 16%. One of the difficulties is that the time of discharge is not always reflected accurately as frequently staff are not entering the information on CAMis at point of discharge and several hours may elapse. Furthermore we are now having more discharges alter in the afternoon and evening due to the Nye Bevan developing into the assessment, short stay mdoel with a third board round occurring at 7pm which results in discharges whereas prior to these board rounds these patients were discharged first thing the flowing day.

Actions completed in the past month to achieve recovery

A significant focus of the transformation nous work has been around board rounds and EDD this will enable better discharge planning and associated increase in time of day of discharge. rate limiting step is EDNs and TTOs these are frequent drivers in delays to time of discharge.

Exception report written by

CrockettG

Next steps

TN work to be embedded. Workstream for EDNS and TTO is underway with some rapid trials on particular wards to be commenced in August.

Timeframe for recovery

September 2019

Assurance Committee

Finance Investment and Performance Committee

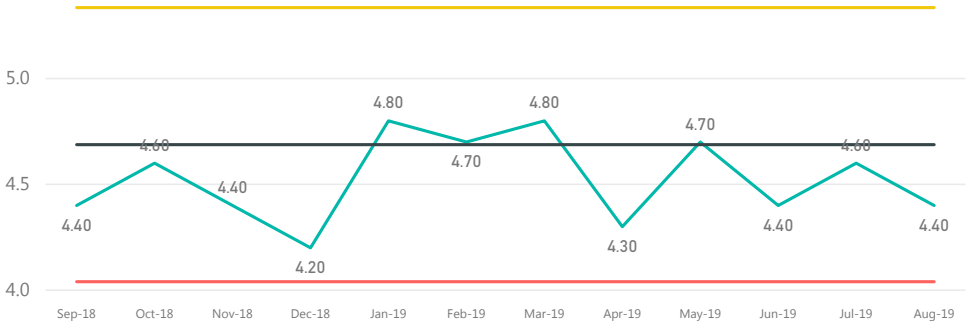
Length of stay - All

August 2019

Target	Actual	Direction of Travel	Accountable Executive
4.2	4.4	↑	Debbie Needham

Performance vs Target

Measure Value Average Lower Limit Upper Limit



Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
4.4	4.6	4.4	4.2	4.8	4.7	4.8	4.3	4.7	4.4	4.6	4.4

What is driving under performance?

slight increase in LOS from previous month 0.2%. This is related to acuity of patients, speciality demand and also number of patients waiting on external speciality supports.

Actions completed in the past month to achieve recovery

A significant focus has been on patients 7-20 days to ensure that we are not accepting any delays and doing everything within our internal remit to expedite discharges. This focus needs to be embedded across the organisation and driven by ward clnical staff to advocate and push for patients plans etc. Ward staff now attend site twice and day and advise of any potential and confirmed discharges and escalate any delays e.g. waiting on speciality input. alongside this there is a daily top 20 summit which has seen our longest length of stay patients to ensure they are continually monitored and actions completed .

Timeframe for recovery

September 2019

Next steps

Stroke pathway to be formally reviewed in light of number of patients waiting on community stroke beds, NOF pathway now has ICT actively pulling from the wards, cardiology demand remains high with outliers.

Exception report written by

CrockettG

Assurance Committee

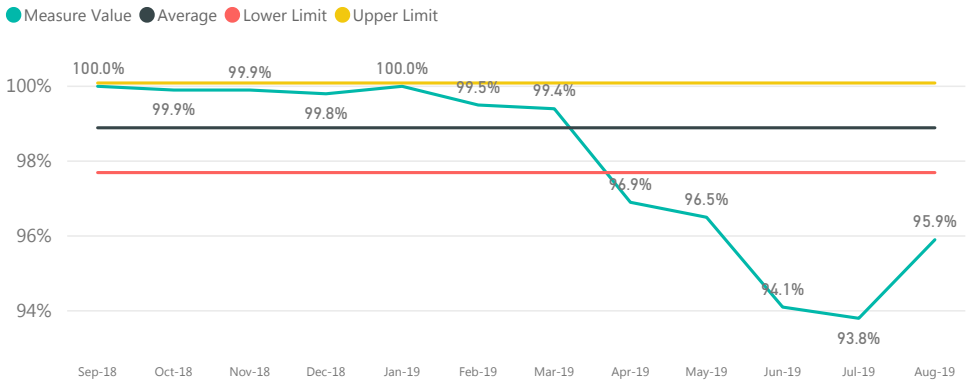
Finance Investment and Performance Committee

Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test

August 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
99.1 %	95.9 %	↑	Debbie Needham

Performance vs Target



Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
100.0 %	99.9 %	99.9 %	99.8 %	100.0 %	99.5 %	99.4 %	96.9 %	96.5 %	94.1 %	93.8 %	95.9 %

What is driving under performance?

• Huge improvement seen in the diagnostic position this month with an increase from 93.7% to 95.9% with 120 patients removed from the backlog and circa 170 left • Failure to achieve target due to Endoscopy and ongoing problems with the washers. Lists were lost due to washer failures and then lists lost when the new washers were commissioned and 'bedded in' resulting in 250 breaches • There have been 100 breaches in Cardiology due to the use of the heart centre over the winter to bed patients. As such we have been unable to get patients in within six week for key diagnostics cardiology tests. • It is expected to take 3 months to regain the diagnostics position • Increasing referral numbers via 2ww route and inpatient referrals have added to the backlog issues

Actions completed in the past month to achieve recovery

• Washers have been replaced and are now working normally • Outsourcing of Endoscopy activity of circa 250 patients to Blakelands to support the capacity gap. • Insourcing contract agreed to provide 4 weekend Endoscopy session a week • Additional lists are being provided in house where possible • Use of Heart Centre running additional diagnostics lists at the weekend • Full validation of all lists to ensure all breaches are accurate

Exception report written by

HollandC1

Next steps

Plan is to have the backlog cleared by the end of October

Timeframe for recovery

October 2019

Assurance Committee

Finance Investment and Performance Committee

Report To	**Trust Board**
Date of Meeting	**26 September 2019**

Title of the Report	**Workforce Performance Report**
Agenda item	**14**
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 an increase in sickness absence from August 2019.
- Decrease in compliance rate for Mandatory Training, Role Specific Essential Training and Appraisals.
- Update in respect of organisational development initiatives.

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 – 3.1, 3.2 and 3.3
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 Committee

The Committee is asked to Note the report.

1. People Capacity

Key Areas of Success

- A business case to recruit an additional 159 registered nurses during 2020/21 has been approved. In doing so the Trust will meet full establishment for nursing by August 2020 and thus eliminate the need for agency expenditure. A task and finish group has been established to manage the project.

Key Areas of Concern

- Sickness absence continues to be above Trust target of 3.8% for a period in excess of 12 months. The main driver for sickness absence is 'stress/anxiety/depression/other psychiatric illnesses. A new mental health service has been established within the Occupational Health team and mechanisms to monitor impact are under development.

Key Progress Update

- Further to the Consultation meetings with the users of the TRAC electronic recruitment system, an on-boarding survey has been completed to gain feedback on applicants' experience of the recruitment process for employees who started in June and July 2019. 53 responses were received out of 101 employees who were sent the survey. 8 specific questions were asked and the results were broadly 75% had a positive experience and 25% had a negative experience. In response to the findings of the on-boarding survey immediate actions have been implemented in relation to communication with candidates and ways to enhance the efficiency of the timeliness of recruitment. The on-boarding survey will continue to be carried out on a monthly basis and the results analysed on a quarterly basis.

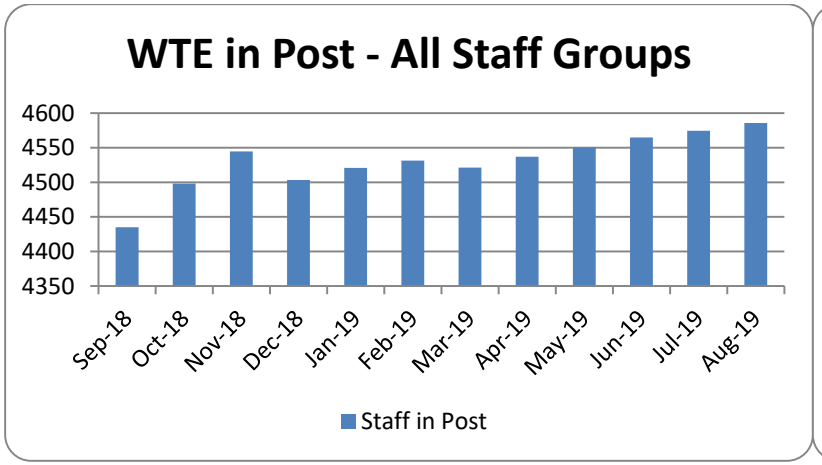
- A provisional launch date is being identified to occur within the next 4 to 6 weeks for the Patchwork system which will enable the Trust to advertise Bank shifts to medical staff via a mobile application. It is expected that this will reduce agency in favour of bank. The system is initially being rolled out in A&E and Medicine and then Trust wide two weeks later. Representatives from Patchwork will commence training for key stakeholder's week commencing 23 September 2019. Communications regarding the systems availability will be rolled out week commencing 23 September 2019. A full assessment of the benefits of the system will be undertaken towards the end of the three month free trial so that consideration can be given as to whether the system should be permanently implemented.

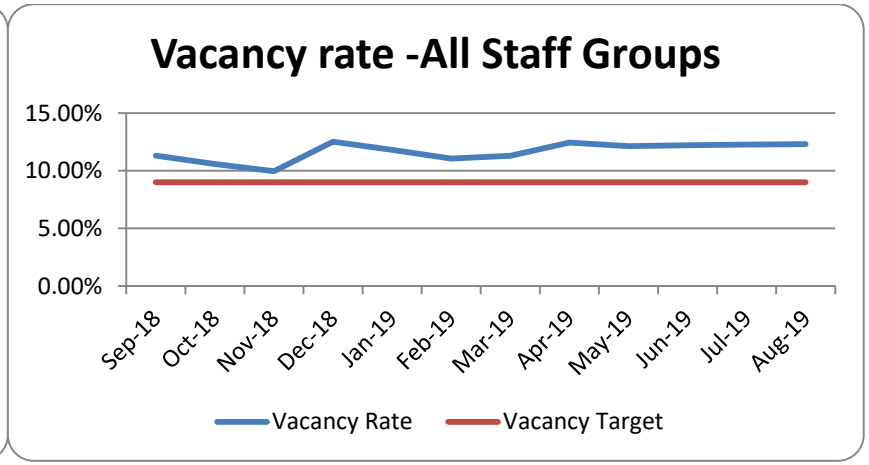
- The Trust has commenced involvement in cohort 5 of NHSIs nurse retention direct support programme. This will involve the development of an action plan over the next three months to address and reduce nurse turnover in conjunction with nursing colleagues and with support from NHSI.

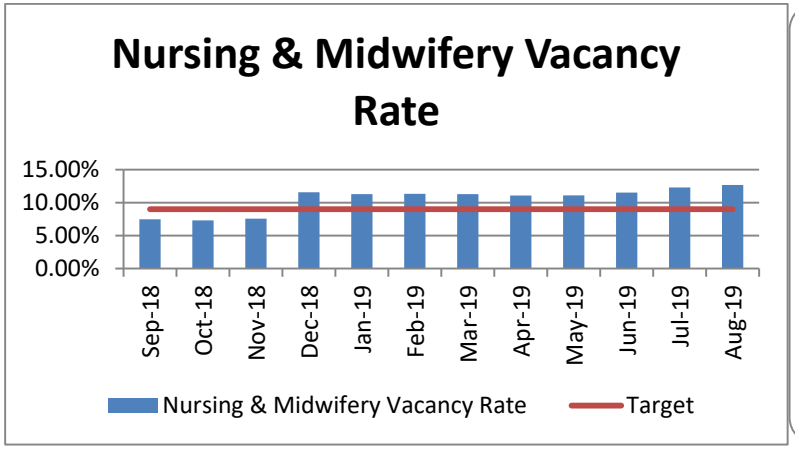
UNIVERSITY OF LEICESTER
Associate Teaching Hospital

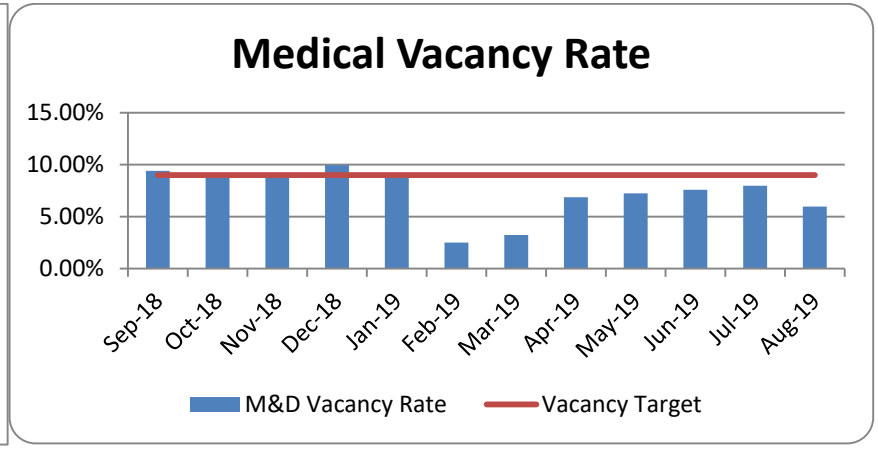
NHS
Northampton General Hospital
NHS Trust

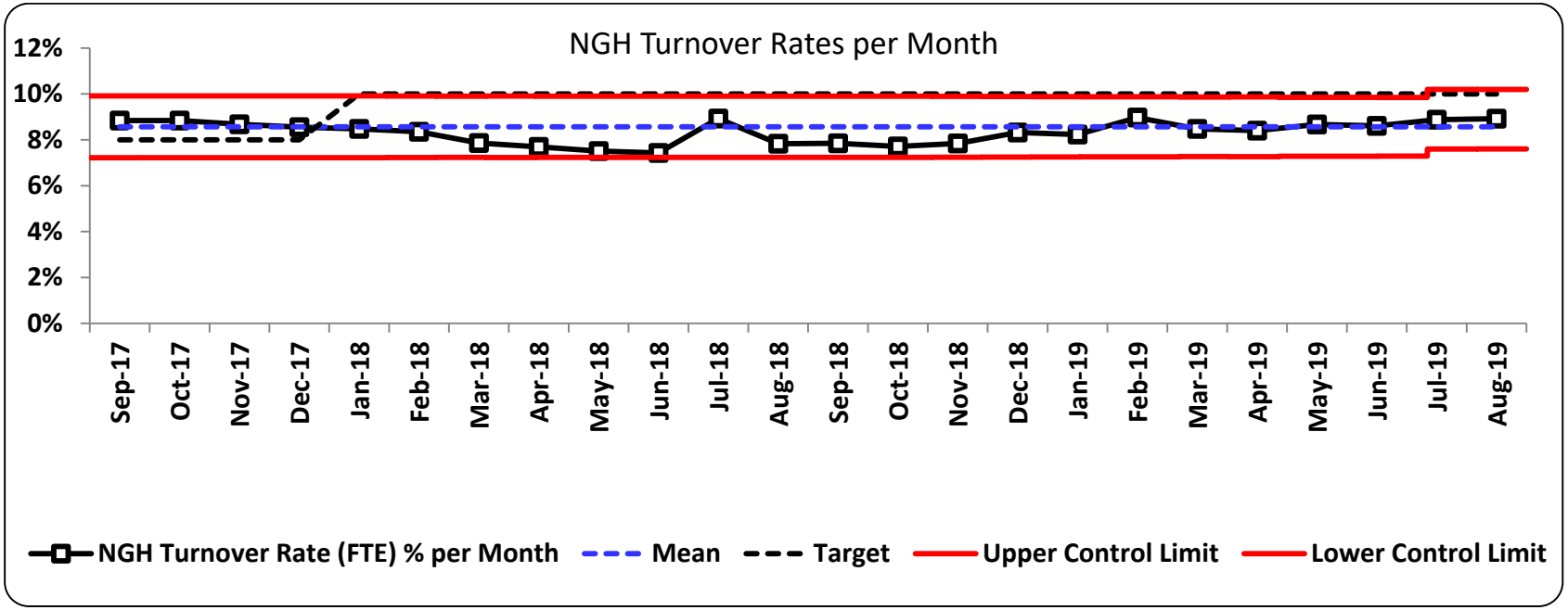
People Capacity





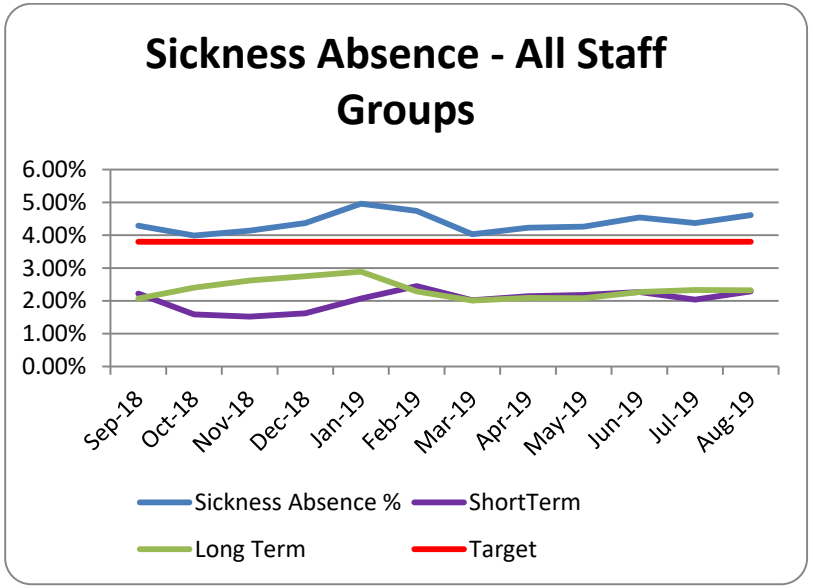


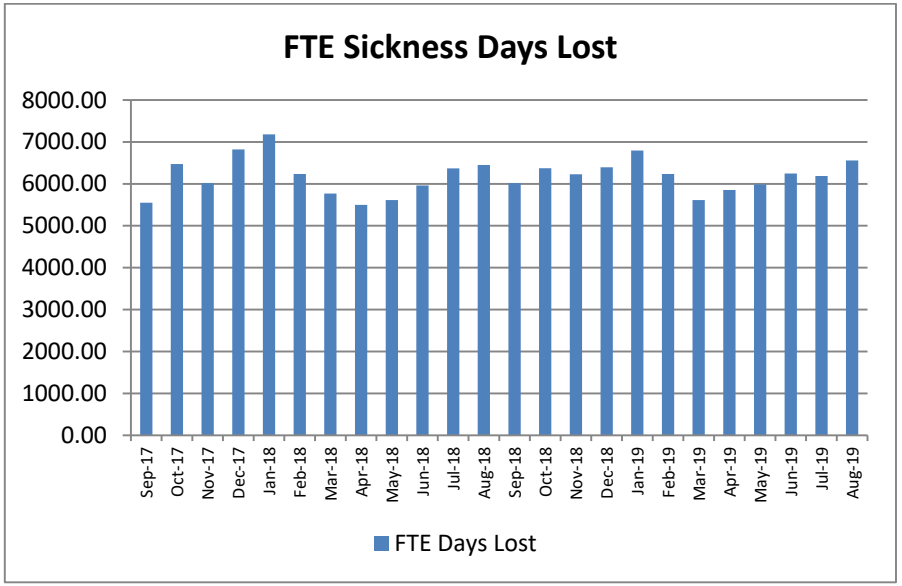




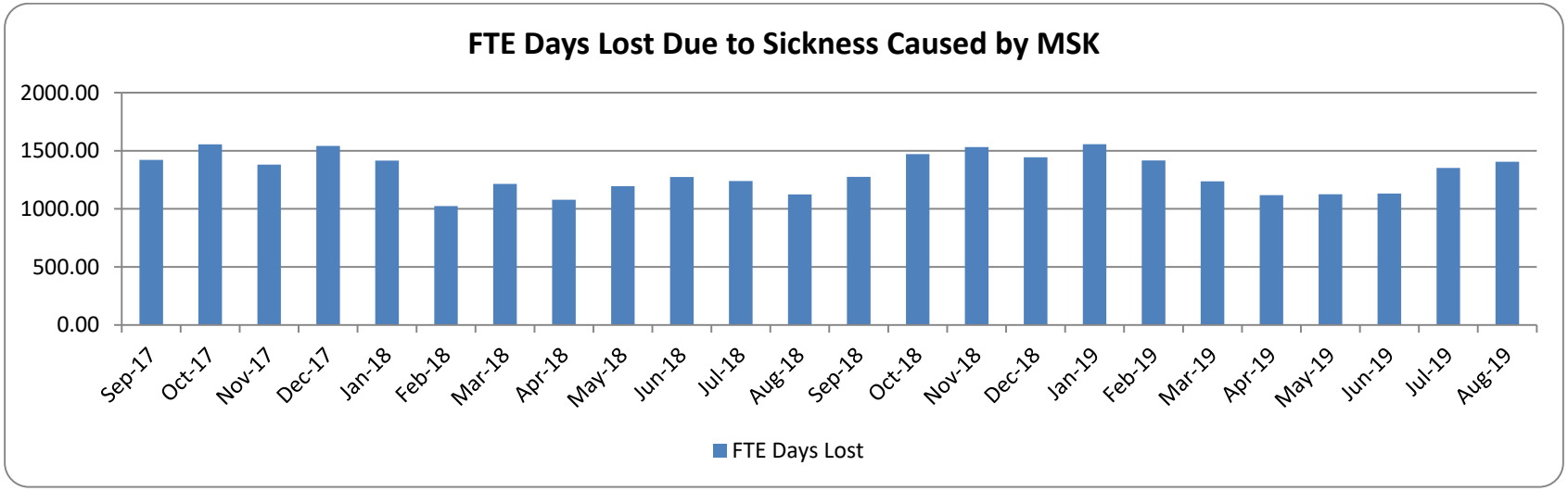
Trust-wide Reason for Resignation September 2018 - August 2019	WTE
Voluntary Resignation - Relocation	73.39
Retirement Age	57.45
Voluntary Resignation - Work Life Balance	52.16
Voluntary Resignation - Promotion	43.32
Voluntary Resignation - Other/Not Known	26.25
Voluntary Resignation - Health	22.65
Voluntary Resignation - To undertake further education or training	16.42
Dismissal - Capability	15.77
Voluntary Resignation - Better Reward Package	11.73
Voluntary Early Retirement - with Actuarial Reduction	11.47

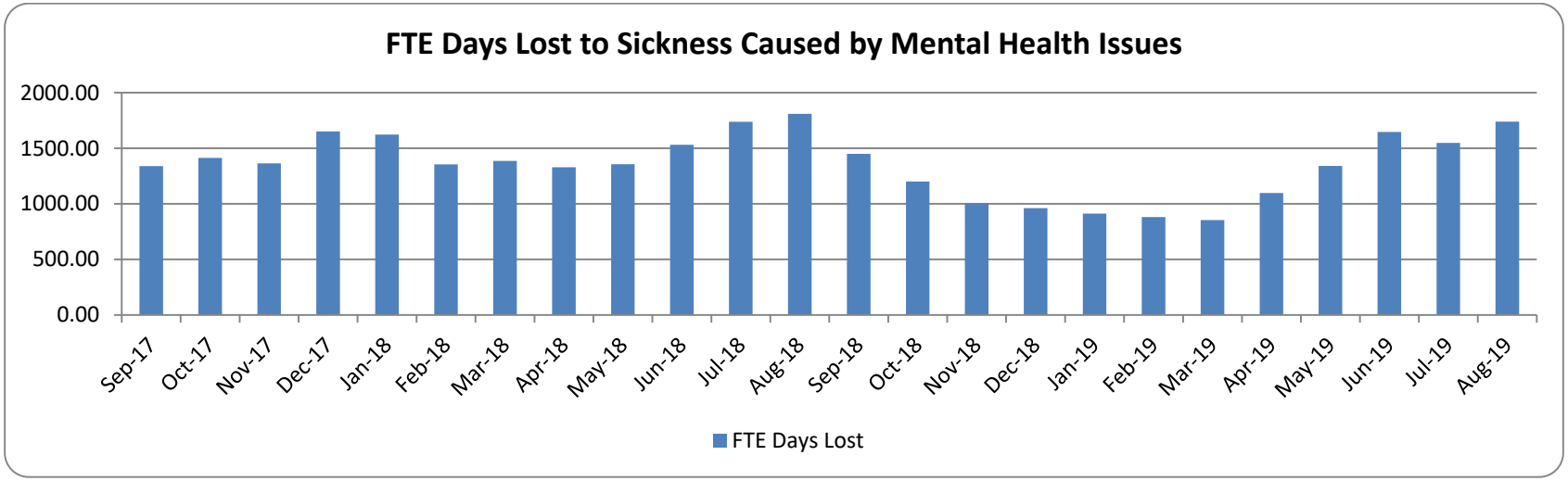
In each of the top three categories for 'Reason for Resignation' detailed above, Nursing & Midwifery had the highest proportion of leavers citing these reasons for leaving.





01st September 2018 - 31st August 2019				
Absence Reason	Headcount	Abs Occurrences	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	465	643	14,656.45	19.70
S98 Other known causes - not elsewhere classified	998	1,321	11,496.28	15.40
S12 Other musculoskeletal problems	333	426	6,672.87	9.00
S11 Back Problems	371	510	5,206.24	7.00
S25 Gastrointestinal problems	1226	1,610	4,667.56	6.30


FTE Days Lost Due to Sickness Caused by MSK
2000.00
1500.00
1000.00
500.00
0.00
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
FTE Days Lost


FTE Days Lost to Sickness Caused by Mental Health Issues
2000.00
1500.00
1000.00
500.00
0.00
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
FTE Days Lost

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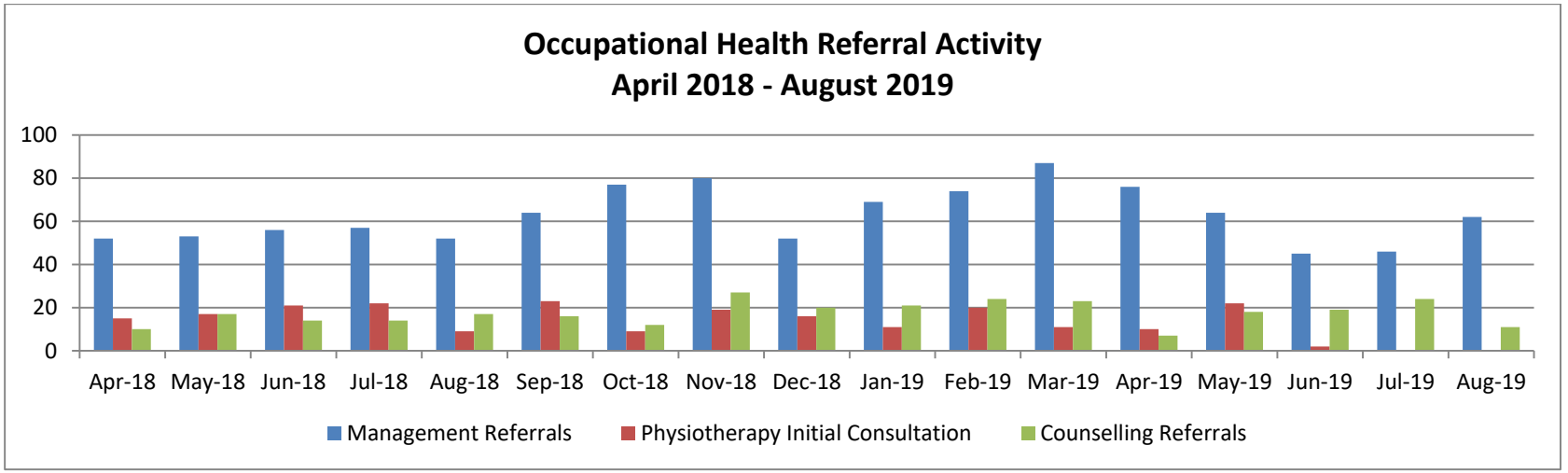
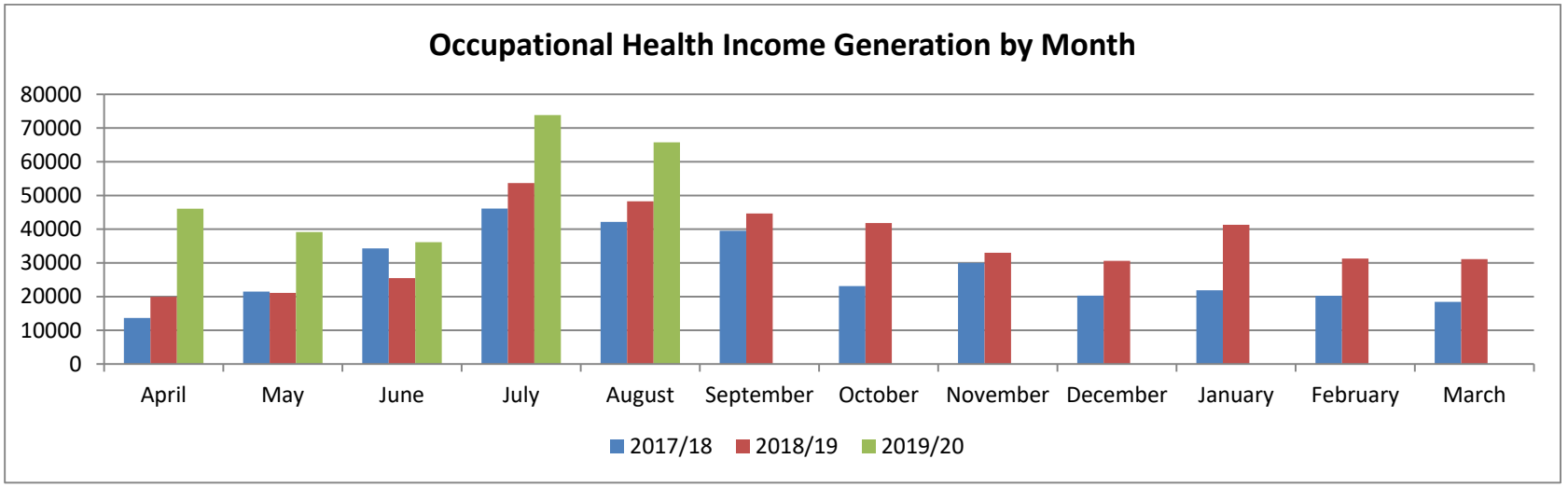
Occupational Health Activity





2. People Capability

Key areas of success

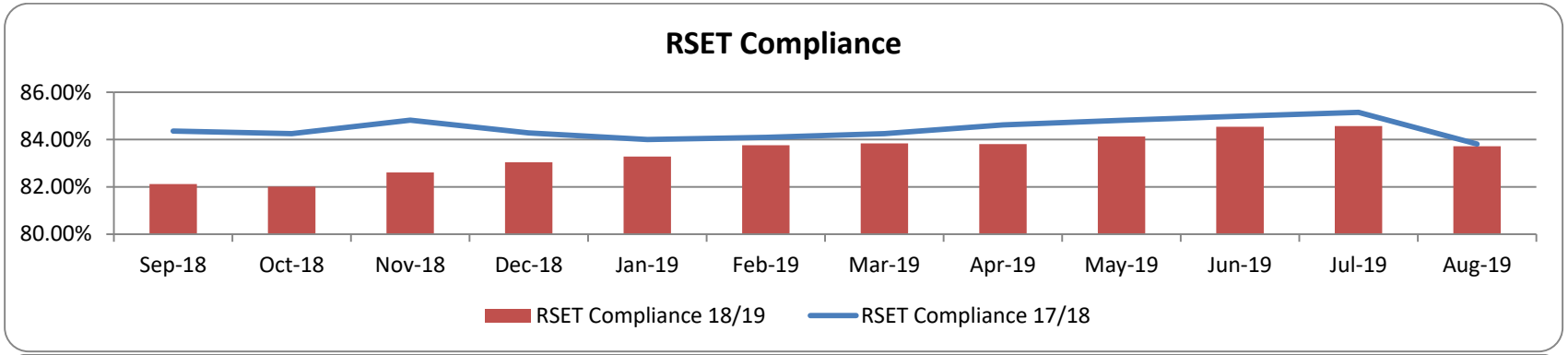
- The Apprenticeship Training Services contract with the Open University has now been approved. However, discussions are now taking place on the duration of the programme, which has increased by 6 months.
- English and Maths Functional Skills continue to be offered to staff. Over the past year there have been 45 staff who have passed their English exams and 34 staff who have passed their Maths exams. 4 staff failed either their Maths or English exams with 4 currently re-sitting.
- Following a training provider for apprenticeships going into administration we have now successfully signed up Pier Training and all staff have been transferred.

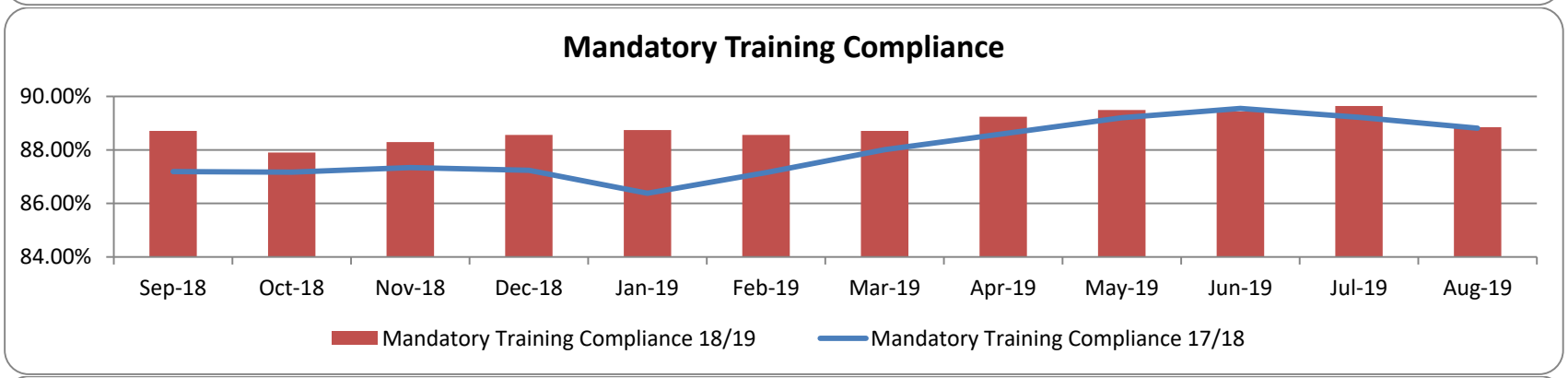
Key areas of concern

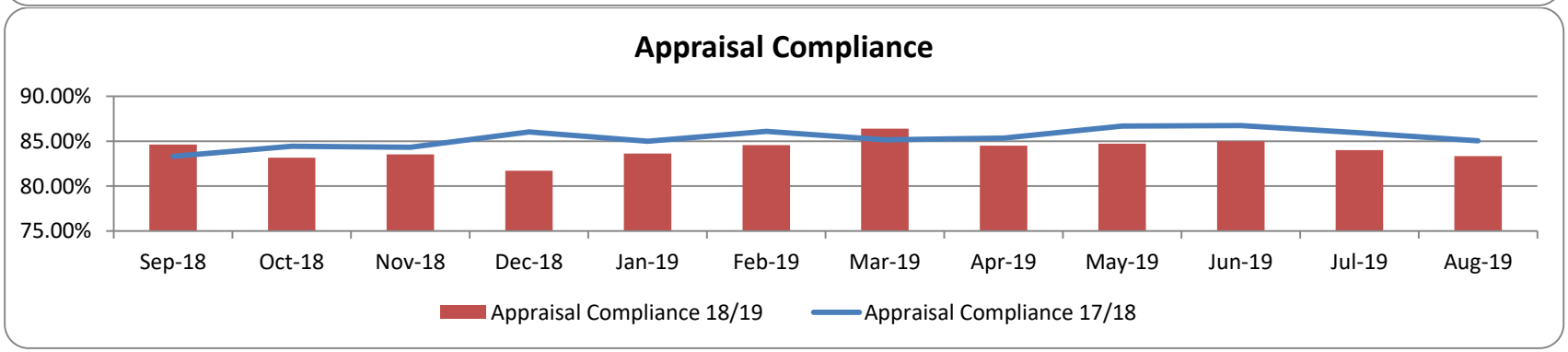
- Blood Training and BLS training are below 80% compliance
- Appraisals and RSET compliance is below 85%
- The Government has reviewed function skills and has now re-aligned these to GCSE's. We are currently exploring the consequences of this, but early signs suggest that the Maths exams are now much harder to pass. All internal courses have been increased from 4 to 6 weeks in duration to take this into account.

Key progress update

- Diabetes/Insulin Safety has become RSET so work is being undertaken to align this in ESR. Whilst this work is happening the e-learning programme will be launched in September.
- A Work Experience Task & Finish group has been created which includes colleagues from L&D, Practice Development and other key people within the Trust. This group has been created to address the backlog of applications for work experience and to plan for future applications.
- The HRBPs continue to address those managers with low mandatory and role specific training compliance and where necessary create action plans.


RSET Compliance
86.00%
84.00%
82.00%
80.00%
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
RSET Compliance 18/19
RSET Compliance 17/18


Mandatory Training Compliance
90.00%
88.00%
86.00%
84.00%
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Mandatory Training Compliance 18/19
Mandatory Training Compliance 17/18


Appraisal Compliance
90.00%
85.00%
80.00%
75.00%
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Appraisal Compliance 18/19
Appraisal Compliance 17/18

3. People Culture

Key areas of success

- A coaching skills programme was piloted during June/July 2019 with 18 members of staff participating and this programme was positively evaluated. This is now ready for roll out from October 2019 to aid in developing a supportive environment that promotes accountability and facilitates a culture of improvement.

Key areas of concern

- Further funding for the Respect and Behaviour campaign from NHSI/E is unlikely to be available and therefore the Trusts programme will need to be modified accordingly.

Key progress taken

- The 'Summer of engagement' has been taking place over August and September 2019, with Exec and senior leaders facilitating focus groups with all teams across the Trust to allow staff to have a voice and contribute ideas for how to change and improve upon the culture based around the themes outlined. Themes are being gathered and presented in a board paper for consideration by the newly appointed interim Chief People Office and interim HR Director and Trust Board.

Recorded attendance for the engagement sessions by division to date is as follows:

Division	Number attended	Total number in division	% attended
Surgery	52	1162	4.5
Medicine	79	1270	6.2
Women's, Childrens & Oncology	100	1061	9.4
Clinical Support	34	648	5.2
Support Services	108	1008	10.7
Total for Trust	373	5149	7.2

The total numbers in attendance for organisational development Respect & Support Campaign for culture change

Quarter	Month	Respect and Support training					Resilience	Courageous Conversations	Round Table Facilitation
		CB&IB for Staff	Leading with Respect for Managers	Grand Total	Total no. of staff	% of staff			
	Jul-18	NA	NA	NA			25	NA	NA
	Aug-18	NA	NA	NA			30	NA	NA
	Sep-18	71	77	148			146	NA	NA
2018-19 Q2		71	77	148			201	NA	NA
	Oct-18	NA	NA	NA			63	NA	NA
	Nov-18	47	47	94			23	11	NA
	Dec-18	NA	NA	NA			41	NA	NA
2018-19 Q3		47	47	94			127	11	NA
	Jan-19	NA	NA	NA			8	NA	9
	Feb-19	NA	20	20			41	NA	NA
	Mar-19	32	NA	32			21	24	17
2018-19 Q4		32	20	52			70	24	26
	Apr-19	NA	28	28			8	NA	NA
	May-19	52	NA	52			14	9	NA
	Jun-19	NA	44	50			6	NA	NA
2019-20 Q1		52	72	124			28	9	NA
2019-20 Q2	Jul-19	NA	NA	NA			11	18	14
Total number attended Launch to month 1 of Q2 2019-20		202	216	418	5182	8.1	437	62	40

Northampton General Hospital NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**26 September 2019**

Title of the Report	**Fire Safety Annual Report**
Agenda item	**15**
Presenter of the Report	
Author(s) of Report	
Purpose	
Executive summary **holding sheet**	
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	

Northampton General Hospital NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**26 September 2019**

Title of the Report	**Fire Compliance statement**
Agenda item	**16**
Presenter of the Report	
Author(s) of Report	
Purpose	
Executive summary **holding sheet**	
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	

UNIVERSITY OF LEICESTER
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Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26th September 2019**

Title of the Report	**Corporate Governance Report**
Agenda item	**17**
Presenter of Report	Claire Campbell, Director of Corporate Development, Governance and Assurance
Author(s) of Report	Claire Campbell, Director of Corporate Development, Governance and Assurance
Purpose	Information
Executive summary This report provides the Board with information on a range of corporate governance matters and in particular includes formal reporting on the Use of the Trust Seal pursuant to the Trust's Standing order 12.3.	
Related strategic aim and corporate objective	N/A
Risk and assurance	This report provides assurance to the Board in respect to compliance with Standing Orders and the Trust's Standards of Business Policy (superseded in year by the Conflict of Interests Policy)
Related Board Assurance Framework entries	N/A
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (/**N**) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (/**N**)
Legal implications / regulatory requirements	This report provides the Board with information on a range of corporate governance matters and in particular includes formal reporting on the Use of the Trust Seal pursuant to the Trust's Standing order 12.3

Actions required by the Trust Board

The Trust Board is asked to:

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

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Corporate Governance Report

1. Introduction

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

2. Use of the Trust Seal

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

The seal has been not been used during Quarter Four 2018/19 and Quarter One 2019/20.

3. Declarations of Hospitality and Declarations of Interest

Staff within the Trust are required by the Standards of Business conduct Policy (superseded in year by the Conflict of Interests Policy) to declare any hospitality and/or gifts received.

Staff are also required to declare any conflicts of interest with regard to the following:

- Meals & Refreshments
- Travel & accommodation
- External Employment
- Shareholdings or ownership issues
- Patents
- Loyalty Interests
- Donations
- Sponsorship of events/ research/ posts
- Clinical private practice

Staff are given regular reminders through Trust communication mechanisms regarding their liabilities in respect to the requirements of this policy.

Responses received in the last three quarters can be found in the table below.

Time period	Number of declarations (gifts and hospitality)	Declarations of Interest (Yes return)	Declarations of Interest (No return)	Total
Q4 2018/19	34	10	15	59
Q1 2019/20	25	1	3	29
Q2 2019/20	16	3	0	19

The above declarations of gifts and hospitality include declarations from departments where lunch has been provided during an educational session and may involve a group of staff but is counted as a single declaration.

The overall total number of eligible staff (new starters/ recent return) who returned a Declaration of Interest from 1 September 2019 – 16 September 2019 is 44 (15 yes, 29 a nil return).

The overall total number of staff eligible to complete a Declaration of Interest form is 255 staff. The overall numbers of staff who have responded in year are 231, with 24 staff who remain outstanding. The majority of outstanding returns are from Consultant staff, with a small number of senior managers.

In November 2018 the Divisional Directors were provided with the names of individuals outstanding within their Divisions, following which the Medical Director and Chief Operating Officer chased those outstanding in April 2019.

With the introduction of the revised Conflict of Interest policy and a Private Patients policy it is envisaged that compliance from Consultants will improve over the next few months as all consultants are required to declare private work (whether internal or external to the Trust) or confirm a nil return.

Further work is underway to ensure the capture of new starters eligible to complete Declarations of Interest at appointment and collation and chasing of non- responders in a timelier manner.

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Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26th September 2019**

Title of the Report	**EU Exit Operational Readiness**
Agenda item	**18**
Presenter of the Report	Deborah Needham – Chief Operating Officer, Deputy Chief Executive
Author(s) of Report	Jeremy Meadows – Head of Resilience and Business Continuity
Purpose	For assurance/information/awareness.

Executive summary

This paper sets out the current status of EU Exit negotiations, summarises implications for the NHS and our preparations to date for a 'no deal' Brexit.

NGH may be affected if the UK leaves the EU on 31st October 2019 without an agreement for future trade arrangements between the EU and the UK. Risk factors relevant to the NHS are set out in a guidance document issued by DHSC: EU Exit Operational Readiness Guidance; 21 December 2018.

At the time of writing, there is currently no parliamentary majority to support the terms of Her Majesty's Government's (HMG) proposed deal to leave the EU: the default position of leaving the EU without a deal is unacceptable to many MPs. The UK and the EU agreed a deal in November 2018 but MPs rejected it three times.

HMG has issued general guidance to public and private sector businesses and organisations. This guidance is supplemented by more specific risk scenarios identified by DHSC. So far, no risks to the Trust are reported.

On the basis that so far no risks to the Trust are reported, Trust Board is asked to be assured that:

- Corporate and division-level preparations for a 'no-deal' exit from the EU are being directed by DHSC / NHS England and their partner bodies (e.g. NHS Improvement, NHS Digital);
- Through oversight by the Trust's Resilience Planning Group the Trust is following current guidance; and that,
- Risk to the Trust's services is being managed so far as is reasonably practicable in the circumstances.

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? Strategic aim 1 – focus on quality and safety
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks (**Y**)
Related Board Assurance Framework entries	BAF 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)? (**N**)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper (**N**)

Actions required by the Group

The Group is asked to:

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

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EU Exit Operational Readiness, September 2019

1. Introduction

Northampton General Hospital NHS Trust (NGH, the Trust) may be affected if the UK leaves the EU at 23:00 on the 31st October 2019 without an agreement for future trade arrangements between the EU and the UK.

The Trust's legal and contractual duties as a provider of healthcare to the NHS mean that individual services are required to mitigate risk to patients, staff and those using our premises. The same legal and contractual duties require the management of risk to be appropriately governed. As a consequence, risk to the Trust is:

- Less likely to come from single factors affecting individual services.
- More likely to come from several factors occurring at or about the same time and lasting for a protracted period of time.

These factors are being assessed and reviewed on an on-going basis by the Trust's Brexit Planning Group, which agreed utilisation of the Trust's major incident command and control procedures for managing significant incidents of risk resulting from the UK leaving the EU.

2. The NHS and No Deal Brexit

The Trust's Brexit Planning Group, on behalf of the Resilience Planning Group is acting in accordance with national, regional and local guidance, which is to follow advice issued to various services maintained and provided by the Trust (for example: Estates and Facilities, IT, Procurement, HR, Pharmacy) and summarised in EU Exit Operational Readiness Guidance (Department of Health and Social Care; 21 Dec 2018).

National guidance focuses on the reasonable worst-case (RWC) planning assumptions of a no-deal scenario. This paper summarises the preparations for a no-deal Brexit and presents requirements for a likely invocation of national NHS Command and Control.

The imminent departure of the United Kingdom from the European Union at 23:00 on the 31st October 2019 may cause a number of significant risks to materialise, either at or about the time of departure or in the following days, weeks, months and years.

- Those most immediate risks are likely due to the movement of goods, people and data (whether through delays, price or availability).
- Those less obvious risks occur in the following days, weeks, months and years due to the renegotiation of contracts and variation of trading standards (meaning supplies become unavailable or nearest equivalents no longer meet our requirements or specification).
- Of concern will be those risks not directly within our control; for example: public order, buying habits, banking and healthcare 'returns' (i.e. UK citizens living abroad and no longer able to access healthcare in their adopted country).

In addition to existing NHSE Command and Control arrangements, the Department Health and Social Care together with NHS England, NHS Improvement and PHE have established an Operational Response Centre to lead on responding to any disruption to the delivery of health and care services in England, that may be caused or affected by EU Exit, to co-ordinate information flows and reporting.

The Trust has set up a Brexit planning group to plan for the consequences of UKs exit from the EU. The key points of interest to be considered or noted are:

- We have undertaken a business continuity review that represents through planning for the events and actions that we can control locally. It is exceptionally hard to quantify these risks because of the amount of unknown variables.

- A trust-wide Business Continuity Plan for a no-deal EU Exit has been created and approved by the Brexit Planning Group. This document will be needed if the UK leaves the EU on 31st October 2019 without a deal. Depending on the outcome of the negotiations, it can be revoked or amended as required.

- In terms of potential for major operational impact and severe and widespread risks to patient safety, the greatest concern is the availability of medicines, devices and clinical supplies. DHSC guidance has advised that a central exercise has been undertaken to identify all those medicines and consumables with an EU manufacturing touchpoint; however the findings of that exercise have not been made available so it is not possible for NHS trusts to know which products are most at risk.

- DHSC have advised that in response to the reasonable worst-case (RWC) planning assumptions surrounding the supply of medicines and medical products, a coordinated National Supply Disruption Response system has been put in place to manage issues arising following the exit day. These were supported by buying additional warehouse space for medicines and securing freight capacity on routes away from the short straits (between Calais/Dunkirk/Coquelles and Dover/Folkestone) which are expected to experience reduced traffic flow.

- DHSC guidance continues to explicitly forbid any stockpiling. We are assured that pharmaceutical companies and other suppliers will hold six weeks of stock in the country, in addition to normal levels. As a result we are ensuring that the trust complies with the instructions not to stockpile drugs, medical devices and other consumable items locally.

- Work is in hand by NHSSC/NHSE/NHSI to review supply chain contracts under their management and used by the trust.

- The following functions are identified as more likely to be affected by a no-deal Brexit scenario:
  - Supply of medicines and vaccines.
  - Supply of medical devices and clinical consumables.
  - Supply of non-clinical consumables, goods and services.
  - Workforce.
  - Reciprocal healthcare.
  - Research and clinical trials.
  - Data sharing, processing and access.

The above areas have undertaken risk assessments based on the potential risks associated with Brexit.

- Weekly meetings will reconvene with health partners on the 17th September to ensure a coordinated approach. There is increased engagement with Northamptonshire Local Resilience Forum.
- Escalation of issues will be via the trust's tried and tested command and control structure. Out of hours on-call arrangements will remain unchanged, with additional executive support for director's on-call.
- An enhanced Weekend Plan will be in force for the period Thursday 31st October to Thursday 7th November.
- In order to maintain business as usual during this period, data reporting will continue to follow current routes. As a result data requests will continue to be collated and uploaded by Informatics colleagues.

Proposed Daily Battle Rhythm commencing 1st November 2019:

- 10:00: Multi-Agency Health Economy Tactical Coordinating Group (HETCG) Teleconference
- 10:30: Standard Daily System Wide Teleconference
- 13:00: Tactical Coordinating Group Meeting (If required)
- 16:00: Strategic Coordinating Group Meeting (If required)
- 17:00: Deadline for daily SDCS (Unify) situation report. It is expected that further reporting will be by exception only.

- Work is taking place to ensure that all of our key suppliers and contractors are geared up for Brexit.
- Bringing up to date and testing of business continuity planning for various scenarios that emerge from Brexit.
- Areas are undertaking table-top exercises based on the key scenarios provided by NHS England. The scenarios are used to test particular aspects of business continuity plans and to address potential system wide impacts.
- HR are monitoring the number of EU staff in order to determine the impact of the EU exit on the workforce and escalate potential shortages. Approximately 8% of the trust's workforce are EU nationals (408 staff). The trust has demonstrated support for EU staff by publicising and paying for their settled status application fees, the cost associated with this scheme has since been removed. No members of staff have indicated that they will leave as a result of Brexit.
- The Trust's staff and public communications can be used to promote confidence in the trust and wider health economy's ability to manage any disruption due to a no-deal Brexit – allaying anxiety, myths and fears. We will provide useful updates to questions which may emerge.

- A data field has been added to the Datix incident reporting webpage in order to identify and monitor any incidents within the trust that have been the result of Brexit.

3. Conclusion

The Trust has identified the Chief Operating Officer/Deputy CEO as the SRO to oversee the work to ensure continuity of supply of goods and services in the event of a no-deal Brexit. Some categories of spend and suppliers are best engaged at a national level and these are being managed centrally by the DHSC. All other categories and suppliers have been reviewed as part of a self-assessment methodology and submitted to the DHSC on 30th November 2018. It is anticipated that the national team will disseminate its latest national assurance template requirement for completion following the EU Exit Regional Workshop on 17th September 2019.

The Trust is following national guidance in preparing for a no-deal exit of the UK from the EU and has arrangements in place to mitigate any risks that may arise from this scenario. The SRO will keep the Board informed of any implications of the withdrawal agreement as further information is provided, if this is enacted.

4. Recommendations

The Board is asked to note the content of the report.

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**26th September 2019**

Title of the Report	**EPRR Self-Assessment Assurance Report**
Agenda item	**19**
Presenter of Report	**Deborah Needham** Chief Operating Officer/Deputy CEO
Author(s) of Report	**Jeremy Meadows** Head of Resilience & Business Continuity
Purpose	For information/awareness.

Executive summary

To provide an update of the EPRR self-assessment undertaken in August 2019 and progress against the NHS England Core Standards.

As an acute provider of NHS Funded Care, the Trust is required to be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect health or patient safety. These could be anything from severe weather to an infectious disease outbreak or a major transport accident. Under the Civil Contingencies Act (2004), NHS organisations and providers of NHS funded care must show that they can effectively respond to emergencies and business continuity incidents while maintaining services to patients. This is referred to as 'emergency preparedness, resilience and response' (EPRR).

The NHS England Core Standards for EPRR are the minimum standards which NHS organisations and providers of NHS funded care must meet.

The following is a summary of the Trust's self-assessment against these requirements and governs the work plan for the next 12 months.

Related strategic aim and corporate objective	**Strategic aim 1 – focus on quality and safety**
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks (**Y**)

Related Board Assurance Framework entries	**BAF 1.6**
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (**N**) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (**N**)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper (**N**)

Actions required by the Committee

The Committee is asked to:

- To note the contents of this paper.
- Approve the proposed overall assessment of Fully Compliant.

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Associate Teaching Hospital

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Trust Board
26th September 2019
EPRR Self-Assessment Assurance Report

1. Introduction

Emergency Preparedness, Resilience and Response (EPRR) is key to ensuring that the Trust is able to respond to a variety of incidents whilst continuing to provide its essential services. The Civil Contingencies Act (CCA, 2004) places a number of statutory duties on the Trust as a Category 1 Responder. These duties include:

- Risk assessments to inform contingency planning
- Emergency planning
- Business continuity planning
- Co-operation with other responders
- Information sharing with other responders
- Warning, informing and advising the public in the event of an emergency.

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

2. Criteria for assessment of Core standards

The past 12 months have resulted in continued improvement in the implementation and development of emergency planning within the Trust. Key areas of improvement for 2019 have been the rollout of the new trustwide major incident alerting system, and the recent ratification of a number of key policies and procedures.

A robust and stringent process with Executive and Senior Management engagement has been followed to complete the self-assessment exercise to ensure that the results provide a true reflection of the Trust's overall position against the NHS Core Standards for Emergency Preparedness, Resilience and Response.

The NHS Core Standards for EPRR are the basis of the assurance process. These have remained as they were in the 2018-19 assurance, with only minor clarifications made.

The Trust is required to benchmark each theme against the following compliance levels:

- Fully Compliant
- Partially Compliant
- Non-Compliant

Table 1 below provides an overview of the Trust's position against the Core Standards which is described through a series of 64 criteria.

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	14	0	0
Command and control	2	2	0	0
Training and exercising	3	3	0	0
Response	7	7	0	0
Warning and informing	3	3	0	0
Cooperation	4	4	0	0
Business Continuity	9	9	0	0
CBRN	14	14	0	0
Total	64	64	0	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Severe Weather Response	15	15	0	0
Long term adaptation planning	5	5	0	0
Total	20	20	0	0

Table 1: NGH Core Standards Review 2019.

The topic of this year's deep dive element focusses on severe weather and climate adaptation. This is as a result of a request from the Government's Environmental Audit Committee which has responsibility for assessing adaptation to climate related issues. It is deemed that the Trust is fully compliant with the twenty core standards as a result of sustainability initiatives which continue to be guided by a Board-approved Sustainability Strategy, annual plan, external resource efficiency targets and feedback from our staff. All sustainability activities are reported informally through a monthly newsletter sent to all departments and a network of champions across the hospital.

The EPRR self-assessment tool is attached for awareness. **APPENDIX 1**

NHS England will be conducting site visits to assess the Trust's preparedness. This is followed by a formal evaluation of the Trusts' self-assessment submission at the Assurance Panel on the 20th September.

On the basis of the Self-Assessment, the Trust will be declaring an overall rating of Fully Compliant, with 100% of all criteria being Fully Compliant. The definitions of full, substantial, partial and non-compliance are included below for awareness.

Compliance level	Definition
Not compliant	Not compliant with the core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.
Partially compliant	Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months.
Fully compliant	Fully compliant with core standard.

3. Summary

Based on the evidence above, the Trust should be assured that measures are in place to adequately respond to incidents. The Emergency Planning and Business Continuity function has observed a marked improvement over the past few years and this has seen an improvement in the Trust's capabilities to plan for and respond to a major incident or failure in business continuity.

A number of moderate business continuity incidents have highlighted the Trust's ability to perform in accordance with the Command and Control structure, maintaining a focus on patient safety and providing the best possible care.

The emergency planning cycle will continue to determine the emergency planning and business continuity work plan for 2019-20. The key areas that will be prioritised within the next 12 months will continue to be Major Incident and Business Continuity planning and training and exercising, with an ongoing review of plans and close working with external stakeholders.

To provide further reassurance the Emergency Planning and Business Continuity Team will continue to engage with clinical and corporate teams to ensure the work programme is delivered to a high standard and timescale.

4. Recommendation

The Board is asked to note the contents of the report and approve the proposed overall assessment of Fully Compliant.

APPENDIX 1

NHS Core Standards self assessment tool \

Please select type of organisation: **Acute Providers**

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	14	0	0
Command and control	2	2	0	0
Training and exercising	3	3	0	0
Response	7	7	0	0
Warning and informing	3	3	0	0
Cooperation	4	4	0	0
Business Continuity	9	9	0	0
CBRN	14	14	0	0
Total	64	64	0	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Severe Weather response	15	15	0	0
Long Term adaptation planning	5	5	0	0
Total	20	20	0	0

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role	Y	• Name and role of appointed individual	Deborah Needham, Chief Operating Officer and Deuputy Chief Executive is the Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR).	Fully compliant				
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	Emergency Preparedness and Resilience Policy NGH-PO-389 advises of resources, funding and implementation and training requirements.	Fully compliant				
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	Annual EPRR report is submitted toTrust Board	Fully compliant				
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes.	Y	• Process explicitly described within the EPRR policy statement • Annual work plan	As per Emergency Preparedness and Resilience Policy, the Resilience Planning Group is the forum for reviewing the EPRR work programme following a review of lessons identified from incidents & exercises, risks and assurance processes. The core standards work programme forms the basis of the annual work programme	Fully compliant				
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	The Board are satisfied that the Trust has appropriate resources to fulfill it's EPRR requirements.	Fully compliant				
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement	Incident response plans advise of the requirement for review following activation and consideration of lessons identified. Debrief of and feedback from past incidents is a standing item on the Resilience Planning Group agenda.	Fully compliant				
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	Corporate, Resilience and Divisional risk registers are in place and are regularly reviewed at governance meetings. Resilience specific risk register is reviewed at Resilence Planning Group meetings and is reported to the monthly Risk Group. Risks scoring 15 and above are escalated to the Corporate Risk Register.	Fully compliant				
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	EPRR Risks are reviewed at the monthly Trust Risk Group. Risks with a score greater than 15 are discussed at the Corporate Risk Group.	Fully compliant				
9	Duty to maintain plans	Collaborative planning	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Y	Partners consulted with as part of the planning process are demonstrable in planning arrangements	Partners are consulted as part of the planning process.	Fully compliant				
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	An internal escalation response to increased system pressures/ disruption to services that are or will have a detrimental impact on the organisation's ability to deliver safe patient care, the decalaraion of a Critical Incident is detailed within the Corporate Major Incident Plan.	Fully compliant	Situation, Background, Assessment, Recommendation (SBAR) template to be added to the Incident Directors Action Card, during next review of Major Incident Plan.			
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trustwide Major Incident Plan is in place.	Fully compliant				
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trustwide Heatwave Plan is in place.	Fully compliant				
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trustwide Adverse Weather Plan is in place.	Fully compliant				
15	Duty to maintain plans	Pandemic influenza	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trustwide Pandemic Influenza Plan in place.	Fully compliant				
16	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases such as Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3 and PPE trained individuals commensurate with the organisational risk.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trustwide Infection Prevention and Control Policy is in place.	Fully compliant				

17	Duty to maintain plans	Mass countermeasures	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including arrangement for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. CCGs may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	An LRF Plan in place, however the scale of the response will be dependant on the incident and requested at such time. The Trust will envoke it's Business Continuity Procedures to ensure critical services are maintained wherever possible.	Fully compliant				
18	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust Capacity Management, Escalation and Patient Moves Plan.	Fully compliant				
19	Duty to maintain plans	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	In the event of a major incident, the Trust will activate the Majax element of the patient tracking system, Symphony. Each patient presenting during this time is assigned a unique reference number until discharge.	Fully compliant				
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Lockdown and Evacuation plans in place to shelter or evacuation patients, staff and visitors.	Fully compliant				
21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Updated to incorporate partial lockdown and progressive restriction of access / egress.	Fully compliant				
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Joint plan in place with Northants Police regarding the management of high profile patients.	Fully compliant				
23	Duty to maintain plans	Excess death planning	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Covered by LRF Excess Deaths Plan. Internal surge plan also exists with links between MKH and KGH and formal arrangements with local undertakers.	Fully compliant				
24	Command and control	On-call mechanism	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	Tried-and-tested dual tier on-call manager and director system in place consisting of suitably trained on-call staff. External partners are familiar with our out-of-hours contact details in the event of an incident. Head of Resilience contactable by numerous means out-of-hours.	Fully compliant				
25	Command and control	Trained on-call staff	On-call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf of the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Y	• Process explicitly described within the EPRR policy statement	EPRR policy advises: Ensure all staff who participates in the Trust on-call system are trained in emergency and contingency response, including JESIP. Role specific Action Cards are contained within the Major Incident Plan. Centrally stored on-call shared drive repository of key resources for on-call staff.	Fully compliant				
26	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Y	• Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	Processes covered in on-call training above. Training needs analysis undertaken and training records are kept to demonstrate attendance.	Fully compliant				
27	Training and exercising	EPRR exercising and testing programme	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part	Y	• Exercising Schedule • Evidence of post exercise reports and embedding learning	A training and exercising needs analysis and schedule is in place to in order to test and validate plans as per the requirements of the CCA. Post exercising debriefs are undertaken in order to identify, capture and act upon areas for improvement.	Fully compliant				
28	Training and exercising	Strategic and tactical responder training	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation.	Y	• Training records • Evidence of personal training and exercising portfolios for key staff	Certificates issued to attendees following training sessions undertaken in accordance with the National Occupational Standards.	Fully compliant				
30	Response	Incident Co-ordination Centre (ICC)	The organisation has a preidentified Incident Co-ordination Centre (ICC) and alternative fall-back location(s). Both locations should be annually tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Y	• Documented processes for establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards	The Trust has a predetermined Incident Co-ordination Centre and back up location. The primary location is the Site Management Office to ensure familiarity. The backup location is Training Room 2 and is used during exercises that require an ICC to be established. The Trust Major Incident Coordination Centre procedure details access, activation and equipment setup.	Fully compliant				
31	Response	Access to planning arrangements	Version controlled, hard copies of all response arrangements are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and hard copies	Electronic copies are available on the Trust Intranet and shared folders. Hard copies of key EPRR plans and procedures are located in key areas across the site.	Fully compliant				

32	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans	Trustwide and local BCP's detail the management of business continuity incidents.	Fully compliant				
33	Response	Loggist	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents. Key response staff are aware of the need for keeping their own personal records and logs to the required standards.	Y	• Documented processes for accessing and utilising loggists • Training records	The Trust has a suite of loggists to be called upon in the event of an incident and are contactable via the major incident call-out system. In the event that a loggist is unavailable, particularly during the initial stages of an incident out of hours, decision makers are advised to keep contemporaneous notes.	Fully compliant				
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps • Evidence of testing and exercising	This is undertaken by the on-call executive and is detailed with the Major Incident Plan. On-call staff have access to Resilience Direct and have the ability to access any SitReps uploaded to the incident page.	Fully compliant				
35	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	Guidance is available to appropriate staff either electronically or hard co	ED have access to electronic copies of the clinical guidelines for major incidents and mass casualty events which was updated in 2018. Awaiting reciept of hardcopies of the updated version.	Fully compliant				
36	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y	Guidance is available to appropriate staff either electronically or hard co	ED staff have access to 'CBRN incidents: clinical management & health protection' and 'Chemical, biological, radiological and nuclear incidents: clinical management and health protection (2018)' guidance which adds additional material on a range of new and emerging threats.	Fully compliant				
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	Corporate communications team have detailed media handling policy in place and have recent experience of advising the public to choose well. Colleagues are aware of the importance of providing information in a timely manner. Major Incident Plan details how to communicate with stakeholders. Experience of producing a joined up media strategies with partner agencies via the SCG. Trust Social Media Policy is in place.	Fully compliant				
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	Corporate communications team have detailed media handling policy in place and have recent experience of advising the public to choose well. ED have an information leaflet for patients in the department which is distributed in the event of a major incident.	Fully compliant				
39	Warning and informing	Media strategy	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'	Processes are in place to nominate a spokeperson in the event of local media enquiries. Communications team distribute messages to the public via social media and the Trust website.	Fully compliant				
40	Cooperation	LRHP attendance	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75% annually) Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings	AEO/Deputy attendance at LHRP meetings.	Fully compliant				
41	Cooperation	LRF / BRF attendance	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • Governance agreement if the organisation is represented	CCG representation at the LRF.	Fully compliant				
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	LRF mutual aid arrangements are in place and are referenced within appropriate plans.	Fully compliant				
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	The Trust has signed the LRF Multi-Agency Information Sharing Agreement. The LRF Data Sharing Plan is invoked in the event of an emergency.	Fully compliant				
47	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	Corporate Business Continuity Plan outlines the requirement to undertake BC planning.	Fully compliant				
48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	The BCMS details relevant responsibilities, objectives, and resource requirements.	Fully compliant				
49	Business Continuity	Business Impact Assessment	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Y	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support.	The BIA is reviewed annually. More frequently if lessons learned following an incident are to be included.	Fully compliant				
50	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance	GDPR action plan in place, DSP(IG) toolkit achieved.	Fully compliant				
51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be reviewed regularly (at a minimum annually), or following organisational change, or incidents and exercises.	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Trust BCP's contains consideration for responding, recovering and managing its services during disruptions to people, information and data, premesis, suppliers & contractors and IT & infrastructure as per the requirements of ISO22301:2012.	Fully compliant				
52	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers	Depertmental BCRP's are completed in line with Key Performance Indicators. Reports of any exercises are reported via Assurance, Risk and Compliance to the Board.	Fully compliant				
53	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	Internal audits frequently undertaken to ensure best practice. Reports to the Board via the Assurance, Risk and Compliance Group.	Fully compliant				
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	There is a process to review BCRPs following an incident, restructure or change of supplier/provider.	Fully compliant				
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	Departments assess the business continuity plans of new providers in order to receive assurance of arrangements in the event of a business continuity incident.	Fully compliant				
56	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	Detailed within the CBRN/Hazmat Plan. The decontamination file includes details for TOXBASE and PHE (CRCE & NPIS).	Fully compliant				

57	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Trust specific CBRN/Hazmat Plan is allgned to national IOR guidance. It includes: • Identification of a CBRN incident and details the proccess for activating the plan • Steps 1-2-3 • Dry decontamination and wet decontamination • Contact details • Management of hazardous waste • Stand-down procedure, recovery and return to normal • Appendix 6 details access to national stocks of prophylaxis and Pods. Requests for access to stockpiles are to be made by the on-call exec after discussion with the 1st Consultant in ED.	Fully compliant				
58	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities	Risk assessments have been completed and appropriate training is in place: • Procedures to follow are listed in ED • Only appropriately trained staff undertake decontamination procedures • No contact by clinical staff until fully protected with appropriate PPE, assessment of whether wet or dry decontamination is appropriate (caustic chemical or not) • 1 day decontamination specific training takes place quarterly for ED staff • ED staff induction includes decontamination and major incidents.	Fully compliant				
59	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y	Rotas of appropriately trained staff availability 24 /7	There are sufficient numbers of decontamination-trained nursing staff with ED to ensure cover 24/7. A list of suitably trained staff is available to call-in if additional assistance should be required.	Fully compliant				
60	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Completed equipment inventories; including completion date	CBRN store contains response box and appropriate decontamination equipment as per the inventory list to ensure safe decontamination of patients and protection of staff. Any equipment used is replenished in a timely manner.	Fully compliant				
61	CBRN	PRPS availability	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	Y	Completed equipment inventories; including completion date	The Trust holds 18 replacement PRPS suits.	Fully compliant				
62	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y	Record of equipment checks, including date completed and by whom.	All equipment is serviced within required timescales. • Suits tested by Respirex annually. Currently in the process of receiving replacement suits. • Tent manufacturer is no longer in business, however the Trust's primary means of decontamination is the internal shower room. The tent is in addition to this should the anticipated number of patients exceed the throughput of the internal shower room. In this case, mass decontamination is expected to take place at the scene. Visual check of tent is undertaken during training sessions. • RAM GENES are tested by Medical Physics. This is staggered (October and December) to ensure 1x RAM GENE is always within the department. • Internal shower is flushed by housekeeping staff on a regular basis.	Fully compliant				
63	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y	Completed PPM, including date completed, and by whom	As above.	Fully compliant				
64	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	Organisational policy	Arrangements are in place for the disposal of PPE as per guidance of 1st April 2015.	Fully compliant				
65	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y	Maintenance of CPD records	Rhiannon Baker (ED Sister & CBRN Training Lead) has received EMAS HART train the trainer training: • Acute CBRNe/Initial Operational Response (IOR) Train the Trainer Course. • EMAS PRPS/Decontamination Train the Trainer Course 10th April 2018.	Fully compliant				
66	CBRN	Training programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training	Rhiannon Baker is the designated training lead for CBRN. Training days cover: • How to deal with contaminated patients • Donning and doffing VHF PPE (including FIT testing) • Donning and doffing PRPS suits • Wet and dry decontamination • IOR • Erection of the tent • RAM GENEs	Fully compliant				
67	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	Maintenance of CPD records	In addition to the ED Decontamination training lead, there are 4x further collegues who are EMAS approved HAZMAT / CBRN trained trainers.	Fully compliant				
68	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londoncn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination techniqus	ED receptionists are aware of the requirement to inform self presenters to leave the building and await further instruction. Clinical staff to get appropriate PPE or PRPS suits. Staff to assist contaminated patients to undertake IOR dry decontamination or advise to enter the decontamination room, if required.	Fully compliant				
69	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y		All staff who are likely to come into contact with confirmed infectious respiratory viruses have been FIT tested and have 24/7 access to FFP3 masks.	Fully compliant				

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Severe Weather											
Domain: Severe Weather Response											
1	Severe Weather response	Overheating	The organisation's heatwave plan allows for the identification and monitoring of inpatient and staff areas that overheat (For community and MH inpatient area may include patients own home, or nursing/care home facility)	Y	The monitoring processes is explicitly identified in the organisational heatwave plan. This includes staff areas as well as inpatient areas. This process clearly identifies relevant temperature triggers and subsequent actions.	In place in the Trusts Heatwave Plan	Fully compliant				
2	Severe Weather response	Overheating	The organisation has contingency arrangements in place to reduce temperatures (for example MOUs or SLAs for cooling units) and provide welfare support to inpatients and staff in high risk areas (For community and MH inpatient area may include patients own home, or nursing/care home facility)	Y	Arrangements are in place to ensure that areas that have been identified as overheating can be cooled to within reasonable temperature ranges, this may include use of cooling units or other methods identified in national heatwave plan.	Arrangements in place to source temporary airconditioning units for clinical areas prior to forecast hot weather.	Fully compliant				
3	Severe Weather response	Staffing	The organisation has plans to ensure staff can attend work during a period of severe weather (snow, flooding or heatwave), and has suitable arrangements should transport fail and staff need to remain on sites. (Includes provision of 4x4 where needed)	Y	The organisations arrangements outline: - What staff should do if they cannot attend work - Arrangements to maintain services, including how staff may be brought to site during disruption - Arrangements for placing staff into accommodation should they be unable to return home	The Trust Adverse Weather Plan outlines plans for providing accommodation or 4x4 support for staff. Staff are advised of the requirement to attend the site, where safe to do so. Utilising public transport, car sharing with a 4x4 owning colleague or walking.	Fully compliant				
4	Severe Weather response	Service provision	Organisations providing services in the community have arrangements to allow for caseloads to be clinically prioritised and alterative support delivered during periods of severe weather disruption. (This includes midwifery in the community, mental health services, district nursing etc)	Y	The organisations arrangements identify how staff will prioritise patients during periods of severe weather, and alternative delivery methods to ensure continued patient care	In the event of severe weather, patient assessments are undertaken over the phone to determine whether visits are essential. Team leaders meet to review where staff live, identifying which staff have 4x4 vehicles and which patients are local to GP surgeries.	Fully compliant				
5	Severe Weather response	Discharge	The organisation has polices or processes in place to ensure that any vulnerable patients (including community, mental health, and maternity services) are discharged to a warm home or are referred to a local single point-of-contact health and housing referral system if appropriate, in line with the NICE Guidelines on Excess Winter Deaths	Y	The organisations arrangements include how to deal with discharges or transfers of care into non health settings. Organisation can demonstrate information sharing regarding vulnerability to cold or heat with other supporting agencies at discharge	The patient discharge information leaflet advises patients of considerations prior to going home. This includes ensuring the accommodation will be warm enough.	Fully compliant				
6	Severe Weather response	Access	The organisation has arrangements in place to ensure site access is maintained during periods of snow or cold weather, including gritting and clearance plans activated by predefined triggers	Y	The organisation arrangements have a clear trigger for the pre-emptive placement of grit on key roadways and pavements within the organisations boundaries. When snow / ice occurs there are clear triggers and actions to clear priority roadways and pavements. Arrangements may include the use of a third party gritting or snow clearance service.	Contract in place to ensure paths and roadways on the site are gritted.	Fully compliant				
7	Severe Weather response	Assessment	The organisation has arrangements to assess the impact of National Severe Weather Warnings (including Met Office Cold and Heatwave Alerts, Daily Air Quality Index and Flood Forecasting Centre alerts) and takes predefined action to mitigate the impact of these where necessary	Y	The organisations arrangements are clear in how it will assesses all weather warnings. These arrangements should identify the role(s) responsible for undertaking these assessments and the predefined triggers and action as a result.	Members of the Resilience Planning Group receive Met Office warnings. The Head of Resilience circualtes wider, as required. Staff informed via internal comms and Social Media. Weather related meetings convened in the event of severe forecasts.	Fully compliant				
8	Severe Weather response	Flood prevention	The organisation has planned preventative maintenance programmes are in place to ensure that on site drainage is clear to reduce flooding risk from surface water, this programme takes into account seasonal variations.	Y	The organisation has clearly demonstratable Planned Preventative Maintenance programmes for its assets. Where third party owns the drainage system there is a clear mechanism to alert the responsible owner to ensure drainage is cleared and managed in a timely manner	Planned, Preventative Maintenance programe in place. Campbell sweeping attend once a year to clear all the site gullies. Catch pits/separator routinely emptied by Northants waste company.	Fully compliant				
9	Severe Weather response	Flood response	The organisation is aware of, and where applicable contributed to, the Local Resilience Forum Multi Agency Flood Plan. The organisation understands its role in this plan.	Y	The organisation has reference to its role and responsibilities in the Multi Agency Flood Plan in its arrangements. Key on-call/response staff are clear how to obtain a copy of the Multi Agency Flood Plan	The Trust has contributed to the LRF Multi Agency Flood Plan.	Fully compliant				
10	Severe Weather response	Warning and informin	The organisation's communications arrangements include working with the LRF and multiagency partners to warn and inform, before and during, periods of Severe Weather, including the use of any national messaging for Heat and Cold.	Y	The organisation has within is arrangements documented roles for its communications teams in the event of Severe Weather alerts and or response. This includes the ability for the organisation to issue appropriate messaging 24/7. Communications plans are clear in what the organisations will issue in terms of severe weather and when.	The Trust heatwave and Adverse Weather plans detail communication requirements in accordance with warning levels.	Fully compliant				

11	Severe Weather response	Flood response	The organisation has plans in place for any preidentified areas of their site(s) at risk of flooding. These plans include response to flooding and evacuation as required.	Y	The organisation has evidence that it regularly risk assesses its sites against flood risk (pluvial, fluvial and coastal flooding). It has clear site specific arrangements for flood response, for known key high risk areas. On-site flood plans are in place for at risk areas of the organisations site(s).	The site is not prone to flooding. Horizontal evacuation as per fire plans.	Fully compliant				
12	Severe Weather response	Risk assess	The organisation has identified which severe weather events are likely to impact on its patients, services and staff, and takes account of these in emergency plans and business continuity arrangements.	Y	The organisation has documented the severe weather risks on its risk register, and has appropriate plans to address these.	The Trust has tried and tested weather plans and risks are added to the resilience or corporate risk register as appropriate.	Fully compliant				
13	Severe Weather response	Supply chain	The organisation is assured that its suppliers can maintain services during periods of severe weather, and periods of disruption caused by these.	Y	The organisation has a documented process of seeking risk based assurance from suppliers that services can be maintained during extreme weather events. Where these services can't be maintain the organisation has alternative documented mitigating arrangements in place.	Robustness of supply chain strengthened and tested for Brexit. Increaded resilience due to the ability to receive deliveries Out Of Hours. To-date we have not experienced any issues with supply. Historically, failed delieveries have been as the result of vehicles being unable to gain access to the site. A contract is now in place to ensure on-site roads and paths are cleared of snow and ice. We do have resilience with some key consumables stocked on site and with forecast of extreme weather we could flex this to support short term disruption.	Fully compliant				
14	Severe Weather response	Exercising	The organisation has exercised its arrangements (against a reasonable worst case scenario), or used them in an actual severe weather incident response, and they were effective in managing the risks they were exposed to. From these event lessons were identified and have been incorporated into revised arrangements.	Y	The organisation can demonstrate that its arrangements have been tested in the past 12 months and learning has resulted in changes to its response arrangements.	Severe weather & Heatwave plans activated in the past 12 months.	Fully compliant				
15	Severe Weather response	ICT BC	The organisations ICT Services have been thoroughly exercised and equipment tested which allows for remote access and remote services are able to provide resilience in extreme weather e.g. are cooling systems sized appropriately to cope with heatwave conditions, is the data centre positioned away from areas of flood risk.	Y	The organisations arrangements includes the robust testing of access services and remote services to ensure the total number of concurrent users meets the number that may work remotely to maintain identified critical services	IT cooling systems are sized appropraitely to cope with heatwave conditions. 2x data centres are both located away from areas of flood risk. Large percentage of workforce live within walking distance of the hospital, in conjunction with staff who are able to work remotely, in order to maintainan critical services,	Fully compliant				
Domain: long term adaptation planning											
16	Long term adaptation planning	Risk assess	Are all relevant organisations risks highlighted in the Climate Change Risk Assessment are incorporated into the organisations risk register.	Y	Evidence that the there is an entry in the organiations risk register detailing climate change risk and any mitigating actions	There is a risk assessment within the adaptation policy, and where necessary added to the risk register.	Fully compliant				Our Adaptation Policy was published in 2018 outlining the steps we will take to adapt to the impact of climate change on services and infrastructure.
17	Long term adaptation planning	Overheating risk	The organisation has identified and recorded those parts of their buildings that regularly overheat (exceed 27 degrees Celsius) on their risk register. The register identifies the long term mitigation required to address this taking into account the sustainable development commitments in the long term plan. Such as avoiding mechanical cooling and use of cooling higherachy.	Y	The organisation has records that identifies areas exceeding 27 degrees and risk register entries for these areas with action to reduce risk	Areas have temperature monitoring in place, those recording excessive temperatures add entries onto their Divisional risk register and form action plans.	Fully compliant				
18	Long term adaptation planning	Building adaptations	The organisation has in place an adaptation plan which includes necessary modifications to buildings and infrastructure to maintain normal business during extreme temperatures or other extreme weather events.	Y	The organisation has an adaptation plan that includes suggested building modifications or infrastructure changes in future	Draft Adaption Plan relating to climate change as per the Sustainability Strategy and Management Plan.	Fully compliant				
19	Long term adaptation planning	Flooding	The organisations adaptation plans include modifications to reduce their buildings and estates impact on the surrounding environment for example Sustainable Urban Drainage Systems to reduce flood risks.	Y	Areas are identified in the organisations adaptation plans that might benefit drainage surfaces, or evidence that new hard standing areas considered for SUDS	The site is not prone to flooding. New Nye Bevan unit involved the installation of a large undergound surface water abatement unit installed for a once in a 200 year occurrence. Retrofitting of other areas not yet considered.	Fully compliant				
20	Long term adaptation planning	New build	The organisation considers for all its new facilities relevant adaptation requirements for long term climate change	Y	The organisation has relevant documentation that it is including adaptation plans for all new builds	See above reference water abatement unit.	Fully compliant				

Ref	Domain	Standard	Detail	Evidence - examples listed below	Organisation Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
11	Duty to maintain plan	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	An internal escalation response to increased system pressures/ disruption to services that are or will have a detrimental impact on the organisation's ability to deliver safe patient care, the decalaraion of a Critical Incident is detailed within the Corporate Major Incident Plan.	Fully compliant	Situation, Background, Assessment, Recommendation (SBAR) template to be added to the Incident Directors Action Card during next review of Major Incident Plan.			

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COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: Thursday, September 26, 2019

Title	**Finance Committee Highlight Report**
Chair	**David Moore**
Author (s)	**David Moore**
Purpose	**To advise the Board of the work of the Trust Board Committees**

Executive Summary

The Committee met on August 21, 2019 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:	**BAF References:**
• Finance Report Month 4	• 5.1
• Forecast Report M4 2019/20	• 5.1
• WCO Division Financial Update	• 5.1
• Changing Care @NGH	• 5.2
• Operational Scorecard	• 1.1+2+4+5
• Estates Compliance Programme Update	• 1.7
• Highlight Report from IT	• 1.8
• Cyber Security Quarterly Update	• 1.8
• Business Cases	
○ Nurse Recruitment	• 3.1+3.2
○ Obstetrics and Gynaecology	• 1.5

Key areas of discussion arising from items appearing on the agenda

- The Committee received the Finance Report for Month 4 and was disappointed to see a reversal of the positive trend of the prior month; M4 was negative to plan by 609K meaning the YTD negative variance is now stretched to 1.8M on a pre-PSF/FRF basis (5.493M on a post-PSF/FRF basis). The key driver of the negative variance continues to be pay levels where Agency and Bank costs were significantly overspent – indeed at record levels; income for the month was however above plan. The fact that escalation wards had remained open and that external beds had been closed was exacerbating the situation;
- A Financial Recovery Plan is being finalized for submission to regulators and key components were reviewed. The Committee will scrutinize the final plan at September's meeting with a focus on measures being taken to close the remaining 1.6M gap to full year plan. The Committee discussed the need to continue to drive the Changing Care @NGH programme while noting that in-house focused transformation was not sufficient and that full involvement of STP partners was essential especially on the demand side.
- The Committee will closely monitor progress against the FRP as well as the success in implementing further centralized control on pay and non-pay. The Committee will also continue to hold Divisions to account for their performance through reviews at each of its meetings;
- The WCO Division gave a verbal update of their financial challenges most of which were set in the context of an environment were recruiting and retaining staff was getting increasingly difficult;
- The Committee discussed the CIP programme and again expressed concern at the fact that only 83% of the required 13.23M in saves had been identified and that 61@ of the 4.25M delivered to date was non-recurrent. The Committee welcomed the appointment of Mr Mayes to lead the programme which

it felt could act as a catalyst to ratcheting the transformation programme up to ensure delivery;

- The Committee reviewed Operational Performance and was disappointed to note that the Trust continued to miss most National Targets. Problems with Endoscopy were also discussed and the fact that waiting times were now out to 6 weeks. On a positive note it appeared that unappointed follow-ups had plateaued and were now reducing in the major areas of concern;
- The Committee was pleased to receive the Estates Compliance monthly report and the fact that the programme was well on track;
- The Director of IT delivered the highlights report and gave an update on the many projects that were currently in progress. On the downside it was noted that the department was recruiting for 23.25 WTE roles and currently has vacancies of 15;
- The Committee received an extremely thorough Cyber Security Report from the Director of IT which outlined progress on ensuring the Trust had rigorous defences against cyber threats. The Committee noted that the business model for paying for certain software solutions, such as DeepTrace, was changing from a one-off payment model to a subscription model which meant that investments could not be capitalized. The Committee also noted the collaboration taking place with KGH. The Director of IT was generally satisfied with the levels of security that were installed or planned while noting that cyber security was characterized by an ever changing and potentially dangerous, landscape.

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

- **Business Cases:**
  - **Nurse Recruitment:** The Committee approved the spend required to hire an additional 159 international Agency nurses commencing April 2020. This will result in a Nursing workforce to be over established by 23 WTE equivalent nurses by September 2020, which is then maintained at between 10 and 20 WTE over establishment as forecasted turnover rises and normal nurse recruitment resumes. Although fluctuations will inevitably occur from time to time, recruitment plans will aim to keep staffing levels as close as possible to budgeted establishment once full establishment is reached. The Committee agreed to a total spend of £2.1M in 20/21 which after saves coming from the elimination of premia paid on Agency and Bank staff would be a net cost to the Trust of £631K. This initiative would lead to net budget savings in 21/22 of £1.6M.
  - **Obstetrics and Gynaecology:** Covering the recruitment of 3 staff to provide safe and efficient emergency service, split the Obstetrics and Gynaecology rota, support junior doctors and provide more effective cross cover during annual leave. The case also addresses safety concerns around emergency on-call services where currently Consultants can have elective activity while on call. The case also allows for increased income due to the ability to operate additional clinics. The total additional spend approved by the Committee, net of additional income is £101K in 19/20 and £147K in 20/21.
- The Committee noted that since these cases were using resources from the 20/21 financial year, there would be little money available for "spend only" business cases in the planning round starting later in this financial year and there was every likelihood that only "invest to save" business cases could be considered.

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

- None that are not mentioned 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

- No further actions required of the Board.

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COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: *September 2019*

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

Executive Summary

The Committee met on *23 August 2019* 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)* **1.1; 1.2; 1.4; 1.5;1.6:**
Lung Cancer Pathway Update Corporate Scorecard for Quality Highlight Report from PCEEG Complaints Quarterly Report Standing Items related to Nursing and Midwifery, Infection Prevention, Medical Director, QIA and Compliance Reports.	

Key areas of discussion arising from items appearing on the agenda

Two positive areas were highlighted in respect of the work associated with a successful and timely CNST Maternity Incentive Scheme submission, and with the Infection Prevention and Control Initiative achieving finalist status at the HSJ Awards.

Other key discussion areas are highlighted in the following sections.

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

1. Lung Cancer Pathway. Whilst the report and progress were supported, it was considered that interim targets should be identified to provide reassurance of progress. In addition, key risks should be identified with mitigations and ownership of these clearly stated.
2. East Midlands Clinical Senate Review of the Breast Service was presented in the Medical Director's Report. QGC has requested an action plan to be presented that addresses the Report's key recommendations. In addition, clarity surrounding the public release date was requested given some of the conclusions.
3. Prohibition Notice was issued by HSE to the Category 3 Lab. Appropriate actions have been completed, the notice rescinded, and satisfactory plans now in place.

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

1. Post Partum Haemorrhage Rates. The Trust remains an outlier. An action plan is in place but the QGC have requested that progress against this is monitored with further reports to the QGC.
2. MSSA hospital onset bacteraemia. The annual target is 13, and 10 cases have already

been confirmed in the first 3 months of the current year. The Infection Prevention Steering Group have approved an action plan, and monthly updates have been requested to be provided to QGC. 3. ePMA. There are continuing issues with the current system forcing VTE assessment. The provider has been notified that the Trust will seek a new solution if this is not resolved. This has potential significant implications with respect to costs of IT software infrastructure and staff retraining. 4. Never Event has currently been recorded related to a guidewire being left in a chemotherapy line, though it is understood that this was incorrectly recorded.	
Legal implications/ regulatory requirements	The above report provides assurance in relation to CQC Regulations and BAF entries as detailed above.
Action required by the Board The Board are asked to: 1. Note the report 2. Seek areas of clarification as required.	

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COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: *26 September 2019*

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

Executive Summary

The Committee met on *28 August 2019* 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:

- Mandatory Training/Appraisals
- Summer of Engagement update
- Medical Revalidation
- Medical Recruitment Strategy
- GMC Survey action plans
- Occupational Health
- Talent Academy
- Safe Nurse Staffing
- Report of Safe Working Hours

Board Assurance Framework entries *(also cross-referenced to CQC standards)*

3.1
1.5,3.1,3.2,3.3

Key areas of discussion arising from items appearing on the agenda

- **Mandatory Training/Appraisals**: Drop in surgery appraisal rates to be followed up by HR. Issue with appraisal data not being up to date. Process to be reviewed with update at Sept meeting. **(OC/JB, Sept)**
- **Respect & Support:** concern at low level of attendance from medical divisions. Sessions to be incorporated into existing Division meetings (Division Directorates/HR)
- **Medical Revalidation:** Increase in number of doctors requiring revalidation. Exploring piloting outsourcing of appraisals due to lack of trained resources at NGH or KGH. **(MM)**
- **Medical Recruitment strategy:** Update deferred for 3 months to allow accommodation of clinical fellowship model and in depth medical workforce planning in conjunction with KGH. Progress update in November **(MM/JB, Nov)**
- **GMC Survey:** In response to GMC survey red flags, been working with the Acting Post-Graduate Dean to adopt long-term approach, piloting with Oncology, who will present update at September meeting, attended by HEEM. Will Take learning from this forward into Medicine/Surgery Divisions, which will feedback in Jan/Feb **(MM/NH, Sept)**
- **Occupational Health Annual Report:** positive report and good income generation noted, however concerns on referral waiting time. JB to review with update in October. **(JB, Oct)**
- **Talent Academy:** On track re intake and looking positive. Issues with Northampton

University so intake moved to OU. Working with UON to resolve. **(SO)**

- **Safe Staffing:** Maintaining at 99% despite heavy pressures – August may be a struggle. Nurse recruitment business plan approved. Work to commence next year.
- **Report on Safe Working hours: Presented by new guardian, Dr Saleem Salako, with renewed energy.** Progress being made re attendance at junior doctors forum, drop in clinics. No issue re exception reporting. £63k made available to support junior doctors – to be used to provide project management support. Joint Task force to be set up by Phil and Janine with input from Division Heads to get accurate establishment figures. Faye Gordon to provide input as she has done a lot of work on getting accurate establishment data. Update at next meeting.
  (JB/PB)
- Junior Doctor's new contract and implications for rotas etc raised as concern – JB to produce summary of implications for Trust – update TBC

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

Mandatory Training/Appraisals accuracy of data **(OC/JB, Sept)**
Medical Recruitment strategy update **(MM/JB, Nov)**
GMC Survey, Oncology action plans **(MM/NH, Sept)**
Safe Working Hours, progress on accurate establishment data **(JB/PB, Sept)**
Junior doctor new contract and implications for rota **(JB, TBC)**
Occupational Health referral time issue **(JB, Oct)**

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

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

Action required by the Board

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: 26 September 2019

Title	**HMT Exception Report**
Chair	**Dr Sonia Swart (CEO)**
Author (s)	**Ms Deborah Needham (Deputy CEO/COO)**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met on 3 September 2019 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:

1. CEO update
2. Divisional scorecards
3. Cancer performance
4. IBP framework
5. Financial recovery
6. Clinical senate update
7. Urgent care
8. Oncoplastic breast business case

Board Assurance Framework entries
1.1, 1.2, 2.2, 3.1, 3.2,

Key areas of discussion arising from items appearing on the agenda

CEO update
An update was provided by the CEO detailing the NHS provider's campaign for capital investment changes and the link to the 5 year plan.

Divisional Scorecards
The divisional scorecards were highlighted for information and by exception:

Womens, Childrens, Oncology, Haematology & Cancer – Nursing workforce gaps in oncology

Medicine – Urgent care pressures & diagnostic waits

Surgery – Unappointed follow up patients within the H&N directorate & actions being taken.

Clinical Support services – Outpatient contact centre.

Cancer performance
An update was provided by Mr Cooper for the improving June & July cancer performance, including actions being taken for challenged pathways. Harm reviews in place with no harm noted for any patients waiting over 104 days.

IBP framework
Mr Pallot gave an update on the Integrated business planning framework including timescales and requirements from divisions and directorates.

Financial recovery
In the absence of the Director of finance, the deputy DoF gave a presentation on the current financial position, including a summary of the actions being taken to deliver a balanced position. The requirements for divisions and directorates to ensure further savings were realised was also discussed and noted.

Clinical senate update
Mr Metcalfe gave an update on the recent East Midlands clinical senate visits for Breast & Cardiology. The senate visits consist of a panel of experts who walk and assess the patient pathway, speak to clinicians and then feedback with recommendations for improvement.

Urgent care
Mrs Needham gave a verbal update on the urgent care transformation programme and progress against the four work streams which are in place and being led by herself, Mr Metcalfe & Mrs Oke.

Oncoplastic breast business case
Mr Kerr presented a business case for a 4th Oncoplastic specialist breast surgeon. The case was presented as a "invest to save" business case. The HMT supported the case and recommended its approval to the Finance & performance committee.

Any key actions agreed / decisions taken to be notified to the Board
The 4th Oncoplastic breast surgeon business case was recommended for approval to the finance & performance committee.

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

All areas of risk regarding quality and performance are covered in Trust Board reports and detailed on the risk register.

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

Action required by the Board

To note the contents of the report.

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

AGENDA

NHS Northampton General Hospital NHS Trust

PUBLIC TRUST BOARD

Thursday 26 September 2019
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 A Burns	**Verbal**
	2.	Declarations of Interest	Note	Mr A Burns	**Verbal**
	3.	Minutes of meeting 26 July 2019	Decision	Mr A Burns	**A.**
	4.	Matters Arising and Action Log	Note	Mr A Burns	**B.**
	6.	Patient Story	Receive	Executive Director	**Verbal.**
	7.	Chairman's Report	Receive	Mr A Burns	**Verbal**
	8.	Chief Executive's Report	Receive	Dr S Swart	**C.**
10:15	**CLINICAL QUALITY AND SAFETY**				
	9.	Medical Director's Report including • Learning from Deaths Update • GMC Survey Results Update	Assurance	Mr M Metcalfe	**D.**
	10.	Director of Nursing and Midwifery Report	Assurance	Ms S Oke	**E.**
	11.	Patient Experience Survey Update	Assurance	Ms S Oke	**F.**
10:40	**OPERATIONAL ASSURANCE**				
	12.	Month 05 Finance Report	Assurance	Mr P Bradley	**G.**
	13.	Operational Performance Report	Assurance	Mrs D Needham	**H**
	14.	Workforce Performance Report	Assurance	Mrs J Brennan	**I.**
11:10	**FOR INFORMATION & GOVERNANCE**				
	15.	Fire Safety Annual Report	Assurance	Mr S Finn	**J.**
	16.	Fire Safety Board Compliance Statement	Assurance	Mr S Finn	**K.**
	17	Corporate Governance Report	Assurance	Ms C Campbell	**L.**
	18.	Brexit Update	Assurance	Mrs D Needham	**M.**
11:40	**COMMITTEE REPORTS**				
	19.	Highlight Report from Finance and Performance Committee	Assurance	Mr D Moore	**N.**
	20.	Highlight Report from Quality Governance	Assurance	Mr J Archard-	**O.**

Time	Agenda Item		Action	Presented by	Enclosure
		Committee		Jones & Prof T Robinson	
	21.	Highlight Report from Workforce Committee	Assurance	Ms A Gill	**P.**
	22.	Highlight Report from HMT	Assurance	Dr S Swart	**Q.**
11:50	**23.**	**ANY OTHER BUSINESS**		Mr A Burns	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held at 09:30 on 28 November 2019 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).