UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Public Trust Board

Thursday 30 January 2020

09:30

Board Room
Northampton General Hospital

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

A G E N D A

NHS
Northampton General Hospital
NHS Trust

PUBLIC TRUST BOARD

Thursday 30 January 2020
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 28 November 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	**PERFORMANCE**				
	9.	Integrated Performance Report	Assurance	Dr S Swart	**D.**
	10.	End of Year Financial Position	Assurance	Mr P Bradley	**E.**
	11.	Agency Staff Governance	Assurance	Mr M Smith	**F.**
	12.	Board Assurance Framework (Q3)	Assurance	Ms C Campbell	**G.**
	13.	EU Exit Operational Readiness	Assurance	Mrs D Needham	**H.**
	14.	Standing Orders/ SFI & Scheme of delegation	Approval	Ms C Campbell Mr P Bradley	**I.**
	15.	Maternity Review	Assurance	Ms S Oke	**J.**
11:10	**STRATEGY**				
	16.	NGH Improvement Plan	Assurance	Ms C Campbell	**K.**
	17.	Freedom To Speak Up Strategy & Self-Assessment	Assurance	Ms C Campbell	**L.**
12:00		**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 26 March 2020 in the Board Room at Northampton General Hospital.

Time	Agenda Item	Action	Presented by	Enclosure
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

Thursday 28 November 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
	Dr E Heap	Associate Non-Executive Director
	Mr D Moore	Non-Executive Director
	Ms J Houghton	Non-Executive Director
	Mr J Archard-Jones	Non-Executive Director
	Mr D Noble	Non-Executive Director
	Mr M Metcalfe	Medical Director
In Attendance		
	Ms C Campbell	Director of Corporate Development Governance and Assurance
	Mr M Smith	Chief People Officer
	Mr C Pallot	Director of Strategy & Partnerships
	Mr S Finn	Director of Facilities and Capital Development
	Ms S Watts	Associate Director of Communications
	Miss K Palmer	Executive Board Secretary
	Mr C Holland	Deputy Chief Operating Officer
	Ms T Swain	(Agenda Item – Patient Story only)
Apologies		
	Prof T Robinson	Non-Executive Director
	Mrs D Needham	Chief Operating Officer & Deputy Chief Executive

TB 19/20 073 Introductions and Apologies

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

Apologies for absence were recorded from those listed above.

TB 19/20 074 Declarations of Interest

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

TB 19/20 075 Minutes of meeting 26 July 2019

The minutes of the Trust Board meeting held on 26 September 2019 were presented for approval.

The Board resolved to **APPROVE** the minutes of the Minutes of meeting 26 September 2019.

TB 19/20 076 Matters Arising and Action Log 26 September 2019

The Board **NOTED** the Action Log and Matters Arising from the 26 September 2019.

TB 19/20 077 Patient Story

Ms Oke introduced Ms T Swain who shared her patient story with the Board.

Ms Swain worked at the CCG and had trained as a nurse at NGH. She advised that

in the middle of October she had a histamine attack at home. An ambulance was called and she was brought into resus. She had no comprehension of the date, time or place. She noted that that the A&E doctor had been lovely and kind.

Ms Swain stated that she had a CT scan and was in resus from 11pm till 4pm the next day. The staff were fantastic. The staff assessed and reviewed her very quickly with a treatment plan put in place. Her BP was very high and she was tachycardic for a while. She was surprised how many visitors there was in resus considering the acuity of some patients. She noted that there was no clock in resus.

Ms Swain commented that she was then moved to majors where there was also no clock. The ward was very busy and she was moved into the corridor to wait for a bed on Walter Tull. It was noted that Walter Tull was extremely busy. She was ready to be discharged at 7pm however she had to request that she was discharged without a doctor seeing her. She left at 1.30am. Ms Swain came back in the morning to collect her discharge summary.

Ms Swain highlighted that on 11.30pm on Walter Tull a decision was made to flip the bay. This was not good for patients as at this time as patients should be settled for the night. She remarked that staff had suffered racism from an elderly patient. The staff had handled this with dignity.

Ms Swain advised that all staff introduced themselves. She stated that there had been a shortage of pillows.

Ms Swain informed the Board that the staff on Walter Tull had been critical of the Executive Team. They believed that the Executive Team did not know the pressure staff were under.

Ms Gill remarked that it was good to see good patient care from staff. She asked what more could the staff have done. Ms Swain commented that night staff had been the ones to make the comment in relation to the Executive Team. These staff had seen limited visibility of the Executive Team and needed to know that their concerns were being listened to.

Ms Swain reported that the handovers had all been seamless.

Mr Metcalfe thanked Ms Swain for her story. He asked what could have been done differently given the context of a busy pressured hospital. Ms Swain suggested the AMP’s could be utilised more.

Ms Houghton referred back to the high number of visitors in ED. She queried whether this should be reviewed. Ms Houghton believed the reinstating the Board to Wards for the Trust Board would be positive. Ms Oke confirmed that this was happening.

Mr Finn confirmed that he would look into the clock issue.

Mr Smith queried how Ms Swain knew her DTA time. Ms Swain explained that she had heard the nurses talking about this.

Dr Swart remarked that this was good perspective to have. She noted that the Executive Team did hospital walkabouts however potentially not enough and visiting night staff needed to be considered. Dr Swart asked what the interaction between staff on the ward was like. Ms Swain advised that on Walter Tull it had been light hearted and banter was witnessed. On Majors she did not see much interaction as it was very busy and on Resus it had been well coordinated with the shift leader

identifiable.

Mr Burns thanked Ms Swain for her helpful comments.

Ms Gill challenged whether the greater utilisation of AMP's had been considered. Mr Metcalfe clarified that it had been discussed at HMT and had been agreed as part of the winter plan to look at in more detail.

Mr Moore asked if there was a protocol for flipping bays. Ms Oke explained that it needed to be done to maintain same sex provision and that there was a protocol in place. The flipping of bays needed to be identified as soon as possible.

Mr Richard-Noel queried how this type of feedback would be usually picked up. Ms Oke confirmed that it could come in via a compliant or her directly which actions would then be identified. This one had been informally to Ms Oke.

The Board **NOTED** the Patient Story.

TB 19/20 078 Chairman's Report

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

Mr Burns reminded the Board that the Trust was still in the pre-election period and this would not finish until the formation of a government.

Mr Burns, Mr Moore and CCG had interviewed for two NED roles. There had been excellent candidates and two had been recommended for appointment.

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

TB 19/20 079 Chief Executive's Report

Dr Swart presented the Chief Executive's Report.

Dr Swart advised that the Northamptonshire Health Care Partnership long term plan would be discussed once purdah had passed.

Dr Swart stated that in October the Trust had been advised that the outcome of the CQC inspection was a change in rating from 'Good' to 'Requires Improvement'. A briefing was conducted with staff. Importantly the urgent and emergency care services continued to be rated as 'Good' whilst being under relentless pressure.

Dr Swart reported that October had been very busy which had led to a number of cancelled operations. There had been 60 operations cancelled at short notice. This was done in the best interests of keeping patients safe.

Dr Swart remarked that the Trust had been on Opel 4 yesterday and had GOLD meetings instated due to the unacceptable level of pressure in the Trust. There were 70 patients in A&E overnight and there had been a long wait for beds. This position had improved this morning. The Executive Team went out to the wards and noted that staff were working exceptionally hard. A formal thanks needed to be passed on to the teams.

Dr Swart commented that ambulances are struggling to unload patients and this was another system of the pressure. There were safety rounds being completed. She had been down to speak to the patients and the patients had appreciated the good level of care that they had been receiving.

Dr Swart discussed what was being done about demand. There was a plan in place

to have a new way of discharging patients coming into effect 02 December 2019. It was important that this plan was effective.

Dr Swart was attending an urgent care meeting with the regulators week commencing 02 December 2019. She stressed that it was some electives and not all electives that were being cancelled. There was a prioritisation process in place.

Dr Swart advised that initiatives continued. There are volunteers helping out on the wards. The Trust would release communication on the Trust's winter message. In this would include staff stories and statistics. Some of the information published in the media was incorrect for example the Trust was not diverting ambulances.

Ms Gill asked if there was any lessons learnt in regards to the adverse media stories. Dr Swart explained that the Trust would not usually release the information without a formal plan. The information had been leaked. Mrs Watts stated that the Trust usually had a good relationship with the media.

Mr Richard-Noel queried how media publicity was picked up by the Trust. Mrs Watts clarified that commentary was monitored. Mr Richard-Noel asked if there were any lessons learnt. Mrs Watts had included the phrase 'hospital in Northampton' to their watch list.

Mr Moore asked for an update on the community beds. Mr Holland advised that there was 12 at Southfields and 5 at Murry Fields. Dr Swart confirmed that from 2 December a plan had been put in place for there to be 100 extra beds in the community (50 for KGH and 50 NGH). There would also be a piece of work looking at the 20 longest admitted patients. Mr Moore asked for Dr Swart's level of confidence in this. Dr Swart admitted she was slightly worried and was approaching this with caution. The plan was reasonable and Mr Holland was the Trust's representative at the Urgent Care Board in which this was discussed.

Ms Gill queried whether there was to be any more MADE events. Mr Holland remarked that an event had been planned before Christmas and another in the new year. He stressed the importance that if these events were done too often they become business as per usual.

Mr Burns commented that it would only get worse in the next few weeks and to not underestimate the difficulties incurred leading up to an election.

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

TB 19/20 080 Integrated Performance Report

Dr Swart introduced the new Integrated Performance Report. This was work in progress and combined elements of both the new and old report. The information team had worked extremely hard to produce the first Integrated Performance Report. She asked the lead Directors to deliver a highlight on their section to the Board.

Mr Holland drew the Board to page 69 of the report pack. It was reported that A&E performance had deteriorated in October and again into November. The previous day had been one of the most difficult days Mr Holland had experienced. Mr Holland stated that there was increased acuity and the number of ambulance arrivals had also increased. There was an issue of black breaches due ambulances waiting more an hour to offload. There would be meetings with EMAS to discuss further. The Trust had also experienced diverts from other hospitals.

Mr Holland commented on the new discharge process with a social worker or a discharge coordinator on every ward to support discharge. The health economy had

a plan to get 60 (30 from NGH 30 KGH) of our longest staying patients out of hospital by 24th December. An associate director from social services was leading this work and the plan was to repeat the process for another 60 in January From Monday the IDT would allocate a member of staff to each ward. This was a markedly different way of working.

Mr Holland advised that in relation to cancer the 62 day performance had increased. The other cancer metrics were performing well. The Trust was having 2 PTL meetings a week. The full cancer plan had been presented to the November Finance & Performance Committee. There had been no 52 week breaches.

Mr Holland stated the elective care team were looking at reducing the new average number of weeks wait. The Trust had a target set of 10.9 and it was at 10.75 weeks at present.

Ms Houghton remarked that the Quality Governance Committee (QGC) had discussed urgent care and the number of patient moves overnight. These patients had been risk assessed and an ED checklist was completed. A short paper would be presented on this subject to the December QGC.

Ms Houghton believed that at 66 pages the Integrated Performance Report was still a too lengthy report. She also noticed that Mrs Brennan's name still remained as lead for some actions. She liked the inclusion of the SPC charts.

Mr Archard-Jones noted that with the 50 patients removed from the Trust and the cancelled electives, there would be an impact on the finances. Dr Swart clarified that the Trust had put a bid forward for winter funding.

Ms Gill acknowledged the progress made against the cancer standards and wondered if any learning could be sought from this. Mr Holland would be meeting with the cancer leads to discuss and focus would continue. Mr Metcalfe believed that the new dynamic cancer lead had been positive and that the Directorates needed to continue to own their pathways.

Mr Burns stressed that a safe and secure urgent care system was the top priority. The issue with ambulance handovers needed to be acknowledged and resolved. Dr Swart concurred. She commented that cancer patients and those with a serious health risk were prioritised.

Mr Burns liked the inclusion of the SPC charts.

Ms Oke delivered the Director of Nursing update which was on page 67 of the report pack.

Ms Oke advised that FFT had deteriorated. She discussed complaints with the Board. The common themes were delays, communication issues and cancellations. These were on the Patient Experience Group agenda as well as what could be done to improve patient expectations. The complaint response rate had improved from the previous month and the complaints team expected to achieve above 90% in December.

Ms Oke stated that the Trust achieved 99% new Harm Free Care in the National Safety Thermometer point prevalence study. A focus continued on ensuring that all incidences of Hospital Acquired Pressure Ulcers and patient's falls are investigated with learning taken into practice. It was noted last month that there were a number of cases of device related pressure ulcers developing and this is the focus of the NSHI collaborative which the team was participating in.

Ms Oke reported that there were 6 cases of Clostridium difficile identified in September taking the Trust to 25 cases year to date. The Trust ceiling was set at 40 cases. There were 7 MSSA cases in month raking the year to date total to 19 against an internal ceiling of 13. All cases all are subject to investigation and are found to be unavoidable.

Ms Oke provided a safeguarding update. The Trust was working actively with its partners and a close eye was being kept this following challenged with the local authority services.

Mr Metcalfe shared the Medical Director update with the Board.

Mr Metcalfe advised that the HSMR this remains within expected range as did the SHMI.

Mr Metcalfe stated there was a Never Event update on page 68 of the report pack. These had been discussed in detail at QGC as did the Serious Incidents.

Mr Metcalfe reported that VTE electronic forcing function was due to go live 09 December.

Mr Smith presented the Chief People Officer update.

Mr Smith commented that sickness absence continued to rise month on month. It was noted that long term sickness was highest recorded in Surgery. This needed to be looked into including how prevention of the sickness to start with and then how to welcome staff back. The short term sickness was highest in medicine. The flu vaccination would help the prevention agenda.

Mr Smith stated that there was a good health and wellbeing agenda. This may need to be looked at in ways to target staff differently.

Mr Smith advised that the time to hire metric had a target set of 8 weeks. This was currently at 9.6 weeks.

Mr Smith informed the Board that mandatory training was being explored. There would be a full breakdown presented to the January Workforce Committee.

Mr Smith provided an update on the new pension scheme. There had been 3 applicants to date at NGH. There would be an update on the lifetime allowance in Dr Swart's blog. The changes to the NHS pension would be worked through and communicated to staff. Mr Burns remarked that it needed to be a nationally applied rule.

Mr Moore referred to the Trust level vacancy rate. He challenged what this actually meant and there needed to be granularity behind this. Ms Gill clarified that this had been discussed in detail at the Workforce Committee.

Mr Burns stated that the staff SPC charts were worrying.

Mr Bradley delivered the Director of Finance update to the Board.

Mr Bradley drew the Board to page 66 of the report pack. There had been a detailed discussion at Finance & Performance Committee on the financial plan. He advised that the month 7 results showed a pre-PSF/FRF £2.8m negative variance to plan. This had been due to a combination of Elective in patient cancellations as a result of

operational pressures and a reduction in high value Daycase activity (Cardiology largely due to sickness). There had also been a change in income in relation to non-electives. He remarked that non-elective growth was up 8.5% and there had been an increase in ambulatory care of 47%.

Mr Bradley reported that the cost received per patient had dropped from £1.5k to £1k in Nye Bevan for instance.

Mr Bradley commented that the most likely year end forecast was still being worked out.

Mr Bradley stated that in month pay was £1.2m adverse which was £4.7m year to date. The medical staff budgets were almost £600k overspent in month with £350k of that in the medical division. Mr Bradley advised that nursing staff numbers had increased by 60wte in month but 28wte were supernumerary and the Trust had to double run from a cost perspective during October.

Mr Bradley explained that the electives for October were 110 less than planned. There were cancellations and most of these were unplanned due to emergency pressures.

Mr Bradley commented that given where the Trust was financially he believed that the financial position was fairly unrecoverable therefore the Trust would not hit the control total. The Trust needed to start preparing the year-end forecast change documentation to ensure the figures submitted after December results are met at the end of March 2020. These would need to go to the December Audit committee and Board. Then signed off by the Chairman, Finance & Performance Committee and the STP.

Ms Houghton thanked Mr Bradley for the SPC charts. She referred to page 86 of the report pack which included the SPC chart for bank and agency pay. She shared that Milton Keynes had tried a new nurse roster app and suggested that this could be looked into.

Mr Smith explained that medical agency staff was the biggest staff group for agency staff. This needed to be understood and remarked that in June medical pay doubled.

Mr Richard-Noel queried whether the use of technology to create apps had been looked into. Mr Smith confirmed that the patchwork app had been trialled which was where shifts could be booked online.

Ms Gill asked what the control and approval process was for agency spend. Mr Bradley clarified that there was a medical agency meeting. There is work to be done with HR to refocus this group and on tightening the process. This had been discussed in detail at the Finance & Performance Committee.

Mr Burns found the SPC graphs to be illuminating.

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

TB 19/20 081 Generator Outage Update

Mr Finn presented the Generator Outage Update.

Mr Finn shared with the Board a brief summary of testing process which was included on page 91 of the report pack. There had been an electrical generator failure following routine testing on 29 October 2019. The routine 'on load' test for the old site had been carried out as planned. After approximately 20 minutes, two

generators went into fault. The Estates team remain present throughout the tests so were able to reinstate the mains supplies and restored power to all areas within 5 minutes.

Mr Finn advised that the initial investigation of the two generators showed that the controls showed a fault had occurred which lead to the generators shutting down.

Mr Finn listed the actions taken which were included in page 92 of the report pack. This further went on to detail what had gone well and areas of learning.

Mr Finn stressed to the Board that the failure had not been linked to the shortage experienced in February 2019.

The Board **NOTED** the Generator Outage Update.

TB 19/20 082 Flu vaccination for Healthcare Workers

Ms Oke and Mr Smith presented the Flu vaccination for Healthcare Workers

Mr Burns congratulated the Trust on their flu vaccination rate.

Ms Oke advised that the flu vaccination uptake was 83.4% which was 12% higher than the previous year. The Trust had achieved its CQUIN.

Mr Burns remarked that it was good for staff resilience and congratulated all involved in achieving this.

The Board **NOTED** the Flu vaccination for Healthcare Workers.

TB 19/20 083 Board Assurance Framework (Q2)

Ms Campbell presented the Board Assurance Framework (Q2).

Ms Campbell advised that since the last report and following the CQC inspection and recommendations, the BAF has been reviewed by the Board in a development session, reformatted and updated in line with an exemplar format provided by the CQC ensuring no previously identified good practice has been lost in the change. The BAF was included from page 109 to 124 of the report pack.

Ms Campbell stated that the actions within the BAF should be looking forward and not be retrospective. The actions included names and due dates. The BAF also linked to the corporate risk and CQC standard.

Ms Campbell referred the Board to page 107 of the report pack which featured the risk matrix and order of severity.

Ms Campbell expanded on a few changes to risk scores highlighted in the BAF. It was noted that; Risk ID 1.3 ' Risk of failing CQUIN standards leading to lost opportunity to improve service quality and financial risk of due to loss of funding associated with CQUIN attainment' had decreased in score from 16 to 12 due to baseline data now being available, Risk ID 3.1 ' Risk that the Trust fails to achieve optimum workforce capacity to deliver best possible care now and in the future' had increased from 10 to 15 due to gap in staffing vacancies and Risk ID 5.3 ' Risk that the Trust fails to manage its Capital programme within Capital Resource limit or fails to secure sufficient funding for infrastructure and equipment improvements' had increased from 15 to 20 due to increased pressure on capital from infrastructure incidents.

Ms Campbell advised that the BAF would link to the new strategy pledges and this

was for further debate by the Executive Team. She had also amended the definition for Zero risk has been slightly amended to add “With no or negligible potential risk to staff /patients” as requested. She requested Board approval of this. The Board **APPROVED** the risk appetite statement and framework.

Mr Moore referred the Board to risk 1.6 on page 114 of the report pack. He queried whether the initial score of 25 was correct. Mr Metcalfe would support the risk score of 25. Ms Oke concurred.

Ms Houghton complimented the new format of the BAF. She questioned whether there should be a risk for safeguarding included. Ms Campbell clarified that it should be featured under risk 1.4 and would ensure this was included.

Action: Ms Campbell

Mr Burns drew the Board to page 108 of the report pack. He struggled to understand the difference between the top and bottom risk. He was informed that risk 3.2 was about capability and not numbers.

Mr Noble liked the new format of the BAF. He found the target dates tight for some of the actions. Ms Campbell explained that some dates default to the next year and that she could modify the wording to reflect this.

Action: Ms Campbell

The Board **NOTED** the Board Assurance Framework (Q2).

TB 19/20 084 Revalidation Report – Compliance Statement

Mr Metcalfe presented the Revalidation Report – Compliance Statement.

Mr Metcalfe advised that this had been presented to the Workforce Committee who had recommended approval.

The Board **APPROVED** the Revalidation Report – Compliance Statement.

TB 19/20 085 CQC Report & Action Plan

Ms Campbell presented the CQC Report & Action Plan.

Ms Campbell noted that the Trust Board was aware of the change to ratings. The final reports contained the ‘must’ and ‘should’ actions. These can be found are listed in the improvement plan (Appendix A). There were a total of three ‘must’ actions and 36 ‘should’ actions. A summary was provided on page 139 of the report pack. The likelihood score had also been included.

Ms Campbell informed the Board that at the time of writing the report, 28 actions out of a total of 126 have been completed. The process for confirming closure of actions would be for the Lead Executive to sign off on receipt of the required evidence and for the Executive team to ratify prior to the Quality Governance Committee.

Ms Houghton queried what mechanism was there to know the changes had been implemented from the actions. Ms Campbell explained that there was a database of evidence held by the governance team.

The Board **NOTED** the CQC Report & Action Plan.

TB 19/20 086 People Strategy Update Report

Mr Smith presented the People Strategy Update Report.

Mr Smith advised that this had been presented to the October Board of Directors and

it had been requested that it be shared in the Public domain.

Mr Smith stated that over 1000 people participated during the engagement events and provided important feedback and clear priorities for action. A Diversity & Inclusion manger had been appointed to address areas under the culture objective. There were a number of Health & Wellbeing initiatives which would continue. The OD Team would also carry out targeted interventions.

Mr Smith remarked that the People Plan had been included in communications and CEO Blog. It would be shared at the December HMT with it also highlighted in Core-Brief and Question-Time.

Mr Smith reported that there would be a HR and OD day on the 18 December with KGH to share ideas of best practice.

Mr Burns asked if Mr Smith was comfortable with the process and resource. He confirmed that he was.

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

TB 19/20 087 Communications Strategy Update

Ms S Watts presented the Communications Strategy Update.

Ms Watts advised that the Trust was in year one of its 2018-2021 communications strategy. The Trusts communications reach over 9000 people.

Ms Watts remarked that the average online response time was 35 minutes. It was important for the Trust to be very responsive.

Ms Watts stated that the Trust always looked to strengthen its local media links. The Trust also created its own animations, videos and promotions.

Ms Watts informed the Board that NHSE had contacted the Trust in relation to their flu campaign material.

Ms Watts confirmed that the Trust Facebook page had approximately 1000 followers.

Ms Watts discussed the proactive work done with Twitter accounts. Staff accounts linked to NGH were taken down if they are not used in 6 months. There is training provided for the staff that required a Trust twitter account.

Mr Archard-Jones asked if the Trust worked collaboratively with KGH. Ms Watts explained the two acutes get in contact with one another if there is a shared story and also with joint messaging over winter.

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

TB 19/20 088 FTSU Bi-Annual Report

Ms Campbell presented the FTSU Bi-Annual Report.

Ms Campbell advised that within the timeframe there were 28 cases reported. This was a big increase from the previous two quarters and this increase correlated with the relaunch of Freedom to Speak Up in January 2019.

Ms Campbell referred the Board to page 179 of the report pack listed the content and source of cases reported.

Ms Campbell stated that the Values Ambassador role was introduced in the Trust in January 2019. It was noted that identification and training of individuals had taken place in Q1 & 2 with seven individuals in place by Q3.

Ms Campbell reported that concern raised by staff group (where known) was listed on page 179 of the report pack. A summary of the Trust Guardian role activity in year to date followed on page 180 of the report pack. She had presented at two Junior Doctor Induction sessions- “Meet the Guardians” with the Guardian Of Safe Working.

Ms Campbell drew the Board to page 181 of the report section 4.5. The Freedom to Speak Up Guardians in NHS Trusts provided data to the NGO on the number of speaking up cases raised with them during the first and second quarters of 2019/20. The Trust’s date correlated with this.

Ms Campbell advised that in section 4.6 case reviews were detailed and these had been discussed at the Workforce Committee. There were 102 recommendations which a gap analysis had been completed and would be shared in the Board development session.

The Board **NOTED** the FTSU Bi-Annual Report.

TB 19/20 089 NEDs Roles

Ms Campbell presented the NEDs Roles

Ms Campbell asked that the Board approved Mr D Moore as the Vice-Chairman and Senior Independent Director.

Ms Houghton asked if deputy Chairs should be included within the paper. Ms Campbell believed that this should be agreed via the relevant Committee.

Ms Houghton commented that she was the maternity safety champion and did this need to be included. Mr Burns asked that the Non-Executive Directors clarified their roles and reserves for the Committees to Ms Campbell.

The Board **NOTED** the NEDs Roles and **APPROVED** Mr D Moore as the Vice-Chairman and Senior Independent Director.

TB 19/20 090 Any Other Business

There was no other business to discuss.

Date of next Public Board meeting: Thursday 30 January 2020 at 09:30 in the Board Room at Northampton General Hospital.

Mr A Burns called the meeting to a close at 12:15pm

Public Trust Board Action Log **Last update** **10/01/2020**

Item No	Month of meeting	Minute Number	Paper	Action Required	Responsible	Due date	Status	Updates
Actions - Slippage								
Actions - Current meeting								
116	Nov-19	TB 19/20 083	Board Assurance Framework (Q2)	Ms Houghton complimented the new format of the BAF. She questioned whether there should be a risk for safeguarding included. Ms Campbell clarified that it should be featured under risk 1.4 and would ensure this was included.	Ms Campbell	Jan-20	On Agenda	
117	Nov-19	TB 19/20 083	Board Assurance Framework (Q2)	Mr Noble liked the new format of the BAF. He found the target dates tight for some of the actions. Ms Campbell explained that some dates default to the next year and that she could modify the wording to reflect this.	Ms Campbell	Jan-20	On Agenda	
Actions - Future meetings								

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Report To	**Public Trust Board**
Date of Meeting	**30 January 2020**

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

This paper is for: (delete as appropriate)

□ √ Note	□ √ Assurance
For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

Executive summary
The report highlights key business and service issues for Northampton General Hospital NHS Trust in recent weeks.

Related Strategic Pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Strengthen and integrate local clinical services particularly with Kettering General Hospital* 4. *Create a great place to work, learn and care to enable excellence through our people*
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks
Related Board Assurance Framework entries	BAF – please enter BAF number(s)
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.
Financial Implications	
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper

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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Public Trust Board
30 January 2020

Chief Executive's Report

1. Group Management Model

On Thursday 9 January, 24 hours ahead of planned media and stakeholder activity, staff at NGH and Kettering General Hospital were informed of our plans to move towards a group management model to strengthen health services in Northamptonshire. This move demonstrates our strong commitment to greater collaboration between our hospitals and a commitment from the senior management teams to work much more closely together.

Our intention is to:

- Appoint a group chief executive to serve the two hospitals who will report to the group chairman (Alan Burns)
- In time to move to the appointment of a group chief finance officer, group director of strategy and group chief people officer.
- Each hospital will continue to have a Trust board with at least a managing director post along with a number of key executive posts that will include a director of operations/chief operating officer, medical director and a director of nursing.
- Set up a management board across both hospitals that will oversee the work required to set up the formation of the group services with the joint appointment of clinical posts during the next few months.

We will continue to keep board members updated on progress and development as we move forwards to support the development of plans that will result in more sustainable high quality clinical services for the population of Northamptonshire. The two acute hospitals working together look forward to developing the best possible hospital services and also to working collaboratively with the wider health and care partnership.

2. Urgent Care

The New Year has seen little let-up in demand for our services and the first week of January saw unprecedented levels of demand, with more than 400 patients attending our emergency department every day. Patient safety has remained our key priority and staff have been doing all they can to enable more flow within the hospital. The level of teamwork has been commendable.

The commitment and dedication of members of TeamNGH at all levels has not gone unnoticed, and our team of non-clinical staff who have volunteered to go out and provide additional support to clinical colleagues have been offered a real and valuable insight into the work they do.

It is clear that the hospital has struggled with capacity constraints in the ED department and in terms of bed availability and as we work with our partners in health and social care to improve urgent care services and develop alternatives to hospital care it will be equally important to identify additional emergency department capacity for two particular groups of patients - paediatric patients and their parents and elderly patients who are frail.

3. Our Patients

When everyone is busy, it's easy to forget the impact our behaviour has on others, but it is clear that our patients and their families do notice. They not only comment on the kindness, compassion and standard care they have received, they also note that this has taken place in a pressurised environment and, despite all that is going on, TeamNGH has remained calm and caring, providing much-valued and needed support and reassurance to patents and their families.

A recent social media post said '*This experience really got me thinking about how much we all complain about wait times and the NHS (myself included) and what would happen if we didn't have these people helping us. When it really matters, they are on it.'*

4. Our Staff

Board members will be aware of the importance of ensuring we provide support for our staff so they can continue to provide the best possible care and, as stated above, 'be on it'. We are mindful of the impact that is created by the challenges we face of rising demand, patient expectation and being able to discharge our patients safely and effectively in order to create capacity.

Staff are encouraged and supported to maintain and improve their physical and mental health through our health and wellbeing programme. As well as a range of emotional support already available we are now offering members of TeamNGH a trial of SilverCloud – an online CBT (cognitive behavioural therapy) support. The programme offers information and support for people experiencing problems related to mental health and can be accessed by staff any time from a computer, smart phone or tablet.

In addition to online CBT, we have also launched a free, confidential 24 hour telephone employee assistance provision (EAP) hosted by Vivup. And, on 6 February we are taking part inTime to Talk Day, when we will be offering members of TeamNGH the chance to call in and have a chat over a cup of tea about anything that is on their mind. Mental health problems affect one in four of us, yet too many people are made to feel isolated, ashamed and worthless because of this. During Time to Talk Day we will be encouraging everyone to be more open about mental health – to talk, listen to change lives. We know that talking about mental health can feel awkward, but it doesn't have to. Staff are invited to come and talk to trained mental health champions anytime between 10am and 3pm in the large hall at Cripps Postgraduate Medical Centre.

5. NHS Long Term Plan

A range of workshops and meetings relating to the NHS Long Term Plan have involved all partners in Northamptonshire in considering how we need to work differently to achieve improved outcomes for patients in Northamptonshire . This will entail a focus on transforming services whilst paying attention to the development of our workforce. There is a clear recognition that considering the enablers of change includes a revised approach to strategic planning, financial frameworks, information technology and innovation, a strategic plan for estates and good clinical engagements. This is also a time to re-emphasise the importance of involvement of our community. As the various strategic plans move forward with implementation and delivery strategies, it will be important to continue to consider how all the partner organisation boards help to drive and sustain these key tasks.

6.Awards

I was delighted to learn that six of our apprentices are set to collect awards at the NHCP Annual Apprenticeship Awards on 7 February. It is testament to the teamwork and support offered to our apprentices by both our learning and development team and colleagues across TeamNGH.

Dr Sonia Swart
Chief Executive

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**30 January 2020**

Title of the Report	**Integrated Performance Report**
Agenda item	**9**
Presenter of Report	Dr S Swart - CEO
Author(s) of Report	Mrs D Needham – COO/DCEO Mrs S Oke – Director of Nursing Mr M. Metcalfe – Medical Director Mr P. Bradley – Director of Finance Mr M. Smith – Chief People Officer Mr S. McGarvey – Head of information

This paper is for: (delete as appropriate)

□ Approve	□ Receive	□ Note	x□ Assurance
To formally receive and discuss a report and approve its recommendations OR a particular course of action	To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it	For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

Executive summary

The paper is presented to provide information and assurance to the board on the key national performance, quality, finance & workforce KPI's

The report details key exceptions via the integrated scorecard using statistical process control and the NHSI methodology of reporting.

The summary sheets completed by each director form the overall executive summary

Related Strategic Pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Create a sustainable future supported by new technology* 4. *Strengthen and integrate local clinical services particularly with Kettering General Hospital* 5. *Create a great place to work, learn and care to enable excellence through our people* 6. *Become a University Hospital by 2020 becoming a centre of*

	excellence for education and research *(Delete as applicable)* *ALL*
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) ALL
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (Y/N) 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)? (Y/N) If yes please give details and describe the current or planned activities to address the impact.
Financial Implications	
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 new format & associated metrics noting improvements required
3. Seek clarification on performance & actions being taken.

Corporate Scorecard – Integrated performance report

Date: January 2019
Reporting Period: December 2019

Northampton General Hospital NHS
NHS Trust

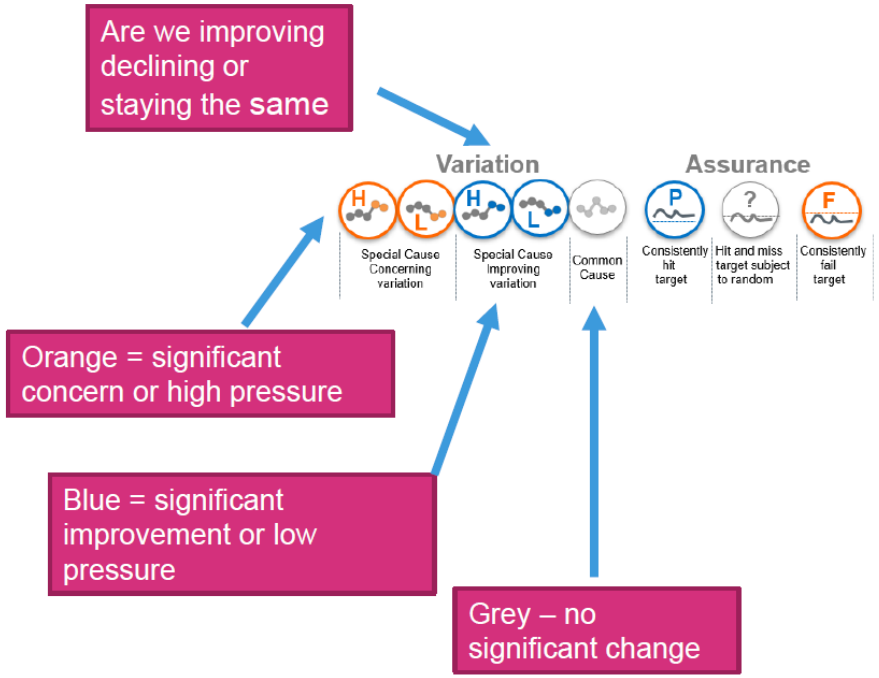
Pilot SPC Charts

Collaboration work with KGH and a wish to move to a common style of Board reporting was agreed by the Collaboration Steering Group in August 2019. Subsequently, an assessment of both Boards' report was completed, leading to eight metrics being agreed for both trusts to report on using SPC. The number of metrics moved to SPC will increase over the next few months, with the format of the Corporate Scorecard changing accordingly.

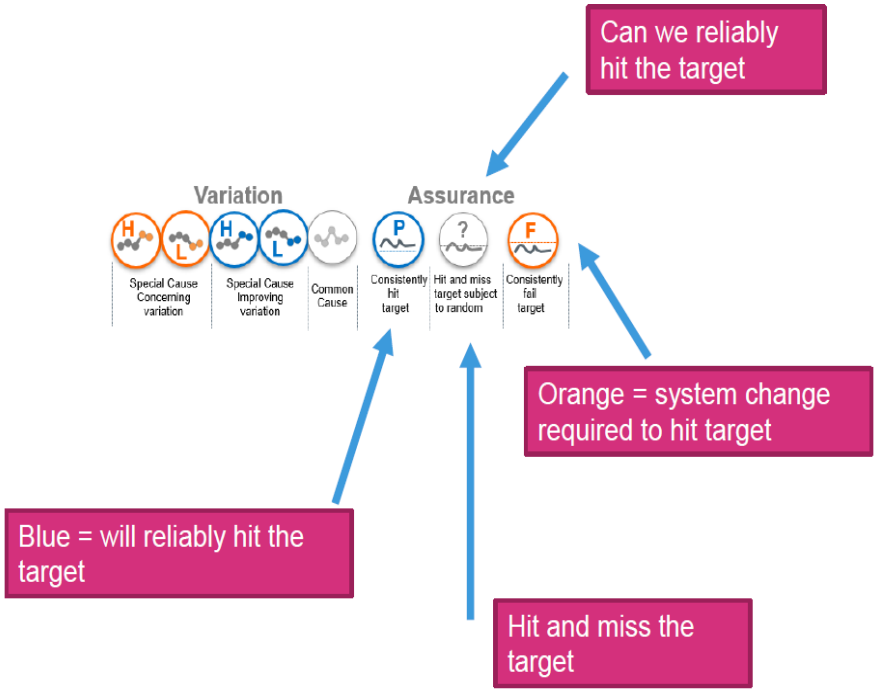
The reports that follow use the key below. A recap of using these descriptions is also included

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

High level key - variation



High level key - assurance



Domains: Caring, Effective & Safe

Domain	Metric	Target	Variation	Assurance	Chart
Caring	Complaints responded to within agreed timescales	90%			
Caring	Friends & Family Test % of patients who would recommend: A&E	86%			
Caring	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	96%		F	Page 8
Caring	Friends & Family Test % of patients who would recommend: Maternity - Birth	97%			
Caring	Friends & Family Test % of patients who would recommend: Outpatients	94%			
Caring	Mixed Sex Accommodation	0	L	P	

Caring Domain - Non-SPC Metrics

Section:	Indicator:	Target:	Nov-19	Dec-19	Chart
Caring	Compliments	N/A	4,006	3,952	

Domain	Metric	Target	Variation	Assurance	Chart
Effective	Percentage of discharges before midday	25%	L	F	Page 10
Effective	# NoF - Fit patients operated on within 36 hours	80%		P	
Effective	Maternity: C Section Rates	29%			
Effective	Mortality: HSMR	106		P	
Effective	Mortality: SHMI	109	Outside Control Limits	P	Page 35
Effective	Stranded Patients (ave.) as % of bed base	40%		F	Page 11
Effective	Super Stranded Long Stay Patients (ave.) as % of bed base	25%			

Effective Domain - Non-SPC Metrics

Section:	Indicator:	Target:	Nov-19	Dec-19	Chart
Effective	Patient Ward Moves Overnight (22:00 - 06:59)	=0	387	423	
Effective	Readmissions within 30 days of previous reporting month	<=12%	13.3%	13.3%	
Effective	% Daycase Rate	>=80%	87.1%	86.3%	
Effective	Failed Daycases as a % of Planned Daycases	N/A	2.7%	2.5%	

Domain	Metric	Target	Variation	Assurance	Chart
Safe	HOHA and COHA (C-Diff > 2 Days)	3			
Safe	MSSA > 2 Days	1			
Safe	VTE Risk Assessment	95%	Outside Control Limits		Page 33
Safe	Transfers: Patients transferred out of hours (between 10pm and 7am)	60		P	
Safe	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	98%			

Safe Domain - Non-SPC Metrics

Section:	Indicator:	Target:	Nov-19	Dec-19	Chart
Safe	Never event incidence	0	0	0	
Safe	Number of Serious Incidents (SI's) declared during the period	N/A	0	1	
Safe	MRSA > 2 Days	0	0	1	
Safe	New Harms	<=2%	1.4%	1.2%	
Safe	Appointed Fire Wardens	>=85%	97.2%	96.2%	
Safe	Fire Drill Compliance	>=85%	54.8%	37.5%	
Safe	Fire Evacuation Plan	>=85%	46.7%	46.0%	

Domains: Responsive

Domain	Metric	Target	Variation	Assurance	Chart
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	90%	Outside Control Limits	F	Page 12
Responsive	Average Ambulance handover times	00:15:00	H	F	Page 13
Responsive	Ambulance handovers that waited over 30 mins and less than 60 mins	25	Outside Control Limits	F	Page 14
Responsive	Ambulance handovers that waited over 60 mins	10	Outside Control Limits	F	Page 15
Responsive	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons		L	F	Page 16
Responsive	Delayed transfer of care	23		?	
Responsive	Average Monthly DTOCs	23		?	
Responsive	Average Monthly Health DTOCs	7		F	Page 17
Responsive	Cancer: Percentage of patients treated within 31 days	96%		?	

Domain	Metric	Target	Variation	Assurance	Chart
Responsive	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	98%		?	
Responsive	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	94%		?	
Responsive	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	94%		?	
Responsive	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	85%		F	Page 18
Responsive	Cancer: Percentage of patients treated within 62 days of referral from screening	90%		?	
Responsive	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	85%		?	
Responsive	RTT over 52 weeks	0	L	?	
Responsive	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	99%	L	F	Page 19
Responsive	Stroke patients spending at least 90% of their time on the stroke unit	80%	L	?	
Responsive	Suspected stroke patients given a CT within 1 hour of arrival	50%		P	

Responsive Domain - Non-SPC Metrics

Section:	Indicator:	Target:	Nov-19	Dec-19	Chart
Responsive	RTT Average wait incomplete pathways	<=10.9	10.1	N/A	
Responsive	Unappointed Follow Ups	=0	7334	7685	
Responsive	Cancer: Faster Diagnosis Standard	>=63%	67%	N/A	

Domains: Well Led

Domain	Metric	Target	Variation	Assurance	Chart
Well Led	Income YTD (£000's)	>=0	H	?	
Well Led	Surplus / Deficit YTD (£000's)	>=0	Outside Control Limits	?	Page 21
Well Led	Pay YTD (£000's)	>=0	Outside Control Limits	F	Page 22
Well Led	Non Pay YTD (£000's)	>=0	Outside Control Limits	?	Page 23
Well Led	Bank & Agency / Pay %	7.5%	Outside Control Limits	F	Page 24
Well Led	CIP Performance YTD (£000's)	>=0		P	
Well Led	Sickness Rate	3.8%	Outside Control Limits	F	Page 36

Domain	Metric	Target	Variation	Assurance	Chart
Well Led	Staff: Trust level vacancy rate - All	9%	H	F	Page 27
Well Led	Staff: Trust level vacancy rate - Medical Staff	9%	Outside Control Limits	P	Page 28
Well Led	Staff: Trust level vacancy rate - Registered Nursing Staff	9%		F	Page 29
Well Led	Staff: Trust level vacancy rate - Other Staff	9%		F	Page 30
Well Led	Turnover Rate	10%	H	P	
Well Led	Percentage of all trust staff with mandatory training compliance	85%		P	
Well Led	Percentage of all trust staff with role specific training compliance	85%	Outside Control Limits	F	Page 31
Well Led	Percentage of staff with annual appraisal	85%		?	
Well Led	Job plans progressed to stage 2 sign-off	90%		F	Page 34

Well Led Domain - Non-SPC Metrics

Section:	Indicator:	Target:	Nov-19	Dec-19	Chart
Well Led	CIP Performance - Recurrent	N/A	39.4%	No Data	
Well Led	CIP Performance - Non Recurrent	N/A	47.2%	No Data	
Well Led	Percentage of all trust staff with mandatory refresher fire training compliance	>=85%	82.7%	No Data	

Directors view – Director of Nursing

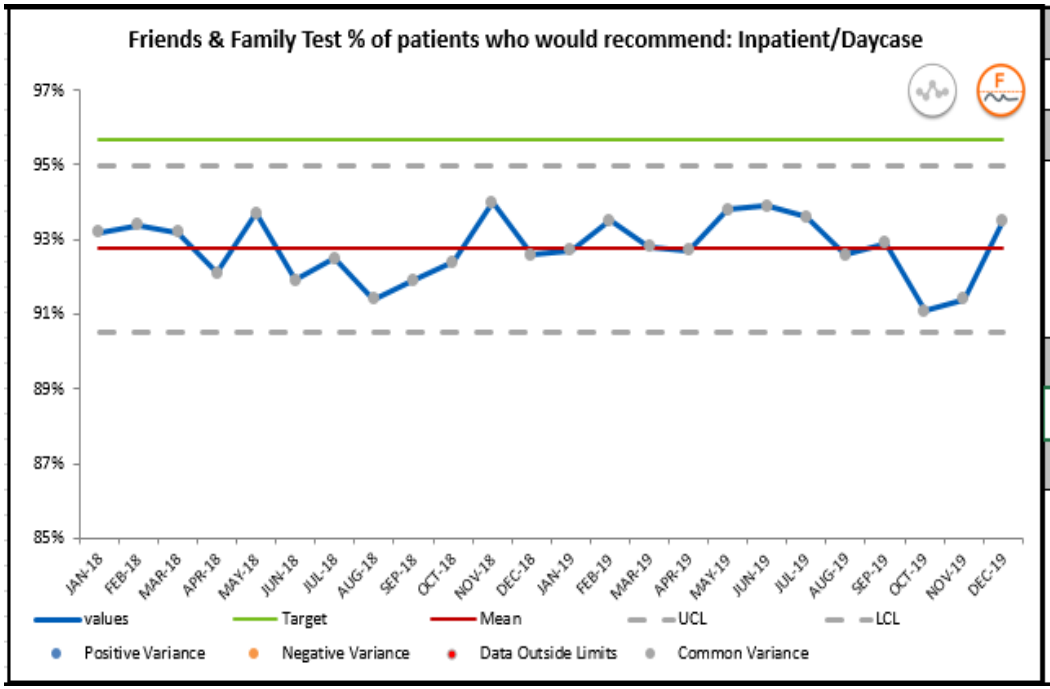
Performance

In November and December there has been an increase in recommendation rates to 93.6% which is now 1.9% below the national recommendation rate.

Action taken

A drive for further improvement includes targeted action in day case areas, work with Pharmacy to improve communication regarding medication and the undertaking of bespoke surveys in local areas to address identified issues. A triangulation exercise has also been completed from the five national surveys in 2018/9 with action plans being executed. Progress will be monitored through the Patient and Carer Experience and Engagement Group.

SPC Charts – Friends & Family Test - % of patients who would recommend Inpatient & Daycase



DEC-19
93.5%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95.7%
Target Achievement
Metric is consistently failing the target

What the chart tells us:
The change in the Friends & Family test is following common cause variation.

Context:
The result for Inpatient and Day Case continues to be within normal levels of variation. The Inpatient and Day Case result is 2.2% below the national average for December when compared with 4.3% for November. Results per ward continue to vary greatly.

Actions Completed:
The Right Time survey continues alongside bespoke surveys which identify specific areas where further improvement is needed. The patient experience team continues to hold multidisciplinary meetings including Right Time forums, Councils and train within the nurse development programmes to raise awareness of patient experience and the common themes. A thematic triangulation has been undertaken within the patient experience team to look at the common themes which are coming out from five national surveys. This work will lead to targeted action plans.

Actions:
- Continue with training and attendance at multidisciplinary meetings to raise awareness of patient experience.
- Disseminate the results from the thematic triangulation and request action plans from relevant leads.
- The Surgery Division are looking at ways to improve communication with patients that are cancelled for surgery as an increase has been seen with the current trust pressures.

Directors view – Chief Operating Officer / DCEO

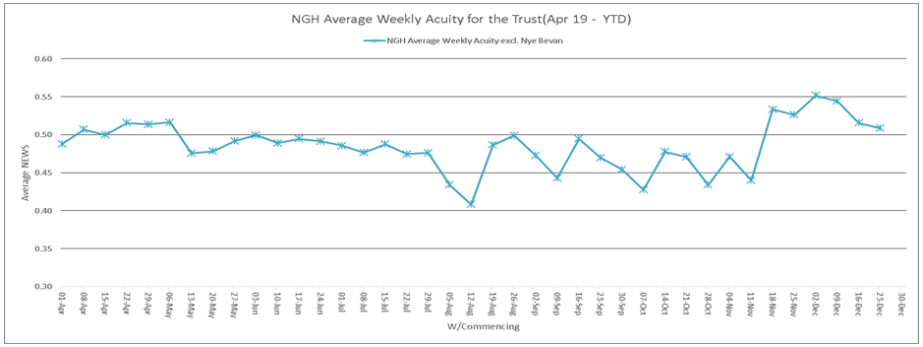
Performance - A&E 4hrs

- Performance deteriorated in December
- Emergency activity remained variable with peaks in activity during the evenings
- Numbers of stranded patients increased
- Acuity of patients was very high along with high levels of occupancy in level 2 & 3 beds (ITU/HDU)
- Exit block within A&E caused a high number of patients waiting to handover from the ambulance service (30 mins & 60 mins)

Actions being taken
Winter plan in place with significant support from the PMO continues
A meeting with the consultants, nurse managers & divisional management teams took place on 7th January to discuss the challenges with the high bed occupancy levels and agree actions
Routine elective work has significantly reduced

Cancer waiting times

- 62 day performance decreased in month mainly due to urology & colorectal capacity



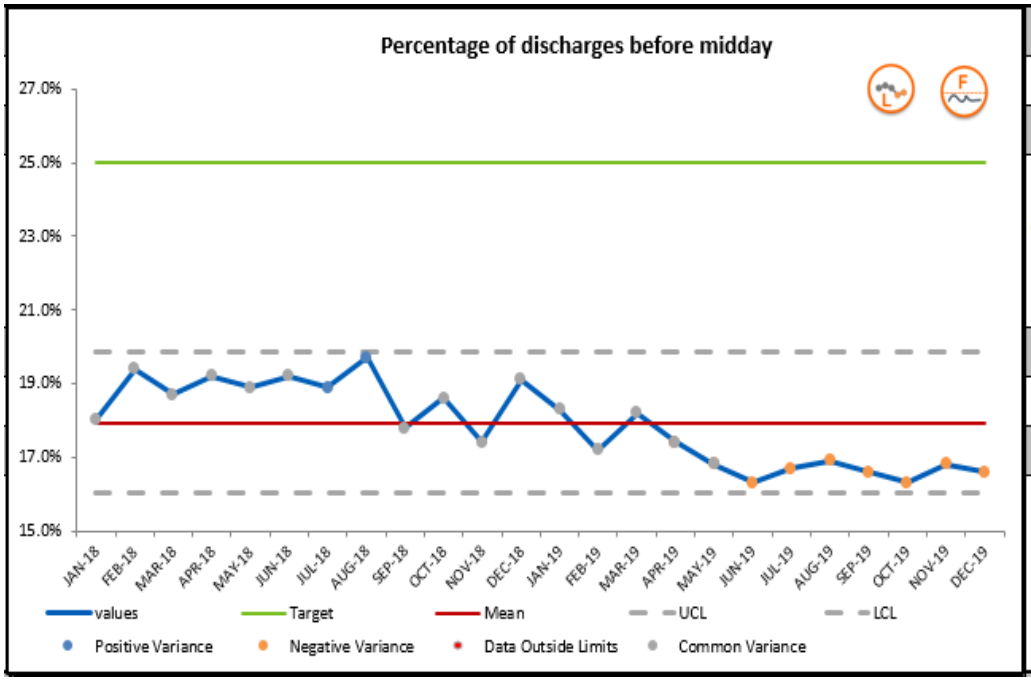
Actions being taken:
2 x weekly PTL meetings in place
Straight to test for colorectal being planned
Lung pathway being reviewed
Urology pathway – changes to one stop being taken

Diagnostics – 6 weeks

- Performance has decreased slightly but in January has started to improve, this is due to an increase in patients waiting for an USS.

Actions being taken:
Additional capacity is in place to manage the demand

SPC Charts – Discharges by Midday



DEC-19
17%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance below the mean
Target
25%
Target Achievement
Metric is consistently failing the target

What the chart tells us:

Discharges before midday is showing negative trend against the mean

Context:

Current performance of 16.9% discharges against a target of 25% and improvement of 0.8% on previous month

Although patients are moved to the Discharge Suite as early discharges to free up the bed, they do not leave the site early due to EDN's and TTO's not completed timely.

Patients for care in the community are usually notified on the day that the care is in place so patient needs to be prepared for discharges and EDN's TTO's and transport booked on the day.

Previous Actions:

Early bird' patients identified to the site team at the 4pm bed meeting for the following morning

Current workstream led by Deputy MD is focussing on improving the EDN and TTO processes

Private transport crews are supporting the service provided by EMAS to improve the transport response times

NGH volunteers supporting discharge suite by collecting TTO's from Pharmacy for patients

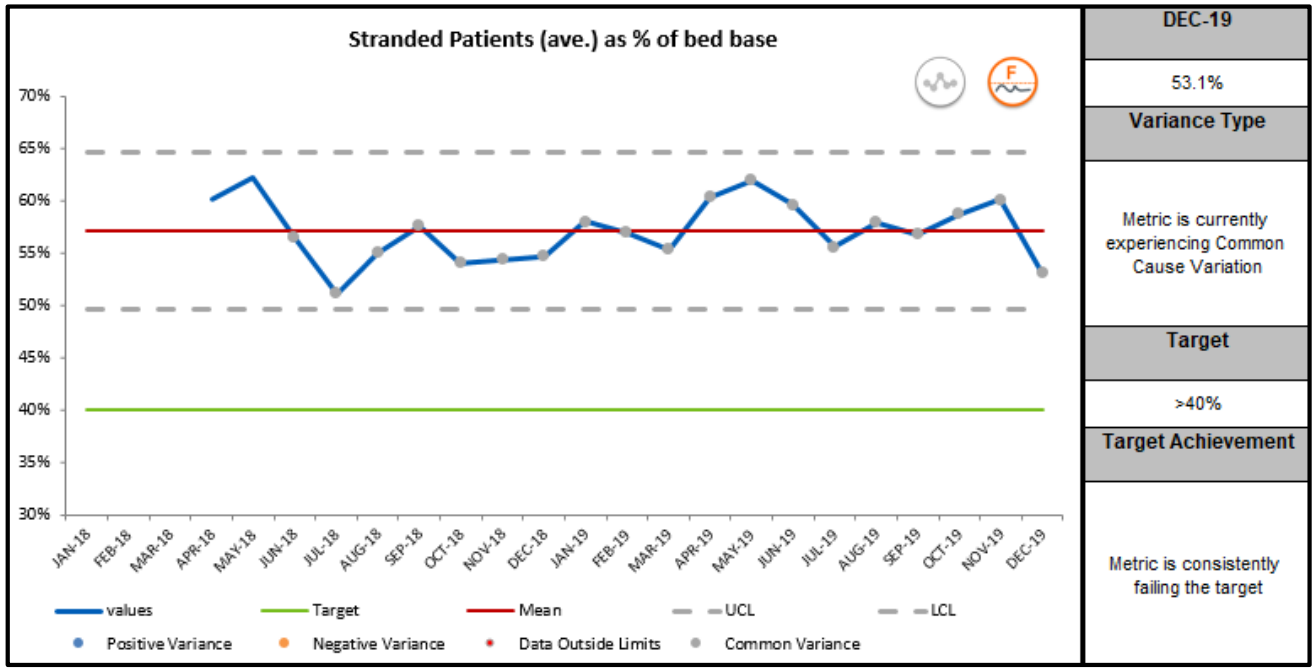
Discharge team admin staff phoning wards as soon as notified of bed allocation in rehab units.

Actions:

Winter plan in place

Focus on identification of early discharges & prep for home

SPC Charts – Stranded patients (avg.) as a % of bed base



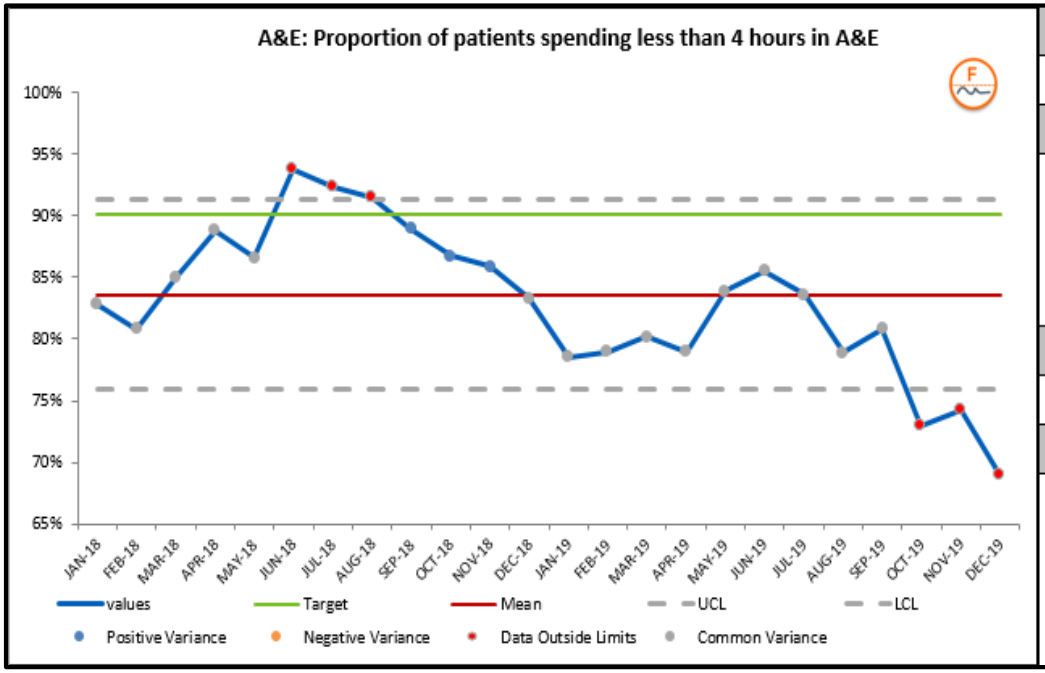
DEC-19
53.1%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
>40%
Target Achievement
Metric is consistently failing the target

Context:
Improvement noted during December of patients in hospital for 7 days or more

Actions:
Winter plan in place
Safety of patients prioritised daily
Further meeting has taken place on 7th January 2020 with Consultants, nurses and managers to identify & put into place further change/action
Additional focused board rounds are taking place

What the chart tells us:
The performance and variation of stranded patients as a % of the bed base is showing common cause variation; performance is within the expected levels.

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



DEC-19
68.9%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
90.1%
Target Achievement
Metric is consistently failing the target

What the chart tells us:

The variation in this indicator is showing special cause variation with variation for the past two months siting outside the control limits; this suggests a need for further investigation.

Context:

Recent analysis has shown that there has been a significant increase in the time admitted patients are waiting for speciality review and admission to a bed since September. Blocked ED cubicle space then slows internal ED flow which affects non admitted performance also.

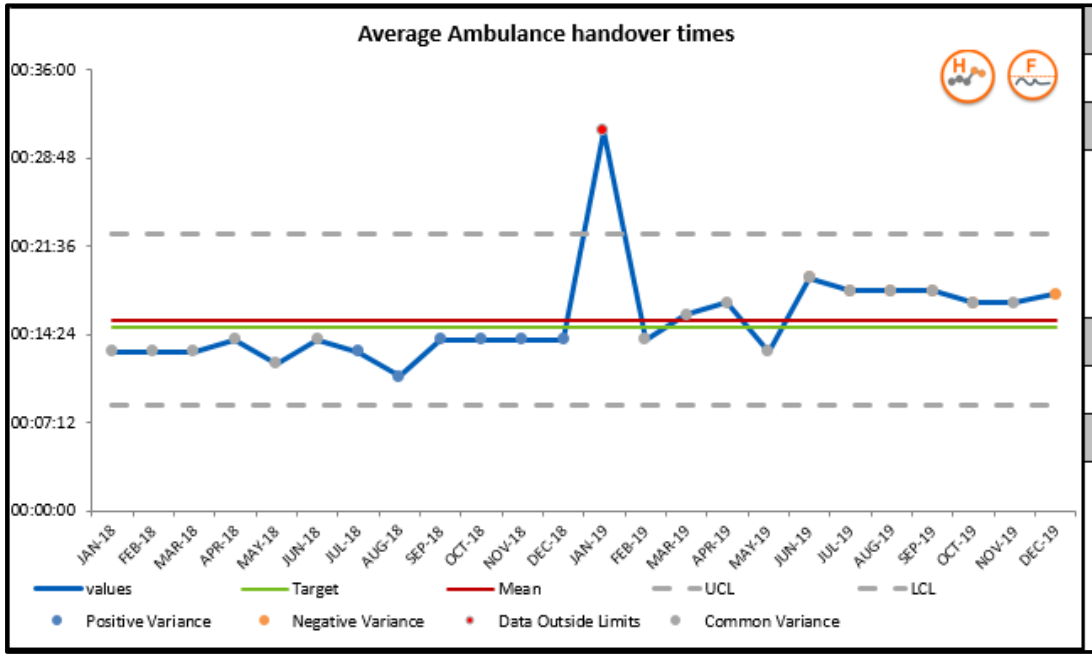
Actions completed:

Data analysis undertake.
Additional temporary nursing staffing being sourced, though shift fill is proving a challenge.
Safety of patients prioritised daily
Further meeting has taken place on 7th January 2020 with Consultants, nurses and managers to identify & put into place further change/action
Additional focused board rounds are taking place

Actions:

Winter plan in place with full time programme manager
ED senior team are working on improving triage & initial assessment processes and improving shop floor management to enable flow.
This will not address admitted performance, however will improve safety and performance on other KPIs once embedded.
Urgent care programme being re-established and agreed with Medical and Nursing Director
Additional capacity is being sourced in the community as part of the winter system plan

SPC Charts – Average ambulance handover times



DEC-19
00:17:42
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance above the mean
Target
00:15:00
Target Achievement
Metric is consistently failing the target

Context:

What is driving under performance?
Recent analysis has shown that there has been a significant increase in the time admitted patients are waiting for speciality review and admission to a bed since September.

Actions Completed:

Actions completed in the past month to achieve recovery:
Additional wheelchairs to promote fit to sit & portering support, regular escalation shifts to enable QUE OUT of ED to prevent the need to QUE IN.

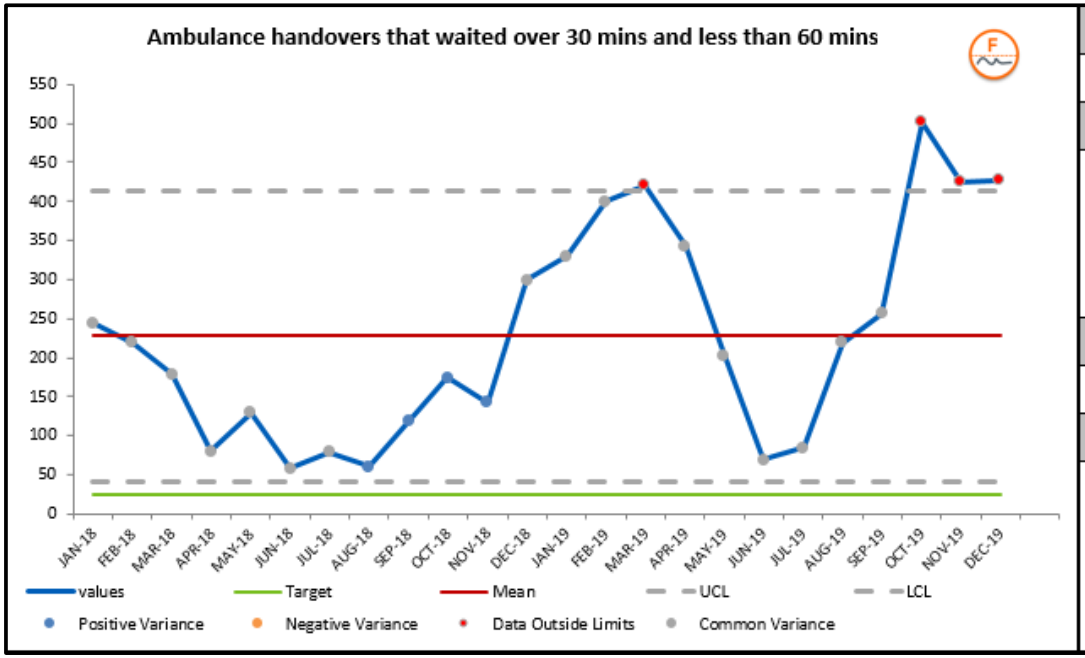
Actions:

- Training all band 6 & 7 nurses, and all middle grades and Juniors in different ways of managing ED flow and space.
- Replacing ineffective COWs in progress.
- Additional staffing for escalation being sourced.
- Work on data quality and EMAS collaboration

What the chart tells us:

The performance and variation relating to ambulance handovers is showing a special cause variation; performance is outside the upper control limit.

SPC Charts – Ambulance handovers that waited over 30 minutes and less than 60 minutes



DEC-19
427
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
25
Target Achievement
Metric is consistently failing the target

Context:

What is driving under performance?
Recent analysis has shown that there has been a significant increase in the time admitted patients are waiting for speciality review and admission to a bed since September.

Actions Completed:

Actions completed in the past month to achieve recovery:
Additional wheelchairs to promote fit to sit & portering support, regular escalation shifts to enable QUE OUT of ED to prevent the need to QUE IN.

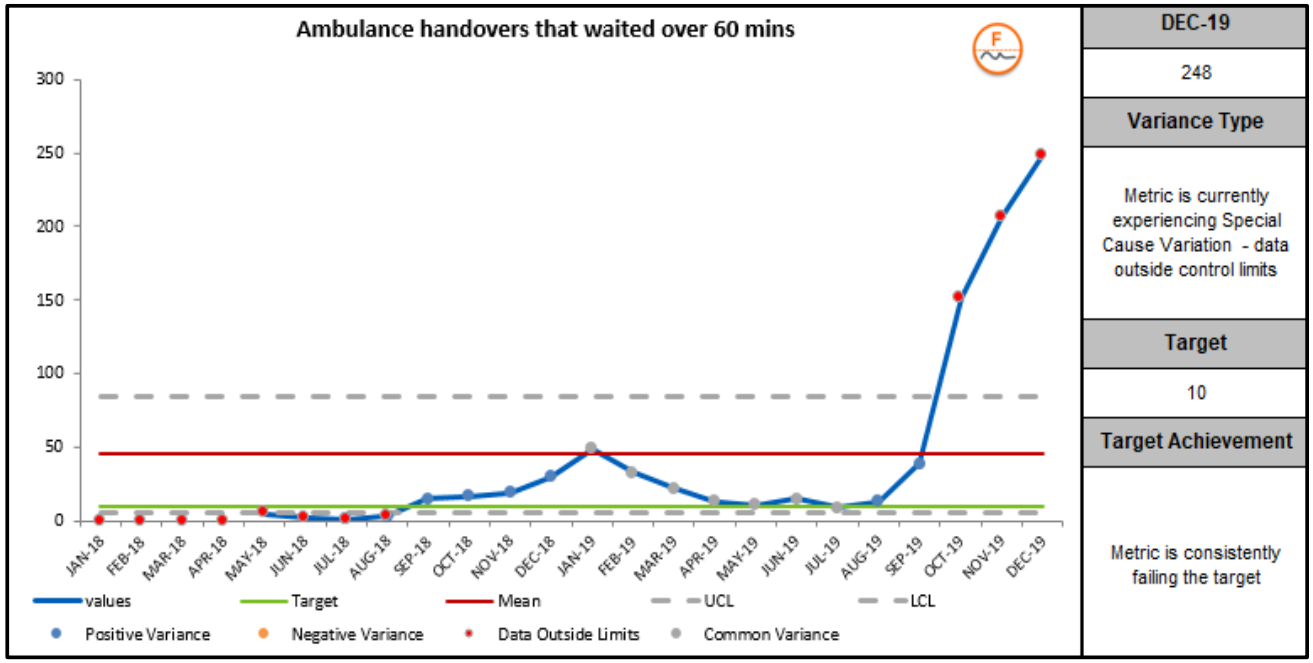
Actions:

- Training all band 6 & 7 nurses, and all middle grades and Juniors in different ways of managing ED flow and space.
- Replacing ineffective COWs in progress.
- Additional staffing for escalation being sourced.
- Work on data quality and EMAS collaboration

What the chart tells us:

The performance and variation relating to ambulance handovers that took between 30 and 60 minutes is showing a special cause variation; performance is outside the upper control limit.

SPC Charts – Ambulance handovers that waited over 60 mins



DEC-19
248
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
10
Target Achievement
Metric is consistently failing the target

Context:

What is driving under performance?
Recent analysis has shown that there has been a significant increase in the time admitted patients are waiting for speciality review and admission to a bed since September.

Actions Completed:

Actions completed in the past month to achieve recovery: Additional wheelchairs to promote fit to sit & portering support, regular escalation shifts to enable QUE OUT of ED to prevent the need to QUE IN.

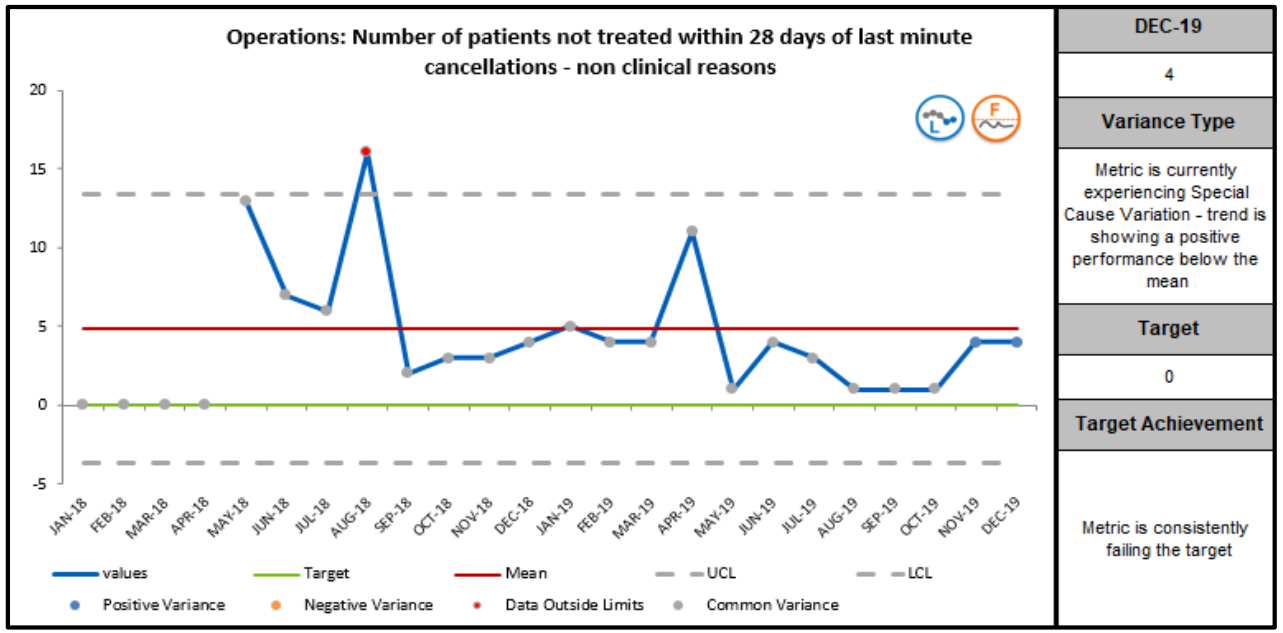
Actions:

- Training all band 6 & 7 nurses, and all middle grades and Juniors in different ways of managing ED flow and space.
- Replacing ineffective COWs in progress.
- Additional staffing for escalation being sourced.
- Work on data quality and EMAS collaboration

What the chart tells us:

The performance and variation relating to ambulance handovers greater than 60 minutes is showing a special cause variation; performance is greater than the upper control limit.

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



DEC-19
4
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a positive performance below the mean
Target
0
Target Achievement
Metric is consistently failing the target

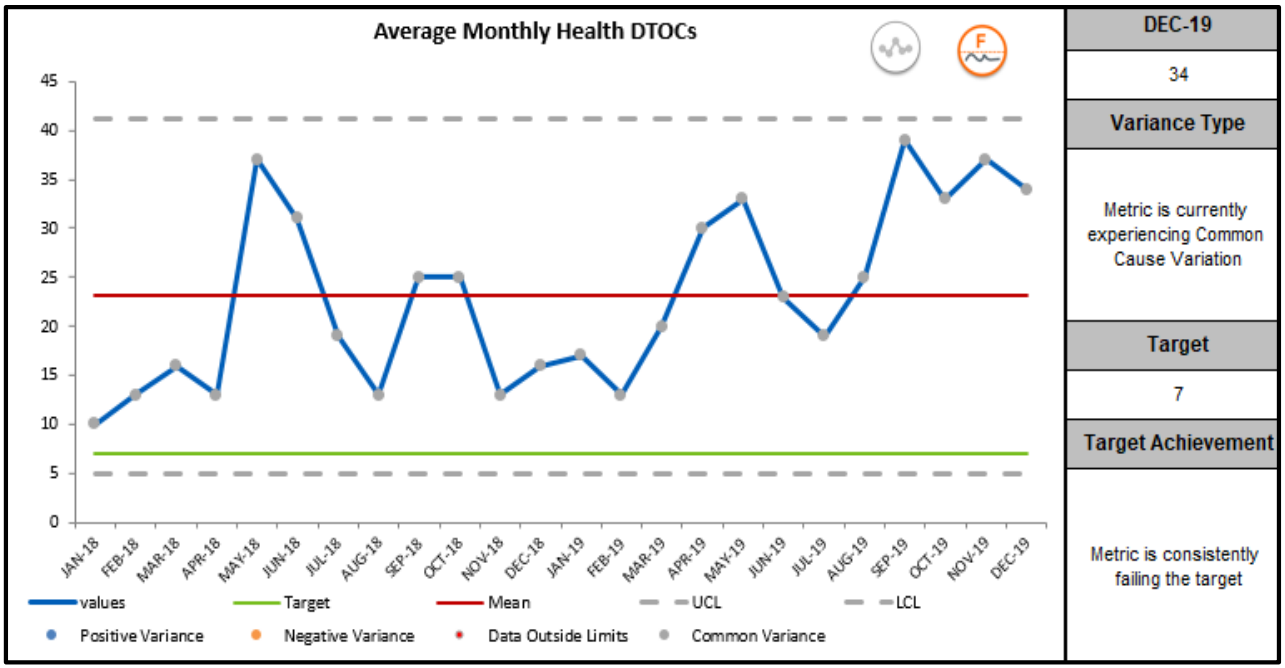
Context:

2 General Surgical - was booked within timeframe but due to a cancer case we moved the patients and treated the patients outside the 28 day timeframe; 1 Orthopaedic - sub specialist surgeon required which due to leave was unable to be arranged within timeframe; 1 Ophthalmology - one-off lens availability resulted in needing to schedule procedure beyond 28 day timeframe

What the chart tells us:

The performance and variation relating to cancelled operations not treated within 28 days showing a positive performance below the mean.

SPC Charts – Average monthly health DTOCs



DEC-19
34
Variance Type
Metric is currently experiencing Common Cause Variation
Target
7
Target Achievement
Metric is consistently failing the target

What the chart tells us:

The performance and variation relating to average monthly health DTOCs is showing common cause variation, performance is within the expected limits based on historic performance.

Context:

Continued delays within the system
Capacity constraints across all partners
Transport & TTO delays internally

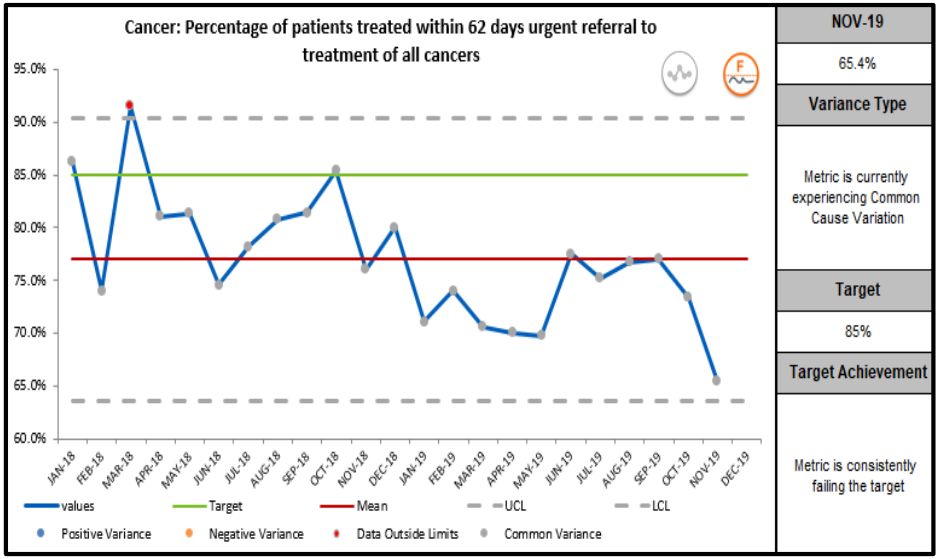
Actions Completed:

New 1 page PDNA process in place
Twice daily HUB's set up to process the PDNA's
Stranded review completed in December on every patient in the Trust,
Home for Christmas Top 30 patient's task group formed to expedite and support discharges
Daily review of Top 20
Twice weekly Tracking meetings with Discharge Coordinators and Social

Actions:

Home for January plan
Changes with IDT
Additional bedded capacity
Continued process with simplified PDNA
Daily escalation calls

SPC Charts – Cancer: Percentage of patients treated within 62 days



What the chart tells us:

The variation in the cancer performance identifies a common cause variation; performance is within the expected level based on historical performance.

Context:

The Trust has undertaken 110 treatments with 38 breached, and resulted in performance of 65.5%. Whilst the number of treatments has remained consistent the significant increase in breaches has led to such reduced performance. Breast, Gynaecology and Sarcoma achieved the standard. The most challenged sites were Upper GI and Urology sharing 19 breaches between them. Individual tumour site performance is shown below: Brain 100% Breast 86.7% Colorectal 58.3% Gynaecology 86.4% Haematology 42.8% Head & Neck 44.4% Lung 78.6% Sarcoma 100% Skin 81.2% Upper GI 32.2% Urology61%

12 patients were treated in November that had been on their pathway for 104+ days

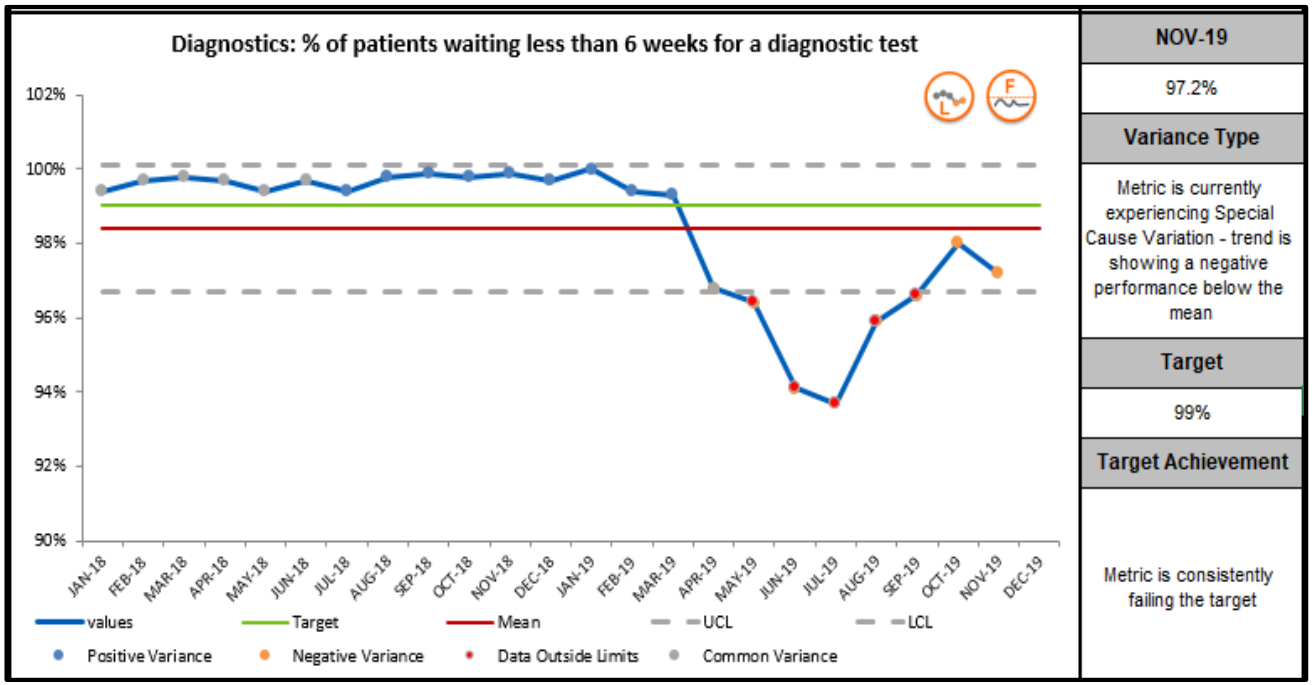
Actions completed:

Weekly task and finish groups to support pathway redesign for Lung, prostate, colorectal and gap analysis completed for new Upper GI pathway.
The cancer management team continue to meet monthly with each tumour site to continue to understand challenges, successes, escalate issues and support the national directives being delivered to improve pathways.

Actions:

- Cancer Management team have an away day planned beginning of February to reflect on past performance and identify areas for prioritisation Feb 2020
- Gynaecology Surgical position re-advertised. Applications have been received with interviews due to take place 6th March. Department has now treated the same number of patients in 19/20 as it did the whole of 18/19 with an expected 30 treatments in Q4
- STT for Colonoscopy Working Group to continue to meet and expedite implementation by April 2020
- Full rollout of beginning of RAPID prostate pathway for all referrals received from Jan 2020 now additional nurse in place to triage
- Action plan to be developed for Upper GI pathway against gap analysis March 2020
- Paper for Cancer Board on Imaging challenges and possible solutions- March 2020
- All sites to update recovery plans and develop 2020 trajectory for 62 days- Jan 2020

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



NOV-19
97.2%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance below the mean
Target
99%
Target Achievement
Metric is consistently failing the target

Context:

Capacity issues with endoscopy resolved. By 1st February 2020 endoscopy will be working within the 6 week target.

Cardiology – breaches are due to limited capacity in the heart centre as the area has been utilised as an escalation ward for emergency patients consistently during December.

USS breaches are due to an increase in activity

Actions:

USS outsourcing taken place & additional capacity during evenings/weekends is in place

Additional lists are being undertaken for cardiology.

What the chart tells us:

The reporting of the 6 week diagnostic test identifies negative variation against the mean; the last 7 or more performance levels are below the mean.

Directors view – Director of Finance

The Trust did not meet its financial plan for December and missed it by £1,274k resulting in a year to date adverse variance of £4,778k against plan. As a result of missing the financial trajectory, we have not accounted for the related Provider Sustainability Funding of £5,064k, therefore the total year to date adverse variance to plan is £9,842k.

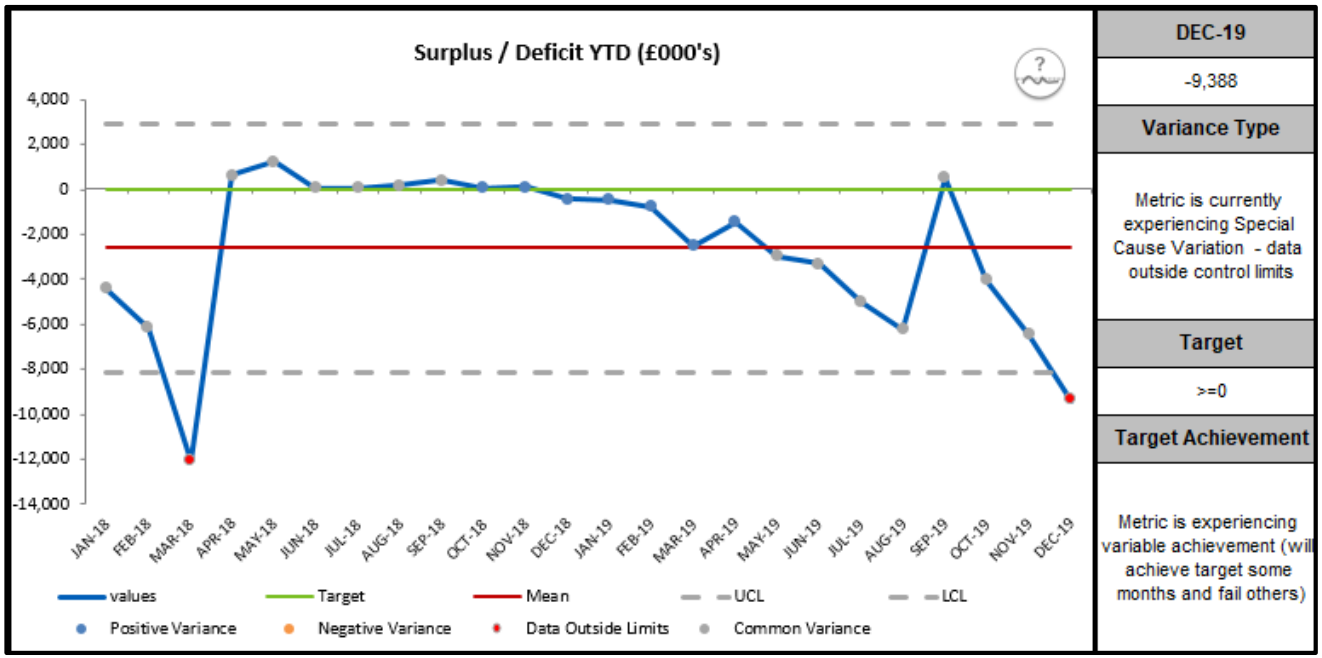
The financial position continues to be driven by high pay costs not sufficiently covered by income largely due to the urgent care pressures and loss of elective activity. The hospital continues to be very busy and demand for services continues to outweigh mitigations from closer working with System partners aimed at improving flow and discharges.

We continue to work on our internal mitigations including financial recovery plans which have been delivering monthly, as well as closer working with System partners however the scale of the urgent care pressures means that we are unlikely to recover the position. Therefore we have followed the NHSE/I reforecast protocol and submitted a revised pre PSF / FRF deficit plan. The details are included in the Year End Position paper provided under separate cover.

Capital spend is £4,517k at month 9 which is below plan by £284k, although about 79% of the plan is committed and the overall plan is expected to be delivered.

Cash balance at the end of the month is £2,046k and we continue to monitor this and manage the cash position carefully to ensure that we pay staff and suppliers on time.

SPC Charts – Surplus/Deficit YTD



DEC-19
-9,388
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
>=0
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

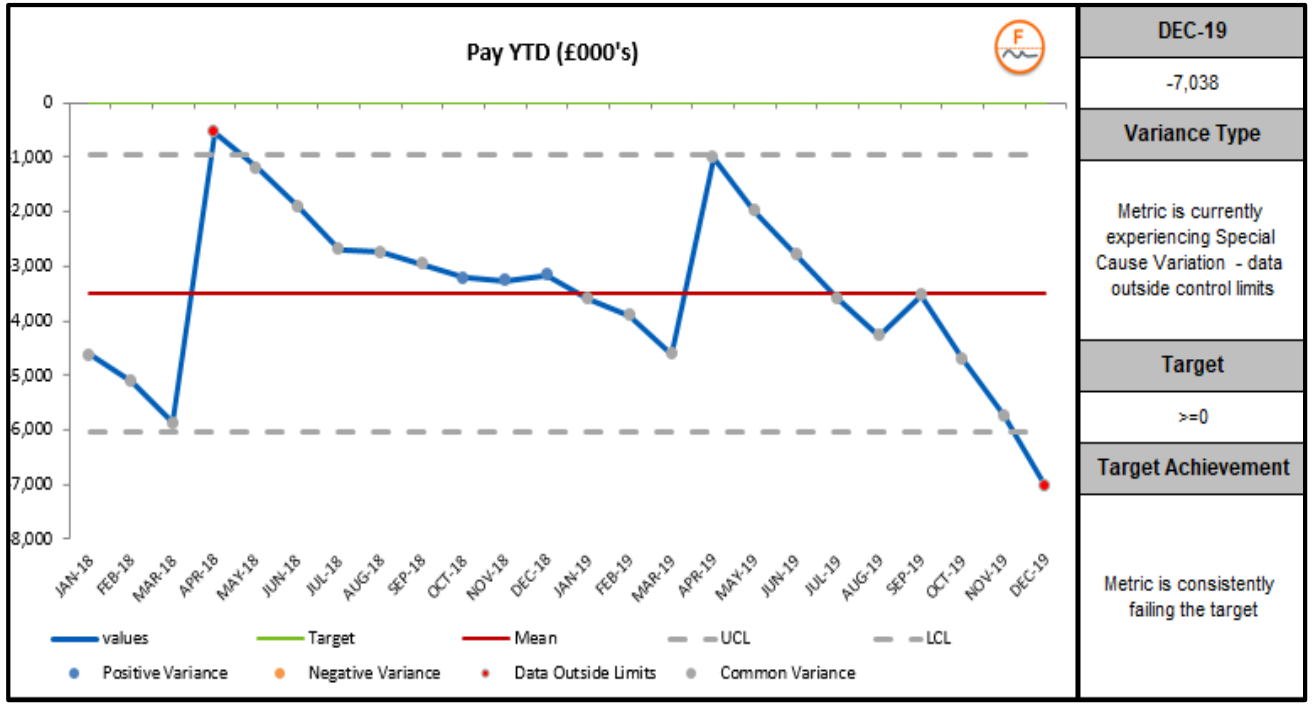
Context:

Actions:

What the chart tells us:

The variation in the Pay YTD identifies that performance is outside the lower control limit; lower than the expected parameters for this measure based on the previous 24 months performance.

SPC Charts – Pay YTD



DEC-19
-7,038
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
>=0
Target Achievement
Metric is consistently failing the target

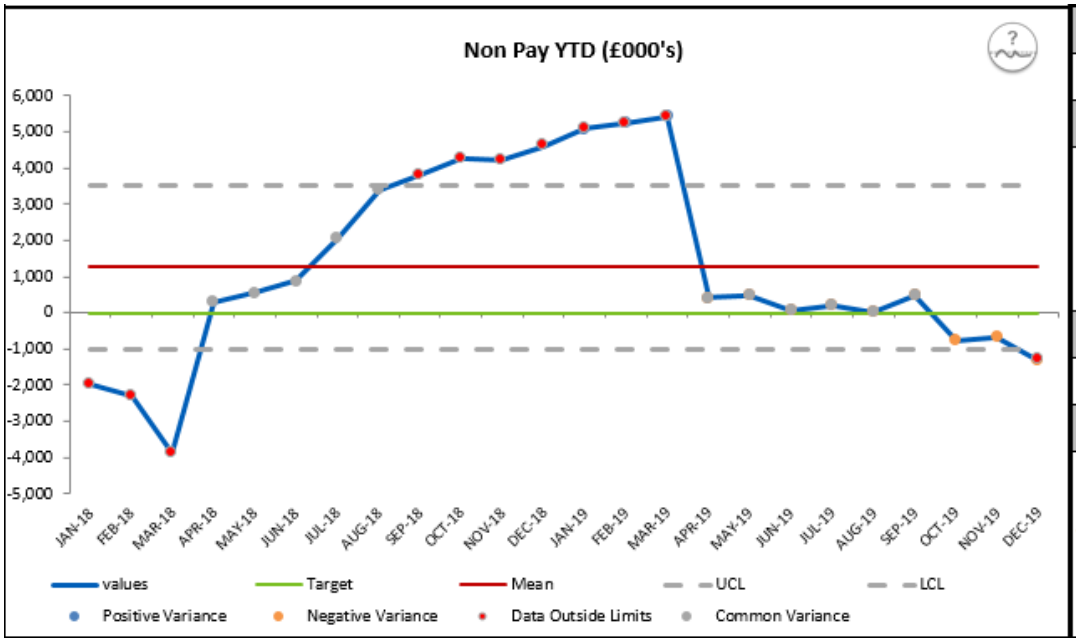
Context:

Actions:

What the chart tells us:

The variation in the Pay YTD identifies that performance is outside the lower control limit; lower than the expected parameters for this measure based on the previous 24 months performance.

SPC Charts – Non-Pay YTD



DEC-19
-1,315
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
>=0
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

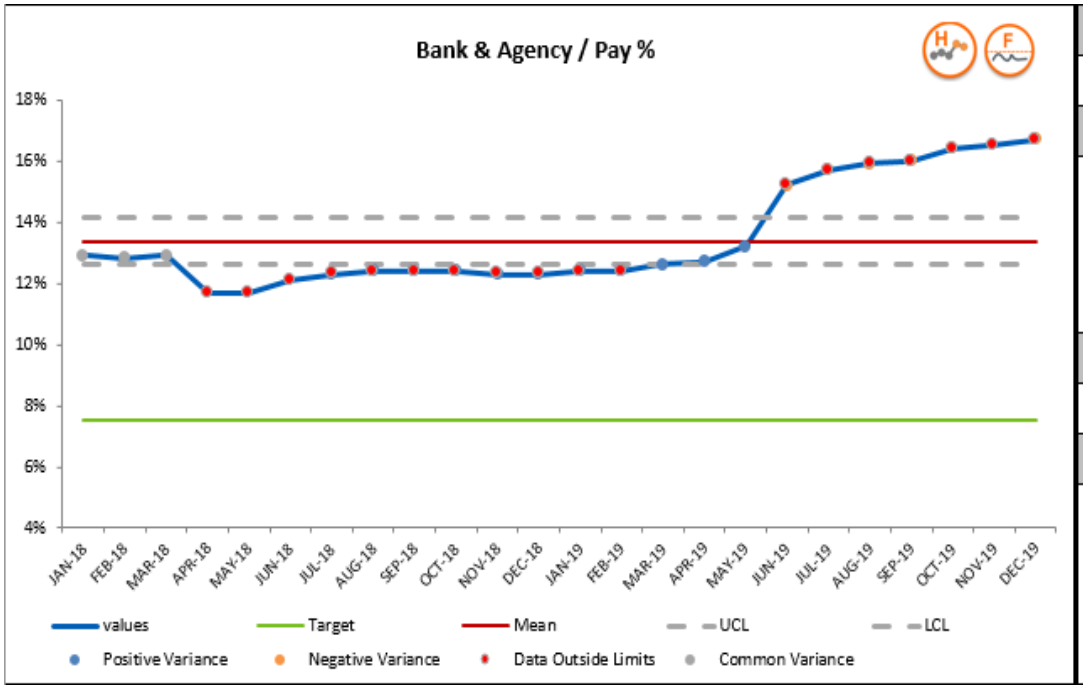
Context:

Actions:

What the chart tells us:

The variation in the Pay YTD identifies that performance is outside the lower control limit; lower than the expected parameters for this measure based on the previous 24 months performance.

SPC Charts – Bank & Agency spend



DEC-19
16.7%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance above the mean
Target
7.5%
Target Achievement
Metric is consistently failing the target

Context:

Actions:

What the chart tells us:

The variation in the bank and agency spend is showing special cause variation with the past 7 reported periods showing performance outside the upper control limits; this suggests a need for further investigation and consideration in the future around recalculating the control limits.

Directors view – Chief People Officer

Vacancy Rates

There was a further decrease in the overall Trust vacancy rate since November 2019 however, the Trust vacancy factor continues to be static at both a Trust wide and Divisional level but remains above the 9% target at 11.73%.

The vacancy factor for medical staff rose slightly to 4.61%, while nursing and midwifery vacancy factor decreased marginally to 10.02%. The overseas nurse recruitment trip to India concluded on 13 January 2020 and the team has safely returned to the UK having made 68 job offers. A further team flew out to the Philippines on 14 January 2020 to recruit nurses.

The risk of reduced workforce capacity brought about as a result of the Trusts vacancies continues to be mitigated through backfilling vacancies with bank and agency staff, however to do so is a high cost to the Trust. With regard to medical agency spend, fortnightly meetings are now taking place with the Divisional Directors, Divisional Managers and Finance in order to focus on ensuring costs associated with medical temporary staffing are closely managed and kept to a minimum. This will include ensuring permanent recruitment plans are in place and agency use exit strategies are established.

The recruitment time to hire is as follows:

	Oct-19		Nov-19		Dec-19	
Advertising start date to unconditional offer	67.4 Calendar Days	9.6 weeks	61.1 Calendar Days	8.73 weeks	64.5 Calendar Days	9.21 weeks
Authorisation Granted to start date	86 Calendar Days	12.29 weeks	76.1 Calendar Days	10.87 weeks	73.9 Calendar Days	10.55 weeks

(The current Trust target is 14 weeks with a stretch target of 11 weeks)

Turnover

Turnover decreased since November and remains below the Trust target of 10% across the Trust. Although nursing and midwifery turnover has been stable and stands at 6.58%, as at the month of December, internal movement of nurses from core and specialist areas is high and is being monitored through the monthly nurse recruitment and retention meetings. Internal movers have been identified and an initial survey to understand the reasons for movement from these areas is being devised and the need for leaver's questionnaires to be undertaken for internal movements will be promoted.

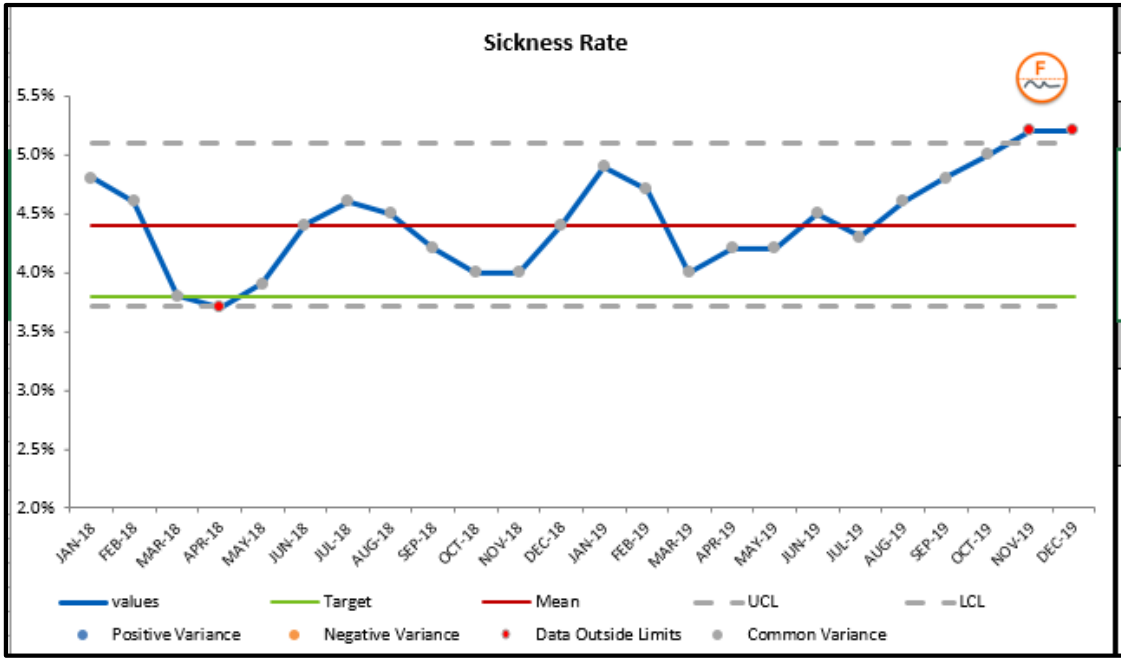
Attendance

The Trusts attendance target is 96.2% (3.8% absence target) and current attendance rates remain below this target and have marginally decreased from November 2019 to 94.73% (October 2019 was 94.78%). The management of sickness absence is being supported by HR Business Partners and Occupational Health with preventative measures being taken through the Trusts Health and Wellbeing programme and the provision of a counselling psychologist service to staff. The highest reasons for absence reported continue to be due to mental wellbeing and anxiety and musculoskeletal conditions.

Competency

Compliance with the Trusts mandatory training saw an increase since November 2019 as did Appraisal and RSET compliance. Mandatory training compliance continues to be above Trust target however, Appraisal and RSET compliance continue to be below the Trust target of 85%. A more detailed report on competency compliance is contained with the workforce papers circulated.

SPC Charts – Sickness Rate



DEC-19
5.2%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
3.8%
Target Achievement
Metric is consistently failing the target

What the chart tells us:

The variation in the performance of the sickness rate performance is showing special cause variation with data outside the expected levels; performance is outside the upper control level for the past 2 reporting periods.

Context:

Anxiety and depression continues to be the most common reason for absence together with MSK problems.

Actions completed:

Actions completed in the past month to achieve recovery Robust sickness management continues with support from the HR Business Partners and HR Advisors.

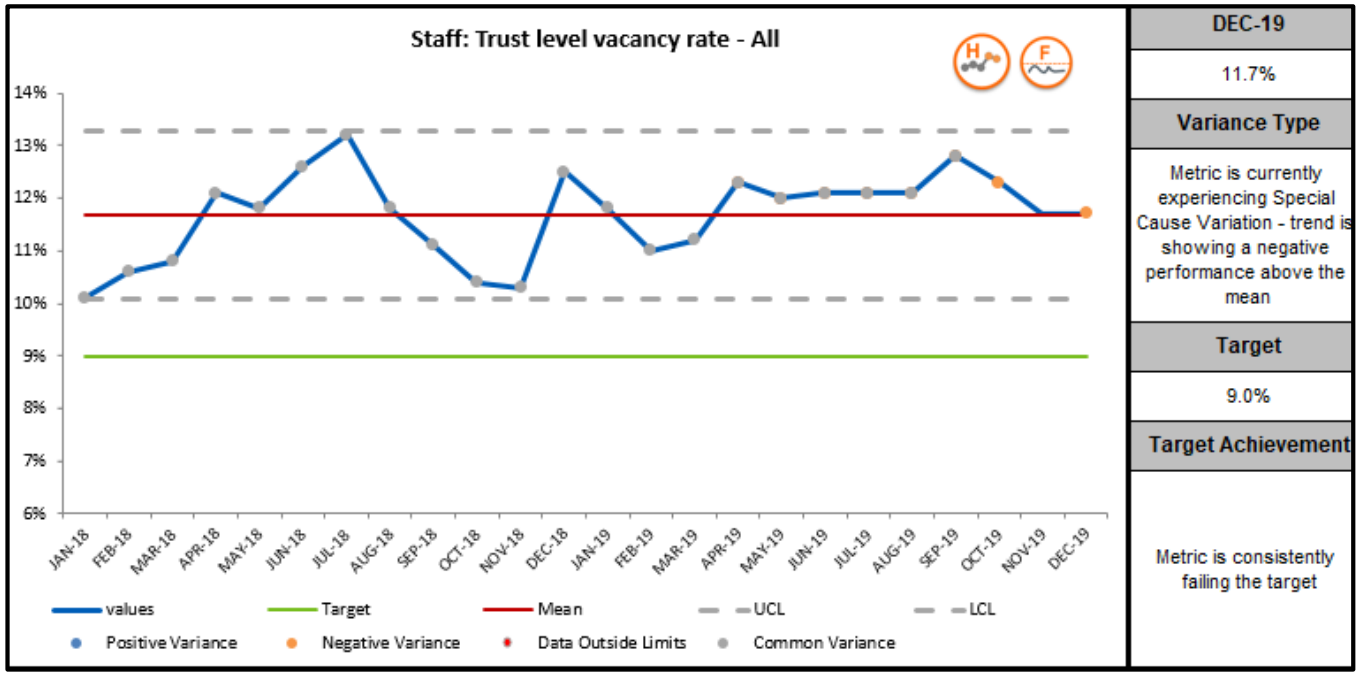
A counselling psychologist service is now well established to support staff in difficulty.

(December 2019)

Actions:

- Continue to manage sickness absence across all areas of the Trust. (On-going)
- HR Business Partners to raise sickness as part of the divisional management meetings. (On-going)
- As part of the newly formed people strategy work is under way to try to manage sickness absence in a more preventative way through health and wellbeing initiatives. (February 2020)

SPC Charts – Trust level vacancy rate - all



DEC-19
11.7%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance above the mean
Target
9.0%
Target Achievement
Metric is consistently failing the target

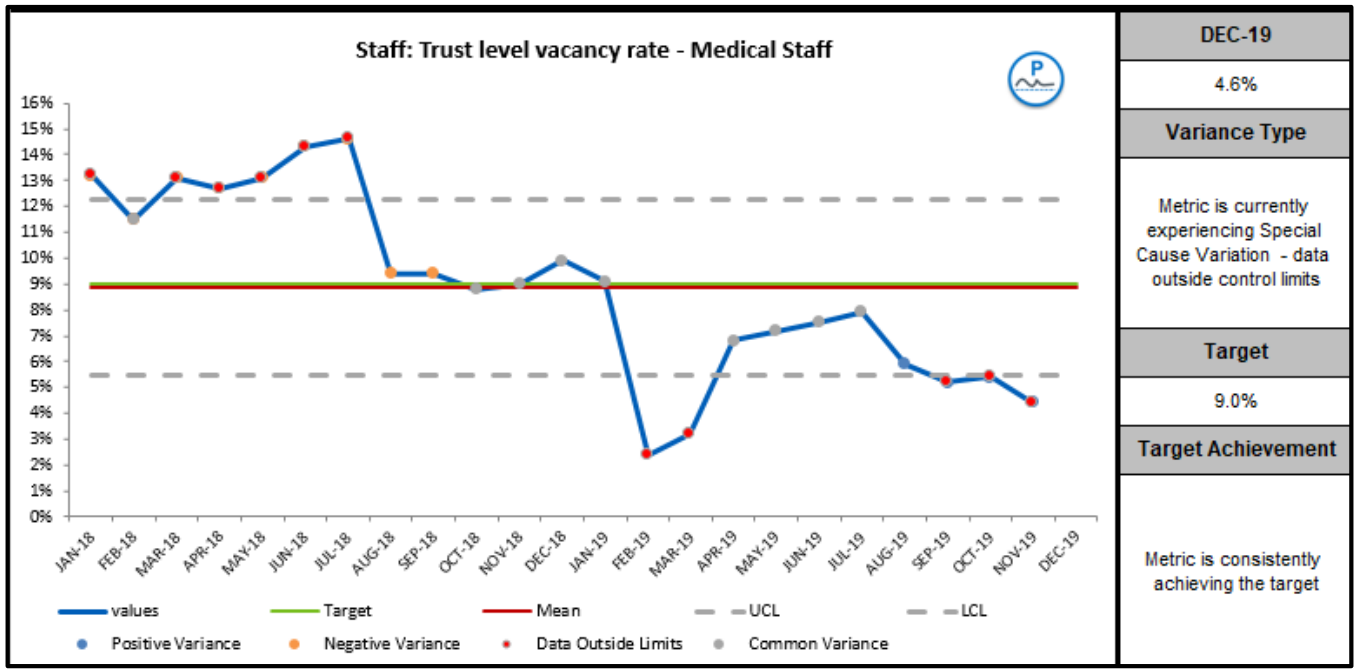
Context:
There is a national shortage of nursing staff and medical staff along with a shortage within other professional allied specialities

Actions completed:
Local recruitment continues and overseas nurse recruitment has taken place in India and the Philippines.

Actions:
- Further Nursing Skype Interviews to be undertaken with overseas nurses (Jan 2020)
- Medical recruitment continues (On-going)
- Therapies scoping social media campaign. (February 2020)
- Profile of Respiratory being raised through use of Best of Both Worlds in order to try to attract Respiratory Consultant Candidates. (January 2020)

What the chart tells us:
The variation in trust level vacancies for all staff is showing special cause variation; performance is showing a high negative trend against the mean

SPC Charts – Trust level vacancy rate – Medical Staff

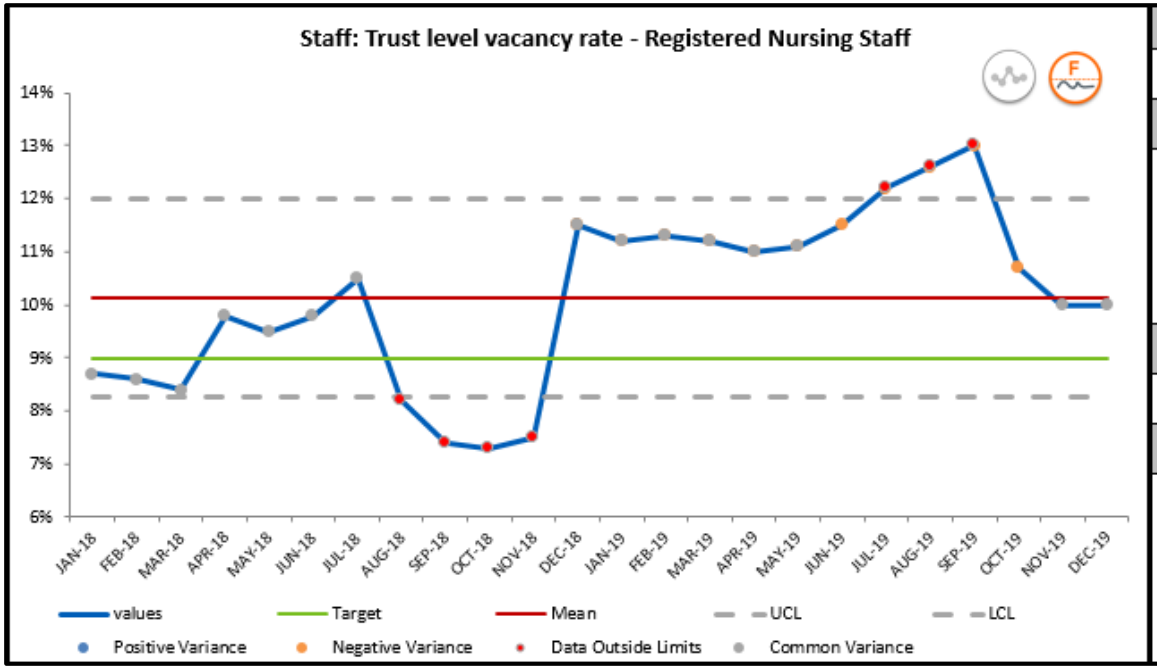


DEC-19
4.6%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
9.0%
Target Achievement
Metric is consistently achieving the target

Context:
Shown for information as the performance is outside the control limits but representing a positive performance.

What the chart tells us:
The variation in trust level vacancies for medical staff is showing special cause variation; performance is outside the control limits for the past 3 reporting periods

SPC Charts – Trust level vacancy rate – Registered nursing staff



DEC-19
10.0%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
9.0%
Target Achievement
Metric is consistently failing the target

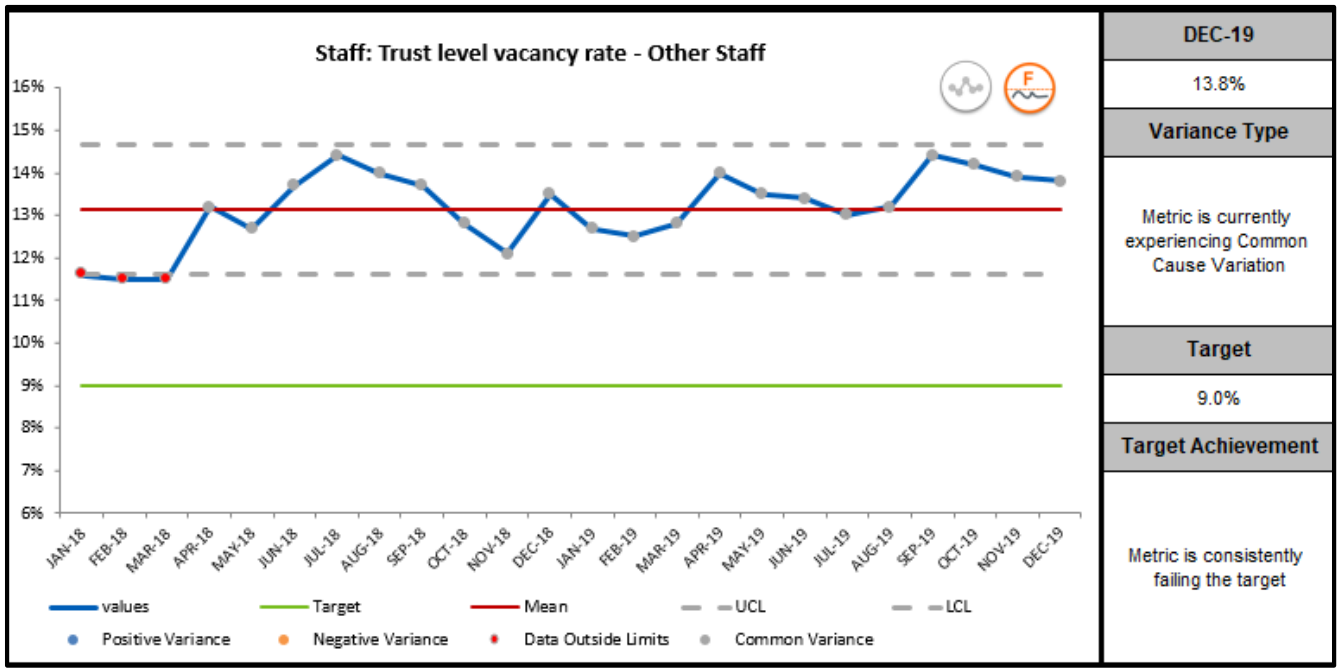
Context:
There is a national shortage of nursing staff

Actions completed:
Local recruitment continues and overseas nurse recruitment has taken place in India and the Philippines resulting in 143 offers being made in total.

Actions:
- Further Nursing Skype Interviews to be undertaken with overseas nurses (Jan 2020)

What the chart tells us:
The variation in trust level vacancies for nursing staff is showing common cause variation; performance is within the expected levels

SPC Charts – Trust level vacancy rate – Other staff



DEC-19
13.8%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
9.0%
Target Achievement
Metric is consistently failing the target

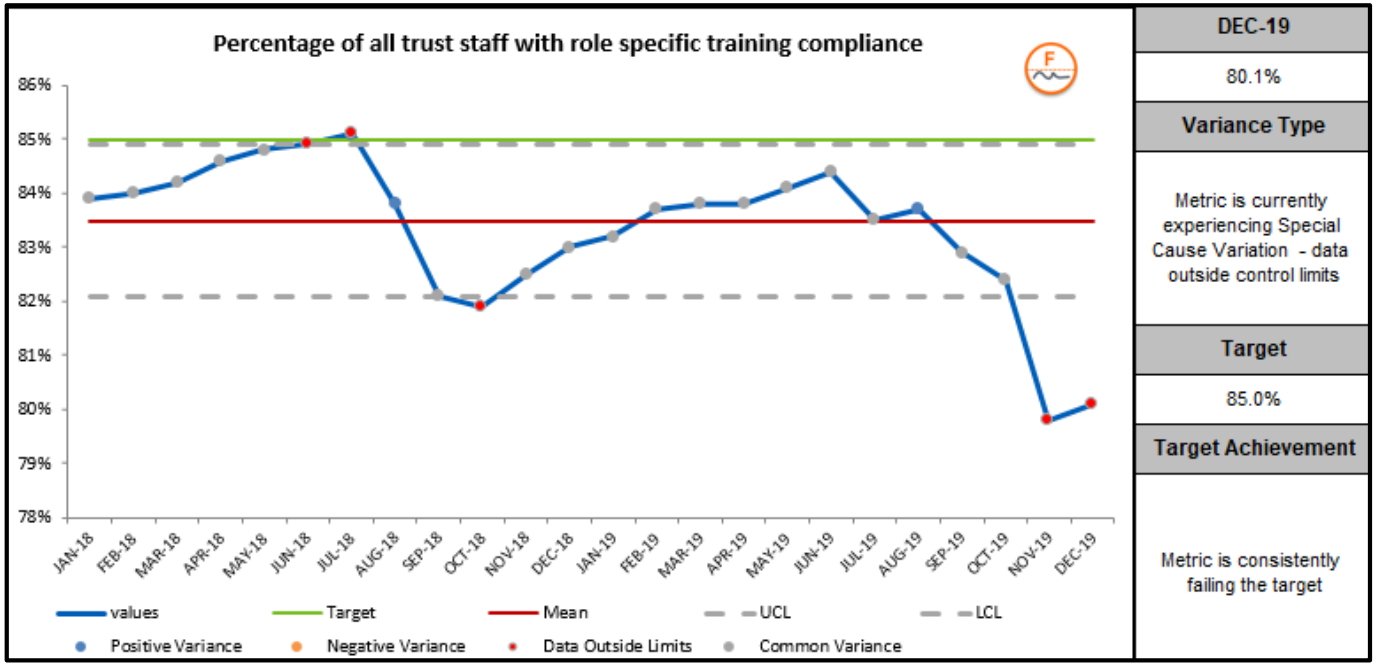
Context:
There is a national shortage within professional allied specialities

Actions completed:
Actions completed in the past month to achieve recovery
Radiology have sponsored two candidate through a top up course so they can practice at the level required within a year. If this is successful, this approach will be adopted to create a pipeline of candidates.

Actions:
Continue sourcing candidates and complete interviews for direct and agency candidates – Jan 2020
Therapies scoping social media campaign. (February 2020)
Assessment of the viability of an international recruitment campaign for Occupational Therapist is being undertaken. (January/February 2020)

What the chart tells us:
The variation in trust level vacancies for other staff is showing common cause variation; performance is within the expected levels

SPC Charts – Staff with role specific training compliance



DEC-19
80.1%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
85.0%
Target Achievement
Metric is consistently failing the target

What the chart tells us:

The variation is showing special cause variation with the last 2 reported periods showing performance outside the lower control limits; this suggests a need for further investigation.

Context:

Job roles within the Trust are not being aligned to Role Specific Training subjects Inflexibility of the national OLM system means that the lowest dominator that training can be aligned to is position level not assignment level. There is no ability to change the current system VTE have re-aligned their training to positions which has resulted in an additional 1933 staff now requiring this training

Actions completed:

Due to the number of positions being created each month, work continues on looking at a process which makes aligning Role Specific subjects to new positions more efficient and timely – Nov 2019. Promotion on the importance of RSET is included in the appraisal training – Nov 2019

Actions:

- HRBP's to raise importance of compliance at the DMT's – On-going
- Implementation by 2020 of employee self-service – On-going
- Explore the possibility of introducing Inter Authority Transfers (IAT), which will transfer training for staff moving from one Trust to another – Dec 2019

Directors view – Medical Director

Overview

The trust has enjoyed a year of sustained improvements in incident reporting and management with implementation of learning. Clinical incident reporting continues to improve. There have been some delays more recently apparent to providing evidence of implementation of learning consistent with the extraordinary operational pressures experienced by the clinical teams. Other insights are consistent with this, including the rates of clinical role specific training compliance and renewal of documents. The clinical quality and effectiveness group discussed the need to balance demands upon the time of the clinical teams prioritising patient safety. It was recognised that rate of improvement of the metrics outlined above will reflect this balance.

Venous Thromboembolism prophylaxis (VTE)

The introduction this month of mandated VTE assessments through the electronic prescribing function is expected to significantly improve performance and accuracy of reporting.

Controlled drugs

The security of controlled drugs in clinical areas is being increased following learning from incidents relating to stock reconciliation and misappropriation. Immediate steps have been taken and a programme of work will be managed through the medicines governance structure with updates provided to quality governance committee.

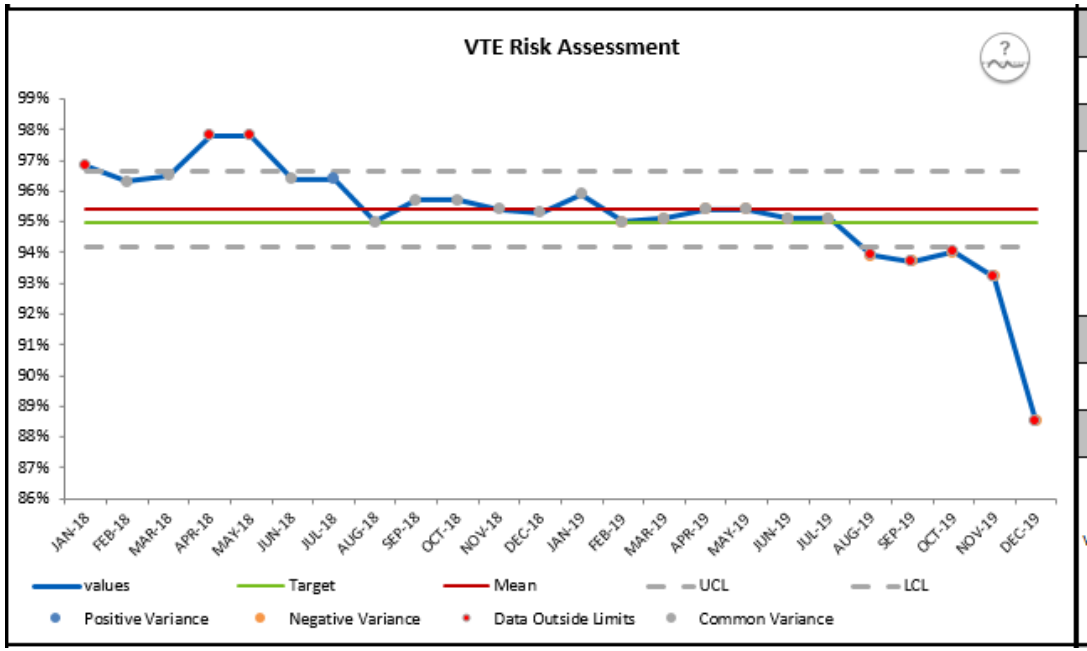
Patient harm

The increase in reporting of clinical incidents has not been associated with an increase in moderate or above harm nor any particular themes in relation ot standards of care.

Mortality

The trust remains within as expected ranges for HSMR and SHMI. The relatively better SHMI compared with HSMR persists and the decrease SHMI is significant.

SPC Charts – VTE Assessment



DEC-19
88.5%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
95%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

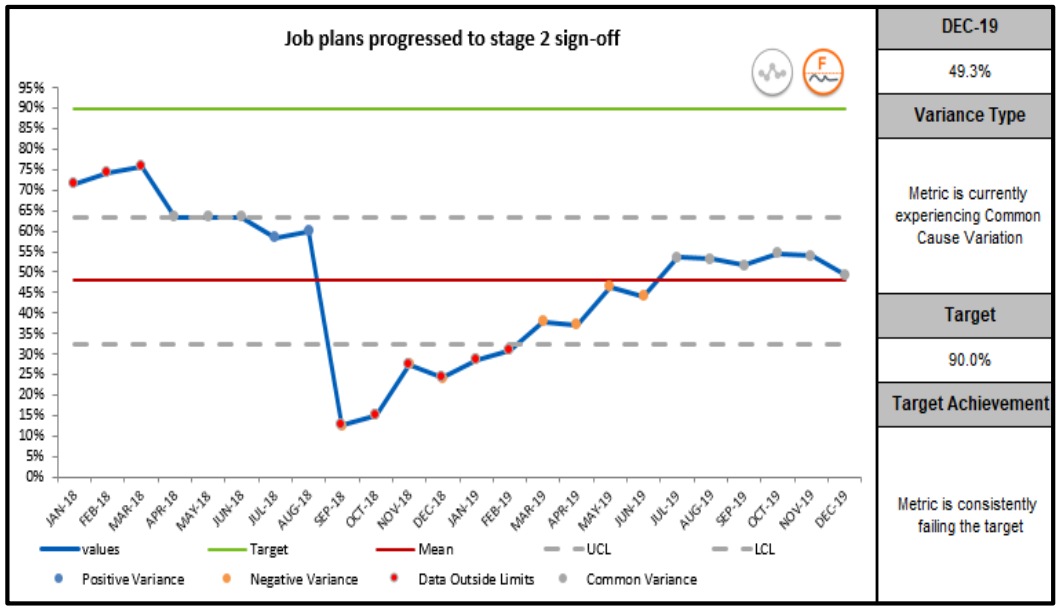
Context:

The metric presented is the capture of VTE 1st assessment at discharge on the eDN (electronic discharge notification). This does not reflect accurately the completion against Nice Guidance and Royal College standards. It remains below target.

Actions:

The ePMA (electronic prescribing) upgrade mandating VTE assessment prior to prescription was installed on the 8th of January. Reporting for subsequent months will be based on ePMA data and therefore be more accurate. Compliance is expected to improve substantially also.

SPC Charts – Job plans progressed to stage 2 sign-off



What the chart tells us:

The variation in trust level vacancies for all staff is showing common cause variation; performance is within the expected levels

Context:

Job planning data was rebased during September 2018 with divisions agreeing that for a job plan to be compliant it must have been reviewed within a 12 month period and progressed to second stage sign off – i.e.: a job plan that is aligned with the speciality demand and, clinician availability (for the purpose of recording compliance this is the numerator). The denominator will continue to be dynamic as this is attributed to the number of all clinicians within the speciality /division, varying as new consultants either join or leave the speciality workforce and is presented as a rolling 12 month period.

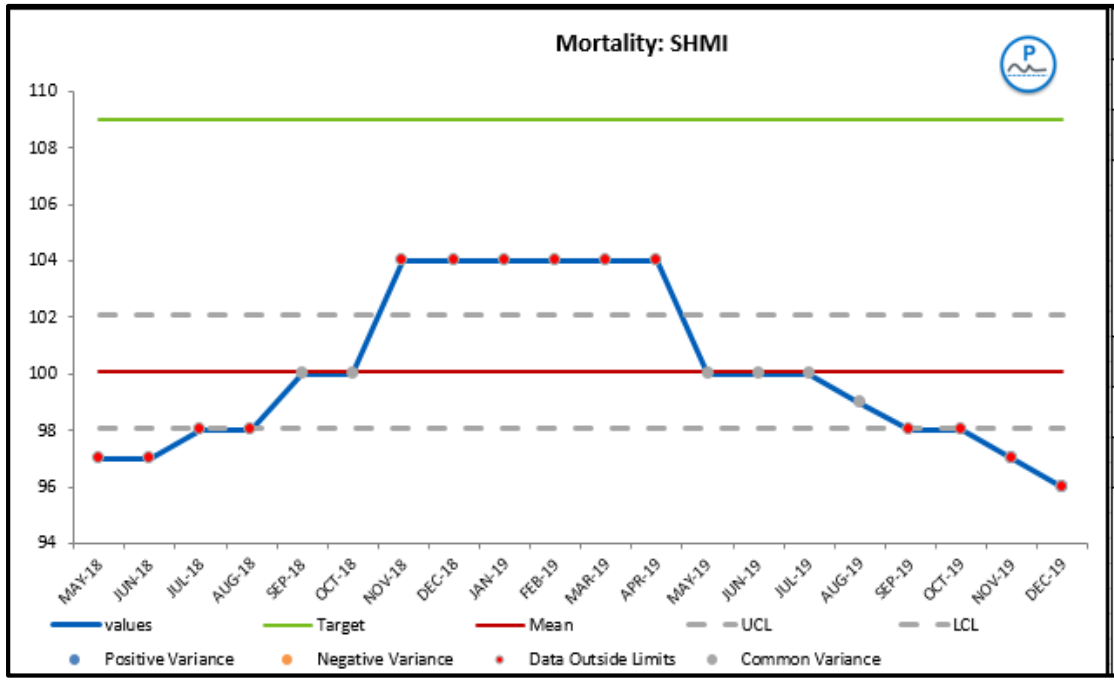
Actions completed:

During December preliminary reviews continue to take place within Inpatient Specialities with colleagues considering their working weeks ahead of receiving the service plans and subsequently 1:1 entry meetings. Executive review of service plans takes place in January which will then inform entry. Job plans continue to achieve final sign off for all the Outpatients specialties. Progress within Urgent Cares is poor due to the continued pressure at the front door and the Trust as a whole has slipped by 3% mainly attributed to annual leave and immense pressures during December. The recovery of the Trust position has slowed due to aforementioned progress update. Requests to progress urgently have been provided to all divisions on the 2nd January and the MD has been updated with all positioning. To assist Clinical Directors the Project Manager has supported in meeting consultants for ad-hoc reviews. This has helped to resolve working patterns and pay change complexities expediting completion, allowing the Clinical Director to review and approve or edit as appropriate. We continue to process multiple pay reductions each month as we bring all colleagues to the 12PA ceiling.

Actions:

- As aforementioned, Managers and Clinical Directors are supported by the QI team to ensure progress is maintained.
- Changes to Job Plans are reflected in pay and tracked and reported on a monthly basis.
- All job plans awaiting second stage sign off are being notified to the departments to ensure timely progression and expedited to the MD when necessary.
- Following the update on the 2nd January a mid-month review will be provided to assure the MD divisions are progressing.

SPC Charts – Mortality: SHMI



DEC-19
96
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
109
Target Achievement
Metric is consistently achieving the target

Context:
Shown for information as the performance is outside the control limits but representing a positive performance.
It is notable that SHMI has decreased substantially whereas HSMR (within "expected" range on Dr Foster, has been relatively static. A key difference between the 2 metrics is that SHMI incorporates post discharge mortality for up to 30 days.

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Report To	**TRUST BOARD**
Date of Meeting	**30th January 2020**

Title of the Report	Year End Forecast Financial Position
Agenda item	**10**
Presenter of Report	Phil Bradley, Director of Finance
Author(s) of Report	Bola Agboola, Deputy Director of Finance

This paper is for:

✓ ☐ Approve

To formally receive and discuss a report and approve its recommendations OR a particular course of action

Executive summary

As discussed previously at Trust Board, Audit Committee and the Finance and Performance Committee the financial position of the Trust has deteriorated since September 2019 to such an extent that we are unable to recover the position by year end in order to hit our control total for 2019/20.

Working internally on our mitigations and financial recovery plans alongside agreeing a year end income deal with Nene and Corby CCGs has not been sufficient to turn around the expenditure we have had to incur to meet the urgent care pressures we have been experiencing.

Working together across the Northants health and care system with our system partners in producing a system financial recovery plan has shown that collectively we cannot offset the forecast deficit at NGH.

We have therefore followed the NHSE/I reforecast protocol and submitted a revised pre PSF / FRF deficit of £8.5m, £19.5m deficit post PSF/FRF, alongside our Q3 financial submission on 23rd January, 2020.

Related Strategic Pledge	✓ *We will put quality and safety at the centre of everything we do* ✓ *Create a sustainable future supported by new technology*
Risk and assurance	The recurrent deficit and I&E plan position for FY19-20 signals another challenging financial year.
Related Board Assurance Framework entries	BAF 3.1 (Sustainability); 5.1 (Financial Control); 5.2 (CIP delivery); 5.3 (Capital Programme).

Equality Analysis	N/A
Financial Implications	£8.5m adverse to plan
Legal implications / regulatory requirements	NHS Statutory duties

Actions required by the Board

The Board is asked to approve the financial forecast for the year and the protocols that have been followed in line with NHSE/I requirement.

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

2019-20 Year End Financial Forecast

(Based on Month 9 position)

Report to

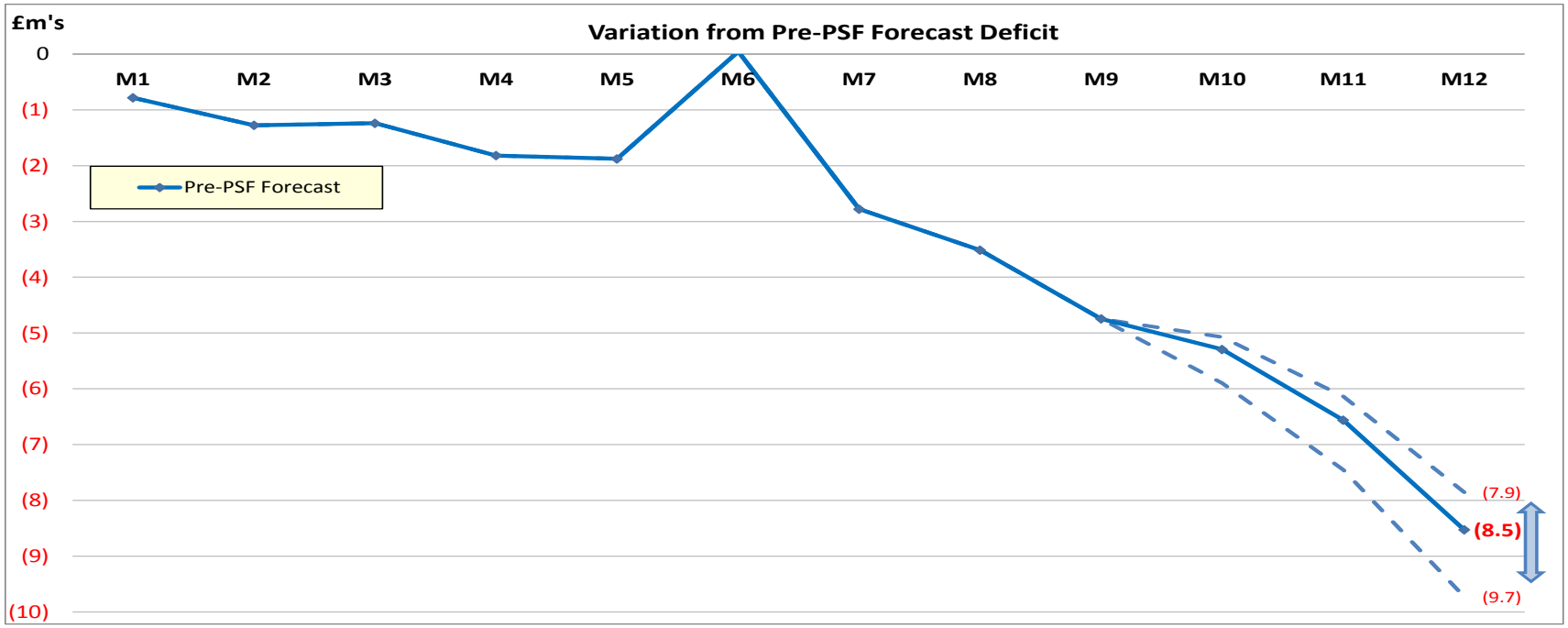
Trust Board

January 2020

1.0 Summary

- The Trust financial position at the end of month 9 is £18.2m deficit, which is £4.8m worse than plan. As a result PSF funding of £5.1m will be missed bringing the total overspend to date to £9.8m deficit.
    - The reasons for this overspend are multi-faceted but largely borders on operational pressures as a result of increased urgent care demand. This has adversely affected income from elective activity (which is more financially viable), as well as increased the level of temporary pay spend (agency spend).
    - Through the year, we put in a number of measures to support the financial recovery including Divisional recovery plans, which have delivered month on month. However the impact of the urgent care pressures have caused further deterioration.
    - These reasons and the actions being taken have been discussed at different Board and Committee meetings through the year.
- Given this position, we have calculated a forecast position for the Trust which suggests an overspend of £8.5m plus £11m PSF totalling £19.5m
    - We have been able to agree a year-end deal with our main Commissioner – Nene CCG which has helped to provide some certainty to the forecast income.
    - There are some risks associated with this forecast, mainly to do with Winter, and the impact on operational pressures, staffing and delayed transfers of care but these are being managed as best as possible.
- This position has been discussed previously with the Trust Board and extensively at Finance and Performance Committee, at Audit Committee, with system partners as part of the system FRP submitted in December 2019 and at our regular Finance Assurance Meetings with NHSE/I.
- NHSE/I protocols for reforecast requires we follow the governance process (as above) and submit a revised forecast by January 23 2020, following discussion with their Regional team. Protocols shown on Appendix.
- The Divisions will now be managed on the revised forecast pay and non-pay spends to ensure that the forecast can be delivered.

2.0 Forecast



At the end month 9, the forecast suggests a range of £(7.9)m to £(9.7)m adverse to the pre-PSF plan as shown in the below graph, with the most likely scenario expected to be around £(8.5)m adverse to plan. Winter continues to be the biggest risk facing the Trust both operationally and financially.

We have prepared this forecast on the basis of all known information at this point but there remains a risk that unforeseen circumstances may impact this forecast further, especially around Pay cost. However mitigations are in place as far as possible, and the year-end deal with Nene CCG has helped to provide certainty to the forecast income position.

Adverse Changes to an In-Year Financial Forecast Protocol - Board Assurance Statement

Organisation Name Northampton General Hospital NHS Trust

The board are required to respond "confirmed" or "not confirmed" to the following statements (notes below)

Board Response

Where a commissioner / provider plans to make an adverse change to an in-year forecast it must be reported through the national reporting process and accompanied with this board assurance statement which has been signed by the commissioner / provider chair; accountable officer / chief executive; chief financial officer / director of finance and the audit committee chair. Additionally sign off is required by the system STP leader or financial lead.

For finance:

The board has been fully briefed on the planned adverse change to forecast and has adhered to the NHSE/I protocol for ***adverse changes to the in-year forecasts*** prior to requesting the change.	**Confirmed**
All reporting revisions are accompanied with detailed actions and the commissioner / provider will continue to explore all options to recover the position and achieve delivery of the original financial plan.	**Confirmed**
The board / governing body is fully committed to the delivery of the recovery plan and will actively monitor the recovery plan milestones.	**Confirmed**
In advance of formally reporting a forecast outturn variance from plan the commissioner / provider has discussed the financial deterioration and remedial actions with the NHSE/I regional director and regional director of finance	**Confirmed**

For governance:

The senior clinical decision making body within the commissioner / provider has been engaged with and are party to the identification and delivery of the recovery actions	**Confirmed**
The executive committee, finance committee and board have considered and agree the proposed financial forecast revision and recovery actions	**Confirmed**
System review requirements, confirmation that the position has been discussed and agreed at a sustainability and transformation partnerships (STP) level and that all options for mitigation including systems wide solutions have been explored	**Confirmed**

Board Declaration

I can confirm that in my capacity as a member of the board, I understand the financial forecast, its key drivers and where there has been a variance signalled, I can confirm that we will continue to explore all options to recover the position and deliver the original plan that was signed off by this board and that these actions have been and will be considered in full by clinical decision making groups, the finance committee, and the board as a minimum.

Signed on behalf of the board of directors

Signature		Signature	
Name	Sonia Swart	Name	Alan Burns
Capacity	Chief Executive	Capacity	Chair
Date	20/01/2020	Date	21-1-2020
Signature		Signature	
Name	Phil Bradley	Name	John Archard-Jones
Capacity	Finance Director	Capacity	Audit Committee Chair
Date	20/01/2020	Date	21/01/2020

System sign off by STP

Signature	
Name	Rachel Hardy
Capacity	STP Leader / Finance lead
Date	20/1/2020 20/01/2020

The Office of Mark Mansfield
St Chad's Court
213 Hagley Road
Birmingham
B16 9RG

0300 123 2821

21 October 2019

Sent by e-mail to:

NHS Provider Directors of Finance

NHS CCG Chief Finance Officers

Dear Colleagues

Re: Protocol for Changes to an In-Year Financial Forecast

I am writing to you to inform you of the national protocol for any changes to organisational financial forecasts during 2019/20. This will be familiar to colleagues in Provider organisations and will now be applied to Clinical Commissioning Groups.

There is a local and national expectation that organisations work to deliver or exceed the plans they made in spring. The bottom line trajectories for future years will be based on the Control Totals for each organisation for 2019/20 and so any overspends in the current year will need to be recovered through greater spending reductions in future years.

As you know, the Midlands regional financial position is under some pressure and several organisations are reporting levels of unmitigated risks at this stage of the year. To mitigate this position, as a Regional Team, we have been working with a number of organisations to effect change to the projected financial trajectories for the year and it is, therefore, our expectation that this protocol will only be used in a limited number of cases.

cont ……

The protocol, which is attached for your information, has been established as a formal process of challenge and sign off and will be managed at a Regional level. It is expected that in advance of any formal reporting of a forecast variance from plan, you will be required to have discussed the financial deterioration with the Regional Director and Regional Director of Finance and that your organisation should be able to demonstrate the actions that have been taken to address the deterioration. Please refer to the attached document for more detailed guidance.

This process applies to revenue plans only but the control of capital expenditure is also very important and so any emerging risks relating to capital plans should be discussed with the finance team at the earliest opportunity.

For those organisations which are currently reporting financial risk, we will be initiating a further series of Regional Review Meetings with organisations and/or systems to review the financial position. It will be in these forums that we will wish to discuss with you the actions that the organisation is taking to mitigate the risk as per the protocol.

If you have any questions regarding this protocol, please contact your NHS England and NHS Improvement finance contact in the first instance.

With kind regards,

Yours faithfully

Mark Mansfield
NHS England and NHS Improvement

Enclosures: **Joint Provider and CCG Protocol.**
Board Assurance Statement.

cc: Senior Finance Leadership Team, NHS England and NHS Improvement
Directors of Strategic Transformation, NHS England and NHS Improvement

Protocol for Changes to an In-Year Financial Forecast

1. Introduction

1.1 NHS providers and commissioners submitted financial plans for 2019/20. These plans were quality impact assessed and signed off by individual boards / governing bodies prior to submission.

1.2 The achievement of financial balance, whilst maintaining the quality of healthcare provision, is a key objective for all organisations. The future success of the NHS depends on clinical commissioning groups (CCGs), direct commissioners (DCs) which includes specialised commissioning, and providers delivering or over achieving the plans that they have signed up to and boards / governing bodies must take organisational and personal accountability for meeting their financial and performance commitments.

1.3 In exceptional circumstances it may be necessary for an NHS commissioner or provider board / governing body to reconsider its planned forecast outturn position. In this event, the primary focus must be the identification and delivery of a recovery plan that demonstrates the mitigating actions being implemented that ensure any proposed adverse revision to forecast outturn is minimised, managed and fully recovered at the earliest possible time.

1.4 To demonstrate the highest standards of governance and for purposes of consistency and transparency, the protocol set out below should be followed by all commissioner and provider boards / governing bodies considering the reporting of a deterioration in the forecast outturn against their planned position for the year. Similar processes will be operated to control directly commissioned services.

1.5 The introduction of this protocol by NHS England and Improvement (NHSE/I) should not be taken by boards / governing bodies as permission to deteriorate financial positions. All reporting revisions must be accompanied by the actions required to return to planned positions.

1.6 The protocol is required to be followed for all deteriorations in positions, it does not apply to improvements in positions, but these should still be communicated and discussed with regional teams in advance of any changes being formally recorded.

2. Protocol

2.1 Revisions to forecast outturns can only be made once a commissioner or provider's plan for the year has been agreed and only at the quarterly

reporting points in the year and must be made through the standard quarterly reporting process. Where, in exceptional circumstances, a movement is required on a non-quarter-end month, this should only be undertaken with the express agreement of the NHSE/I regional director of finance. Other important considerations are:

- NHSE/I would not expect to see any changes in the first quarter given that this follows closely after the planning process.
- Changes in the final quarter will be looked on as a sign of very poor financial control likely to attract further scrutiny. Where such movements are identified and changes required in months 10 and 11, the protocol process must be initiated as soon as the deviation becomes known.
- The protocol should be used to record all adverse movements from plan regardless of whether an organisation is still within its control total.
- If the protocol process has been invoked for an adverse change in position, any subsequent changes from the revised forecast outturn position will require the process to start again. This would be particularly relevant for an organisation that changes its forecast early in the year and then finds that it has worsened later in the year. A further deterioration will be viewed as very poor forecasting and lack of financial control.

2.2 **In advance of formally reporting a forecast outturn variance from plan**, commissioners / providers are required to have discussed the financial deterioration with the respective NHSE/I executive regional director and regional director of finance.

2.3 This engagement must be underpinned with a commissioner / provider prepared detailed report that clearly includes details of:

- The key financial drivers for the deterioration;
- An analysis of the underlying causes;
- The actions being taken to address the deterioration and evidenced confirmation that:
    - Relevant partner organisations have been informed of the position and all opportunities for support have been explored and the recovery actions agreed;
    - The senior clinical decision making body within the commissioner / provider has been engaged with and are party to the identification and delivery of the recovery actions;

- Commissioner / provider executive committee, finance committee and board / governing bodies have considered and agree the proposed financial forecast revision and recovery actions.

2.4 This recovery plan described must explicitly reference:

- Details of the additional measures immediately implemented to improve financial control and where applicable working capital/cash management, including capital programme review. This will include all discretionary spend, agency / locum spend, supplies and consumable spend.
- Details of how the commissioner / provider is reviewing:
  - The affordability of planned investments to improve service quality and performance;
  - The acceleration of the delivery of productivity opportunities identified by the Carter review and other efficiency programmes;
  - The acceleration or extension of quality innovation productivity and prevention (QIPP) schemes and areas such as Rightcare.
  - The acceleration of proposals for sub-scale service consolidation or closure;
  - The impact on patient safety and experience of recovery actions;
- The demonstration of quarter on quarter improvement in income and expenditure run-rate from the point the revision is submitted and how QIPP, or cost improvement programmes (CIP) delivery is being maximised.

2.5 **System review requirements**, system level sign off is required to confirm that the position has been discussed and agreed at a sustainability and transformation partnership (STP) level and that all options for mitigation including systems wide solutions have been explored. This should involve the following stages:

- Commissioners / providers must demonstrate that discussions have taken place with partner organisations to resolve any material issues that could affect the partners' abilities to meet their control totals. There should be an audit trail that shows the partners agreement on the nature and cause of a problem (defined as a deviation from plans) and that the options for mitigation across the system have been properly considered.

- STP partner organisations must have the opportunity to be able to provide peer commentary on the position reached within the organisation. This will ensure there is a system wide understanding of the circumstances leading to a change in planning assumptions.

- Within an integrated care system ICS there may be the added impact that an organisation that cannot meet its control totals, could impact on the provider sustainability fund (PSF) and commissioner support fund (CSF) of all partners. In these circumstances the ICS will need to decide whether there are any system-wide solutions that could be triggered to provide mitigation for the affected organisation's financial pressures. This should be brokered and approved by the ICS.

2.6 When a formal revision to forecast outturn under this protocol is made through the national reporting process, it must be accompanied by a board assurance statement (BAS) signed by the commissioner / provider chair, accountable officer / chief executive, chief financial officer / director of finance, and audit committee chair in respect of the organisation's adherence to this protocol and their commitment to the delivery of the recovery plan. Additionally, STP sign off is required, this will be the signature of the STP leader or finance lead. This statement will be addressed to the chair and chief executive of NHSI/E and will be formally reported to that organisation's board.

2.7 The regional team will notify organisations how they wish the BAS to be submitted. Organisations are required to liaise with regional teams early in the process and well in advance of any monthly or quarterly reporting deadlines. Monitoring arrangements will be determined by the executive regional director to ensure that focus and delivery is maintained.

Report To	**Trust Board**
Date of Meeting	**Thursday 30 January 2020**

Title of the Report	**Agency Staff Governance**
Agenda item	**11**
Presenter of Report	Mark Smith, Chief People Officer
Author(s) of Report	Adam Cragg, Head of Resourcing & Employment Services
This paper is for:	
Assurance : To reassure the Board that controls and assurances are in place	
Executive summary This report provides an overview of the governance arrangements in place for the booking of agency staff and agency spend controls.	
Related Strategic Pledge	Which strategic pledge does this paper relate to? *1. We will put quality and safety at the centre of everything we do*
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks : No
Related Board Assurance Framework entries	BAF – please enter BAF number(s) 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? (Y/N) 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)? (Y/N) N

	If yes please give details and describe the current or planned activities to address the impact.
Financial Implications	N?A
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper No

Actions required by the Trust Board

The Trust Board is asked to note the report.

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

TRUST BOARD

THURSDAY 30 JANUARY 2020

AGENCY STAFF GOVERNANCE

Introduction

This report describes the governance arrangements for the use of agency staff.

There are two Trust policies that govern the use of agency staff. One relates to nursing and midwifery and the other to all other staff groups including medical staff.

The only agencies that are used to engage agency staff are those that are on a recognised procurement framework.

Bookings for medical agency staff, Allied Health Professionals and senior managers are centrally coordinated by the HR locum centre.

Nursing and Midwifery agency staff are centrally coordinated by the Nursing Temporary staffing office.

Pre-requisites for booking Agency Staff

Managers are advised of their obligation to take into account planned absence and a degree of unplanned absence when managing leave to ensure there is adequate cover from existing staff.

Before requesting agency staff, managers are required to ensure that all internal options for sourcing additional staff including the staff bank have been explored and exhausted. As such the booking of agency staff is a last resort.

Agency Booking Process

Non-Nursing Agency Bookings

All requests for agency bookings must be approved by a manager with the designated authority to do so. For non-nursing roles this is undertaken via Trac, the Trusts recruitment system, at which point the request is provided with a unique approval number and processed by the HR Locum Centre.

Designated framework agencies are then contacted by the temporary staffing office and CVs are obtained, pay rates negotiated and employment clearance compliance checked prior to the CVs being sent to the appropriate manager for approval.

All pay rates are checked against the NHSI capped rates and in the event that the pay rate exceeds the NHSI cap, the relevant Director's authorisation is required before the agency booking is able to proceed.

Nursing Agency Bookings

For Agency nursing staff the booking process is administered through the electronic bank system through the provision of a unique identifier to those managers with the authority to book agency staff. The system prevents the ability to book agency staff through anything other than approved agencies. The requirement to use the electronic bank system for all nurse agency bookings is reflected in the Trusts Standing Financial Instructions and monitored accordingly. Pay rates for agency nursing are not negotiated, these are pre-determined as part of the April 2016 NHSI Agency Rate Caps for each Band.

In the event that the agency request occurs outside of core business hours, the above process is managed for all staff groups by the site management team who are fully trained and have access to information to which they can refer if necessary

Compliance with Employment Checks for Agency Workers

All employment clearances for agency workers are undertaken by the employing agency. In the case of medical and senior manager agency workers the HR Locum Centre check that these employment clearances have been appropriately obtained by the agency prior to providing the details of the candidate to the manager making the agency request. The employment clearances that are checked are as follows:

- Right to work
- Qualifications/Training
- Employment history and referencing
- Occupational Health
- DBS
- Verification of ID
- Professional registration (where appropriate)

The nurse bank temporary staffing office does not check that the employment clearances have been appropriately obtained by the agency and rely entirely on the framework to monitor this through regular audits by them. The framework agencies that are utilised by the Trust are obligated to demonstrate to NHSI that their compliance with the above employment checks are appropriately carried out and are subject to audit as part of the terms of being on an established Framework.

Identification checks are conducted upon arrival of the agency worker.

Local Induction

For medical staff a local induction is carried out for each agency worker by the HR Locum Centre during core office hours. For out of hours, the Site Management team are required to ensure that the medical agency worker receives a local induction.

For all other staff groups, the line manager to whom the agency worker is allocated is required to carry out a local induction upon arrival.

Allied Health Professionals (AHPs)

Historically, the management of agency AHPs was managed locally within departments. This is now in the process of being centralised within the HR Locum Centre. Centralisation of AHP agency bookings will provide greater support to those areas requiring agency bookings as well greater central oversight and assurance that the bookings are managed in accordance with the requirements detailed above.

Control of Agency Spend

Whilst is necessary from time to time to utilise agency staff due to staff shortages, agency spend is monitored and minimised through the negotiation of the best rates, adherence to the NHSI caps and ensuring that agency use can only be approved by a manager with the designated authority to do so.

Agency use is also monitored through the Agency Reduction Meeting, which is a bi-weekly meeting to provide high support and high challenge for each Division and to oversee the Trusts, agency spend, workforce planning, specifically recruitment to vacancies and review Roster Confirm and Challenge.

Efforts to control and minimise Medical agency spend are also being undertaken through the utilisation of software provided by 'Patchwork' on a trial basis. This software enables available medical shifts to be easily publicised via a mobile application that enables medical staff to easily select shifts that are convenient for them to work.

This functionality seeks to grow the medical bank through making it easier for substantively employed doctors to access bank shifts, whilst also appealing to doctors not employed by the Trust who wish to have the ability to see and book bank shifts at Northampton General Hospital. All newly on-boarded bank doctors are subject to the same employment checks as substantive employees and are processed through the Medical Staffing Department in the normal way. The system prioritises Bank workers over agency workers to the extent whereby booked agency shifts can be overridden and worked by a bank worker in the event of a bank worker becoming available and in doing so incentivises agency workers to join the Trust bank. The software platform has also been implemented by the HR Locum Centre to facilitate shifts being booked by Advanced Clinical Practitioners within the A&E Department.

In addition to the use of this software, the Allocate roster system is being rolled by the HR Locum Centre to medical staff within the A&E department to better enable the management of the medical roster and provide greater visibility of staff deployment and leave management. Both initiatives are aimed at minimising reliance on agency workers and the associated costs.

Report To	**Trust Board**
Date of Meeting	**30th January 2020**

Title of the Report	**Board Assurance Framework Q3 2019-20**
Agenda item	**12**
Presenter of the Report	Claire Campbell, Director of Corporate Development, Governance and Assurance
Author(s) of Report	Claire Campbell, Director of Corporate Development, Governance and Assurance

This paper is for: (delete as appropriate)	
□ √**Note**	□√ **Assurance**
For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

1. Executive summary

This report describes the Q3 position in relation to the Board Assurance Framework and risks associated to delivery of corporate objectives described on the BAF.

The purpose of the BAF is to provide the Trust Board of Directors with a simple but comprehensive method for the oversight of the effectiveness of the controls on the principal risks to meeting the Trust's objectives.

The BAF maps out both the key controls in place to manage the principal risks and also how sufficient assurance has been gained about the effectiveness of these controls. It also provides a structure for various audit programmes and evidence to support the Annual Governance Statement.

All Board committees and the Board review the BAF quarterly. Each risk has been assigned to one or more Board committees. The Board has agreed to maintain this reporting process and frequency.

2. Assurance

The Trust Board is only properly able to fulfil responsibilities through an understanding of the principal risks facing the organisation. The Board, therefore needs to determine the level of assurance that should be available to them with regard to those risks. Risks have been assigned to specific Board committees for discussion and challenge prior to presentation at Trust Board.

3. Population of the BAF

Executive Director Leads have reviewed and updated all sections of the BAF with a particular emphasis on any gaps in control, gaps in assurance, and the assurance position. The actions and milestones have been updated accordingly.

4. Changes to the BAF during Q3

General changes made are as follows:

- Since the last report the BAF has been further amended and updated in line with an exemplar format provided by the CQC ensuring no previously identified good practice has been lost in the change. Underlying cause/ source of risk has been summarised and articulated in addition to the

Corporate Risk Register references.

- The date risk expected to be removed for the BAF has been updated to date of next full review
- All corporate risk references have been reviewed and updated
- The underlying causes of risks have been defined.

The following updates have been made to the Risks assigned to the Board committees:

1.1 Risk of failure to meet regulators minimum fundamental standards to avoid enforcement action, intervention or suspension of services- Quality Governance Committee

- Gaps in control and actions have been updated.

Actions update:

1. The NGH Improvement Plan has been updated and will be reported monthly to QGC and Bi-monthly to Trust Board
2. HEE/GMC action plans- a project manager has been appointed to coordinate the improvement work and the action remains ongoing
3. Positive progress in delays in closure of SI's and CAS Alerts- 1 CAS alert remains open with no others at risk

1.2 Risk of Failing to meet local and national quality and performance standards leading to poor experience and financial risk of contract penalties- Finance & Performance

- Gaps in assurance and actions updated

Actions update:

1. Winter plan is being operationalised
2. Weekly cancer PTL meetings continue
3. Routine work is being outsourced as required across all specialities
4. Elective procedures cancelled where necessary to ensure capacity for emergencies

1.3 Risk of failing CQUIN standards leading to lost opportunity to improve service quality and financial risk of due to loss of funding associated with CQUIN attainment- Quality Governance Committee

- Gaps in assurance and actions updated.
- Score reduced from 12 to 8 due to year end agreement with CCG.

Actions update:

1. EPMA upgrade in train
2. Appointment process for two CQUIN admin support posts in train to support delivery of all CQUINS and provide support to clinical staff, managed by Governance Team

1.4 Risk of avoidable harm to patients resulting in adverse publicity and public confidence in NGH as hospital of choice- Quality Governance Committee

- Existing controls, gaps in assurance and actions updated.

Actions update:

1. Rollout of EPMA – completed
2. Digitisation of deteriorating Patient Care Plan delayed and due date extended to March
3. Mortality Lead appointed and has commenced in post
4. Medical Director in discussion with HSIB lead regarding timeliness of learning from Perinatal Incidents- supported by QGC

1.5 Risk that Trust fails to deliver high quality services across all wards and clinical departments at all hours on each day of the week resulting in skills and capacity constraints impacting on patient safety and experience- Quality Governance Committee

- Existing controls and gaps in assurance.

Actions update:

1 & 2- work remains ongoing

3. Update of QI Strategy in train

1.6 Risk title revised from "Risk of poor standards of care in ward and other areas due to inability to recruit adequate numbers of appropriately qualified nursing staff leading to suboptimal patient care and poor staff experience", to inability to recruit adequate numbers of nursing staff - Quality Governance Committee/ Workforce Committee

- Existing controls, sources of assurance and actions updated.

Actions update:

1. Action Plan now in progress following commencement of the NHS Recruitment and retention collaboration. Date updated to reflect this
2. Work is ongoing in anticipation of the arrival of the next cohort of overseas nurses from April 2020 – to continue for six to 8 months following arrival

3. Assessment and accreditation rolling out to Paeds, Maternity and Theatres
4. Implementation delayed of the safe care electronic tool- date revised

1.7 Risk of failures related to failing infrastructure due to aging estate leading to poor patient environment, poor infection control and potential health and safety failure- Quality Governance Committee/ Finance & Performance Committee

- Gaps in control and actions updated. The decant plan is at risk for 20/21 due to lack of access to wards. Design and planning works continue and options for temporary wards are being explored but, it is probable that there will be no decant work with in the wards during 20/21).

Actions update:

1. Further posts have been filled during Dec/Jan (fire officer and mechanical maintenance engineer). Senior maintenance manager & electrical maintenance manager interviews due end of the month. Deputy Director Role advert closes end of January. Trade staff vacancy interviews due before the end of the month.
2. These works continue and are reported monthly to FPC.
   Trust Governance team undertaking a review of the governance structure
3. Estates strategy paper and discussion was held at December Board meeting. The Board discussion was able to give further direction for the strategy development.
4. The new accommodation block and new main entrance are both potentially at risk due to new financial regulations. These are being discussed with each provider in meetings attended by NGH Finance Director and Director of Estates. Discussions are also being held with NHSI/E for support. This will be an ongoing 'business as usual' action to seek additional funding and will be included within the estates strategy.

1.8 Risk of failures in data quality, ICT infrastructure and/or a successful cyber security attack may lead to loss of service with staff being unable to access patient records with a significant impact on patient care and reputational risk to the Trust- Finance & Performance

- Existing controls and actions updated.

Actions update:

1. Training- action continues
2. Network access control -Professional services to install and configure the Network Access Control is starting on 13/01/2020
3. 4 WiFi access points left to be deployed. Once this is complete the all old Wi-Fi infrastructure will be removed from NGH.
4. HSCN migration ongoing to migrate to a more secure bandwith connection that provides an additional ten times bandwidth (100Mb to 1000Mb) (NHS Net). There have been extreme delays in migration of the Trust's main hospital switchboard telephone number. This is a pre-requisite to be able to migrate to HSCN. The migration to HSCN is also a dependency from the NHS Mail migration. With the intervention of the Chief Operating Officer, the Trust now has director level contacts at Virgin Media and BT. The voice migration issue is now being investigated by all parties at pace, due to this intervention.
5. Windows to migrate to Windows 7 (2785 completed- 833 remain)
6. USB Port Control – This action will result in only allowing Trust approved USB devices to work in Trust computers.

2.1 Risk that the Trust fails to promote a culture which puts patients first- Quality Governance Committee

- No changes

Actions update:

1 & 2 remain ongoing

3. Deputy Director of Nursing- Patient Experience, post appointed

3.1 Risk that the Trust fails to achieve optimum workforce capacity to deliver best possible care now and in the future- Workforce Committee

- No changes

Actions update:

1. Overseas recruitment has commenced
2. Oncology work continues

3.2 Risk that the Trust fails to achieve optimal workforce capability to deliver best possible care now and in the future- Workforce Committee

- Target score, Gaps in assurance and actions updated. Target score reduced from 8 to 4 as target achieved.

Actions update:
1. Talent Management development- in train
2. Implementation of People Plan 2019-2020- in train
3. Deep dive reports into staff group compliance with training to be presented to workforce committee from Jan 2020

3.3 Risk that we fail to engage and nurture our staff leading to a lack of energy and commitment and an optimal culture- Workforce Committee

- Existing controls, sources of assurance and actions updated.

Actions update:
1. Health & Well- Being Strategy reviewed- due date amended to March
2. People Plan Implementation- reviewed and ongoing
3. Values Ambassador role development- completed- 8 fully trained, further tranche to be identified
4. Review of Respect & Support Initiative- completed
5. Staff survey 2019 outcomes – review and report to Board due in February

4.1 Risk that failure to progress clinical collaboration as an integral part of the Northamptonshire Health and Care Partnership will not provide the optimal range of core acute services within Northamptonshire leading to a deficit of provision, increased health inequalities and barriers to healthcare access- Finance & Performance

- Sources of assurance and actions updated.

Actions update:
1. Acceleration of the programme of collaboration with KGH- group model approved, action updated to implementation of group model
2. Annual Planning process- delivering internal clinical sustainability reviews- date extended to end of the financial year

3 & 4 remain in progress

5.1 Risk that the Trust fails to have financial control measures in place to deliver its 2018/19 financial plan- Finance & Performance Committee

- Existing controls, sources of assurance and actions updated.
- Score increased from 20 to 25 due to increased risk to delivery of financial plan

Actions update:
1. Transformation & efficiency programme changes to be implemented- in train
2. System financial recovery plans submitted to support financial re-forecasting

5.2 Risk that the Trust fails to deliver the cost savings associated with the Changing Care @ NGH Programme- Finance & Performance Committee

- Existing controls and actions updated.
- Risk score increased from 20 to 25- due to increased risk to delivery of cost savings

Actions update:
1. Transformation & efficiency programme changes in train
2. Prioritisation framework agreed at December Finance and Performance Committee

5.3 Risk that the Trust fails to manage its Capital programme within Capital Resource limit or fails to secure sufficient funding for infrastructure and equipment improvements Finance & Performance Committee

- Existing controls, sources of assurance and actions updated.

1. Tactical and strategic review of estates portfolio- completed and estates strategy presented to Trust Board in December 2019
2. Submit additional bids wherever possible- updated

Risk Score: The risk score has increased overall in this quarter from 250 to 256 for 16 risks.
The BAF is attached (Appendix 1).

The actions associated with the pledges reported in the last quarter require further review to ensure risks have been appropriately linked; to ensure no new risks are identified as a result of the actions, including a review of Pledge 6 and identification of risks associated with this work.

Related strategic aim and corporate objective	ALL

Risk and assurance	The Board assurance framework describes key risks to the Trust's corporate objectives and informs the organisational Annual Governance Statement
Related Board Assurance Framework entries	ALL
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	The Board assurance framework is cross referenced to the Care Quality Commission Standards of Quality and Safety which the organisation has a statutory duty to meet.

Actions required

The Board is asked to:

- Note the changes made to the BAF
- Consider if the Board is gaining sufficient assurance that controls and actions in place are mitigating risks described

Consequence Score/ Domain	Likelihood Score/Domain				
	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Almost certain
5 Catastrophic		1.1; 1.4;	3.1;	1.7; 5.3;	1.6; 5.1; 5.2
4 Major		3.2; 1.3;	1.5; 2.1;	4.1;	1.2; 1.8
3 Moderate					3.3;
2 Minor					
1 Negligible					

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

BAF risks in order of severity:

1.6	Risk of poor standards of care in ward and other areas due to inability to recruit adequate numbers of appropriately qualified nursing staff leading to suboptimal patient care and poor staff experience	25
5.1	Risk that the Trust fails to have financial control measures in place to deliver its 2019/20 financial plan	25
5.2	Risk that the Trust fails to deliver the cost savings associated with the Changing Care @ NGH programme	25
1.2	Risk of failing to meet local and national quality and performance standards leading to poor experience and financial risk of contract penalties	20
1.7	Risk of failures related to failing infrastructure due to aging estate leading to poor patient environment, poor infection control and potential health and safety failures	20
1.8	Risk of failures in data quality, ICT infrastructure and/or a successful cyber security attack may lead to loss of service with staff being unable to access patient records with a significant impact on patient care and reputational risk to the Trust	20
5.3	Risk that the Trust fails to manage its Capital programme within Capital Resource limit or fails to secure sufficient funding for infrastructure and equipment improvements	20
4.1	Risk that failure to progress clinical collaboration as an integral part of the Northamptonshire Health and Care Partnership (Northamptonshire's Sustainability and Transformation programme) will not provide the optimal range of core acute services within Northamptonshire leading to a deficit of provision, increased health inequalities and barriers to healthcare access.	16
3.1	Risk that the Trust fails to achieve optimum workforce capacity to deliver best possible care now and in the future	15
3.3	Risk that we fail to engage and nurture our staff leading to a lack of energy and commitment and an optional culture	15
1.5	Risk that Trust fails to deliver high quality services across all wards and clinical departments at all hours on each day of the week resulting in skills and capacity constraints impacting on patient safety and experience	12
2.1	Risk that the Trust fails to promote a culture which puts patients first	12
1.1	Risk of failure to meet regulators minimum fundamental standards to avoid enforcement action, intervention or suspension of services	10
1.4	Risk of avoidable harm to patients resulting in adverse publicity and public confidence in NGH as hospital of choice	10
3.2	Risk that the Trust fails to achieve optimal workforce capability to deliver best possible care now and in the future	8
1.3	Risk of failing CQUIN standards leading to lost opportunity to improve service quality and financial risk of due to loss of funding associated with CQUIN attainment	8

Principal Risk 1: Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.			
BAF Risk No.1.1 Risk of failure to meet regulators minimum fundamental standards to avoid enforcement action, intervention or suspension of services			
Risk Classification: Compliance	**Risk Owner:** DCD,G & A	**Scrutinising Committee:** Quality Governance Committee	
Date Risk Opened: 1/4/19	**Date of next full review of BAF:** 1/4/20		
Changes since last review:			
Underlying Cause/ Source of Risk: CRR reference risks: 646; 1303;1782; 1867;1879;1902; 1911; 1303	**Initial score**	**Current score**	**Target score**
	10 (5x2)	15 (5x3)	5 (5x1)

Existing Controls	**Positive Assurance of Controls**
1. Clinical Governance structures and processes 2. Clinical Audit strategy 3. Board to Ward visits 4. Quality metrics in Performance report to Board 5. Divisional Quality Governance reports to Clinical Quality & Effectiveness Committee 6. Quality meetings with commissioners 7. Quality Governance committee 8. Clinical Quality & Effectiveness Group 9. Patient and Carer experience Group 10. ARC reports to QGC 11. Ward Accreditation. 12. CQC Relationship meetings	• QGC report to Trust Board (L2) • Trusts Quality Improvement scorecards (L1) • Assessment and accreditation reports to Trust Board (L1) • Divisional Quality Governance assurance reports to CQEG (L1) • Compliance reports to QGC (L1) • Peer review & screening QA visits (L3) • Internal audit reports (L3) • ARC reports to QGC(L1) • CQC Insight report (L3) • CQC Engagement meetings (L3)

Gaps in Controls

- Trust has red flags related to Medical Trainee reports
- CQC Insight report indicates that the Trust's composite indicator score is similar to other trusts that are more likely to be rated requires improvement.
- CQC Report (2019) overall rating of Requires Improvement
- Capacity Pressures impacting on SSNAP compliance

Further Actions	**Responsible Person/s**	**Due Date**
1. NGH Improvement Plan developed for implementation	1. Claire Campbell	February 2020
2. HEE/GMC action plans in progress	2. Matt Metcalfe	February 2020
3. Robust management of delays in closure of SI's and CAS alerts	3. Claire Campbell	February 2020
4. Full capacity protocol instigated- Overflow stroke beds agreed to be monitored	4. Debbie Needham	February 2020

Principal Risk 1: Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.			
BAF Risk No. 1.2 Risk of failing to meet local and national quality and performance standards leading to poor experience and financial risk of contract penalties			
Risk Classification: Operational	**Risk Owner:** COO	**Scrutinising Committee:** Finance & Performance Committee	
Date Risk Opened: 1/4/19	**Date of next full review of BAF: 1/4/20**		
Changes since last review:			
Underlying Cause/ Source of Risk: CRR reference risks: 368; 1303; 1782; 1795; 1867; 1911; 1902;1930;2131;2132; Multiple sources of risk exacerbated by high demand and high patient acuity.	**Initial score** 20 (4x5)	**Current score** 20 (4x5)	**Target score** 8 (4x2)

Existing Controls	**Positive Assurance of Controls**
1. Performance management framework policy 2. Bed meetings and safety huddle daily with escalation processes in place 3. Symphony IT monitoring system in use for A&E 4. A&E delivery Board 5. Cancer Improvement Group meeting monthly 6. County wide Cancer Board meets monthly 7. Somerset reporting cancer 8. Twice weekly tracking for DTOC 9. Elective Care Board CCG Monthly 10. Weekly performance meeting in place	• Performance metrics at corporate, divisional and directorate level (L1) • Integrated performance report to Trust Board and committees (L1) • A&E received rating of Good in CQC inspection 2019 (L3) • Benchmarking against other Trusts. (L3) • Winter Plan. (L1)

Gaps in Controls

1. Report to Board indicates under performance for: Cancer targets (62 days) / A & E /RTT
2. Attendances, admissions, and acuity remain high
3. Outsourcing of elective activity to reduce backlog
4. Social Care reductions impacting on discharge and flow in hospital
5. Key posts in A&E remain difficult to recruit to.
6. Key nursing and medical posts remain difficult to recruit to.

Further Actions	**Responsible Person/s**	**Due Date**
1. Winter Plan- currently being operationalised 2. Weekly Cancer PTL with 1 deep dive a week 3. Further outsourcing of routine work to private sector across all specialities 4. Cancelled elective procedures to increase bed capacity for emergencies	1-4 Debbie Needham	1. 31 March 2020 2. 30 Jan 2020 3. 31 March 2020 4. 31 March 2020

Principal Risk 1: Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.		
BAF Risk No.1.3 Risk of failing CQUIN standards leading to lost opportunity to improve service quality and financial risk of due to loss of funding associated with CQUIN attainment		
Risk Classification: Quality & Finance	**Risk Owner:** MD	**Scrutinising Committee:** Quality Governance Committee
Date Risk Opened: 1/4/19	**Date of next full review of BAF: 1/4/20**	
Changes since last review:		

Underlying Cause/ Source of Risk: CRR reference risks: 2005; National Requirements, benchmarking unavailable at start of the year and data collection elements disproportionately onerous.	**Initial score**	**Current score**	**Target score**
	8 (4x2)	8 (4x2)	8 (4x2)

Existing Controls	**Positive Assurance of Controls**
1. Clinical Quality and Effectiveness Group 2. Quality Governance Committee 3. Contracting meetings with Commissioners 4. Finance and Performance committee 5. Regular contract meetings with CCG 6. CQUINs oversight Group	• Quarterly reports to commissioners (L3) • Quarterly reports to Clinical Quality and Effectiveness Group (CQEG) (L1) • Reports from CQEG to Quality Governance committee (L1) • Quality Governance report to Trust Board (L2)

Gaps in Controls

1. Lack of electronic patient record restricts capacity for data collection

Further Actions	**Responsible Person/s**	**Due Date**
1 Baseline data available and updated. Data collection issues for falls and anti-microbial stewardship needs. EPMA upgrade has potential to support antimicrobial and elements of Falls CQUINS.	1. Matt Metcalfe	Feb 2020
2 Appointment of two admin support posts for CQUINS	2. Fiona Barnes	Feb 2020

Principal Risk 1: Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.

BAF Risk No.1.4 Risk of avoidable harm to patients resulting in adverse publicity and public confidence in NGH as hospital of choice

Risk Classification: Quality	**Risk Owner:** MD	**Scrutinising Committee:** Quality Governance Committee
Date Risk Opened: 1/4/19	**Date of next full review of BAF: 1/4/20**	
Changes since last review:		

Underlying Cause/ Source of Risk:	**Initial score**	**Current score**	**Target score**
CRR reference risks: 368, 1411,1478, 1757, 1782, 1867, 1879, 1911, 1955, 1972, 2150, 2177, 2187, 2193 Multiple sources of risk exacerbated by high demand and high patient acuity.	10 (5x2)	10 (5x2)	5 (5x1)

Existing Controls	**Positive Assurance of Controls**
1. Monthly review of Dr Foster information and alerts 2. Mortality Review Group 3. Audit plan 4. Incident and SI reporting policy 5. Monthly Clinical Quality and Effectiveness Group 6. Monthly Quality Governance committee 7. Countywide Patient safety M&M meetings 8. Review of Harm Group weekly 9. Dare to Share alternate monthly 10. FIT Group 11. MASH referral system 12. NGH Safeguarding Team	• Reports from Mortality review to CQEG and QGC (L1) • HSMR & SHMI data (L3) • CQEG reports to Quality Governance committee (L1) • Quality reports to Quality Governance and Trust Board (L1) • Quality Governance reports to Trust Board (L2) • Dr Foster data reports (L3) • Results from Clinical audit (L1) • Review of Harm Group monitoring implementation for SI action plans (L1) • National Learning and reporting system data (L3) • Incident report to Quality Governance committee (L1) • Safety thermometer metrics via DoN report (L2) • Delivery of infection control trajectory requirements at end of 2019/20 (L1) • Reports to FIT Group (L1)

Gaps in Controls

1. Dr Foster data outlier re
2. NICE-/ VTE compliance remains inconsistent
3. Recurrent themes of harm identified requiring thematic approach to redress.
4. System Safeguarding resources and infrastructure

Further Actions	**Responsible Person/s**	**Due Date**
1. 9th December – roll out of EPMA which includes VTE assessments	1. Matt Metcalfe	1. Completed
2. Completion of work to digitise and mandate use of Deteriorating Patient Care Plan	2. Dr Hardwick	2. March 2020
3. Appoint Mortality Lead	3. Matt Metcalfe	3. Completed
4. Discussions with HSIB regarding timeliness of learning from perinatal incidents	4. Matt Metcalfe	4. March 2020

Principal Risk 1: Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.		
BAF Risk No.1.5 Risk that Trust fails to deliver high quality services across all wards and clinical departments at all hours on each day of the week resulting in skills and capacity constraints impacting on patient safety, experience and quality of care		
Risk Classification: Quality	**Risk Owner:** MD/DON	**Scrutinising Committee:** Quality Governance Committee
Date Risk Opened: 1/4/19	**Date of next full review of BAF: 1/4/20**	
Changes since last review:		

Underlying Cause/ Source of Risk: CRR reference risks 1757, 368, 1280 Insufficient clinical staffing to provide 24/7 service.	**Initial score**	**Current score**	**Target score**
	12 (4x3)	12 (4x3)	8 (4x2)

Existing Controls	**Positive Assurance of Controls**
1. Reports to Clinical Quality and Effectiveness Group (CQEG) – 7 day services 2. CQEG reports to QGC 3. Job planning processes 4. Review of clinical models in line with Trust 60 bedded unit 5. Safe Nursing & Midwifery Staffing Report 6. Quality Account & process 7. Quality Improvement Strategy 8. Assessment and Accreditation report to Board on standards of nursing care	• Associate Medical Director report to CQEG (L1) • Quality Governance report to Trust Board (L2) • Clinical Collaboration work to ensure robust services county wide across both acute Trusts (L1) • Self-assessments (Assurance Framework return) undertaken biennially against 7 day services criteria (L1 • Mortality review reports to QGC and Trust Board (L1) • Safer staffing metrics (L1) • Delivery of Quality Priorities (L1)

Gaps in Controls
1. Weekend capacity of medical staffing
2. Nurse vacancy rate

Further Actions	**Responsible Person/s**	**Due Date**
1. Medical rota revision 2. Plan to roll out ERostering 3. Revision/ update of Quality Improvement Strategy	1. Geraldine Harrison 2. Fiona Poyner 3. Matt Metcalfe/ Sheran Oke	1. 31/3/2020 2. 31/3/2020 3. 28/2/2020

Principal Risk 1: Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.

BAF Risk No.1.6 Inability to recruit adequate numbers of nursing staff

Risk Classification: Quality	**Risk Owner:** DON	**Scrutinising Committee:** Quality Governance & Workforce
Date Risk Opened: 1/4/19	**Date of next full review of BAF: 1/4/20**	
Changes since last review:		

Underlying Cause/ Source of Risk:	**Initial score**	**Current score**	**Target score**
CRR reference risks; 1280, 1188, 979, 1280, 1598, 1665, 1682, 1879,1962,1967,2219 National shortage of Nursing and Midwifery qualified staff.	25 (5x5)	25 (5x5)	10 (5x2)

Existing Controls	**Positive Assurance of Controls**
1. Nursing recruitment and retention plan including both UK and overseas recruitment programmes. 2. Three times daily safety/staffing huddles led by senior nursing team /Staffing escalation protocol 3. Nursing Talent Academy providing career pathway 4. Monitoring standards of care through the Assessment and Accreditation process reporting to Board 5. Patient and Carer Engagement and Experience Group 6. Safeguarding policies/ staff training 7. Nurse Staffing Recruitment and Retention Group 8. Nursing and Midwifery strategy 9. Quality Governance Committee 10. Workforce committee	• Nursing recruitment monthly recruitment pipeline tracker (L1) • Monthly reports from Workforce committee to Trust Board (L2) • Report to workforce committee (L1) • Quality Governance report to Trust Board (L2) • Incident reporting (L1) • Staff satisfaction survey (L3) • Patient feedback (L3) • Acuity and skill mix reviews (Bi- annual) (L1) • Open and Honest Care report (L1) • Safety thermometer (L1) • Patient harm data (Including falls, pressure ulcers)d incidence and benchmarking (L1) • Nurse fill rate (L1)

Gaps in Controls

1. Vacancy rates of qualified nursing staff

Further Actions	**Responsible Person/s**	**Due Date**
1. NHS Recruitment & Retention collaboration	1. Fiona Barnes	1. Sept 2020
2. Cultural awareness and pastoral enhancement	2. OD Team & EDI Lead	2. April 2020
3. Assessment & Accreditation roll out to Paeds, Maternity & Theatres	3. QA Matron & PNS	3. June 2020
4. Implementation of Safe Care Electronic tool	4. Head of Nurse Bank & PNS	4. May 2020

Principal Risk 1: Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.

BAF Risk No. 1.7 Risk of failures related to failing infrastructure due to aging estate leading to poor patient environment, poor infection control and potential health and safety failures

Risk Classification: Infrastructure	**Risk Owner:** DE&F	**Scrutinising Committee:** Quality Governance & Finance & Performance
Date Risk Opened: 1/4/19	**Date of next full review of BAF: 1/4/20**	
Changes since last review:		

Underlying Cause/ Source of Risk: CRR reference risks; 1701, 1738, 1174, 258, 1177, 1287, 1373, 1699, 1703, 1893, 1986, 1702, 1414. Failure of multiple estates components or systems due to age, accessibility and lack of funding	**Initial score**	**Current score**	**Target score**
	20 (5x4)	20 (5x4)	10 (5x2)

Existing Controls	**Positive Assurance of Controls**
1. Health and Safety committee 2. Fire safety committee 3. Estates Compliance group 4. Facilities Governance group 5. Water safety group 6. Resilience planning group 7. Business continuity plan 8. Training and scenario exercises undertaken 9. Annual capital programme 10. Medical Gas committee 11. Ventilation group 12. Asbestos group 13. Fire Safety Task and Finish Group 14. Assurance & Risk Committee	• H&S reports to Quality Governance committee (L1); QGC reports to Trust Board (L2); F & P reports to Trust Board (L2) • Resilience planning group reports to Assurance, risk & compliance group (L1) • Assurance, risk and compliance group reports to QGC (L1) • Capital Group reports to F& P committee (L1) • Annual Audit of high risk and statutory systems; ventilation, asbestos, electrical, medical gas, electrical, lifts, pressure systems, water • PLACE audits (L3); H&S risk assessments (L1) • Fire safety inspections (L3); Annual external review of water hygiene (L3) • HSE inspection(L3) ; ERIC self- assessment returns (L1) • Premises Assurance model self- assessment (L1); • Internal Audit report- Limited assurance opinion – Health and Safety (L3) • Back log maintenance programme in place based on risk assessment (L1)

Gaps in Controls

1. Large Backlog maintenance risk requires greater funding than is available 2. Estates strategy currently being reviewed for alignment in light of revised Clinical Strategy, KGH collaboration work and STP/HCP outputs. 3 Reduced capital plan due to financial constraints. 4 Review of internal assurance against key estates elements shows short fall. 5 Limited access to clinical areas to carry out maintenance and compliance work.

Further Actions	**Responsible Person/s**	**Due Date**
1. Recruit into key estates vacancies	1. Stuart Finn	1. Mar 20
2. Deliver action plans against key estates elements to improve assurance and reduce risks	2. Stuart Finn	2. Jul 20
3. Review Estates strategy to align with KGH, STP/HCP and Clinical strategy	3. Stuart Finn	3. Mar 20
4. Seek additional routes to Capital funding to reduce backlog and align with Estates strategy & Masterplan and Clinical strategy	4. Stuart Finn	4. Mar 20

Principal Risk 1: Failure to deliver high quality services could lead to avoidable patient harm, ineffective outcomes and poor patient experience. In turn this would cause the Trust to perform poorly against national and local quality and performance targets leading to financial loss and loss of reputation and risk of noncompliance with Care Quality Commission Fundamental Standards. Risk that inadequate data quality could lead to poor information in respect to performance and quality indicators which the Trust utilises in overseeing Quality and Safety.		
BAF Risk No. 1.8 Risk of failures in data quality, ICT infrastructure and/or a successful cyber security attack may lead to loss of service with staff being unable to access patient records with a significant impact on patient care and reputational risk to the Trust		
Risk Classification: Infrastructure	**Risk Owner:** COO	**Scrutinising Committee:** Finance & Performance
Date Risk Opened: 1/4/19	**Date of next full review of BAF: 1/4/20**	
Changes since last review:		

Underlying Cause/Source of Risk: CRR reference risks 1954, 1733, 1984, 1918, 1482, 1684, 1707, 1918, 1954, 2020, 2039, 2151, and 2170. Cyber risks, Information security and aging ICT infrastructure.	**Initial score**	**Current score**	**Target score**
	20 (4x5)	20 (4x5)	8 (4x2)

Existing Controls	**Positive Assurance of Controls**
1. IT reporting to Finance and Performance committee 2. Elective access policy and Data quality SOPs in place 3. Microsoft Advanced Threat Detection (ATP) alerts 4. Intrusion Prevention blocking and alerts from the Trust's boundary firewalls 5. Anti-Virus in place. 6. Microsoft Patching – All Trust workstations and Servers are patched. 7. SPAM Emails are automatically quarantined. Any SPAM that is not quarantined is manually blocked when reported 8. Weekly Care Cert meetings held between NGH and KGH. 9. Web Filtering –blocks malicious and non-Trust related web traffic. 10. Enhanced Anti-Ransomware protection. 11. Tape backups (off-line backups) – The Trust now backs up data to tape regularly	• Reports from IT to Finance and Performance committee (L1) • Minutes from IT committee (L1) • Application of additional Sophos updates(L2) • IT strategy updated (L1) • Data Quality Audits. (L1) • Blocked Activity reported to IT Committee (L1) • Free NHS WiFi

Gaps in Controls

1. IT Team vacancies/ Ability for users to plug old equipment into network/ Limited knowledge of staff regarding cyber security and Potential for incorrect data input due to human error

Further Actions	**Responsible Person/s**	**Due Date**
1. Training	1. Dave Smith	1. Mar 2020
2. Network access control (plug in USB)	2. Dave Smith	2. Feb 2020
3. 4 WiFi access points left to be deployed	3. Dave Smith	3. Feb 2020 (review)
4. HSCN ongoing to migrate to a more secure bandwith connection (NHS Net)	4. Dave Smith	4. April 2020 (review)
5. Windows to migrate to Windows 7 (2529 completed- 1162 remain)	5. Dave Smith	5. Aug 2020
6. USB Port control	6. Dave Smith	6. Nov 2020

Principal Risk 2 – Failure to deliver patient focussed care may lead to reputational risk and poor patient experience. this may cause the Trust to perform poorly against national and local patient experience surveys affecting reputation as hospital of choice for our local population and beyond.				
BAF Risk No. 2.1 Risk that the Trust fails to promote a culture which puts patients first				
Risk Classification: Patient Experience	**Risk Owner:** DON	**Scrutinising Committee:** Quality Governance		
Date Risk Opened: 1/4/19	**Date of next full review of BAF: 1/4/20**			
Changes since last review:				
Underlying Cause/ Source of Risk: CRR reference risks 1955, 1867, 2003 Multiple sources of risk exacerbated by high demand and high patient acuity.		**Initial score** 12 (4x3)	**Current score** 12 (4x3)	**Target score** 4 (4x1)

Existing Controls	**Positive Assurance of Controls**
1. Patient and Carer experience and engagement Group with the following reporting: • Dementia Group • End of Life Group • Disability Partnership forum • Learning and Disability Group 2. PALS and Complaints team 3. Link with Health watch Northampton 4. Regular performance reviews by Division including patient experience KPIs 5. Patient Experience manager 6. Safeguarding policies and training 7. Appointment of Head of Diversity & Inclusion 8. Guidelines that identify how we manage patients with protected characteristics 9. Patient Involvement Strategy 10. Volunteer Strategy	• Patient satisfaction survey (L3) • Complaints report to Quality Governance committee (L1) • Complaint review Panel (L1) • Quality Governance reports to Trust Board (L2) • NHS Choices feedback (L3) • CQC inspection (L3) • F&F tests results (2019) (L3) • Patient story to the Board (L1) • Board to Ward visits (L1) • National Survey results: Cancer; Urgent Care; Inpatient; Paediatric & Young people and Outpatient surveys (L3) • PLACE audits (L3) • Assessment and Accreditation scheme reports to Board (L1) • Divisional Quality Governance reports to CQEG (L1) • Pathway to Excellence (L3)

Gaps in Controls

1. Opportunity for collaborative working with patients and carers to improve and inform service development

Further Actions	**Responsible Person/s**	**Due Date**
1. Undertake a co design service development to enhance collaborative working 2. Enhance the role/ profile of patient experience champions locally	1 & 2: Rachel Lovesey	1. June 2020 2. March 2020

Principal Risk 3 – Failure to develop, value and support our staff may lead to poor standards of care, poor staff training and difficulty in recruiting and retaining high calibre staff.		
BAF Risk No. 3.1 Risk that the Trust fails to achieve optimum workforce capacity to deliver best possible care now and in the future		
Risk Classification: Human Resources	**Risk Owner:** CPO	**Scrutinising Committee:** Workforce
Date Risk Opened: 1/4/19	**Date of next full review of BAF: 1/4/20**	
Changes since last review:		

Underlying Cause/ Source of Risk: CRR reference risks 1682, 1280, 2075,2070,2145,1188,979,1348,1764,1844 National workforce shortages of clinical staff	**Initial score**	**Current score**	**Target score**
	10 (5x2)	15 (5x3)	5 (5X1)

Existing Controls	**Positive Assurance of Controls**
1. People Plan 2019 -2020 2. Nurse Recruitment and retention strategy 3. Recruitment team within HR including dedicated Clinical Resourcing Manager 4. Recruitment policies and procedures 5. Annual business planning process includes workforce plan 6. Workforce Plan submitted to LWAB 7. Medical Workforce strategy 8. Sickness Absence management policy 9. Occupational Health Service 10. Bank staff service 11. E-rostering 12. Apprenticeship scheme 13. Regular skill mix reviews in Nursing 14. Northamptonshire Branding- Best of Both Worlds 15. Weekly Agency meeting 16. Alternative pension contribution policy	• Workforce report to workforce committee (L1) • Line managers receive compliance rates for appraisal (L1) • Workforce committee reports to Trust Board (L2) • Nurse Recruitment plan and retention report to Workforce Committee (L1) • Staffing data report to Workforce Committee and Quality Governance Committee (L1) • Patient survey (L3) • Staff survey (L3) • Medical Trainee survey (L3) • Internal Audit – Sickness Absence audit (L3) • OH Annual Report (L1)

Gaps in Controls
1. Difficulties in recruiting to vacancies due to national shortages
2. Trust has red flags related to Medical Trainee survey reports
3. Opening of escalation areas dilutes capacity

Further Actions	**Responsible Person/s**	**Due Date**
1. Overseas nursing recruitment- in train 2. Work underway in Oncology in response to medical trainee reports	1. Mark Smith 2. Bronwen Curtis	1. April 2020 2. Feb 2020

Principal Risk 3 – Failure to develop, value and support our staff may lead to poor standards of care, poor staff training and difficulty in recruiting and retaining high calibre staff.		
BAF Risk No. 3.2 Risk that the Trust fails to achieve optimal workforce capability to deliver best possible care now and in the future		
Risk Classification: Human Resources	**Risk Owner:** CPO	**Scrutinising Committee:** Workforce
Date Risk Opened: 1/4/19	**Date of next full review of BAF: 1/4/20**	
Changes since last review:		

Underlying Cause/Source of Risk:	**Initial score**	**Current score**	**Target score**
Operational pressures impact on staff training and development	8 (4x2)	8 (4x2)	4 (4x1)

Existing Controls	**Positive Assurance of Controls**
1. People Plan 2019-2020 2. Study leave policy 3. Appraisal policy 4. Statutory and mandatory training policy 5. Annual business planning process includes workforce planning 6. Leadership and Management development programmes for leaders 7. Practice Development Team for Nursing staff 8. Director of Medical Education for medical staff 9. Consultant Foundation programme 10. Continuing professional development and in house training programmes for staff. 11. Nursing and Midwifery Committee	• Workforce report to workforce committee (L1) • Workforce Committee reports relating to revalidation and Medical Education (L1) • Workforce committee reports to Trust Board (L2) • Line managers receive compliance rates for appraisal (L1) • Staff survey results relating to training and development (L3) • Nursing revalidation report (L1) • Divisional scorecards and Performance Review process (L1)

Gaps in Controls

1. Underperformance against target on Statutory & Mandatory training for specific staff groups
2. Apprenticeship Levy attainment remains challenging
3. Organisational Pressures

Further Actions	**Responsible Person/s**	**Due Date**
1. Talent Management development in train	1. Mark Smith	1. Mar 2020 (review)
2. Implementation of People Plan 2019-2020	2. Mark Smith	2. Mar 2020 (review)
3. Deep dive reports into staff group compliance with training	3. Mark Smith	3. Jan 2020

Principal Risk 3 – Failure to develop, value and support our staff may lead to poor standards of care, poor staff training and difficulty in recruiting and retaining high calibre staff.		
BAF Risk No. 3.3 Risk that we fail to engage and nurture our staff leading to a lack of energy and commitment and an optional culture		
Risk Classification: Human Resources	**Risk Owner:** CPO	**Scrutinising Committee:** Workforce
Date Risk Opened: 1/4/19	**Date of next full review of BAF: 1/4/20**	
Changes since last review:		

Underlying Cause/Source of Risk: CRR reference risks: 2003	**Initial score**	**Current score**	**Target score**
	15 (3x5)	15 (3x5)	6 (3x2)

Existing Controls	**Positive Assurance of Controls**
1. BAME Group (staff) 2. Workforce committee 3. Trust leadership Model 4. Freedom to Speak up Policy and process 5. Bullying and Harassment Policy 6. Grievances at Work policy. 7. Health and Wellbeing Strategy 8. People Plan 2019-2020 9. Diversity & Inclusion Manager post 10. Diversity & Inclusion Steering Group	• Organisational Development updates to Workforce Committee, includes staff engagement and staff survey results(L1/ L3) • Equality and Human Rights Group (staff) reports to Workforce Committee and Trust Board (L1/ L2) • Web based incident reporting system available for staff (L1) • Staff survey (L3) • Guardian of Safe working hours report to Workforce Committee and annually to Trust board (L1) • Freedom to Speak Up Guardian Report to Workforce Committee and Trust Board (L1) • Workforce committee reports to Trust Board (L2) • Staff Friends and Family Test (L3) • Health & Wellbeing reports to workforce Committee (L1) • Sickness rate (L1) • Approval of People Plan by Trust Board (L1)

Gaps in Controls

1. Trust results in staff survey relating to bullying and harassment require improvement

Further Actions	**Responsible Person/s**	**Due Date**
1. Health & Well- Being Strategy	1. Mark Smith	1. Mar 2020 (review)
2. People Plan Implementation	2. Mark Smith	2. Mar 2020 (review)
3. Values Ambassador role development	3. Claire Campbell	3. Completed
4. Review of Respect & Support Initiative	4. Bronwen Curtis	4. Completed
5. Staff survey 2019 outcomes – review and report to Board	5. Mark Smith	5. Feb 2020

Principal Risk 4 – Failure to develop a sustainable future for Northampton General Hospital through delivery of high quality effective services in collaboration with partner organisations		
BAF Risk No. 4.1 Risk that failure to progress clinical collaboration as an integral part of the Northamptonshire HCP will not provide the optimal range of core acute services within Northamptonshire leading to a deficit of provision, increased health inequalities and barriers to healthcare access.		
Risk Classification: Partnerships	**Risk Owner:** DoS&P	**Scrutinising Committee:** Finance & Performance
Date Risk Opened: 1/4/19	**Date of next full review of BAF: 1/4/20**	
Changes since last review:		

Underlying Cause/Source of Risk: CRR reference risks 1309 Northamptonshire HCP fail to deliver service and financial sustainability for NGH and local providers	**Initial score**	**Current score**	**Target score**
	16 (4x4)	16 (4x4)	4 (4x1)

Existing Controls	**Positive Assurance of Controls**
1. Board and Executive updated monthly on progress of the Health and Care Partnership 2. Executive oversight 3. Collaboration Steering Board and associated governance framework 4. Monthly updates to the Board via CEO report 5. Non Exec Directors attend NED countywide and Chairs meetings 6. Integrated Business Planning Group/ Strategic planning group 7. County wide Finance Directors Group 8. Chair & CEO are members of HCP Board 9. DoS&P is senior responsible officer for the Unified Acute Model work stream and MSK work stream of HCP 10. Significant partnerships described in Annual Plan 11. Annual contract negotiation and service planning processes leading to a Board approved contract and annual plan 12. Regulatory oversight of the annual planning process	• New Trust strategy in place with aligned estates strategy in progress reports to Trust Board (L1) • Estates strategy and master plan in place with plans for Health and Well Being Campus being delivered alongside external partners (L1) • Service line reports (SLR) (L1) • Medium term financial sustainability plan (L1) • HCP Board in place update reports to Trust Board (L2) • Plans delivered for collaboration with partners in respect to: Rheumatology; Dermatology; Stroke, MSK (L2) • Plans in development for; Plastics; Ophthalmology; Urology; ENT; Cardiology • Reports on all collaboration schemes to Unified Acute Model Board (L2) • Annual capacity and demand analysis and associated contract agreements • Partnership in place with UHL NHS Trust for oncology services (L1)

Gaps in Controls

1. Trust capacity issues have led to outsourcing and loss of market share; 2. Out of hospital work-streams fail to deliver reductions in activity; 3 Challenging relationships with local partners in context of health economy financial challenges; 4 Reduction in funding of adult social care leading to increased admissions; 5 Lack of Resource to support implementation of scheduled care programme is a risk; 6 Resistance to collaboration within some of clinical workforce due to capacity.

Further Actions	**Responsible Person/s**	**Due Date**
1. Implementation of Group model	1. Sonia Swart/ Chris Pallot	1. Mar 2020 (review)
2. Annual Planning process- delivering internal clinical sustainability reviews	2. Chris Pallot	2. 31/1/2020
3. Continue to explore options to integrate tertiary services, e.g. Head & Neck on a regional basis	3. Chris Pallot	3. 31/03/20
4. Integration with Unitaries and Primary Care Networks	4. Chris Pallot	4. 31/08/20

Principle Risk 5: Failure to deliver financial stability may affect the quality of services and the future sustainability and viability of the Trust		
BAF Risk No. 5.1 Risk that the Trust fails to have financial control measures in place to deliver its 2019/20 financial plan		
Risk Classification: Finance	**Risk Owner:** DoF	**Scrutinising Committee:** Finance & Performance
Date Risk Opened: 1/4/19	**Date of next full review of BAF: 1/4/20**	
Changes since last review:		

Underlying Cause/Source of Risk: CRR reference risks; 44, 1757, 2008, 2009, 2010, 2011, 2015, 2016, 2017. Requirement to return to financial balance in the medium term.	**Initial score**	**Current score**	**Target score**
	10 (5x2)	25 (5x5)	10 (5x2)

Existing Controls	**Positive Assurance of Controls**
1. Finance and Performance committee 2. Changing Care @NGH programme Board 3. Divisional performance reviews 4. Trust has signed ETO compliant contract 5. Regular contract review meetings 6. Audit arrangements 7. SFOs SFIs & SOD 8. Policies and procedures 9. Financial and accounting systems 10. Counter Fraud plan 11. Purchasing and Supplies Strategy & Policies 12. Financial Assurance meetings with NHSE/I (monthly) 13. HCP Finance Director meetings 14. Fortnightly Divisional escalation meetings	• Monthly report to Finance and Performance committee (L1) • Finance and Performance committee Report to Board (L2) • Finance KPIs (L1) • Provision for potential fines against contract set aside in monthly position (L1) • Audit committee reports to Trust Board (L2) • Outcome of NHSE/I accountability meetings (L3) • LCFS rated Green (L3) • NHSE/I rating for Single Oversight Framework (L3) • Internal Audit (L3) • External Audit (L3)

Gaps in Controls

1. Pay spend above plan and activity below plan
2. Agency expenditure is currently above the set target for 19/20.
3. Trust is scoring 4 against Finance and the Single Oversight Framework.
4. CIP delivery to the value of £13.6m to be confirmed.

Further Actions	**Responsible Person/s**	**Due Date**
1. Transformation & efficiency programme changes to be implemented- in train 2. System financial recovery plans submitted to support financial re-forecasting	1. Chris Pallot 2. Phil Bradley	1. Feb 2020 2. Feb 2020

Principle Risk 5: Failure to deliver financial stability may affect the quality of services and the future sustainability and viability of the Trust		
BAF Risk No. 5.2 Risk that the Trust fails to deliver the cost savings associated with the Changing Care @ NGH programme		
Risk Classification: Finance	**Risk Owner:** DoF	**Scrutinising Committee:** Finance & Performance
Date Risk Opened: 1/4/19	**Date of next full review of BAF: 1/4/20**	
Changes since last review:		

Underlying Cause/Source of Risk: CRR reference risks 1747, 44 Requirement to deliver CIP target recurrently	**Initial score**	**Current score**	**Target score**
	15 (5x3)	25 (5x5)	10 (5x2)

Existing Controls	**Positive Assurance of Controls**
1. Changing Care @NGH programme Board 2. Finance and Performance committee 3. Schemes are clinically led with Exec sponsorship 4. Divisional CIP requirement in addition to Changing Care @NGH schemes 5. Divisional monitoring of delivery 6. Purchasing and Supplies Strategy & policies 7. Fortnightly Divisional escalation meetings	• PMO team engaged to oversee and manage cost improvement delivery (L1) • Changing Care @NGH scheme delivery tracker (L1) • Monthly FRP report to Finance and Performance committee (L1) • Finance and Performance committee • Report to Board (L2) • Quality Impact assessment process for all schemes within CIP programme to ensure quality and safety not affected (L1) • Use of Carter portal providing "model hospital" benchmark data. (L1) • GIRFT opportunities pursued (L3)

Gaps in Controls

1. The level of identified recurrent CIPs is currently c40%.

Further Actions	**Responsible Person/s**	**Due Date**
1. Transformation & efficiency programme changes to be implemented 2. Prioritisation framework to be implemented	1. Chris Pallot 2. Phil Bradley	1. Feb 2020 2. Completed

Principle Risk 5: Failure to deliver financial stability may affect the quality of services and the future sustainability and viability of the Trust				
BAF Risk No. 5.3 Risk that the Trust fails to manage its Capital programme within Capital Resource limit or fails to secure sufficient funding for infrastructure and equipment improvements				
Risk Classification: Finance	**Risk Owner:** DoF	**Scrutinising Committee:** Finance & Performance		
Date Risk Opened: 1/4/19	**Date of next full review of BAF: 1/4/20**			
Changes since last review:				
Underlying Cause/Source of Risk: CRR reference risks; 2014, 1860 Insufficient Capital funds to meet Trusts requirements		**Initial score** 10 (5x2)	**Current score** 20 (5x4)	**Target score** 10 (5x2)

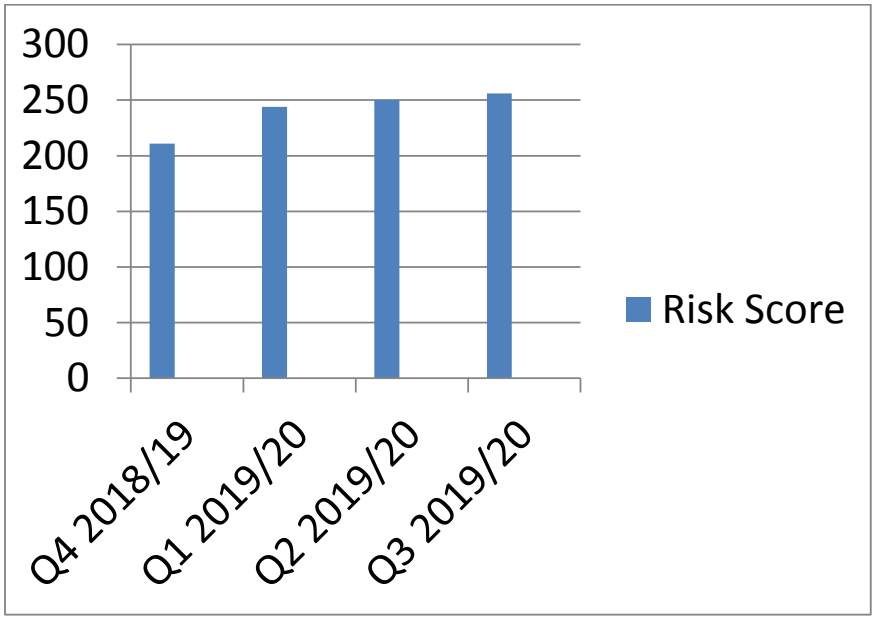
Existing Controls	**Positive Assurance of Controls**
1. Capital Committee 2. Finance and Performance committee 3. 5 year capital plan 4. Purchasing and Supplies Strategy 5. Leasing strategy in place/ IFRS16 6. Hospital Management Team Meetings 7. Business Case process	• Finance report to Finance and Performance committee • Includes progress on capital planning and expenditure plus forecast expenditure (L1) • Report to Board (L2) • Internal audit (L3) • External Audit (L3)

Gaps in Controls

1. The Trust has a large backlog maintenance programme
2. The estate of the Trust is ageing.
3. Affordability of additional capital
4. Additional access to capital limited in infrastructure incidents

Further Actions	**Responsible Person/s**	**Due Date**
1. Tactical and strategic review of estates portfolio 2. Submit additional bids wherever possible e.g. electrical infrastructure, IT and Paediatric ED	1. Stuart Finn 2. Phil Bradley	1. Completed 2. 31/3/20

Movements on Board Assurance Framework (since previous Quarter)	
ADDITIONS	NONE
INCREASES	5.1 Score increased from 20 to 25 due to increased risk to delivery of financial plan
	5.2 Score increased from 20 to 25- due to increased risk to delivery of cost savings
DECREASES	1.3 Score decreased from 12 to 8 due to year end agreement with CCG
CLOSURES/ AMALGAMATED	NONE



Graph shows risk score of 256 for 16 Risks

Executive Leads

CEO	Chief Executive Officer
COO	Chief Operating Officer
MD	Medical Director
DoN	Director of Nursing
DoF	Director of Finance
CPO	Chief People Officer
DoE&F	Director of Estates and Facilities
DoS&P	Director of Strategy and Partnerships
DoCD G&A	Director of Corporate Development, Governance and Assurance

CQC Fundamental standards

Regulation 8	General
Regulation 9	Person centred care
Regulation 10	Dignity and Respect
Regulation 11	Need for Consent
Regulation 12	Safe care and treatment
Regulation 13	Safeguarding service users from abuse and improper treatment
Regulation 14	Meeting nutritional and hydration needs
Regulation 15	Premises and equipment
Regulation 16	Receiving and acting on complaints
Regulation 17	Good governance
Regulation 18	Staffing

Levels of Assurance	**ASSURANCE LEVEL**
Level 1 (L1)	Management or Operational Assurance e.g. Reports to Board and Board committees
Level 2 (L2)	Oversight functions e.g. reports from Audit committee / Clinical Performance committee to Board
Level 3 (L3)	Independent / external assurance e.g. CQC inspection / audits / external review

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30th January 2020**

Title of the Report	**EU Exit Operational Readiness**
Agenda item	**13**
Presenter of Report	Deborah Needham – Chief Operating Officer, Deputy Chief Executive
Author(s) of Report	Jeremy Meadows – Head of Resilience and Business Continuity

This paper is for: (delete as appropriate)

□ Approve	□ Receive	□ Note	x□ Assurance
To formally receive and discuss a report and approve its recommendations OR a particular course of action	To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it	For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

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.

At the time of writing, MPs voted for the European Union Withdrawal Agreement Bill to pass its remaining Commons stages. The House of Lords will now debate the key areas of the Bill.

Following the successful vote of the Withdrawal Agreement Bill, the Prime Minister has agreed that Operation Yellowhammer should be halted with immediate effect due to the decreased likelihood of the UK leaving the EU without a deal, and no further preparation is needed for a no-deal exit on 31st January 2020.

Professor Keith Willet has confirmed that no-deal planning is to cease at an NHS commissioner and provider level

Related Strategic Pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Create a sustainable future supported by new technology* 4. *Strengthen and integrate local clinical services particularly with Kettering General Hospital* 5. *Create a great place to work, learn and care to enable*

	excellence through our people 6. *Become a University Hospital by 2020 becoming a centre of excellence for education and research* ALL
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks YES
Related Board Assurance Framework entries	BAF – please enter BAF number(s) 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 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.
Financial Implications	NO
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper YES

Actions required by the Trust Board

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.

Enclosure H

Ministry of Housing, Communities & Local Government

Louise Spencer
Resilience and Emergencies Division

Ministry of Housing, Communities & Local Government
2 Marsham Street
London
SW1P 4DF
Email:
Louise.Spencer@communities.gov.uk

To: Chairs of Local Resilience Forums

24 December 2019

Dear Colleagues,

STAND DOWN ON NO DEAL PREPARATIONS FOR 31 JANUARY 2020

Following the successful vote on the 2nd reading of the Withdrawal Agreement Bill, I can confirm that the Prime Minister has agreed that Operation Yellowhammer should be halted with immediate effect due to the decreased likelihood of the UK leaving the EU without a deal on 31 January 2020.

This means that the operational phase of Yellowhammer will not be stood up in January 2020 and no further preparation is needed for a no deal exit on 31 January 2020. We will not be requiring any further reporting from LRFs on Yellowhammer preparedness.

The passing of the Withdrawal Agreement Bill means we will transition into the negotiation period without any changes to current arrangements. The Government will now focus on the delivery aspects of the current deal, the future relationship negotiations and preparing for the end of the implementation period.

There is an LRF Chairs' call on 8 January 2020, which will be an opportunity for you to raise any issues and for Government to share further communications.

I would like to thank you for your focus and commitment to ensuring the UK's preparedness for a no deal exit. It has been a very significant undertaking, but your dedication and professionalism has shone through.

I hope you have a restful festive break and I look forward to working with you during 2020.

Yours sincerely,

Louise Spencer, Deputy Director, Resilience and Emergencies Division

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Report To	**TRUST BOARD**
Date of Meeting	**30th January 2020**

Title	Standing Orders & SFI's
Agenda item	14
Sponsoring Director	Claire Campbell, Director of Corporate Development, Governance & Assurance and Phil Bradley, Director of Finance
Author(s)	Claire Campbell , Director of Corporate Development, Governance & Assurance and Derek Stewart, Associate Director of Finance – Financial Services

This paper is for:

□√ Approve	□√ Assurance
To formally receive and discuss a report and approve its recommendations OR a particular course of action	To reassure the Board that controls and assurances are in place

Executive summary

These documents have been benchmarked against other organisations and the following changes undertaken:

- Revision of the SO's to a more generic and succinct document in plain English
- Revision of the SFI's to a more generic and succinct document supported by department held procedures as the current Trust version is currently very detailed
- A review of existing delegated limits to generic roles
- Ensure that the three documents are consistent from a finance, procurement and governance perspective.

Following the Audit meeting in September the Standing Orders & Standing Financial Instructions were discussed have been updated to incorporate comments from that meeting.

The role of Senior Independent Director remains within the document following agreement and ratification of post holder at November 2019 Board. The role of a Non-Executive responsible for Security Management was agreed not to be included in line with other organisations.

The Scheme of Delegation has been fully reviewed, discussed with the Director of Finance, Deputy Director of Finance, Head of Procurement and Associate Director of Finance – Financial Services. Appendix 2, relates to all non-pay approvals and has been identified at officer level to incorporate a consistent approach within the organisation.

The Associate Director of Finance – Financial Services, Head of Procurement and Director of Corporate Development Governance and Assurance reviewed, revised and updated these documents.

The Audit Committee approved the revised Standing Orders, Standing Financial Instructions and Scheme of Delegation at the December 2019 meeting. The documents for Board ratification are attached (Appendix A): Standing Orders, SFI's and Scheme of Delegation

Related Strategic Pledge	Which strategic pledge does this paper relate to? 1.We will put quality and safety at the centre of everything we do 2.Deliver year on year improvements in patient and staff feedback 3.Create a sustainable future supported by new technology
Risk and assurance	Ensuring that all staff comply with Trust procedure
Related Board Assurance Framework entries	BAF 3.1, 5.1
Equality Impact Assessment	N/A
Financial Implications	Documents support good financial governance
Legal implications / regulatory requirements	Standing Orders/SFI's and Scheme of Delegation support the implementation of the Statutory Framework Trusts are required to work within
Actions required by the Board The Board is asked to ratify the revised Standing Orders, Standing Financial Instructions and Scheme of Delegation following approval by the Audit Committee.	

SECTION A: INTRODUCTION AND DEFINITIONS FOR STANDING ORDERS

STANDING ORDERS:

1. INTRODUCTION

1.1. The Standing Orders including the Scheme of Delegation, Standing Financial Instructions, Conflicts of Interest Policy and Counter Fraud, Bribery and Corruption Policy provide a comprehensive regulatory and business framework for the Trust. All directors, and all members of staff, should be aware of the existence of these documents and be familiar with all relevant provisions. These rules fulfil the dual role of protecting the Trust's interests and protecting the staff from any possible accusation that they have acted less than properly.

2. EXECUTIVE SUMMARY

2.1. Standing Orders govern the way that the Trust, its directors and employees operate. They demonstrate to the public that the Trust is well managed and that we conduct our business with probity, transparency and in accordance with our responsibilities for the stewardship of public funds.

3. POLICY STATEMENT

3.1. Failure to comply with any part of the Standing Orders is a disciplinary matter, which could result in dismissal. Non-compliance may also constitute a criminal offence of fraud in which case the matter will be reported to the Trust's local counter fraud specialist in accordance with the Counter Fraud, Bribery and Corruption Policy. Where evidence of fraud, corruption or bribery offences is identified, this may also result in referral for prosecution which could lead to the imposition of criminal sanctions and/or notification to professional organisations.

4. DEFINITIONS

Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990, the NHS Act 2006 and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in this interpretation and in addition:

- **"Accountable Officer"** means the NHS officer responsible and accountable for funds entrusted to the Trust. They shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

- **"Associate Director"** means a person, who is appointed to sit on a committee, sub-committee, officer group or working party appointed by the Trust.

- **"Audit Committee"** means the committee of the Board whose responsibility is to provide assurance to the Board that effective risk management, internal control and governance processes are maintained and that the Trust's activities comply with the law, guidance and codes of conduct governing the NHS. The committee provides a formal independent mechanism for ensuring a co-ordinated approach for achieving sound financial and managerial control.

- **"Board"** means the chairman, executive and non-executive directors of the Trust collectively as a body.

- **"Chairman of the Board (or Trust)"** is the person appointed by the Secretary of State for Health as advised by NHS Improvement to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chairman of the Trust" shall be deemed to include the Vice-Chairman of the Trust if the Chairman is absent from the meeting or is otherwise unavailable.

- **"Chief Executive"** means the chief officer of the Trust.

- **"Committee"** means a committee appointed by the Trust.

- **"Committee members"** mean those people formally appointed by the Board to sit on and/or chair specific committees.

- **"Commissioning"** means the process for determining the need for and, for obtaining the supply of healthcare and related services by the Trust within available sources

- **"Contracting and procuring"** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

- **"Director of Finance"** means the chief financial officer of the Trust.

- **"Establishment Order"** shall mean the Northampton General Hospital NHS Trust (the Trust) is a statutory body which came into existence on 01 April 1994 under the Northampton General Hospital National Health Service Trust (Establishment) Order 1993 No 2561.

- "**Executive Director"** means the Chief Executive and Directors who are appointed in accordance with the 1990 National Health Service Trusts (Membership and Procedure) Regulations [SI 1990/2024].

- **"Legal Adviser"** is a properly qualified person (not necessarily an employee) appointed by the Trust to provide legal advice.

- **"Nominated officer"** means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

- **"Non-Executive director"** means a Member of the Trust who is not an officer of the Trust and is not to be treated as an officer by virtue of regulation 1(3) of the Membership, Procedure and Administration Arrangements Regulations.

- **"Officer"** means employee of the Trust or any other person holding a paid appointment or office with the Trust.

- **"Quality Governance Committee"** means a committee whose functions are concerned with the arrangements for the purpose of monitoring and improving quality of healthcare for which Northampton General Hospital NHS Trust has responsibility

- **"The Trust Secretary" -** a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the chairman and monitor the Trust's compliance with the law, Standing Orders, and Department of Health guidance and is undertaken by the Director of Corporate Development Governance and Assurance

- **"SFIs"** means Standing Financial Instructions.
- **"SOs"** means Standing Orders.
- **"Trustee(s)" means charity trustee(s).** These are the bodies or individuals who are responsible for the general control and management of the administration of the charity.
- **"Trust"** means the Northampton General Hospital NHS Trust.
- **"Vice-Chairman"** means the non-officer Member appointed by the Board to take on the Chairman's duties if the Chairman is absent for any reason.

Wherever the title Chief Executive, Director of Finance, or other nominated employee is used in these Standing Orders, it shall be deemed to include such other Directors or employees who have been duly authorised to represent them.

Where the term "employee" is used it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

Any references to one gender alone are made for ease of reference only and should be read as equally applicable to both male and female persons.

5. ROLES & RESPONSIBILITIES

5.1. The Board is responsible for giving final approval to updated versions of Standing Orders

5.2. The Audit Committee is responsible for considering draft revisions prior to submission to the Board.

STANDING ORDERS

The Standing Orders including the Scheme of Delegation, Standing Financial Instructions, Conflicts of Interest Policy and Counter Fraud, Bribery and Corruption Policy provide a comprehensive regulatory and business framework for the Trust.

All directors, and all members of staff, should be aware of the existence of these documents and be familiar with all relevant provisions. These rules fulfil the dual role of protecting the Trust's interests and protecting the staff from any possible accusation that they have acted less than properly.

Failure to comply with any part of the Standing Orders is a disciplinary matter, which could result in dismissal. Noncompliance may also constitute a criminal offence of fraud in which case the matter will be reported to the trust's local counter fraud specialist in accordance with the Counter Fraud, Bribery and Corruption Policy. Where evidence of fraud, corruption or bribery offences is identified, this may also result in referral for prosecution which could lead to the imposition of criminal sanctions.

1. INTRODUCTION

1.1. Statutory Framework

The Northampton General Hospital NHS Trust (the Trust) is a statutory body which came into existence on 01 April 1994 under The Northampton General Hospital National Health Service Trust (Establishment) Order 1993 No 2561.

The principal place of business of the Trust is Cliftonville, Northampton, NN1 5BD.

NHS Trusts are governed by Act of Parliament, notably the National Health Service Acts 2006 and 2012 and the functions of the Trust are conferred by such legislation.

As a statutory body, the Trust has specific powers to contract in its own name and is accountable to the Secretary of State for Health. Charitable funds are administered by independent trustees. The NGH Charity is an independent charitable company limited by guarantee. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

The Trust is under a duty to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals. The Board must also comply with the Standards for Members of NHS Boards and CCG Governing Bodies in England 2012.

The Trust will be bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.2. NHS Framework

In addition to the statutory requirements, the Secretary of State through the Department of Health issues further directions and guidance. These are normally issued under cover of a circular or letter.

The Code of Accountability requires that, amongst other things, Boards draw up a schedule of decisions reserved to the Board, and ensure that management

arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The Code also requires the establishment of audit and remuneration committees with formally agreed terms of reference. The Code of Conduct makes various requirements concerning possible conflicts of interest of Board members.

The Freedom of Information Act provides for members of the public to access information on many aspects of the Trust's business.

1.3. Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order (SO) relating to the Arrangements for the Exercise of Trust Functions by Delegation (SO 4), the Trust is given powers to "*make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, subcommittee or joint committee appointed by virtue of SO 5 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State may direct".*

Reservation of Powers to the Board and Delegation of Powers are covered in a separate document (Scheme of Delegation and Reservation). These documents have effect as if incorporated into the Standing Orders and Standing Financial Instructions.

1.4. Integrated Governance

Trust boards maintain an integrated approach to ensure good governance, so that decision making is informed by intelligent information covering the full range of corporate, financial, clinical, information, education and research governance.

2. THE TRUST BOARD

- All business shall be conducted in the name of the Trust.

- The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in Standing Order 3.

- The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in Reservation of Powers to the Board and have effect as if incorporated into the Standing Orders.

2.1. Composition of the Board

In accordance with the Trust's Establishment Order (see SO1.1) and the Membership, Procedure and Administration Arrangements regulations, the composition of the Board shall be:

1) The Chairman of the Trust
2) Up to 5 Non-Executive directors excluding the Chairman
3) One Associate Non-Executive Director nominated by the University of Leicester
4) Up to 5 Executive directors

- The Chief Executive;
  - The Director of Finance;

- The Chief Operating Officer
- The Medical Director
- The Director of Nursing.

The Trust shall have not more than 11 and not less than 8 Members (unless otherwise determined by the Secretary of State for Health and set out in the Trust's Establishment Order or such other communication from the Secretary of State).

2.2. Appointment of the Chairman and Directors

The Chairman is appointed by NHS Improvement/ NHS England on behalf of the Secretary of State for Health.

The Trust shall appoint a committee whose members shall include the Chairman and Non-Executive Directors of the Trust whose function will be to appoint the Chief Executive as a director of the Trust. The Trust shall appoint a committee whose members shall include the Chairman, Non-Executive Directors and Chief Executive whose function will be to appoint the other four Executive Directors of the Trust.

Executive Director appointments are approved by the Board.

The Trust will seek assurance that any individuals under consideration for appointment as Directors of the Trust satisfy the Fit and Proper Person requirements.

2.3. Terms of Office of the Chairman and Directors

The regulations setting out the period of tenure of office of the Chairman and directors and for the termination or suspension of office of the Chairman and directors are contained in the Membership, Procedure and Administration Arrangements and Administration Regulations.

The tenure of office for directors shall be:

2.3.1. Chairman and Non-Executive Directors - as determined by NHS Improvement, but usually for a maximum period of four years, which may be renewable, subject to the provisions of SO 2.8

2.3.2. Chief Executive and Director of Finance – for the period of their employment in those posts

2.3.3. Other Executive Directors – for such period as specified by the Appointing Authority as long as they hold a post in the Trust

2.4. Appointment and Powers of the Vice Chairman and Senior Independent Director

2.4.1. Subject to SO 2.4, for the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chairman, the Chairman and members of the Trust shall appoint a Non-Executive director from among them to be Vice Chairman, and a further Non – Executive Director as the Senior Independent Director, for such period, not exceeding the remainder of his/her term as a member of the Trust, as they may specify on appointing him/her.

2.4.2. Any director so appointed may at any time resign from the office of Vice Chairman by giving notice in writing to the Chairman. The Chairman and

members may thereupon appoint another Non-Executive director as Vice Chairman in accordance with the provisions of Standing Order 2.4).

2.4.3. Where the Chairman of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chairman owing to illness or any other cause, the Vice Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes their duties, as the case may be; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform those duties, be taken to include references to the Vice Chairman.

2.5. Joint Directors

Where more than one person is appointed jointly to a post mentioned in regulation 2(4) (a) of the Membership, Procedure and Administration Arrangements Regulations, those persons shall count for the purpose of SO 2.1 as one person.

Where the office of a Director of the Board is shared jointly by more than one person:

2.5.1. Either or both of those persons may attend or take part in meetings of the Board;

2.5.2. If both are present at a meeting they should cast one vote if they agree;

2.5.3. In the case of disagreements no vote should be cast; and

2.5.4. The presence of either or both of those persons should count as the presence of one person for the purposes of SO 3.14 (Quorum).

2.6. Role of Directors

The Board will function as a corporate decision-making body. Executive and Non-Executive directors will be full and equal members. Their role as members of the Trust Board will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

1) **Executive Directors**
Executive directors shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

2) **Chief Executive**
Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the **Accountable Officer** for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

3) **Director of Finance**
The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

4) **Non-Executive directors**
The Non-Executive directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may, however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

5) **Chairman**
The Chairman shall be responsible for the operation of the Board and chair all Board meetings when present. The Chairman has certain delegated executive powers and must comply with the terms of appointment and with these Standing Orders.

The Chairman shall liaise with NHS Improvement over the appointment of the Non-Executive directors and, once appointed, shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

The Chairman shall work closely with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

2.7. Lead Roles for Board Directors

The Chairman will ensure that the designation of lead roles or appointments of Board directors as required by the Department of Health or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a lead Board director with responsibilities for Infection Control or Safeguarding etc.).

2.8. Corporate Role of the Board

2.8.1. All business shall be conducted in the name of the Trust.

2.8.2. All funds received in Trust (i.e. donations, legacies etc.) shall be held in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

2.8.3. The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in SO 3.

2.8.4. The Board shall define and regularly review the functions it exercises on behalf of the Secretary of State.

2.9. Schedule of Matters reserved to the Board and Scheme of Delegation

The Board has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in the "Schedule of Matters Reserved to the Board" and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

3. MEETINGS OF THE TRUST

3.1. Admission of Public and the Press

3.1.1. The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Trust (Board) but shall be required to withdraw upon the Trust (Board) resolving in accordance with the following:

"A body may, by resolution, exclude the public from a meeting (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted….." (Section 1(2) Public Bodies (Admission to Meetings) Act 1960)

3.1.2. The Chairman shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board resolving as follows:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public" (utilising the power given in section 1(8) Public Bodies (Admission to Meetings) Act 1960)

3.1.3. Nothing in these Standing Orders shall require the Trust (Board) to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Board.

3.2. Calling Meetings

3.2.1. Ordinary meetings of the Trust Board shall be held at regular intervals at such times and places as the Board may determine.

3.2.2. The Chairman of the Trust may call a meeting of the Board at any time. One third or more members of the Board may requisition a meeting in writing. If the Chairman refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

3.3. Notice of Meetings and the Business to be transacted

3.3.1. Before each meeting of the Board, a notice specifying the business proposed to be transacted shall be delivered to every Director, so as to be available at least three clear days before the meeting.

3.3.2. Want of service of the notice on any director shall not affect the validity of a meeting.

3.3.3. In the case of a meeting called by Directors in default of the Chairman calling the meeting, the notice shall be signed by those members.

3.3.4. Before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's office at least three clear days before the meeting. (Required by the Public Bodies (Admission to Meetings) Act 1960 (4) (a).

3.4. Agenda and Supporting Papers

3.4.1. The Board may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

3.5. Submission of Papers to Board Meetings

3.5.1. All Board papers should be submitted to the Executive Board Secretary seven days prior to the Board meeting. In exceptional circumstances, and only with the prior agreement of the Chairman, late papers may be accepted.

3.6. Chairman of Meeting

3.6.1. At any meeting of the Trust Board the Chairman, if present, shall preside. If the Chairman is absent from the meeting, the Vice Chairman (if the Board has appointed one), if present, shall preside. If the Chairman and Vice Chairman are both absent, the remaining Board members shall choose a Non-Executive director from among their number to act as Chair.

3.6.2. If the Chairman is absent from a meeting temporarily on the grounds of a declared conflict of interest, the Vice Chairman, if present, shall preside. If the Chairman and Vice Chairman are absent, or are disqualified from participating, the remaining Board members shall choose a Non-Executive director from among their number to act as Chair

3.7. Reporting to and Consultation with the Public

The Trust will publicise and hold an annual public meeting in accordance with the NHS Trusts (Public Meetings) Regulations 1991 (SI(1991)482).

3.8. Chairman's Ruling

Statements by Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

3.9. Voting

3.9.1. Every question at a meeting shall be determined by a majority of the votes of the directors present (including the Chairman) and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chairman of the meeting shall have a second (casting) vote.

3.9.2. All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.

3.9.3. If at least one-third of the directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each director present voted or abstained.

3.9.4. If a director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

4.8.5 In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

4.8.6 An officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

3.10. Secretariat and Minutes

3.10.1. The Executive Board Secretary or a nominated deputy shall attend the meetings of the Trust Board and its Committees. The Executive Board Secretary will be responsible for maintaining the records of such meetings. The minutes of the proceedings shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

3.10.2. No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.10.3. Minutes shall be circulated in accordance with directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public as required by the Freedom of Information Act.

3.11. Joint Directors

Where the office of a director of the Board is shared jointly by more than one person:

(a) Either or both of those persons may attend or take part in meetings of the Board:
(b) If both are present at a meeting they should cast one vote if they agree:
(c) In the case of disagreements no vote should be cast:
(d) The presence of either or both of those persons should count as the presence of one person for the purposes of quorum.

3.12. Variation and Amendment of Standing Orders

These Standing Orders shall be amended only if:

- no fewer than half the total of the Trust's non-Executive Directors vote in favour of amendment; and
- at least two-thirds of the Board directors are present; and

- the variation proposed does not contravene a statutory provision or direction made by the Secretary of State.

3.13. Record of Attendance

The names of the Chairman and Directors present at the meeting shall be recorded in the minutes.

3.14. Quorum

3.14.1. No business shall be transacted at a meeting unless at least one third of the whole number of the Chairman and members (including at least two Executive directors and two Non-Executive directors) is present. Directors are not permitted to dial into Board meetings.

3.14.2. An officer in attendance for an Executive director (Officer Member) but without formal acting up status does not count towards the quorum.

3.14.3. If the Chairman or Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.14.4. If after 15 minutes from the time appointed for a meeting of the Trust Board to take place no quorum is present, then there shall be no meeting. Likewise, if during a meeting the Chairman, after counting the number of directors present, declares that there is no quorum, the meeting shall stand adjourned to a time arranged by the Chairman or to the next ordinary meeting of the Trust Board.

4. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

Subject to such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions:

- by a committee, sub-committee or,
- individuals appointed by virtue of Standing Order 5.1 or 5.2 below or by an officer of the Trust,
- or by another body as defined below,

in each case subject to such restrictions and conditions as the Trust thinks fit.

- Regulations provide for the functions of Trusts to be carried out for the Trust by third parties.

- Where a function is delegated by these regulations to another NHS body, the Trust has responsibility to ensure that the proper delegation is in place. In other situations, i.e. delegation to committees, sub committees or officers, the Trust retains full responsibility.

4.1. Emergency Powers

The powers which the Board has reserved to itself within these Standing Orders may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman after having consulted at least two Non-Executive directors. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Trust Board for formal ratification.

4.2. Unavailability of Chairman/Vice-Chairman

Save as expressly provided for in these Standing Orders:

- In addition to the statutory powers of the vice Chairman, if the Chairman is unavailable for whatever reason to transact the business of the Trust expressly or impliedly delegated to the Chairman, then, if so requested by the Chief Executive, the Vice-Chairman shall be empowered to act in the Chairman's place and to exercise all the powers and duties of the Chairman until the Chairman is again available;

- If the Vice-Chairman is unavailable for whatever reason to transact the business of the Trust expressly or impliedly delegated to the Vice-Chairman, then if so requested by the Chief Executive in relation to any particular matter, any Non-Executive Director shall be empowered to act in the Vice-Chairman's place and exercise all the powers and duties of the Vice-Chairman (including the power contained in the previous part of this Standing Order) in relation to that matter;

4.3. Delegation to Committees

4.3.1. The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, or joint-committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, or subcommittees, or joint committees, and their specific executive powers shall be approved by the Board.

4.3.2. The powers of such committees shall be limited to those set out in their terms of reference.

4.4. Delegation to Officers

4.4.1. Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Trust.

4.4.2. The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

4.4.3. Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Director of Finance or other Executive directors to provide information and advise the Board in accordance with

statutory or Department of Health requirements. Outside these statutory requirements the roles of the Director of Finance shall be accountable to the Chief Executive for operational matters.

4.4.4. The arrangements made by the Board as set out in the Scheme of Delegation and Reservation shall have effect as if incorporated in these Standing Orders.

4.5. Non Compliance with Standing Orders

If for any reason these Standing Orders are not complied with, full details, including justification and the circumstance, shall be reported to the next formal meeting of the Board for action or ratification. All Directors of the Board and officers have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

4.6. Relationship to other Trust Policy Statements/Procedures, Regulations and the Standing Financial Instructions

4.6.1. Policy Statements: General Principles

The Board has delegated the approval of most new and revised Trust core policies and guidelines to the Trust's Procedural Document Group reporting to the Clinical Quality and Effectiveness Group. The Trust Procedural Document Group will agree and approve policy statements and procedures which will apply to all or specific groups of staff employed by the Trust and others working in the Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Procedural Document Group Committee minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

4.6.2. Specific Policy Statements

Notwithstanding the application of SO 4.6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- The Conflict of Interest Policy for Trust staff.
- The Disciplinary Policy, Procedure and Rules, the Disciplinary Procedure for Medical and Dental Staff, and the Grievance Policy and Procedure for Northampton General Hospital NHS Trust
- The Counter Fraud, Bribery and Corruption Policy

4.6.3. Standing Financial Instructions

Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

5. COMMITTEES

5.1. Subject to such directions (and to guidance issued by the Department of Health) as may be given by the Secretary of State for Health, the Trust may and, if directed by him, shall appoint committees of the Trust, or together with one or more health service bodies or other Trusts, appoint joint committees, consisting wholly or partly of the Chairman and Directors of the Trust or other health service bodies or wholly of persons who are not directors of the Trust or other health service bodies in question.

5.2. A committee or joint committee appointed under this regulation may, subject to such directions as may be given by the Secretary of State or the Trust or other health service bodies in question, appoint sub-committees consisting wholly or partly of members of the committee or joint committee (whether or not they are directors of the Trust or other health service bodies in question); or wholly of persons who are not directors of the Trust or other health service bodies or the committee of the Trust or other health service bodies in question.

5.3. The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Trust. In such cases the term "Chairman" is to be read as a reference to the Chairman or person presiding at the meeting of the committee as the context permits, and the term "director" is to be read as a reference to a member of the committee also as the context permits. (There is no requirement to hold meetings of committees, established by the Trust, in public.)

5.4. Each such committee shall have such terms of reference and powers and be subject to such conditions, as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.5. Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board.

5.6. The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither directors nor officers, shall be appointed to a committee, the terms of such appointment shall be within the powers of the Board as defined by the Secretary of State. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.7. Where the Board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the regulations and directions made by the Secretary of State.

5.8. The Trust Board will from time to time, review committees or sub-committees terms of reference, membership establishment or reporting arrangements and any subsequent changes will be appropriately approved and recorded.

5.9. Committees established by the Trust Board are: (Terms of Reference are available from the Trust CEO Office)

- Audit Committee
- Quality Governance Committee
- Remuneration and Nominations Committee
- Finance, Investment and Performance Committee
- Workforce Committee
- Other Committees as determined by the Board

5.10. Confidentiality:

A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board or shall otherwise have concluded on that matter.

A director of the Trust or member of the committee shall not disclose any matter reported to the Board or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or committee shall resolve that it is confidential.

6. DUTIES AND OBLIGATIONS OF BOARD MEMBERS/DIRECTORS AND STAFF UNDER THESE STANDING ORDERS

6.1. Declaration of Interests

All Non-Executive Directors, Associate Non-Executive Directors, all Executive Directors and all other officers of the Trust are required to comply with the Conflicts of Interest Policy.

6.2. Advice on Interests

If Board Directors has any doubt about the relevance of an interest, this should be discussed with the Chairman of the Trust or with the Director of Corporate Development, Governance and Assurance

6.3. Recording of Interests in Trust Board Minutes

At the time Board members' interests are declared, they should be recorded in the Trust Board minutes. Any changes in interests should be declared at the next Trust Board meeting following the change occurring and recorded in the minutes of that meeting.

6.4. Publication of Declared Interests in Annual Report

Board directors' updated declarations of interests will be published in the Trust's annual report.

6.5. Conflicts of Interest which Arise During the Course of a Meeting

At the start of every Board meeting, there will be an agenda item which invites directors to declare whether they have any interests which might be relevant to any items of business on that agenda. Directors should declare all such interests, on each occasion, whether or not they have already declared them for the purposes of the register of declared interests. If a conflict of interest is established, the Board director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. The Chairman shall rule on any issues of doubt, having first considered the applicability of standing orders in this regard.

6.6. Register of Interests

6.6.1. The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board Directors. A copy of the register will be included in the papers for the public Board meeting.

6.6.2. These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding 12 months will be incorporated.

6.6.3. The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

6.7. Exclusion in Proceedings of the Board

6.7.1. Subject to the following provisions of this Standing Order, if the Chairman or a director of the Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

6.7.2. The Secretary of State may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him/her in the interests of the National Health Service that the disability should be removed.

6.7.3. The Board may exclude the Chairman or a director of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he/she has a pecuniary interest is under consideration.

6.7.4. Any remuneration, compensation or allowance payable to the Chairman or a director by virtue of paragraph 11 of Schedule 5A to the National Health Service Act 1977 (pay and allowances) shall not be treated as a pecuniary interest for the purpose of this Standing Order.

6.7.5. This Standing Order applies to a committee or sub-committee and to a joint committee or sub-committee as it applies to the Trust and applies to a member of any such committee or sub-committee (whether or not he/she is also a director of the Trust) as it applies to a director of the Trust.

6.8. Canvassing of and Recommendations by Directors and Officers in Relation to Appointments

6.8.1. Canvassing of directors of the Trust or members of any committee or officers of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

6.8.2. Directors of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

6.9. Relatives of directors or officers

6.9.1. Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a

relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal.

6.9.2. The Chairman and every Director and officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

6.9.3. On appointment (and prior to acceptance of an appointment in the case of Executive directors), directors should disclose to the Trust whether they are related to any other director or holder of any office under the Trust.

7. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

7.1. Custody of the Seal

The Common Seal of the Trust shall be kept by the Director of Corporate Development, Governance and Assurance in a secure place.

7.2. Sealing of Documents

The Seal is a corporate signature. It may be interchangeable with the words "for and on behalf of the Trust" for documents of minor importance and/or value. The use of the Seal indicates that the document is important and/or valuable. No common law exists regarding any financial limits which require a Seal. However, a Seal must be used in the conveyancing of land.

If the Trust gives an undertaking, the sealing of a document imposes an obligation. A signature does not reduce the obligation, but a Seal reaffirms the obligation expressed within the document. In cases where the Trust is uncertain, a signature could be offered "for and on behalf of the Trust" and if this is refused, the Seal can be used.

The Trust or its officers may decide that a document shall be sealed, within the provisions of the NHS Acts.

7.2.1. The following documents must be sealed:

- All contracts for the purchase or lease of land and/or buildings.
- All documents relating to the transfer or sale of shares, bonds and other financial instruments.

7.2.2. The following documents may be sealed:

- Legal agreements and licences.
- When a Seal is requested by the other party or parties.

The Trust Board has delegated the responsibility for the use of the Trust's Seal to the Chief Executive and the Director of Corporate Development, Governance and Assurance. However, in the absence of either of these two officers, the Chairman and/or another director (not from the originating department) duly authorised by the

Chief Executive may attest the use of the Seal. Amendments to documents under Seal should be initialled by those attesting the use of the Seal. Every instance of the use of the Seal must be reported to the Trust Board for ratification and recorded in the minutes of the meeting.

7.3. Register of Sealing

The Director of Corporate Development, Governance and shall keep a register in which she, or an officer from the Trust Office authorised by her, shall enter a summary record of the sealing of every document. Each record must be signed by those officers attesting the use of the Seal.

7.4. Signature of Documents

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or an Executive director.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

8. MISCELLANEOUS

8.1. Review of Standing Orders

Upon each updating of these Standing Orders, the Board shall determine the next appropriate review date.

8.2. Joint Finance Arrangements

The Board may confirm contracts to purchase from a voluntary organisation or a local authority using its statutory powers. The Board may also use statutory powers to confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services.

8.3. Partnership Arrangements

The Trust shall ensure, through the Chief Executive, that there are processes in place for establishing and reviewing the effectiveness of all partnership arrangements and that these are appropriate for the local circumstances.

8.4. Conflict

In the event of any conflict between the Standing Orders and any statutory provision, regulation or direction by the Secretary of State, the latter shall prevail.

STANDING FINANCIAL INSTRUCTIONS – REVISED DECEMBER 2019

CONTENTS

1. INTRODUCTION

These Standing Financial Instructions (SFIs) are issued in accordance with the Financial Directions issued by the Secretary of State for Health under the provisions of Section 99 (3), 97 (A) (4) and (7) and 97 (AA) of the National Health Service Act 1977 for the regulation of the conduct of the Trust in relation to all financial matters The Code of Accountability requires that the Trust shall give, and may vary or revoke Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. These Standing Financial Instructions (SFIs) are issued in accordance with the Code.

These Standing Financial Instructions together with the Standing Orders, Conflicts of Interest Policy and Counter Fraud and Bribery and Corruption Policy provide a comprehensive regulatory and business framework for the Trust. They shall have effect as if incorporated in the Standing Orders (SOs).

All directors and all members of staff should be aware of the existence of these documents and be familiar with all relevant provisions. These rules fulfil the dual role of protecting the Trust's interests and protecting the staff from any possible accusation that they have acted improperly.

2. EXECUTIVE SUMMARY

These Standing Financial Instructions identify the financial responsibilities, policies and procedures adopted by the Trust and apply to everyone working for the Trust and its constituent organisations including Trading Units and wholly owned subsidiary organisations.

Standing Financial Instructions govern the way in which the Trust undertakes its financial business and how all those working for the Trust shall operate. They demonstrate to the public that the Trust is well managed and that we conduct our business with probity, transparency and in accordance with our responsibilities for the stewardship of public funds.

They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes.

All financial procedures must be approved by the Director of Finance.

3. POLICY STATEMENT

Standing Financial Instructions are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They identify the financial responsibilities that apply to everyone working for the Trust. The user of these Standing Financial Instructions should also be familiar with and comply with the Trust's Standing Orders.

Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions, the advice of the Director of Finance must be sought before acting.

The Trust will regard the failure to comply with these Standing Financial Instructions as a disciplinary matter, which could result in dismissal.

If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All directors of the

Board, and all staff, have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible. Non-compliance may also constitute a criminal offence in which case the matter will be reported to the Trust's Counter Fraud Specialist and/or the Police for action to be taken which may result in referral for prosecution. Civil action may also result to recover the Trust's losses and costs.

4. DEFINITIONS

Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990, the NHS Act 2006 and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in this interpretation and in addition:

- "Accountable Officer" means the NHS officer responsible and accountable for funds entrusted to the Trust. He shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

- "Associate Director" means a person, who is appointed to sit on a committee, sub-committee, officer group or working party appointed by the Trust.

- "Audit Committee" means the committee of the Board whose responsibility is to provide assurance to the Board that effective risk management, internal control and governance processes are maintained and that the Trust's activities comply with the law, guidance and codes of conduct governing the NHS. The committee provides a formal independent mechanism for ensuring a co-ordinated approach for achieving sound financial and managerial control.

- "Board" means the chairman, executive and non-executive directors of the Trust collectively as a body.

- "Budget" means a resource, expressed in financial terms, proposed by the Trust for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

- "Budget Holder" is an executive director, or other officer, with delegated authority to manage finances (income and expenditure) for a specific area of the organisation.

- "CFS" means Counter Fraud Specialist
  .
- "Chairman of the Board (or Trust)" is the person appointed by the Secretary of State for Health as advised by the NHS Improvement to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chairman of the Trust" shall be deemed to include the vice-chairman of the Trust if the chairman is absent, or is otherwise unavailable.

- "Chief Executive" means the chief officer of the Trust.

- "Director of Finance" means the chief financial officer of the Trust.

- "Committee" means a committee appointed by the Trust.

- "Committee members" mean those people formally appointed by the Board to sit on and/or chair specific committees.

- "Contracting and procuring" means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

- "Establishment Order" shall mean the Northampton General Hospital NHS Trust (the Trust) is a statutory body which came into existence on 01 April 1994 under the Northampton General Hospital National Health Service Trust (Establishment) Order 1993 No 2561.

- "Executive Director" means the Chief Executive and Directors who are appointed in accordance with the 1990 National Health Service Trusts (Membership and Procedure) Regulations [SI 1990/2024].

- "Legal Adviser" is a properly qualified person (not necessarily an employee) appointed by the Trust to provide legal advice.

- "Level 1 Officer" } Refer to
- "Level 2 Officer" } Scheme of
- "Level 3 Officer" } Delegation 'List of
- "Level 4 Officer" } Officers'

- "Membership, Procedure and Administration Arrangements Regulations" means NHS Membership and Procedure Regulations (SI 1990/2024) and subsequent amendments.

- "Nominated officer" means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

- "Non-Executive Director" means a Director of the Trust who is not an officer of the Trust and is not to be treated as an officer by virtue of regulation 1(3) of the Membership, Procedure and Administration Arrangements Regulations.

- "Officer" means employee of the Trust or any other person holding a paid appointment or office with the Trust.

- "The Trust Secretary" - a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the chairman and monitor the Trust's compliance with the law, Standing Orders, and Department of Health guidance and is undertaken by the Director of Corporate Development Governance and Assurance

- "SFIs" mean Standing Financial Instructions.

- "SOs" mean Standing Orders.

- "Trust" – Northampton General Hospital NHS Trust

- "Tendering and Contract Procedures" refers to the procedures within Procurement Policy and Procedure Manual. NGH PO363 refers and the manual is available on intranet

- "Vice-Chairman" means the Non-Executive Director appointed by the Board to take on the chairman's duties if the chairman is absent for any reason.

All references in this document expressed in the masculine shall be deemed to also include the feminine.

Wherever the title Chief Executive, Director of Finance, Information and Procurement, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

5. ROLES AND RESPONSIBILITIES

5.1 The Trust Board

The Trust Board is responsible for giving final approval to updated versions of Standing Financial Instructions.

The Board exercises financial supervision and control by:

(a) formulating the financial strategy and agreeing the long term financial model
(b) requiring the submission and approval of budgets within approved allocations/overall income
(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money) and
(d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation and Reservation document

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Scheme of Delegation and Reservation.

The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.

5.2 Chief Executive

Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State for Health, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

The Chief Executive and Chief Financial Officer will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

It is a duty of the Chief Executive to ensure that existing members of the Board and employees and all new appointees are put in a position to understand their responsibilities within these Instructions.

5.3 Director of Finance

The Director of Finance is responsible for:

(a) ensuring that the Standing Financial Instructions are maintained and regularly reviewed

(b) implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies
(c) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions
(d) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Director of Finance include:

(a) the provision of financial advice to other members of the Board and employees
(b) the design, implementation and supervision of systems of internal financial control and
(c) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties

5.4 All Staff

All members of the Board and employees, severally and collectively, are responsible for:

(a) conforming to the requirements of Standing Orders, Standing Financial Instructions, the Scheme of Delegation and Reservation and Financial Procedures
(b) the security of the property of the Trust;
(c) avoiding loss
(d) exercising economy and efficiency in the use of resources

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

For any and all directors of the Board and employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Director of Finance.

6. POLICY AND/OR PROCEDURAL REQUIREMENTS

6.1 Audit

6.1.1 Audit Committee

In accordance with Standing Orders the Board shall formally establish an Audit Committee, with clearly defined terms of reference (based on those contained in the latest NHS Audit Committee Handbook), which will provide an independent and objective view of internal control by:

(a) Overseeing Internal and External Audit services;
(b) Reviewing financial systems;
(c) Monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) Reviewing schedules of losses and compensations and making recommendations to the Board.
(f) Reviewing the information prepared to support the Annual Governance Statement prepared on behalf of the Board and advising the Board accordingly.

Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health. Matters pertaining to fraud, bribery and/or corruption must be reported to the CFS for investigation in accordance with the Trust's Counter Fraud, Bribery and Corruption Policy.

6.1.2 Director of Finance

It is the responsibility of the Director of Finance to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when/if an internal audit service provider is changed.

The Minutes of Audit Committee meetings shall be formally recorded and submitted to the Board.

The Director of Finance is responsible for:

(a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;
(b) Ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;
(c) Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud bribery or corruption;
(d) Ensuring that an annual internal audit report is prepared by the Internal Audit service provider for the consideration of the Audit Committee and the Board. The report must cover:

    (i) a clear opinion on the effectiveness of internal control in accordance with current controls assurance guidance issued by the Department of Health including for example compliance with control criteria and standards.
    (ii) major internal financial control weaknesses discovered
    (iii) progress on the implementation of internal audit recommendations
    (iv) progress against plan over the previous year
    (v) strategic audit plan covering the coming three years
    (vi) a detailed plan for the coming year

The Director of Finance, designated internal auditors and CFS are entitled (without necessarily giving prior notice) to require and receive:

(a) Access to all records, documents, correspondence and data owned or controlled by the Trust, relating to any financial or other relevant matter under investigation or review, including documents of a confidential nature;
(b) Access at all reasonable times to the Chairman, any Executive or Non-Executive Director, officer, land or premises of the Trust;
(c) The production of any cash, stores or other property of the Trust under the control of the Chairman, any Executive or Non-Executive Director or officer of the Trust; and
(d) Explanations concerning any matter under investigation or review.

The Trust's Chief Executive and Director of Finance are responsible for ensuring that access rights are given to NHS Counter Fraud Authority where necessary for the prevention, detection and investigation of cases of fraud, bribery and corruption, in accordance with NHS Counter Fraud Authority Provider Standards.

6.1.3 Role of Internal Audit

The purpose and objectives of the Internal Audit service provider are:

(a) to provide an independent and objective opinion to the Accountable Officer (Chief Executive), Audit Committee and the Board on the strength of risk management, financial and operational controls and governance framework and the degree to which these support the achievement of the Trust's agreed objectives
(b) to report findings and recommendations for improvement that are beneficial to the Trust and to line management in the audited areas, and to report the associated level of audit assurance gained
(c) to add further value by providing an independent and objective consultancy service – specifically to help management to improve their risk management, control and governance arrangements

Irregularities - Whenever any matter arises which involves, or is thought to involve, fraud, bribery or corruption, the matter must be reported to the CFS, in accordance with the Trust's Counter Fraud, Bribery and Corruption Policy. All other irregularities, or suspected irregularities, concerning cash, stores, or other property of the Trust, or the exercise of any function of a pecuniary nature, must be notified to the Director of Finance immediately.

The Head of Internal Audit and the CFS shall be entitled to attend any Audit Committee meetings.

The Head of the Internal Audit Service shall be accountable to the Director of Finance in accordance with the Service Level Agreement. The reporting system for internal audit shall be agreed between the Director of Finance, Information and Procurement, the Audit Committee and the Head of the Internal Audit Service. The agreement shall be in writing and shall comply with the guidance on reporting contained in the Public Sector Internal Audit Standards. The reporting system shall be reviewed at least every three years.

Internal Audit terms of reference shall have effect as if incorporated within these Standing Financial Instructions. The terms of reference cover the scope of internal audit work, authority and independence, management responsibilities, co-ordination of assurance work, reporting and key outputs and the operational responsibilities.

6.1.4 External Audit

The External Auditor is appointed and paid for by the Trust following an appropriate procurement procedure. The appointment must be approved by the Trust Board, based on a recommendation by the Audit Committee and the resulting contract and the relationship managed by the Trust.

Although the contract length can be anything from one to five years, a period of three to five years is 'normal' and considered an appropriate period for an auditor to develop a strong understanding of the organisation. Contracts can be awarded with an optional extension period, such as three years with an optional two year extension. Whatever length of contract is chosen, it must be agreed at an early stage.

The Trust must publish a notice within 28 days of appointing the auditor stating that the appointment has been made, the identity of the auditor and the length of the appointment. This notice must also summarise the advice given by the Auditor Panel and be published either on the Trust's website or in such a way that those whom it serves/ to whom it is accountable see it.

The Audit Committee must ensure a cost-efficient service.

Should there appear to be a problem with the external audit service then this should be raised with the External Auditor and referred on to the Audit Committee if the issue cannot be resolved.

6.1.5 Fraud Bribery and Corruption

In line with their responsibilities, the Chief Executive and the Director of Finance shall monitor and ensure compliance with The NHS Standard Contract in respect of fraud, bribery and corruption and the NHS Counter Fraud Authority's Standards for NHS Providers.

The Trust shall nominate a suitable person to carry out the duties of the CFS as specified by NHS Counter Fraud Authority's NHS Counter Fraud Manual and associated guidance.

The CFS shall report to the Director of Finance and shall work with the NHS Counter Fraud Authority in accordance with the Counter Fraud Authority's Standards for NHS Providers and the NHS Counter Fraud Manual and associated guidance.

6.1.6 Security Management

In line with their responsibilities, the Chief Executive will monitor and ensure compliance with directions issued by the Secretary of State for Health on NHS security management.

The Trust shall nominate a suitable person to carry out duties of the Local Security Management Specialist as specified by the Secretary of State for Health guidance on NHS security management.

The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

6.2 Business Planning, Budgets, Budgetary Control, Capital Expenditure and Monitoring

6.2.1 Preparation and Approval of Business Plans and Budgets

The Chief Executive will compile and submit to the Board an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain:

(a) a statement of the significant assumptions on which the plan is based
(b) details of major changes in workload, delivery of services or resources required to achieve the plan

Prior to the start of the financial year the Chief Financial Officer will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Trust's integrated

business plan and its long term financial model
(b) accord with activity and manpower plans
(c) be produced following discussion with appropriate budget holders
(d) be prepared within the limits of available funds and
(e) Identify potential risks

The Chief Financial Officer shall monitor financial performance against the budget and the business plan, periodically review them, and report to the Board.

All budget holders must provide information as required by the Chief Financial Officer to enable budgets to be compiled and financial performance against budgets to be monitored.

The Chief Financial Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

6.2.2 Budgetary Delegation

The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement
(e) achievement of planned levels of service; and
(e) the provision of regular reports

The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

Non-recurring expenditure budgets or income should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

6.2.3 Budgetary Control and Reporting

The Chief Financial Officer will devise and maintain systems of budgetary control. These will include:

(a) Monthly financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date showing trends and forecast year-end position
(ii) movements in working capital
(iii) capital project spend against the Trust's capital plan by sub-group of the Capital Committee and projected outturn against annual plan
(iv) explanations of any material variances from plan
(v) details of any corrective action where necessary and the Chief Executive's and/or Chief Financial Officer, Information and Procurement's view of whether such actions are sufficient to correct the situation

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible
(c) investigation and reporting of variances from financial, activity and manpower budgets
(d) monitoring of management action to correct variances and
(d) arrangements for the authorisation of budget transfers

Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Board except where authority has been given under 6.2.2 above;
(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement and budget transfer;
(c) no permanent employees are appointed without the approval in writing of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board.

The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Financial Efficiency Plan.

6.2.4 Capital Expenditure

The general rules applying to delegation and reporting shall also apply to capital expenditure. All capital procurement shall be carried out in accordance with the Tendering and Contract Procedures. (The particular applications relating to capital investment and financing are contained in Section 6.9 of these Standing Financial Instructions.)

6.2.5 Monitoring Returns

The Chief Executive is responsible for ensuring that all weekly, monthly, quarterly and annual financial monitoring forms are submitted to NHS Improvement (NHSI), the trust regulator, in accordance with the prescribed deadlines.

6.3 Annual Accounts and Reports

The Director of Finance, Information and Procurement, on behalf of the Trust, will:

(a) prepare financial accounts and returns in accordance with the accounting policies and guidance given by the Department of Health and the Treasury, the Trust's accounting policies, and International financial reporting standards
(b) prepare and submit annual financial reports to the Department of Health certified in accordance with current guidelines and
(c) submit financial returns on a monthly, quarterly and annual basis to the Department of Health in accordance with the timetable prescribed by the Department of Health.

The Trust's annual accounts must be audited by the Trust's External Auditor. The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the relevant Department

of Health guidance including that contained in the Department of Health Group Accounting Manual.

6.4 Banking Arrangements

6.4.1 General

The Chief Financial Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account Department of Health guidance/directions.

The Board shall approve the banking arrangements as specified by the Department of Health.

6.4.2 Bank Accounts

The Chief Financial Officer is responsible for the operation of all the Trust's bank accounts and for:

(a) ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made
(b) reporting to the Board all instances where bank accounts may become or have become overdrawn (together with remedial action taken and
(c) monitoring compliance with Department of Health guidance on the level of cleared funds

6.4.3 Banking Procedures

The Chief Financial Officer will prepare detailed instructions on the operation of all Trust bank accounts that must include:

(a) the conditions under which any bank account shall be operated, including the limit to be applied to any overdraft;
(b) those authorised to process bank transfers and sign cheques drawn on the Trust's accounts.

No-one except the Chief Financial Officer shall open or maintain a bank account in the name of the Trust.

6.4.4 Debit/Credit Card Receipts

All arrangements to utilise collection of monies using debit/credit cards shall be approved by the Chief Financial Officer

Debit/credit card machines shall only be operated by suitably trained and authorised persons who will comply with the Payment Card Industry Data Security Standard (PCI DSS) rules and procedures.

6.4.5 External Borrowing

The Chief Financial Officer will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital and any proposed new borrowing, within the limits set by the Department of Health. The Chief Financial Officer is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

Any application for a loan or overdraft shall only be made by the Chief Financial Officer or by an employee so delegated by him or the Trust board.

The Chief Financial Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.

All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement must be authorised by the Chief Financial Officer, Information and Procurement.

All long term borrowing must be consistent with the plans outlined in the current financial plan as reported to NHS Improvement.

6.4.6 Investments

Temporary cash surpluses must only be held in such investments as authorised by the Department of Health and authorised by the Board.

The Chief Financial Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

The Chief Financial Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

6.5 Income, Fees and Charges and Security of Cash, Cheques and Other Negotiable Instruments

6.5.1 Income Systems

The Chief Financial Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

The Chief Financial Officer is also responsible for the prompt banking of all monies received.

6.5.2 Fees and Charges

The Trust shall follow the Department of Health's advice in setting prices for NHS service agreements.

The Chief Financial Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health's Commercial Sponsorship – Ethical Standards in the NHS shall be followed.

All employees must inform the Chief Financial Officer promptly of money due from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions in order to facilitate the timely raising of invoices and collection of the debt.

Under no circumstances will the Trust accept cash payments in any currency in excess of €15,000 in respect of any single transaction or series of transactions which appear to be

linked. Any attempts by an individual to effect payment above this amount should be notified immediately to the Chief Financial Officer.

6.5.3 Debt Recovery

The Chief Financial Officer is responsible for the appropriate recovery action on all outstanding debts.

Income not received should be dealt with in accordance with losses procedures. (See section 6.11).

The Chief Financial Officer is responsible for ensuring that systems are in place to prevent overpayments. Where overpayments occur systems should be in place for their detection and recovery immediately initiated.

6.5.4 Security of Cash, Cheques and other Negotiable Instruments

The Chief Financial Officer is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable
(b) ordering and securely controlling any such stationery
(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines and
(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust

Official money shall not under any circumstances be used for the encashment of private cheques, or for the granting of personal loans of any kind.

All cheques and cash receipts shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Financial Officer.

The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

6.5.5 Free of Charge/Donated Goods/Services

Free of charge or donated goods or equipment from any supplier or would be supplier to the Trust must not be used to avoid the procurement regulations.

A Level 2 or 3 Officer must approve in writing the acceptance of such goods or services prior to delivery. If the goods are to be donated or accepted on loan, whether for service provision or testing, before such approval may be given:

(a) an official order number must be allocated if the acquisition by this method is part of a procurement process by the Trust
(b) the owner must provide a written indemnity to the Trust, which will be signed, if necessary, on the Trust's behalf by the Chief Executive or an officer authorised by the Chief Executive

(c) responsibility for maintenance and other revenue consequences must be agreed in writing and must be approved in accordance with these Standing Financial Instructions

The acceptance of any such goods or services must be confirmed in writing to the donor/owner and, except in the case of charitable donations, such confirmation shall include a notice that the acceptance does not amount to an express or implied obligation on the Trust to continue to use the goods/services or to purchase any other goods/services.

The donation of clinical equipment shall undergo the same rigour as applied to an NHS funded purchase.

Where there are revenue consequences arising out of the donation of any asset then the donation shall not be accepted or put into use until a budget has been agreed with the Chief Financial Officer in respect of the revenue consequences.

6.5.6 Payment in Kind to the Trust

A Level 2 or 3 Officer may authorise the provision by the Trust of services to third parties in return for payments in kind provided:

(a) the value received is reasonably commensurate with the value given
(b) the arrangement is confirmed in writing to the third party under the signature of a Level 2 or 3 Officer and a copy retained
(c) the confirmation includes a notice that the Trust reserves the right to joint ownership on terms to be agreed or fixed by arbitration of any intellectual property arising from the collaboration between the Trust and the third party
(d) the confirmation includes a notice that the arrangement does not bind the Trust to continue any collaboration on the terms agreed or to purchase/use the benefits of any collaboration

6.6 **NHS Service Agreements for Provision of Services**

The Chief Executive, as the accountable officer, is responsible for ensuring the Trust enters into suitable contracts or service level agreements (SLAs) with service commissioners for the provision of NHS services. All contracts and SLAs should aim to implement the agreed priorities contained within the Commissioning Agreement and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information on cost and volume of services;
- the Department of Health's Operating Framework for the NHS;
- that all agreements build where appropriate on existing partnership arrangements;

A good agreement will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The agreement will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

The Chief Executive, as the accountable officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the service agreements.

6.7 Payments to Board Directors, Staff and Other Workers

6.7.1 Board Directors (Chairman and Non-Executive Directors)

The Trust will pay allowances to the Chairman and Non-Executive Directors of the Board in accordance with instructions issued by the Secretary of State for Health.

6.7.2 Remuneration and Terms of Service (Executive Directors and Staff)

In accordance with Standing Orders, the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

Remuneration and terms and conditions of employment shall follow those nationally agreed by the Department of Health except where specifically agreed otherwise by the Board.

The Board shall approve procedures presented by the Chief Executive or the Director of Human Resources for the determination of remuneration and terms and conditions of service which are not agreed nationally or for any variations to nationally agreed arrangements.

6.7.3 Funded Establishment

The manpower plans incorporated within the authorised annual budget will form the funded establishment.

The funded establishment of any Clinical Division or Corporate Directorate may not be varied in any way which causes expenditure to exceed the authorised annual budget without the prior written approval of the Chief Financial Officer, Information and Procurement.

6.7.4 Staff Appointments

No Executive Director or other employee may engage, re-engage, or re-grade employees, either on a permanent or temporary basis, or agree changes to any aspect of remuneration unless:

(a) he or she is exercising economy and efficiency in the use of human resources;
(b) it is within the limit of his or her approved budget and funded establishment.

Any monies due to employees as a result of all employments with the Trust howsoever arising shall be paid through the Trust payroll.

6.7.5 Contracts of Employment

The Board shall delegate responsibility to the Director of Human Resources for:

(a) ensuring that all employees are issued with a Contract of Employment in a form which complies with employment legislation and
(b) dealing with variations to, or termination of, contracts of employment in accordance with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation and

(c) advising employees of the need to conform to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation and Reservation

6.7.6 Processing Payroll

The Chief Financial Officer is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications
(b) the final determination of pay and allowances
(c) making payment on agreed date; and
(d) agreeing method of payment

The Chief Financial Officer will issue instructions regarding:

(a) verification and documentation of data

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances
(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay
(d) security and confidentiality of payroll information
(e) checks to be applied to completed payroll before and after payment
(f) authority to release payroll data under the provisions of the Data Protection Act
(g) methods of payment available to various categories of officer
(h) procedures for payment by cheque, bank direct credit (including BACS), or cash to employees and officers
(i) procedures for the recall of bank direct credits (including BACS) and stopping of cheques
(j) pay advances and their recovery
(k) maintenance of regular and independent reconciliation of pay control accounts
(l) separation of duties of preparing records and handling cash and
(m) a process to ensure the recovery from employees and leavers of sums of money and property due from them to the Trust

Appropriately nominated managers have delegated responsibility for:

(a) submitting time records and other notifications in accordance with agreed timetables
(b) submitting appointment forms and change forms in the prescribed form, immediately upon knowing the effective date of an employee's appointment or change in circumstances
(c) completing time records and other notifications in accordance with the Chief Financial Officer, Information and Procurement's instructions and in the form prescribed by the Chief Financial Officer and
(d) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employees or worker's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Chief Financial Officer must be informed immediately

Regardless of the arrangements for providing the payroll service, the Chief Financial Officer shall ensure that the chosen method is supported by appropriate and adequate procedures with internal controls and audit review and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

6.7.7 Off Payroll Workers including Agency, Self-employed or Third Party Contractors

Where exceptional circumstances exist within a department and agency, self-employed workers or workers supplied via a third party are to be retained then:

(a) the contract may only be entered into by a budget holder having sufficient resources within the limit of his budget who is authorised for that purpose by the Chief Executive or his delegated officer; and
(b) the Chief Financial Officer shall be consulted if the contractor is not on the current list of authorised suppliers; and
(c) the Director of Human Resources shall be consulted with regard to the remuneration package in which the hourly rate of pay of any workers employed through an agency shall be "rate cap" compliant, as determined by NHSI. Any deviation from this should be exceptional and only on the grounds of patient safety and authorised in writing by the Director of H R; and
(d) contractual provisions shall be put in place which allow the Trust to seek assurance regarding the income tax and national insurance contribution obligations of the person engaged and the ability to terminate the contract if that assurance is not provided; and
(e) their employment status shall be reviewed by the Chief Financial Officer prior to the commencement of their engagement to ensure that income tax deductions and national insurance contributions for both the Trust and worker are properly made and paid to HM Revenue & Customs in line with current legal and regulatory requirements.

If there is any doubt as to the correct taxation treatment or the engagement is potentially novel or contentious then the agreement of the Chief Financial Officer and the Director of H R shall be obtained before entering into such an arrangement.

6.8 Non-Pay Expenditure

6.8.1 Delegation of Authority

The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services and
(b) the maximum level of each requisition and the system for authorisation above that level

The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services and this shall be followed when entering into any agreement. Contract terms and conditions used in contracts shall only be those approved by the Trust.

Where consultants are to be engaged on any project with a contracted cost exceeding £50,000 the permission of NHSI must be obtained through the submission of a business case, setting out the requirement, before entering into the contract.

Any agreement for the supply of workers shall only be entered into after fully considering and ensuring compliance with any relevant provisions contained in section 6.7.7 of these

instructions and where necessary obtaining advice from the Chief Financial Officer and the Director of HR.

Before entering into contracts for the supply of goods and services or works contracts and especially overseas contracts, taxation advice (including where appropriate customs advice) shall be obtained from the Chief Financial Officer, Information and Procurement. Agreement of the Chief Financial Officer and also where relevant the Director of Estates and Facilities shall be obtained before entering into any potentially novel or contentious arrangement with a supplier or contractor.

6.8.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Head of Procurement shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Financial Officer (and/or the Chief Executive) shall be consulted.

The Chief Financial Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

The Chief Financial Officer will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed;
(b) prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds
(c) be responsible for the prompt payment of all properly authorised accounts and claims
(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for

(i) A list of Board directors and employees (including specimens of their signatures) authorised to certify invoices;
(ii) Certification which shall confirm that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality and price, and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct, with discounts having been taken where appropriate;
- VAT has been correctly accounted for with recovery being identified where appropriate, and
- the account is in order for payment;

(iii) A timetable and system for submission to the Chief Financial Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment;
(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received (except as below).

Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (cash flows must be discounted to Net Present Value (NPV) using the National Loans Fund (NLF) rate plus 2%);
(b) The appropriate Executive Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;
(c) Exceptions to the requirements of sections (a) and (b) above:
(i) service and maintenance contracts which require payment when the contract commences;
(ii) minor services such as training courses and conference bookings for individuals or magazine subscriptions;
(iii) prepayments of up to £500 where a value for money and financial risk assessment demonstrates clear advantage in early payment.

(d) The Chief Financial Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account relevant public procurement rules where the contract is above a stipulated financial threshold).

(e) The budget holder is responsible for ensuring that all items due under a prepayment contract are received in a timely manner and he must immediately inform the appropriate Director or Chief Executive if problems are encountered.

Official Orders must:

(a) be consecutively numbered;
(b) be in a form approved by the Chief Financial Officer;
(c) state the Trust's terms and conditions of trade; and
(d) only be issued to, and used by, those duly authorised by the Chief Executive.

Officers must ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer and that:

(a) All contracts (other than for simple purchases permitted within the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Financial Officer and Director of Estates and Facilities in advance of any commitment being made.
(b) contracts above specified thresholds are advertised and awarded in accordance with the relevant rules on public procurement;
(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by NHSI and the Department of Health and Social Care;

(d) no order shall be issued for any item or items to any firm which as made an offer of gifts, reward or benefit to directors or employees, other than:
(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;
(ii) conventional hospitality, such as lunches in the course of working visits;

Reference shall be made to the Trust's Conflicts of Interests Policy.

(d) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Financial Officer on behalf of the Chief Executive;
(f) all goods, services, or works are ordered on an official order except works and services purchased from petty cash or items bought using purchasing cards executed in accordance with the contract. For clarification the Chief Financial Officer will determine the nature of expenditure which does not require control through an official purchase order and review this on an annual basis;
(g) Contracts shall be put in place with verbal orders only being issued very exceptionally - by an employee designated by the Chief Executive in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";
(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;
(i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;
(j) changes to the list of directors, employees and officers authorised to certify invoices are notified to the Chief Financial Officer, Information and Procurement;
(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Financial Officer , Information and Procurement; and
(l) petty cash records are maintained in a form as determined by the Chief Financial Officer, Information and Procurement.

The Chief Executive and Chief Financial Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and Health Building Note 00-08 Part A: Strategic framework for the efficient management of healthcare estates and facilities. The technical audit of these contracts shall be the responsibility of the relevant Director.

6.9 Capital Investment, Private Financing, Leases, Asset Registers and Security of Assets

6.9.1 Capital Investment

The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and
(c) shall ensure the availability of resources to finance all revenue consequences, including VAT and any charges levied on capital developments.

For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case (in line with the current Department of Health guidance) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and
(ii) appropriate project management and control arrangements are in place; and
(iii) advice is taken and acted upon to minimise the VAT and other taxes payable; and
(iv) the appropriate Trust personnel and external agencies have been involvement; and
(v) that the Chief Financial Officer has certified professionally to the costs and revenue consequences detailed in the business case.

(b) Where the sum involved exceeds delegated limits, the business case must be referred to the NHS Improvement and/or Department of Health in line with current guidelines.

For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of CONCODE.

The Chief Financial Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HM Revenue & Customs guidance.

The Chief Financial Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure, which as a minimum shall include reporting to the Board on:

(a) an individual scheme/project
(b) the source and level of funding, and
(c) the expenditure incurred against the annual profile

The approval of a capital programme shall not constitute approval for the initiation of expenditure on any individual scheme, because it is also necessary to undertake the mandatory procurement processes of the Trust.

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with current Department of Health guidance and the Trust's Standing Orders.

The Chief Financial Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the latest delegated limits for capital schemes as notified by the Department of Health.

Procure 22 is a partnering framework and procurement method, with a choice of six key supply chain partners which will run until 2020. It is managed by the Department of Health (supported by HM Treasury and the Cabinet Office) to deliver fixed price design and build projects.

It is the recommended procurement method for publicly-funded capital projects over £1million. The framework operates in line with best practice as set out by HM Treasury and the Cabinet Office. It is integral to Health Building Note (HBN) 00-08 Part A: Strategic framework for the efficient management of healthcare estates and facilities (Section 4: Improved efficiencies in capital procurement, refurbishments and land management). This

method should be considered for all construction projects and used where in line with best practice as set out in HBN 00-08, Parts A and B. The management of contracts awarded under the Procure 22 Framework Agreement shall follow the current guidelines issued by the Department of Health.

All orders and contracts agreed under the Contract Framework Agreement shall be priced.

The Contract Framework Agreement should be reviewed at regular intervals, usually annually, to ensure anticipated benefits are being realised and that cost improvement and value for money objectives are achieved.

The Contract Framework Agreement shall be subject to formal tender procedures and shall comply with the EU directives governing public procurement.

The Chief Financial Officer or the Director of Estates shall issue procedure notes governing the control, management, reporting and audit arrangements of the Contract Framework Agreement.

The Committee overseeing the capital programme shall receive regular reports on the performance of the Contract Framework Agreement and detailed project progress reports on all ongoing schemes.

Any capital monies spent should be in accordance with the requirements of the Department of Health & Social Care Group Accounting Manual.

6.9.2 Private and External Finance

When the Trust proposes to finance capital investment other than through internally generated cash, the following procedures shall apply:

The instructions contained in the Tendering and Contract Procedures relating to Private Finance shall be followed.

The Chief Financial Officer shall demonstrate that the use of external finance to support capital investment is secured under the Department of Health's borrowing procedures.

Where the equipment leasing arrangements are proposed these should be authorised by signature by the Chief Financial Officer.

6.9.3 Leases (Finance and Operating)

Where it is proposed that leasing (either operating or finance) shall be considered in preference to capital procurement then the following should apply:

(a) the selection of a contract/finance company shall be on the basis of competitive tendering and quotations sought via the Procurement Department;
(b) the Chief Financial Officer or nominated deputy shall ensure that the proposal demonstrates best value for money; and
(c) all proposals to enter into a leasing agreement shall be agreed in writing by the Chief Financial Officer or nominated deputy prior to acceptance.

In the case of property leases the guidance in Health Building Note 00-08, Parts A and B – Strategic framework for the efficient management of healthcare estates and facilities shall be followed.

6.9.4 Asset Registers

The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Financial Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

The Trust shall maintain an asset register for recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Group Manual for Accounts as issued by the Department of Health.

Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architects certificates, suppliers' invoices and other documentary evidence in respect of purchases from third parties;
(b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and
(c) lease agreements in respect of assets held under a finance lease and capitalised.

Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

The Chief Financial Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

The value of each asset shall be depreciated using methods and rates as specified by the Trust's accounting policies.

6.9.5 Security of Assets

The overall control of fixed assets is the responsibility of the Chief Executive.

Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Financial Officer, Information and Procurement. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;
(b) identification of additions and disposals;
(c) physical security of assets;
(d) periodic verification of the existence of, condition of, and title to, assets recorded;
(e) identification and reporting of all costs associated with the retention of an asset; and
(f) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

All discrepancies revealed by verification of physical assets to the fixed asset register shall be notified to the Director of Finance, Information and Procurement.

Each employee has a responsibility for the security of the property of the Trust and for ensuring that any borrowing or private use of Trust equipment, goods, services and facilities is authorised by their line manager or head of department. It is the responsibility of Executive Directors and senior employees in all disciplines to apply appropriate routine security checks and practices in relation to Trust and NHS property. Any breach of agreed security practices must be reported in accordance with these Standing Financial Instructions, the Trust's policy on Fraud, Bribery and Corruption and the Security Management Policy.

Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

Where practical, assets should be marked as Trust property.

All land and property transactions shall follow the guidance provided in Health Building Note 00-08, Parts A and B – Strategic framework for the efficient management of healthcare estates and facilities.

6.10 Stores and Receipt of Goods

Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;
(b) subjected to annual stock take;
(c) valued at the lower of cost and net realisable value except where otherwise determined by the Trust's accounting policies.

Subject to the responsibility of the Chief Financial Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Financial Officer, Information and Procurement. The control of any pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated Estates manager.

The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as NHS property.

The Chief Financial Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

Stocktaking arrangements shall be agreed with the Chief Financial Officer and there shall be a physical check covering all items in store at least once a year.

Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Financial Officer, Information and Procurement.

The designated manager/Pharmaceutical Officer shall be responsible for a system approved by the Chief Financial Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles.

The designated officer shall report to the Chief Financial Officer any evidence of significant overstocking and of any negligence or malpractice (see also section 6.11, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

For goods supplied via NHS Supply Chain, the Chief Executive shall identify those authorised to requisition and accept goods via this route. The authorised person shall check receipt against the delivery note and report discrepancies to the Chief Financial Officer to

avoid overpayment where such discrepancies cannot be resolved via the Central Procurement Team.

6.11 Disposals and Condemnations, Losses and Special Payments

6.11.1 Disposals and Condemnations

The Chief Financial Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Chief Financial Officer of the estimated market value of the item, taking account of professional advice where appropriate.

All unserviceable articles shall be:

(a) Condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Financial Officer;
(b) recorded by the Condemning Officer in a form approved by the Chief Financial Officer that will indicate whether the articles are to be condemned, converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Financial Officer.

The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Financial Officer who will take the appropriate action.

6.11.2 Losses and Special Payments

The Chief Financial Officer must prepare procedural instructions on the recording of and accounting for losses, and special payments.

Any officer of the Trust discovering or suspecting a loss of any kind must immediately notify their supervisor, line manager or head of department, except where fraud, bribery or corruption is suspected in which case a referral must be made to the CFS for investigation in accordance with the Trust's Counter Fraud, Bribery and Corruption Policy.

For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Financial Officer must immediately notify:

(a) the Board, and
(b) the External Auditor.

In those cases where theft or criminal damage is involved, the Chief Financial Officer must also inform the Police and the CFS.

Novel, contentious or repercussive losses and special payments must be referred to the Department of Health. The Chief Financial Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

For any loss, the Chief Financial Officer should consider whether any insurance claim could be made.

The Chief Financial Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

All losses and special payments must be reported to the Audit Committee.

6.12 Information Technology

The Chief Financial Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall (in liaison with the Chief Information Officer (CIO)):

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;
(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;
(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he may consider necessary are being carried out.

The Chief Financial Officer shall satisfy himself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

In the case of computer systems which are proposed (i.e. including those applications which the majority of NHS bodies in the locality wish to sponsor jointly) all responsible Executive Directors and officers will send to the Chief Financial Officer:

(a) details of the outline design of the system;
(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

The Chief Financial Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Chief Financial Officer shall periodically seek assurances that adequate controls are in operation.

Where computer systems have an impact on corporate financial systems the Chief Financial Officer shall satisfy himself that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
(c) Chief Financial Officer staff have access to such data; and
(d) such computer audit reviews are being carried out as are considered necessary.

Risk Assessment - The Chief Financial Officer shall (in liaison with the Chief Information Officer) ensure that risks to the Trust arising from the use of Information Technology are effectively identified and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

6.13 Patients', Unclaimed and Found Property

Patients' Property

The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets,

- hospital admission documentation and property records,

- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into the Trust's premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

The Chief Financial Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients.

Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Chief Financial Officer. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965), the production of probate or letters of administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

Unclaimed and Found Property

Any unclaimed or found property shall be handed in to the Trust, either via the Security Office or in the case of cash or other valuables directly to the Cashier's Office.

Every effort shall be made to reunite the property with the rightful owner, ensuring that a patient's right to confidentiality is not compromised.

Items of low value not claimed within three months shall be disposed of as appropriate and any cash or proceeds of sale banked into the Trust's exchequer account.

Items other than clothing found by members of the public may be reclaimed by the finder on production of the property receipt after three months, providing in the case of clothing the intention to claim the item was made clear at the time of depositing with the Trust.

Any items found by an employee are construed as being found in the course of their duties and therefore employees are unable to claim ownership of such found items.

6.14 Risk Management

The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health requirements, which must be approved and monitored by the Board.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;
b) engendering among all levels of staff a positive attitude towards the control of risk;
c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
d) contingency plans to offset the impact of adverse events;
e) audit arrangements including internal audit, clinical audit, health and safety review;
f) decision on which risks shall be insured;
g) arrangements to review the risk management programme;
h) appropriate levels of external accreditation.

The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on the effectiveness of Internal Control within the Annual Report and Accounts as required by current Department of Health guidance.

The Board shall decide if the Trust will insure through the various schemes administered through NHS Resolution or self-insure for some or all of these risks. If the Board decides not to use the NHS Resolution schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

With four exceptions the Trust may not enter into insurance arrangements with commercial insurers. The exceptions are:

a) insuring motor vehicles owned by the Trust including third party liability arising from their use;

b) where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into;

c) where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from NHS Resolution.

d) where it is necessary to ensure that the Trust is able to continue providing a service where adequate levels of insurance are not available under any of the schemes administered by NHS Resolution, the Trust arranges a policy in the name of "the employees of the Trust" or "members, for the time being, of a specific team". In such cases, the premium must be:

(i) Paid by the use of charitable funds, providing the Trust establishes 1 through the Charity Commission, or other relevant regulatory body, whether this is an appropriate use of funds, or

(ii) Paid by members of the team and then reimbursed by the Trust, or

(iii) Paid by the Trust, provided this is with the recognition, and approval, of the Chief Financial Officer and/or Internal Audit.

In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Chief Financial Officer should first consult the NHS Resolution.

Where the Board decides to use the schemes administered by NHS Resolution, the Chief Financial Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme.

The Chief Financial Officer shall ensure that documented procedures cover these arrangements.

Where the Board decides not to use the schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Chief Financial Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Financial Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.

NHS Resolution schemes may require members to make some contribution to the settlement of claims (the 'deductible element'). The Chief Financial Officer should ensure documented procedures also cover the management of claims and payments below the deductible element in each case.

6.15 Miscellaneous

6.15.1 Charitable Donations

(a) Northamptonshire Health Charity is the official charity for the Trust's hospitals. It is accountable to the Charity Commission for funds held on trust. All donations received by the Trust must be passed to Northamptonshire Health Charity promptly, for banking and administration.

(b) Where staff are aware of patients or groups who wish to set up a charity for any part `of the hospitals, they should contact Northamptonshire Health Charity to find appropriate designated NGH Charity funds into which monies can be directed.
(c) The charity is independent from the Northampton General Hospital NHS Trust and no separate charitable bank accounts shall be opened or maintained.

6.15.2 Acceptance of Gifts by Staff

The Trust Secretary shall ensure that all officers are made aware of the Trust's Conflicts of Interest Policy, which deals with the acceptance of gifts and other benefits in kind by staff.

6.15.3 Retention of Records

(a) The Chief Executive shall be responsible for maintaining archives for all documents required to be retained in accordance with Department of Health guidelines. The Trust's Policy on the retention and disposal of records shall also be followed.
(b) The documents held in archives shall be capable of retrieval by authorised persons.
(c) Records held in accordance with Department of Health guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

6.15.4 Partnership Agreements

The Trust shall ensure, through the Chief Executive, that there are processes in place for establishing and reviewing the effectiveness of all partnership arrangements and that these are appropriate for the local circumstances.

6.15.5 International Financial Reporting Standards (IFRS)

The Trust is required to report all its financial transactions in compliance with IFRS subject to amendments issued by the Department of Health through the NHS Group Manual for Accounts. It is important that the reporting requirements of IFRS are anticipated and provided for when making decisions which have an impact on the Trust's financial position. This is particularly the case in respect of capital investment, leasing, use of external private finance and contractual relationships with other parties. The Chief Financial Officer and his team should be consulted for advice in such instances.

7.0 Training, Implementation and Resources

7.1 Training

There are no specific training needs arising from this Policy. Managers and staff may seek advice from the Associate Director of Finance – Financial Services in the case of a query. This Policy will be included in the Trust Policy Document Library for reference by staff as appropriate.

7.2 Implementation

There is no specific new implementation required. Following approval by the Trust Board the revised document will be communicated to staff via a communication programme administered by the Chief Financial Officer, Information and Procurement.

7.3 Resources

There are no additional resource requirements arising from this version.

8. Relevant Legislation, National Guidance and Associated NGH Documents

8.1 Legislation

Criminal Procedure and Investigation Act, 1996
Government Resources and Accounts Act, 2000
Proceeds of Crime Act, 2002
National Health Service Act 2006
Fraud Act 2006
Bribery Act 2010
Health and Social Care Act, 2012
The Government Resources and Accounts Act 2000 (Estimates and Accounts) Order, 2016
Finance Act, 2017
Criminal Finances Act, 2017
The Money Laundering, Terrorist Financing and Transfer of Funds Information on the Payer) Regulations 2017

8.2 National Guidance

Model Standing Financial Instructions - Department of Health
HSG 93/5 – Standards of Business Conduct for NHS Staff
The Code of Conduct for NHS Managers (October 2002)
The Green Book – HM Treasury (2003) Code of Accountability in the NHS (2004)
Managing Public Money – HM Treasury (2013 with amendments in 2018)
Monthly Financial Monitoring Guidance for NHS Trusts - NHS Improvement
Department of Health & Social Care Group Accounting Manual

8.3 Associated NGH Documents

Trust Standing Orders
Counter Fraud, Bribery and Corruption Policy
Trust Tendering and Contract Procedure
Secure Management of Patient's and Found Property Policy
Conflicts of interest policy, bribery and fraud policies

NGH SCHEME OF DELEGATION REVIEW – DECEMBER 2019

1.	Introduction The Standing Orders including the Scheme of Delegation, Standing Financial Instructions, Standards of Business Conduct Policy and Fraud Policy provide a comprehensive regulatory and business framework for the Trust. All directors, and all members of staff, should be aware of the existence of these documents and be familiar with all relevant provisions. These rules fulfil the dual role of protecting the Trust's interests and protecting the staff from any possible accusation that they have acted less than properly. The Scheme of Delegation describes the powers which the Board reserves to itself and those which are delegated to officers.
2.	Policy Statement: Failure to comply with any part of the Standing Orders is a disciplinary matter, which could result in dismissal. Non-compliance may also constitute a criminal offence of fraud in which case the matter will be reported to the trust's local counter fraud specialist in accordance with the Fraud Policy. Where evidence of fraud, corruption or bribery offences is identified, this may also result in referral for prosecution which could lead to the imposition of criminal sanctions.
3.	Definitions See Scheme of Delegation in Appendix 1
4.	Roles and Responsibilities 4.1 The Board is responsible for giving final approval to updated versions of the Scheme of Delegation. 4.2 The Audit Committee is responsible for considering draft revisions prior to submission to the Board. 4.3 The Chief Executive and the Director of Corporate Development Governance and Assurance are responsible for ensuring that the Scheme of Delegation is maintained and regularly reviewed. 4.4 All directors and employees of the trust are responsible for complying with the Scheme of Delegation.
5.	Policy / Procedure Monitoring Matrix

Minimum requirement to be monitored	Responsible individual/ group/ committee	Process for monitoring e.g. audit	Frequency of monitoring	Responsible individual/ group/ committee for review of results	Responsible individual/ group/ committee for development of action plan	Responsible individual/ group/ committee for monitoring of action plan
Failure to comply with the Scheme of Delegation would constitute a breach of Standing Orders	Chief Executive	Audit Committee	As and when	Trust Board	Chief Executive	Audit Committee

6.	**Relevant Legislation, National Guidance and Associated Documents:** NHS Act 2006 and 2012 Standing Orders Standing Financial Instructions Tendering and Contract Procedures Conflicts of Interest Policy

Appendix 1

SCHEME OF DELEGATION AND RESERVATION

THE BOARD	DECISIONS RESERVED TO THE BOARD
THE BOARD	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.
THE BOARD	**Regulations and Control** 1. Approve Standing Orders (Secretary of State), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Note any urgent decisions taken in accordance with emergency powers under Standing Orders. 5. Approve a scheme of delegation of powers from the Board to committees and officers 6. Require and receive the declaration of Board directors' interests that may conflict with those of the Trust and determining the extent to which that director may remain involved with the matter under consideration. 7. Require and receive any referral from the Audit Committee about the declaration of officers' interests that may conflict with those of the Trust. 8. Approve arrangements for dealing with complaints. 9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 10. Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action. 11. Ratify or otherwise the recommendations of the Trust's committees where the committees do not have executive powers. 12. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. 13 Approve arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property. 14. Authorise use of the seal. 15. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with Standing Orders. 16. Ensure the application of appropriate disciplinary processes for directors of the Board or officers who are in breach of statutory requirements or Standing Orders.

THE BOARD	DECISIONS RESERVED TO THE BOARD
THE BOARD	**Appointments/ Dismissal** 1. Appoint the vice Chair of the Board. 2. Appoint and dismiss committees (and individual members) that are directly accountable to the Board. 3. Appoint, appraise, discipline and dismiss executive directors (subject to committee functions) 4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies.
THE BOARD	**Strategy, Plans and Budgets** 1. Define the strategic aims and objectives of the Trust and approve the Business Plan (and associated strategic documents) and the Annual Plan 2. Approve proposals for ensuring quality and developing integrated governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State. 3. Approve the Trust's policies and procedures for the management of risk. 4. Approve the Trust's Capital Programme. 5. Approve Outline and Final Business Cases for Capital Investment (subject to detailed Scheme of Delegation) 6. Approve budgets. 7. Approve annually the Trust's proposed organisational development proposals. 8. Approve proposals for acquisition, disposal or otherwise legal change of use of land and/or buildings. 9. Approve PFI proposals (subject to national rules). 10. Approve the opening of bank accounts. 11. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the specified officers (for losses and special payments) previously approved by the Board. 12. Approve individual compensation payments above delegated limits 13. Approve proposals for action on litigation against or on behalf of the Trust. 14. Review use of NHS Resolution risk pooling schemes (LTPS/CNST/RPST).
THE BOARD	**Policy Determination** 1. Approve significant management policies including human resources policies incorporating the arrangements for the appointment, removal and remuneration of staff.
THE BOARD	**Audit** 1. Approve the audit arrangements for the Trust. 2. Receive the annual management letter from the external auditor and agree proposed action, taking account of

THE BOARD	DECISIONS RESERVED TO THE BOARD
	the advice, where appropriate, of the Audit Committee. 3. Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.
THE BOARD	**Annual Reports and Accounts** 1. Receipt and approval of the Trust's Annual Report, Quality Account, Annual Accounts and Self Certification.
THE BOARD	**Monitoring** 1. Receive such reports as the Board sees fit from committees in respect of their exercise of powers delegated. 2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. 3. Receive reports from Director of Finance on financial performance against budget and plans. 4. Receive reports from Director of Finance on actual and forecast income from activity contracts

DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES

COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
AUDIT COMMITTEE	Current Terms of Reference held by Executive Board Secretary
REMUNERATION AND TERMS OF SERVICE COMMITTEE	Current Terms of Reference held by Executive Board Secretary
OTHER COMMITTEES OF THE BOARD	Current Terms of Reference held by Executive Board Secretary

SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM

DELEGATED TO	DUTIES DELEGATED
CHIEF EXECUTIVE (CE)	Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources
CE AND DIRECTOR OF FINANCE AND PROCUREMENT (DOF)	Ensure the accounts of the Trust are prepared under principles and in a format directed by the Secretary of State. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the Board.
CHIEF EXECUTIVE	Sign a statement in the accounts outlining responsibilities as the Accountable Officer. Sign a statement in the accounts outlining responsibilities in respect of Internal Control.
CHIEF EXECUTIVE	Ensure effective management systems that safeguard public funds and assist the Trust Chair to implement requirements of corporate governance including ensuring managers: • "have a clear view of their objectives and the means to assess achievements in relation to those objectives • be assigned well defined responsibilities for making best use of resources • have the information, training and access to the expert advice they need to exercise their responsibilities effectively."
CHAIR	Implement requirements of corporate governance.
CHIEF EXECUTIVE	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out on reports from national or regulatory bodies.
DOF	Operational responsibility for effective and sound financial management and information.
CHIEF EXECUTIVE	Primary duty to see that DoF discharges this function.
CHIEF EXECUTIVE	Ensuring that expenditure by the Trust complies with Parliamentary requirements.

DELEGATED TO	DUTIES DELEGATED
CE and DoF	Chief Executive, supported by Director of Finance, to ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.
CHIEF EXECUTIVE	If Chief Executive considers the Board or Chair is doing something that might infringe probity or regularity, they should set this out in writing to the Chair and the Senior Independent Director/ Board. If the matter is unresolved, they should ask the Audit Committee to inquire and if necessary the NHSE/I and Department of Health.

SCHEME OF DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
BOARD	Approve procedure for compliance with the Conflict of Interest Policy.
BOARD	Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, public interest disclosures and breaches of Standards for Members of NHS Boards and Clinical Commissioning Group Governing Bodies in England and other ethical concerns.
ALL BOARD DIRECTORS	Subscribe to Standards for Members of NHS Boards and Clinical Commissioning Group Governing Bodies in England.
BOARD	Board directors share corporate responsibility for all decisions of the Board.
CHAIR AND NON EXECUTIVE DIRECTORS	Chair and Non-Executive Directors are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for the discharge of those responsibilities.
BOARD	The Board has six key functions for which it is held accountable by the Department of Health on behalf of the Secretary of State: 1. to ensure effective financial stewardship through value for money, financial control and financial planning and strategy;

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
	2. to ensure (including through the Fit and Proper Persons Test) that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 3. to appoint, appraise and remunerate senior executives; 4. to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them; 5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 6. to ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.
BOARD	It is the Board's duty to: 1. act within statutory financial and other constraints; 2. be clear what decisions and information are appropriate to the Board and draw up Standing Orders, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these, 3. ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account; 4. establish performance and quality measures that maintain the effective use of resources and provide value for money; 5. specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities; 6. establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the committee, the limit to their powers, and the arrangements for reporting back to the main Board.
CHAIR	It is the Chair's role to: 1. provide leadership to the Board; 2. enable all Board directors to make a full contribution to the Board's affairs and ensure that the Board acts as a team; 3. ensure that key and appropriate issues are discussed by the Board in a timely manner, 4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. lead Non Executive Board directors through a formally appointed Remuneration Committee of the main Board on the

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
	appointment, appraisal and remuneration of the Chief Executive and (with the latter) other executive Board directors; 6. advise the NHSE/I on the performance of Non-Executive Board directors.
CHIEF EXECUTIVE	The Chief Executive is accountable to the Chair and Non-Executive Directors of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Executive as Accountable Officer are laid out in the Trust's Annual Governance Statement.
NON-EXECUTIVE DIRECTORS	Non-Executive Directors are appointed by NHSI to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Department of Health to Ministers and to the local community.
CHAIR AND DIRECTORS	Declaration of relevant and material interests.
BOARD	NHS Boards must comply with legislation and guidance issued by the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

SCHEME OF DELEGATION FROM STANDING ORDERS

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
CHAIR	Final authority in interpretation of Standing Orders
BOARD	Appointment of Vice Chair
CHAIR	Call meetings.
CHAIR	Chair all Board meetings and associated responsibilities.
CHAIR	Give final ruling in questions of order, relevancy and regularity of meetings.

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
CHAIR	Having a second or casting vote
BOARD	Suspension of Standing Orders
AUDIT COMMITTEE	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
BOARD	Variation or amendment of Standing Orders
BOARD	Formal delegation of powers to committees or joint committees and approval of their constitution and terms of reference.
CHAIR & CHIEF EXECUTIVE	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive Directors.
CHIEF EXECUTIVE	The Chief Executive shall prepare a Scheme of Delegation identifying his proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
ALL	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
THE BOARD	Declare relevant and material interests.
CHIEF EXECUTIVE	Maintain Register(s) of Interests.
ALL STAFF	Comply with national guidance on Standards of Business Conduct for NHS Staff.
ALL	Disclose relationship between self and candidate for staff appointment. (CE to report the disclosure to the Board.)
CHIEF EXECUTIVE	Keep seal in safe place and maintain a register of sealing.
CHIEF EXECUTIVE/ EXECUTIVE DIRECTOR	Approve and sign all documents, which will be necessary in legal proceedings.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
DOF	Approval of all financial procedures.
DOF	Advice on interpretation or application of Standing Financial Instructions.
ALL DIRECTORS OF THE BOARD AND OFFICERS	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.
CHIEF EXECUTIVE	Responsible as the Accountable Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.
CHIEF EXECUTIVE & DOF	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
CHIEF EXECUTIVE	To ensure all Board directors and officers, present and future, are notified of and understand Standing Financial Instructions.
DOF	Responsible for: a) Implementing the Trust's financial policies and coordinating corrective action; b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; d) Providing financial advice to directors of the Board and officers; e) Maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties.
ALL DIRECTORS OF THE BOARD AND OFFICERS	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
CHIEF EXECUTIVE	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
	expenditure or who is authorised to obtain income is made aware of these instructions and their requirement to comply.
AUDIT COMMITTEE	Provide independent and objective view on internal control and probity.
AUDIT COMMITTEE CHAIR	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
DOF	Ensure an adequate internal audit service, for which he is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.)
DOF	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
AUDIT COMMITTEE	Ensure cost-effective External Audit.
CHIEF EXECUTIVE & DOF	Monitor and ensure compliance with Secretary of State Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.
CHIEF EXECUTIVE	Monitor and ensure compliance with directions issued by the Secretary of State and/or guidance from NHS Protect on NHS security management including appointment of the Local Security Management Specialist.
CHIEF EXECUTIVE	Compile and submit to the Board a plan which takes into account financial targets and forecast limits of available resources. The plan will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources required to achieve the plan.
DOF	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
DOF	Ensure adequate training is delivered on an ongoing basis to budget holders.
CHIEF EXECUTIVE	Delegate budget to budget holders.

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
DOF	Devise and maintain systems of budgetary control.
CHIEF EXECUTIVE	Identify and implement cost improvements and income generation activities in line with the financial plan.
CHIEF EXECUTIVE	Submit monitoring returns
DOF	Preparation of annual accounts and reports.
DOF	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. (Board approves arrangements.)
DOF	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
ALL OFFICERS	Duty to inform Director of Finance of money due from transactions which they initiate/deal with.
CHIEF EXECUTIVE	Tendering and contract procedure
OFFICERS AUTHORISED IN STANDING ORDERS	Waive requirement for competitive quotations or tenders (i.e. authorise soliciting of single quotations or tender) - Appendix 2 provides further clarification for occurrences when a waiver is not required
DIRECTOR OF FINANCE	Report waivers of requirement for competitive tendering to the Audit committee
DOF	Responsible for the receipt, endorsement and safe custody of tenders received to ensure compliance with all NGH procurement requirements
DOF	Maintain a register (including by electronic systems) to show each set of competitive tender and quotation invitations despatched.
DOF	Where one tender is received will assess for value for money and fair price.
CHIEF EXECUTIVE	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
CHIEF EXECUTIVE	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
BOARD	All PFI proposals must be agreed by the Board.
CHIEF EXECUTIVE	The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.
CHIEF EXECUTIVE	The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
CHIEF EXECUTIVE	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
CHIEF EXECUTIVE	The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.
CHIEF EXECUTIVE	Must ensure the Trust enters into suitable Service Level Agreements (SLAs) with commissioners for the provision of NHS services
CHIEF EXECUTIVE	As the Accountable Officer, ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA
BOARD	Establish a Remuneration & Terms of Service Committee
DOF	Payroll: a) specifying timetables for submission of properly authorised time records and other notifications; b) final determination of pay and allowances; c) making payments on agreed dates; d) agreeing method of payment; e) issuing instructions
DOF	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
NOMINATED MANAGER	Ensure that all employees are issued with a contract of employment in a form approved by the Board and which complies with employment legislation; and deal with variations to, or termination of, contracts of employment.
CHIEF EXECUTIVE	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level. (See below)
CHIEF EXECUTIVE	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
REQUISITIONER	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought.
DOF	Shall be responsible for the prompt payment of accounts and claims.
DOF	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; b) Prepare procedural instructions (provided within the Procurement Manual / Policy) on the obtaining of goods, works and services incorporating the thresholds; these documents can be located on the Trust's intranet: http://thestreet/CorporateInformation/Departments/Finance/Downloads/The-Procurement-Manual-v1.0.pdf http://thestreet/CorporateInformation/Departments/Finance/Downloads/Procurement-Policy.pdf c) Be responsible for the prompt payment of all properly authorised accounts and claims; d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; e) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; f) Instructions to employees regarding the handling and payment of accounts within the Finance Department; g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received
BUDGET HOLDER	Ensure that all items due under a prepayment contract are received (and immediately inform Director of Finance if problems are encountered).

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
MANAGERS AND OFFICERS	Ensure that they comply fully with the guidance and limits specified by the Director of Finance.
CHIEF EXECUTIVE DOF	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the national guidance.
DOF	The Director of Finance will advise the Board on the Trust's ability to pay dividend on PBC and report, periodically, concerning the PDC debt and all loans and overdrafts.
DOF	To seek approval for short term borrowing.
DOF	Will advise the Board on investments and report, periodically, on performance of same.
DOF	Prepare detailed procedural instructions on the operation of investments held.
CHIEF EXECUTIVE	Capital investment programme: a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans b) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; c) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; d) ensure that, in the case of major schemes, a business case is produced for each proposal.
DOF	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
DOF	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
DOF	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
DOF	Maintenance of asset registers

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
DOF	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
DOF	Calculate and pay capital charges in accordance with Department of Health requirements.
CHIEF EXECUTIVE	Overall responsibility for fixed assets.
DOF	Approval of fixed asset control procedures.
BOARD, EXECUTIVE DIRECTORS AND ALL SENIOR STAFF	Responsibility for security of Trust assets including notifying discrepancies to Director of Finance, and reporting losses in accordance with Trust procedure.
DOF	Identify persons authorised to requisition and accept goods.
DO ESTATES AND FACILITIES	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
DOF	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.
ALL STAFF	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the Chief Executive and Director of Finance.
DOF	Where a criminal offence is suspected, Director of Finance must inform the police if theft or criminal damage is involved. In cases of fraud and corruption Director of Finance must inform the relevant LCFS and NHS Protect.
DOF	Notify NHS Counter Fraud Authority and External Audit of all frauds.
DOF	Notify Board and External Auditor of losses caused by theft, arson, neglect of duty or gross carelessness (unless trivial).
DOF	Maintain losses and special payments register.
DOF	Responsible for accuracy and security of computerised financial data.

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
CHIEF EXECUTIVE	Publish and maintain a Freedom of Information Scheme.
CHIEF EXECUTIVE	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place
DOF	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
DOF	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients.
CHIEF EXECUTIVE	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff
BOARD	Approve and monitor arrangements for risk management.
BOARD	Decide whether the Trust will use the risk pooling schemes administered by NHS Resolution or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.

DETAILED SCHEME OF DELEGATION

The Scheme of Delegation as set out below represents the lowest level to which authority is delegated. All items concerning finance must also be carried out in accordance with Standing Financial Instructions and Standing Orders.

DELEGATED MATTER	AUTHORITY DELEGATED TO
1. Maintenance / Operation of Bank Accounts	Director of Finance
2. Management of Budgets Responsibility of keeping non-contracted income/ expenditure within budgets	

DELEGATED MATTER	AUTHORITY DELEGATED TO
a) At individual budget level (Pay and Non Pay)	Budget Manager
b) For the totality of services covered in a division or corporate directorate	Divisional Director / Director
3. Capital and/or Revenue Business Cases	
a) Capital Investments b) Revenue business cases (including consultant cases of need) c) Bids (including tenders) to external bodies	See appendix one for delegated authority
4. Reporting of Waivers of Requirement for Competitive Tendering	
All waivers of the requirement for competitive tendering to be reported to the Audit Committee	Director of Finance
5. Opening of Quotations and Tenders – managed electronically by Head of Procurement	
a) Opening Quotations	Head of Procurement (or their nominated officer)
b) Opening Tenders	Head of Procurement (or their nominated officer)
6. Intention to Award Contracts to Successful Bidder (following Evaluation), including the decision to utilise contracts negotiated external to the Trust, for example, framework agreements, Government procurement services	
a) Revenue and Capital (other than Energy Contracts) up to £499,999	Head of Procurement
b) Revenue and Capital (other than Energy Contracts) £500,000 +	Head of Procurement acting with Director of Finance
7. Signature (and variation) of all Formal Legal Contract Documentation – Goods and Services **Note – for the avoidance of doubt, officers within the Procurement function may, under the authority of the Head of Procurement, complete and issue documentation which, in itself, constitutes the trust entering into a binding contract with an external supplier. However, such documentation will be based upon the prior authorisation of the relevant budget holder and is therefore an administrative action undertaken with the budget holder's due authority. The same principle applies to officers acting under**	

DELEGATED MATTER	AUTHORITY DELEGATED TO
the authority of the Director of Estates and Facilities Management.	
a) Signature of all contract documentation for goods & services (following any necessary legal advice and the agreement to award contract to successful bidder where appropriate)	Level 1 Officers
b) Subsequent variations to contracts (following any necessary legal advice)	Signatory under 7(a) or any officer of same or higher grade reference appendix 1
8. Sealing of Documents as Required by Law: For avoidance of doubt, this includes conveyances of interest in land and deeds.	
a) Authorisation to apply the Trust seal	Trust Board
b) Application of the Trust seal in accordance with Standing Orders	(1) The Chair or another person (namely, the Director of Corporate Development Governance and Assurance and (2) One other director of the Board
c) Custody of the Trust seal and the keeping of a register of sealings	Director of Corporate Development Governance and Assurance
9. Requisitioning - Non Pay Revenue and Capital Expenditure/Ordering/ Payment of Goods & Services: Note the following are subject to any temporary, additional approval requirements which may be implemented from time to time on the authority of the Board	
a) Orders up to £10,000	Level 3 Officers
b) Orders from £ 10,000 - £24,999	Level 2 Officers
c) Orders from £25,000 - £49,999	Level 1 Officers

DELEGATED MATTER	AUTHORITY DELEGATED TO
d) Orders from £50,000 - £99,999	Executive Directors
e) Orders of £100,000 - £249,999	Deputy Chief Executive / Chief Operating Officer
f) Orders of £250,000 - £499,999	Director of Finance
g) Orders of £500,000 - £999,999	Chief Executive
h) Orders of £1,000,000 - £2,999,999	Chief Executive and Director of Finance
i) Orders > £3,000,0000	Trust Board
10. Capital Schemes	
a) Selection of architects, quantity surveyors, consultant engineer and other professional advisors within EU regulations	Director of Estates and Facilities (or their nominated officer), acting together with the project manager
b) Financial monitoring and reporting on all capital scheme expenditure	Director of Finance
C) Disposal or acquisition of land & land interests	Chair and Chief Executive, acting together
11. Agreements Concerning Interest in Land: **See also requirements for sealing (above)**	
a) Preparation and signature of all tenancy agreements/licences for all staff and others subject to Trust Policy on accommodation for staff.	Director of Finance acting with the Director of Estates and Facilities
b) Preparation and signature of all other tenancy agreements/licenses (including those through which the Trust is obtaining an interest on the premises of other organisations)	
c) Amendments (including extensions and terminations) to existing leases	

DELEGATED MATTER	AUTHORITY DELEGATED TO
d) Letting of premises to outside organisations	
e) Approval of rent based on professional assessment	
f) Approval of any concessionary leases or rents	
12. Condemning & Disposal : **(Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively)**	
a) revenue items with current / estimated purchase price < £100	Head of Department
b) revenue items with current purchase new price > £100	Condemning Officer
c) disposal of x-ray films (subject to estimated income of £2,500 per sale)	Head of Radiology
d) disposal of x-ray films (subject to estimated income between £2,500 and £5,000)	Head of Radiology & Director of Finance
e) disposal of x-ray films > £5,000	Chief Executive
f) disposal of capital assets with a zero net book value	Head of Department / Service Manager
g) disposal of mechanical and engineering plant (subject to estimated income of less than £1,000 per sale)	Project Manager
h) disposal of mechanical and engineering plant (subject to estimated income between £1,000 and £5,000)	Director of Estates & Facilities
i) disposal of mechanical and engineering plant (subject to estimated income	Chief Executive

DELEGATED MATTER	AUTHORITY DELEGATED TO
of > = £5,000)	
j) disposal of equipment (subject to estimated income of £5,000)	Chief Executive
13. Losses, Write-off & Compensation	
a) Losses of cash due to theft, fraud, overpayment and others b) Fruitless payments (including abandoned capital schemes) c) Bad debts and claims abandoned, including private patients, overseas visitors and other d) Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to culpable causes (e.g. fraud, theft, arson) or other e) Extra contractual payments to contractors f) Ex gratia payments - patients and staff for loss of personal effects	£0 to £10k HOD / DDOF £10k to £50k DOF £50k to £100k CEO £100k + Trust Board £0 to £50k DDOF £50k to £100k DOF £100k to £250k CEO £250k + Trust Board Salary Overpayments £0k to £1k ADOF - FS £1k to £10k HOD / DDOF £10k to £50k DOF £50k to £100k CEO £100k + Trust Board Private Patients / Overseas Visitors £0k to £1k ADOF – FS / ADOF - IC £1k to £10k HOD / DDOF £10k to £50k DOF £50k to £100k CEO £100k + Trust Board Non NHS Debtors £0k to £100k DOF / CEO £100k + Trust Board £0k to £50k DOF £50k to £100k CEO £100k + Trust Board

DELEGATED MATTER	AUTHORITY DELEGATED TO
g) Ex gratia payments - other	£0k to £50k – DOF / CEO £0k to £10k (Personnel cases) (CPO) £0k to £5k (Loss of patient effects (HoD/DDoF) £0k to £100k CEO £100K + Trust Board
h) Payments or admissions of liability for personal injury claims involving negligence where legal advice has been obtained and relevant guidance applied up to Trust delegated limit (in accordance with the scheme administered by NHS Resolution)	£0k to £100k CEO £100k + Trust Board
i) Compensation payments made under legal obligation	£0k to £100k DOF £100k to £500k CEO £500k + Trust Board
j) Reporting all Losses, Write-offs and Compensations to the Audit Committee	Director of Finance
14. Setting of Fees and Charges	
a) Private Patient, Overseas Visitors, Income Generation and other patient related services.	Director of Finance with the Director of Strategy and Partnerships
b) Charges for all NHS Contracts	Director of Finance with the Director of Strategy and Partnerships
15. Engagement of Individuals not Employed by the Trust/Consultancy Services: (note that items 15 c) to 15 e) are also subject to additional Trust wide controls on agency staffing which may be varied from time to time and can be obtained from Human Resources)	
a) Non Medical Consultancy Staff	Director of Finance up to Trust delegated limit
b) Instructing Trust's Solicitors (including legal advice to be provided to	Director of Strategy and Partnerships

DELEGATED MATTER	AUTHORITY DELEGATED TO
organisations hosted by the Trust)	
c) Nursing and Midwifery Temporary Staffing	Matrons (or above)
d) Medical Temporary Staffing	Medical Staffing / Medical Director / Divisional Director
e) All other staff groups	Divisional Manager (or above)
16. Reporting of Incidents to the Police	
a) All incidents	Individual Officers or LSMS Officers
17. Petty Cash Disbursements (not applicable to Central Cashiers Office)	
a) Expenditure up to £50 per item, including release of patients' monies by ward staff	Level 2 and 3 Officers
18. Trust Financial Procedures	
a) Maintenance & Update of Trust Financial Procedures	Director of Finance
19. Personnel and Pay: (note that section 19 is are also subject to additional Trust wide controls which may be varied from time to time and can be obtained from Human Resources)	
a) Authority to fill funded post on the establishment with permanent staff	Authorised Appointing Officer with Finance Manager / Director of Finance / Chief Operating Officer
b) Authority to appoint staff to post not on the formal establishment	Executive Team Meeting / Finance & Performance Committee
c) Pay - Authority to complete standing data forms effecting pay, new	Authorised Appointing Officer

DELEGATED MATTER	AUTHORITY DELEGATED TO
starters, variations and leavers	
d) Pay - Authority to complete and authorise staff attendance records	Authorised Appointing Officer
e) Pay - authority to authorise overtime /	Authorised Appointing Officer
f) Pay - authority to authorise travel & subsistence expenses	Authorised Appointing Officer
g) Pay - ad hoc payments	Level 1 and above
h) Pay - protection of pay and conditions	Chief People Officer
20. Authorisation of Research Projects	
a) Authorisation of R&I projects including clinical trials	Medical Director / Appropriate Divisional Director with * Director of Strategy and Partnerships ** Head of Procurement
b) Commercial research agreements	
c) Non commercial agreements *	
d) Material transfer agreements **	
e) Sponsorship statements for NGH	
f) Sponsorship authorisation on research ethics application form	
g) Research agreements (delegating / clarifying responsibilities of chief/principal investigator at the trust)	

DELEGATED MATTER	AUTHORITY DELEGATED TO
21. Infectious Diseases & Notifiable Outbreaks	
a) Notification to relevant authorities	Infection Prevention and Control Lead Officer
22. Overall Responsibility for Patients' Property	
a) Informing Patients, Guardians and Staff of Trust's Policy	All Clinical Teams
b) Overall Custody and Care	Director of Nursing (belongings on ward/dept) Director of Finance (belongings in patient finance office)
c) Release of Patients' Property	Director of Nursing (belongings on ward/dept) Director of Finance (belongings in patient finance office)
23. Partnership Arrangements	
a) Implementing processes for establishing and reviewing the effectiveness of all partnership arrangements	Chief Executive / Director of Strategy and Partnerships
24. Corporate Compliance	
a) Review of fire precautions	Director of Estates and Facilities Management
b) Review of all statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	Director of Estates and Facilities Management
c) Review of Medicines Inspectorate Regulations	Chief Pharmacist
d) Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Director of Estates and Facilities Management
e) Compliance with the Data Protection Act	CIO in conjunction with Caldicott Guardian
f) Monitor proposals for contractual arrangements between the Trust and outside bodies	Director of Finance / Director of Strategy & Partnerships

g) Review of the Trust's compliance regarding confidential information (Senior Information Responsible Officer)	CIO
h) The keeping of registers for the following: ⇒ Declaration of Interests ⇒ Declaration of Sponsorship ⇒ Declaration of Hospitality	Director of Corporate Development Governance and Assurance
i) Retention of Records	Chief Information Officer

Key
CEO – Chief executive Officer
DoF – Director of Finance
HoD – Head of Department
DDoF – Deputy Director of Finance
CPO – Chief People Officer
ADOF –FS – Associate Director of Finance – Financial Services
ADOF – IC – Associate Director Finance – Income & Commissioning

APPENDIX 2

SCHEME OF DELEGATION FOR NON-PAY EXPENDITURE - LIST OF OFFICER LEVELS

DELEGATED LEVELS	LIST OF OFFICERS
£3,000,000 and above	⇒ Trust Board
£1,000,000 to £2,999,999	⇒ Chief Executive with Director of Finance
£500,000 to £999,999	⇒ Chief Executive
£250,000 to £499,999	⇒ Director of Finance
£100,000 to £249,999	⇒ Deputy Chief Executive / Chief Operating Officer
£50,000 to £99,999 **EXECUTIVE TEAM**	⇒ Director of Nursing, Midwifery & Patient Services ⇒ Medical Director ⇒ Director of Corporate Development Governance and Assurance ⇒ Director of Strategy Partnerships ⇒ Director of Estates & Facilities ⇒ Director of Workforce, Development & Transformation
£25,000 to £50,000 **LEVEL 1 OFFICERS**	⇒ Divisional Directors ⇒ Divisional Managers ⇒ Deputy Directors ⇒ Chief Pharmacist (pharmaceutical products only)
£10,000 to £24,999 **LEVEL 2 OFFICERS**	⇒ Heads of Service – Radiology / Therapies / Pathology ⇒ Heads of Corporate Departments/Specialties – IT / Facilities ⇒ Pathology Services Manager ⇒ Associate Director of Nursing ⇒ Associate Directors ⇒ Laboratory/Haematology Manager (blood products only)

	⇒ Clinical Directors
Up to £9,999 **LEVEL 3 OFFICERS**	⇒ Matrons ⇒ Directorate Managers ⇒ Laboratory/Haematology Manager (except blood products) ⇒ Remaining budget holders

APPENDIX 3

WAIVERS REPORTING CLARIFICATION

Waivers are a mechanism to capture purchased goods and/or services that for whatever reason have not gone through the Procurement route.

Some waivers presented are fully justified, for example where there is genuinely a sole supplier or a situation where moving away from the original equipment manufacturer (OEM) could impact on quality and/or the effective operation of goods/services in question.

For example;

- VARIAN Linear Accelerators (LINACS). Given the specialist nature of the equipment supplied, no other manufacturer or third party provider can service this equipment.
- Software licences – when the initial contract period has concluded the Trust may choose to continue using a particular piece of software and as such, licence and maintenance costs would still apply and tendering would add no value as it is only the software supplier who can licence and maintain.
- Olympus endoscopes can be maintained by third party providers, however, due to distribution licence agreements, only Olympus can supply OEM parts. Third parties rely on third party parts which if fitted can impact on quality and longevity of equipment.
- Standardisation – when purchasing equipment we do tender to drive best value, however, in subsequent years as monies become available we will purchase the same items to support standardisation ensuring familiarisation and clinical safety.

The above are just some example where we currently report waivers to Audit committee.

The proposal moving forward is that we continue to log all waivers as now, but only report genuine waivers to Audit Committee.

The full list will always be available for scrutiny, however, a clear list of exclusions will be agreed and communicated resulting in fewer waivers being reported to Audit committee. Therefore the waivers that are reported to Audit Committee would be those that would expect scrutiny.

For example;

- Breaches – Waiver on a waiver
- Waivers submitted after goods and/or services have been supplied
- Waivers in excess of EU legislation
- Waivers due to time constraints

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Report To	**Trust Board**
Date of Meeting	**30 January 2020**

Title of the Report	**Maternity Report**
Agenda item	**15**
Presenter of Report	Sheran Oke – Director of Nursing, Midwifery & Patient Services
Author(s) of Report	Christine Ainsworth – Acting Head of Midwifery
This paper is for:	
□ Assurance	
To reassure the Board that controls and assurances are in place	

Executive summary

This report provides further detail on the five red risks on the corporate and divisional risk register in relation to maternity services as well as an overview of the feedback from staff and patients on our maternity services

All five red risks on the Corporate risk register have robust actions aimed at mitigating the risks to patients and staff.

The Trust provides a number of methods for women and their families to provide unsolicited feedback including a very active Maternity Voices Partnership (MVP):

- 2018 CQC National Maternity Survey, NGH was one of the top five NHS Trusts scoring better than most Trusts in the survey results
- 2019 CQC National Maternity Survey. At the time of writing this report the Trust had received the early release of the benchmark results in advance of the national publication (expected end January 2020). There were no statistically significant changes within any questions.

As part of the National Maternal & Neonatal Health Safety Collaborative - the maternity services undertook a PASCAL Safety Culture Survey in July 2018. Following discussion with the national team, the maternity services have implemented many strategies aimed at supporting staff wellbeing and resilience. This has included gaining external and charitable funding to train staff in Human Factors, and TRiM® / SrRaW ® as part of the 'March on Stress' strategy which helps organisations to build

resilience by safeguarding the psychological wellbeing of personnel through the prevention, detection and treatment of occupational and operational stress, including post-traumatic stress disorder (PTSD).	
Related Strategic Pledge	Which strategic pledge does this paper relate to? *1. We will put quality and safety at the centre of everything we do*
Risk and assurance	**Risk and assurance** Does the content of the report present any risks to the Trust or consequently provide assurances on risks No
Related Board Assurance Framework entries	**Related Board Assurance Framework entries**
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) 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.
Financial Implications	**Financial Implications** None
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper None

Actions required by the Board

The Board is asked to:

- Note the information contained in this report
- Identify any areas where additional assurance is required.

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Maternity Report

1. Introduction

NHS care strives to be person-centred and this is particularly true of maternity services. Because of this it is difficult to chart one route that suits all. For some women the experience will be straightforward; others will need extensive services from community care to neonatal care for sick babies and intensive care for sick mothers. The Trust is well aware of the risks involved in providing these services and over the years the Women's Directorate have put in place arrangements to manage and protect those working in and using our services.

Following a presentation to the Board in December which provided assurance around the many safety aspects surrounding maternity services both nationally and locally it was requested that further detail be provided on the five high risks on the corporate and divisional risk register in relation to maternity services and feedback from staff and patients on our maternity services.

2. Risks Identified

Since the publication of the Kirkup report there have been numerous national maternity drivers for change. These include:

- Department of Health – Spotlight on maternity: contributing to the Government's national maternity ambition
- NHS England – Better Births, Improving outcomes of maternity services in England: A Five Year Forward View (2016)
- Department of Health - Safer Maternity Care: Next steps towards the national maternity ambition (2016)
- NHS England - Saving Babies Lives (2016)
- NHS Improvement – Maternity and Neonatal Safety Collaborative (MatNeo) (2016)
- Department of Health - Safer Maternity Care: The National Maternity Safety Strategy – Progress and Next Steps (2017)
- NMC – Amendments to modernise midwifery regulation and improve the effectiveness and efficacy of fitness to practise – Removal of Statutory Supervision and implementation of the contractual requirement to have Professional Midwifery Advocate (PMA) service (2017)
- NHS Improvement – Avoiding Term Admissions into Neonatal Units (2017)
- NHSR – CNST Maternity Incentive Scheme Safety Actions (2018)
- NHS England - Saving Babies Lives Version 2 (2019)

Whilst all the drivers are aimed at improving the safety of care for women and their babies, they do pose a potential risk as they involve significant changes in ways of working.

Whilst some funding has been provided via the Local Maternity Systems, this funding is non recurrent and therefore cannot be used to provide additional staff to progress improvement projects. The service therefore has to deliver against challenging targets whilst maintaining day to day safety needs.

The following risks which are reflected on the Directorate's / Corporate Risk Register relate to the implementation of the national requirements:

Risk Title	RR	Driver	Existing Controls / Actions to mitigate	Target date for completion
Maintenance of Midwife to Birth Ratio		Better Births (Continuity workstream)	Business Case submitted to increase budgeted establishment Increased use of existing substantial staff on the Bank (enhanced rate) to ensure safe staffing on the Labour Ward / Wards Activity forecast monitored by Interim HoM on EDD on the number of bookings - activity shows ongoing increase Escalated to Divisional Management Team Meetings / Performance Meeting – Staffing Paper submitted to Trust Board September 2019 Review of escalation process to ensure staff are supported at times of very high activity by senior midwifery / obstetric staff Birth rate Plus acuity tools implemented - recognised and validated tool to assess the number of whole time equivalent midwives required to deliver care Implementation of Maternity Safety Huddle – Senior Team review staffing needs according to acuity and staff redeployed to maintain safety	June 2020 (dependant on outcome of business case)
Out of hours staffing (ST3 and above) is inadequate for the level of activity		Safer Maternity Care	Increase in the number of SHO/FY during the weekend day time to reduce some of the workload. Weekly rota meeting - Clinical Director, Directorate Manager, Clinic Co-ordinators, Junior Doctor Rota Co-ordinator and trainee representative Use of agency locums for unfilled shifts where possible	June 2020 (dependent on outcome of business case)

Risk Title	RR	Driver	Existing Controls / Actions to mitigate	Target date for completion
			Business case submitted - proposal to increase registrar staffing to 12 and SHO staffing to 10. This will increase the ST3 and above to 2 during evenings and weekend daytimes. There will still be one ST3 and above at night.	
Patient safety / experience / reputational risk due to inability to provide dedicated triage area on/near labour ward		Saving Babies Lives CNST Incentive Scheme	Review best practice for Obstetric Triage. Working party attended study day for the Birmingham Symptom Obstetric Triage system (March 2019) – requires 3 or 4 bedded dedicated Triage area to implement – Business case submitted to reconfigure Labour Ward. Agreed by Executive Team. Currently with Estates for Options Appraisal In the interim Triage provided on the Maternity Day Unit - 08.00 - 19.30 Monday to Friday and 08.00 - 16.00 weekends and bank holidays - outside these hours women are seen on Labour Ward. Maternity referral criteria reviewed and updated (April 2019) Reminders to staff re; Triage, escalation and CTG review Triage Boards in Maternity Day Unit and Labour Ward updated to include time woman arrives	September 2020
Difficulty demonstrating compliance with the Saving Babies Lives Care Bundle due to the requirements for external reporting of audit results and the level of work required		Saving Babies Lives CNST Incentive Scheme	All five elements implemented but further work required to embed practice and monitor actions so that compliance can be demonstrated to NHSE/I Fetal Surveillance Midwife (1wte) and Healthy Lifestyle Midwife (0.6wte) commenced in post April 2019 – non recurring funding for 12 months. Put forward as cost pressures	March 2020

Risk Title	RR	Driver	Existing Controls / Actions to mitigate	Target date for completion
			Successful bid to fund 0.4 wte Fetal Monitoring Champion until end March 2020 – further training required to deliver the requirements of the CNST Incentive Scheme Year 3. Gap analysis against Year 3 standards currently being developed – to request funding of post through the CNST monies. MESC bid submitted to purchase scan machine for labour ward – increasing need for growth scans has resulted in breaches in the 72 hour referral to scan time. Having a scan machine for Labour Ward will mean that women attending out of hours can be scanned by the Registrar/Consultant negating the requirement to refer to Midwife Led scan clinic	
Maternity Activity & Capacity		Better Births (Continuity workstream)	Business Case submitted to reconfigure Labour Ward – agreed by Executive Team. Currently with Estates for Options Appraisal Review escalation response to ensure that there is senior midwifery/Obstetrician input during times of high activity Implementation of maternity huddle Operational Manager attendance at Trust Huddles and reports on escalation status Implementation of Birth Rate Plus acuity tools Monitoring of expected and projected bookings, births, EDDs Consideration of capping bookings / deliveries - currently out of area referrals not accepted on the birth centre.	September 2020

3. Patient and Staff Feedback

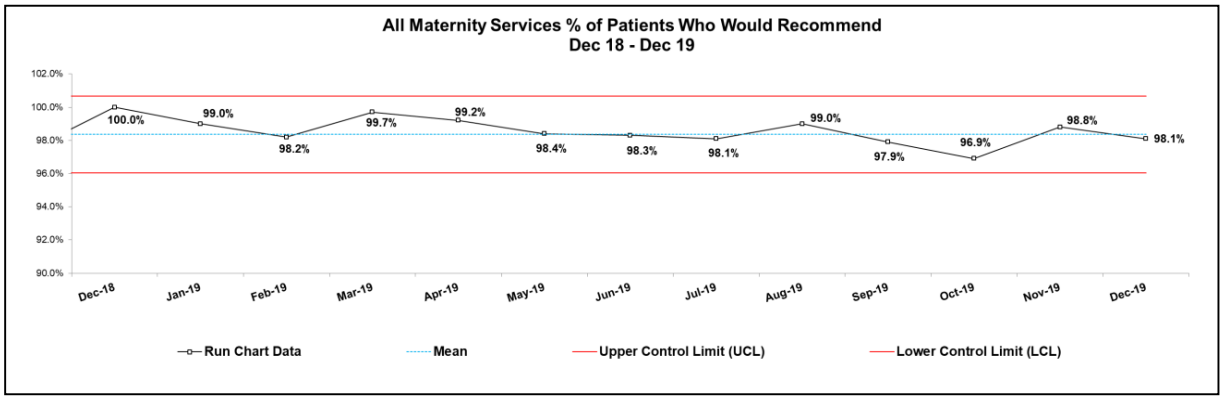
The Trust provides a number of methods for women and their families to provide unsolicited feedback. These include:

- Friends and Family Test (FFT)
- CQC Maternity Survey
- NHS Choices Website
- NGH Website / Facebook Group
- Maternity Voices Partnership (MVP) – Meetings, focus groups and via Facebook page
- Healthwatch 15 steps visit
- Meet the Matrons Clinic – held weekly

The Maternity FFT dataset includes FFT responses from NHS funded maternity services. Responses to the maternity FFT are captured at 4 points: antenatal care, birth, postnatal ward and postnatal community.

Indicator	Target	OCT-19	NOV-19	DEC-19
Friends & Family Test % of patients who would recommend: Maternity - Antenatal Community	>=95.8%	100.0%	97.7%	92.6%
Friends & Family Test % of patients who would recommend: Maternity - Birth	>=96.8%	97.7%	99.1%	99.1%
Friends & Family Test % of patients who would recommend: Maternity - Postnatal Ward	>=95%	95.2%	98.9%	98.1%
Friends & Family Test % of patients who would recommend: Maternity - Postnatal Community	>=97.8%	98.1%	97.9%	100.0%

The following SPC shows the overall % of patients who would recommend NGH maternity services over the last 12 months.



The CQC National Maternity Survey

In the 2018 CQC National Maternity Survey, NGH was identified as one of the top five NHS Trusts scoring better than most Trusts in the survey results.

The hospital participated in a further CQC National Maternity Survey in 2019 with responses from 123 women who had given birth either within their home or within the hospital in January 2019 – response rate 39.2% (national response rate 36.5%).

The Trust has received an early release of the benchmark results in advance of the national publication. The benchmark report contains the same scoring and 'banding' (how your Trust performed compared to other Trusts across England) but it does not include the national scores.

Eighteen questions were amended since the administration of the 2018 survey which meant they could not be compared against previous results.

Banding Results

- For 2019, NGH had 3 questions which were 'Better' than the national average, these were;

Questions	NGH 2019 Score	NGH 2018 Score
During your pregnancy, did you have a telephone number for a member of the midwifery team that you could contact?	10.00	9.8
During your pregnancy, if you contacted a midwifery team, were you given the help you needed?	9.2	8.8
During your pregnancy did midwives provide relevant information about feeding your baby?	8.3	n/a

- The remaining questions (45) were all 'About the same' as the national averages.
- No questions performed as 'Worse' than the national average
- There were no statistically significant changes within any questions.

Staff Feedback

As part of the National Maternal and Neonatal Health Safety Collaborative, the maternity services undertook a PASCAL Safety Culture Survey in July 2018. The survey was sent to all midwives, Maternity Support Workers, Obstetricians, Neonatologists, Anaesthetists, Neonatal Nurses and Theatre Nurses.

Baseline data was taken from the result of the PASCAL survey which showed 88% midwives felt that there was good teamwork within the service and 80% rated their working conditions as good, however 46% of staff reported that they felt exhausted at the end of their shifts and lacked resilience and only 33% felt that there was a non punitive response to the investigation of errors.

Following discussion with the national team, the maternity services commenced a quality improvement project with the following aims:

- Project 3 Aim: To decrease the number of staff who report feeling exhausted at the end of the working day by 20% by April 2021

- Project 4 Aim: To increase staff's positive overall perception of patient safety by 20% by April 2021

Actions already implemented include:

- Implementation of the RCM Caring for You Campaign
- Resilience Training via external facilitator funded through Charitable Funds
- Human Factors Training for all levels of staff
- Launch of the Professional Midwifery Advocate service
- Daily safety huddles
- Regular Kitchen Table events
- Implementation of 10 @ 10 – all staff encouraged to get together for a cup of tea at 10.00 every morning (when it is safe to do so).
- Implementation of Learning from Excellence – focus on positive rather than negatives
- Implementation of Mr & Mrs Maternity Nominations (staff recognition)
- Implementation of TRiM® – Trauma Risk Management is a trauma-focused peer support system designed to help people who have experienced a traumatic or potentially traumatic event (maternity services currently have staff trained as TRiM® Practitioners and TRiM Managers)
- Implementation of SrRaW ® - Sustaining Resilience at Work aimed at the detection of workplace stress, spotting the signs of psychological distress. Practitioners have the knowledge and skills necessary to help improve the mental health of colleagues through planning, guidance, signposting and effective mentoring. (staff trained as StRaW Managers and StRaW Practitioners)

7. Next Steps

- Given the significant changes that have been implemented nationally in response to the Kirkup Report, the maternity services have commenced a multi-disciplinary review of all 44 recommendations to ensure that the changes have not impacted on other areas of concern raised by Kirkup. The review will be completed by 14th February 2020 and will be presented to the Maternity Governance Group on 21st February 2020.

- When the Ockenden Review into concerns at the Shrewsbury & Telford Hospitals NHS Trust is published a multi-disciplinary meeting will be held to undertake a further gap analysis.

6. Actions required by the Board

- Note the information contained in this report
- Identify any areas where additional assurance is required

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Report To	**Trust Board**
Date of Meeting	**30th January 2020**

Title of the Report	**NGH Improvement Plan**
Agenda item	**16**
Presenter of Report	Ms Claire Campbell, Director of Corporate Development, Governance and Assurance
Author(s) of Report	Mrs Sarah Brown, Compliance Governance Manager

This paper is for:

☐ Note	☐ Assurance
For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

Executive summary

- Further to publication of the final reports, the Trust has developed an improvement plan to address the 'must' and 'should' actions listed in the reports.
- The Trust received three requirements notices. Two in relation to the proper and safe use of medicines (Medicine and Maternity) and one in relation to receiving and acting on complaints (Maternity).
- 24 actions have been closed in month
- All actions have been completed for the three requirement notices and the supporting evidence of completion is in place
- 55 actions are outstanding and remain on track for completion by the deadline date
- 29 actions have had been changed (mainly the date for completion)(detail in report)
- 5 actions require the evidence of completion to be identified (detail in the report)
- 10 actions have been signed off as complete but the evidence of completion is required (detail in the report)

Related strategic pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Create a sustainable future supported by new technology* 4. *Strengthen and integrate local clinical services particularly with Kettering General Hospital* 5. *Create a great place to work, learn and care to enable excellence through our people*
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks: **Yes** Failure to meet statutory requirements can lead to improvement notices, and prosecution and in extremes withdrawal of Trust services

Related Board Assurance Framework entries	All
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? **No** Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? **No**
Financial Implications	Some actions will require additional funds e.g. business cases and capital projects. Failure to meet requirements can lead to fines.
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper: **Yes** **CQC Fundamental Standards** The Trust has been issued with three requirement notice following the CQC inspection. Two in relation to Regulation 12 (2) (g): The proper and safe use of medicines. One in relation to Regulation 16 (2): Receiving and acting on complaints.

Actions required by the Trust Board:

The Board is asked to:

- Accept this report as part of the assurance process, showing the Trust has and is taking action to address the concerns raised in the CQC reports and undertakings requirements.
- Challenge any areas of concern or where it is felt that progress is not occurring in a timely manner, or evidence of completed action is not forthcoming.

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

NGH Improvement Plan

1. Introduction

The CQC completed a use of resources, core service and well-led inspection of the Trust on 4th June 2019, 11th -13th June 2019 and 24th -25th July 2019 respectively. Three services were reviewed as part of the core service inspections, Urgent and Emergency Service, Medical Care (including older people's care) and Maternity. This was the first time the Trust has had a use of resources inspection as part of the updated CQC inspection methodology.

The final reports were published on 24th October 2019. Three reports were published:

- Provider report
- Evidence appendix (to support the provider report)
- Use of resources report

The reports are available on the CQC website https://www.cqc.org.uk/provider/RNS/reports

2. Progress against actions

2.1 NGH Improvement Plan (Update)

Following the publication of the reports, the 'must' and 'should' actions from the reports, have been transposed and used to form the detail of the NGH Improvement Plan. The Trust was issued with three requirement notices. The current version of the plan is provided in *Appendix A*. Actions have been provided, to show how the Trust will complete each of the 'must' and 'should' concerns raised in the reports. A deadline date, evidence of completion and a score for the likelihood of completion are also included.

The likelihood score is rated from 1 (rare- not going to happen) to 5 (almost certain) to mirror the likelihood scoring within the Trusts risk assessment processes. Only one action is currently scored as unlikely (15.3) this is due to the lack of available capital funding, to make the necessary changes to the paediatric ED layout.

The improvement plan was approved at Public Trust Board on 28th November 2019. The process for confirming closure of actions , is for the Lead Executive to 'sign off' on receipt of the required evidence and for the Executive team to ratify, prior to the monthly Quality Governance Committee meeting. An update will also be provided to Public Trust Board on a bi-monthly basis.

Report Month	Total actions remaining	Number closed in month	Number outstanding (on track)	Number overdue
November 2019	126	30	96	0
December 2019	96	17	79	0
January 2020	79	24	55	0

2.2 List of actions closed in month

Detail is provided in the NGH Improvement Plan (see Appendix A)

2.2.1 January 2020 closures

Action number	Concern	Action/s
2	**Staff must follow systems and processes when safely prescribing, administering, recording and storing medicines. The service must ensure medicines are in date and medicine waste and returns are stored securely. Infusions that require protection from light must be stored appropriately. Staff must ensure medicines stored in the medicine trolley are stored in their original boxes to ensure expiry dates and names of medicines are visible. Staff must ensure action is taken to address repeated high room temperature values, where the recommended storage conditions for medicines have been exceeded. (Regulation 12 (2) (g): The proper and safe management of medicines). The maternity service must ensure information and guidance about how to complain is widely available to everyone who uses the service. (Regulation 16: (2) Receiving and acting on complaints).**	2.5 Approve business case for maternity Pharmacist
3	**The maternity service must ensure information and guidance about how to complain is widely available to everyone who uses the service. (Regulation 16: (2) Receiving and acting on complaints).**	3.1 4Cs information leaflets and posters to be displayed in all areas 3.2 'Meet the Matron' posters displayed in all areas- so service users can raise concerns 3.3 Use of Big Word translation services 3.4 Develop poster which contains information in other languages for women and families in whom English is not their first language
8	**a) The trust should review the effectiveness of its audit committee b) The trust should consider the observations in relation to the audit committee to ensure that only realistic and deliverable internal audit recommendations are agreed in future, and that internal audit recommendations, as far as is practicable, are implemented within agreed timescales.**	8.4 Agreed to include committee self-assessment at the end of each meeting 8.8 Closure of salary overpayment issue via audit committee (Cross reference with action no 14.)
10	**The trust should consider the structure, management and oversight arrangements for its quality improvement function**	10.2 Recommendations of review to be presented to Trust Board
12	**The trust should take steps to assure itself that the interventions in progress to address bullying and poor behaviour are having an impact at pace**	12.2 Targeted interventions in 'hotspots'

15	**The service should continue to re-assess the layout of the paediatric emergency department to ensure it meets the Children and Young People in Emergency Care Settings 2012 standards**	15.4 Review pathways for use of PAU and increased activity
16	**The service should make arrangements so patient group directions are regularly checked and updated on the trust internal website**	16.1 This action is included within the Medicines Optimisation action plan (part of the Medicines Optimisation Strategy 2016- 2020).
18	**The service should take action to improve the median time from arrival to treatment**	18.1 Implement winter actions 18.4 Rapid improvement project with IDT
20	**The service should check catering staff are following infection prevention and control protocols**	20.1 Induction training for new starters 20.2 Infection Prevention representation at Catering Meetings regarding PPE 20.3 Infection Prevention Mandatory training - 3 yearly for non-clinical staff 20.4 Environment audits and Catering audits are carried out when infection is identified 20.5 Domestic monthly cleaning audits include host/hostess staff - hand hygiene etc observed
27	**The service should consider reviewing environment and facilities for inpatient outliers staying on the Heart Centre**	27.1 Complete review of Heart Centre environment and facilities
28	**The service should consider addressing cultural issues across some medical wards**	Covered within action 12
30	**The service should ensure women can access the service when they need it and receive the right care promptly and that waiting times from referral to treatment and arrangements to admit, treat and discharge women are in line with national standards**	30.3 Review midwifery ultrasonography scan clinics to ensure adequate capacity 30.5 Seek further funding / training for more midwives to be trained in 3rd Trimester scanning
32	**The service should ensure managers are planning the service for the long term. For example, to enable planning and organisation of services so they met the needs of the local population within the local expected population growth**	32. 2 Develop integrated Business Plan for Maternity Services
33	**The NHS trust should continue working to ensure optimisation of its substantive medical workforce and reduce reliance on agency staff.**	33.1 Reinforce medical agency committee

2.3 Updates on actions which are overdue

None for January 2020

2.4 Changes to actions

Action number	Action	Change to action
3.4	**Develop poster which contains information in other languages for women and families in whom English is not their first language**	06/01/2020 Evidence of completion changed to Copy of poster (previous evidence QuEST Audit)
4.2	**Board to consider frequency of reporting of BAF.**	20/12/2019 Evidence of completion changed to Board development programme. (previous evidence Board paper)
5.2	**Training refresh for all ARC members on risk, including mitigation, and controls**	31/12/2019 Date changed from 12/12/2019 to 29/02/2020 as unable to present at ARC meeting Dec 2019 due to software issues.
9.1	**Refresh well- led Board knowledge**	20/12/2019 Date changed from 19/12/2019 to 30/01/2020 as Dec 2019 Board meeting overran. To now take place Jan 2020. All other actions moved back one month
9.2	**Identify basic specification of need**	20/12/2019 Date changed from 19/12/2019 to 30/01/2020 as Dec 2019 Board meeting overran. To now take place Jan 2020. All other actions moved back one month
9.3	**Commission external review via competitive quotes**	20/12/2019 See action 9.1- date for completion changed to 29/02/2020 (from 31/01/2020)
9.4	**Undertake governance review**	20/12/2020 See action 9.1- date for completion changed to 30/04/2020 (from 31/03/2020)
9.5	**Provide evidence to NHSE/I**	20/12/2020 See action 9.1- date for completion changed to 30/04/2020 (from 31/03/2020)
11.2	**Continue to engage partners in large scale strategic changes**	13/01/2020 Evidence of completion added in- Examples of work with partners
11.3	**Continue to engage partners in strategic operational issues and decision making**	13/01/2020 Evidence of completion added in- Examples of work with partners
12.2	**Targeted interventions in 'hotspots'**	06/01/2020 Evidence of completion changed from Staff Survey 2020 to Example of targeted intervention work in 'hotspot' area
12.3	**Incorporate 'Civility Saves Lives' into Respect and Support programme**	06/01/2020 Civility Saves Lives to be incorporated from Feb 2020. Completion date changed from 31/12/2019 to 29/02/2020
15.1	**Set up working group to establish with Paediatrics and Estates to review the current working practices that our Paediatric area has to meet these standards.**	09/01/2020 Plans are being drawn up to extend the Children's cubicle area by 2 cubicles. Work will progress in Q4. Change date of completion/ review from 31/12/2019 to 31/03/2020

15.2	**Develop options paper looking at expanding or relocating the department. Seek potential options for capital funding.**	See update for action 15.1 Change date of completion/ review from 31/12/2019 to 31/03/2020
15.3	**Complete works to change the department**	See update for action 15.1 Change date of completion/ review from 31/12/2019 to 31/03/2020
17.1	**Mandatory training compliance of all staff groups is reviewed at every Urgent Care Governance meeting**	13/01/2020 Change of date from 31/12/2019 to 29/02/2020 to enable full update from Urgent Care service
17.2	**Clinical Director for Urgent Care will remind all medical staff of their need to complete the training**	13/01/2020 Change of date from 31/12/2019 to 29/02/2020 to enable full update from Urgent Care service
21.1	**The Trust have invested in lockable trollies in order to store patient records securely**	13/01/2020 Evidence of completion added in - Confirmation email from Senior member of Nursing team
21.2	**Lockable cupboards are available for the safe storage of patient records**	13/01/2020 Evidence of completion added in - Confirmation email from Senior member of Nursing team
21.3	**Annual Information Governance mandatory training for all staff**	13/01/2020 Evidence of completion added in- Relevant section from Data Protection Toolkit submission
21.4	**Governance team to complete spot audits of compliance on wards and departments (Dec 2019 and March 2020). Findings to be shared at Assurance, Risk and Compliance meeting)**	13/01/2020 Action amended to: Data Quality, Security and Protection team to complete spot audits…… Evidence of completion added in- Data Protection Audit results
21.5	**All areas need to demonstrate compliance as part of the Ward Accreditation Assessment**	13/01/2020 Evidence of completion added in- Relevant Assessment and Accreditation document
22.2	**Relaunch of LocSSIPs - training and comms**	31/12/2019 Change of completion date from 01/05/2020 to 30/06/2020 due to increase to work programme (new Clinical Lead supporting project) 05/12/2019 Date changed from 01/04/2020 to 01/05/2020 due to progress with action 22.1
22.3	**Audit of compliance**	31/12/2019 Change of completion date from 01/05/2020 to 30/06/2020 due to increase to work programme (new Clinical Lead supporting project) 05/12/2019 Date changed from 01/09/2020 to 31/10/2020 due to progress with action 22.2
23.1	**Inpatients cared for on outlying wards have a designated medical team to review patients. This is monitored and audited twice weekly by reviewing the medical**	06/01/2020 Change of completion date from 31/12/2019 to 29/02/2020. Action in progress – exec confirm not yet for sign off

	plans in the patient's medical records	
23.3	**Number of medical outliers to be communicated daily via Sitrep (Whats app)**	13/01/2020 Evidence of completion added in- Examples of Sitrep communications
24.2	**Action plan developed linking multiple reports/ workstreams in Cardiology**	13/01/2020 Completion date changed from 31/12/2019 to 16/02/2020 due to cancellation of planned meeting due to trust pressures and need to test approach in Breast Service first
36.1	**Cancer recovery plan in place**	09/01/2020 Completion date changed from 31/12/2019 to 31/03/2020. Plan is in place – exec confirm not yet for sign off
36.2	**AE plan in place as per actions 18 and 23**	09/01/2020 Completion date changed from 31/12/2019 to 31/03/2020. Plan is in place – exec confirm not yet for sign off

2.5 Evidence
Evidence to close actions will be provided by the action owner to the relevant Executive Lead, they will review prior to sign off of the action. Evidence will be collated by the Compliance Team. The Team will complete a final review of the evidence and raise any concerns with the Executive Lead. If evidence is not sufficient to demonstrate completion, the action will be re-opened. Any gaps in the evidence at time of writing are included in the table below.

Action number	**Action**	**Gaps in evidence**
15.4	**Review pathways for use of PAU and increased activity**	Action signed off as completed. Need evidence of completion
18.1	**Implement winter actions**	Need to identify evidence of completion (on previous report)
18.3	**Review Heat activity Re-define programme Re-launch**	Need to identify evidence of completion (on previous report)
20.1	**Induction training for new starters**	Action signed off as completed. Need evidence of completion
20.2	**Infection Prevention representation at Catering Meetings regarding PPE**	Action signed off as completed. Need evidence of completion
20.3	**Infection Prevention Mandatory training - 3 yearly for non-clinical staff**	Action signed off as completed. Need evidence of completion
20.4	**Environment audits and Catering audits are carried out when infection is identified**	Action signed off as completed. Need evidence of completion
20.5	**Domestic monthly cleaning audits include host/hostess staff - hand hygiene etc observed**	Action signed off as completed. Need evidence of completion
23.2	**Ward staff escalate any issues regarding medical reviews at the x3 daily Site meetings.**	Action signed off as completed. Need evidence of completion
23.3	**Number of medical outliers to be communicated daily via Sitrep (Whats app)**	Action signed off as completed. Need evidence of completion
27.1	**Complete review of Heart Centre**	Action signed off as completed. Need

	environment and facilities	evidence of completion
35.1	**Support the transformation of the quality function**	Need to identify evidence of completion (on previous report)
35.2	**Integrate productivity improvements in OD interventions**	Need to identify evidence of completion (on previous report)
35.3	**Introduce talent management**	Need to identify evidence of completion (on previous report)
39.4	**Put in place a new Facilities Governance committee and structure**	Action signed off as completed. Need evidence of completion

2.6 Updates from external reporting to CQC/ NHSE/I
A meeting was held with NHSE/I in early January 2020 to discuss progress with the Improvement plan.
The CQC will be meeting with the Trust on 24th January 2020 for their relationship meeting. Progress with the Improvement Plan will be discussed at this meeting. The CQC have asked a number of questions ahead of this meeting and requested to see evidence of completion for some of the actions, particularly those relating to the requirement notices.

3. Assessment of Risk

The Trust has been issued with three requirement notices by CQC. A requirement notice is issued when a service is found to be in breach of one of the fundamental standards of care; the standards below which care must never fall. These fundamental standards are linked to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Trust must be able to demonstrate it has taken action to address these breaches. If not, there is the potential for further enforcement action to be taken against the Trust (warning notice) or prosecution (with qualifications). Please refer to section 2.6 for detail on updates provided to the CQC to show progress with the actions associated with the requirement notices.

The summary detail of the three requirement notices is provided in the table below. Further detail can be found in the improvement plan (appendix A)

Core service	Regulation	Brief detail	Progress update
Medical care (including older people's care)	**Regulation 12 (2) (g): The proper and safe use of medicines**	Staff not always ensuring the proper and safe management of medicines	All actions completed and supporting evidence in place
Maternity	**Regulation 12 (2) (g): The proper and safe use of medicines**	Staff not always following systems and processes when prescribing, administering, recording and storing medicines	All actions completed and supporting evidence in place
Maternity	**Regulation 16 (2): Receiving and acting on complaints.**	Information on how to make a complaint was not seen at the time of the inspection	All actions completed and supporting evidence in place

4. Agreed governance reporting framework

The Improvement Plan will be presented to Executive meetings and the Quality Governance Committee on a monthly basis. Bi-monthly updates will be presented at Public Trust Board.

The process for confirming closure of actions will be for the Lead Executive to sign off on receipt of the required evidence and for the Executive team to ratify prior to the Quality Governance Committee.

5. Recommendations

The Board is asked to:

- Accept this report as part of the assurance process, showing the Trust has and is taking action to address the concerns raised in the CQC reports
- Challenge any areas of concern or where it is felt that progress is not occurring in a timely manner, or evidence of completed action is not forthcoming.

NGH Improvement Plan
(Incorporating CQC Inspection Report outcomes published October 2019/ NHSE/I Undertakings actions)

12/01/2020
V4

21/01/2020

No	Concern: Medicine Division Requirement notice	Action	Deadline	Progress/ Comments
1	The trust must ensure the proper and safe management of medicines. Staff must follow current national practice to check patients receive the correct medicines. The service must have systems to ensure staff are aware about safety alerts and incidents. Staff must store and manage all medicines and prescribing documents in line with the provider's policy. (Regulation 12 (2) (g): The proper and safe management of medicines).	1.1 Implementation of Task and Finish Group chaired by Medical Director	01/08/2019	Completed
		1.2 Medicines Optimisation Work plan updated to include CQC recommendations (post inspection)	02/08/2019	21/12/2019 Update from Chief Pharmacist advise safety alerts already shared across the Trust but exploring the use of Netconsent for this as well. Help raise profile and enable audit of staff accessing documents. Also provide historic reminders of key messages Completed
		1.3 Ongoing enhanced audits monitored through medicines governance structure	31/12/2019	20/12/2019 Update from Chief Pharmacist- Audit form approved August 2019 - changes made after 3 months of use and discussions at MOSG. Completed Audits remain ongoing
		1.4 Safe & Secure Controlled Drug audit carried out on a monthly basis	31/12/2019	20/12/2019 Update from Chief Pharmacist- Audits are completed monthly for areas of poor compliance (normally done quarterly). CD Audit form has been updated. Plan is to combine CD and MM audits, completed jointly by Nursing and Pharmacy from April 2020 Completed Audits remain ongoing

No	Concern: Womens Childrens, Oncology & Haematology and Cancer Services Division Requirement notice	Action	Deadline	Progress/ Comments
2	Staff must follow systems and processes when safely prescribing, administering, recording and storing medicines. The service must ensure medicines are in date and medicine waste and returns are stored securely. Infusions that require protection from light must be stored appropriately. Staff must ensure medicines stored in the medicine trolley are stored in their original boxes to ensure expiry dates and names of medicines are visible. Staff must ensure action is taken to address repeated high room temperature values, where the recommended storage conditions for medicines have been exceeded. (Regulation 12 (2) (g): The proper and safe management of medicines). The maternity service must ensure information and guidance about how to complain is widely available to everyone who uses the service. (Regulation 16: (2) Receiving and acting on complaints).	2.1 Implementation of Task and Finish Group chaired by Medical Director	01/08/2019	Completed
		2.2 Medicines Optimisation Work plan updated to include CQC recommendations (post inspection)	31/10/2019	Completed
		2.3 Ongoing enhanced audits monitored through medicines governance structure	31/12/2019	20/12/2019 Update from Chief Pharmacist- Audit form approved August 2019 - changes made after 3 months of use and discussions at MOSG. Completed Audits remain ongoing
		2.4 Safe & Secure Controlled Drug audit carried out on a monthly basis	31/12/2019	20/12/2019 Update from Chief Pharmacist- Audits are completed monthly for areas of poor compliance (normally done quarterly). CD Audit form has been updated. Plan is to combine CD and MM audits, completed jointly by Nursing and Pharmacy from April 2020 Completed Audits remain ongoing
		2.5 Approve business case for maternity pharmacist	31/12/2019	20/12/2019 Chief Pharmacist email - confirm Exec team approve business case and recruitment will commence Jan 2020, with view to providing service from April 2020. 18/12/2019 Supporting evidence saved- business case and emails re taking case to Dec 2019 Finance Committee 05/12/2019 Action updated to Approve business case for maternity pharmacist (previous action Appoint maternity pharmacist)
3	The maternity service must ensure information and guidance about how to complain is widely available to everyone who uses the service. (Regulation 16: (2) Receiving and acting on complaints).	3.1 4Cs information leaflets and posters to be displayed in all areas	31/12/2019	06/01/2020 Completed. Audits will remain ongoing. No concerns with compliance. Evidence also included of attendance at Meet the Matrons clinic - 3 months of data. Women are accessing this service to discuss their care 18/12/2019 S.Oke advise spot audits will be available for CQC engagement meeting Jan 2020 05/12/2019 Leaflets and posters on display. Meet the Matron posters are also on display in all areas of maternity. Flyers to support the availability of the above are also now included within the mothers discharge pack
		3.2 'Meet the Matron' posters displayed in all areas- so service users can raise concerns	31/12/2019	06/01/2020 Audits provided which show posters on display and evidence of clinics taking place 05/12/2019 Meet the Matron posters are available in all areas of maternity
		3.3 Use of Big Word translation services	31/12/2019	6/01/2020 Information available in ward areas. Currently included in maternity's 'Stork Talk' newsletter to remind staff. HOM continues to monitor use of interpreters 05/12/2019 Message relayed through safety huddles, information also available in ward areas. Currently included in maternity's 'Stork Talk' newsletter to remind staff. HOM is monitoring use of interpreters
		3.4 Develop poster which contains information in other languages for women and families in whom English is not their first language	31/12/2019	06/01/2020 Poster on display at hospital. Information booklets available in Romanian. Polish, Lithuanian and Bengali (most common languages). Provided to women at booking appointment by Community Midwife. Evidence of completion changed to Copy of poster 05/12/2019 Information also provided by midwives at booking appointment by community midwife. New poster under design to signpost. leaflets being translated into other languages (most commonly used)

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
4	a) The trust should review its board assurance framework to ensure it provides adequate assurance b) he trust should consider tabling the board assurance framework monthly and consider how current gaps in assurance are highlighted. This consideration should inform debate on the sufficiency of the actions taken to close these gaps, and the associated timelines	4.1 BAF to be reviewed by Board- benchmarked against CQC advised exemplar document and revised format to be agreed. This will assist in improving assurance, highlight gaps in assurance and timely actions as a result.	31/12/2019	Completed
		4.2 Board to consider frequency of reporting of BAF.	26/09/2019	20/12/2019 Evidence of completion changed to Board development programme (from Board paper). Frequency of reporting discussed as part of presentation for 4.1 Completed- Board agreed to leave as quarterly reporting in line with other Trusts.
		4.3 BAF content reviewed and links to strategy pledges included	28/11/2019	Completed
		4.4 BAF presented in revised format	28/11/2019	Completed

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
5	The trust should review its risk register so staff can easily track changes to risk or mitigation and improve clarity on how the existing controls relate to the risk as stated in the risk register	5.1 Revised report format for ARC, Board and its committees	31/10/2019	Completed
		5.2 Training refresh for all ARC members on risk, including mitigation, and controls	29/02/2020	13/01/2020 Link to training provided. 31/12/2019 Video presentation due at ARC Dec 2019 - lack of presentation software on the day. Expected Jan 2020 or Feb 2020. Date changed to end of Feb 2020 (from 12/12/2019). Link to online training to be provided. 18/12/2019 Email sent to action owner asking if amended date required as training not yet provided at ARC
		5.3 Deep dives into Divisional Risk Registers	31/10/2019	Completed
		5.4 Introduction of Datix Cloud to improve risk management processes	01/04/2020	

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
6	The trust should consider how it could improve the effectiveness of its medicines audit processes	6.1 Action is covered by Medicines Optimisation Action Plan (part of the Medicines Optimisation Strategy 2016-2020). The action plan is monitored through Medicines Optimisation Strategy Group which reports to CQEG	31/12/2019	Completed
		6.2 See also entry and actions for action 1	31/12/2019	Completed

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
		7.1 The Infection Prevention Team carried out a six week audit of all wards, departments, Outpatient areas and Theatres looking in every bin, the results of which were fed back to senior staff	30/09/2019	CompletedAudit results available
		7.2 Focus on findings of these audit results with a view to improving compliance	31/12/2019	Completed. Audit results shared with Ward Manager, Matron and Infection Prevention Steering group & IPC Operational group on a monthly basis

7	The trust should consider its methods of assurance relating to the segregation of clinical waste	7.3 Established a rolling audit programme to carry out a detailed Infection Prevention audit	31/12/2019	Completed. Audit rolling plan developed and implemented
		7.4 A screensaver has been produced and displayed across the Trust	30/09/2019	Completed. Screensaver developed and launched across the Trust
		7.5 Key issues are raised at the Infection Prevention Operational Group, Link Nurse Meetings and Infection prevention Steering Group	31/12/2019	Completed. Minutes available from Infection Prevention Steering Group & IPC Operational Group on a monthly basis
		7.6 Weekly walk arounds with Claire Topping, Sustainability Manager	31/12/2019	Completed. Weekly walk rounds completed by Sustainability Manager & IPC team. Findings shared with Ward Manager and Infection Prevention Steering Group & IPC Operational group on a monthly basis

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
8	a) The trust should review the effectiveness of its audit committee b) The trust should consider the observations in relation to the audit committee to ensure that only realistic and deliverable internal audit recommendations are agreed in future, and that internal audit recommendations, as far as is practicable, are implemented within agreed timescales.	8.1 Agree Committee membership and Lead Executive	24/09/2019	Completed
		8.2 Meeting with Committee Chair and Lead Exec to discuss issues raised in CQC report and Committee effectiveness review	10/10/2019	Completed
		8.3 Revise committee reporting matrix	15/10/2019	Completed
		8.4 Agreed to include committee self-assessment at the end of each meeting	18/12/2019	20/12/2019 Require final version of minutes from meeting
		8.5 Agreed to include actions from clinical audit and compliance with Clinical audit bi- annually	15/10/2019	Completed
		8.6 Ensure only realistic and deliverable IA recommendations are agreed in future and monitor delivery against agreed timescale	31/03/2020	
		8.7 Ensure Audit committee takes a zero tolerance to longstanding issues and seeks resolution	31/03/2020	
		8.8 Closure of salary overpayment issue via audit committee (Cross reference with action no 14.)	18/12/2019	20/12/2019 Exec email- discussed at Audit Committee and Finance and Performance. Require final version of minutes from meeting

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
9	The trust should consider an external review of its governance structure and systems	9.1 Refresh well- led Board knowledge	30/01/2020	20/12/2019 Exec email- actions relating to 9.1 and 9.2 postponed as Dec 2019 Board overran. To now take place in Jan 2020 (changed from 19/12/2019). All other actions to be moved back one month.
		9.2 Identify basic specification of need	30/01/2020	20/12/2019 Exec email- actions relating to 9.1 and 9.2 postponed as Dec 2019 Board overran. To now take place in Jan 2020 (changed from 19/12/2019). All other actions to be moved back one month.
		9.3 Commission external review via competitive quotes	29/02/2020	20/12/2019 See action 9.1- date for completion changed to 29/02/2020 (from 31/01/2020)
		9.4 Undertake governance review	30/04/2020	20/12/2020 See action 9.1- date for completion changed to 30/04/2020 (from 31/03/2020)
		9.5 Provide evidence to NHSE/I	30/04/2020	20/12/2020 See action 9.1- date for completion changed to 30/04/2020 (from 31/03/2020)

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
10	The trust should consider the structure, management and oversight arrangements for its quality improvement function	10.1 Collective transformation resource reviewed	01/04/2020	18/12/2019 Transformation Resource paper to be presented at Finance and Performance meeting 19/12/2019 Completed
		10.2 Recommendations of review to be presented to Trust Board	01/04/2020	13/01/2020 Discussed and recommendations approved at Dec 2019 Finance and Performance meeting (Committee of Board)

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
11	The trust should continue to engage all its partners in operational and strategic decision making	11.1 To publish the new strategy and retain evidence of consultation with partners.	01/11/2019	13/01/2020 Strategy includes how partners were consulted and input used Completed
		11.2 Continue to engage partners in large scale strategic changes	01/11/2019	13/01/2020 Evidence of completion added in- Examples of work with partners Completed and remains ongoing
		11.3 Continue to engage partners in strategic operational issues and decision making	01/11/2019	13/01/2020 Evidence of completion added in- Examples of work with partners Completed and remains ongoing

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
12	The trust should take steps to assure itself that the interventions in progress to address bullying and poor behaviour are having an impact at pace	12.1 Review impact of current programme	31/10/2019	Completed. Feedback responded to from staff in the People's Plan
		12.2 Targeted interventions in 'hotspots'	31/12/2019	06/01/2020 Freedom to Speak Up/HR/OD linkage created. Targeted interventions plans are in place or being progressed for 'hotspot' areas (Oncology, Cardiology and Maternity) Evidence of completion changed from Staff Survey 2020 to Example of targeted intervention work in 'hotspot' area
		12.3 Incorporate 'Civility Saves Lives' into Respect and Support programme	29/02/2020	06/01/2020 Piloting GMC professional standards in January 2020 to incorporate Civility Saves Lives for roll out from February 2020. Completion date changed from 31/12/2019 to 29/02/2020

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
13	The trust should consider commissioning a more detailed analysis of the drivers of its deficit to inform those elements that are within its gift to be able to address both directly and indirectly	13.1 Work with NHSE/I to agree process to complete this (using their expertise and knowledge)	01/04/2020	

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
14	The trust has plans to introduce an electronic solution between the human resources function and payroll to seek to address the issue of staff overpayments. The trust should consider requesting an internal audit function review of the planned electronic solution, in order that any control weaknesses can quickly be identified and addressed.	14.1 Request an internal audit review and address weaknesses	01/04/2020	

No	Concern: Urgent and Emergency Services Quality "Should" actions	Action	Deadline	Progress/ Comments
15	The service should continue to re-assess the layout of the paediatric emergency department to ensure it meets the Children and Young People in Emergency Care Settings 2012 standards	15.1 Set up working group to establish with Paediatrics and Estates to review the current working practices that our Paediatric area has to meet these standards.	31/03/2020	09/01/2020 Update from D.Needham Plans are being drawn up to extend the Children's cubicle area by 2 cubicles. Work will progress in Q4. Change date of completion/ review to 31/03/2020 from 31/12/2019 04/12/2019 Update from S.Finn The group have identified a short term solution to reconfigure and expand the department.
		15.2 Develop options paper looking at expanding or relocating the department. Seek potential options for capital funding.	31/03/2020	09/01/2020 See update for action 15.1. Change of completion/ review date to March 2020 (from 31/12/2019) 04/12/2019 Update from S.Finn Initial long term, high level plans have been produced but funding has not been identified to allow the scheme to progress at this time. A short term solution has been identified and is currently being costed. A paper will be presented to ET for approval in Jan 20
		15.3 Complete works to change the department	31/03/2020	09/01/2020 Linked in with action 15.1, Change of completion/ review date to 31/03/2020 from 31/12/2019 Review date of 31/12/2019
		15.4 Review pathways for use of PAU and increased activity	31/12/2019	09/01/2020 Email from D.Needham. Pathways from A&E to PAU in place. Evidence of completion required
16	The service should make arrangements so patient group directions are regularly checked and updated on the trust internal website	16.1 This action is included within the Medicines Optimisation action plan (part of the Medicines Optimisation Strategy 2016- 2020).	31/12/2019	20/12/2019 Further supporting evidence added in. Action complete 18/12/2019 Supporting evidence added re amendments to PGD process
		16.2 Include process in revised Medicines Management Policy	31/03/2020	18/12/2019 Supporting evidence added re amendments to PGD process 05/12/2019 Action changed to 'Include process in revised Medicines Management Policy'. Date revised to 31/03/2020 (from 31/12/2019) Previous action was 'See also entry for action 1

17	The service should take action so medical staff are compliant with the trust target for safeguarding children level three training	17.1 Mandatory training compliance of all staff groups is reviewed at every Urgent Care Governance meeting	29/02/2020	13/01/2020 Compliance Governance Manager review plan. No current update available at time of writing report. Extend date of completion by 1 month to 29/02/2020 (from 31/12/2019) . Compliance team will raise at Urgent Care Governance meeting on 16/01/2020 05/12/2019 Exec owner changed from Matthew Metcalfe to Mark Smith
		17.2 Clinical Director for Urgent Care will remind all medical staff of their need to complete the training	29/02/2020	13/01/2020 Compliance Governance Manager review plan. No current update available at time of writing report. Extend date of completion by 1 month to 29/02/2020 (from 31/12/2019). Compliance team will raise at Urgent Care Governance meeting on 16/01/2020 05/12/2019 Exec owner changed from Matthew Metcalfe to Mark Smith
		17.3 The Safeguarding Team provide regular updates of who needs to completed training and this will be monitored for medical staff who are not completing the training and are repeatedly on the list	01/04/2020	05/12/2019 Exec owner changed from Matthew Metcalfe to Mark Smith
18	The service should take action to improve the median time from arrival to treatment	18.1 Implement winter actions	31/12/2019	09/01/2020 Email from D. Needham. In progress- ET updated weekly. Evidence of completion required, Action completed
		18.2 Appoint PMO lead for Urgent Care and Winter	12/11/2019	Completed
		18.3 Review Heat activity 18.3 Re-define programme 18.3 Re-launch	29/02/2020	09/01/2020 Email from D. Needham. Meeting planned for PMO, DoIN, Med Dir and COO to relaunch. Winter actions taken priority. Completion date changed to 29/02/2020 (from 31/12/2019)
		18.4 Rapid improvement project with IDT	09/12/2019 (and ongoing)	09/01/2020 Email from D.Needham. Action is completed. Evidence of completion required

No	Concern: Medical Care Quality "Should" actions	Action	Deadline	Progress/ Comments
19	The service should check medical staff are up to date with mandatory, safeguarding and mental capacity training	19.1 Use of Netconsent software to check and force compliance	01/04/2020	
		19.2 Provide additional sessions of 'bundles' of mandatory training for trust grade staff	01/04/2020	
20	The service should check catering staff are following infection prevention and control protocols	20.1 Induction training for new starters	30/04/2020	06/01/2020 Email from S.Finn. IPC mandatory training and bespoke food hygiene induction training is in place for all new starters and existing staff. Action completed. Evidence of completion required 04/12/2019 Catering and IPC meeting held 29 Nov 19 to discuss and agree actions. Documentation including HASAP (Hazard and Critical Control Process) has been shared with IPC who are reviewing. Next meeting to be arranged in Jan 20
		20.2 Infection Prevention representation at Catering Meetings regarding PPE	30/04/2020	06/01/2020 Email from S.Finn PPE is issued to all food handlers/production staff. Ward hostesses uniforms are issued and protective aprons and gloves available. Staff are trained in food hygiene procedures which include PPE. Staff records evidence training and issue of PPE. Action completed. Evidence of completion required. 04/12/2019 As above
		20.3 Infection Prevention Mandatory training - 3 yearly for non-clinical staff	30/04/2020	06/01/2020 Email from S.Finn. This has been reviewed by SF and BW and recorded as completed. Evidence of completion required. 04/12/2019 This is in place for all catering staff and monitored via mandatory training results and at appraisals. Every 'food handler' also complete 'Food Hygiene' course
		20.4 Environment audits and Catering audits are carried out when infection is identified	30/04/2020	06/01/2020 Email from S.Finn. Audits and inspections are in place and carried out regularly. Post infection audits and inspections are carried out by IPC and include ward kitchens. This has been reviewed by SF and BW and recorded as completed. Evidence of completion required 04/12/2019 IPC have been asked to comment
		20.5 Domestic monthly cleaning audits include host/hostess staff - hand hygiene etc observed	30/04/2020	06/01/2020 Email from S.Finn. This has been been reviewed by SF and BW and recorded as completed. Evidence of completion required. 04/12/2019 This is in place as part of the cleaning audits. The ward kitchens are scored separately as part of the audit and include the ward host/hostess
		20.6 A review of catering procedures and working practices will be carried out by Infection control and the Catering management team	30/04/2020	06/01/2020 Email from S.Finn. BW arranging follow-up meeting with IPC. 04/12/2019 Catering and IPC meeting held 29 Nov 19 to discuss and agree actions. Documentation including HASAP (Hazard and Critical Control Process) has been shared with IPC who are reviewing. Next meeting to be arranged in Jan 20
21	The service should keep all confidential patient records securely	21.1 The Trust have invested in lockable trollies in order to store patient records securely	30/09/2019	Completed
		21.2 Lockable cupboards are available for the safe storage of patient records	30/09/2019	Completed
		21.3 Annual Information Governance mandatory training for all staff	31/12/2019	13/01/2020 Further email confirmation of the below received 05/12/2019 Completed As part of the Data Security and Protection Tool kit, the trust met the 95% Mandatory Information Governance training requirement for 2019 and are working towards this requirement in time for the March 2020 submission
		21.4 Data Quality, Security and Protection team to complete spot audits of compliance on wards and departments (Oct 2019 and March 2020). Findings to be shared at Assurance, Risk and Compliance meeting)	01/04/2020	14/01/2020 Action amended to read Data Quality, Security and Protection team to complete ..... Date of audit completed changed to Oct 2019 Evidence provided for audit completed Oct 2019. Results discussed at Data Governance Group. 05/12/2019 On Track - Spot audits of 12 wards have been carried out so far this financial year. The findings are to be published at the next Data Governance Group Meeting which feeds into the Assurance Risk and Compliance group as appropriate
		21.5 All areas need to demonstrate compliance as part of the Ward Accreditation Assessment	01/04/2020	07/01/2020 Evidence of related documents used for Assessment and Accreditation provided 05/12/2019 On track, being included in ward Assessment & Accreditation process, not as yet reported owing to timings of Assessments
22	The service should introduce local procedures for invasive procedures in non-theatre settings	22.1 LocSSIP documents reviewed and updated	01/02/2020	05/12/2019 Date changed from 01/01/2020 to 01/02/2020 due to current progress with workstream
		22.2 Relaunch of LocSSIPs - training and comms	30/06/2020	31/12/2019 Email from Mi.Metcalfe. Work programme has increased. New Clinical Lead for this. Plan to revise the template for the Trust and do base line audit of documents in existence and staff awareness. Re-launch planned for June 2020. Completion date changed to 30/06/2020 (from 01/05/2020) 05/12/2019 Date changed from 01/04/2020 to 01/05/2020 due to progress with action 22.2
		22.3 Audit of compliance	31/10/2020	31/12/2019 See comment for 22.2. Completion date changed to 31/10/2020 (from 01/09/2020) 05/12/2019 Date changed from 01/08/2020 to 01/09/2020 due to progress with action 22.1
23	The service should manage medical outliers so they are seen in a timely manner	23.1 Inpatients cared for on outlying wards have a designated medical team to review patients. This is monitored and audited twice weekly by reviewing the medical plans in the patient's medical records	29/02/2020	06/01/2020 Email from D. Needham. Each outlying ward has nomi
		23.2 Ward staff escalate any issues regarding medical reviews at the x3 daily Site meetings.	31/10/2019	13/01/2020 Evidence of completion required Completed and ongoing review quarterly .
		23.3 Number of medical outliers to be communicated daily via Sitrep (Whats app)	31/10/2019	13/01/2020 Evidence of completion required Completed and ongoing review quarterly
		24.1 East Midlands Clinical Senate review completed August 2019- Terms of reference included private practise arrangements	31/08/2019	Completed

24	The service should consider how it manages private and NHS patients for cardiology procedures to ensure equity of access	24.2 Action plan developed linking multiple reports/ workstreams in Cardiology	16/02/2020	13/01/2020 Compliance Governance Manager involved in this workstream. Meeting planned for 07/01/2020 (cancel due to Trust pressures) rebooked for 16/01/2020. Progress has also been made with using this approach in Breast- method can now be transferred to Cardiology. Completion date changed from 31/12/2019 to 16/02/2020. 18/12/2019 Action plan in place to address concerns from Senate visit. Meeting held 17/12/2019 to identify relevant reports for Cardiology- further meeting planned 07/01/2020
25	The service should review clinical guidelines to check they are current	25.1 Netconsent to ensure guidelines reviewed in line with policy	01/04/2020	18/12/2019 Overdue Policies / guidelines are presented at every PDG to gain support from PDG members to address those that are overdue. Reminders are also sent via NetConsent system.
		25.2 Use of PDG report to show reduction in overdue guidelines	01/04/2020	18/12/2019 Monthly report provided to CQEG which demonstrates the reduction in the number of overdue documents. This will be a long term action.
26	The service should consider reviewing storage and security of substances subject to control of substance hazardous to health (COSHH)	26.1 All storage areas reviewed during core service inspection and security risks removed	30/06/2019	08/01/2020 Email from F. Barnes. DofN complete further spot check on door codes before Christmas (late evening and night shift). None found. Completed (spot audit to review ongoing compliance planned late November 2019)
27	The service should consider reviewing environment and facilities for inpatient outliers staying on the Heart Centre	27.1 Complete review of Heart Centre environment and facilities	31/03/2020	09/01/2020 Email from D.Needham. Undertaken as part of escalation areas review previously. Action completed. Evidence of completion required.
28	The service should consider addressing cultural issues across some medical wards	Covered within action 12	31/12/2019	Covered within action 12
29	The stroke services to consider improving compliance with completion of VTE assessments	29.1 To monitor stroke service VTE compliance via thrombosis committee and implement actions if compliance has not improved	31/03/2020	

No	Concern: Maternity Services Quality "Should" actions	Action	Deadline	Progress/ Comments
30	The service should ensure women can access the service when they need it and receive the right care promptly and that waiting times from referral to treatment and arrangements to admit, treat and discharge women are in line with national standards	30.1 Continue monitoring access to maternity services by 10+0 weeks and 12+6 weeks	31/10/2019	Completed
		30.2 Monitor access to scan appointment within 72 hours for women with reduced/static growth	30/11/2019	Completed Currently monitoring is in place, to be added to dashboard as from December
		30.3 Review midwifery ultrasonography scan clinics to ensure adequate capacity	31/12/2019	06/01/2020 Email from DofN to confirm completed. Evidence provided. 05/12/2019 MDU midwife currently completing QI project reviewing demand to baseline match capacity developing a better triage system
		30.4 MESC bid for ultrasound machine for Labour Ward to prevent overnight referrals to MDU / Midwife Scan clinics	31/03/2020	08/01/2020 Continue to await feedback on bid 05/12/2019 Bid has been submitted, feedback awaited
		30.5 Seek further funding / training for more midwives to be trained in 3rd Trimester scanning	31/03/2020	06/01/2020 No requirement at present to train additional midwives. As per 30.3 - 2 midwives will complete training in April 2020. Funding currently available via HEE if situation changes - next course September 2020. Action completed. 05/12/2019 Two midwives have to date commenced the training scanning programme. Funding currently available via HEE. Currently exploring how places can be accessed going forward as next programme is Sept 20
		30.6 Monitor Triage waiting times on Maternity Dashboard – monthly report to Directorate / Divisional Governance Group.	31/10/2019	Completed (see evidence for 30.2)
		30.7 Business case to reconfigure Labour Ward which will make a dedicated Triage area and provide easier access to obstetric care. It will also reduce attendances / waiting times on the Maternity Day Unit.	31/03/2020	05/12/2019 Business case submitted awaiting outcome
31	The service should formally monitor delayed discharges and how frequently induction of labours or elective caesarean sections are delayed (or cancelled) so the service can analyse and monitor trends to inform future plans	31.1 Develop audit proforma for delayed/cancelled IOL and elective caesarean sections	01/04/2020	06/01/2020 Audit proforma developed and circulated to all staff - December 2019 Every induction to be audited as well as cancelled electives, To continue and feedback through Divisional Governance meetings 05/12/2019
		31.2 Reasons for delayed discharges discussed and documented at the Maternity Safety Huddle	01/04/2020	05/12/2019 This is currently under development and on track to deliver by stated deadline
		31.3 Monthly report to Directorate Governance Group and Divisional Governance Group	01/04/2020	05/12/2019To commence Feb 2020
		31.4 Business case for pharmacy support to assist with delayed discharges for take home medications	01/04/2020	06/01/2020 Business case supported and recruitment underway 05/12/2019 Please refer to No.2.5 Business case has been completed and due for submission in Dec 19
32	The service should ensure managers are planning the service for the long term. For example, to enable planning and organisation of services so they met the needs of the local population within the local expected population growth	32.1 Develop Long Term Plan in conjunction with the Local Maternity System	01/04/2020	05/12/2019 Long Term Plan developed, awaiting feedback
		32. 2 Develop integrated Business Plan for Maternity Services	01/04/2020	06/01/2020 Email from DofN to confirm action completed. 05/12/2019 Plan has been developed and has been presented to the Divisional Team meeting
		32.3 Engagement in East Midlands Clinical Network as well as other Regional / National events and meetings	01/04/2020	05/12/2019 Trust team has attended and engaged in events, sharing findings and outcomes with local teams
		32.4 Monthly report to Divisional Management Board on forecasted activity based on bookings	01/04/2020	05/12/2019 Commenced
		32.5 Business case to be submitted to reconfigure Sturtridge Labour Ward – non clinical rooms changed into clinical rooms, dedicated Triage area consisting of 4 rooms which could be used as further birthing rooms at times of high activity	01/04/2020	05/12/2019 Business case submitted awaiting outcome
		32.6 Business case to be submitted for midwifery staffing to be submitted to ensure sufficient staff are available for the higher level of activity / acuity forecast.	01/04/2020	05/12/2019 Safe staffing review using Birthrate plus - Business case submitted awaiting outcome
		32.7 Ensure sufficient midwifery staff in post to meet the Continuity of Carer agenda as per Better Births	01/04/2020	05/12/2019 Safety champions meetings occur bi monthly, all discussion minuted

No	Concern: Use of resources 'Should' Actions	Action	Deadline	Progress/ Comments
33	The NHS trust should continue working to ensure optimisation of its substantive medical workforce and reduce reliance on agency staff.	33.1 Reinforce medical agency committee	31/12/2019	14/01/2020 Email from L.Ludgrove to advise meeting today did not go ahead due to lack of attendance. Reschedule to next week. Agenda and ToRR to be provided. 08/01/2020 Monitoring meetings refreshed. New fortnightly meetings to start from 14/01/2020. Attendance to include Execs to support strategic decision making on reducing medical agency spend.
		33.2 Review medical recruitment strategy	03/04/2020	
34	This NHS trust should continue working to achieve further efficiencies from collaborative working with partners in its clinical and support services	34.1 Continue to seek opportunities to collaborate on the delivery of clinical and support services with partners within Northants and Leicestershire	31/10/2019	14/01/2020 See supporting evidence for Action 11 Completed Ongoing through the life of the new strategy and Long Term Plan
		34.2 Continue to pursue opportunities with KGH through the Unified Acute Model workstream of the HCP	31/10/2019	14/01/2020 See supporting evidence for Action 11 Completed Ongoing through the life of the new strategy and Long Term Plan
35	The NHS trust should continue focusing on building internal capacity and capability to deliver trust wide workforce and service productivity improvements	35.1 Support the transformation of the quality function	31/03/2020	06/01/2020 Integration on plan for Quarter 1 20/21. HR and OD support in place
		35.2 Integrate productivity improvements in OD interventions	31/03/2020	06/01/2020 Oncology plan fully integrated
		35.3 Introduce talent management	31/03/2020	06/01/2020 Launch Jan 2020 with focus on directorate/divisional management

36	The NHS trust should ensure the improvements that they make in pathways results in achieving better performance against constitutional operational standards	36.1 Cancer recovery plan in place	31/03/2020	09/01/2020 Email from D.Needham. Recovery plan is in place. Completion date amended to 31/03/2020 (from 31/12/2019). Action not yet signed off Review date (31/12/2019)
		36.1 AE plan in place as per actions 18 and 23	31/03/2020	09/01/2020 Email from D.Needham. Recovery plan is in place. Completion date amended to 31/03/2020 (from 31/12/2019) Action not yet signed off.
37	The NHS trust should ensure existing cost improvement initiatives achieve the expected reduction of its expenditure run-rate and overall cost base.	37.1 Development of a recurrent savings plan	31/03/2020	Part of budget setting for 20/21
38	The NHS trust should develop a plan to return to finance balance on recurrent basis	38.1 Development of System 3 year financial strategy	31/03/2020	
		38.2 Development of a LTFM to see if this is possible	30/06/2020	
39	The NHS trust should progress implementation of its five-year estates maintenance plan.	39.1 Continued recruitment into newly created Estates maintenance posts. Some key roles already filled.	01/06/2020	06/01/2020 Further posts have been filled - during Dec 19/Jan 20 (fire officer and mechanical maintenance engineer). Senior maintenance manager & electrical maintenance manager interviews due end of Jan 2020. Deputy director role advert closes end of Jan 2020. Trade staff vacancy interviews due end of Jan 2020 04/12/2019 Recruitment continues to be difficult but remaining posts are being actively managed
		39.2 Implementation of new CMMS (computer maintenance management system)	01/08/2020	06/01/2020 Independent review starting 7 Jan 20 04/12/2019 An independent review of the existing system has been arranged. This will include recommendations and action plan to implement the system and utilise the reporting function. Date of review TBC
		39.3 Development of key maintenance compliance reports from CMMS to be presented at Facilities Governance commitee	01/08/2020	6 Jan 20 update Independent review starting 7 Jan 20 04/12/2019 An independent review of the existing system has been arranged. This will include recommendations and action plan to implement the system and utilise the reporting function. Date of review TBC
		39.4 Put in place a new Facilities Governance committee and structure	30/09/2019	Completed

NGH Improvement Plan
(Incorporating CQC Inspection Report outcomes published October 2019/ NHSE/I Undertakings actions)

12/01/2020
V4

21/01/2020

No	Concern: Medicine Division Requirement notice Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date Completed	Evidence of completion	Likelihood of completion	Progress/ Comments
1	The trust must ensure the proper and safe management of medicines. Staff must follow current national practice to check patients receive the correct medicines. The service must have systems to ensure staff are aware about safety alerts and incidents. Staff must store and manage all medicines and prescribing documents in line with the provider's policy. (Regulation 12 (2) (g): The proper and safe management of medicines).	Matthew Metcalfe	Maxine Foster/ Associate Directors of Nursing/ Midwifery	1.1 Implementation of Task and Finish Group chaired by Medical Director	01/08/2019	01/08/2019	1.1 Updated Medicines Optimisation workstream	5- Almost certain	Completed
		Matthew Metcalfe	Maxine Foster/ Associate Directors of Nursing/ Midwifery	1.2 Medicines Optimisation Work plan updated to include CQC recommendations (post inspection)	02/08/2019	31/10/2019	1.2 Papers of Task and Finish Group- updates provided to CQEG	5- Almost certain	21/12/2019 Update from Chief Pharmacist advise safety alerts already shared across the Trust but exploring the use of Netconsent for this as well. Help raise profile and enable audit of staff accessing documents. Also provide historic reminders of key messages Completed
		Matthew Metcalfe	Maxine Foster/ Associate Directors of Nursing/ Midwifery	1.3 Ongoing enhanced audits monitored through medicines governance structure	31/12/2019	03/12/2019	1.3 Audit results/ report and meeting minutes	5- Almost certain	20/12/2019 Update from Chief Pharmacist- Audit form approved August 2019 - changes made after 3 months of use and discussions at MOSG. Completed Audits remain ongoing
		Matthew Metcalfe	Maxine Foster/ Associate Directors of Nursing/ Midwifery	1.4 Safe & Secure Controlled Drug audit carried out on a monthly basis	31/12/2019	03/12/2019	1.4 Audit results/ report and meeting minutes	5- Almost certain	20/12/2019 Update from Chief Pharmacist- Audits are completed monthly for areas of poor compliance (normally done quarterly). CD Audit form has been updated. Plan is to combine CD and MM audits, completed jointly by Nursing and Pharmacy from April 2020 Completed Audits remain ongoing

No	Concern: Womens Childrens, Oncology & Haematology and Cancer Services Division Requirement notice Undertakings Section 4 (both action 2 and 3)	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
2	Staff must follow systems and processes when safely prescribing, administering, recording and storing medicines. The service must ensure medicines are in date and medicine waste and returns are stored securely. Infusions that require protection from light must be stored appropriately. Staff must ensure medicines stored in the medicine trolley are stored in their original boxes to ensure expiry dates and names of medicines are visible. Staff must ensure action is taken to address repeated high room temperature values, where the recommended storage conditions for medicines have been exceeded. (Regulation 12 (2) (g): The proper and safe management of medicines). The maternity service must ensure information and guidance about how to complain is widely available to everyone who uses the service. (Regulation 16: (2) Receiving and acting on complaints).	Matthew Metcalfe	Maxine Foster/ Associate Directors of Nursing/ Midwifery	2.1 Implementation of Task and Finish Group chaired by Medical Director	01/08/2019	01/08/2019	2.1 Updated Medicines Optimisation workstream	5- Almost certain	Completed
		Matthew Metcalfe	Maxine Foster/ Associate Directors of Nursing/ Midwifery	2.2 Medicines Optimisation Work plan updated to include CQC recommendations (post inspection)	31/10/2019	31/10/2019	2.2 Papers of Task and Finish Group- updates provided to CQEG	5- Almost certain	Completed
		Matthew Metcalfe	Maxine Foster/ Associate Directors of Nursing/ Midwifery	2.3 Ongoing enhanced audits monitored through medicines governance structure	31/12/2019	03/12/2019	2.3 Audit results/ report and meeting minutes	5- Almost certain	20/12/2019 Update from Chief Pharmacist- Audit form approved August 2019 - changes made after 3 months of use and discussions at MOSG. Completed Audits remain ongoing
		Matthew Metcalfe	Maxine Foster/ Associate Directors of Nursing/ Midwifery	2.4 Safe & Secure Controlled Drug audit carried out on a monthly basis	31/12/2019	03/12/2019	2.4 Audit results/ report and meeting minutes	5- Almost certain	20/12/2019 Update from Chief Pharmacist- Audits are completed monthly for areas of poor compliance (normally done quarterly). CD Audit form has been updated. Plan is to combine CD and MM audits, completed jointly by Nursing and Pharmacy from April 2020 Completed Audits remain ongoing
		Matthew Metcalfe	Maxine Foster/ Christine Ainsworth	2.5 Approve business case for maternity pharmacist	31/12/2019	20/12/2019	2.5 Submitted business case	4- Likely	20/12/2019 Chief Pharmacist email - confirm Exec team approve business case and recruitment will commence Jan 2020, with view to providing service from April 2020. 18/12/2019 Supporting evidence saved- business case and emails re taking case to Dec 2019 Finance Committee 05/12/2019 Action updated to Approve business case for maternity pharmacist (previous action Appoint maternity pharmacist)

3	The maternity service must ensure information and guidance about how to complain is widely available to everyone who uses the service. (Regulation 16: (2) Receiving and acting on complaints).	Sheran Oke	Christine Ainsworth/Lorraine Ryan	3.1 4Cs information leaflets and posters to be displayed in all areas	31/12/2019	31/12/2019	3.1 Three spot audits to confirm leaflets and posters on display	5- Almost certain	06/01/2020 Completed. Audits will remain ongoing. No concerns with compliance. Evidence also included of attendance at Meet the Matrons clinic - 3 months of data. Women are accessing this service to discuss their care 18/12/2019 S.Oke advise spot audits will be available for CQC engagement meeting Jan 2020 05/12/2019 Leaflets and posters on display. Meet the Matron posters are also on display in all areas of maternity. Flyers to support the availability of the above are also now included within the mothers discharge pack
		Sheran Oke	Christine Ainsworth/Lorraine Ryan	3.2 'Meet the Matron' posters displayed in all areas- so service users can raise concerns	31/12/2019	31/12/2019	3.2 Record of when Senior Midwifery Team walk arounds completed	5- Almost certain	06/01/2020 Audits provided which show posters on display and evidence of clinics taking place 05/12/2019 Meet the Matron posters are available in all areas of maternity
		Sheran Oke	Christine Ainsworth/Lorraine Ryan	3.3 Use of Big Word translation services	31/12/2019	31/12/2019	3.3 Briefing to staff to remind them to use Big Word	5- Almost certain	6/01/2020 Information available in ward areas. Currently included in maternity's 'Stork Talk' newsletter to remind staff. HOM continues to monitor use of interpreters 05/12/2019 Message relayed through safety huddles, information also available in ward areas. Currently included in maternity's 'Stork Talk' newsletter to remind staff. HOM is monitoring use of interpreters
		Sheran Oke	Christine Ainsworth/Lorraine Ryan	3.4 Develop poster which contains information in other languages for women and families in whom English is not their first language	31/12/2019	31/12/2019	3.4 Copy of poster	5- Almost certain	06/01/2020 Poster on display at hospital. Information booklets available in Romanian, Polish, Lithuanian and Bengali (most common languages). Provided to women at booking appointment by Community Midwife. Evidence of completion changed to Copy of poster 05/12/2019 Information also provided by midwives at booking appointment by community midwife. New poster under design to signpost, leaflets being translated into other languages (most commonly used)

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
4	a) The trust should review its board assurance framework to ensure it provides adequate assurance b) The trust should consider tabling the board assurance framework monthly and consider how current gaps in assurance are highlighted. This consideration should inform debate on the sufficiency of the actions taken to close these gaps, and the associated timelines	Claire Campbell	Claire Campbell	4.1 BAF to be reviewed by Board- benchmarked against CQC advised exemplar document and revised format to be agreed. This will assist in improving assurance, highlight gaps in assurance and timely actions as a result.	31/12/2019	26/09/2019	4.1 Board development programme	5- Almost certain	Completed
		Claire Campbell	Claire Campbell	4.2 Board to consider frequency of reporting of BAF.	26/09/2019	26/09/2019	4.2 Board development programme	4- Likely	20/12/2019 Evidence of completion changed to Board development programme (from Board paper). Frequency of reporting discussed as part of presentation for 4.1 Completed- Board agreed to leave as quarterly reporting in line with other Trusts.
		Claire Campbell	Claire Campbell	4.3 BAF content reviewed and links to strategy pledges included	28/11/2019	28/11/2019	4.3 Board paper	4- Likely	Completed
		Claire Campbell	Claire Campbell	4.4 BAF presented in revised format	28/11/2019	28/11/2019	4.4 Board paper	4- Likely	Completed

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
		Claire Campbell	Simon Hawes	5.1 Revised report format for ARC, Board and its committees	31/10/2019	31/10/2019	5.1 Reports to ARC, Board and its committees	4- Likely	Completed

5	The trust should review its risk register so staff can easily track changes to risk or mitigation and improve clarity on how the existing controls relate to the risk as stated in the risk register	Claire Campbell	Simon Hawes	5.2 Training refresh for all ARC members on risk, including mitigation, and controls	29/02/2020		5.2 Training presentation	4- Likely	13/01/2020 Link to training provided. 31/12/2019 Video presentation due at ARC Dec 2019 - lack of presentation software on the day. Expected Jan 2020 or Feb 2020. Date changed to end of Feb 2020 (from 12/12/2019). Link to online training to be provided. 18/12/2019 Email sent to action owner asking if amended date required as training not yet provided at ARC
		Claire Campbell	Simon Hawes	5.3 Deep dives into Divisional Risk Registers	31/10/2019	31/10/2019	5.3 ARC minutes	4- Likely	Completed
		Claire Campbell	Simon Hawes	5.4 Introduction of Datix Cloud to improve risk management pr	01/04/2020		5.4 Training presentation on new module	4- Likely	

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
6	The trust should consider how it could improve the effectiveness of its medicines audit processes	Matthew Metcalfe	Maxine Foster	6.1 Action is covered by Medicines Optimisation Action Plan (part of the Medicines Optimisation Strategy 2016-2020). The action plan is monitored through Medicines Optimisation Strategy Group which reports to CQEG	31/12/2019	03/12/2019	6.1 Action Plan & most recent report to CQEG	5- Almost certain	Completed
		Matthew Metcalfe	Maxine Foster	6.2 See also entry and actions for action 1	31/12/2019	03/12/2019	6.2 See above - action 1	5- Almost certain	Completed

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
7	The trust should consider its methods of assurance relating to the segregation of clinical waste	Sheran Oke	Wendy Foster/ Claire Topping	7.1 The Infection Prevention Team carried out a six week audit of all wards, departments, Outpatient areas and Theatres looking in every bin, the results of which were fed back to senior staff	30/09/2019	30/09/2019	7.1 Audits completed over 6 weeks	5- Almost certain	Completed Audit results available
		Sheran Oke	Wendy Foster/ Claire Topping	7.2 Focus on findings of these audit results with a view to improving compliance	31/12/2019	05/12/2019	7.2 Action plans from audits/ improvement work	5- Almost certain	Completed. Audit results shared with Ward Manager, Matron and Infection Prevention Steering group & IPC Operational group on a monthly basis
		Sheran Oke	Wendy Foster/ Claire Topping	7.3 Established a rolling audit programme to carry out a detailed Infection Prevention audit	31/12/2019	05/12/2019	7.3 Rolling audit programme	5- Almost certain	Completed. Audit rolling plan developed and implemented
		Sheran Oke	Wendy Foster/ Claire Topping	7.4 A screensaver has been produced and displayed across the Trust	30/09/2019	30/09/2019	7.4 Screensaver	5- Almost certain	Completed. Screensaver developed and launched across the Trust
		Sheran Oke	Wendy Foster/ Claire Topping	7.5 Key issues are raised at the Infection Prevention Operational Group, Link Nurse Meetings and Infection prevention Steering Group	31/12/2019	05/12/2019	7.5 Minutes from IPOG, Link nurse meetings and IPSG	5- Almost certain	Completed. Minutes available from Infection Prevention Steering Group & IPC Operational Group on a monthly basis
		Sheran Oke	Wendy Foster/ Claire Topping	7.6 Weekly walk arounds with Claire Topping, Sustainability Manager	31/12/2019	05/12/2019	7.6 Notes from weekly walk arounds and any actions to be taken	5- Almost certain	Completed. Weekly walk rounds completed by Sustainability Manager & IPC team. Findings shared with Ward Manager and Infection Prevention Steering Group & IPC Operational group on a monthly basis

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
		Claire Campbell	Claire Campbell	8.1 Agree Committee membership and Lead Executive	24/09/2019	24/09/2019	8.1 Named attendees and Lead Exec	5- Almost certain	Completed
		Claire Campbell	Claire Campbell	8.2 Meeting with Committee Chair and Lead Exec to discuss issues raised in CQC report and Committee effectiveness review	10/10/2019	10/10/2019	8.2 Meeting outcomes as agreed below	5- Almost certain	Completed
		Claire Campbell	Claire Campbell	8.3 Revise committee reporting matrix	15/10/2019	15/10/2019	8.3 Revised reporting matrix	5- Almost certain	Completed

8	a) The trust should review the effectiveness of its audit committee b) The trust should consider the observations in relation to the audit committee to ensure that only realistic and deliverable internal audit recommendations are agreed in future, and that internal audit recommendations, as far as is practicable, are implemented within agreed timescales.	Claire Campbell	Claire Campbell	8.4 Agreed to include committee self-assessment at the end of each meeting	18/12/2019	18/12/2019	8.4 Minutes of December 2019 meeting	4- Likely	20/12/2019 Require final version of minutes from meeting
		Claire Campbell	Claire Campbell	8.5 Agreed to include actions from clinical audit and compliance with Clinical audit bi- annually	15/10/2019	15/10/2019	8.5 Revised reporting matrix	4- Likely	Completed
		Claire Campbell	Claire Campbell	8.6 Ensure only realistic and deliverable IA recommendations are agreed in future and monitor delivery against agreed timescale	31/03/2020		8.6 TIAA Recommendation tracker	3 - Possible	
		Claire Campbell	Claire Campbell	8.7 Ensure Audit committee takes a zero tolerance to longstanding issues and seeks resolution	31/03/2020		8.7 Audit Committee minutes	3 - Possible	
		Claire Campbell	Claire Campbell	8.8 Closure of salary overpayment issue via audit committee (Cross reference with action no 14.)	18/12/2019	18/12/2019	8.8 Minutes of December 2019 meeting	3 - Possible	20/12/2019 Exec email- discussed at Audit Committee and Finance and Performance. Require final version of minutes from meeting

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
9	The trust should consider an external review of its governance structure and systems	Claire Campbell	Claire Campbell	9.1 Refresh well- led Board knowledge	30/01/2020		9.1 Presentation	4- Likely	20/12/2019 Exec email- actions relating to 9.1 and 9.2 postponed as Dec 2019 Board overran. To now take place in Jan 2020 (changed from 19/12/2019). All other actions to be moved back one month.
		Claire Campbell	Claire Campbell	9.2 Identify basic specification of need	30/01/2020		9.2 Specification document	4- Likely	20/12/2019 Exec email- actions relating to 9.1 and 9.2 postponed as Dec 2019 Board overran. To now take place in Jan 2020 (changed from 19/12/2019). All other actions to be moved back one month.
		Claire Campbell	Claire Campbell	9.3 Commission external review via competitive quotes	29/02/2020		9.3 Supplier engaged	4- Likely	20/12/2019 See action 9.1- date for completion changed to 29/02/2020 (from 31/01/2020)
		Claire Campbell	Claire Campbell	9.4 Undertake governance review	30/04/2020		9.4 Governance review completed	4- Likely	20/12/2020 See action 9.1- date for completion changed to 30/04/2020 (from 31/03/2020)
		Claire Campbell	Claire Campbell	9.5 Provide evidence to NHSE/I	30/04/2020		9.5 Outcome evidence	4- Likely	20/12/2020 See action 9.1- date for completion changed to 30/04/2020 (from 31/03/2020)

No	Concern: Trustwide Quality "Should" actions Undertakings Section 5	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
10	The trust should consider the structure, management and oversight arrangements for its quality improvement function	Matthew Metcalfe	Phil Bradley	10.1 Collective transformation resource reviewed	01/04/2020	03/12/2019	10.1 Completed review 10.1 New organogram for QI resource	4- Likely	18/12/2019 Transformation Resource paper to be presented at Finance and Performance meeting 19/12/2019 Completed
		Matthew Metcalfe	Phil Bradley	10.2 Recommendations of review to be presented to Trust Board	01/04/2020	19/12/2019	10.2 Completed review	4- Likely	13/01/2020 Discussed and recommendations approved at Dec 2019 Finance and Performance meeting (Committee of Board)

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
11	The trust should continue to engage all its partners in operational and strategic decision making	Chris Pallot	Chris Pallot	11.1 To publish the new strategy and retain evidence of consultation with partners.	01/11/2019	01/11/2019	11.1 New strategy 11.1 Responses from partners	5- Almost certain	13/01/2020 Strategy includes how partners were consulted and input used Completed
		Chris Pallot	Chris Pallot	11.2 Continue to engage partners in large scale strategic changes	01/11/2019	01/11/2019	11.2 Examples of work with partners	5- Almost certain	13/01/2020 Evidence of completion added in- Examples of work with partners Completed and remains ongoing
		Chris Pallot	Chris Pallot	11.3 Continue to engage partners in strategic operational issues and decision making	01/11/2019	01/11/2019	11.3 Examples of work with partners	5- Almost certain	13/01/2020 Evidence of completion added in- Examples of work with partners Completed and remains ongoing

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
12	The trust should take steps to assure itself that the interventions in progress to address bullying and poor behaviour are having an impact at pace	Mark Smith	Bronwen Curtis	12.1 Review impact of current programme	31/10/2019	31/10/2019	12.1 Summer of engagement feedback 12.1 Hotline cases	5 - Almost certain	Completed. Feedback responded to from staff in the People's Plan
		Mark Smith	Bronwen Curtis	12.2 Targeted interventions in 'hotspots'	31/12/2019	31/12/2019	12.2 Example of targeted intervention work in 'hotspot' area	4 - Likely	06/01/2020 Freedom to Speak Up/HR/OD linkage created. Targeted interventions plans are in place or being progressed for 'hotspot' areas (Oncology, Cardiology and Maternity) Evidence of completion changed from Staff Survey 2020 to Example of targeted intervention work in 'hotspot' area
		Mark Smith	Bronwen Curtis	12.3 Incorporate 'Civility Saves Lives' into Respect and Support programme	29/02/2020		12.3 Staff survey 2020	4 - Likely	06/01/2020 Piloting GMC professional standards in January 2020 to incorporate Civility Saves Lives for roll out from February 2020. Completion date changed from 31/12/2019 to 29/02/2020

No	Concern: Trustwide Quality "Should" actions Undertakings Section 2	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
13	The trust should consider commissioning a more detailed analysis of the drivers of its deficit to inform those elements that are within its gift to be able to address both directly and indirectly	Phil Bradley	Bola Agboola	13.1 Work with NHSE/I to agree process to complete this (using their expertise and knowledge)	01/04/2020		13.1 Copy of agreed process	3 - Possible	

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
14	The trust has plans to introduce an electronic solution between the human resources function and payroll to seek to address the issue of staff overpayments. The trust should consider requesting an internal audit function review of the planned electronic solution, in order that any control weaknesses can quickly be identified and addressed.	Mark Smith	Adam Cragg	14.1 Request an internal audit review and address weaknesses	01/04/2020		14.1 Internal audit report and action plan	4 - Likely	

No	Concern: Urgent and Emergency Services Quality "Should" actions	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
15	Undertakings Section 4 The service should continue to re-assess the layout of the paediatric emergency department to ensure it meets the Children and Young People in Emergency Care Settings 2012 standards	Deborah Needham	Tristan Dyer/ Head of Estates	15.1 Set up working group to establish with Paediatrics and Estates to review the current working practices that our Paediatric area has to meet these standards.	31/03/2020		15.1 Minutes from Working Group	5- Almost certain	09/01/2020 Update from D.Needham Plans are being drawn up to extend the Children's cubicle area by 2 cubicles. Work will progress in Q4. Change date of completion/ review to 31/03/2020 from 31/12/2019 04/12/2019 Update from S.Finn The group have identified a short term solution to reconfigure and expand the department.
		Deborah Needham	Tristan Dyer/ Head of Estates	15.2 Develop options paper looking at expanding or relocating the department. Seek potential options for capital funding.	31/03/2020		15.2 Options paper	5- Almost certain	09/01/2020 See update for action 15.1. Change of completion/ review date to March 2020 (from 31/12/2019) 04/12/2019 Update from S.Finn Initial long term, high level plans have been produced but funding has not been identified to allow the scheme to progress at this time. A short term solution has been identified and is currently being costed. A paper will be presented to ET for approval in Jan 20
		Deborah Needham	Tristan Dyer/ Head of Estates	15.3 Complete works to change the department	31/03/2020		15.3 Completion of works	2 - Unlikely	09/01/2020 Linked in with action 15.1, Change of completion/ review date to 31/03/2020 from 31/12/2019 Review date of 31/12/2019

		Deborah Needham	Tristan Dyer/ Owen Cooper	15.4 Review pathways for use of PAU and increased activity	31/12/2019	31/12/2019	15.4 Increase referrals to PAU from A&E	4- Likely	09/01/2020 Email from D.Needham. Pathways from A&E to PAU in place. Evidence of completion required
16	Undertakings Section 4 The service should make arrangements so patient group directions are regularly checked and updated on the trust internal website	Matthew Metcalfe	Maxine Foster	16.1 This action is included within the Medicines Optimisation action plan (part of the Medicines Optimisation Strategy 2016-2020).	31/12/2019	20/12/2019	16.1 Action plan 16.2 Most recent report taken to CQEG	4- Likely	20/12/2019 Further supporting evidence added in. Action complete 18/12/2019 Supporting evidence added re amendments to PGD process
		Matthew Metcalfe	Maxine Foster	16.2 Include process in revised Medicines Management Policy	31/03/2020		16.2 Revised Medicines Management Policy	5- Almost certain	18/12/2019 Supporting evidence added re amendments to PGD process 05/12/2019 Action changed to 'Include process in revised Medicines Management Policy'. Date revised to 31/03/2020 (from 31/12/2019) Previous action was 'See also entry for action 1
17	Undertakings Section 4 The service should take action so medical staff are compliant with the trust target for safeguarding children level three training	Mark Smith	Tristan Dyer	17.1 Mandatory training compliance of all staff groups is reviewed at every Urgent Care Governance meeting	29/02/2020		17.1 Governance report and governance meeting minutes	4 - Likely	13/01/2020 Compliance Governance Manager review plan. No current update available at time of writing report. Extend date of completion by 1 month to 29/02/2020 (from 31/12/2019_. Compliance team will raise at Urgent Care Governance meeting on 16/01/2020 05/12/2019 Exec owner changed from Matthew Metcalfe to Mark Smith
		Mark Smith	Tristan Dyer	17.2 Clinical Director for Urgent Care will remind all medical staff of their need to complete the training	29/02/2020		17.2 Email sent to medical staff	4 - Likely	13/01/2020 Compliance Governance Manager review plan. No current update available at time of writing report. Extend date of completion by 1 month to 29/02/2020 (from 31/12/2019). Compliance team will raise at Urgent Care Governance meeting on 16/01/2020 05/12/2019 Exec owner changed from Matthew Metcalfe to Mark Smith
		Mark Smith	Tristan Dyer	17.3 The Safeguarding Team provide regular updates of who needs to completed training and this will be monitored for medical staff who are not completing the training and are repeatedly on the list	01/04/2020		17.3 Training information over 3 months and identification of medical staff on the list more than once	4 - Likely	05/12/2019 Exec owner changed from Matthew Metcalfe to Mark Smith
18	Undertakings Section 1 The service should take action to improve the median time from arrival to treatment	Deborah Needham	Claire Dannatt	18.1 Implement winter actions	31/12/2019	31/12/2019		5- Almost certain	09/01/2020 Email from D. Needham. In progress- ET updated weekly. Evidence of completion required, Action completed
		Deborah Needham	Deborah Needham	18.2 Appoint PMO lead for Urgent Care and Winter	12/11/2019	12/11/2019	18.2 PMO lead identified and commenced	5- Almost certain	Completed
		Deborah Needham	Deborah Needham	18.3 Review Heat activity 18.3 Re-define programme 18.3 Re-launch	29/02/2020			5- Almost certain	09/01/2020 Email from D. Needham. Meeting planned for PMO, DofN, Med Dir and COO to relaunch. Winter actions taken priority. Completion date changed to 29/02/2020 (from 31/12/2019)
		Deborah Needham	Deborah Needham	18.4 Rapid improvement project with IDT	09/12/2019 (and ongoing)	09/12/2019	18.4 Time to PDNA reduced	4 - Likely	09/01/2020 Email from D.Needham. Action is completed. Evidence of completion required

No	Concern: Medical Care Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
19	The service should check medical staff are up to date with mandatory, safeguarding and mental capacity training	Mark Smith	Sally Shocklidge/ Becky Samson	19.1 Use of Netconsent software to check and force compliance	01/04/2020		19.1 Information provided on Netconsent	4 - Likely	
		Mark Smith	Sally Shocklidge/ Becky Samson	19.2 Provide additional sessions of 'bundles' of mandatory training for trust grade staff	01/04/2020		19.2 Dates training bundle provided and attendance records	4 - Likely	
		Stuart Finn	Wendy Foster/ Brian Willet	20.1 Induction training for new starters	30/04/2020	06//01/2020	20.1 Induction training	5- Almost certain	06/01/2020 Email from S.Finn. IPC mandatory training and bespoke food hygiene induction training is in place for all new starters and existing staff. Action completed. Evidence of completion required 04/12/2019 Catering and IPC meeting held 29 Nov 19 to discuss and agree actions. Documentation including HASAP (Hazard and Critical Control Process) has been shared with IPC who are reviewing. Next meeting to be arranged in Jan 20

20	The service should check catering staff are following infection prevention and control protocols	Stuart Finn	Wendy Foster/ Brian Willet	20.2 Infection Prevention representation at Catering Meetings regarding PPE	30/04/2020	06/01/2020	20.2 Meeting minutes	5- Almost certain	06/01/2020 Email from S.Finn PPE is issued to all food handlers/production staff. Ward hostesses uniforms are issued and protective aprons and gloves available. Staff are trained in food hygiene procedures which include PPE. Staff records evidence training and issue of PPE. Action completed. Evidence of completion required. 04/12/2019 As above
		Stuart Finn	Wendy Foster/ Brian Willet	20.3 Infection Prevention Mandatory training - 3 yearly for non-clinical staff	30/04/2020	06/01/2020	20.3 See 20.1	5- Almost certain	06/01/2020 Email from S.Finn. This has been reviewed by SF and BW and recorded as completed. Evidence of completion required. 04/12/2019 This is in place for all catering staff and monitored via mandatory training results and at appraisals. Every 'food handler' also complete 'Food Hygiene' course
		Stuart Finn	Wendy Foster/ Brian Willet	20.4 Environment audits and Catering audits are carried out when infection is identified	30/04/2020	06/01/2020	20.4 Audits/ report and meeting minutes where presented	5- Almost certain	06/01/2020 Email from S.Finn. Audits and inspections are in place and carried out regularly. Post infection audits and inspections are carried out by IPC and include ward kitchens. This has been reviewed by SF and BW and recorded as completed. Evidence of completion required 04/12/2019 IPC have been asked to comment
		Stuart Finn	Wendy Foster/ Brian Willet	20.5 Domestic monthly cleaning audits include host/hostess staff - hand hygiene etc observed	30/04/2020	06/01/2020	20.5 Audits/ report and meeting minutes where presented	5- Almost certain	06/01/2020 Email from S.Finn. This has been been reviewed by SF and BW and recorded as completed. Evidence of completion required. 04/12/2019 This is in place as part of the cleaning audits. The ward kitchens are scored separately as part of the audit and include the ward host/hostess
		Stuart Finn	Wendy Foster/ Brian Willet	20.6 A review of catering procedures and working practices will be carried out by Infection control and the Catering management team	30/04/2020		20.6 Completed review	5- Almost certain	06/01/2020 Email from S.Finn. BW arranging follow-up meeting with IPC. 04/12/2019 Catering and IPC meeting held 29 Nov 19 to discuss and agree actions. Documentation including HASAP (Hazard and Critical Control Process) has been shared with IPC who are reviewing. Next meeting to be arranged in Jan 20
21	The service should keep all confidential patient records securely	Sheran Oke	Fiona Barnes/ Sally Shocklidge	21.1 The Trust have invested in lockable trollies in order to store patient records securely	30/09/2019	30/09/2019	21.1 Confirmation email from Senior member of Nursing team	5- Almost certain	Completed
		Sheran Oke	Fiona Barnes/ Sally Shocklidge	21.2 Lockable cupboards are available for the safe storage of patient records	30/09/2019	30/09/2019	21.2 Confirmation email from Senior member of Nursing team	5- Almost certain	Completed
		Sheran Oke	Fiona Barnes/ Sally Shocklidge	21.3 Annual Information Governance mandatory training for all staff	31/12/2019	05/12/2019	21.3 Relevant section from Data Protection Toolkit submission	5- Almost certain	13/01/2020 Further email confirmation of the below received 05/12/2019 Completed As part of the Data Security and Protection Tool kit, the trust met the 95% Mandatory Information Governance training requirement for 2019 and are working towards this requirement in time for the March 2020 submission
		Sheran Oke	Fiona Barnes/ Sally Shocklidge	21.4 Data Quality, Security and Protection team to complete spot audits of compliance on wards and departments (Oct 2019 and March 2020). Findings to be shared at Assurance, Risk and Compliance meeting)	01/04/2020		21.4 Data Protection Audit results	5- Almost certain	14/01/2020 Action amended to read Data Quality, Security and Protection team to complete ..... Date of audit completed changed to Oct 2019 Evidence provided for audit completed Oct 2019. Results discussed at Data Governance Group. 05/12/2019 On Track - Spot audits of 12 wards have been carried out so far this financial year. The findings are to be published at the next Data Governance Group Meeting which feeds into the Assurance Risk and Compliance group as appropriate
		Sheran Oke	Fiona Barnes/ Sally Shocklidge	21.5 All areas need to demonstrate compliance as part of the Ward Accreditation Assessment	01/04/2020		21.5 Relevant Assessment and Accreditation document	5- Almost certain	07/01/2020 Evidence of related documents used for Assessment and Accreditation provided 05/12/2019 On track, being included in ward Assessment & Accreditation process, not as yet reported owing to timings of Assessments

22	The service should introduce local procedures for invasive procedures in non-theatre settings	Matthew Metcalfe	Michelle Metcalfe	22.1 LocSSIP documents reviewed and updated	01/02/2020		22.1 Completed documents	5- Almost certain	05/12/2019 Date changed from 01/01/2020 to 01/02/2020 due to current progress with workstream
		Matthew Metcalfe	Michelle Metcalfe	22.2 Relaunch of LocSSIPs - training and comms	30/06/2020		22.2 Education/ Comms provided and timelines	4 - Likely	31/12/2019 Email from Mi.Metcalfe. Work programme has increased. New Clinical Lead for this. Plan to revise the template for the Trust and do base line audit of documents in existence and staff awareness. Re-launch planned for June 2020. Completion date changed to 30/06/2020 (from 01/05/2020) 05/12/2019 Date changed from 01/04/2020 to 01/05/2020 due to progress with action 22.2
		Matthew Metcalfe	Michelle Metcalfe	22.3 Audit of compliance	31/10/2020		22.3 Audit forward programme and outcome of audit	4 - Likely	31/12/2019 See comment for 22.2. Completion date changed to 31/10/2020 (from 01/09/2020) 05/12/2019 Date changed from 01/08/2020 to 01/09/2020 due to progress with action 22.1
23	The service should manage medical outliers so they are seen in a timely manner	Deborah Needham	Divisional Director for Medicine	23.1 Inpatients cared for on outlying wards have a designated medical team to review patients. This is monitored and audited twice weekly by reviewing the medical plans in the patient's medical records	29/02/2020		23.1 Twice weekly audits	5- Almost certain	06/01/2020 Email from D. Needham. Each outlying ward has nominated consultant. Audits completed within the division by the management team. Date of completion amended to 29/02/2020 (from 31/12/2019). Not yet signed off by exec lead. 31/12/2019 Review date of 31/12/2019
		Deborah Needham	Divisional Director for Medicine	23.2 Ward staff escalate any issues regarding medical reviews at the x3 daily Site meetings.	31/10/2019	31/10/2019	23.2 Notes from x3 daily site meetings	5- Almost certain	13/01/2020 Evidence of completion required. Completed and ongoing review quarterly .
		Deborah Needham	Divisional Director for Medicine	23.3 Number of medical outliers to be communicated daily via Sitrep (Whats app)	31/10/2019	31/10/2019	23.3 Examples of Sitrep communications	5- Almost certain	13/01/2020 Evidence of completion required. Completed and ongoing review quarterly
24	The service should consider how it manages private and NHS patients for cardiology procedures to ensure equity of access	Matthew Metcalfe	Fay Gordon	24.1 East Midlands Clinical Senate review completed August 2019- Terms of reference included private practise arrangements	31/08/2019	31/08/2019	24.1 Completed report	5- Almost certain	Completed
		Matthew Metcalfe	Fay Gordon	24.2 Action plan developed linking multiple reports/ workstreams in Cardiology	16/02/2020		24.2 Action plan	5- Almost certain	13/01/2020 Compliance Governance Manager involved in this workstream. Meeting planned for 07/01/2020 (cancel due to Trust pressures) rebooked for 16/01/2020. Progress has also been made with using this approach in Breast- method can now be transferred to Cardiology. Completion date changed from 31/12/2019 to 16/02/2020. 18/12/2019 Action plan in place to address concerns from Senate visit. Meeting held 17/12/2019 to identify relevant reports for Cardiology- further meeting planned 07/01/2020
25	The service should review clinical guidelines to check they are current	Matthew Metcalfe	Caroline Corkerry	25.1 Netconsent to ensure guidelines reviewed in line with policy	01/04/2020		25.1 Sample of reminders sent out using Netconsent	3 - Possible	18/12/2019 Overdue Policies / guidelines are presented at every PDG to gain support from PDG members to address those that are overdue. Reminders are also sent via NetConsent system.
		Matthew Metcalfe	Caroline Corkerry	25.2 Use of PDG report to show reduction in overdue guidelines	01/04/2020		25.2 PDG reports	4- Likely	18/12/2019 Monthly report provided to CQEG which demonstrates the reduction in the number of overdue documents. This will be a long term action.
26	The service should consider reviewing storage and security of substances subject to control of substance hazardous to health (COSHH)	Sheran Oke	Fiona Barnes	26.1 All storage areas reviewed during core service inspection and security risks removed	30/06/2019	30/06/2019	26.1 Senior staff visited areas and ensured door codes removed 26.1 Spot audit of compliance to be completed by Health and Safety team late November 2019	5- Almost certain	08/01/2020 Email from F. Barnes. DofN complete further spot check on door codes before Christmas (late evening and night shift). None found. Completed (spot audit to review ongoing compliance planned late November 2019)
27	The service should consider reviewing environment and facilities for inpatient outliers staying on the Heart Centre	Debbie Needham	Fay Gordon	27.1 Complete review of Heart Centre environment and facilities	31/03/2020	09/01/2020	27.1 Completed review	4- Likely	09/01/2020 Email from D.Needham. Undertaken as part of escalation areas review previously. Action completed. Evidence of completion required.

28	The service should consider addressing cultural issues across some medical wards	Mark Smith	Bronwen Curtis	Covered within action 12	31/12/2019	31/12/2019	See action 12	See action 12	Covered within action 12
29	The stroke services to consider improving compliance with completion of VTE assessments	Matthew Metcalfe	Amanda Bisset	29.1 To monitor stroke service VTE compliance via thrombosis committee and implement actions if compliance has not improved	31/03/2020		29.1 Copy of meeting minutes and associated actions (if relevant)	4- Likely	

No	Concern: Maternity Services Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
30	The service should ensure women can access the service when they need it and receive the right care promptly and that waiting times from referral to treatment and arrangements to admit, treat and discharge women are in line with national standards	Sheran Oke	Christine Ainsworth/Sue Lloyd	30.1 Continue monitoring access to maternity services by 10+0 weeks and 12+6 weeks	31/10/2019	31/10/2019	30.1 Maternity Dashboard 30.1 Minutes of Directorate Governance Meetings	5- Almost certain	Completed
		Sheran Oke	Christine Ainsworth/Sue Lloyd	30.2 Monitor access to scan appointment within 72 hours for women with reduced/static growth	30/11/2019	30/11/2019	30.2 Datix Incidents / Trends 30.2 Minutes of Maternity Risk Group Meeting / Directorate Governance Group Meeting	5- Almost certain	Completed Currently monitoring is in place, to be added to dashboard as from December
		Sheran Oke	Christine Ainsworth/Sue Lloyd	30.3 Review midwifery ultrasonography scan clinics to ensure adequate capacity	31/12/2019	31/12/2019	30.3 Service review presented to the Directorate Management Board	5- Almost certain	06/01/2020 Email from DofN to confirm completed. Evidence provided. 05/12/2019 MDU midwife currently completing QI project reviewing demand to baseline match capacity developing a better triage system
		Sheran Oke	Christine Ainsworth/Sue Lloyd	30.4 MESC bid for ultrasound machine for Labour Ward to prevent overnight referrals to MDU / Midwife Scan clinics	31/03/2020		30.4 Completed bid.	4- Likely	08/01/2020 Continue to await feedback on bid 05/12/2019 Bid has been submitted, feedback awaited
		Sheran Oke	Christine Ainsworth/Sue Lloyd	30.5 Seek further funding / training for more midwives to be trained in 3rd Trimester scanning	31/03/2020	06/01/2020	30.5 Additional training places available for midwives	4- Likely	06/01/2020 No requirement at present to train additional midwives. As per 30.3 - 2 midwives will complete training in April 2020. Funding currently available via HEE if situation changes - next course September 2020. Action completed. 05/12/2019 Two midwives have to date commenced the training scanning programme. Funding currently available via HEE. Currently exploring how places can be accessed going forward as next programme is Sept 20
		Sheran Oke	Christine Ainsworth/Sue Lloyd	30.6 Monitor Triage waiting times on Maternity Dashboard – monthly report to Directorate / Divisional Governance Group.	31/10/2019	31/10/2019	30.6 Maternity Dashboard 30.6 Minutes of Directorate/Divisional Governance Group	5- Almost certain	Completed (see evidence for 30.2)
		Sheran Oke	Christine Ainsworth/Sue Lloyd	30.7 Business case to reconfigure Labour Ward which will make a dedicated Triage area and provide easier access to obstetric care. It will also reduce attendances / waiting times on the Maternity Day Unit.	31/03/2020		30.7 Completed business case	3 - Possible	05/12/2019 Business case submitted awaiting outcome
31	The service should formally monitor delayed discharges and how frequently induction of labours or elective caesarean sections are delayed (or cancelled) so the service can analyse and monitor trends to inform future plans	Sheran Oke	Christine Ainsworth	31.1 Develop audit proforma for delayed/cancelled IOL and elective caesarean sections	01/04/2020		31.1 Audit proforma	5- Almost certain	06/01/2020 Audit proforma developed and circulated to all staff - December 2019 Every induction to be audited as well as cancelled electives, To continue and feedback through Divisional Governance meetings 05/12/2019 Supported by snapshot audit, every induction audited as well as cancelled electives, To continue and feedback through Divisional Governance meetings
		Sheran Oke	Christine Ainsworth	31.2 Reasons for delayed discharges discussed and documented at the Maternity Safety Huddle	01/04/2020		31.2 Maternity Safety Huddle sheets	5- Almost certain	05/12/2019 This is currently under development and on track to deliver by stated deadline
		Sheran Oke	Christine Ainsworth	31.3 Monthly report to Directorate Governance Group and Divisional Governance Group	01/04/2020		31.3 Monthly reports / Minutes of Directorate / Divisional Governance Grou	5- Almost certain	05/12/2019 To commence Feb 2020
		Sheran Oke	Christine Ainsworth	31.4 Business case for pharmacy support to assist with delayed discharges for take home medications	01/04/2020		31.4 Approved business case	3 - Possible	06/01/2020 Business case supported and recruitment underway 05/12/2019 Please refer to No.2.5 Business case has been completed and due for submission in Dec 19

32	The service should ensure managers are planning the service for the long term. For example, to enable planning and organisation of services so they met the needs of the local population within the local expected population growth	Sheran Oke	Sue Lloyd	32.1 Develop Long Term Plan in conjunction with the Local Maternity System	01/04/2020		32.1 Long Term Plan submitted to NHSE/I	5- Almost certain	05/12/2019 Long Term Plan developed, awaiting feedback
		Sheran Oke	Sue Lloyd	32. 2 Develop integrated Business Plan for Maternity Services	01/04/2020	06/01/2020	32.2 Integrated Business Plan	5- Almost certain	06/01/2020 Email from DofN to confirm action completed. 05/12/2019 Plan has been developed and has been presented to the Divisional Team meeting
		Sheran Oke	Sue Lloyd	32.3 Engagement in East Midlands Clinical Network as well as other Regional / National events and meetings	01/04/2020		32.3 Minutes from Network meetings	5- Almost certain	05/12/2019 Trust team has attended and engaged in events, sharing findings and outcomes with local teams
		Sheran Oke	Sue Lloyd	32.4 Monthly report to Divisional Management Board on forecasted activity based on bookings	01/04/2020		32.4 Reports and minutes of Divisional Management Board meetings	5- Almost certain	05/12/2019 Commenced
		Sheran Oke	Sue Lloyd	32.5 Business case to be submitted to reconfigure Sturtridge Labour Ward – non clinical rooms changed into clinical rooms, dedicated Triage area consisting of 4 rooms which could be used as further birthing rooms at times of high activity	01/04/2020		32.5 Business Case submitted in line with trust process	3/4 (outcome dependent)	05/12/2019 Business case submitted awaiting outcome
		Sheran Oke	Sue Lloyd	32.6 Business case to be submitted for midwifery staffing to be submitted to ensure sufficient staff are available for the higher level of activity / acuity forecast.	01/04/2020		32.6 Business case submitted in line with trust process	5 (outcome dependent 4)	05/12/2019 Safe staffing review using Birthrate plus - Business case submitted awaiting outcome
		Sheran Oke	Sue Lloyd	32.7 Ensure sufficient midwifery staff in post to meet the Continuity of Carer agenda as per Better Births	01/04/2020		32.7 Minutes of the Maternity Safety Champions Meetings	5- Almost certain	05/12/2019 Safety champions meetings occur bi monthly, all discussion minuted

No	Concern: Use of resources 'Should' Actions	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
33	Undertakings Section 4 The NHS trust should continue working to ensure optimisation of its substantive medical workforce and reduce reliance on agency staff.	Mark Smith	Louise Ludgrove	33.1 Reinforce medical agency committee	31/12/2019	12/12/2019	33.1 Minutes of meeting	4 - Likely	14/01/2020 Email from L.Ludgrove to advise meeting today did not go ahead due to lack of attendance. Reschedule to next week. Agenda and TofR to be provided. 08/01/2020 Monitoring meetings refreshed. New fortnightly meetings to start from 14/01/2020. Attendance to include Execs to support strategic decision making on reducing medical agency spend.
		Mark Smith	Louise Ludgrove	33.2 Review medical recruitment strategy	03/04/2020		33.2 Strategy in place	4 - Likely	
34	Undertakings Section 2 This NHS trust should continue working to achieve further efficiencies from collaborative working with partners in its clinical and support services	Chris Pallot	Chris Pallot	34.1 Continue to seek opportunities to collaborate on the delivery of clinical and support services with partners within Northants and Leicestershire	31/10/2019	31/10/2019	34.1 Evidence of collaboration work with relevant groups- e.g emails/ proposals for joint working	4 - Likely	14/01/2020 See supporting evidence for Action 11 Completed Ongoing through the life of the new strategy and Long Term Plan
		Chris Pallot	Chris Pallot	34.2 Continue to pursue opportunities with KGH through the Unified Acute Model workstream of the HCP	31/10/2019	31/10/2019	34.2 Workstream model 34.2 Business cases e.g MSk and Stroke	4 - Likely	14/01/2020 See supporting evidence for Action 11 Completed Ongoing through the life of the new strategy and Long Term Plan
35	Undertakings Section 4 The NHS trust should continue focusing on building internal capacity and capability to deliver trust wide workforce and service productivity improvements	Mark Smith	Bronwen Curtis	35.1 Support the transformation of the quality function	31/03/2020			3 - Possible	06/01/2020 Integration on plan for Quarter 1 20/21. HR and OD support in place
		Mark Smith	Bronwen Curtis	35.2 Integrate productivity improvements in OD interventions	31/03/2020			3 - Possible	06/01/2020 Oncology plan fully integrated
		Mark Smith	Bronwen Curtis	35.3 Introduce talent management	31/03/2020			4 - Likely	06/01/2020 Launch Jan 2020 with focus on directorate/divisional management
	Undertakings Section 1	Debbie Needham	Owen Cooper	36.1 Cancer recovery plan in place	31/03/2020		36.1 Most recent version of recovery plan	3- Possible	09/01/2020 Email from D.Needham. Recovery plan is in place. Completion date amended to 31/03/2020 (from 31/12/2019). Action not yet signed off Review date (31/12/2019)

36	The NHS trust should ensure the improvements that they make in pathways results in achieving better performance against constitutional operational standards	Debbie Needham	Debbie Needham Sheran Oke Matthew Metcalfe	36.1 AE plan in place as per actions 18 and 23	31/03/2020		36.2 AE plan	3- Possible	09/01/2020 Email from D.Needham. Recovery plan is in place. Completion date amended to 31/03/2020 (from 31/12/2019) Action not yet signed off.
37	**Undertakings Section 2** The NHS trust should ensure existing cost improvement initiatives achieve the expected reduction of its expenditure run-rate and overall cost base.	Phil Bradley	Robert Mayes	37.1 Development of a recurrent savings plan	31/03/2020		37.1 Savings plan	5- Almost certain	Part of budget setting for 20/21
38	**Undertakings Section 2** The NHS trust should develop a plan to return to finance balance on recurrent basis	Phil Bradley	Phil Bradley	38.1 Development of System 3 year financial strategy	31/03/2020		38.1 STP financial strategy	3- Possible	
		Phil Bradley	Phil Bradley	38.2 Development of a LTFM to see if this is possible	30/06/2020		38.2 LTFM	3 - Possible	
39	**Undertakings Section 4** The NHS trust should progress implementation of its five-year estates maintenance plan.	Stuart Finn	James Stewart	39.1 Continued recruitment into newly created Estates maintenance posts. Some key roles already filled.	01/06/2020		39.1 Recruitment plan and updates as posts are filled	5- Almost certain	06/01/2020 Further posts have been filled - during Dec 19/Jan 20 (fire officer and mechanical maintenance engineer). Senior maintenance manager & electrical maintenance manager interviews due end of Jan 2020. Deputy director role advert closes end of Jan 2020. Trade staff vacancy interviews due end of Jan 2020 04/12/2019 Recruitment continues to be difficult but remaining posts are being actively managed
		Stuart Finn	James Stewart	.39.2 Implementation of new CMMS (computer maintenance management system)	01/08/2020		39.2 Confirmation email new CMMS in place and in use	5- Almost certain	06/01/2020 Independent review starting 7 Jan 20 04/12/2019 An independent review of the existing system has been arranged. This will include recommendations and action plan to implement the system and utilise the reporting function. Date of review TBC
		Stuart Finn	James Stewart	39.3 Development of key maintenance compliance reports from CMMS to be presented at Facilities Governance committee	01/08/2020		39.3 Maintenance compliance reports and copy of meeting minutes	5- Almost certain	6 Jan 20 update Independent review starting 7 Jan 20 04/12/2019 An independent review of the existing system has been arranged. This will include recommendations and action plan to implement the system and utilise the reporting function. Date of review TBC
		Stuart Finn	James Stewart	39.4 Put in place a new Facilities Governance committee and structure	30/09/2019	30/09/2019	39.4 Governance structure and terms of reference for meetings	5- Almost certain	06/01/2020 Review meeting arranged for 9 Jan 2020 This action can be closed as committee and structure is in place Evidence of completion required 04/12/2019 Facilities Governance structure is in place. Trust Governance team have been asked to review the structure to ensure it is sufficient. Date for review TBC Completed (since initial version of action plan- update provided as above)

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Report To	**TRUST BOARD**
Date of Meeting	**30th January 2019**

Title of the Report	**Freedom to Speak Up Strategy & Self-Assessment**
Agenda item	**13**
Presenter of Report	Claire Campbell Director of Corporate Development, Governance and Assurance/ Freedom to Speak up Guardian
Author(s) of Report	Claire Campbell Director of Corporate Development, Governance and Assurance/ Freedom to Speak up Guardian

This paper is for:

□√ Approve	□√ Receive
To formally receive and discuss a report and approve its recommendations OR a particular course of action	To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it

Executive summary: The FTSU Strategy & Self-Assessment have been completed with comments received from Board members and Values Ambassadors. The final documents are attached for Board ratification following Workforce Committee approval.

Related Strategic Pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Create a great place to work, learn and care to enable excellence through our people*
Risk and assurance	The report provides assurance that the Trust is meeting its legal duties with respect to Freedom to Speak Up.
Related Board Assurance Framework entries	1.1; 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) 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)
Financial Implications	None
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper – Requirements of NHSE/I

Actions required by the Board:

The Board is asked to:

- Ratify the FTSU strategy and Board Self-Assessment

FREEDOM TO SPEAK UP STRATEGY & SELF-ASSESSMENT

1. TRUST STRATEGY & SELF ASSESSMENT

In 2015 Sir Robert Francis produced his Freedom to Speak Up Review which, amongst a range of recommendations and principles, called for all NHS organisations to appoint a Freedom to Speak Up (FTSU) Guardian to improve the way each organisation deals with concerns raised by NHS staff as part of the process of fostering “a culture of safety and learning in which all staff feel safe to raise concerns”.

Guidance from NHS Improvement and the National Freedom to Speak Up Guardian has called for all NHS organisations to have a FTSU strategy. The FTSU Strategy supports the overall Trust Strategy and the Trusts vision and values.

In November 2019 the Trust Board reviewed the draft FTSU Strategy. Following the meeting Board members were asked to forward any additional comments. Values Ambassadors were also asked to comment and took the opportunity to do so. Comments received from Board members and Values Ambassadors have been incorporated into a final document which has been approved by the Workforce Committee at their January meeting attached (Appendix 1).

Following approval the document content will be converted into a more visually appealing document before publication and circulation to staff.

In July 2019 NHS England & NHS Improvement published “Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts” alongside supplementary guidance.

This revised guidance set out expectations of boards and board members in relation to Freedom to Speak Up and is accompanied by a number of supplementary resources, a streamlined toolkit and contains some practical ‘how to’ information.

The revised guidance was utilised to review progress the trust has made against the original document and refine Freedom to Speak Up development plans. NHS Improvement requires all Trusts in England to use the self-review tool to identify areas for development and improve the effectiveness of their leadership and governance arrangements in relation to Freedom to Speak Up.

The self-assessment review was undertaken in the November Board development session and the final document is attached (Appendix 2) following comments received. Actions required from the self-review tool have been amalgamated into the strategy. The document has been approved by the Workforce Committee at their January meeting.

2. RECOMMENDATIONS

The Board is asked to:

- Ratify the FTSU strategy and Board Self-Assessment

FREEDOM TO SPEAK UP STRATEGY

1. INTRODUCTION

"Our vision: To provide the best possible care"

The Trust's vision can only be delivered within a positive workplace culture where staff feel able to raise any concern that impacts on the delivery of safe, effective, high quality care.

The Trust has four Values:

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

Freedom to speak up supports the four Trust values, which describe how we should behave towards each other, care for our patients and work with our partners - putting patient safety above all else.

Within the overall Trust Strategy (2019) which was written in response to consultation with staff, Pledge 5 "Create a great place to work, learn and care to enable excellence through our people" tells us that we should further increase the number of Values Ambassadors within teams, and an action has been identified "to develop our Freedom to Speak up campaign to ensure staff can openly challenge practices they do not believe fit with our values."

The Trust had been on a trajectory of continuous improvement with regards to feedback received as part of the annual NHS National Staff Survey; however recent results have shown an overall decline in staff engagement and specifically faced challenges with regards to bullying and harassment. The recent National Trainee Survey for junior medical staff also highlighted a number of red flags and finally the CQC also noted staff experience as a cause for concern in the recent hospital inspection report published in October 2019.

The People Plan has been devised in support of NGH Strategy, in line with the NHS Interim People Plan and in response to the feedback from the recent staff survey results, feedback from regulators and information obtained from the Trust's large engagement plan over the summer months. Over 1000 people participated during the engagement events and provided important feedback and clear priorities for action. The plan identifies the strategic imperatives for the next year and outlines the areas of focus for People Plan Work Programme for 2019/20. The plan has been built to ensure delivery of objectives during 2019 and 2020. The plan is centred on the Trust vision to provide best possible CARE.

The CARE element of the plan centres around Culture, Achievement, Resourcing and Environment. The plan is designed to enable action as soon as possible, aimed to improve staff experience. Freedom to Speak Up is identified as one of the programmes of work within the Culture section of the plan. The Trusts Freedom to speak up strategy has been developed to support the Trusts vision, values and the actions identified within the Trust Strategy and the People Plan.

The Freedom to Speak Up Guardian Surveys run over the last couple of years have indicated that a positive speaking up culture is associated with higher performing organisations, as rated by the CQC. The annual NHS staff survey contains several questions that serve as helpful indicators of the

speaking up culture in trusts. Working with NHS England, the NGO have brought four questions together into a 'Freedom to Speak Up (FTSU) index'. In the 2018 Staff survey, staff responded as follows to these four key questions:

2018 Staff Survey Data	2017/18 NGH Trend	2018 Score	2017 Score	2016 Score	2015 Score	Acute Trusts 2018
17a) My organisation treats staff who are involved in an error, near miss or incident fairly	▲	59.2%	55.6%	57.8%	50.5%	58.5% (above)
17b) My organisation encourages us to report errors, near misses or incidents	▼	87.3%	88%	86.8%	86.3%	88.0% (below)
18a) If you were concerned about unsafe clinical practice I would know how to report it	▼	94.4%	95.8%	94.4%	92.8%	94.2% (above)
18b) I would feel secure in raising a concern about unsafe clinical practice	▼	69.2%	70.5%	69.5%	66.8%	69.2% (equal to)

The information shows a decline in the confidence of staff to raise concerns and that the organisation would address concerns once raised. Many Freedom to Speak Up cases raised in year include issues with staff behaviour which either result in staff feeling unable to raise concerns direct to line managers or colleagues, or where behaviours make staff feel unsafe to raise concerns.

The National Freedom to Speak Up Guardians Office (NGO) established a case review process to review the handling of concerns raised by workers in NHS trusts and/or the treatment of the person or people who spoke up, and to publish the findings where it appeared that there is evidence that the Trust has not responded appropriately to a concern raised by staff. Case reviews make recommendations on how to improve support for speaking up where there was evidence of failure to follow good practice. Case reviews do not investigate the merits of the original concern raised and focus on learning not blaming. Reviews are carried out collaboratively with the CQC and NHSI.

Of the recommendations from the seven Case Review reports published to date and the 102 recommendations made, these have been reviewed and a gap analysis undertaken which has identified the following recommendations relevant to NGH that require further work:

- Review of response times, investigation timing and feedback to be undertaken as some investigations have been lengthy
- Further discussion and review with HR regarding links with FTSU and relevant HR policies, support for staff and communication regarding access to FTSU Guardian as well as clear guidance for staff suffering detriment
- Additional evidence regarding measures to monitor processes and culture within the Trust including evidence of senior leaders input
- Completion of Trust strategy and self-assessment
- Training- inclusion in staff induction and review of training in line with revised training guidance (August 2019) to ensure embedding into Trust practice

The NGO also published National guidelines on Freedom to Speak Up training in the health sector in England in August 2019, the guidelines are for any individual or organisation commissioning or delivering Freedom to Speak Up training, and are applicable to providers of healthcare, regulators,

and other bodies with a role in healthcare. They cover core training for all workers including line and middle manager training and senior leaders' training.

The guidelines are designed to improve the quality, clarity and consistency of training and include suggestions of the methodology that organisations could employ when designing training. Organisations are encouraged to bring existing training in line with the guidelines at the earliest opportunity.

Other key publications include "Guidance for boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts". This revised guidance sets out expectations of boards and board members in relation to Freedom to Speak Up to use the self-review tool to identify areas for development and improve the effectiveness of their leadership and governance arrangements in relation to Freedom to Speak Up.

Key Objectives: 2020

The following key Objectives have been identified from the above information:

a) Raise the profile and visual leadership of FTSU with the support of Values Ambassadors
b) Ensure FTSU training is available for all staff - and included in Trust Induction
c) Ensure that learning from patient and staff safety concerns is shared as appropriate
d) Ensure timely investigations, and clear and concise feedback is delivered to all who raise concerns
e) Improve triangulation of information with HR/ governance to identify areas of concern proactively, and review policies and guidance for staff
f) Develop a business as usual culture of speaking up

The above objectives have been formalised into an action plan with timeframes for delivery (Appendix A).

Objective	Actions	Timeframe	How we will measure progress/ evidence of completion	Person responsible
1. Raise the profile and visual leadership of FTSU with the support of Values Ambassadors	Increase numbers of Values Ambassadors recruited and trained (10 per year)	Dec 2020	10 additional Ambassadors trained in year	FTSU Guardian
	Include staff from a variety of clinical/ non clinical backgrounds, BAME and other specific staff groups to reflect staff population	Dec 2020	Ambassadors reflect staff population. Increase in staff speaking up from BAME and other staff groups.	FTSU Guardian
	Introduce frequent informal meetings with Ambassadors to provide support/ information	Dec 2020	Freedom to Speak up forum established and attended	FTSU Guardian
	Provide access to FTSU Guardian for support/ debrief for Ambassadors following any contacts	Dec 2020	Support provided as required	FTSU Guardian
	Work with communication team to continue to raise the profile of FTSU and new Ambassadors as they are appointed	Dec 2020	Ongoing communication strategy developed and implemented Delivery of FTSU month (October 20)	Comms team/ FTSU Guardian
2. Ensure FTSU training is available for all staff - and included in Trust Induction	Trust Induction: Core training will be developed for all staff regardless of their terms of contract.	June 2020	Trust Induction includes specific FTSU session	HR/ FTSU Guardian
	Provide ad hoc FTSU sessions to departments requesting this or areas of concern	June 2020	Continue to provide ad hoc training	FTSU Guardian
	Review opportunities to provide elearning for Line and Middle Managers	June 2020	Awaiting NGO guidance on elearning packages	FTSU Guardian/ NGO
	Revise training programme content and worker groups in line with NGO guidance	July 2020	Training programmes reflect NGO guidance	FTSU Guardian/ NGO
3. Ensure that learning from patient and staff safety concerns is shared as appropriate	Present learning to Dare to Share/ safety huddles or other Trust events	Aug 2020	Improvement in staff survey engagement scores (17a &b)	FTSU Guardian/ Medical Director
	Provide anonymised information on Intranet regarding learning from cases	Aug 2020	Data available on the intranet and utilised in training	FTSU Guardian/ Comms
4. Ensure timely investigations, and clear and concise feedback is delivered to all who raise	Set clear Terms of reference for investigations, together with agreed timelines	April 2020	Terms of Reference and timescales for investigations agreed and shared with the member of staff concerned.	FTSU Guardian
	Improve tracking of investigations and	April 2020	Improve how the FTSU Guardian	FTSU Guardian

concerns	agree feedback to Guardian		tracks progress on investigations. Evidenced in FTSU reports	
	Develop evaluation feedback for staff raising concerns	April 2020	Feedback from staff on satisfaction with outcomes and investigations	FTSU Guardian
5. Improve triangulation of information with HR/ governance to identify areas of concern proactively, and review policies and guidance for staff	Formalise triangulation meetings with HR to identify trends, hot spots and any early warning signs	April 2020	Work in close partnership, meeting regularly with HR and OD colleagues	FTSU Guardian/ HRD
	Improve positive responses to staff survey questions regarding raising concerns	Jan 2021	Improvements in staff survey results for Q17a & b and Q18a & b i.e. FTSU Index questions	FTSU Guardian/ Governance Team/ HR & OD team
6. Develop a business as usual culture of speaking up	Board to review and approve FTSU strategy	Jan 2020	Strategy approved by Trust Board	Trust Board
	Board to approve completed self-review tool	Jan 2020/ July 2020	Self-review tool approved – 6 monthly review	Trust Board
	Celebrate examples of improvements made as a result of staff speaking up	Dec 2020	Explore opportunities to identify staff awards category for learning from speaking up/ incidents	FTSU Guardian/ CEO
	Review any cases where staff suffered detriment as a result of speaking up	Dec 2020	HR support and address issues found with appropriate response	HRD

Freedom to Speak Up review tool for NHS trusts and foundation trusts

July 2019

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
1. Behave in a way that encourages workers to speak up					
Individual executive and non-executive directors can evidence that they behave in a way that encourages workers to speak up. Evidence should demonstrate that they: • understand the impact their behaviour can have on a trust's culture • know what behaviours encourage and inhibit workers from speaking up • test their beliefs about their behaviours using a wide range of feedback • reflect on the feedback and make changes as necessary • constructively and compassionately challenge each other when appropriate behaviour is not displayed	Section 1 p5	**Partially Jan 20**	July 20	• Freedom to speak up included in programmes of work (culture) in the NGH People Plan 2019-20 • Appointment of Trust Diversity & Inclusion Manager • Establishment of BAME network • Executive & NEDs appraisal processes in place • Board visibility via Board visits and link wards for Execs • Board development sessions • Review of Respect & Support campaign impact • Internal annual reviews of committee effectiveness • Well- Led Board self-assessment (Feb 2019) • Board development review of committee content and reports • Positive National staff survey results for 2018 ○ organisation treats staff who are involved in an error, near miss or incident fairly Increased from 55.6% to 59.2% (above average) (17a) • Relaunch of FTSU at start of the calendar year with comms support has seen increase in number of concerns raised	• National staff survey results for 2018- improvements required in the following measures: ○ Have you personally experienced harassment, bullying or abuse at work from managers? Marginal decrease from 17.9% to 17.8% (above average) ○ Have you personally experienced harassment, bullying or abuse at work from other colleagues? Increased from 20.1% to 24.5% (above average) ○ My organisation encourages us to report errors, near misses or incidents. Decreased from 88% to 87.3% (below average) (17b) ○ If you were concerned about unsafe clinical practice, you would know how to report it. Decreased from 95.8 % to 94.4% (above average) (18a) ○ Do you feel secure raising concerns about unsafe clinical practice reduced from 70.5% to 69.2% (average) (18b) • Introduction of further inclusion networks • Ongoing comms involvement/ support

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
2. Demonstrate commitment to FTSU					
The board can evidence their commitment to creating an open and honest culture by demonstrating: • there are a named executive and non-executive leads responsible for speaking up • speaking up and other cultural issues are included in the board development programme • they welcome workers to speak about their experiences in person at board meetings • the trust has a sustained and ongoing focus on the reduction of bullying, harassment and incivility • there is a plan to monitor possible detriment to those who have spoken up and a robust process to review claims of detriment if they are made • the trust continually invests in leadership development • the trust regularly evaluates how effective its FTSU Guardian and champion model is • the trust invests in a sustained, creative and engaging communication strategy to tell positive stories about speaking up.	p6 Section 1 Section 2 Section 3	**Partially Jan 20**	July 20	• Named NED and Exec Lead • Leads named in policy • FTSU and People Plan Board development sessions • Respect & support campaign & training • Leadership programmes in place • Regular meetings between FTSU Guardian and HR • Values Ambassadors have provided personal stories on staff intranet	• Review impact of respect & support training/ processes • Use of staff stories at Trust Board to learn from FTSU cases • Evaluation of the FTSU Guardian and Values Ambassadors role • External review (TBC) of FTSU Guardian role, including numbers of Ambassadors, deputy and feasibility of joint Guardian/ Exec Lead role to continue • Review the monitoring and tackling cases of detriment robustly • Use of internal case studies

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
3. Have a strategy to improve your FTSU culture					
The board can evidence it has a comprehensive and up-to-date strategy to improve its FTSU culture. Evidence should demonstrate: • as a minimum – the draft strategy was shared with key stakeholders • the strategy has been discussed and agreed by the board • the strategy is linked to or embedded within other relevant strategies • the board is regularly updated by the executive lead on the progress against the strategy as a whole • the executive lead oversees the regular evaluation of what the strategy has achieved using a range of qualitative and quantitative measures.	P7 Section 4	**Partially Jan 20**	Mar 20	• Draft Strategy developed	• Strategy requires Board input, discussion and agreement • Strategy to be reviewed and shared by Values Ambassadors • Strategy to be presented to Public Board meeting for ratification • Strategy updates to be included in quarterly reports to Workforce Committee and Bi-annually to Trust Board
4. Support your FTSU Guardian					
The executive team can evidence they actively support their FTSU Guardian. Evidence should demonstrate: • they have carefully evaluated whether their Guardian/champions have enough ringfenced time to carry out all aspects of their role effectively • the Guardian has been given time and resource to complete training and development	p7 Section 1 Section 2 Section 5	**Partially Jan 20**	July 20	• Regular meetings between FTSU Guardian with CEO/ CPO & HR Director/ Trust Chairman • Guardian has completed NGO training programme • Guardian supported to attend East Midlands Regional meetings • Guardian supported to attend NGO events/ conferences • Examples of where Guardian has	• Diary regular meetings with Lead NED • Review of FTSU Guardian role/ time allocation • Enable access to employee relations data for triangulation purposes

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
• there is support available to enable the Guardian to reflect on the emotional aspects of their role • there are regular meetings between the Guardian and key executives as well as the non-executive lead. • individual executives have enabled the Guardian to escalate patient safety matters and to ensure that speaking up cases are progressed in a timely manner • they have enabled the Guardian to have access to anonymised patient safety and employee relations data for triangulation purposes • the Guardian is enabled to develop external relationships and attend National Guardian related events				escalated issues to CEO/ DON/ HRD and MD • Guardian has access to anonymised patient safety information	
5. Be assured your FTSU culture is healthy and effective					
Evidence that you have a speaking up policy that reflects the minimum standards set out by NHS Improvement. Evidence should demonstrate: • that the policy is up to date and has been reviewed at least every two years • reviews have been informed by feedback from workers who have spoken up, audits, quality assurance findings and gap analysis against recommendations from the National Guardian.	P8 Section 8 National policy	**Fully Jan 20**	July 20	• Policy updated in July 2019 • Policy reviewed and co-produced with HR • No gaps found in relation to review of recommendations arising from NGO case studies	• Future reviews to include Values Ambassadors

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
Evidence that you receive assurance to demonstrate that the speaking up culture is healthy and effective. Evidence should demonstrate: • you receive a variety of assurance • assurance in relation to FTSU is appropriately triangulated with assurance in relation to patient experience/safety and worker experience. • you map and assess your assurance to ensure there are no gaps and you flex the amount of assurance you require to suit your current circumstances • you have gathered further assurance during times of change or when there has been a negative outcome of an investigation or inspection • you evaluate gaps in assurance and manage any risks identified, adding them to the trust's risk register where appropriate.	P8 Section 6	**Partially Jan 20**	July 20	• Quarterly reports presented by Guardian to Workforce Committee • Bi- annual reports presented by Guardian to public Trust Board • Regular meetings with HR Director • Gap analysis undertaken of NGO case studies • Guardians data log of concerns raised	• Enable access to employee relations data for triangulation purposes • Triangulation via patient experience/ themes and source (where known) of FTSU cases
The board can evidence the Guardian attends board meetings, at least every six months, and presents a comprehensive report.	P8 Section 7	**Fully Jan 20**	July 20	• Public Trust Board paper written and presented by Guardian (April & September)	
The board can evidence the FTSU Guardian role has been implemented using a fair recruitment process in accordance with the example job description (JD) and other guidance published by the National Guardian.	Section 1 NGO JD	**Fully Jan 20**	July 20	• Job role included in that of the Director of Corporate Development, Governance & Assurance through open competition • Role of FTSU Guardian follows the National JD	• Review of FTSU Guardian role

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
The board can evidence they receive gap analysis in relation to guidance and reports from the National Guardian.	Section 7	**Fully Jan 20**	July 20	• Included in reports to Workforce committee • Gaps identified added to Strategy action plan	
6. Be open and transparent					
The trust can evidence how it has been open and transparent in relation to concerns raised by its workers. Evidence should demonstrate: • discussion with relevant oversight organisation • discussion within relevant peer networks • content in the trust's annual report • content on the trust's website • discussion at the public board • welcoming engagement with the National Guardian and her staff	P9	**Partially Jan 20**	July 20	• Guardian linked with BMA training via NGO • Open and transparent discussions (without breaching confidentiality) when concerns raised e.g. CQC • Guardian interview with CQC for Well- Led Assessment • Guardian regularly presents "meet the Guardians" with GOSW to Doctors in training • Guardian has regular contact with NGO office • FTSU role referred to in Annual Quality Account with speaking up included as a Quality Priority in terms of introduction of the Values Ambassador role in year • Guardian attends Regional & National events • FTSU Bi-annual reports to Trust Board • Reports to workforce and Board include NGO publication information • Variety of ways available to report concerns including anonymously	• Discussion with MD/GOSW and Dir of Medical Ed to further clarify processes raised by Doctors in training • Information available on Trust website to be reviewed • Freedom to Speak up/ staff engagement conference 2020- invite National Guardian • Increase links with Staff side • Ensure joint Annual report and Quality Account in 2020 includes FTSU high level data

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
7. Individual responsibilities					
The chair, chief executive, executive lead for FTSU, Non-executive lead for FTSU, HR/OD director, medical director and director of nursing should evidence that they have considered how they meet the various responsibilities associated with their role as part of their appraisal.	Section 1	**Not- Jan 20**	July 20	• Roles and responsibility documents shared with Exec Team and Lead NED	• Evidence to be collated from 2020 appraisals

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

A G E N D A

NHS
Northampton General Hospital
NHS Trust

PUBLIC TRUST BOARD

Thursday 30 January 2020
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 28 November 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	**PERFORMANCE**				
	9.	Integrated Performance Report	Assurance	Dr S Swart	**D.**
	10.	End of Year Financial Position	Assurance	Mr P Bradley	**E.**
	11.	Agency Staff Governance	Assurance	Mr M Smith	**F.**
	12.	Board Assurance Framework (Q3)	Assurance	Ms C Campbell	**G.**
	13.	EU Exit Operational Readiness	Assurance	Mrs D Needham	**H.**
	14.	Standing Orders/ SFI & Scheme of delegation	Approval	Ms C Campbell Mr P Bradley	**I.**
	15.	Maternity Review	Assurance	Ms S Oke	**J.**
11:10	**STRATEGY**				
	16.	NGH Improvement Plan	Assurance	Ms C Campbell	**K.**
	17.	Freedom To Speak Up Strategy & Self-Assessment	Assurance	Ms C Campbell	**L.**
12:00		**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 26 March 2020 in the Board Room at Northampton General Hospital.

Time	Agenda Item	Action	Presented by	Enclosure
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).				