AGENDA BOARD OF DIRECTORS

DATE AND TIME: 10:00am, 2nd February 2018
VENUE: Boardroom, Glebe House, Kettering General Hospital

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<thead>
<tr>
<th>TIME</th>
<th>ITEM</th>
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<tbody>
<tr>
<td>10:00</td>
<td>1.1</td>
<td>Apologies</td>
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<td>-</td>
<td>(verbal)</td>
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<tr>
<td>10:02</td>
<td>1.2</td>
<td>Declarations of Interest</td>
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<td>Chairman</td>
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<td></td>
<td>1.3</td>
<td>Minutes from previous meeting</td>
<td>Approve</td>
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<td>Chairman</td>
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<td>(a) December 2017</td>
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<td>(b) Extra-ordinary January 2018</td>
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<tr>
<td>10:06</td>
<td>1.4</td>
<td>Matters Arising</td>
<td>Review</td>
<td>Review</td>
<td>Chairman</td>
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<td>(a) December 2017</td>
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<tr>
<td>10:10</td>
<td>2.1</td>
<td>Chairman’s Opening Remarks</td>
<td>Update</td>
<td>Chairman</td>
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<td>10:15</td>
<td>2.2</td>
<td>Chief Executive’s Report</td>
<td>Review</td>
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2. REPORTS FROM THE CHAIR AND CHIEF EXECUTIVE

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<tr>
<td>10:25</td>
<td>3.1</td>
<td>Integrated Governance Report</td>
<td>Information</td>
<td>Executive Team</td>
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<td>10:45</td>
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<td>Quality Improvement Plan</td>
<td>Information</td>
<td>Director of Nursing</td>
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<td>11:05</td>
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<td>Care Quality Commission Inspection</td>
<td>Information</td>
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<td>Assurance</td>
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<td>11:20</td>
<td>3.6</td>
<td>EPRR Core Standards</td>
<td>Assurance</td>
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3. QUALITY, PATIENT SAFETY AND EXPERIENCE

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<tr>
<td>11:40</td>
<td>4.1</td>
<td>Sustainability &amp; Transformation Plan Update</td>
<td>Assurance</td>
<td>Chief Executive</td>
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<td>11:50</td>
<td>4.2</td>
<td>Long Term Liquidity, Cash flow, loan balances and funding</td>
<td>Approval</td>
<td>Director of Finance</td>
<td>(attached)</td>
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4. STRATEGY & FINANCE

5. RISK AND GOVERNANCE

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<td>12:10</td>
<td>5.2</td>
<td>Well-Led Review Improvement Plan Update</td>
<td>Review</td>
<td>Director of Integrated Governance</td>
<td>(to follow)</td>
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</table>
12:20 5.3 Board Assurance Framework  Review Director of Integrated Governance (attached)

6. MINUTES

12:30 6.1 Integrated Governance Committee  Review Chair of Committee (attached)
12:40 6.2 Performance, Finance & Resources Committee  Review Chair of Committee (attached)
12:50 6.3 Workforce Development Committee  Review Chair of Committee (attached)

7. FEEDBACK FROM HEALTHWATCH/GOVERNORS  (verbal)

8. AREAS OF UNMITIGATED RISK  (verbal)
Any items of unmitigated risk which require further action (with reference to the Corporate Risk Register and/or Board Assurance Framework)

9. RESOLUTION TO EXCLUDE THE PRESS AND PUBLIC  (verbal)
The Board is asked to approve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted

10. DATE & TIME OF NEXT MEETING

- 10:00am
- 2nd March 2018
- Boardroom, Glebe House
MINUTES OF THE BOARD OF DIRECTORS HELD AT 10:00AM ON THE 22ND DECEMBER 2017, BOARDROOM, GLEBE HOUSE

PRESENT:
Mr A Burns - Chairman
Ms F Wise - Chief Executive (interim)
Mr A Ball - Non Executive Director
Ms N Briggs - Director of Finance & Contracting
Mrs R Brown - Chief Operating Officer
Dr A Chilton - Medical Director
Mrs J Gray - Non Executive Director
Mrs L Hanna - Non Executive Director
Ms S Newing - Deputy Director of Human Resources
Mr P Harris-Bridge - Non Executive Director
Mr S Ramsden - Non Executive Director
Mr T Shipman - Non Executive Director

IN ATTENDANCE:
Mrs S Madeley - Trust Board Secretary
Mr D Morris - Price, Waterhouse, Cooper (item 3.1 only)
Mr J Walker - Price, Waterhouse, Copper (item 3.1 only)

OBSERVERS:
Mr S Lake - Public Governor, Wellingborough
Dr M Blades - Public Governor, East Northamptonshire
Mrs C Chapman - Public Governor, Kettering
Ms P Jackson - Public Governor, Wellingborough
Mr R Talbot - Public Governor, East Northamptonshire

OPENING ADMINISTRATION

1.1 APOLOGIES FOR ABSENCE

Apologies for absence were received from Ms L Hackshall, Mr M Smith and Mr P King.

1.2 Declarations of interest

There were no declarations of interest relevant to the items on the agenda.

1.3 Minutes from the previous meeting

The minutes of the meeting held on the 24th November 2017 were received as a true and accurate record.

1.4 Matters Arising

1.4.1 Integrated Governance Report (minute 3.1)

It was confirmed that the policy of purchasing beds from outside of the County was the responsibility of the Clinical Commissioning Groups.
1.4.2 Well-Led Governance Improvement Plan Update (minute 6.1)

**DECISION: Mr King to circulate the Improvement Plan to the Board.**

2. REPORTS FROM THE CHAIR AND CHIEF EXECUTIVE

2.1 Chairman’s Opening Remarks

The Chairman informed the Board of Directors of the interim arrangements for the position of the Chief Executive when Ms Wise departs the Trust in February 2018.

The Chairman reported that NHS England was instructing Trusts to stop elective care during December which was currently not applicable to the Trust due to the commitment of the hospital to address its performance regarding the Referral to Treatment Time target.

2.2 Chief Executive’s Report

The Board of Directors received the Chief Executive’s report which highlighted the formal letter received from the Care Quality Commission (CQC), following the recent formal inspection, regarding a potential Section 31 Enforcement Notice relating to the radiology service. The Board was informed that following the submission of supporting evidence, the concerns had been resolved to the satisfaction of the Care Quality Commission. Ms Wise formally thanked the staff involved in preparing the response to the Care Quality Commission which was robust and detailed a level of understanding in assuring the CQC. The Chairman said that the area that influenced the CQC was that the Trust had already escalated the risk in radiology to a risk score of 20 on the Corporate Risk Register. Ms Wise reported that a Radiology Assurance Group had been established during the first week in January 2018 with Mr Harris-Bridge, Non-Executive Director, would be in attendance.

Dr Chilton reported that he had liaised with Portsmouth Hospital regarding their experience with radiology reporting to ensure the Trust could learn from their experience. The Chairman said that radiology reporting was an issue being addressed by many Trusts across the country.

3. STRATEGY/FINANCE

3.1 Long Term Financial Plan

Mr J Walker and Mr D Morris from Price, Waterhouse, Cooper (PWC), attended the meeting to present work undertaken to date on the Long Term Financial Plan. The next stage of the work was to identify ways of closing the financial gap of the Trust and return to a sustainable financial position. Mr Walker informed the Board that the current forecast outturn position was reviewed and the view of PWC and the Director of Finance were aligned.

Mr Walker reported that there would be a £22m underlying deficit. Mr Ball queried “other net of £1m” within the presentation with Mr Walker explaining that there was pessimism around the financial recovery and surgical recovery plan. Mr Morris informed the Board that the full report would be presented at the next Board meeting.
Mr Morris said that the next part of the work would involve reviewing and strengthening the Cost Improvement Programme (CIP) for 2018/19. Mr Morris said that the deficit would not be able to close the gap within the Trust and this would have to be addressed with the health economy. Mr Shipman said the Trust has a risk of incurring 3-3.5% in fines from the Clinical Commissioning Group along with income reduction which was a substantial part of the deficit and queried if this was a typical issue reflected across the Country. Mr Morris said that Midlands and East had always been prepared to use the acute services contract penalties and fines which comes from the Director of Commissioning and added that fines were higher in this part of the Country.

Mr Morris said that the Trust should ensure it was identifying everything that was due for payment and ensure that coding was robust with clinicians capturing the appropriate data. This may reach an affordability gap as the Trust would then be able to identify what was owed for the Trust. Mr Morris added that PWC would also review the coding provision within the Trust.

The recommendations being presented include strengthening the PMO function to ensure that clinical business units (CBUs) could be challenged to drive new opportunities and it should be made clear that operational improvements should not be seen as a finance challenge.

Mr Morris reported that the grip and control process within the Trust were adequate but there was more that could be done. Mr Morris added that CIPs were more likely to be delivered when they were identified by the clinical business units. There needed to be a wider engagement to develop CIPs for 2018-2019. Communication within the Trust was good and it was noted that previous findings of financial reviews should be shared widely within the Trust in a clear way to ensure that staff were fully engaged. Dr Chilton said that a tight central grip could, on occasions, have unintended consequences with Ms Briggs replying that she would much rather the organisation took the lead in driving efficiencies and productivity to move out of “grip and control”.

Mr Ball said that the Trust was at an ideal time to ensure cost control and cost avoidance was high on the agenda of the new Clinical Divisions following the conclusions of the organisational restructure.

Mrs Hanna said that appraisals could be used to hold people to account to ensure delivery of cost improvement plans and queried the actions being taken to support this. Ms Briggs said that the process of selecting people in the new structure would also come with a detailed Personal Development Plan. Ms Wise said that the Trust was restructuring with the same people and the staff had to work in a different way and the Trust has to give them to tools to undertake their role effectively.

Mr Ramsden queried the areas where the Trust was inefficient, and Mr Morris stated that within Phase 2 the existing CIPs would be reviewed; the existing productivity schemes would be reviewed, and areas highlighted where they could be pushed further which would then identify the gaps within the Trust. The process was to find steps to progress to ensure the Trust could move to being a sustainable position in the next three years. The next steps would be for the Trust to engage with the healthcare system as soon as possible and encourage other players within the health economy to undertake a similar exercise.
Ms Briggs said that the full report on the long term financial plan would provide a baseline and the next stage was to develop a strategic financial plan.

The Chairman said that the vision and style we wish to portray was that the Trust needed an empowered clinically led organisation and the Board needed to develop a vision to inform staff how the financial position would improve. This needed to be built into a complex picture of what was expected from staff and what needed to be delivered. Mr Morris said that the most successful health economies were where there were strong relationships between Chairs and Chief Executives of all health economy partners.

The Chairman thanked Price, Waterhouse, Cooper for their presentation.

**DECISION:**  
(a) The Board of Directors would receive a detailed report on the Long Term Financial Model at the January 2018 Board Meeting.

3.2 Month 8 and Quarter 3 Reforecast

Ms Briggs presented a report regarding the month 8 financial position and quarter 3 reforecast and stated that the financial position of £24-£25m assumed there would be theatre recovery and continued savings on agency spend. The contingency that had not been committed would be released and the financial recovery program would need to deliver £200k per month.

Mr Harris-Bridge reported that the Performance, Finance & Resources Committee had discussed addressing the different scenarios being given to the Committee, i.e. holding to the financial plan and at the Quarterly Review Meeting with NHS Improvement the Trust was informed to be realistic regarding what was going to be delivered. The Committee debated whether it was realistic to hold £19.9m deficit position and it was a unanimous decision that that would not be tenable. The challenge by the Committee to the Executive Team was if the position moved to £24-25m was there absolute confidence that this would be delivered.

Ms Wise said that a decision was required to be submitted to the regulator by the 15th January 2018 and therefore discussions would be held outside of the Board of Directors, involving the Chairman and the Chair of Audit and Performance, Finance & Resources Committee.

Ms Briggs said timing was critical as decision making should sit within the new clinical structures and added that serious change would happen when risks were foreseen and currently staff within the CBUs do not have that capacity. The two things which will help support the CBUs would be with the business part of the work being undertaken in addition to the involvement of the Executive Team which was the critical difference from two years ago. The Chairman said that nerve would be required and there was a lot of work being undertaken.

**DECISION:**  
(a) The Board of Directors delegated authority to the Chairman and Chairs of Audit and Performance, Finance & Resources Committee to review the position with the Director of Finance
4. QUALITY, PATIENT SAFETY AND EXPERIENCE

4.1 Integrated Governance Report and Mortality Dashboard

Quality Performance

Dr Chilton presented the Quarter 2 Mortality Dashboard to the Board of Directors. It was reported that Mr Ball had attended a mortality meeting and reported that there was a high level of maturity from staff regarding how mortality was being addressed. Mr Ball stated that he had attended a “Learning from Deaths” event in Leicester where it was acknowledged by attendees that the dashboard from the Trust was leading the way in mortality reporting.

Dr Chilton highlighted “hill-spot” issue which related to a postage situation which had caused a delay in tests being undertaken. It was reported that this had affected 31 children and a number of tests had been redone and the samples had been couriered to the laboratory.

Operational Performance

Mrs Brown reported that during November the Trust remained under significant urgent care pressure seeing a reduction in its performance against the A&E transit time target of 76.4%. The Trust continued to see a strong performance against all the cancer waiting time standards and was achieving 7 out of the 7 targets in November 2017. The Trust had a total of 3,910 patients waiting over 18 weeks for treatment and a performance of 81.7%. As of the 30th November 2017, the Trust was not achieving against the Referral to Treatment (RTT) recovery plan target of 87%. It was noted that whilst the Trust was not achieving against this target, it had demonstrated improvement throughout 2017-18 and continued to reduce the number of the longest patients on the waiting list.

The Board was informed that the Trust had received £2.2m winter monies which in part were being used to support the purchase of additional beds, therapies etc to support the flow of patients through the Trust. It was noted that the Trust had been successful in incorporating the urgent care attendances from the Corby Urgent Care Centre within the urgent care data.

Dr Chilton reported that there had been a flu outbreak on Lilford ward which had been contained and it was noted that there was a 100% staff flu vaccination on the ward.

Financial Performance

The financial report detailed that the month 8 deficit was £1.6m against a plan of £0.7m resulting in a £1m adverse variance. The year to date position was £19m deficit culminating in a £5.4m adverse variance. It was reported that the grip and control actions, financial recovery plan and theatres recovery plan continued to deliver and in the case of trauma and orthopaedics, elective activity over delivered against the recovery plan.
Workforce

It was reported that improvements had been made within the workforce objectives which was a very positive position with the Trust being under sustained operational pressures. The Board noted that the vacancy rate had decreased from 9.61% to 8.69%. The appraisal rate was 84.65% which was a slight increase on the previous month. Sickness absence remained under target with short term absence at 2.28% and long-term absence at 1.60%. Statutory & mandatory training continues to meet the target with the main area of concern relating to safeguarding training within Anaesthesia which was being addressed.

4.2 Quality Improvement Plan

Ms Wise presented the monthly update against the “must do” and “should do” actions of the Quality Improvement Plan. The report detailed the areas which had a “declined” position and the interventions being taken to address the action to improve the position.

Mrs Gray explained that the new Head of Nursing had attended a recent Governor Governance Group meeting where it was reported that he had seen large improvements within the Women & Children’s Clinical Business Unit.

The Chairman said that he was not yet convinced about the urgency and pace relating to the outstanding actions on Skylark ward but added that the Trust had to ensure the whole workforce kept children safe. Ms Wise said that to address the issue of all Trust staff and visitors gaining access to the ward, actions were being taken review moving the reception desk.

Mr Harris-Bridge said that Board Committees still reviewing actions and expected that the Committees should be working to a single version of the plan with Ms Wise stating that this would be addressed for the next round of the Committee meetings.

4.3 Care Quality Commission Inspection Well-Led Feedback

The Board was presented with the formal feedback letter from the Care Quality Commission in relation to their Well-Led Inspection undertaken on the 29th November 2017 – 1st December 2017 which also included the formal response from the Trust.

Mr Ramsden raised the previously reported issue of bullying and Ms Wise stated that where investigations were underway, and staff named, discussions would initially be held within the private part of a Board Meeting. Ms Wise said that the Board would receive a report early in the New Year regarding the management approach to bullying and a confidential report in a private session of the Board regarding issues relating to bullying raised through the CQC Inspection.

DECISION: The Board of Directors to receive a report early in the New Year regarding how the Trust addresses bullying allegations.
5. **RISK AND GOVERNANCE**

5.1 **Council of Governors**

The Trust Board Secretary prepared a report for the Board which detailed recommendations from the Council of Governors. The Council was recommending proposals to enhance the way Governors interacted with the Trust. This involved reviewing the Council Sub Groups, attendance at Board meetings, attendance at Board Committees, a review of the Code of Conduct and amending the term of office for a Governor allowing them to serve for three terms.

**DECISION:** The Board of Directors unanimously supported the recommendations in the report and noted the next steps to enact the changes to the Council of Governors from January 2018.

5.2 **NHS Improvement: Quarterly Review Feedback**

The Board of Directors was presented with the formal feedback letter from NHS Improvement following the meeting with the Trust on the 29th November 2017. The Board noted that the key areas of discussions related to the year to date financial performance; forecast outturn; financial planning for 2018/19 and operational performance covering A&E and Referral to Treatment Time (RTT) performance. The letter was received and noted.

6. **MINUTES**

6.1 **Audit Committee**

Mr Shipman provided a verbal update on the issues discussed at the last meeting of the Audit Committee. A specific issue highlighted at the Audit Committee and raised at the Performance, Finance & Resources Committee related to the Board Assurance Framework for 2017-18. The discussions related to ensuring that progress was regularly reported this financial year against the strategic objectives until the revised framework was introduced for 2018-19 and the Committees had requested urgent feedback from the Director of Integrated Governance. Ms Wise stated that during January a review of the Well-Led Improvement Plan would be undertaken, and the Board Assurance Framework would be a focus and reported that the Improvement Director, Ms A Helleur would be working with the Director of Integrated Governance in prioritising the actions detailed within the Well-Led Improvement Plan.

Mr Shipman highlighted the audit on the NICE Guidelines and Mr Ramsden said that the issue of compliance with NICE guidelines was also raised at the Integrated Governance Committee (IGC). Ms Wise said that she had reported at the IGC that the Board had agreed high level national priorities that had to be a focus of the Trust which would result in other areas not taking as high a priority to address. Dr Chilton said that all of the NICE Guidelines had been reviewed with the Audit Manager and no issue had been identified as a risk for the Trust.

6.2 **Integrated Governance Committee**

The draft minutes from the meeting held on the 21st November 2017 were received and noted.
Ms Gray reported on the meeting held on the 19th December 2017 and stated that the Committee had discussed the areas which needed to be a priority and highlighted previous discussions at the Board meeting relating to the significant operational challenges and restructure challenges that it had to be recognised that with capacity constraints within Clinical Business Units, only so much could be achieved.

6.3 Performance, Finance & Resources Committee

The draft minutes of the meeting held on the 22nd November 2017 were received and noted.

Mr Harris-Bridge reported on discussions held at the Committee on the 20th December 2017. Mr Harris-Bridge stated that the Committee had discussed the issue of booking out of hours locums which was not subject to the same controls as other agency staff. Dr Chilton reported that actions were being taken in relation to ensuring a formal framework was put in place.

It was noted that in relation to estates and facilities, concerns were raised with the Chief Executive at the Committee meeting regarding capital spend and compliance. Ms Wise said that there was consultancy support in place during January 2018 and the priorities for the estates department would be supporting staff and to review the risk register and the mitigating actions which would be completed in January 2018. The Chairman queried when the capital programme would be brought to the Board with Ms Briggs responding that this would be presented to the PFR Committee in January 2018.

6.4 Workforce Development Committee

The draft minutes of the meeting held on the 22nd November 2017 were received and noted.

Ms Gray reported that due to capacity issues and annual leave the Committee had the COO and Deputy Directors of Nursing and HR present at the meeting and a decision was taken to focus on priorities which included safe staffing, the Quality Improvement Plan, the workforce dashboard and risk portfolio. The performance of the team at the Committee was commendable indicating their ability to understand the data and information and to present appropriate assurance to the Committee regarding the plans being put in place.

7. FEEDBACK FROM HEALTHWATCH/GOVERNORS

7.1 Governors

Mr Lake reported that at a recent national meeting of Lead Governors discussions were held regarding the involvement of Governors in “significant transactions”. Mrs Madeley reported that a paper would be presented to a future Council meeting to provide a briefing for Governors.

8. AREAS OF UNMITIGATED RISK

There were no areas of unmitigated risk identified at the meeting.
9. **ANY OTHER BUSINESS**

9.1 **MRI Scanner**

Ms Briggs informed the meeting that the Board had previously approved the purchase of a MRI scanner which was in line with capital programme at a cost of £1.2m. Ms Briggs reported that the formal Business Case would return to the Board for Directors and requested formal approval for a purchase order to be raised.

**DECISION:** The Board of Directors approved the proposal that a purchase order be raised for a MRI Scanner in line with the approved capital programme.

9.2 **Senior Independent Director**

The Chairman thanked Mr Ramsden, Vice Chairman and Senior Independent Director for his involvement with the Trust and wished him well for his retirement.

10. **RESOLUTION TO EXCLUDE THE PRESS AND PUBLIC**

The Board approved that members of the press and other member of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted.
MINUTES OF THE EXTRA-ORDINARY BOARD OF DIRECTORS HELD AT 11:00AM
ON THE 11th JANUARY 2018, BOARDROOM, GLEBE HOUSE

PRESENT: Mr A Burns - Chairman
Ms F Wise - Chief Executive (interim) (via teleconference)
Ms N Briggs - Director of Finance & Contracting
Mrs R Brown - Chief Operating Officer
Dr A Chilton - Medical Director
Mrs J Gray - Non Executive Director
Ms L Hackshall - Director of Nursing
Mrs L Hanna - Non Executive Director (via teleconference)
Mr P Harris-Bridge - Non Executive Director
Mr T Shipman - Non Executive Director
Mr M Smith - Director of Human Resources & OD

IN ATTENDANCE: Mrs S Madeley - Trust Board Secretary
Ms P Grimmett - Director of Strategy (item 2.2 only)
Mr J Gamble - Deputy Director of Finance (item 2.2 only)

1.1 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr A Ball and Mr P King.

1.2 Declarations of interest

There were no declarations of interest relevant to the items on the agenda.

2. STRATEGY/FINANCE

2.1 Financial Re-forecasting Position

Following the Board of Directors meeting held in December 2017, the Board agreed to hold an extra-ordinary meeting in January 2018 to receive an assessment of the current financial projections and forecast outturn scenarios detailing the risks and mitigations for 2017/18 financial position.

Ms Briggs had previously informed the Board meeting that month 9 was expected to be broadly in line with the financial plan with no significant recovery being forecasted. It was reported that what had materialised was a £2.8m deficit which was 100% driven by trading and costs. Pay and agency costs had reduced in line with the financial recovery plan and all corporate cost improvement plans have all continued to materialise. The variance was largely attributable to clinical income. The largest driver of the overspend related to consultant annual leave as the financial plan had forecasted that the majority of leave would be taken in January, however most had been taken in December which had provided a “double hit” for the Trust.
Ms Briggs reported that day case activity for general surgery and urology had exceeded the plan 3 months in a row. Ms Briggs added that the Trust had received, in month 8, the first tranche of winter funding totalling £728K which would be allocated 50% in December and January and the funds were received on the condition that the funds were attributed to offset costs the Trust had already committed to. This would leave the Trust with a year to date position of £22m deficit which was over the £19.9m plan.

The Trust had received correspondence from NHS England and NHS Improvement to put in place plans to cancel non-urgent planned care for the 2 week period over Christmas and the New Year and on the 2nd January 2018 further correspondence was received from the National Director of Urgent & Emergency Care requiring the Trust to extend the arrangements to the 31st January 2018. The potential impact on the Trust would be up to £6m if all planned worked was stopped; up to £4.5m impact if only urgent and 52 weeks and cancers continued and up to £3.5m if clinical support, Women & Children’s and surgical outpatients and day case continue going against the National Director or Urgent and Emergency Care’s instruction.

Mrs Brown said that the letter stated that cancellations must happen if there was an impact on non-elective care and added that where there was no direct correlation, the Trust was continuing with activity.

Mr Shipman queried if there were other areas that could be brought on line without being detrimental to urgent care with Mrs Brown reporting that all areas were being reviewed and implemented where possible. The Chairman said that the Board expected the Executive Team to use their judgement to continue activity where appropriate but not to the detriment of the urgent care pathway.

The Chairman stated that the Board of Directors was going to review the financial position regarding the implications for Month 10 and to ensure the financial position was also addressed within the STP Governance Framework. The Chairman added that the Board of Directors was requesting that the Executive Team had the freedom to breach the guidance to operationally manage the Trust by addressing cancers, 52 week waits and then any other activity that did not affect the urgent care pathway and then to work within the principles of the national letter.

Mr Shipman queried the action being taken to address consultant annual with Mrs Brown reporting that the Business Unit Directors had been contacted and the Clinical Business Units had been requested to present at the Performance Review meeting to present their plan to schedule additional clinics between now and the end of March 2018 to ensure maximum trading. Mrs Brown added that annual leave was being micro-managed through the workforce meetings.

Post Meeting Update by the Director of Finance:

A meeting had been held with NHS Improvement and the Trust's assigned Financial Improvement Director regarding the month 9 financial position. The month 9 position has been improved by £0.8m to £2m bringing it in line with plan through:

- phasing 100% of Tranche 1 winter funding into December (£0.4m) this is within the Trusts gift and was aimed at covering costs the Trust had already committed to winter.
- releasing a further £0.4m of the Trusts internal contingency for unplanned income variations
The Trust was advised to submit a letter from the Chairman on behalf of the Board stating that the current forecast was with known risks that have a range of impacts largely related to January’s trading position.

In addition, to note that the Board would look to work with the STP and once all mitigations had been exhausted would be working to ensure an accurate assessment of the position after M10 results.

The Trust year to date position was £21.2m and would mean that January 2018 would be worse as the Trust would not release any contingency or additional funds, therefore the month of January would see the gross impact of winter.

This was discussed with the Acting Chief Executive and Chair of Audit Committee and the Chief Executive and Chairman would be briefed before submitting the return to NHSI on the 16th January 2018.

**DECISION:**

(a) The Director of Finance will draft correspondence for the Chairman to sign for NHS Improvement regarding the forecast year-end financial position which would be circulated to all Board Members.

(b) The Executive Team to pay particular attention to the consultant leave planning arrangements to maximise trading in the final quarter of the year.

2.2 Urgent Care Hub: Outline Business Case

Board Members were requested, following the Board of Directors meeting on the 22nd January 2018, to submit comments to the Director of Strategy regarding the Outline Business Case for the Urgent Care Centre. Ms Grimmett thanked everyone for their questions and comments which were useful in strengthening the case. There were however two specific issues which remained outstanding for a discussion today; how we use the remaining estate vacated by the build, and the affordability of the scheme.

The question regarding the remaining estate, relates to how the Trust could use this to improve its effectiveness and efficiency of delivering other services. Ms Grimmett said that there were significant clinical and capacity issues within the current outpatient department, which is co-located to the current A&E. Indeed the Trust has CQC concerns that cannot be adequately resolved due to the limitations on space. The current A&E could therefore be used as decant space to allow outpatient improvement works, to improve our capacity to meet current demand, and to drive the repatriation of activity from the private sector or increase market share for the Trust from out of county. The other opportunity could relate to Clifford and MAU to address short term issues relating to a decant/winter escalation facility and in the longer term the space could be utilised to protect winter elective capacity and to avoid the need for subcontracting work to the private sector. It was noted that on the outline plans, a training space/admin offices had been included for the second floor and these areas could be re-located to the current A&E space and different funding streams could be used for the training space. This would be investigated further during FBC stage. Ms Briggs reported that there was £40m of activity within the County going to the Woodlands Hospital.

Mr Shipman recommended that the overheads should be reduced to 4% and this was agreed.
Mrs Gray queried longer term sustainability and the financial deficit issue and Mr Shipman reported that further detail would need to be provided when the Full Outline Business Case was prepared which would also incorporate the Long Term Financial Model for the Trust.

The Chairman said that the argument regarding a “hot” and “cold” site/activity was not appropriate for the size of Northamptonshire, but the OBC did need to make it clear that should a ‘hotter’ and ‘colder’ site be decided as part of the acute, then we would still require this facility to meet the urgent care needs of this end of the county.

The Chairman said that it was relatively easy to make the case about certain specialities going to either acute site (KGH & NGH) and this was in line with the STP. Due to the geography of the county and the level of emergency activity of the north of the county being in excess of 400 attendances a day, the Trust would still need an urgent care facility on this site. The Chairman added that it was important that the Trust could provide a clear plan for the use of the vacant space to make this an economically viable case.

Ms Briggs said that an additional column would be added to the financial information regarding the I&E for sustainability.

The Chairman said that the next steps would be for a formal letter to be sent to the STP and Clinical Commissioning Group requesting their support.

Mr Shipman suggested a summary to accompany the Outline Business Case to highlight the key issues to ensure that NHS Improvement can see affordability. Ms Grimmett agreed to prepare a summary and would circulate to Board Members and then for sign off by the Chairman.

The Board was informed that the timeframe for the Outline Business Case to be submitted to NHS Improvement was the 31st January 2018.

It was agreed that Ms Grimmett would provide a Communications Plan to the next Board meeting. Board Members raised the issue of briefing all of the local MPs and to ensure that Wellingborough was also detailed within the Outline Business Case as previously only Kettering and Corby were specifically mentioned. The Chief Executive agreed to brief the Chairman on the position of the three MPs.

**DECISION:**

(a) The Outline Business Case to detail that the Trust had a clear plan regarding the utilisation of the original A&E space

(b) An executive summary of the case to be written

(c) A formal letter to be sent to the STP and the Clinical Commissioning Groups with the revised Executive Summary detailing the affordability reasoning.

(d) The Board of Directors would receive an outline communications plan at the next Board meeting.

(e) The Outline Business Case would specifically mention Wellingborough as a key catchment area of the Trust.

(f) The Chief Executive to brief the Chairman regarding the position of the three MPs.

3. **DATE & TIME OF NEXT MEETING**
- 10:00am, 2\textsuperscript{nd} February 2018
- Boardroom, Glebe House
<table>
<thead>
<tr>
<th>MINUTE REF</th>
<th>ITEM</th>
<th>LEAD</th>
<th>ACTIONS TAKEN SINCE MEETING &amp; OUTCOME/IMPACT OF ACTION</th>
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</thead>
<tbody>
<tr>
<td>1.4.2</td>
<td>1.4.2 Well-Led Governance Improvement Plan Update (minute 6.1)</td>
<td>P. King</td>
<td>On the agenda for the meeting</td>
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<tr>
<td></td>
<td>To circulate the Improvement Plan to the Board.</td>
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<tr>
<td>3.1</td>
<td>Long Term Financial Plan</td>
<td>N. Briggs</td>
<td>Scheduled to return to the Board in March 2018</td>
</tr>
<tr>
<td></td>
<td>The Board of Directors would receive a detailed report on the Long Term Financial Model at the January 2018 Board Meeting.</td>
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<tr>
<td>4.3</td>
<td>Care Quality Commission Inspection Well-Led Feedback</td>
<td>M. Smith</td>
<td>To be presented at the March meeting</td>
</tr>
<tr>
<td></td>
<td>The Board of Directors to receive a report early in the New Year regarding how the Trust addresses bullying allegations.</td>
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# TABLE OF MATTERS ARISING FROM THE EXTRA-ORDINARY BOARD OF DIRECTORS
# MEETING HELD ON 11<sup>th</sup> JANUARY 2018

<table>
<thead>
<tr>
<th>MINUTE REF</th>
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<tbody>
<tr>
<td>2.1</td>
<td>Financial Re-forecasting Position</td>
<td>N. Briggs</td>
<td>Actioned and submitted to NHS Improvement</td>
</tr>
<tr>
<td></td>
<td>The Director of Finance will draft correspondence for the Chairman to sign for NHS Improvement regarding the forecast year-end financial position which would be circulated to all Board Members.</td>
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<td>2.2</td>
<td>Urgent Care Hub: Outline Business Case</td>
<td>P. Grimmett</td>
<td>Amended following discussions held at the Extra-ordinary Board meeting</td>
</tr>
<tr>
<td></td>
<td>The Outline Business Case to detail that the Trust had a clear plan regarding the utilisation of the original A&amp;E space</td>
<td>P. Grimmett</td>
<td>Actioned</td>
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<td></td>
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<td>P. Grimmett</td>
<td>Actioned</td>
</tr>
<tr>
<td></td>
<td>The Chief Executive to brief the Chairman regarding the position of the three local MPs.</td>
<td>F. Wise</td>
<td></td>
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### EXECUTIVE SUMMARY

The report highlights a number of local and national events that have taken place since the last meeting of the Board of Directors and are not covered elsewhere on the agenda.

### ACTION REQUIRED BY THE BOARD OF DIRECTORS:

The report is for **INFORMATION** and the Board is asked to **NOTE** the and **DISCUSS** the contents of the report.

### RISK TO THE TRUST:

Not applicable to this report

### INCLUSION AND DIVERSITY:

Items sited within this report refer to services aimed at supporting inclusion

### WORKFORCE ISSUES:

Not applicable to this report

### FINANCIAL IMPLICATIONS:

Not applicable to this report

### COMMUNICATION/CONSULTATION:

Not applicable to this report

### STRATEGIC OBJECTIVE:

Not applicable to this report

### CQC DOMAIN:

Well-Led
CHIEF EXECUTIVE’S REPORT

1. BACKGROUND

1.1 The report is presented to the Board to highlight national and local issues affecting the Trust.

2. LOCAL ISSUES

2.1 CEO Key Messages to the Organisation

Through my Chief Executive weekly bulletins, the following messages have been given to the organisation:

Fire Safety

Staff have been reminded of the requirement to be up to date with fire training and familiarise themselves with their local procedures. The Trust has been undertaking fire evacuation drills where important learning has been gained which demonstrates the value of these mock exercises.

Maintaining our Care Values under pressure

Through the weekly bulletin I have acknowledged that even though we are all under a great deal of pressure at the moment, we need to continue to treat each other with the respect, compassion and empathy that we expect for ourselves, and expect to be accountable for our behaviours. In short we need to live our Care Values every day no matter what. Our Care Values don’t just apply to how we interact with our patients and the public but also with each other.

KGH Care at Home

As previously reported to the Board, KGH Care at Home is a scheme we have developed jointly with an independent provider of community nursing, care and therapy services that will enable us to transfer patients back to their own home (including care home if that is their usual place of residence) whilst remaining under the care of a KGH consultant until they are ready to be finally discharged into the care of their GP and if needed community care services. This is a really exciting development for us and enables us to create a “virtual ward” of up to 28 places in the community and launches within the Trust on the 5th February 2018.
2.2 Working with Partners

On the 18th January 2018, I attended the Health & Well Being Board where discussions included resetting care in Corby; the system review by the Care Quality Commission; suicide prevention strategy; Better Care Fund Update and an update on housing and planning across the county. The minutes from the November 2017 meeting are attached for information. *(Appendix A)*

The Chairman and I also attended the Sustainability & Transformation Partnership Board on the 18th January 2018 and a formal update report is on the agenda.

2.3 Board Development

The Board held the first Board Development session on the 22nd January 2018 which was facilitated by NHS Providers. The session included receiving feedback from the self-assessment questionnaire completed by Board Members. This was followed by development sessions on “What is a Unitary Board”; “effective challenge and effective meetings” and “structures & relationships that support good Boards”.

2.4 Northamptonshire County Council

The Secretary of State for Housing, Communities and Local Government, Sajid Javid, has made the announcement that a government inspector has been appointed to review financial management at Northamptonshire County Council.

Under powers granted to Mr Javid under the Local Government Act 1999, the Secretary of State can commission an independent inspection to better understand whether a council is complying with its ‘best value’ duty – a legal requirement to ensure good governance and effective management of resources.

The Secretary of State has now has appointed Max Caller CBE to complete a report. The inspector will carry out an inspection to better understand the authority’s compliance with its best value duty. The matters to be covered initially by the inspection will relate to the authority’s corporate governance and financial management systems.

The inspector will report their findings by 16 March 2018. If the report shows that the council is in breach of its best value duty, the Secretary of State will then consider whether or not to exercise his powers of intervention under section 15 of the 1999 Act."

2.5 Corby Clinical Commissioning Group

NHS Corby Clinical Commissioning Group (CCG) has published its plans for the future of health services in Corby. Following a period of engagement, the CCG intends to retain an urgent on-the-day service and increase primary care capacity (GP-related services) ensuring an on-the-day appointment for anyone who needs one. The plans will be discussed at an extraordinary Governing Body meeting at 6pm on Tuesday 30 January at the Cube in Corby *(this meeting is open to the public)*. They have been directly influenced by the views of local people, following a period of public engagement. The key themes raised included:

- Major concerns about primary care access.
- Difficulties with making the correct choices about which service to use to get the “right care, first time”.

3
Strong support for continuing an urgent service in Corby, longer primary care opening hours and more resources to prevent ill health.

The CCG intends to procure a GP-led service to take up the work of Corby Urgent Care Centre (UCC). The terms of the UCC’s contract mean that the contract cannot continue beyond March 2019.

This new ‘Same Day Access Hub’ will effectively offer the same services as those currently provided by the UCC. It will be open 8am to 8pm every day of the year, deliver on-the-day care for people with minor injuries and illness, and have access to x-ray and other diagnostics. However, it will be accessed by appointment rather than the UCC’s current walk-in arrangement, with appointments arranged by specially trained navigators to ensure people are booked into the right service.

Because the new model of care will not be a material change to what is currently offered, Corby CCG does not need to formally consult. Formal adoption of the plans is subject to agreement by the CCG Governing Body on 30th January 2018.

3. NATIONAL ISSUES

3.1 Care Quality Commission

3.1.1 Fit & Proper Persons Guidance

The CQC has updated guidance on Regulation 5 - the fit and proper persons requirement for directors. This is to reflect the changes outlined in their recent ‘next phase of regulation’ consultation. The guidance provides a more detailed explanation of what CQC interprets as serious mismanagement and serious misconduct. It also offers greater clarity about the obligations and responsibilities of those holding director roles.

The fit and proper persons requirement (FPPR) was introduced in response to concerns raised following investigations into Mid Staffordshire NHS Foundation Trust and Winterbourne View Hospital. All providers registered with the CQC must assure themselves that all directors (or those in equivalent roles) who are responsible and accountable for delivering care are fit to carry out their responsibility for the quality and safety of care.

The role of the CQC is to make sure that providers have appropriate recruitment and performance management processes in place. The CQC can take action against a provider if they believe they are failing to meet the requirement.

The updated guidance will be reviewed by the Trust Board Secretary and incorporated into the Trust Fit & Proper Persons Policy.

3.1.2 Independent health consultation

The CQC plans to publish a consultation on 26 January 2018 on its proposals for regulating independent healthcare (care that is provided by organisations that are not NHS trusts or GP services) in the next phase of inspections. In the draft consultation, CQC proposes to rate them in the same way that it rates other services: including rating on a four point scale (outstanding to inadequate), for the five key questions.
For some of the larger providers, such as the Community Interest Companies (CICs) that provide a range of NHS funded services, where it is appropriate, CQC may inspect them in the same way as NHS trusts. The CQC plans to publish its consultation response and begin to rate those types of services in June 2018.

3.2 **NHS England**

3.2.1 **Consultation on Accountable Care Organisations (ACOs)**

NHS England has announced it will be launching a consultation on the contracting arrangements for Accountable Care Organisations (ACOs). There is widespread support for ending the fragmented way that care has been provided to improve services for patients and the NHS has been working towards this in a number of ways.

ACOs are just one of these ways and are intended to allow health and care organisations to formally contract to provide services for a local population in a coordinated way.

An ACO is not a new type of legal entity and so would not affect the commissioning structure of the NHS. An ACO would simply be the provider organisation which is awarded a single contract by commissioners for all the services which are within scope for the local accountable care model. Therefore any proposal to award an ACO contract would engage local commissioners’ own duties under the NHS Act 2006. Any area seeking to use an ACO contract would need to comply with longstanding public procurement law.

The consultation will set out how the contract fits within the NHS as a whole, address how the existing statutory duties of NHS commissioners and providers would be performed under it (including how this would work with existing governance arrangements), and will set out how public accountability and patient choice would be preserved.

Subject to the outcome of the consultation, the two areas at the forefront of using a contract of this sort are Dudley, and Manchester’s proposed local care organisation. Emerging bidders for both proposals are NHS bodies, have the support of local GPs and are not private sector organisations.

Given the interest in the ACO proposals NHS England will hold a 12 week public consultation process to provide further clarity about their role and scope.

NHS England will seek views from stakeholders and the public as well as explaining what the contract is, why it is useful and what it would mean for patients and for the NHS. No ACO contract will be awarded in the meantime.

ACOs are only one tool for integrating primary care, mental health, social care and hospital services and not the only or main way to integrate services. Most areas are seeking to do so through voluntary, non-contractual partnerships where GPs, hospitals, commissioners and local government collaborate to improve services for their population. NHS England will be announcing the next wave of these collaborative partnerships shortly.

FIONA WISE
CHIEF EXECUTIVE
Minutes of the Health and Wellbeing Board Meeting
held at 10.30 am on Thursday 9th November 2017
Innovation Centre, University of Northampton

Present:

Cllr. Sylvia Hughes - (SH) Cabinet Member for Health and Wellbeing, Northamptonshire County Council
Dr Darin Seiger - (DS) Chair, NHS Nene Clinical Commissioning Group
Vice Chair
Cllr Chris Millar - (CM) Leader, Daventry District Council
Vice Chair
Dr Jo Watt - (JW) Chair, NHS Corby Clinical Commissioning Group
Cllr Heather Smith - (HS) Leader, Northamptonshire County Council
Teresa Dobson - (TD) Chair, Healthwatch
Dawn Cummins - (DC) Chief Executive, Voluntary Impact, Northamptonshire
Crishni Waring - (CW) Chair, Northamptonshire Healthcare Foundation Trust
Lesley Hagger - (LH) Director for Childrens, Families and Education, Northamptonshire County Council
Lucy Wightman - (LW) Director of Public Health, Northamptonshire County Council
Cllr Bill Parker - (BP) Cabinet Member for Adults, Northamptonshire County Council
Substitute
Dr Jonathan Ireland - (JI) Chair, LMC
Stephen Mold - (SM) Northamptonshire Police and Crime Commissioner
Chris Pallot - (CP) Director of Strategy and Partnerships, Northampton General Hospital
Substitute
Wendy Hoult - (WH) Better Care Fund Implementation Manager, NHS England
Substitute
Dr Steve O’Brien - (SOB) Dean of the Faculty for Health and Society, University of Northampton
Substitute
James Andronov - (JA) Assistant Chief Constable, Northamptonshire Police

In Attendance as observers:

Peter Lynch - (PL) Health and Wellbeing Board Business Manager, Northamptonshire County Council
Northamptonshire Healthcare Foundation Trust
Nicci Marzec - (NM) Early Intervention Director, Office of Northamptonshire Police and Crime Commissioner
Gordon King - (GK) Deputy Director for Mental Health, Northamptonshire Healthcare Foundation Trust
Mike Coupe - (MC) STP Director, NHS Nene Clinical Commissioning Group
Tim Bishop - (TB) Chair, Northamptonshire Safeguarding Adults Board
Keith Makin - (KM) Chair, Northamptonshire Safeguarding Childrens Board
A1 Declarations of Interest:

SH formally requested any declarations of interest. CP advised he is Chair of Voluntary Impact Northamptonshire.

A3 Minutes from the previous meeting 14th September 2017:

One amendment is to be made to the minutes from the previous meeting held on the 14th September, paragraph A4.3 change initials from JW to JWs. The rest of the minutes were agreed as an accurate record

Action: CB

A4 Matters Arising

A4.1 CP gave the Board an update on the recent CQC inspection which took place at Northampton General Hospital (NGH). Inspection visits in previous years classified NGH as needing improvement, and in some areas as providing inadequate care. Following two CQC inspections this year NGH was assessed against 5 domains, whether the care is safe, effective, caring, responsible and well led. NGH has now received a classification of good across all domains and outstanding in well led and A&E provision. CP praised the work of all the staff at NGH and thanked partners for their support throughout the process. The focus for NGH now is to maintain and improve on these classifications during the current challenging environment.

A4.2 DS confirmed that following consultation with NHS Nene CCG and NHS Corby CCG Boards a proposal has been submitted to the Secretary of State for Health for approval for CD to be the interim Chief Accountable Officer for Nene CCG whilst she remains the substantive Accountable Officer for NHS Corby CCG.

A4.3 SH advised that Simon Weldon has been appointed as Chief Executive for Kettering General Hospital and will start in his new role April 2018. FW will continue as interim Chief Executive until then.
A4.4 SH gave an update on the Library re-design consultation undertaken by Northamptonshire County Council (NCC). The footfall for people attending libraries to borrow books is in decline, but footfall is increasing for people accessing library premises for community activities. NCC has considered the geography, social dimensions and footfall of the current libraries and recommended three options for the consultation. Currently there have been 1500 enquiries and 21 of the libraries under consultation have asked for additional information. Meetings have been scheduled with communities to discuss the opportunities for operating community libraries and there have been some offers of sponsorship. SH asked All to review the consultation and provide feedback.

Action:All

A4.5 SH confirmed the next Health and Wellbeing Board meeting on the 18th January 2018 will commence at 8.00 am, beginning with a private session facilitated by John Bewick, to review partnership working and development of the Board objectives.

A5 Board Membership:

A5.1 SH gave the Board an update on the recent changes in Board membership:

- Damon Lawrenson (DL) the Interim Chief Executive of Northamptonshire County Council will become a Board member,
- LW has now been appointed as Director of Public Health and will sit as a permanent member of this Board,
- EMAS had requested to join the Board, but this was not approved over concerns around the suitability of the nature of role proposed as their representative.

The Board endorsed the decisions of the Board Executive.

B1 Health and Wellbeing Board Development Day Report: Mental Health

B1.1 GK gave the Board a brief overview of the Health and Wellbeing Board Development session held on the 12th October 2018 and thanked the Board for its continued support for mental health and its wider context. The development session focused on the crisis concordat moving forward, showcasing recovery focused work and the concept of co-production. The following presentations were delivered:

- Paul Flecknoe and Sharon Gibbard on what does recovery mean,
- A service user on the employment IPS services,
- Chris Berry on the Northants Personality Disorder Hub,
- Housing, as housing and employment are key elements in maintaining good mental health and helping with recovery and preventing relapse.

A workshop session was then held on the Recovery College and how this links into the wider network. The presentation from this development session will be circulated with the minutes and asked all to review.

Action:CB/All

B1.2 JI has discussed the Recovery College work with Dr David Smart and asked if this concept could be made available to a wider group, for patients attending general practice who are suffering from poor mental health but who do not necessarily want to be referred to another level of care. GK noted people enrol on the Recovery College as students whether staff or service users and GK is looking to roll this concept out into primary care either through IAPT referrals or from conversations with GPs or voluntary sector. GK added some of the discussions and decisions made during the development session will become part of Prevention Concordat work.
C1 Update Report: Board Member Organisations and Activity

C1.1 SH noted the Partners Strategic Partner update report will be taken as read and asked if any Board member has questions, they should liaise directly with the appropriate board member.

C1.2 DC gave a brief update from the voluntary sector. Work has been undertaken by the voluntary sector through the prevention workstream of the STP and this work is fundamental in bringing extra funding into the county. The voluntary sector does have access to apply for extra funding from different avenues that partner organisations do not. The voluntary sector is also engaged with European Social Fund (ESF) and membership of the Commsortia are developing proposals to attract ESF funding into the county.

C1.3 WH gave a brief update from NHS England. Following the submission of the Northamptonshire BCF to NHS England an escalation meeting was held in London and attended by partners within the county. The outcome of this meeting was the recognition of the good partnership working which has taken place and an approval of a local trajectory to address DToC and this is awaiting formal sign off. AE confirmed following the escalation meeting, all the schemes contained within the BCF have agreement on who will take ownership, how to deliver and where the risk will sit. NHS England is focusing on DToC over the next few months and are having weekly reporting on numbers people expect to achieve across the region.

C1.4 LW gave an update on the uptake of flu vaccinations for children. Last year there was variable uptake on flu vaccinations across the county, but this year there has been good partnership working this year to increase the uptake, involving communication teams, health visitors, and school nurses. JI noted a key initiative is to ensure NHS Frontline staff are vaccinated but there has been confusion around the vaccination of locums within primary care which has now been resolved. But there is still an issue with GP Practices having no claim back mechanism for vaccinating their staff.

C2 STP Update

C2.1 MC presented a reported on the progress of the STP and highlighted some key points:

- MC will be overhauling the reporting process of the STP in 2018.
- The STP reset which has taken place over the previous few months will be completed by the end of December 2017.
- In order to resolve the governance issues a draft governance structure has been completed and was discussed at the first meeting of the new STP Partnership Board on the 24th October. It is expected to be signed off once clarity has been reached about the most appropriate way of engaging with general practice and primary care.
- The Fighting Fund is in the process of being confirmed which will target supporting the implementation of new models of care and for project change managers to support each of the key priorities contained within the STP.
- The Chief Executives have agreed in principle who will be leading on each of the key priority workstream and the process of identifying senior responsible officers for each workstream has begun.
- Recruitment is underway for a part time clinical lead who will focus on enabling clinical driven management.
- The STP Partnership Board has now replaced the STP Programme Board, and Tansi Harper will continue to chair the Stakeholder Board. A future workshop is planned to identify a process of co-designing and get stakeholders to identify how they should be involved in the STP.
In early 2018 there will be a planning process for each of the workstreams and key performance indicators and metrics will be used to give assurance on performance of each of the workstreams.

MC raised two concerns, there is still no clear relationship between STP and the Health and Wellbeing Board (HWBB) and as the CCGs develop their QIPP programmes this could lead to a danger of overspill and duplication of work, but it is hoped this will be mitigated once the clinical lead is recruited to and a system strategy created.

C2.2 SH asked the Board to discuss the Boards relationship with the STP, as currently in the STP governance structure there is a dotted line between this Board and the STP, which is not in line with other areas of the country. The following comments were noted:

- Concerns were raised about where prevention sits within the STP, as it is not seen as a priority workstream, and as the voluntary sector has now been moved to sit on the Stakeholder Board, this indicates a direction of travel away from prevention to clinical outcomes. As prevention is needed in order to reduce the costs and numbers of admissions to hospital.
- The current governance structure is not clear and all partners contribute to acute outcomes, with both urgent care and community care elements of the STP have a social prescribing support element to them. Partners need to re-align to new priorities and understand what the facilitating factors are to achieving outcomes.
- There needs to be clear articulation about what the HWBB wants to see reported from the STP programme regarding how the STP is contributing to Health and Wellbeing Strategy key priorities and what are the gaps, ensuring no duplication is taking place.
- Within the documents of the STP is patient’s constitutional rights and one of these is for the public/patients to have the right to make choices about the services commissioned.

C2.3 MC confirmed there is no loss of commitment to the health and wellbeing agenda, there are national and local priorities and the first set of priorities is set by the NHS England around the Five Year Forward View. The real test is how to get the system as a whole to invest in health and wellbeing when providers are facing serious financial challenges. The Five Year Forward View and the STP have more NHS focused priorities, and public engagement is key to finding solutions and need to consider how this can be achieved going forward.

C2.4 The Board agreed on a preference of a solid line to show the positive working relationship between the HWBB and STP, highlighting the good partnership arrangements already in place across the county. The HWBB could act as an enabler to bring about change, provide oversight and accountability which would be in line with the BCF governance arrangements. SH will meet with AH, to discuss this in more detail.

Action: SH

C3 Corby Urgent Care Centre

JW gave the Board an update on the Corby Urgent Care Centre. The financial impact of the expert determination process is approximately £3.5 million pounds which has resulted in an overall evaluation of healthcare provision in Corby, ensuring this is completed as soon as possible. There is a period of pre consultation and engagement with a wide variety of groups across Corby, once this process is complete a period of formal consultation will begin with identified agreed models of care. LW offered the support of the public health team in terms of research to Corby for the evaluation and consultation process if needed. CP also offered support from Northampton General Hospital. JW confirmed conversations have taken place with providers across the system to make them aware of the possible implications for the service re-design in Corby. LH suggested as Northamptonshire County Council undertake their own consultation on proposed changes to services within Corby it would be beneficial to exchange learning. JW confirmed that NHS Nene and NHS Corby CCGs have approved a joint dis-investment and de-commissioning policy which is led by the joint quality team.
C4 JSNA Update

LW gave the Board a brief update on the Joint Strategic Needs Assessment (JSNA). A number of chapters have been prioritised in the JSNA and these are reliant on the STP clinical priority areas around prevention. The Prevention Concordat has been launched and work on the mental health JSNA needs assessment has begun which is fundamental in underpinning the plan as it develops. An oral health chapter is also being added to the JSNA and a needs assessment is being undertaken by a dental therapy fellowship post and is joint funded with public health and Health Education England. TD raised the issue of people not being able to access oral healthcare when in care homes or are housebound.

C5 iBCF Update

AE gave the Board a brief update on the iBCF and highlighted the following areas:

- Currently awaiting approval for the overall BCF plan and DToCs remains the key focus for this winter.
- Joint work is being completed with the CCGs regarding admissions to hospital from care homes, care homes are facing extreme pressure and 70 care home places have been lost in recent months due to care home closures. Nursing provision within care homes is a big challenge within the county. The smaller private care homes are suffering more, mainly due to staffing issues, recruitment and retention. SOB noted with the cap on the number of student coming through universities lifted it is hoped this will lead to more qualified nurses coming through.
- Continuing to look at other options such as step down care with CCGs for assessments out of hospital.
- There is a big issue with the level of frailty in patients when admitted to the acutes as in some cases people are leaving it too late to seek medical health when ill resulting in a hospital admission. CP noted although NGH emergency admissions are not increasing, the numbers of those who are extremely frail is, which increases the number of patients admitted staying in hospital for over 20 days.
- JI added people will always get ill and reach the last stages of their life and there is a need to ensure whilst we do our upmost with the prevention agenda, secondary care services are available for this eventuality.
- Work is ongoing in trying to prevent admissions into care homes and Northamptonshire have one of the lowest admission rates to care homes in the country.
- There has been a 15% increase in capacity for home care this year, but there is still a 1000 hours waiting for home care due to capacity issues. AE is hopeful working with the voluntary and community sector can help improve this provision across the county.
- A key focus this year work jointly with NHFT and CCGs is to improve outcomes for people with a mental health learning disability, to move away from traditional residential care placements.
- iBCF money will be used to improve interventions within the community such as expanding the re-enablement teams, working with the intermediate care teams and looking at community based care around families.
- LW advised as part of NCC consultation a proposal is for First for Wellbeing Wellbeing Advisors to focus and support patients who are at highest risk of being frail, with multiple clinical issues and social issues.
- JA noted 30% of calls received by Northamptonshire Police are public sector welfare incidents where there is a concern for someone’s safety, in particular with dementia patients which adds pressure to services on a relatively small police force. JA will share the data on missing persons with LW to assist with the preventative workstream and asked if this work could be discussed in more detail at a Board meeting in the future. The Board agreed.

Action:JA
C6 Housing and Planning Workstream Group update

C6.1 CM gave the Board an update from the Housing and Planning Workstream Group. This workstream was established following a Health and Wellbeing Board Development session on the 29th June 2017. It was recognised the health sector needs to be part of the planning processes particularly at the beginning, to ensure they achieve optimum funding and facilities needed for the anticipated population growth. The group was developed to ensure a more co-ordinated approach for planning and health, to ensure the correct infrastructure for health and wellbeing is included in the planning process and ensure positive health opportunities are built in.

C6.2 At the first meeting in October it was agreed for two sub groups would be established to design a protocol for health and planning, based on an existing document drawn up in Nottinghamshire, and to lead on the work of a case study (a Sustainable Urban Extension [SUE] in Kettering). This work will not just be about formulating the health infrastructure required for planning new developments, but will also relate to formulating an evidence base for, and the delivery of, preventative aspects which will contribute to building healthier communities. The group will produce a “Who Does What?” document, designed to inform organisations about the inner workings of the planning system where it pertains to health and well-being. There is a proposal to second a planner for a year to work within the health sector to work with planners and develop a countywide Health Supplementary Planning Document. TD noted that we need to be mindful it is about building communities and ensure parks, leisure facilities and community groups are taken into consideration. DS added that NHS England have appointed a dedicated Estate Manager for Northamptonshire.

C7 Northamptonshire Safeguarding Adults Board (NSAB) Annual Report

TB gave the Board an overview of the Northamptonshire Safeguarding Adults Board (NSAB) Annual Report. Key highlights from the report are:

- Prevention is a priority for safeguarding adults at risk,
- Need to ensure there is enough quality staff within these care homes and ensure they are well trained.
- The importance of good housing to ensure people are kept safe.
- There are some national issues around the Mental Capacity Act and the Deprivation of Liberty Safeguards which Northamptonshire are having to put a lot of resource into managing the impact to ensure the customers get the outcomes they want.
- The role of the safeguarding should be included within the STP.
- There is a clearer membership structure, and changes have been made to the NSAB board structure due to the implementation of the integrated business office for safeguarding across children and adults.
- The priorities for this year are around making safeguarding personal, focusing on what customers think about the interventions and support offered, what has the experience been? Have the interventions made a difference?
- The Care Act has created new categories particularly around self-neglect - there is a need to become more aware of self neglect which impacts on housing and the fire service due to dangers around fire.
- A National survey on how safe people feel in their own homes gives the ability to correlate a range of indicators to give a sense of how prevention is working.

DS added it would be beneficial to incorporate some of the indicators collated by NSAB from partners into the Health and Wellbeing Strategy, to ensure we have traction.
**C8 Northamptonshire Safeguarding Childrens Board (NSCB)**

**C8.1** KM gave the Board a brief overview of the Northamptonshire Safeguarding Childrens Board (NSCB) Annual Report, which has been made accessible to several groups this year and the annual report for 2018 will produce a version accessible to children and young people. Key highlights from the report are:

- The NSCB has been restructured to have fewer sub groups to become more focused and making better use of data, by having a complete comprehensive data set the NSCB can help contribute to having countywide data set.
- The quality assurance process has been tightened up, six audits a month are completed on various topics to ensure we have a clearer picture in the county. Every agency must produce a section 11 audit return enabling people to have comprehensive discussion about their safeguarding approach.
- A review will take place on NSCB operations, including frequency of meetings, how to be more strategic and link across to planning processes and ensuring there are good links with partners and their reporting boards.
- Northamptonshire has a high level of looked after children as there isn't sufficient early intervention for prevention taking place through tier 4 services.
- There is some inconsistency around child protection planning, inconsistent attendance in conferences and producing reports, although police attendance has improved.
- Work is ongoing to reduce the high turnover in staff and reducing the number of agency workers.

JW asked for clarification on who the other primary health care referrers are, KM will clarify and feedback to Health and Wellbeing Board to be circulated with the minutes.

*Action:* KM

**C8.2** The Board discussed the issue of children with lower level issues who have regular contact with services but with no interventions in place. The following comments were noted:

- Work around ACEs is not just about financial gains it is about improving lives for the young people and improving their outcomes for adult life.
- LH has completed some work this week about the direct correlation between poor housing and leading to poor education outcomes for children
- There are few tier 2 services for interventions in the county and children need to get worse before they can meet a threshold for interventions to be put in place, particular with mental health conditions.
- The work from ACEs task and finish group, will show links that a high proportion of those involved in violence offences, poor mental health and substance misuse, suffered ACEs and were involved in childrens social care.
- There is a need to coordinate the statutory boards effectively, SM, LH and LW will meet to discuss proposals on how statutory boards can be more aligned for discussion at the next meeting.

*Action:* SM/LH/LW

- Primary care often see the transition between adults and children services and children do fall through gaps in services and these are often hard to reach families.
- LW asked partners to ensure their representatives attend the ACEs sub group meetings. LW will circulate information regarding current membership of the ACEs task and finish group to the Board and asked All to review feedback to LW any gaps.

*Action:* LW
C10 Changes to Local Safeguarding Arrangements

KM gave the Board a brief overview of the Changes to Local Safeguarding Arrangements consultation currently taking place, which finishes in December 2017. There are three elements to the consultation:

- Safeguarding Children’s Boards would be replaced by three safeguarding partners: local authorities, Police and Clinical Commissioning groups. There would also be associated partners/relevant agencies. This would be a permissive piece of legislation and boards are not required to make any changes but it could present new opportunities, for instance the NSCB could join up with other areas/counties.
- There would also be changes to the child death overview panels, based on the population size and moved to a health operation but it is still unclear exactly where they would sit in health.
- A national board would determine which cases go on to a serious case review and all data correlations and analysis on a serious case review would be carried out within 5 working days which is unreachable.

E1 Prevention Concordat

LW gave a brief overview of the work taking place around the Prevention Concordat. Currently a needs assessment is underway and there is a Health and Wellbeing Board Development Session on Prevention Concordat taking place on the 16th November.

F1 Take Home Messages

CP gave the Take Home Messages from today’s meeting:

- It is important to recognise senior leadership changes taking place and we all need to be mindful of this.
- All need to provide feedback on the consultation of the service review of libraries.
- The recovery for mental health is a good example of partnership working.
- The updates from the BCF and iBCF show progress is being made on delivery
- The Board should note the broad discussion on how important prevention is for all of us and for its inclusion within the STP.
- Need to think about the input and impact from reports and how we link the work we do to safeguarding.

Date of the Next Meeting

The date of the next meeting will be on the 18th January 2018, at Sunley Management Centre, commencing with a private meeting at the earlier time of 8.00 am.

Signed………………………………………

Dated………………………………………
# Integrated Governance Report

**Board of Directors:**

**Agenda Item:**

**Subject:**

**Responsible Director:**

**Author:**

**Previously Considered By:**

**Executive Summary:**

To provide a detailed report regarding the quality, operational and financial performance of the organisation.

**Action Required by the Board of Directors:**

The Board of Directors is asked to **note & discuss** the contents of the report.

**Risk to the Trust (include reference to BAF or Corporate Risk Register):**

Detailed within the report.

**Workforce Issues:**

(Ending including training and education implications)

Workforce issues contained within the report.

**Inclusion and Diversity**

Equality Impact Neutral

**Financial Implications:**

Specify No/Yes (Detailed within the report).

Financial implications contained within the report.

**Communication/Consultation Issues:**

(Ending patient and public involvement)

The performance of the organisation is detailed within the Board Brief circulated to staff and Governors.

**Strategic Objective:**

(specify trust strategic objective)

To be a clinically led and financially sustainable organisation

**CQC Domains:**

- **safe**
- **effective**
- **caring**
- **responsive to people’s needs**
- **well-led**

Please indicate which domain the report is providing assurance on.

---

Chairman: Alan Burns  
Interim Chief Executive: Fiona Wise
In M9 (December 17) Kettering General Hospital Foundation Trust cared for: 7,444 ED attenders, 2,943 non-elective patients, 379 patients undergoing elective inpatient care, 2,916 day cases, 260 births and 18,288 outpatient attenders

Operational pressures have impacted upon performance, finance and workforce in the month of December. With a combination of increased elderly patients being admitted, high levels of DTOC patients, resulting in an increase use of escalation beds, medical outliers and reduced elective capacity. In addition, the impact of Noro virus and influenza resulted in ward closures and further stressing a fragile system.

The operational impact of the above has meant the trust has not delivered the transit target for A&E and “black breaches” ambulance hand over delays greater than 1 hour have increased.

The financial impact of these pressure is also significant, with increased cost of escalation bed capacity, bank and agency staffing and lost income through reduced elective activity.

In support of reducing urgent care pressure on the hospital the Trust Board has approved the Outline Business Case for a new Emergency Department with co-located Assessment Unit to be built on the main hospital site.

Next steps are to secure STP and NHSI approval to fund the loan required and proceed to Full Business Case and appoint a development partner.

It is envisaged construction will commence autumn 2019 with the new building operational from Spring 2022.

The executive team would like to thank all staff for their hard work, dedication and compassionate care during these challenging times.
## Performance Dashboard for December 2017

### QUALITY

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<tr>
<th>KPI</th>
<th>Target Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
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<th>Feb-18</th>
<th>Mar-18</th>
<th>Total</th>
<th>DQ</th>
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<tr>
<td>62 day wait for first treatment from urgent GP referral to treatment: all cancers</td>
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<td>Maximum waiting time of 4 hours in A&amp;E from arrival to admission, transfer or discharge</td>
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<td>Maximum waiting time of 31 days from diagnosis to treatment for all cancers</td>
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<td>Ambulance hand-overs in excess of 1 hour (Black Breaches) (Source: EMAS)*</td>
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### FINANCE AND RESOURCES

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<th>Jul-17</th>
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<th>Mar-18</th>
<th>Total</th>
<th>DQ</th>
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<tr>
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<td>Sickness Absence</td>
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<td>Bradley and Medication Training</td>
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<td>Safe Staffing Matrix - Nursing and Care staff (Day)</td>
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<td>99.7%</td>
<td>99.3%</td>
<td>99.3%</td>
<td>99.3%</td>
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<tr>
<td>Safe Staffing Matrix - Nursing and Care staff (Night)</td>
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<td>99.7%</td>
<td>99.3%</td>
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### WORKFORCE

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<tr>
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<tbody>
<tr>
<td>Vacancy</td>
<td>7%</td>
<td>6.96%</td>
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<tr>
<td>Turnover</td>
<td>11%</td>
<td>9.93%</td>
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<td>Sickness Absence</td>
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<td>Bradley and Medication Training</td>
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<td>Safe Staffing Matrix - Nursing and Care staff (Day)</td>
<td>98.2%</td>
<td>99.7%</td>
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<td>Safe Staffing Matrix - Nursing and Care staff (Night)</td>
<td>98.2%</td>
<td>99.7%</td>
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### DQ (Data Quality Key)

- No assurance
- Limited assurance
- Reasonable assurance
- Excellent assurance
Performance framework—Clinical Business Unit delivery against objectives

The below is the Trust’s balanced score card for performance, outlining delivery across a wide range of performance measures, and giving the Trust’s internal rating of its clinical area’s. The Trust currently has 7 out of 7 of its CBU’s in enhanced monitoring, with their financial position being a major contributor to this.

### Performance Management Framework (minimum standards)

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<tr>
<th>Status / Performance Score</th>
<th>Local Quality standards (Month 1-9)</th>
<th>Workforce (Month 9)</th>
<th>Executive concern (Month 9)</th>
<th>Finance (Month 1-9)</th>
<th>Operational Performance (Quarter 3)</th>
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<tbody>
<tr>
<td>Clinical Services</td>
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<td>Reporting times in Radiology</td>
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<td>Partially achieved (Transit times)</td>
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<td>Medicine</td>
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<td>Partially achieved (Transit times &amp; RTT)</td>
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<tr>
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<td>Partially achieved (Transit times &amp; RTT)</td>
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<td>Surgery</td>
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<td>W&amp;C</td>
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<td>Refer to quality dashboard</td>
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<td>CQC Actions</td>
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#### Key to performance framework

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<th>Status / Performance Score</th>
<th>Local Quality standards (Month 1-9)</th>
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<th>Finance (Month 1-9)</th>
<th>Operational Performance (Quarter 3)</th>
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<td>Local Quality standards under achieved</td>
<td>CQC Actions</td>
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<td>CQC Actions</td>
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- **Earned Autonomy**
  - Operational performance: minimum - Fully achieved
  - Financial performance: minimum - Fully achieved
  - Executive concern: minimum - Fully achieved
  - Workforce standards: min 2 out the remaining 2 framework to be fully achieved
  - Local Quality standards: under achieved

- **Usual performance management arrangements**
  - Operational performance: minimum - Partially achieved
  - Financial performance: minimum - Partially achieved
  - Executive concern: minimum - Partially achieved
  - Workforce standards: min 1 out the remaining 2 framework to be partially achieved
  - Local Quality standards: under achieved

- **Enhanced monitoring**
  - Operational performance
  - Financial performance
  - Executive concern
  - Workforce standards
  - Local Quality standards

- **Special measures**
  - Operational performance
  - Financial performance
  - Executive concern
  - Workforce standards
  - Local Quality standards
Quality of Care

**Summary:** The data for December 2017 highlights sustained improvement/compliance with a number of key practice standards, but challenges continue with discharge letters produced within 24 hours of discharge. December was a challenging month due patient acuity, particularly across the Christmas and New Year period resulting in the opening of escalation areas and the sharing of the staffing resource to deliver care to more patients. Articulated in the staffing report is a recognition of ward areas of concern relating predominantly to staffing levels. The draft Quality Improvement Strategy was presented at TMC in January with a three week engagement plan to capture clinical contributions to this prior to finalising and launching the finished article in March 2018. In December the Trust reported 3 serious incidents, all of which are under investigation. 1 case involved a maternal death that post mortem has concluded was of natural causes. The family and staff have been supported through this case.

### Sustained standards/Improvements for December 2017 reporting period:

- Complaints response performance improved from 68 to 94% representing a shift in the team structure and CBU engagement.
- Friends and Family performance is at 98%. The Patient Experience Manager has facilitate two public engagement events that will help shape the way in which we involve the wider community. An electronic feedback system is being installed with data available from April 2018. Both events were supported by Healthwatch and the CQC.
- Compliance with C-Difficile remains below trajectory with in month only 1 case reported. No MRSA Bacteraemia since May 2015. Work programme established with the Whole Health Economy on driving down E-Coli infections.
- The number of cardiac arrests outside of the ED and Catheter laboratory continues at below trajectory with 9 against the Trust trajectory of 11. Compliance NEWS and PEWS recording remains at or above trajectory.
- Roll out for the NHSE Safeguarding Assurance Tool that is underway with data being available for Maternity and Childrens from April 2018.
- The rate of patients not receiving critical medications was below 1.5% marking a sustained improvement in this standard.

### Key risks and actions:

- The largest risk throughout December centres on the demand for our services by patients with high acuity needs, meaning that flow through the hospital particularly across the holiday period was greatly impacted upon. This resulted in the opening of escalation beds and a sharing of the staff resource. At each safety huddle and capacity meeting concerns regarding care and safety were discussed and action taken to mitigate wherever possible. Staff concerns have been reflected in the increase in datixs submitted regarding staffs ability to meet all the care needs of patients. The focus at this time was on safe practice, e.g. medications, observations, and mobility. Corporate clinical and non-clinical staff supported wards and departments in undertaking direct care or providing drinks and talking with patients and families.
- Whilst the standard quality metrics have not seen a significant down turn, the number of datixs regarding PTD, falls, medications and aggressive behaviour affecting staff, may when validated show an increase.
- The Emergency Department experienced periods of ‘corridor’ waits with additional staff drafted in to support patients in this area.
- The impact of escalation and corridor waits has been on patient experience and dignity which may result in increased complaints. The Quality Governance Team visited and spoke with patients across the Trust with a focus on those in escalation areas with few specific complaints raised. These were discussed with the Matrons at the time to address.
- The DoN and Medical Director have met and written to staff to thank them for there support and dedication to patients during such a difficult time.
- Safeguarding: issues regarding concerns with referrals to the Multi-Agency Safeguarding Hub and difference between the level of risk we consider and that accept-
### Governance Dashboard

**January 2018 - December 2017 Data**

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**Clinical Safety**

- **DVT rate**: Reduce number of DVTs caused by 50% annually in 2018-2022.
- **Septicemia rate**: Reduce number of septicemias by 20% annually in 2018-2022.
- **Pneumonia rate**: Reduce number of pneumonia by 20% annually in 2018-2022.
- **Catheter-related infections**: Reduce number of catheter-related infections by 20% annually in 2018-2022.

**Quality Improvement**

- **Reduction in readmissions**: Reduce 30-day readmission rate by 20% annually in 2018-2022.
- **Improvement in patient satisfaction**: Increase patient satisfaction scores by 20% annually in 2018-2022.
- **Reduction in medication errors**: Reduce medication errors by 50% annually in 2018-2022.

**Financial Performance**

- **Revenue growth**: Increase annual revenue by 5% annually in 2018-2022.
- **Expense reduction**: Reduce annual expenses by 5% annually in 2018-2022.
- **Net profit margin**: Increase net profit margin by 5% annually in 2018-2022.

**Strategic Initiatives**

- **New service line development**: Launch new service line by 2018-2022.
- **Expansion of clinical facilities**: Expand clinical facilities by 20% annually in 2018-2022.
- **Partnership with external organizations**: Establish partnerships with external organizations by 2018-2022.

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**Figure 1:** Graphic representation of the above metrics showing trends and performance over the specified period. **Figure 2:** Graphical comparison of performance against set goals for each metric, with highlighted areas indicating areas of improvement or lapses in performance. **Figure 3:** Bar charts and line graphs depicting the impact of strategic initiatives on key performance indicators.
Operational Performance

Summary

The Trusts Transit time performance has improved during the month of December with the inclusion of Corby urgent care centre activity within the Trust reported performance, with a whole health system performance of 85.5% being achieved against a 90% STF target. The Trusts individual performance for the month was 73.4%, with 1,989 4 hour transit time breaches.

The Trust continues to see a strong performance against all the cancer waiting times standards and is achieving 7 out of 7 targets in December 2017 (un-validated performance); and the Trust anticipates sustained delivery against these performance standards going forward.

With a total of 4,187 patients waiting over 18 weeks for treatment and a performance of 79.6% at the 31st of December 2017, the Trust is not achieving against its Referral to Treatment (RTT) recovery plan. Whilst the Trust is not achieving against this target it has demonstrated sustained improvement throughout 2017-18 with the exception of December and continues to reduce the numbers of the very longest patients on its waiting list.

The Trust continues to achieve against the diagnostic standard for the month of December, with 45 patients waiting over 6 weeks from referral to diagnostic test.

Cancer Standards

The Trust has achieved all cancer standards for December, and expects to maintain its performance against all the standards during Quarter 4.

Based upon un-validated data for December the Trust has achieved the 62 day cancer target, with a 8 breaches and a provisional performance of 85.0% (target 85%) Additional diagnostics activity along with the Trust seeing a record number of patients within 2 weeks following an urgent GP referral (99% of patients) has supported the Trust in maintaining the cancer waiting times performance.

Referral to Treatment (RTT) standards

The Trust is not delivering against the RTT incomplete standard (92% of the patients waiting within 18 weeks), and is off track against its agreed STF trajectory’s with a performance of 79.6% (trajectory 88.0%). The Trusts reduction in performance this month was as the result of reduced clock stops / treatment due to bank-holidays, cancellations due to urgent care pressures, and a reduced level of additions to the waiting list (GP Referrals). To improve performance the Trust is working with commissions on demand management schemes, a Health wide workshop to develop plans for key services to recover 18 week performance; and once the urgent care pressures reduce additional capacity is now available to the Trust with the re-opening of theatre capacity, following refurbishment of the Trust main theatre complex.

A key focus for the Trust is the reduction in the level of patients waiting in-excess of 52 weeks at the end of December the Trust has a total of 17 patients waiting over 52 weeks, and continues to treat these patients as a priority.

Transit time performance

The Trust has underachieved against the 95%, 4 hour transit time target in December, with a performance of 85.5%, local STF trajectory of 90%.

The Trusts performance continues to be impacted upon by a greater level of breaches due to bed availability and ED capacity (delays to be seen in ED). December has seen an increase in urgent care pressures with a statistically significant increase in the number of elderly complex patients (patients over 75 years of age) being admitted to hospital, and an increase in beds being used for medical patients, with increased use of escalation capacity and medical outliers.
Operational Performance—continued

The main focus of the Trust is to ensure appropriate quality and safety standards are maintained for patients while the Trust is under urgent care pressure, the Trust continues to run at bed occupancy rates in excess of 99%, and has seen a significant increase in ED demand over time. The Trust is looking to address these issues in the longer term though its urgent care hub, outline business case.

The Trust has seen a small increase in A&E attendances and Emergency admissions during December, with the graphs below showing the long term change in emergency demand. Most significant however has been the increase in patients 75 years and over being admitted to the hospital and using a bed, these patients on average stay in hospital twice as long as patients less than 75, and often have complex needs to allow them to leave hospital.

Trust continues to see a high level of patients in its beds that should be receiving care elsewhere, “delayed transfers of care”, with on average 39.6 beds used by these patients per day during December 2017, the reduction of this is a key priority for the Trust and the wider health system, with the national ECIP team working with the Trust and wider health system on this issue.

Actions being taken by the Trust to improve Urgent care performance include;

- Consultant Connect to launch a A&E Advice line first week of Jan 18. This line will be used by GPs and EMAS to ensure that appropriate patients are sent to A&E.
- Electronic whiteboards to be placed in wards to support the embedding of SAFER and Red to Green with the support of ECIP.
- Focus on leadership in ED and reduce variation to provide consistency across the Trust
- Continue to drive improvement in Trust performance and time to be seen in A&E
- Concentrated effort within CBUs to ensure increase discharges and enable flow throughout December.
- Ambulatory Care to be optimised via the Accelerated Ambulatory Care programme
- All patients presenting to ED with a GP letter to be directed to Ambulatory care
- Confirm and challenge meetings to be held by COO to reduce number of super stranded patients (patients in hospital for 21 days or more)
- Health care at home to begin pilot in readiness to go live in February 2018
Workforce Objective 1 – Our ability to attract, recruit and retain appropriately skilled staff
The vacancy rate has increased this month from 8.69% to 9.22%, with 354.87 WTE vacancies. 434.42 WTE posts are being actively recruited to, with 219.71 posts being advertised and 214.71 post having been offered. There are 62 Medical vacancies (13%), 21 posts have been offered, 26 currently being advertised and 15 to be re-advertised following unsuccessful recruitment. Nursing vacancies are currently at 178.75 WTE, 82.37 posts have been offered, 123.21 are currently being advertised. Further vacancy detail by CBU and staff group is provided at the Workforce Committee, including time to hire from vacancy approval to start date which for non-medical staff is 84.6 days (91 day target) and for medical posts 128.90 days (140 day target). Recruitment this remains a priority, with a recruitment and retention summit being held with key stakeholders to review the current recruitment plans and develop the next steps for recruitment, the next recruitment event has been set for the 24th February 2018. Turnover is slightly above the Trust target at 11.28% is has been the subject of focus and analysis with action taking place across the Trust for this issue which is recognised nationally with the net number of nursing staff within the NHS decreasing.

Workforce Objective 3 – Provision of excellent education, learning and development (incl. Leadership)
Appraisal rates are 82.9%, which is a decrease on the previous month, the area of concern continues to be surgery and anaesthesia, there are plans in place to address this particularly during any theatre downtime. A significant level of detail is reviewed against the appraisal data with the number of appraisals due to be completed known (Mth 10, 287, Mth 11, 274 and Mth 12, 201) however the impact of non-elective pressures and deployment of resources is likely to significantly impact performance for Month 10.

All Mandatory and Statutory training subjects are above the 85% target, however there are certain areas and staff groups where compliance is low, each CBU has the breakdown of this information. The Mandatory and Statutory subjects for 2018/19 are being reviewed as part of the learning and education group as subjects such as Basic Life Support and PREVENT are to be included. There continues to be an increase in e-learning within these subjects which is supporting compliance.

Workforce Objective 4 – Improving Health and Wellbeing
Sickness absence increased from Month 8 to 9 by 0.08% but remained under the 4% threshold, with short term absence at 2.30% and long term at 1.65%. The new sickness policy has now been implemented. The flu campaign vaccination rate is 62% for frontline staff, with the aim of reaching 75% by the end of February 2018. A number of initiatives have and will continue to be used to encourage uptake of the vaccination to protect our staff and patients.

Workforce Objective 8 – Culture, Communication and Values – We Will CARE Together
A number of engagement events took place during December including a gift for each substantive staff. Members of staff were able to collect a reusable water bottle or coffee cup, with staff encouraged to keep hydrated and take a break, as a result of the event the Trust also expects a reduction in plastic and coffee cup waste. A random act of kindness also took place which included a Christmas card for every service within the Trust and the delivery of mince pies and chocolates to some services. The 13th December Leadership Brief also saw the launch of the CARE congratulations card for leaders to thank individuals within the Trust for demonstrating a CARE value including a reward to be reclaimed at a food or beverage outlet within the Trust.
Workforce Objective 1 – Our ability to attract, recruit and retain appropriately skilled staff

**Vacancy**

- January: 10.00%
- February: 9.00%
- March: 8.00%
- April: 7.00%
- May: 6.00%
- June: 5.00%
- July: 4.00%
- August: 3.00%
- September: 2.00%
- October: 1.00%
- November: 0.00%
- December: 0.00%

**Turnover**

- January: 14.00%
- February: 13.00%
- March: 12.00%
- April: 11.00%
- May: 10.00%
- June: 9.00%
- July: 8.00%
- August: 7.00%
- September: 6.00%
- October: 5.00%
- November: 4.00%
- December: 3.00%

**Resourcing Position**

- WTE: Budgeted, Actual, Of Concern, On Target

**Starters and Leavers**

- Starters: Blue line
- Leavers: Red line

**Key**

- Current Rolling Year
- Previous Rolling Year
- KPI
- Monthly Turnover

**Target**

- 7%
- 11%
## Workforce Objective 3 – Provision of excellent education, learning and development

### Business Units

<table>
<thead>
<tr>
<th>Statutory and Mandatory Training</th>
<th>Trust Compliance</th>
<th>Trust Threshold</th>
<th>Adult Medicine</th>
<th>Anaesthesia</th>
<th>Clinical Support</th>
<th>Core Services</th>
<th>Corporate</th>
<th>Estates &amp; Facilities</th>
<th>Specialty Medicine</th>
<th>Surgery</th>
<th>Urgent Care</th>
<th>Women &amp; Child</th>
</tr>
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<tbody>
<tr>
<td>Fire Safety</td>
<td>87.4%</td>
<td>85%</td>
<td>-0.4%</td>
<td>84.1%</td>
<td>-0.5%</td>
<td>91.2%</td>
<td>-0.3%</td>
<td>88.0%</td>
<td>-1.9%</td>
<td>91.8%</td>
<td>-0.1%</td>
<td>85.4%</td>
</tr>
<tr>
<td>Health and Safety</td>
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<td>85%</td>
<td>-0.7%</td>
<td>84.4%</td>
<td>-0.8%</td>
<td>91.2%</td>
<td>-0.6%</td>
<td>88.4%</td>
<td>-1.2%</td>
<td>90.7%</td>
<td>-0.3%</td>
<td>83.5%</td>
</tr>
<tr>
<td>Manual Handling</td>
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<td>-0.8%</td>
<td>84.7%</td>
<td>-1.1%</td>
<td>91.2%</td>
<td>-0.2%</td>
<td>88.6%</td>
<td>-1.8%</td>
<td>90.6%</td>
<td>-0.2%</td>
<td>83.4%</td>
</tr>
<tr>
<td>Safeguarding Adults</td>
<td>99.3%</td>
<td>85%</td>
<td>-0.9%</td>
<td>85.0%</td>
<td>-0.9%</td>
<td>91.2%</td>
<td>-0.2%</td>
<td>89.4%</td>
<td>-1.1%</td>
<td>90.5%</td>
<td>-0.1%</td>
<td>84.5%</td>
</tr>
<tr>
<td>Safeguarding Children</td>
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<td>-0.8%</td>
<td>84.9%</td>
<td>-0.9%</td>
<td>91.2%</td>
<td>-0.2%</td>
<td>89.4%</td>
<td>-1.0%</td>
<td>90.5%</td>
<td>-0.1%</td>
<td>84.5%</td>
</tr>
<tr>
<td>Equality, Dignity &amp; Respect</td>
<td>97.9%</td>
<td>85%</td>
<td>-0.9%</td>
<td>85.0%</td>
<td>-0.9%</td>
<td>91.2%</td>
<td>-0.2%</td>
<td>89.4%</td>
<td>-1.0%</td>
<td>90.5%</td>
<td>-0.1%</td>
<td>84.5%</td>
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<tr>
<td>Infection Control</td>
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<td>-0.9%</td>
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<td>-0.9%</td>
<td>91.2%</td>
<td>-0.2%</td>
<td>89.4%</td>
<td>-1.0%</td>
<td>90.5%</td>
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<td>84.5%</td>
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<td>Information Governance</td>
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<td>-0.9%</td>
<td>85.0%</td>
<td>-0.9%</td>
<td>91.2%</td>
<td>-0.2%</td>
<td>89.4%</td>
<td>-1.0%</td>
<td>90.5%</td>
<td>-0.1%</td>
<td>84.5%</td>
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<tr>
<td>MCA Awareness</td>
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<td>85.0%</td>
<td>-0.9%</td>
<td>91.2%</td>
<td>-0.2%</td>
<td>89.4%</td>
<td>-1.0%</td>
<td>90.5%</td>
<td>-0.1%</td>
<td>84.5%</td>
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<td>Risk Management</td>
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<td>85.0%</td>
<td>-0.9%</td>
<td>91.2%</td>
<td>-0.2%</td>
<td>89.4%</td>
<td>-1.0%</td>
<td>90.5%</td>
<td>-0.1%</td>
<td>84.5%</td>
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### Trust Appraisals

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<tr>
<th>Trust Compliance</th>
<th>Trust Threshold</th>
<th>Adult Medicine</th>
<th>Anaesthesia</th>
<th>Clinical Support</th>
<th>Core Services</th>
<th>Corporate</th>
<th>Estates &amp; Facilities</th>
<th>Specialty Medicine</th>
<th>Surgery</th>
<th>Urgent Care</th>
<th>Women &amp; Child</th>
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<tr>
<td>Appraisals</td>
<td>85%</td>
<td>85%</td>
<td>-0.4%</td>
<td>74.1%</td>
<td>-0.9%</td>
<td>91.2%</td>
<td>-0.3%</td>
<td>88.0%</td>
<td>-1.3%</td>
<td>-0.2%</td>
<td>91.8%</td>
</tr>
</tbody>
</table>

### Key

- **Current Rolling Year**
- **Previous Rolling Year**
- **Target - 85%**
- **Green**
- **KPI**
- **Amber**
- **60%**
Workforce—Safe staffing—Nursing (Month 9)

- NQB data identifies that in month the percentage fill rate decreased from 93.9% in November to 92.9%. This excludes escalation areas that required cover.
- Position supported by deployment of Practice Development staff to deliver direct care and a reduction in sickness/absence and vacancy.
- The number of shifts not filled by temporary staff however increased to 20.3% of all requested shifts.
- The number of patients requiring enhanced observation increased further demonstrating the challenges posed within acute care environments of patients with challenging behaviours. The DoN is engaged with a national workstream considering alternatives to ‘security’ for patients with challenging behaviour with Trust representatives meeting national peers commencing April.

Risks and Mitigations

- Areas that continue to face particular staffing challenges are MAU, Poplar, Barnwell Trauma Unit, Lamport/Twywell Ward and Harrowden C. The 1 Matron gaps whilst awaiting recruitment are noted and risk assessed in Clifford, MAU. The Head of Nursing for Urgent Care is supporting these areas.
- Based on feedback from staff the DoN held a Quality Summit with the Lead Nurse and Matron of Lamport and Twywell Ward to ensure that despite staffing concerns care quality was not deteriorating. The position with complaints and harms does not differ in this area to others, however staff concern regarding staffing levels and ward identity were articulated. The Medicine CBU have been asked to be clear about the model of care for L&T in order for the Deputy Director of Nursing to conduct a skill mix review and pilot of new ways of working supported by the Releasing Time to Care/ Productive Ward initiative. Similarly the DoN met with Harrowden C staff to better understand their retention issues with the HoN and Lead Nurse working up a plan to address their perspective.
- Across the Christmas and New Year despite minimal levels of annual leave being granted it was a challenge to cover every ward area and escalation areas with normal staffing levels. Areas and staffing were risk assessed and mitigated by support from the Practice Development and Education teams wherever possible. Staff reported to the Executive and Union colleagues about their concerns regarding staffing levels. The DoN met with the Lead Nurses and Matrons to articulate the context within which the Trust was working and wrote to all staff to recognise their concerns and provide support. Each area received at least daily visit from a Senior Nurse.
- Challenges with regards to the affordability of recruitment programmes such as Nursing Associates and International Return to Practice Nurses have been raised and discussed at Performance Reviews. It is evident given the decreasing national pool of nurses that we have to invest in ‘grow your own’ methods, whilst recognising the short term financial impact and this will continue to be monitored. The DDoN is undertaking a skills mix review and will choose areas to pilot team that are comprised of different roles rather than traditional nurse and support worker teams. The DoN has commenced discussions with NHSi and NHSE with regards to completing NQB data in this face of change.

Recruitment and Retention

- A recruitment and retention summit has generated key actions for improvement.
- Talent Tuesdays continue.
- The next recruitment fair is 24/2/18.
- The Trust continues to support overseas nurses to attain UK registration, Return to Practice, Pharmacy Technicians in ward establishments, and Nursing Associates.
### Workforce—Safe staffing—Nursing (Month 9) Continued

<table>
<thead>
<tr>
<th>Month</th>
<th>UNIFY Actuals vs plan</th>
<th>CHPP Trust average (excl. ITUs)</th>
<th>Sickness</th>
<th>Turnover FTE</th>
<th>Vacancies</th>
<th>Vacancies FTE</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>N&amp;M</td>
<td>HCA's</td>
<td>N&amp;M</td>
<td>HCA's</td>
</tr>
<tr>
<td>April</td>
<td>94.2%</td>
<td>7.7%</td>
<td>4.3%</td>
<td>5.3%</td>
<td>8.9%</td>
<td>6.0%</td>
</tr>
<tr>
<td>May</td>
<td>97.6%</td>
<td>7.8%</td>
<td>4.0%</td>
<td>5.8%</td>
<td>8.4%</td>
<td>6.2%</td>
</tr>
<tr>
<td>June</td>
<td>93.9%</td>
<td>7.7%</td>
<td>5.2%</td>
<td>6.8%</td>
<td>8.6%</td>
<td>5.9%</td>
</tr>
<tr>
<td>July</td>
<td>91.7%</td>
<td>7.6%</td>
<td>5.3%</td>
<td>7.8%</td>
<td>8.4%</td>
<td>5.6%</td>
</tr>
<tr>
<td>August</td>
<td>91.4%</td>
<td>7.3%</td>
<td>5.37%</td>
<td>7.54%</td>
<td>8.42%</td>
<td>6.05%</td>
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<tr>
<td>September</td>
<td>90.1%</td>
<td>7.5%</td>
<td>4.78%</td>
<td>6.42%</td>
<td>9.20%</td>
<td>6.20%</td>
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<tr>
<td>October</td>
<td>92.0%</td>
<td>7.7%</td>
<td>4.38%</td>
<td>6.66%</td>
<td>9.30%</td>
<td>6.07%</td>
</tr>
<tr>
<td>November</td>
<td>93.9%</td>
<td>7.8%</td>
<td>4.52%</td>
<td>5.87%</td>
<td>9.27%</td>
<td>6.91%</td>
</tr>
<tr>
<td>December</td>
<td>92.5%</td>
<td>7.8%</td>
<td>4.68%</td>
<td>5.51%</td>
<td>9.07%</td>
<td>7.19%</td>
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### Nurse Staffing Actuals

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<th>Ward</th>
<th>RN Day</th>
<th>HCA Day</th>
<th>RN Night</th>
<th>HCA Night</th>
<th>Comments</th>
<th>RN</th>
<th>HCA</th>
<th>Total</th>
<th>Nov Validated PTD Grade 2/3</th>
<th>PALS</th>
<th>Complaints</th>
<th>Nov Meds</th>
<th>Falls</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAU</td>
<td>92.8%</td>
<td>100.6%</td>
<td>91.0%</td>
<td>101.5%</td>
<td></td>
<td>4.2</td>
<td>2.8</td>
<td>7.0</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lumport</td>
<td>94.3%</td>
<td>102.2%</td>
<td>95.2%</td>
<td>130.2%</td>
<td>12hrs HCA Special, 12Hrs RN extra</td>
<td>2.8</td>
<td>3.1</td>
<td>5.9</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Twywell</td>
<td>95.3%</td>
<td>94.6%</td>
<td>96.9%</td>
<td>95.2%</td>
<td></td>
<td>2.9</td>
<td>2.6</td>
<td>5.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Cranford</td>
<td>96.6%</td>
<td>81.0%</td>
<td>89.7%</td>
<td>95.8%</td>
<td></td>
<td>3.2</td>
<td>2.9</td>
<td>6.1</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pretty Wards</td>
<td>95.7%</td>
<td>96.3%</td>
<td>98.4%</td>
<td>98.2%</td>
<td>AP in trained numbers, HCA assisting with LD patient, HCA moved from D&amp;C lounge to</td>
<td>3.3</td>
<td>3.4</td>
<td>6.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harrowden A</td>
<td>88.3%</td>
<td>78.9%</td>
<td>92.7%</td>
<td>84.9%</td>
<td>High acuity, 1 x bedwatch HCA, AP used as RN, HCA special</td>
<td>4.2</td>
<td>2.5</td>
<td>6.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Harrowden C</td>
<td>84.6%</td>
<td>102.0%</td>
<td>97.6%</td>
<td>97.8%</td>
<td>Matron in numbers</td>
<td>4.0</td>
<td>3.1</td>
<td>7.1</td>
<td>2</td>
<td>1</td>
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<tr>
<td>Naseby Wards</td>
<td>95.7%</td>
<td>94.5%</td>
<td>97.8%</td>
<td>105.9%</td>
<td>Bedwatch, using HCA specials</td>
<td>2.9</td>
<td>4.5</td>
<td>7.4</td>
<td>2</td>
<td>2</td>
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<tr>
<td>Clifford</td>
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<td>94.4%</td>
<td>101.3%</td>
<td>High acuity, skill mix</td>
<td>4.5</td>
<td>2.9</td>
<td>7.4</td>
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<td></td>
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<tr>
<td>Oakley/CCU</td>
<td>94.8%</td>
<td>90.8%</td>
<td>96.5%</td>
<td>111.3%</td>
<td>Patients bedded in CPAU</td>
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<td>2.6</td>
<td>10.2</td>
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## Workforce—Safe staffing—Nursing (Month 9) Continued

<table>
<thead>
<tr>
<th>Ward</th>
<th>RN Day</th>
<th>HCA Day</th>
<th>RN Night</th>
<th>HCA Night</th>
<th>Comments</th>
<th>RN</th>
<th>HCA</th>
<th>Total</th>
<th>Nov Validated PTD Grade 2/3</th>
<th>PALS</th>
<th>Complaints</th>
<th>Nov Meds</th>
<th>Falls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashton</td>
<td>95.0%</td>
<td>86.7%</td>
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<td>122.6%</td>
<td>AP day off, HCA moved to other wards, increased HCA's for trauma acuity</td>
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<td>2.7</td>
<td>7.0</td>
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<tr>
<td>Barnwell Trauma Unit</td>
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<td>109.8%</td>
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<td>123.2%</td>
<td>Bedwatch</td>
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<td>3.7</td>
<td>7.2</td>
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<tr>
<td>DASU</td>
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<td>103.8%</td>
<td>101.4%</td>
<td>103.2%</td>
<td>SDCU closed so extra Agency</td>
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<td>3.1</td>
<td>7.9</td>
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<td></td>
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<tr>
<td>Deene Ward</td>
<td>97.6%</td>
<td>91.5%</td>
<td>96.0%</td>
<td>100.0%</td>
<td>High acuity, special HCA</td>
<td>3.5</td>
<td>3.0</td>
<td>6.5</td>
<td></td>
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<td></td>
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<tr>
<td>Deene C</td>
<td>85.4%</td>
<td>92.5%</td>
<td>96.3%</td>
<td>94.8%</td>
<td>Matron in numbers, staff sickness</td>
<td>4.8</td>
<td>3.8</td>
<td>8.6</td>
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<td></td>
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<td>Geddington</td>
<td>95.9%</td>
<td>98.3%</td>
<td>97.2%</td>
<td>91.9%</td>
<td>RN and HCA moved to assist other areas</td>
<td>3.9</td>
<td>2.7</td>
<td>6.6</td>
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<td></td>
<td></td>
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<tr>
<td>Lilford</td>
<td>98.2%</td>
<td>91.9%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>Own trained banked, sickness, matron in numbers</td>
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<td>3.6</td>
<td>9.6</td>
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<tr>
<td>ITU</td>
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<td>95.6%</td>
<td>83.9%</td>
<td>Low acuity</td>
<td>24.9</td>
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<td>27.1</td>
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<td>112.9%</td>
<td>101.6%</td>
<td>96.8%</td>
<td></td>
<td>4.8</td>
<td>5.0</td>
<td>9.8</td>
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<tr>
<td>Poplar</td>
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<td>111.1%</td>
<td>79.8%</td>
<td>145.2%</td>
<td>Matron in numbers</td>
<td>3.0</td>
<td>4.1</td>
<td>7.1</td>
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<td>Maple</td>
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<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
<td>5.7</td>
<td>3.3</td>
<td>9.0</td>
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<tr>
<td>NICU</td>
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<td>96.2%</td>
<td>82.6%</td>
<td>100.0%</td>
<td>Sickness, high acuity</td>
<td>10.4</td>
<td>2.2</td>
<td>12.7</td>
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<td></td>
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<tr>
<td>Skylark</td>
<td>97.1%</td>
<td>100.0%</td>
<td>95.9%</td>
<td>100.0%</td>
<td>Increased staffing due to high acuity, sickness</td>
<td>6.6</td>
<td>1.9</td>
<td>8.5</td>
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</tr>
<tr>
<td>Rowan</td>
<td>93.9%</td>
<td>92.5%</td>
<td>94.2%</td>
<td>100.0%</td>
<td></td>
<td>5.7</td>
<td>3.4</td>
<td>9.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>
Executive Summary

The M9 deficit was £2.1m against a plan of £2.0m resulting in a £0.1m adverse variance. The YTD position is £21.3m deficit culminating in a £5.6m YTD adverse variance. In Month 9 the Trust experienced significant, and higher than planned, winter pressures including the costs associated with opening escalation areas. This was largely offset by additional winter funding. This leaves the largest variance, the Month 9 trading position driven by consultant annual leave and the early impact of winter and snow on Outpatient income.

In month the Trust released £800k of contingency, in part to offset winter costs, £500k of Contingency remains. The Trust also recognised £1.2m of the newly agreed Winter funding in Month 9. The Contingency and Underlying position are shown below:

<table>
<thead>
<tr>
<th></th>
<th>Budget £m</th>
<th>Released to date £m</th>
<th>Remaining £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning Assumptions</td>
<td>(0.5)</td>
<td>0.5</td>
<td>(0.0)</td>
</tr>
<tr>
<td>Support to Productivity</td>
<td>(0.5)</td>
<td>0.3</td>
<td>(0.2)</td>
</tr>
<tr>
<td>Regulatory burden</td>
<td>(0.5)</td>
<td>0.3</td>
<td>(0.2)</td>
</tr>
<tr>
<td>Winter pressures</td>
<td>(1.0)</td>
<td>0.7</td>
<td>(0.3)</td>
</tr>
<tr>
<td>Total</td>
<td>(2.5)</td>
<td>2.0</td>
<td>(0.5)</td>
</tr>
</tbody>
</table>

Month 9

The Month 9 financial position was impacted considerably by, earlier than expected, winter pressures. The drivers of the monthly position are:

- Escalation Areas -£0.5m
- Trust wide clinical income reduction -£0.8m
- Clinical Support non-pay -£0.2m
- Critical Care underperformance -£0.1m
- Non Elective under performance (both HRG 4+ and Claremont) -£0.2m
- Endoscopy Closure -£0.1m
- Medway & Bank Partners - £0.2m

These overspends were offset by; corporate CIP over delivery and agency reduction, £0.3m, Financial Recovery plan delivery £0.2m, Winter funding of £1.2m and brought forward contingency release £0.4m
Month 9 - Finance

YTD Position
The YTD position is £21.3m deficit which is 107% of the full year plan and £5.6m variance YTD. The greatest drivers of this variance YTD are unplanned and non-recurrent in nature;
- £1.5m Theatre closure delays (N/R)
- £0.8m Endoscopy delays (N/R)
- £1.2m overseas nurses and HCA utilisation (N/R)
- £0.6m Critical Care productivity (N/R)
- £1.1m Escalation costs (N/R)
- £0.3m Medinet losses (N/R)
- £1.6m clinical support tele radiology and outsourcing (a proportion of this is recurrent in nature)
- £0.7m under utilisation of Claremont (N/R)

There is then the recurrent HRG 4+ issue at £1.0m. These are offset by £1.8m agency reductions and £1.1m over achievement of corporate CIPs, FRP achievement of £0.5m. The position at Month 9 includes £0.7m Tranche 1 winter funding and £0.5m Tranche 2 winter funding.

Forecast
The forecast remains at £19.9m the next opportunity to change this forecast is month 10. The year to date deficit is £21.3m, there are significant risk and uncertainties built within the forecasted £19.9m. The Trust is further investigating these risk/ mitigations before committing to an alternative year end position.

Risks and Mitigations
The risks not included in the YTD position are Sepsis, £0.4m FYE and MRET, £1.5m. Sepsis is subject to national determination between NHSI and NHSE. MRET is a contracting dispute over the baseline; the penalty assumed in the position is £4.8m with no reinvestment if the CCGs were to win the dispute it would result in a further £1.4m penalty. The greatest risk to the forecast outturn position is the impact of the letter the Trust received from the National Director for Urgent and Emergency Care requiring cancellation of all non-essential elective appointments up until the 31st January. The potential risk to the Trust could be as great as £6m, depending on the level of cancellations in January.

To mitigate these the Trust is; undertaking an MRET baseline review to perform a baseline evaluation in line with the NHS Standard contract guidance and Tranche 2 Winter Funding – this will be released against any additional costs the Trust has suffered to improve NEL flow & A&E performance.
## Finance balanced scorecard

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Status</th>
<th>Trust</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normalised Net Surplus / (Deficit)</td>
<td>Net income and expenditure</td>
<td>A</td>
<td></td>
<td>The deficit in-month is £2.1m which is a £0.1m adverse variance to plan. The key drivers are Escalation costs, Non Elective Income under performing, Critical Care Income, HCAs overspends, Clinical support and Estates non pay overspends. Offset by winter funding income and contingency release</td>
</tr>
<tr>
<td>Agency Spend</td>
<td>Agency spend against plan</td>
<td>G</td>
<td></td>
<td>Agency spend is £1.0m in-month which is on plan.</td>
</tr>
<tr>
<td>QIPP Saving</td>
<td>Savings against the QIPP Savings plan. This includes both cost and income generation schemes</td>
<td>A</td>
<td></td>
<td>QIP delivery in month is on plan</td>
</tr>
<tr>
<td>Capital Expenditure</td>
<td>Cumulative expenditure against the capital plan</td>
<td>R</td>
<td></td>
<td>Total expenditure in December is £1m with total expenditure of £8.1m YTD. Expenditure YTD includes £1.3m for the new car park deck (not on revised plan, funded by a lease).</td>
</tr>
<tr>
<td>Cash</td>
<td>Cash held</td>
<td>G</td>
<td></td>
<td>The cash position is £1.5m against a plan of £1.2m. The Trust has drawn £20.3m in revenue loan support and £8.1m in capital loan support to 31 Dec 17</td>
</tr>
<tr>
<td>CBU</td>
<td>RAG</td>
<td>M1-M9 Budget</td>
<td>M1-M9 Actual</td>
<td>Variance</td>
</tr>
<tr>
<td>--------------------</td>
<td>-----</td>
<td>---------------</td>
<td>---------------</td>
<td>----------</td>
</tr>
</tbody>
</table>
| Adult Medicine     |     | £14,461       | £12,529       | (£1,932) | *Nursing and medical pay overspends due to continued high levels of vacancy and sickness  
|                    |     |               |               |          | *Non Pay overspends (drugs and Claremont care workers)  
|                    |     |               |               |          | *NEL income underperformance due to Claremont                                                                                                                                  |
| Specialty Medicine |     | £8,406        | £5,559        | (£2,848) | *Reduced NEL and daycase income due to AL and increased patient complexities  
|                    |     |               |               |          | *Scientific and Nursing pay due to vacancies and sickness  
|                    |     |               |               |          | *Cardiology clinical supplies overspend                                                                                                                                          |
| Urgent Care        |     | £803          | (£479)        | (£1,282) | *Reduced A&E and NEL income  
|                    |     |               |               |          | *Nursing and medical pay overspends due to vacancies and unfunded areas (FAU, red area & A&E medics)  
|                    |     |               |               |          | *PCS cost pressure                                                                                                                                                    |
| Surgery            |     | £16,665       | £13,514       | (£3,151) | *Theatre closures / Productivity income shortfall mainly in T&O  
|                    |     |               |               |          | *Medinet net cost due to lower than expected number of patients per list  
|                    |     |               |               |          | *Agency Medical vacancy cover, mainly in Orthopaedics and General Surgery  
|                    |     |               |               |          | *Theatre cancellations due to bed pressures  
|                    |     |               |               |          | CIP shortfall as a result of unidentified schemes against the stretch target                                                                                                 |
| Anaesthesia        |     | (£10,023)     | (£10,667)     | (£645)   | *TU and Pain income under-performance  
|                    |     |               |               |          | offset by Theatre Pay overspends due to a high level of vacancies                                                                                                             |
| Woman & Child      |     | £11,305       | £9,907        | (£1,308) | *Income shortfalls mainly in Obs & Gynae across DC/EL and NEL  
|                    |     |               |               |          | *Junior doctors overspends  
|                    |     |               |               |          | *Non Pay - NHS invoices for booked births delivered in other NHS Trusts  
|                    |     |               |               |          | CIP shortfall as a result of unidentified schemes against the stretch target                                                                                                 |
| Clinical Support   |     | (£5,642)      | (£8,264)      | (£2,622) | *Endoscopy closure; Reduced Direct Access Income  
|                    |     |               |               |          | *Non Pay overspends (Reagents, Telrad, Outsourced Ultrasound, Sendaways)  
|                    |     |               |               |          | CIP shortfall as a result of unidentified schemes against the stretch target                                                                                                 |
| Core Services      |     | (£1,290)      | (£1,271)      | £20      |                                                                                                                   |
| Medical Records & Outpatients | | (£3,681) | (£3,599) | £83 | *Vacancies                                                                                                                                                                         |
| Corporate          |     | (£36,721)     | (£27,332)     | £9,389   | *Agency contingency, unplanned contingency release, CIP offset, New Dev’s/CCG budget not utilised, corporate vacancies, Commissioning gains, Capital gains, accruals release/other less Foureys cost |
| Facilities         |     | (£9,977)      | (£11,156)     | (£1,179) | *Electricity rate increase, pay - sickness cover, non-pay, CIP underperformance                                                                                                  |
| **Grand Total**    |     | (£15,695)     | (£21,260)     | (£5,565) |                                                                                                                   |
## Underlying Position YTD

### Pressure / Risks

<table>
<thead>
<tr>
<th>Description</th>
<th>Rec/NR</th>
<th>M1-8</th>
<th>M9</th>
<th>Forecast M10-12</th>
<th>Forecast Outturn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Deficit</td>
<td></td>
<td>(13.7)</td>
<td>(2.0)</td>
<td>(4.2)</td>
<td>(19.9)</td>
</tr>
<tr>
<td>Endoscopy Closure</td>
<td>N/R</td>
<td>(0.7)</td>
<td>(0.1)</td>
<td>(0.2)</td>
<td>(1.0)</td>
</tr>
<tr>
<td>Theatre Closure / Productivity</td>
<td>N/R</td>
<td>(1.5)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non Elective - Medicine</td>
<td>N/R</td>
<td>(0.5)</td>
<td>(0.1)</td>
<td>-</td>
<td>(0.7)</td>
</tr>
<tr>
<td>Non Elective - HRG 4+</td>
<td>R</td>
<td>(0.9)</td>
<td>(0.1)</td>
<td>(0.2)</td>
<td>(1.3)</td>
</tr>
<tr>
<td>Critical Care Productivity</td>
<td>R</td>
<td>(0.5)</td>
<td>(0.1)</td>
<td>(0.2)</td>
<td>(0.8)</td>
</tr>
<tr>
<td>Overseas Nurses / Urgent Care HCA over-establishment</td>
<td>N/R</td>
<td>(1.1)</td>
<td>(0.1)</td>
<td>(0.2)</td>
<td>(1.3)</td>
</tr>
<tr>
<td>Escalation Costs</td>
<td>N/R</td>
<td>(0.5)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Medinet</td>
<td>N/R</td>
<td>(0.3)</td>
<td>-</td>
<td>-</td>
<td>(0.3)</td>
</tr>
<tr>
<td>Clinical Support Non Pay</td>
<td>50% N/R</td>
<td>(1.4)</td>
<td>(0.2)</td>
<td>(0.5)</td>
<td>(2.1)</td>
</tr>
<tr>
<td>CIP Performance</td>
<td>R</td>
<td>(0.9)</td>
<td>-</td>
<td>(0.7)</td>
<td>(1.6)</td>
</tr>
<tr>
<td>Consultancy costs</td>
<td>N/R</td>
<td>(0.4)</td>
<td>-</td>
<td>(0.6)</td>
<td>(1.0)</td>
</tr>
<tr>
<td>Medway</td>
<td>N/R</td>
<td>-</td>
<td>(0.1)</td>
<td>-</td>
<td>(0.1)</td>
</tr>
<tr>
<td>Bank Partners</td>
<td>R</td>
<td>(0.1)</td>
<td>(0.1)</td>
<td>(0.2)</td>
<td>(0.3)</td>
</tr>
<tr>
<td>Other CBU trading issues</td>
<td>N/R</td>
<td>(0.2)</td>
<td>(0.8)</td>
<td>(1.0)</td>
<td></td>
</tr>
<tr>
<td>Estates Spends</td>
<td>50% N/R</td>
<td>(0.9)</td>
<td>(0.2)</td>
<td>(0.2)</td>
<td>(1.2)</td>
</tr>
</tbody>
</table>

### Mitigations

<table>
<thead>
<tr>
<th>Description</th>
<th>Rec/NR</th>
<th>M1-8</th>
<th>M9</th>
<th>Forecast M10-12</th>
<th>Forecast Outturn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accruals release</td>
<td>N/R</td>
<td>0.5</td>
<td>-</td>
<td>-</td>
<td>0.5</td>
</tr>
<tr>
<td>Commissioning gains</td>
<td>N/R</td>
<td>0.4</td>
<td>-</td>
<td>-</td>
<td>0.4</td>
</tr>
<tr>
<td>Corporate CIP</td>
<td>N/R</td>
<td>1.1</td>
<td>0.2</td>
<td>0.4</td>
<td>1.7</td>
</tr>
<tr>
<td>Agency Reduction</td>
<td>R</td>
<td>1.9</td>
<td>0.1</td>
<td>0.6</td>
<td>2.6</td>
</tr>
<tr>
<td>Non operating Expenditure</td>
<td>R</td>
<td>0.3</td>
<td>0.1</td>
<td>0.6</td>
<td>0.4</td>
</tr>
<tr>
<td>Delayed capital programme</td>
<td>R</td>
<td>-</td>
<td>0.6</td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td>Surgery Recovery Plan</td>
<td>R</td>
<td>0.1</td>
<td>0.3</td>
<td>0.7</td>
<td></td>
</tr>
<tr>
<td>Contingency</td>
<td>N/R</td>
<td>-</td>
<td>0.4</td>
<td>0.3</td>
<td>0.7</td>
</tr>
<tr>
<td>Winter Funding</td>
<td>N/R</td>
<td>-</td>
<td>1.2</td>
<td>1.3</td>
<td>2.5</td>
</tr>
<tr>
<td>FRP</td>
<td>R</td>
<td>0.3</td>
<td>0.2</td>
<td>1.1</td>
<td>1.6</td>
</tr>
<tr>
<td>New Actions</td>
<td>N/R</td>
<td>-</td>
<td>4.2</td>
<td>4.2</td>
<td></td>
</tr>
</tbody>
</table>

**Month 9 Underlying Position**

The movements from plan in month 9 have been detailed in earlier slides.

The key point to note on this slide is the forecast underlying deficit of £20.4m. As the table shows the Trust has experienced significant non recurrent pressures in 2017/18, Month 9 being no exception. However, the majority of both the pressures and mitigations are non recurrent in nature.

The underlying position can be broadly summarised as the planned deficit plus the losses sustained in the move to HRG4+. Other recurrent overspends have been mitigated by recurrent benefits in year.
## BOARD OF DIRECTORS:
2 FEBRUARY 2018

### AGENDA ITEM:
3.2

### SUBJECT:
DIRECTOR OF NURSING AND QUALITY REPORT

### RESPONSIBLE DIRECTOR:
Leanne Hackshall  
Director of Nursing and Quality

### AUTHOR:
Leanne Hackshall  
Director of Nursing and Quality

### PREVIOUSLY CONSIDERED BY:
N/A

### EXECUTIVE SUMMARY:
This new report provides members of the Board of Directors with an update in relation to the Director of Nursing portfolio. This update includes:

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Infection Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional developments</td>
<td>Patient Experience</td>
</tr>
<tr>
<td>Practice Developments</td>
<td>STP</td>
</tr>
</tbody>
</table>

### ACTION REQUIRED:
The Board of Directors is asked to note and discuss the content of this paper.

### RISK TO THE TRUST (include reference to BAF or Corporate Risk Register)
Non delivery of key elements of the Director of Nursing portfolio could negatively impact on delivery of the Trusts strategic objectives

### WORKFORCE ISSUES: (including training and education implications)
Review of skill mix and establishments that considers the role played by professionals other than registered nurses

### DIVERSITY & INCLUSION
BME Leadership developments

### FINANCIAL IMPLICATIONS:
Specify No/Yes (Detailed within the report).
Future workforce changes and leadership

### COMMUNICATION/CONSULTATION ISSUES (including patient and public involvement)
Consultation of Quality and Nursing/Midwifery Strategies and key workstreams

### STRATEGIC OBJECTIVE: (specify trust strategic objective)
All

### CQC DOMAINS
- safe.
- effective.
- caring.
- responsive to people’s needs.
- well-led

Well-Led
DIRECTOR OF NURSING REPORT October 2017 - February 2018

1. BACKGROUND

This paper seeks to provide members of the Board with a summary of key issues, achievements and challenges within the Director of Nursing and Quality portfolio.

To frame this and to strengthen the direction of travel for nursing and midwifery a strategy describing a Framework of Excellence on a page has been drafted and shared with the Lead Nurses for consultation with their teams before approval and launch in April. This is specific to the nursing agenda and will support delivery of the Quality Improvement Strategy rather than duplicate.

The Quality Improvement strategy in its draft form was discussed at the Trust Management Committee with key questions posed to the membership in line with wider consultation on the finalised product. The DoN and Medical Director are undertaking this key piece of work together.

2. NURSING DEVELOPMENTS AND LEADERSHIP – PUTTING KGH NURSING AND MIDWIFERY ON THE MAP

2.1 NHSE Perceptions of Nursing initiative
Badged under the 70th anniversary of the NHS and in response to image, recruitment and retention issues in nursing the Chief Nursing Officer has launched a campaign to get nurses and midwives talking about what would help support the professions going forward. The three themes identified are: influencing educational environments, influencing the current nursing and midwifery workforce and influencing key influencers such as the public, politicians and other professionals.

The DoN has signed up to the forum to share and learn alongside others and is supporting a nurse and midwife to attend a conference that runs parallel to this year’s CNO conference to be part of this exciting agenda and to return to the Trust energized and equipped with resources to promote nursing as a career choice.

2.2 NHSi Collaboratives
The DoN has identified nurses to work on national projects to review practice related to urinary tract infections, falls and enhanced observation of the patient with challenging behaviours. The intention is to develop nurses, to learn from others and share best practice locally and to ensure that KGH nurses are recognised at a national level.

2.3 Leadership programmes
Following the review of the needs of Matron and Lead Nurse leadership development by Professor Mandy Ashton a programme commencing in March has been agreed by the DoN; ‘Nursing Leadership – from Stabilisation to Sustaining Excellence. This will facilitate not only growth in confidence, competence and resilience but will support the attainment of the developing nursing and midwifery strategy and Quality Improvement Strategy
3. PRACTICE/SERVICE DEVELOPMENTS

**Releasing Time to Care** – This a fundamental piece of work will support the delivery of a number of other initiatives and the Nursing and Midwifery Strategy as without it wards/departments will continue to try and absorb many workstreams without a clear view as to effective systems, processes and priorities. This in turn promotes effective team-working, productivity and resilience. The DoN is being supported by a Clinical Transformational Facilitator to see this implemented across the Trust and involving for example the education team, HR and Practice Development teams as resources. The work has commenced through a culture survey of ward areas to better understand how teams are currently thinking, feeling and where they feel the focus for improvement should be.

**SAFER** – The DoN is the Executive Lead for the implementation of this framework approach to improving the flow of patients through the hospital with a focus, similar to the above, on removing any aspects of service delivery that do not add value and/or delay discharge. Additional support has been provided by a Clinical Transformation Manager who is socialising the model and working with ECIP. Wards achieving compliance are highlighted through the internal facebook page and Twitter to maintain momentum through recognition of improvement.

**Ward Accreditation** – Through the support of a part-time project nurse the DoN has a plan for the implementation of Ward Accreditation. This is being piloted now in three ward areas – Maple, Deene B and Nasebys. The wards are undertaking a self-assessment against key practice standards to be completed by the end of January. This will be followed up by a validation visit with improvement plans presented to the February Matrons Forum and agreement then of a roll out plan to encompass all adult inpatient areas. The governance methodology has been defined. To support the confidence of nurses presenting their data regarding, quality, patient experience and staffing the DoN has implemented Quality Councils that each area will present out bi-annually through a scheduled programme. This provides the opportunity to explore performance and compliance and to source solutions to areas of non-compliance.

4. PATIENT EXPERIENCE STEERING GROUP

Two Public Engagement events were held in December and January attended by the CQC Manager and Healthwatch. Feedback from these is to be discussed at the next PESG to determine future action.

The electronic feedback system will be in place by the end of March 2018 with the functionality developing over the following 6 months to ensure we are asking the right questions at the right time for maximum gathering of intelligence, upon which to act.

Coming from the last inpatient survey noise at night was seen to be a key issue for which the DoN has launched a campaign to reduce noise levels.

5. STP INVOLVEMENT

Whilst a Lead Nurse for the STP is recruited the DoN and the DoN from NHFT are jointly sharing a portfolio that ensures the nursing and allied health professional voice in terms of workforce, professions, safety and governance are represented through the workstreams.

6. (DIS) ABILITY NETWORK

The DoN launched this network in December meeting with members of the Trust who have or represent those that have a disability to begin to scope out future work programmes to drive change to their working experiences.
7. RECOMMENDATION

The Board of Directors is asked to note and discuss the content of this paper.
AGENDA ITEM: 3.3
SUBJECT: CQC QUALITY IMPROVEMENT PLAN UPDATE
RESPONSIBLE MANAGER/DIRECTOR: Leanne Hackshall
Director of Nursing and Quality
AUTHOR: Leanne Hackshall and Helen Mills
Quality and Compliance Manager
PREVIOUSLY CONSIDERED BY: Board Subcommittees

EXECUTIVE SUMMARY:
As in previous months this report provides an updated position against the actions set out in the Quality Improvement Plan designed to deliver the MUST and Should Do’s identified by the Care Quality Commission following their October 2017 Inspection. The data within this report is the position as at the of December 2017.

Within this report a high level view of activities in month and positive, declining movement against KPIs is articulated. A large number of Key Performance Indicators have been achieved and evidence for the judgement is available. This report includes that have moved or remain on track to deliver.

This report has extrapolated those KPIs that have moved either in a positive/negative direction in the reporting period

CQC KPI Progress

MUST Dos Position Changes and the subcommittees responsible for oversight of performance against the Key Performance Indicators

Improved

2 – Improved position: On Track to Delivered (WDC)
4 – Improved position: On Track to Delivered (WDC)
8 – Improved position: Overdue to Delivered (IGC)
9a – Improved position: Overdue to Delivered (IGC)
18 – Improved position: Overdue to Delivered (IGC)
22a – Improved position: Overdue to Delivered (IGC)

**Declined**

6a – Declined position: Due to Overdue (PFR)
12 – Declined position: Delivered to Overdue (WDC)

**SHOULD Dos Position Changes**

**Improved:**

36 – Improved position: On Track to Delivered (WDC)
45 – Improved position: On Track to Delivered (IGC)

**Declined:**

27 – Declined position: Delivered to Overdue (IGC)

<table>
<thead>
<tr>
<th><strong>ACTION REQUIRED:</strong></th>
<th>For Board to receive the report and acknowledge position against KPIs, actions and risks.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RISK TO THE TRUST</strong> (include reference to BAF or Corporate Risk Register)</td>
<td>Recorded where relevant in CBU Risk Registers and BAF.</td>
</tr>
<tr>
<td><strong>WORKFORCE ISSUES:</strong> (including training and education implications)</td>
<td>Recruitment to roles identified within the QIP continues</td>
</tr>
<tr>
<td><strong>DIVERSITY &amp; INCLUSION</strong></td>
<td>In designing and implementing improvements the needs of the patient groups we served are considered</td>
</tr>
<tr>
<td><strong>FINANCIAL IMPLICATIONS:</strong> Specify No/Yes (Detailed within the report).</td>
<td>Failing to deliver improved care and systems could result in increased claims and/or penalties</td>
</tr>
<tr>
<td><strong>COMMUNICATION/CONSULTATION ISSUES</strong> (including patient and public involvement)</td>
<td>Weekly programme management approach employed with Heads of Nurses in attendance with governance.</td>
</tr>
<tr>
<td><strong>STRATEGIC OBJECTIVE:</strong> (specify trust strategic objective)</td>
<td>To provide high quality care to the patients and communities that we serve.</td>
</tr>
<tr>
<td><strong>CQC DOMAINS</strong></td>
<td>All</td>
</tr>
<tr>
<td>- safe.</td>
<td></td>
</tr>
<tr>
<td>- effective.</td>
<td></td>
</tr>
<tr>
<td>- caring.</td>
<td></td>
</tr>
<tr>
<td>- responsive to people’s needs.</td>
<td></td>
</tr>
<tr>
<td>- well-led</td>
<td></td>
</tr>
<tr>
<td><strong>Please indicate which domain the report is providing assurance on</strong></td>
<td></td>
</tr>
</tbody>
</table>
CQC QUALITY IMPROVEMENT PLAN UPDATE (DECEMBER 2017 POSITION)

1. BACKGROUND
The Trust has continued to work towards delivery of its Quality Improvement Plan through a number of activities, for example education, training, recruitment and changes in process.

2. OVERVIEW
A large number of the KPIs have been delivered with evidence collated to provide assurance against these, there are however others that the Trust has not achieved and or cannot demonstrate where improvements have reported that these are consistently delivered. A key focus for the Trust is cultural change for compliance and sustained improvement, to be delivered through a clear Quality Improvement Strategy developed through wide engagement, leadership development and changes in structure.

Engagement on the QIS has commenced, consultation regarding restructure has concluded and leadership programmes are scheduled.

3. POLICY
It is recognised that consistent delivery of KPIs can be impacted on by system demands and is therefore important that resilience and adherence to all practice standards is considered in all improvement activities.

The Director of Nursing has introduced a model of Quality Councils which sees the Nurse Executive receiving a presentation from each ward Matron and Lead Nurse on performance against quality standards, staffing – recruitment and retention, patient experience and incidents. The intention of the QCs is to ensure that ward leaders have a good understanding of the quality of care in their area and to provide guidance in addressing areas of non-compliance. These are scheduled so that each ward presents at least twice per year and this will ultimately support Ward Accreditation for which an implementation plan is now agreed.

3.1 MUST Dos
2 – Improved position: On Track to Delivered (WDC)
“Ensure there is a sufficient number of medical registrars and junior doctors to cover out of hours and weekend shifts at all times across medical care wards”
Timeline exceeded. Each shift will be covered with a minimum of 90% of the required establishment for that shift of medical staff.

4 – Improved position: On Track to Delivered (WDC)
“To ensure a qualified children’s nurse works in the outpatient department in accordance with Royal College of Nursing guidance, ‘Defining staffing levels for children and young people’s services’ which states that, ‘a minimum of one registered children’s nurse must be available at all times to assist, supervise, support and chaperone children’"
Timeline exceeded. Four study days have already taken place in 2017 with 35 staff from all OPD areas attending. Four more booked for 2018 with an attendance of 48 expected. Ongoing provision for new starters after April 18 to be discussed with OPD leads.
6a – Declined position: Due to Overdue (PFR)
“Ensure that there are effective processes in place to measure time to initial clinical assessment for ambulance handovers and self-presenting patients.”

Medway now able to capture time to observations on a daily basis. December compliance for observations within 30 minutes was 40% changing the RAG. A lack of IT resource to enable staff to note on Medway the time of observations and space within the ED are noted to be two key challenges to meeting best practice. Both are being addressed with footprint improvements dependent upon the time taken to refurbish the department.

<table>
<thead>
<tr>
<th></th>
<th>0-15</th>
<th>16-30</th>
<th>31-45</th>
<th>46-60</th>
<th>&gt;60</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov 2017</td>
<td>16.0%</td>
<td>23.2%</td>
<td>16.0%</td>
<td>16.0%</td>
<td>28.7%</td>
</tr>
<tr>
<td>Dec 2017</td>
<td>16.2%</td>
<td>23.4%</td>
<td>16.2%</td>
<td>12.0%</td>
<td>32.2%</td>
</tr>
</tbody>
</table>

8 – Improved position: Overdue to Delivered (IGC)
To ensure the security of the paediatric ward and Rowan ward at all times and review security system on the post-natal ward to minimise the risk of visitors accessing the ward without being challenged

There have been no breaches of security. In Skylark daily ward safety walks are completed by lead nurse and head of nursing. For additional security the doors will be switched from automatic to manual.

9a – Improved position: Overdue to Delivered (IGC)
“Ensure staff in medical care follow the hospital’s medication policy in the safe prescribing, cancelling, handling, storage, recording and administration of medicines”
Medicines Safety Thermometer shows omitted doses of all medications with no documentation at 5% which is the Trust threshold for compliance.

12 – Declined position: Delivered to Overdue (WDC)
“To ensure that staff in ED and medical care have had sufficient training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLs).”
The Electronic Staff Record workforce reports are now being utilised for this reporting. December’s figures are not available at time of reporting, but retrospective consideration of Novembers ESR report shows compliance across Adult and Specialty Medicine and Urgent Care at 76.7% which is below the 85% standards. Additional training continues to be provided to improve the position.

18 – Improved position: Overdue to Delivered (IGC)
“To ensure complaints are handled in line with hospital policy and effective systems are in place to monitor this”
At the end of November an interim complaints manager commenced. Significant work has been undertaken to understand processes and improve progress of complaints. December’s compliance has improved to 94%.
Complaints responded within timescales: April - 91%, May - 87%, June - 92%, July - 98%, August - 97%, September - 91%, October - 79%, November - 68%, December - 94%.
The new model of Improvement and Governance Business Partners, commencing in the next few months will be key to supporting the resolution of complaints and responses in a timely manner.
22a – Improved position: Overdue to Delivered (IGC)
“Ensure ligature audits are undertaken and acted upon in the children and young people’s service”
Daily environmental checks continue to be undertaken as part of daily security safety audit.
Environmental checks completed as part of CAMHS risk assessment which include ligature checks.

3.2 SHOULD DOS
27 – Declined position: Delivered to Overdue (IGC)
“Review staff training and awareness of major incident policy and equipment.”
It has been identified that medical staff do not currently receive major incident training.
This is to be considered and a resolution identified.

36 – Improved position: On Track to Delivered (WDC)
“Review systems for staff in ICU to provide level three safeguarding children's training.”
Timeline achieved. Compliance > 85%

45 – Improved position: On Track to Delivered (IGC)
“To review assessment and screening of delirium for patients cared for in the ICU.”
Timeline achieved. Relevant patients are being screened for Delirium.

3.3 CQC November Inspection Update
Further to the report in December including a timeline and contacts during the inspection, in December and early January 2018 the Trust has received additional requests for information. Confirmation from the CQC was received regarding receipt of all required data

Possible Urgent Enforcement Action – Section 31 of the Health and Social Care Act 2008 from CQC letter Received 19th December

Trust Response Letter (via email) on 20th December for the Radiology Reporting possible enforcement notice (6 document submissions)
21st December additional queries (four) for clarification received, responded to via email

Trust response via email on the 29th December to initial concerns raised in feedback letter re ED patients

National Winter Pressures Request from CQC letter Received 2nd January 2018

Trust response via email to Winter Pressures Letter sent 4th January 2018

Additional Visit Data Requests Received 10th January 2018
Requests for data from
- Surgery (SURG)  - Diagnostics (DIAG)
- Outpatients (OPD)  - Maternity and Gynaecology (M&G)

Trust response to Additional Data Requests sent via email and through secure portal 12th January 2018 (49 document submissions)
4. RISK
Each of the MUST and Should Do actions has an associated risk assessment with some appearing on the Corporate Risk Register as above 16. These are monitored and updated by the divisions at their CBU Governance meetings and reviewed through a schedule at the Risk Management Steering Group.

Identified within the Executive Summary derived from the QIP the following are those areas ‘at risk’:
- The ability of the Trusts Oracle Learning System to provide the level of training compliance data needed remains a significant challenge requiring many man hours to input and extrapolate data
- Medicines safety whilst improvements seen, these have to be demonstrated to be sustainable.
- Documentation including notes storage and patient confidentiality, with a Trust wide need in the future to undertake a full review of how it documents and how it uses records
- Referral to Treatment times continue to make improvements
- Ambulance handover times and time to clinical observation for self-presenting patients remains a challenge with a greater ability to measure performance through changes to Medway recording systems

4.2 During December and into January the Trust has experienced unprecedented demand with a high number of patients with high acuity requiring the need for additional beds and with this an increase in workforce. Risk assessments were undertaken when opening additional areas and for staffing.

5. DATA QUALITY

5.1 The Data creating this sheet has been taken from Datix Action Log.

6. FINANCIAL IMPLICATIONS

6.1 Ongoing staff development for quality improvement, sustainable change and compliance

7. ACTION REQUIRED BY THE BOARD
For the Board to receive the report and to agree actions in relation to addressing the risks identified within this report and approving requests for date changes.

Leanne Hackshall, Director of Nursing and Quality
<table>
<thead>
<tr>
<th>Priority</th>
<th>CQC Responsible Sub Board</th>
<th>CQC Executive Lead</th>
<th>CQC Responsible</th>
<th>CQC Required Outcome</th>
<th>Due date</th>
<th>KPI</th>
<th>June Based on QIP RAG document</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Post CQC Letter 22.11.17</th>
<th>Nov</th>
<th>Dec</th>
<th>December Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Workforce Development Committee Director of Human Resources &amp; Organisational Development (HRD)</td>
<td></td>
<td></td>
<td>Ensure there is a sufficient number of medical registrars and junior doctors to cover out of hours and weekend shifts at all times across medical care wards</td>
<td>31/07/2017</td>
<td>Each shift will be covered with a minimum of 90% of the required establishment for that shift of medical staff</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>Delivered (CQC Actions)</td>
<td>Achieved KPI - Ongoing Monitoring</td>
</tr>
<tr>
<td>5</td>
<td>Workforce Development Committee Director of Human Resources &amp; Organisational Development (HRD)</td>
<td></td>
<td></td>
<td>In the child’s and young people service. There must be suitable numbers of staff trained in Advanced Paediatric Life Support and/or European Paediatric Life Support</td>
<td>30.03.18 Revised (TMC Agreed Sept 17)</td>
<td>The Paediatric team will have to work at least one member who has attained the APLS/EPLS certificate per shift</td>
<td>On track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>Delivered (CQC Actions)</td>
<td>The Trust has failed to deliver this standard with 203 black breaches recorded in December 2017. Despite these exceptions, the Trust have achieved an average clinical hand over time of 26 mins 47 secs. (EMAS average 25 mins). Work with EMAS continues</td>
</tr>
<tr>
<td>6</td>
<td>Performance, Finance and Resources Committee Chief Operating Officer (COO)</td>
<td></td>
<td></td>
<td>Ensure that there are effective processes in place to measure time to prioritise, assess and treat all patients attending the ED.</td>
<td>30/06/2017</td>
<td>Track Breaches will be in line with top 10 in the EMAS cluster = &lt;9 per month</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>On track to deliver</td>
<td>Delivered (CQC Actions)</td>
<td>Midway is now able to capture time to observations on a daily basis. December compliance for observations within 30 minutes was 40% 0-15 16-30 31-45 46-60 &gt;60 Nov 2017 16.0% 23.2% 15.7% 28.7% Dec 2017 16.2% 23.4% 16.2% 20.2% T1 equipment is required to improve the timeliness for the staff to record the results.</td>
</tr>
<tr>
<td>6a</td>
<td>Performance, Finance and Resources Committee Chief Operating Officer (COO)</td>
<td></td>
<td></td>
<td>Ensure that there are effective processes in place to measure time to prioritise, assess and treat all patients attending the ED.</td>
<td>30.03.18 Revised (TMC Agreed Sept 17)</td>
<td>79% of physiological observations will be recorded within 30 minutes by 30.09.17 95% of physiological observations will be recorded within 15 minutes by April 2018</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Due / Some Issues (narrative disclosure)</td>
<td>Due / Some Issues (narrative disclosure)</td>
<td>Due / Some Issues (narrative disclosure)</td>
<td>Overdue / Not on Track to deliver</td>
<td>Midway is now able to capture time to observations on a daily basis. December compliance for observations within 30 minutes was 40% 0-15 16-30 31-45 46-60 &gt;60 Nov 2017 16.0% 23.2% 15.7% 28.7% Dec 2017 16.2% 23.4% 16.2% 20.2% T1 equipment is required to improve the timeliness for the staff to record the results.</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Workforce Development Committee Director of Human Resources &amp; Organisational Development (HRD)</td>
<td></td>
<td></td>
<td>To ensure that all staff in outpatients who have direct contact and assess and treat children have the appropriate level of Paediatric competencies to provide safe care and treatment</td>
<td>31/01/2018</td>
<td>83% of staff requiring Safeguarding Level 3 will have completed by due date 83% of staff requiring PILS will have completed by due date 83% of staff requiring Paediatric Competencies will have completed by due date</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>SkyPark - daily ward safety walks undertaken by lead nurse and head of nursing. Awaiting final quote from estates to revert security doors to manual opening instead of automatic opening.</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Integrated Governance Committee Director of Nursing &amp; Quality (DoNQ)</td>
<td></td>
<td></td>
<td>To ensure the security of the paediatric ward and Rowan ward at all times and review security system on the post-natal ward to minimise the risk of visitors accessing the ward without being challenged</td>
<td>30/05/2017</td>
<td>There will be no breaches of security</td>
<td>Delivered (CQC Actions)</td>
<td>Delivered (CQC Actions)</td>
<td>Delivered (CQC Actions)</td>
<td>Delivered (CQC Actions)</td>
<td>Delivered (CQC Actions)</td>
<td>Delivered (CQC Actions)</td>
<td>Delivered (CQC Actions)</td>
<td>Delivered (CQC Actions)</td>
<td>Delivered (CQC Actions)</td>
</tr>
</tbody>
</table>
## CQC Quality Improvement Plan Key Performance Indicators

**Updated - 17.01.2017**

<table>
<thead>
<tr>
<th>Priority</th>
<th>QCC Required Outcome</th>
<th>Due date</th>
<th>KPI</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Post QCC Letter 22.11.17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Safe Prescribing (Signature, Date, Dose, Frequency)</td>
<td>Not split in June</td>
<td>Due / Some Issues (narrative disclosure)</td>
<td>Due / Some Issues (narrative disclosure)</td>
<td>Due / Some Issues (narrative disclosure)</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
</tr>
<tr>
<td></td>
<td>Storage and Security</td>
<td>Not split in June</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
</tr>
<tr>
<td></td>
<td>Controlled Drug Compliance</td>
<td>Not split in June</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
</tr>
<tr>
<td></td>
<td>Administration</td>
<td>Not split in June</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
</tr>
</tbody>
</table>

### MUST DO

**Integrated Governance Committee**
Director of Nursing & Quality (DoNQ)

9a. Ensure staff follow the hospital’s medication procedure for obtaining medicines for patients out of hours (continued)

<table>
<thead>
<tr>
<th>Due date</th>
<th>KPI</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Post QCC Letter 22.11.17</th>
</tr>
</thead>
<tbody>
<tr>
<td>31/07/2017</td>
<td>80% (by staff group) of all staff would have completed by due date</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
</tr>
</tbody>
</table>

**Workforce Development Committee**
Director of Human Resources & Organisation Development (HRD)

11. To ensure all staff have the required statutory and mandatory training and effective systems are in place to monitor this (continued)

<table>
<thead>
<tr>
<th>Due date</th>
<th>KPI</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Post QCC Letter 22.11.17</th>
</tr>
</thead>
<tbody>
<tr>
<td>31/07/2017</td>
<td>85% of staff requiring MCA and Dolls in surgery would have completed by due date</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
</tr>
</tbody>
</table>

**Workforce Development Committee**
Director of Human Resources & Organisation Development (HRD)

12. To ensure that staff in ED and medical care have had sufficient training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLs).

<table>
<thead>
<tr>
<th>Due date</th>
<th>KPI</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Post QCC Letter 22.11.17</th>
</tr>
</thead>
<tbody>
<tr>
<td>30/06/2017</td>
<td>85% of all HCAs in surgery would have had sufficient training in the MCA and Dolls by due date</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
</tr>
</tbody>
</table>

**Workforce Development Committee**
Director of Nursing & Quality (DoNQ)

13. To ensure there are processes and procedures for all staff in surgery to adhere to the Food Safety Act 1990 and the Food Hygiene Regulations 2006 (Temperature Control Schedule 2004) (No.852/2004)

<table>
<thead>
<tr>
<th>Due date</th>
<th>KPI</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Post QCC Letter 22.11.17</th>
</tr>
</thead>
<tbody>
<tr>
<td>30/06/2017</td>
<td>All HCAs' and 10% of RNs across Surgery &amp; Anaesthetics have undertaken the eLearning package within 3 months (by Oct)</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
</tr>
</tbody>
</table>

### December Progress

- April - 93%
- May - 98.9%
- June - 96%
- July - 85.3%
- August - 97.7%
- September - 95.1%
- October - 95.9%
- November - 97.5%
- December - 94.5%

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**Key**

- Must Do: Immediate action required.
- Start: Initiation of improvement.
- Monitor: Tracking progress.
- Complete: Target achieved.

**Reported and discussed at** Board, Workforce Development Committee, Board, Monthly CQC Meeting. Variability in the level of compliance between different elements of training and varied departments. Continually seeking ways to improve uptake and access to training including e-learning and changes to delivery mode.

**Across Adult Medicine, Pharmacy Medicine and Urgent Care MCA Compliance for November was 78.7%**

**Awaiting December training report**
**Updated - 17.01.2017**

**CQC Quality Improvement Plan Key Performance Indicators**

<table>
<thead>
<tr>
<th>Priority</th>
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</tr>
</thead>
<tbody>
<tr>
<td>MUST DO</td>
<td>Integrated Governance Committee</td>
<td>Director of Nursing &amp; Quality (DonNQ)</td>
<td>14</td>
<td></td>
<td>To ensure that theatre staff comply with the Standards and Recommendations for Safe Perioperative Practice 2011 by the Association of Perioperative Practice on the hospital’s operating theatre policy and the theatre standard operating procedure regarding the wearing of cover gowns and footwear when leaving and entering the theatre area</td>
<td>30/09/2017</td>
<td>External audits demonstrate improvement in compliance to achieve 95% consistently by 31st October</td>
<td>On track to deliver</td>
<td>Due / Some Issues (narrative disclosure)</td>
<td>On track to deliver</td>
<td>Due / Some Issues (narrative disclosure)</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Audit to change to full Uniform Audit including within and outside of the theatre environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MUST DO</td>
<td>Integrated Governance Committee</td>
<td>Director of Nursing &amp; Quality (DonNQ)</td>
<td>16</td>
<td></td>
<td>Ensure that patients’ records are completed with appropriate information to understand their care plans</td>
<td>30/09/2017</td>
<td>All records are contemporaneous and individualised</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>A roll out of revised nursing documentation is underway. The Trust recognises though the need to review all documentation within the Quality Improvement Strategy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MUST DO</td>
<td>Integrated Governance Committee</td>
<td>Director of Nursing &amp; Quality (DonNQ)</td>
<td>16A</td>
<td></td>
<td>Ensure all patients have person-centred care plans that are well maintained and reflect appropriately patients’ changing needs and treatment</td>
<td>30/09/2017</td>
<td>All records are contemporaneous and individualised</td>
<td>Due / Some Issues (narrative disclosure)</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
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<td></td>
</tr>
<tr>
<td>MUST DO</td>
<td>Integrated Governance Committee</td>
<td>Chief Operating Officer (COO)</td>
<td>17</td>
<td></td>
<td>Ensure all confidential patient information in medical care, surgery and gynaecology and outpatients and diagnostics are stored in accordance with the Data Protection Act 1998</td>
<td>30.06.17</td>
<td>All confidential is stored in accordance with the data protection act</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
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<tr>
<td>MUST DO</td>
<td>Integrated Governance Committee</td>
<td>Director of Nursing &amp; Quality (DonNQ)</td>
<td>18</td>
<td></td>
<td>To ensure complaints are handled in line with hospital policy and effective systems are in place to monitor this</td>
<td>31/12/2016</td>
<td>Complaints response performance &gt;=90%</td>
<td>Delivered (CQC Actions)</td>
<td>Delivered (CQC Actions)</td>
<td>Delivered (CQC Actions)</td>
<td>Delivered (CQC Actions)</td>
<td>Complainats responded within timescales: April - 91%, May - 87%, June - 92%, July - 98%, August - 97%, September - 91%, October - 79%, November - 68%, December - 94%</td>
<td></td>
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<tr>
<td>MUST DO</td>
<td>Performance, Finance and Resources Committee</td>
<td>Chief Operating Officer (COO)</td>
<td>19</td>
<td></td>
<td>To monitor patients referral to treatment times, and assess and monitor the risk to patients on the waiting list in surgery, children and young people’s service and outpatients and diagnostic services</td>
<td>31/08/2017</td>
<td>See RTT Performance Metrics</td>
<td>Due / Some Issues (narrative disclosure)</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
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<tr>
<td>MUST DO</td>
<td>Integrated Governance Committee</td>
<td>Director of Nursing &amp; Quality (DonNQ)</td>
<td>21</td>
<td></td>
<td>To ensure all staff are supported to recognise and escalate potential risks to safety and quality of care and treatment for all patients and to ensure effective systems are in place to assess, mitigate and monitor these risks. The hospital should ensure that the risk registers are accurate and reflective of risks in series</td>
<td>31/10/2017</td>
<td>100% of existing risk assessments are on Data: Minutes of CBU Governance meetings evidence update and review of the risks</td>
<td>Due / Some Issues (narrative disclosure)</td>
<td>Due / Some Issues (narrative disclosure)</td>
<td>Due / Some Issues (narrative disclosure)</td>
<td>Due / Some Issues (narrative disclosure)</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>1:1 sessions delivered Clinical and Non-Clinical induction and refresher training updated</td>
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<tr>
<td>MUST DO</td>
<td>Integrated Governance Committee</td>
<td>Director of Nursing &amp; Quality (DonNQ)</td>
<td>22</td>
<td></td>
<td>To review the incident reporting processes in children’s and young people’s service to ensure all incidents are reported and investigated and that actions agreed correlate with the concerns identified, are acted on and lessons learned are shared accordingly</td>
<td>30/07/2017</td>
<td>Less than 10% of incidents recorded on Datix will exceed 20 days overdue</td>
<td>Delivered (CQC Actions)</td>
<td>Delivered (CQC Actions)</td>
<td>Delivered (CQC Actions)</td>
<td>Delivered (CQC Actions)</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>In Date: 7 Datixes 25%</td>
<td>Overdue: 21 Datixes 75%</td>
<td>Total: 28 Datixes</td>
</tr>
<tr>
<td>Priority</td>
<td>CQC Responsible Sub Board</td>
<td>CQC Executive Lead</td>
<td>CQC Ref</td>
<td>CQC Required Outcome</td>
<td>Due date</td>
<td>KPI</td>
<td>June Based on QIP RAG document</td>
<td>July</td>
<td>Aug</td>
<td>Sept</td>
<td>Oct</td>
<td>Nov</td>
<td>Dec</td>
<td>December Progress</td>
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<tr>
<td>MUST DO</td>
<td>Integrated Governance Committee</td>
<td>Director of Nursing &amp; Quality (DoN&amp;Q)</td>
<td>22a</td>
<td>Ensure ligature audits are undertaken and acted upon in the children and young people’s service</td>
<td>30/07/2017</td>
<td>Evidence of annual audit</td>
<td>On track to deliver</td>
<td>Delivered (CQC Actions)</td>
<td>Delivered (CQC Actions)</td>
<td>Delivered (CQC Actions)</td>
<td>Delivered (CQC Actions)</td>
<td>Delivered (CQC Actions)</td>
<td>Delivered (CQC Actions)</td>
<td>Daily environmental checks continue to be undertaken as part of daily security safety audit. Environmental checks completed as part of CAMHS risk assessment which include ligature checks.</td>
<td></td>
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</tr>
<tr>
<td>SHOULD DO</td>
<td>Integrated Governance Committee</td>
<td>Head of Nursing</td>
<td>23</td>
<td>To review the environment in reception area so ED so that patients’ privacy and confidentiality can be respected.</td>
<td>30/09/2017</td>
<td></td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>The environment within which patients are streamed in minors remains a challenge. Works have been costed to improve to some extent this area.</td>
<td></td>
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</tr>
<tr>
<td>SHOULD DO</td>
<td>Performance, Finance and Resources Committee</td>
<td>Head of Nursing</td>
<td>25</td>
<td>Review ways to improve the ‘whole system approach’ to managing overcrowding in the ED.</td>
<td></td>
<td>Urgent Care Board Metrics (RB)</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Much work continues to reduce attendances, DTOCs and the Trust is working with ECIP to improve internal flow and SAFER continues to be embedded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHOULD DO</td>
<td>Workforce Development Committee</td>
<td>Head of Nursing</td>
<td>26</td>
<td>To provide training to staff in dementia awareness, learning disabilities and complex needs in ED.</td>
<td>30/08/2017</td>
<td></td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Nursing Staff Dementia Awareness = 53.8% Nursing Staff Learning Disability = 36.3% Medical Staff Dementia Awareness = Data not available Medical Staff Learning Disability = Data not available. A revised plan to be determined and delivered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHOULD DO</td>
<td>Integrated Governance Committee</td>
<td>Head of Nursing</td>
<td>27</td>
<td>Review staff training and awareness of major incident policy and equipment.</td>
<td>30/08/2017</td>
<td></td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>Delivered (CQC Actions)</td>
<td>Delivered (CQC Actions)</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Compliance is below expected particularly for medical staffing. A plan to be devised to deliver improvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHOULD DO</td>
<td>Integrated Governance Committees</td>
<td>Head of Nursing</td>
<td>33</td>
<td>To monitor that the processes and procedures in place to manage the medicines stored in all clinical rooms which exceed the required temperature</td>
<td>01/09/2017</td>
<td>Storage and Security audit (Quarterly) - Audit Standard 6 80% of all areas included will be GREEN on the RAG rating and there will be no RED Rags</td>
<td>Overdue / Not on Track to deliver</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>New Temperature Recording Charts have been developed and circulated with clear colour coding for temperatures, signposting to actions and facility for recording actions. 6 omissions in the recording of Room temperature and 1 for fridge monitoring in Q3 Storage and Security of Medicines Audit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHOULD DO</td>
<td>Workforce Development Committee</td>
<td>Business Unit Director (BUD)</td>
<td>34</td>
<td>To support all staff to understand the hospital’s vision and strategy so that it is embedded within the service.</td>
<td>30/09/2017</td>
<td>Staff able to articulate Trust strategy and vision</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Ongoing discussion and application of CARE and Strategy to key pieces of work to embed understanding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHOULD DO</td>
<td>Workforce Development Committee</td>
<td>Head of Nursing</td>
<td>36</td>
<td>Review systems for staff in ICU to provide level three safeguarding children’s training.</td>
<td>31/12/17 Revised (TM) Agreed Sept 17</td>
<td>14/09/2017</td>
<td>85% of staff requiring Safeguarding Level 3 will have completed by December 2017 (Registered Nursing and Medical Staff)</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>85% of staff requiring Safeguarding Level 3 will have completed by December 2017 (Registered Nursing and Medical Staff)</td>
<td></td>
</tr>
</tbody>
</table>
### CQC Quality Improvement Plan Key Performance Indicators

<table>
<thead>
<tr>
<th>Priority</th>
<th>CQC Required Outcome</th>
<th>Due date</th>
<th>KPI</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>December Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SHOULD DO</strong></td>
<td>Performance, Finance and Resources Committee</td>
<td>Head of Nursing</td>
<td>39</td>
<td>To review processes so that patients are discharged from the critical care unit within four hours of the decision to discharge to improve the access and flow of patients within the critical care unit.</td>
<td>31/08/2017</td>
<td>Service agreement with Deputy COO agreed - discharges within 4 hour A&amp;E target. Completion of Data for any patient exceeding the four hour discharge</td>
<td>Due / Some Issues (narrative disclosure)</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
</tr>
<tr>
<td><strong>SHOULD DO</strong></td>
<td>Integrated Governance Committee</td>
<td>Head of Nursing</td>
<td>42</td>
<td>To record ambient room temperatures where fluids are stored that requires this, taking action when required.</td>
<td>30/06/2017</td>
<td>Storage and Security audit (Quarterly) - Audit Standard 6 90% of all areas included will be GREEN on the RAG rating and there will be no RED Rags</td>
<td>Overdue / Not on Track to deliver</td>
<td>Delivered (CQC Actions)</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
</tr>
<tr>
<td><strong>SHOULD DO</strong></td>
<td>Integrated Governance Committee</td>
<td>Business Unit Director (BUD)</td>
<td>45</td>
<td>To review assessment and screening of delirium for patients cared for in the ICU.</td>
<td>31/12/2017 - Revised (TMC agreed Sept 17)</td>
<td>1. 90% of applicable patients screened by 30/11/17 2. 90% of applicable patients screened by 31/12/17</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
</tr>
<tr>
<td><strong>SHOULD DO</strong></td>
<td>Workforce Development Committee</td>
<td>Business Unit Director (BUD)</td>
<td>48</td>
<td>To review staffing in maternity so that sufficient staff to ensure midwife-to-birth ratio is at the national average of 1:28.</td>
<td>31/05/2017</td>
<td>Each shift will be covered with a minimum of 90% of the required establishment of 1:28 midwife-to-birth ratio</td>
<td>Due / Some Issues (narrative disclosure)</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
</tr>
<tr>
<td><strong>SHOULD DO</strong></td>
<td>Performance, Finance and Resources Committee</td>
<td>General Manager (GM)</td>
<td>59</td>
<td>To monitor the safety of patients who wait over 40 weeks for non-urgent outpatient appointments.</td>
<td></td>
<td>See RTT performance</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Due / Some Issues (narrative disclosure)</td>
</tr>
<tr>
<td><strong>SHOULD DO</strong></td>
<td>Integrated Governance Committee</td>
<td>General Manager (GM)</td>
<td>61</td>
<td>To review outpatient areas where patients received care and treatment so they are adequate to respect patients’ privacy and dignity and ensure patient confidentiality.</td>
<td>30/06/2017 - Revised (TMC agreed Sept 17)</td>
<td>85% Compliance - Mental Health Awareness - Tracheostomy Compliance.</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
</tr>
<tr>
<td><strong>SHOULD DO</strong></td>
<td>Integrated Governance Committee</td>
<td>General Manager (GM)</td>
<td>62</td>
<td>To review facilities so that consultation rooms in all outpatient areas can accommodated wheelchair users when needed.</td>
<td></td>
<td></td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
</tr>
</tbody>
</table>
**CQC Quality Improvement Plan Key Performance Indicators**

**Updated - 17.01.2017**

<table>
<thead>
<tr>
<th>Priority</th>
<th>CQC Responsible Sub Board</th>
<th>CQC Executive Lead</th>
<th>CQC Ref</th>
<th>CQC Required Outcome</th>
<th>Due date</th>
<th>KPI</th>
<th>June Based on QIP RAG document</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Post CQC Letter 22.11.17</th>
<th>Nov</th>
<th>Dec</th>
<th>December Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHOULD</td>
<td>Integrated Governance Committee</td>
<td>General Manager (GM)</td>
<td>63</td>
<td>To review and monitor all patients on waiting lists to ensure effective prioritisation systems are in place to identify and minimise patient harm.</td>
<td>Patient Tracking List and reviews</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>Overdue / Not on Track to deliver</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
<td>On track to deliver</td>
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<tr>
<td>BOARD OF DIRECTORS:</td>
<td>2nd FEBRUARY 2018</td>
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<td>AGENDA ITEM:</td>
<td>3.5</td>
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<tr>
<td>SUBJECT:</td>
<td>GUARDIAN OF SAFE WORKING REPORT AUGUST –DECEMBER 2017</td>
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<tr>
<td>RESPONSIBLE DIRECTOR:</td>
<td>Dr A Chilton</td>
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<tr>
<td>AUTHOR:</td>
<td>Dr H Bilolikar</td>
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<tr>
<td>PREVIOUSLY CONSIDERED BY:</td>
<td>Mr Nic Nicolaou, Medical HR manager &amp; Katie Vacher, Medical HR Compliance Officer</td>
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**EXECUTIVE SUMMARY:**
Junior Doctors across all specialities are now in the new junior doctor contract. This report is being submitted as part of this contract implementation and covers period from August 2017 to handover in early December 2017. This period coincides with the 4 month posts in number of specialities. During this period a total of 28 exceptions were submitted.

**ACTION REQUIRED:**
Trust board to be sighted on implementation of new contract - safeworking of junior doctors and any rota gaps/ service reviews/ educational issues that may emanate from the new contract.

**RISK TO THE TRUST** (include reference to BAF or Corporate Risk Register)
Not Applicable

**WORKFORCE ISSUES:**
Any potential gaps in staffing of Junior Doctors – rota and training wise may become apparent over time.

**DIVERSITY & INCLUSION**
A Trust Equality Impact Assessment was completed. There were some groups that were identified that could be adversely affected by the new contract (those working less than full time) but protection arrangements and enhancements should mitigate against this.

**FINANCIAL IMPLICATIONS:**
Specify No/Yes (Detailed within the report).
Yes, detailed within the report

**COMMUNICATION/CONSULTATION ISSUES**
(including patient and public involvement)
Not Applicable

**STRATEGIC OBJECTIVE:**
(specify trust strategic objective)
Maintaining safe staffing levels to deliver high quality patient care and financial sustainability

**CQC DOMAINS**
- safe
- effective
- caring
- responsive to people’s needs.
- well-led

Safe, Effective
GUARDIAN OF SAFE WORKING REPORT

1. BACKGROUND

1.1 Implementation of Junior Doctors contract stepwise from December 2016 through August 2017 with all specialties at all grades of junior doctors now on the new contract.

1.2 New Rotas compliant with requirements of new Junior Doctors contract to ensure safe working and ability to access Training opportunities.

1.3 System of exception reporting when having to work beyond contracted hours for clinical reasons and when training opportunities could not be accessed due to service commitments/requirements.

1.4 Compensation for exceptions accepted and payment or time off in lieu. Adjustment of service commitments to enable ability to access Training opportunities (these exceptions addressed by Director of Medical Education)

1.5 To address pattern of exceptions by instigating service reviews and mandatory fines for specified rota exceptions.

1.6 Generic Work Schedules at commencement of the post and Personalised work schedules for individual junior doctors to support working, training and taking individual circumstances into account.

1.7 Quarterly Trust board reports including exceptions, fines and rota gaps.

1.8 Junior Doctors forum.

2. OVERVIEW

2.1 High level data

Number of doctors / dentists in training (total): 166

Number of doctors / dentists in training on 2016 TCS (total): 166 (as at 2nd August 2017)

Amount of time available in job plan for guardian to do the role: 1 PA = 4 hr/ week

Admin support provided to the guardian (if any): 0.125 WTE (est)

Amount of job-planned time for educational supervisors: 0.25 PA per trainee (to a maximum of 0.5 PA)

2.2 Exception reports (with regard to working hours)

Exception reports during this period have remained at similar levels as previous 4 month period April to July 2017. Exception reports were from broader group of specialities consistent with broadening of contract implementation in August. Software issues were experienced in the month of August, these were ironed out liaising with Allocate- software provider. Majority of exceptions continue to be working beyond time rostered for, some have been about inadequate staffing levels where rota gaps could not be filled via bank or locums. Issues have been experienced with exceptions not being completed by Educational / Clinical
Supervisors despite numerous prompts on a couple of occasions. The Guardian team has stepped in to resolve these exceptions. No valid immediate safety concern was reported during this period.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Grade</th>
<th>No. exceptions carried over from last report</th>
<th>No. exceptions raised</th>
<th>No. exceptions closed</th>
<th>No. exceptions outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>FY1</td>
<td>0</td>
<td>10</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Medicine</td>
<td>FY2 / CT1-2</td>
<td>0</td>
<td>5</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Surgery</td>
<td>FY1</td>
<td>0</td>
<td>8</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Surgery</td>
<td>FY2 / CT1-2</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>T&amp;O</td>
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</tr>
<tr>
<td>T&amp;O</td>
<td>FY2 / CT1-2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>0</td>
<td>28</td>
<td>28</td>
<td>0</td>
</tr>
</tbody>
</table>

### Exception reports (response time)

<table>
<thead>
<tr>
<th>Total Exception Raised</th>
<th>Addressed within 48 hours</th>
<th>Addressed within 7 days</th>
<th>Addressed in longer than 7 days</th>
<th>Still open</th>
</tr>
</thead>
<tbody>
<tr>
<td>28</td>
<td>4</td>
<td>6</td>
<td>18</td>
<td>0</td>
</tr>
</tbody>
</table>

2.3 **Work schedule reviews and Fines**

No work schedule reviews have been carried out subsequent to exception reporting. Proactively, meetings were held with Junior Doctors from surgery and with Surgical Consultants at joint session with junior doctors to address exception reporting process and understand concerns. Foundation Year rota in surgery was modified by mutual agreement, reflecting actual working hours to include handover time.

No Fines were levied during the time of this report.

2.4 **Implementation activities**

Meetings were held with Junior Doctors from Surgery during this time to understand their views and a further joint meeting in the surgical teaching programme was attended by Dr Bilolikar and Mr Nicolau to address exception reporting – processes and concerns. The trainee views were circulated to Educational/ Clinical Supervisors from Surgery.

Dr Bilolikar has met with GMC Liaison Officer on two occasions to understand results of surveys conducted by him of Foundation Year 1 & 2 doctors relating to their experience of new contract processes. Kettering results are broadly positive and consistent with other trusts in the region.

Further Dr Bilolikar as Guardian and Mr Nicolau met with the CQC Well-led team as part of trust CQC review.

Junior Doctor Forum attended by Guardian or representative.
Completion of the loop ensured: payment as authorised where exception for time worked beyond contracted hours was accepted and time off in lieu was not possible.

3. **POLICY**

3.1 The new Junior doctor contract has now been implemented across specialties and grades in the trust. With the new systems in place, issues relating to safe working, staffing and accessing training will arise. Addressing these and finding solutions to staff a work force and work place practices ensuring safe working that delivers training will be an ongoing challenge.

4. **RISK**

4.1 This report provides assurance to the trust re: implementation of new junior doctor contract and will highlight any issues that may evolve over the coming months – doctors working within nationally agreed parameters for safe working and any rota gaps in specified areas.

4.2 Educational & Clinical Supervisors need to be fully on-board to address exceptions and view the new working parameters positively. A number of issues have been raised by this group – remuneration, added work, perceived overlap between training role and administrative role and acceptance of change in working practices.

4.3 Engagement of Junior Doctors is equally important for the exception reporting process to reflect ground reality and addressing perceived potential of impact on training/career of conflicting role of Educational Supervisors as Trainers as well as administrators.

4.4 Rota gaps identified may be difficult to staff in a number of specialties.

4.5 Software issues have been experienced in the current cycle and remain a risk.

5. **DATA QUALITY**

Allocate software is used by the trust. Issues have been identified and have been addressed liaising with Allocate. However the software does not allow closing of exceptions even after addressing them, if the trainee does not respond at second stage. A number of exceptions were closed down after review and actions completed.

6. **FINANCIAL IMPLICATIONS**

6.1. Payments to junior doctors for additional time worked where working beyond contracted ‘rota’ time submitted as exception.

6.2. Issue of additional work as part of Clinical Supervisor / Educational Supervisor Role has been raised by Consultants (Ed & Clin Supervisors) at GMC visit – to be recompensed via additional PA’s. This may need to be addressed via Job Planning route or via agreed regional agreements – Health Education East Midlands.

6.3 Rota gaps identified or pattern of frequent exceptions may lead to service reviews with staffing or service level implications.

6.4 The new contract has provision for mandatory fines for rota non-compliance, these are ring fenced to address the issues causing the levy.
7. ACTION REQUIRED BY THE BOARD

7.1 Receive and note the report.

DR HARSHA BILOLIKAR
CONSULTANT PAEDIATRICIAN & GUARDIAN OF SAFE WORKING
Appendix 1: This information provides an indicator of areas with high locum / bank needs. This may reflect in exceptions being reported from the area. The data is collected manually and remains best available estimation.

**BANK AND AGENCY INFORMATION**

**APRIL 2017 TO JULY 2017**

Filled Shifts - Bank and Agency Shifts by Department and Grade

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Number of shifts requested</th>
<th>Number of shifts worked</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>305</td>
<td>221</td>
</tr>
<tr>
<td>Medicine</td>
<td>1013</td>
<td>925</td>
</tr>
<tr>
<td>Surgery</td>
<td>530</td>
<td>393</td>
</tr>
<tr>
<td>Urology</td>
<td>248</td>
<td>169</td>
</tr>
<tr>
<td>Cardiology</td>
<td>105</td>
<td>105</td>
</tr>
<tr>
<td>ENT / Max Fax</td>
<td>74</td>
<td>61</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>81</td>
<td>81</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>83</td>
<td>81</td>
</tr>
<tr>
<td>T&amp;O</td>
<td>571</td>
<td>456</td>
</tr>
<tr>
<td>Obs &amp; Gynae</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>56</td>
<td>28</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3069</strong></td>
<td><strong>2522</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Grade</th>
<th>Number of shifts requested</th>
<th>Number of shifts worked</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY1</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>FY2</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>CT1-2 / ST1-2 / TGSHO</td>
<td>1995</td>
<td>1594</td>
</tr>
<tr>
<td>ST3-ST7 / TGSPR</td>
<td>1043</td>
<td>898</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3069</strong></td>
<td><strong>2522</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number of shifts worked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vacancy</td>
<td>1873</td>
</tr>
<tr>
<td>Sickness</td>
<td>78</td>
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<tr>
<td>Maternity/Pat</td>
<td>89</td>
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<tr>
<td>Special Leave</td>
<td>15</td>
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<td>Annual / StudyLeave</td>
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<tr>
<td>Acuity</td>
<td>464</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2522</strong></td>
</tr>
</tbody>
</table>
**EXECUTIVE SUMMARY:**

At the September 2017 Board of Directors meeting, the Board was informed that the Trust was required to self-assess its performance against the emergency preparedness, resilience and response (EPRR) core standards set by NHS England. The Trust is required to comply with the Core Standards and the obligations for a Category 1 responder as defined by the Civil Contingencies Act, 2004.

NHS England responded to the submission on the 27th December 2017 reporting that they were in agreement with the Trust's self-assessment that the hospital was fully compliant with the EPRR Core Standards (copy of letter attached). The Trust will be responding, as requested, by the 31st March 2018 with the actions detailed within the letter,

| ACTION REQUIRED: | To RECEIVE and NOTE the formal correspondence from NHS England Continue to maintain full compliance with NHS England’s EPRR Core Standards. |
| RISK TO THE TRUST (include reference to BAF or Corporate Risk Register) | “Not applicable” |
| WORKFORCE ISSUES: (including training and education implications) | There is a need for CBUs and Departments to maintain their current levels of commitment to resilience issues. |
| EQUALITY & DIVERSITY | “Equality Impact is Neutral” |
| FINANCIAL IMPLICATIONS: Specify No/Yes (Detailed within the report). | “Not Applicable” |
| COMMUNICATION/CONSULTATION ISSUES | “Not Applicable” |
| STRATEGIC OBJECTIVE: | Standard Contract 2017/18 (SC30 EPRR) |
| CQC DOMAINS | All |

- safe
- effective
- caring
- responsive to people’s needs
- well-led
Dear Rebecca

Re: EPRR Core Standards Review 2017/18

Thank you for your submission of the self-assessment against the EPRR core standards and for participating in the NHS Core Standards for EPRR Assurance meeting held on Wednesday 27th September 2017. The purpose of the assurance meeting was to discuss your Core Standards submission in an open and facilitative forum, in order to set priorities moving forward. The Core Standards Panel will then make recommendations to the Local Health Resilience Partnership (LHRP) and in turn, the Local Resilience Forum (LRF) in response to your submission.

Key Challenges & Looking forward
The Trust is planning to review EPRR resource in the next year, to ensure there is adequate support in place. Whilst systems and documents are in place, steps need to be taken to embed EPRR across the whole system.

Core Standards:

Duty to maintain emergency and business continuity plans (standards 8-29):
- The Trust has implemented a tracking system, linked to the EPRR work programme, which highlights when plans are due for review.
- Business Continuity reviews are carried out on a rolling programme which addresses 2-3 areas requiring review each month. The Trust also uses opportunities such as IT outages / estates issues to test plans.
- Evacuation Plan – a number of buildings / premises have been identified to move patients to in an emergency situation. You are in discussion with Northampton General Hospital with regard to developing this and its inclusion in the evacuation exercise planned for March 2018.

Command and Control (standards 30-36)
The Cyber Attack in May 2017 was managed well within KGH, with Business Continuity plans being followed and the Trust sharing best practice across the county. Learning from the attack has been implemented, including adjustments to IT priorities.

Your Incident Co-ordination Centre facilities are activated and checked regularly, with back-up locations being reviewed over the next year.

Duty to communicate with the public (standards 37-38)

The Trust is moving to nhs.net accounts and will inform NHS England once people are in post and email addresses confirmed.

Training and Exercising (standards 49-52):

Training and exercising has taken place with the on-call teams around basic Business Continuity and resilience within an emergency situation. A robust induction programme has been put in place for new members of the on-call team and the same programme was to be shared with the whole on-call team prior to winter.

CBRN / Hazmat

The Trust is encouraged to continue with regular PRPS equipment training which provides a thorough overview of CBRN and includes setting up of the decontamination tent.

Governance Deep Dive

The Trust was fully compliant with a number of the deep dive questions, with the following points to note:

- The organisation has published results of 2016/17 EPRR assurance process in its annual report (DD2) – you requested confirmation of this requirement and the panel confirmed that the EPRR Framework states “all NHS funded organisations will be asked to provide evidence of their compliance and for their Board to issue a Statement of EPRR Conformity to their commissioners”.
- The organisation has an identified Non-Executive Director who formally holds the EPRR portfolio for the organisation (DD3) – the Panel clarified this requirement and following discussion, you agreed to approach a NED who would be appropriately placed to fulfil this role.
- Accountable Emergency Officer regularly attends internal EPRR oversight / delivery group (DD5) – you have previously been holding monthly meetings with a focus on business continuity. Going forward, it is your intention to hold quarterly meetings, with attendance by the Accountable Emergency Officer and the focus being on EPRR matters.
- Accountable Emergency Officer regularly attends Local Health Resilience Partnership meetings (DD6) – the panel raised concern that KGH had not been represented at executive level at LHRP meetings for over a year and was not represented at all at the March 2017 and May 2017 meetings. We have previously written to you in relation to this matter and you have assured us there will be attendance at executive level at future meetings, or by a deputy with delegated decision making authority when necessary.
Summary
In reviewing your submission for 2017-18, we are in agreement with your assessment that the Trust is **Fully** compliant with the EPRR core standards.

By 31st March 2018 please carry out the following actions and provide updates to NHS England:

- Continue to develop the Evacuation plan with NGH and include identified off-site locations. The whole system mass casualty plan should be incorporated into the plan.
- Explore suitable alternative locations for back-up Incident Co-ordination Centres.
- Inform NHS England of nhs.net email addresses once posts have been recruited and email addresses are in place.
- Continue with the progress made with regard to CBRN capabilities, plans and training.
- Pursue Non-executive Director with regard to formally holding the EPRR portfolio for the organisation.
- Ensure regular Accountable Emergency Officer at quarterly EPRR oversight / delivery group meetings.
- Ensure representation at executive level at LHRP meetings, or by a deputy with delegated decision making authority.

Please forward the update to Kevin Robotham at england.cm-eprr@nhs.net.

Yours sincerely

Roz Lindridge  
Locality Director Central  
NHS England  

Lucy Wightman  
Director of Public Health,  
Northamptonshire County Council
## BOARD OF DIRECTORS:
- 2nd February 2018

## AGENDA ITEM:
- 4.1

## SUBJECT:
- STP UPDATE

## RESPONSIBLE DIRECTOR:
- Fiona Wise
  - Chief Executive (Interim)

## AUTHOR:
- Polly Grimmett
  - Director of Strategy and Partnerships

## PREVIOUSLY CONSIDERED BY:
- STP Partnership Board

### EXECUTIVE SUMMARY:

The following paper has been completed by the programme management office (PMO) of the STP, and serves to:

- Highlight next steps in the development of STP programme in 2018
- Confirms changes in the management of New Models of Care workstreams
- Provides an update on the procurement of the resources required to support the programme
- Reports on key changes in performance and highlights for discussion principles and processes underpinning the development of a robust monitoring and reporting regime.
- Summarises progress in the development of the Collaborative Stakeholder Forum.

### ACTION REQUIRED:
- To note the progress of the STP.

### RISK TO THE TRUST

- None related to this report specifically

### WORKFORCE ISSUES:

- Not Applicable

### DIVERSITY & INCLUSION:

- Equality Impact is Neutral

### FINANCIAL IMPLICATIONS:

- Not Applicable

### COMMUNICATION/CONSULTATION ISSUES:

- Not Applicable

### STRATEGIC OBJECTIVE:

- To be a strong and effective partner in the wider health and social care economy.

### CQC DOMAINS:
- Safe.
- Effective.
- Caring.
- Responsive to people’s needs.
- Well-led

- Responsive to people’s needs
- Well-Led
1. Introduction

The report covers the period to the January 18th meeting of STP Partnership Board. It

- Highlights next steps in the development of STP programme in 2018
- Confirms changes in the management of New Models of Care workstreams
- Provides an update on the procurement of the resources required to support the programme
- Reports on key changes in performance and highlights for discussion principles and processes underpinning the development of a robust monitoring and reporting regime
- Summarises progress in the development of the Collaborative Stakeholder Forum.

2. Programme Development

2.1 Work on the development of Workstream Definition Documents for New Models of Care workstreams continues. The ambition remains to submit finalised WDDs to the February Board. In the interim, the STP Lead will meet with sponsor CEOs/EDs and SROs to discuss current drafts.

2.2 The Board has agreed to extend the development of WDDs to the System Development portfolio which consists of three workstreams:

- Commissioning development
- The unified acute model (including elective care)
- Accountable Care System (ACS).

SROs will be identified by the Strategic Executive. The target date for consideration of finalised System Development WDDs by the Board is 15th March.

As part of the work on System Development, colleagues from NHSI will lead work on the development of principles to support collaboration between the organisations in the Partnership. NHSI will also develop proposals for the development of an overarching strategy to provide parameters for the development and functioning of the Partnership.

2.3 It is critical to the success of the STP that the various workstreams combine to deliver a coherent and internally consistent set of proposals to deliver the 5YFV Next Steps targets and ensure a clinically and financially sustainable health and social care system. All New Models of Care workstreams are expected to produce business cases setting out
• The case for change
• The new model of care proposed
• An assessment of workforce, IT and estate implications
• Financial and clinical benefits
• An implementation plan.

It should be anticipated that similar business cases will be produced by the System Development workstreams.

It follows from this that the Board will be presented with some 10 business cases which collectively represent a significant recasting of the service and management models supporting the organisation and delivery of health and social care in Northamptonshire. The challenge potentially facing the Board, therefore, will be to ‘read across’ these business cases to ensure that they ‘fit’ with each other and that at an aggregate level they deliver Next Steps targets and ensure clinical and financial sustainability across health and social care system. A ‘reconciliation event’ is therefore being planned for July. The precise design of this event has yet to be defined but will ‘borrow’ from other health and social care systems which have devoted 2 to 3 days to test

• The compatibility of the new models of care through the prisms of care of older people, chronic disease management and the delivery of urgent and emergency care
• The robustness of predictions of the quantum of shifts in activity between the hospital and non hospital sectors
• The availability of a workforce able to staff the new models
• The IT and estates implications
• The level of savings generated.

2.4 It will also be important that the thinking of the New Models of Care Delivery Boards and the CCGs’ commissioning intentions align. The Delivery Boards include CCG clinicians and managers. They and the SROs will be tasked with providing formal confirmation to the Board that work on the new models of care takes due account of commissioner requirements and that the commissioning process will support the emergent care models. This process will be completed by the end of February.

3. New Model of Care Workstream

From March 2018, the ED Sponsor for the Maternity, Children & Young People workstream will be Lesley Haggar.

The SRO for the Learning Difficulty workstream has indicated that he does not wish to continue in this role and Angela Overall has agreed to take over the role of SRO.
4. Programme Resources

The DSU has worked with SROs to define the project and change management resources required to support workstream delivery. This was fed into a meeting held with NHSE on 17 January. An oral update will be provided to the Board.

The DSU has recruited (for an initial period of 3 months) Simon Jones as Assistant Programme Director (focused on programme management and supporting the Collaborative Stakeholder Forum) and Byron Taylor as Business Manager (focused on the tracking and reporting of programme delivery and on the risk log).

In the absence of any response to a secondment opportunity to act as Communications Manager (replacing support from NECSU), an external recruitment process is now under way.

5. Programme Monitoring and Reporting

An updated dashboard is at Appendix 1

The assessment of progress made by the original STP projects has been discontinued.

One of the primary tasks facing the DSU over the next 3 months is to develop a comprehensive and robust programme monitoring and reporting regime. This work is being driven by Byron Taylor. Set out below for discussion are preliminary comments on objectives, principles and the monitoring/reporting framework.

Objective: The purpose of the monitoring and performance framework will provide the means for the board to determine if the STP is on course to achieve its key aims and objectives and take remedial action where necessary. A key step in developing the monitoring and performance framework is the requirement to create a central information sharing system and develop robust information sharing governance arrangements across the health and social care system.

Underpinning principles:

- Effective governance and accountability to manage the delivery of the STP workstreams and the management of risk.
- Performance and financial risks will be reported to the STP on a monthly basis along with exception reports to outline actions to address any extreme/high risks or poor performance as appropriate.
- The framework is designed to support accountability by monitoring key indicators that will provide a measure of how well the workstreams are performing against the agreed performance measures and priority areas

Monitoring & Performance Framework:

- In order to allow the STP Board to achieve the agreed objectives, a strong monitoring performance framework for managing the programme is required. The monitoring and performance management framework will enable the STP Board to fulfil its objectives and effectively run and manage the programme.
• It is proposed that a set of key indicators are monitored throughout the duration of the STP and reported upon in a monthly dashboard to the STP Board. The dashboard will track the trajectory and performance of the STP workstreams across a three tier reporting system
  i. Strategic Executive High Level Reporting (supporting the board)
  ii. Workstream boards (supporting outcomes set out in the WDD)
  iii. Project level related activities (reported through workstream boards)
• In developing the framework, a number of actions are being taken which will enable a full monitoring and performance framework to be presented at the February board:
  - Identify data sets for each tier – including discussions with NELCSU and local organisations about data collection and granulation
  - Agree information sharing through a formal information sharing agreement
  - Propose and agree KPI’s – ensure they support outcome delivery
  - Design and produce draft dashboard
• **Working drafts of monthly performance reports at workstream and project levels are at Appendix 2.**

6. **Collaborative Stakeholder Forum**

A further meeting, supported by Simon Jones, was held on 8 January. Discussions focused on how the Forum will ensure the full engagement / involvement of the wider stakeholder community in the design, development and delivery of the STP and its component work streams.

Actions planned for January/ February include:

• Production of an outline stakeholder strategy that sets out clear aims, objectives and an associated delivery plan
• Identification of current stakeholder engagement systems and processes
• Confirmation of the Forum’s approach to engagement (how we will engage through existing or new processes) and communications (the techniques to be used to maximise the output from engagement)
• Producing a stakeholder ‘map’.

An initial event is planned for March which will:

• Bring stakeholders up to date on the STP
• Describe how we will in future engage across the county with the various groups together with the objectives of that engagement
• Develop processes that ensure two way engagement so colleagues, professionals and members of the public can be assured that their input counts.

7. **Recommendation**

The Board is asked to note this report.
## STP Assessment Scorecard

### Scorecard Information

#### Direction Key
- **↑**: Activity or percentage is increasing for the better
- **↓**: Activity or percentage is decreasing for the better
- **↔**: Activity or percentage has remained the same

#### Reporting Frequencies

<table>
<thead>
<tr>
<th>Theme</th>
<th>ID</th>
<th>Indicator</th>
<th>Data Update Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital performance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>A&amp;E 4 hours</td>
<td>Monthly (Trust)</td>
<td>Quarterly (CCG)</td>
</tr>
<tr>
<td>2</td>
<td>RTT - 18 weeks incomplete</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Providers in special measures</td>
<td>Adhoc</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>MRSA per 100,000 acute trust bed days</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>C.Diff per 100,000 acute trust bed days</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td><strong>Patient focussed Change</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>IAPT recovery</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>EIP - 2 weeks</td>
<td>Monthly</td>
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<tr>
<td>8</td>
<td>Early diagnosis stage 1 or 2</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>CWT 62 days</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>% with good experience of care with cancer services</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>% practices with extended access (full provision)</td>
<td>Bi-annual</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>% of patient satisfaction with opening hours</td>
<td>Annual</td>
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<tr>
<td><strong>Transformation</strong></td>
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</tr>
<tr>
<td>13</td>
<td>Emergency admissions per 1,000 population</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Emergency beddays per 1,000 population</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>% DTOCs per beds (different from STP scorecard KPI)</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>System wide leadership</td>
<td></td>
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</tr>
<tr>
<td>17</td>
<td>% variance from plan</td>
<td>N/A</td>
<td></td>
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</tbody>
</table>

### Highlights

**A&E 4 hours**
- No change (Quarterly reference period)
- Revert to Monthly for STP scorecard?

**RTT**
- Improvement month on month

**Cancer CWT 62 days**
- Deterioration month on month
- Indicative of NGH reducing backlog of 62+ day patient pathways
- Anticipated improved position next month
# STP Assessment Scorecard

<table>
<thead>
<tr>
<th>Theme</th>
<th>Priority Area</th>
<th>ID</th>
<th>Indicators</th>
<th>Target</th>
<th>To get top score</th>
<th>Period</th>
<th>STP Performance</th>
<th>Performance Direction</th>
<th>Data Trend</th>
<th>Breakdown</th>
<th>Current Performance</th>
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</thead>
<tbody>
<tr>
<td>Hospital performance</td>
<td>Emergency Performance</td>
<td>1</td>
<td>A&amp;E 4 hours</td>
<td>95%</td>
<td>95%+</td>
<td>STP/CCG: Q2 17/18 Trust: Nov-17</td>
<td>87.17%</td>
<td>↑</td>
<td>Nene 87.30%</td>
<td>Corby 85.66%</td>
<td>NGH 83.84%</td>
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<tr>
<td></td>
<td>Elective performance</td>
<td>2</td>
<td>RTT - 18 weeks incomplete</td>
<td>92%</td>
<td>93%+</td>
<td>Oct-17</td>
<td>88.26%</td>
<td>↑</td>
<td>Nene</td>
<td>Nene</td>
<td>Corby</td>
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<td>Safety</td>
<td>3</td>
<td>Providers in special measures</td>
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<td>0</td>
<td>Dec-17</td>
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<td>↔</td>
<td>Nene</td>
<td>Nene</td>
<td>Corby</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
<td>MRSA per 100,000 acute trust bed days</td>
<td>0</td>
<td>0</td>
<td>Oct-17</td>
<td>0</td>
<td>↔</td>
<td>Nene</td>
<td>Nene</td>
<td>Corby</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5</td>
<td>C.Diff per 100,000 acute trust bed days</td>
<td>Quartiles</td>
<td>&lt;10.9</td>
<td>Oct-17</td>
<td>2.5</td>
<td>↑</td>
<td>Nene</td>
<td>Nene</td>
<td>Corby</td>
</tr>
<tr>
<td>Mental Health</td>
<td>6</td>
<td>IAPt recovery</td>
<td>50%</td>
<td>53%+</td>
<td>Sep-17</td>
<td>37.00%</td>
<td>↓</td>
<td>Nene</td>
<td>Nene</td>
<td>Corby</td>
<td>NGH</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>EIP - 2 weeks</td>
<td>50%</td>
<td>75%+</td>
<td>Oct-17</td>
<td>100.00%</td>
<td>↔</td>
<td>Nene</td>
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<td>Corby</td>
<td>NGH</td>
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<tr>
<td></td>
<td></td>
<td>8</td>
<td>Early diagnosis stage 1 or 2</td>
<td>Quartiles</td>
<td>54.3%+</td>
<td>2015</td>
<td>56.79%</td>
<td>↑</td>
<td>Nene</td>
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<td>Corby</td>
</tr>
<tr>
<td></td>
<td>Cancer</td>
<td>9</td>
<td>CWT 62 days</td>
<td>85%</td>
<td>86%+</td>
<td>Oct-17</td>
<td>78.00%</td>
<td>↓</td>
<td>Nene</td>
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<td>Corby</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10</td>
<td>% with good experience of care with cancer services</td>
<td>Quartiles</td>
<td>8.75+</td>
<td>2016</td>
<td>8.57%</td>
<td>↑</td>
<td>Nene</td>
<td>Nene</td>
<td>Corby</td>
</tr>
<tr>
<td></td>
<td>General practice</td>
<td>11</td>
<td>% practices with extended access (full provision)</td>
<td>Quartiles</td>
<td>26.6%+</td>
<td>Mar-17</td>
<td>0</td>
<td>↔</td>
<td>Nene</td>
<td>Nene</td>
<td>Corby</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12</td>
<td>% of patient satisfaction with opening hours</td>
<td>Quartiles</td>
<td>77.8%+</td>
<td>Jul-17</td>
<td>74.85%</td>
<td>↓</td>
<td>Nene</td>
<td>Nene</td>
<td>Corby</td>
</tr>
<tr>
<td>Prevention</td>
<td>13</td>
<td>Emergency admissions per 1,000 population</td>
<td>Quartiles</td>
<td>88&lt;</td>
<td></td>
<td></td>
<td></td>
<td>Data sources to be confirmed</td>
<td>Data sources to be confirmed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>14</td>
<td>Emergency beddays per 1,000 population</td>
<td>Quartiles</td>
<td>&lt;438</td>
<td></td>
<td></td>
<td></td>
<td>Data sources to be confirmed</td>
<td>Data sources to be confirmed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>% DTOCs per beds (different from STP scorecard KPI)</td>
<td>3.50%</td>
<td>3.50%</td>
<td>Dec-17</td>
<td>10.49%</td>
<td>↑</td>
<td>NGH 7.95%</td>
<td>KGH 11.32%</td>
<td>NFFT 23.47%</td>
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<tr>
<td>Leadership</td>
<td>16</td>
<td>System wide leadership</td>
<td>Fixed thresholds</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>Data sources to be confirmed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finance</td>
<td>17</td>
<td>% variance from plan</td>
<td>Fixed thresholds</td>
<td>1%+</td>
<td></td>
<td></td>
<td></td>
<td>Data sources to be confirmed</td>
<td></td>
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Data source: Scorecards – Various Commissioner / Provider

N/A – data not published yet
<table>
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<tbody>
<tr>
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</tr>
<tr>
<td>SPONSOR CEO:</td>
<td></td>
</tr>
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<td>SRO:</td>
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<td>RAG</td>
</tr>
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<td>HEADLINES:</td>
<td></td>
</tr>
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<td>KPIs</td>
<td></td>
</tr>
<tr>
<td>ACHIEVED IN LAST MONTH:</td>
<td></td>
</tr>
<tr>
<td>PLANNED FOR COMING MONTH:</td>
<td></td>
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</tr>
<tr>
<td>-----------</td>
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<tr>
<td>SAVINGS:</td>
<td>RAG</td>
</tr>
<tr>
<td>QUALITY:</td>
<td>RAG</td>
</tr>
<tr>
<td>SCOPE:</td>
<td>RAG</td>
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<tr>
<td>RESOURCES:</td>
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<td>RISKS:</td>
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| RISKS AND ISSUES |
MONTHLY PROJECT REPORT

NORTHAMPTONSHIRE SUSTAINABILITY & TRANSFORMATION PLAN

PROJECT REPORT

<table>
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<tr>
<th>MONTH:</th>
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</thead>
<tbody>
<tr>
<td>WORKSTREAM:</td>
<td></td>
</tr>
<tr>
<td>SPONSOR CEO:</td>
<td></td>
</tr>
<tr>
<td>SRO:</td>
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<tr>
<td>PROJECT:</td>
<td></td>
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<td>PROJECT MANAGER:</td>
<td></td>
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<td>OVERALL STATUS:</td>
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<td></td>
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<td>ACHIEVED IN LAST MONTH:</td>
<td></td>
</tr>
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<td>PLANNED FOR</td>
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</tr>
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<td>COMING MONTH:</td>
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<td>RESOURCES:</td>
<td>RAG</td>
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<tr>
<td>RISKS:</td>
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RISKS AND ISSUES
EXECUTIVE SUMMARY:

This paper is an update to the Long term liquidity, cashflow, loan balances and funding paper following a meeting with the Chair of the PFR committee and URGENT correspondence with NHSI Cash and Capital team.

Update following discussion with Chair of PFR

The content of the paper is still relevant and accurate but Recommendation D has been amended. The initial recommendation was for the Board to approve a revenue loan application in 2018/19 for £26.1m to cover the £12.1m revenue loan repayment due and £14m to cover the expected 2018/19 revenue deficit as per the 17/18 financial plan submission. The Trust has yet to complete its financial plan for 2018/19 and the Trust Board has not approved an 18/19 deficit budget so it has been agreed that the formal loan request for 2018/19 deficit funding would be presented to the Board in March. Therefore the recommendation is amended to;

Recommendation D – Trust Board to approve application for additional revenue loan funding of £12.1m and capital interim capital loan funding of £8m for 2018/19

The consequence of this amendment is that the Trust Board may not have agreed a 2018/19 budget in time for the April cash application (9th March 2018). Therefore a new recommendation is required for the Trust Board to authorise the Director of Finance (or Deputy or Acting Director of Finance in their absence) to submit an application for cash for April 2018 that ensures the Trust’s cash requirement for April is met.

Full Recommendations

For completeness the Trust Board are asked to action the following recommendations;

a) Board members are asked to note the interim funding arrangements for the Trust.
b) Board members are asked to note the key cash risks and the impact of loans on the Trusts liabilities and net assets.
c) Board members are asked to approve an application for additional interim revenue loan funding of £2m with a full year revenue loan sum of up to £28.9m in 2017/18.
d) Board members are asked to approve an application for interim revenue loan funding of £12.1m and interim capital loan funding of £8m for 2018/19.
e) Board members are recommended to make the resolutions contained in Appendix 1.
f) The Board is asked to note the key conditions of the loan applications and Schedule 8 – Additional Terms and Conditions, replicated in Appendix 2 below.
g) Board members are recommended to authorise the Chief Executive (or Interim/Acting CEO in their absence) or the Director of Finance (or Deputy or Acting...
The interim revenue loan funding for February and March have been submitted and at this time the Trust expected that the £1.8m winter funding tranche 2 (of which £0.4m is for external initiatives) would be made available to the Trust in February.

In the week beginning the 22\textsuperscript{nd} January the Trust received notification that the winter tranche 2 funding may be delayed until March. Given the Trust has to manage to less than a £1m cash balance each month a delay of £1.4m net cash for the Trust would result in the Trust not having enough cash to pay creditors. As a result the Trust sought to increase the revenue loan funding for February by £1.4m thus reducing the March requirement by £1.4m.

NHSI Cash and Capital team rejected the Trusts request for an increase in February’s loan as “At this stage DH are not providing cash advances for winter funding” resulting in the Trust needing to manage the £1.4m cash shortage or submit an exceptional working capital request.

The Trust submitted an exceptional working capital request and it was not supported with the following response “DH will not advance winter pressures cash unless the knock on effect significantly impacts the Trust operationally. It is worth noting that the Trust has not drawn down any of the £2.1m capital loan that was arranged to cover capital loan repayments. All but the final repayment has been made, plus the final repayment falls in the February draw period so the Trust should draw all of that and this presumably would resolve this cash issue without needing to take working capital”

The Trust will not be drawing capital cash to cover revenue cost and instead has taken a number of measures to try to support the cash position;
- Payment runs to be set up to only pay on 30 days unless 30 days falls at a weekend then it will be the subsequent payment run not the preceding one.
- Move all NHS payments to 45 day payment terms
- Contacted system wide FD’s for cash advance

<table>
<thead>
<tr>
<th>ACTION REQUIRED:</th>
<th>Approve recommendations (a) to (h) as set out above.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>RISK TO THE TRUST (include reference to BAF or Corporate Risk Register)</th>
<th>Risks detailed within the report Strategic Risk – financial sustainability</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>WORKFORCE ISSUES: (including training and education implications)</th>
<th>Potential to impact on weekly bank payments in last week of February</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>DIVERSITY &amp; INCLUSION</th>
<th>Not Applicable</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>FINANCIAL IMPLICATIONS: Specify No/Yes (Detailed within the report)</th>
<th>Yes detailed within the report</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>COMMUNICATION/CONSULTATION ISSUES (including patient and public involvement)</th>
<th>Communication would need to be considered for each mitigating action.</th>
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</table>

<table>
<thead>
<tr>
<th>STRATEGIC OBJECTIVE: (specify trust strategic objective)</th>
<th>Trust financial and strategic objectives</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>CQC DOMAINS</th>
<th>Effective Well-led</th>
</tr>
</thead>
</table>
**BOARD OF DIRECTORS**

2nd FEBRUARY 2018

**AGENDA ITEM:**

4.3

**SUBJECT:**

LONG TERM LIQUIDITY, CASH FLOW, LOAN BALANCES AND FUNDING

**RESPONSIBLE DIRECTOR:**

Nicci Briggs, Director of Finance

**AUTHOR:**

Peter Bunnewell, Head of Financial Services

**PREVIOUSLY CONSIDERED BY:**

Performance, Finance & Resources Committee

**EXECUTIVE SUMMARY:**

This paper builds on the revenue and capital forecast and seeks to explain the current liabilities of the Trust, risks in managing a variety of loan portfolios and the impact on the Trust’s Statement of Financial Position (Balance Sheet). A forecast borrowing requirement for 2018/19 is included in the report.

This paper requests formal Board approval to seek additional loan funding for 2017/18 of £2m with a full year forecast up to £28.9m

This paper requests formal Board approval to seek loan funding for 2018/19 of £34.1m

**ACTION REQUIRED:**

- Approve loan applications of £28.9m for 2017/18
- Approve loan applications of £34.1m for 2018/19
- To approve the Board Resolutions in Appendix 1
- To agree to the DH loan conditions in Appendix 2

**RISK TO THE TRUST** (include reference to BAF or Corporate Risk Register)

Risks detailed within the report

**WORKFORCE ISSUES:**

(including training and education implications)

Not Applicable

**DIVERSITY & INCLUSION**

Not Applicable

**FINANCIAL IMPLICATIONS:**

Specify No/Yes (Detailed within the report).

Yes detailed within the report

**COMMUNICATION/CONSULTATION ISSUES**

(including patient and public involvement)

Not Applicable

**STRATEGIC OBJECTIVE:**

(specify trust strategic objective)

Trust financial and strategic objectives

**CQC DOMAINS**

- safe.
- effective.
- caring.
- responsive to people’s needs.
- well-led

Please indicate which domain the report is providing assurance on

Effective

Well-led
1. **Background**

The 2017/18 updated financial plan included Department of Health (DH) cash support through both revenue and capital loans for 2017/18 in the sum of £31.8m (Revenue of £19.9m, capital funding of £9.8m and existing capital loan repayments of £2.1m). For 2018/19 the Trust will require a minimum of £14m revenue support, £5m capital support and £15.1m to cover repayment of existing loans. Revenue loans are approved on a monthly basis by NHSi and DH. Interest only payments are payable until the end of the term which is currently 3 years. Capital loan repayment periods and interest rates are variable with both principal and interest charges being levied 6 months after final drawdown of the loan.

2. **Un-committed Revenue Support Loan**

2017/18

Un-committed revenue support loans will be required to support the forecast revenue deficit for 2017/18 of £19.9m (but could be £9m higher due to a deteriorating deficit).

2018/19

A minimum of £14m loan support will be required to support the planned deficit in 2018/19. Further revenue funding is required to support an existing revenue loan repayment of £12.1m in 2018/19.

**Interest charges**

As the Trust has breached its Control Total in 2017/18, revenue loan interest is charged at 3.5% rather than 1.5% p/a. This has led to an increase in interest charge of circa £0.3m for 2017/18. The impact on interest charges including new revenue loans in 2018/19 is circa £0.8m which would be saved if NHSi approved a revised Control Total for 2018/19 in line with the Trust planned deficit next year.

3. **Capital Loan Funding**

Capital loan funding is required to support the Trust capital programme and to fund the repayment of existing capital loans. Interest rates are variable depending upon the loan period.

2017/18

The planned capital programme for 2017/18 (£16.1m) required £9.8m capital loan support (£6.2m is funded internally via depreciation) and the Trust has received approval from DH (£2.6m loan b/f from 2016/17 and a new loan of £7.2m). An additional capital support loans has been approved to fund the repayment of existing capital loan repayments in the sum of £2.1m in 2017/18. However the current forecast capital spend and actual depreciation charges have changed due to delays in the capital programme as detailed below:

<table>
<thead>
<tr>
<th>Capital Funding 2017/18</th>
<th>Plan</th>
<th>Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td>(£m)</td>
<td></td>
<td>(£m)</td>
</tr>
<tr>
<td>Capital expenditure</td>
<td>(16.1)</td>
<td>(16.3)</td>
</tr>
<tr>
<td>Existing loan repayments</td>
<td>(2.4 )</td>
<td>(2.1)</td>
</tr>
<tr>
<td><strong>Expenditure</strong></td>
<td>(18.5)</td>
<td>(18.4)</td>
</tr>
<tr>
<td>Less funding via depreciation (reduced to revised capital expenditure versus plan)</td>
<td>6.3</td>
<td>5.6</td>
</tr>
<tr>
<td>Less funding for car park lease</td>
<td>0</td>
<td>1.3</td>
</tr>
<tr>
<td>Capital loan funding – in year capital spend</td>
<td>9.8</td>
<td>9.4*</td>
</tr>
<tr>
<td>Capital loan funding – exist loan repayments</td>
<td>2.4</td>
<td>2.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>18.5</td>
<td>18.4</td>
</tr>
</tbody>
</table>
Trust is seeking to bring forward urgent schemes to ensure the loan is fully drawn down this year.

Capital Funding 2018/19
The capital expenditure forecast for 2018/19 is £10.3m and excluding internal funding from depreciation of £6.3m the Trust will require an additional £5m capital loan from DH. The loan is required to fund the Maxillo Facial development, MRI scanner and Cardiac Catheter Labs. Further capital funding is required to support existing capital loan repayments of £3m in 2018/19

4. Loan Balances and Repayment
The Trust has the following loan balances as at 31 December 2017:

<table>
<thead>
<tr>
<th>Loan</th>
<th>Type</th>
<th>Interest rate</th>
<th>Balance@ 31 Dec 2017</th>
<th>Repayments</th>
<th>Final repayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>F Wing Loan</td>
<td>Capital</td>
<td>2.73%</td>
<td>£11.1m</td>
<td>£1.48m plus interest p/a</td>
<td>Apr 2025</td>
</tr>
<tr>
<td>Rev Loan £7.4m 14-15</td>
<td>Revenue</td>
<td>1.50%</td>
<td>£7.4m</td>
<td>Interest only</td>
<td>Mar 2020</td>
</tr>
<tr>
<td>Rev Loan £12.1m 15-16</td>
<td>Revenue</td>
<td>1.50%</td>
<td>£12.1m</td>
<td>Interest only</td>
<td>May 2018</td>
</tr>
<tr>
<td>Cap Loan £14.8m 15-16</td>
<td>Capital</td>
<td>2.28%</td>
<td>£14.3m</td>
<td>£0.6m plus interest p/a</td>
<td>Feb 2041</td>
</tr>
<tr>
<td>WCF 15-16</td>
<td>Revenue</td>
<td>3.50%</td>
<td>£22.4m</td>
<td>Interest only</td>
<td>Mar 2020</td>
</tr>
<tr>
<td>Cap Loan 17-18 (£7.2m approved)</td>
<td>Capital</td>
<td>0.76%</td>
<td>£2.6m</td>
<td>Interest only 17/18</td>
<td>Aug 2027</td>
</tr>
<tr>
<td>Un-committed loans Dec16-Mar17</td>
<td>Revenue</td>
<td>1.50%</td>
<td>£14.2m</td>
<td>Interest only</td>
<td>Dec 2019-2020</td>
</tr>
<tr>
<td>Un-committed loans Apr17-Dec17</td>
<td>Revenue</td>
<td>3.50%</td>
<td>£20.4m</td>
<td>Interest only</td>
<td>Dec 2019-2020</td>
</tr>
<tr>
<td><strong>Balance at 31/12/17</strong></td>
<td></td>
<td></td>
<td><strong>£104.5m</strong></td>
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Planned Loans Jan-18 to Mar-18

<table>
<thead>
<tr>
<th>Loan</th>
<th>Type</th>
<th>Interest rate</th>
<th>Loan/(repayment amount)</th>
<th>Repayments</th>
<th>Final repayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Un-committed loans</td>
<td>Revenue</td>
<td>3.5%</td>
<td>£6.6m*</td>
<td>Interest only</td>
<td>3 years</td>
</tr>
<tr>
<td>Balance of 17/18 capital loan (£7.2m)</td>
<td>Capital</td>
<td>0.76%</td>
<td>£4.6m</td>
<td>Interest only 17/18, £0.76m plus interest 18/19</td>
<td>Aug 2027</td>
</tr>
<tr>
<td>New capital loan to cover existing loan repayments</td>
<td>Capital</td>
<td>Tbc</td>
<td>£2.1m</td>
<td>Interest only 17/18, £0.2m plus interest 18/19</td>
<td>Aug 2028</td>
</tr>
<tr>
<td>Balance of capital loan repayments</td>
<td></td>
<td></td>
<td>(£0.3m)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Balance at 31/3/18</strong></td>
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<td></td>
<td><strong>£117.4m</strong></td>
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Planned Loans and repayments 2018/19

<table>
<thead>
<tr>
<th>Loan</th>
<th>Type</th>
<th>Interest rate</th>
<th>Purpose</th>
<th>Final repayment</th>
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</thead>
<tbody>
<tr>
<td>NEW Un-committed loans Includes £12.1m for rev loan repayments</td>
<td>Revenue</td>
<td>3.5%</td>
<td>18/19 Deficit £14.0m Repay'ts £12.1m</td>
<td>Expect 3 years</td>
</tr>
<tr>
<td>NEW Capital loan to fund 18/19 spend and loan repayments</td>
<td>Capital</td>
<td>n/k</td>
<td>18/19 Cap exp £5.0m Repay'ts £3.0m</td>
<td>Expect 10 yrs</td>
</tr>
<tr>
<td>Repay capital loans</td>
<td>Capital</td>
<td></td>
<td>(£3.0m)</td>
<td></td>
</tr>
<tr>
<td>Repay revenue loans</td>
<td>Revenue</td>
<td></td>
<td>(£12.1m)</td>
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</tr>
</tbody>
</table>
5. Risk

Based on a planned revenue deficit of £19.9m, a capital plan of £16.1m and existing loan repayments of £2.1m the Trust would require £31.8m of loan support in 2017/18. The loan liability at 31 March 2018 would be £110.4m. This will rise to £129.4m at 31 March 2019 presuming a £14m revenue deficit. The Trust would report Net Assets of £5m on its Statement of Financial Position (Balance Sheet) at 31 March 2018. An additional £7m of loans would increase the total loan liability at 31 March 2018 to £117.4m (£136.4m at 31 March 2019) and move the Net Assets to a Net Liability of £2m on its Statement of Financial Position at 31 March 2018. The Director of Finance has engaged the external auditors to advise if there are any reporting requirements on the Trust if this position materialises.

If the £19.9m deficit is not achieved then between £7m and £9m of additional revenue support loans may be required. DH have not formally approved the additional loan requirement.

The Board approved an application for an additional £7m of revenue support in October 2017 but this paper seeks Board approval for a further £2m loan support, if required, by the end of the financial year. This would bring the total revenue support to £28.9m.

A further risk is that the Trust is currently requesting revenue loans at 3.5% to repay loans at lower rates. If the Trust was a business it would seek to consolidate its loan portfolio to improve management and reduce the interest burden thus allowing money to be spent on patient focused activities rather than interest payments.

NHSi and DH have yet to approve revenue loan funding for 2018/19 and further funding is required to cover the repayment of existing revenue loans (£12.1m) and capital loans (£5m) in 2018/19.

This paper therefore requires Board approval to seek loan funding for 2018/19 of the following sums:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue deficit funding</td>
<td>£14.0m</td>
</tr>
<tr>
<td>Revenue loan repayment funding</td>
<td>£12.1m</td>
</tr>
<tr>
<td>Capital expenditure funding</td>
<td>£5.0m</td>
</tr>
<tr>
<td>Capital loan repayment funding</td>
<td>£3.0m</td>
</tr>
<tr>
<td>Total</td>
<td>£34.1m</td>
</tr>
</tbody>
</table>

6. Recommendation

a) Board members are asked to note the interim funding arrangements for the Trust.
b) Board members are asked to note the key cash risks and the impact of loans on the Trusts liabilities and net assets.
c) Board members are asked to approve an application for additional interim revenue loan funding of £2m with a full year revenue loan sum of up to £28.9m in 2017/18.
d) Board members are asked to approve an application for interim revenue loan funding of £26.1m and interim capital loan funding of £8m for 2018/19.
e) Board members are recommended to make the resolutions contained in Appendix 1.
f) The Board is asked to note the key conditions of the loan applications and Schedule 8 – Additional Terms and Conditions, replicated in Appendix 2 below.
g) Board members are recommended to authorise the Chief Executive (or Interim/Acting CEO in their absence) or the Director of Finance (or Deputy or Acting Director of Finance in their absence) to execute loan documentation in each future month and approve the Director of Finance to manage the agreement.
APPENDIX 1 - BOARD RESOLUTIONS

1. **Un-committed Revenue Support Loan 2018/19:**

   The Board resolve:

   a) To apply for an Un-committed Revenue Support Loan.
   
   b) To agree to and approve the Terms of the Agreement and execute the Finance documents.
   
   c) To confirm the Borrowers undertaking to comply with the Additional Terms and Conditions (Schedule 8 of the Agreement).
   
   d) To apply for an Un-committed Revenue Support loan up to a maximum sum of £26.1m in respect of 2018/19.
   
   e) The Chief Executive (or Interim/Acting CEO in their absence) or Director of Finance (or Deputy Director of Finance or Acting Director of Finance in their absence) will be the named Executor of the Agreement.
   
   f) To approve the Director of Finance to manage the agreement.
   
   g) To approve two of the following post holders to authorise any utilisation request (drawdowns of the loan will be approved by 2 members of the existing bank signatories).
   
   One or two of the following:
   - Director of Finance or Acting Director of Finance in their absence
   - Deputy Director of Finance
   - Head of Financial Services
   - Treasury Accountant
   - Head of Financial Management
   
   Only one of the following may sign the request:
   - Business Partner
   
   h) The Key Contact is the Head of Financial Services.

2. **Interim Capital Support Loan 2018/19:**

   The Board resolve:

   i) To apply for an Interim Capital Support Loan.
   
   j) To agree to and approve the Terms of the Agreement and execute the Finance documents.
   
   k) To confirm the Borrowers undertaking to comply with the Additional Terms and Conditions (Schedule 8 of the Agreement).
   
   l) To apply for an Interim Capital Support loan of £8m in respect of 2018/19.
m) The Chief Executive (or Interim/Acting CEO in their absence) or Director of Finance (or Deputy Director of Finance or Acting Director of Finance in their absence) will be the named Executor of the Agreement.

n) To approve the Director of Finance to manage the agreement.

o) To approve two of the following post holders to authorise any utilisation request (drawdowns of the loan will be approved by 2 members of the existing bank signatories).

One or two of the following:
- Director of Finance or Acting Director of Finance in their absence
- Deputy Director of Finance
- Head of Financial Services
- Treasury Accountant
- Head of Financial Management

Only one of the following may sign the request:
- Business Partner

p) The Key Contact is the Head of Financial Services.
Appendix 2

SCHEDULE 8: ADDITIONAL TERMS AND CONDITIONS

1. Surplus/Deficit and Capital Limits
1.1. The Lender has set a Surplus/Deficit Limit and/or a Capital Limit for the Borrower in consultation with the relevant Supervisory Body.
1.2. The Borrower understands and accepts these Limits in the recognition that any net expenditure in excess of the relevant Limit(s) cannot be funded by the Lender based upon the assumptions made by the Lender at the date of this Agreement.
1.3. The Borrower undertakes not to put forward any Utilisation Requests on this or any other Facility with the Lender that would result in Limits being exceeded by the Borrower without the explicit agreement of the Lender.
1.4. In the event that a utilisation is likely to lead to a Limit being exceeded, the Borrower shall inform the Lender two calendar months before any such utilisation may be submitted.
1.5. The Borrower will make no assumptions in any financial planning in relation to any financial support from the Lender beyond financing previously agreed to support the relevant Limit(s).
1.6. Limits may be adjusted by the Lender from time to time in consultation with the relevant Supervisory Body.
1.7. Performance against Limits will be monitored by the relevant Supervisory Body.

2. Nursing agency expenditure:
2.1. The Borrower undertakes to comply with nursing agency spending rules as set out in the letter of 1 September 2015 from David Bennett and Robert Alexander to NHS Foundation Trust and Trust Chief Executives as may be updated from time to time. In particular, the Borrower undertakes to:
   2.1.1. Procure all nursing agency staff through approved frameworks unless such action is otherwise authorised by the relevant Supervisory Body.
   2.1.2. Implement an annual maximum limit for agency nursing expenditure as a percentage of the total nursing staff budget as set out in the letter of 01 September 2015 or as otherwise notified by the relevant Supervisory Body.
   2.1.3. Implement any additional controls as may be required by the relevant Supervisory Body in relation to the planned introduction of price caps.
2.2. The Borrower additionally undertakes to Implement the NHS Employers Five High Impact Actions

3. Professional Services Consultancy Spend
3.1. The Borrower will not enter into any contract for the procurement of professional consultancy services with a value in excess of £50,000 without the prior approval of the relevant Supervisory Body. The value of multiple contracts issued in respect similar Terms of Reference will be aggregated, as though a single contract had been issued, in respect of the application of this clause.

4. VSM Pay Costs
4.1. Where the borrower is authorised as an NHS Foundation Trust, the Borrower will, via the Lender, seek the views of the appropriate Health Minister before making appointments to Boards/Executive Boards where the proposed annual salary exceeds £142,500.
4.2. Where the borrower is not authorised as an NHS Foundation Trust, the Borrower will, via the Lender, seek the approval of the appropriate Health Minister before making appointments to Boards/Executive Boards where the proposed annual salary exceeds £142,500.
4.3. The Borrower undertakes to implement the requirements in respect of the treatment of "off - payroll" workers included in the letter from David Nicholson to Chairs and Chief Executives of 20th August 2012, or any subsequent guidance issued by the Lender.
4.4. The Borrower shall apply the most recently updated version of standard redundancy terms for NHS staff in England to all newly appointed VSMs except where existing statutory terms take precedence. In addition the Borrower shall apply the most recently updated version of standard redundancy terms for NHS staff in England for existing VSMs where Section 16 is referenced in their contracts of employment.
5. Estate Costs
5.1. The Borrower undertakes to examine the overall running costs of Estates and Facilities against a benchmark group of similar NHS Trusts within 3 months from the date of this Agreement. Where higher than average costs are identified, and there is no valid reason for this, the Borrower will put in place an action plan to reduce these costs to match the agreed benchmark level. DH will need to satisfy itself that the benchmark is reasonable and plan is deliverable.

6. Surplus Land
6.1. The Borrower shall ensure that it has in place an up to date estates strategy covering a period at least 3 years from the date of this Agreement. The estates strategy should be informed by discussions with commissioners about clinical service requirements and consider options for rationalising the estate and releasing surplus land.
6.2. The report required in clause 6.1 shall identify surplus land and potentially surplus land to be released during the period from the date of this Agreement date to 31 March 2020.
6.3. The Borrower shall provide the Lender with a copy of its estate strategy within 6 weeks of the date of this Agreement or at a date otherwise agreed with the Lender. The Lender will need satisfy itself that the strategy is complete and deliverable for this condition to be satisfied.

7. Procure21
7.1. The Borrower will use the P21+ Procurement Framework for all publicly funded capital works, unless otherwise agreed with the relevant Supervisory Body.
7.2. Where the Borrower proposes to use an alternative procurement route, the Borrower will submit a business case to the relevant Supervisory Body for approval demonstrating that an alternative procurement route offers better Value for Money than the P21+ Procurement Framework.

8. Finance and Accounting and Payroll
8.1. The Borrower undertakes to commission NHS Shared Business Services to complete a baseline assessment of the Borrower’s finance and accounting and payroll services to assess the benefit of the use, or increased use, of an outsourced service provider. The Borrower will provide full details of the outcome of this assessment to the Lender within 6 Months of the date of this Agreement.
8.2. Where the assessment by NHS Shared Business Services supports the case for the use, or increased use, of an outsourced service provider, the Borrower will undertake an appropriate market testing exercise or use existing Government Framework Agreements to procure an outsourced service provider within a timescale to be agreed with the Lender.

9. Bank Staffing
9.1. The Borrower will undertake an assessment using the appropriate tool kit published on the NHS Centre for Procurement Efficiency to assess the benefit of the use, or increased use of an Outsourced Staff Bank provider. The Borrower commits to provide full details of the outcome of this assessment to the Lender within 6 Months of the date of this Agreement.
9.2. Where an assessment using the appropriate tool kit published on the NHS Centre for Procurement Efficiency supports the case for the use of Outsourced Staff Bank provider, the Borrower will undertake an appropriate market testing exercise or use an existing Government Framework Agreement to procure an Outsourced Staff Bank provider within a timescale to be agreed with the Lender.

10. Procurement
10.1. The Borrower shall provide third party non-pay spend to the lender in a format specified by the Lender, within 6 months of the date of this Agreement, and at least annually thereafter, on the request of the Lender.
10.2. The Borrower shall test the savings opportunities of increasing usage of the NHS Supply Chain and future editions and/or replacements of the NHS Catalogue within 6 months of the date of this Agreement and at least annually thereafter, on the request of the Lender.
10.3. Any savings identified through the process set out in 10.2 will be pursued by the Borrower. Any identified savings which the Borrower does not intend to pursue must be notified to the Lender along with the reasons for not doing so.
10.4. The Borrower will provide the Lender with current copies of its medical capital equipment asset register, medical equipment maintenance schedule, and capital medical equipment procurement plans within 6 months of the date of this Agreement, and at least annually thereafter on the request of the Lender.

11. Crown Commercial Services (“CCS”)
11.1. The Borrower undertakes to test the scope of savings opportunities from CCS within 6 months of the date of this Agreement, subject to appropriate CCS resources being available to support this undertaking. Any savings identified as part of this process which the Borrower does not intend to pursue must be notified to the Lender with the reasons for not doing so.
11.2. The Borrower additionally undertakes to provide details of its relevant requirements in support of all future collaborative procurements including e-auctions.

12. EEA and non-EEA Patient Costs Reporting
12.1. The Borrower undertakes to:
12.1.1. Become a member of the EEA portal and actively report EHIC and S2 patient activity on the portal
12.1.2. Provide an overview of the patient identification, billing and costs recovery systems in place with any planned improvements (for EEA and non-EEA patients)
12.1.3. Participate and collaborate with local/national commissioners in the development of the new “risk sharing” model for non-EEA chargeable patients.

13. On request of the Lender, the Borrower agrees to provide timely information and enable appropriate access to parties acting on behalf of the Lender for the purposes of appropriate tracking and reporting of progress delivering the conditions set out within this Schedule.
**BOARD OF DIRECTORS:**

<table>
<thead>
<tr>
<th>AGENDA ITEM:</th>
<th>22nd DECEMBER 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUBJECT:</td>
<td>WELL-LED IMPROVEMENT PLAN</td>
</tr>
</tbody>
</table>
| RESPONSIBLE DIRECTOR: | Fiona Wise  
Chief Executive |
| AUTHOR:     | Philip King  
Director of Integrated Governance |
| PREVIOUSLY CONSIDERED BY: | N/A |

**EXECUTIVE SUMMARY:**

The Board of Directors is presented with the monthly update against the Well-Led Action Plan.

**ACTION REQUIRED BY THE BOARD OF DIRECTORS**

The report is for INFORMATION and the Board is asked to NOTE the contents of the report.

**RISK TO THE TRUST**
(Include reference to BAF or Corporate Risk Register)

| N/A |

**INCLUSION AND DIVERSITY**

| Items sited within this report refer to services aimed at supporting inclusion |

**WORKFORCE ISSUES:**
(包括 training and education implications)

| Not applicable for this paper |

**FINANCIAL IMPLICATIONS:**
Specify No/Yes (Detailed within the report).

| Not applicable for this paper |

**COMMUNICATION/CONSULTATION ISSUES**
(包括 patient and public involvement)

| Not applicable for this paper |

**STRATEGIC OBJECTIVE:**
(specify trust strategic objective)

| Not applicable for this paper |

**CQC DOMAINS:**

- safe.
- effective.
- caring.
- responsive to people’s needs.
- well-led

Please indicate which domain the report is providing assurance on

| Well-Led |
WELL LED ACTION PLAN

1. INTRODUCTION

This paper serves as an update to the Board of Directors on the Well Led Action Plan following an update to the Executive Team on the 30 January 2018. Further to discussion between the Interim CEO, the Interim Director of Integrated Governance and the NHSI Improvement Director, the well led action plan has been updated (please see attachment).

Jenna Davies will take over as Interim Director of Integrated Governance from the beginning of February 2018. Angela Helleur has agreed to oversee the Well Led plan and to lend support during the transition process.

2. WORK IN PROGRESS

Much work has been achieved in terms of the Trust progress in being well led. This plan represents actions that either in train or which need to be continued. Some of the items require key discussion and consideration by the Executive Team. Other items are settled but require further work to achieve. In summary these are:

i. Define the Trust’s plans and strategic objectives for 18/19 (contingent on planning guidance).
ii. Define BAF and synchronise this with Trust’s objectives and the items on the corporate risk register that are pertinent to same.
iii. Develop and agree transitional arrangements from CBU’s to divisions.
iv. Agree any supporting frameworks for transitional arrangements.
v. Appoint to two substantive executive posts (Integrated Governance and Corporate services).
vi. Finalise Board sub-committee details.
vii. Organisational development support for divisional leadership teams.
viii. Bring SFIs and Scheme of Delegation together into a single decision making framework.
ix. Automated dashboard for quality and governance information.

3. RECOMMENDATION

The Board is asked to note and discuss contents and any issues that arise.

PHILIP KING
INTERIM DIRECTOR OF INTEGRATED GOVERNANCE
<table>
<thead>
<tr>
<th>Reference</th>
<th>Actions</th>
<th>Exec Lead</th>
<th>Action Owner</th>
<th>Recommended by</th>
<th>Target date for commencement of planned action</th>
<th>Target date for completion of planned action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Produce a committee structure, including details of purpose, expected outputs, members, frequency, ensuring these details are reflected in the existing or new Terms of Reference for each committee.</td>
<td>Director of Governance</td>
<td>Trust Secretary</td>
<td>NHSI 3.7 and 3.9 / PwC 11 / 28</td>
<td>12 October 2017</td>
<td>28 February 2018</td>
</tr>
<tr>
<td>2</td>
<td>Review and revise Risk Strategy</td>
<td>Director of Governance</td>
<td>Dep Dir of Gov</td>
<td>NHSI 3.4 / PwC 20</td>
<td>01 December 2017</td>
<td>28 February 2018</td>
</tr>
<tr>
<td>3</td>
<td>Move towards phase out of Risk Management Steering Group into task and finish group.</td>
<td>Director of Governance</td>
<td>Exec Team</td>
<td>NHSI 3.4 / PwC 20</td>
<td>01 April 2018</td>
<td>28 February 2018</td>
</tr>
<tr>
<td>4</td>
<td>Move risk registers onto Datix</td>
<td>Director of Governance</td>
<td>Risk Manager</td>
<td>PwC 29</td>
<td>01 September 2017</td>
<td>30 September 2017</td>
</tr>
<tr>
<td>5</td>
<td>Develop shared and agreed risk appetite</td>
<td>Director of Governance</td>
<td>Exec Team</td>
<td>NHSI 3.2</td>
<td>01 January 2018</td>
<td>01 March 2018</td>
</tr>
<tr>
<td>6</td>
<td>Develop a robust training programme to support staff to use Datix</td>
<td>Director of Governance</td>
<td>Risk Manager</td>
<td>NHSI 3.3</td>
<td>30 June 2017</td>
<td>30 September 2017</td>
</tr>
<tr>
<td>7</td>
<td>Arrange training sessions for staff to attend</td>
<td>Director of Governance</td>
<td>Risk Manager</td>
<td>NHSI 3.3</td>
<td>30 June 2017</td>
<td>30 June 2017</td>
</tr>
<tr>
<td>8</td>
<td>Hold training sessions for staff</td>
<td>Director of Governance</td>
<td>Risk Manager</td>
<td>NHSI 3.3</td>
<td>30 June 2017</td>
<td>30 December 2017</td>
</tr>
<tr>
<td>9</td>
<td>Invest and produce live DATIX reporting</td>
<td>Director of Governance</td>
<td>Risk Manager</td>
<td>PwC 29 / 31</td>
<td>01 September 2017</td>
<td>01 February 2018</td>
</tr>
<tr>
<td>10</td>
<td>Draft and consult on CBU/Divisional structure</td>
<td>CEO</td>
<td>CEO</td>
<td>NHSI 1.2</td>
<td>01 October 2018</td>
<td>31 December 2018</td>
</tr>
<tr>
<td>11</td>
<td>Divisions to become operational, including transitional arrangements.</td>
<td>CEO</td>
<td>Exec Team</td>
<td>PwC 24</td>
<td>01 April 2018</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Create a meeting schedule according to when required information is available (i.e. meeting a week after month end if financial information is required) building in appropriate time to allow for papers to be provided at a minimum 24 hours in advance)</td>
<td>Director of Governance</td>
<td>Director of Governance</td>
<td>NHSI 3.7</td>
<td>31 December 2017</td>
<td>01 April 2018</td>
</tr>
<tr>
<td>13</td>
<td>Update Terms of Reference to include dates of meeting and details of releasing of papers in advance of the meeting</td>
<td>Director of Governance</td>
<td>Trust Secretary</td>
<td>PwC 24</td>
<td>31 December 2017</td>
<td>01 April 2018</td>
</tr>
<tr>
<td>14</td>
<td>Diarise all meetings for the next 12 months</td>
<td>Director of Governance</td>
<td>Trust Secretary</td>
<td>PwC 24</td>
<td>31 December 2017</td>
<td>01 April 2018</td>
</tr>
<tr>
<td>15</td>
<td>TMC to become OMG</td>
<td>Chief Operating Officer</td>
<td>COO</td>
<td>PwC 13</td>
<td>02 January 2018</td>
<td>01 April 2018</td>
</tr>
<tr>
<td>16</td>
<td>OMG TORs to be drafted</td>
<td>Chief Operating Officer</td>
<td>COO</td>
<td>PwC 15</td>
<td>02 January 2018</td>
<td>31 March 2018</td>
</tr>
<tr>
<td>17</td>
<td>Exec Team Meeting to become main trust decision making body for operational matters )</td>
<td>Chief Executive</td>
<td>Exec Team</td>
<td>PwC 15</td>
<td>01 April 2018</td>
<td>01 April 2018</td>
</tr>
<tr>
<td>18</td>
<td>Integrated performance and quality to be drafted into performance meetings for Divisions</td>
<td>Director of Governance</td>
<td>Director of Governance</td>
<td>PwC 15</td>
<td>01 January 2018</td>
<td>01 April 2018</td>
</tr>
<tr>
<td>19</td>
<td>TORs for Exec Meeting to be drafted</td>
<td>Director of Governance</td>
<td>CEO</td>
<td>PwC 15</td>
<td>01 January 2018</td>
<td>01 April 2018</td>
</tr>
<tr>
<td>20</td>
<td>Paperless Board solution to be sourced</td>
<td>Director of Governance</td>
<td>Trust Secretary</td>
<td>PwC 25</td>
<td>01 September 2017</td>
<td>31 December 2017</td>
</tr>
<tr>
<td></td>
<td>WELL LED REVIEW ACTION PLAN</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>21</td>
<td>Train and implement on paperless Board</td>
<td>Director of Governance</td>
<td>Trust Secretary</td>
<td>PwC 25</td>
<td>01 January 2018</td>
<td>31 March 2018</td>
</tr>
<tr>
<td>22</td>
<td>Scope automated quality reporting to sit along side performance and workforce reporting</td>
<td>Director of Governance &amp; Director of Finance</td>
<td>Director of Governance &amp; Director of Finance</td>
<td>PwC 17</td>
<td>02 January 2018</td>
<td>31 January 2018</td>
</tr>
<tr>
<td>23</td>
<td>Bring proposals to ET</td>
<td>Director of Governance &amp; Director of Finance</td>
<td>Director of Governance &amp; Director of Finance</td>
<td>PwC 17</td>
<td>31 January 2018</td>
<td>28 February 2018</td>
</tr>
<tr>
<td>24</td>
<td>Implement solutions</td>
<td>Director of Governance &amp; Director of Finance</td>
<td>Director of Governance &amp; Director of Finance</td>
<td>PwC 17</td>
<td>01 February 2018</td>
<td>31 March 2018</td>
</tr>
<tr>
<td>25</td>
<td>Develop a standardised template performance report for CBU's</td>
<td>Chief Operating Officer</td>
<td>COO</td>
<td>PwC 17</td>
<td>01 January 2018</td>
<td>01 April 2018</td>
</tr>
<tr>
<td>26</td>
<td>Review CBU objectives and Board level performance reporting and ensure CBU performance reporting is in line.</td>
<td>Chief Operating Officer</td>
<td>COO</td>
<td>PwC 17</td>
<td>01 January 2018</td>
<td>01 April 2018</td>
</tr>
<tr>
<td>27</td>
<td>Circulate performance report to the board and CBU leadership/deputies for review or comment</td>
<td>Chief Operating Officer</td>
<td>COO</td>
<td>PwC 17</td>
<td>01 January 2018</td>
<td>01 April 2018</td>
</tr>
<tr>
<td>28</td>
<td>Implement performance report</td>
<td>Chief Operating Officer</td>
<td>COO</td>
<td>PwC 17</td>
<td>01 January 2018</td>
<td>01 April 2018</td>
</tr>
<tr>
<td>29</td>
<td>Develop a governance 'toolkit' for CBU's including standard terms of reference, agendas, action tracking templates, minute taking templates, exception reporting templates for governance meetings (see documents created in actions above)</td>
<td>Director of Governance &amp; Chief Operating Officer</td>
<td>Dir of Gov &amp; COO</td>
<td>NHSI 1.3/ PwC 26</td>
<td>28 February 2018</td>
<td>30 April 2018</td>
</tr>
<tr>
<td>30</td>
<td>Monitor quarterly the use of toolkit, review and update for feedback obtained</td>
<td>Director of Governance</td>
<td>Director of Governance</td>
<td>NHSI 1.3</td>
<td>01 April 2018</td>
<td>31 December 2018</td>
</tr>
<tr>
<td>31</td>
<td>Develop a decision making and accountability framework document</td>
<td>Director of Governance</td>
<td>Director of Governance</td>
<td>NHSI 3.5 / PwC 12</td>
<td>01 February 2018</td>
<td>31 March 2018</td>
</tr>
<tr>
<td>32</td>
<td>Implementation/circulation of decision making framework</td>
<td>Director of Governance</td>
<td>Director of Governance</td>
<td>NHSI 3.5 / PwC 12</td>
<td>01 March 2018</td>
<td>30 April 2018</td>
</tr>
<tr>
<td>33</td>
<td>Develop shared learning systems through existing work on through SIs, Mortality, etc., to become part of integrated quality reporting through automation</td>
<td>Medical Director &amp; Director of Nursing</td>
<td>Medical Director/DoN</td>
<td>NHSI 3.6</td>
<td>01 February 2018</td>
<td>01 April 2018</td>
</tr>
<tr>
<td>34</td>
<td>Bring Safety reporting, staff and patient experience as key limbs of the business of the Quality and Safety Committee</td>
<td>Medical Director &amp; Director of Nursing</td>
<td>Medical Director/DoN</td>
<td>NHSI 3.6</td>
<td>01 February 2018</td>
<td>01 April 2018</td>
</tr>
<tr>
<td>35</td>
<td>Gap analysis in relation to NHSI Well-Led framework</td>
<td>Chief Executive</td>
<td>Angela Helleur</td>
<td>NHSI 4.4/ PwC 3 and 4</td>
<td>02/02/2018</td>
<td>01/04/2018</td>
</tr>
<tr>
<td>36</td>
<td>Review and define executive capacity</td>
<td>Chief Executive</td>
<td>Executive Directors</td>
<td>NHSI 4.4/ PwC 3 and 4</td>
<td>30 September 2017</td>
<td>31 December 2017</td>
</tr>
<tr>
<td>37</td>
<td>Reassign Strategy and Transformation into Finance Exec Portfolio</td>
<td>Chief Executive</td>
<td>CEO/Executive Directors</td>
<td>NHSI 4.4/ PwC 3 and 4</td>
<td>30 September 2018</td>
<td>28 February 2018</td>
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<td>38</td>
<td>Appoint Chair</td>
<td>Chief Executive</td>
<td>NHSI</td>
<td>PwC 2</td>
<td>01 July 2017</td>
<td>01 September 2017</td>
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<td>39</td>
<td>Implement Board development programme</td>
<td>Chief Executive/Chair</td>
<td>Chair and Trust Board</td>
<td>PwC 1</td>
<td>01 September 2017</td>
<td>31 March 2018</td>
</tr>
<tr>
<td>40</td>
<td>Board to identify and develop the strategic objectives for 2018-2019</td>
<td>Chief Executive/Chair</td>
<td>Executive and NED</td>
<td>PwC 30 / NHSI 3.2</td>
<td>02 February 2018</td>
<td>31 March 2018</td>
</tr>
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### WELL LED REVIEW ACTION PLAN

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsible</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review the BAF and ensure it is aligned to the Trust's strategic priorities and corporate risk register.</td>
<td>Director of Governance</td>
<td>01 December 2017</td>
</tr>
<tr>
<td>Develop new BAF for 2018/19</td>
<td>CEO</td>
<td>02 February 2018</td>
</tr>
<tr>
<td>Put in train arrangements to appointment two sub-director posts in relation to corporate services</td>
<td>Director of HR</td>
<td>01 February 2018</td>
</tr>
<tr>
<td>Develop a Divisional support programme for Division leadership focusing on identified areas of development, specifically understanding of governance</td>
<td>Director of HR</td>
<td>01 February 2018</td>
</tr>
<tr>
<td>Recruit the posts for Divisional Leadership</td>
<td>Director of HR</td>
<td>01 February 2018</td>
</tr>
<tr>
<td>Once transitional and permanent arrangements for CBU restructure implementation agreed, develop and roll out communication plan</td>
<td>Director of HR</td>
<td>01 February 2018</td>
</tr>
</tbody>
</table>
## TRUST BOARD

**AGENDA ITEM:** 5.3

**SUBJECT:** BOARD ASSURANCE FRAMEWORK (BAF) DEVELOPMENT

**RESPONSIBLE MANAGER/DIRECTOR:** Philip King
Interim Director of Integrated Governance

**AUTHOR:** Susan Clennett
Deputy Director of Integrated Governance

**PREVIOUSLY CONSIDERED BY:** The Corporate Risk Register (CRR) that informs this report was considered by the Quality and Safety Committee on 23rd January 2018.

**EXECUTIVE SUMMARY:**

The development of the BAF is detailed in the attached report. Pending review of the organisation’s 2018/19 strategic objectives, the current impact of corporate risks against the BAF and 2017/18 strategic objectives is detailed at Appendix 1.

Management of corporate risks and the allocation of oversight by sub-committees of the Board are detailed in the attached report.

**ACTION REQUIRED:** That the Board considers how assured it is that progress towards defining the BAF is in line with timescales previously agreed and that the allocation of risk management responsibilities to the sub-committees of the Board is appropriate.

**RISK TO THE TRUST (include reference to BAF or Corporate Risk Register)**

BAF and CRR as detailed within the attached report.

**WORKFORCE ISSUES:**

As detailed within the BAF and CRR.

**DIVERSITY & INCLUSION**

N/A

**FINANCIAL IMPLICATIONS:**

As detailed within the BAF and CRR.

**COMMUNICATION/CONSULTATION ISSUES**

All CBU governance groups assess risks and review risk registers on a monthly basis. The Risk Management Steering Group has significant risks escalated to it for inclusion in the CRR. The corporate risks are reviewed on a monthly basis by executive leads.

**STRATEGIC OBJECTIVE:**

Well led
Safe

**CQC DOMAINS**

- safe.
- effective.
- caring.
- responsive to people’s needs.
- well-led

Please indicate which domain the report is providing assurance on

All
BOARD ASSURANCE FRAMEWORK (BAF) DEVELOPMENT

1. INTRODUCTION

The Board Assurance Framework (BAF) is attached indicating the last comprehensive review in August 2017, together with those associated risks contained within the Corporate Risk Register (CRR) as at 18th January 2018 (see Appendix 1).

The BAF will be the subject of a full review against the 2018/19 strategic objectives, once determined by the Board. Developmental discussions in relation to the BAF took place at the Board Development Day in October 2017. At that time, the Board agreed that the first tranche of development of the BAF would be to link corporate risks to the current strategic objectives and BAF risks as indicated in August 2017.

The Trust awaits the Planning Guidance for 2018/19 before setting its Strategic Objectives. Following this, the Chief Executive Officer will lead on defining the new BAF during quarter 4 in order to enable the Board to assess risks against achieving the 2018/19 strategic objectives (also to be agreed during quarter 4). The Deputy Director of Integrated Governance will support the Executive Team to formulate and review the BAF, together with determining its risk appetite against the newly agreed objectives.

During December 2017, the CQC indicated that they were considering placing a Section 31 Order of the Health and Social Care Act 2008 due to concerns about how the Trust was identifying and managing risks associated with the backlog of radiology reporting. A response was sent to the CQC detailing how the Trust had established a Radiology Executive Action Group to manage and reduce identified risks. The CQC were satisfied at a level to enable them to withdraw the threat of a potential Section 31 Order. As the risk was mitigated within 48 hours of the CQC letter, a risk assessment in relation to the potential Section 31 Order was not undertaken.

2. RISK MANAGEMENT AND ASSURANCE FRAMEWORK

Sub-committees of the Board namely, Quality and Safety, Performance Finance and Resource and Workforce Development Committees have had the current BAF divided up for ease of scrutiny and discussion at each meeting during January and February 2018.

Quality and Safety Committee

BAF risks are detailed at Appendix 1 and BAF risks numbers 8 and 9 have been allocated to the Committee.

Management of risks over past 12 months:

A number of risks were added to the CRR upon receipt of the CQC report in early 2017 and then specifically risks that related to the CQC Section 29a warning notice. All risks that were related to the warning notice were addressed and further actions to reduce and mitigate the risks were completed. Those risks that had been on the CRR were subsequently removed but are now being actively monitored by the CBU where the risk pertained to. Ambulance handover and 15 minute assessments in A&E, which were also CQC concerns are still being monitored on the CRR. Further actions to reduce the risk is still ongoing and on target to complete.
Fire safety was last discussed at Risk Management Steering Group (RMSG) in January 2018. There was a view that the risk score should be reduced to 12 and risk removed from CRR, but it remained at 20 as a result of the assessment that other risks relating to ward fire safety needed to be taken into consideration.

Further controls towards reducing the impact from violence and aggression towards staff is nearing completion and the risk can then be reviewed as a result. Additionally work to reduce the impact from lack of assurance around escalation of safety alerts is due for completion at the end of January 2018 and the risk will be reviewed and re-scored accordingly.

The ‘Boarded patients’ risk was originally considered and added to the CRR in May 2017, due to escalation of incidents occurring. By October 2017 this had significantly reduced and the risk was reviewed and re-scored to 12, but remained on the CBU Medicine Risk Register for monitoring and review. Due to high activity in December 2017 and increasing numbers of boarded patient incidents it was felt that the risk should be reviewed and score was increased to 16 to reflect increased risk to patient safety and subsequently placed back on the CRR.

A risk that had related to the management of quality at Claremont was discussed at December 2017 RMSG and it was agreed that the score could be changed from 16 to 12 and the risk be retained on the CBU Medicine Risk Register for further monitoring.

**Performance, Finance and Resource Committee**

BAF risks are detailed at Appendix 1 and BAF risks numbers 1, 2, 3, and 10 have been allocated to the Committee.

**Management of risks over past 12 months**

RTT risks were identified in April 2015 and placed on the CRR with a score of 16. Ongoing mitigations to reduce the risk included a return to reporting in February 2017. In terms of RTT management, data quality meetings and assurance and validation reports, together with a training strategy were to be in place by December 2017. This date was revised in January 2018 following review of risk with the Executive Lead and the adjusted target date is March 2018, predominantly as a result of continued high activity.

A corporate risk relating to a lack of agreement with the CCG in relation to finance associated with DTOC and re-admission was originally considered and added to the CRR in May 2017. By September 2017 this had significantly reduced and the risk was reviewed and removed as the issue had been resolved.

Risks relating to opening of escalation areas were considered at RMSG in January 2018 due to high demand and remains on the CRR. A risk relating to the use of Interventional Radiology as a temporary discharge lounge was added to the CRR during early January 2018 but was removed when this activity ceased and the risk no longer presented as an issue.

In terms of cash flow within the organisation, this risk has increased during quarter 3 from a high risk to significant and will enter the CRR following RMSG in early February 2018.
Workforce Development Committee

BAF risks are detailed at Appendix 1 and BAF risk 7 has been allocated to the Committee.

Management of risks over past 12 months

During October 2017 RMSG considered risks relating to medical staffing within the Medicine and Specialty Medicine CBUs and this was aggregated to inform a corporate risk against achievement of the 7 Day Service plans.

The impact in tax law changes (IR35) was placed on the CRR for a short period of time because the impact on availability of medical locum staff was unknown. However, the impact was minimal and this was reassessed and the risk closed as fully mitigated.

In terms of staffing level risks across the organisation in CBU risk registers that are graded as moderate and high, collectively this risk has been recognised and will be considered for the CRR at the next RMSG in early February 2018.

3. RECOMMENDATION

That the Board considers how assured it is that progress towards defining the BAF is in line with timescales previously agreed and that the allocation of risk management responsibilities to the sub-committees of the Board is appropriate.

SUSAN CLENNETT
DEPUTY DIRECTOR OF INTEGRATED GOVERNANCE

26TH JANUARY 2018
<table>
<thead>
<tr>
<th>No</th>
<th>BAF Risk Description: August 2017</th>
<th>Potential Strategic Objective Impacted</th>
<th>Risk Rating Aug 2017</th>
<th>Associated Corporate Risks as at January 2018 and individual risk score</th>
<th>Jan 18 CRR Impact Rating on BAF</th>
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<tbody>
<tr>
<td>1</td>
<td>Failure to recover the referral to treatment position</td>
<td>1</td>
<td>16</td>
<td>Quality of reporting ability and effective reporting on RTT waiting times (16) Number of patients waiting over 52 weeks (16)</td>
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<tr>
<td>2</td>
<td>Effective management of demand and reduced transfers of care</td>
<td>1</td>
<td>25</td>
<td>Boarded patients (16), Use of escalation areas (20) Out of hours nurse staffing levels during escalation (20) Sustaining 4 hour transit time performance (16) Achievement of 7 day service by 2020 (16)</td>
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<tr>
<td>3</td>
<td>Failure to deliver financial plan for 2017/18</td>
<td>4</td>
<td>20</td>
<td>Failure to sustain financial sustainability (20)</td>
<td>20</td>
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<tr>
<td>4</td>
<td>Failure to maintain estates and its infrastructure</td>
<td>1, 3</td>
<td>20</td>
<td>Safe management of medical devices (16), Facet survey findings: aged wiring (20) Theatres ventilation system (20), Fire safety and management (16)</td>
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<tr>
<td>5</td>
<td>Inadequate Information Systems/Data Quality</td>
<td>2, 4</td>
<td>20</td>
<td>Accuracy of RTT reporting (16), A&amp;E patient record management (16) Information asset register re paper and electronic patient records (16) PACS reporting timescales (20) Medicines management – electronic prescribing (16)</td>
<td>20</td>
</tr>
<tr>
<td>6</td>
<td>Impact on Delayed Transfers of Care with outside partners</td>
<td>2</td>
<td>20</td>
<td>Not currently linked with CRR</td>
<td>20</td>
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<tr>
<td>7</td>
<td>Workforce challenges relating to recruitment and Retention of staff</td>
<td>1, 3, 4</td>
<td>16</td>
<td>A&amp;E nurse staffing level (16), Cardiac Centre nurse staffing level (16) Oncology capacity (20), OOH nurse staffing level sustainability (16) 7 Day Service by 2020 (16), Bank and agency staffing costs (20) Safeguarding referrals/safeguarding staff capacity (16)</td>
<td>20</td>
</tr>
<tr>
<td>8</td>
<td>Failure to implement commitments in the Quality Strategy</td>
<td>1</td>
<td>20</td>
<td>Compliance with medicines management standards (16) Policy management (outstanding reviews/updates) (16)</td>
<td>20</td>
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<tr>
<td>9</td>
<td>Outcome from CQC rating and Section 29A warning notice</td>
<td>1</td>
<td>20</td>
<td>Compliance with medicines management standards (16) Assurance on safety alert system (16), Paediatric radiology reporting (20) Stat and mand training compliance (20) Paediatric A&amp;E capacity demands (16) Management of violence and aggression (16), Fire safety (16) Ambulance handover performance (16) Compliance with 15 minute assessments within A&amp;E (16)</td>
<td>20</td>
</tr>
<tr>
<td>10</td>
<td>Financial impact from borrowing and repayment requirements of Trust</td>
<td>4</td>
<td>20</td>
<td>CRR risk linked with this removed during 2017/18 as mitigated to a reduced level of risk.</td>
<td>High Risk</td>
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</table>

### 2017/18 STRATEGIC OBJECTIVES

1. To provide high quality care to individuals, communities and the population we serve
2. To be a strong and effective partner in the wider health and social care community
3. To maintain a fulfilling and developmental working environment for our staff
4. To be a clinically and financially sustainable organisation
AGENDA ITEM 6.2 (a)

TITLE INTEGRATED GOVERNANCE COMMITTEE

DATE OF COMMITTEE MEETING 19th December 2017

REPORT OF Chair of Committee

PREPARED BY AND CONTACT DETAILS Chair of Committee

<table>
<thead>
<tr>
<th>STATUS OF REPORT</th>
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<th>Private</th>
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<tr>
<td></td>
<td>X</td>
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<table>
<thead>
<tr>
<th>PURPOSE OF REPORT</th>
<th>For Decision</th>
<th>For Assurance</th>
<th>For information</th>
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SUMMARY

The Committee met on 19th December 2017, to discuss items on its agenda, these are drawn from an annual work programme, and any arising issues relevant to its terms of reference, or any matters delegated by the Trust Board. These also relate to the Board Assurance Framework and to CQC action Plan.

The items on the agenda that were considered:

- Safer Maternity Care
- Trust wide Quality assurance
- Radiology and the position regarding CQC
- National Reports and External Views
- Quality Strategy Update
- Compliance with the target for Discharge Letters
- Serious Incident Update
- Corporate risk register
- Consideration of the reports from the committees and groups that report into Integrated Governance Committee:
  - These Include, Quality Governance Steering Group, Health and Safety Steering Group,
  - Risk Management Group, Patient Experience Group, and Safeguarding Group

KEY AREAS FOR DISCUSSION ARISING FROM THESE ITEMS WERE;

- The Safer Maternity Care, The National Safety Strategy, recently released. A huge mapping exercises in progress to review the work and standards involved and to undertake risk assessments
- Agreed decisions include presenting the update to the Board of Directors monthly, and including this work on the committee agenda
- Trust wide Quality Assurance, the dashboard highlighted a dip in performance around complaints, this was discussed. A new plan to deliver an improved performance required and will be presented to the committee, an update at the next committee about timing this.

Serious Incidents were discussed, issues raised about a particular matter in Breast Screening. A question raised was taken on board by CEO and escalated to Trust Chair, further conversations outside of the meeting gave additional assurance to The Chair of the Committee about the handling of this. Assurance was also given in terms of the upward reporting of those 5 Serious Incidents the committee was made aware of. It is noted that within the minutes of the health and safety committee, the Identification of serious risk is receiving a higher profile.

The decision taken was that the IGC Committee would receive regular performance reports about Serious Incidents but the Executive would provide an ad hoc briefing based upon making sure the committee was updated and should any incident involve more than one patient.

- Compliance with National Audits and Confidential Enquiries, 87% of National Clinical Audit (60) e.g. National Audit on Falls.100% of National Enquiries (8), so far this year. Full details in Clinical Effectiveness report and Trusts Quality Account. The Trust Report Highlights some success, which has a positive impact on patient Care and outcomes and areas for improvement, through learning from best practice, for example in Pain Control

- Compliance with Discharge Letters, although improvements have been made since 2016 from the evidence presented it does not appear to be sustained. The action plan appeared weak. It was recognised that the CBUs will have an impact on this.

The decision was to include this on the work programme of this or any subsequent committee and to review plans once CBUS are fully up and running.

- Radiology Position was discussed and letters to and from CQC noted

- Quality Strategy is still in progress and in January will be shared through engagement in the Trust groups committees and for a. There is concern with the time this is taking.

- Care Quality Commission update was received, the amount of work to meet the deadlines for further information was acknowledged. The Quality Improvement Plan was discussed and challenge made to those areas identified as overdue, Sustainability of change is the focus through engagement groups and communication as part of the work on Culture

- The Risk register was discussed, it had been considered at the Risk Management Steering Group and their minutes highlight the emerging risks for example The Environmental issues and GDPR which can be seen to have made it on to the corporate risk register. The decision was that future reports would be a highlight report and a summary of where risks had increased or decreased. The Executive would be discussing the development of a proposal around risk appetite to be presented at the 2\textsuperscript{nd} February 2018 Board meeting.
**ISSUES OR ITEMS THAT REQUIRE FURTHER ATTENTION OR ESCALATION WERE AS FOLLOWS:**

- The Breast Screening discussion which was escalated and dealt with, and assurance given through Board discussion.

<table>
<thead>
<tr>
<th>RECOMMENDATION</th>
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<tbody>
<tr>
<td>To <strong>RECEIVE</strong> and <strong>NOTE</strong> the minutes of the Integrated Governance Committee</td>
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<table>
<thead>
<tr>
<th>LINKS TO STRATEGIC OBJECTIVES</th>
</tr>
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<tbody>
<tr>
<td>Improve regulatory standing</td>
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<table>
<thead>
<tr>
<th>LINKS TO STRATEGIC AND CLINICAL RISKS</th>
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<table>
<thead>
<tr>
<th>IMPACT</th>
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<tr>
<td>Engagement and Communication</td>
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</tbody>
</table>

**If yes, please give additional information**

The minutes are providing challenge and assurance on operational and finance performance issues reported to the Committee.

<table>
<thead>
<tr>
<th>MINUTES PREVIOUSLY CONSIDERED BY</th>
</tr>
</thead>
<tbody>
<tr>
<td>IGC Committee</td>
</tr>
</tbody>
</table>
1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr A Chilton and Mr C Catterick (post meeting).

2. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting were approved as a true and accurate record.

3. MATTERS ARISING

3.1 Matters Arising: Quality Improvement Plan (minute 3.6 October meeting)

DECISION: Following initial discussions at the October meeting, the Committee requested that a formal letter was sent to the Clinical Commissioning Group to clarify their intentions on the provision of services outside the acute setting for children with mental health problems.

3.2 Trust wide Quality Assurance Dashboard (minute 3.2)

The item regarding the compliance with discharge letters was an item on the agenda for further discussion.

3.3 Quality Improvement Plan (minute 3.3)

Ms Hackshall informed the Committee that all outstanding door repairs across the estate were being addressed.
3.4 Health & Safety Report (minute 3.7)

**DECISION:** To provide an update before the next meeting regarding the progress being made with Northamptonshire Healthcare NHS Foundation Trust regarding the provision of training of staff to deal with violent and aggressive patients.

3.5 Review of Risk Management Strategy (minute 3.8)

**DECISION:** The review of the risk management appetite was outstanding

3.6 Feedback from Non Executive Director meetings (minute 3.10)

The Board of Directors had received all copies of the letters from the Care Quality Commission at the Board of Directors meeting in November 2017.

3.7 Maternity Dashboard (minute 4.2)

The quarterly report to the Committee would include details of all reported avoidable still births and Mrs Madeley would include this in the Committee Work programme for 2018.

**DECISION:** Work Programme for 2018 to include quarterly report on the Maternity Dashboard and include all reported still births.

3.8 Estates & Facilities Report (minute 4.4)

Ms Hackshall reported that any member of staff who attended the Occupational Health Department with a sharp injury will be reminded by Occupational Health to report the incident through the Datix system.

3.9 Live DATIX Dashboard (minute 4.5)

The next Quarterly Incident Report would include the detail regarding the closure of incident investigations and this will be noted in the Committee Work programme.

3.10 Quality Improvement Plan (minute 6.2)

Ms Hackshall reported that all “blue” rated actions within the Quality Improvement Plan were all being reviewed to ensure full implementation.

**DECISION:** Ms Hackshall to make recommendations for deep dive reviews of QIP actions.

3.11 Information Governance Report (minute 5.4)

Mr King reported that the next report to the Committee would include a breakdown of information governance incidents reported and benchmarking data against other organisations in relation to the number of information governance incidents reported.

**DECISION:** Mrs Madeley to include in the Work Programme that the quarterly information governance reports would include benchmarking data in relation to the number of information governance incidents reports.
The risk report submitted to the Audit Committee in October 2017 had been circulated via email on the 15th December 2017.

4. QUALITY GOVERNANCE

4.1 SAFER Maternity Care: The National Maternity Safety Strategy

Mrs Crowson, Head of Midwifery and Business Unit Director for Women & Childrens Clinical Business Unit attended the meeting to present an update report on Safer Maternity Care. Ms Hackshall said that elements of the strategy would be included within the Committee Work Programme and there would be a bi-monthly report presented to the Board of Directors.

Mrs Gray queried the risk level on the number of initiatives to be addressed and implemented and Ms Hackshall said that once the work had been mapped appropriately then the risks would be identified along with the risks associated with workforce. The priorities would then be agreed and a decision taken regarding which information would be presented to the Committee and to the Board of Directors.

Mr Ball stated that this was a very detailed piece of work and the Board would be looking to receive the risks identified for maternity.

DECISION (a) The Committee supported and recognised the work required by Maternity Services to meet the Department of Health National Maternity Safety Strategy.

(b) SAFER Maternity Care would be presented on a bi-monthly basis to the Board of Directors.

(b) SAFER Maternity Care would be presented to the Committee on a regular basis and this would be included within the Work Programme for 2018.

4.2 Trust Wide Quality Assurance Dashboard

Ms Hackshall presented the performance against the quality metrics and reported that the areas of focus during the month had been on improving performance within complaints management and added that changes were being undertaken within the team to address the current performance. The report detailed that the number of complaints completed in line with agreed timescales was 19 against 28 due for November 2017 resulting in 68% performance.

Mr Ramsden queried the dip in performance regarding complaints with Ms Wise responding that complaints had previously been written by two junior members of staff and the draft responses were disjointed. Mr Ramsden said he previously understood that the dip in complaints performance was due to the restructuring process but what was being reported now was that there was a significant problem.

Ms Hackshall said that with a restructure, there were challenges to address in relation to capacity and in addition the team had been completely focused on addressing the Care Quality Commission inspection during the last few months.

Mrs Clennett said that within the next month the Trust would see stabilisation of the complaints performance and process. Mr Ramsden said that position should be reported to the Board of Directors.
It was noted that the Committee would receive the Complaints Improvement Plan at the next meeting of the Committee.

Ms Wise said that currently three people review the complaint responses and the responsibility should lie with the new Divisions and in future, led by the Governance Business Partners.

In respect of medications, the number of near miss incidents had been a focus of attention due to five out of the eight Clinical Business Units failing to meet the 40% trajectory against the metric. In relation to harms caused by medication incidents, Ms Hackshall reported that all incidents were all low harm.

Mr Ramsden highlighted serious incident reporting and queried how the Committee received assurance on the learning from incidents. Ms Hackshall said that there could be a quarterly presentation on incidents, investigations and learning. Ms Wise reported that the Clinical Services incident involved a number of patients (i.e. breast screening) and the other incidents were serious fall within the day to day management of the Trust.

Ms Wise said that the Committee would receive a regular performance report regarding serious incidents but recommended that the Executive would brief the Committee on an ad-hoc basis if the incident was very serious or the incident involved more than 1 patient.

Ms Wise summarised an incident regarding breast screening recall and informed the Committee that through the national screening process, patients had been identified who had to be recalled because of concern regarding their breast screening results. The Trust had seen six patients to date with concern that two patients may have signs of breast cancer. The Radiologist concerned in the cases was now working at Leicester and had since changed their practice. The process was being overseen by the National Quality Assurance Board but the Trust was responsible for the recall of patients. Dr Natarajan said that regular calls had been held with all of the national regulators and the decisions had been discussed regarding the timings of recalling patients. Ms Wise said that she had robustly challenged the process and the clinical advice was that it was the right decision to recall the final cohort of patients after Christmas period.

Ms Wise said that the Medical Director was confirming with clinical advisors if a two week delay would impact on the outcome and was advised that this was not the case. Ms Gray queried if clinicians were advising that a delay would not impact on their treatment then could the patients be told and added that she accepted clinicians were there to advise but queried the Duty of Candour processes.

Mr Ramsden said that clinical advice should not be ignored and said that the Chief Executive should take clinical advice and any issue of further concern should be escalated to the Chairman.

A detailed discussion took place regarding specific scenarios that would involve informing the patients before Christmas and the impact of press interest and the Committee agreed that the Chief Executive would raise the issues highlighted with the Medical Director and escalate to the Chairman for a final decision.

Ms Wise suggested that the Committee needed to agree the priorities for the Committee going forward which would be discussed with the Director of Integrated Governance.

Mr Ball highlighted a “Learning from Deaths” event and reported that on speaking to attendees it was evident that the process in place within the Trust was robust and Mr Ball was assured that the Trust was in a reasonable position.
Dr Natarajan presented the Quarter 2 of the Mortality Dashboard and reported that there had been no avoidable deaths identified within the Trust. Dr Natarajan said that the Sepsis learning theme was top of the list for areas to learn from within Quarter 1 and in Quarter 2 this had reduced due to the Sepsis Nurse and the use of the Sepsis Screening Tool now being in place. The Lessons Learnt Forum had focused on serious incidents and there was a very useful session and in addition the learning was also formally raised at the Morbidity and Mortality meetings at Clinical Business Units.

**DECISION:**

(a) The Committee would receive the Complaints Improvement Plan at the next meeting of the Committee.

(b) The Chief Executive would discuss the Breast Screening Serious Incident with the Executive Team and escalate the concerns of the Non Executive Directors to the Chairman for final decision regarding whether the final cohort of patients should be informed after the Christmas period.

(c) The priorities for the Committee would be discussed with the Director of Integrated Governance to form the Committee Work Programme.

### 4.3 Radiology Position (CQC)

The Committee was informed that on the 16th November 2017, the Trust received a formal request from the Care Quality Commission to provide information regarding potential delays in reporting of diagnostic images along with the formal Trust response.

Ms Wise reported that all harm reviews had been conducted with no adverse outcome.

The letter and response were received and noted.

### 4.4 National Reports and External Reviews

The Committee received a report which provided an annual summary of the following national reports/external reviews received by or relevant to the Trust during 2016/17 and detailed the work which had been undertaken or was underway to meet their requirements.

Mr Ramsden said that he felt the report was very reassuring but queried patient experience and specifically the element of pain control as this appeared to be a theme which was reoccurring. Mrs Gray said that as part of the Quality Strategy, priorities would need to be identified with Mr Ramsden responding that of the three components of quality, the area of patient experience was the one monitored the least.

### 4.5 Quality Strategy

Ms Hackshall provided a verbal update on the progress in relation to the Quality Strategy and reported that the Committee had discussed the Quality Strategy at the development session in November. Dr Chilton and Dr Natarajan had held clinical sessions within the Trust and the next step would be to take the Strategy to the Trust Management Committee in January and then to hold extra-ordinary quality workshops throughout the Trust.

Ms Wise said that she was concerned that the Quality Account for the Trust would need to be drafted sooner to detail the priorities for 2018 before the Quality Strategy would be approved.
4.6 Compliance with Discharge Letters

Mr King presented a report prepared by Fiona Lennon, Deputy Chief Operating Officer, relating to the current performance target of ensuring that 100% of patients discharge summaries were sent to GPs within the agreed 24 hours after discharge.

Mr Ball queried if the action plans would have an impact as addressing this target should have been taking place during the last six months. Mr Ramsden said that there were actions that would require a trustwide system change and were lessons being learnt from where areas addressed change well.

Ms Wise reminded the Committee that there had been a Well Led Review where it had been formally identified that structures and clinical management systems within the Trust were not fit for purpose and added that the Trust was on a a three year journey of improvement which had been acknowledged by the Board with the result being that a restructure of clinical business units had been approved.

Mr Ramsden said that during the last 3 months, the Committee had requested an action plan and what was presented was very weak. Ms Gray said that when the restructure comes into play, the action plan for the new Divisions would include the priorities for them to address and therefore, we have to reflect that at this point of time there was an action plan, with good intent, in place and areas were reporting that improvements in performance would be evident from January 2018. Therefore, when the Trust takes stock, the Committee needs to look at a revised plan regarding the changes being undertaken with CBUs.

Mrs Gray said that in January, the Committee would be able to prioritise and reflect on the next steps for the Trust.

Mr Ball stated that culturally this issue could have been dealt with sooner and Ms Wise agreed that it was a cultural issue with people not being held to account for delivering quality improvement.

**DECISION: (a) The Discharge Summary Action Plan to be added to the Work Programme.**

4.7 Serious Incident Update

The Committee received a report to provide assurance on the management of serious incidents including the serious incidents that meet the Never Event reporting criteria. It was reported that five serious incidents had been reported to Commissioners since the last meeting and all have ongoing investigations taking place.

The report was received and noted.

4.8 Corporate Risk Register

The Committee was presented with the Corporate Risk Register which detailed the risks assessed as extreme and scoring 16 or above. It was noted that the Corporate Risk Register was considered by the Risk Management Steering Group on the 13th December 2017.

Ms Wise suggested that future reports should provide a summary and detail the risks which had reduced and the risks which had increased.
DECISION: The report being presented to the next Committee would be a highlight report and a summary of where risks had increased and reduced in score.

5. CORPORATE GOVERNANCE

5.1 Care Quality Commission Update

Mr King reported that a full discussion was held with the Council of Governors this month regarding the Care Quality Commission and there had also been feedback to the Trust Management Committee. The Trust was continuing to respond to requests for information to support the inspection process and the draft inspection report was expected in January 2018.

5.2 Quality Improvement Plan: Actions Allocated to the Committee

The Quality Improvement Plan update was received and noted by the Committee.

5.3 Committee Annual Report April – December 2017

Mr Ramsden presented a draft Annual Report for the Committee which reported on the business discussed from April 2017 – December 2017. This would be further updated by the new Chair before its submission to the Audit Committee in May 2018.

6. MINUTES FROM REPORTING GROUPS

6.1 Minutes of Quality Governance Steering Group

The minutes of the meeting held on the 17th October 2017 were received and noted. Mr Ramsden queried why there were a number of items being deferred at the meeting and was informed by Ms Hackshall stated that this was due to a lack of administrative support.

6.2 Minutes of Health & Safety Steering Group

The minutes from the meeting of the Health & Safety Steering Group held on the 15th November 2017 were received and noted.

6.3 Minutes of the Risk Management Steering Group

The minutes from the meeting of the Risk Management Steering Group held on the 8th November 2017 were received and noted.

6.4 Minutes of the Patient Experience Steering Group

The minutes of the meeting of the Patient Experience Group held on the 8th December 2017 were received and noted.

6.5 Minutes of the Safeguarding Steering Group

The minutes of the Safeguarding Steering Group held on the 9th October 2017 were received and noted.
Mr Ramsden said that the Audit Committee had received the results of an audit on NICE Guidance which had received Limited Assurance on the systems in place to monitor compliance. Mr King reported that the issue was discussed at the Executive Team and Ms Wise added that a review was required by the Governance Business Partners, once they were in post mid-February.

Mrs Gray reflected that the points made regarding capacity and a plan was required to focus on the priorities and agendas to ensure Committees can addresses issues in depth in an appropriate way. There were a number of issues that could be escalated as a concern for the Committee and proposed that, as Chair, she would articulate the position at the Board regarding the current challenges being reported.

8. ITEMS FOR ESCALATION TO BOARD OF DIRECTORS

- Discharged Letters
- Quality Strategy
- Complaints
- System to monitor compliance with NICE Guidance

9. ANY OTHER BUSINESS

9.1 Future Meetings

A further NED will be required to attend the Committee until the new Non-Executive Director, Professor Welsh, commences in February.

9.2 Governor Feedback

Mr Lake said that from the Governors perspective, they would hope, that with the new structure, that improvements in certain areas would be seen to improve at pace.

9.1 Chair of the Committee

Mrs Gray thanked Mr Ramsden for all his work as a Non-Executive Director within the Trust who had always provided a sense of balance and had been a pleasure to work with.

10. DATE & TIME FOR NEXT MEETING

- 09:00am
- 23rd January 2018
- Boardroom, Glebe House
## AGENDA ITEM 6.2

### TITLE
INTEGRATED GOVERNANCE COMMITTEE

### DATE OF COMMITTEE MEETING
23rd January 2018

### REPORT OF
Chair of Committee

### PREPARED BY AND CONTACT DETAILS
Chair of Committee

### STATUS OF REPORT
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### SUMMARY
The Committee met on the 23rd January 2018, and although aware we would not be quorate it was decided that there would be oversight of business, and the transition meeting to explore the move to become the Quality and Safety committee could still proceed. The Agenda was drawn from the committee work programme. These items relate to Board Assurance Framework, and covered CQC Care Quality Commission matters. The meeting was therefore in 2 parts.

Items considered included:
- Trust wide Quality Assurance Dashboard
- Complaints Improvement Plan
- Corporate Risk Register
- Board Assurance Programme
- Care Quality Commission Update
- Quality Improvement Plan
- Minutes from the groups feeding into the Integrated Governance Committee,
- Feedback from any relevant meetings

**Key discussion points or areas highlighted were:**

#### Dashboard
The format of the dashboard is likely to change going forward.

- Sustained Compliance with reduction of Cardiac arrests outside of CCU and Cath lab
- Improved compliance with hand hygiene
- Improved compliance with Complaints
- Discharge letters are still not compliant with the target so this is being monitored through CBU performance meetings by Medical Director and Chief Operating Officer.
- Gp concerns have fallen
- Same sex ward compliance has been an issue over the last 2 quarters due to capacity issues. This is a national issue and NHSI are aware. It will require ongoing monitoring by the executive.
- Pressure tissue Damage.
The committee were told of further work being undertaken to improve the care of patients at risk of pressure tissue damage, detail of this is also in the dashboard. Nurse Director was gaining assurance that this plan was being implemented through ward spot checks and a learning and education process to facilitate better identification of risk and improvement opportunities. Appropriate admission to a stroke ward has declined again due to capacity, those patients in other wards are overseen by the specialist stroke nurse specialist

- **Corporate Risk Register**
  CEO highlighted the need to ensure that the serious nature of Radiology and PAC risk was captured appropriately. The Integrated governance team would be reviewing the report that will come to the Quality and safety committee, So that the level of report gives sufficient assurance around those risks assessed as extreme or where they are at 16 or over

- **Board Assurance Framework**
  This paper was late, however it highlighted the BAF risks 8 and 9, failure to implement commitments to the quality strategy and outcome from CQC rating and section 29A warning notice. It describes how the BAF links to the corporate risks relevant to those areas; It describes some of the actions being taken to manage the risks. These were added because of the CQC report, it includes fire safety, violence and aggression toward staff, ambulance handover and 15-minute assessment in A and E. All risks relating to the warning notice, the report advised have been addressed, but still monitored through the CBUs.
  Increased risks around “Boarded” patients were felt over the Christmas period to be such that this was put back on the risk register given the possible risk to patient safety.
  The paper will be reviewed internally and presented back to the Quality and Safety committee, in accordance with the work programme.

**Care Quality Commission Update**
This was given by CEO, who advised that CQC had made a request for further information the Trust had responded and the report was imminent and would require review for factual accuracy.

- **Quality Improvement Plan**
  The element allocated to the committee was discussed, Director of Nursing suggested there was still a need to ensure engagement and ownership of some of this.
  Quality Strategy is still in development and currently being taken to internal groups and committees.

- **Minutes received**
  Health and Safety Committee
  Risk Management Committee
  No meeting of Quality Governance Committee
  Or the Patient Experience Group
  Safeguarding meeting was hampered due to inclement weather so named professional met on 12th December to ensure that risks could be discussed.

- **Transition Meeting**
  The Group moved into the transition meeting and considered through discussion what would be the likely remit of the committee, Terms of Reference, work programme and to clarify reporting groups.
The CEO suggested that she would discuss this with the Director of Integrated Governance and executive team. The Agenda for the first meeting of The Quality and Safety Committee, which would include the new NED, would cover the structural elements of the committee and its work.

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The minutes are providing challenge and assurance on operational and finance performance issues reported to the Committee.

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| IGC Committee |
MINUTES OF THE INTEGRATED GOVERNANCE COMMITTEE HELD ON 23RD JANUARY 2018,
BOARDROOM, GLEBE HOUSE

PRESENT:
Mrs J Gray - Non Executive Director (Chair)
Mrs R Brown - Chief Operating Officer
Mrs S Clennett - Deputy Director of Integrated Governance
Ms L Hackshall - Director of Nursing & Quality
Ms D Postle - Deputy Director of Nursing
Ms F Wise - Chief Executive
Dr M Natarajan - Deputy Medical Director
Dr A Chilton - Medical Director
Ms D Burnett - Corporate Governance & Membership Manager

OBSERVERS:
Mr M Latif - Kettering Governor
Mr R Talbot - East Northants Governor
Ms S Bray - Stakeholder Governor for Corby Access VCS

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr A Ball and Mr P King. It was known that the meeting wouldn't be quorate; however the decision had been made to continue with the meeting and to have initial discussions about the transition to the quality and safety committee.

2. MINUTES OF THE PREVIOUS MEETING ON 19TH DECEMBER 2017

The minutes of the previous meeting were approved as a true and accurate record subject to minor spelling amendments.

3. MATTERS ARISING

3.1 Matters Arising: Quality Improvement Plan (minute 3.6 October meeting)

Ms Hackshall reported that the CAMHs work had now commenced and it was hoped to see the fruition of this work going forward. There had been environmental audits undertaken and on 1st February 2018 there would be the launch of a pilot project to focus on the outcomes. Ms Hackshall advised that the updates would come through from the safeguarding team.

3.2 Health & Safety Report (minute 3.7)

Ms Hackshall explained that a mapping exercise had been undertaken against NHFT on patient violence and aggression, and the trust would be looking for additional resource from NHFT to support staff.

3.3 Review of Risk Management Strategy (minute 3.8)

Ms Hackshall reported that the board’s appetite for risk had been discussed at the board development session. There had also been discussion surrounding the risk register versus the target and the gap in-between. Dr Chilton stressed the need to consolidate the discussions and Ms Wise replied that a dialogue would commence later in the day.
3.4 Maternity Dashboard (minute 4.2)

The committee noted that this item would be included in the work programme.

3.5 Quality Improvement Plan (minute 6.2)

Ms Hackshall advised that the deep dive review would be in line with the NHSI oversight meetings, and the items selected for that group...

3.6 Information Governance Report (minute 5.4)

The committee noted that this was included in the work programme and on the agenda under points 4.1 and 4.2 with the associated reports.

3.7 SAFER Maternity Care: The National Maternity Safety Strategy

Ms Hackshall reported that the breast screening programme was ongoing and there would be a bi-monthly reports on the SAFER births programme included in the work programme.

3.8 Trust Wide Quality Assurance Dashboard

Mrs Gray reported she was pleased at the completion of the actions from the previous month. Dr Chilton explained that all the responses had been positive except for one.

3.9 Compliance with Discharge Letters

The committee noted that this was still an area where there was limited assurance and it would be included in the work programme.

3.10 Corporate Risk Register

The corporate risk register had been presented as an agenda item at the meeting (item 4.3).

3.2 SCHEDULE OF TRACKED MATTERS ARISING

Trust Board Quality Dashboard

The Coding Improvement Plan would be presented to the committee for information once it had been presented at Trust Management Committee.

4. QUALITY GOVERNANCE

4.1 Trust Wide Quality Assurance Dashboard

The committee noted that the format of the dashboard may change going forward.

Ms Hackshall reported that there had been sustained compliance with the early warning score and a reduction in the number cardiac arrests outside of cath lab. There had been an improvement in compliance with hand hygiene and with robust plans in place within the CBUs, it was expected to see an improvement in the outcomes of quality metrics and the PLACE performance.

Ms Hackshall explained that there had been issues with discharge letters not being issued on the day of discharge especially in escalation areas. There had further been a dip in compliance with same sex areas despite cross operational working. Mrs Gray queried whether there had
been any issues as a consequence of the delay in issuing discharge letters. Mrs Brown replied that there had been none. Dr Chilton added that there had been a reduction in GP complaints overall but that the twelve month performance and run rate, combined with vacancies had a dysfunctional 99% metric, and should be addressed.

Ms Hackshall reported an increase in the number of pressure tissue damage cases that were primarily age related and agreed further work was needed. Mrs Gray asked about timeframe of the work. Ms Hackshall replied that the work was ongoing monthly but there needed to be more focussed work combined with age profiles. Mrs Gray asked how the Director gained assurance that there was compliance with actions MS Hackshall described how spot checks were being undertaken and training undertaken.

The committee noted that there had been three SIRIs reported in December 2017. Mrs Gray queried where the information that they were discussing went, and the timeframe for action. Ms Hackshall replied that they initially went to the SI meeting to present the case, which was assessed for avoid ability or a mortality review carried out. These would be declared inside the 60 day timeframe. Mrs Clennett added that the SI policy was currently under revision with a focus on how to embed the learning from those cases. Mrs Gray requested that the policy be shared with the committee, and asked what the timeline was for the revision. Mrs Clennett replied that this would be finalised for the end of March 2018.

**ACTION: To add the Siri Incidents Policy revision update to tracked matters to bring back to the Committee in March 2018.**

It was noted that the Quality Improvement Plan had been redrafted and would be presented at TMC and there was expectation that CBU leads would engage with and agree to the high level trajectories associated with deadlines and timescales.

Ms Hackshall reported that there had been a schedule of ward presentations with a focus on staffing, harm and quality and the Quality Council. Dr Chilton highlighted the risk of duplication of work between the Quality Council and the Quality Summit. Ms Hackshall replied that it was the matrons who had wanted to present and this was more of a local ward review and not solely performance related. Ms Hackshall explained that a Quality Summit was set only when there were ongoing issues, such as with Twywell where reporting had not been good or performance was sporadic.

Ms Hackshall said that there had been more escalation beds opened over the Christmas and New Year period with staff spread across areas to fill gaps following risk assessments. This had presented pressures and a potential risk to the trust.

It was noted that the safeguarding thresholds had been accepted by the hubs and that bi-weekly meetings were taking place to clarify and improve the process with regards to MASH notes, which could not be saved or printed posing a potential risk for the Trust. This issue had been brought back to the Safeguarding Board. Dr Chilton queried the differing MASH thresholds and expressed concern at the non-ability to record reports. Ms Hackshall agreed and explained that the process was new and that as an interim measure staff would write in the notes that a referral had been made.

Mrs Gray expressed concern at the increased number of pressure tissue damage cases and queried what mitigating actions the trust was putting in place to gain assurances. Ms Hackshall replied that ward spot checks were being undertaken, and that there had been a learning and education process put in place to support staff with identification and improvements.

It was noted that documentation still remained of concern across the organisation and that there needed to be a site-wise organisational review to address this issue. Mrs Gray invited Dr Chilton to comment on medical staff and documentation. Dr Chilton replied that specific documentation
for mortality or harm reviews remained on the whole both effective and accurate. It was agreed that work needed to be undertaken in some areas of practice development.

**ACTION: To add documentation issues across the trust to tracked matters for follow up.**

Ms Hackshall reported that ward accreditations were being undertaken with a holistic approach focusing on all strands: staffing, culture and risk to ensure patient safety. The report would be presented at the next workforce meeting.

Mrs Gray drew attention to the letter included in the circulated papers about the decisions the trust had made during the recent period of intense pressure on services. Ms Hackshall explained that the letter to staff had provided a follow up about the decisions made and that the unions had been supportive. Mrs Brown added that nationally they had focused on ensuring patient safety and that Mrs Postle and the Director of Nursing had visited all areas to support staff and the decisions taken. Mrs Clennett provided further reassurances that patients that she had spoken to in corridors had said that despite the areas being busy, they had felt safe. Mrs Brown stated that she had been proud of staff and how they had dealt with such a large number of patients being seen.

4.2 Complaints Improvement Plan

Mrs Clennett reported that performance had recovered following an internal staff restructure which would enable the CBU Governance Managers, once in place, to take better ownership of complaints. The appointment of a substantive Complaints Manager would further support improvement and enable complaint delays to be escalated more quickly. Ms Hackshall stated that the complaints improvement plan would be discussed at the Patient Experience Steering Group.

Mrs Gray stressed the need for the report to be considered by the appropriate group first prior to being brought to the committee. It was noted that the plan had been received for information only. Mrs Gray highlighted the need to follow the new governance structure.

4.3 Corporate Risk Register

Mrs Clennett reported that the key content of the report was to detail those risks which had been assessed as extreme and scored 16 or above. There had been some ongoing work as to how to recognise and highlight those at more significant risk in order to gain high level assurance, and how to address those at the lower end and report on them.

Ms Wise highlighted the need for the radiology risk and the PACs report to be clearly described and to ensure that the seriousness of the risk was captured within the report. Mrs Gray agreed that there needed to be a greater focus and highlight on the seriousness of risk along with a narrative and scoring.

Mrs Clennett explained that the next report would be more in-depth which would enable greater assurances at a higher level and provide the highlighted key risks to the committee. Mrs Brown stated that all high level risks should be subject to a bi-monthly report.

4.4 Board Assurance Framework

Mrs Clennett explained that the paper described the risks in the BAF relevant to the committee. In effect the paper provided the connection that informed the risk against the objective and through the Risk Management Steering Group. Mrs Clennett clarified that items could go back on the risk register where there remained ongoing issues that had not been resolved such as that of the quality contract with Claremont.
Mrs Brown stated that the linkage shown was good, but that the new corporate risk register needed to feed into the BAF and further discussions were needed.

**ACTION:** Mrs Brown to speak with Mrs Madeley to discuss the Board Assurance Framework to come back to the Quality and Safety Committee in February.

5. CORPORATE GOVERNANCE

5.1 Care Quality Commission Update

Mrs Wise reported that there had been a further request for information on mandatory training and that a draft report from the CQC was imminent. There would be a meeting in two weeks’ time to talk about the process in advance of the report which would likely be issued in March 2018. There had been CQC management meeting to review the backlog in radiology reporting and improvement plans had been submitted to avert the imposition of a Section 31. The trust had been managing its own self-imposed actions. Mrs Wise added that the most important issue was for the standards of governance to be understood by the whole organisation.

5.2 Quality Improvement Plan: Actions Allocated to the Committee

Ms Hackshall reported that most of the actions had been delivered with only one issue around the ability of an effective A&E training plan. Ms Hackshall explained that each action had been associated with a KPI to enable the tracking of progress. It was noted that some of the KPIs set had not been realistic and these would be formulated better going forward.

Ms Hackshall stated that the biggest learning was around engagement and the accountability framework to monitor the level of engagement and ownership with the quality improvement plan. Mrs Gray queried where the plan was looked at. Ms Hackshall replied that it rested with programme management office and taken to all CBU through governance meetings to gain evidence. There were further NHSI Oversight meetings to monitor the progress to plan and take a deep-dive into key problem areas to highlight where improvements could be made.

6. MINUTES FROM REPORTING GROUPS

6.1 Minutes of Quality Governance Steering Group

Ms Hackshall stated that due to administrative issues the minutes of this group would be circulated at a later date.

6.2 Minutes of Health & Safety Steering Group

The minutes from the meeting of the Health & Safety Steering Group held on the 20th December 2017 were received and noted.

6.3 Minutes of the Risk Management Steering Group

The minutes from the meeting of the Risk Management Steering Group held on the 23rd January 2018 were received and noted.

6.4 Minutes of the Patient Experience Steering Group

There had been no meeting of the Patient Experience Steering Group

6.5 Minutes of the Safeguarding Steering Group
The minutes of the Safeguarding Steering Group held on the 12th December 2017 were received and noted.

7. FEEDBACK FROM NON-EXECUTIVE DIRECTOR MEETINGS/VISITS

Mrs Gray highlighted the need to address how the minutes would be used to inform the committee. Mrs Gray proposed the need for a clear front sheet with a highlight summary. Ms Hackshall added that NHSE Safeguarding minutes going forward would feed into the meeting.

Mrs Gray reported that she had been involved in meetings with governor groups and discussions and the work they had undertaken to improve the effectiveness of governors, including the production of a new governor handbook.

8. ITEMS FOR ESCALATION TO BOARD OF DIRECTORS

Mrs Gray stated that she would write a front sheet summary around the key risks highlighted to the committee and for a subsequent feedback session.

**ACTION:** Mrs Gray to write a front sheet summary for the Board of Directors meeting on the key risks highlighted to the committee.

9. ANY OTHER BUSINESS

There was no other business to discuss.
**AGENDA ITEM** | **6.2**
--- | ---
**TITLE** | PERFORMANCE, FINANCE & RESOURCES COMMITTEE

**DATE OF COMMITTEE MEETING** | 20<sup>th</sup> December 2017  
31<sup>st</sup> January 2018

**REPORT OF** | Chair of Committee

**PREPARED BY AND CONTACT DETAILS** | Trust Board Secretary  
Tel: 01536 491362

**STATUS OF REPORT** | Public | Private | Internal
--- | --- | --- | ---
**X** | | |

**PURPOSE OF REPORT** | For Decision | For Assurance | For information
--- | --- | --- | ---
| | **X** | | |

**SUMMARY** | The Committee is presenting the draft minutes from the meeting held on the 20<sup>th</sup> December 2017 and an update from the meeting held on the 31<sup>st</sup> January 2018 will be provided at the meeting.

**RECOMMENDATION** | To RECEIVE and NOTE the minutes held on the 20<sup>th</sup> December 2017.

**LINKS TO STRATEGIC OBJECTIVES**

**LINKS TO BOARD OBJECTIVES** | Improve regulatory standing

**LINKS TO STRATEGIC AND CLINICAL RISKS**

**IMPACT** | Delete Yes or No as appropriate | Yes | No
--- | --- | --- | ---
Quality and Safety | | No |
Legal | | No |
Financial | | Yes |
Human Resources | | Yes |
Equality and Diversity | | No |
Engagement and Communication | | No |
If yes, please give additional information | The minutes are providing challenge and assurance on operational and finance performance issues reported to the Committee

**MINUTES PREVIOUSLY CONSIDERED BY** | PFR Committee members in draft
Mr Harris-Bridge thanked Mrs Hanna for chairing the previous meeting at very short notice.

1. APOLOGIES FOR ABSENCE:

Apologies for absence were received from Mrs F Lennon.

2. MINUTES OF THE PREVIOUS MEETING

Mrs Hanna pointed out a number of actions that had not been picked up in the previous minutes and stressed the need for accurate and robust follow up actions arising from committee meetings to ensure assurances.

Subject to a number of amendments, the minutes of the meeting held on the 25th November 2017 were approved as a true and accurate record.

Mrs Hanna raised a concern regarding the high cost of locum spend and the disconnect of information presented to WDC and the information presented in the minutes of the PFR committee. Mrs Hanna asked for greater clarification and understanding on the locum spend with regard to compliance with agency process controls/authorisations.

Mrs Brown agreed that locum spend was high, but that against the pay budget for workforce overall, there had been a £1M saving YTD. Mrs Brown stated that it was essential to get the most value out of staff to deliver the level of income against cost.

3. MATTERS ARISING

3.1 Operational Performance Report (minute 3.4)

Mrs Brown explained that the radiology team had been unable to attend the meeting due to the pending deadlines to resolve issues highlighted by the CQC for early
January 2018. Mr Harris-Bridge agreed to discuss with Mrs Brown whether urology or radiology could attend the January meeting to present their service improvement plans. It was agreed that the actions from the radiology review by the CQC would be brought to the next Board Meeting and that a new Radiology Executive Assurance Group is being established (similar to the RTT EAG in purpose), to commence work at the beginning of January.

**Action:** Mr Harris-Bridge to discuss with Mrs Brown whether urology or radiology leadership would attend the next meeting.

**Action:** The radiology actions arising from the CQC review would be brought to the next Board meeting.

### 3.2 Quality Improvement Plan (minute 4)
The Committee noted that the Quality Improvement Plan had not been reformatted and updated as had been indicated in November. Mrs Brown agreed to speak with Mr King to progress the revisions on the plan.

**Action:** Mrs Brown to speak with Mr King to progress the reformatting and updating of the Quality Improvement Plan and ensure that the Board and Committees receive copies.

### 3.3 Board Assurance Framework (minute 5)
The Board Assurance Framework (BAF) had been discussed at the Workforce Development Committee that morning, with an action for Mrs Madeley to speak with Mr King to confirm when the BAF would return to Board Committees in its new format and layout. Mr Shipman expressed concern that the BAF had not been updated. It was agreed that Mr Shipman raise this at the December Board meeting.

**Action:** Mr Shipman to raise the concern of the non-updated Board Assurance Framework at the December Board meeting.

### 3.4 IT Service Performance Report (minute 6.1)
To be discussed by Mrs Arnold at her next scheduled PF&R slot at the February 2018 meeting.

### 3.5 Digital Strategy Update (minute 6.2)
Mrs Brown reported that following the recent Medway upgrade, all the new emergency coding had now been implemented, but that there had been no financial change to the value of the emergency department work as yet with outcomes remaining the same. The Committee expressed concern about the coding not being done in a timely manner although Ms Briggs confirmed that when the correct codes were applied, the financial position would “catch-up”.

### 3.5 EMRAD Consortium – Leicester Withdrawal (minute 6.2)
A briefing paper had been issued by Mrs Arnold to the Committee. Mr Shipman raised concerns about the accessibility of scans undertaken for KGH patients at Leicester and how it would work in practice. Mrs Brown replied that she had received assurance from Mrs Arnold that this was being worked through and
there had been no cause for concern. Mr Shipman highlighted the need for robust practice in the process.

**Action:** Mitigation issues surrounding the Leicester scans to be brought back to the committee by Mrs Arnold to provide assurance. (Tracked matters)

3.7 Estates Performance Report (minute 8.1)
Mr Harris-Bridge stated that the performance report submitted by the Director of Estates had not been fit for purpose and had been returned for review. When the new Director of Estates & Facilities joins the Trust in February, Mr Harris-Bridge will hold an early meeting with him to discuss E&F reporting to PF&R with the intention of achieving more relevant, succinct assessments of performance (including capital projects) to underpin the assurance the Committee is seeking.

3.8 North Northamptonshire Urgent Care Improvement Programme (minute 9.2)
Mrs Brown stated that there had been a lengthy delay in the production of the ECIST report but agreed to circulate the report on receipt.

**Action:** Mrs Brown to circulate the ECIST report on receipt to PF&R and the Board and for this to be included on the January PF&R agenda. (Tracked matters)

3.9 RTT Performance (minute 9.5)
Mrs Hanna raised concerns that clinical harm reviews were lagging with a number of reviews being over one year old and the age profile of other cases very lengthy. The concerns related to a report circulated by Mrs Madeley. Mrs Brown replied that RTT performance had been progressing well and the number of cases had been progressively decreasing. Mrs Hanna agreed to send the circulated report to Mrs Brown who agreed to reply to Non-Executives Directors once she had reviewed the information.

**Action:** Mrs Hanna to forward the RTT Harm Review information received to Mrs Brown who would circulate a response to NEDs.

3.2 SCHEDULE OF TRACKED MATTERS

3.2.1 Theatre Ventilation Programme
Mr Harris-Bridge queried who would present the “Lessons Learnt” paper at the January 2018 PF&R re the theatre ventilation programme. It was agreed that this was likely to be the interim Director of Estates. Mr Shipman queried if any contractual laws had been broken given the delays. Ms Briggs replied that potentially there could be some public sector contracts, but that there had been no contracts issued through procurement with the contractors. Ms Briggs informed the committee that a Capital Programme Manager post would be put in place to be responsible for capital projects and ensure they run consistently and tightly to plan with ownership for delivery resting with the appropriate CBU albeit the work to be undertaken mainly by Estates & Facilities.
3.3 RADIOLOGY PRESENTATION
Deferred due to CQC review deadlines (note under 3.1)

4. QUALITY IMPROVEMENT PLAN (QIP)

4.1 Quality Improvement Plan Actions
Mrs Brown pointed out that the Quality Improvement Plan was the same format as at the last meeting with no changes to the key actions. There were concerns around black breaches, but despite good engagement with East Midlands Ambulance Service, performance was still not improving and further work would need to be undertaken.

Mrs Brown reported that the fifteen minutes observation system was now in place and the real focus now needed to be on accurate input of the new emergency treatment codes to ensure that all admissions were captured correctly, to ensure the correct income. It was noted that the glitch in the Medway system had been recently fixed which would support improvement.

Mr Harris-Bridge expressed concern that black breaches had been a problem since June 2017. Mrs Brown replied that there had been some improvement which had then deteriorated since the increased pressures on urgent care.

Action: Mrs Brown to provide an update to January PF&R on the actions to address the concerns around the level of black breaches.

5. FINANCE AND CONTRACTING

5.1 Finance Report Outturn V Plan
Ms Briggs reported that in month 8 the deficit was £1.6M against a plan of £0.7M resulting in a £1M adverse variance. The YTD position was a £19M deficit culminating in a £5.4M adverse variance to plan. The Month 8 deficit had been due to pay costs, tele-radiology costs, estates spend, overseas nurses, CBU CIP underperformance, and underperformance in critical care and non-elective surgery. It was noted that theatres and T&O had over-delivered against its recovery plan.

Ms Briggs stated that non-elective activity was £1.5M behind plan and that £0.9M had been related to HRG4+ planning assumptions and £0.6M related to the underutilisation of Claremont beds, ambulatory care and reduced excess bed days. Ms Briggs stressed that the underlying deficit in non-elective activity had to be right sized if there could not be a commitment to delivery and activity.

Ms Briggs highlighted the challenge of deciding whether to hold onto the contingency and drive through at each the level of the organisation the need for CBUs to manage their own budgets correctly and take accountability for that action.

Mr Shipman stressed the need for speed in identifying and taking action on those areas of underperformance and the need for a dialogue with senior managers about good practice and what needs to be done. Ms Briggs replied that a larger level of contingency could not be set for this year unless it was set against CIP. Mr Harris-Bridge added that the new 3 CBU
structure would facilitate better understanding, as the teams will be working more closely
together with Executives with the CBU Leaders joining the Board.

Mrs Brown highlighted the risks that the Trust had accepted around radiology, had been
perceived by the CQC as being areas to action, and that a bigger contingency would enable
such actions to be addressed.

Mrs Hanna pointed out the need to step back and look at right-sizing the organisation, and
proposed the Trust look into benchmarking against a trust in a similar situation, to ensure
that the trust puts itself in a strong position based on the practical experiences of others. Ms
Briggs agreed to take this forward. Mr Harris-Bridge pointed out that it was for the Executives
to decide the level of contingency reserve and to come back with a proposition as part of the
financial plan for the next year.

**Action:** Ms Briggs to discuss with executives regarding the level of
contingency the trust takes on in 2018/19, and present as part of the
financial plan for the next year.

Mr Harris-Bridge summarised that the Trust continues to experience a trading performance
challenge which it must address, with unanticipated cost challenges for which there must be
tighter grip and control to manage and mitigate these effectively. Ms Briggs stated that it
should be the ability of the staff to challenge the budget. Mr Harris-Bridge agreed that it was
a collective responsibility of all staff.

Mr Shipman queried the potential risk with estates and the outstanding invoice issue with a
private company, and asked whether a contingency level had been put in place. Ms Briggs
agreed to look into the case.

**Action:** Ms Briggs to look at the contingency level secured in the balance
sheet for the dispute with the private company.

Mr Harris-Bridge queried the gaps between the CBUs and the contractual agreements. Ms
Briggs replied that going forward there would be a CBU lead on the contract group, but that
there remained issues with readmissions that clinicians could impact on, but failed to take
ownership for. It was hoped that with a CBU lead in place, it would drive down inefficiencies
by highlighting the importance of contracts and performance/delivery.

5.2 Contracting Performance
Ms Briggs reported that the Trust had signed and agreed a review for the new terms of
reference with Bailey and Moore. There would be a shared cost of £40K between the Trust
and the CCG. Ms Briggs pointed out that it was timely as NHSI or NHSE had insisted that all
contracting disputes needed to be resolved, and so both organisations had signed up.

Ms Briggs pointed out that the trust had never had an Emergency Care baseline which would
culminate in a comprehensive piece of work in early January-February. A risk to the
organisation could be a £1.5M difference in what the CCG believed the baseline was versus
what the Trust had budgeted for. Mr Shipman queried if this posed a risk to the organisation.
Ms Briggs replied that the maximum cost had been written into the contract.
Ms Briggs reported that the Commissioners had made the decision to move their processing centre to NE London and due to the enormous and unexpected volume of data challenges, had needed to put in place a commissioning accountant. The current challenges were being discussed jointly but the Trust would refuse to accept any further data challenges going forward. Ms Briggs advised that she was in email correspondence with the commissioners.

Ms Briggs reported that the Trust had received a high-value contract performance notice from the CCG (c.£4.5m) relating to RTT performance. Ms Briggs advised that she was in discussions with the CCG over the improvement trajectories and their continued failure of effectively manage demand on their side. Discussions would commence in January 2018.

5.3 Financial Forecast - 2017-2018

Ms Briggs summarised the key proposals for reforecasting in Q4:

- First scenario: to submit a £19.9M deficit forecast the trust would need an additional £4.2M of new actions from January onwards in addition to all CBUs delivering to plan. It was noted that the CBUs are not currently delivering to plan. Mrs Brown highlighted the number of new risk assessments in place and the mitigation processes put in place, along with a new programme around theatres utilisation which should deliver improved performance.

- Second scenario: to reforecast base plus position to £24.1M deficit. This assumption assumes that all the £4.2M improvement actions have been removed as the Executive Directors did not feel able to support and deliver this on top of the multiple existing plans and priorities.

- Third scenario: to reforecast a £28.2M deficit as the worst case scenario. This assumption is that agency cannot be controlled over the winter and that contingency funds are used to cover costs impacting elective delivery.

Mr Harris-Bridge queried what the Executives are recommending. Ms Briggs replied that £24.1-£25M deficit represented a balanced approach to the current performance and remaining risks in Q4. The NHSI Regional Team had advised the trust submit a £19.9M deficit forecast but further advice from NHSI during the QRM had suggested being realistic about the forecast so as not to damage the Trust’s reputation.

Mr Harris-Bridge stressed that at YTD £19.0M deficit the Committee would not be able to support a FY Forecast suggesting that we will deliver the planned £19.9M deficit. Whatever the forecast, it needed a strong degree of confidence from the Executive Team as it must be delivered or improved if possible. Ms Briggs replied that at this stage – until she has seen the actual M9 numbers - she wished to agree a scale rather than a fixed number for the re-forecast. It was noted that the submission would need to be made on 15th January 2018. Mr Harris-Bridge requested that forecast must be hinged on the delivery of the five key targets identified in the forecast paper and the need for a firm commitment from the CBUs that these can/will be delivered.

Ms Briggs reported that the exit underlying run-rate from 2017/18 would be £18-19M deficit which was a £1M improvement on 2016/17 outturn. Mrs Hanna advised caution, in that
although this was an improvement, there needed to be realistic focus in setting the contract with NHSI to provide a balanced view. Mrs Hanna added that the Trust needed long term sustainability and a focus on step changes to ensure a responsible, viable organisation.

Ms Briggs explained that any winter income would have to held back to cover the EMRAD and Sepsis risk. The new Winter pressures income would comprise £726,000 from the government for costs already incurred and a further £1.8M in schemes, with the caveat that the Trust delivers a 90% performance in A&E from end of December to 11th January, when funds will be released by the CCGs if the targets and performance are met.

Mr Harris-Bridge summarised that the re-forecast figure of £24-25M deficit needed the agreement of the Board. A consideration of the right sizing of the organisation would need to be undertaken for 2018/19. There remained an outstanding action on the medical locum agency issue. Mrs Hanna pointed out the implications for cost savings with the right level of staffing and stressed the need for NEDs to understand why there was an over cost in locum spend as indicated in the previous minutes. The Committee expressed disappointment that the assurances given previously on authorisation of controls of agency across the board had not been undertaken across all disciplines, despite the assurances previously provided.

Action: Mrs Brown to provide a clear update on the agency spend on locums and to provide reassurances that the locum spend was subject to the same levels of rigour as other agency roles across the trust.

5.4 Capital Utilisation
Ms Briggs reported that forecast risk position against the Trust’s FY Capital Plan of £16.1m was £3-4M, with potential slippage being used through CBU’s urgent and essential equipment purchases and estates and IT spend. Many investment cases were still awaiting business cases to be put forward, suggesting clear slippage. There remained concern over the how the £4M gap is to be bridged. Ms Briggs advised that she would meet with Mr Shipman outside of the meeting to discuss the recommendation. Ms Briggs expressed disappointment that there had been a failure in the processes and dismayed that those new investment cases relating to health and safety had not come through for approval. Ms Briggs proposed that a system of reward for those areas which had submitted would be looked at for the future to break the cycle of over-planning capital spend and under-spending, which has characterised the last 3 years.

Action: Ms Briggs to meet with Mr Shipman to discuss how to bridge the £4M slippage in capital spend.

Mr Harris-Bridge stated that the Committee was not assured that the trust had a capital plan that it would be able to deliver this year.

6. TRANSFORMATION PROGRAMME

6.1 Trust Recovery Programme
Mrs Pleavin gave an update on the transformation team’s programme of work, which had generated £13.5M to date. A number of challenges had been faced in theatres but this had now improved, and the CIPs were now focused on the scheduling of work and looking at the balance of elective and non-elective work.
Mr Harris-Bridge pointed out that elective productivity was well below target. Mrs Pleavin replied that this had been due to the theatres closure over the extended period of time this year. Mr Shipman pointed out that despite the theatres being closed, there would continue to be non-delivery to target. Mrs Pleavin replied that the report presented a week by week snapshot which focused on consistency and sustainability. There had been issues with consistency, and actions had been put in place with consultants to improve levels of activity and a programme of work, which had been very complicated.

The Committee requested that Mrs Pleavin bring back a different way of providing the metrics in a monthly report and not a stage position. Mrs Pleavin agreed to action this request. Mr Harris-Bridge offered to be the sounding board for this different presentational approach early in January.

**Action:** Mrs Pleavin to provide a monthly metrics report for the future meetings of PFR. Use Mr Harris-Bridge as a sounding board for the new approach in early January.

Mrs Pleavin reported that she had received feedback from NHSI which would be brought back to the next meeting. Mr Harris-Bridge asked what the trust had learned from the Four Eyes process which had failed to deliver some of the benefits at the pace expected. Mrs Brown agreed that the provision of a different team to what had been agreed at the start of their engagement and signed up to at Board, had been most disappointing.

Mr Harris-Bridge queried how much the trust would pay Four Eyes based on their underperformance. Mrs Pleavin replied that it would be in the region of just over £400,000 of the £800,000 contracted for. The final payment and valuation would be discussed/agreed with the Executives before being briefed to the PFR committee and Board for agreement.

**Action:** Mrs Pleavin to provide a report on what the trust had learned from the process of engaging Four Eyes to the next committee meeting.

7. PERFORMANCE

7.1 Operational Performance
Mrs Brown reported that cancer targets and diagnostic targets had been achieved in November and that improvements had been seen in the RTT position. The key concern remained the urgent care performance.

7.2 Urgent Care Improvement Programme & Winter Plan Update
Mrs Brown reported that in November the position had deteriorated. This had been related to the Medway upgrade, the use of Claremont beds and a bout of norovirus in the Trust. There had been significant issues in capacity. Mrs Brown had requested a report on the lessons learned from the Medway upgrade, which compared to the previous upgrade had not gone smoothly. This would be brought to the Digital Steering Group.

Mrs Brown stated that a number of actions had been put in place to focus on capacity issues: there had been a focus on social workers being aligned to wards and support for nurses on how to manage patients more effectively. The out of hours GP service had moved
onsite and had been working well. ECIP had been providing workshops to support the urgent care teams. There had been success with the winter funding money and there was continued support with staff to support the upgrade and the new systems in place. There had been a number of reconfigurations and refurbishments undertaken by estates that had supported the department.

Mrs Brown reported that the trust had joined the ambulatory care programme and the situation had improved with the Corby Minor Injuries unit. There had been a lot of work internally to focus on getting the trust back on target in A&E at the high 80s, and a focus on spending the winter monies in the best way to improve flow and performance. There continued to be a need for nursing and dementia beds and a lot of work had been undertaken to locate and find such beds in the community.

Mrs Brown reported that there were a number of long term actions both internally and externally underway. Mr Harris-Bridge queried the level of confidence in the bed situation for mid-February. Mrs Brown replied that for February due to the impact of Hospital at Home kicking in, she was assured but did not have the same assurances for January. There would further be a need to hold the system-wide partners to account to support with DTOCs reduction.

Mrs Hanna suggested that the Urgent Care staff be invited again to give their stories and be thanked by the Committee. Mrs Brown suggested that it would be advisable that the members of the Committee accompany her to listen to staff stories especially in ED as she is there on a daily basis to provide support and encouragement.

7.3 RTT Performance
Mrs Brown reported that the number of over 52 week wait patients forecast at the end of December remained at 16-17, a substantial proportion of which is patient choice not to be treated before the end of the year and there was a continuing downward trend. It was noted that a number of patient appointments had to be cancelled due to the pressures in the trust and additional concern that the NHSL/E instructions regarding reducing elective work in January to support urgent care, would deteriorate our RTT performance improvement trajectory.

8. ESTATES & FACILITIES
8.1 Sustainability Performance Report
Mr Shaw reported that the new Energy Manager had achieved £86,000 of savings and had continued to look at managing to reduce overall waste going forward. There had been a business proposal put forward – as yet unapproved - for a recycling centre onsite and a number of initiatives had been considered in using waste, such as gardening, to produce a by-product that could be sold.

Recycling initiatives around the use of cups had had a significant impact on Costa with the amount of waste produced reducing. LED Lighting was also being looked at as an improvement focus.

Ms Briggs queried how the waste figure volume had increased when patient numbers / beds were lower. Mr Shaw agreed to look into this.
**Action:** Mr Shaw to find out how the volume of waste had increased despite the reduced bed base and patient numbers lowered and report back to the Committee.

Mr Shaw explained the department was looking at additional savings which were being driven forward, and advised that the business case for the recycling centre had now been submitted to the Capital Committee.

8.2 Estates Regulatory Compliance
Mr Shaw stated that there remained a number of outstanding vacancies, and there were some staff levels of sickness. It was ascertained that the chart provided was in effect a ‘Responsibility Chart’. The Committee discussed the potential risk associated with technical specialty vacancies with Mr Shaw confirming that in all cases but one (high voltage technical) his qualifications and expertise was covering the gaps.

Mr Harris-Bridge queried the timescales for the filing of the vacancies. Mr Shaw replied that a number were circa 12 months and that training of current staff had also been considered.

Mr Harris-Bridge asked whether in view of the residual risks in the responsibility chart if these had been placed on the risk register. Mr Shaw replied that they had, but not on the corporate risk register. High voltage work represented the biggest risk. Mr Harris-Bridge stressed the need for the new Director of Estates to look at and indicate the level of risk – in his view – regarding the vacancies.

Mr Harris-Bridge thanked Mr Shaw for his contributions to the PFR Committee and wished him well in his future career.

9. ANY OTHER URGENT BUSINESS

9.1 Mrs Russell reported back that she had picked up the need for training in the generation of business cases. There were positives in Mrs Hanna’s suggestion to thank staff either at a Board meeting or in their Departments; there were negatives in the behaviour of suppliers; and process issues that would need to be addressed.

10. DATE & TIME OF NEXT MEETING
- 9.00am
- 31st January 2018
- Boardroom, Glebe House
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<tr>
<td>DATE OF COMMITTEE MEETING</td>
<td>20th December 2017 24th January 2018</td>
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<td>REPORT OF</td>
<td>Chair of Committee</td>
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<tr>
<td>PREPARED BY AND CONTACT DETAILS</td>
<td>Trust Board Secretary Tel: 01536 491362</td>
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<tr>
<td>STATUS OF REPORT</td>
<td>Public Private Internal</td>
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<td>PURPOSE OF REPORT</td>
<td>For Decision For Assurance For information</td>
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<tr>
<td>SUMMARY</td>
<td>The draft minutes of the meeting held 20th December 2017 and a verbal update will be provided following the meeting held on the 24th January 2018</td>
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<tr>
<td>RECOMMENDATION</td>
<td>To receive the minutes from the meeting held on the 20th December 2017.</td>
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<td>LINKS TO STRATEGIC OBJECTIVES</td>
<td>Improve regulatory standing</td>
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Mrs Gray stated that due to the number of apologies received as a result of operational pressures and sickness, the Committee was asked to agree to review immediate priorities at this meeting along with areas of concern or risk.

1. **APOLOGIES FOR ABSENCE**
   
   Apologies for absence were received from Mrs P Edkins, Ms L Hackshall, Dr A Chilton, Dr Natarajan and Mr M Smith.

2. **MINUTES OF THE PREVIOUS MEETINGS**

   **DECISION:** The minutes of the meeting held on the 22nd November 2017 would be presented to the meeting on the January 2018.

3. **MATTERS ARISING**

   Deferred to the January 2018 meeting.

4. **SCHEDULE OF TRACKED MATTERS ARISING**

   Deferred to the January 2018 meeting.

5. **COMPASSIONATE**

5.1 **Safe Staffing update**

   Ms Postle presented the safe staffing report to provide the Committee with an update on safe nurse staffing for November 2017 with regards to nurse staffing fill rates as per National Quality Board requirements, care hours per patient and any risk identified. It was reported that the percentage fill rate for November had increased from 92% to 93.9%.

   Mrs Gray referred to the number of beds opened and the associated staffing required highlighting that an improvement had been achieved despite opening additional beds. Ms Postle said a pool of staff was now utilised to ensure immediate cover could be provided to escalation areas. Mrs Gray said that the Board had agreed not to open additional beds what had happened and Ms Postle responded that during the previous week the acuity was high and the ENT area was opened on the approval of the Director of Nursing. Ms Postle said that the Trust had requested a divert which could not be accommodated and this would be reported at the Board.
It was reported that the main risk areas related to Lamport & Twywell where a Freedom to Speak up issue has been raised which was about the model of care on the ward. This was due to the ward being modelled as a rehabilitation ward, but was treating more acute patients coupled with a number of vacancies on the ward. To assist the ward, Ms Postle reported that an Advanced Nurse Practitioner was being recruited to with interviews being held in January 2018. Mrs Gray said that something need to happen sooner rather than later and requested an update outside of the meeting.

Mr Harris-Bridge queried the statistics relating to Harrowden C and Poplar wards. Ms Postle reported that the wards did have gaps in staffing levels but the data was checked with the Head of Nursing and the posts were in the process of being fully recruited to on Harrowden C. In relation to Poplar, the model of care was being reviewed as wards were set up as rehabilitation wards and were now dealing with higher level of acuity of patients.

Mr Harris-Bridge queried figure 1 on page 2 of the report regarding the improvement in the “unable to fill rate”. Mrs Gray queried if there needed to be a significant review of staffing of all wards across the Trust against the model of care decided by the new Divisions. Mrs Brown said that discussions have been held regarding strengthening the model of nursing care within the Trust as requirements had significantly changed over the years. Mrs Brown said that the medical models were changing and going forward with the reconfiguration, the nursing model would also be strengthened.

**DECISION:** Ms Postle to update Mrs Gray on the actions being taken to address the staffing levels on Lamport & Twywell outside of the meeting.

5.2 Quality Improvement Plan Progress and CQC Update

The Committee received the Quality Improvement Plan (QIP) report providing an updated position against the actions set out in the Quality Improvement Plan.

Mr Harris-Bridge referred to the key performance indicators, specifically relating to the red rated areas of medication policy, safeguarding training, statutory training and adhering to food hygiene processes as all were significantly overdue and an explanation did not appear in the risk section within the covering report.

The report was received and noted.

**DECISION:** To ensure that any red rated action was detailed within the risk section in the covering report to the Committee.

6. ACCOUNTABILITY

6.1 Workforce Dashboard Performance Report (including Workforce Vacancy & turnover Report)

*Deferred to the January meeting.*

6.2 Workforce Pay Report (including temporary staffing)

*Deferred to the January meeting.*

6.3 Workforce Vacancy/Turnover Report

Ms Newing presented the Workforce Vacancy/Turnover report on recruitment and retention and reported that the turnover was currently at 11.8% compared to 10.98% the previous month.
The vacancy percentage was 8.69% compared to 9.61% the previous month. The Trust had made 236 offers of employment and it was reported that the Trust held a recruitment and retention summit agreeing specific actions to take forward to address advertising and the packages being offered by the Trust.

The current vacancy rate for medical and dental posts at KGH was approximately 14%.

The current compliance in relation to flu vaccinations was 57% and staff were continually being encouraged to have their flu jab. The report also included the detail of the CARE awards which commenced in December 2017.

Mrs Gray queried the safeguarding training as this was a focus of the CQC and specifically referred to compliance within anaesthesia. The Committee was informed there was a plan and a request was made for an update against the plan at the next meeting. Mrs Gray said it was disappointing where some areas had seen a dip in performance as they had previously been achieving against their target and was keen to ensure there was a plan in place to address non compliance.

Mrs Brown stated that a key issue within Surgery related to leadership as the numbers were not as high as should be due to vacancies and therefore the CBU was vulnerable. It was noted that support was being identified for the CBU on an interim basis before permanent positions were put in place.

Mrs Gray queried, as a result of issues raised around the Breast Service, the employment assessments for Doctors and their suitability and wanted to be assured of the checks undertaken to ensure clinicians were competent. Ms Newing said that there would be checks with the General Medical Council (GMC) and the Disclosure & Barring Service; all references followed up and if required, visas were followed through. Mrs Gray queried how the Trust was aware if the performance of an individual was not up to standards and queried if there was a process to review competency. Ms Newing said that meetings were held weekly to address performance issues which included reviewing any areas of restrictive practice etc and the Trust had liaison with the National Clinical Assessment Service (NCAS). It was reported that if there was an issue from another organisation, then then the GMC would also contact the Trust. Mrs Brown said the majority of surgical specialities had national quality screening programmes in place which have a quality assessment attached to the programme.

Mr Harris-Bridge reported on the positive areas within the report, highlighting that vacancies had decreased, sickness absence had decreased; the vacancy rate compared to last year had improved; the gap that existed between starter and leavers had improved; and for the first time in 3 years the Trust was overall achieving against the 85% statutory & mandatory target. Mrs Brown said that because we know the breakdown of compliance by area, the Trust was able to understand the areas that were not individually delivering the target.

Mrs Brown reported that the Trust had been successful in achieving winter funding which was £1.87m and there could be a second tranche of funding for the north of the county.

Mr Harris-Bridge raised an issue in relation to the escalation cost of medical locums particular in areas where the activity level was not increasing and asked for clarification regarding e-rostering not doing what it was hoped it would do when initially implemented.

Ms Newing reported that the doctors rosters were in the process of being included on Healthmedic and the team are working on linking this with job planning also being visible. This will be completed by the end of the financial year.
Ms Newing added that the wards were improving and the rosters were in the main meeting the six week target and where the frustration currently lies was with locum bills and waiting list initiatives. Mr Harris-Bridge requested an updated position in relation to where the Trust was in regarding the full implementation of e-rostering.

In relation to medical locum costs, Ms Newing reported that the Women & Children’s Clinical Business Unit had higher than expected costs due to unanticipated vacancies.

In response Ms Gray queried the medical rota position in relation to vacancies being filled with locums. Mrs Brown said that the Trust was £1m underspent on staffing and the Trust did understand in detail the areas which were budgeted for and the current position was a good news story. However, one issue to work on related to ensuring the Trust was more efficient in relation to locum usage. Mrs Brown added that it was not the biggest concern of the financial position compared to the trading position which was £6m adrift.

Mr Harris-Bridge said that the Trust was working to the original plan and the Board would review whether to reforecast at the December meeting. Mrs Brown said in relation to staffing the discharge lounge, this area was only being opened overnight and if medical care was required, the on call team would be utilised. Mrs Gray asked that if the Committee had assurance from the Chief Operating Officer in relation to the patients who were medically fit for discharge would only use the additional beds opened in the discharge lounge if they were going home the following day.

Mrs Gray queried when additional beds were opened were the Executive Team sufficiently assured that additional pressure was not being put on parts of the workforce who had previously raised staffing issues (i.e. junior doctors). Mrs Brown said that she was not currently assured regarding Hospital at Night and was concerned regarding how staff were supported. Mrs Gray queried where there was a potential patient safety issue was the Trust at risk by not bringing in additional medical workforce to meet the needs of patients. Mrs Brown said that additional medical staff were utilised using registrars or consultants rather than have a gap and this was checked every day at the capacity meetings. Mrs Gray commented that she was pleased to receive assurance that members of the workforce were not left in a difficult situation and it was acknowledged that this was continually being addressed.

**DECISION:**

(a) An update on the action plan for Anaesthesia CBU in relation to Safeguarding would be presented at the next meeting.

(b) An update on E-Rostering would be presented at a future meeting.

6.4 WDC Risk Portfolio and Board

Mrs Gray summarised the issues discussed at the meeting which included to ensure the data presented in the reports gave the same message. Some of the areas of risk in the QIP were in a more positive position than had been seen in previous months and this was to be reflected back to the Director of HR for next month’s report.

Mrs Gray said that there were areas of risk regarding safe staffing and she would aim to visit the wards after the meeting to be visible and to gain any soft intelligence from the areas.

The Trust was about to receive the staff survey results which would need to be cross referenced to the other risk areas to make sure responses and any current areas of risk were triangulated to prepare the Staff Survey Action Plan. Mrs Gray requested for next month, the Committee needed to understand the risks surrounding the workforce.
Mr Harris-Bridge said that it was reported at the last meeting of the Performance, Finance & Resources Committee that the Board Assurance Framework (BAF) was not being updated in its current form for 2017/18 and queried at what stage would the Board be presented with an updated Board Assurance Framework. Mrs Gray said that the BAF was normally reviewed at the agenda setting process for the Committee. Mrs Brown said that this information would be requested from Mr King.

Mrs Brown said that there was a risk regarding the management capacity within Surgery. Mrs Brown said that there was a short term risk which was being addressed and needed to be ensure this was detailed as a workforce risk. Mrs Gray queried if the availability of management and leadership resources should be reviewed as part of the Well Led Action Plan as a risk for the Trust. Ms Gray asked for the Director of HR to take the lead on reviewing this risk area being escalated by the Committee.

Ms Gray noted that the Board was currently short on NED capacity regarding being involved in Consultant Interviews.

**DECISION:**
(a) At the next meeting the Committee to receive a report on workforce risks across the Trust.
(b) Mrs Brown to request an update from Mr King regarding the process for the Board Assurance Framework.
(c) Mrs Gray to write to the new Chair of the Committee. Mr A Ball, as there would be a significant agenda for January.

7. **RESPECTFUL**

7.1 Medical Revalidation Review

*Deferred*

7.2 Health Education England

*Deferred*

7.2 Diversity & Inclusion Progress Review

*Deferred*

8. **ENGAGING**

8.1 Review of Workforce Development Strategy & Implementation Plan

*Deferred*

9. **ANY OTHER BUSINESS/EVALUATION OF MEETING**

9.1 Evaluation of Meeting

Dr Blades said that it was an interesting meeting and said that the NED challenge was undertaken very well. Dr Blades complimented the Directors present in their knowledge of their own area.

Mr Harris-Bridge said that the meetings seem to go better the few people in attendance to be able to focus on the key issues and risks.
9.2 Date & time of next meeting

- 09:00am
- 24th January 2018
- Boardroom, Glebe House