Public Trust Board

Thursday 28 November 2019

09:30

Board Room
Northampton General Hospital

AGENDA Northampton General Hospital NHS Trust

PUBLIC TRUST BOARD

Thursday 28 November 2019
09:30 in the Board Room at Northampton General Hospital

Time		Agenda Item	Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr A Burns	**Verbal**
	2.	Declarations of Interest	Note	Mr A Burns	**Verbal**
	3.	Minutes of meeting 26 September 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.	Generator Outage Update	Assurance	Mr S Finn	**E.**
	11.	Flu vaccination for Healthcare Workers	Assurance	Mr M Smith Ms S Oke	**F.**
	12.	Board Assurance Framework (Q2)	Assurance	Ms C Campbell	**G.**
	13.	Revalidation Report – Compliance Statement	Assurance	Mr M Metcalfe	**H.**
11:10	**STRATEGY**				
	14.	CQC Report & Action Plan	Assurance	Ms C Campbell	**I.**
	15.	People Strategy Update Report	Assurance	Mr M Smith	**J.**
	16.	Communications Strategy Update	Assurance	Dr S Swart	**K.**
11:40	**CULTURE**				
	17.	FTSU Bi-Annual Report	Assurance	Ms C Campbell	**L.**
	18.	NEDs Roles	Assurance	Ms C Campbell	**M.**
11:50	**19.**	**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 30 January 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).

Minutes of the Public Trust Board

Thursday 26 September 2019 at 09:30 in the Board Room at Northampton General Hospital

Present

	Mr A Burns	Chairman
	Dr S Swart	Chief Executive Officer
	Mrs D Needham	Chief Operating Officer & Deputy Chief Executive
	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
	Prof T Robinson	Non-Executive Director
	Ms J Houghton	Non-Executive Director
	Mr J Archard-Jones	Non-Executive 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
	Dr M Minassian	Deputy Medical Director and Divisional Director - CSS
	Miss K Palmer	Executive Board Secretary
	Ms K Mcgrath	(Agenda Item – Patient Story only)

Apologies

	Mr D Noble	Non-Executive Director
	Mr M Metcalfe	Medical Director

TB 19/20 050 Introductions and Apologies

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

Mr Burns introduced Mr M Smith and Prof Robinson. This was their first Trust Board at NGH.

Apologies for absence were recorded from those listed above.

TB 19/20 051 Declarations of Interest

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

TB 19/20 052 Minutes of meeting 26 July 2019

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

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

TB 19/20 053 Matters Arising and Action Log 26 July 2019

Action Log Item 103

Ms Oke confirmed that this would be presented to the next **Public Trust Board** with the Director of Nursing Report**.**

DRAFT

Action Log Item 109 – closed
This item was now closed as it had been presented to the previous Board.

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

TB 19/20 054 Patient Story

Ms Oke introduced Ms K XX who delivered her patient story to the Board.

Ms ? advised that in May 2019 she came to A&E as she believed she had tonsillitis. She could not swallow or talk. From A&E she was triaged to Fitstop. She noted that the surgical SR was calm when treating her. She was then discharged home however the next day her throat had again swollen therefore she attended A&E.

Ms ? commented that she got the treatment she required and experienced good communication. It was noted that everything was explained to her and she was started on a course of medication. She was woken at 3am to be informed that she did not have tonsillitis and was offered a drink of water. At 8am the consultant visited her and she was given a clear treatment plan.

She noted that all other patients within her area were given their medication on time.

Ms ? remarked that she had now changed her practice as a nurse following her experience. She appreciated how terrified patients must sometimes feel.

Ms Houghton thanked Ms ? for sharing her story. She believed it would be good to share her story with staff.

Mr Moore stated that it was good to hear examples of positive communication and best possible care.

The Board **NOTED** the Patient Story.

TB 19/20 055 Chairman's Report

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

Mr Burns informed the Board that the CQC response letter would be discussed in the Private Board.

Mr Burns advised that Mr Paul White had been formally appointed as the independent Chair (of HCP) for a period of three months. He noted that this was not long to deliver what was required however hoped it would go well.

Mr Burns reported that a NED had been appointed through the NEXT scheme. His name was Mr Tremaine Richard-Noel. He would be starting in October and Mr Moore would be his mentor.

Mr Burns commented that interview dates for further new NEDs had been scheduled for the end of November. These were for a new Non-Executive Director and a new Associate Non-Executive Director.

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

TB 19/20 056 Chief Executive's Report

Dr Swart presented the Chief Executive's Report.

Dr Swart advised that NHS Providers had launched a national campaign calling on the government to help rebuild the NHS. The local MP's were keen to support the

Trust. She commented that she had informed the MP's that Paediatric ED was an investment priority for NGH. Dr Swart also referred to need to improve the Estate. There would be a coordinated estate plan in the HCP going forward. It was important to get the MP's involved.

Dr Swart shared the positive news that planning permission for the Maggie's Centre had been approved.

Dr Swart noted the importance of engaging with staff. There had been common messages come through from the medical staff regarding inclusion and this would be picked up.

Dr Swart stated that there was an increased focus on system finances and this needed to be monitored.

Dr Swart informed the Board that the Trust had not yet received the final CQC report and once the Trust had, it would respond appropriately.

Mr Archard-Jones referred to the mention of new nurses from India in the CEO report. He queried the importance of this. Dr Swart explained that this cohort of nurses were very pleased to be here and were very positive when she had spoken to them. Dr Swart stressed the need to make them feel welcome.

Mr Archard-Jones asked when the full CQC report would be issued. Dr Swart clarified that currently it was embargoed and once this has been lifted the full report would be issued. The report is currently in the factual accuracy checking stage

Mr Moore noted that it was positive to see the CEO's Blog mention capital investment. It was good to socialise the issue. He remarked that Northamptonshire did not get capital investment despite it being one the biggest growing counties in regards to population growth.

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

TB 19/20 057 **Medical Director's Report**

Dr Minassian presented the Medical Director's Report.

Dr Minassian advised that the rolling 12 month HSMR to January 2019 for the Trust remained within the "expected" range.

Dr Minassian anticipated that the EPMA forcing function for VTE assessment would be live in November 2019.

Dr Minassian delivered an update on the East Midlands Clinical Senate Reviews. The reports had been shared with the services with action plans based on the recommendations.

Dr Minassian reported that a GMC survey results report had gone to the Workforce Committee. He asked for the Board presentation to be deferred to November to ensure action plans are available to be shared. The Board agreed.

Mr Burns asked if the Clinical Senate Review had been shared at the Quality Governance Committee (QGC). He was informed that it had been presented to the August QGC.

Ms Houghton shared with the Board an update on her recent visit to Addenbrookes Hospital. She had attended with the Medical Director and the Head of Governance to

talk to Addenbrookes Associate Medical Director and Medical Director. They had attended their Mortality Committee to gain learning points on how to strengthen NGH's Mortality Committee.

Ms Gill queried the number of Serious Incidents as she noted that there had been 16 year to date. Dr Minassian explained that last year there had been 34 therefore statistically the figure did not appear out of character.

Ms Houghton shared her concern that the 'Number of Serious Incidents (SI's) declared during the period' metric had a target of 0. This should be an ambition and not a target. Dr Minassian would share this feedback with the Medical Director.

Mrs Needham drew the Board to page 29 of the report pack risk ID 368. She would be asking the Divisions to review the risk score due to the increased level of activity last week. She believed this risk score of 15 to be too low. Mr Burns noted that it would be difficult to go into winter with no or limited escalation capacity.

Ms Gill challenged risk ID 966 as it had increased from 6 to 20. It was clarified that this was due to external reasons to NGH.

Dr Minassian informed the Board that HEEM had attended the Workforce Committee in relation to GMC survey concerns.

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

TB 19/20 058 **Director of Nursing and Midwifery Report**

Ms Oke presented the Director of Nursing and Midwifery Report.

Ms Oke advised that there had been dip in the complaints response rate however there had been significant challenges in the Complaints Team. The Complaints Team had now recruited and would be training new members which would enable recovery of the response rate compliance.

Ms Oke drew the Boards attention to page 42 of the report pack. She reported that pressure ulcer numbers had increased. There had been category 4 pressure ulcer reported on Hawthorn. The root cause analysis would be done and any learning addressed. Four members of the Trust had attended the first day of the NHS Improvement PU collaborative recently. It was noted that project work would now commence focussing on specific areas, baseline data and change projects are being planned. One project will be on heel related tissue damage.

Ms Oke stated that Safeguarding Training Compliance remained a high priority. The Trust was just below the training compliance rate of 85%. There were plans in place to address this.

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

Ms Oke referred the Board to page 47 of the report pack which showed that the Trust had again received notification of potential outlier status for PPH > 1500 mls with a PPH rate of 4.2% against a national mean of 2.9%. The Clinical Director for the area presented to the QGC and had provided assurance that this was being addressed.

Ms Oke advised that Becket and Head & Neck ward went to their Best Possible care panels during July. The panel are recommended that both areas received Best Possible Care status. She would like to enhance the Best Possible Care status for

other disciplines.

Ms Oke remarked that a Quality Matron would be joining the Trust in mid-October.

Ms Oke stated that the Trust was shortlisted for 4 Nursing Times Awards. The Trust was also shortlisted as one of the employers of the year. It was noted that 5 staff were selected to represent NGH in partnership with Cavell at the House of Lords.

Mr Smith commented on how the Trust celebrated some of these positive outcomes. He queried what happened when a ward won best possible care status. It was explained that a plaque is put outside the ward entrance and there was a ceremony to celebrate this. These are taken down if the ward loses this status.

Ms Gill noted the PPH outlier status and asked what was being done. Ms Houghton explained that a paper had been presented to QGC which had given some assurance this was being mitigated. The figures presented were very outdated and the Trust was currently at 2.9%.

Mrs Needham expressed concern of awarding Head & Neck Best Possible Care Status. She had a poor experience on the ward the day prior. Ms Oke clarified that the ward had 3 green ratings, had gone to panel and had presented a portfolio of evidence. Mr Burns commented that if a Board member raised concern this needed to considered. Dr Swart reminded the Board that the assessment had been done in a moment in time.

Mr Burns asked that the Best Possible Care panel took another chance to review Head & Neck for Best Possible Care status on the request of the Trust Board.

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

TB 19/20 059 **Patient Experience Survey Update**

Ms Oke presented the Patient Experience Survey Update.

Ms Oke advised that the survey looked at the experiences of people who were discharged from NGH in July 2018. Between August 2018 and January 2019, a questionnaire was sent to a number of these patients. The response rate for NGH was 42% and the national response rate was 45%. She urged to Board to apply a level of caution when reading results due to the significant time lapse therefore the findings had a limited level of usefulness.

Ms Oke reported that the overall inpatient experience score was 7.9/10. This was similar to previous years. Overall, 11 categories were scored ‘about the same’ as other Trusts participating in the survey. In three of the categories there was one question in each where we scored ‘worse’ than other Trusts.

Ms Oke detailed the questions where the Trust had scored ‘worse’. These were patients being told how they could expect to feel after operation or procedure, Doctors answering questions in a way that patients could understand and noise from other patients at night.

Ms Oke explained that the next step would be discussing the report with the Divisions and across the Trust. There were actions already underway at address some of the areas highlighted in the survey. These included pharmacy dispensing drugs, improvements to the discharge plans, outpatient booking system and noise at night.

Ms Oke has asked the Head of Patient Experience to collate the findings of a

number of surveys and analyse these. This would then be monitored via the Patient Experience Group.

Ms Houghton noted the survey results seemed similar to other hospitals and it was good to see actions already underway to address some of these. She expressed concern in regards to the leaving hospital category and questions related to medication. Ms Oke confirmed that had now been increased pharmacy presence on the ward and instructions on the medication were to become more visible. The discharge checklist was also being updated.

Prof Robinson queried whether information sheets were being used for patients. Ms Oke remarked that these were being revisited.

Mr Moore noted that there was no action plan with dates included in the report. He believed it would also be good to see some of the free text comments made in the survey. Mr Burns concurred and asked the Ms Oke included an update in her next Director of Nursing Report to Trust Board **(November).**

Action: Ms Oke

Ms Gill asked if the comments could be linked to a ward. She was informed that these comments were anonymised.

The Board **NOTED** the Patient Experience Survey Update.

TB 19/20 060 Month 05 Finance Report

Mr Bradley presented the Month 05 Finance Report.

Mr Bradley advised that the month 5 results remained disappointing. The Trust had a pre-PSF overspend against plan of £1.89m which was a £59k adverse movement in month and had lost PSF and FRF of £4.7m which left the month 5 position at £6.6m adverse to plan. The Divisional financial recovery plans did not deliver the expected levels in month.

Mr Bradley remarked that pay costs continued to overspend and was the cause of the current financial position. The year to date pay was £4.27m overspent once unplanned pay savings of £3.05m had been removed. Unless the Trust brings down this overspending run rate the achievement of the control total is at a huge risk. Mr Bradley stated that agency costs in month are at their highest level for a few years at £1.58m versus the £934k target. The Divisional Recovery Plans had some large pay reductions included in them and these would be reviewed on a monthly basis.

Mr Bradley reported that non pay was £213k adverse in month but £4k underspent year to date after excluded drugs and medicines. The main non-pay issues in month related to prosthesis, training, energy and postage.

Mr Bradley commented that clinical income was £345k above plan in month and £1.24m above plan year to date. The main area of over performance related to non-elective admissions however the Trust remained of plan on both elective and outpatient activity.

Mr Bradley informed the Board that savings showed a slight over achievement to date but this was mainly due to non-recurrent pay savings. There was currently forecasted to be a gap in achieving the savings target and the level of recurrent savings was well below plan. The escalation and Changing Care meetings along with the Financial Recovery Plan were picking this issue up.

Mr Bradley advised that Trust reserves were almost exhausted particularly the winter

funds and those set aside for the escalation ward. In previous years the Trust had been able to offset overspends elsewhere in the Trust by reserves but this would not happen in 2019/20.

Mr Bradley remarked that by not receiving the PSF/FRF funding was beginning to put a strain on the Trust's cash position and the Trust may see a build-up of delayed payments to creditors as a result.

Mr Bradley summarised that August was another disappointing month from a financial perspective. The Financial Recovery Plan (FRP) had been sent to the regulators. This would be discussed with the regulators 27 September 2019. As a result the Trust had re-instated some of the central controls and meetings in relation to recruitment authorisation, medical agency and ADH approvals with more to follow if recovery does not show the expected results.

Mr Bradley noted the system finances and what possibilities there were about maximising the PSF/FRF across the system. There also needed to be a discussion on risk appetite and that patient safety always come first. The financial governance processes needed to be tightened up. He informed the Board that the revised SFI's, SoD and Standing Orders would be in place by Christmas and education would be needed on these.

Mr Bradley remarked on salary overpayments and this issue would be raised with the new Chief People Officer.

Mr Moore delivered an update on the previous days Finance & Performance Committee (F&P). The F&P Committee all wanted to meet the control total however accepted that this would be difficult. The current forecast shows that the Trust would miss the target by £2.4m. He has asked that the Divisions presented against the FRP's in upcoming F&P Committees.

Mr Moore stated that discussions were being had on fresh ways of thinking. These included ADH rates and escalation beds. The Trust spent a record £1.8m on agency and this needed to be reduced.

Ms Gill asked Mr Bradley to expand on his remark of tightening financial governance. Mr Bradley explained that processes and procedures needed to be tightened.

Ms Houghton expressed her concern over the high number of patients which then are unable to be discharged quickly enough. She referred to page 70 of the report pack and where it was mentioned that there was a seasonal increase in demand for RN cover during the holiday month. She believed that there should have been built in an allowance for this. Mr Bradley clarified that there was a minimum and maximum set on the rotas and believed the issues to be based more around vacancies.

Mrs Needham advised that in relation to financial governance there had been one Division which had struggled more than the others. With new management within this Division she hoped the Trust would see better financial governance. She commented that the majority of agency spend had been approved due to safety.

Mrs Needham expressed her concern on social care support. There had been a large drop in the number if patients that had been discharged into the community with a package of care. This had been raised as a risk at LRF.

Mrs Needham noted the need to discuss risk appetite. If the Trust did not open Benham Ward this would impact on A&E, there would be exit blocks and potentially SI's.

Mr Archard-Jones believed that ADH rates needed to be revisited. This was in the Trust's control and could help with staff morale.

Dr Swart stated that ways or working needed to be looked at differently. There would need to be some investment into change management. Also the topic of private sector work needed to be discussed.

Mr Burns believed that the long and short term plans needed to be separated. He requested that the Board held a development session on the long term solution to the problem and create a different way of moving forward.

Mr Burns asked the Board to think aggressively and creatively in pursuit of a much improved discharge process. He asked that this was an area of concentration over the next month.

Dr Swart commented that the Trust must take part in the short term plans as part of the HCP. Mr Burns remarked that the Trust needed to be confident that it could drive the short term plans.

The Board **NOTED** the Month 05 Finance Report.

TB 19/20 061 **Operational Performance Report**

Mrs Needham presented the Operational Performance Report.

Mrs Needham advised that acuity had increase this week with critical care being full. There had been an increase in DTOC's and was currently at 62. The DTOC numbers had tripled in comparison to last year.

Mrs Needham reported that attendees to A&E in the evening had increased and the majority of these were EMAS attendees. It was noted that EMAS were currently using higher numbers of HCA's and technicians rather than paramedics. Mr Burns asked for further information on this. Mrs Needham confirmed that EMAS had been invited to attend the COO group. She believed 40-50% of attendees in the evening did not need to come in.

Mrs Needham commented that the number of beds provided by Avery had reduced by 22 which is in line with what was planned in year one of the Nye Bevan investment.

Mrs Needham expressed her concern in relation to winter. There had been an increased number of frail elderly admissions and the Trust had not yet experienced the potential impact of the flu. She stated that whilst the Trust had internal plans she has asked the CCG to organise a winter workshop which will enable the county to understand each other's plans and then to plan for gaps.

Mrs Needham informed the Board that the Internal Transformation Programme continued. There was a greater emphasis on rota changes in A&E, increased numbers of same day discharge and direct referrals to Nye Bevan along with a full review by the IDT.

Mrs Needham delivered a cancer update to the Board. The Trust was in an improved position for cancer and had met 7 of the 9 standards. She had a regional telephone call with the regulators last week. The Trust had been asked to improve breast, gynaecology and skin performance to near 100%.

Mrs Needham shared her concern on the 62 day pathway. The number of referrals

from GP's when the patient had been fully informed of their reason for referral worried her as some patients delayed their appointment. She noted that patient choice on the colorectal pathway had become problematic. There are patients referred for a colonoscopy who have requested a CT scan instead. The Trust did not have the capacity to meet this demand.

The Trust was on Opel 4 yesterday.

Ms Gill noted that work done by Transformation-Nous on discharge and asked whether this had been embedded. Mrs Needham shared that whilst confident that improvements had been embedded on some wards not all wards had. Dr Swart had asked Transformation-Nous for their observations. Transformation-Nous advised of some cultural issues at ward level however they did think it was doable to address.

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

TB 19/20 062 **Workforce Performance Report**

Mr M Smith presented the Workforce Performance Report.

Mr Smith advised that turnover needed to be stabilised. The Trust had joined the NHS collaborative 'way4?'.

Mr Smith believed that the vacancy rate would be addressed with the recent approval of the international nurse recruitment business. He informed the Board that he would be looking at the time to hire as one of his priorities.

Mr Smith commented on sickness absence. There was now an increased provision of mental health support in occupational health.

Mr Smith stated that he would be presenting a Summer of Engagement update to the **November** Board. The 2019-20 staff survey was about to go live.

Mr Smith discussed the 'Making Quality Count' presentation at the Workforce Committee. It had highlighted the length of time it takes for investigations to be completed. There is a significant amount of work that needed to be done. A recent internal audit had confirmed this.

Ms Houghton noted that recruitment was a global issue. She queried whether HEEM had offered any input when they had attended the September Workforce Committee. Mr Smith clarified that HEEM did not comment on the subject. He believed that the long term plan had to involve changes to roles and an example of this was the Nurse Associate Roles.

Ms Houghton commented that once Paramedics become degree level this could also have an impact. Dr Swart advised that the GMC were looking to regulate physician associates.

Mr Burns remarked that the NHS has always had issues with workforce recruitment. There was a need to think creatively.

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

TB 19/20 063 **Fire Safety Annual Report**

Mr Finn presented the Fire Safety Annual Report.

Mr Finn advised that an independent peer review had recently been completed.

Mr Finn informed the Board that the Trust Fire Safety risk sat at 25. A monthly compliance report is presented to the Finance & Performance Committee and a bi-weekly group also meets. There is an improved Fire Safety Policy and fire wardens carry out fire safety checks. The fire wardens covered 95% of the site and all high risk areas are having their risk assessments reviewed. It has been agreed that additional training will be given to the Fire Response Team.

Mr Finn stated that Unwanted Fire Signals has dropped by 28%. All fire doors are also being verified. A compartmentation survey had been done.

Mr Finn reported that there was continued focus to improve quality of fire safety training and increase compliance above 85%.

Mr Finn commented that an area that had only limited assurance an action plan was devised.

Mr Finn noted that the risk score of 25 would be reviewed at the end of the financial year.

Mr Finn advised that he had a good response from the local fire service and there has been discussion about a live exercise on site.

Mr Bradley remarked that he Chairs the bi-weekly group. He concurred with Mr Finn's report and that the risk score would be assessed at the end of financial year. There was a huge amount of work ongoing and was moving in the right direction.

Mr Burns noted that this was good report. He asked Mr Finn to also focus on the tidiness of the estate.

The Board **NOTED** the Fire Safety Annual Report.

TB 19/20 064 Fire Safety Board Compliance Statement

The Board **APPROVED** the Fire Safety Board Compliance Statement.

TB 19/20 065 Corporate Governance Report

Ms Campbell presented the Corporate Governance Report.

Ms Campbell advised that the Trust Seal had not been used. She would therefore only report this to the Board via exception in future.

Mr Burns queried whether counter fraud should be invited to attend Board. It was noted that counter fraud attended Audit Committee.

Ms Campbell reported that there was 24 Declaration of Interests outstanding. Ms Campbell is to work with HR on capturing new consultants Declaration of Interests upon commencement of employment. The use of net.consent would also be explored.

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

TB 19/20 066 Brexit Update

Mrs Needham presented the Brexit Update

Mrs Needham advised that there had been no decision made on a deal when the UK is planning to leave the EU on 31 October 2019.

Mrs Needham commented that the Resilience Planning Group had formed an EU Exit Group to ensure all risks had been identified and where possible plans are in place. The longer term risks are highlighted in the report.

Mrs Needham stated that a lot of information following exercise is being held centrally by the DHSC for example the coordinated response centrally to medicine supply.

Mrs Needham has spoken to the CCG to ask for a system group to be set up. She has learnt that LRF were holding a weekly call however no information had been coming through to health. This had now been rectified and a CCG group had been set up.

Mrs Needham informed the Board that daily reporting was likely to happen before the UK left the EU.

The Board **NOTED** the Brexit Update.

TB 19/20 067 EPRR Self-Assessment Assurance Report

Mrs Needham presented the EPRR Self-Assessment Assurance Report.

Mrs Needham advised that this was the annual self-assessment report for emergency preparedness resilience and response core standards.

Mrs Needham reported that NHSE/I came into the Trust last week to visit A&E. They spoke to staff and interviewed herself and the Resilience Planning Manager. The interview appeared to go well and the Trust would hear back in the next two months.

Mr Moore asked if a full test was ever conducted. He was informed that this happened every three years and was a desktop exercise.

The Board **NOTED** the EPRR Self-Assessment Assurance Report

TB 19/20 068 Highlight Report from Finance and Performance Committee

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

TB 19/20 069 Highlight Report from Quality Governance Committee

Professor Robinson informed the Board that at the August QGC the Committee was advised that the recent Never Event had been downgraded to a Serious Incident.

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

TB 19/20 070 Highlight Report from Workforce Committee

Ms Gill summarised the key items from the September Workforce Committee. These included:

- Junior Doctor Contract – there was no major implications felt by the Trust this year.
- Making Quality Count Presentation had been received by the Committee.
- Summer of Engagement update.
- Medical Education – the Surgery action plan had been shared. The phase one part of the plan would be implemented immediately with phase 2 following a similar approach to the Oncology action plan.
- Junior Doctor Induction – this had gone positively and a further update would be presented to the October Committee.

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

TB 19/20 071 Highlight Report from HMT

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

TB 19/20 072 Any Other Business

There was no other business to discuss.

Date of next Public Board meeting: Thursday 28 November 2019 at 09:30 in the Board Room at Northampton General Hospital.

Mr A Burns called the meeting to a close at 12:10pm

Public Trust Board Action Log

Last update **15/10/2019**

Item No	Month of meeting	Minute Number	Paper	Action Required	Responsible	Due date	Status	Updates
Actions - Slippage								
Actions - Current meeting								
111	Jul-19	TB 19/20 033	Medical Director's Report	There would be an internal governance and medical education review on Oncology and this would report to the Workforce Committee in September. Mr Burns requested that an update also came to the September Trust Board. He suggested that the Head of Medical Education and a Junior Doctor to be involved in this presentation	Mr Metcalfe	Nov-19	On Agenda	**deffered from September to November 2019**
115	Sep-19	TB 19/20 059	Patient Experience	Mr Moore noted that there was no action plan with dates included in the report. He believed it would also be good to see some of the free text comments made in the survey. Mr Burns concurred and asked the Ms Oke included an update in her next Director of Nursing Report to Trust Board (November).	Ms Oke	Nov-19	On Agenda	
112	Jul-19	TB 19/20 034	Director of Nursing and Midwifery Report	Mr Moore queried the two wards at Avery. These were confirmed to be Blenheim and Cliftonville. The beds on Cliftonville were due to be removed due to concerns previously discussed on this ward. Ms Spellman advised that notice had been served for September. The Trust was in the process of procuring 24 beds and the Trust was out to the care homes as an interim measure. Dr Swart remarked that this needed to be resolved before winter. This was being discussed by Mrs Needham and the CEO group. Mr Burns asked for an update on this to the November Board	Mrs Needham	Nov-19	On Agenda	**Update Matters Arising**
103	Mar-18	TB 18/19 249	Paediatric Nurse in Paediatric ED	Mr Burns asked for a future report on registered Paediatric Nurse in Paediatric ED.	Ms Oke	Nov-19	On Agenda	**Update in DoN Report**
Actions - Future meetings								
94	Jan-19	TB 17/18 206	Chief Executive's Report	Mrs Brennan commented that the workforce plan was under development and this was split into 5 workstreams. The plan would be shared in March with the detail received by the Autumn. An update would be brought to the Trust Board when circulated.	Mrs Brennan	Oct-19	Completed - presented October BoD	**Update from May Board - Mrs Brennan updated the Board and informed them that the National Workforce plan had still not been released. Once it had been she would update the Board.** **Update from **July** Board - Mrs Brennan commented that the workforce plan had been referenced in the People Strategy. A full report would be coming to the October Board.**
114	Jul-19	TB 19/20 038	People Strategy Update	Mr Burns believed asking staff what type of rewards that appreciate to also be a good step forward. Mr Burns requested an update to the October Board.	Mrs Brennan	Oct-19	Completed - presented October BoD	**went to October Board of Directors**

NHS
Northampton General Hospital
NHS Trust

Enclosure C

Report To	**Public Trust Board**
Date of Meeting	**28 November 2019**

Title of the Report	**Chief Executive's Report**
Agenda item	***8***
Presenter of the Report	Dr Sonia Swart, Chief Executive
Author(s) of Report	Dr Sonia Swart, Chief Executive and Sally-Anne Watts, Associate Director of Communications
Purpose	For information and assurance
Executive summary The report highlights key business and service issues for Northampton General Hospital NHS Trust in recent weeks.	
Related strategic aim and corporate objective	N/A
Risk and assurance	N/A
Related Board Assurance Framework entries	N/A
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	None
Actions required by the Trust Board The Trust Board is asked to note the contents of the report	

Public Trust Board
28 November 2019

Chief Executive's Report

1. Northamptonshire Health Care Partnership

The Northamptonshire Health and Social Care System has taken a number of steps to refresh the way the system works together in order to be able to set out a credible, aligned and integrated approach that offers better quality, more sustainable and more affordable services for the future. The plans have been produced in a way that has engaged teams from all parts of the health and social care system, as well as taking account of the views of patients, service users and public feedback from stakeholder events and surveys. This has resulted in broad agreement on the priorities that need to be addressed, the reasons for changes that are required and the way change needs to be supported.

A huge amount of work will be required to transform services in the way that has been outlined and there is also agreement regarding the scale of the challenge. Much of the work will be described in outline when the long-term plans are published and it is very much accepted that this is all work in progress. The only certainty at present is that there is a shared desire and will to do things differently in order to bridge the gaps in quality, sustainability and inequality that currently exist. There are plans to discuss the emerging plans and further decisions with Boards in December and January.

2. Care Quality Commission (CQC)

In October we advised that the outcome of our CQC inspection was a change in rating from 'Good' to 'Requires Improvement'. We briefed staff the day before the formal announcement, as I did not want them to hear the news on the way in to work as they listened to my interview on BBC Radio Northampton at 7.20am.

The CQC assessed the quality of three core services – urgent and emergency care, medical care and maternity. We were also assessed against the domains of 'Well-led' and 'Effective use of resources'.

We were rating as 'Good' for having Caring, Effective and Responsive Services, but assessed as 'Requires Improvement' for having Well-led and Safe services. Importantly despite the relentless pressure experienced by our emergency department, and elsewhere in the hospital, our urgent and emergency care services continue to be rated as 'Good'. Maternity and medical care were assessed as 'Requires Improvement'.

Following my radio interview we held a number of briefings for staff, which allowed a 30 minute Q&A session as we understood from the summer of engagement that the opportunity to share knowledge and opinion, and ask questions, is important for TeamNGH.

It is important that we remember that the CQC found some outstanding areas of practice and made some very positive comments about the numerous areas where we are doing well. The inspection team highlighted the good, kind and compassionate care provided to patients and the high quality interactions they observed between patients and staff. They also found that many members of TeamNGH are actively involved in improvement initiatives and there is shared learning from incidents.

Since our last CQC inspection in 2017 we have seen unprecedented levels of activity as the demand for our services has risen. This has impacted on our ability to sustain and improve our services, and has also had an impact on the way we work with one another. As an organisation that is focused on continuous improvement, we believe the CQC inspection offers us an opportunity to reflect and take forward learning and good practice across the trust.

A key message ending the staff briefings and taken forward in subsequent blogs and communications is the extension of the concept of 'Best Possible Care' for patients to include best possible care for staff, emphasising our duty to treat each other with respect and support.

3. Our Staff

Board members will be aware of our engagement sessions that took place over the summer to inform the development of a new plan to support our workforce. I would like to take this opportunity on behalf of the Board to thank everyone who participated, facilitated and fed back the outputs of the many sessions that were held. Particular thanks are due to our organisational development team who organised the sessions and captured all the feedback.

Everyone who led an engagement session enjoyed the opportunity to speak with colleagues from across the organisation. We heard the views of more than 1000 members of TeamNGH, who had some great ideas. We listened to insights, stories and learned about what really matters to the people who make up TeamNGH. We heard some things that concerned us and we now understand what we need to do.

All of the feedback has formed the basis of our new People Plan, which we will share with TeamNGH as soon as it has been through the relevant approval stages. We have sent out some of the plans and immediate actions in a couple of communications/blogs and will continue this over the following 12 months with input from as many people as possible including a range of stories from staff that reflect the experiences they have had and the improvements they notice as a result of our work.

A key element of the feedback from all our discussions was the importance of how we treat and understand one another. A key message for all of teamNGH is therefore that this really does matter, more than many of us realised and almost more than anything else. We plan to weave that into all our programmes of work and particularly into the way we respond to the winter pressures.

We followed the summer of engagement with some briefing sessions for staff following the outcome of our CQC inspection. I took the opportunity during and after the briefing, supported by our executive and organisational development teams to talk to staff not only about the CQC inspection, but also what we had learned from the summer of engagement. Everyone who attended was asked three questions:

- How would you like to be involved in working differently over the winter?
- How would you like to be involved in implementing our people plan?
- What are the great things you're doing to support one another within your team?

The responses have been collated and will be shared with TeamNGH.

4. Winter messaging

The pressures within the NHS nationally, regionally and locally are well publicised and despite undertaking meticulous planning, there is increased demand on hospitals during the winter period.

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Every day our staff have to balance the needs of their patients so they can provide care to those who need it most. This will include making decisions around who needs a bed most – the patient waiting in the emergency department, the patient with cancer waiting for an operation or the patient who is waiting for planned, non-urgent surgery.

As providers and commissioners of NHS services we continually review how we allocate our resources. Our daily challenge is to manage the risk of the additional demand our A&E services creates, and ensure our patients are kept safe. We have to make sure we think clearly about how we can do what is best for our patients in terms of the impact on them, their families and the people who care for them.

By taking the decision to reschedule a relatively small number of non-urgent inpatient operations over the coming months we remove the risk of distressing patients with repeat cancellations. Plans are being developed with colleagues in surgery and our commissioners to take this forward. Patients requiring day case procedures, patients with cancer requiring surgery and those who need urgent/emergency care will continue to be operated on at NGH.

For NGH this involves planning which routine patients can be admitted to NGH and, if not, agreeing whether alternative provision is available. All urgent, emergency and cancer patients will be admitted as usual. We believe around 30 patients each month may either have a longer wait or may be treated at an alternative provider. We are currently in discussions to obtain additional capacity, where needed at other providers

Our aim is to avoid cancelling patients without proper notice, which we accept is distressing for our patients. I recently met with a patient and his family to discuss the impact of multiple cancellations. This patient spoke highly of the care he had received from our staff, and both he and his family were clear that the purpose of the meeting was that they wanted to help us understand the impact of an unplanned cancellation from their perspective.

Our priority is to ensure we continue to provide care to those who need it most; prioritising emergency, cancer and complex operations whilst also being able to admit all emergency patients from our emergency department.

Before we had time to finalise our plans and firm up on our communication to GPs and patients a member of the public was alerted to our plans. Without possession of the full facts this person alleged on social media that all operations were being cancelled for the next four months which, as board members will be aware, is certainly not the case.

The social media post was picked up by the Health Service Journal (HSJ) and, using figures already in the public domain they reported that we would be cancelling over 15,000 operations. This led to a flurry of other misleading reports on social media and in online publications and media enquiries which were handled by our communications team and colleagues from NHS England. They were able to get some the misleading statements taken down entirely from online sources whilst others were amended to reflect the true position.

After we issued an initial holding statement we agreed a joint statement with our commissioners and NHS England. I gave interviews to BBC Look East and BBC Radio Northampton to reassure our patients and the public about our plans and we also posted our statement on our social media channels. The response from the public has been very supportive, with positive comments about the care they receive at NGH whilst also being aware of the pressure of rising demand.

Our communications team has been working with colleagues across the Northamptonshire Health and Care Partnership to develop an effective communications plan to support urgent and emergency care over the winter period.

This year our communications team is taking a wider, and bolder, approach to winter messaging and, having secured system funding, has developed a 12 week campaign that will include messaging on billboards, at bus stops, inside buses and also on the rear. The campaign starts in early December and will run through to March 2020. The visuals will also appear in targeted social media posts throughout the period.

We have shared the creative content developed by our comms team with colleagues at KGH, who will be adapting and using it to support their winter messaging alongside the 'Next Time' campaign, which is also supported by our messaging. By working together we aim to achieve a far greater messaging reach and impact.

We are also developing a responsive microsite 'NGH Winter Watch' to share weekly updates with TeamNGH. This will sit alongside our new TeamNGH Facebook community to enable staff without regular access to email at work to keep up to date with what is happening and share knowledge and experiences with colleagues. The Winter Watch site will sit alongside a Winter Watch Blog giving weekly updates on the things that are happening actively using stories from around the hospital with an editorial comment in the CEO blog style supported by a range of guest editors/bloggers.

A key feature of the winter watch will to be to draw out all the important things that are happening already, updates on the projects that are underway and news about new initiatives planned alongside some key numbers that shed light on the various components of urgent care. We have continued our focus on same day emergency access this year, with increasing numbers of patients seen through this route and also continue to improve our internal systems. There is more to do, however, and more to do also with partners in the health system if we are to ensure that we meet the needs of our population in terms of urgent care services.

5. Awards

One of our midwives, Samukeliso Tennyson, was highly commended in the UK Midwife Achievement Award category at the International Midwifery Awards. Sam, who has been a midwife at NGH for 8 years, was recognised for her work on the Mpilo Life Project which she started 8 years ago to provide midwifery support in her home country, Zimbabwe.

Sam was just one of three midwives to be shortlisted in the UK Midwife Achievement Award category, and her commendation is well-deserved.

The work of Anne-Marie Dunkley, our health and wellbeing manager, has been recognised in the NHSE/I and Burdett Trust National Retention Awards, where NGH has been shortlisted for the best health and wellbeing, rewards and health benefits offer award. The winner will be announced on 19 November. Also shortlisted were members of our practice development team for the best support to new starters and newly qualified award.

Dr Sonia Swart
Chief Executive

Enclosure D

Report To	Public Trust Board
Date of Meeting	28 November 2019

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
Purpose	For information / assurance

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 is split into two sections:

1. A new format for reporting key exceptions via the integrated scorecard using statistical process control and the NHSI methodology of reporting. (this is not complete and forms a limited number of KPI's)
2. The old format using exception reports based on Red RAG rated KPIs from the integrated scorecard. (this is a complete list of exceptions)

The old format will be presented to the board until which time the new methodology for reporting is complete and has been accepted by the board.

Report two
Each of the indicators which are red rated has an accompanying exception report for areas which require assurance and have been discussed in detail at the relevant committees of the Board.

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? All
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks 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? (N) If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N) If yes please give details and describe the current or planned activities to address the impact.
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper – No

Actions required by the Committee

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

Northampton General Hospital NHS NHS Trust

Corporate Scorecard 2019/2020 OCT - Not Yet Published

Domain	Indicator	Executive Owner	Target	Target Set By	Direction of Travel	Trend	NOV-18	DEC-18	JAN-19	FEB-19	MAR-19	APR-19	MAY-19	JUN-19	JUL-19	AUG-19	SEP-19	OCT-19
Caring	Complaints responded to within agreed timescales	Sheran Oke	>=90%				97.4%	98.0%	100.0%	100.0%	100.0%	97.7%	96.1%	94.5%	83.7%	72.7%	88.5%	83.9%
	Friends & Family Test % of patients who would recommend: A&E	Sheran Oke	>=86.4%	Nat			88.1%	85.9%	85.1%	80.9%	83.3%	85.3%	86.8%	86.0%	82.1%	81.9%	85.4%	80.1%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	Sheran Oke	>=95.7%	Nat			94.0%	92.6%	92.7%	93.5%	92.8%	92.7%	93.8%	93.9%	93.6%	92.6%	92.9%	91.1%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	Sheran Oke	>=96.8%	Nat			96.6%	100.0%	99.4%	98.6%	99.3%	99.3%	98.6%	99.0%	97.7%	98.6%	96.5%	97.7%
	Friends & Family Test % of patients who would recommend: Outpatients	Sheran Oke	>=93.8%	Nat			93.8%	93.5%	93.5%	93.6%	93.3%	93.3%	93.6%	94.7%	93.1%	93.8%	93.3%	92.8%
	Mixed Sex Accommodation	Sheran Oke	=0	Nat			0	0	4	2	0	0	0	0	0	0	0	0
	Compliments	Sheran Oke	-	NGH			4,335	3,541	4,269	3,639	4,007	3,647	3,697	3,595	4,363	4,367	3,721	4,004
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	Debbie Needham	>=90.1%	Nat			85.9%	83.3%	78.5%	79.0%	80.2%	79.0%	83.9%	85.5%	83.6%	78.9%	80.8%	73.0%
	Average Ambulance handover times	Debbie Needham	<=15 mins				00:14	00:14	00:31	00:14	00:16	00:17	00:13	00:19	00:18	00:18	00:18	00:17
	Ambulance handovers that waited over 30 mins and less than 60 mins	Debbie Needham	<=25				142	299	330	400	420	343	203	69	84	219	256	501
	Ambulance handovers that waited over 60 mins	Debbie Needham	<=10				19	30	49	33	22	13	11	15	9	13	39	151
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Debbie Needham	=0				3	4	5	4	4	11	1	4	3	1	1	3
	Delayed transfer of care	Debbie Needham	=23	NGH			10	24	12	11	20	31	34	21	32	47	50	51
	Average Monthly DTOCs	Debbie Needham	<=23	NGH			15	20	20	17	29	41	41	32	30	37	54	43
	Average Monthly Health DTOCs	Debbie Needham	<=7	NGH			13	16	17	13	20	30	33	23	19	25	39	33
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	Debbie Needham	>=93%	Nat			88.5%	86.1%	73.7%	81.9%	73.3%	70.5%	91.0%	85.7%	95.5%	No data submitted		
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	Debbie Needham	>=93%	Nat			40.2%	35.4%	60.2%	69.3%	66.4%	27.2%	42.1%	54.0%	96.8%	No data submitted		
	Cancer: Percentage of patients treated within 31 days	Debbie Needham	>=96%	Nat			94.8%	96.5%	92.1%	94.1%	94.4%	94.5%	96.4%	95.5%	96.1%	93.5%	96.2%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	Debbie Needham	>=98%	Nat			100.0%	100.0%	98.9%	100.0%	94.8%	100.0%	99.0%	98.5%	98.7%	100.0%	97.1%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	Debbie Needham	>=94%	Nat			96.6%	94.8%	97.9%	97.9%	95.0%	96.1%	97.7%	91.5%	98.2%	94.7%	97.1%	
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	Debbie Needham	>=94%	Nat			93.7%	93.7%	80.0%	100.0%	86.6%	90.0%	100.0%	90.9%	94.1%	83.3%	100.0%	
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	Debbie Needham	>=85%	Nat			76.0%	80.0%	71.1%	74.0%	70.6%	70.0%	69.8%	77.5%	75.2%	76.7%	77.0%	
	Cancer: Percentage of patients treated within 62 days of referral from screening	Debbie Needham	>=90%	Nat			100.0%	81.8%	90.4%	100.0%	100.0%	90.0%	95.8%	66.6%	100.0%	100.0%	100.0%	
	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	Debbie Needham	>=85%	Nat			83.6%	89.1%	84.0%	80.0%	92.5%	80.5%	88.2%	88.5%	47.5%	80.0%	79.1%	
	Cancer: Faster Diagnosis Standard	Debbie Needham	>=63%	Nat												66.5%	68.2%	
	RTT waiting times incomplete pathways	Debbie Needham	>=92%	Nat			82.1%	81.5%	81.6%	80.7%	80.0%	79.0%	80.6%	82.5%	82.5%	No data submitted		
	RTT Average wait incomplete pathways	Debbie Needham	<=11.9	Nat												10.9	10.5	

Northampton General Hospital NHS Trust

Corporate Scorecard 2019/2020 OCT - Not Yet Published

Domain	Measure	Lead	Target	Source	1	2	3	4	5	6	7	8	9	10	11	12
	RTT over 52 weeks	Debbie Needham	=0	Nat	0	0	1	3	1	0	1	0	0	0	0	
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	Debbie Needham	>=99.1%	Nat	99.9%	99.7%	100.0%	99.4%	99.3%	96.8%	96.4%	94.1%	93.7%	95.9%	96.6%	
	Stroke patients spending at least 90% of their time on the stroke unit	Debbie Needham	>=80%		95.6%	100.0%	79.6%	66.2%	75.4%	96.6%	93.7%	74.5%	83.3%	64.2%	69.4%	79.6%
	Suspected stroke patients given a CT within 1 hour of arrival	Debbie Needham	>=50%		95.0%	95.3%	89.3%	82.4%	92.3%	98.1%	90.6%	90.9%	91.8%	85.7%	89.7%	82.8%
	Unappointed Follow Ups	Debbie Needham	=0	NGH			8,608	8,723	9,957	10,119	10,363	10,385	9,670	9,801	9,783	8,967
Well Led	Bank & Agency / Pay %	Janine Brennan	<=7.5%	NGH	12.3%	12.3%	12.4%	12.4%	12.6%	12.7%	13.2%	15.2%	15.7%	15.9%	16.0%	16.4%
	Sickness Rate	Janine Brennan	<=3.8%	NGH	4.0%	4.4%	4.9%	4.7%	4.0%	4.2%	4.2%	4.5%	4.3%	4.6%	4.8%	5.0%
	Staff: Trust level vacancy rate - All	Janine Brennan	<=9%	NGH	10.3%	12.5%	11.8%	11.0%	11.2%	12.3%	12.0%	12.1%	12.1%	12.1%	12.6%	12.3%
	Staff: Trust level vacancy rate - Medical Staff	Janine Brennan	<=9%	NGH	9.0%	9.9%	9.1%	2.4%	3.2%	6.8%	7.2%	7.5%	7.9%	5.9%	5.2%	5.4%
	Staff: Trust level vacancy rate - Registered Nursing Staff	Janine Brennan	<=9%	NGH	7.5%	11.5%	11.2%	11.3%	11.2%	11.0%	11.1%	11.5%	12.2%	12.6%	13.0%	10.7%
	Staff: Trust level vacancy rate - Other Staff	Janine Brennan	<=9%	NGH	12.1%	13.5%	12.7%	12.5%	12.8%	14.0%	13.5%	13.4%	13.0%	13.2%	14.4%	14.2%
	Turnover Rate	Janine Brennan	<=10%	NGH	7.8%	8.3%	8.2%	8.9%	8.4%	8.4%	8.6%	8.6%	8.8%	8.9%	9.1%	9.1%
	Percentage of all trust staff with mandatory training compliance	Janine Brennan	>=85%	NGH	88.2%	88.5%	88.7%	88.5%	88.6%	89.2%	89.4%	89.4%	No data submitted	88.8%	88.0%	87.5%
	Percentage of all trust staff with mandatory refresher fire training compliance	Janine Brennan	>=85%	NGH	81.9%	82.8%	82.0%	81.9%	82.7%	83.6%	84.4%	84.5%	No data submitted	84.8%	83.0%	82.3%
	Percentage of all trust staff with role specific training compliance	Janine Brennan	>=85%	NGH	82.5%	83.0%	83.2%	83.7%	83.8%	83.8%	84.1%	84.4%	No data submitted	83.7%	82.9%	82.4%
	Percentage of staff with annual appraisal	Janine Brennan	>=85%	NGH	83.5%	81.6%	83.6%	84.5%	86.4%	84.5%	84.7%	85.0%	No data submitted	83.3%	82.0%	82.5%
	Job plans progressed to stage 2 sign-off	Matt Metcalfe	>=90%	NGH	27.5%	24.2%	28.6%	30.9%	37.8%	37.1%	46.4%	44.1%	53.6%	53.2%	54.5%	No data submitted
	Income YTD (£000's)	Phil Bradley	>=0	NGH	(2,957) Adv	(3,550) Adv	(3,093) Adv	(3,256) Adv	(2,887) Adv	(985) Adv	(1,358) Adv	(600) Adv	(1,333) Adv	(1,309) Adv	4,191 Fav	2,140 Fav
	Surplus / Deficit YTD (£000's)	Phil Bradley	>=0	NGH	97 Fav	(432) Adv	(460) Adv	(761) Adv	(2,512) Adv	(1,477) Adv	(2,949) Adv	(3,321) Adv	(5,036) Adv	(6,228) Adv	491 Fav	(4,028) Adv
	Pay YTD (£000's)	Phil Bradley	>=0	NGH	(3,277) Adv	(3,165) Adv	(3,614) Adv	(3,901) Adv	(4,623) Adv	(1,021) Adv	(1,978) Adv	(2,786) Adv	(3,599) Adv	(4,270) Adv	(3,540) Adv	(4,703) Adv
	Non Pay YTD (£000's)	Phil Bradley	>=0	NGH	4,204 Fav	4,612 Fav	5,088 Fav	5,232 Fav	5,437 Fav	407 Fav	474 Fav	67 Fav	217 Fav	4 Fav	491 Fav	(775) Adv
	Salary Overpayments - Number YTD	Phil Bradley	=0	NGH	167	195	209	230	266	55	34	57	72	92	125	150
	Salary Overpayments - Value YTD (£000's)	Phil Bradley	=0	NGH	340.9	371.9	392.3	454.4	509.2	156.6	86.4	156.8	183.8	232.3	288.1	333.3
	CIP Performance YTD (£000's)	Phil Bradley	>=0	NGH	1,821 Fav	1,554 Fav	2,030 Fav	1,458 Fav	1,458 Fav	246 Fav	686 Fav	1,147 Fav	553 Fav	570 Fav	441 Fav	No data submitted
	CIP Performance - Recurrent	Phil Bradley	-	NGH		64.5%	65.9%	65.5%	69.0%	39.0%	39.9%	42.2%	41.8%	43.1%	37.8%	No data submitted
	CIP Performance - Non Recurrent	Phil Bradley	-	NGH		39.1%	40.4%	41.0%	41.0%	42.8%	38.7%	39.6%	46.2%	41.7%	46.6%	No data submitted
	Maverick Transactions	Phil Bradley	=0	NGH		15	21	21	19	18	18	22	27	19	13	33
	Waivers which have breached	Phil Bradley	=0	NGH		1	0	0	0	4	1	2	1	2	3	1
Effective	Stranded Patients (ave.) as % of bed base	Debbie Needham	<=40%	NGH	54.4%	54.7%	58.0%	57.0%	55.3%	60.4%	62.0%	59.6%	55.6%	57.9%	56.8%	58.7%
	Super Stranded Long Stay Patients (ave.) as % of bed base	Debbie Needham	<=25%	NGH	23.1%	23.1%	23.8%	21.6%	22.0%	27.9%	29.6%	26.3%	23.6%	25.3%	23.0%	23.9%
	Length of stay - All	Debbie Needham	<=4.2	NGH	4.4	4.2	4.8	4.7	4.8	4.3	4.7	4.4	4.6	4.4	4.2	4.5

Northampton General Hospital NHS Trust

Corporate Scorecard 2019/2020 OCT - Not Yet Published

	Percentage of discharges before midday	Debbie Needham	>25%	NGH	17.4%	19.1%	18.3%	17.2%	18.2%	17.4%	16.8%	16.3%	16.7%	16.9%	16.6%	16.3%
	Readmissions within 30 days of previous reporting month	Matt Metcalfe	<=12%								12.7%	13.6%	13.3%	13.4%	13.1%	13.3%
	# NoF - Fit patients operated on within 36 hours	Matt Metcalfe	>=80%		82.7%	100.0%	86.4%	81.8%	90.9%	83.3%	92.0%	83.7%	90.4%	85.1%	84.2%	100.0%
	Maternity: C Section Rates	Matt Metcalfe	<29%		31.3%	32.1%	32.3%	27.2%	36.0%	28.1%	33.3%	27.1%	30.6%	28.7%	27.9%	33.1%
	Mortality: HSMR	Matt Metcalfe	106	Nat	106	106	105	106	104	103	104	105	0	102	104	103.5
	Mortality: SHMI	Matt Metcalfe	109	Nat	104	104	104	104	104	104	100	100	100	99	98	98
	Patient Ward Moves Overnight (22:00 - 06:59)		=0							738	817	830	851	334	333	456
	% Daycase Rate		>=80%							81.2%	82.6%	83.0%	81.1%	83.5%	84.9%	87.3%
	Failed Daycases as a % of Planned Daycases		-							1.8%	2.6%	2.6%	2.6%	2.4%	2.1%	2.3%
Safe	Transfers: Patients transferred out of hours (between 10pm and 7am)	Debbie Needham	<=60	NGH	36	35	53	51	35	35	35	17	No data submitted	22	42	52
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	Debbie Needham	>=98%	NGH	97.2%	91.4%	98.1%	96.0%	100.0%	100.0%	100.0%	100.0%	No data submitted	100.0%	100.0%	100.0%
	Never event incidence	Matt Metcalfe	=0	NGH	0	0	0	0	0	0	0	0	1	0	1	1
	Number of Serious Incidents (SI's) declared during the period	Matt Metcalfe	0		0	3	7	1	0	0	2	3	7	2	4	7
	VTE Risk Assessment	Matt Metcalfe	>=95%		95.4%	95.3%	95.9%	95.0%	95.1%	95.4%	95.4%	95.1%	95.1%	93.9%	93.7%	90.0%
	MRSA > 2 Days	Sheran Oke	=0	Nat	0	0	0	0	0	0	0	0	0	0	0	0
	HOHA and COHA (C-Diff > 2 Days)	Sheran Oke	<=3	Nat	0	1	0	0	0	2	3	1	3	3	2	4
	MSSA > 2 Days	Sheran Oke	<=1	NGH	1	0	1	2	0	5	4	1	1	1	3	4
	New Harms	Sheran Oke	<=2%	NGH	0.67%	0.99%	0.62%	0.15%	1.71%	1.59%	1.89%	1.44%	2.16%	1.19%	1.21%	0.96%
	Appointed Fire Wardens	Stuart Finn	>=85%	Nat		85.6%	88.1%	90.7%	91.2%	91.2%	91.2%	91.2%	No data submitted	95.6%	97.2%	97.2%
	Fire Drill Compliance	Stuart Finn	>=85%	Nat		62.0%	59.7%	56.7%	57.2%	53.0%	43.2%	41.2%	No data submitted	55.9%	52.7%	51.6%
	Fire Evacuation Plan	Stuart Finn	>=85%	Nat		89.2%	89.2%	67.5%	72.6%	70.6%	68.5%	66.4%	No data submitted	51.0%	52.1%	48.9%

No data submitted — Data not provided

(grey) — No data - pre KPI implementation or post KPI swtich off

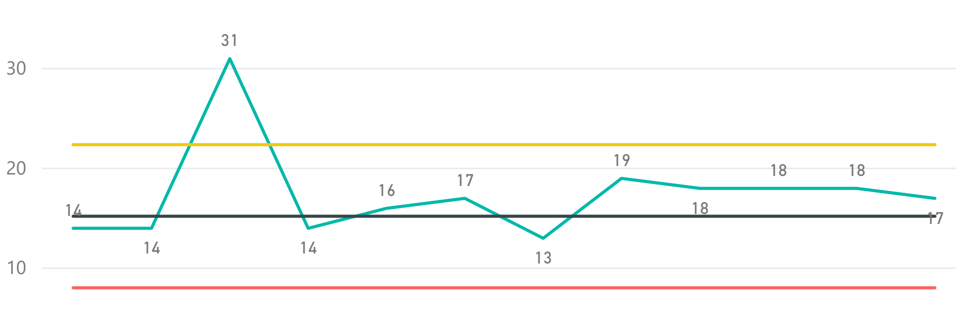
Enclosure D

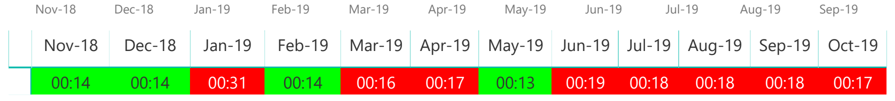
Corporate Scorecard Exception Reports

Average Ambulance handover times

October 2019	Target	Actual	Direction of Travel	Accountable Executive
	00:15	00:17		Debbie Needham

Performance vs Target





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

Timeframe for recovery

November 2019

Exception report written by

CrutchleyR

Assurance Committee

Directorate Management Board

Next steps

All SDEC Pathways have been shared with EMAS Quality & Compliance manager and are being discussed at their next Clinical Governance meeting. Increased capacity , with a Dr in Majors Lite to facilitate flow for Ambulance patients into Fit Stop. Ensure effective streaming through Majors Lite: in October 344 patients seen in majors Lite • 42% were discharged home (up from 17% in September) • 15% to UTC • 9% to other clinics • 13% to ACC • 15% referred direct to specialty • 6% referred in to main ED (20 patients)

What is driving under performance?

The main driver for this Increase in ambulances waiting on average longer than 15 minutes is internal flow constraints and increased demand across the organisation.

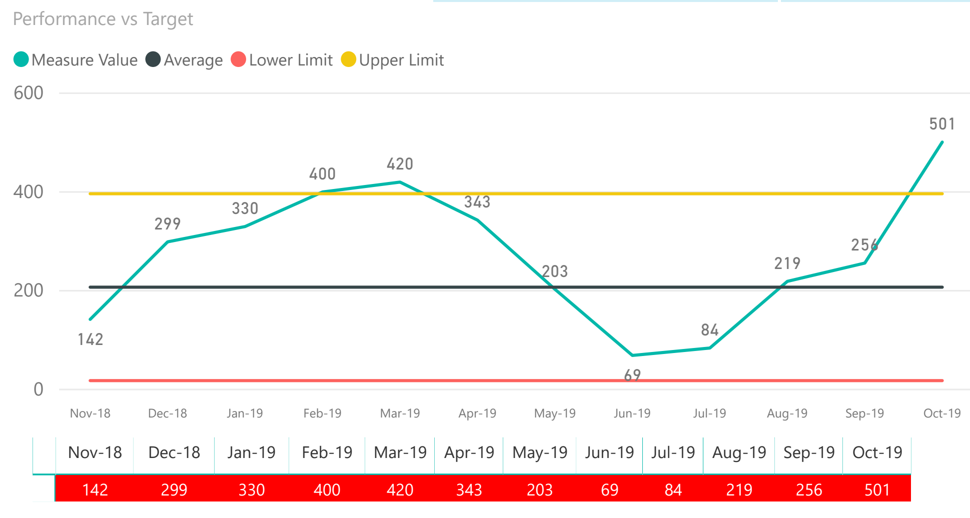
Actions completed in the past month to achieve recovery

Continued to work with EMAS to highlight other pathways to be accessed and not just conveyance to ED - Working towards access to SDEC pathways. Joint spot audits undertaken with EMAS to look for paramedic pathfinder compliance and gaps in community accessed pathways – no significant gaps were identified.

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

October 2019

Target	Actual	Direction of Travel	Accountable Executive
25	501	↓	Debbie Needham



Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
142	299	330	400	420	343	203	69	84	219	256	501

What is driving under performance?

The main driver for this Increase in volume of ambulances waiting longer than 30 minutes and less than 60 minutes is internal flow constraints and increased demand across the organisation. September and October have been challenging and demanding months for the organisation. With sustained increased activity, the department has become regularly space constrained, leading to increase in ambulance waiting longer than 30 minutes.

Actions completed in the past month to achieve recovery

Continued to work with EMAS to highlight other pathways to be accessed and not just conveyance to ED - Working towards access to SDEC pathways. Joint spot audits undertaken with EMAS to look for paramedic pathfinder compliance and gaps in community accessed pathways – no significant gaps were identified.

Timeframe for recovery

November 2019

Exception report written by

CrutchleyR

Assurance Committee

Directorate Management Board

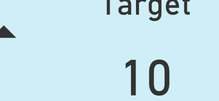
Next steps

All SDEC Pathways have been shared with EMAS Quality & Compliance manager and are being discussed at their next Clinical Governance meeting. Increased capacity , with a Dr in Majors Lite to facilitate flow for Ambulance patients into Fit Stop. Ensure effective streaming through Majors Lite: in October 344 patients seen in majors Lite • 42% were discharged home (up from 17% in September) • 15% to UTC • 9% to other clinics • 13% to ACC • 15% referred direct to specialty • 6% referred in to main ED (20 patients)

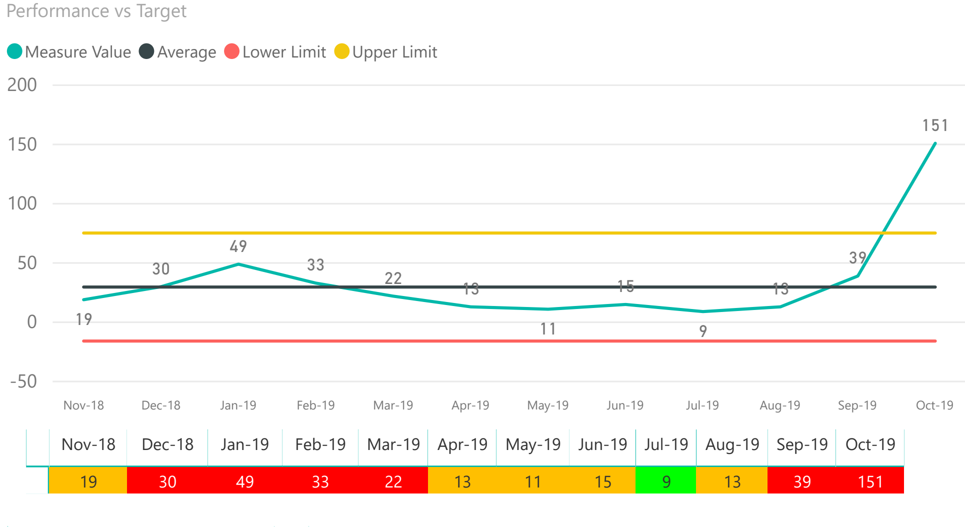
Ambulance handovers that waited over 60 mins

October 2019

Target	Actual	Direction of Travel	Accountable Executive
10	151		Debbie Needham



Performance vs Target



Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
19	30	49	33	22	13	11	15	9	13	39	151

What is driving under performance?

A significant increase in 60 minute ambulance delays from previous month. The increase in ambulance delays whilst disappointing to note the increase, is as a result of an internal flow within the organisation and inability to offload ambulances within the required timeframe.

Actions completed in the past month to achieve recovery

Escalation of ambulance delays - internal escalation process reinstated and now being followed. Continued to work with EMAS to highlight other pathways to be accessed and not just conveyance to ED - Working towards access to SDEC pathways. Implementation of dashboard for Ambulance – IBOX

Timeframe for recovery

November 2019

Exception report written by

CrutchleyR

Assurance Committee

Directorate Management Board

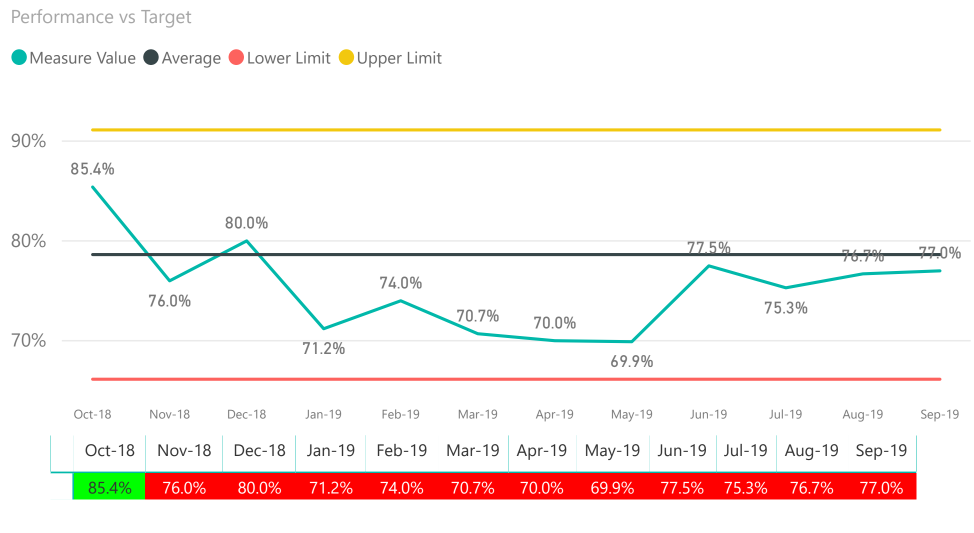
Next steps

Ensure Escalation processes are followed All SDEC Pathways have been shared with EMAS Quality & Compliance manager and are being discussed at their next Clinical Governance meeting. Increased capacity, with a Dr in Majors Lite to facilitate flow for Ambulance patients into Fit Stop. Ensure effective streaming through Majors Lite: in October 344 patients seen in majors Lite • 42% were discharged home (up from 17% in September) • 15% to UTC • 9% to other clinics • 13% to ACC • 15% referred direct to specialty • 6% referred in to main ED (20 patients)

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

September 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
85.0%	77.0%	↑	Debbie Needham



Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
85.4%	76.0%	80.0%	71.2%	74.0%	70.7%	70.0%	69.9%	77.5%	75.3%	76.7%	77.0%

What is driving under performance?

The Trust has undertaken 91.5 treatments with 21 of them breached, this is a slight reduction on previous months, resulting in performance of 77% which is a slight improvement on August. Breast, Skin and Urology are achieving the 62 day standard for September This is the first time in 9 months Urology have met the standard which is fantastic news. Challenges remain for access to initial outpatients within some services, diagnostics, numerous MDT discussions and access to outpatients after MDT

Actions completed in the past month to achieve recovery

Site ptl meetings corporate ptl meetings weekly performance meeting to discuss themes and pathway blocks Draft paper to non executive board to highlight challenges and possible solutions continued work on RAPID and NOLCP pathways Refreshed job description shared with tumour site leads for sign off

Exception report written by

BuckleyS

Timeframe for recovery

December 2019

Assurance Committee

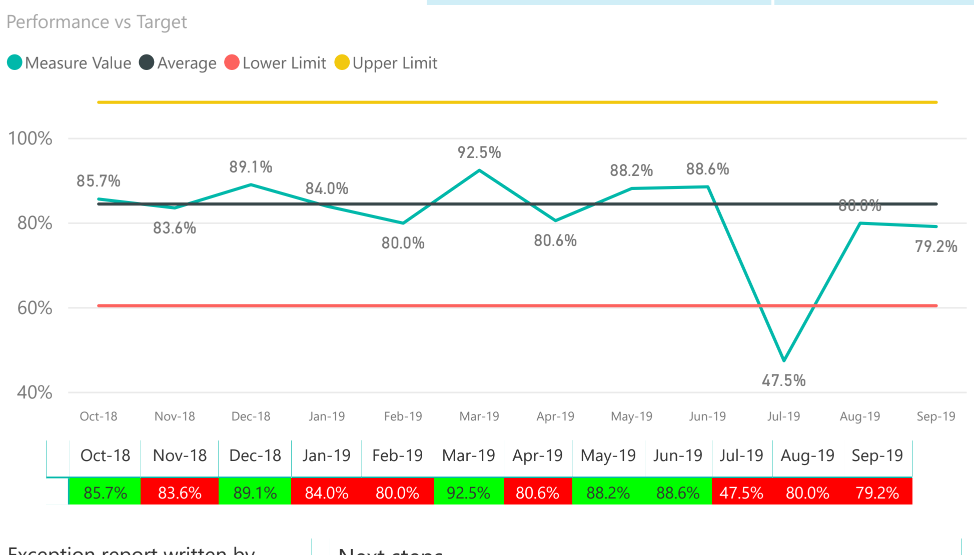
Finance Investment and Performance Committee

Next steps

Cancer Management Team to meet regularly with each tumours site now Clinical Director has allocated 1 day a week in job plan from November

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

September 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	85.0%	79.2%	↓	Debbie Needham



Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
85.7%	83.6%	89.1%	84.0%	80.0%	92.5%	80.6%	88.2%	88.6%	47.5%	80.0%	79.2%

What is driving under performance?

The Trust has not met the standard for consultant upgrade, reaching 79.2% against the local target of 85%, 5 accountable breaches (7 patients) – 4 due to complex pathways, 1 due to capacity problems in radiology and 2 due to medical reasons

Actions completed in the past month to achieve recovery

Upgrade patients continue to be tracked, monitored at site ptl meetings and at the corporate ptl meetings in order to expedite next steps.

Exception report written by

BuckleyS

Next steps

As above

Timeframe for recovery

November 2019

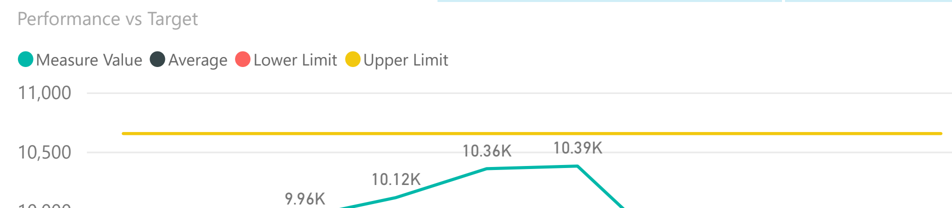
Assurance Committee

Finance Investment and Performance Committee

Unappointed Follow Ups

October 2019

Target	Actual	Direction of Travel	Accountable Executive
0	8967	↑	Debbie Needham



Performance vs Target

Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
8608	8723	9957	10119	10363	10385	9670	9801	9783	8967

What is driving under performance?

Current capacity shortage for news, follow ups and cancer patients.

Actions completed in the past month to achieve recovery

Follow up PTL is being scrutinised by the elective Access Lead and the management of follow up patients, as well as RTT and cancer patient pathways will be monitored on a named patient basis.

Timeframe for recovery

February 2020

Next steps

Set up weekly FUP PTL meetings by specialty, which will also fall under the performance management structure.

Exception report written by

BoydellT

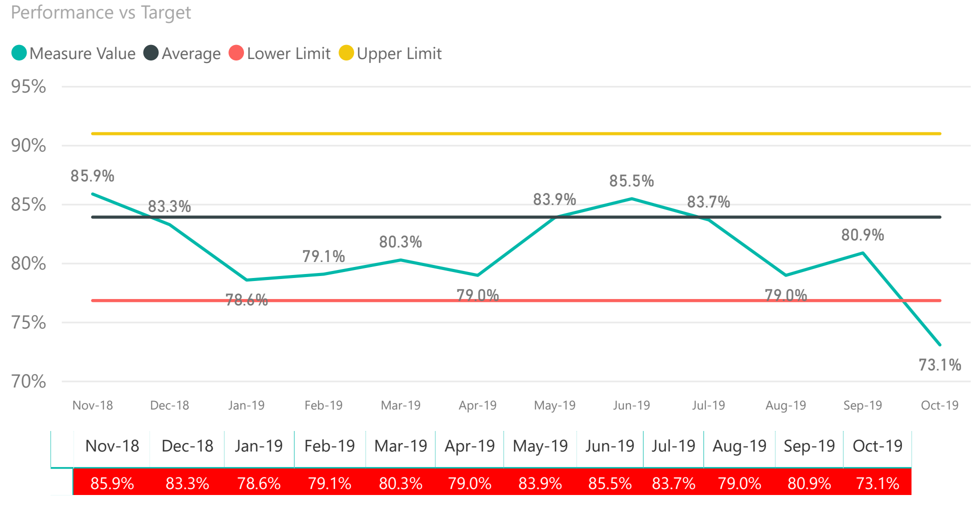
Assurance Committee

Finance Investment and Performance Committee

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

October 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	90.1%	73.1%		Debbie Needham

Performance vs Target



Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
85.9%	83.3%	78.6%	79.1%	80.3%	79.0%	83.9%	85.5%	83.7%	79.0%	80.9%	73.1%

What is driving under performance?

The main driver for the reduction in the proportion of patients spending less than 4 hours in A&E is internal flow constraints and demand across the organisation. This can be demonstrated by 86% of non-admitted patients spending less than 4 hours in A&E, whereas 35% of admitted patients spent less than 4 hours in A&E. With sustained activity the department has become regularly space constrained, leading to increase in patients spending longer than 4 hours in A&E.

Actions completed in the past month to achieve recovery

Development of training and supporting overseas appointments within the department. Collaboration with EMAS to highlight community pathways available and use of ACC to reduce conveyance rates to the Emergency Department. Rapid transfer and identification of patients suitable for Nye Bevan to decongest Emergency Department. ACC/SEDC - Long term development plan in progress of being developed to support reduction of patients attending ED. Continue the support of Streaming and Majors Lite projects. Increased hours of UTC to further support department at times of increased activity, ongoing work with commissioning colleagues to identify inappropriate attendances and maximise accessible pathways through development of a Directory of Service. Escalation processes reinstated for Ambulance Transfer waits and speciality referrals.

Exception report written by

CrutchleyR

Timeframe for recovery

November 2019

Assurance Committee

Finance Investment and Performance Committee

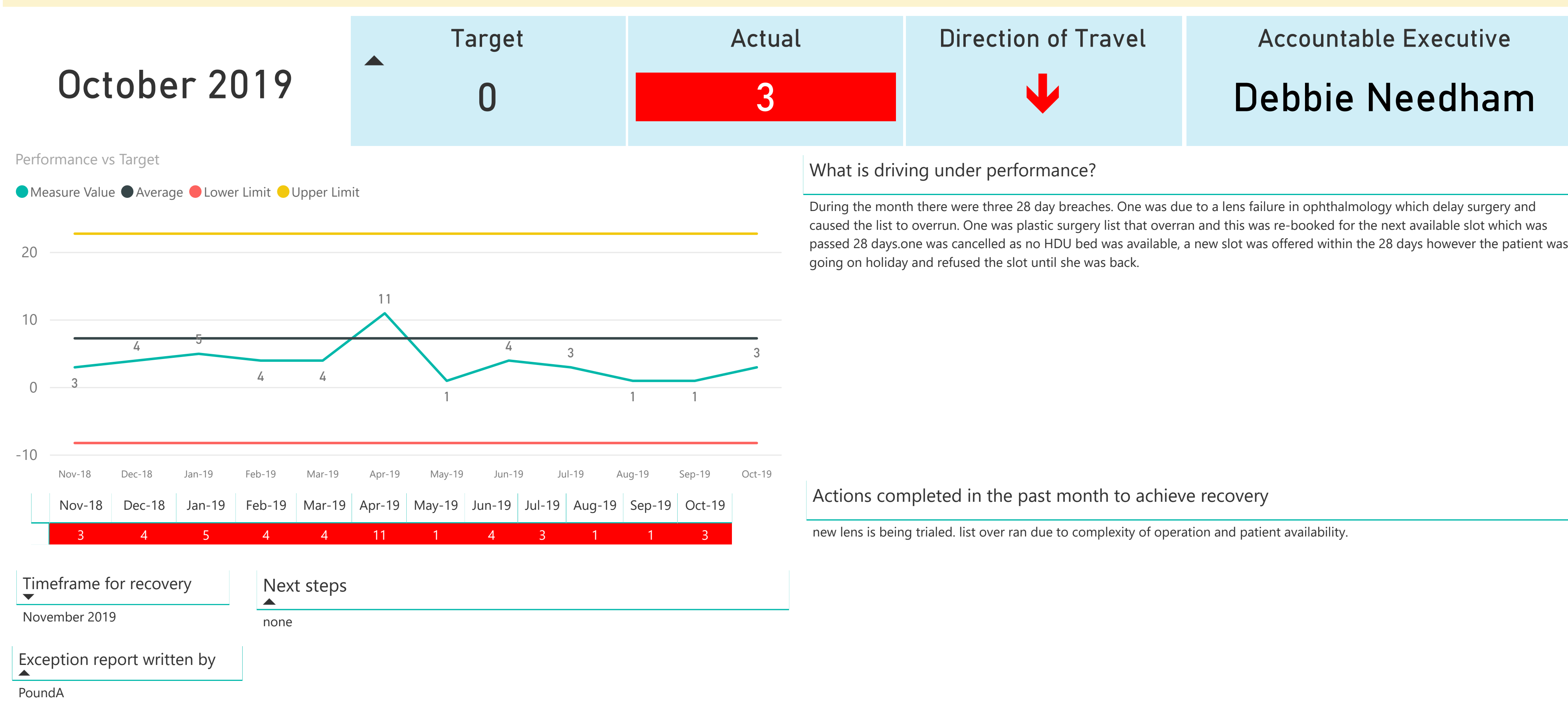
Next steps

Ensure all escalation processes are followed Overnight streaming to be introduced in January – recruitment underway SDEC extending hours to 08:00-22:00 from December 2nd Continue development of Directory of Service. Work underway with Out-of-Hours provider to increase streaming of patients during the Out-of-Hours period Continue to stream patients effectively at the front door - 36% of all ED attendances (4071 patients) in October were streamed by PCSS: 32% of all ED attendances(3968 patients) were diverted from ED by our front door services. Of these only 7% (284 patients) were put through to main ED • 8% to majors lite • 30% UTC • 44% to Injury Service • 1% ACC • 4% other clinics

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

October 2019

Target	Actual	Direction of Travel	Accountable Executive
0	3	↓	Debbie Needham



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

What is driving under performance?

During the month there were three 28 day breaches. One was due to a lens failure in ophthalmology which delay surgery and caused the list to overrun. One was plastic surgery list that overran and this was re-booked for the next available slot which was passed 28 days.one was cancelled as no HDU bed was available, a new slot was offered within the 28 days however the patient was going on holiday and refused the slot until she was back.

Actions completed in the past month to achieve recovery

new lens is being trialed. list over ran due to complexity of operation and patient availability.

Timeframe for recovery

November 2019

Next steps

none

Exception report written by

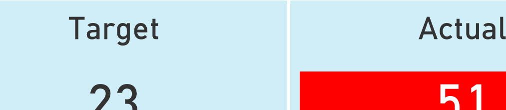
PoundA

Assurance Committee

Finance Investment and Performance Committee

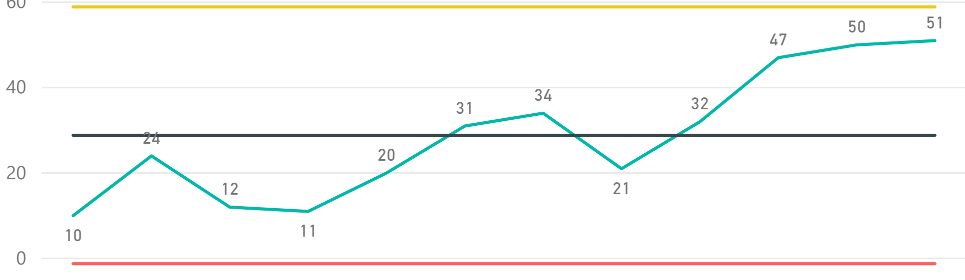
Delayed transfer of care

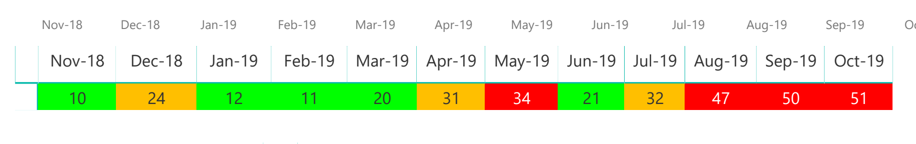
October 2019



Target	Actual	Direction of Travel	Accountable Executive
23	51		Debbie Needham

Performance vs Target





Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
10	24	12	11	20	31	34	21	32	47	50	51

What is driving under performance?

Actions completed in the past month to achieve recovery

Timeframe for recovery

Next steps

Exception report written by

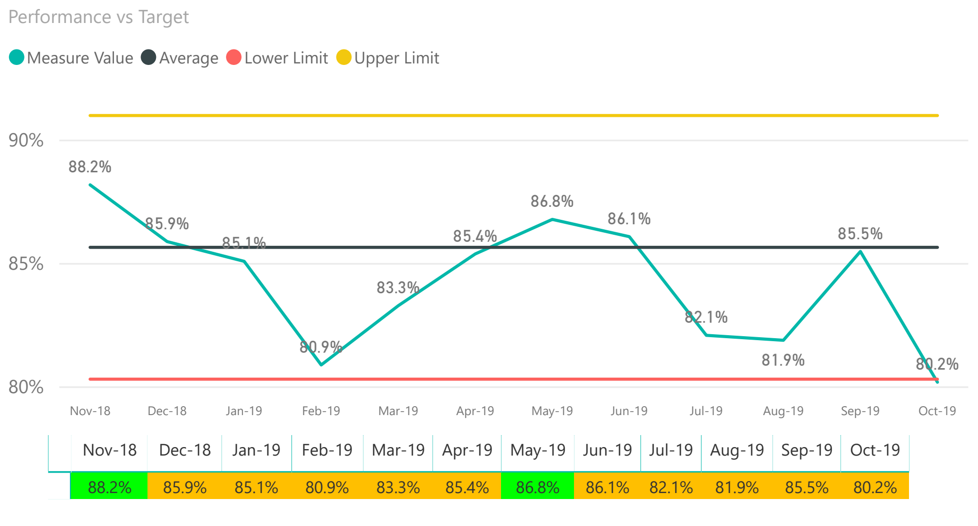
Assurance Committee

Finance Investment and Performance Committee

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

October 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
86.4%	80.2%		Sheran Oke



Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
88.2%	85.9%	85.1%	80.9%	83.3%	85.4%	86.8%	86.1%	82.1%	81.9%	85.5%	80.2%

What is driving under performance?

The recommendation rate for A&E (inc Springfield, ambulatory care and eye casualty) was 6.2% below the national average when comparing the result for October with the most recent national average data available (August 2019). This is 5.3% decrease from the September result which was at 0.9% below the national average. Trust pressures increased within October and this can be seen within the A&E free text comments where waiting within the A&E department was mentioned frequently.

Actions completed in the past month to achieve recovery

A&E continue with the initiative implemented at the beginning of the year to reduce waiting times for lower priority patients according the emergency needs.

Exception report written by

LovesyR

Timeframe for recovery

March 2020

Assurance Committee

Quality Governance Committee

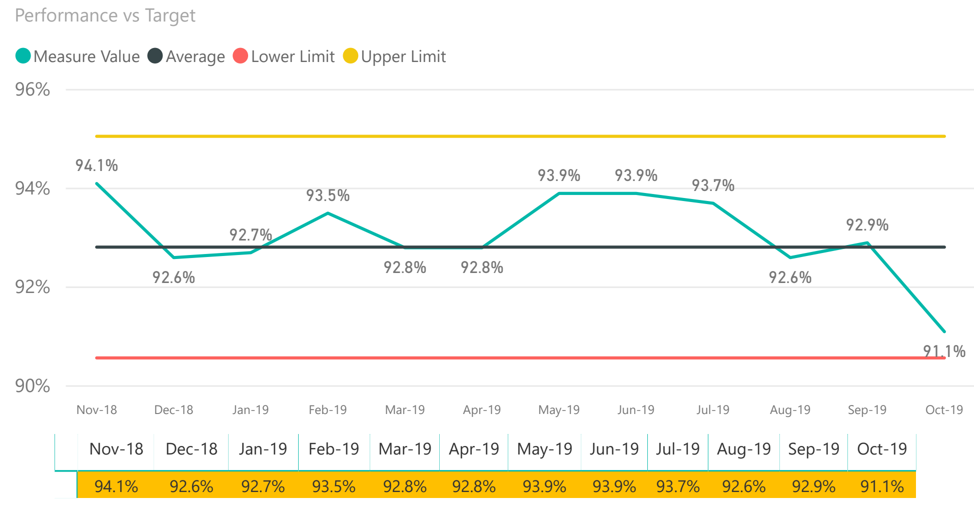
Next steps

Monitor the impact of the new initiative in A&E. A piece of work in Ophthalmology is also being undertaken regarding waiting times in eye casualty (For NHSE reporting, Eye Casualty is included within the A&E results).

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

October 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	95.7%	91.1%	↓	Sheran Oke

Performance vs Target



Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
94.1%	92.6%	92.7%	93.5%	92.8%	92.8%	93.9%	93.9%	93.7%	92.6%	92.9%	91.1%

What is driving under performance?

The result for Inpatient and Day Case continues to be within normal levels of variation. The Inpatient and Day Case result is 4.6% below the national average for October when compared with 2.8% for September. Results per ward continue to vary greatly.

Actions completed in the past month to achieve recovery

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.

Exception report written by

LovesyR

Timeframe for recovery

March 2020

Assurance Committee

Quality Governance Committee

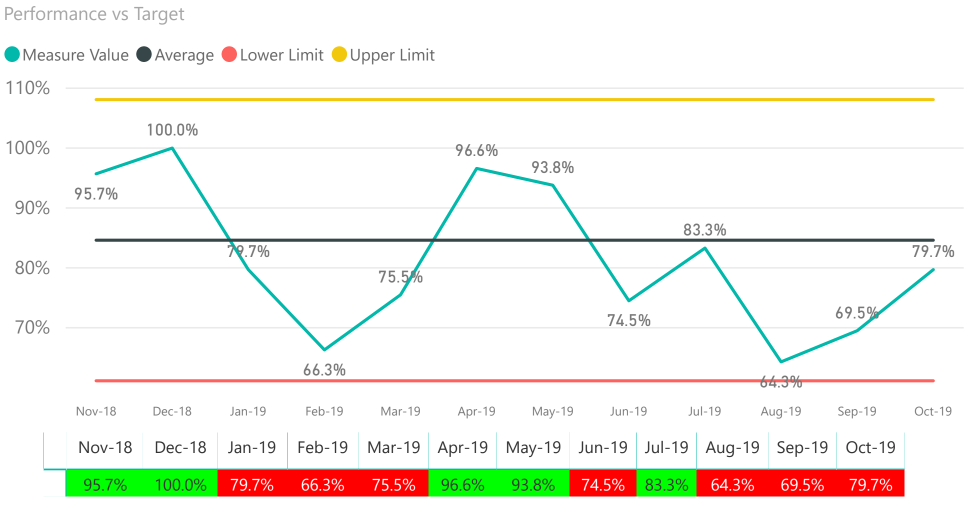
Next steps

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.

Stroke patients spending at least 90% of their time on the stroke unit

October 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	80.0%	79.7%	↑	Debbie Needham

Performance vs Target



Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
95.7%	100.0%	79.7%	66.3%	75.5%	96.6%	93.8%	74.5%	83.3%	64.3%	69.5%	79.7%

What is driving under performance?

Actions completed in the past month to achieve recovery

Exception report written by

Next steps

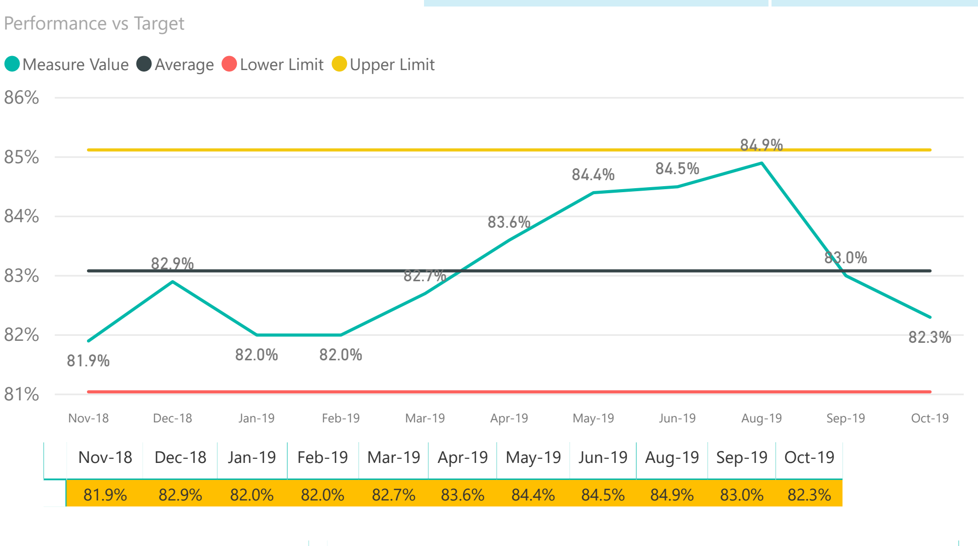
Timeframe for recovery

Assurance Committee

Quality Governance Committee

Percentage of all trust staff with mandatory refresher fire training compliance

October 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	85.0%	82.3%	↓	Janine Brennan



Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Aug-19	Sep-19	Oct-19
81.9%	82.9%	82.0%	82.0%	82.7%	83.6%	84.4%	84.5%	84.9%	83.0%	82.3%

What is driving under performance?

Actions completed in the past month to achieve recovery

Exception report written by

Next steps

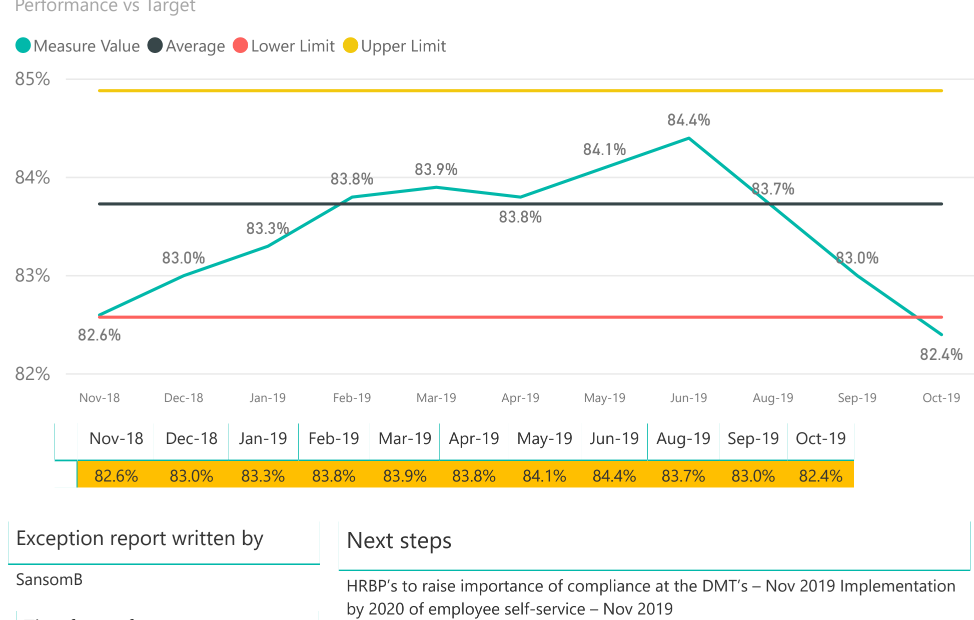
Timeframe for recovery

Assurance Committee

Workforce Committee

Percentage of all trust staff with role specific training compliance

October 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	85.0%	82.4%	↓	Janine Brennan



Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Aug-19	Sep-19	Oct-19
82.6%	83.0%	83.3%	83.8%	83.9%	83.8%	84.1%	84.4%	83.7%	83.0%	82.4%

What is driving under performance?

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

Actions completed in the past month to achieve recovery

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 – Oct 2019 Promotion on the importance of RSET is included in the appraisal training – Oct 2019

Exception report written by

SansomB

Timeframe for recovery

April 2020

Assurance Committee

Workforce Committee

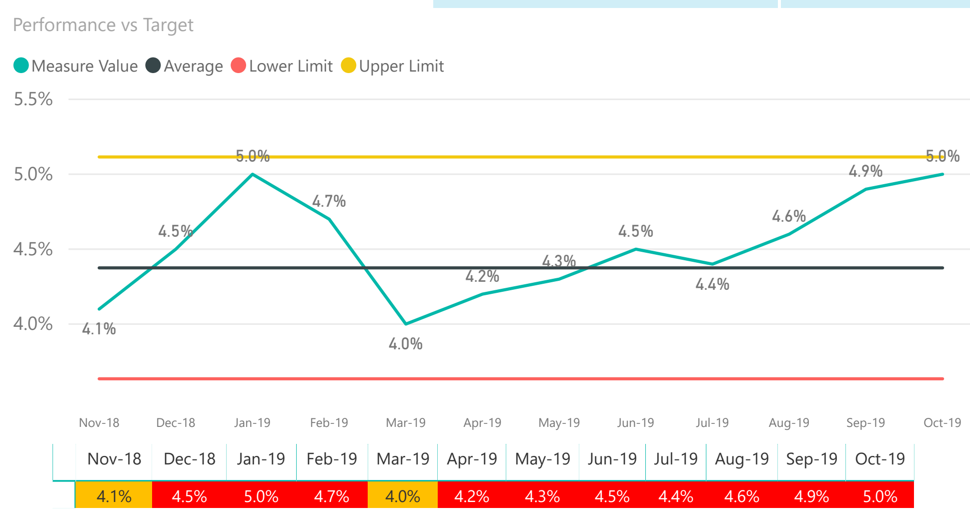
Next steps

HRBP's to raise importance of compliance at the DMT's – Nov 2019 Implementation by 2020 of employee self-service – Nov 2019

Sickness Rate

October 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	3.8%	5.0%		Janine Brennan

Performance vs Target



Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
4.1%	4.5%	5.0%	4.7%	4.0%	4.2%	4.3%	4.5%	4.4%	4.6%	4.9%	5.0%

What is driving under performance?

Anxiety and depression plus pregnancy related absences are high. There are a high number of bullying and harassment cases across all divisions. Staff survey results and reasons for absence data suggest staff are experiencing an increase in MSK problems.

Actions completed in the past month to achieve recovery

Robust sickness management continues with support from the HR Business Partners and HR Advisors. (October 2019)

Exception report written by

SansomB

Timeframe for recovery

April 2020

Assurance Committee

Workforce Committee

Next steps

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. (December 2019) Sickness reporting will now reflect attendance levels rather than absence levels to acknowledge and promote the health and wellbeing of staff. (November 2019)

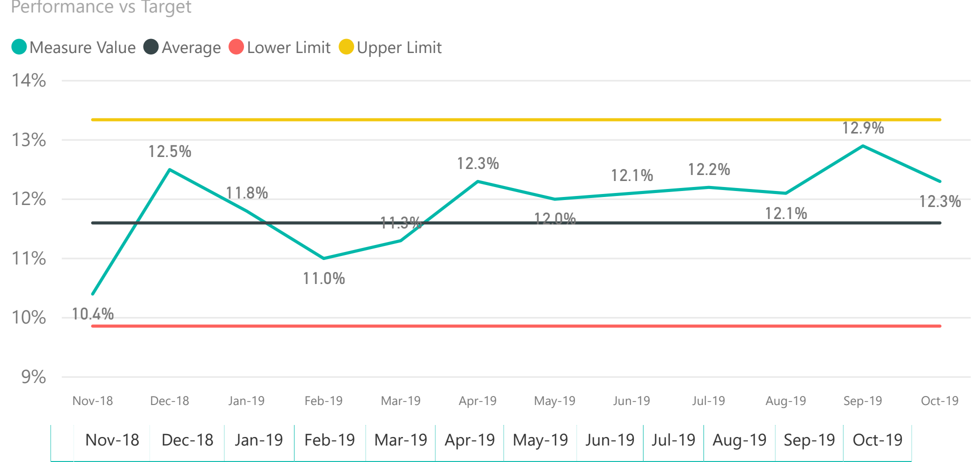
Enclosure D

Staff: Trust level vacancy rate - All

October 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
9.0%	12.3%	↑	Janine Brennan

Performance vs Target



Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
10.4%	12.5%	11.8%	11.0%	11.3%	12.3%	12.0%	12.1%	12.2%	12.1%	12.9%	12.3%

What is driving under performance?

There is a national shortage of nursing staff along with a shortage within other professional allied specialities

Actions completed in the past month to achieve recovery

Local recruitment continues – Oct 2019 Overseas recruitment for nurses continues including direct overseas recruitment through existing oversea recruits – Oct 2019 Conducted and completed procurement process for additional overseas recruitment – Oct 2019 Clinical Resourcing Manager working closely with hard to recruit areas – Oct 2019 Started a Radiography campaign – Oct 2019

Exception report written by

SansomB

Timeframe for recovery

September 2020

Assurance Committee

Workforce Committee

Next steps

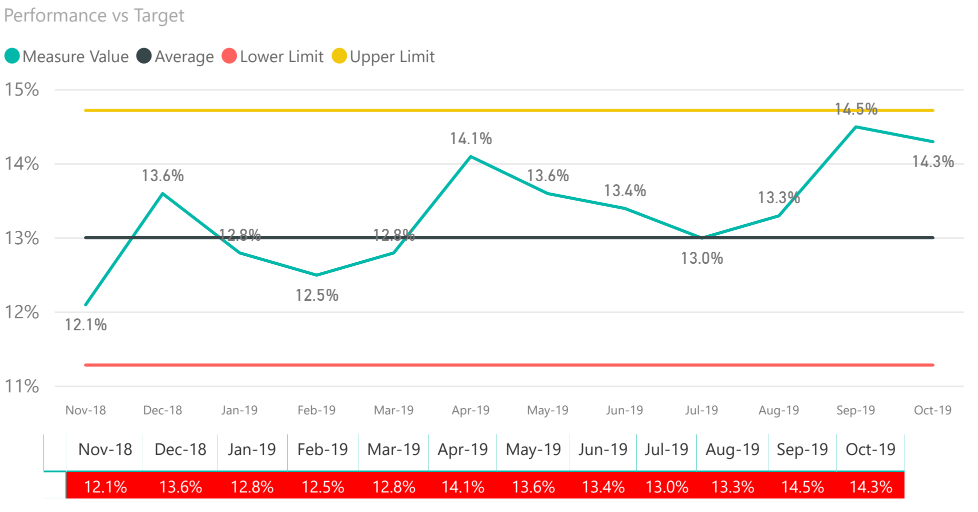
Plan overseas trips to recruit overseas nurses – Nov 2019 Undertake skype interviews – Nov 2019 Clinical Resourcing Manager will contact Managers to support them with advertising their vacancies – Nov 2019 Continue sourcing candidates and complete interviews for direct and agency candidates – Nov 2019

Staff: Trust level vacancy rate - Other Staff

October 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
9.0%	14.3%		Janine Brennan

Performance vs Target



Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
12.1%	13.6%	12.8%	12.5%	12.8%	14.1%	13.6%	13.4%	13.0%	13.3%	14.5%	14.3%

What is driving under performance?

There is a national shortage within professional allied specialities

Actions completed in the past month to achieve recovery

Clinical Resourcing Manager working closely with hard to recruit areas – Oct 2019 Started a Radiography campaign – Oct 2019

Exception report written by

SansomB

Timeframe for recovery

September 2020

Assurance Committee

Workforce Committee

Next steps

Continue sourcing candidates and complete interviews for direct and agency candidates – Nov 2019

Staff: Trust level vacancy rate - Registered Nursing Staff

October 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
9.0%	10.7%		Janine Brennan

Performance vs Target

Measure Value, Average, Lower Limit, Upper Limit

14%
12%
10%
8%

Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
7.6%	11.6%	11.3%	11.3%	11.3%	11.1%	11.1%	11.5%	12.3%	12.7%	13.1%	10.7%

What is driving under performance?

There is a national shortage of nursing staff

Actions completed in the past month to achieve recovery

Local recruitment continues – Oct 2019 Overseas recruitment for nurses continues including direct overseas recruitment through existing oversea recruits – Oct 2019 Conducted and completed procurement process for additional overseas recruitment – Oct 2019

Exception report written by

SansomB

Timeframe for recovery

September 2020

Assurance Committee

Workforce Committee

Next steps

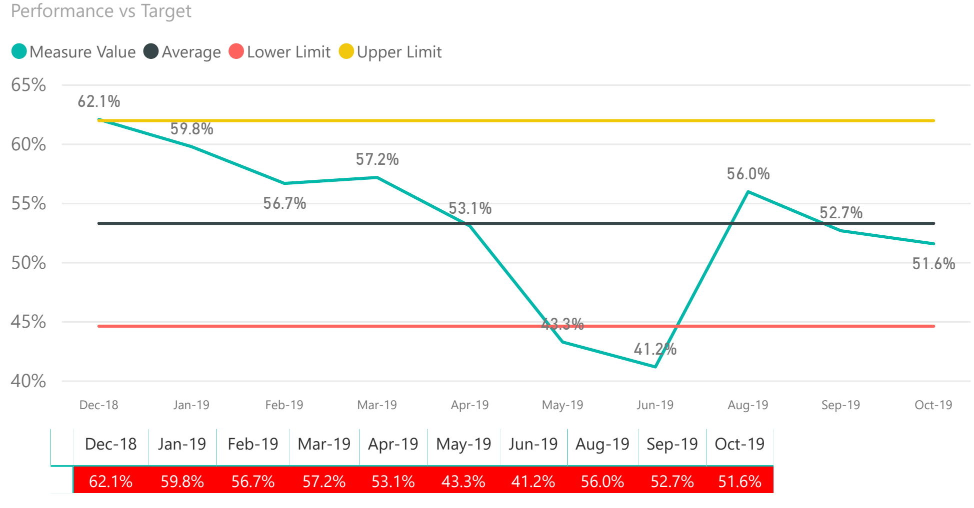
Plan overseas trips to recruit overseas nurses – Nov 2019 Undertake skype interviews – Nov 2019 Clinical Resourcing Manager will contact Managers to support them with advertising their vacancies – Nov 2019

Fire Drill Compliance

October 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
85.0%	51.6%		Stuart Finn

Performance vs Target



Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Aug-19	Sep-19	Oct-19
62.1%	59.8%	56.7%	57.2%	53.1%	43.3%	41.2%	56.0%	52.7%	51.6%

What is driving under performance?

In order to provide a more accurate and meaningful record of fire drills, we have ceased to accept an unplanned evacuation as a drill. This has lead to a drop in fire drills and Table Top exercises, but through training and assistance we envisage that this will improve, particularly table tops

Actions completed in the past month to achieve recovery

We encourage departments to contact us should they need any assistance with their fire Drills, and as with Evacuation Plans we re-iterate this in training (Refreshers, Inductions, RoK etc)

Exception report written by

WrightA1

Timeframe for recovery

December 2019

Assurance Committee

Finance Investment and Performance Committee

Next steps

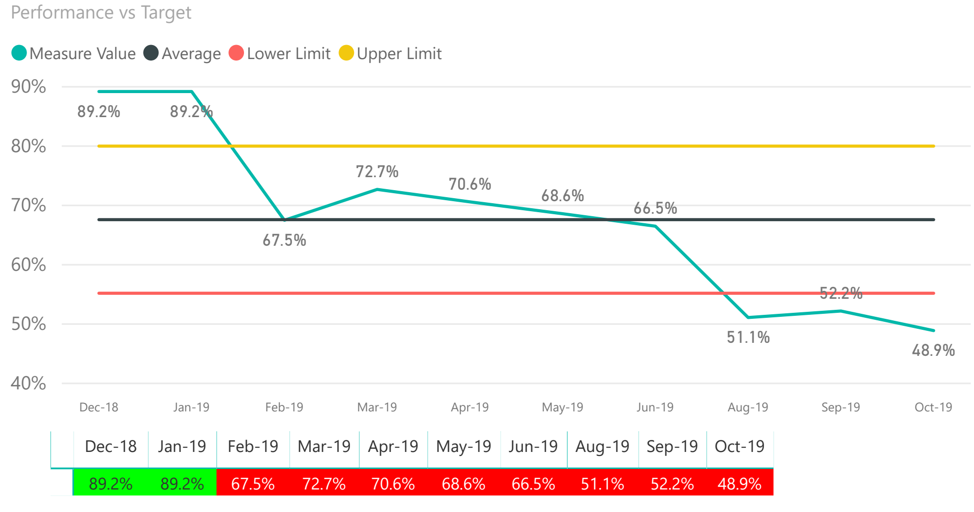
Again a pro-active approach from Divisional and Department managers is needed to get compliance in this area above 85%.

Fire Evacuation Plan

October 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
85.0%	48.9%		Stuart Finn

Performance vs Target



Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Aug-19	Sep-19	Oct-19
89.2%	89.2%	67.5%	72.7%	70.6%	68.6%	66.5%	51.1%	52.2%	48.9%

What is driving under performance?

We have worked hard over the previous few months in order to update our database and this provides a very accurate representation of our current position. We continue to emphasise, in training sessions and on our ward visits, that timely review of evacuation plans is important.

Actions completed in the past month to achieve recovery

The Fire Team will continue to stress this point in our various meetings with wards and departments, and will encourage them to contact us at any time for us to assist as required. We are always available to help in reviewing plans with them as necessary.

Exception report written by

WrightA1

Timeframe for recovery

December 2019

Assurance Committee

Finance Investment and Performance Committee

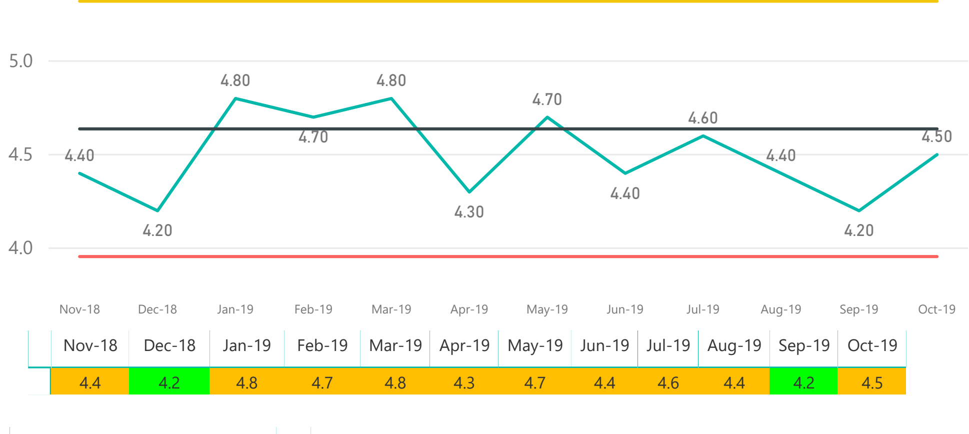
Next steps

We continue to encourage Divisional and Department Managers to play a roll in ensuring these plans are reviewed and forwarded to us in a timely manner.

Length of stay - All

October 2019

Target	Actual	Direction of Travel	Accountable Executive
4.2	4.5	↓	Debbie Needham



Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
4.4	4.2	4.8	4.7	4.8	4.3	4.7	4.4	4.6	4.4	4.2	4.5

What is driving under performance?

Actions completed in the past month to achieve recovery

Timeframe for recovery

Next steps

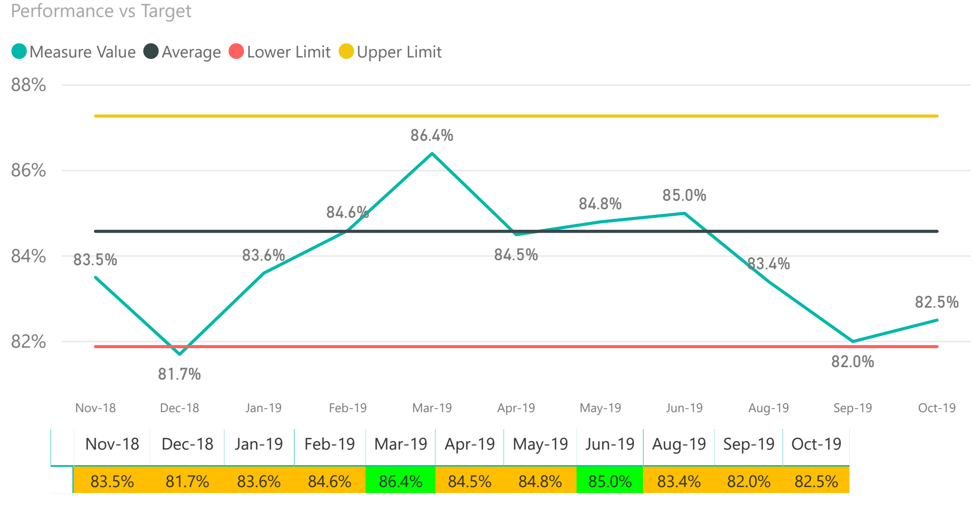
Exception report written by

Assurance Committee

Finance Investment and Performance Committee

Percentage of staff with annual appraisal

October 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	85.0%	82.5%		Janine Brennan



Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Aug-19	Sep-19	Oct-19
83.5%	81.7%	83.6%	84.6%	86.4%	84.5%	84.8%	85.0%	83.4%	82.0%	82.5%

What is driving under performance?

The appraisal spreadsheet covers two months, so some areas have waited until the final cut-off date to notify L&D of the appraisal, even though the appraisal may have occurred during the first month meaning the member of staff is one month out of date. Appraisal information is being received after the submission deadline. The number of new starters within some depts. has affected the overall % compliance due to timing of start date and appraisal date. Some of the 'appraisal co-ordinators' have left this role and the area has not allocated a replacement. Therefore we are not receiving the relevant appraisal spreadsheet within the required timeframes.

Actions completed in the past month to achieve recovery

The L&D manager has attend some DMB and DMT meetings to understand the reasons for low compliance and to reiterate processes. Main reasons for low compliance have been sickness and mat leave – Oct 2019 Training for managers continues which covers the process of submission of data. 1:1's are also being conducted with managers – Oct 2019 Areas without an 'appraisal co-ordinator' have been asked to allocate this role to someone and to notify L&D so we can make them aware of the process and support them – Oct 2019

Exception report written by

SansomB

Timeframe for recovery

January 2020

Assurance Committee

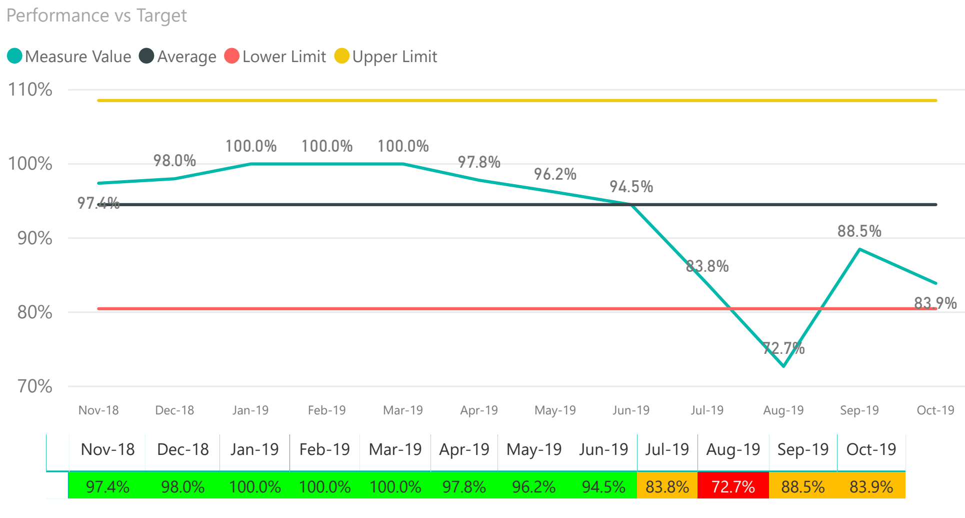
Workforce Committee

Next steps

The HRBPs to address with those managers with low compliance and if necessary create action plans – Nov 2019 Those managers who have a discrepancy with the % of compliance have been asked to contact the L&D manager so an audit can be carried out – Nov 2019

Complaints responded to within agreed timescales

October 2019	PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
	90.0%	83.9%	↓	Sheran Oke



Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
97.4%	98.0%	100.0%	100.0%	100.0%	97.8%	96.2%	94.5%	83.8%	72.7%	88.5%	83.9%

Exception report written by

CooperL1

Timeframe for recovery

December 2019

Assurance Committee

Quality Governance Committee

Next steps

At present the focus is on ensuring that new members of staff are trained as quickly and efficiently as possible in order for them to support the service moving forwards. Ways of working are continually reviewed to see if any changes may be made to improve efficiency although this is limited given that there are statutory regulations in place. Weekly reports are issued Trust wide to ensure that Divisional colleagues are aware of any delays.

What is driving under performance?

Performance has been impacted due to reduced staffing levels. This has been due to an unexpected bereavement within the team and another member of the team moving to an internal promotion. Maximum holidays during this period have also had a significant impact and at times the service has been running with less than 50% of the normal staffing levels. A restructure has also taken place whereby the Head of Department is now managing 4 services rather than 1. The services have required considerable support during a period of change.

Actions completed in the past month to achieve recovery

Recruiting is now complete and 2 new members of staff remain in training at present. To support the service a temporary Complaints Officer is in post focusing solely on the completion of Trust responses. The response rate has improved by 14% in the last month which is a significant achievement.

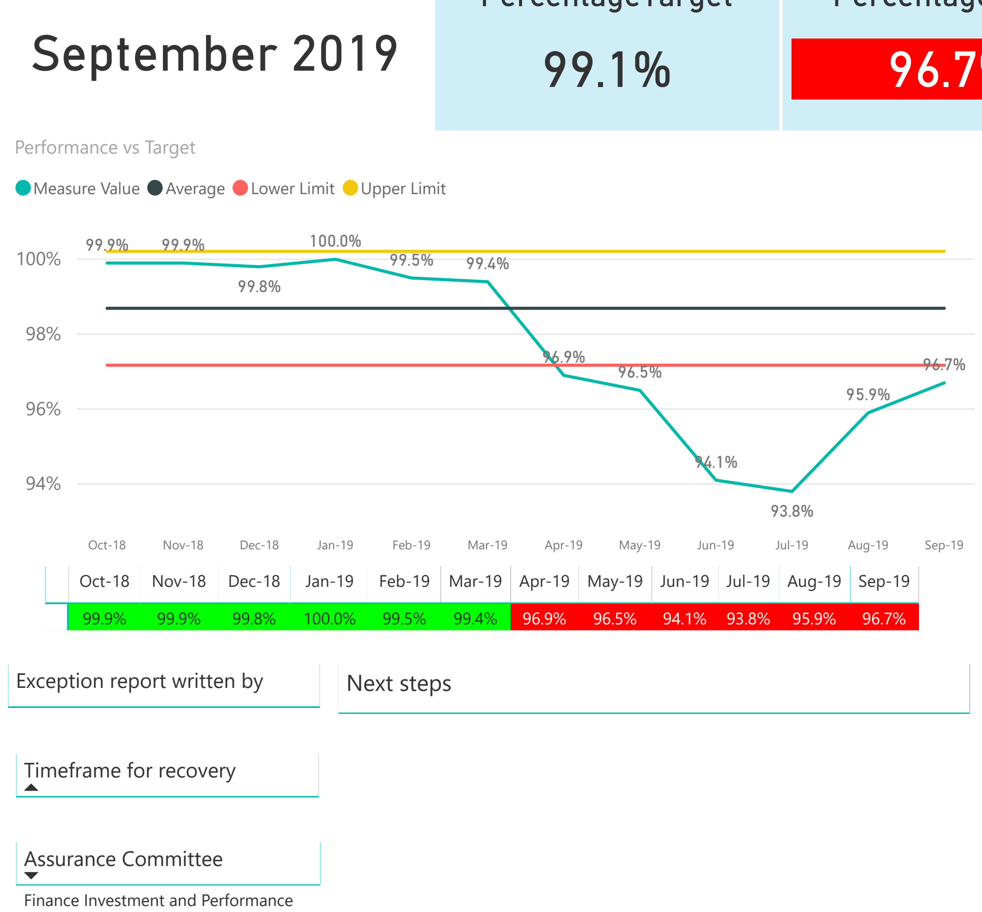
Enclosure D

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

September 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
99.1%	96.7%	↑	Debbie Needham

Performance vs Target



Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
99.9%	99.9%	99.8%	100.0%	99.5%	99.4%	96.9%	96.5%	94.1%	93.8%	95.9%	96.7%

What is driving under performance?

Actions completed in the past month to achieve recovery

Exception report written by

Next steps

Timeframe for recovery

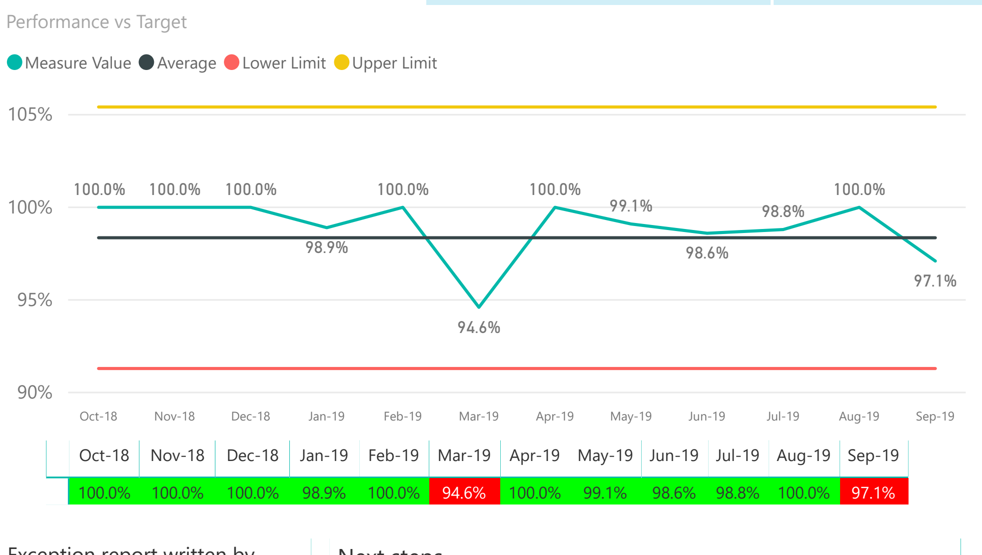
Assurance Committee

Finance Investment and Performance Committee

Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug

September 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
98.0%	97.1%		Debbie Needham



Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
100.0%	100.0%	100.0%	98.9%	100.0%	94.6%	100.0%	99.1%	98.6%	98.8%	100.0%	97.1%

What is driving under performance?

The Trust has not met the subsequent drug standard reaching 97.1% with 2 breaches, 1 breach in colorectal due to treatment being deferred due to funding not being requested and 1 breach in urology due to an administrative error with booking the procedure, there has been a reduction in the number of subsequent drug treatments for September which has affected the Trusts ability to meet the standard

Actions completed in the past month to achieve recovery

As the Trust regularly meet this standard, it has been failed ro September due to a reduction in treatments, oncology and cancer services continue to monitor performance against this standard and expedite treatment which is within our control.

Exception report written by

BuckleyS

Next steps

As above

Timeframe for recovery

November 2019

Assurance Committee

Finance Investment and Performance Committee

Delayed transfer of care

October 2019

Target	Actual	Direction of Travel	Accountable Executive
23	51	↓	Debbie Needham

Performance vs Target

Measure Value · Average · Lower Limit · Upper Limit

60
40
20
0

10 24 12 11 20 31 34 21 32 47 50 51

Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19

Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
10	24	12	11	20	31	34	21	32	47	50	51

What is driving under performance?

Actions completed in the past month to achieve recovery

Exception report written by

Next steps

Timeframe for recovery

Assurance Committee

Finance Investment and Performance Committee

Never event incidence

October 2019

Target	Actual	Direction of Travel	Accountable Executive
0	1	⇔	Matt Metcalfe

Performance vs Target

Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
0	0	0	0	0	0	0	0	1	0	1	1

What is driving under performance?

Actions completed in the past month to achieve recovery

Exception report written by

Next steps

Timeframe for recovery

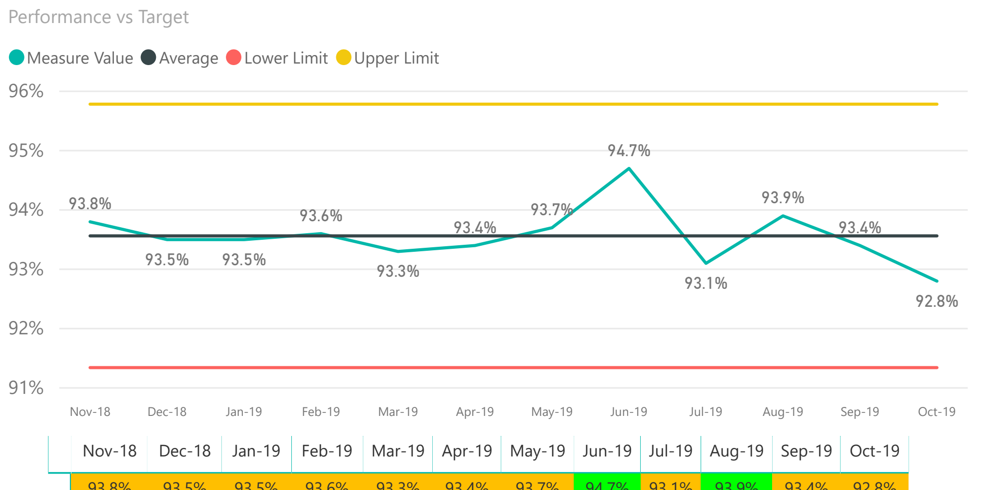
Assurance Committee

Quality Governance Committee

Friends & Family Test % of patients who would recommend: Outpatients

October 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
93.8%	92.8%	↓	Sheran Oke



Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
93.8%	93.5%	93.5%	93.6%	93.3%	93.4%	93.7%	94.7%	93.1%	93.9%	93.4%	92.8%

What is driving under performance?

The result for Outpatients in October was 1% below the national average compared with September achieving above target by 0.4%.

Actions completed in the past month to achieve recovery

Patient Experience Champions have been recruited to raise awareness of the importance of patient experience and to disseminate this to their teams. There are currently 4 recruited from within Outpatients.

Exception report written by

LovesyR

Timeframe for recovery

March 2020

Assurance Committee

Quality Governance Committee

Next steps

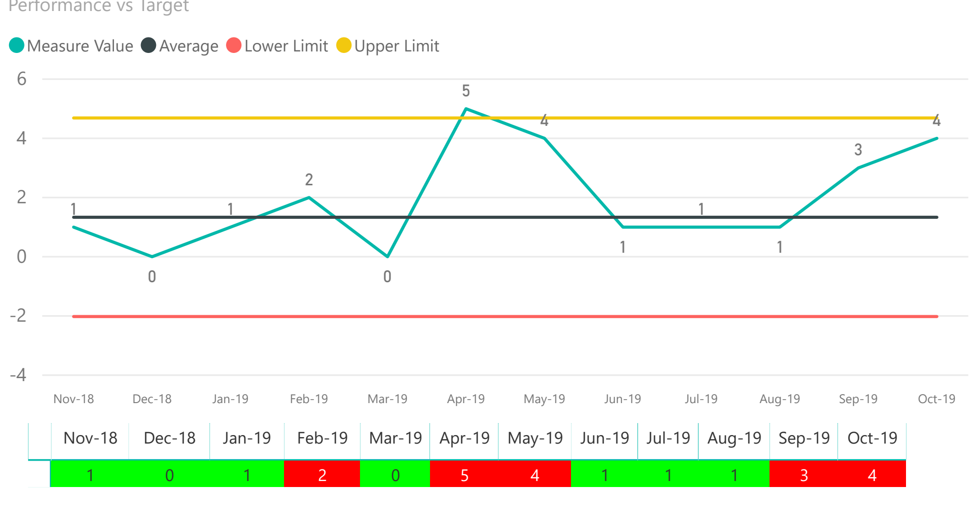
Continue with trust wide recruitment of patient experience champions. Surgery division are currently reviewing the ways in which patients are communicated with when their surgery is cancelled. There is also work being undertaken to review current waiting times within Opthalmology. All of this work is likely to have an impact on patient experience within the surgery division.

MSSA > 2 Days

October 2019

Target	Actual	Direction of Travel	Accountable Executive
1	4		Sheran Oke

Performance vs Target



Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
1	0	1	2	0	5	4	1	1	1	3	4

Exception report written by

CrutchleyR

Timeframe for recovery

November 2019

Assurance Committee

Quality Governance Committee

Next steps

(Below are 3 actions from the MSSA reduction plan, not all actions, as identified in the previous paragraph this is monitored through IPSG) • To scope out the introduction of non-ported cannulas across the Trust, with the exception of theatres, a meeting is being held on November 14th 2019. An options appraisals paper will then be presented to the Clinical Quality and Effectiveness Group (CQEG). • To trial chlorehexidine port covers on the end of long- term lines in paediatrics. Paediatric shared decision making council have taken the lead for the project with support from IPC. This action is on track. • To implement annual assessment of competence for Aseptic Non Touch Technique (ANTT) – this has commenced in the Surgical Division but not the Medical Division. This will be

What is driving under performance?

There is no National mandated ceiling. The Trust has set itself an internal ceiling of 13 hospital onset MSSA bacteraemia for 2019/20. In October there were 4 patients who developed a hospital onset MSSA bacteraemia. One of these patients was a relapse case. At the end of October there were 19 patients who developed a hospital onset MSSA bacteraemia.

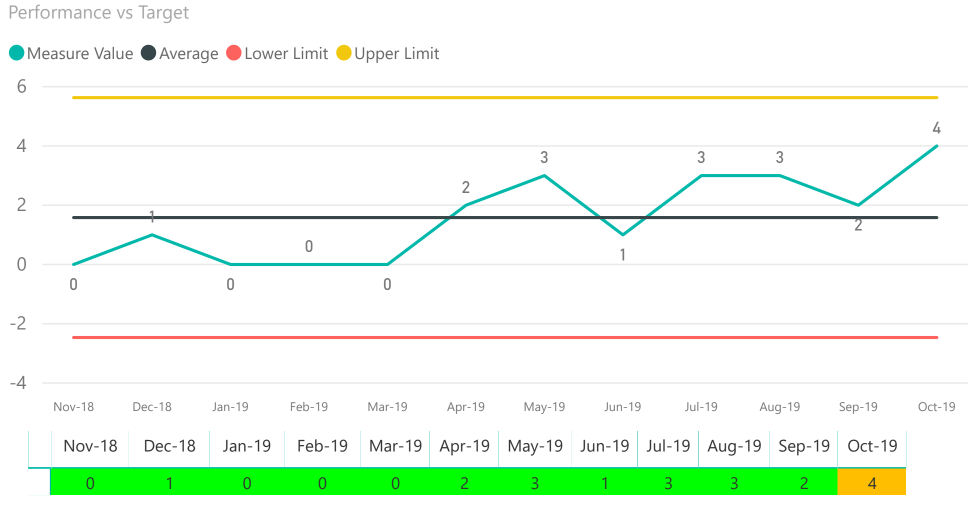
Actions completed in the past month to achieve recovery

The Infection Prevention and Control Team have performed a thematic review on the first 15 patients that were identified as hospital onset MSSA bacteraemia and this was presented at the Infection Prevention Steering Group (IPSG) meeting on 25th September 2019. This classification continues in October. This identifies which case was unavoidable and avoidable. 10 of the 18 patients were already colonised with MSSA on admission. The classification enables the IPCT to focus on the avoidable MSSA bacteraemias. One of the key themes is vascular access devices for example cannulas. A reduction plan has been produced and is being monitored through IPSG. This will be presented again at IPSG in December 2019.

HOHA and COHA (C-Diff > 2 Days)

October 2019

Target	Actual	Direction of Travel	Accountable Executive
3	4		Sheran Oke



Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
0	1	0	0	0	2	3	1	3	3	2	4

What is driving under performance?

The Trust has an external ceiling of 40 patients with Hospital Onset Healthcare (HOHA) Associated Clostridium difficile Toxin A and B positive and Community Onset Healthcare Associated (COHA) Clostridium difficile Toxin A and B positive for 2019-2020. In October there were 2 patients who developed a HOHA and 2 patients who developed a COHA. At the end of October there were 13 patients who developed a HOHA and 13 patients who developed a COHA.

Actions completed in the past month to achieve recovery

There is a Clostridium difficile plan of work which is monitored quarterly through the Infection Prevention and Control Steering Group quarterly. This was presented in October 2019. This is due to be presented again in January 2020.

Exception report written by

CrutchleyR

Timeframe for recovery

January 2020

Assurance Committee

Quality Governance Committee

Next steps

All patients that are identified as having a HOHA or a COHA have a Post Infection Review (PIR) performed, with input from the Community Infection Prevention and Control Team for the COHA's. This is then reviewed by the Clinical Commissioning Group (CCG) who then identify if there are any lapses in care. 18 patients have been reviewed to date by the CCG and there have been no lapses in care. Monthly reports reporting on HOHA's and COHA's are reported at the Infection Prevention Steering Group and the Infection Prevention Operational Group meetings. This is also reported quarterly through the Clinical Quality and Effectiveness Group (CQEG) and the Quality Governance Committee.

Readmissions within 30 days of previous reporting month

October 2019

PercentageTarget	PercentageValue	Direction of Travel	Accountable Executive
12.0%	13.4%	↓	Matt Metcalfe

Performance vs Target

Measure Value | Average | Lower Limit | Upper Limit

14.0%
13.5%
13.0%
12.5%
12.0%

13.7%
13.5%
13.4%
13.3%
13.2%
12.7%

May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19

May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
12.7%	13.7%	13.3%	13.5%	13.2%	13.4%

What is driving under performance?

Actions completed in the past month to achieve recovery

Exception report written by

Next steps

Timeframe for recovery

Assurance Committee

Quality Governance Committee

Corporate Scorecard – Integrated Performance Report

Date: November 2019
Reporting Period: October 2019

Pilot SPC Charts

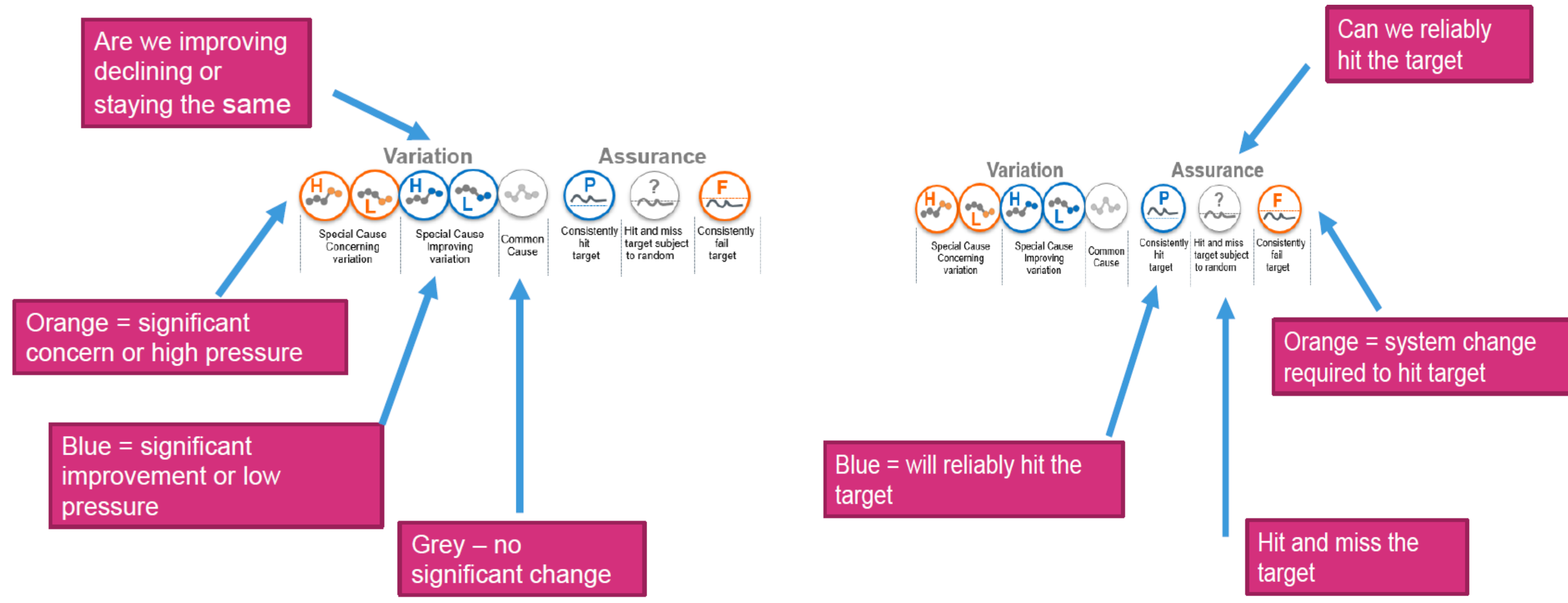
Collaboration work with KGH and a wish to move to a common style of Board reporting was agreed by the Collaboration Steering Group in August 2019. Subsequently, an assessment of both Boards' report was completed, leading to eight metrics being agreed for both trusts to report on using SPC. The number 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		
	H L	H L	?	P	F
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

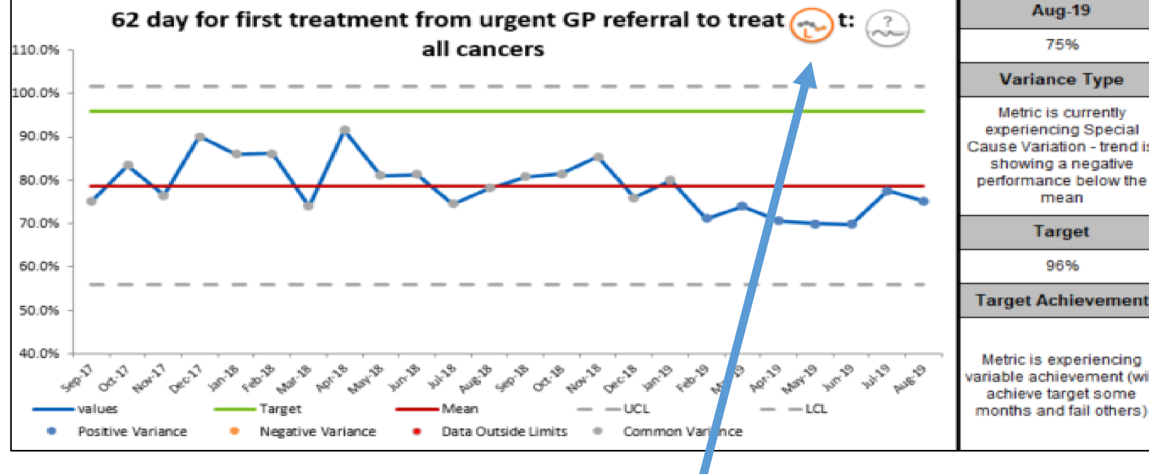
High level key - variation

High level key - assurance



SPC Exception Chart Template

High level chart summary



Background: Brief definition of the metric
What the chart tells us: Commentary about the variation and target achievement.
Issues: Any issues related to meeting the target
Actions: Things in train to address improvement or maintenance of the performance. This may be identifying when a step change in process takes place, which should also be annotated on the chart.
Mitigations: Things in place already to assist in achievement of the target.

Variance and assurance icons as shown in summary table

Narrative to support interpretation of the chart

SPC Metric Summary

Corporate Scorecard Area	Metric	Target	Variation	Assurance	Chart
Caring	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	96%		F	Page 12
Effective	Mortality: HSMR	>= 100		?	Page 13
	Mortality: SHMI	>= 100		?	Page 14
Responsive	31 day for second or subsequent treatment - anti cancer drug treatments	98%		?	Page 15
	31 day for second or subsequent treatment - surgery	94%		?	Page 16
	62 day for first treatment from urgent GP referral to treatment: all cancers	85%	L	F	Page 17
	62 day for first treatment from consultant screening service referral: all cancers	90%		?	Page 18
	Ambulance handovers that waited over 60 mins	0		F	Page 19
Safe	Never Event Incidence	0		?	Page 20
	Number of Serious Incidents (SI's) declared during the period				Page 21
	HOHA (C-Diff > 2 Days)	2		?	Page 22

SPC Metric Summary

Corporate Scorecard Area	Metric	Target	Variation	Assurance	Chart
Well Led	Staff: Trust Level Vacancy Rate - All	9%	L	F	Page 23
	Staff: Trust Turnover Rate - All	10%	L	P	Page 24
	Staff: Trust level Sickness Rate - All	3.8%		F	Page 25
	Percentage of staff with annual appraisal	85%		?	Page 26
	Percentage of all trust staff with mandatory training compliance	85%		P	Page 27
	Bank & Agency Pay %	<= 7.5%	H	F	Page 28
	Income YTD (£000's)	> 0		?	Page 29
	CIP Performance YTD (£000's)	> 0		P	Page 30

Directors View – Chief People Officer

Vacancy Rates

- Although there was a small decrease in overall vacancy rates since September 2019, the Trust vacancy factor continues to be static at both a Trust wide and Divisional level but remains above the 9% target.
- Arrangements have now been made with the successfully procured recruitment agencies to travel to India and the Philippines to recruit nurses in early January 2020. The recruited nurses are anticipated to arrive from April 2020.
- Within Medical recruitment, A&E middle grade vacancies present a challenge and therefore particular resourcing focus is being applied in this area which has resulted in 14 candidates being identified with a total of 5 interviews scheduled to take place during November and December 2019.
- The risk of reduced workforce capacity brought about as a result of the Trusts vacancies is mitigated through backfilling vacancies with bank and agency staff, however to do so is a high cost to the Trust. In order to mitigate this risk, a vacancy control process is in place for bank and agency cover.
- Time to hire is as follows and work is underway to look at the recruitment process as a whole in order to see where further efficiencies may be achieved.

Turnover

- Turnover remains static and is overall below Trust target of 10% across the Trust. As part of the retention collaborative exercise, Focus Groups are being undertaken to consider opportunities to improve retention nurse rates. Work is also being undertaken to 'buddy' top 3 wards with bottom 3 wards of those areas where staff are leaving.

Attendance

- The Trusts attendance target is 96.2% (3.8% absence target) and current attendance rates remain above this target and have increased from September 2019 to 94.97%, 5.03%. 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.

Competency

- Compliance with the Trusts mandatory training target continues to be consistently achieved. Appraisal compliance is below the Trust target of 85% for the month October 2019, but having seen a declining position in recent months compliance increased since September 2019. Where additional support is necessary work will be undertaken with the managers to improve the position.

Directors View – Director of Finance

Financial plan - Income

- The Trust missed its financial plan in October by £2.8m due to a combination of Elective list cancellations as a result of operational pressures, a reduction in high value Daycase activity (Cardiology largely due to sickness). Although the hospital was very busy in October, Non-elective activity presented more in low-tariff areas like Ambulatory care, Nye Bevan, COA and therefore did not generate sufficient income above plan to offset pay cost.

Pay

- In addition pay costs was higher than usual as a result of additional nursing costs (increase in substantive staffing with new students and increase in temporary staffing to cover sickness, vacancy and maintain safe staffing). There were also a couple of agency doctor invoices not previously notified for accrual and we will be doing some work with the Divisions on how to prevent future occurrences.

Non pay

- An increase in non-pay costs more than expected in areas such as medicines, lab consumables, radiology outsourcing, coupled with overspends on staff recruitment costs and Estate costs contributed to the significant variance to plan reported in October.

Directors View – Director of Nursing

Harm Free Care – The Trust achieved 99% new Harm Free Care in the National Safety Thermometer point prevalence study, however a focus continues on ensuring that all incidences of Hospital Acquired Pressure Ulcers and patients falls are investigated and learning is taken into practice. It is noted last month that there were a number of cases of device related pressure ulcers developing, this is the focus of the NSHI collaborative which the team is participating in.

Infection Prevention- There were 6 cases of Clostridium difficile identified in September (3 COHA and 3 HOHA) taking us to 25 cases year to date. Trust ceiling is set at 40 cases. MSSA cases in month totalled 7 which takes our 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. To note that the MSSA upward trend is reflected across East Midlands and Nationally.

Safeguarding – Recognising that there remain challenges within our local authority services, the Children's Safeguarding Team continue to experience gaps/omissions within children's services. These concerns are captured and shared with the CCG on a weekly basis. All efforts continue to ensure that identified staff achieve the level 3 safeguarding training, this should be achieved by February 2020.

Patient Experience – Complaints response rates show continues improvement from previous months currently this is at 88%, we expect this to achieve above 90% in December. A focus on evidencing lessons learnt from complaints is currently being driven by the team. The National Urgent Care survey 2018 has been published which has highlights our ED department performing 'about the same' as other Trusts but Springfield (Urgent Care Centre) was classified as being 'worse than expected', this report , corresponding actions and monitoring will be discussed at the PCEEG meeting in December.

Directors view – Medical Director

- **HSMR** this remains within expected range and there are no outlying high risk diagnoses. Work continues on individual SMR outliers and alerts, and in particular upon congestive cardiac failure. November's mortality review group meeting was cancelled due to winter pressures.

- **SHMI** remains as expected and continues to run lower than HSMR.

- **Never Events** do not lend themselves well to SPC charts, the 2 most recent have been investigated and significant learning derived. The retained swab after episiotomy has resulted in a LOCSSIP for perineal repair in delivery suites. The wrong tooth extraction (investigated jointly with NHFT) has resulted in a check and confirm process being piloted successfully which will be rolled out into standard practice, along with mitigations for environmental distractors on what are busy lists.

- **Serious Incidents** work continues to improve timeliness of SI investigations and reports. The monitoring of completion of action plans demonstrates a sustained improvement of the timeliness of completion.

Directors View – Chief Operating Officer / DCEO

Performance - A&E 4hrs

- Performance deteriorated in October
- Emergency activity remained higher than plan
- Delayed transfers of care increased to 51 in month. Stranded & superstranded numbers of patients also increased
- Acuity of patients was high along with high levels of occupancy in level 2 & 3 beds (ITU/HDU)
- Total number of ambulances increased significantly in October
- Exit block within A&E caused a high number of patients waiting to handover from the ambulance service (30 mins & 60 mins)

Action

Winter plan in place with significant support from the PMO
Routine elective work has ceased

Cancer waiting times

- 62 day performance increased in month

Action

Specific time allocated for the cancer lead clinician to support delivery
2 x weekly PTL meetings in place
Full cancer plan for discussion at November F&P committee

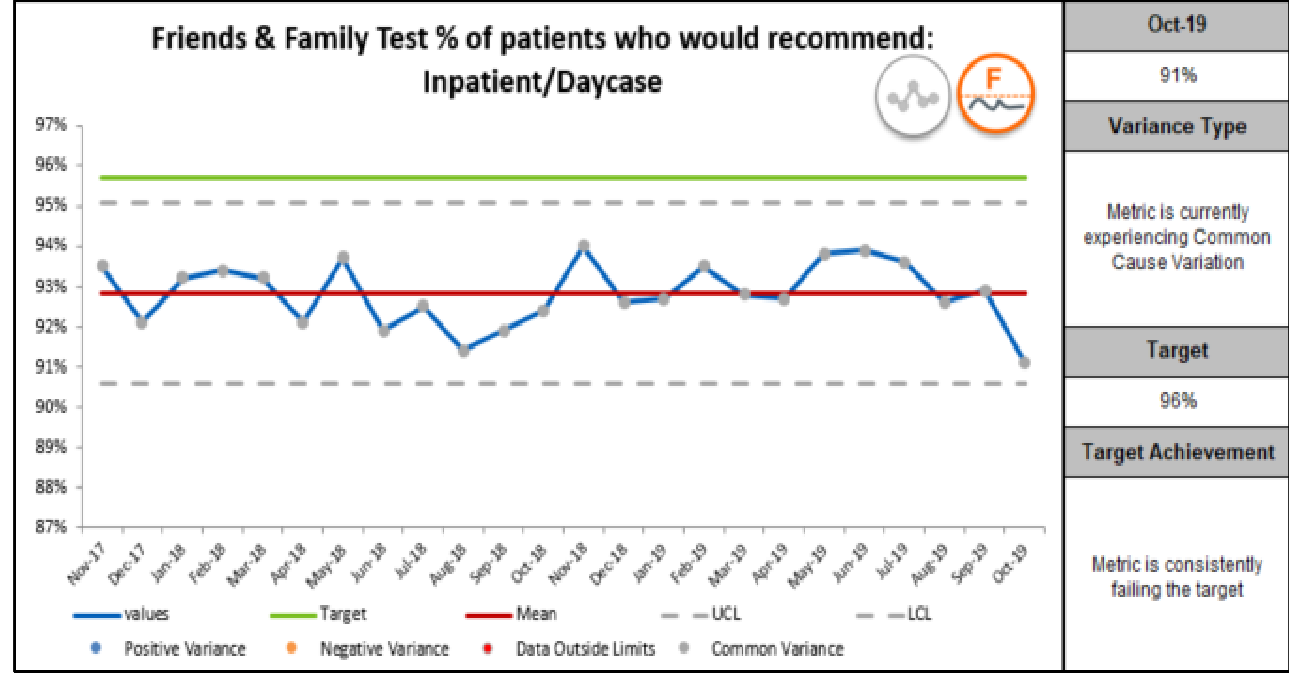
Diagnostics – 6 weeks

- Performance continues to improve and will be on target for December 2019

Elective care

- Un-appointed follow ups reduced in month

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



What the chart tells us:

The change in the Friends & Family test is following common cause variation.

It also tells us that the Trust is consistently failing the target and is unlikely to achieve the target with the current process/ operational configuration.

Context:

The result for Inpatient and Day Case continues to be within normal levels of variation. The Inpatient and Day Case result is 4.6%
below the national average for October when compared with 2.8% for September. Results per ward continue to vary greatly.

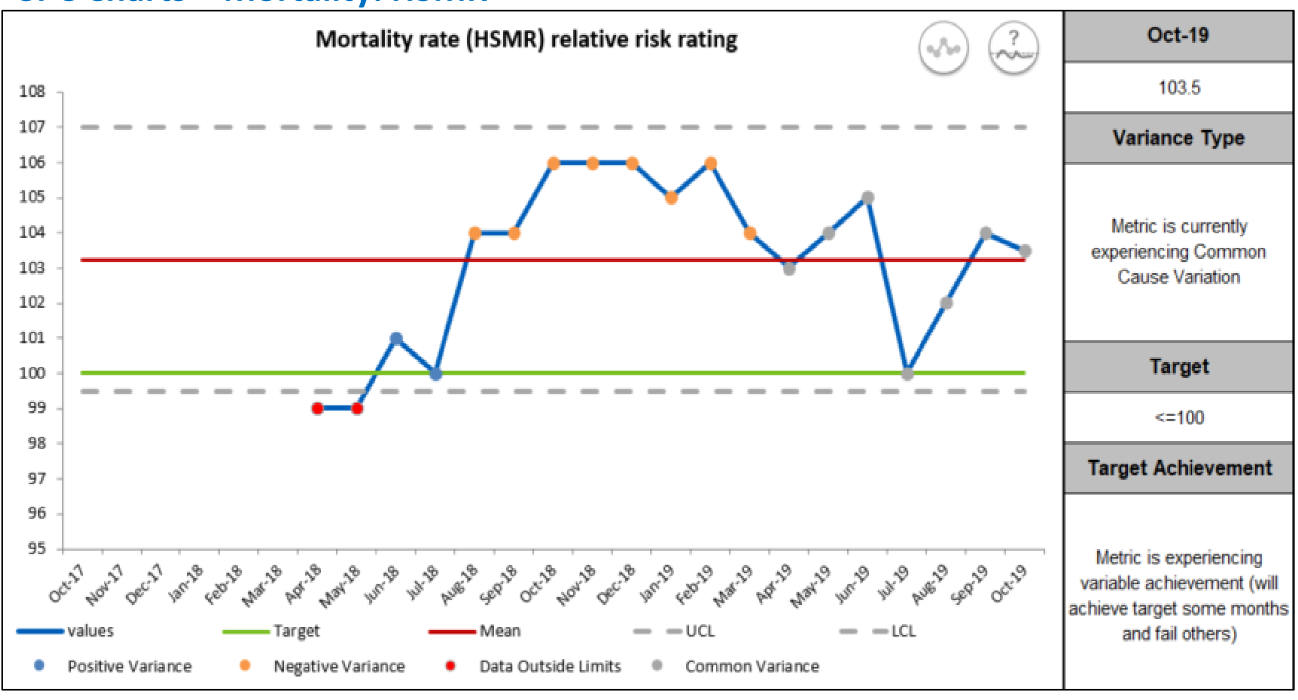
Actions Completed:

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.

SPC Charts – Mortality: HSMR



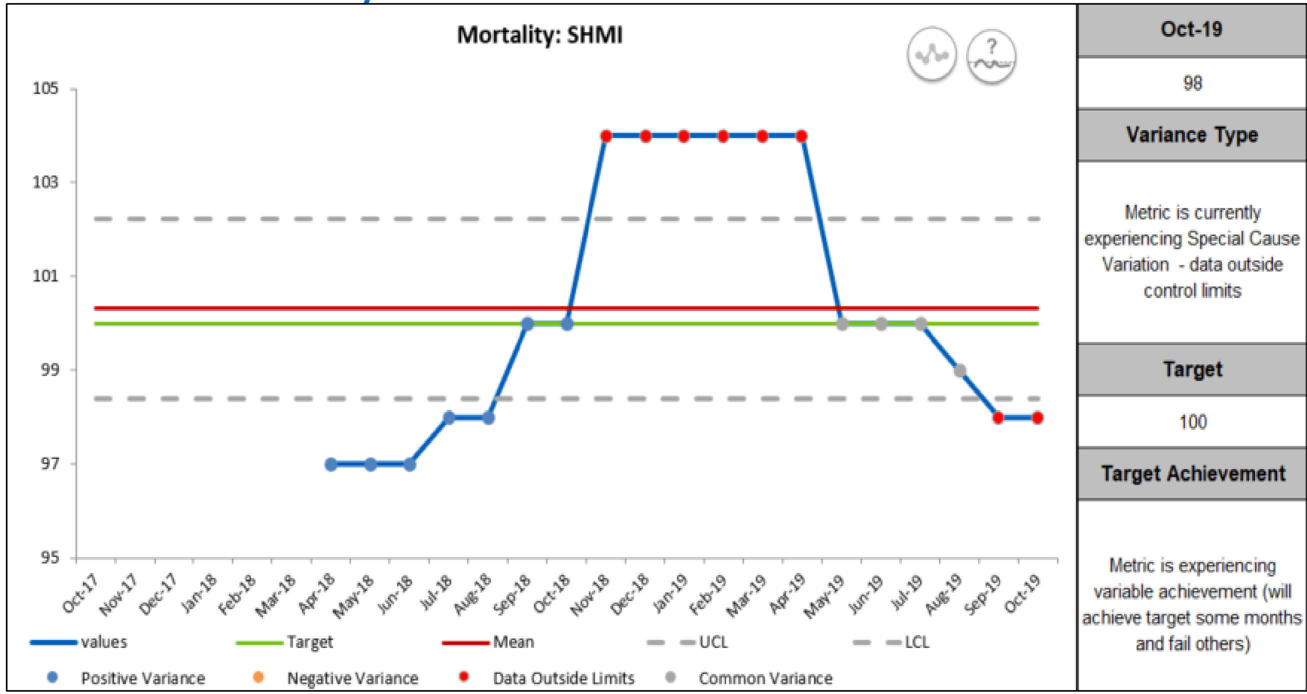
Context:

Actions:
No actions required – achieving. This chart would only normally be presented by areas not achieving the required performance level.

What the chart tells us:
The variation in the HSMR mortality indicator is following common cause variation; performance is within the expected levels based on the historic data.

It also tells us that the Trust is consistently achieving the target.

SPC Charts – Mortality: SHMI



Context:

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published monthly as a National Statistic by NHS Digital.

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

Actions:

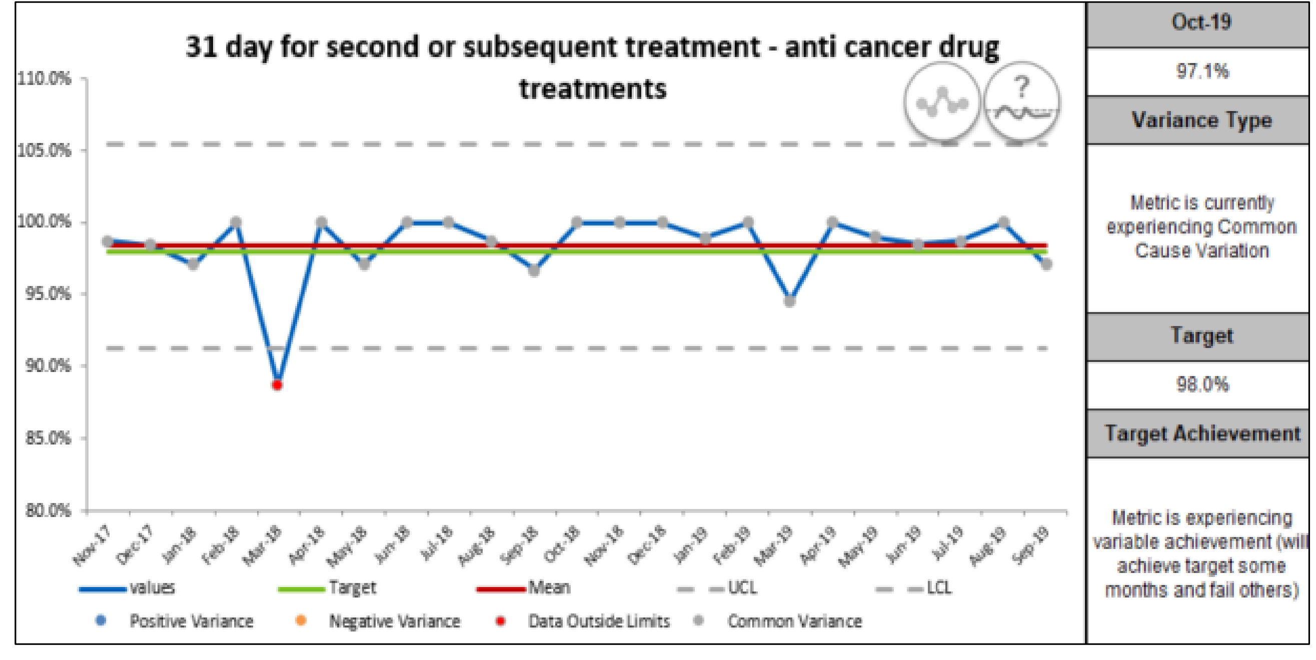
There is an indication that SHMI has fallen significantly over recent months compared to the Trust's own performance. Benchmarked nationally the trust remains as expected (within 2SD) of peer risk adjusted 30 day mortality rates.

What the chart tells us:

The change in the SHMI mortality indicator is showing special cause variation with a negative beneficial performance against the mean.

It also tells us that the Trust is experiencing variable achievements in performance.

SPC Charts – 31 day for second or subsequent treatment - anti cancer drug treat



Context:

Actions:

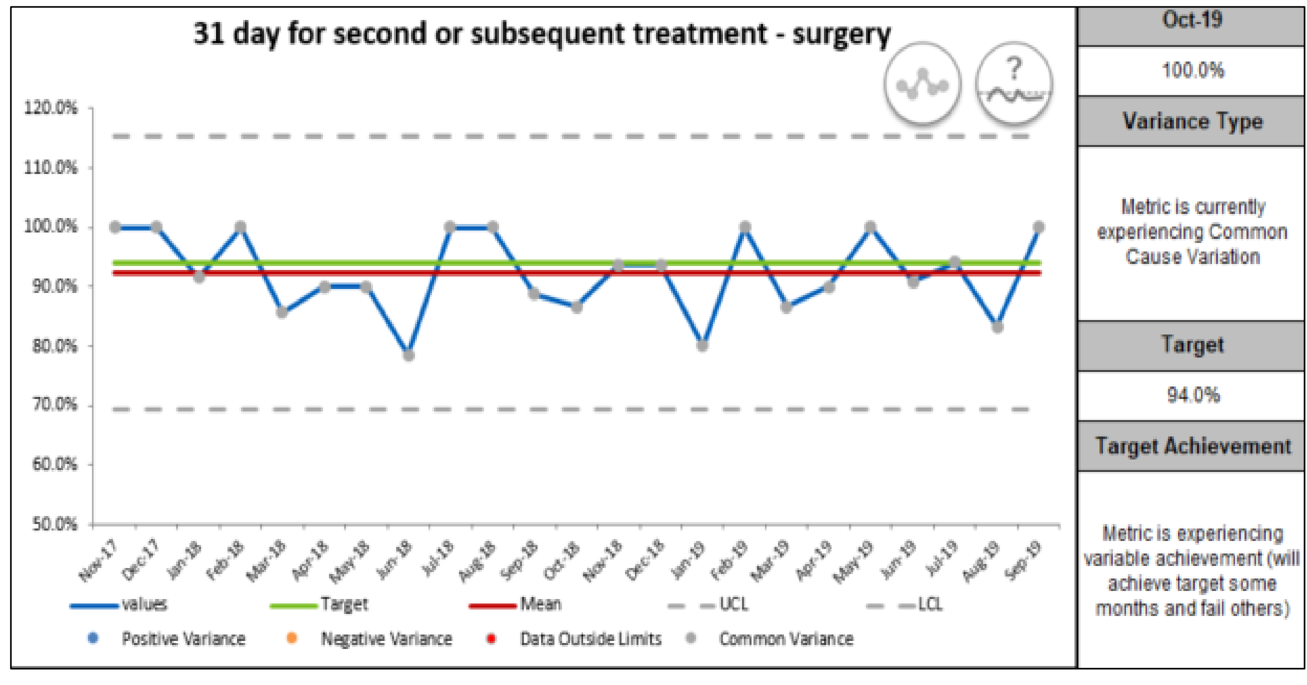
No actions required – achieving. This chart would only normally be presented by areas not achieving the required performance level.

What the chart tells us:

The performance of the 31 day target for subsequent treatment – anti cancer drugs identifies common cause variation; this means performance is within the expected level based on historical performance.

It also tells us that the Trust is experiencing variable achievements in performance; this means that assurance of achieving the target is limited on a month by month basis.

SPC Charts – 31 day for second or subsequent treatment - Surgery



Oct-19
100.0%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
94.0%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Context:

Actions:

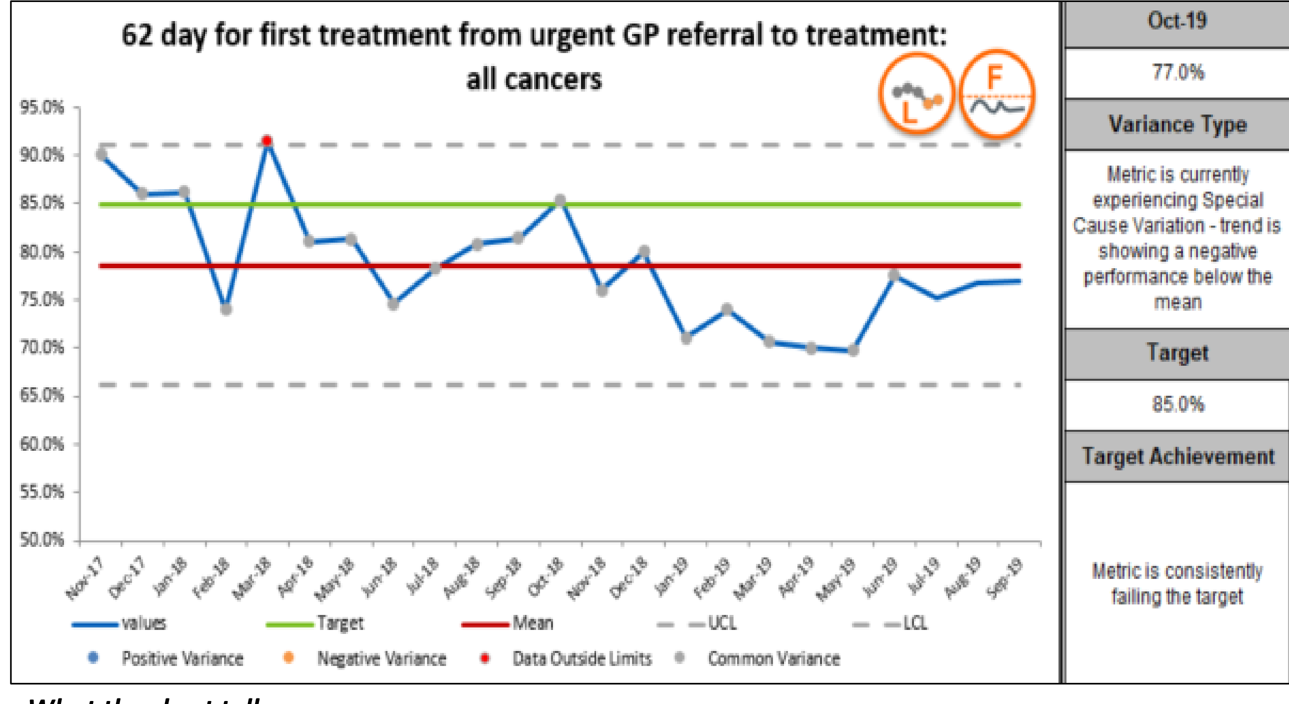
No actions required – achieving. This chart would only normally be presented by areas not achieving the required performance level.

What the chart tells us:

The performance of the 31 day target for subsequent treatment – surgery identifies common cause variation; performance is within the expected level based on historical performance.

It also tells us that the Trust is experiencing variable achievements in performance; this means that assurance of achieving the target is limited on a month by month basis.

SPC Charts – 62 day for first treatment from urgent GP referral to treatment: all



What the chart tells us:

The variation in this indicator is showing special cause variation with a negative performance against the mean which suggests a need for further investigation.

It also tells us that the Trust is consistently failing the target and is unlikely to achieve the target with the current process/ operational configuration.

Context:

The Trust has undertaken 91.5 treatments with 21 of them breached, this is a slight reduction on previous months, resulting in performance of 77% which is a slight improvement on August. Breast, Skin and Urology are achieving the 62 day standard for September This is the first time in 9 months Urology have met the standard which is fantastic news. Challenges remain for access to initial outpatients within some services, diagnostics, numerous MDT discussions and access to outpatients after MDT.

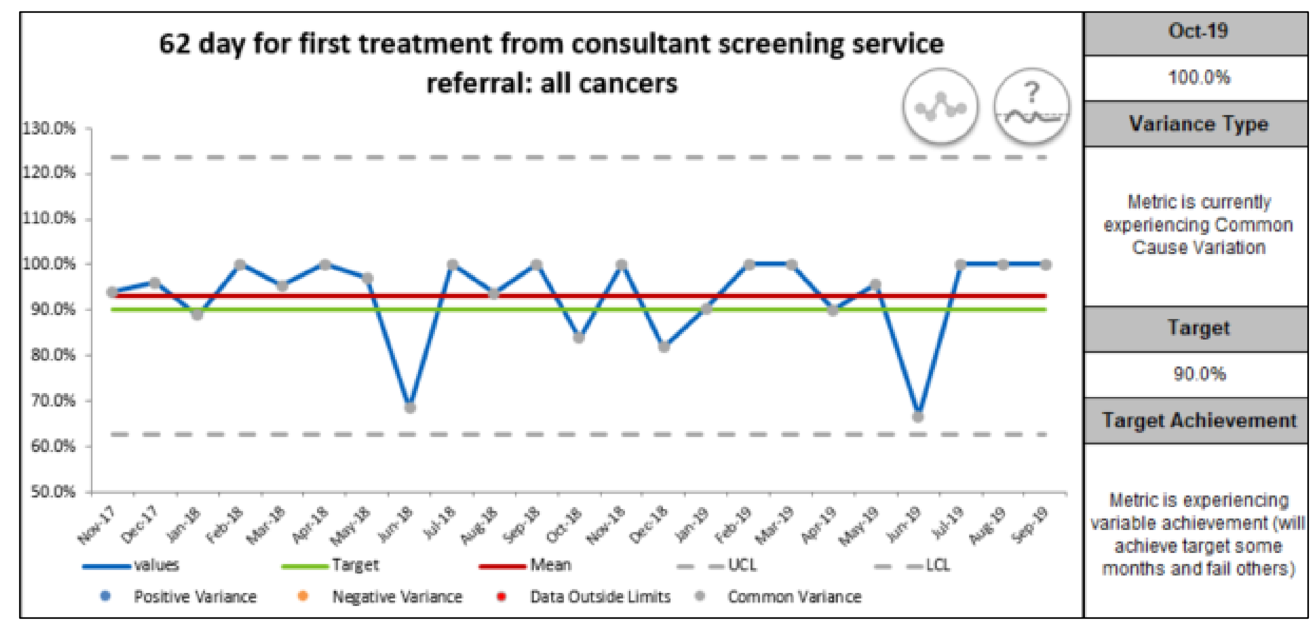
Actions Completed:

Site PTL meetings corporate PTL meetings weekly performance meeting to discuss themes and pathway blocks Draft paper to non executive board to highlight challenges and possible solutions continued work on RAPID and NOLCP pathways Refreshed job description shared with tumour site leads for sign off.

Actions:

- Cancer Management Team to meet regularly with each tumours site now Clinical Director has allocated 1 day a week in job plan from November

SPC Charts – 62 day for first treatment from consultant screening service referral: all cancers



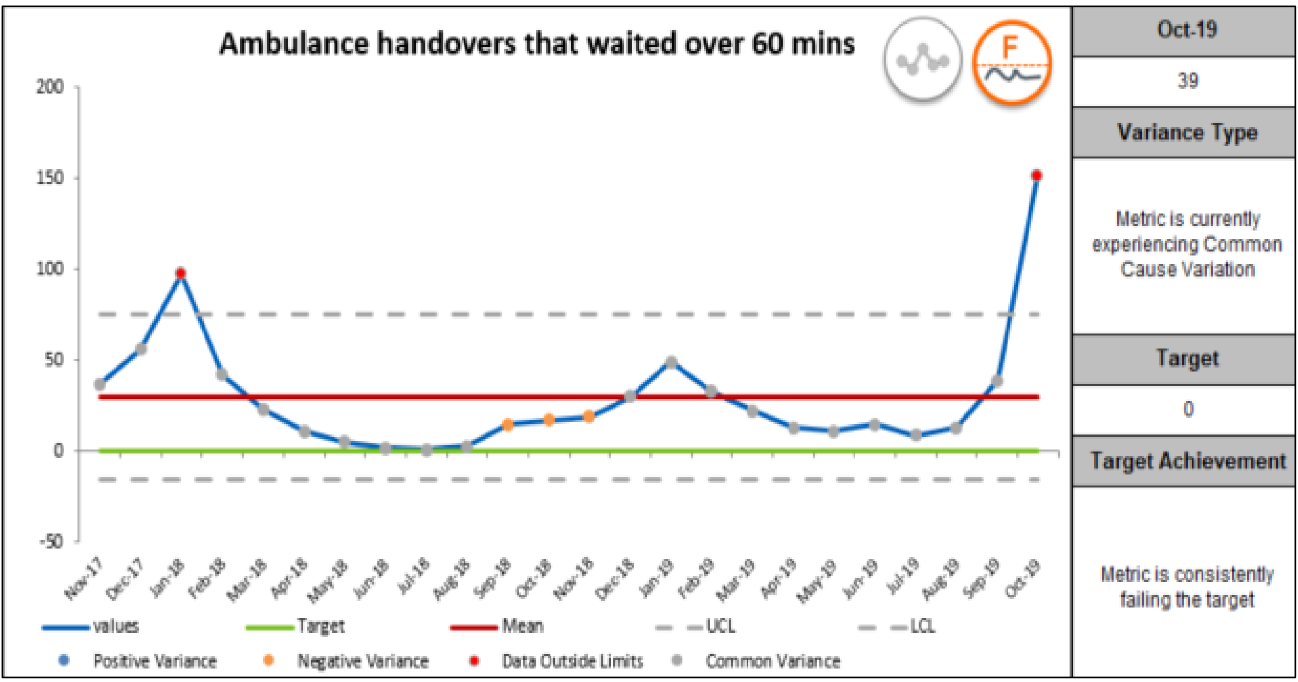
Context:

Actions:
No actions required – achieving. This chart would only normally be presented by areas not achieving the required performance level.

What the chart tells us:
The performance of the 62 day target for first treatment from a consultant screening service identifies common cause variation; performance is within the expected level based on historical performance.

It also tells us that the Trust is experiencing variable achievements in performance; this means that assurance of achieving the target is limited on a month by month basis.

SPC Charts – Ambulance handovers that waited over 60 mins



What the chart tells us:

The performance and variation relating to ambulance handovers which took longer than 60 minutes is showing a common cause variation; performance is within the expected level based on historical performance.

It also tells us that the Trust is experiencing variable achievements in performance; this means that assurance of achieving the target is limited on a month by month basis.

Context:

A significant increase in 60 minute ambulance delays from previous month. The increase in ambulance delays whilst disappointing to note the increase, is as a result of an internal flow within the organisation and inability to offload ambulances within the required timeframe.

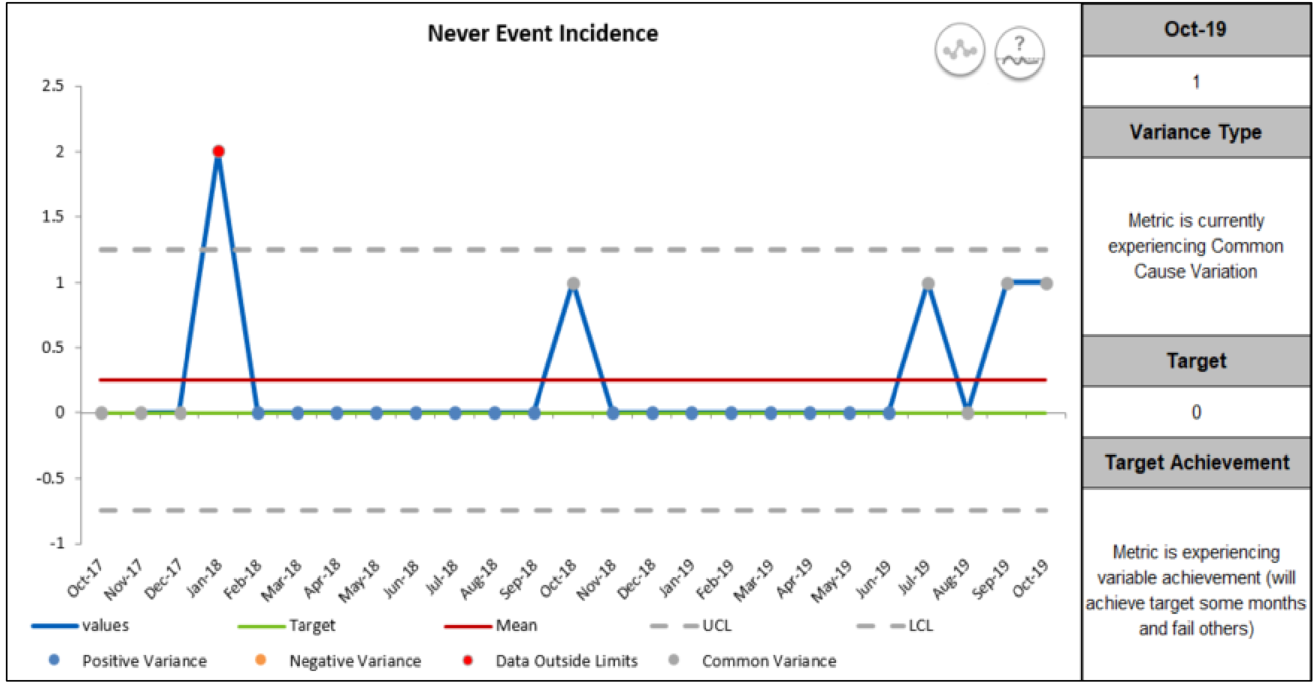
Actions Completed:

Continued to work with EMAS to highlight other pathways to be accessed and not just conveyance to ED - Working towards access to SDEC pathways. Joint spot audits undertaken with EMAS to look for paramedic pathfinder compliance and gaps in community accessed pathways – no significant gaps were identified.

Actions:

- All SDEC Pathways have been shared with EMAS Quality & Compliance manager and are being discussed at their next Clinical Governance meeting.
- Increased capacity , with a Dr in Majors Lite to facilitate flow for Ambulance patients into Fit Stop.
- Ensure effective streaming through Majors Lite: in October 344 patients seen in majors Lite • 42% were discharged home (up from 17% in September) • 15% to UTC • 9% to other clinics • 13% to ACC • 15% referred direct to specialty • 6% referred in to main ED (20 patients)

SPC Charts – Never Event Incidence



Context:

Actions:

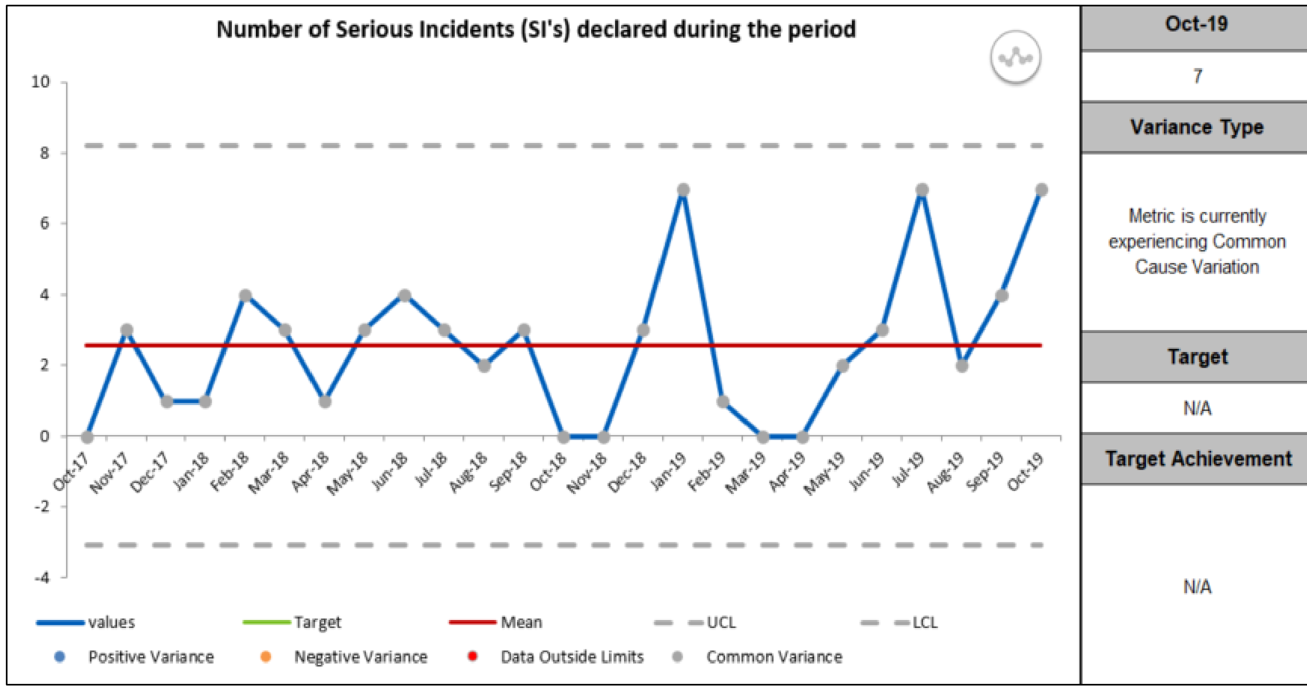
No actions required – achieving. This chart would only normally be presented by areas not achieving the required performance level.

What the chart tells us:

The variation in the incidence of never events identifies a common cause variation; performance is within the expected level based on historical performance.

It also tells us that the Trust is experiencing variable achievements in performance; this means that assurance of achieving the target is limited on a month by month basis.

SPC Charts – Number of Serious Incidents (SI's) declared during the period



Context:

Actions:

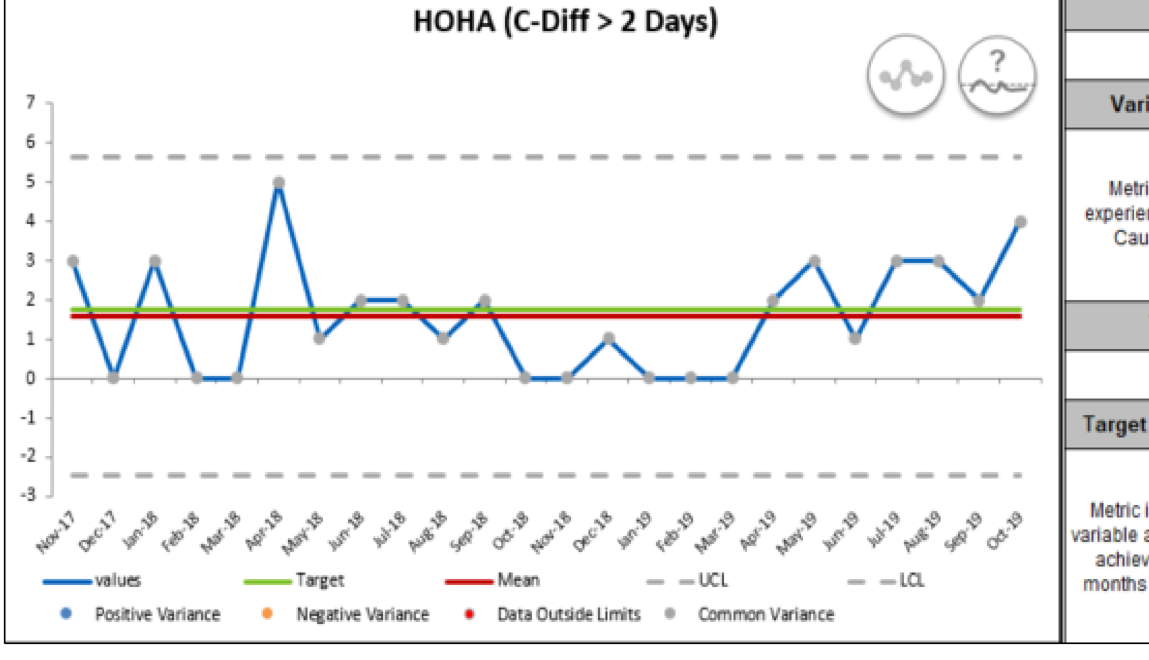
No actions required – achieving. This chart would only normally be presented by areas not achieving the required performance level.

What the chart tells us:

The reporting of serious incidents identifies levels within common cause variation; performance is within the expected level based on historical performance.

It also tells us that the Trust is experiencing variable achievements in performance.

SPC Charts – HOHA (C-Diff > 2 Days)



Oct-19
4
Variance Type
Metric is currently experiencing Common Cause Variation
Target
2
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

What the chart tells us:

The performance and variation of the Hospital Onset Healthcare (HOHA) Associated Clostridium displays common cause variation; performance is within the expected level based on historical performance.

It also tells us that the Trust is experiencing variable achievements in performance; this means that assurance of achieving the target is limited on a month by month basis.

Context:

The Trust has an external ceiling of 40 patients with Hospital Onset Healthcare (HOHA) Associated Clostridium difficile Toxin A and B positive and Community Onset Healthcare Associated (COHA) Clostridium difficile Toxin A and B positive for 2019-2020. In October there were 2 patients who developed a HOHA and 2 patients who developed a COHA. At the end of October there were 13 patients who developed a HOHA and 13 patients who developed a COHA.

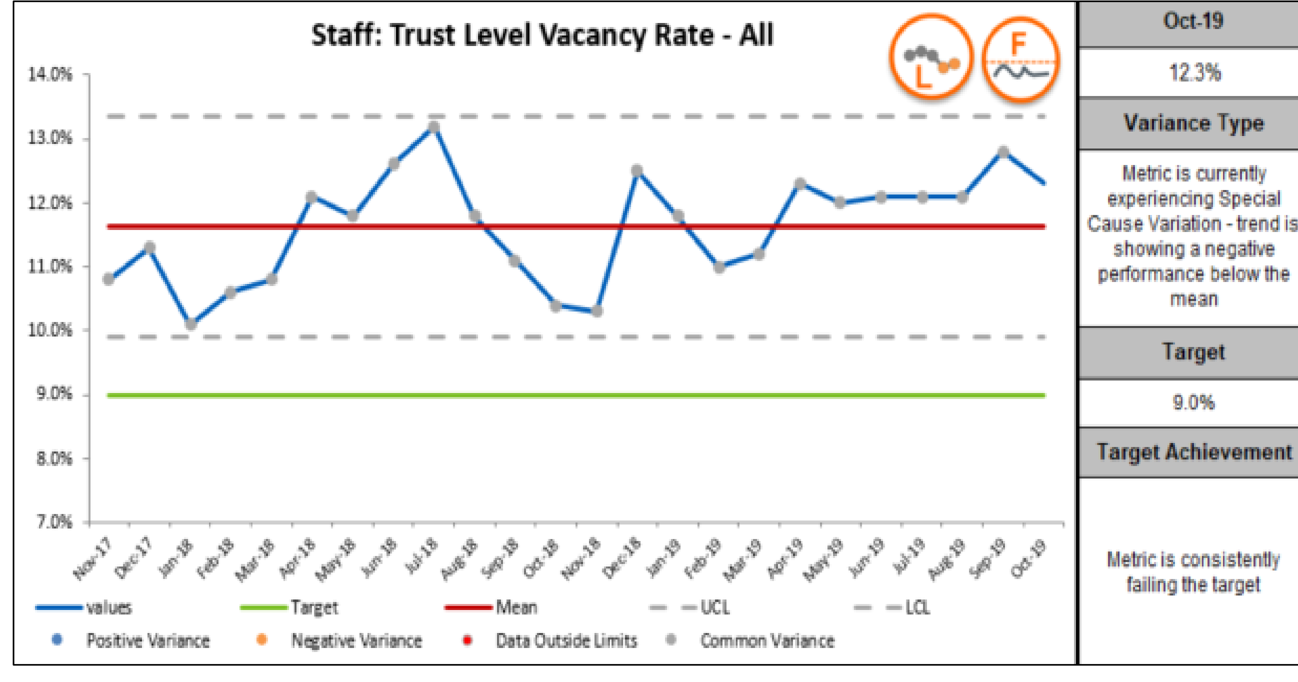
Actions Completed:

There is a Clostridium difficile plan of work which is monitored quarterly through the Infection Prevention and Control Steering Group quarterly. This was presented in October 2019. This is due to be presented again in January 2020.

Actions:

- All patients that are identified as having a HOHA or a COHA have a Post Infection.
- Review (PIR) performed, with input from the Community Infection Prevention and Control Team
- for the COHA's. This is then reviewed by the Clinical Commissioning Group (CCG) who then identify if there are any lapses in care. 18 patients have been reviewed to date by the CCG and there have been no lapses in care.
- Monthly reports reporting on HOHA's and COHA's are reported at the Infection Prevention Steering Group and the Infection Prevention Operational Group meetings. This is also reported quarterly through the Clinical Quality and Effectiveness Group (CQEG) and the Quality Governance Committee.

SPC Charts – Staff: Trust Level Vacancy Rate - All



Oct-19
12.3%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance below the mean
Target
9.0%
Target Achievement
Metric is consistently failing the target

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

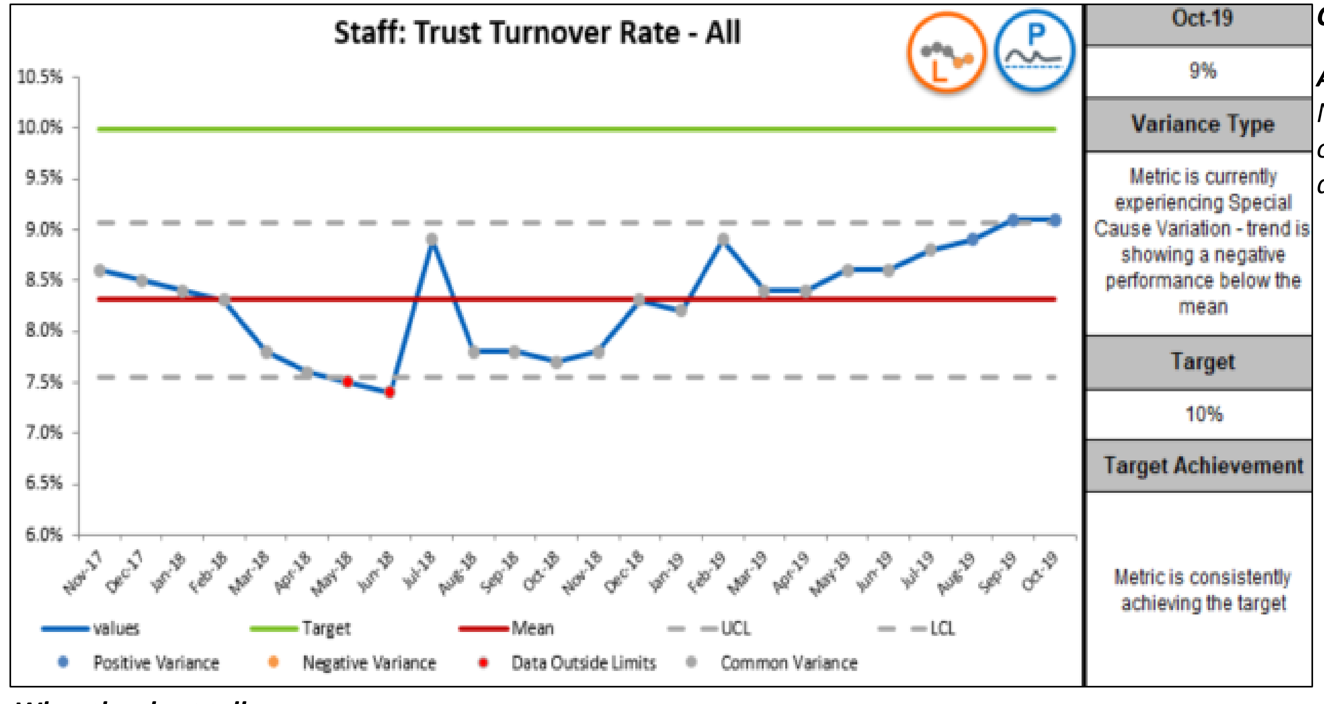
Actions Completed:
- Local recruitment continues – Oct 2019
- Overseas recruitment for nurses continues including direct overseas recruitment through existing oversea recruits – Oct 2019
- Conducted and completed procurement process for additional overseas recruitment – Oct 2019
- Clinical Resourcing Manager working closely with hard to recruit areas – Oct 2019
- Started a Radiography campaign – Oct

Actions:
- Plan overseas trips to recruit overseas nurses – Nov 2019
- Undertake skype interviews – Nov 2019
- Clinical Resourcing Manager will contact Managers to
- support them with advertising their vacancies – Nov 2019
- Continue sourcing candidates and complete interviews for direct and agency candidates – Nov 2019

What the chart tells us:
The variation in the vacancy rate indicator is showing special cause variation with a negative performance against the mean which suggests a need for further investigation.

It also tells us that the Trust is consistently failing the target and is unlikely to achieve the target with the current process/ operational configuration.

SPC Charts – Staff: Trust Turnover Rate - All



Oct-19
9%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance below the mean
Target
10%
Target Achievement
Metric is consistently achieving the target

Context:

Actions:

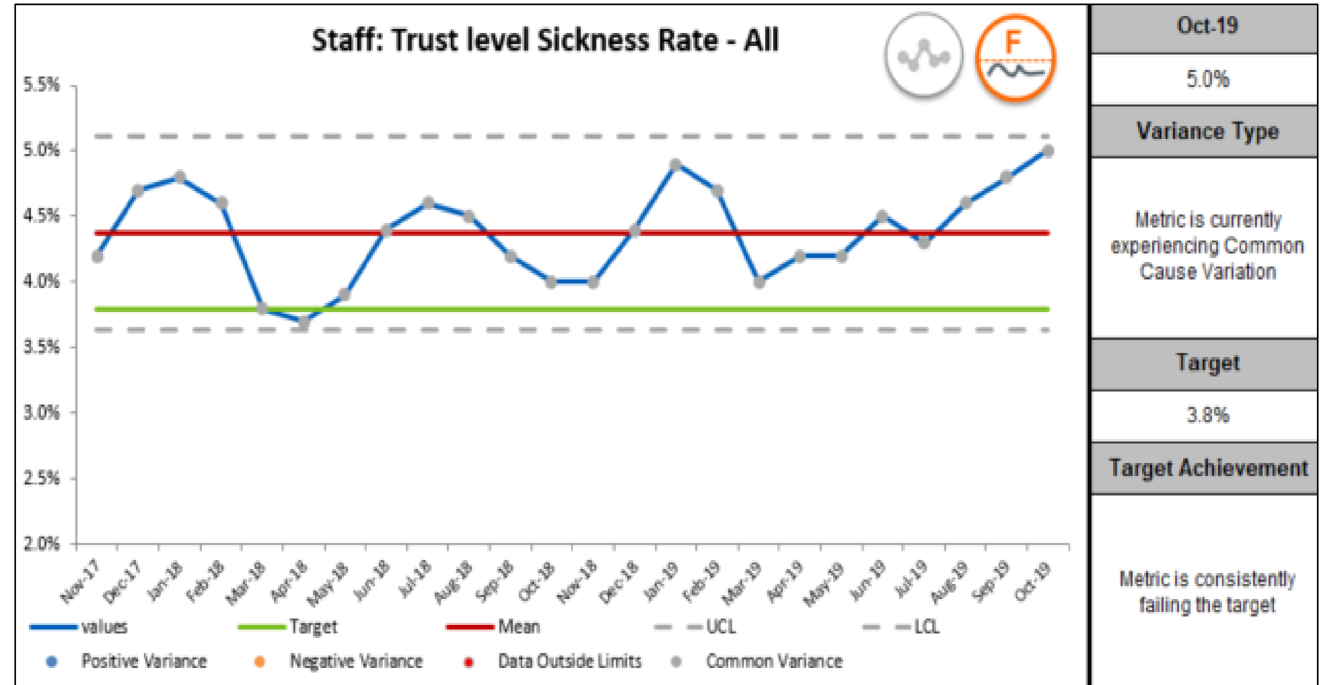
No actions required – achieving. This chart would only normally be presented by areas not achieving the required performance level.

What the chart tells us:

The variation in the staff turnover rate indicator displays special cause variation with a negative performance against the mean which suggests a need for further investigation.

Assurance on this metric is marked positively; the Trust is consistently achieving the target.

SPC Charts – Staff: Trust Level Sickness Rate - All



What the chart tells us:

The performance of trust level sickness rate identifies common cause variation; performance is within the expected level based on historical performance.

It also tells us that the Trust is consistently failing the target and is unlikely to achieve the target with the current process/ operational configuration.

Context:

Anxiety and depression plus pregnancy related absences are high. There are a high number of bullying and harassment cases across all divisions. Staff survey results and reasons for absence data suggest staff are experiencing an increase in MSK problems.

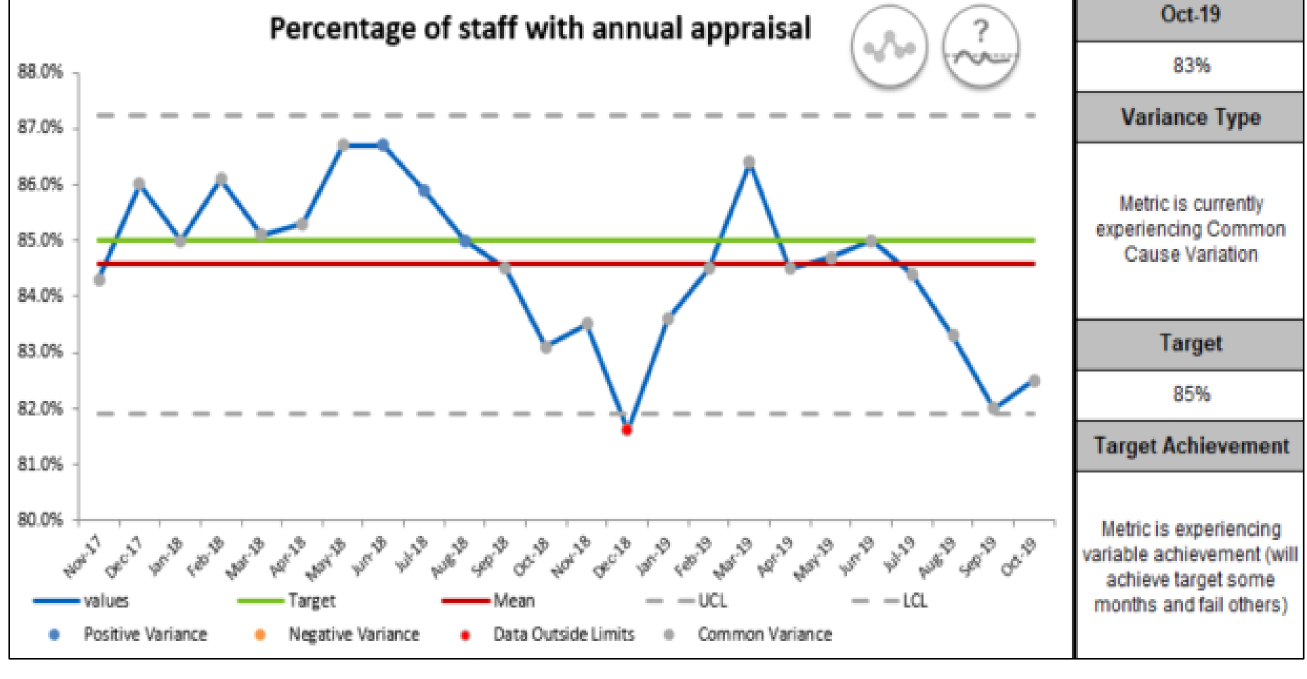
Actions Completed:

Robust sickness management continues with support from the HR Business Partners and HR Advisors. (October 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 (December 2019).
- Sickness reporting will now reflect attendance levels rather than absence levels to acknowledge and promote the health and wellbeing of staff (November 2019).

SPC Charts – Staff: Percentage of Staff with Annual Appraisal



Context:

The appraisal spreadsheet covers two months, so some areas have waited until the final cut-off date to notify L&D of the appraisal, even though the appraisal may have occurred during the first month meaning the member of staff is one month out of date. Appraisal information is being received after the submission deadline. The number of new starters within some depts. has affected the overall % compliance due to timing of start date and appraisal date. Some of the 'appraisal co-ordinators' have left this role and the area has not allocated a replacement. Therefore we are not receiving the relevant appraisal spreadsheet within the required timeframes.

Actions Completed:

The L&D manager has attend some DMB and DMT meetings to understand the reasons for low compliance and to reiterate processes. Main reasons for low compliance have been sickness and mat leave – Oct 2019 Training for managers continues which covers the process of submission of data. 1:1's are also being conducted with managers – Oct 2019. Areas without an 'appraisal coordinator' have been asked to allocate this role to someone and to notify L&D so we can make them aware of the process and support them – Oct 2019

Actions:

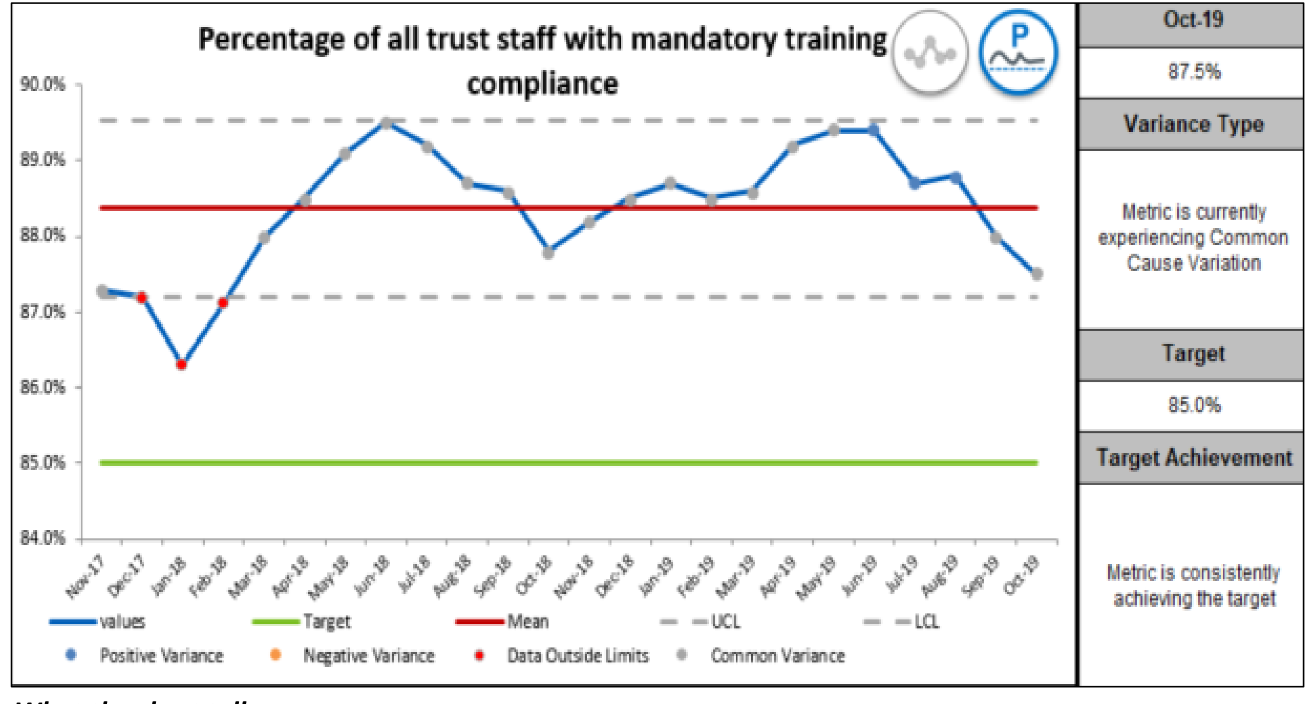
- The HRBPs to address with those managers with low compliance and if necessary create action plans – Nov 2019
- Those managers who have a discrepancy with the %
- of compliance have been asked to contact the L&D manager so an audit can be carried out – Nov 2019

What the chart tells us:

The performance and variation of staff appraisals identifies common cause variation; performance is within the expected level based on historical performance.

It also tells us that the Trust is experiencing variable achievements in performance; this means that assurance of achieving the target is limited on a month by month basis.

SPC Charts – Percentage of all trust staff with mandatory training compliance



Oct-19
87.5%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85.0%
Target Achievement
Metric is consistently achieving the target

Context:

Actions:

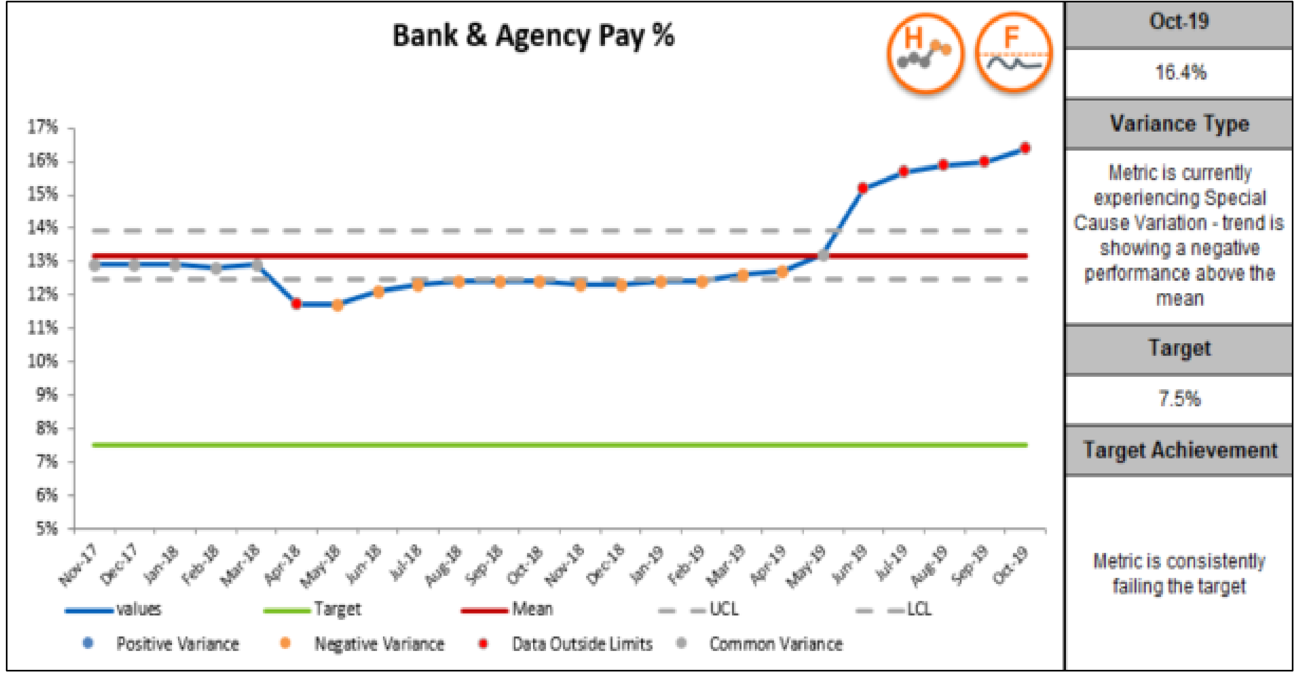
No actions required – achieving. This chart would only normally be presented by areas not achieving the required performance level.

What the chart tells us:

Performance and variation of mandatory training compliance identifies common cause variation; performance is within the expected level based on historical performance.

It also tells us that the Trust is consistently achieving this target.

SPC Charts – Bank & Agency Pay %



Context:

Actions:

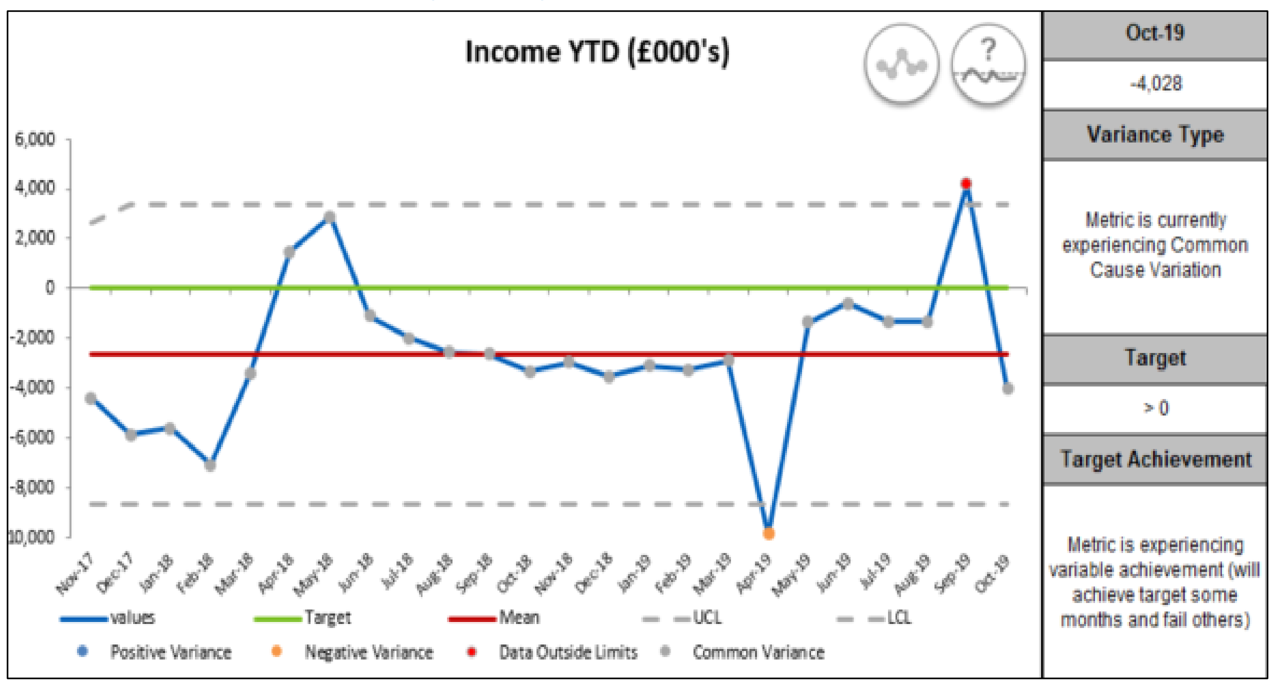
The variation of monthly performance and the persistent failure against the target identifies that this metric will not be achieved based on the current processes that are in place

What the chart tells us:

The variation in the bank and agency pay indicator is showing special cause variation with a negative performance against the mean which suggests a need for further investigation.

It also tells us that the Trust is consistently failing the target and is unlikely to achieve the target with the current process/ operational configuration.

SPC Charts – Income YTD (£000's)



Oct-19
-4,028
Variance Type
Metric is currently experiencing Common Cause Variation
Target
> 0
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

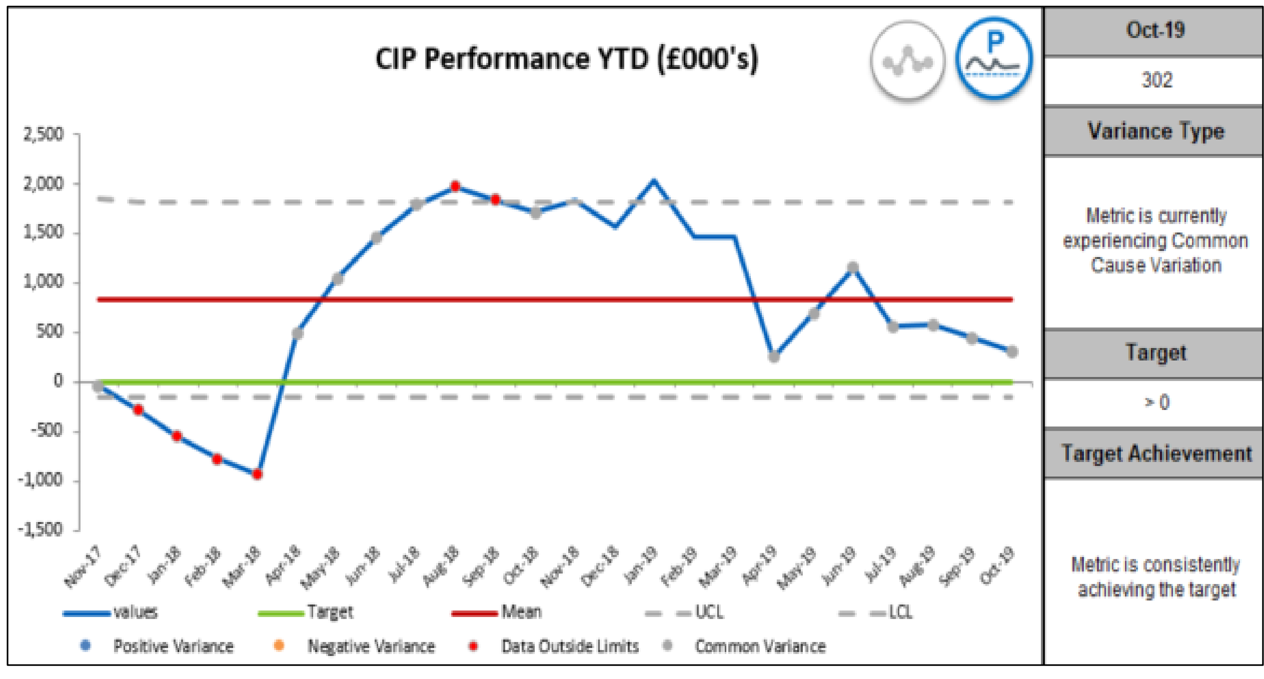
What the chart tells us:
The variation in the income YTD indicator is showing special cause variation with a positive performance against the mean with September's performance outside the expected level of variation.

It also tells us that the Trust is experiencing variable achievements in performance; this means that assurance of achieving the target is limited on a month by month basis.

Context:

Actions:
No actions required – achieving. This chart would only normally be presented by areas not achieving the required performance level.

SPC Charts – CIP Performance YTD (£000's)



Context:

Actions:

No actions required – achieving. This chart would only normally be presented by areas not achieving the required performance level.

What the chart tells us:

The performance and variance of the CIP delivery identifies common cause variation; performance is within the expected level based on historical performance.

It also tells us that the Trust is consistently achieving the target

Northampton General Hospital
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**Thursday 28 November 2019**

Title of the Report	**Generator Outage Update**
Agenda item	**10**
Presenter of Report	**Stuart Finn, Director of Estates and Facilities**
Author(s) of Report	**Stuart Finn, Director of Estates and Facilities**
Purpose	This report is being presented to the Board for assurance and information)

Executive summary
On 29 October 2019, routine ‘on load’ generator test for the old site was carried out as planned.
Main electrical supplies were isolated and the generators started and supported the load. After approximately 20 minutes, generators 6 & 7 went into fault and area at the west of site lost electrical power (for less than 5 minutes).
Temporary generators were installed and tested within 24 hours

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? Focus on quality & safety
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks All risks currently on risk register
Related Board Assurance Framework entries	BAF – please enter BAF number(s) 1.2, 1.5, 1.7, 5.3
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? No 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)? No If yes please give details and describe the current or planned activities to address the impact.
Legal implications / regulatory requirements	Failure to meet statutory obligations under Health and Safety legislation

Actions required by the Trust Board

The Board is asked to:
1. Note the report
2. Seek areas of clarification as required
3. Support/approve the action plans

Enclosure E

Generator Testing Update Report for Trust Board November 2019

Introduction
This report has been produced to provide details of electrical generator failure following routine testing on 29 October 2019.

Back-up generators support all electrical supplies across NGH; this means in the event of an electrical power outage, generators will re-provide all electrical supplies.

There are 6 x backup generators across site; all of which have been replaced with in the last 10 years.
Estates test the generators weekly ‘off load’ (not connected to site load) and every 6 weeks they are tested ‘on load’ (main electrical supplies are switched off to replicate a power failure and the generators are run for an hour).

The site is divided in two for the ‘on load’ tests (old site and new site) and each site is tested 3 weeks apart.
Generator test areas are shown below in figure 1.

The highlighted bubble on the old site shows the area supplied by generators 6 & 7.
The remaining areas on the old site are supported by generator C.

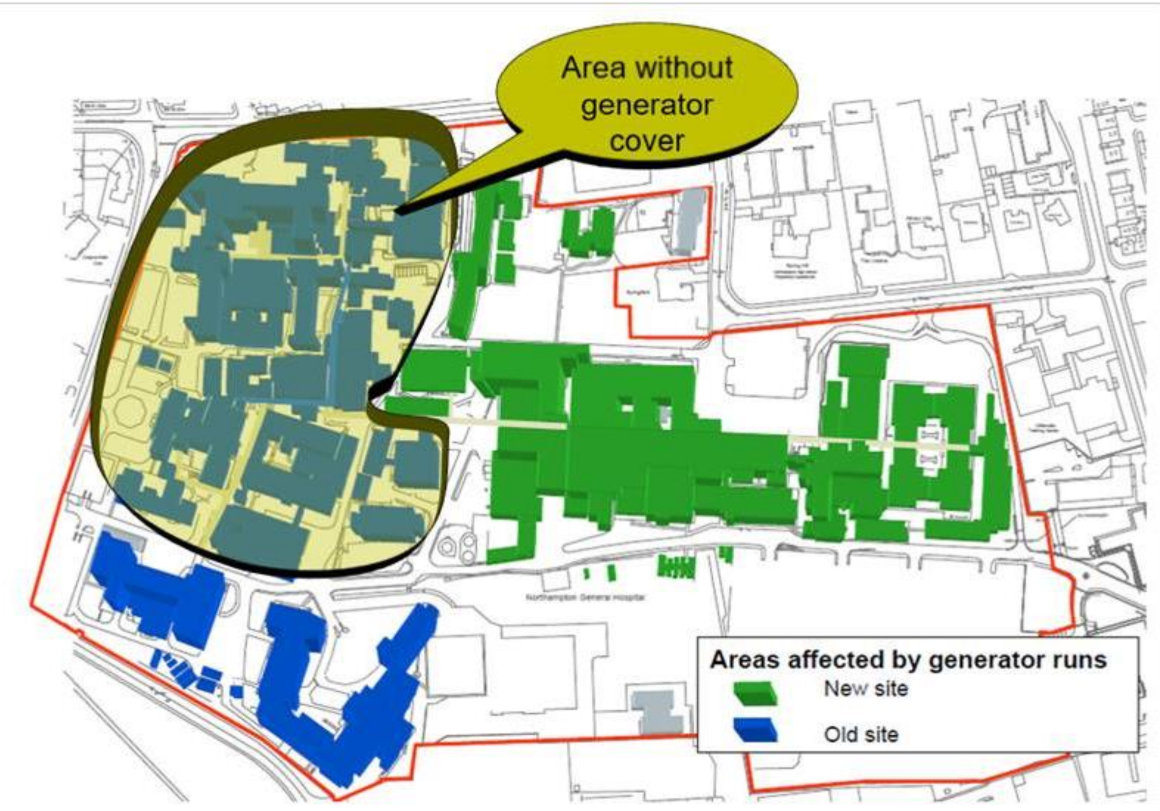


Fig.1 Generator Test Areas

Details of Outage
On 29 October 2019 at 07.00hrs, the routine 'on load' test for the old site was carried out as planned. Notification of these regular tests are emailed out to site prior to testing giving details of the test and areas that will be affected.

At 07.00hrs, main electrical supplies were isolated and the generators started and supported the load. After approximately 20 minutes, generators 6 & 7 went into fault and the area highlighted in Fig.1 lost electrical power (generators 6 & 7 are configured as a pair; they run together and support a common load).
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.

Initial investigation of generator 6 & 7controls showed a fault had occurred which lead to the generators shutting down.

Actions Taken (following reinstatement of mains power)

- Estates team carried out immediate inspections of all electrical switch rooms and equipment and confirmed all electrical supplies had been reinstated and that there were no faults on the system.
- The generators were also inspected and no obvious faults were found.
- Site wide email was sent out to inform affected areas of the issue
- The specialist generator contractor attended site at 10am to investigate the generators. Following initial investigation the contractor made changes to the control software and a retest was carried out at 3pm.
- During the second test, the generators started when mains supply was isolated but immediately went into fault when the load was switched on to them.
- Estates reinstated mains supplies and then carried out the test again but with only half the load; the generators took the load and ran on load succesfully.
- Mains supplies were reinstated and then the test was run again with the other half of the load.
- Further testing and fault finding would have caused continued disruption to site so it was decided to use the Estates contingency plan and install a temporary generator.
- Temporary generator was delivered and connected by Estates early hours of the morning. An on load re-test was carried out and all emergency supplies confirmed as working correctly by 5am.
  The areas originally supported by generator 6 & 7 are now divided allowing 6 & 7 to supply half the original load and the new temporary generator to supply the remaining half
- A further on load test was successfully carried the following day

What Went Well

- Routine testing schedule highlighted a fault under controlled conditions
- Experienced Estates team were able to respond and minimise impact
- Specialist generator contractor attended site within contracted hours
- Estates Contingency plan worked well and a temporary generator was delivered, connected and tested
- Regular update communications via Exec WhatsApp group
- Estates team attended all theatre areas to keep them informed
- Clinical teams in affected areas, led by Divisional Director and Senior Managers responded well and worked with Estates team
- UPS (battery back-up) systems were tested in each area to give clinical team assurance they were operational

Learning and Actions

Learning	Action	Update	Who	When
Generator failure linked to excessive load	Full load bank testing of all generators across site (this was already planned as part of the electrical compliance action plan). This will confirm the exact load capacity of the generator sets	The electrical load profile for each sub-station has already been recorded. Once the load bank tests are completed, we will know what additional generator capacity may be required.	Estates	Feb 20
	Design and tender and install additional generators		Estates	Aug 20
The UPS (battery back-up) system serving labour theatres failed	Review if UPS systems can be remotely monitored 24/7 and alarms reported to Switchboard. Other high-risk alarms across site are monitored in this way.	UPS system was repaired and back on line within 24 hours. All UPS systems across site are under an annual manufacturer's maintenance contract and are inspected weekly by Estates.	Estates	Jan 20
	Clinical Engineering to investigate/cost the option of holding central mobile UPS system for theatres across site.		Clinical Engineering	Jan 20
During the incident, Estates managers were regularly called to give repeat updates to departmental managers.	Review how regular updates can be shared with end users		Estates/ Comms	Jan 20
End users were not aware of resilience systems eg theatres did not know what UPS systems were in place and how long they would last	Estates to deliver short training sessions for end users		Estates	Jan 20

Further Information
Electrical supplies at NGH are distributed across the site via an 11,000 volt distribution network.

At 8 x high voltage substations, these supplies are stepped down to 400V, which then feed numerous low voltage switch rooms, which, in turn supply departments/areas.

A phased electrical infrastructure upgrade programme has been running over a number of years and has delivered the replacement of; all high voltage switch gear, all site back-up generators, all primary low voltage switch gear and the current programme includes replacement of low voltage distribution equipment on the west end of site.

The original essential/non essential supplies configuration only supported approx. 70% of electrical supplies across site. The upgrade programme has allowed for the entire site to now be supported by the generators.

The replacement of ageing switchgear and distribution panels at the west end of site was brought forward into this year's capital plan following the investigation into a site wide electrical outage in February 19; this work is due to complete February 20.

The Estates capital programme has also included additional UPS/IPS (battery back-up) systems to all theatres and other key areas such as Gossett.
A new UPS system is currently being installed to serve ITU/HDU and surrounding wards.

Following an underground cable fault on the site HV distribution power in February 2019, a review of the infrastructure was commissioned as part of the action plan.
That review has confirmed that the existing site generators have available capacity but they have reached their maximum limits.
The current phase of works is reviewing the initial load that is presented to the generators when they start. This will confirm what additional capacity is required and feed into design works.

Current healthcare guidance states that the generators should be configured as N+1 – this means a second backup generator should be installed in the event the first is not available.
A full risk assessment will be required to understand the risk of diverting limited capital from other key Estates backlog elements.

NHS
Northampton General Hospital
NHS Trust

Enclosure F

Report To	**Public Trust Board**
Date of Meeting	**28 November 2019**

Title of the Report	**Flu vaccination for Healthcare Workers**
Agenda item	**11**
Presenter of Report	Mr M Smith and Ms S Oke
Author(s) of Report	Claire Brown OH Manager
Purpose	For assurance that the Trust is addressing the 'best practice' in line with the NHS England requirements

Executive summary

The flu vaccination uptake at the time of this paper being written was **82.8%** which is **12% higher** than the same period last year. The CQUIN target uptake percentage is **80%** by the end of February 2020. The percentage can fluctuate due to the national requirement to update the flu data sets on a monthly basis.

There has been an early uptake of the flu vaccine in 19/20 season with a significant peak in the first two weeks. The increase in communications, and the use of the 'Neds' story video has made a difference to those who have never had a flu vaccination previously, with employees now coming forward for the first time to have their vaccine.

There has been a significant drop in the first month of those employees declining to have the flu vaccination which is encouraging. In 18/19 the figure was **199** and in 19/20 it is **down to 33** for the same period.

A brief overview of the content of the paper
1. Activity data
2. Flu campaign
3. Data collection
4. Vaccine decline data
5. Trust Self-Assessment

Related strategic aim and corporate objective	Objective 1 – Focus and Quality and Safety. We will avoid harm, reduce mortality and improve patient outcomes through a focus on quality outcomes, effectiveness and safety.
Risk and assurance	Yes – risk of non-vaccinated employees working in high risk areas passing on virus to patients

Related Board Assurance Framework entries	BAF 2.1
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? **No** Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? **No**
Legal implications / regulatory requirements	**No**

Actions required by the Trust Board

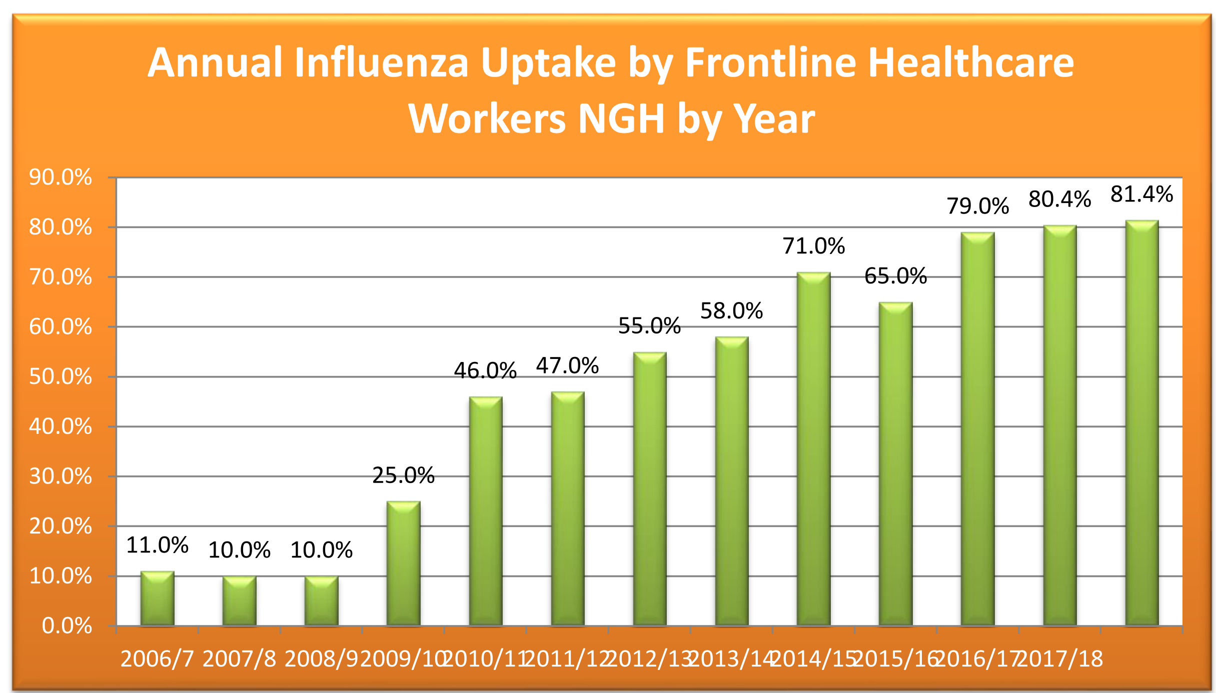
This paper provides information and assurance regarding the implementation of the national flu campaign for healthcare workers at NGH.

This paper gives information for the self-assessment by Trusts in support of the flu campaign.

1. Activity Data

The ambition for flu uptake is to vaccinate as many employees with patient contact and patient related work activities. There are always employees who decline to have their vaccine due to personal reasons which means that 100% would never be achievable.

The uptake of vaccine at NGH has increased significantly over the past 12 years, but seems to have plateaued in the last three years albeit at a significantly higher level than previous.



2. Flu Campaign

The Occupational Health team at NGH have led a robust programme of vaccination opportunities which has increased the final uptake for the national data requirements to its highest level in **2018/19 of 81.4%**. The campaign now runs from October to March due to the requirements of the Flu CQUIN. Data statistics are provided to the national data set IMMFORM until the beginning of March 2020 when the final data collection is completed. At the time of this report, the **uptake for 19/20** is **75% in the first month** and **82.8% in the second month** of the campaign which has never been achieved before.

The CQUIN target has been achieved each year since being part of the scheme.

19/20 CQUIN Indicators:

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
<60%	No payment
60% up to 79.99%	partial payment to be calculated
80% or above	100% payment

The planning of the flu campaign commences in January each year with the ordering of the vaccine.

5500 doses of quadrivalent vaccine (QIV) and **200** doses of trivalent vaccine (aTIV for the over 65 age group) have been secured for this year's campaign which includes:-

- Clinics in the Cyber café which commenced on October 7th and run for weeks 1 and 2
- Week 3 to12 – daily trolley visits across site visiting wards and departments with Wednesdays as a static clinic in the Cyber Café to the end of November.
- Visits to induction and training days
- Bespoke visits to areas on request
- Friday evening and Saturday morning trolley rounds (*this year's improvement is to have three trolleys visiting simultaneously for better coverage*)
- Sunday evening and Monday morning trolley round (*a new weekend addition for this season again with three trolleys*)
- Early weekday morning trolley rounds
- Individual appointments in Occupational Health at date/time convenient to the employee
- Normalising the vaccination into all new starters work health assessment on employment
- Data capture from work health questionnaires of new employees having had their vaccine in another employment
- Data capture of any employee having their flu vaccination at an alternative supplier such as their own GP or local pharmacy
- Targeted departmental visits for areas of low uptake.

3. Data Collection

Significant amounts of data are required including:-

- IMMFORM website – updated each month for the final CQUIN total
- Weekly uptake for Public Health England/NHSI
- Trust uptake figures communicated to wards and areas via communications team.

An additional OH team member has been recruited since the 18/19 campaign to assist with the significant amount of data inputting required.

Other aspects that have to be integrated into the data collection are the monthly removal of leavers and addition of new starters, removal of those employees on maternity leave and sick leave; thereby the denominator and numerator will fluctuate slightly each month and potentially change the uptake percentage.

4.

5. Vaccination Decline Data

From October 7th to November 7th there have only been 33 employees who have declined to have the vaccination. In the same time period in 18/19 there had been 199 employees decline their flu vaccination. This is very encouraging and reflects the number of employees who have voiced their acknowledgement of the communication threads around 'Neds Story' and that this has changed their attitude towards the vaccine.

Reasons for not having the flu vaccination in the 19/20 season have already been captured as follows:-

Nurse	I don't like needles / Don't want it
HCA	I don't believe the evidence / Concerned about side effects
Sister	Allergy to eggs
HCA	I'm Concerned about side effects
Clerk	I don't like needles
Matron	Decision not to
Porter	I don't believe the evidence / Concerned about side effects
Admin Manager	Allergies to many medications
Receptionist	I'm Concerned about side effects
Supt Radiographer	Allergies
Radiographer	I'm concerned about possible side effects
Clinical Supervisor	Allergies
Pharmacy Technician	Made me ill
Ward Clerk	Decision not to
Nurse	Decision not to
Porter	Decision not to
Junior Sister	Decision not to
Nurse	Decision not to
Bank HCA	Decision not to
Bank Nurse	Allergies
Bank MSW	Other reason - not given
Nurse	I'm concerned about possible side effects

This has highlighted that both clinical and non-clinical staff are declining the vaccination in this season, but the number is significantly lower than last year.

6. Self-Assessment Healthcare worker flu vaccination best practice management checklist 19/20

A	Committed leadership	Trust Self-Assessment
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	The ambition of 100% is recognised however it is also acknowledged that there will always be employees that genuinely cannot have the vaccine. Data capture has already commenced from the following questions for new starters:- 1. Have you had your vaccine elsewhere – so we can add them into our numbers 2. Reason for not wanting it if applicable – so we can add opt outs to our data Further data capture using individual 'declined' forms will be captured throughout the campaign by individuals completed a decline slip.
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers	Vaccine ordered in January and delivered into NGH over three dates. All vaccine is now on site at NGH, which is required to fulfil the campaign. An additional 500 doses of vaccine were sourced in week two of the campaign as the update was higher than previous. In addition aTIV has been ordered for the 65 and over age group
A3	Board receive an evaluation of the flu programme 2019/20, including data, successes, challenges and lessons learnt	Success 18/19 was for 81.4% which was reported to the board via HR Director. Updates are currently provided weekly to the Deputy CEO and other board members. Challenges discussed at CQUIN meetings and Infection Prevention Committee (IPC)
A4	Agree on a board champion for flu campaign	As previous years it would be the Director for Infection Prevention
A5	All Trust board members receive flu vaccination and publicise this	Arranged for 28 November 2019 at 2pm following the Trust Board meeting.
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	The flu team activities are incorporated into the IPC, CQUIN committee and Health and Safety Committee meetings.
A7	Flu team to meet regularly from September 2019	As above in A6

B	**Communications plan**	
B1	Rationale for the flu vaccination programme to be published – sponsored by senior clinical leaders and trade unions	Communications Team provided with all relevant information to devise the flu campaign comms programme via intranet/twitter/facebook
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Arranged and communicated, also hard copy information packs sent to all clinical areas with hard copies for display
B3	Board and senior managers having their vaccinations to be publicised	Trust Directors attended the first flu clinic on 7th October for their vaccinations and communications provided widespread publicity. The Trust Board vaccinations as per A5
B4	Flu vaccination programme and access to vaccination on induction programmes	Trolley visits to inductions and has also been offered to all new starters as part of their health assessment/vaccination review on commencement
B5	Programme to be publicised on screensavers, posters and social media	As per B1
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	Data will be provided once the data collection tool is finalised and data entry has commenced. Time will need to be given to enter the data so it is expected that there will be a four week delay will be standard until the clinics settle. The data collection and collation is a manual process
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	Not possible to fully deliver C1 as this model has not worked in the past for NGH . For 19/20 however there are two peer vaccinators trained to cover Maternity area due to low uptake in the past and for next year's campaign peer vaccinators have been requested for ITU/CCU
C2	Schedule for easy access drop in clinics agreed	Planned and communicated
C3	Schedule for 24 hour mobile vaccinations to be agreed	Weekends and evening trolley rounds already planned and communicated – additional trolley rounds for 19/20 include Friday night/Saturday morning - Sunday night/Monday morning – both using three trolleys with six OH team members.
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	Incentives approved and arranged
D2	Success to be celebrated weekly	As part of the comms plan as per B1

Report To	Trust Board
Date of Meeting	28 November 2019

Title of the Report	Board Assurance Framework Q2 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
Purpose	To provide the Board with up to date information on the Board Assurance Framework (BAF).This report describes the Q2 position in relation to the Board Assurance Framework and risks associated to delivery of corporate objectives described on the BAF. To present the amended Risk Appetite Framework and Statement for approval.

1. Executive summary

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.

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 Board also discussed amending the BAF to link the risks to the Trust pledges in the recently launched Trust strategy and these have been aligned to the pledges as outlined in section 5.

The Board also reviewed the Trusts risk appetite framework and definition and agreed to amend this from the "Averse to Hungry scale" to the "Zero to Very High scale" as identified in section 6. As well as the Risk Appetite Statement.

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 previous BAF iteration in line with the Trust pledges 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 Q2

General changes made are as follows:

- Complete review of the BAF. All risks reviewed for their validity and whether still current. BAF content moved into revised exemplar format, all content reviewed and agreed by Lead Directors.
- Additional information has been added in the BAF presentation which includes placement of individual risks on a risk matrix and the risks listed in order of severity.

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
- Existing controls, sources of assurance, gaps in control and actions have been updated.

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
- Existing controls, sources of assurance, gaps in assurance and actions updated

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
- Existing controls, sources of assurance, gaps in assurance and actions updated. Baseline data now available, therefore the score has been decreased from 16 to 12.

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, sources of assurance, gaps in assurance and actions updated.

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, sources of assurance, gaps in assurance and actions updated.

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- Quality Governance Committee/ Workforce Committee
- Existing controls, sources of assurance, gaps in assurance and actions updated.

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
- Existing controls, sources of assurance, gaps in assurance and actions updated.

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, sources of assurance, gaps in assurance and actions updated.

2.1 Risk that the Trust fails to promote a culture which puts patients first- Quality Governance Committee
- Existing controls, sources of assurance, gaps in assurance and actions updated.

3.1 Risk that the Trust fails to achieve optimum workforce capacity to deliver best possible care now and in the future- Workforce Committee
- Existing controls, sources of assurance, gaps in assurance and actions updated. Risk score increased from 10 to 15 due to gap in staffing vacancies

3.2 Risk that the Trust fails to achieve optimal workforce capability to deliver best possible care now and in the future- Workforce Committee
- Existing controls, sources of assurance, gaps in assurance and actions updated.

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, gaps in assurance and actions updated.

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
- Existing controls, sources of assurance, gaps in assurance and actions updated.

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, gaps in assurance and actions updated.

5.2 Risk that the Trust fails to deliver the cost savings associated with the Changing Care @ NGH Programme- Finance & Performance Committee
- Existing controls, sources of assurance, gaps in assurance and actions updated.

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, gaps in assurance and actions updated. Risk score increased from 15 to 20 due to increased pressure on capital from infrastructure incidents

Risk Score: The risk score has increased overall in this quarter from 244 to 250 for 16 risks.
The BAF is attached (Appendix 1). Further work is required to define underlying causes of risks.

5. Trust Strategy

In the recent launch of the new Trust strategy six Pledges are included, these have been linked to the BAF risks as follows, noting some risks link to more than one pledge:

5.1 We will put quality and safety at the centre of everything we do

a. BAF Risk No.1.1 Risk of failure to meet regulators minimum fundamental standards to avoid enforcement action, intervention or suspension of services
b. 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
c. BAF Risk No.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
d. 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
e. BAF Risk No.1.4 Risk of avoidable harm to patients resulting in adverse publicity and public confidence in NGH as hospital of choice
f. 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
g. BAF Risk No.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

5.2 Deliver year on year improvements in patient and staff feedback

a. 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
b. BAF Risk No.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
c. BAF Risk No. 2.1 Risk that the Trust fails to promote a culture which puts patients first

5.3 Create a sustainable future supported by new technology

a. 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
b. 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
c. 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
d. 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

e. BAF Risk No. 5.1 Risk that the Trust fails to have financial control measures in place to deliver its 2019/20 financial plan
f. BAF Risk No. 5.2 Risk that the Trust fails to deliver the cost savings associated with the Changing Care @ NGH programme
g. 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

5.4 Strengthen and integrate local clinical services particularly with Kettering General Hospital

a. 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.

5.5 Create a great place to work, learn and care to enable excellence through our people

a. BAF Risk No.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
b. BAF Risk No.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
c. 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
d. 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
e. 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

5.6 Become a University Hospital by 2020 becoming a centre of excellence for education and research

a. 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
b. 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

The actions associated with the pledges will be reviewed in more detail for Q3 report 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.

6. Risk Appetite

Assessment	Description of potential effect
Zero Risk Appetite	The Trust Board aspires to avoid risks under any circumstances that may result in reputation damage, financial loss or exposure, major breakdown in services, information with no or negligible potential risk to staff /patients.
Low Risk Appetite	The Trust Board aspires to avoid (except in very exceptional circumstances) risks that may result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / patients.
Moderate Risk Appetite	The Trust Board is willing to accept some risks in certain circumstances that may result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / patients.
High Risk Appetite	The Trust Board is willing to accept risks that may result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / patients.
Very High Risk Appetite	The Trust Board accepts risks that are likely to result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential serious risk of injury to staff / patients.

Enclosure G

At the September Board development meeting, the Board reviewed and agreed an amended framework for Risk Appetite as above. The definition for Zero risk has been slightly amended to add “With no or negligible potential risk to staff /patients” as requested.

The Board also agreed the following risk appetite statement:

Strategic Priority/ Principle risk	Risk Appetite
1 Focus on Quality & Safety	Low
2 Exceed Patient Expectations	Low
3 Enabling Excellence Through our People	Moderate
4 Transform our Services to Deliver Better Care and Value with Long Term Sustainability	Moderate
5 Ensure a Financially Sustainable Future	Moderate

The Board is asked to approve the amended framework and statement as above.

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 review, changes made to the BAF
- Consider if the Board is gaining sufficient assurance that controls and actions in place are mitigating risks described
- Approve the amended risk Appetite and Framework

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;
4 Major		3.2;	1.5; 2.1;	4.1;	1.2; 1.8 5.1; 5.2
3 Moderate				1.3;	3.3;
2 Minor					
1 Negligible					

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

Enclosure G

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
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
5.1	Risk that the Trust fails to have financial control measures in place to deliver its 2019/20 financial plan	20
5.2	Risk that the Trust fails to deliver the cost savings associated with the Changing Care @ NGH programme	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
1.3	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	12
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

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 risk expected to be removed from BAF:** 1/4/20	

Changes since last review:

Underlying Cause/ Source of Risk: CRR reference risks 1782, 1879, 1911, 366, 1867, 1902, 1611, 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

Further Actions	**Responsible Person/s**	**Due Date**
1. NGH Improvement Plan developed for implementation 2. HEE/GMC action plans in progress 3. Robust management of delays in closure of SI’s and CAS alerts	1.& 3 Claire Campbell 2. Matt Metcalfe	January 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 risk expected to be removed from BAF:** 1/4/20	
Changes since last review:		

Underlying Cause/ Source of Risk: CRR reference risks 1196,1611,1303, 368, 1305,1782, 1911,1867, 1902	**Initial score**	**Current score**	**Target score**
	20 (4x5)	20 (4x5)	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	• 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 and E /RTT
2. Attendances, admissions, and acuity remain high
3. Lack of capacity within endoscopy services causing outsourcing to private sector
4. Outsourcing of elective activity to reduce backlog
5. Social Care reductions may impact on attendance in A&E and flow in hospital
6. Key posts in A&E remain difficult to recruit to.
7. Key nursing and medical posts remain difficult to recruit to.

Further Actions	**Responsible Person/s**	**Due Date**
1. Winter Plan- Operationalise 2. Relaunch HEAT Programme with PMO Support 3. 3 x Weekly Cancer PTL with 1 deep dive a week 4. Further outsourcing of routine work to private sector	1-3 Debbie Needham 4 Chris Pallot/ Debbie Needham	1. 1st Dec 2019 2. 1st Jan 2020 3. 30th Jan 2020 4. 30 Dec 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 risk expected to be removed from BAF:** 1/4/20	
Changes since last review:		

Underlying Cause/ Source of Risk: CRR ref	**Initial score**	**Current score**	**Target score**
	8 (4x2)	12 (4x3)	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. Potential loss of 1.5% of contract value
2. 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. Discuss opportunities for improving automation of data collection	1 Matt Metcalfe	1 Jan 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 risk expected to be removed from BAF:** 1/4/20	
Changes since last review:		

Underlying Cause/ Source of Risk: CRR reference risks 1879, 1782, 1955, 368, 1867,	**Initial score**	**Current score**	**Target score**
	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	• Reports from Mortality review to CQEG and QGC (L1) • HSMR & SHMI data (L3) • CQEG reports to Quality Governance committee (L1) • Medical and Nurse Director reports to Quality Governance and Trust Board, including Quality Priorities(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.

Further Actions	**Responsible Person/s**	**Due Date**
1. 9th December – roll out of EPMA which includes VTE assessments 2. Completion of work to digitise and mandate use of Deteriorating Patient Care Plan	1. Matt Metcalfe 2. Dr Hardwick	1. Jan 2020 2. Jan 2020

<table>
<tr><td colspan="6">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.</td></tr>
<tr><td colspan="6">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</td></tr>
<tr><td>Risk Classification: Quality</td><td colspan="2">Risk Owner: MD/DON</td><td colspan="3">Scrutinising Committee: Quality Governance Committee</td></tr>
<tr><td>Date Risk Opened: 1/4/19</td><td colspan="5">Date risk expected to be removed from BAF: 1/4/20</td></tr>
<tr><td colspan="6">Changes since last review:</td></tr>
<tr><td colspan="3" rowspan="2">Underlying Cause/ Source of Risk: CRR reference risks 1756, 1757, 368, 1280,</td><td>Initial score</td><td>Current score</td><td>Target score</td></tr>
<tr><td>12
(4x3)</td><td>12
(4x3)</td><td>8
(4x2)</td></tr>
<tr><td colspan="2">Existing Controls</td><td colspan="4">Positive Assurance of Controls</td></tr>
<tr><td colspan="2">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 Staffing Report
6. Quality Account & process
7. Quality Improvement Strategy</td><td colspan="4">• 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)</td></tr>
<tr><td colspan="6">Gaps in Controls
1. Weekend capacity of medical staffing</td></tr>
<tr><td colspan="3">Further Actions</td><td colspan="2">Responsible Person/s</td><td>Due Date</td></tr>
<tr><td colspan="3">1. Medical rota revision
2. Plan to roll out ERostering</td><td colspan="2">1. Geraldine Harrison
2. Fiona Poyner</td><td>1. 31/3/2020</td></tr>
</table>

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 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

Risk Classification: Quality	**Risk Owner:** DON	**Scrutinising Committee:** Quality Governance & Workforce
Date Risk Opened: 1/4/19	**Date risk expected to be removed from BAF:** 1/4/20	

Changes since last review:

Underlying Cause/ Source of Risk:	**Initial score**	**Current score**	**Target score**
CRR reference risks1455, 1280, 1188, 1756,1682	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. Workforce committee 3. Daily safety huddles x 3 led by Senior nursing team 4. Quality Governance committee 5. Patient and Carer experience Group 6. Safeguarding policies/ training 7. Staffing escalation protocol 8. Nurse Staffing Group 9. Assessment and Accreditation Scheme reports to Board 10. Nursing and Midwifery strategy	• Nursing recruitment monthly recruitment pipeline tracker (L1) • Monthly reports from Workforce committee to Trust Board (L2) • Quarterly workforce report to workforce committee (L1) • Quality Governance report to Trust Board (L2) • Incident reporting (L1) • Staff satisfaction survey (L3) • Patient satisfaction survey (L3) • Acuity and skill mix studies for nursing (Bi- annual) (L1) • Open and Honest Care report (L1) • Safety thermometer KPI's (L1) • Falls data and benchmarking (L1) • Nurse fill rate template (L1)

Gaps in Controls

1. Vacancy rates of qualified nursing staff

Further Actions	**Responsible Person/s**	**Due Date**
1. NHS Recruitment & Retention collaboration 2. Cultural awareness and pastoral enhancement 3. Assessment & Accreditation roll out to Paeds, Maternity & Theatres 4. Implementation of Safe Care Electronic too	1. Fiona Barnes 2. OD Team & Tim Brown 3. Margot Emery & PNS 4. Mark Ingram & PNS	1. Jan 2020 2. Jan 2020 3. Jan 2020 4. Jan 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 risk expected to be removed from BAF:** 1/4/20		
Changes since last review:			
Underlying Cause/ Source of Risk:	**Initial score**	**Current score**	**Target score**
CRR reference risks 1701, 1738, 1783, 1174, 258, 1177, 1287, 1373, 1699, 1703, 1893, 1986, 1702	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, but decant plan in place.

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

<table>
<tr><td colspan="5">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.</td></tr>
<tr><td colspan="5">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</td></tr>
<tr><td>Risk Classification: Infrastructure</td><td colspan="2">Risk Owner: COO</td><td colspan="2">Scrutinising Committee: Finance & Performance</td></tr>
<tr><td>Date Risk Opened: 1/4/19</td><td colspan="4">Date risk expected to be removed from BAF: 1/4/20</td></tr>
<tr><td colspan="5">Changes since last review:</td></tr>
<tr><td colspan="2" rowspan="2">Underlying Cause/Source of Risk: CRR reference risks 1660, 1954, 1733, 1984, 1918</td><td>Initial score</td><td>Current score</td><td>Target score</td></tr>
<tr><td>20
(4x5)</td><td>20
(4x5)</td><td>8
(4x2)</td></tr>
<tr><td colspan="2">Existing Controls</td><td colspan="3">Positive Assurance of Controls</td></tr>
<tr><td colspan="2">1. IT reporting to Finance and Performance committee
2. Elective access policy
3. Data quality SOPs in place
4. Microsoft Advanced Threat Detection (ATP) alerts
5. Intrusion Prevention alerts
6. Anti-Virus in place
7. Microsoft Patching – All Trust workstations and servers are patched as required
8. SPAM Emails blocked when reported
9. Weekly Care Cert meetings held
10. Web Filtering –blocks malicious and non-Trust related web traffic.
11. Anti-Ransomware protection.
12. Tape backups (off-line backups) – The Trust now backs up all data to tape regularly</td><td colspan="3">• 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</td></tr>
<tr><td colspan="5">Gaps in Controls
1. IT Team vacancies
2. Ability for users to plug old equipment into network.
3. Limited knowledge of staff regarding cyber security and Potential for incorrect data input due to human error</td></tr>
<tr><td colspan="2">Further Actions</td><td colspan="2">Responsible Person/s</td><td>Due Date</td></tr>
<tr><td colspan="2">1. Training
2. Network access control (plug in USB)
3. 209 WiFi access points left to be deployed
4. HSCN ongoing to migrate to a more secure bandwith connection (NHS Net)
5. Windows to migrate to Windows 7 (2529 completed- 1162 remain)</td><td colspan="2">1. Dave Smith
2. Dave Smith
3. Dave Smith
4. Dave Smith
5. Dave Smith</td><td>1. Jan 2020
2. Feb 2020
3. Feb 2020 (review)
4. April 2020 (review)
5. Aug 2020</td></tr>
</table>

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 risk expected to be removed from BAF:** 1/4/20	

Changes since last review:

Underlying Cause/ Source of Risk: CRR reference risks 1955, 366, 1305, 1867, 2003	**Initial score**	**Current score**	**Target score**
	12 (4x3)	12 (4x3)	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 3. Appointment of Deputy Director of Nursing- Patient Experience	1 & 2: Rachel Lovesey 4. Sheran Oke	1. June 2020 2. March 2020 3. Dec 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 risk expected to be removed from BAF:** 1/4/20				
Changes since last review:					
Underlying Cause/ Source of Risk: CRR reference risks 1682, 1280, 1455			**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	• 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 medical and nursing vacancies due to national shortages
2. Trust turnover rate > 8% target
3. Trust has red flags related to Medical Trainee survey reports
4. Opening of escalation areas dilutes capacity

Further Actions	Responsible Person/s	Due Date
1. Overseas nursing recruitment- Hub funding approved	1. Mark Smith	1. Jan 2020
2. Work underway in Oncology in response to medical trainee reports	2. Bronwen Curtis	2. 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. 3.2 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 risk expected to be removed from BAF:** 1/4/20			
Changes since last review:				
Underlying Cause/Source of Risk: CRR 1305.		**Initial score**	**Current score**	**Target score**
		8 (4x2)	8 (4x2)	8 (4x2)

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

Further Actions	Responsible Person/s	Due Date
1. Talent Management development 2. Implementation of People Plan 2019-2020	1. Mark Smith 2. Mark Smith	1. Jan 2020 (review) 2. Jan 2020 (review)

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 risk expected to be removed from 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. Raising concerns at Work policy 6. Bullying and Harassment Policy 7. Grievances at Work policy. 8. Health and Wellbeing Strategy 9. People Plan 2019-2020 10. Diversity & Inclusion Manager post	• 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 Junior doctors 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. Jan 2020 (review)
2. People Plan Implementation	2. Mark Smith	2. Jan 2020 (review)
3. Values Ambassador role development	3. Claire Campbell	3. Jan 2020 (review)
4. Review of Respect & Support Initiative	4. Bronwen Curtis	4. Jan 2020 (review)

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 risk expected to be removed from BAF:** 1/4/20	
Changes since last review:		

Underlying Cause/Source of Risk:	Initial score	Current score	Target score
Underlying Cause/Source of Risk: CRR reference risks 1309	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 (L2) • Plans in development for; Plastics; Ophthalmology; Urology; Orthopaedics; MSK; 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. Acceleration of the programme of collaboration with KGH	1. Sonia Swart/ Chris Pallot	1. Jan 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 risk expected to be removed from BAF:** 1/4/20		
Changes since last review:			
Underlying Cause/Source of Risk: CRR reference risks 1748, 1204, 1196, 44, 1757, 1953, 697, 1750	**Initial score**	**Current score**	**Target score**
	8 (4x2)	20 (4x5)	8 (4x2)

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. NHSE/I review meetings 12. Purchasing and Supplies Strategy & Policies 13. Financial Assurance meetings with NHSE/I (monthly)	• 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)

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	1. Chris Pallot	1. 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 risk expected to be removed from BAF:** 1/4/19		
Changes since last review:			
Underlying Cause/Source of Risk: CRR reference risks 1747, 44	**Initial score**	**Current score**	**Target score**
	12 (4x3)	20 (4x5)	8 (4x2)

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	• 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)

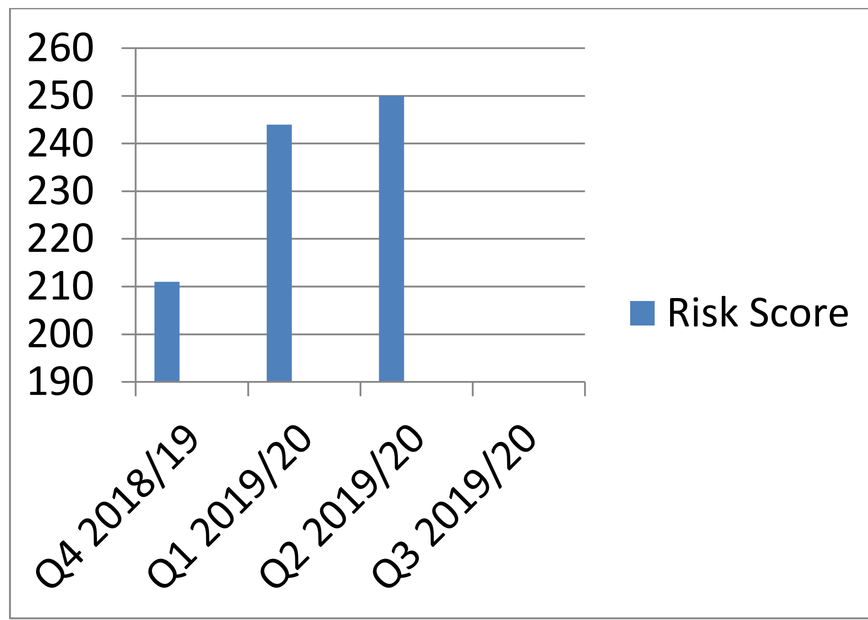
Gaps in Controls

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. Jan 2020 (review)

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 risk expected to be removed from BAF:** 1/4/19				
Changes since last review:					
Underlying Cause/Source of Risk: CRR reference risks 1605, 1749			**Initial score**	**Current score**	**Target score**
			10 (5x2)	20 (5x4)	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 6. Hospital Management Team Meetings	• Finance report to Finance and Performance committee • Includes progress on capital planning and expenditure plus forecast expenditure (L1) • Finance and Performance committee • Report to Board (L2) • Internal 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			1. Stuart Finn 2. Phil Bradley		1. 31/12/19 2. 31/3/20

Movements on Board Assurance Framework (since previous Quarter)	
ADDITIONS	NONE
INCREASES	3.1 Score increased from 10 to 15 due to gap in staffing vacancies
	5.3 Score increased from 15 to 20 due to increased pressure on capital from infrastructure incidents
DECREASES	1.3 Score decreased from 16 to 12 due to availability of baseline data
CLOSURES/ AMALGAMATED	NONE



Graph shows risk score of 250 for 16 Risks

Enclosure G

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

NHS
Northampton General Hospital
NHS Trust

Enclosure H

Report To	**Public Trust Board**
Date of Meeting	**28th November 2019**

Title of the Report	**Revalidation Report – Compliance Statement**
Agenda item	**13**
Presenter of Report	Mr Matthew Metcalfe, Medical Director/Responsible Officer
Author(s) of Report	Mr Matthew Metcalfe, Medical Director/Responsible Officer Dr Fiona Poyner, Deputy RO/Appraisal Lead Ms Elizabeth Smillie, Project Manager
Purpose	Annual report mandated by NHS England
Executive summary The report provides assurance that the medical appraisal and revalidation process is carried out effectively and subject to the correct governance processes.	
Related strategic aim and corporate objective	Improve our core clinical standards to provide a high quality environment for our patients
Risk and assurance	Effective governance to support medical revalidation
Related Board Assurance Framework entries	BAF 4.2
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain

	groups/protected characteristics)? (N) If yes please give details and describe the current or planned activities to address the impact.
Legal implications / regulatory requirements	The Medical Professional (Responsible Officers) Regulations 2010 as amended in 2013 and The General Medical Council (Licence to Practice and revalidation) Regulations Order of Council 2012.

Actions required by the Board

The Board is asked to:
- Approve the report for submission to NHS England

Designated Body Annual Board Report
Section 1 – General:

The board of Northampton General Hospital NHS Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: 06/06/2019 Action from last year: N/A Comments: AOA submitted on time. Action for next year: N/A

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: N/A Comments: Medical Director is the responsible officer for the Trust. Action for next year: N/A

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: N/A Comments: Action for next year: N/A

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: N/A Comments: Record is maintained by the Appraisal & Revalidation team Action for next year:

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: N/A Comments: Appraisal & Revalidation policy reviewed in 2019. Action for next year: N/A

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: N/A Comments: Peer review was completed in October 2016. Action for next year: N/A

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: N/A Comments: The Appraisal & Revalidation Team offer support to all doctors working in the Trust with their appraisal and revalidation. Action for next year: N/A

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: Further work needed to improve compliance Comments: Compliance further dropped this year due to a lack of appraisers and increased numbers of doctors joining the Trust in the last quarter of the year. Action for next year: Further recruitment of appraisers is ongoing to manage demand. We have employed an external agent to conduct some appraisals to help with the backlog.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: N/A Comments: Action is being taken to improve compliance Action for next year: Ongoing recruitment of appraisers. Possible delegation of more appraisees to external agents

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: N/A

Comments: Policy was due for review in 2019 and has been reviewed and approved.

Action for next year: N/A

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:

Comments: Shortage of appraisers in 2018/19, ongoing recruitment of appraisers to meet demand. Training updates have been delivered. Existing appraisers have been asked to do additional appraisals where possible. External agent employed.

Action for next year: Continuing recruitment of appraisers

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Action from last year: N/A

Comments: Regular training events organised for appraisers, Quality Assurance meetings held quarterly and results shared at the regular appraiser meetings.

Action for next year: Training and QA to continue

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: N/A

Comments: Quarterly Quality Assurance meetings held, feedback given to individual appraisers as required and findings reported through quarterly board report

Action for next year: N/A

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: N/A

Comments: No issues

Action for next year: N/A

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: N/A

Comments: No issues

Action for next year: N/A

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: N/A

Comments: There is an established clinical governance framework. There are weekly Review of Harm Group (ROHG) meetings an all doctors are informed if they are involved in any incidents. Each directorate has regular minuted clinical governance meetings.

Action for next year: N/A

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year:

Comments: All trainees get ARCPs and all other junior doctors have clinical supervisors. If any issues are identified with consultant staff this is handled by the RO/Deputy RO and appraisers are notified if there are particular issues that need discussing at the appraisal.

Action for next year:

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: N/A Comments: This is in place. Action for next year: N/A

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[2].

Action from last year: A medical staff concerns group has been established and all issues are logged. An internal audit of performance against policy when formal process is invoked has been undertaken, providing limited assurance. Comments: Action for next year: Implement improvements based on internal audit report

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[3].

Action from last year: N/A Comments: Appraisal & revalidation team have a process for responding to requests for information on doctors formally connected to the Trust and request information on new doctors at the point of connection to the Trust. Action for next year: N/A

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Comments: This is in place Action for next year:

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

> Action from last year: N/A
>
> Comments: Pre-employment checks are carried out by the Human Resources department for all doctors.
>
> Action for next year: N/A

Section 6 – Summary of comments, and overall conclusion

Further work was required from the previous year to improve compliance of doctors having an annual appraisal completed. Unfortunately due to appraisers resigning, retiring and long term sickness compliance further declined in 2018/19. We also had a large number of Trust Grade and Bank doctors, many of whom were new the UK and the appraisal process. Many of these were recruited in the last quarter of the year and we lacked capacity to provide the necessary appraisals with this group that require higher input. Recruitment of appraisers has been successful for the current year and we will continue to recruit further to enable us to meet demand and improve our compliance. We have also begun to use an external third party to conduct some of our outstanding appraisals. Any doctors for whom we have any concerns are appraised by someone in house.

Section 7 – Statement of Compliance:

The Board of Northampton General Hospital NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

Report To	**Public Trust Board**
Date of Meeting	**28th November 2019**

Title of the Report	**NGH Improvement Plan**
Agenda item	**14**
Presenter of Report	Ms Claire Campbell, Director of Corporate Development, Governance and Assurance
Author(s) of Report	Mrs Sarah Brown, Compliance Governance Manager
Purpose	To inform the Trust Board of the outcome and change to ratings following the CQC inspections which took place in June 2019 and July 2019. The report also details the actions the Trust are taking to address the concerns in the report via the improvement plan.

Executive summary

- The overall rating for the Trust has reduced from good to requires improvement.
- The trust was rated as requires improvement for both quality and use of resources.
- The rating has reduced from good to requires improvement for the core services of Maternity and Medical care (including older people's care).
- 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).
- The Trust took immediate action in relation to concerns raised by CQC at the time of the inspection.
- 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 improvement plan will be presented at each Public Trust Board to show the progress the Trust has made in addressing the concerns in the report.
- The Trust has also added reference to "Undertakings for Northampton General Hospital NHS Trust" requirements where these mirror "must" and "should" CQC actions.

Related strategic aim and corporate objective	All
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, fines and / or 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)**
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:

- Discuss and where appropriate challenge the content of the NGH Improvement Plan to ensure it addresses the concerns raised in the CQC reports and undertakings requirements.
- Consider if the actions put in place to address the 'must' and 'should' actions are appropriate, robust and timely
- Decide if additional actions are required to address the concerns raised in the CQC reports
- 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.

Enclosure I

Public Trust Board
28th November 2019
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

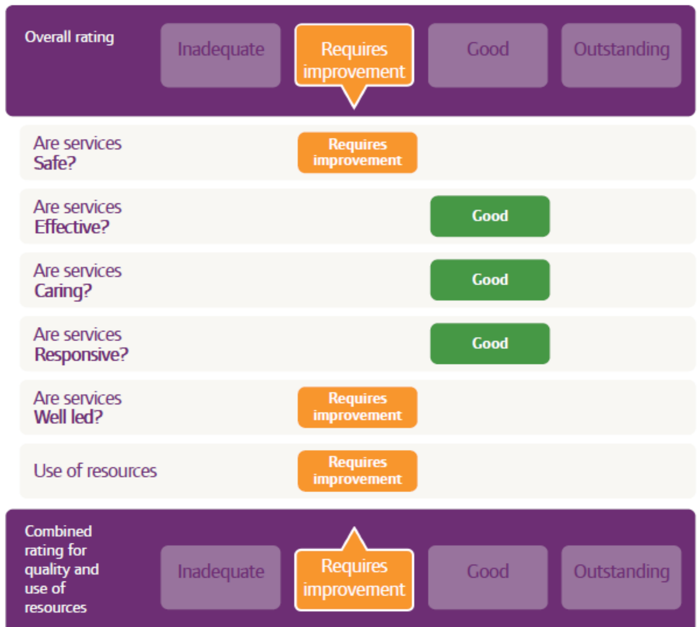
2. Body of Report

2.1 Change to ratings

The overall rating for the trust has reduced from good to requires improvement. The Trust is provided with a rating for quality and use of resources; the Trust was rated requires improvement for both of these, giving the combined overall rating of requires improvement. The Trust also saw a reduction in its overall ratings for safe and well-led from good to requires improvement. This information is provided below

Last rated
24 October 2019

Northampton General Hospital NHS Trust



There was a change in the rating for two of the three core services inspected, Maternity and Medical care (including older people's care) both changed from good to requires improvement. Urgent care maintained its overall rating of good, but was rated good rather than outstanding for

well-led this time. The images below show the changes in ratings from July 2017 inspection to July 2019 inspection.

Last rated
8 November 2017

Northampton General Hospital NHS Trust

Northampton General Hospital

Overall rating: Good (scale: Inadequate / Requires improvement / Good / Outstanding)

	Safe	Effective	Caring	Responsive	Well led	Overall
Medical care (including older people's care)	Good	Good	Good	Good	Good	Good
Urgent and emergency services (A&E)	Good	Good	Good	Good	Outstanding ☆	Good
Surgery	Good	Good	Good	Good	Good	Good
Intensive/critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children & young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Good	Good	Good

Last rated
24 October 2019

Northampton General Hospital NHS Trust

Northampton General Hospital

Overall rating: Requires improvement (scale: Inadequate / Requires improvement / Good / Outstanding)

	Safe	Effective	Caring	Responsive	Well led	Overall
Medical care (including older people's care)	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Services for children & young people	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Maternity	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Updated posters showing the new ratings are on display around the hospital site, at the main entrances. This meets the legal requirements of Regulation 20A: Requirement as to display of performance assessments.

2.2 Immediate action taken by the Trust

Following the core service inspections the Trust received verbal feedback from CQC on a number of areas of concern.

Learning from CQC core service review

Issue Raised	Actions	Outcome(s)
Medicines Management	• Work overseen by task and finish group • Instigated safe and secure medicines audits • PGD processes • Staff communications/safety huddles	• Frequent audits introduced with improvements noted • All PGDs up to date and staff are signed off as competent
Clinical waste segregation	• Increased audits in place • Reiteration of policy to staff • Staff communications/safety huddles	• New bins and labels ordered to reflect correct practice and support staff in ensuring policy adherence/compliance
LocSIPPS	• Task and finish group to review all LocSIPPS prior to relaunch	• All documents collated; work ongoing to update
COSHH security	• All storage areas reviewed during core inspection and security risks removed	• All COSHH substances securely managed
Children's ED facilities	• ED Team meeting with estates to identify potential solutions to the problem	• Short-term – actively moving patients through to PAU to free up space • Medium and long term solutions to be identified
Maternity leadership	• Review support required and identify solutions • Values in practice review completed	• Resignation of head of midwifery received • Support from KGH head of midwifery to support gaps with recruitment process • Head of midwifery post to go out to advert
Staff behaviours	• Discussed in context of our draft people strategy • Staff engagement programme designed	• Summer of staff engagement in train

The Trust took immediate action to address these and the table on the next page below summarises the action taken. This information was fed back to the CQC during the well-led inspection. The evidence appendix report acknowledges the changes made: *''The trust responded quickly to concerns raised as part of our core service inspections. They took some immediate actions and made plans to tackle the issues raised over the medium and long terms."*

2.3 Summary detail of must and should actions in the CQC reports and development of NGH Improvement Plan

The final reports contain the 'must' and 'should' actions. These can be found are listed in the improvement plan (Appendix A). There are a total of three 'must' actions and 36 'should' actions. A summary is provided below:

Must/ Should	Quality or Use of resources report	Core service or Trust wide
3 Must actions	Quality report	1 Medical care 2 Maternity
11 Should actions	Quality report	Trust wide
4 Should actions	Quality report	Urgent and Emergency Services
11 Should actions	Quality report	Medical care (including older people's care)
3 Should actions	Quality report	Maternity
7 Should actions	Use of resources report	Trust wide

These have been transposed from the report and used to form the detail of the Trust improvement plan. 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 changes to the paediatric ED layout.

At the time of writing the report, 28 actions out of a total of 126 have been completed. These are identified in green in the improvement plan. Outstanding actions are shown in orange and overdue actions in red.

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.

2.4 Outstanding practice noted in the reports

Whilst the reports raised many concerns, there were some areas of outstanding practice noted in the quality report. These were:

- The hospital was accredited by UNICEF UK as being a baby friendly hospital for the second time in March 2019
- Northampton General Hospital was the only maternity service in the East Midlands to successfully demonstrate compliance against all ten maternity safety actions set out by the clinical negligence scheme for trusts maternity incentive scheme, which was launched by NHS Resolution in 2018
- The trust was awarded international accreditation status of the Pathway to Excellence program from the American Nurses Credentialing Centre. In November 2018, the trust became the first UK hospital to receive the award which recognises health care organisations that provide a positive practice environment for nurse and midwives
- The trust had collaborated with a local university to develop a three-year, part time masters level degree programme in quality improvement

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).

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
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
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
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

4. Recommendations

The Board is asked to:

- Discuss and where appropriate challenge the content of the NGH Improvement Plan to ensure it addresses the concerns raised in the CQC reports
- Consider if the actions put in place to address the 'must' and 'should' actions are appropriate, robust and timely
- Decide if additional actions are required to address the concerns raised in the CQC reports
- 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

5. Next Steps

The Improvement Plan will be presented to Executive meetings and the Quality Governance Committee on a monthly basis.

Following presentation of this initial version of the improvement plan and report updates will be provided Bi- monthly to Public Trust Board meetings until the improvement plan has been completed. This will include actions which have been closed and progress updates for outstanding actions.

NGH Improvement Plan
(Incorporating CQC Inspection Report outcomes published October 2019/ NHSE/I Undertakings actions)

20/11/2019

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 overseen 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	Completed
		1.3 Ongoing enhanced audits monitored through medicines governance structure	31/12/2019	
		1.4 Safe & Secure Controlled Drug audit carried out on a monthly basis	31/12/2019	

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 overseen 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	
		2.4 Safe & Secure Controlled Drug audit carried out on a monthly basis	31/12/2019	
		2.5 Appoint maternity pharmacist	31/12/2019	
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	
		3.2 'Meet the Matron' posters displayed in all areas- so service users can raise concerns	31/12/2019	
		3.3 Use of Big Word translation services	31/12/2019	

No	Concern: Trustwide Quality "Should" actions	Action	Deadline	Progress/ Comments
		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	

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	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	
		4.4 BAF presented in revised format	28/11/2019	

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	12/12/2019	
		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	
		6.2 See also entry for action 1	31/12/2019	

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	Completed
		7.2 Focus on findings of these audit results with a view to improving compliance	31/12/2019	

No	Concern	Action	Deadline	Progress/ Comments
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	
		7.4 A screensaver has been produced and displayed across the Trust	30/09/2019	Completed
		7.5 Key issues are raised at the Infection Prevention Operational Group, Link Nurse Meetings and Infection prevention Steering Group	31/12/2019	
		7.6 Weekly walk arounds with Claire Topping, Sustainability Manager	31/12/2019	

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	
		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	

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	19/12/2019	
		9.2 Identify basic specification of need	31/12/2019	
		9.3 Commission external review via competitive quotes	31/01/2020	
		9.4 Undertake governance review	31/03/2020	
		9.5 Provide evidence to NHSE/I	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	

No	Concern	Action	Deadline	Progress/ Comments
10	improvement function	10.2 Recommendations of review to be presented to Trust Board	01/04/2020	

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	Completed
		11.2 Continue to engage partners in large scale strategic changes	01/11/2019	Completed and remains ongoing
		11.3 Continue to engage partners in strategic operational issues and decision making	01/11/2019	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	
		12.2 Targeted interventions in 'hotspots'	31/12/2019	
		12.3 Incorporate 'Civility Saves Lives' into Respect and Support programme	31/12/2019	

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.	31/12/2019	
		15.2 Develop options paper looking at expanding or relocating the department. Seek potential options for capital funding.	31/12/2019	
		15.3 Complete works to change the department	31/12/2019	Review date of 31/12/2019
		15.4 Review pathways for use of PAU and increased activity	31/12/2019	
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	
		16.2 See also entry for action 1	31/12/2019	

No	Concern	Action	Deadline	Progress/ Comments
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	31/12/2019	
		17.2 Clinical Director for Urgent Care will remind all medical staff of their need to complete the training	31/12/2019	
		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	
18	The service should take action to improve the median time from arrival to treatment	18.1 Implement winter actions	31/12/2019	
		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	31/12/2019	
		18.4 Rapid improvement project with IDT	09/12/2019 (and ongoing)	

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	
		20.2 Infection Prevention representation at Catering Meetings regarding PPE	30/04/2020	
		20.3 Infection Prevention Mandatory training - 3 yearly for non-clinical staff	30/04/2020	
		20.4 Environment audits and Catering audits are carried out when infection is identified	30/04/2020	
		20.5 Domestic monthly cleaning audits include host/hostess staff - hand hygiene etc observed	30/04/2020	
		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	
		21.1 The Trust have invested in lockable trollies in order to store patient records securely	30/09/2019	Completed

21	The service should keep all confidential patient records securely	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	
		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)	01/04/2020	
		21.5 All areas need to demonstrate compliance as part of the Ward Accreditation Assessment	01/04/2020	
22	The service should introduce local procedures for invasive procedures in non-theatre settings	22.1 LocSSIP documents reviewed and updated	01/01/2020	
		22.2 Relaunch of LocSSIPs - training and comms	01/04/2020	
		22.3 Audit of compliance	01/08/2020	
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	31/12/2019	Review date of 31/12/2019
		23.2 Ward staff escalate any issues regarding medical reviews at the x3 daily Site meetings.	31/10/2019	Completed and ongoin review quarterly
		23.3 Number of medical outliers to be communicated daily via Sitrep (Whats app)	31/10/2019	Completed and ongoin review quarterly
24	The service should consider how it manages private and NHS patients for cardiology procedures to ensure equity of access	24.1 East Midlands Clinical Senate review completed August 2019- Terms of reference included private practise arrangements	31/08/2019	Completed
		24.2 Action plan developed linking multiple workstreams in Cardiology	31/12/2019	
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	
		25.2 Use of PDG report to show reduction in overdue guidelines	01/04/2020	
26	The service should consider reviewing storage and secuirty 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	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	
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 servcie 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	
		30.2 Monitor access to scan appointment within 72 hours for women with reduced/static growth	30/11/2019	
		30.3 Review midwifery ultrasonography scan clinics to ensure adequate capacity	31/12/2019	
		30.4 MESC bid for ultrasound machine for Labour Ward to prevent overnight referrals to MDU / Midwife Scan clinics	31/03/2020	
		30.5 Seek further funding / training for more midwives to be trained in 3rd Trimester scanning	31/03/2020	
		30.6 Monitor Triage waiting times on Maternity Dashboard – monthly report to Directorate / Divisional Governance Group.	31/10/2019	Completed
		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	
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	
		31.2 Reasons for delayed discharges discussed and documented at the Maternity Safety Huddle	01/04/2020	
		31.3 Monthly report to Directorate Governance Group and Divisional Governance Group	01/04/2020	
		31.4 Business case for pharmacy support to assist with delayed discharges for take home medications	01/04/2020	
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	
		32. 2 Develop integrated Business Plan for Maternity Services	01/04/2020	
		32.3 Engagement in East Midlands Clinical Network as well as other Regional / National events and meetings	01/04/2020	
		32.4 Monthly report to Divisional Management Board on forecasted activity based on bookings	01/04/2020	

No	Concern	Action	Deadline	Progress/ Comments
		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	
		32.6 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	
		32.7 Ensure sufficient midwifery staff in post to meet the Continuity of Carer agenda as per Better Births	01/04/2020	

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	
		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	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	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	
		35.2 Integrate productivity improvements in OD interventions	31/03/2020	
		35.3 Introduce talent management	31/03/2020	
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	31/12/2019	Review date (31/12/2019)
		36.1 AE plan in place as per actions 18 and 23	31/12/2019	Review date (31/12/2019)
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	
		39.2 Implementation of new CMMS (computer maintenance management system)	01/08/2020	
		39.3 Development of key maintenance compliance reports from CMMS to be presented at Facilities Governance committee	01/08/2020	

Enclosure I

			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)

18/11/19
V1 (3)

20/11/2019

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 overseen 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	Completed
		Matthew Metcalfe	Maxine Foster/ Associate Directors of Nursing/ Midwifery	1.3 Ongoing enhanced audits monitored through medicines governance structure	31/12/2019		1.3 Audit results/ report and meeting minutes	5- Almost certain	
		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		1.4 Audit results/ report and meeting minutes	5- Almost certain	

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 overseen 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	2.2 Medicines Optimisation Work plan updated to include CQC recommendations (post inspection)	31/10/2019	31/10/2019	1.2 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		1.3 Audit results/ report and meeting minutes	5- Almost certain	
		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		1.4 Audit results/ report and meeting minutes	5- Almost certain	
		Matthew Metcalfe	Maxine Foster/ Christine Ainsworth	2.5 Appoint maternity pharmacist	31/12/2019		2.2 Approved business case	4- Likely	
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		3.1 Three spot audits to confirm leaflets and posters on display	5- Almost certain	
		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		3.2 Record of when Senior Midwifery Team walk arounds completed	5- Almost certain	
		Sheran Oke	Christine Ainsworth/Lorraine Ryan	3.3 Use of Big Word translation services	31/12/2019		3.3 Briefing to staff to remind them to use Big Word	5- Almost certain	
		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		3.4 QuEST Audit (QCI)	5- Almost certain	

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) 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	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 paper	4- Likely	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		4.3 Board paper	4- Likely	
		Claire Campbell	Claire Campbell	4.4 BAF presented in revised format	28/11/2019		4.4 Board paper	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
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	5.1 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
		Claire Campbell	Simon Hawes	5.2 Training refresh for all ARC members on risk, including mitigation, and controls	12/12/2019		5.2 Training presentation	4- Likely	
		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 pro	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		6.1 Action Plan & most recent report to CQEG	5- Almost certain	
		Matthew Metcalfe	Maxine Foster	6.2 See also entry for action 1	31/12/2019		6.2 See above - action 1	5- Almost certain	

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
		Sheran Oke	Wendy Foster/ Claire Topping	7.2 Focus on findings of these audit results with a view to improving compliance	31/12/2019		7.2 Action plans from audits/ improvement work	5- Almost certain	
		Sheran Oke	Wendy Foster/ Claire Topping	7.3 Established a rolling audit programme to carry out a detailed Infection Prevention audit	31/12/2019		7.3 Rolling audit programme	5- Almost certain	
		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
		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		7.5 Minutes from IPOG, Link nurse meetings and IPSG	5- Almost certain	
		Sheran Oke	Wendy Foster/ Claire Topping	7.6 Weekly walk arounds with Claire Topping, Sustainability Manager	31/12/2019		7.6 Notes from weekly walk arounds and any actions to be taken	5- Almost certain	

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

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	8.2 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
		Claire Campbell	Claire Campbell	8.4 Agreed to include committee self-assessment at the end of each meeting	18/12/2019		8.4 Minutes of December 2019 meeting	4- Likely	
		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		8.8 Minutes of December 2019 meeting	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
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	19/12/2019		9.1 Presentation	4- Likely	
		Claire Campbell	Claire Campbell	9.2 Identify basic specification of need	31/12/2019		9.2 Specification document	4- Likely	
		Claire Campbell	Claire Campbell	9.3 Commission external review via competitive quotes	31/01/2020		9.3 Supplier engaged	4- Likely	
		Claire Campbell	Claire Campbell	9.4 Undertake governance review	31/03/2020		9.4 Governance review completed	4- Likely	
		Claire Campbell	Claire Campbell	9.5 Provide evidence to NHSE/I	31/03/2020		9.5 Outcome evidence	4- Likely	

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		10.1 Completed review 10.1 New organogram for QI resource	4- Likely	
		Matthew Metcalfe	Phil Bradley	10.2 Recommendations of review to be presented to Trust Board	01/04/2020		10.2 Completed review	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
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	Completed
		Chris Pallot	Chris Pallot	11.2 Continue to engage partners in large scale strategic changes	01/11/2019	01/11/2019		5- Almost certain	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		5- Almost certain	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
	The trust should take steps to assure itself that the	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	

12	interventions in progress to address bullying and poor behaviour are having an impact at pace	Mark Smith	Bronwen Curtis	12.2 Targeted interventions in 'hotspots'	31/12/2019		12.2 Staff survey 2020	4 - Likely	
		Mark Smith	Bronwen Curtis	12.3 Incorporate 'Civility Saves Lives' into Respect and Support programme	31/12/2019		12.3 Staff survey 2020	4 - Likely	

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.	31/12/2019		15.1 Minutes from Working Group	5- Almost certain	
		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.	31/12/2019		15.2 Options paper	5- Almost certain	
		Deborah Needham	Tristan Dyer/ Head of Estates	15.3 Complete works to change the department	31/12/2019		15.3 Completion of works	2 - Unlikely	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		15.4 Increase referrals to PAU from A&E	4- Likely	
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		16.1 Action plan 16.2 Most recent report taken to CQEG	4- Likely	
		Matthew Metcalfe	Maxine Foster	16.2 See also entry for action 1	31/12/2019		6.2 See above - action 1	5- Almost certain	
17	Undertakings Section 4 The service should take action so medical staff are compliant with the trust target for safeguarding children level three training	Matthew Metcalfe	Tristan Dyer	17.1 Mandatory training compliance of all staff groups is reviewed at every Urgent Care Governance meeting	31/12/2019		17.1 Governance report and governance meeting minutes	4 - Likely	
		Matthew Metcalfe	Tristan Dyer	17.2 Clinical Director for Urgent Care will remind all medical staff of their need to complete the training	31/12/2019		17.2 Email sent to medical staff	4 - Likely	
		Matthew Metcalfe	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	
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			5- Almost certain	
		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	31/12/2019			5- Almost certain	

		Deborah Needham	Deborah Needham	18.4 Rapid improvement project with IDT	09/12/2019 (and ongoing)		18.4 Time to PDNA reduced	4 - Likely	

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/ Matthew Metcalfe	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	
20	The service should check catering staff are following infection prevention and control protocols	Stuart Finn	Wendy Foster/ Brian Willet	20.1 Induction training for new starters	30/04/2020		201. Induction training	5- Almost certain	
		Stuart Finn	Wendy Foster/ Brian Willet	20.2 Infection Prevention representation at Catering Meetings regarding PPE	30/04/2020		202 Meeting minutes	5- Almost certain	
		Stuart Finn	Wendy Foster/ Brian Willet	20.3 Infection Prevention Mandatory training - 3 yearly for non-clinical staff	30/04/2020		20.3 See 20.1	5- Almost certain	
		Stuart Finn	Wendy Foster/ Brian Willet	20.4 Environment audits and Catering audits are carried out when infection is identified	30/04/2020		20.4 Audits/ report and meeting minutes where presented	5- Almost certain	
		Stuart Finn	Wendy Foster/ Brian Willet	20.5 Domestic monthly cleaning audits include host/hostess staff - hand hygiene etc observed	30/04/2020		20.5 Audits/ report and meeting minutes where presented	5- Almost certain	
		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	
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		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		5- Almost certain	Completed
		Sheran Oke	Fiona Barnes/ Sally Shocklidge	21.3 Annual Information Governance mandatory training for all staff	31/12/2019			5- Almost certain	
		Sheran Oke	Fiona Barnes/ Sally Shocklidge	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)	01/04/2020			5- Almost certain	
		Sheran Oke	Fiona Barnes/ Sally Shocklidge	21.5 All areas need to demonstrate compliance as part of the Ward Accreditation Assessment	01/04/2020			5- Almost certain	
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	01/01/2020		22.1 Completed documents	5- Almost certain	
		Matthew Metcalfe	Michelle Metcalfe	22.2 Relaunch of LocSSIPs - training and comms	01/04/2020		22.2 Education/ Comms provided and timelines	4 - Likely	
		Matthew Metcalfe	Michelle Metcalfe	22.3 Audit of compliance	01/08/2020		22.3 Audit forward programme and outcome of audit	4 - Likely	
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	31/12/2019		23.1 Twice weekly audits	5- Almost certain	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	Completed and ongoin 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		5- Almost certain	Completed and ongoin 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 workstreams in Cardiology	31/12/2019		24.2 Action plan	5- Almost certain	

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No	The service should review clinical guidelines to check they are current	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
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	
		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	
26	The service should consider reviewing storage and secuirty 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 visted 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	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		27.1 Completed review	4- Likely	
28	The service should consider addressing cultural issues across some medical wards	Mark Smith	Bronwen Curtis	Covered within action 12	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 servcie 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	
		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		30.2 Datix Incidents / Trends 30.2 Minutes of Maternity Risk Group Meeting / Directorate Governance Group Meeting	5- Almost certain	
		Sheran Oke	Christine Ainsworth/Sue Lloyd	30.3 Review midwifery ultrasonography scan clinics to ensure adequate capacity	31/12/2019		30.3 Service review presented to the Directorate Management Board	5- Almost certain	
		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	
		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		30.5 Additional training places available for midwives	4- Likely	
		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
		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	
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	
		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	
		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 Governan	5- Almost certain	
		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	
	The service should ensure managers are planning the service for the long term. For example, to enable	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	
		Sheran Oke	Sue Lloyd	32. 2 Develop integrated Business Plan for Maternity Services	01/04/2020		32.2 Integrated Business Plan	5- Almost certain	
		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	
		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	

No	Concern: Use of resources 'Should' Actions	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
32	planning and organisation of services so they met the needs of the local population within the local expected population growth	Sheran Oke	Sue Lloyd	32.5 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)	
		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)	
		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	
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		33.1 Minutes of meeting	4 - Likely	
		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	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	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	
		Mark Smith	Bronwen Curtis	35.2 Integrate productivity improvements in OD interventions	31/03/2020			3 - Possible	
		Mark Smith	Bronwen Curtis	35.3 Introduce talent management	31/03/2020			4 - Likely	
36	**Undertakings Section 1** The NHS trust should ensure the improvements that they make in pathways results in achieving better performance against constitutional operational standards	Debbie Needham	Owen Cooper	36.1 Cancer recovery plan in place	31/12/2019		36.1 Most recent version of recovery plan	3- Possible	Review date (31/12/2019)
		Debbie Needham	Debbie Needham Sheran Oke Matthew Metcalfe	36.1 AE plan in place as per actions 18 and 23	31/12/2019		36.2 AE plan	3- Possible	Review date (31/12/2019)
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-	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	
		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	

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	year estates maintenance plan.	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	
		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	Completed

Enclosure I

NHS
Northampton General Hospital
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**28 November 2019**

Title of the Report	**NGH People Plan**
Agenda item	**15**
Presenter of Report	Mark Smith, Chief People Officer
Author(s) of Report	Mark Smith, Chief People Officer
Purpose	1. To update the Trust Board on progress against the shaping of the People Plan 2. To seek approval for the Work Programme 2019/20

Executive summary

- The People Plan has been devised in support of NGH Strategic Plan 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 plan has been shared at the Board development session in October and has been discussed with regards to responding to the recent CQC outcome for the Trust and actions from within the plan will be further discussed during December at the Trust's Hospital Management Team meeting and the Trust's Core Brief and Question Time sessions.
- Action plans are being devised to support implementation over the short and medium term.

Related strategic aim and corporate objective	Deliver year-on-year improvement in patient and staff feedback. Create a great place to work, learn and care to enable excellence through our people.
Risk and assurance	Risks will be identified and mitigated.

Related Board Assurance Framework entries	3.1, 3.2 and 3.3.
Equality Analysis	Implementation plans will be tested for equality considerations.
Legal implications / regulatory requirements	Normal legal and regulatory requirements apply.

Actions required by the Board

The Board is asked to:

- Approve and support the People Plan Work Programme 2019/20

Northampton General Hospital NHS Trust – People Plan 2019/20

Situation

Staff engagement within the Trust has recently declined. There have been a number of sources of feedback which have indicated that the Trust is required to improve its current employment offering and support to staff. The Trust, in the recent past until 2018, 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 as previously presented to the Trust Board had 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 with regards to the junior doctor experience whilst at the Trust. Finally the CQC also noted staff experience as a cause for concern in the recent hospital inspection report published in October 2019.

Assessment and Action

The challenges with regards to staff experience were acted upon by the Trust's senior management team. In recognising that in order to enhance the staff experience, the best way to understand that action which to take was to undertake an engagement exercise across the Trust. This exercise, known as the summer of engagement was completed during the summer concluding in September. In holding engagement sessions across the Trust with all staff groups in a range of forums the senior leadership team sought views as to how working as part of TeamNGH could be improved. The sessions were very valuable, attended by 1000 members of staff and the feedback received was themed in order for action to be taken across the Trust. However, senior leaders within the session were also tasked with undertaking some immediate action within their work environment based on feedback received.

During the summer, the Trust Strategy was also produced centred on providing 'Best Possible Care', the National NHS Interim People Plan was also launched. Taking the feedback from the summer of engagement, the strategic direction of the Trust and the national framework of the Interim NHS People Plan the attached People Plan for the Trust over the next year was developed. A longer term people strategy for the Trust is also being worked upon which, with the recent interim appointment of a Chief People Officer working for the Trust and Kettering General Hospital NHS FT (KGH), will be designed reviewing the needs of the acute sector within the Northamptonshire Health and Care Partnership and will incorporate the National NHS People Plan when launched, likely to be in early 2020.

The People Plan, attached in Appendix One, contains a People Plan mission statement which is 'To create a great place to work, learn and CARE for the people of TeamNGH'. 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. Some of the actions taken already are highlighted below:

<u>Culture</u>

Under the Culture objective within the plan there are five areas of focus for the Trust. Immediate actions have already taken place within the appointment of a Diversity and Inclusion manager for the Trust, the recent establishment of a BAME Network, which the CEO and CPO attended as part of the summer of engagement events. Other inclusion networks will be established shortly and they will be hugely beneficial to the Trust with regards to understanding the diverse needs of the workforce

Achievement

Within achievement the Trust has started to work within the Leadership Academy with regards to a talent management approach. The Organisational Development offering within the Trust has also been reviewed, with more focused interventions taking place within teams where more direct support is required, many of the activities taking place include building strength and trust within teams where challenge can be made and embraced.

Resourcing

The national shortage of clinical staff within certain staff groups is known and is reflected in the NHS Interim People Plan, the Trust has already worked upon and approved a plan of international recruitment which will commence during December and January. A medical recruitment plan is also being devised to support with closing the Trust vacancy gap which will reduce the pressure the current workforce have articulated. The time to hire metric within the recruitment function is also being reviewed as to how this can be improved to facilitate new members of TeamNGH becoming part of the team as soon as possible.

Environment

The Trust has good health and wellbeing intervention in place currently, however a strategy for further development has been developed, along with the introduction shortly of an Employee Assistance Programme which will provide additional support for staff, in line with feedback received. Flexible working was also flagged as an issue during the recent summer of engagement, a new policy and process for flexible working has been designed and will be trialled in some areas of the Trust in the next couple of months before being launched across the Trust.

The above provides some highlights of actions currently being undertaken of which there are many more local and corporate actions which should start to improve the staff experience within the Trust. The People Plan has been communicated as part of the response to the findings of the recent CQC inspection, the plan will also be discussed at the Hospital Management Team meeting, the Trust Core Brief and Question Time sessions during December.

In addition the two Human Resources and Organisational Development functions of our Trust and KGH will be becoming together during December to share learning and ideas for future development of the people offering within both Trusts.

Recommendations

Whilst the Trust Board were able to review an earlier draft of the People Plan during October, the Board are recommended to approve the People Plan for 2019/20 and acknowledge the further development towards a People Strategy in collaboration with KGH during 2020.

NGH People Plan 2019 - 2020

NGH Vision

To provide the best possible **CARE**

NGH Strategy 2019 - 2024

Summer of Engagement

NHS People Plan

- Make NHS the best place to work
- Improve our leadership culture
- Urgent action on shortages
- 21st century workforce
- New operating model for workforce

NGH People Plan Mission

To create a great place to work, learn and **CARE** for the people of Team NGH

- Nurturing a **C**ulture defined by trust & respect which has inclusion at its heart
- **A**chievement for leaders & managers whose purpose is to care for, support & enable their staff to do their best each & every day
- **R**esourcing for today and the future
- Enabling a supportive **E**nvironment

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NGH People Plan: 2019-20 Programmes of Work – providing the best possible CARE

Culture

- Respect & support/civility saves lives
- Diversity & Inclusion
- Freedom to Speak Up
- Leadership behaviour
- On boarding plus

Achievement

- Development offering
- Talent management
- Focussed interventions
- Freedom to act
- Team Togetherness

Resourcing

- Hard to fill posts
- Recruitment offering e.g. Time to Hire
- New job roles
- Collaboration
- Apprentices

Environment

- Health & Wellbeing
- Flexible working
- Policy alignment
- Disatisfier removal
- Social capital

- Innovation and technology
- Collaboration
- Communication & Engagement
- HR/OD capability development
- Process improvement
- Living the values
- Synergy with patient experience

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Northampton General Hospital NHS Trust

Enclosure K

Report To	**Public Trust Board**
Date of Meeting	**28 November 2019**

Title of the Report	**2018-2021 Communications Strategy Progress Report**
Agenda item	***16***
Presenter of the Report	Sally-Anne Watts, Associate Director of Communications
Author(s) of Report	Sally-Anne Watts, Associate Director of Communications and Kieran Jones, Communications Officer
Purpose	For information and assurance
Executive summary The report provides a summary of progress against our 2018-2021 communications strategy.	
Related strategic aim and corporate objective	N/A
Risk and assurance	N/A
Related Board Assurance Framework entries	N/A
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	None
Actions required by the Trust Board The Trust Board is asked to note the contents of the report	

Communications strategy

2018-2021

Progress report

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We aspire to excellence
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Introduction

Communications – current position

We're consolidating progress towards becoming an organisation which promotes and provides opportunities for staff, patients and the public to communicate and engage with us.

Going forward there will be a greater emphasis and focus on internal communication to support TeamNGH as we work through some important issues:

- Rising demand for hospital services
- A new approach to people, culture and workforce
- Best Possible care for patients and staff
- Collaboration and partnership working

What this means

- Subject-based communications are the norm; proactive rather reactive communication, where reality matches rhetoric.
- Context setting and expert advisers – we help people understand their role – and ours - within the wider organisation, healthcare community and NHS. And how we can most effectively use our communication expertise and tools to promote and enhance our services.
- Resource management – strategic communications planning, using evidence-based communication tactics to achieve results.

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Components of the strategy

The vision of the communications strategy is unchanged:
'Effective communication at the heart of all we do'

Six key components underpinned by the following principles:

- Open and honest communication, in line with our values
- Clear, coherent, consistent messages
- Planned, proactive and targeted activity
- Research and evidence-based communication to meet individual, issue and service-specific needs
- Multi-channel communications for maximum reach
- Staff first – no surprises
- Effective communication is not the sole responsibility of the communications team
- The communications team is responsible for message design and delivery; managers are responsible for sharing messages with teams and individual staff are responsible for ensuring they are kept informed

Effective communication at the heart of all we do

1. Embed understanding and ownership of our values
2. Involve and inform staff in our vision and direction
3. Develop and improve our digital and social media channels
4. Enhance and improve our communication with patients and the public
5. Work closely with local partners to provide joined-up communications
6. Protect and enhance our reputation as a leader in innovation and a great place to work

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Summary of progress

In 2017/18	Now
• Proactive, planned communications activity • Good progress made towards implementing robust, systematic and effective two-way staff communication • Strong brand and corporate image: #TeamNGH • Good progress made towards publishing outcomes so they can be easily understood • Actively seeking patient and public involvement to improve and enhance service provision • Work continues to develop strong and effective relationships with stakeholders • Proactive role in public health messaging • Active partner in local stakeholder communications; established relationships with local influencers • Award-winning, planned, targeted communications campaigns with measurable outcomes • Effective use of social media with strong digital/social presence	• Targeted communication campaigns • Briefing events well attended. Opportunities for feedback • Staff actively involved in strategy development • TeamNGH Facebook community launched; learning from summer of engagement to inform ongoing communication activity and strategy development • Greater prominence to brand; brand guidelines produced, greater visibility of values • Planned and targeted communications activity in collaboration with NHCP • Stronger links with local MPs • Strengthened links with local and regional media • Effective use of targeted social media advertising, eg recruitment campaigns • Working with local businesses to extend reach • Extending message reach through collaboration and external advertising

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Embed understanding and ownership of our values

TeamNGH brand and values

- Values visible across the site
- Brand guidelines
- Patient safety campaign

Strengthened reward and recognition

- Everyday Heroes
- Long Service Awards
- Best Possible Care Awards

Culture and behaviours

- Respect and support campaign
- Freedom to Speak Up

Coming soon

- Bringing our values to life
- NGH wall of fame

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Involve and inform staff in our vision and direction

7 animations

Understanding and awareness

- CQC inspection – preparation and briefings
- Be Safe Not Sorry Campaign
- Flu jab and grab campaign
- Insight features on services/staff

Communication and engagement

- Extensive use of social media
  - TeamNGH Facebook community
- Question time briefings – experience sharing
- CEO blog
- Refreshed core brief

Coming soon

- NGH Winter Watch 2019/2020
- Strategy visuals to go alongside our values
- Combined annual report and quality account
- Intranet 'The Street' redesign
- Award register and support for award nominations

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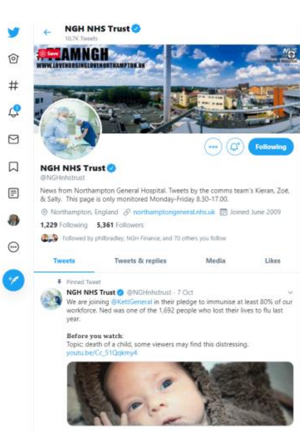
Develop and improve our social media channels - 1



Capability and Capacity

- Digital Academy for TeamNGH
- Social media policy developed and implemented

Twitter

- 5,361 followers, a 33% increase on 2018. Av 3 new followers a day
- 1,532 reviews – current score 3.8/5

Facebook

- 14.1k followers, 20% increase on 2018. Av weekly reach exceeds 80k (60% increase)
- Messages responded to promptly – average response time 35 mins

Instagram

- 2,155 followers, a 79.58% increase on 2018. Average weekly reach in excess of 2k

YouTube

- 281 subscribers – average of 1,200 video views per month

Linkedin

- 5,174 followers – average of 715 page views per month – managed by HR

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Develop and improve our social media channels - 2

Website (internet) analytical information (12 months)

- 341,000 unique visitors to website – 79.5% increase on 2018
- 564,000 individual sessions on website – 92.8% increase on 2018
- Average session duration: 1m 43s
- Top traffic sources: organic search and direct access
- 58.4% of users use: mobile device | 32.6% Desktop | 9.1% Tablet |
- Average of 1,100 website visitors per day

Intranet (The Street) analytical information (6 months)

- 32,000 unique visitors to intranet
- 559,000 individual sessions on intranet
- Average session duration: 4m 43s
- Top traffic sources - direct, referral from northamptonformulary.nhs.uk and itservicedesk
- 77.2% of users use a: desktop | 19.5% Tablet | 3.3% Mobile |
- Average of 2,400 intranet visitors per day

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Develop and improve our social media channels - 3

Search engine performance

- 695,625 people found us on Google in the last quarter – 74.6% of those were direct searches, 24.6% were discoveries.
- The two most searched terms were 'Northampton general hospital and NGH'
- Over 1,000 different search terms have led users to our website
- 233 Google reviews – rating 3.2 out of 5

Google

Google Search I'm Feeling Lucky

User actions

- There have been a total of 57,200 'user actions' in the last quarter
  - 8,970 people clicked 'Visit website'
  - 33,500 people requested directions to our site – 912 were inside the NN1 postcode
  - 14,700 called 01604 634700 via Google

Coming soon

- Promote the NGH digital academy to improve quality and delivery of intranet content
- Work with the web development team to improve the design of the intranet
- Survey staff on their usage of various areas of the intranet
- Make improvements to our website that will benefit our site rank on search engines
- Add/improve the keywords and metadata on the 2,000+ individual pages on our website

Enhance and improve our communication with patients and the public

Winter/urgent care

- County-wide urgent/winter care campaign 2019/20

Stakeholders

- MPs – regular meetings and briefings
- Media – links with local, regional and national media outlets
- Live content on screens in waiting areas
- GP newsletter

Coming soon

- Review/refresh of NGH website design and content
- Open day in 2020
- New smoke-free signage, supported by video content

Potential

- Live waiting times on screens in the ED
- Paid-for advertising on screens
- ITV features
- Extending message reach through collaboration with KGH/NHCP

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Protect and enhance our reputation as a leader in innovation and a great place to work

Recruitment and retention

- Pathway to Excellence®
- Targeted social media advertising
- National award recognition/celebration
- Overseas nurses

Coming soon

- Role-specific, personalised web content to support recruitment
- Redevelopment of south entrance
- Maggie's Centre

Potential

- Diversity and inclusion – NGH BAME group – 2020 calendar
- Research and development – awareness and recruitment campaign
- Working with University of Northampton on improvement projects

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Work with partners to provide joined-up communications

Northamptonshire Health and Care Partnership (NHCP)

- County-wide urgent care/winter communications plan for 2019/20
- Shared approach agreed with KGH on winter messaging

Northamptonshire Health Charity

- Promotion of fundraising successes and opportunities

MPs

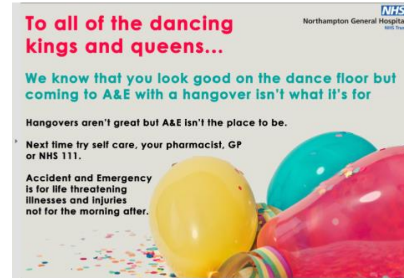
- Regular meetings and briefings

Local businesses

- Support for health and wellbeing activities
- Support for winter communications 2019/20

Coming soon

- NHCP podcasts



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Effective communication at the heart of all we do – 2020 focus

Improving staff engagement

- Valuing, rewarding and recognising our staff
- A programme for listening and responding to feedback
- Supporting HR/OD/transformation campaigns that drive involvement and engagement

Improving staff communication

- Segmenting of audiences for more meaningful and targeted communication
- Strengthened divisional communications support
- Clear and consistent single narrative for context (aligned to strategic priorities and values)

Strengthened approach to collaborative working

- Identifying opportunities for joint working

Local, regional and national profile

- Media – being ambitious in the opportunities we explore
- Recruitment
- National Awards and recognition for TeamNGH

Team stability

- Developing the team
- Building on foundations in place

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Report To	PUBLIC TRUST BOARD
Date of Meeting	28 NOVEMBER 2019

Title of the Report	**Freedom to Speak Up Bi- Annual Report**
Agenda item	**17**
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
Purpose	The report provides an update into the work of Trust in respect to Freedom to Speak Up requirements and ongoing work to support this agenda.
Executive summary The report provides the background to the introduction of Freedom to Speak Up and progress made to develop clear systems and process at Northampton General Hospital. It provides information on concerns raised in the first two quarters of this financial year. It also provides detail of case content, open and closed cases and outcomes and sources of concerns raised. The report provides an overview of the Trust Guardians role and activity year to date and outlines the further development of the values ambassador role training. National Guardians Office and NHSI/E publications are also highlighted, with a review and gap analysis of the recommendations from all seven case studies undertaken to date.	
Related strategic aim and corporate objective	Focus on Quality and Safety Enabling 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	BAF 1 BAF 2
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
Legal implications / regulatory requirements	There is a legal requirement under the Health and Social Care Act to appoint a Freedom to Speak Up Guardian.
Actions required by the Board The Board is asked to: • The Board is asked to note and comment on the content of the report, and accept this paper for information and assurance.	

Enclosure L

FREEDOM TO SPEAK UP BI ANNUAL REPORT NOVEMBER 2019/20

1. INTRODUCTION

In February 2015 the recommendations of "Freedom to Speak Up" (Chaired by Sir Robert Francis QC) were published. The review concluded that there was a serious issue in the NHS that required urgent attention if staff are to play their full part in maintaining safe and effective services for patients.

A number of recommendations were made to deliver a more consistent approach to whistleblowing across the NHS, including the requirement for all organisations to appoint a Freedom to Speak Up Guardian and the development of a single national integrated whistleblowing policy to help normalise the raising of concerns.

The agreed reporting route for Freedom to Speak up at the Trust is the Workforce Committee (quarterly) with a bi-annual report to Trust Board. The Freedom to Speak Up Guardian maintains a case log, to oversee the management and timeliness of investigations and outcomes and ensure the Trust policy is followed.

2. FREEDOM TO SPEAK UP CASES QUARTERS 1 & 2 (April- September 2019)

Within the timeframe being reported, 28 cases were reported. This is big increase on the previous two quarters when 17 cases were reported in total (1 in quarter 3 and 16 in quarter 4). This increase correlates with the relaunch of Freedom to Speak Up in January 2019.

2.1 Content of cases reported:

Category	**Q1**	**Q2**	**Total**
Patient safety/ quality	5	6	**11**
Staff safety/ Training	2	2	**4**
Bullying and harassment	6	10	**16**
Systems, processes or policies	6	1	**7**
Environment/ infrastructure	1	0	**1**
Workplace culture	2	1	**3**
Leadership	4	1	**5**
Use of resources	1	0	**1**

Noting most cases raised contain more than one issue.

2.2 Source of cases reported

Source	**Q1**	**Q2**	**Total**
FTSU Guardian	11	14	**25**
CQC	1	0	**1**
GOSW	0	2	**2**

The Values Ambassador role was introduced in the Trust in January 2019. Identification and training of individuals took place in Q1 & 2 with seven individuals in place by Q3. Future reports will include numbers of cases raised through the Ambassadors.

2.3 Concern raised by staff group (where known)

Staff group	**Q1**	**Q2**	**Total**
Doctor	2	2	**4**
Nurse	2	4	**6**
Midwife	2	1	**3**
AHP	1	2	**3**
Pharmacist	1	0	**1**
Admin	0	3	**3**
Cleaning/ Catering/ Maintenance/ Ancillary staff	0	2	**2**
Corporate	0	0	**0**
Board Members	0	0	**0**
Anonymous	4	2	**6**
Total	**12**	**16**	**28**

Of the above cases at time of report;
- 8 remain open with ongoing investigations/ or report write up underway
- 1 referred to Fraud
- 9 referred to the Respect & Support Helpline
- 1 referred direct to HR
- 2 referred to relevant Executive colleagues with the permission of the individual
- 20 cases closed

0 cases were reported where the individual indicated they are suffering detriment as a result of speaking up.

3. TRUST GUARDIAN ROLE- ACTIVITY IN YEAR TO DATE

- Met with the newly appointed Guardian of Safe Working to discuss how we support each other's guardian roles and identify solutions to the challenges faced at a local level. Discussions underway regarding a joint presentation to Junior Doctors "Meet the Guardians"
- Presented at two Junior Doctor Induction sessions- "Meet the Guardians" with the GOSW
- Provided training to specific departments on request regarding Freedom to Speak Up
- Launched the Values Ambassador training with OD team – 9 individuals trained (subsequently 2 have unfortunately stepped down, one as resigned from post and the other due to other work pressures). A further 7 individuals have expressed an interest with a further training session to be identified.
- Provided follow up training for Values Ambassadors
- Completed the National Guardians Office Annual Survey for FTSU Guardians
- Planned activities for FTSU Month with communications team for October 2019
- Working closely with OD team regarding further session for all trained Ambassadors and ongoing support.
- Attended KPMG- Ethics Champions Panel session in September on behalf of the National Guardians Office to promote the role of FTSU Guardians in the NHS and learn from non NHS organisations systems
- Completed quarterly returns to National Guardians Office for Q1 and Q2 within required deadlines

4. NATIONAL GUARDIANS OFFICE (NGO)

The NGO and NHSE/I published the following key documents:

4.1. Alliance against bullying and harassment in the NHS

The above publication was launched following a conference hosted by the Royal College of Surgeons of Edinburgh and the National Guardian's Office in September 2018. An informal anti-bullying alliance has been formed to share ideas and enact initiatives across health, including the National Guardian's Office, NHS Improvement, NHS Employers, GMC, BMA and several of the Royal Colleges. The anti-bullying alliance recognises that by working in partnership, we can together help create the culture and leadership needed to eradicate bullying. The document aims to give an overview of some of the initiatives being enacted across the healthcare professions to tackle undermining behaviours and bullying. The full report can be found at: https://www.rcsed.ac.uk/media/417910/antibullying-3april2019-002.pdf

4.2. Census for NHS Trusts and Foundation Trusts

The NGO launched their census exercise for Trusts where all Trusts were asked that everyone registered in the National directory to review contact details and check that the information held is accurate and up-to-date. The Trust submitted the information by the deadline required.

4.3. Guidance for boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts

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 sets out expectations of boards and board members in relation to Freedom to

Speak Up and is now accompanied by a number of supplementary resources, a streamlined toolkit and contains some practical 'how to' information.

The revised guidance should be utilised to review progress the trust has made against the original document and refine Freedom to Speak Up development plans. As before, these plans should be discussed with the board and ideally shared with workers.

NHS Improvement would like 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.

This will be utilised in the self-assessment review planned for Board development at the end of the month.

4.4. National guidelines on Freedom to Speak Up training in the health sector in England
Published by the NGO 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 are set out in three parts covering:

- Core training for all workers
- Line and middle manager training
- 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.

Speaking up has an essential part to play in patient safety and the experience of workers – the NGO believes that it should be considered on a par with other mandatory training. Additionally, whilst it is expected that Freedom to Speak Up Guardians have an interest in training, there is no expectation for them to deliver it to all staff.

4.5. Q1 & 2 speaking up data published
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.

<u>Q1 data headlines from Trusts:</u>
- 3,156 cases were raised to Freedom to Speak Up Guardians / ambassadors / champions
- 767 of these cases included an element of patient safety / quality of care
- 1,213 included elements of bullying and harassment
- 116 related to incidents where the person speaking up may have suffered some form of detriment
- 439 anonymous cases were received
- 3 organisations did not receive any cases through their Freedom to Speak Up Guardian
- 197 out of 224 NHS trusts sent returns

<u>Q2 data headlines from Trusts:</u>
- 3,473 cases were raised to Freedom to Speak Up Guardians / ambassadors / champions
- 844 of these cases included an element of patient safety / quality of care
- 1,240 included elements of bullying and harassment
- 127 related to incidents where the person speaking up may have suffered some form of detriment
- 455 anonymous cases were received
- 2 organisations did not receive any cases through their Freedom to Speak Up Guardian
- 201 out of 224 NHS trusts sent returns

4.6. Case Reviews

The case review process was established by the NGO 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 publish the findings where it appears 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 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.

In the first two quarters of this year a further two Case Reviews have been published; Brighton & Sussex University NHS Trust in June 2019 and North West Ambulance Service NHS Trust in September 2019.

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 by the FTSU Guardian. This has been reported to the Workforce Committee to ascertain what lessons can be learnt to improve FTSU systems and processes, to encourage staff and embed FTSU into the organisational culture. This has identified the following recommendations relevant to NGH that require further work as follows:

- 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 above five key areas will be identified within the Trusts Self-assessment and action plan for implementation.

5. FURTHER WORK REQUIRED

The following areas of work have been prioritised to further the FTSU agenda at NGH:

- Review of the Trusts self- Assessment and implement areas for development which include the development of an overarching strategy and improvement plan and improved communications with respect to Freedom to Speak up, to be discussed and presented to November Board Development.
- Identify training opportunities/programme within induction for all Trust staff to raise the profile of FTSU in the Trust
- Further support to Values Ambassadors and additional training sessions

6. RECOMMENDATIONS

The Board is asked to note and comment on the content of the report, and accept this paper for information and assurance.

Northampton General Hospital NHS Trust

Report To	Trust Board Meeting
Date of Meeting	28 November 2019

Title of the Report	Non-Executive Director Roles
Agenda item	18
Presenter of Report	Claire Campbell- Director of Corporate Development, Governance & Assurance
Author(s) of Report	Claire Campbell- Director of Corporate Development, Governance & Assurance
Purpose	To provide context and background to the appointment of Committee Chairs and Vice Chairman/Senior Independent Director roles.
Executive summary This report outlines changes made to roles and responsibilities of Non-Executive Directors (NED) as a result of the recent changes to NED membership of the Board. It provides an outline of the roles of the Vice Chair and Senior Independent Director and confirms committee chairs and membership.	
Related strategic aim and corporate objective	1.
Risk and assurance	None
Related Board Assurance Framework entries	1.1
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
Legal implications / regulatory requirements	None but best practice guidance as follows: NHS Foundation Trust Code of Governance/ Your statutory duties, A reference guide for NHS Foundation Trust governors Trust Standing Orders (2016)

Actions required by the Board

The Board is asked to:
- Approve the appointment of Mr David Moore as the Vice Chairman/Senior Independent Director
- Note the changes to Chairs and membership of Board committees

Non- Executive Director Roles

1. Introduction

This report outlines changes made to roles and responsibilities of Non-Executive Directors as a result of the recent changes to NED membership of the Board.
.
The appointment of a Senior Independent Director (SID) is not mandatory but is considered good practice, drawing on practice in the private sector, based on the Combined Code of Corporate Governance as noted in the NHS Foundation Trust Code of Governance.

Changes to committee Chairs and membership have also been agreed as outlined below.

2. Role Changes

2.1. Vice Chairman: This position will preside at meetings of the Board when the Trust Chairman is unavailable or if the Chairman declares an interest that prevents him from taking part in the discussion of a matter before the Board. The term of office for the Vice Chairman shall be the same as the term of office for which the Non -Executive Director has been appointed to the Board. Mr David Moore has been approached and has agreed to take the position of Vice Chairman, subject to Board approval.

2.2. Senior Independent Director: This position provides the following support in addition to the same duties as the other Non-Executive Directors:

- Provide support for the Chair in the delivery of his objectives
- Ensure the views of other Directors are conveyed to the Chair
- Ensure that appropriate succession plans are in place for the Board and are being followed.
- Carry out an annual evaluation of the Chair in conjunction with the other Non- Executive Directors whilst also taking account of the views of the Executive Directors.
- Chair the nominations committee and take responsibility for an orderly succession process for the Chair.
- In circumstances where the Board is undergoing a period of stress the Senior Independent Director has a vital role in intervening to resolve issues of concern, e.g. Chairs performance. In these circumstances the Senior Independent Director will work with the Chair and other Directors to resolve significant issues. The Senior Independent Director role will be identified and named in the Trusts Annual Report.

Mr David Moore has been approached and has agreed to take the position of Senior Independent Director, subject to Board approval.

3. Committee Chairs and membership

- Finance & Performance Committee: Mr David Moore (Chair). Membership- Tremaine Richard-Noel, Ann Gill, David Noble/ new NED,
- Audit Committee: John Archard- Jones (Chair). Membership: Anne Gill, Tom Robinson, Jill Houghton, Tremaine Richard- Noel and Chairman by invitation
- Quality Governance Committee: Prof Tom Robinson (Chair), Membership: Jill Houghton, John Archard-Jones
- Workforce Committee: Anne Gill (Chair). Membership: David Moore, Emma Heap/ New NED

All Non-Executive Directors are ex- officio at all Board and sub- committees and have the right to attend any meeting.

Nominated members must arrange for a substitute Non –Executive Director to attend meetings in the event they are unable to attend to ensure all meetings are quorate.

AGENDA Northampton General Hospital NHS Trust

PUBLIC TRUST BOARD

Thursday 28 November 2019
09:30 in the Board Room at Northampton General Hospital

Time		Agenda Item	Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr A Burns	**Verbal**
	2.	Declarations of Interest	Note	Mr A Burns	**Verbal**
	3.	Minutes of meeting 26 September 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.	Generator Outage Update	Assurance	Mr S Finn	**E.**
	11.	Flu vaccination for Healthcare Workers	Assurance	Mr M Smith Ms S Oke	**F.**
	12.	Board Assurance Framework (Q2)	Assurance	Ms C Campbell	**G.**
	13.	Revalidation Report – Compliance Statement	Assurance	Mr M Metcalfe	**H.**
11:10	**STRATEGY**				
	14.	CQC Report & Action Plan	Assurance	Ms C Campbell	**I.**
	15.	People Strategy Update Report	Assurance	Mr M Smith	**J.**
	16.	Communications Strategy Update	Assurance	Dr S Swart	**K.**
11:40	**CULTURE**				
	17.	FTSU Bi-Annual Report	Assurance	Ms C Campbell	**L.**
	18.	NEDs Roles	Assurance	Ms C Campbell	**M.**
11:50	**19.**	**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 30 January 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).