## AGENDA BOARD OF DIRECTORS

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

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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
- 6th April 2018
- Boardroom, Glebe House
# AGENDA BOARD OF DIRECTORS

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

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Chairman: Alan Burns  
Interim Chief Executive: Fiona Wise
6. RISK AND GOVERNANCE

12:25 6.1 Well-Led Review Improvement Update  Review  Director of Integrated Governance (interim) (to follow)

12:35 6.2 Risk Management: Risk Appetite Statement  Approval  Director of Integrated Governance (interim) (attached)

7. MINUTES

12:40 7.1 Audit Committee  Review  Chair of Committee (attached)

12:55 7.2 Integrated Governance Committee  Review  Chair of Committee (attached)

12:50 7.3 Performance, Finance & Resources Committee  Review  Chair of Committee (attached)

1:00 7.4 Workforce Development Committee  Review  Chair of Committee (verbal)

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)

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10. DATE & TIME OF NEXT MEETING

- 10:00am
- 6th April 2018
- Boardroom, Glebe House
PRESENTATION ON THE PATHOLOGY SERVICE

Following discussions at the October 2017 Board of Directors meeting, Dr McCreanor was invited to present to the Board to present on the future vision for the pathology service. The Board received a presentation which provided the background to national reports reporting that £200m national savings were required for pathology services. NHS Improvement provided a vision for pathology services putting patients first by providing services which were clinically excellent, cost effective and integrated with health strategy. Dr McCreanor reported that the Carter Report detailed that savings of £200,000 were expected for Trust but this were yet to be identified. The data provided evidence that the Trust was more cost effective than neighbouring Trusts.

Dr McCreanor reported that a regional pathology network was being proposed with the Trust in the network of Midlands & East 2. The proposed model was based upon a network of pathology providers supported by a single network governance framework led by a Network Executive Board.

A NHS Improvement Executive Workshop was being held on the 2nd February 2018 where commitment was being sought from all the Trusts to (a) establish a Network Executive Board; (b) to contribute funding of approximately £100,000 per annum per Trust to establish the network; (c) to share data required to complete a detailed baseline and (d) to establish an operational model.

Mr Shipman queried investment for ICT with Dr McCreanor stating that a business case was being worked upon to connect with other providers.
Mr Harris-Bridge asked if the sufficient change would provide benefits with Dr McCreanor reporting that this would be identified through the completion of the baseline assessment. Ms Briggs reported that the Trust had met with NHS Improvement and it would may cost the Trust to join the Network as the Trust was the most cost effective organisation, however, the Trust needed to be involved to ensure that the savings made by the Trust were not used to fund some of the bigger hubs within the network.

Mrs Gray queried the risks and it was acknowledged that risk identification would be undertaken within the baseline activity along with the required mitigations. Dr McCreanor said that the Trust would want to continue to offer an excellent pathology service to primary care.

Professor Welsh queried if NHS Improvement could point towards a large hub that was already working well with Dr McCreanor responding that a hub near Hull had been working well for the last 20 years. Ms Wise said that the Trust wanted to ensure that the outcome was for the Trust to continue to provide a high quality pathology service to patients and GP practices. Ms Wise said that Northampton General Hospital had requested conversations with the Trust regarding the implications of the network to the acute unified offer.

The Chairman said that due to shortages of skilled staff, automation of services and the formation of a regional network, the proposal was an obvious way forward. The Chairman said that the Trust was committed to ensuring the network worked and it was an essential requirement that the baseline was undertaken correctly.

**DECISION:** *The Board of Directors was committed to the Network, working primarily alongside Northampton and Leicester and the whole Network.*

**OPENING ADMINISTRATION**

1.1 **APOLOGIES FOR ABSENCE**

Apologies for absence were received Mr A Ball, Mr S Lake and Mrs S Hills (*Healthwatch*).

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 22nd December 2017 and the extra-ordinary Board of Directors meeting held on the 11th January 2018 were approved as a true and accurate record.

1.4 **Matters Arising**

**Matters Arising from the meeting held on the 22nd December 2017**

1.4.1 **Well-Led Governance Improvement Plan Update (minute 1.4.2)**

The Well-Led Improvement Plan which was requested at the last meeting was an item on the agenda for discussion.
1.4.2 Long-Term Financial Plan (minute 3.1)

**DECISION:** A report on the Long Term Financial Plan would return to the Board of Directors in March 2017.

1.4.3 Care Quality Commission Inspection Well-Led Feedback (minute 4.3)

**DECISION:** The Board requested an update on how the Trust addressed bullying allegations which would be presented to the Board of Directors in March 2018.

Matters Arising from the meeting held on the 11th January 2018

1.4.4 Financial Re-forecasting Position (minute 2.1)

The Board was informed that following the extra-ordinary Board of Directors meeting the Director of Finance had submitted correspondence to NHS Improvement regarding the forecast year-end financial position.

1.4.5 Urgent Care Hub: Outline Business Case (minute 2.2)

Following the meeting, the Outline Business Case was amended to detail that (a) the Trust had a clear plan regarding the utilisation of the existing space within the A&E Department; (b) an executive summary of the case; (c) a formal letter was sent to the STP and the Clinical Commissioning Groups detailing the affordability reasoning and (d) the case would specifically detail Wellingborough as a key catchment area of the Trust.

**DECISION:** The Board of Directors would receive a communications plan at the next meeting.

2. REPORTS FROM THE CHAIR AND CHIEF EXECUTIVE

2.1 Chairman’s Opening Remarks

The Chairman welcomed Professor C Welsh to the Board meeting as the new Non-Executive Director on the Board.

The Chairman reported that the Corby Clinical Commissioning Group proposals for the Corby Urgent Care Centre would be discussed during the private part of the meeting.

The Chairman informed the Board that there was a meeting on the 5th February 2018 being facilitated by NHS Improvement with the Chairmen and Chief Executives of Trusts in the health economy regarding the progress being made on the STP to ensure meaningful collaboration.

2.2 Chief Executive’s Report

The Board of Directors received the Chief Executive’s report which highlighted national and local issues affecting the Trust.
The Board received and noted the minutes of the Health & Wellbeing Board held on the 9th November 2017.

Ms Wise specifically highlighted staff behaviours within the Trust and staff had been reminded of the CARE values which the Trust adhered to.

Ms Wise reported that the draft Care Quality Commission (CQC) Inspection report, which was currently being reviewed for factual accuracy, was due to be published early March 2018.

Mr Harris-Bridge queried acute representation at the Health & Wellbeing meetings with Ms Wise reporting that it was a meeting where the Trust was in the middle of the inspection process with the CQC and was therefore unable to attend the last meeting. Mr Harris-Bridge queried if the system was working more collaboratively with Ms Wise reporting that it was working due to the receipt of additional winter monies and highlighted the challenges with Northamptonshire County Council being subject to a substantial value for money review.

3. QUALITY, PATIENT SAFETY & EXPERIENCE

3.1 Integrated Governance Report

The Integrated Governance report was presented to the Board which reported that during month the Trust saw 7,444 people attending the A&E Department; with 2,943 patients being treated for non-elective care; 379 patients underwent elective inpatient care; 2,916 day cases; 260 births and 18,288 outpatient appointments.

Quality & Safety Performance

Ms Hackshall presented the quality & safety metrics relating to December 2017 and reported that the Trust continued to work to improve compliance with issuing discharge letters which was being led by the Medical Director and the Chief Operating Officer. The risks in relation to quality related to the number of patients attending the Trust over 75 years of age which was higher than the Trust had seen and the acuity of these patients was higher which had significant affected the Trust in terms of capacity. The Board was informed that the corporate non-clinical teams had been supporting various areas across the Trust.

Ms Hackshall reported that the reduction of funding had resulted in the Domestic Abuse Adviser at the Trust no longer being available which was being raised on a county-wide basis. Mr Shipman queried if any of the reductions in service had been out to consultation by the County Council and it was confirmed that this was not the case.

The Chairman queried the resistance to opening and closing the escalation areas within the hospital. Ms Hackshall said that discussions were held with clinicians to only open areas if safety could be maintained and the closure of all escalation areas was addressed at each Safety Huddle meeting.
Mrs Gray queried the level of assurance the Executive receive regarding escalation areas with Ms Hackshall responding that there were daily ward rounds by the Executive Team and Lead Nurses who undertook quality visits in the escalation areas. The Board was informed that staff were also redeployed to the A&E department to address handovers from ambulance staff to maintain flow.

Dr Chilton provided an overview of the clinical actions taken to address the escalation areas to maintain safety across the Trust.

Mrs Brown reported that lessons learnt would be reviewed by the Trust Management Committee relating to the winter pressures being experienced by the Trust and then presented to the Board of Directors. The Chairman stated that a possible recommendation through the lessons learnt process could be to reduce elective care for a 10 month period for 2018/19. Ms Wise stated that the Trust was also being encouraged to review the elderly/frailty model.

Mrs Gray queried if the national requirement to reduce elective work had had an impact on the Trust. Mrs Brown said that the Trust had plans to cancel elective activity, apart from cancers or clinically urgent, for the first two weeks in January. With the national letter, the Trust had extended this to the whole of January.

**DECISION:** A Lessons Learnt report on the winter pressures would be presented to the Board of Directors meeting in March 2018.

**Operational Performance**

Mrs Brown reported that the Trust was reporting a positive performance in all of the indicators relating to cancer positive and in relation to diagnostics, the Trust was achieving the position in December. For the Referral to Treatment Time (RTT) target the position relating to patients waiting over 18 weeks had been stabilised.

The Board was informed, that in relation to urgent care, the Trust had not seen 12 hour trolley waits which was a tribute to staff who had been working under extremely challenging circumstances. Mrs Brown said that for urgent care performance, the Trust was including the activity from Corby Urgent Care Centre.

Mrs Brown provided a detailed explanation of the actions being taken within the Trust to address patient flow through the hospital and the specific actions being taken to address stranded patients.

Mrs Gray queried the impact of mental health patients within the stranded and super stranded patients and asked about the developments required to ensure the discharge letters were issued on a timely basis. Mrs Brown said that with the Medway re-configuration the Trust was reviewing all paperless solutions for the Trust with the aim for this to be implemented by 2020. Mrs Gray reported that this would continually to be monitored at the Integrated Governance Committee.
Dr Chilton said that the metric of being 100% compliance with the issue of discharge letters was not realistic due to a number of issues which included junior doctor vacancies and locum and agency staff in place and weekends with a depilated workforce, therefore, the target should be reviewed.

Mr Shipman highlighted patients over the age of 75 and the growth reported in the Urgent Care Hub Outline Business Case and asked that the Trust reviewed this data further to plan for the future regarding managing the increased numbers and was informed that this work would be undertaken as part of the required capacity plan for the Trust.

**Workforce Performance**

Mr Smith informed the Board that the Trust had a further recruitment open day on the 24th February 2018 to recruit to nursing and healthcare assistant posts. There was an acknowledgement nationally that the net nursing figures were down the first time in seven years. There had been a reduction in appraisal rates and the Human Resources department would be reviewing the position to ensure that the Trust would be reporting compliance based on a 10 month period in relation to the winter pressures.

Mr Smith reported that the flu compliance rate was 63% and the Trust was continuing to proactively encourage staff to receive their flu vaccination.

The Chairman said that if there was to be a flu epidemic and the Trust had areas where vaccination rates were low, this presented a significant risk to the Trust. Therefore, an effort was required through the summer period to understand the issues for the Groups of staff who refuse to receive their flu vaccination. Ms Wise said that the staff providing flu vaccinations had received unwarranted behaviour by certain groups of staff which was being addressed by the Chief Executive.

**DECISION:** The Executive Team to review lessons learnt in relation to the flu vaccination and promoting the vaccination with staff. This issue would be added to the work programme of the Workforce Development Committee.

The Chairman highlighted discussions at the Board Development session regarding the content of the integrated report to the Board and the requirement for key performance indicators to be reviewed and agreed by the Board. The specific action was "for a further discussion and a finalised report on “super” key performance indicators and assurance mapping by May 2018. Therefore, the Board would be presented with the draft indicators during April 2018.

**DECISION:** The Board of Directors would receive the draft key performance indicators for a revised integrated governance report to the Board in draft by April 2018.

**Financial Performance**

In relation to the 2018/2019 Financial Plan, national guidance was still awaited from NHS Improvement.
However, the Trust was continuing to develop a financial plan and was reviewing activity and establishments. The Cost Improvement Plans would be set against 25 themes to drive through the organisation in the region of 4% - 6%. Mr Shipman said that the Model Hospital data, for certain specialities had been updated nationally and Ms Briggs confirmed that this would be reviewed to drive specialities where opportunities were evident.

Mr Harris-Bridge highlighted the substantial non recurrent costs which the Trust and incurred and driven the deficit and it was important that these were addressed for the next financial year. Ms Briggs reported that once a draft plan was in place then more stretching targets would be set around the CIPs to create a larger financial “buffer” for the Trust. In addition, the scale of unplanned costs needed to be addressed and the Trust needed to improve the way unplanned events arose. The Trust had to make decisions regarding how capital activity was undertaken to ensure capital works, clinical activity etc were aligned. Mr Harris-Bridge said that the lack of planning guidance was having an impact on the Trust regarding the planning. The Chairman stated that the Board may have to hold additional meetings of the Board or Committees once the planning guidance was received.

Mrs Hanna highlighted that issue of addressing capital spend in line with the plan. Ms Wise said that an action plan was being put in place for Estates that would detail the priorities of the business cases in terms of managing the estate risks across the Trust which be in place by the end of February.

**DECISION:** To take a decision if extra-ordinary Board meeting or Board Committee meetings would need to be arranged once the national guidance was received.

3.2 Director of Nursing & Quality Report

The Board was presented with a report from the Director of Nursing & Quality which provided an update in relation to the nursing portfolio.

Mrs Gray queried the implications of BREXIT on nursing within the Trust. Ms Hackshall reported that the Trust was addressing the issue and the priority for the hospital was to develop “home-grown” staff to fill vacancies. Mr Smith added that the representatives from the Trust had attended a BEXIT Network meeting where issues were being discussed and it was noted that it had been reported nationally that applications from the European Union had reduced by 92%.

The report was received and noted.

3.3 Quality Improvement Plan

The Quality Improvement Plan report provided an updated position against the actions set out in the Quality Improvement Plan designed to deliver the “must” and “should” do actions identified by the Care Quality Commission following the inspection in October 2017. The report was received and noted.
3.4 Guardian of Safe Working

Dr Bilolikar, Guardian of Safe Working, presented an update report to the Board for August 2017 to early December 2017. It was reported that all specialities had entered the new junior doctor contract from August 2017. During the period a total of 28 exceptions were submitted and were in the main submitted from the surgery clinical business unit. The issues raised included trainees being unable to log onto the Allocate website and disquiet from surgical trainees with consultant attitudes. In relation to attitudes, meetings were arranged with representatives of the surgical trainees, the human resources department and the Guardian of Safe Working to resolve the specific issues being raised.

It was noted that the Dr Bilolikar had met with the General Medical Council (GMC) Liaison Officer to understand Y1 and Y2 doctors survey which was conducted by the GMC with the results being broadly consistent with other hospitals in the region.

The Board was informed that a meeting was held with the Guardian of Safe Working with the CQC as part of the formal inspection process.

Mrs Gray said that she had attended one of the Medical Education meetings where Dr Bilolikar presented where it appeared that the issues being raised were a mammoth task and was really pleased to see that a number of the issues raised had been resolved.

The Chairman thanked Dr Bilolikar for his report to the Board.

3.6 EPRR Core Standards

Mrs Brown reported that at the September 2017 Board of Directors meeting that the Trust was required to self-assess performance against the emergency preparedness, resilience and response (EPRR) Core Standards set by NHS England. The self-assessment was submitted and it was reported that NHS England had responded to the submission on the 27th December 2017 reporting that they were in agreement with the self-assessment that the hospital was fully compliant with the EPRR Core Standards.

The Board noted that the Trust would be responding by the 31st March 2018 to actions detailed within the response letter.

3.7 General Data Protection Regulations (GDPR)

The Chairman raised an additional issue not on the agenda which related to the progress being made regarding the implementation of GDPR and queried where the Trust was debating the issue. Ms Wise reported that the new Quality & Safety Committee (currently Integrated Governance Committee) would have a task and finish group receiving reports from the Information Governance Group. Following discussions at the Performance, Finance & Resources Committee, Mr Harris-Bridge stated that the Committee had been assured that processes within the Trust were in place. This echoed by Ms Wise and Mr Shipman that Mrs Arnold, Director of IT, had appropriate process in place in relation to GDPR.
4. STRATEGY & FINANCE

4.1 Sustainability & Transformation Plan (STP) Update

The Board of Directors was presented with a report, which have been completed by the Programme Management Office of the STP which (a) highlighted the next steps in the development of the STP programme in 2018; (b) provided clarification in the management of New Models of Care work streams; (c) detailed an update on the procurement of the resources required to support the programme and reported on key changes in performance and (d) highlighted the discussion principles and processes underpinning the development of monitoring and reporting.

Mr Harris-Bridge raised concerns that the Chair and NED meetings have been cancelled and therefore there had not been sight of any plans in relation to the programme. The Chairman said that the meetings would change to a Stakeholder Group to address the issue communication across the Health Economy.

The report was received and noted.

4.2 Long Term Liquidity, Cash Flow, Loan Balances and Funding

Ms Briggs informed Board Members that an updated report relating to the long term liquidity, cash flow, loan balances and funding had been circulated to the Board of Directors following a meeting with the Chair of Performance, Finance & Resources Committee. Ms Briggs informed the meeting that the paper was presented to request the approval of a further application of revenue funding of £2m in 2017/18 because of the uncertainty around the forecast deficit position.

Ms Briggs also requested the Board to support draw down of the already approved Capital loan to ensure capital loan repayments are met this financial year.

The Board agreed that the Chair of the Audit Committee and Chair of Performance, Finance & Resources Committee would review the applications before submission of any request for 2018/19 by the 9th March 2018.

Ms Briggs stated that under the Section 42 conditions, (To Note: Section 42A of the NHS Act 2006 related to how the Secretary of State may exercise his powers to provide financial assistance to Foundation Trusts.) the Trust would have to submit a report, to the Board and then onto the Regulator, on a quarterly basis. The Chairman requested that a report on the Section 42 Conditions was submitted to the PFR Committee on a quarterly basis.

Mrs Hanna queried that due to the number of loans, how would the Trust commence discussions with the Regulators regarding the steps required to have sensible discussions regarding consolidation of the loans to assist the Trust to become a safe organisation, Ms Briggs said that the statement from NHS Improvement was that they would not discuss consolidation of loans and added that the Trust needed to return to the Control Total regime.
The second option related to a discussion with a representative from the Department of Health regarding how they expected the Trust to manage with the current profile of loans which would continue for the next 5 years.

Mr Shipman said that the same issues would also relate to other Trusts and recommended highlighting this with the Department of Health. Ms Briggs said that by the end of the financial year could be approximately 20-30 Trusts in the same. It was suggested that perhaps contact could be made with NHS Providers to represent Trusts in negative balances. Professor Welsh queried the national position with Ms Briggs reporting that most acute Trusts would have some form of loans and there would be approximately 15% of Trusts who had severe cash issue to address.

The report detailed that the Trust submitted an additional revenue support request for February to support the reprofiling of winter funding. This was rejected by the Department of Health Cash and Capita team. The Trust subsequently submitted an exceptional working capital request which was not supported with the Department of Health stating that the department would not advance winter pressures cash unless the knock on effect significantly impacts the Trust operationally. Ms Briggs reported that the Trust would not be drawing capital cash to cover revenue cost and instead has taken a number of measures to try to support the cash position instead a number of cash saving measures would be enforced. These included payment runs to be set up to only pay on 30 days unless 30 days falls at a weekend; to move all NHS payments to 45 day payment terms and to contact system wide Finance Directors for a cash advance.

Ms Hanna said that she was unhappy that Trust was being asked to break public sector procurement regulations and asked for the interest rate charge to be included within the financial forecast.

Ms Briggs said that the Trust was not the only Trust taking these actions.

Mrs Brown said that she was very concerned regarding the lack of support from the Commissioners regarding the position of the Trust as the system should be working closely together in the current challenging financial environment.

Mrs Gray queried if there was documented responses from the regulators relating to all financial decisions with Ms Briggs reporting that all responses from the Department of Health were received via email, and therefore documented.

Mr Shipman queried if the Trust had approached local authorities for short term financial support. Ms Briggs said that she had not approached the County Council but would investigate if conversations could be held with other District Councils to assist the Trust.

The Chairman said that the problem would not be solved solely by the Trust and the view should be taken to concentrate returning to the control total regime. The Trust would have to be extremely focused on addressing this position in the next financial year.

**DECISIONS:**

(a) The Board of Directors noted the interim funding arrangements for the Trust.
(b) Board Members noted the key cash risks and the impact of the loans on the Trust liabilities and net assets.

(c) Board Members approved an application for additional interim revenue loan funding of £2m with a full year revenue loan sum of up to £28.9m in 2017/2018.

(d) The Board of Directors Members approved an application for interim revenue loan funding of £12.1m and interim capital loan funding of £8m for 2018/19.

(e) The Board of Directors approved the Board Resolutions in Appendix 1 to the minutes

(f) The Board of Directors agreed to the Department of Health Additional Terms and Conditions in Appendix 2.

(g) The Board of Directors authorised the Chief Executive (or interim/Acting CEO in their absence) or the Director of Finance (or Deputy of 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.

(h) The Board of Directors authorised 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 requirements for April is met.

(i) The Board agreed that the Chair of the Audit Committee and Chair of Performance, Finance & Resources Committee would review the applications before submission of any request by the 9th March 2018.

(j) It was suggested that perhaps contact could be made with NHS Providers to suggest national representation for Trusts in negative financial balance.

(k) The Chairman requested that a report on the Section 42 Conditions was submitted to the PFR Committee on a quarterly basis.

(l) The Board approved the Director of Finance to draw down Capital loans in 2017/18 relating to the capital programme and repayment of capital loans.

5. RISK AND GOVERNANCE

5.1 Well-Led Review Improvement Plan Update


Ms Wise reported that a new interim Director of Integrated Governance would commence on the 5th February 2018 replacing Mr P King. The Board was informed that the Executive Team had discussed the risk appetite statement for the Trust which would be presented to the Board of Directors in March 2018.
It was agreed that Board Development sessions would not discuss Board business. The Chairman said if progress was made to improving the reporting of operational performance discussions of the Board, then the Board could then ensure there was additional focus on strategic discussions.

**DECISION:** *The Risk Appetite Statement for the Trust would be presented to the Board of Directors in March 2018.*

5.2 Board Assurance Framework

Ms Wise presented the report relating to the work undertaken on the Board Assurance Framework.

Mr Shipman queried estates in relation to the area of fire prevention and Ms Wise said that the risk was being managed and controls were in place and therefore the risk had been scored in the context of the work being undertaken and professional fire prevention advice being received.

Mrs Gray said that GDPR was discussed by the Integrated Governance Committee and queried if the this was being reviewed through the risk management processes and Ms Hackshall agreed that this was the case.

6. MINUTES

6.1 Integrated Governance Committee

The minutes of the Integrated Governance meeting held on the 19th December 2017 were received and noted. Mrs Gray reported on the meeting had held a development session to commence discussions on the new terms of reference for a Quality & Safety Committee.

6.2 Performance, Finance & Resources Committee

The minutes of the Performance, Finance & Resources Committee held on the 20th December 2017 were received and noted. Mr Harris-Bridge reported on the meeting held on the 31st January 2017 and stated that the Committee had commended how staff had addressed the pressures the Trust was experiencing and asked for the thanks of the Committee to be passed on to all teams. The Committee had discussed the areas of radiology reporting and had discussed the mitigating actions being taken in relation to the high number of patients attending the A&E in relation to health & safety legislation. Mrs Brown added that this issue was linked to the strategy for urgent care and the issue of ensuring the Trust followed appropriate process when the Trust was in an escalated major incident environment and this would be addressed as part of the lessons learnt paper on winter pressures. Professor Welsh asked for the risks to patients and staff to be reflected within the lessons learnt review with Mrs Brown acknowledging that this would be addressed.

6.3 Workforce Development Committee

The minutes of the Workforce Development Committee held on the 20th December 2017 were received and noted.
7. **FEEDBACK FROM HEALTHWATCH/GOVERNORS**

Dr Blades said that she welcomed the stakeholder group in relation to the STP and highlighted the issue of the hydration of patients.

8. **AREAS OF UNMITIGATED RISK**

No areas of unmitigated risk were raised during the meeting.

9. **ANY OTHER BUSINESS**

9.1 **Chief Executive**

The Chairman thanked Ms Wise for her contribution to the Trust during her role as interim Chief Executive.

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.
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.
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.
# Table of Matters Arising from the Board of Directors Meeting Held on 2nd February 2018

<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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</table>
| 1.4.2      | Long Term Financial Plan (minute 3.1)  
A report on the Long Term Financial Plan would return to the Board of Directors in March 2017 | N. Briggs | Scheduled for discussion within Part II of the Board Meeting. |
| 1.4.3      | Care Quality Commission Inspection Well-Led Feedback (minute 4.3)  
The Board requested an update on how the Trust addressed bullying allegations which would be presented to the Board of Directors in March 2018. | M. Smith | Scheduled for the April meeting |
| 1.4.5      | Urgent Care Hub: Outline Business Case (minute 2.2)  
The Board of Directors would receive a communications plan at the next meeting. | N. Briggs | |
| 3.1        | Integrated Governance Report  
The Board of Directors would receive the draft key performance indicators for a revised integrated governance report to the Board in draft by April 2018.  
**Operational Performance**  
A Lessons Learnt report on the winter pressures would be presented to the Board of Directors meeting in March 2018.  
**Workforce Performance**  
The Executive Team to review lessons learnt in relation to the flu vaccination programme and promoting the vaccination with staff. This issue would be added to the work programme of the Workforce Development Committee  
**Financial Performance**  
To take a decision if extra-ordinary Board meeting or Committee meetings were arranged once the national guidance was received. | R. Brown | Scheduled for the April meeting |
| 4.2        | Long Term Liquidity, Cash Flow, Loan Balances and Funding  
To contact NHS Providers to suggest national representation for Trusts in negative financial | N. Briggs | |
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<tr>
<th>MINUTE REF</th>
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<tr>
<td></td>
<td>balance. To investigation the possibility of the Trust approaching District Councils regarding the cash position of the Trust.</td>
<td>N. Briggs</td>
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<tr>
<td>5.1</td>
<td>Well-Led Improvement Plan Update The Risk Appetite Statement for the Trust would be presented to the Board of Directors in March 2018.</td>
<td>J. Davies/S. Clennett</td>
<td>On the agenda</td>
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<tr>
<td>DATE OF BOARD MEETING</td>
<td>MINUTE REFERENCE</td>
<td>OWNER</td>
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| 22nd December 2017   | 1.4.2 (3.1 November 2017 meeting) | N. Briggs | Long-Term Financial Plan  
A report on the Long Term Financial Plan would return to the Board of Directors in March 2017. | March 2018 | March 2018 |
| 22nd December 2017   | 1.4.3            | M. Smith | Care Quality Commission Inspection Well-Led Feedback  
The Board requested an update on how the Trust addressed bullying allegations which would be presented to the Board of Directors in March 2018. | April | |
| 11th January 2018    | 1.4.5            | N. Briggs | Urgent Care Hub: Outline Business Case (minute 2.2)  
The Board to receive a communications plan in relation to the Urgent Care Hub. | April | |
| 2nd February 2018    | 3.1             | R. Brown | Integrated Governance Report  
The Board of Directors would receive the draft key performance indicators for a revised integrated governance report to the Board in draft by April 2018. | April 2018 | |
<table>
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<tr>
<th>BOARD OF DIRECTORS</th>
<th>2nd MARCH 2018</th>
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<tbody>
<tr>
<td>AGENDA ITEM</td>
<td>2.2</td>
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<tr>
<td>SUBJECT:</td>
<td>CHIEF EXECUTIVE’S REPORT</td>
</tr>
</tbody>
</table>
| RESPONSIBLE DIRECTOR | Fiona Wise  
Chief Executive |
| AUTHOR: | Sharan Madeley  
Trust Board Secretary |
| PREVIOUSLY CONSIDERED BY: | N/A |

**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:

Visit by the Minister for Health and President of the Royal College of Physicians

On the 15th February 2018, we were visited by the Minister for Health and Social Care, Jeremy Hunt and Professor Jane Dacre, President of the Royal College of Physicians, as part of a national drive to improve patient safety within the NHS. Mr Hunt gave a patient safety presentation and answered questions about the NHS and its many challenges.

Dr Andrew Chilton, Medical Director and Deputy Director of Nursing and Quality, Diane Postle, gave a presentation on the Trust’s safety ethos and what we do to monitor and maintain high standards.

Mr Hunt had a very brief tour of the A&E department where he was shown the capacity and environmental issues we face every day, particularly as the Trust has now submitted a Business Case for a new Emergency Department that he will eventually be asked to consider. The event was attended by 84 staff from across KGH’s

Financial Position of the Trust

At this month’s Leadership Brief I discussed the current financial position of the Trust and some of the actions we are introducing to address this. At the end of January the Trust year to date deficit was £26.1m and the Trust had agreed with our regulators at the beginning of the year that our deficit would be £19.9m. The Trust must manage it’s spend over the final 2 months of the year to under £3m if we are to avoid further intervention from the regulator. Whilst some of this overspend can be attributed to the fact that in January we cancelled our planned activity as directed by the government we know that a proportion of this is due to elements that are directly within our control. And so at Leadership Brief I outlined a number of immediate actions that are required to ensure that we remain within the £3million spending cap.

Maintaining Quality & Safety

Senior Managers were informed at the Leadership Brief this month for a need to ensure consistency across the organisation in delivering high standards of safe care and treatment. The key messages from the Care Quality Commission initial inspection report were emphasised which included:
• Person centred care, especially for people with mental health needs who require acute care
• Dignity and respect
• Safeguarding systems and training
• Premises and equipment
• Governance and in particular oversight of incidents and embedding learning
• Staffing levels and competencies

Norovirus update

The Board will be aware through discussions at Board Committees, that the Trust has been addressing influenza and Norovirus outbreaks. A number of wards have had to close during the month which adds additional pressure to capacity challenges within the Trust. The Trust did initially restrict visiting but this currently only applies to the wards which are closed due to patients being symptomatic.

KGH Care at Home

In my Chief Executive weekly bulletin on the 9th February 2017, I briefed the Trust that the new KGH Care at Home service was operational and ask staff to ensure they consider this service option for their patients. I have received positive feedback to date which included details of one patient who had been unwell and needed three times a day IV antibiotics and who was now being cared for at home and “sitting on the sofa watching TV with her husband” This patient would otherwise have had to stay in hospital to receive the remainder of their care.

Operational Pressures

I have attached correspondence sent to staff this week regarding the continuation of severe service pressures which provides clear expectations regarding how the Trust is managing flow and capacity. (attached)

2.2 Northamptonshire County Council (NCC)

The Board was briefed regarding the current financial position at NCC at the previous Board meeting. Stakeholders received the following statement on the 9th February 2018:

_Northamptonshire County Council has announced details of how it will tighten spending controls after the authority’s Director of Finance issued a Section 114 notice. The notice means that no new expenditure is permitted, with the exception of safeguarding vulnerable people and statutory services. The council will continue to honour existing commitments and contracts. The notice primarily relates to the current financial year, but there may be some impact on the council’s proposed budget for 2018/19, which is due to be discussed at the Full Council meeting on February 22nd and which will now be subject to ongoing review over the coming weeks.

It was issued in light of the severe financial challenge facing the authority and the significant risk that it will not be in a position to deliver a balanced budget by the end of the year. This is an emergency situation where a response is required by legislation. In order to clamp down on spending an Emergency Expenditure Control Protocol has been set up.

This will ensure that council workers carry out their duties in line with contractual obligations and to acceptable standards, while being aware of the financial situation. Any spending that is not essential or which can be postponed should not take place and essential spend will be monitored._
To that end a Chief Executive Approval Panel has been established to examine and monitor all expenditure and make sure money is only spent as required under statute, to safeguards the vulnerable residents of the county or meet our existing contract obligations.

The only allowable expenditure permitted under the emergency protocol will include the following categories:

- Existing staff payroll and pension costs
- Expenditure on goods and services which have already been received
- Expenditure required to deliver the council’s provision of statutory services at a minimum possible level
- Urgent expenditure required to safeguard the vulnerable citizens of the county
- Expenditure required through existing legal agreements and contracts
- Expenditure funded through ring-fenced grants
- Expenditure necessary to achieve value for money and/or mitigate additional in year costs

Councillors have 21 days from when the Section 114 notice was issued to discuss the implications and this is due to be addressed at the Full Council meeting on February 22.

2.3 Corby Clinical Commissioning Group

The Board was briefed on the process being followed by NHS Corby Clinical Commissioning Group (CCG) regarding the future use of Corby Urgent Care Centre and the Board of Directors received a presentation from the Clinical Chair Dr Watt and Chief Officer, Carole Dehghani at the last Board meeting. The CCG's plans were approved by its Governing Body at an extraordinary meeting on 30th January. The plans outline how it intends to retain an urgent service and increase primary care capacity (GP-related services) — ensuring an on-the-day appointment for anyone who needs one.

The plans have been influenced by the views of local people, following a period of public engagement.

The CCG is now inviting local people to shape how they will access future healthcare services in the town. From Monday 12th February until midnight on Sunday 8th April people will be able to submit comments using a questionnaire available online and in paper format.

The CCG’s engagement team will be out in Corby and the surrounding area, visiting supermarkets, the market, the library, GP surgeries, community groups and workplaces. They will be giving out copies of the information document and questionnaire and answering questions on how to be part of this continuing conversation about healthcare in Corby.

3. NATIONAL ISSUES

3.1 Kirkup Review into Liverpool Community Health

The independent review into Liverpool Community Health Trust was commissioned by NHS Improvement. Following the publication of the review, NHS Providers has provided a briefing which summarises the review findings and recommendations with implications for the whole provider sector. NHS Providers will be seeking to understand the implications this report and its recommendations will have on the regulation and oversight of trusts, as well as working closely with the Department of
3.2 Sustainability & Transformation Partnerships (STPs) and Accountable Care

Please find attached a background briefing (attached appendix) which brings together information on the development of Sustainability and Transformation Partnerships (STPs), accountable care systems (ACSs) and accountable care organisations (ACOs). This forms part of NHS Providers new programme on STPs and accountable care.

This briefing and further information on STPs and accountable care is available on our website: http://nhsproviders.org/topics/transforming-care

This briefing draws on national policy information and their conversations to date with trusts and other stakeholders. It includes:

- the national policy story so far, as plans evolved into partnerships
- definitions of key terms associated with STPs, accountable care, and new care models
- five conditions for success based on their conversations with trusts
- NHS Providers’ position and information on the support trusts can access from NHS Providers

3.3 Care Quality Commission

The National Audit Office has released a report on the Adult Social Care Workforce in England (the Executive Summary is attached).

The Chief Inspector of Adult Social Care at the Care Quality Commission, Andrea Sutcliffe, said: "People who use adult social care services, their families and carers, need skilled staff who are valued and properly supported to carry out their critically important roles to deliver great care. We share the National Audit Office (NAO) concerns about the difficulties the sector faces in recruiting and retaining care staff, nurses and managers and see evidence from our inspections of the detrimental impact this can have on the quality of care people receive."

The Government will be publishing a Green Paper later this year regarding the future of adult social care.

FIONA WISE
CHIEF EXECUTIVE
Dear Colleagues,

The Trust continues to experience severe service pressures arising from ED attendances, capacity constraints and our ability to discharge patients. To enable improvements with flow and high quality care it is necessary to remove the additional bedded areas and increase senior decision makers to support clinical and service delivery. We recognise the majority of you have been working tirelessly to meet the clinical demand but despite best efforts our position remains static. The current situation is crowding out opportunity for education and a focus on quality. Delayed Transfers of Care are at a historic low, but due to the level of additional escalation areas open we have seen an increase in the number of patients who are stranded/super-stranded.

Whilst the escalation areas and outliers have been a way of managing flow they are now compromising flow with an inability to see all patients to facilitate timely discharge. A case in point - between Saturday and Tuesday we discharged 61 fewer patients than we normally discharged and yesterday there were 72 of 139 patients deemed medically fit for supported discharge but not moving in a timely manner. These are the patients that appear on tracking lists and form only 20% of the overall picture. It is likely that there are many more. There are a number of key actions required to return the Trust to a safe level of occupancy and service delivery. Each CBU and member of staff is expected to consistently ensure the following to prevent a relapse to this really unsatisfactory and demoralising position.

Creating Trust Flow and Capacity
Effective, evidence based demand management, including working with all local providers to ensure access to primary care, community services, social care and voluntary sector support, continues to be central to developing resilience plans locally. This includes ensuring continuation of discharge processes through local health and care economies working together to assess capacity across residential facilities.

1. De-escalate additional bedded areas and outliers in the following order:
   - SDCU now returned to surgery CBU - completed
   - Cath lab by Friday 23 February 2018
   - Barnwell’s reduce 12 medical outliers by 2 March 2018
   - Deene’s reduce 14 medical outliers by 2 March 2018
   - DDU x 3 beds by 9 March 2018
   - Ambulatory care by 9 March 2018
   - ENT by 15 March 2018

Once these areas are de-escalated they will not be used for escalation again.
2. Source additional senior medical staff providing cover in ED from 16:00 – 24:00 supporting admission avoidance and the bedding of patients in ED overnight that leads to morning DTAs
3. Two additional medical Consultants have been identified to commence shortly to oversee the care of outliers and escalation areas supporting discharge and patient flow until these areas are de-escalated
4. Consider alternative ways of working for the medical teams
5. Support surgical elective admissions through the ring fencing of Ashton, DASU and SDCU
6. KGH @home to continue increasing discharge numbers as per plan from the wards
7. Over the last 18 months the Trust has been seeking to implement SAFER with varying success. These principles support us and the patient in agreeing and sticking to a plan for improved flow, patient outcome patient and patient/staff satisfaction.

Embed the principles of SAFER ensuring Red to Green days are acted upon through effective early decision making and a check to see that actions have been taken as agreed/followed up if not. Vigi Arun, Mamta Tailor and Anna Awoliyi of the Clinical Transformation Team are there to help you if needed.
8. Consider how in working hours patients can be directly admitted to speciality wards in Medicine, particularly respiratory and gastroenterology to prevent multiple patient moves around the Trust to create MAU/Clifford capacity. Patient moves are referenced to add risk and length of stay and definitely increases complaints.
9. The Business Unit leadership team with Clinical Directors are expected to demonstrate partnership working in delivering the actions set out and resolve the current challenges.

This includes each CBU allocating just 1 person per day to lead capacity and patient flow (1 from Urgent Care and 1 from Medicine). Ideally this would be an individual who could do this for a minimum of 2 days consecutively to ensure consistency and knowledge of patients.
At times of OPEL 3 or 4 the individual will be supported either by the GM, HoN or BUD at capacity meetings.
All individuals should arrive with a brief SITREP on their CBU including current empty beds, known discharges and potential discharges. If there is negative balance to the expected numbers a plan of mitigation needs to be presented. This SITREP will also cover any safety and staffing concerns.

This change is aimed in supporting our colleagues to be visible and functioning in their ward areas to facilitate safe patient care which includes patient flow - embedding of SAFER, SafeCare, quality improvement, staff recruitment and retention etc.

Yours Sincerely
Fiona Wise  
Chief Executive Officer (INTERIM)

Andrew Chilton  
Medical Director/Responsible Officer

Leanne Hackshall  
Director of Nursing & Quality
STPs AND ACCOUNTABLE CARE
background briefing

As part of our new programme on sustainability and transformation partnerships (STPs) and accountable care, this briefing brings together an overview of how national policy has evolved to promote system-based collaboration, including the development of STPs, accountable care systems (ACSs) and accountable care organisations (ACOs). It includes:

- the national policy story so far, as plans evolved into partnerships
- definitions of key terms associated with STPs, accountable care, and new care models
- five conditions for success based on our conversations with trusts
- NHS Providers’ position and information on the support trusts can access from us.

Key points

- NHS trusts support the principle of collaboration at the heart of the STP/ACS approach; it provides one solution to the challenges facing health and care by focusing on local system partnerships rather than isolated activity by any single organisation.

- Trusts are leading, and contributing to, the development of STPs/ACSs, and ACOs across the country and will continue to play a pivotal leadership role in many local areas.

- Key examples of the changes underway in some areas include the development of more strategic approaches to commissioning, through the merger of clinical commissioning groups (CCGs), integrating commissioning with local authorities and the emergence of ACOs, as well as the integration of services, horizontally and vertically, between providers.

- However, the pace of change varies considerably across the country largely dependent on whether areas have a history of strong relationships on which to build. We look forward to working with the national bodies to ensure that all STPs receive the support they need to develop, particularly those areas which are progressing more slowly.

- The national bodies must be clear about the core aims of STPs and ACSs and avoid overloading them, for example, with requests to monitor and deliver new policy aims.

- We need an honest conversation about how to develop governance and accountability mechanisms which support system-level partnerships and complement the statutory obligations of their component organisation – in the case of trusts, the unitary board. We also need to ensure public engagement and consultation on plans for change.

- We need to develop a shared understanding about the terms used in relation to accountable care, particularly the definition of an ACO, as set out by the Department of Health (DH) and NHS England. Local partners must be clear about the contractual and partnership models underpinning new and integrated approaches.
Trusts will recall the genesis of STPs as sustainability and transformation plans which NHS and care organisations were asked to develop collaboratively in new footprints as part of the planning guidance\(^1\) at the end of 2015. These plans were designed to address the core gaps set out in the *Five year forward view*\(^2\) of improving health equity, closing the financial gap, and reducing unwarranted variation in quality.

Plans for the 44 STPs which now exist across England were published by December 2016 and involve trusts and foundation trusts, CCGs, specialised providers, primary care, local authorities including social care and public health, and sometimes private and voluntary sector provision.

In March 2017 NHS England published *Next steps on the Five year forward view (Next steps)*\(^3\) which made clear the expectation that STPs evolve as long-term partnerships rather than time limited plans, as well as an ambition for STP footprints to become ACSs and for some geographical areas to develop ACOs.

Trusts’ experiences of developing, and contributing to, the development of their STP or ACS vary considerably depending on a range of factors. These include: the quality and history of local relationships; leadership capacity; the financial and operational challenges facing the health economy and its component organisations; the size and nature of the population; and the geographical challenges inherent in some of the footprints.

Those systems progressing at pace often benefit from a more manageable population size, coterminous boundaries between (some if not all) partners, fewer organisations in the footprint and a natural geographical boundary, consistent with how patients access services in that area. However, local leaders from STP and ACS areas where plans are more advanced uniformly point to a history of trusted partnership working as the foundation for their achievements and future aspirations. They often describe the STP/ACS process as adding momentum to existing plans. Other areas will require more time upfront to build trust, form relationships and move towards the collective agreement of aims and objectives.

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In July 2017, NHS England published a progress dashboard for STPs in which five were rated outstanding, 20 advanced, 14 making progress and four needs most improvement.

There has been some turnover of STP leads during their short lifetime. However, at the time of writing there were 19 provider chief executive leads, 15 CCG leads, four local authority leads and six independent leads. Fulfilling the role of STP lead and contributing to an STP requires significant leadership time. Consequently some STP leads, including trust chief executives, are adopting the STP lead role full time.

Governance and the art of the possible

The move towards locally-based collaboration rather than competition as the key driver of improvement in the system marks a significant shift in national policy, not least given that much of the latter is underpinned legislatively by the Health and Social Care Act 2012. While the current legal frameworks certainly do not prevent partnership working and integration in different forms, this makes for a complex environment for trusts, and their partners, to navigate.

STPs have no legal status and derive their decision making powers from the statutory bodies which comprise them. Reconfiguring services in health and care is always controversial and despite the high-level parameters for public engagement within the Next steps document, this remains a challenge and a source of media and political attention locally and nationally. For example, although Labour has consistently supported devolution and the integration of health and care, they have concerns about the development of STPs and ACOs on the grounds they are not based in statute and, in their view, could open the NHS up to privatisation, an argument which is gaining ground.

The Next steps document also sets out some expectations with regard to governance. This includes the requirement that each STP forms “a board drawn from constituent organisations...including appropriate non-executive participation, partners from general practice, and in local government wherever appropriate”. In addition, “formal CCG committees in common or other appropriate decision making mechanisms [should be created] where needed for strategic decisions between NHS organisations”.

We know that developing the governance mechanisms to underpin local relationships and support the legal duties for decision making and accountability in the component partner

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6 https://www.england.nhs.uk/stps/view-stps/#mids
organisations remains a priority for trusts.\textsuperscript{10} Many trust boards have raised issues about how best to ensure non-executive and governor engagement in the STP process, as well as clinical engagement. In addition to recent publications such as *The art of the possible* with Hempsons, NHS Providers will share existing practice with regard to governance more widely this year as part of our STPs and accountable care programme.

\textbf{In a challenged local health and care economy our partners are committed to the destination and the benefits for our population but we’re discovering the best route to get there. We do need an honest conversation about governance and what is possible in the existing frameworks.}

Sue Harris, Director of Strategy and Partnerships, Worcestershire Health and Care NHS Trust, and Communications and Engagement Lead, Herefordshire and Worcestershire STP

\section*{A vehicle for change?}

There is no doubt that STPs, ACSs, and ACOs are seen nationally as the mechanism to deliver the aspirations of the *Five year forward view* including returning the system to financial balance. Our analysis from speaking with trusts is that STPs are being used locally as a catalyst to:

- plan and deliver the local reconfiguration of services
- helpfully support discussions on day-to-day operational collaboration for instance on winter planning
- as a means of driving and locally overseeing new models of integrated care.

However there is also concern from trusts that STPs are also being asked by the national bodies to act as:

- The default footprint to deliver national policy. Initiatives and increasingly funding are now passed down for delivery at STP footprints. Recent examples include the introduction of system control totals with the ability to apply to NHS Improvement and NHS England to adjust organisational control totals as long as the system target is met; the allocation of capital funding for 18/19 to the eight ACSs; and monitoring requests relating to workforce; and
- An additional layer of performance management with a strong encouragement for STPs to monitor and manage finance and performance at a system levels.

\footnote{Research from the HFMA shows majority of CCG and provider finance managers have concerns about governance and this reflects feedback from our members: https://www.hfma.org.uk/publications/details/nhs-financial-temperature-check-briefing-november-2017 (accessed 18 Dec 2017)
Our view is that there is considerable variation in different STPs’ capacity to deliver on all of these expectations at pace.

In those areas with established partnerships, the renewed focus on collaboration is certainly fueling significant structural change, not least the development of a more strategic approach to commissioning. This includes mergers of CCGs11 or arrangements whereby several CCGs appoint a shared accountable officer12 and the development of integrated commissioning arrangements with local authorities.13

In addition, there is a trend towards the consolidation of provider organisations through new alliances and groups, or proposed merger both to tackle financial challenges and to reduce unwarranted variation in quality standards. The extent to which an STP/ACS drives this degree of change will vary considerably but in some areas they are becoming a natural vehicle for conversations to tackle deep seated issues such as:

- developing a more preventative and population health-based approach
- moving care closer to home
- improving pathways for clinical services through horizontal and or vertical integration
- managing pressures on the ambulance service
- delivering efficiencies through integration of back office and clinical services across a number of providers (horizontal integration).

Clearly those STPs/ACSs with more established relationships will rightly be keen to negotiate more freedoms and flexibilities in exchange for taking on collective responsibilities for finance and performance at a system level. However other STPs lack the relationships, mandate or infrastructure to deliver such a challenging range of priorities so quickly.

It is also important to remember that the NHS has always delivered across a number of footprints and will continue to do so. As such, the STP will play an important role but will not always be the optimum mechanism for delivery. For example, specialised and ambulance services operate to a wider population on regional and sub regional footprints which are larger than an STP; at the other end of the spectrum much of the frontline integration of health and social care is taking place on sub STP footprints in place-based or neighbourhood systems; and some initiatives will continue to be delivered by individual organisations.

13 https://www.hsj.co.uk/workforce/council-chiefs-to-take-on-leadership-of-several-ccgs/7021284.article (accessed 19 Dec 2017)
It has become clear over recent months that the terminology and acronyms used to describe collaboration and accountable care approaches are not always fully understood or are being used interchangeably. Here we offer definitions and commentary on the most commonly used concepts to support a shared understanding and effective communication.

Population health

Given the focus on prevention at the heart of the Five year forward view approach it is natural that STPs/ACSs should be developed with the aspirations of population health in mind. In some local areas this will mean widening partnerships to address the wider determinants of health – housing, education, transport and access to services. The King’s Fund defines population health as “addressing the health outcomes of a defined group of people, as well as the distribution of health outcomes within the group so that health equity – the avoidable differences in health between different parts of the population – is a core part of understanding population health.”

How far STPs and ACSs are able to move to population health approaches in the short term will depend on shared understanding and analysis of the issues facing their population, and the ability to take stock and invest in new ways of working rather than be drawn into operational imperatives. As Chris O’Neill, Director of Humber Coast and Vale STP puts it, “We are trying to encourage providers and their partners to think ‘future state’ – with an increasing, collective focus on population health rather than organisational targets.”

Trusts also recognised the importance of wider partnership working in delivering a more outcome-focused, population-based approach. Many cited the importance of relationships with primary care and local government in particular. For instance, Jade Renville, Trust Secretary, Taunton and Somerset NHS Foundation Trust commented: “Our STP senior responsible officer is from local government and engagement with the council, social care and wider services has been a core benefit of the partnership to date.”

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Accountable care systems (ACS)

The *Next steps* document describes an ACS as “an ‘evolved’ version of an STP that is ‘working as a locally integrated health system...in which NHS organisations (both commissioners and providers), often in partnership with local authorities, choose to take on clear collective responsibility for resources and population health”15 either on the STP footprint or, more likely, a smaller, sub STP footprint.

In return for increased responsibilities as a system, an ACS will have access to new freedoms and flexibilities. These include: the development of a system-level performance scorecard; a system-level control total; the potential for CCGs to have delegated decision rights in respect of primary care, mental health and specialised services; transformation funding; and support from NHS England and NHS Improvement to develop new ways of working. The national bodies are also working with ACSs to develop an approach to system-level oversight and a governance maturity tool to assess the level of freedoms an ACS should enjoy, in complement to existing, institutionally-focused regulation.

NHS England has identified the following eight areas to lead the development of ACSs. They have each developed a memorandum of understanding with the national bodies.

1. Frimley Health including Slough, Surrey Heath and Aldershot
2. South Yorkshire and Bassetlaw, covering Barnsley, Bassetlew, Doncaster, Rotherham and Sheffield
3. Nottinghamshire, with an early focus on Greater Nottingham and Rushcliffe
4. Blackpool and Fylde Coast with the potential to spread to other parts of the Lancashire and south Cumbria at a later stage
5. Dorset
6. Luton, with Milton Keynes and Bedfordshire
7. Berkshire West, covering Reading, Newbury and Wokingham
8. Buckinghamshire

In addition to the Manchester devolution arrangements,16 Surrey Heartlands will receive support to integrate health and care in a devolution agreement. Further ACSs are expected to be confirmed by NHS England and NHS Improvement in 2018.17

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16 https://www.greatermanchester-ca.gov.uk/homepage/59/devolution
Accountable care organisations (ACOs)

The King’s Fund sums up the emergence of accountable care as “relatively new”, originating in the United States and representing “the most recent manifestation of well-known integrated systems, such as Kaiser Permanente.” They identify three common characteristics of accountable care organisations: “firstly, that they involve a provider or an alliance of providers which collaborate to meet the needs of a defined population, secondly, that the providers take responsibility for a budget allocated by commissioner(s) and thirdly, that the ACO works under a contract that specifies the outcomes and objectives it is required to deliver within a given budget, often extending over a number of years.”

In the Next steps document, NHS England describes the potential for an ACS to evolve into an ACO. In practice, and depending on patient populations and local relationships, presumably an ACS could also develop more than one ACO within its footprint.

Given the varied connotations of the term accountable care organisation it is important to focus on what the development of an ACO means for health and care within the English NHS. NHS England states that an ACO occurs “where the commissioners in that area have a contract with a single organisation for the great majority of health and care services and for population health in the area.” A recent DH consultation on the development of the existing accountable care contract makes clear that the two vanguard models, multi-speciality community provider (MCP) and integrated primary and acute care systems (PACs) could also be considered as accountable care organisations.

Our understanding is therefore that the development of an ACO requires the creation of a strategic commissioning function procuring one organisation to take responsibility for delivering outcomes for a given population, within an agreed budget, over an agreed timeframe. Within this, the contracted organisation would adopt tactical commissioning responsibilities and deliver particular services with a range of different partners.

As the ACO contract can only be let to one provider, there is a clear opportunity for trusts to adopt a leadership role in collaboration with partners in this regard. Commentators recently suggested that existing trusts and foundation trusts, or a newly formed trust, could be the legal entity for developing an ACO. In addition, DH is seeking to make minor amendments to ten regulations by February 2018 to allow for the development of ACOs (for example to allow GPs to stay on their existing contracts within an ACO, and to set out how NHS pensions would apply for staff in an ACO).

18 https://www.kingsfund.org.uk/publications/accountable-care-organisations-explained
Given the complexity of these changes, the indications are that the national bodies do not envisage working with many ACOs in the short term. In fact NHS England acknowledges that only "a few areas are on the road to developing an ACO" (often where an MCP or PACs vanguard project has progressed successfully), that this process takes years and involves a complex procurement process and a different approach to risk management. The national bodies have confirmed they are currently working closely with four local areas where a procurement process to establish an ACO is underway.

Despite the definitions above, trusts and their partners are understandably adopting the language of accountable care in different ways and pursuing similar outcomes and objectives through partnerships and alliances. While this makes sense where it helps to drive collaborative, patient-centred behaviours, it is important to ensure clarity is maintained on the legal, contractual and governance frameworks underpinning the approach.

In West, North and East Cumbria we are identifying and promoting the collaborative behaviours we know will support the development of accountable care, and we are doing it from existing resources. We are establishing a joint executive team and developing joint non-executive positions between the two major provider trusts in our ACS to support this endeavour.

Daniel Scheffer, Joint Company Secretary for Cumbria Partnership NHS Foundation Trust and North Cumbria University Hospitals NHS Trust

Vanguards and new care models

National funding and support for the new care models originally announced in the Five year forward view comes to an end at the end of this financial year. However, at local levels, work continues both within and outside of the official programme to develop more integrated models of care for patients. The achievements of many of the vanguards have been acknowledged, not least in reducing hospital admissions and the learning from the programme should inform the development of STPs, ACSs and ACOs.

Moreover many of the STPs/ACSs seen to be progressing well include and involve new care models already in operation. In some areas this adds another level of complexity to STP and ACS plans but in many local areas it will make sense to develop or pilot integration at sub-STP levels.

The following provides a reminder of the main vanguard new care models:


The multispecialty community provider model (MCP) focuses on moving specialist care out of hospitals and into the community. Groups of GP practices work together and collaborate with other health and social care professionals to provide a range of primary, community, outpatient, mental health and social care services. MCPs build on an understanding of population health needs and ultimately might take on contractual responsibility for the health budget for their whole population. As set out above, this model is considered to be a form of ACO.

Integrated primary and acute care systems (PACS) have a similar population health focus to MCPs, but they also join up hospitals with primary, community and mental health services to improve the coordination of care and move care out of hospital where it is appropriate to do so. Under the PACS model, a single entity – typically a lead provider – would take responsibility for the health needs of the whole population and the delivery of health care services. As set out above, this model is considered to be a form of ACO.

Acute care collaboration (ACC) vanguards link local acute hospital providers together to improve the clinical quality and financial sustainability of care services. The organisational form of these models ranges from collaborative to contractual and can include consolidation. The scope of their services includes hospital groups in which several providers work collaboratively under a single group structure and formal joint working arrangements; multi-service networks in which several providers work collaboratively to provide a range of clinical and non-clinical services; and single service networks in which networks of trusts and their clinical teams work on a specific service.

For example, Matt Graham, Programme Director, West Yorkshire Association of Acute Trusts, describes the approach in the West Yorkshire and Harrogate Health and Care Partnership: “The West Yorkshire Association of Acute Trusts (WYAAT) is an acute care collaboration between the six acute trusts in West Yorkshire and Harrogate and we have established a committee in common of chairs and chief executives to oversee the collaboration. Although WYAAT was created before the STP process, it has become a core part of the WYH Health and Care Partnership. The lead chief executive for WYAAT sits on the partnership’s leadership executive and other chief executives lead partnership workstreams. WYAAT provides a natural delivery mechanism for a number of system-wide programmes both to deliver efficiencies and improve the quality of services for patients. As part of the partnership, we are using WYAAT to build a bottom-up approach, based on eliminating unwarranted variation through strong clinical involvement, to tackle a range of issues, from back office efficiencies, through networked clinical support services, to transformation of clinical services.”

Enhanced health in care homes vanguards aim to improve older people’s quality of life and healthcare. NHS services work closely with care home providers, local authorities and the voluntary sector to join up health, care and rehabilitation services, optimising the health of elderly residents.

In order to deliver the five principles set out in the Keogh review, urgent and emergency care vanguards are also improving the coordination of services to reduce pressure on A&E departments.
Five keys to success

From our conversations with trusts involved in STPs at all levels of development, the common enablers we have identified can be summarised as follows:

- **The quality of relationships between all key players in the local system:** GPs, local authorities, CCGs, acute, mental health, ambulance and specialist providers – alongside consideration of the voluntary and private sectors.

- **The quality and capacity of local leaders** and their ability to engage and mobilise the wider workforce, including clinicians, and engage with the public. Many people mentioned how difficult it is to find the capacity and resource to drive change until it becomes ‘the day job’.

- **A collective commitment to prioritise the needs of patients and the system** at the expense of the individual institution, based on a shared understanding and analysis of local challenges.

- **A ruthless focus on a small number of practical priorities** and a drive for practical improvements on the ground in chosen priority areas, rather than just trying to build a grand plan.

- **A culture of pragmatism meets continuous improvement.** Trying new things, learning and making improvements if it doesn’t work.

In terms of enablers, the starting point for any collaboration is trust. Resources to invest in a change management process, and to explore flexibilities in how we make best use of our valued workforce at a system level would also be of benefit.

*Jane Tomkinson, Chief Executive, Liverpool Heart and Chest NHS Foundation Trust and Senior Responsible Officer for the cardiovascular strand of the Cheshire and Merseyside STP*

In West, North and East Cumbria, we are lucky to have a relatively simple, decluttered landscape with a manageable number of partners. We have one system-wide vision, which has improving population health at the heart of it. We have developed eight place-based, integrated care teams in our ACS as the focus for building our population health management system. We are also encouraging our staff to ‘think without walls’ and developing system-wide enabling strategies to support them in this such as organisational development, information management and technology, and a shared and consistent improvement methodology.

*Ramona Duguid, Programme Director, West, North and East Cumbria Integrated Health and Care System – ACS/ACO*
NHS Providers’ view

In summary, STPs are clearly developing at different paces across the country. Those involved in the ACS model or developing an ACO are progressing well. Other areas need additional time and resource to invest in relationship building to underpin new partnerships.

We fully support the principle of collaboration underpinning the STP process and the move to develop accountable care models which will improve and integrate services for local populations. We welcome the focus on population health approaches and a clear acknowledgement from government and the national bodies that the solutions to the challenges facing health and care services in England lie in system-based solutions rather than isolated activity by individual organisations. We also welcome the opportunities for local leadership generated by STPs/ACSs and the emergence of ACOs in some parts of the country. We strongly support the national bodies’ acceptance that depending on their starting point, different parts of the country will develop their approaches at different paces and in different ways.

It is clear that NHS trusts are, rightly, playing a key role in both leading and contributing to new partnerships to improve outcomes and address the challenges set out in the Five year forward view of improving health inequity, improving quality and reducing the financial gap.

However in order for trusts, their partners and the wider public to reap the rewards of the significant resource, leadership time and energy invested in the STP and ACS process, it is essential to remain realistic about the scale of the ask of STPs and their component organisations. We must ensure that both trusts and the STPs they contribute to are set a deliverable task within the available funding envelope. These new partnerships and approaches, however well intentioned, are developing within a legislative framework and a system architecture set up for different times and a competitive rather than collaborative approach which will create additional complexities to navigate – locally and nationally. As the recent legal challenge demonstrates, it is important that the national bodies have a convincing public narrative in support of the approach.

During the development of STPs, we have raised concerns about the pace of change expected and the multiple priorities asked of STPs by national bodies. While we welcome the investment and support that NHS England and NHS Improvement are offering to well-established partnerships, it is only fair to providers, their partners and taxpayers that support (and funding) is offered to STPs at all stages of development. It would be wrong to penalise those populations where STPs are developing at a slower pace, for a range of legitimate reasons.

We also have concerns about the increasing tendency for STPs to become the default footprint for delivering national policy initiatives when they do not have the mandate, statutory authority, or infrastructure to deliver. On the other hand, we accept that more established and progressive partnerships will benefit from negotiating additional freedoms and flexibilities with the national bodies.

While STPs and ACSs are an understandable and pragmatic solution to the complex challenges facing the health and care system, it is important not to lose sight of the fact that
statutory responsibilities in the system still lie with individual organisations, notably trusts, and CCGs. We look forward to working with trusts and the national bodies to ensure that the governance arrangements at a system level complement the statutory accountabilities of provider boards and other organisations. We also recognise the importance of non-executive engagement, clinical engagement and public consultation on new proposals at organisational and system levels.

We look forward to working with trusts and their partners, the national bodies and partner organisations such as the NHS Confederation, the Local Government Association, NHS Clinical Commissioners and think-tanks to help capture and share the learning from the development of STPs/ACs, and ACOs. We hope our new programme of influence and support in this space will both support our trusts and help fuel debate about the next steps for system-level collaboration and accountable care.
In the next six months we will be setting out a programme of support for members around STPs, ACSs and ACOs which will build on the learning from a shared programme of support (with NHS Confederation, NHS Clinical Commissioners and the Local Government Association) for the vanguard programme and include:

- briefings, blogs, articles and case study publications with a clear focus on sharing practice and understanding of the trust provider perspective
- publications such as our Provider voices series to capture the range of views on STPs, ACSs and accountable care and fuel debate
- the development of our work on governance mechanisms to support STPs, ACSs and ACOs
- maximising opportunities to use our existing networks, development offers and events to showcase case study examples and offer a safe space for providers to share achievements and concerns, include our board development programme, GovernWell, and executive and non-executive induction, annual conference, Governor focus conference and the governance conference
- in addition, we look forward to exploring how our existing partnership with the NHS Confederation, NHS Clinical Commissioners and the Local Government Association can develop new and more bespoke offers of peer-based support for those STP areas voluntarily seeking additional help.

For more information: www.nhsproviders.org/stps-and-accountable-care

Suggested citation: NHS Providers (December 2017), STPs and accountable care: background briefing.
Kirkup Review into Liverpool Community Health

Background to the review

The independent review was commissioned by NHS Improvement (NHSI) following concerns raised about care delivered at Liverpool Community Health NHS Trust (LCH) during November 2010 to December 2014. The findings of a Care Quality Commission (CQC) inspection at the trust in late 2013 identified a range of issues at the trust that required an immediate response to system failings identified.

Following publication of the CQC inspection report, NHSI oversaw a number of changes to executive directors at the trust. The trust board commissioned a quality, safety and management assurance review, carried out by Capsticks Solicitors LLP. The report raised concerns about the quality of the healthcare being provided to patients in the community and in HMP Liverpool and about the management culture of the trust and practices demonstrated by senior managers.

The review findings

The review found that the trust experienced significant failings in care quality, including an inexperienced management and director team. The review found that the trust was focussed on its pursuit of Foundation Trust (FT) status and achieving very significant cost savings required by its commissioners. As a result of drastic cost improvement measures, the trust reduced staff numbers and the management lead for clinical quality was unclear.

The review also examined the role of the external bodies responsible for overseeing the trust. The report highlights that during the period covered by the review, organisational structures changed radically and responsibilities moved to new organisations. In 2013, clinical commissioning groups (CCGs) took on responsibility for the commissioning of services and performance management from primary care trusts (PCTs). In the same year, the strategic health authorities’ (SHAs) responsibility for non-foundation trusts and PCTs transferred to the NHS Trust Development Authority (NHS TDA). In 2013, NHS England became responsible for commissioning prison health services. At the time, Monitor played a central role in authorising, monitoring and regulating NHS Foundation Trusts (FTs) and the CQC was responsible for inspecting that standards were being met.

The report suggests that all these organisations had insufficient indication of the problems in the trust to prompt a more complete examination of its services, and earlier intervention would have reduced the avoidable harm that occurred.
Recommendations

While the review examined LCH specifically, its recommendations are likely to impact on the sector as a whole, including the role of the national bodies. These recommendations include:

- In approving trust board appointments, NHSI should take note of the level of experience of appointees and level of risk in the trust, and should ensure a system of support and mentorship for board members where indicated.
- Regulators and oversight organisations should review how they work together jointly at regional and national level, and implement mechanisms to improve the use of information and soft intelligence more effectively.
- Regulators and oversight organisations should ensure that, during both local and national reorganisations and reconfigurations, performance and other service information is properly recorded and communicated to successor organisations.
- The Department of Health and Social Care should review the working of the Care Quality Commission fit and proper person’s test, to ensure that concerns over the capability and conduct of NHS executive and non-executive directors are definitively resolved and the Ministerial statement to the House of Commons 8 February 2018.

Next steps

Stephen Barclay MP, Minister of State, Department of Health and Social Care (DHSC) made a statement on the independent review on 8 February 2018 and stated that the government accept the recommendations in full. The DHSC will also:

- Write to all the organisations named in the recommendations, asking them to confirm what steps they will take to implement the recommendations, or to set out their reasons for not doing so.
- Discuss the terms of the review of the fit and proper person’s test with the Rosie Cooper MP and appoint someone to undertake that review “within the coming days”. The Minister suggested the review will need to address the operation and purpose of the fit and proper test, including but not limited to: where an individual moves to the NHS in another part of the United Kingdom; where they leave but subsequently provide healthcare services to the NHS from another healthcare role, such as with a charity or a healthcare company; where differing levels of professional regulation apply, such as a chief executive who is a clinician compared to one who is a non-clinician; where there is a failure to cooperate with a review of this nature and what the consequences of that should be; and reviewing the effectiveness of such investigations themselves when they are conducted.
- Review the effectiveness of sanctions where records go missing in a trust, or where records appear to have been destroyed.
- Advise on what disciplinary action could be taken against individuals in relation to the findings of the review.
• Ask NHS Improvement and NHS England to clarify the circumstances under which roles were found or facilitated for individuals identified in the report as bearing some responsibility for the issues at the trust.

**NHS Providers view**

NHS Providers will be engaging in the above next steps and implementation of the recommendations. We will be seeking to understand the implications this report and its recommendations will have on the regulation and oversight of NHS trusts and foundation trusts, as well as working closely with the Department of Health and Social Care on its review of the fit and proper persons test. We have already had in depth discussions with a number of member trusts, CQC and NHSLI about how the fit and proper persons test is applied and how trusts respond to concerns raised.

It is essential that DHSC and the national bodies take a balanced approach, mitigating the risk of another case of systemic care quality failings with proportionate and risk-based regulation.

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Cassandra Cameron, Policy Advisor (Quality) cassandra.cameron@nhsproviders.org
Department of Health & Social Care

The adult social care workforce in England
## Key facts

<table>
<thead>
<tr>
<th>1.34m</th>
<th>2009</th>
<th>6.6%</th>
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</thead>
<tbody>
<tr>
<td>1.34m was the estimated number of jobs (excluding personal assistants and NHS jobs) in the adult social care sector in England in 2016-17</td>
<td>2009 was the last time a national workforce strategy was published by the Department of Health &amp; Social Care</td>
<td>6.6% was the vacancy rate for jobs across the care sector in 2016-17</td>
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<table>
<thead>
<tr>
<th>£16.8 billion</th>
<th>27.8%</th>
<th>£7.50</th>
<th>11.3%</th>
<th>16%</th>
<th>2 million</th>
</tr>
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<tbody>
<tr>
<td>is the sum of £14.8 billion of net current expenditure on care by local authorities and £2.0 billion allocated from the NHS through the Better Care Fund in 2016-17</td>
<td>was the turnover rate across all care jobs in 2016-17</td>
<td>was the median pay per hour for a care worker in the independent care sector in 2016-17</td>
<td>was the vacancy rate for registered managers in 2016-17, the highest vacancy rate in care</td>
<td>of registered nurses in 2016-17 who were non-British European Economic Area nationals, the highest percentage for any care job</td>
<td>was the Centre for Workforce Intelligence's 2014 principal projection of the demand for full-time equivalent jobs in adult social care by 2035</td>
</tr>
</tbody>
</table>
Summary

1. Adult social care comprises personal care and practical support for older adults who cannot manage the tasks of everyday life and for working-age adults with physical disabilities, learning disabilities, or physical or mental illnesses. It also includes support for their carers. Most care is provided unpaid by family or friends (known as ‘informal care’). The amount of informal care provided affects the amount of formal care that is needed, provided and publicly funded through local authorities or through people funding their own care privately. Policy choices on eligibility for publicly funded care changes the number of people who qualify, and therefore the number who might need to buy their own care, rely on informal care, or have their care needs unmet.

2. In 2016-17, net current expenditure by local authorities on care was £14.8 billion. Additionally, around £2.0 billion of funding allocated to the NHS was transferred to pooled budgets with local authorities, through the Better Care Fund, to support care. Local authorities commission most care from the independent (private and voluntary) sector. Around 65% of providers’ income comes from care arranged by local authorities, so public funding is essential to the sustainability of the sector. Care arranged by local authorities includes some contributions from users. Estimates by the Office for National Statistics and Carers UK, respectively, of the value of informal care range from £57 billion to over £100 billion per year. Demographic trends suggest that demand for care will continue to increase and people’s care needs will continue to become more complex. To meet these challenges, the care workforce needs to grow and the nature of care and support needs to transform.

3. In 2016-17, the care workforce in England consisted of around 1.34 million jobs in the local authority and independent sectors. The full-time equivalent number of jobs was around 1.0 million. This excludes an estimated 145,000 job for personal assistants, employed by recipients of personal budgets and self-funders, and 91,000 people who have care jobs but are employed within the NHS. In our report, unless otherwise stated personal assistants and NHS staff are excluded from our analysis.

4. The Department of Health & Social Care (the Department), formerly the Department of Health, is responsible for adult social care policy, as it was before its name-change in January 2018. One of the nine priorities in its Shared Delivery Plan: 2015 to 2020, published in February 2016, was to “make sure the health and care system workforce has the right skills and the right number of staff in the most appropriate settings to provide consistently safe and high quality care”. The Department has an objective to integrate health and social care more closely by 2020.
Local authorities commission care. The Care Act 2014 sets out minimum standards of care that local authorities must offer. It places a duty on local authorities to ensure that there is diversity and quality in the market of care providers so that there are enough high-quality services for people to choose from. Local authorities must also step in to ensure that no vulnerable person is left without the care they need if their service closes due to business failure. Most care is provided by independent providers, which are autonomous businesses responsible for employing, training and setting pay, terms and conditions for their own workforces. There are around 20,300 organisations providing care, resulting in a care market that is fragmented with complex chains of commissioning, provision and accountability.

Skills for Care (an independent charity and company limited by guarantee) is the Department’s delivery partner for leadership and workforce development in care. Skills for Care provides practical resources and support to help care providers recruit, retain, develop and lead their workforces. In both 2016-17 and 2017-18, the Department provided £23.5 million in funding for Skills for Care, including around £2 million for maintaining the National Minimum Data Set for Social Care (NMDS-SC). This data set is the leading source of workforce information for the whole care sector, collected from local authorities and, on a voluntary basis, from care providers. We have drawn extensively on these data in our report. We follow Skills for Care’s terminology throughout the report, unless where stated otherwise.

Our report

This report considers the Department’s role in overseeing the adult social care workforce and assesses whether the size and structure of the care workforce are adequate to meet users’ needs for care now, and in the future, in the face of financial challenges and a competitive labour market.

In Part One, we profile the range of care jobs and the workforce, and examine workforce trends and cost pressures within the care sector. In Part Two, we examine the challenges that providers face in recruiting and retaining workers in three job roles facing pressures: care workers, registered managers and registered nurses. We also examine the number of non-British European Economic Area (EEA) workers in the care workforce. In Part Three, we examine the adequacy of strategic workforce planning at national, regional and local levels.

Our main methods were analysis of available workforce data; visits to local areas to meet with representatives of local authorities and independent providers; interviews with representatives of other organisations operating within adult social care; a review of published research on the care workforce; and a review of relevant departmental documents. Our audit approach and methods are covered in Appendices One and Two.
Key findings

Signs of problems within the workforce and wider impact

10 **Turnover and vacancy rates across the social care workforce are high.**
In 2016-17, the annual turnover of all care staff was 27.8%. The proportion of vacancies in care rose from 5.5% in 2012-13 to a peak of 7.0% in 2015-16, falling slightly to 6.6% in 2016-17. Two roles in particular – care workers and registered nurses – have high vacancy and turnover rates compared with other roles within social care. High vacancy rates and turnover can disrupt the continuity and quality of care for service users and also mean providers incur regular recruitment and induction costs (paragraphs 1.7 to 1.9).

11 **Growth in the number of jobs has fallen behind growth in demand for care.**
The Department commissioned modelling based on 2014 data that suggested the number of full-time equivalent jobs in care would need to increase by around 2.6% per year until 2035 to meet increased demand. However, the annual growth in the number of jobs since 2013 has been 2% or lower. The failure of formal care to meet this increased demand may have contributed to the growth in individuals’ care needs not being met. Age UK estimated that 1.2 million people over the age of 65 had some level of unmet care needs in 2016-17, up from 1 million in 2015-16 (paragraphs 1.6, 1.17 to 1.18 and 3.2 to 3.5).

12 **In October 2017, the Care Quality Commission (CQC) stated that the sustainability of the care market remained precarious.**
In its annual report on the state of health care and social care, the CQC said that demand for care is increasing but capacity is reducing. It was concerned about a reduction in the number of nursing home beds, the high level of vacancies across the care sector and the severe pressures acute hospitals are facing. As at 31 July 2017, 19% of adult social care providers required improvement and 1% were rated as inadequate. Of the five areas in which the CQC judges providers, ‘safety’ is the main one in which providers need to improve. The CQC says ‘safety’ is linked to the number and quality of staff (paragraphs 1.15 to 1.16).

Recruitment and retention challenges

13 **Care work is viewed by the public as low skilled and offering limited opportunities for career progression.**
Research by the UK Commission for Employment and Skills found that employers reported recruitment challenges due to a negative perception of the care workforce and lower-level caring roles in particular. Roles in the care sector suffer from low prestige and perceived poorer options for career progression when compared with similar roles in the NHS (paragraphs 2.2 to 2.4).
14 Providers and commissioners of care have raised concerns that low pay for care workers is contributing to high vacancy and turnover rates. In 2016-17, the care worker vacancy rate was 7.7% and turnover was 33.8%. Around half of care workers were paid £7.50 per hour or below (the National Living Wage was £7.20 in 2016-17). There was lower turnover among higher-paid care workers. Research by Skills for Care found that care providers with the lowest turnover rates ensured people knew that they paid at least the National Living Wage, and made care work more attractive by, for example, investing in staff development and offering flexible working (paragraphs 1.7 to 1.9, 2.6 to 2.10, and 2.15 to 2.16).

15 The vacancy rate for nurses more than doubled between 2012-13 and 2016-17. The vacancy rate for registered nursing jobs in care was 9.0% in 2016-17. This increased from 4.1% in 2012-13, despite the overall number of jobs falling from 51,000 to 43,000. In February 2015, the Department hosted a symposium to look at the issues around recruitment and retention of nurses in care. Attendees noted the lack of prestige of working in care compared with working for the NHS and the poorer options for career and pay progression (paragraphs 2.19 to 2.22).

16 In 2016-17, 7% of the care workforce were non-British EEA nationals, with nursing the job role in care that had the highest proportion of non-British EEA workers. There was wide regional variation in the proportion of non-British EEA nationals working in care, from 2% in the North East to 13% in London. Non-British EEA nationals made up 16% of registered nurses working within care. Across health and social care, the number of nurses joining the Nursing and Midwifery Council register from the EU (excluding from the UK) increased from around 16,800 in March 2013 to around 38,000 in March 2017. However, since July 2016 the number of nurses joining the UK register for the first time from the EU has dropped (paragraphs 2.23 to 2.26).

17 Providers have particular difficulty recruiting to the role of registered manager. Since 2010, CQC has required all regulated adult social care establishments to have a registered manager. This regulation is regarded as essential to providing a safe service. The registered manager, along with the registered provider, is legally accountable for compliance with laws and regulations. In 2016-17, the vacancy rate for registered managers was 11.3%, the highest rate across all care roles. There is concern in the sector about the low number of care workers willing to seek promotion into this role because of the high level of responsibility compared with the level of pay (paragraphs 2.17 to 2.18).
Strategic oversight and support for workforce planning

18 The Department does not have an up-to-date care workforce strategy and roles and responsibilities of the bodies involved in delivering care are not clear. The Department’s last workforce strategy, Working to put people first: the strategy for the adult social care workforce in England, was published in 2009. It is available on the National Archive website only, and gives responsibility to some organisations that no longer exist. Health Education England published a draft workforce strategy, Facing the Facts, Shaping the Future – a draft health and care workforce strategy for England to 2027, for consultation in December 2017. The draft strategy is mainly concerned with the health sector, and coverage of the care sector is short and lacking detail. Despite publishing the strategy, Health Education England has no formal responsibility for the adult social care workforce; responsibility lies with the Department. The Department is currently working with Skills for Care on a consultation exercise to inform future strategies. The Department acknowledges that a strategy for care will need to take into account proposals in the green paper on care for older people, which is due to be published in summer 2018. A comprehensive strategy will require the roles of the various bodies involved in delivering care to be more clearly defined and agreed across the sector (paragraphs 1.2 and 3.7 to 3.11).

19 Local and regional bodies and partnerships are not taking the lead on workforce planning in the absence of a national strategy. Our review of local authorities’ market position statements and of sustainability and transformation partnerships’ plans found that few local areas have detailed plans for the care workforce. The Department does not oversee the workforce planning of local authorities or partnerships (paragraphs 3.12 to 3.15).

20 The Department cannot demonstrate that the sector is sustainably funded, which makes workforce planning difficult. Between 2010-11 and 2016-17, spending on care by local authorities (including funding transferred from the NHS through the Better Care Fund), reduced by 5.3% in real terms. Spending power for local authorities, in total, is forecast to reduce a further 0.2% in real terms between 2017-18 and 2019-20, despite rising demand, increased complexity of care, and financial pressure such as the National Living Wage. The sector remains concerned that there is no certainty about whether the extra £2 billion in government funding for social care between 2017-18 and 2019-20 is a permanent increase. In the Association of Directors of Adult Social Services’ 2017 annual survey, completed by 95% of directors, only 3% stated that they were fully confident that they will be able to meet their statutory duties relating to care in 2019-20. Uncertainty over the sustainability of funding makes it difficult for local authorities to plan how much care, and at what price, they will be able to purchase. This affects providers’ ability to undertake workforce planning (paragraphs 1.10 to 1.11).
21 Four-fifths of local authorities are paying fees to providers that are below the benchmark costs of care. Our analysis shows that only 18% of local authorities were paying an average fee for homecare that was at or above the United Kingdom Homecare Association’s recommended minimum sustainable price for homecare of £16.70 per hour in 2016-17, a rate that the Department, in the guidance to the Care Act 2014, suggests local authorities should have regard to. In 2016-17, local authorities paid an average cost of £15.52 per hour for homecare. In November 2017, the Competition and Markets Authority estimated that if local authorities were to pay the full cost of care home placements for all residents they fund, the additional cost to them of these higher fees would be around £1 billion per year. Self-funders paid on average 41% more for a care home placement. Fees in future years will need to take account of the requirement for providers to pay increases in the rate of the National Living Wage. There is a risk that continued low fees will deter future investment by providers in areas with high proportions of people receiving care funded by the local authority (paragraphs 1.12 to 1.14).

22 The Department is not doing enough to support the development of a sustainable care workforce. Both providers and commissioners from local authorities told us that current funding constraints mean they must prioritise the provision of care in the short-term over offering extensive long-term support for learning and career development to their staff. Nationally, Skills for Care is the Department’s delivery body for leadership and workforce development. In 2016-17, the Department provided £21.5 million in funding for Skills for Care (excluding the money to maintain the National Minimum Data Set for Social Care) to oversee and administer workforce initiatives. This equated to just £14 per worker. As a result, initiatives to support the sector are generally small-scale, which reduces their coverage and potential impact (paragraphs 2.4 to 2.5).

23 Integration of health and social care is not expected to significantly reduce the number of care jobs required. While integration may meet the needs of service users more effectively, workforce modelling commissioned by the Department in 2014 suggested that increased levels of health and care integration will not significantly reduce the forecast increase in the number of jobs required. In February 2017, we reported on the slow pace of integration. Barriers to integrating the health and social care workforces include differences in working culture, professional boundaries and different terms and conditions across the health and local government sectors (paragraphs 1.3 and 3.6).¹

Conclusion on value for money

24 The one and a half million people working in adult social care in England provide essential support to adults with care needs, yet the care sector is undervalued and its workers poorly rewarded. Providers are having increasing difficulty recruiting and retaining workers, and the number of individuals with some level of unmet care needs is increasing.

25 Despite these highly visible challenges, the Department does not have a current workforce strategy and key commitments it has made to both enhance training and career development and tackle recruitment and retention challenges have not been followed through. There is no evidence that the Department is exercising oversight over local authorities and local health and care partnerships for their responsibilities relating to the adult social care workforce. As a result, the actions taken by the Department in its oversight role have not demonstrably improved the sustainability of the workforce and so have not achieved value for money. The Department needs to address this challenge urgently and give the care workforce the attention it requires, so that the sector has the right people to provide consistently safe and high-quality care.

Recommendations

26 A care workforce that is suitably planned, supported and resourced would improve the quality of care, thereby improving the experience and safety of users, and in addition alleviate pressures on the health service.

a The Department should produce a robust national workforce strategy to address the major challenges currently facing the care workforce. The Department has policy responsibility for the care workforce, and should involve other key stakeholders, principally the Ministry of Housing, Communities & Local Government. The strategy should be consistent with reforms stemming from the planned green paper. If a strategy is combined with health, care must receive equivalent prominence.

b The Department needs to understand and plan long-term for the effect on the workforce that integration of health and care, and other potential changes to how care is delivered, will bring. The Department should set out clearer career pathways for workers in care that link with roles in health. The Department should consider how best to address differences in pay and conditions across the health and care sectors, in relation to supporting recruitment and retention in care.
c The Department should encourage local and regional bodies to produce workforce strategies that complement the national strategy. The Department should gain assurance that every area has a clear plan, aligned with the national strategy and local NHS plans. Local areas should plan how to work effectively with other statutory bodies, such as local Jobcentre Plus offices. The Department should gain assurance that local or regional bodies are holding providers to account for delivery.

d The Department should assess whether current initiatives, both national and local, to support recruitment, retention and development are sufficient. The Department should identify ways to boost the impact of these initiatives and consider increasing the scale of those shown to be successful.

e The Department should establish how much funding the sector will need over the long term and make the consequences of any funding gap clear. The Department should consider sharing its modelling of cost and demand pressures on the care sector to help commissioners set appropriate fees for providers; this includes the costs arising from future changes to the National Living Wage.
**BOARD OF DIRECTORS:**

2\(^{nd}\) MARCH 2018

**AGENDA ITEM:**

3.1

**SUBJECT:**

INTEGRATED GOVERNANCE REPORT

**RESPONSIBLE DIRECTOR:**

Chief Executive  
Director of Nursing & Quality  
Medical Director  
Director of Finance  
Chief Operating Officer  
Director of HR & OD

**AUTHOR:**

Chief Executive  
Director of Nursing & Quality  
Medical Director  
Director of Finance & Contracting  
Chief Operating Officer  
Director of HR & OD

**PREVIOUSLY CONSIDERED BY:**

Integrated Governance Committee  
Performance, Finance & Resources Committee  
Workforce Development Committee

**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:** *(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** *(including 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.*
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST

INTEGRATED GOVERNANCE REPORT

Month 10, Quarter 4, 2018
Executive Summary

In M10 (January 2018) Kettering General Hospital Foundation Trust cared for: 7,273 ED attenders, 3,215 non-elective patients, 287 patients undergoing elective inpatient care, 2,986 day cases, 253 births and 22,730 outpatient attenders.

Operational pressures have significantly impacted upon performance, finance and workforce in the month of January 2018; with very high levels elderly patients attending ED with respiratory conditions and falls and high numbers of these patients being admitted to the Trusts beds. This has resulted in an increase in the use of escalation beds and medical outliers; along with reduced elective capacity in response to a directive from NHS England to stop elective activity to free up capacity for urgent care patients. In addition, the Trust been impact on by Noro virus and influenza leading to 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.
## Performance Dashboard for January 2018

### QUALITY

| Indicator | Target | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Year to date
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<tbody>
<tr>
<td>31 day wait for second or subsequent treatment - surgery</td>
<td>94.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>98.0%</td>
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<tr>
<td>31 day wait for second or subsequent treatment - anti cancer drug treatments</td>
<td>98.0%</td>
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<td>62 day wait for first treatment from urgent GP referral to treatment : all cancers</td>
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<td>88.8%</td>
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<tr>
<td>62 day wait for first treatment from consultant screening service referral : all cancers</td>
<td>90.0%</td>
<td>100.0%</td>
<td>94.4%</td>
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<tr>
<td>Referral to Treatment waiting times - Non admitted, target 95% within 18 weeks</td>
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<td>81.9%</td>
<td>78.2%</td>
<td>82.4%</td>
<td>82.4%</td>
<td>83.8%</td>
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<tr>
<td>Referral to Treatment waiting times - admitted, target 90% within 18 weeks</td>
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<td>62.3%</td>
<td>55.4%</td>
<td>53.3%</td>
<td>52.7%</td>
<td>53.4%</td>
<td>58.1%</td>
<td>60.2%</td>
<td>61.5%</td>
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<tr>
<td>Referral to Treatment waiting times - Incomplete, target 92% within 18 weeks</td>
<td>92.0%</td>
<td>72.7%</td>
<td>74.1%</td>
<td>76.0%</td>
<td>77.5%</td>
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<td>80.6%</td>
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<tr>
<td>Maximum waiting time of 4 hours in A&amp;E from arrival to admission, transfer or discharge</td>
<td>95.0%</td>
<td>83.9%</td>
<td>86.3%</td>
<td>88.5%</td>
<td>89.7%</td>
<td>82.7%</td>
<td>84.4%</td>
<td>80.6%</td>
<td>76.4%</td>
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<tr>
<td>Maximum waiting time of 2 weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals</td>
<td>93.0%</td>
<td>97.7%</td>
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<td>97.5%</td>
<td>97.5%</td>
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<tr>
<td>Two week wait from referral to date first seen - symptomatic breast patients</td>
<td>93.0%</td>
<td>98.2%</td>
<td>97.1%</td>
<td>98.2%</td>
<td>97.1%</td>
<td>98.2%</td>
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<td>97.1%</td>
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<tr>
<td>Maximum waiting time of 31 days from diagnosis to treatment for all cancers</td>
<td>96.0%</td>
<td>100.0%</td>
<td>99.7%</td>
<td>100.0%</td>
<td>99.7%</td>
<td>100.0%</td>
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</table>

### WORKFORCE

| Indicator | Target | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Year to date
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</tr>
</thead>
<tbody>
<tr>
<td>Vacancy</td>
<td>7%</td>
<td>7.96%</td>
<td>6.73%</td>
<td>7.58%</td>
<td>8.37%</td>
<td>9.15%</td>
<td>9.49%</td>
<td>9.61%</td>
<td>8.69%</td>
<td>9.22%</td>
<td>9.32%</td>
<td>9.42%</td>
<td>9.52%</td>
<td>9.62%</td>
</tr>
<tr>
<td>Turnover</td>
<td>11%</td>
<td>9.93%</td>
<td>9.65%</td>
<td>9.74%</td>
<td>9.83%</td>
<td>9.73%</td>
<td>9.98%</td>
<td>10.98%</td>
<td>11.18%</td>
<td>11.28%</td>
<td>11.42%</td>
<td>11.58%</td>
<td>11.72%</td>
<td>11.93%</td>
</tr>
<tr>
<td>Sickness Absence</td>
<td>4%</td>
<td>3.8%</td>
<td>3.7%</td>
<td>4.3%</td>
<td>4.86%</td>
<td>4.53%</td>
<td>4.28%</td>
<td>3.93%</td>
<td>3.88%</td>
<td>3.96%</td>
<td>5.06%</td>
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<tr>
<td>Appraisals</td>
<td>85%</td>
<td>82%</td>
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<td>85.2%</td>
<td>84.3%</td>
<td>84.4%</td>
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<td>Statutory and Mandatory Training</td>
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<td>88%</td>
<td>87%</td>
<td>88%</td>
<td>89%</td>
<td>80%</td>
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<td>89%</td>
<td>88%</td>
<td>80%</td>
<td>88%</td>
</tr>
<tr>
<td>Safe Staffing Matrix - Nursing and Care staff (Day)</td>
<td>100%</td>
<td>96.3%</td>
<td>96.7%</td>
<td>94.3%</td>
<td>92.3%</td>
<td>90.7%</td>
<td>92.3%</td>
<td>93.3%</td>
<td>95.8%</td>
<td>94.0%</td>
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<td>94.0%</td>
<td>94.0%</td>
<td>94.0%</td>
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<tr>
<td>Safe Staffing Matrix - Nursing and Care staff (Night)</td>
<td>100%</td>
<td>101.0%</td>
<td>100.6%</td>
<td>99.4%</td>
<td>100.1%</td>
<td>97.1%</td>
<td>100.0%</td>
<td>101.7%</td>
<td>101.9%</td>
<td>100.7%</td>
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</tbody>
</table>

### OPERATIONAL

| Indicator | Target | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Year to date
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Clostridium difficile year on year reduction (total cases)</td>
<td>26 (National target)</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
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<tr>
<td>Grade 3 avoidable PTD</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
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<td>1</td>
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<td>1</td>
<td>1</td>
<td>1</td>
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<td>1</td>
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<tr>
<td>Number of Falls with moderate Harm</td>
<td>36</td>
<td>9</td>
<td>15</td>
<td>13</td>
<td>10</td>
<td>8</td>
<td>2</td>
<td>4</td>
<td>8</td>
<td>5</td>
<td>7</td>
<td>7</td>
<td>7</td>
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</table>

### FINANCE AND RESOURCES

| Indicator | Target | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Year to date
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</thead>
<tbody>
<tr>
<td>Income and expenditure</td>
<td>(6.1)</td>
<td>(6.7)</td>
<td>(5.7)</td>
<td>(6.8)</td>
<td>(3.9)</td>
<td>(5.8)</td>
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<td>(29.9)</td>
<td>(29.9)</td>
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<tr>
<td>EBITDA</td>
<td>(4.2)</td>
<td>(4.5)</td>
<td>(3.5)</td>
<td>(6.8)</td>
<td>(1.5)</td>
<td>(3.1)</td>
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<td>(21.7)</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 Trusts 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.
Quality of Care

Summary: The data for January 2018 highlights sustained improvement/compliance with a number of key practice standards, but with the sustained demand for services and additional beds open there has been a deterioration in the number of cases of grade 3 pressure tissue damage, medication incidents, same sex compliance, and an increase in antibiotic consumption. The number of patients admitted over the age of 75 years remains higher than in the months prior to December. Flu and norovirus have seen beds and bays closed to admissions throughout the month. The Trust reported 2 serious incidents, all of which are under investigation.

Sustained standards/Improvements for January 2018 reporting period:

- Complaints response performance improved to 100% with all responses sent to the complainant in the timescale agreed.
- Friends and Family performance remains at 98%. The second public engagement event was held February 21st, 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.
- The number of cardiac arrests outside of the ED and Catheter laboratory continues at below trajectory and compliance NEWS and PEWS recording remains at or above trajectory.
- The rate of patients not receiving critical medications was 1.2% against the 1.5% trajectory marking a sustained improvement in this standard which has in the past been 20%
- Q2 mortality reviews 50-55% of adult in-patient deaths—0 avoidable deaths identified

Deteriorating standards for January 2018 reporting period:

- The number of same sex breaches was 4 above the 0 standard. Work ongoing to increase discharges to facilitate flow and avoid such incidents
- The % of discharge letters produced on the day of discharge is at 88% representing an improvement and discussed widely at IGC
- 3 x avoidable PTD grade 3 were validated for December which is above the monthly less than 1. The Trust also reported 103 cases of PTD on admission.
- Decembers validated medication incidents reflects a reduction in reported but not to expected 3 per month = 5. All were low harm
- In the last quarter antibiotic consumption has increased in part due to the acuity of patients and respiratory infections. A focus on stewardship and training continues

Key risks and actions:

- The largest risk in January continued to be the number of medical patients within the Trust, seeing outliers and use of escalation beds, compromising patient experience, elective activity, education/training, the staffing resource and practice/service developments. Ongoing vacancy and increased sickness added to organisational pressure and challenges in managing risks.
- As suggested in the last Board report whilst staff can manage to deliver quality care during times of high acuity and demand if this continues indefinitely there is the potential for increased incidents. A view of the January/February position (not yet validated) with regards to PTD and Falls appears to indicate this to be the case.
- Work to return the Trust to safe levels of occupancy continues with delayed transfers of care lower than they have been for many months with the focus now turned to the ‘super stranded’ group of patients and the embedding of the SAFER principles.
- To address staffing gaps Trust staff have worked over and above contracted hours and the cost of agency has escalated. Corporate staff have continued to work clinically with staffing considered at daily safety huddles and capacity meetings along with safety/risks.
- The Trust continues to see a higher number of Datixs submitted regarding staffing levels and ability to deliver all aspects of care. Recruitment continues and a review of ward skills mix to change the make up of staffing going forward is underway to be reported in April.
- Patients attending the Emergency Department have experienced periods of ‘corridor’ waits with additional staff drafted in to support care delivery in this area.
- An additional risk to Safeguarding has arisen with 3 of the 4 Corporate team resigning—all for different reasons. The DoN is seeking interim support both internally and externally whilst recruitment processes concludes and has sought the support of the Safeguarding Team in Commissioning.
## Governance Dashboard

<table>
<thead>
<tr>
<th>February 2018 - January 2018 Data</th>
<th>Month 1</th>
<th>Month 2</th>
<th>Month 3</th>
<th>Month 4</th>
<th>Month 5</th>
<th>Month 6</th>
<th>Month 7</th>
<th>Month 8</th>
<th>Month 9</th>
<th>Month 10</th>
<th>Month 11</th>
<th>Month 12</th>
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<tr>
<td><strong>Key Performance Indicators</strong></td>
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<td><strong>Midpoint</strong></td>
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### Additional Information

- **Type of Measurement**: This column indicates whether a measurement is a type of data, midpoint, actual, goal, or data.
- **Baseline**: This column shows the baseline value for each type of measurement.
- **Midpoint**: This column shows the midpoint value for each type of measurement.
- **Actual**: This column shows the actual value for each type of measurement.
- **Goal**: This column shows the goal value for each type of measurement.
- **Data**: This column provides the source of the data used for each type of measurement.
Operational Performance

Summary
The Trusts Transit time performance has reduced during the month of January, with a whole health system performance of 83.9% being achieved against a 90% STF target. The Trusts individual performance for the month was 68.9%, with 2,290, 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 January 2018 (un-validated performance); and the Trust anticipates sustained delivery against these performance standards going forward.

With a total of 4,326 patients waiting over 18 weeks for treatment and a performance of 79.3% as at the 31st of January 2018. Whilst the Trust is not achieving against this target it has demonstrated sustained improvement throughout 2017-18 with the exception of December and January which have been impacted upon by urgent care pressure and a directive from NHS England to stop elective activity; despite this the Trust continues to reduce the numbers of the very longest patients on its waiting list, with 14 patients waiting over 52 weeks at the end of January 2018.

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

Based upon un-validated data for January the Trust has achieved the 62 day cancer target, with a 6 breaches and a provisional performance of 88.8% (target 85%)

Additional diagnostics activity along with the Trust seeing a high numbers of patients within 2 weeks following an urgent GP referral (97.7% 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 79.3% (trajectory 89.0%). The Trusts reduction in performance this month was as the result of reduced clock stops / treatment, and cancellations due to urgent care pressures and a directive from NHS England to stop elective activity to free up capacity for urgent care patients. A Health wide workshop to develop plans for key services to recover 18 week performance is to be held in March, with plans in-line with the new national planning guidance for 2018-19; and the Trust has planned additional capacity during February and March and anticipates improving performance over the coming months.

A key focus for the Trust is the reduction in the level of patients waiting in-excess of 52 weeks at the end of January the Trust has a total of 14 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 January, with a performance of 83.9%, 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). January 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 (with a increase in respiratory conditions and falls), this resulting in an increase in beds being used for medical patients, with greater use of escalation bed capacity and medical outliers (medical patients being managed on non medical wards).
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 an increase in A&E attendances and Emergency admissions during January, 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 has seen a reduction in the level of patients in its beds that should be receiving care elsewhere, “delayed transfers of care”, with on average 25.6 beds used by these patients per day during January 2018, despite this reduction the Trust remains under significant bed pressure, with 41.4 medical outliers in its beds and on average 36 escalation beds open during the month to cope with demand.

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

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 especially identification of discharges the day prior to discharge.
Ambulatory Care to be optimised via the Accelerated Ambulatory Care programme. Their initial recommendations are due on 7th March.
All patients presenting to ED with a GP letter to be directed to Ambulatory care.
Medical Consultant allocated daily per medical ward and escalation area.
Wards to continue to be supported to embed SAFER and Red to Green with the support of ECIP.
Weekly confirm and challenge meetings continue in February with the DCOO for all patients over day 21 not referred for supportive discharge, to reduce number of super stranded patients.
Tracking calls with health system partners being undertaken by COO/DCOO to review all patients needing support on discharge and unblock any issues.
Spot purchase of beds processes agreed and being implemented in January 2018.
Health Care at Home goes live on 5th February 2018.
Consultant Connect pilot to commence to launch an A&E Advice Line with EMAS. This line will be used by EMAS to ensure that appropriate patients from care homes are sent to A&E.
Workforce Objective 1 – Our ability to attract, recruit and retain appropriately skilled staff
The vacancy rate has increased this month from 9.22% to 9.32%, with 359.11 WTE vacancies, 485.13 wte posts are being actively recruited to, with 231.39 posts being advertised and 253.74 post having been offered. There are 55 Medical vacancies (11%), 30 posts have been offered, 28 currently being advertised and 10 to be re-advertised following unsuccessful recruitment. Nursing vacancies actively being recruited to are 227.86 wte, 96.71 posts have been offered, 131.15 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 100 days and increase of 16 days due to the new year period (91 day target) and for medical posts 119.70 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 above the Trust target at 11.42% this is a subject of focus and analysis with action taking place across the Trust.

Workforce Objective 3 – Provision of excellent education, learning and development (incl. Leadership)
Appraisal rates are 80.3%, which is a decrease on the previous month of 2.61%, the area of concern continues to be surgery and anaesthesia, there are plans in place to address this particularly during any theatre downtime and it was confirmed in the CBU performance reviews that the position will improve by Month 11. A significant level of detail is reviewed against the appraisal data with the number of appraisals due to be completed known however the impact of non-elective pressures and deployment of resources is likely to continue to significantly impact appraisal performance.
A majority of 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. 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 9 to 10 by 1.1% and over the Trust 4% threshold, this increase is predominantly within short term absence following the weather, increased flu presentation and operational pressure. The flu campaign vaccination rate is 65% for frontline staff, with the aim of reaching 70% 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 7 – Equality and Diversity
The Trust has achieved a good record on its diversity and inclusion work relating to recruitment, selection and retention; as benchmarked with other Trusts. The Trust has retained the Mindful Employer Status as well as being designated as a Disability Confident Employer. A number of staff networks have been set up and launched to support staff from European Union, Black and Minority Ethnic background and those with a disability.

<table>
<thead>
<tr>
<th>Highlights</th>
<th>Vacancy</th>
<th>Sickness</th>
<th>Turnover</th>
<th>Appraisals</th>
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<tr>
<td>Movement on previous month</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
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<tr>
<td>% Change on previous month</td>
<td>0.11%</td>
<td>1.10%</td>
<td>0.13%</td>
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Workforce Dashboard

Reporting Period: January 2018 Month 10

Kettering General Hospital
NHS Foundation Trust

HR Statistics

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<td>4048</td>
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<td>Budgeted WTE Jan</td>
<td>3852.34</td>
<td>4015.32</td>
</tr>
<tr>
<td>Whole Time Equivalent (WTE) Jan</td>
<td>3493.23</td>
<td>379.78</td>
</tr>
<tr>
<td>Vacancy Rates WTE Jan</td>
<td>3508.11</td>
<td>379.78</td>
</tr>
<tr>
<td>Turnover Jan</td>
<td>11.58%</td>
<td>11.58%</td>
</tr>
</tbody>
</table>

Vacancy Rates

<table>
<thead>
<tr>
<th>Month</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td>7%</td>
<td>9.32%</td>
<td>9.90%</td>
</tr>
<tr>
<td>Feb</td>
<td>9.32%</td>
<td>15.57%</td>
<td>4.01%</td>
</tr>
<tr>
<td>Mar</td>
<td>9.90%</td>
<td>4.01%</td>
<td>10.54%</td>
</tr>
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</table>

Turnover

<table>
<thead>
<tr>
<th>Month</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td>11%</td>
<td>11.42%</td>
<td>10.04%</td>
</tr>
<tr>
<td>Feb</td>
<td>11.42%</td>
<td>11.51%</td>
<td>12.28%</td>
</tr>
<tr>
<td>Mar</td>
<td>10.04%</td>
<td>12.28%</td>
<td>10.91%</td>
</tr>
</tbody>
</table>

Resourcing Position

<table>
<thead>
<tr>
<th>Month</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td>14.00%</td>
<td>14.00%</td>
<td>14.00%</td>
</tr>
<tr>
<td>Feb</td>
<td>14.00%</td>
<td>14.00%</td>
<td>14.00%</td>
</tr>
<tr>
<td>Mar</td>
<td>14.00%</td>
<td>14.00%</td>
<td>14.00%</td>
</tr>
</tbody>
</table>

Target - 7% Red  Target - 11% Amber

Key:
- Current Rolling Year (dashed line=projection)
- Previous Rolling Year
- KPI
- Monthly Turnover

RAG Status:
- Action Required
- Of Concern
- Off Target
- On Target

- % of 7% from last month
- % of 7% from last year
- % of 7% from last 12 months
## 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>
</tr>
</thead>
<tbody>
<tr>
<td>Fire Safety</td>
<td>87.5%</td>
<td>85%</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>87.2%</td>
<td>85%</td>
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<tr>
<td>Manual Handling</td>
<td>87.3%</td>
<td>85%</td>
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<tr>
<td>Safeguarding Adults</td>
<td>87.5%</td>
<td>85%</td>
</tr>
<tr>
<td>Safeguarding Children</td>
<td>87.4%</td>
<td>85%</td>
</tr>
<tr>
<td>Equality, Dignity &amp; Respect</td>
<td>93.1%</td>
<td>85%</td>
</tr>
<tr>
<td>Infection Control</td>
<td>88.5%</td>
<td>85%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>88.5%</td>
<td>85%</td>
</tr>
<tr>
<td>MCA Awareness</td>
<td>89.1%</td>
<td>85%</td>
</tr>
<tr>
<td>Risk Management</td>
<td>89.1%</td>
<td>85%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trust Appraisals</th>
<th>Trust Compliance</th>
<th>Trust Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appraisals</td>
<td>80.3%</td>
<td>85%</td>
</tr>
</tbody>
</table>

### Key
- **Green**: Current Rolling Year (dashed line = projection)
- **Amber**: Previous Rolling Year
- **Red**: KPI

### Target - 85%

#### Statutory & Mandatory Training

<table>
<thead>
<tr>
<th>Month</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trend</td>
<td>100%</td>
<td>90%</td>
<td>80%</td>
<td>70%</td>
<td>60%</td>
<td>50%</td>
<td>40%</td>
<td>30%</td>
<td>20%</td>
<td>10%</td>
<td>0%</td>
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</tbody>
</table>

#### Appraisals

<table>
<thead>
<tr>
<th>Month</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trend</td>
<td>100%</td>
<td>90%</td>
<td>80%</td>
<td>70%</td>
<td>60%</td>
<td>50%</td>
<td>40%</td>
<td>30%</td>
<td>20%</td>
<td>10%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Workforce—Safe staffing—Nursing (Month 10)
• NQF data identifies that in month the percentage fill rate remained static, but excludes escalation area cover.
• The number of shifts not filled by temporary staff increased by 3.1% to 23.4% of all requested shifts representing 510 shifts across both nursing and support workers.
• The above were exacerbated by higher sickness/absence rates, higher turnover and greater vacancy.
• Corporate staff from Practice Development and Education teams have continued to provide support as have theatre practitioners.
• The number of patients requiring enhanced observation increased further demonstrating the challenges posed within acute care environments of patients with challenging behaviours.

Risks and Mitigations
• Areas that continue to face particular staffing challenges are MAU, Clifford, Barnwell Trauma Unit, Lamport/Twywell Ward and Harrowden. Staff from other areas have been moved to provide cover and support in those areas with the greatest vacancy. Ward rosters have been rebased to see minimum levels of substantive staff per shift to ensure a balance of substantive vs temporary staffing.
• On a weekly basis leads meet with the HRD and Deputy Director of Nursing to review staffing gaps and temporary staffing to consider risks and control as possible temporary spend.
• The Deputy Director of Nursing is undertaking in line with the latest National Quality Board guidance (January 2018) a review of all wards skills mix and establishments to facilitate new ways of working with a different make up of staff, e.g. therapists, technicians.
• The Releasing Time to Care/Productive Ward initiative has commenced with an engagement exercise that seeks to identify from staff what they feel would make positive improvements to the delivery of care in their area for greater productivity and satisfaction.
• Staff capability in using SafeCare is being further supported to ensure the system is used to its capacity to provide greater intelligence regarding acuity, dependency mapped to the resource to facilitate reviews.

Recruitment and Retention
• A recruitment fair held 24/2/18 and the nursing team continue to consider how we support student nurses in the trust to take up permanent employment in the future.
• 19 Trainee Nursing Associates have all passed the first year of their 2 year programme with developments nationally moving forward on what this role will be able to deliver upon qualification next year. The plan is to recruit a further 18 in April 2018.
• 53 International Nurses have gained NMC registration with a further 4 in the current programme representing an effective employment model.
• All nurses expecting to revalidate have been supported and signed off demonstrating a successful implementation of NMC best practice and fitness to practice.
• The Leadership programme for Lead Nurses and Matrons commences in April and is based on accountability and resilience.
## Workforce—Safe staffing—Nursing (Month 10 Continued)

<table>
<thead>
<tr>
<th>Month</th>
<th>UNIFT Actuals vs plan</th>
<th>CHPP Trust average (excl. ITUs)</th>
<th>Sickness N&amp;M Registered</th>
<th>HCA's Registered</th>
<th>Turnover FTE N&amp;M Registered</th>
<th>HCA's Registered</th>
<th>Vacancies N&amp;M Registered</th>
<th>HCA's Registered</th>
<th>Vacancies FTE N&amp;M Registered</th>
<th>HCA's Registered</th>
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</thead>
<tbody>
<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>
<td>9.8%</td>
<td>10.7%</td>
<td>111.82</td>
<td>64.91</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>
<td>9.7%</td>
<td>9.8%</td>
<td>110.94</td>
<td>59.77</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>
<td>10.5%</td>
<td>9.8%</td>
<td>120.75</td>
<td>59.8</td>
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<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>
<td>11.0%</td>
<td>9.7%</td>
<td>126.23</td>
<td>59.17</td>
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<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>
<td>10.60%</td>
<td>11.73%</td>
<td>121.94</td>
<td>71.32</td>
</tr>
<tr>
<td>September</td>
<td>90.1%</td>
<td>7.3%</td>
<td>4.78%</td>
<td>6.42%</td>
<td>9.20%</td>
<td>6.20%</td>
<td>11.26%</td>
<td>11.48%</td>
<td>129.58</td>
<td>69.74</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>
<td>10.44%</td>
<td>13.74%</td>
<td>121.24</td>
<td>84.28</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>
<td>9.12%</td>
<td>15.85%</td>
<td>105.85</td>
<td>97.20</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>
<td>6.39%</td>
<td>16.47%</td>
<td>71.74</td>
<td>101.01</td>
</tr>
<tr>
<td>January</td>
<td>92.4%</td>
<td>7.7%</td>
<td>5.52%</td>
<td>7.86%</td>
<td>9.76%</td>
<td>7.63%</td>
<td>7.65%</td>
<td>15.53%</td>
<td>85.99%</td>
<td>95.24%</td>
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### Nurse Staffing Actuals

<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>Dec 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>96.1%</td>
<td>127.8%</td>
<td>95.5%</td>
<td>101.6%</td>
<td></td>
<td>4.4</td>
<td>3.3</td>
<td>7.7</td>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lamport</td>
<td>91.0%</td>
<td>115.7%</td>
<td>99.9%</td>
<td>134.9%</td>
<td>HCA Specials &amp; Bedwatch</td>
<td>2.8</td>
<td>3.4</td>
<td>6.2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Twywell</td>
<td>89.7%</td>
<td>88.9%</td>
<td>95.2%</td>
<td>101.6%</td>
<td>HCA Specials &amp; Bedwatch</td>
<td>2.9</td>
<td>2.6</td>
<td>5.4</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cranford</td>
<td>89.0%</td>
<td>87.9%</td>
<td>91.9%</td>
<td>92.5%</td>
<td>Increased Bedwatch</td>
<td>3.1</td>
<td>3.0</td>
<td>6.1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pretty Wards</td>
<td>88.2%</td>
<td>93.2%</td>
<td>96.6%</td>
<td>95.9%</td>
<td></td>
<td>3.1</td>
<td>3.3</td>
<td>6.4</td>
<td>1</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Harrowden A</td>
<td>91.6%</td>
<td>97.5%</td>
<td>124.7%</td>
<td>100.0%</td>
<td>High Acuity</td>
<td>4.9</td>
<td>3.1</td>
<td>7.9</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harrowden C</td>
<td>92.5%</td>
<td>101.7%</td>
<td>99.2%</td>
<td>96.8%</td>
<td>Significant vacancies &amp; Sickness</td>
<td>4.2</td>
<td>3.1</td>
<td>7.3</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td>Naseby Wards</td>
<td>91.4%</td>
<td>99.7%</td>
<td>97.8%</td>
<td>109.1%</td>
<td>Increased Bedwatch</td>
<td>2.8</td>
<td>4.7</td>
<td>7.5</td>
<td>1</td>
<td>2</td>
<td>2</td>
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<td></td>
</tr>
<tr>
<td>Clifford</td>
<td>89.7%</td>
<td>88.4%</td>
<td>93.5%</td>
<td>90.9%</td>
<td>Maternity Leave &amp; Sickness</td>
<td>4.5</td>
<td>2.9</td>
<td>7.4</td>
<td>2</td>
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<td>1</td>
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<td></td>
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</table>
M10 POSITION

The M10 position is £4.8m deficit giving a £3m unfavourable variance to plan and is split into 3 areas;

- 17/18 continued pressures £0.6m deficit - these are the items listed above such as endoscopy delays, HRG 4+ etc.
- Impact of winter not covered by winter funding or non elective performance £0.5m – these are cancelled electives, escalation costs and increased utilities offset partially by £1.3m additional income through NEL and winter funding
- Emerging risks £1.9m
  - Four Eyes final invoice £0.4m
  - Corona electricity dispute £0.4m
  - Agency backlog invoices £0.4m
  - CQUIN 0.5% removal £0.7m

These emerging risks would usually be covered by contingency but the contingency was used to support winter pressures thus reducing the true impact of winter.

M10 YTD

The YTD position is £26.1m deficit which is an £8.6m variance YTD of which the key variances are;

- NON RECURRENT
  - £1.5m Theatre closures
  - £0.9m Endoscopy
  - £1.8m telereadiology and clinical support costs
  - £3.0m winter escalation and lost elective income not covered by additional funding
  - £1.9m unplanned pressures/ emerging risks
  - £1.2m overseas nurses initiative

- RECURRENT
  - £1.3m HRG 4+
  - £0.6m Critical Care

- OFFSET
  - £2.0m agency reduction
  - £2.2m FRP and Corporate CIPS
Finance Executive Summary

January 2018 (Month 10)

FORECAST

The Trust is re-forecasting the 2017/18 deficit to £29.9m. This assumes the release of £0.5m contingency, a benefit regarding winter costs against funding £0.2m and a reduction in agency spend £0.2m. This revised forecast will be challenging, to achieve it the Trust will;

• Remove all “pools” of agency
• Stop all agency/locum and bank where areas are over established, any emergency cover must be approved by Director on Call
• Commence full programme of day case work by Monday 19th February
• Commence all Orthopaedics elective activity Monday 26th February
• Close all escalation areas and have full programme of elective work by 1st March
• Manage annual leave to 15% of substantive staff

UNDERLYING POSITION

The underlying position is £22m which is the £19.9m 18/19 plan plus HRG4+ (£1.6m) all other recurrent issues such as tele radiology and critical care have been offset with recurrent savings such as agency reductions

The reported variance for 17/19 of £29.9m is therefore down to £8m of non-recurrent issues, £4m winter not covered by additional income or NEL, £3m Capital delays impacting elective activity, £1m of nursing initiatives to support longer term staffing strategy. There are then £2.5m of truly unplanned events such as CQUIN, invoices, etc. that would have been covered by the £2.5m contingency if this had not been allocated against winter.

RISKS

The risks not included in the YTD position are Sepsis, £0.4m FYE and MRET, £1.4m. 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. This is currently being independently validated, if the validation agreed with the CCGs position it would result in a further £1.4m penalty.
Utilities is a significant pressure for the Trust in M10, there is a risk this impact could continue resulting in a potential risk of £0.8m to the 2017/18 forecast position.
**Finance Executive Summary**

**MITIGATIONS**

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

There is an opportunity for the Trust to negotiate a year end deal with commissioners with the possibility of a £1m benefit, the release of contingency £0.5m and continued performance to reduce agency £0.2m, reduction in escalation costs with escalation areas expecting to close by 1st March.

<table>
<thead>
<tr>
<th>£m</th>
<th>Option 1 - base (30.80)</th>
<th>Option 2 - upside (30.80)</th>
<th>Option 3 - downside (30.80)</th>
</tr>
</thead>
<tbody>
<tr>
<td>M10 YTD</td>
<td>(26.10)</td>
<td>Contingency 0.40</td>
<td>Contingency 0.50</td>
</tr>
<tr>
<td>M11</td>
<td>(2.80)</td>
<td>Winter 0.25</td>
<td>Escalation 0.40</td>
</tr>
<tr>
<td>M12</td>
<td>(1.90)</td>
<td>Agency 0.25</td>
<td>Winter 0.40</td>
</tr>
<tr>
<td>FOT</td>
<td>(30.80)</td>
<td>Total (29.90)</td>
<td>Agency 0.20</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Year End 1.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total (28.30)</td>
<td>Total (33.20)</td>
</tr>
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</table>
## Finance Balance Scorecard

### Finance Report
January 2018 (Month 10)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Status</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normalised Net Surplus / (Deficit)</td>
<td>Net income and expenditure</td>
<td>R</td>
<td>The deficit in-month is £4.8m which is a £03.0m adverse variance to plan. The key drivers are costs of winter, Non Elective income under performing, overseas nurses, bank partners, agency backlog invoices, Corona &amp; Four Eyes. Offset by winter funding income and contingency release</td>
</tr>
<tr>
<td>Agency Spend</td>
<td>Agency spend against plan</td>
<td>R</td>
<td>Agency spend is £0.5m adverse variance to plan in month.</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>CIP 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>Total expenditure in January is £0.8m with YTD expenditure of £8.9m. This includes £1.3m for the car park deck (not on plan, funded via a separate lease)</td>
</tr>
<tr>
<td>Cash</td>
<td>Cash held</td>
<td>G</td>
<td>The cash position is £1.3m versus a plan of £1.2m. The trust has drawn £23.8m revenue loan support funding and £6.3m capital loan support funding to the 31 January 2018</td>
</tr>
</tbody>
</table>
## Finance Balance Scorecard - CBUs

### Finance Report
January 2018 (Month 10)

<table>
<thead>
<tr>
<th>CBU</th>
<th>RAG</th>
<th>M1-M10 Budget</th>
<th>M1-M10 Actual</th>
<th>Variance</th>
<th>Key Drivers of YTD performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Medicine</td>
<td></td>
<td>£16,105</td>
<td>£13,635</td>
<td>(£2,470</td>
<td>*Nursing and medical pay overspends due to continued high levels of vacancy, sickness and winter escalation cover.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*Non Pay overspends (drugs, Hospital at Home, winter pressures spot beds and Claremont care workers)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*NEL income underperformance due to Claremont</td>
</tr>
<tr>
<td>Specialty Medicine</td>
<td></td>
<td>£9,340</td>
<td>£6,451</td>
<td>(£2,888</td>
<td>*Reduced NEL and daycase income due to AL and increased patient complexities</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*Scientific and Nursing pay due to vacancies, sickness and high acuity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*Cardiology clinical supplies overspend</td>
</tr>
<tr>
<td>Urgent Care</td>
<td></td>
<td>£807</td>
<td>(£733)</td>
<td>(£1,540</td>
<td>*Reduced A&amp;E income due to ECDS implementation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*Nursing and medical pay overspends due to vacancies, winter escalation and unfunded areas (FAU, red area &amp; A&amp;E medics)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*Non Pay overspends (PCS cost pressure, drugs and clinical supplies due to winter escalation)</td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td>£18,469</td>
<td>£14,773</td>
<td>(£3,696</td>
<td>*Theatre closures / Productivity income shortfall mainly in T&amp;O</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*Theatre cancellations due to bed pressures</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*Medinet net cost due to lower than expected number of patients per list</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*Agency Medical vacancy cover, mainly in Orthopaedics and General Surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*CIP shortfall as a result of unidentified schemes against the stretch target</td>
</tr>
<tr>
<td>Anaesthesia</td>
<td></td>
<td>(£11,179)</td>
<td>(£11,826)</td>
<td>(£646</td>
<td>*ITU and Pain income under-performance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*Offset by Theatre Pay underspends due to a high level of vacancies</td>
</tr>
<tr>
<td>Woman &amp; Child</td>
<td></td>
<td>£12,542</td>
<td>£11,072</td>
<td>(£1,470</td>
<td>*Income shortfalls mainly in Obs &amp; Gynae across DC/EL and NEL</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*Junior doctors overspends</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*Non Pay – NHS invoices for booked births delivered in other NHS Trusts</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*CIP shortfall as a result of unidentified schemes against the stretch target</td>
</tr>
<tr>
<td>Clinical Support</td>
<td></td>
<td>(£6,293)</td>
<td>(£9,116)</td>
<td>(£2,823</td>
<td>*Endoscopy closure; Reduced Direct Access Income</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*Non Pay overspends (Reagents, Telerad, Outsourced Ultrasound, Sendaways)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*CIP shortfall as a result of unidentified schemes against the stretch target</td>
</tr>
<tr>
<td>Core Services</td>
<td></td>
<td>(£1,435)</td>
<td>(£1,412)</td>
<td>£23</td>
<td>*Vacancies</td>
</tr>
<tr>
<td>Medical Records &amp; Outpatients</td>
<td></td>
<td>(£4,081)</td>
<td>(£3,999)</td>
<td>£82</td>
<td>*Vacancies</td>
</tr>
<tr>
<td>Corporate</td>
<td></td>
<td>(£40,684)</td>
<td>(£32,275)</td>
<td>(£8,409</td>
<td>*Agency contingency, unplanned contingency release, CIP offset, New Devs/CQC budget not utilised, corporate vacancies, Commissioning gains, Capital gains, accruals release/other less Foureyes consultancy, Bank Partners transaction costs and Gas supplier dispute</td>
</tr>
<tr>
<td>Facilities</td>
<td></td>
<td>(£11,062)</td>
<td>(£12,657)</td>
<td>(£1,595</td>
<td>*Electricity rate increase and utilities increased usage, pay - sickness cover, additional capacity pressures in soft facilities management, additional maintenance costs, CIP underperformance</td>
</tr>
</tbody>
</table>

**Grand Total**

| (£17,481)       | (£26,087)      | (£8,606)       |
### BOARD OF DIRECTORS

**2^rd MARCH 2018**

### AGENDA ITEM :

3.3

### SUBJECT:

MATERNITY SAFETY IMPROVEMENT PLAN

### RESPONSIBLE DIRECTOR:

Leanne Hackshall, Director of Nursing and Quality

### AUTHOR:

Eilish Crowson, Business Unit Director

Nicki Perry, Quality Matron

### EXECUTIVE SUMMARY:

The maternity Service is committed to work collaboratively to achieve the visions detailed through Maternity Transformation Programme which will be delivered from recommendations in *Better Births (2016)*, and *Safer Maternity Care (2016)*, with a primary focus on improving safety to drive improvement in our maternity services. The KGH Maternity Safety Improvement Plan (2016-2020) is structured around the five key drivers for delivering safer maternity care, which are based on the guidance set out in Spotlight on Maternity:- Leadership, Learning and best practice, Teams, Data and Innovation, underpinning a commitment to achieve the targets set out in the Saving Babies Lives Bundle.

This exception report will provide detail against those outcome indicators given within the report that are rag rated as ‘Amber’ or ‘Red’ to enhance the detail given in the action plan within the report.

### ACTION REQUIRED:

Board members are to note the content of the report as it serves as an opportunity to benchmark progress and achievement against a planned trajectory of improvement.

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

Non delivery of improvements in maternity care compromises our strategic objectives, will result in increased claims, poor patient satisfaction and Trust reputation

### WORKFORCE ISSUES: (including training and education implications)

Work ongoing to address continuity of care model with workforce

Need to train further midwives third trimester scanning

### FINANCIAL IMPLICATIONS:

Specify No/Yes (Detailed within the report).

Potential for increased/changes to workforce and equipment

### COMMUNICATION/CONSULTATION ISSUES (including patient and public involvement)

Wide communication with staff and patient representative groups

### CQC DOMAINS

- Safe
- Effective
- Caring
- Responsive to people’s needs
- Well-led

---

1
QUARTERLY SAFETY IMPROVEMENT PLAN UPDATE EXCEPTION REPORT

1. OVERVIEW

1.1 Progress against many outcome indicators within the report is good, with many areas of MDT training and development continuing at a steady pace. The Forum for reviewing Unexpected Term Admissions to LNU is well established and the learning is being applied to practice and shared within the team.

1.2 The red and amber areas of exception within the report have been the same areas for two consecutive months. Where improvement is not clearly demonstrated, a Risk Assessment has been uploaded to the Risk Register.

2. MATTERS ARISING

2.1 The plan has been reviewed and amended in line with recent guidance from the Department of Health (Safer Maternity Care, November 2017).

3. RED/AMBER EXCEPTIONS TO BE HIGHLIGHTED

- The introduction of community Modified Early Obstetric Warning Score (MEOWS) specific pathway within the Community setting on QGSG agenda for March 2018 (confirmation awaited). There were initial delays within e-procurement and achieving printing. Sepsis Champion for the Trust proposed awaiting guidance from anticipated changes to the National Sepsis Tool, to ensure compatibility with Community MEOWS. The national change has still not been achieved, so the CBU will press forward with the documents as is to achieve use in practice. Roll out anticipated for April 2018.

  Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) Maternal report 2013-2015 published Dec 17 has a recommendation of recognition of sepsis in community. This work will support that recommendation in practice

- Trust Review of the Royal Surrey ‘Bobble Hat Care Bundle’ for babies at risk of hypothermia was achieved by LNU (Neonatal Unit) MDT. Meeting between Ward Matrons to discuss implementation of an amended pathway into KGH practise scheduled for February 2018.

- Safety Huddle review achieved in June 2017. Amended Safety Huddle process was proposed for November 2017. Matron and Lead Midwife have meeting scheduled for February 2018 to agree changes to the proforma and process to ensure consistency of meeting content and formulary. Should be in place for March 2018.

- Birthrate plus acuity tool initially delayed but commenced February 5th. First months data capture will be reviewed to ‘go live’ March 2018.
Antenatal MDT to be ‘re-launched’ March 2018, led by Consultant Miss Kirsty Adcock. Quality Matron and Miss Adcock attending Leicester Antenatal MDT March 2018 to learn from Leicester process, which is reported to work well.

The Perinatal Mental Health care pathway implementation is in progress, whilst there has been some delay we are finalising Consultant clinic times in partnership with NHFT.

21% of obstetricians of Registrar Grade and above have achieved the mandatory completion of K2 training package (this was 27% Qtr 2). Some have attended CTG Masterclass in lieu of K2 – leaving 53% who have achieved neither. This has been escalated to the BUD and will be discussed at Cabinet in March 2018. Risk Assessment has been completed in conjunction with Patient Safety Lead.

LNU forum has identified that Data inputting on BADGER net is likely not comprehensive enough in preparation for the PRB pathways commencing in April 2018. A quality assurance audit will be undertaken in February 2018. BUD has written to LNU Lead Clinician re action required to improve data entry on BADGER net.

4. **FURTHER REQUIREMENTS**

4.1 NHS plan for 18/19 requires all units to meet the Saving Babies Lives Bundle to now be met in full by March 19 this will require some further midwives to be trained in third trimester scanning to support overall capacity demand. We are currently addressing this.

5. **ACTION REQUIRED BY THE BOARD**

5.1 Members of Board are asked to receive the Safety Improvement plan and discuss progress
Kettering General Hospital Maternity Safety Improvement Plan

Contributing to the Governments National ambition for delivering

Safer maternity care

2016 - 2020

Eilish Crowson, Head of Midwifery & Nursing
Nicki Perry, Quality Matron

February 2018 update for Qtr 3 – Version 5

Chairman : Graham Foster JP
Interim Chief Executive: Fiona Wise
February 2018

Introduction

Kettering General Hospital is committed to develop its maternity service to deliver care that is safe, personalized and with the best possible outcomes for all. The maternity Service is committed to work collaboratively to achieve the visions detailed through Maternity Transformation Programme which will be delivered from recommendations in Better Births (2016), and Safer Maternity Care (2016), all with a primary focus on improving safety and to drive improvement in our maternity services.

We are focused on working together with Clinical Networks, MBRRACE, patient safety collaboratives and Public Health work to actively develop and continuously review to implement best safety practice into our unit. Reducing stillbirth and babies affected by brain injuries that occur during or soon after birth is a central priority for the NHS, and Kettering General Hospital Women & Child Health CBU is committed to achieve the targets set out in the Saving Babies Lives Bundle.

KGH safety plan will be structured around the five key drivers for delivering safer maternity care, which are based on the guidance set out in Spotlight on Maternity:

- Leadership,
- Learning and best practice,
- teams,
- data,
- innovation
Our ambition

In order to develop the service to be as safe as it can be, we recognise the importance of strong leadership within the team. Strong leadership promotes a professional culture which facilitates and empowers teams to provide the best possible care. Strong leadership enables the fostering and development of collaborative relationships across networks to support the delivery of safer maternity care. A Board level Maternity Champion to be appointed and a bespoke Maternity Safety Plan to be made public and included within the quality account will strengthen Leadership and focus Maternity Services at Board Level.

We recognise the importance of promoting a culture of safety that is underpinned by openness and a desire to learn lessons from investigations. We share a drive to continuously improve and benchmark our local service which is key to provide a focus on prevention and quality, and review of local actions that may be required to further develop the overall service and take action to apply best practise to the care that we deliver.

We appreciate the importance of investing in the capability and skills of the multi-disciplinary team and we are committed to provide access to evidenced based training and development for the entire multi-disciplinary team. A developed and motivated team provides safer care.

We are committed to the use of electronic systems to improve local and National data collection, and as such will continue to contribute to national and local surveys. We need to ensure the Trust is reporting to maternity Services Dataset and other key data sets such as MBRRACE-UK, RCOG, Each Baby Counts, National Neonatal Dataset and National Maternity and Perinatal Audit.

Innovation within the team is supported and encouraged. Innovation leads to improvement and the opportunity to share learning both within, and outside of the organisation to drive up standards. We propose to work collaboratively with Northants Local Maternity Systems (LMS) to achieve the outcomes of Maternity Transformation Programmes. To will take part in the new Maternal and Neonatal Health Quality Improvement Programme.

This Plan will include an update each quarter captured within the body of the document, as opposed to a stand-alone report. Where the CBU is on target, progress will be noted within the plan. In areas where progress is off plan, remedial actions will be given in an action plan at the foot of the document.
Make KGH Maternity Services safe by achieving National ambitions to reduce avoidable harm.

- Put patient safety first
- Be transparent
- Collaborate
- Support staff
- Continuously learn

Reduce avoidable harm associated with deterioration and pre-term birth

Ensure effective Perinatal Mental health & Safeguarding

Reduce the admission of term babies to LNU

Team work

Data

Put patient safety first
Be transparent
Collaborate
Support staff
Continuously learn

Greater continuity of midwifery care
Learn lessons – Education/systems/Processes
Sepsis/MEOWS/Community MEOWS pathways
Management of babies at risk of hypothermia
Reduction in cases of HIE
Management of jaundice
Management of babies at risk of hypoglycaemia
Benchmarking/Audit of service
Training and Development
Process/pathway for perinatal mental health in place
MDT Training & Development
PASCAL metrics review of organisational safety culture & human dimensions
Leadership Development
Handover/Safety huddle on Delivery Suite
MDT care planning in complex AN inpatient cases and other pathways of care including diabetes
Maternity Dashboard
National Neonatal Dataset
MBRRACE-UK and workstreams
Patient/Public Engagement, inclusion in SI investigations
Maternity Services Dataset
Every Baby Counts
<table>
<thead>
<tr>
<th>What are the areas we can make a difference in?</th>
<th>What does success look like?</th>
<th>What do we need for the success to be realised?</th>
<th>Outcome indicators</th>
<th>Lead/Team</th>
<th>Date for completion &amp; progress to date</th>
<th>RAG</th>
</tr>
</thead>
</table>
| **Reduce avoidable harm associated with deterioration and Perinatal morbidity** | Reduction of avoidable term stillbirths, and early neonatal deaths by 30% by 2018 and 50% by 2025. Reduction of HIE acquired during or shortly after birth. | Achieve Saving Babies Lives Care Bundles  
- Reduce smoking in pregnancy  
  
  *(17.5% of mothers were smoking at the time of delivery 2015-2016)*  
- Risk assessment and surveillance for fetal growth restriction  
- Raising awareness of reduced fetal movements | Comparison of smoking rates at booking, and at delivery with quarterly statistics. Referral to smoking cessation team and use of carbon monoxide monitoring.  
Audit, reporting and publishing. Increase of antenatal detection rates.  
Ensure the continuance of Licence costs and data collection through GROW to review the overall service.  
Information given to all women. Protocols in place to manage care of women reporting RFM. | E Crowson  
C Cuckson  
M Tonks  
P Leigh | April 2018.  
**Update 01/18**-  
16.7% of mothers smoking at time of delivery so far this year.  
Audit of delivered SGA babies began in April 17– with 81.9% deliveries captured to Dec 17.  
GROW on Maternity Medway implementation achieved Jan 18  
Need to identify further staff for third trimester scanning to meet fetal surveillance scanning in full by March 19  
100% of women receive information at booking regarding reduced fetal movements through PILS packs, Bounty |
<p>| Listen to me Campaign | • Effective fetal monitoring during labour | All staff trained in interpretation and competency assessed annually. Buddy system in place for escalation. Planned guideline review once majority of staff trained through masterclass. | App and Mama Academy envelopes. Questions regarding fetal movements is now a mandatory field on Maternity Medway. Midwifery compliance currently at 99% for training and assessment of CTG interpretation. East Midlands Maternity Network agree to the regional implementation of FIGO standards for CTG interpretation. Meeting planned 5/2/18 to agree progression and understand training needs required. Guideline update will coincide with regional roll out. |
| Listen to Me campaign to be used in every day practice. Listening to mothers concerns reduces likelihood of deterioration occurring | • Roll out campaign to Rowan ward | Positive patient experience Reduction in complaints for clinical area. 2/18 – CQC feedback – further consideration to | M Tonks P Leigh K Attley May 17 |
| Update 1/18 - Well established on Del Suite – no complaints re ‘not being heard/communication’ in first nine months post roll out. Campaign nominated for |</p>
<table>
<thead>
<tr>
<th><strong>Reduce pre-term birth</strong> – in line with National recommendations from 8% to 6%</th>
<th><strong>Learn lessons</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><em>• Work to achieve care provision pathway that provides pregnant, labouring and postnatal women with greater continuity of carer, as linked to improved outcomes and a reduction in pre-term labour</em></td>
<td><em>• Use locally developed review tool based on MBRACE dataset to undertake perinatal reviews of all stillbirths and early neonatal deaths to influence local action planning to improve outcomes (National Form pending)</em></td>
</tr>
<tr>
<td><em>A reduction in pre-term births (&lt;36+0 weeks gestation) to consistently at or below 6% per annum.</em></td>
<td><em>Record of case reviews and cascade of lessons learnt through monthly newsletter</em></td>
</tr>
<tr>
<td><em>E Crowson M Tonks P Leigh</em></td>
<td><em>S Fretter MDT team</em></td>
</tr>
</tbody>
</table>

**Update 1/18**

- Incorporation as an action from Safer Births update Nov 17.
- Pre-term birth rate at KGH 2017 to present currently at 6.1%

- **Report to CBU Governance every 4 months – last presented 12/10/17.**
- National review tool received, being implemented within CBU.
- KGH to be a part of National Bereavement Care pathway pilot with SANDS.

**SI learning bulletin now shared at each report closure.**

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**be given to additional measures to capture effectiveness of the initiative.**

**HSJ award.**

- Full roll out achieved on Rowan July 2018. 2 complaints in total relating to communication received in QTRs 2&3. Complaint and F&F feedback reviews ongoing.
<table>
<thead>
<tr>
<th>Sepsis/MEOWS pathways</th>
<th>training days</th>
<th>K Austin-Smith N Perry</th>
<th>P Pandey N Perry</th>
<th>K Askin N Perry M Tonks P Leigh</th>
<th><strong>Update 1/18</strong>-Benchmark completed following Nov 17 report publication. Audit schedule for next financial year to be agreed by 28/2/18. <strong>Update 1/18</strong>-Monthly MDT Forum established. First thematic report shared 4/10/17. Presented to Paediatric teaching forum 14/11/17. Analysis undertaken of Datix/NSI themes at CBU Matrons meeting and action plans given against ‘red’ areas.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Audits to be undertaken in line with benchmarking services against best practise and to direct action to improve outcomes</td>
<td></td>
<td></td>
<td></td>
<td><strong>Update 1/18</strong>-SOS boxes present in all CBU areas (10/17) In addition, with next System C upgrade (approx. Qtr 1, 2018) – the question 'have you completed a sepsis audit tool?' will become mandatory on Medway for women</td>
</tr>
<tr>
<td></td>
<td>• MDT review of unexpected term admissions to LNU to identify learning and direct care pathway reviews</td>
<td></td>
<td></td>
<td></td>
<td><strong>Update 1/18</strong>-Monthly NSI capture with action planning around areas of identified shortfalls.</td>
</tr>
<tr>
<td></td>
<td>• Datix and NSI trend analysis</td>
<td></td>
<td></td>
<td></td>
<td><strong>Update 1/18</strong>-Monthly NSI capture with action planning around areas of identified shortfalls.</td>
</tr>
<tr>
<td></td>
<td>• Application of the Sepsis Six Bundle (UK Sepsis Trust) to ensure immediate intervention in cases of suspected adult sepsis. SOS boxes in all ward areas</td>
<td></td>
<td></td>
<td></td>
<td><strong>Update 1/18</strong>-Monthly NSI capture with action planning around areas of identified shortfalls.</td>
</tr>
<tr>
<td></td>
<td>• Ensure all postpartum women and pregnant women over 20 weeks gestation are assessed</td>
<td></td>
<td></td>
<td></td>
<td><strong>Update 1/18</strong>-Monthly NSI capture with action planning around areas of identified shortfalls.</td>
</tr>
</tbody>
</table>
Mothers Smoking at time of Delivery

<table>
<thead>
<tr>
<th>Using the MEOWS scoring system</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatric review following delivery of all new born babies at risk of sepsis using SBAR handover to paediatric team to facilitate review.</td>
</tr>
<tr>
<td>Introduce MEOWS amended location specific pathway within the Community setting.</td>
</tr>
</tbody>
</table>

M Tonks
Matrons
P Pandey
P Leigh

having MEOWS assessment.

NSI themes reviewed at CBU Matrons Forum.

Review of effectiveness of SBAR escalation to paeds undertaken at LNU Forum (Action plan below).

NEWT charts currently at the printers. NEWT will promptly define those babies requiring escalation at risk of sepsis for paed review.

Update 1/18 – Community MEOWS roll out scheduled for April 2018. (Action plan below)
### What are the areas we can make a difference in?

**Reduce the admission of term babies to LNU**

- Reduction in cases of HIE year on year.
- **2 term babies were admitted to LNU 2015-2016 with a diagnosis of HIE Grade 2/3.**

### What does success look like?

- Robust training programme in place regarding CTG interpretation, escalation of CTG concerns and peer review at hourly intervals through labour.
- Mandatory completion of K2 training package for all staff who interpret CTG in their role, with competency assessment annually at local level skills drills classes.
- Weekly MDT forum to review and discuss CTGs and cases to ensure.

### What do we need for the success to be realised?

- Training records
- Attendance records with discussions

### Outcome indicators

<table>
<thead>
<tr>
<th>Lead/Team</th>
<th>Date</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>M Tonks I Karrar</td>
<td>Ongoing</td>
<td>#4</td>
</tr>
<tr>
<td>M Tonks K Longdon K Wagstaff</td>
<td>Update 1/18</td>
<td></td>
</tr>
<tr>
<td>C Cuckson M Tonks P Anderson</td>
<td>99% compliance at CTG training and assessment within midwifery workforce. K2 - 100% compliance for midwifery substantive workgroup. K2 + CTG masterclass training - 47% compliance within senior.</td>
<td></td>
</tr>
</tbody>
</table>

### Trajectory for achievement

- Actual
- Trajectory for achievement

---

Note: The RAG color indicates the status of the project: **#1** for critical, **#4** for urgent, and so on. The update date and compliance numbers are placeholders and should be replaced with actual data.
**0 babies HIE Grade 2/3 2016-2017**

- Robust CBU review of all cases where HIE is diagnosed to ensure team wide learning
- Share HIE case information with NHS Resolution as mandated

**Management of Babies at risk of hypothermia**

- Adapt practice in line with outcomes from the Atain NHS Improvement programme to provide models of care that prevent ‘cold’ babies being unexpectedly admitted to NICU – and reduce the harm associated with mother and baby separation.

A multidisciplinary approach with various teams is being evolved to assess various aspects, thus contributing to the improvement plans.

- Reduction in babies being admitted to LNU with hypothermia
- Trust Review of the Royal Surrey ‘Bobble Hat Care Bundle’ for babies at risk of hypothermia.

Midwives undertaking a preceptorship period will undertake the Atain e-learning packages in relation to avoiding term admission to LNU.

**Update 1/18**

- Review of ‘Bobble Hat’ bundle achieved. Team propose to adopt elements of the pathway. (see action plan)
- LNU Forum to review Term admissions established.
- 0 babies admitted Oct to Dec 17 with temp <36.5 (was 5 babies Apr-Sept 17)
- Hypothermia Audit being undertaken with the active participation of junior doctors – data collection ongoing. Anticipate a retrospective and

| Management of babies with or at risk of hypoglycaemia | • Adapt KGH guidelines in line with best practise in BAPM Framework for Practise in regards to screening for and managing hypoglycaemia | Updated guidelines | P Pandey J Smith | Sept 17 | *Update 1/18* - Guideline written and presented. Further work required and therefore not ratified into practise at present. Review ongoing (see action plan) |

Term Babies admitted to LNU with HIE Grade 2/3
### What are the areas we can make a difference in?

**Perinatal Mental Health & Safeguarding**

- Benchmarking/Audit of service.

### What does success look like?

- Identifying the correct cohort of women who are high risk of mental health conditions
- Referral process in place for proactive management
- Multidisciplinary care planning
- Named Consultant for mental Health
- Vulnerable team and discharge plans

### What do we need for the success to be realised?

<table>
<thead>
<tr>
<th>Outcome indicators</th>
<th>Lead/Team</th>
<th>Date</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit Training</td>
<td>E Payne K Austin-Smith R Haughney P Leigh</td>
<td>April 18</td>
<td>Green</td>
</tr>
</tbody>
</table>

**Update 1/18**

Named Cons identified for women with mental health conditions. Plan progressing for specific clinics for this cohort of women – scheduled for April 18.
| Training | • Ensure all staff working in maternity services are trained to identify the risks and symptoms of women at high risk of perinatal mental health  
• Staff are aware of local pathways for support for anxiety and low level depression to prevent escalation to more serious mental health issues | Training records to confirm attendance  
Clear pathways in place for all staff to access mental health services and at what level | K Wagstaff  
*Update 1/18*  
Education package in progress with staff training on mandatory study days. |

| Process/pathway for perinatal mental health in place | • Guideline to reflect best practice identified by NHS England developing perinatal mental health networks  
• Countywide working group  
• CBU Business Plan  
• Mental Health education package | Guideline updated and published on KNET | E Crowson  
E Payne  
NHFT Commissioners | May 2017  
*Update 1/18*  
Guideline updated and live on KNET (10/17). Collaborative working continues within the Perinatal Mental Health network. DOH bid for countywide services |
<table>
<thead>
<tr>
<th>What are the areas we can make a difference in?</th>
<th>What does success look like?</th>
<th>What do we need for the success to be realised?</th>
<th>Outcome indicators</th>
<th>Lead/Team</th>
<th>Date</th>
<th>RAG</th>
</tr>
</thead>
</table>
| MDT Training & Development                    | Robust MDT training & Development programme | • MDT team x3 groups to undertake PROMPT training and cascade learning  
• A cohort to attend maternal Critical Care course and apply learning to the workplace  
• All staff to undertake the Baby Lifeline CTG masterclass training  
• Community midwifery teams to attend the ‘Childbirth Emergencies in the Community’ course. This course to include EMAS personnel to establish links across these community based work groups  
• 40 MDT staff to attend the Developing Human Factors training course to improve safety and outcomes in the Delivery Suite  
• Maintain statutory and mandatory training programmes | Reflection and potential updates to local guidelines.  
Update local skill drills training to reflect the learning and apply to practise.  
Communications re Safer Maternity Care and the Safety Plan to help staff understand how the whole package fits together. | E Crowson  
C Cuckson  
D Baines  
EMAS  
M Tonks  
P Leigh  
K Wagstaff | March 2018. On target – Update 1/18  
2 MDT groups have attended PROMPT training, third planned. Cascade training within Skills Drills planned for 2018/2019 sessions.  
23 midwives and 6 obstetricians attended a Critical care course Nov 17  
61% staff attended CTG masterclass – further session planned 21/5/18  
50 Community midwives and 10 EMAS staff attended the ‘childbirth emergencies’ |
<table>
<thead>
<tr>
<th>Leadership development</th>
<th>PASCAL metrics review of Organisational culture</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Local programme of clinical Supervision for ward Matrons to provide support and development of leadership skill set</td>
<td>• Implement action plans from first level survey</td>
</tr>
<tr>
<td>• Leadership training programme for Labour Ward leaders</td>
<td>• Regional collaboration across Risk network to facilitate shared learning at Quarterly Risk Forum</td>
</tr>
<tr>
<td>• Await outcomes from national work re Delivery suite co-ordinator role</td>
<td>• Create a safety culture conducive to psychological safety and health, team work and communication</td>
</tr>
<tr>
<td>• Trust leadership training programmes plus post graduate</td>
<td></td>
</tr>
<tr>
<td>What are the</td>
<td>What does</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Safety Huddle</td>
<td>• Maternity team to implement local quality improvement programme regarding a daily MDT safety huddle. The huddle will facilitate risk assessment and escalation, and support collaborative team working and communication to improve patient outcomes</td>
</tr>
<tr>
<td>Shared MDT care planning in complex inpatient antenatal cases</td>
<td>• Maternity team to create and implement an MDT discussion forum to aid shared decision making and care planning in complex antenatal inpatient cases.</td>
</tr>
<tr>
<td>areas we can make a difference in?</td>
<td>success look like?</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Data</td>
<td>Maternity Dashboard</td>
</tr>
<tr>
<td>National Neonatal Data (BadgerNet)</td>
<td>• Ensure continuance of Licence costs and data collection to review overall service</td>
</tr>
<tr>
<td>MBRRACE</td>
<td>(KGH Perinatal mortality Rate 2016 5.1% - MBRRACE adjustment to this figure still awaited)</td>
</tr>
<tr>
<td>Maternal MBRRACE latest report received, benchmarking in progress.</td>
<td></td>
</tr>
<tr>
<td>---</td>
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</tr>
</tbody>
</table>

### Patient/Public Engagement

- Undertake theme analysis of CBU complaints
- Patient stories shared with the team monthly
- Stage events to engage directly with the public, such as the Baby Roadshow, Maternity Voices, LMS work.
- Review of annual National Maternity Surveys to adapt services as appropriate
- ‘You Said/We did’ board in the Rockingham Wing entrance foyer
- Friends & Family review

Reduction in complaints.

Positive patient feedback through platforms such as NHS Choices, Friends & Family.

T Chitakasha
N Perry
E Crowson
M Tonks
P Leigh
J Allen

Ongoing with review at monthly CBU Governance meetings

**Update 1/18**
Lessons learnt from complaints and patient stories shared monthly.

‘You said/We did’ board now displayed. To be updated April 2018.

### Review of acuity data re most

- Ongoing implementation and review of NPSA Intrapartum

M Tonks

**Update 2/18**
<table>
<thead>
<tr>
<th>Monitoring</th>
<th>Scorecard</th>
<th>To establish most efficient method to determine acuity and ultimately required staffing levels</th>
<th>E Crowson</th>
<th>Review achieved (Qtr 3). NPSA scorecard in use. Birthrate Plus acuity tool implemented. Training of coordinators achieved. Data for one month (Feb) to be reviewed to enhance data for progression into March.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective for maternity services</td>
<td>Scorecard</td>
<td>To review Birthrate, NPSA and SAFER Care work with regards sensitivity for maternity care and develop business case for the use of Birthrate resources to assess data and acuity for the delivery suite and Ante/postnatal ward</td>
<td>Workforce plan on acuity review</td>
<td></td>
</tr>
<tr>
<td>Each Baby Counts (1 KGH case fit reporting criteria 2016)</td>
<td>Scorecard</td>
<td>Trust to continue to report to this RCOG National Quality Improvement project</td>
<td>Implement best practise identified from the collation of data</td>
<td>Annual report from Each Baby counts from nationwide data analysis – report for 2016 expected June 2017.Received to benchmark recommendations against local practice</td>
</tr>
</tbody>
</table>

**Monitoring**

Plan is to report to CBU governance on a 4 monthly basis. *With Exception report from 02/18 for March CBU Governance meeting.*

An annual report demonstrating outcome measures and evidence of reduction cases of harm and lessons learnt with embedded evidence will be prepared to support the overall plan.
**Key**

**Currently recorded on the CBU Risk Register**

#1 - Risk of not achieving serial growth scans as per RCOG Green top guideline 31 – **update 1/18** – remains a risk. However, good progress with developing service (additional scanning ‘slots’) and training additional staff to support being made within the CBU.

#2 – Risk closed October 2017

<table>
<thead>
<tr>
<th>Status</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLUE</td>
<td>Not yet commenced</td>
</tr>
<tr>
<td>GREEN</td>
<td>In progress and on track</td>
</tr>
<tr>
<td>AMBER</td>
<td>Behind schedule – corrective plan in place</td>
</tr>
<tr>
<td>RED</td>
<td>Behind schedule - no corrective plan in place. Deadline not met</td>
</tr>
</tbody>
</table>

#3 – Lack of a seven day a week sonography service in early pregnancy

#4 – Risk of low medical compliance with CTG interpretation education.

**Definitions**

- MBRRACE-UK - Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
- HIE - Hypoxic Ischaemic Injury
- LNU - Local Neonatal Unit
- MDT - Multi disciplinary Team

**Light Blue** – Achieved/Complete. (New – October 2017)
**Version history**

Version 1 – January 17 - signed off in March at CBU Governance and Trust

Version 2 – March 17 - Update to ambition, inclusion of abbreviation definitions

Version 3 – April 17 - Update to include information sharing in cases of HIE with NHS Resolution.

Version 4 – October 17 - Quarterly update

Version 5 – February 18 – Quarterly update

**Action plan January/February 18**

<table>
<thead>
<tr>
<th>Issue identified</th>
<th>Action required</th>
<th>Responsibility</th>
<th>Date for achievement</th>
</tr>
</thead>
</table>
| Limited evidence of robust SBAR escalation to Paediatric colleagues | • Staff reminder via HOT topics  
• Print run of new SBAR stickers for paediatric escalation  
• Ongoing monthly LNU Forum review of records  
• - 01/18 - Audit post roll out of SBAR stickers scheduled for end of Qtr 4. | N.Perry  
M. Tonks  
P. Leigh | Oct 17 – achieved  
Jan 18 - achieved  
Monthly LNU Forum review ongoing. |
| Delay in achieving community midwifery MEOWS roll out | • MEOWS charts require printing  
• - 01/18 - Requires ratification by the Trust Sepsis Champions  
• Roll out into practise. | P. Leigh  
e-Proc | Nov 17 –  
New date –  
To be achieved QTR 1 2018/19 |
| Obstetrician CTG education compliance – K2 and Masterclass at 47%  
(was 27% in Oct 17) | • Escalate to Lead Obstetric Consultant  
• Designated doctors to work to ensure completion within four weeks | N Perry  
C Cuckson  
K Adcock | Oct 17 – achieved  
Nov 17  
February 2018 |
<table>
<thead>
<tr>
<th>Issue</th>
<th>Description</th>
<th>Action</th>
<th>Responsible</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inconsistent and incomplete BADGERnet data inputting identified</td>
<td>• To be discussed at Paediatric team meeting &lt;br&gt;• Continue to QA data inputting by LNU Administrator &lt;br&gt;• Ongoing monthly review at LNU Forum. &lt;br&gt;• Ongoing ‘issues’ will lead to BADGER record keeping audit 01/18 - audit now planned for February 2018 in preparation for PRB pathway April 2018 to identify effective service provision and provide assurance of data inputting standards.</td>
<td>N Perry</td>
<td>January 2018 – achieved</td>
<td></td>
</tr>
<tr>
<td>Jaundice guideline not yet updated in line with Atain guidance</td>
<td>• Management of jaundice: Current guideline in place; &lt;br&gt;• Procedure of neonatal exchange transfusion has recently been ratified and adapted from the neonatal ODN</td>
<td>P Pandey J Ford P Leigh M Grey S Calkin C Russell S Hardcastle</td>
<td>Dec 17</td>
<td></td>
</tr>
<tr>
<td>Hypoglycaemia guideline update delayed</td>
<td>• Guideline review in relation to BAPM guidance completed. Now in circulation for comments. &lt;br&gt;• Further work required (possible business case) in relation to blood gas monitoring equipment availability in Ward areas to the standard given within the report.</td>
<td>P Pandey J Smith</td>
<td>Dec 17</td>
<td></td>
</tr>
<tr>
<td>Antenatal MDT not robustly entrenched in practise.</td>
<td>• For re-launch with new date/time and review of criteria/remit of review and new Obstetric consultant Lead &lt;br&gt;• Access Antenatal MDT within Region that is working successfully</td>
<td>K Adcock</td>
<td>March 2018</td>
<td></td>
</tr>
</tbody>
</table>
| Trust Review of the Royal Surrey ‘Bobble Hat Care Bundle’ for babies at risk of hypothermia. | Pathway for implementation of KGH specific amended process to be agreed.  
LNU Lead Matron to meet with PN Ward and Delivery suite Lead Matrons to agree pathway. | N Perry  
J Ford  
K Attley  
P Anderson  
August 2017 |
**BOARD OF DIRECTORS**  
2nd MARCH 2018

**AGENDA ITEM**  
4.1

**SUBJECT:**  
NHS IMPROVEMENT: PROGRESS REVIEW MEETING FEEDBACK

**RESPONSIBLE DIRECTOR**  
Rebecca Brown  
Acting Chief Executive

**AUTHOR:**  
Sharan Madeley  
Trust Board Secretary

**PREVIOUSLY CONSIDERED BY:**  
N/A

**EXECUTIVE SUMMARY**

The Board is presented with the formal feedback letter from NHS Improvement following the last Progress Review Meeting held with the Regulator. The Trust will be responding to all the required actions detailed in the letter.

The Trust has been informed that the next meeting on the 8th March 2018 is cancelled. The next Progress Review Meeting will be on the 12th April 2018.

**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
12<sup>th</sup> February 2018

Fiona Wise  
CEO  
Kettering General Hospital Foundation Trust

Dear Fiona

**Kettering General Hospital FT (‘the Trust’) February 2018 Progress Review Meeting (PRM)**

I am writing to provide action points agreed at the PRM held on 1<sup>st</sup> February 2018 and to set out any specific points or concerns.

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
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</table>
| **Quality** | The Trust met with CQC on 31<sup>st</sup> January to discuss the factual accuracy of the report. The latest date that CQC can publish the report is 6<sup>th</sup> March, however hoping to publish on 26<sup>th</sup> February.  
*Hold a conversation with Kathy McLean (NHSI) to discuss what appropriate resources and support will be given to the Trust during the period of special measures until the Trust is re-inspected and report outcome to Fiona Wise (Trust).* | Jeff Worrall & Maggie Boyd | By end of February |
| **Quality** | The results of the medical engagement survey was discussed at the recent Trust Board. Following this an engagement plan and workforce strategy has been developed which will be taken back to the Board in April.  
*Keep Vanessa Wort (NHSI) updated with the CBU recruitment process.* | Mark Smith | Ongoing |
| **Quality** | Trust provided assurances that it constantly reviews senility and septicaemia deaths due to the amount of historical alerts that have been received. | N/A | N/A |
| **Quality** | Trust confirmed that there are five outlying areas highlighted within the Children and Young People Survey 2016 and an action plan has been developed to address these issues. | N/A | N/A |
| **Quality** | The Trust stated that there is now a maternity plan which incorporates the Saving Babies Lives Care Bundle work.  
*Share a copy of the maternity plan with Vanessa Wort (NHSI).* | Leanne Hackshall |
| **Quality** | Trust provided assurance that the correct process is being followed for Maternity SI’s and that all still births are reported through the SI process. | N/A | N/A |
| **Quality** | Send through to Vanessa Wort (NHSI) the detail behind the pending case due to go to inquest relating to 2016 incident.  
Vanessa Wort (NHSI) to review information once received and share with NHSI communications team in relation to potential media interest | Leanne Hackshall | A.S.A.P  
Vanessa Wort | A.S.A.P once received |
| **Performance (A&E)** | The Trust is now including Corby Urgent Care Centre Type 3 activity on the NHSI A&E SitRep; however the Trust does not include this information in internal conversations to ensure accurate performance measures.  
Trust has asked ECIP to support with the frailty care pathway due to the increase in admissions of patients over 75 years.  
Rebecca confirmed that the Trust would be undertaking further analysis of the frailty patients to understand what the outcomes of care are and will feed back to Adam Andrews (NHSI).  
Trust confirmed it is an outlier on DTOC’s and stranded patients and is undertaking a number of actions to resolve these areas.  
Provide Adam Andrews (NHSI) with the information and trajectories for reducing stranded and super stranded patients which is already being produced for NHS England. | Rebecca Brown | Ongoing  
Rebecca Brown | A.S.A.P |
| **Performance (RTT)** | Trust is planning for a gradual elective restart, looking at mid-to-end of February to a full elective programme return and is working with NHS England to report this formally. | N/A | N/A |
| **Performance (RTT 52+)** | The Trust currently has 17 patients waiting over 52 weeks in January and will be looking to improve this position once the elective programme has restarted. | N/A | N/A |
| **Performance (Cancer)** | Trust confirmed that it would deliver the 62-day Cancer target for January 2018. | N/A | N/A |
| **Capital** | The Urgent Care Hub £44m capital plans have been reviewed by the Trust Board and will be shared with NHS Improvement for review. | Nicci Briggs | Ongoing |
| **Finance** | The Trust’s YTD financial deficit has exceeded the annual plan of £19.9m.  
The M9 position was delivered non-recurrently, with the deficit position benefiting from the in-month release of Trust contingency and winter monies.  
Delivery of M9 and M10 financial recovery plans has been impacted by winter elective cancellations and unplanned annual leave. The Trust estimates the impact | Nicci Briggs | N/A |
of unplanned cancellations in M9 and M10 to be in the range of £3.2-5m. The Trust confirmed that it does not expect a reoccurrence of the annual leave impact on activity in Q4.

The Trust should continue to review opportunities to recover the 17/18 financial position and take all reasonable action to minimise its deficit.

In order to secure 0.5% CQUIN funds, the Trust should comply with recently issued NHS Improvement letter which states that for Trust’s who did not accept the 17/18 control total, NHSI may release the funds where an improvement in the deficit position, commensurate to the CQUIN sum, is shown between M11 and M12.

Finance

PwC draft report on phase 1 of their work to support the development of a LTFM has been received. This is being updated to reflect M9 and M10 baseline positions. The Trust should share the final report with NHSI.

Nicci Briggs  ASAP

Any Other Business

The Trust confirmed that it is currently in conversation with Corby about the future of Corby Urgent Care Centre and the impact this has on patient demand at the Trust.

The Trust will ensure that Adam Andrews (NHSI) is kept informed with the progress of the discussions with Corby.

Nicci Briggs  Ongoing

If you have any queries in relation to this letter, please contact your Senior Delivery and Improvement Lead – adam.andrews@nhs.net

Yours sincerely

Jeffrey Worrall
Delivery and Improvement Director
### BOARD OF DIRECTORS:

| 2nd MARCH 2018 |

### AGENDA ITEM:

| 4.2 |

### SUBJECT:

FINANCIAL POSITION: MONTH 10 REFORECAST

### RESPONSIBLE DIRECTOR:

Nicci Briggs  
Director of Finance

### AUTHOR:

Nicci Briggs  
Director of Finance

### PREVIOUSLY CONSIDERED BY:

Chairman, Chief Executive, Chairs of Audit Committee and PFR Committee

### PURPOSE OF REPORT:

To present the Board of Directors with the submissions sent to NHS Improvement as part of the financial reforecast process.

### EXECUTIVE SUMMARY:

At the Board of Directors meeting on the 2nd February 2018, the Board delegated authority to the Chairman and Chairmen of Audit Committee and Performance, Finance & Resources Committee, to submit the forecast outturn position for 2017/18 to NHS Improvement.

Appendix 1 is the formal letter submitted to the Regional Director of Finance and NHS Improvement. Appendix 2 to the report is the formal template which was submitted to NHS Improvement on the 15th February 2018 and Appendix 3 is the response from NHS Improvement.

### ACTION REQUIRED:

The Board of Directors is asked to RECEIVE and NOTE the submissions made to NHS Improvement

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

Corporate Risk Register: Failure to sustain financial sustainability (Risk Score 20)

### WORKFORCE ISSUES:

Not Applicable – no direct implications regarding training and education.

### DIVERSITY & INCLUSION

Equality Impact is Neutral

### FINANCIAL IMPLICATIONS:

Specify No/Yes (Detailed within the report).

Yes. The report is detailing the financial position for the Trust for 2017/2018

### COMMUNICATION/CONSULTATION ISSUES

Not Applicable – However the position will be communicated within the Trust via Leadership Brief

### STRATEGIC OBJECTIVE:

To be a clinically and financially sustainable organisation

### CQC DOMAINS

Well Led
Dear Mark

I am writing on behalf of the Board of Directors at Kettering General Hospital to provide some context to our M10 results, notify you of our deteriorating forecast position and the actions taken to improve this. I am aware that we cannot formally reforecast but if the opportunity was available the Board would expect to reforecast to £29.9m deficit.

The M10 deficit at £4.8m is £3.0m unfavourable variance to plan largely driven by the continued impact of winter on the trusts cost and trading position. Year to date the Trusts deficit is £26.1m; £2.4m is the cost of winter not covered by additional winter monies (cost is lost elective activity), £1.3m relates to planning variances in NEL (HRG4+), £2.3m capital delays impacting on our ability to deliver elective income and £0.7m lost CQUIN income as a result of the Trust not achieving its 17/18 control total.

The forecast outturn of £29.9m will be a challenge and will require the Trust to;

1. Remove all “pools” of agency.
2. Stop all agency/locum and bank where areas are over established, any emergency cover must be approved by Director on Call
3. Commence full programme of day case work by Monday 19th February
4. Commence all Orthopaedics elective activity Monday 26th February
5. Close all escalation areas and have full programme of elective work by 1st March
6. Manage annual leave to 15% of substantive staff

The greatest risk to the current forecast is that the Trust has a £1.4m lower estimate for MRET than the current contract amount. The Trust and CCGs have engaged Bailey and Moore to provide an independent review of the MRET baseline and reinvestment with both parties committed to enacting the findings into 2017/18. This could also represent an opportunity if review is more favourable to the Trust.

It should be noted that the CCG’s will see the benefit of the CQUIN decision (£0.7m), the lost elective activity over winter (£2.4m) in addition to the in year underperformance due to the closure of the Trust’s theatres (£2.3m). The CCG’s also apply £7.2m of MRET and Readmissions contract levy’s with no reinvestment back in the Trust.
The Trust will strive to enact all of the actions as set out above and push the CCG’s for a more collaborative approach to the 17/18 contract position to help improve on the £29.9m into the £28m - £29m region.

The Trust is currently drawing down monthly interim revenue loans to support the Trusts deficit forecast. The cumulative drawdown loan request to the end of March has been provided to NHSi totalling £28.9m. If the deficit deteriorates beyond this number the Trust will manage this via it’s working balances e.g. delay creditor payments.

Yours sincerely,

Nicci Briggs
Director of Finance
## Adverse Changes to Forecast Protocol - Board Assurance Statement

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

Where a provider plans to make an adverse change to an in-year forecast it must be reported through the national reporting process and accompanied with this Board Assurance Statement which has been signed by the Trust Chair, Chief Executive and Director of Finance

### For finance:

The Board has been fully briefed on the planned adverse change to forecast and has adhered to the NHS Improvement protocol for 'Adverse Changes to the In-Year Forecasts' prior to requesting the change

All reporting revisions are accompanied with detailed actions to confirm how the position will be recovered and the original financial plan will be delivered

The Board is full committed to the delivery of the Trust recovery plan and will actively monitor the recovery plan milestones

In advance of formally reporting a forecast outturn variance from plan the Trust has discussed the financial deterioration and remedial actions with the NHS Improvement Regional Managing Director and Regional Director of Finance

<table>
<thead>
<tr>
<th>Board Response</th>
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<tbody>
<tr>
<td>Confirmed</td>
</tr>
<tr>
<td>Not Confirmed</td>
</tr>
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</table>

### For governance:

Relevant commissioners have been informed of the position and all opportunities for support have been explored and the recovery actions agreed

The senior clinical decision making body within the Trust has been engaged with and are party to the identification and delivery of the recovery actions

The Trust Executive Committee, Finance Committee and Board have considered and agree the proposed financial forecast revision and recovery actions

<table>
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<tr>
<th>Board Response</th>
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<tr>
<td>Confirmed</td>
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### Board Declaration

I can confirm that in my capacity as a member of the Trust Board, I understand the financial forecast, its key drivers and where there has been a variance signalled, I can confirm that additional actions to deliver the original plan that was signed off by this Trust Board have been considered in full by Clinical Decision Making Groups the Finance Committee and the Board as a minimum

Signed on behalf of the board of directors

<table>
<thead>
<tr>
<th>Signature</th>
<th>Name</th>
<th>Capacity</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fiona Wise</td>
<td>Chief Executive</td>
<td>15/02/2018</td>
</tr>
<tr>
<td></td>
<td>Alan Burns</td>
<td>Chair</td>
<td>15/02/2018</td>
</tr>
<tr>
<td></td>
<td>Nicci Briggs</td>
<td>Finance Director</td>
<td>15/02/2018</td>
</tr>
<tr>
<td></td>
<td>Trevor Shipman</td>
<td>Audit Committee Chair</td>
<td>15/02/2018</td>
</tr>
</tbody>
</table>
Dear Nicci

Re: Financial Position

I am writing following our conversation on 15 February 2018 when we discussed your Trust’s 2017/18 financial position and development of 2018/19 financial plans.

2017/18

The Trust has revised its 2017/18 Forecast Financial Outturn (FOT) from a planned deficit of £19.9m to a FOT deficit of £29.6m. The revised FOT reflects the Trust’s disappointing YTD financial under-performance which you believe is predominantly due to non-recurrent events adversely impacting on the Trust’s planned income position. Planned CIPs have largely been delivered and the underlying FOT financial position is a deficit of c.£22m.

In Q2 2017/18, the Trust identified and agreed actions to mitigate emerging financial risks identified in 2017/18. A Financial Recovery Plan was agreed and performance against the Plan has been subject to oversight and scrutiny from NHS Improvement on a monthly basis. Financial improvement actions largely focussed on improving financial control and recovering income under-performance. The financial impact of the planned actions and the pace of delivery of financial improvement, has not been realised as planned. The financial effect of this and the impact of winter on the Trust has been significant and has resulted in a M10 YTD deficit of £25.8m against a planned YTD deficit of £17.8m.

cont ….
As we discussed on our call, it is imperative that the Trust identifies and delivers all reasonable actions that can be taken for the remainder of Q4 2017/18 to demonstrate strong financial control and the Trust Board’s ambition to minimise the reported 2017/18 deficit. Specifically, we agreed that the Trust would take action to:

- Minimise/mitigate the impact of any further downside as a result of the MRET review which is currently being completed by Bailey and Moore.
- Minimise the continued financial impact of elective cancellations where it is operationally appropriate to do so.
- De-escalate temporary emergency capacity where it is operationally appropriate to do so.
- Re-establish the Elective Orthopaedic Activity Recovery Programme as soon as possible.
- Engage with Commissioners to try to agree a fair and reasonable contractual position for 2017/18 which does not put future finances at risk.

In addition to taking these actions, we also agreed that the Trust would prepare an analysis of the drivers of the 2017/18 FOT financial position. It would be useful, if you could produce a short report which sets out the key drivers of the variance from plan (presented in the format of a bridge with accompanying narrative) and whether variances are recurrent/non-recurrent and controllable/non-controllable.

NHS Improvement will continue to work closely with the Trust to track delivery of the 2017/18 financial position and actions being taken by the Trust to improve the financial position.

2018/19

As communicated to you in NHS Improvement’s letter of 6 February 2018, the Trust’s revised 2018/19 Control Total is a deficit of £1.3m including STF of £9.9m.

The Trust is developing its Financial and Operational Plans for 2018/19. CIP schemes in the value range £13-15m are being identified and will focus on key transformational schemes. To date, c.£13m of CIP opportunity has been identified, although these have not been through the full assurance process and are, therefore, not green rated.

cont ….
Despite good initial progress on 2018/19 CIP development, based on the 2017/18 underlying deficit and run-rate, you outlined that you felt that the Trust may not be able to develop credible plans which are in line with the 2018/19 revised Control Total. You would be discussing this with the Trust Board. I would be grateful if you would please set out in a short paper to me, the key reasons why the Trust is unable to bridge the gap to the Control Total, the actions the Trust is planning to take to minimise the deficit in 2018/19 and the financial impact of these actions on the underlying 2017/18 deficit (again presented in the format of a bridge with summary narrative as required).

Please contact Alex Coull on 07595 779 267 / alexandra.coull@nhs.net, or myself, if you have any queries relating to this letter.

With kind regards,

Yours sincerely

Mark Mansfield
Regional Director of Finance
Midlands & East

cc Fiona Wise, Chief Executive, Kettering General Hospital NHS Foundation Trust
Jeff Worrall, Delivery and Improvement Director, Central & South, NHS Improvement
Alex Coull, Head of Business & Finance, Central & South, NHS Improvement
<table>
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<tr>
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<td>AGENDA ITEM:</td>
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| RESPONSIBLE DIRECTOR: | Nicci Briggs  
Director of Finance |
| AUTHOR:             | Nicci Briggs  
Director of Finance |
| PREVIOUSLY CONSIDERED BY: | Exec Directors |

**EXECUTIVE SUMMARY:**

This paper provides the Board with the Draft Financial Plan for consideration taking the Trust from the 17/18 outturn deficit to the 18/19 financial plan of £16.2m.

**ACTION REQUIRED:**
The Board is asked to discuss the options and support submission of the draft plan.

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

Ability to deliver the financial plan

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

Noted in the report

**DIVERSITY & INCLUSION**

Equality Impact is Neutral

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

Yes detailed within the report

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

Communication will need to be considered once recommendations are made.

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

Become a financially sustainable organisation

**CQC DOMAINS**

- safe.
- effective.
- caring.
- responsive to people’s needs.
- well-led
KETTERING GENERAL HOSPITAL
FINANCIAL PLAN DRAFT
SUBMISSION 2018/19
The expected 2017/18 outturn is £29.9m with an underlying deficit of £21.5m. The key FYE/NR resulting in the underlying deficit are; Theatre closure, delays in endoscopy expansion, escalation and winter pressures, Four Eyes, Medinet & overseas nurses.

The Trust is budgeting a £16.2m deficit for 2018/19. This is inclusive of £4.2m Contingency, £14.7m CIP programme (6.3% turnover). The Trust has used NHSI planning guidance for cost inflation with pay set at 1% for AfC. Pay increments (£1.5m) have been used to create an additional pay contingency taking contingency to £4.2m.

This budget includes MRET and Readmissions at £6.1m with no reinvestment and cost pressures relating to; increased CNST £1.1m (14%) and £1m loan interest increases.
CQC Investment
The financial plan includes £1.1m investments to meet CQC requirements over and above the investments made in 2017/18.

Cost Pressures
The Trust has invested £3.8m in cost pressures for 2018/19. Theatre closures related to lost income in April and May due to closure of theatre 1. CNST has increased by 14% resulting in a £1.1m pressure. Financial costs total £2.4m (Depreciation and loan interest).

The loan interest is based no the Trust not hitting the control total and resulting in interest rates of 3% instead of 1.5%. If the Trust hit its control total there is a potential benefit of £0.4m.

Service Developments
The Trust has £0.4m service developments. The Trust has included £0.15m contribution to STP project management and £0.15m to ensure a Palliative Care 7 day service. There has been a reduction in CRN funding resulting in a pressure of £0.04m and an increase in our NHS Property rent of £0.03m.

CIP & QIPP (Including growth)

The Trust has planned for a £14.7m CIP programme detailed in appendix 1 this is 6.3% of turnover and is based on key schemes aimed at reducing clinical variation, improving skill mix, reducing agency burden, procurement and corporate reductions. As there are a number of income related QIPPs only 50% of the growth assumptions have been applied.
Contingency
The Trust has built a £4.2m contingency within 2018/19 financial plan due to the historic levels of unplanned events in the last 3 financial years. The increased contingency is allowed by holding pay increments centrally as the CBU baselines includes a number of over-established areas and high levels of agency and little CBU level QIPP schemes.

Cash
The Trust is currently drawing un-committed loans on a monthly basis to support the revenue deficit. It should be noted the Trust is required to request an additional £12.1m loan at 3.5% interest to repay old revenue loans that are at <1.5% interest.

Loan requirement 2018/19
Revenue
Forecast revenue deficit £16.2m Funding from un-committed loans
Repayment of existing revenue loan £12.1m (due to be repaid May 2018)
Total Revenue Loan Requirement £28.3m

Capital
The Trusts capital programme is focused on must do items that are on the CBU and Trust Risk register. The Trust may require a greater call on capital once the Estates risks are fully understood and a comprehensive Estates plan is put together. The Trust will need to call on the capital loan in the first quarter to ensure operational performance and patient safety is not impacted

Forecast Capital Expenditure £15.0m
Existing Capital loan repayments £3.0m
Less Funding via depreciation (£6.9m)
Capital loan requirement 2017/18 £11.1m

Total Loan Funding requirement £39.4m
Control Total
The chart below shows that for the Trust to achieve a £1.3m deficit control total it would be required to manage all operational and cost of capital requirements to a £1.5m deficit.

Limitations of the draft plan
The Trust is working up a capacity and demand plan and looking to re-profile its Elective activity over 10.5 months. This work will not be complete until the next iteration of the financial plan and as such the profiling of activity, income and non pay has been set at equal twelfths for this submission.

The contract negotiations with CCGs are still in their infancy and as such contract levels are still those set in the two year contract.
Risks

- MRET baseline has yet to be mediated on and could pose a £1.4m risk to the baseline.
- The STP has not set out the financial impacts for 2018/19
- Northamptonshire County Council have issued a Section 114 notice and have not signed off their 2018/19 budget, it is yet to be fully understood the health impact of these social care cuts
- Corby Urgent Care Centre have indicated a desire to move to 100% planned appointments and the operational, quality and financial impacts are still to be worked through
- The CCG’s award MSK triage service to a private provider and may have unwanted impacts on the Trusts elective activity.
- The Trust has a restrained capital plan that is having operational and revenue impacts due to delays in funding these have not been built in and have amounted to over £2m each of the past 3 years.
# Appendix 1

## CIP Opportunities

<table>
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<tr>
<th>ID</th>
<th>RAG</th>
<th>Type</th>
<th>Scheme/work area</th>
<th>Value (£000s)</th>
<th>%</th>
<th>Adjusted Value (£000s)</th>
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<th>NON PAY</th>
<th>INCOME</th>
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<td>Existing CIPs</td>
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<td>106</td>
<td>Existing CIPs</td>
<td>Clinical staffing - Agency/Bank/Locum</td>
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<td>130</td>
<td>Productivities</td>
<td>LoS (excluding DTOCs)</td>
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<td>132</td>
<td>Productivities</td>
<td>Best Practice Tariff</td>
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<td>100%</td>
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<td>135</td>
<td>Productivities</td>
<td>Paediatrics sub-speciality reviews</td>
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<td>136</td>
<td>Productivities</td>
<td>Histoscopy suite and Gynae One Stop</td>
<td></td>
<td>175</td>
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<td>175</td>
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<td>138</td>
<td>Productivities</td>
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<td>900</td>
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**GRAND TOTAL 2018/19**  
23,729  
14,710  
3,764  
4,813  
6,081
**BOARD OF DIRECTORS:**
2nd MARCH 2018

**AGENDA ITEM:**
4.4

**SUBJECT:**
2018/19 CONTROL TOTAL

**RESPONSIBLE DIRECTOR:**
Nicci Briggs
Director of Finance

**AUTHOR:**
Nicci Briggs
Director of Finance

**PREVIOUSLY CONSIDERED BY:**
Exec Directors

### EXECUTIVE SUMMARY:

This paper provides the committee with an assessment of the re-issued financial control total for 2018/19. There are a number of benefits from being in the control total regime such as reduced loan interest to 1.5%, access to the transformation match funding and other incentives in addition to less scrutiny. The Committee and Board must consider these benefits alongside the actions that would be required to deliver such a challenging control total.

**ACTION REQUIRED:**
The Board of Directors should submit the draft plan as it stands at £16.2m and then work up the actions as set out in the report to see how the gap to control total could be bridged. These actions will require support from all parties and regulators. A decision could then be made before the final plan submission on the 30th April.

**RISK TO THE TRUST** *(include reference to BAF or Corporate Risk Register)*
Ability to deliver the financial plan

**WORKFORCE ISSUES:** *(including training and education implications)*
Noted in the report

**DIVERSITY & INCLUSION’**
Equality Impact is Neutral

**FINANCIAL IMPLICATIONS:**
Yes detailed within the report

**COMMUNICATION/CONSULTATION ISSUES** *(including patient and public involvement)*
Communication will need to be considered once recommendations are made.

**STRATEGIC OBJECTIVE:** *(specify trust strategic objective)*
Become a financially sustainable organisation

**CQC DOMAINS**
- safe.
- effective.
- caring.
- responsive to people's needs.
- well-led
KGH 18/19 CONTROL TOTAL

1) 17/18 Forecast Outturn

The Trust has a YTD deficit of £26.1m and has issued a reforecast for the financial year 2018/19 at £29.1m.

The underlying position is £21.5m which is the £19.9m 18/19 plan plus HRG4+ (£1.6m) all other recurrent issues such as tele-radiology and critical care have been offset with recurrent savings such as agency reductions.

Despite these difficulties the Trust is expected to deliver a £15m (6.5% CIP) and a Financial Recovery programme of approximately £0.8m - £1m.

2) Control Total 18/19

Despite the increase of £2.8m of STF the Trust’s control total has moved by only £0.2m requiring the Trust to deliver a gross position of £11.3m which would see a net £11m improvement after inflationary pressures etc.

| 18/19 Control Total (original allocation) | -4.0 |
| STF                                    | 7.1  |
| Gross Deficit                          | -11.1|

| New 18/19 control Total                | -1.3 |
| STF                                    | 9.9  |
| Gross Deficit                          | -11.3|

3) Control Total calculations

When the control total calculations were set the Trust was on a £0.9m block for MRET and £1.5m block for Readmissions. The combined Readmission and MRET penalty is now £7.2m, or a £4.8m increase. (These are the IAP values the Trust has assumed £6.1m in its 17/18 and 18/19 plan)

In addition the Trust has seen its balance sheet severely deteriorate with the loan interest increasing from £0.4m to £3.6m. Even if we offset by the reduction in dividends then there is a minimum of £2.5m net increase.

If these were normalised the Trust’s like for like control total would be between £17.5m - £18.6m.

The chart below shows that for the Trust to achieve a £1.3m deficit control total it would be required to manage all operational and cost of capital requirements to a £1.5m deficit.
4) NGH Control Total

NGH have a £305m turnover and a control total of £8.5m with £12.3m STF giving a gross target deficit of £20.8m. This is 7% of turnover. In comparison KGH’s current control total is 4.7% of turnover. A control total set at 7% of turnover would be £16.8m.

5) 18/19 Planning

The Trust is in the process of creating an LTFM and as part of that assessment PWC have interrogated our plans and looked at the potential stretch the Trust could generate in addition to helping understand the value of the deficit that requires system change.

In this work they believe the best case scenario for 18/19 is £15m deficit, worst case £19m and a base assumption of £17m as set out in Appendix 1.

The Trusts current draft plan sits at £16.2m with a number of risks and CIPs at 6.3% of turnover.

For the Trust to deliver a deficit to hit the control total a number of actions would be required with support from Regulators and the local health economy;

- Coding improvements – the Trust has a £1m - £3m opportunity but this could be subject to a CCG coding and counting challenge and would require external support.
- Reduction of MRET and Re-admissions/ Reinvestment of MRET and Re-admissions – this would require a change of behaviour at the CCGs and with regulators
- External leadership support in Urgent Care and Medicine to reduce clinical variation, promote effective use of resources and ultimately increase flow and reduce length of stay.
6) RECOMMENDATIONS

The Trust Board should submit the draft plan as it stands at £16.2m and then work up the actions as set out above to see how the gap to control total could be bridged. These actions will require support from all parties and regulators. A decision could then be made before the final plan submission on the 30th April.
Trust’s response to the rising financial challenge

In order to close the underlying financial gap, we have explored the following key lines of inquiries within the 5 building blocks. The values of the new ideas have been sensitised and discussed with Director of Transformation. We will continue to work with Nicci Briggs to validate the sensitivities applied over the next few days.

Our key lines of inquiries

- Review existing programmes/plans: acute unified offer, intermediate care strategy and others
- Corporate service consolidation;
- Out of hospital change; and
- Move to Integrated Care.

- Get It Right First Time and Model Hospital;
- Outpatient and theatre efficiency reviews;
- Invoices coding opportunities;
- EHR data benchmarking;
- Portfolio reviews;
- Commissioning for value (incl. RightCare), and
- Last benchmarking (incl. SAFER bundle/ESG).

- Recent Grip and Control reviews; and
- Compare the Trust’s existing CIPs against our CIP directory.

- Pipeline not yet developed; and
- Challenge scheme owners where the existing CIPs might be uplifted.

- We have prioritised CIP opportunities according to their value and complexity of implementation.

- The Trust can maximally achieve £33m saving by FY20/21, still leaving a gap of £7m without a contribution from system changes.
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<td>SUBJECT:</td>
<td>BOARD ASSURANCE FRAMEWORK (BAF) RISK APPETITE AND RISK APPETITE STATEMENT</td>
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<tr>
<td>RESPONSIBLE DIRECTOR:</td>
<td>Jenna Davies Interim Director of Integrated Governance</td>
</tr>
<tr>
<td>AUTHOR:</td>
<td>Susan Clennett Deputy Director of Integrated Governance</td>
</tr>
<tr>
<td>PREVIOUSLY CONSIDERED BY:</td>
<td>Executive Team on 30th January 2018 and 13th February 2018</td>
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**EXECUTIVE SUMMARY:**

The attached paper details the risk appetite set against the current strategic objectives, as agreed by the Executive Team. This is accompanied by a risk appetite statement.

**ACTION REQUIRED:**

To agree the risk appetite against the current strategic objectives, together with a risk appetite statement.

To ensure the Risk Management Strategy is reviewed to take account of the risk appetite and statement and the revised governance reporting and divisional structures.

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

To address the lack of a clear risk appetite for the organisation that informs the BAF and risks within all levels of risk registers.

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

Board Members have received risk management training. Training in risk management continues to be delivered throughout the organisation.

**DIVERSITY & INCLUSION'**

N/A

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

No

**COMMUNICATION/CONSULTATION ISSUES (including patient and public involvement):**

Executive team on 30th January 2018 and 13th February 2018.

**STRATEGIC OBJECTIVE:**

Safe

**CQC DOMAINS**

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

Please indicate which domain the report is providing assurance on

All with a particular focus on well-led.
TRUST BOARD OF DIRECTORS: 2nd March 2018

ORGANISATIONAL RISK APPETITE AND STATEMENT

Purpose

This paper reflects the Executive Team discussions on 30th January and 13th February 2018 in relation to setting a risk appetite for agreement by the Board. Additionally, a ‘risk appetite statement’ is suggested explain the Trust’s tolerance levels of risks in relation to the overarching domains of governance. The Board Assurance Framework (BAF) will inform the board of the level of risk assessed against achievement of each strategic objective and whether those risks are at a level it is prepared to accept.

Board Assurance Framework (BAF)

The BAF provides the Trust with a single, but comprehensive method for the effective and focused management of the principle risks to meeting the Trust’s overall strategic objectives. The BAF must demonstrate that a full range of risks are assessed for impact on achievement of those objectives.

The BAF must demonstrate that external/horizon scanning risks have also been considered. Corporate risks should inform the BAF, together with those where sub-committees of the Board have referred upwards to the BAF.

The BAF is a vital component of providing assurances and gaps in control reported in the Annual Governance Statement.

What is a risk appetite?

This can be described as the amount of risk that an organisation is prepared to accept at any point in time. The Board will make decisions on exposure to the level of risk it will accept in order to deliver its strategy over a given time frame. In practice, an organisation’s risk appetite should address:

- The nature of the risk to be assumed;
- The amount of risk to be taken on;
- The desired balance of risk versus reward.
## Risk appetite levels

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Description of potential effect</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Zero Risk Appetite</strong></td>
<td>The Trust Board <strong>aspires to avoid risks under any circumstances</strong> that may result in reputation damage, financial loss or exposure, major breakdown in services, information.</td>
</tr>
<tr>
<td><strong>Low Risk Appetite</strong></td>
<td>The Trust Board <strong>aspires to avoid (except in very exceptional circumstances)</strong> risks that may result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / patients.</td>
</tr>
<tr>
<td><strong>Moderate Risk Appetite</strong></td>
<td>The Trust Board <strong>is willing to accept some risks in certain circumstances that may</strong> result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / patients.</td>
</tr>
<tr>
<td><strong>High Risk Appetite</strong></td>
<td>The Trust Board <strong>is willing to accept risks that may result</strong> in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / patients.</td>
</tr>
<tr>
<td><strong>Very High Risk Appetite</strong></td>
<td>The Trust Board accepts risks that are likely to result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential serious risk of injury to staff / patients.</td>
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</table>

### Executive team proposed risk appetite

The Executive Team considered the following domains, mapping these against the current Strategic Objectives:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>Safety</td>
<td>Impact on the safety of patients, staff or public</td>
</tr>
<tr>
<td>Quality</td>
<td>Impact on the quality of our services. Includes complaints and audits</td>
</tr>
<tr>
<td>Workforce</td>
<td>Impact upon our human resources (not safety), organisational development, staffing levels and competence and training</td>
</tr>
<tr>
<td>Statutory</td>
<td>Impact upon our statutory obligations, regulatory compliance, assessments and inspections</td>
</tr>
<tr>
<td>Reputation</td>
<td>Impact upon our reputation through adverse publicity</td>
</tr>
<tr>
<td>Business</td>
<td>Impact upon our business and project objectives. Service and business interruption</td>
</tr>
<tr>
<td>Finance</td>
<td>Impact upon our finances</td>
</tr>
<tr>
<td>Environmental</td>
<td>Impact upon our environment, including condition of estates, chemical spills, our carbon footprint</td>
</tr>
<tr>
<td>Domains</td>
<td>Strategic Objective</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Finance</td>
<td>To be Clinically and financially sustainable organisation.</td>
</tr>
<tr>
<td>Safety/Quality/Statutory</td>
<td>To provide high quality care to individuals, communities and the population we serve.</td>
</tr>
<tr>
<td>Business/Reputation</td>
<td>To be a strong and effective partner in the wider health and social care community.</td>
</tr>
<tr>
<td>Workforce/Environmental</td>
<td>To maintain a fulfilling and developmental working environment for our staff.</td>
</tr>
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</table>

**Risk appetite statement**

On an annual basis, the Trust should publish its risk appetite statement with its Risk Management Strategy and enable staff to understand the approach to risk and its management. The statement will also define the Board’s risk appetite for achievement of its strategic objectives.

**Proposed risk appetite statement**

To reflect the Executive Team’s discussions on 30th January and 13th February 2018, the following statement is suggested:

“The Trust recognises that its long term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners.

As such, the Trust will not accept risks that materially impact on patient safety. However, the Trust has a greater appetite to take considered risks in terms of their impact on organisational issues that do not impact on patient safety. The Trust has the greatest appetite to pursue innovation and challenge current working practices and reputational risk in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.”

**Recommendation**

That the Board:

- Agree the risk appetite against the current strategic objectives, together with a risk appetite statement.
- Seek assurance that the Risk Management Strategy is reviewed to take account of the risk appetite and statement and the revised governance reporting and divisional structures.

Susan Clennett  
Deputy Director of Integrated Governance  
22nd February 2018
**AGENDA ITEM:** 7.1

**NAME OF COMMITTEE:** AUDIT COMMITTEE

**DATE OF MEETING:** 14th April 2018

**PREPARED BY AND CONTACT DETAILS:** Trevor Shipman

**PURPOSE OF REPORT:**
- **For Decision:**
- **For Assurance:**
- **For information:**

| X see below | □ |

**SUMMARY OF DISCUSSIONS:**
(Detail areas being escalated to the Board – Please summarise on one page)

1. **Item for approval:**
   Audit Committee recommend to the Board that the Charity Accounts are not consolidated with main trust accounts. This is allowed as immaterial otherwise due to control rules they would have to be merged.

2. **Cyber Security - Reasonable Assurance** – but need to ensure awareness training for all staff is provided and taken up

3. **Payroll Overpayments - Reasonable Assurance** - assurance from Director of Finance re escalation where managers fail to provide timely date re leavers could lead to performance issue

4. **Outpatients Data Quality re KPIs** - concern re this report, but reasonable assurance – note new approach re separation of performance reporting and data quality, but concerned that this was issue given previous issues that had arisen

5. Remaining Internal Audit Resource will not be fully utilised so will be carried forward for Q1 18/19.

6. Current Internal Audit Contract extended for 3 months whilst tendering takes place jointly with NGH. Reduced number of days but resource to be used for other specialised work eg Coding Quality

7. Draft 3 year audit plan approved for purpose of tendering and setting out to cover areas of highest risk

8. **External Audit plan for their work shared and major areas of risk highlighted. Presentation on basis of their Value for Money opinion at which they flagged major risk of having a qualification when testing against NAO criteria - challenged by Committee members**

9. Counter fraud concern that there has been delays in allowing access to computer records and the Executive were instructed to ensure that this was granted before 28th February

10. Noted the financial governance items brought to committee, expressed our great thanks for all the work that Peter Bunnewell had put in over the years in Finance supporting KGH and ensuring that the processes for financial governance worked and that the external auditors had professionally prepared records to audit.
MINUTES OF THE AUDIT COMMITTEE HELD ON THE 14TH FEBRUARY 2018, BOARDROOM, GLEBE HOUSE

PRESENT:  
Mr T Shipman - Non Executive Director (Chair)  
Ms N Briggs - Director of Finance  
Mrs L Hanna - Non Executive Director

IN ATTENDANCE:  
Mr P Bunnewell - Head of Financial Services  
Ms J Davies - Director of Integrated Governance  
Mr P Grady - TIAA Head of Internal Audit (Internal Auditors)  
Mrs J Robinson - TIAA (Internal Auditors)  
Mr S Spiers - Counter Fraud Officer  
Mr M Stokes - Grant Thornton (External Auditors)  
Mrs S Madeley - Trust Board Secretary  
Dr M Blades - Governor (nominated to Audit Committee)

OBSERVERS:  
Mr S Lake - Lead Governor

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Mrs J Gray.

2. DECLARATIONS OF INTEREST

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

3. MINUTES OF THE PREVIOUS MEETING

Subject to minor amendments, the minutes of the meeting held on the 6th December 2017 were approved as a true and accurate record of the meeting.

4. MATTERS ARISING

4.1 Internal Audit Recommendations (previous minute 5.1.2)

**DECISION:** The reporting structure in relation to data quality would be presented at the next Audit Committee meeting.

4.2 Counter Fraud Progress Report (minute 4.8)

The Trust Board Secretary reported that to date, the Trust had only received an email from the Care Quality Commission reporting that NHS Protect would be taking no action in relation to the referral regarding Referral to Treatment Time target.

**DECISION:** The Trust Board Secretary to liaise with the Director of Human Resources (Trust Lead for the RTT Investigation by NHS Protect) to provide a formal letter to the Trust in relation to the closure of the RTT Investigation.
4.3 Board Assurance Framework *(minute 9.1)*

Mr Shipman reported that following discussions at the last meeting regarding the Board Assurance Framework (BAF), clarification was obtained at the December Board meeting that the BAF for 2017/18 would continue to be reported and the newly formatted BAF would commence from Quarter 1 for 2018/19. Ms Davies informed the meeting that the BAF would be presented at the Audit Committee and Board of Director meetings in April 2018.

**DECISION:** The Committee would receive the Board Assurance Framework at the April 2018 meeting.

4.4 Summary Internal Audit Progress Report *(minute 5.1)*

The discussion at the previous Audit Committee meeting on the audit of NICE guidelines was escalated to the Board of Directors and the Integrated Governance Committee meeting in December 2017. In addition, the Chair reported that discussions had taken place for the Executive Team to ensure that lead officers were adhering to deadlines within internal audit reports.

4.5 Counter Fraud Progress Report *(minute 6.1)*

Mr Spiers reported that following discussions with the Deputy Director of Human Resources, Counter Fraud would not be a mandatory training module. In relation to Cyber Security training, Mrs Hanna asked that the Chair of Performance, Finance & Resources (PFR) Committee to include a KPI within the Committee regarding in cyber security training.

Mr Spiers reported on the issue raised at the last meeting regarding an allegation that a member of staff took an externally funded gold trip and informed the Committee that Human Resources had spoken with the member of staff regarding the allegation who had stated that the trips were self funded.

**DECISION:** The Chair to request the Chair of PFR Committee to include compliance with Cyber Security training as a KPI reviewed by the Committee.

5. **INTERNAL AUDIT**

5.1 Summary Internal Audit Progress Report

The Committee received the internal audit progress report which summarised internal audit delivery since the 6th December 2017. There had been three reports finalised which included Cyber Security, Payroll Overpayments and Data Quality (Outpatient Data).

**Cyber Security Review: Reasonable Assurance**

The audit reviewed the security management arrangements for pro-active identification of, and prioritising and mitigating against cyber-crime risks. The audit identified that cyber risk was not included on the ICT or Corporate Risk Register to ensure regular review and scrutiny by the Executive Team. Ms Davies informed the Committee that the issue of Cyber Security was recorded as a risk on the Corporate Risk Register and Mrs Robinson confirmed that evidence had been received from the Director of IT.
Payroll Overpayments: *Reasonable Assurance*

The recommendations were centered on making sure payroll forms were completed on time and that these were submitted within the required payroll deadlines. One of the actions was to ensure a standard proforma was being used to collate information. Mr Bunnewell stated that the forms were electronic but also required Managers to provide additional information to be included, for example, a copy of the Leavers Letter. Mr Bunnewell added that the process relied on ensuring that Managers adhered to the Trust policy. Ms Briggs said that a standardised letter would be put in place to ensure line managers acknowledged their responsibility to sign off changes in payroll for all members of staff. Ms Hanna said that she was pleased to note that if the policy was not adhered to, then it would be addressed as a performance issue.

Mr Shipman queried the terminology in the management response on recommendation 4, page 13, as the word should be `instructed` and not `encouraged` and this would be fed back to the Medical Staffing Manager.

**DECISION:** Mrs Robinson to inform the Medical Staffing Manager of the amendment to the Management Comments for recommendation 4.

Data Quality: Outpatient Data: *Reasonable Assurance*

Amendment to the report: The audit was *Reasonable Assurance* and not *Limited Assurance* as detailed within the report.

The purpose of the audit was to provide assurance on the procedures and governance arrangements in place for data quality and to review a sample of key performance indicators relating to Outpatients, including those reported in the Outpatients Dashboard.

Mrs Hanna said that she was disappointed as the issues highlighted in the audit were, again, in relation to compliance issues and added that she would be interested to know how the Trust would be taking the issue forward. Ms Briggs said that the area of data quality was a focus for the Trust and provided an example of where the Executive Team was reviewing areas of responsibility for information and performance data in relation to the oversight and management of data quality. Ms Briggs added that the Information Department would move under the remit of the new Director of Corporate Services and the Trust would put in place a new role of Head of Information. Ms Briggs reported that the Board held a discussion at the Board Development session last year where it was clearly stated that the Trust was on a journey to address data quality. The new post of Corporate Services would have the responsibility for information which was an appropriate segregation of the areas of performance and information. Mrs Hanna reported that the company, Systems Accountants, may be of help in resourcing appropriate candidates for the post of Head of Information.

Mr Shipman queried who approved the release of data outside of the organisation with Ms Davies outlining the process and adding that the Trust need to have two statutory roles within the Trust relating to the Senior Information Risk Officer (SIRO) and Data Protection Officer (DPO).

Mrs Robinson reported that there were changes to the Audit Plan regarding estates audits following discussions with the Chief Executive and the original four audits had been cancelled and replaced with an audit on Compliance with the Estates Code and on Theatre Ventilation.
Mr Shipman asked if there was anything that required escalation prior to the April meeting. Mrs Robinson said that at this stage there was not and that the audit on Estates Health & Safety Legal Compliance was being addressed with the Deputy Director of Integrated Governance to identify appropriate leads within the Trust.

Mrs Hanna queried the purpose of the Theatre Ventilation audit with Ms Briggs informing the Committee that the audit on Theatre Ventilation would specifically review the issue of value for money. Mr Shipman reported that there was further work was being undertaken in relation to the Fire Audit with an action plan being produced by the 26th February 2018.

Ms Briggs reported that in relation to the priorities for Estates, the initial focus for the new Director of Estates would be on the areas of (a) estates governance, (b) 2018/19 Capital Programme to reduce the top risks within the Trust; (c) a management operational plan, (d) the completion of the fire investigation and (e) a Site Control Plan and Estates Strategy. Ms Briggs said that the Trust was aware of the risks within estates and plans were in place to mitigate the risks.

Mr Shipman highlighted the information contained within Appendix C of the report regarding the briefings available on ‘Developments in Governance, Risk and Control’ and queried how this information was appropriately disseminated into the organisation. Ms Briggs agreed to discuss this further with TIAA at their next management meeting.

Mr Grady said that there was contingency within the plan and Ms Briggs said that an audit was required in relation to a baseline on compliance with GDPR. Ms Briggs reported that the tender for Internal Audit services would be undertaken within Quarter 1.

**DECISION:** Ms Briggs to agree a process to disseminate the information provided by TIAA on briefings on developments in governance, risk and control.

### 5.2 Three Year Audit Plan

Ms Briggs presented the 3 year internal audit plan and reported that the current internal audit contract with TIAA ends on the 31st March 2018. In order to ensure continuity for the final accounts and Head of Internal Audit opinion, the contract had been extended until the end of June 2018. The report proposed that under the new internal audit contract, the number of audit days would be brought in line with comparable organisations. Rather than a separate contingency, audit days have been added to cover emerging Quality, Finance, Workforce and Performance risks.

Ms Hanna said that with the priorities of the Trust she had concerns that the number of audit days would be reduced and highlighted the issue of capital expenditure as an example and suggested that this was brought forward to ensure traction within the Trust. Ms Hanna added that the accuracy of coding required review and requested an audit to recommend what could be undertaken to improve coding within the Trust. Ms Briggs said that it was identified that the Trust did not have the internal resource to review coding and added that she had liaised with external companies who could undertake the work. Mrs Hanna said that she agreed to keeping 200 days for audit work so long that the resource saved would need to be used to address coding across the Trust.

Ms Briggs informed the Committee that in relation to capital expenditure, a new Director of Estates would commence in April 2018 and it had been agreed to re-establish the role of Head of Capital Projects which was previously removed from the structure. The post would work with estates and the new Divisions to ensure projects were delivered. In addition, a Clinical Director would Chair the Capital Group.
Mr Shipman said that an audit should be undertaken regarding how clinical audit was structured within the Trust. Ms Hanna said that it was noted that the Freedom to Speak up Audit was included as this linked to recommendations made in the CQC report.

Mr Shipman said that he welcomed the plan and Mrs Hanna said that it would be helpful to map the plan to the risk framework and with the BAF and it was acknowledged that this would be addressed.

Ms Briggs reported that Northampton General Hospital would join the Trust on the procurement process for Internal Audit Services.

**DECISION:** Ms Briggs to review including an audit focusing on how clinical audit was structured within the Trust.

6. **EXTERNAL AUDIT**

6.1 **External Audit Progress Report**

Mr Stocks presented the External Audit Progress report and informed the meeting that the first interim auditor visit had been undertaken with no issues being highlighted. The second visit was planned for March 2018 with the findings reported to the April Audit Committee meeting.

Mr Stocks highlighted the issue of NHS Companies with some being income generating which had VAT implications for organisations. Mr Shipman said that Foundation Trusts were also potentially liable for corporate tax.

Mr Stocks highlighted compliance with GDPR and to ensure the Trust was clear on compliance.

6.2 **External Audit Plan**

The Committee was presented with the final external audit plan for 2017/2018 which detailed how the External Auditors, Grant Thornton, proposed to gain assurance to be able to provide an opinion on the financial statements.

6.3 **Accounts Timetable/Accounting Policies 2017/2018**

Mr Bunnewell presented the annual review of the accounting policies and the timetable for the production of the Annual Reports and Accounts. The report highlighted the minor amendments contained within the NHS Foundation Trust Annual Reporting Manual for 2017/2018 covering the annual reports and the annual accounts.

Mr Shipman queried the valuation of Thorpe House and Mr Bunnewell has advised the Valuer that a number of floors would not be in functional use and this would be reflected in the Auditors Valuation.

Mrs Hanna queried point 38 and asked if there was a responsibility for the Trust to clearly state that the Trust did not receive Sustainability and Transformation Funding and it was reported that this was detailed, last year, and would also be reflected within the Annual Report and Accounts for 2017/18.

Mr Bunnewell was making a formal recommendation that the Trust would not consolidate the Charitable Funds and it was agreed that Mr Shipman would formally report this to the Board of Directors meeting in March.
Mrs Hanna queried the reporting of the expenditure relating to actions required by the Care Quality Commission with Ms Briggs responding that there had been an increase in spend but not one of materiality.

Mr Bunnewell said that the Annual Report should contain the Audit Committee comments that the Committee had discussed specific issues in relation to control processes which was agreed by Mr Stocks who added that the Audit Committee would be able to add the reasoning relating to discussions held on control processes.

**DECISION:**
(a) The Audit Committee agreed the recommendation in the report not to consolidate the Charitable Funds Accounts on a materiality basis for 2017-2018.
(b) The Audit Chair would formally report the recommendation to the Board of Directors not to consolidate the Charitable Funds Accounts on a materiality basis for 2017-2018.

7. **COUNTER FRAUD**

7.1 **Counter Fraud Progress Report**

Mr Spiers informed the Committee on the current position of Counter Fraud Training and reported that the Cyber Crime module had been approved by IT and emails would be circulated to all staff to undertake the training. It was noted that the Counter Fraud Policy had been reviewed.

The Committee was informed that two investigations were underway, however Counter Fraud was experiencing difficulty in obtaining the required data. Ms Briggs agreed that this would escalated immediately to the Chief Operating Officer and the Committee requested that the issue had to be concluded by the end of February 2018 and the Chairman stressed the importance of ensuring Counter Fraud received timely responses to all requests for information.

Ms Hanna queried overtime claims detailed within the report with Mr Spires reporting that the information was provided on an excel spreadsheet. Mrs Hanna said that it was unacceptable as a spreadsheet could be manipulated and was a control issue. Ms Briggs agreed to highlight the issue with the Director of Human Resources.

Dr Blades raised a query regarding the possibility of staff being reimbursed for the completion of on-line surveys. Mr Spires reported that this would be covered by the current Standards of Business Conduct Policy. Ms Davies said that there was a national policy for for the Receipt of Gifts and Hospitality which would be implemented in the Trust. Ms Davies added that the Trust was currently drafting a Social Media Policy that aligns with the General Medical Council (GMC) and Royal College of Nursing (RCN) regarding the expected behaviours of staff using social media which would be in place by the end of March.

**DECISION:**
(a) Ms Briggs to escalate to the Chief Operating Officer the request to submit information from IT to Counter Fraud to enable an investigation to be progressed.
(b) Ms Briggs to raise with the Executive Team that all staff must be instructed to ensure Counter Fraud received timely responses to all requests for information and that in the specific case discussed access should be given by the end of February at the latest.
(c) Ms Briggs to raise the issue of the use of excel spreadsheets for overtime claims with the Director of Human Resources.
8. GOVERNANCE

8.1 Financial Governance Report

The Committee received and noted the Financial Governance report.

Ms Hanna raised a specific issue relating to the commentary on management accounts in relation to estates losses which should be reviewed as it may suggest a higher total number for stock losses.

Dr Blades queried the term `Fruitless Payments` and Mr Shipman recommended circulating the definition in the Government Accounting Manual. (attached to the minutes)

Dr Blades said that overpayment of salaries should be the responsibility of staff to inform the Trust. Ms Briggs said that there were two routes that the Trust address the issue of overpayment which would be through either (a) a possibility of timesheet fraud or (b) commence internal disciplinary process and reiterate the responsibility of managers to submit timely payroll information. In addition, reminders to all staff were detailed on all payslips to highlight the individuals responsibility to ensure pay was correct.

DECISION: Mr Bunnewell to review the commentary in relation to estates losses in relation to stock.

8.2 Audit Self Assessment

Mr Shipman reported that the Committee would be undertaking a self assessment process.

10. ANY OTHER BUSINESS

10.1 Head of Financial Management

Mr Shipman thanked Mr Bunnewell for all of his hard work during his time at the Trust and in preparing the Annual Accounts each year to a very high standard. Mrs Hanna added that the speed and accuracy in the preparation of the financial accounts had been commented on by the external auditors on numerous occasions and thanked Mr Bunnewell for leading this work.

11. DATE & TIME OF NEXT MEETING

- 09:00am
- 23rd April 2018
- Boardroom, Glebe House

Apologies received from Mr Shipman
The Treasury definition of “Fruitless payments” taken from the HM Treasury’s “Managing Public Money” publication

**Fruitless payments**

A4.10.19 A fruitless payment is a payment which cannot be avoided because the recipient is entitled to it even though nothing of use to the department will be received in return. Some examples are in box A4.10C.

A4.10.20 As fruitless payments will be legally due to the recipient, they are not regarded as special payments. However, as due benefit has not been received in return, they should be treated as losses, and brought to the attention of parliament in the same way as stores losses. Box A4.10C: examples of fruitless payments

A fruitless payment is a payment for which liability ought not to have been incurred, or where the demand for the goods and services in question could have been cancelled in time to avoid liability, for example:

- forfeitures under contracts as a result of some error or negligence by the department;
- payment for travel tickets or hotel accommodation wrongly booked or no longer needed, or for goods wrongly ordered or accepted;
- the cost of rectifying design faults caused by a lack of diligence or defective professional practices; and
- extra costs arising from failure to allow for foreseeable changes in circumstances.
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<thead>
<tr>
<th>AGENDA ITEM:</th>
<th>7.2</th>
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<tbody>
<tr>
<td>NAME OF COMMITTEE:</td>
<td>INTEGRATED GOVERNANCE COMMITTEE/QUALITY AND SAFETY</td>
</tr>
<tr>
<td>DATE OF MEETING:</td>
<td>20th February 2018</td>
</tr>
<tr>
<td>PREPARED BY AND CONTACT DETAILS:</td>
<td>Janet Gray NED</td>
</tr>
</tbody>
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**PURPOSE OF REPORT:**
- For Decision:  
- For Assurance:  
- For information: ✓

**SUMMARY OF DISCUSSIONS:**
(Detail areas being escalated to the Board – Please summarise on one page)

The Committee met on the 20th February, the meeting covered the following areas:
- Corporate Governance
- Terms of Reference
- Potential Quality and safety reporting structure
- Draft work Programme
- Quality Governance
- Trust wide Quality Assurance Dashboard
- Care quality Commission update
- Quality Improvement plan
- Quarter reports on Incidents Investigations and learning

**Highlights**
- The SIRI Incidents Policy was being reviewed and would be presented, for assurance, at the March meeting of the Committee.
- A revised BAF will be developed for 2018/2019 for the April Board of Directors meeting.

**CORPORATE GOVERNANCE**

**Draft Terms of Reference Quality & Safety Committee**

- The draft terms of reference being presented for the Quality & Safety Committee for consideration had been drafted in line with best practice.
- The issue of ensuring clarity of the timeliness and processes required to be undertaken to change of remit of the Committee from an Integrated Governance Committee to a Quality & Safety Committee the process that would be followed would include (a) ensuring that and all the duties of the Committees were aligned, (b) to ensure they were aligned with the Standing Orders and Scheme of Delegation and (c) to ensure a consistent format. Approval by the Board of Directors.
- The Committee could operate in shadow form.
- Triangulation Through Audit Committee
- That Terms of Reference should encapsulate the purpose and relate it for example “to ensure that it was responsible for providing assurance to the Board of Directors that high-quality care was being delivered to all patients and that staff were supported to deliver high quality safe care to patients.”
• It was also agreed to link the Terms of Reference to Strategic Objectives and the CARE values.

Draft Quality & Safety Reporting Structure

• This was looked at and suggestions made

Work Programme for the Committee, to include:

- Regulatory Compliance including safeguarding reporting
- Quarterly Quality & Safety Report, linking back to the CQC Insight Report
- The timings regarding the preparation of the Quality Account
- NICE Compliance
- Data Compliance
- Risk
- The Quality Strategy

.QUALITY GOVERNANCE

Trust Wide Quality Assurance Dashboard

• What was highlighted was a need to contextualise reports so that the frame in which the committee was addressing these matters could be understood when raising a challenge.
• The areas the Trust continued to address included compliance with issuing discharge letters;
• an increase in the number of medication incidents
• an increase in the numbers of grade 3 pressure tissue damage.
• Learning from Deaths dashboard, there had been no any avoidable deaths to date. It was noted that a monthly report would be submitted to the Committee and to the Board of Directors on a quarterly basis.

Care Quality Commission Update

the Trust was waiting for the formal publication of the Inspection Report

Quality Improvement Plan: Actions Allocated to the Committee

• The Committee received the report detailing the quality improvement plan concern was that many of the overdue issues related to the actions being monitored by the Integrated Governance Committee. The executive advised that this would be reviewed upon receipt of the CQC report.

Quarterly Report on Incidents, Investigations & Learning

• The quarterly report on incidents, investigations and learning and specifically highlighted the reduction in the numbers of serious incidents. Questions highlighted that when we focus on harm it almost always is around physical Harm, the team will consider psychological harm in reporting

MINUTES FROM REPORTING GROUPS

Concern was expressed that some meetings had not taken place for 2 months, assurance was given by the executive that CBU performance meetings gave an alternative route to check that key pieces of work were undertaken and assurance is gained

ITEMS FOR ESCALATION TO BOARD OF DIRECTORS

• Safeguarding vacancies highlighted as a corporate risk
• Contextualise the issue of discharge letters
• Good lessons learnt during the meeting regarding ensuring reports, in future, contained relevant contextual information
• The issue regarding commencement of the new committee structure
MINUTES OF THE INTEGRATED GOVERNANCE COMMITTEE HELD ON 20th FEBRUARY 2018,
BOARDROOM, GLEBE HOUSE.

PRESENT:

Mrs J Gray - Non Executive Director (Chair)
Prof C Welsh - Non Executive Director
Mrs S Clennett - Deputy Director of Integrated Governance
Ms J Davies - Director of Integrated Governance
Ms L Hackshall - Director of Nursing & Quality
Mrs F Lennon - Deputy Chief Operating Officer
Ms D Postle - Deputy Director of Nursing & Quality
Dr M Nataragan - Deputy Medical Director
Dr R Imtiaz - Deputy Medical Director
Dr A Chilton - Medical Director
Mrs S Madeley - Trust Board Secretary

NOMINATED:

Mrs G Chapman - Public Governor, Kettering

GOVERNOR

OBSERVERS:

Mr R Talbot - East Northants Governor

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Mrs R Brown.

2. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on the 23rd January 2018 were approved as a true and accurate record subject to minor amendments.

3. MATTERS ARISING

3.1 Trust-Wide Quality Assurance Dashboard (minute 4.1)

The SIRI Incidents Policy was being reviewed and would be presented, for assurance, at the March meeting of the Committee. Ms Davies said that from a NED perspective the Committee should not approve Trust Policies but should receive assurance that policies were being put in place and were embedded.

3.2 Board Assurance Framework (BAF) (minute 4.4)

A revised BAF will be developed for 2018/2019 for the April Board of Directors meeting.

3.3 Items for Escalation to the Board of Directors (minute 8)

The action raised at the last meeting was complete with the Committee Chair presenting a summary report of the key risks being highlighted to the Board of Directors at the January Board of Directors meeting.
4. CORPORATE GOVERNANCE

4.1 Draft Terms of Reference Quality & Safety Committee

Ms Davis said that the draft terms of reference being presented for the Quality & Safety Committee for consideration had been drafted in line with best practice.

Committee Members discussed attendance at the Quality & Safety Committee meetings and it was acknowledged that the core membership of the Committee would be members of the Board of Directors. There would be a clear list of key Deputy Directors and Senior Managers who would be in attendance.

A general amendment would be made to all terms of reference to ensure the word “his” was replaced with “their”.

Mrs Gray raised the issue of ensuring clarity of the timeliness and processes required to change of remit of the Committee from an Integrated Governance Committee to a Quality & Safety Committee and added that the transition should take place as soon as possible. Ms Davies said that the process that would be followed would include (a) ensuring that all the duties of the Committees were aligned, (b) to ensure they were aligned with the Standing Orders and Scheme of Delegation and (c) to ensure a consistent format. Ms Davies explained that all the terms of reference needed to be approved by the Board of Directors but that the Committee could operate in shadow form. Mrs Gray requested that all of the Non Executive Directors were informed of the process and timeline that would be followed to ensure all Committee changes were implemented in a timely manner. Mrs Gray highlighted that she did not agree that this had been clarified with NEDs, particularly as committee times and dates had been changed to reflect the new committees.

Ms Hackshall queried the triangulation of information between Committees regarding, for example of pressure tissure damage, which have an organisational risk on quality and safety and operational performance. Ms Davies said that within governance framework there needed to be a flow of information between Sub Committees. The main conduit would be the Trust Board Secretary who would be in attendance at all Committees. Mrs Gray pointed out that this was also being formalised through the Audit committee.

Professor Welsh said that the terms of reference did not explicitly explain the remit of the Committee and it was agreed that the purpose of the Committee would be “to ensure that it was responsible for providing assurance to the Board of Directors that high quality care was being delivered to all patients and that staff were supported to deliver high quality safe care to patients.” It was also agreed that all Terms of Reference for all Board Committees should link to a Strategic Objective and include the CARE values.

Ms Davies said that within the first quarter, further work would be developed to ensure that the Terms of Reference clearly linked each duty with an outcome.

The Committee agreed that there would be an initial 3 month review with Committee Members and a formal review of the Terms of Reference after a 6 month period.

**DECISION:**

(a) Ms Davies to ensure that all Non Executive Directors would be informed of the timeline for changes to Board Committees.

(b) The Terms of Reference would be amended in line with the comments made and circulated to Committee Members, for final comment, before the next meeting.
4.2 Draft Quality & Safety Reporting Structure

The draft reporting structure was presented to the Committee with Ms Hackshall explaining that at the last meeting, a decision was taken to continue with the Quality Governance Steering Group which would not be chaired by an Executive Director. Ms Hackshall stated that she would review whether the Chief Executive would be chairing the Infection, Prevention & Control Steering Group. Ms Hackshall added that the Risk Management Steering Group would remain and would be a task & finish group until risk management processes were embedded and reviewed within the organisation.

Mrs Gray queried the Health & Safety Steering Group reporting structure and it was agreed that this needed to be reviewed and refreshed. Ms Davies said that the reporting structures under Committees would need a full review, including the number and effectiveness of committees once the Divisions were in place, to ensure appropriate trust wide reporting.

Mrs Gray said that it was evident from the lack of minutes from the reporting groups that a number of meetings had not met she asked if this posed a risk to patients or the organisation with Ms Hackshall explaining that in the main this had been due to operational pressures. Ms Gray said that there was a concern regarding meetings being cancelled and requested assurance that the focus on fire compliance and health & safety had not slipped due to meetings not taking place. Ms Davies reported on the Clinical Business Unit Performance meetings held on the 16th February 2018 where it was evident that even though a number of meetings were cancelled in January, the emerging risks and issues were still appropriately being escalated by the Clinical Business Units.

Ms Hackshall said that the Executive Team needed to review the meetings which could be cancelled during periods of significant operational pressures. Ms Hackshall added that the pressures of capacity and demand were detailed on the risk register.

Ms Davies agreed to liaise with Ms Hackshall regarding reviewing the remit of each group reporting to the Quality & Safety Committee which would return to the Committee before being presented to the Board of Directors.

**DECISION:**

(a) To review the meeting frequency of the Health & Safety Committee and the groups reporting to the Health & Safety Committee.

(b) Ms Davies to raise with the Executive Team the issue of meetings being cancelled or reduced attendance at meetings when the Trust was in significant operational pressures.

(c) Ms Davies to liaise with the management leads for Health & Safety and Fire reporting to obtain assurance that actions were being addressed due to the cancellation of the last round of meetings.

(d) Ms Davies and Ms Hackshall to review the remit of each group reporting into the Quality & Safety Committee.

4.3 Work Programme for the Committee

It was agreed that the Work Programme for a Quality & Safety Committee would be drafted, with input from all Committee Members, to include specific areas of:

- Regulatory Compliance including safeguarding reporting
- Quarterly Quality & Safety Report, linking back to the CQC Insight Report
- The timings regarding the preparation of the Quality Account
- NICE Compliance
Data Compliance

It was agreed that once the Work Programme was approved, it would be circulated through the governance structure at Divisions to ensure all reports were appropriately signed off before being presented to the Committee.

Professor Welsh stated that the reporting groups to the Committees should present a summary report of the issues discussed and escalated. The Committee would then review the process after a six month period to ensure the summary reports were including the appropriate information.

Mrs Gray queried areas where the Committee may wish to champion, i.e. an area that the Committee wished to focus on to make a real difference. Ms Davies said that the focus of the Committee would be on the indicators and priorities within the Quality Account and Quality Strategy. Ms Hackshall reported that the Quality Strategy was being submitted to the Trust Management Committee next week and would be presented to the April Committee and Board of Directors meetings.

**DECISION:**
(a) The draft Work Programme for the Quality & Safety Committee would be prepared and circulated to all Members for comment prior to the next meeting.
(b) Guidance for authors of reports and groups reporting to the Committee would be prepared in a Standing Operating Procedures document for all Committees.
(c) The Quality Strategy would be presented to the Committee at the April meeting.

4.4 Committee Agenda Preparation Schedule

A schedule had been prepared detailing when papers would be circulated to the Committee and it was agreed to include meetings with the Chair and Lead Director following each Committee to prepare the agenda for the next Committee meeting.

**DECISION:** The Agenda Preparation Schedule would be amended to include the agreement of the draft agenda for the next meeting.

5. QUALITY GOVERNANCE

5.1 Trust Wide Quality Assurance Dashboard

The Committee received the Trust wide Quality Assurance Dashboard with Ms Hackshall reporting that the Trust was still significantly challenged from a capacity and flow position. It was noted that with the age profile increasing this was having an effect relating to the increased numbers of pressure tissue damage incidents. Ms Hackshall informed the Committee of the specific actions agreed at an operational meeting yesterday, where the Lead Nurses were freed up from capacity issues to concentrate on their wards. Mrs Gray commented that the number of cardiac arrests outside of A&E was below the Trust trajectory and the Trust was seeing an increase in the number of complaints during the winter period. The areas the Trust continued to address included compliance with issuing discharge letters; an increase in the number of medication incidents and an increase in the numbers of grade 3 pressure tissue damage.

Professor Welsh queried the issue patient flow and the impact on the position of delayed transfers of care (DTOC) and vacancies within the workforce. Ms Hackshall said that DTOCs had reduced within the Trust from 70 to 21 during the last three months.
Dr Chilton said that “Super Stranded” patients had increased (patients in the Trust longer than 21 days) and work was being undertaken to identify the patients who did not have a cogent reason for being in the Trust as these can move on to becoming a DTOC. Dr Chilton said that the areas of challenge for medical vacancies related to junior doctors within general medicine, surgery and orthopaedics. It was reported that the Trust currently had 36 escalation beds, with 44 outliers, with these numbers being seen on a daily basis which were also increasing from January into February.

Professor Welsh highlighted that the report did not cover the areas which were being verbally raised at the meeting and therefore the context was being missed within the reports. Professor added that the report needed to commence with a summary review of the month to provide the context for the Committee and to provide supporting positive data to put the challenges into context. For example, if the number of DTOCs were being reported, it would be helpful for the Committee to know how many patients, in total, had been discharged during the month.

Mrs Gray queried if there had been any significant changes in relation to the concerns being raised by GP practices with the GP Liaison Officer leaving. Mrs Clennett stated that GPs were reporting concerns appropriately rather than requesting, for example, signposting information for patients. Their main point of contact was James Allen, Patient Experience Manager, who was also meeting with all Practice Managers at GP Practices.

Dr Chilton summarised the challenges in achieving the 99% target set for discharge letters and added that he did not feel that the current performance was not aligned to other organisations. Professor Welsh agreed stating that national benchmarking data was not available. Dr Chilton said that with the issues of patient flow and the current level of vacancies needed to be addressed to improve any performance relating to the issue of discharge letters. Dr Imtiaz stated that it may be worth undertaking a review/audit to see if there was a link with patient safety or patient complaints regarding where patients had not received a discharge letter. Professor Welsh said that he was reassured that 88% of patients within the Trust received a discharge letter and stated that whilst the Trust was under pressure with outliers and vacancies, achieving 99% was unrealistic. Mrs Gray said that in terms of contextualising the issue of discharge letters there was an action regarding detailing formally that the Trust would not achieve 99% compliance and describing why the key performance indicator was unrealistic, which needed proper evidence and benchmarking, how this would sit with GPs etc. Ms Hackshall said that the quality strategy would review all of the metrics the Trust would be agreeing to report. Dr Natarajan said that the Trust had not seen an issue of increased complaints from GP practices regarding patient harm in relation to not receiving discharge correspondence.

Mrs Gray said that the Committee was being assured that the metric was being reviewed in line with the key performance indicators which would be detailed in the Quality Strategy.

Mrs Gray asked if there had been an upward trend regarding how the issue of discharge letters were being addressed and if so then it would be sensible to document regarding the performance of the Trust, the issues being addressed, then this would be helpful with the messages for the public., and GP colleagues.

Mrs Gray queried compliance with controlled drugs with Ms Hackshall stating that performance was improving and was being reviewed to ensure performance was maintained.

Dr Natarajan reported on the Learning from Deaths dashboard and stated that there had been no any avoidable deaths to date.
The main challenge would be to sustain the number of reviews being undertaken month on month but added that further practitioners were being engaged to undertake reviews and a Mortality Manager had been recruited. The top 5 learning themes were reported with 50% of reviews having no learning points to be highlighted. It was noted that a monthly report would be submitted to the Committee and to the Board of Directors on a quarterly basis.

**DECISION:** (a) It was agreed that at future meetings the Executive Director Lead would include a summary of the challenges being faced by the Trust in the month, and provide context by including relevant performance information.

5.2 Care Quality Commission Update

Ms Hackshall said that the Trust was waiting for the formal publication of the Inspection Report with no further requests for additional information required from the Trust.

5.3 Quality Improvement Plan: Actions Allocated to the Committee

The Committee received the report detailing the quality improvement plan actions allocated to the Committee for review. Ms Hackshall said that compliance regarding documentation was still an issue for the Trust. Once the final CQC Inspection report was received the KPIs would be clearly defined with the key action being to ensure focus on culture and compliance within the Trust.

Ms Gray said that it was reported at the monthly Oversight meeting with the Regulators that the Trust would want to take stock once the new Inspection report was received. Mrs Gray said that a specific concern was that many of the overdue issues related to the actions being monitored by the Integrated Governance Committee and queried what support was required from the Committee. Ms Hackshall said that the Committee could undertake a “deep-dive” in an area which would also be aligned to the area where NHS Improvement wanted to undertake a deep dive at the bi-monthly Oversight meetings.

**DECISION:** Ms Hackshall to liaise with the Chair of the Committee to schedule in “deep dive” reviews of areas being highlighted for a detailed by review at the Regulator Oversight meetings.

5.4 Quarterly Report on Incidents, Investigations & Learning

Ms Clennett presented the quarterly report on incidents, investigations and learning and specifically highlighted the reduction in the numbers of serious incidents. It was important to provide the 72 hour investigation reports to Commissioners and the Trust was now meeting the target. The report included an exception report in relation to a paediatric case because of a delay due to external police investigation. The Trust was holding twice weekly meetings with the family who would be involved with the Trust investigation. It was noted that there was an extra-ordinary meeting with the Commissioners where the Trust would provide assurance on any outstanding evidence from serious incidents.

Professor Welsh queried Never Events specifically regarding the issue that reports should not state “a Never Event did not cause harm” as there may be physical and or psychological harm suffered by the patient. In addition, Professor Welsh queried whether the Trust focusing on ensuring the Trust met the deadline to report to Commissioners or focused on the event. Mrs Clennett said that the Trust was focused on investigating the physical harm and the patient did not have to return to the Trust for further treatment as quantifying psychological harm was a challenge.
DECISION: To consider the implication of psychological harm in reporting

6. MINUTES FROM REPORTING GROUPS

Mrs Gray expressed concern that meetings had not taken place for 2 months

6.1 Minutes of Quality Governance Steering Group

There were no minutes from the Quality Governance Steering Group presented to the Committee.

6.2 Minutes of Health & Safety Steering Group

There was no meeting held of the Health & Safety Steering Group held in January 2018.

6.3 Minutes of the Risk Management Steering Group

Ms Davies provided verbal feedback on the meeting held on the 7th February 2018 where the Medicines Management Risk Register was discussed and the risk regarding the cash flow position for the Trust.

6.4 Minutes of the Patient Experience Steering Group

There were no minutes from the Patient Experience Steering Group.

6.5 Minutes of the Safeguarding Steering Group

The draft minutes from the meeting of the Saefeguarding Steering Group held on the 11th January 2018 were received and noted.

Ms Hackshall informed the meeting that three out of the 4 posts within safeguarding had tendered their resignations, for different reasons. Mrs Gray asked if this had been placed on the risk register which had been placed onto the risk register. Ms Hackshall was currently reviewing plans for the Trust in relation to Safeguarding.

7. FEEDBACK FROM NON-EXECUTIVE DIRECTOR MEETINGS/VISITS

Mrs Gray attended the visit to the Trust by the Secretary of State for Health & Social Care which was very well received. Mrs Gray had chaired the Consultant Breast Consultant interviews which had a positive outcome regarding the appointment and a meeting was attended in London where a presentation was given by the Chairman on the Care Quality Commission.

8. ITEMS FOR ESCALATION TO BOARD OF DIRECTORS

- Safeguarding vacancies
- Contextualise the issue of discharge letters
- Good lessons learnt during the meeting regarding ensuring reports, in future, contained relevant contextual information
- The issue regarding commencement of the new committee structure
9. **ANY OTHER BUSINESS**

9.1 **Legionella Testing**

Dr Natarajan said that recent checks had been undertaken regarding Legionella levels within Thorpe House. The Committee was assured that the local policy was being followed and repeat testing was being undertaken and meetings had been held with staff groups and all the affected areas had been closed.

9.2 **Flu Outbreak**

Dr Natarajan provided an overview for the Committee on the actions being taken by the Trust in addressing two strains of flu.

9.3 **Governors**

Mrs Chapman said that a pre-meet was held with the Chair of the Committee which was helpful and stated it was positive that the Committee was becoming a Quality & Safety Committee with the patient at the centre of discussions.

*The meeting concluded at 11:05am*
| AGENDA ITEM: | 7.3 |
| NAME OF COMMITTEE: | PERFORMANCE, FINANCE & RESOURCES COMMITTEE |
| DATE OF MEETING: | 31st January 2018 |
| PREPARED BY AND CONTACT DETAILS: | Trust Board Secretary |
| PURPOSE OF REPORT: | For Decision: ☑ | For Assurance: □ | For information: □ |
| SUMMARY OF DISCUSSIONS: (Detail areas being escalated to the Board – Please summarise on one page) | The draft minutes of the meeting are attached. A verbal update will be provided by the Chair of the Committee following the meeting held on the 28th February 2018. |
MINUTES OF THE PERFORMANCE, FINANCE & RESOURCES COMMITTEE HELD ON 31\textsuperscript{st} JANUARY 2018, BOARDROOM, GLEBE HOUSE, TRUST HEADQUARTERS

PRESENT: Mr P Harris-Bridge - Non-Executive Director (Chairman)  
Ms L Hanna - Non-Executive Director  
Mrs R Brown - Chief Operating Officer  
Mr J Gamble - Deputy Director of Finance

IN ATTENDANCE: Mrs A Pleavin - Director of Transformation (item)  
Mrs S Madeley - Trust Board Secretary  
Mr R England - Consultant, Urology Service  
Ms T Boydell - Urology General Manager

OBSERVERS: Mr R Talbot - Nominated Lead Governor  
Mr P Wolliscroft - Public Governor, Kettering.

The Chairman welcomed Mr Talbot as the nominated Lead Governor for the Performance, Finance & Resources Committee. The Chairman highlighted the document "Role and Mandate of Governors on KGH Board of Directors Sub Committees" which the Council agreed to adhere to at their meeting on the 11\textsuperscript{th} January 2018. Mr Harris-Bridge said that he had recommended that for the meetings in this quarter the paper would accompany the agendas.

1. APOLOGIES FOR ABSENCE:

Apologies for absence were received from Ms N Briggs.

2. MINUTES OF THE PREVIOUS MEETING

Subject to a number of minor amendments, the minutes of the meeting held on the 20\textsuperscript{th} December 2017 were approved as a true record.

3. MATTERS ARISING

3.1 Table of Matters Arising

3.1.1 Matters Arising: Operational Performance (minute 3.1)

The Chairman informed the meeting that with the establishment of the Radiology Executive Assurance Group, the view taken was that the service was currently receiving considerable attention to build and implement a plan to reduce the radiology backlog. Therefore, it was not the intention for the service to present to this meeting and the Chief Operating Officer would update the meeting later in the agenda.
3.1.2 Matters Arising: Quality Improvement Plan (minute 3.2)

Following comments made at the last meeting, the Quality Improvement Plan had been updated as requested and was an item for further discussion on the agenda.

3.1.3 Board Assurance Framework (minute 3.3)

The Board of Directors discussed the continuation of the Board Assurance Framework for 2017/18 in the current format which would then be updated into a new format for 2018/19.

3.1.4 EMRAD Consortium – Leicester Withdrawal (minute 3.5)

**DECISION:** The mitigation issues surrounding Leicester scans would be discussed with Mrs Arnold at the February meeting.

3.1.5 North Northamptonshire Urgent Care Improvement Programme (minute 3.9)

The Emergency Care Improvement Programme report was included within item 5.3 on the agenda.

3.1.6 RTT Performance

The issue discussed at the previous meeting relating to RTT Harm Reviews would be discussed later on in the agenda for this meeting.

3.1.7 Quality Improvement Plan Actions

An update on black breaches was included within item 5.3 on the agenda for this meeting.

3.1.8 Finance Report

The issue of the level of financial contingency was included within the financial planning paper for discussion at this meeting.

3.1.9 Financial Forecast 2017-2018

Following the issue raised at the previous meeting regarding an update on the agency spend on locums and assurance of the rigour in place in respect of other agency roles within the Trust, Mrs Brown explained that there are three areas of additional staffing in the organisation which was agency, bank and locums. Mrs Brown said in relation to locums, they were employed on a fixed term basis covering a vacancy/or acting up. There were currently 14 locums in place, permanent/substantive solutions were continually reviewed and there was robust rigour in place to ensure they were of the appropriate calibre for positions they were covering within the Trust.
3.1.10 Capital Utilisation (minute 5.4)

It was reported that Mr Shipman had met with Ms Briggs to discuss how to bridge the £4m slippage in capital spent, which was held on the 29th January 2018.

3.1.1 Trust Recovery Programme (minute 6.1)

The Chairman had agreed with Mrs Pleavin that because of the pressures across the Trust in January 2018, an update would be provided next month.

**DECISION:** The March meeting would receive a monthly metrics report in relation to the Trust Recovery Programme.

3.1.2 Sustainability Performance Report (minute 8.1)

**DECISION:** The issue of requesting information relating to the volume of waste increasing despite the reduced bed base and patient numbers, would be deferred to the February meeting for new Director of Estates.

3.2 Schedule of Matters Arising

**Theatre Ventilation (24th May 2017)**

The Chairman reported that the requested lessons learnt paper should have been received and it has now been agreed with the CEO that the previous Director of Estates would not be required to submit this report since he has left the Trust and the issue/approach now, would be discussed with the Committee later in the agenda.

3.3 Urology Presentation

Mr Harris-Bridge informed the meeting that through the work of the RTT Executive Assurance Group last year, there were four specialities that had provided a challenge in terms of the level of demand versus capacity, urology, general surgery, T&O and ophthalmology. Therefore, these specialities would be invited to the Committee to present overviews of the service and in particular, their plans to close the capacity gap, returning the service to compliance with the RTT service performance target of 92% within 18 weeks.

The urology service presentation provided the detail of the 52+ week breaches from January 2017 to January 2018 in addition to the incomplete pathways data from October to December 2017, detailing a significant reduction from 23rd October 2017 at 3,360 to 18th December 2017 being 1642. There had been usual/expected rise in referral rates to the service within the last three months indicating a stable position.

Mr England reported that Medinet was booked for two weekends at a net cost of £24,000 but no activity was undertaken.
In relation to the cancer target, appointments within 7 days were at 39%, appointments within 14 days at 100%; treatment within 31 days of decision to treat was 100% and treatments within 62 days was 95%. The service saw significant numbers of cancers compared to other specialities and there were challenges in referrals being sent back to secretarial staff to be booked in for appointments which built in a delay.

Mr England reported that work was being undertaken to address capacity and demand and on the back of the GRIFT process, recommendations were made regarding the environment where the service was delivered being a priority for the service to develop a purpose-designed Urology department. Currently the service was fragmented, being delivered through a number of physical areas across the Trust. The proposal was to put the service in one place within the ground floor of the treatment centre, which was currently occupied by pre-admissions.

The Chairman queried the view of the CCG regarding the national shortage of capacity within urology and Mr England stated that in terms of outpatients, the GP service was efficient, for example, the hospital consultant saw 10 patients in the hospital in the same time that only 4 patients would be seen at a GP practice. Mr England said that NGH had the same issues regarding capacity and the only other local provider would be Cambridge or Bedford. Mrs Brown queried if an advert went out for a sixth consultant, would the Trust be able to recruit with Mr England reporting that there were medics coming through the training programme and the advert would have to be timed to coincide with the completion of training. Ms Boydell reported that a business case was being drafted and in respect of the One-Stop clinic a request would be made to GPs to undertake diagnostics before patients were referred to the hospital.

The Chairman queried if there was a clear view of the actions which would improve the service performance, with Mr England stating that these were clinical capacity and environmental space. It was confirmed that both areas would be included within the planning round for 2018/19 and Mrs Brown asked that developments for the service needed to occur within the next 12 months.

Mrs Hanna said that Board Members hear about space planning and queried how realistic was it to use capital to develop space in accordance with a Space Plan. Mrs Brown said that there was a Space Utilisation Group operating and from the CQC point of view there was a requirement to improve the environment and the Trust was aware that this area was a priority for the coming 12 months. Mrs Brown reported that the new Director of Estates would have the priority of developing the Estates Space Plan. Mr England said that the support of the Financial Business Partner and Ms Boydell was crucial for the service to support the clinicians. Mrs Brown said that it was crucial for the service to develop a one stop clinic service to provide quality care for patients.
The Chairman thanked the team for the presentation and assurance had been gained from the presentation specifically in relation to the incomplete pathway performance and asked for the thanks of the Committee to be passed onto the team.

4. QUALITY IMPROVEMENT PLAN

4.1 Quality Improvement Plan (QIP) Actions: PFR Committee

Mrs Brown said that the Quality Improvement Plan would change following the receipt of the latest CQC Inspection report which was due to be published early February 2018. Mrs Brown said that ambulance handovers times and 15 minutes observations remained a challenge in January. It was noted that a new member of staff in ED had focused on the 15 minute observation metric. The challenge remained culture when the department was under pressure and it had to be recognised that the environment was not equipped to deliver this volume and complexity of service.

The Chairman queried what would improve performance of the two metrics with Mrs Brown reporting that in the winter crisis the NHS was currently experiencing, the Trust did not have the number of rooms to cope with the numbers of patients presenting in the department. The Trust was “Manchester Triaging” every patient to ensure a clinical review was undertaken. Mrs Brown said that the areas were vulnerable with the number of patients attending the department and added that the department did not have large numbers of incidents being reported and was therefore ensuring that patient safety was being maintained. The Chairman said that the CQC draft report was identifying the two metrics as safety issues and if the Trust was not meeting national targets why did the COO feel it was not a safety issue. Mrs Brown said that the national measures related to major patients to be seen within 15 minutes which the Trust addressed and the CQC was highlighting the minors/walk in patients.

Mrs Hanna said when Medway was installed, was there a lessons learned process to review the holistic piece including IT resource with Mrs Brown responding that a major Medway upgrade was previously implemented and with the minor upgrade the Trust experienced issues and a lessons learnt process was undertaken.

Mrs Hanna queried where did the Trust benchmark on the 15 minute observation target with Mrs Brown saying that anecdotally the Trust would be broadly the same as other organisations but it was not a nationally reported measure. Mrs Brown added that ECIP was currently in the Trust and they were not reporting that the Trust should be implementing anything different and they had a clear view of the national picture.

The Chairman queried at what stage the plan would be updated with the new CQC inspection report with Mrs Brown reporting that once the report was received, the Trust would implement a new Quality Improvement Plan and would reflect some of the same actions from the original QIP.
Mrs Hanna asked for the action no 19 “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 service” was reported as being delivered by 31st August 2017 and needed to be updated.

**DECISION:** Mrs Brown to instruct the CQC Lead in the Quality Governance Team to update action 19 on the Quality Improvement Plan.

5. **OPERATIONAL PERFORMANCE**

5.1 Operational Performance

Mrs Brown presented the operational performance report and outlined performance against the key national performance metrics.

5.2 Cancer Services

Mrs Brown reported that there was a new Cancer Services Manager in place, Jayne Chambers, who was working extremely well to manage the service. The Trust continued to see positive performance.

The Chairman said that this committee was about seeking assurance on the service and Cancer Services were in an excellent position. In terms of the national target the Trust was doing extremely well and asked for the thanks of the Committee to be passed onto the teams.

**DECISION:** Mrs Brown to formally pass on the thanks of the Committee to the Cancer Services Team.

5.3 Urgent Care Programme

The Chairman firstly highlighted the recent announced changes to the Corby Urgent Care Centre, where the plan is to convert its operation from walk-in urgent-care to “appointment only”. Mrs Brown reported that the Trust had fought for the last two years to include the activity from Corby Urgent Care Centre within the urgent care figures reported by the Trust and added that moving forward there was a requirement for an urgent care strategy across the health economy. The Trust wanted to establish a **hub** to bring urgent care provision to a central point and it was important the Trust remained focused and work together with Corby UCC and the CCG to find the right solution. Mrs Brown said that she was concerned regarding the transition arrangements and secondly how would the culture and practice of the population change regarding patients being able to have same day access to an urgent care service. The Chairman queried if the Urgent Care Centre was re-purposed, would it by definition then be removed from the urgent care activity numbers and it was confirmed this would be the case. In addition, the re-categorisation and changing the nature of the payment received by the Urgent Care Centre, would the funding which was moved in the UCC direction be removed. Mr Gamble responded that you would hope the payment mechanism would change to the point of delivery but cannot yet speculate. The A&E was paid strictly on payment by results so any increase in
patients would lead to an increase in income. However, the Trust was currently exceeding capacity on a daily basis which would lead to additional costs for the Trust in relation to the provision of additional staff to deal with an increase in capacity.

Mrs Brown presented the report on the urgent care programme detailing that the Trust had significant numbers attending the department and felt strongly that the teams were keeping patients safe within the department.

The Chairman queried if there was a maximum number allowed within the Department as currently the maximum was 45 and the Trust was seeing in excess of 100 patients and queried if this was a health & safety risk. Mrs Brown said within the environment at KGH, the Trust cannot shut the doors of A&E. However, Mrs Brown said that she would not hesitate to close the doors if the department was considered to be unsafe. Mrs Brown reported that neighbouring Trusts can accept diverts and have previously assisted the Trust.

Mrs Brown reported that a daily tracking meeting was held on delayed transfers of care (DTOC) and stranded patients, which included all of the patients referred to the Single Point of Access (SPA) service and reported that in December the figure was 49 and currently the Trust had 27 delayed transfers of care patients which was a significant improvement. It was reported that the Trust could now spot-purchase beds in collaboration with health partners to allow patients to be moved out of the hospital when they are ready to go even if their next episode/location is not yet ready to receive them. Mrs Brown said that now DTOCs were being managed it was highlighting the number of patients in beds that required referral to the SPA process. Mrs Brown described the process to address stranded patients who had been in the Trust over 21 days and the processes being undertaken on a daily basis.

Mrs Hanna thanked Mrs Brown for the update and the Board would be formally informed at the meeting on the 2nd February 2018. Mrs Hanna said that with the implementation of new initiatives she was now assured that the teams were still reviewing what was within the gift of the Trust to improve the internal performance of the Trust.

Mrs Brown highlighted the increase in over 75 years patients as the population was increasing and help was required from the team from the Emergency Care Improvement Programme Team (ECIP) on the frailty pathways. Mrs Hanna said she would like to see data relating to Over 75s regarding a rolling 52 week position to provide a true baseline position and it was agreed to discuss the issue outside of the meeting.

The Chairman said that the ECIP report attached to the paper demonstrated that A&E was the default destination for patients with Mrs Brown reporting that the Committee would receive a further detailed report at the next meeting.

The Chairman said that he felt very strongly regarding the national instruction that during January, Trusts were being asked to maintain the urgent care service at the expense of elective care and it was the wrong thing to do as patients were not receiving an appropriate service.
DECISION: (a) Mrs Brown and Mrs Hanna to discuss the reporting of data relating to “Over 75s” activity.
(b) The Committee would receive a more detailed report at the next meeting on the report from the Emergency Care Improvement Programme.

5.4 Referral to Treatment (RTT) Improvement Plan

Mrs Brown reported that the areas that were continually being focused on were the services of Urology, General Surgery, Ophthalmology and Trauma and Orthopaedics. The position and priority of RTT was deprioritised to support urgent care performance in January following a national instruction but the focus of the Trust continued to be on ensuring the number of patients waiting 52 weeks or more for treatment is reduced to zero and to continue to focus on improving performance and driving improvement.

Mrs Brown reported on the clinical harm process and stated that the Trust ensures that every patient waiting over 52 weeks has a clinical harm review. The concern that was raised previously by Mrs Hanna related to a number of clinical harm reviews that appeared to be delayed and there had been a focus at the confirm and challenge meetings which had reduced the small number to eight months cases and it was reported that the usual harm reviews were completed within 3-4 months.

5.5 Radiology Service Improvement Programme

The Committee received a report regarding the Radiology Service Improvement Programme, with Mrs Brown providing a detailed overview of the work being undertaken within the service to reduce the current reporting backlog. Mrs Brown reported that the Trust does not yet have the IT-based OrderComms system, which meant that all requests for any radiology diagnostics continue to be received manually. However, work was underway to ensure this was addressed during this financial year.

The Chairman said that having the opportunity for the manager of radiology to explain the challenges they face at the new Radiology Executive Assurance Group was extremely important and added that the urgent agreed action was to appoint further capacity to support the service. The Chairman added that it was evident that the service was working extremely hard to improve the performance and experience for patients. In addition, it was noted that Commissioners were in attendance at the Radiology Assurance Group.

Mrs Brown reported that the CT or MRI scans were being reported daily and the risk for the service related to plain film reporting.

Mrs Hanna queried the Data Quality Strategy but with issues on RTT and Radiology, how do we make the strategy real and what assurance did the Committee have that the Trust was progressing with the strategy to ensure the appropriate areas were being addressed. The Chairman said that the issue with radiology was regarding
capacity v demand which had created a backlog and was not primarily a data issue. Mrs Brown said that the Trust was aware of the EMRAD issue and also was aware that the manual systems were not good enough. The Trust has external support in place to review data information flows with recommendations expected regarding improving the flow within the Trust.

**DECISION:** The Radiology Manager would be asked to ensure the wording in the report reflected appropriately, the quality of the data within radiology.

6. **TRANSFORMATION PROGRAMME**

6.1 **Trust Recovery Programme**

Mrs Pleavin reported that as at month 9 the Trust had delivered £14.7m of the current year’s recovery plan. The teams were working extremely hard during significant operational challenges as the Trust was currently behind plan. On theatres, the position was awaited regarding the national directive to cancel elective activity and there would, therefore, be an adverse performance in Month 10.

The Committee were being requested to close reporting to the Committee on nursing establishment review, service reviews and agency reduction and outsourcing as there would be no further information to be reported in the final quarter of the financial year.

The Committee requested at the last meeting a lessons learnt on the use of Four Eyes Ltd within the Trust and it was reported that the Trust needed to formally respond to questions from NHS Improvement on the performance of Four Eyes. Mrs Pleavin said that there were detailed key performance indicators in place and the Trust would not be remunerating Four Eyes for the KPIs that had not been delivered which was supported by the Committee. Mrs Pleavin said that the contribution of Four Eyes to the recovery programmes had been very successful in some areas, for example, Outpatients.

Mrs Hanna said that she was uncomfortable with the agency reduction figures and what was seen was a cost reduction and when the figures were reviewed the Trust had overspent against the plan and although recovered on agency had put more labour into the Trust when activity had been reduced. Mrs Pleavin responded that the work around agency expenditure, job planning and utilising the bank, regardless of Four Eyes intervention, still required work to be undertaken. At this moment, we can only report on the forecast made at the beginning of the year. Four eyes contribution was that some programmes have not delivered well and other areas they had delivered better than was expected. Mrs Hanna stated that her request was to test agency reductions as it was not an agency reduction if posts were being back filled with additional permanent staff. The Chairman requested that the question should be responded to via a report to the next PFR Committee.

The Chairman requested that for the report to the next meeting a further table under year to date would be provided to report on the year-end forecast.
DECISION: (a) The Performance, Finance & Resources Committee, supported the recommendation within the report, that Four Eyes Ltd would not be remunerated for the key performance indicators that had not been delivered.

(b) The Committee would receive a report at the next meeting to answer the agency cost question posed by Mrs Hanna

(c) The report to the next meeting would include a further table under year to date would be provided to report on the year-end forecast.

7. FINANCE

7.1 Finance Report

Mr Gamble presented the financial performance report and highlighted the month 9 deficit of £2.9m. The Trust saw significant challenges in month 9 regarding winter pressures which were more severe than previous years. The Committee was informed that escalation areas open which was not covered by the winter funding contingency. The Trust had received winter funding of £700k and £1.8m. The Committee was reminded that the non-recurrent pressures, which included clinical support and estates overspend, were against the original financial plan.

The Committee noted that the forecast remained at £19.9m deficit and Mr Gamble said that this year was the most complex year in the NHS regarding the levels of uncertainty which included the national letter to cancel elective activity. The Chairman said that the decision imposed upon the Trust not to carry out elective work as reported to an extraordinary Board meeting in early January, could have an income effect of between £2m - £6m for the Trust and the Trust would still continue to incur costs of those employed to undertake the elective work.

Mr Gamble highlighted the underlying position for the Trust with agency costs continuing to be reduced and the financial recovery plan still delivering. The Trust has been hit by numerous unexpected pressures which have been mitigated. The underlying position would be a £16.8m deficit moving into 2018/19.

Mr Gamble informed the Committee that national guidance had not yet been received regarding planning for the 2018/19. Therefore, the Director of Finance, has commenced discussions with NHSI regarding the control total for 2018/19. The control total would enable the Trust to access Sustainability and Transformation Funding. The Trust was not waiting for guidance and had commenced budget planning processes and was engaging clinical leads and business unit managers. The Trust was starting from the underlying position at a Clinical Business Unit (CBU) level and each CBU has agreed a financial envelope to work within. The CIP for 2018/19 would involve large transformation schemes to make delivery and traction easier and more successful. Each scheme would be owned by a Director, CBU Lead and Transformation Lead. The report was received and noted.
7.2 Contracting Report

The Committee was presented with the contract performance report for month 9 for 2017/2018. It was reported that discussions with the clinical commissioning groups continued regarding the 2018/19 contract. Mr Gamble reported on MRET activity and estimated that there would be a £1.4m risk for the Trust.

7.3 Finance Plan 2018/19

Mr Gamble gave a verbal update on 2018-19 planning. As at the date of the committee, no national planning guidance had been released. The risk associated with this delay in national planning in the main relates to capital, as late approval of the Trust’s capital plan leads to the Trust underspending in year and cash as the loans required are not clarified at an early opportunity.

Although the national guidance is not received, Mr Gamble assured the committee that the finance team are working on budget setting and have engaged clinical leads and management. The process is based on an agreed envelope, agreed as part of the CBU performance reviews, being the underlying CBU position from 17/18 in addition to certain known pressures in 18/19.

Mr Gamble confirmed that CIP in 2018/19 will be based on Getting It Right First Time and Model Hospital and will be a smaller number of high value schemes.

7.4 Cash Report

The Committee received a report on cash flow, loan balances and funding. This report was updated following a meeting with the Chair of the Committee and urgent correspondence with NHS Improvement Cash and Capital team (as 7.4v2).

The paper was presented to allow the Committee sight of the issue of the revenue loan application, loan repayments and the cash position of the Trust to endorse the recommendations for approval at the next Board of Directors meeting.

Mr Gamble presented the report in two parts. Firstly 2017/18; Mr Gamble drew attention to the second page of the report which detailed the sixteen separate loans the Trust has to manage. He then drew the committee’s attention to the latest correspondence from the NHSI Cash and Capital team, where the delay in receiving Winter Funding will not be covered by DoH Loans. The Trust have put a number of measures in place to improve the cash position in the absence of Loan funding to cover the delay in the Winter Income including: Paying suppliers on 30 days, NHS payments at 45 days and contacted system finance directors for cash advances.

Mrs Hanna said that professionally she was challenged regarding some of the actions being requested by the Trust as the Trust was being asked to take actions which the government did not sponsor, especially in relation to paying invoices for
smaller suppliers. Mr Gamble said that payment of suppliers would in the main remain within 30 days and the Trust would remain within best practice.

Mr Gamble requested that recommendation be made to Board to approve an application for capital loan of £2.1m to fund repayment of existing capital loans.

Furthermore for 2017/18 the Board are requested to approve additional interim revenue loan funding of £2m taking the revenue loans in 2017/18 to a total of £28.9m.

For 2018/19 following discussion with the Chair of the Committee the recommendation has been amended in the revised report for the Board to approve an application for additional revenue loan funding of £12.1m and interim capital loan funding of £8m for 2018/19. I.e. for Revenue Loans only the amount needed to cover the existing loan repayments and not the 2018/19 deficit, as this is still to be ascertained.

The report was also requesting that the Board give delegated authority to the Director of Finance to request the funding for the Trust.

Mrs Hanna said that the Trust was borrowing cash because not in the control targets and was paying more interest and at some point need a conversation on cash and on loans was required by the Board to ensure the Trust was operationally efficient. Mrs Hanna said that the Trust required cash to keep the hospital going but a discussion was required on the number of loans in place.

DECISION: (a) The Committee agreed to endorse the recommendations within the report to the Board of Directors.

(b) The Director of Finance to be requested to schedule a discussion with the Board on the cash and loan position of the Trust to ensure the hospital was operationally efficient.

7.5 Capital Utilisation Report

The Committee received the capital utilisation report for December 2017 which detailed that the risk for the Trust was circa £4m of the capital programme would not be spent by the end of the financial year.

Mr Gamble outlined the plans to allocate the capital funding which included potential purchase of off-site car parks; the purchase of PCs; hardware for ordercoms and the purchase of a mobile MRI scanner.

The Chairman said that the Committee was seeking assurance that capital would be spent before the end of the financial year and spent wisely and the work needed to be shared with the Committee before the next meeting to address the question how the capital spend would be spent and when.
**DECISION:** The Chairman requested a telephone call within the next two weeks to answer what capital would be spent within the next two months.

8. **OTHER URGENT BUSINESS**

8.1 **BAF and Strategic Risks for Performance, Finance & Resources Committee**

The Chairman reported that Mr King had been working on updating the BAF for the last two months and a proposal would be presented to the Board on Friday. Once approved by the Board, the Committee would receive an update every quarter.

8.2 **Estates and Facilities Reporting: 2018 Approach**

The Committee was informed that a meeting had been held with the Deputy Director of Estates regarding reporting to PFR Committee and a meeting would be held with the new Director of Estates once he commences in February 2018.

The February PF&R Committee would be the next time Estates & Facilities performance would be presented to the Committee.

8.3 **Estates, Audits & Lessons Learnt**

The Chairman reported on the outstanding lessons learnt paper on the Theatre Ventilation programme. The Chairs of the Audit Committee and PFR Committee took concerns to the Chief Executive and Director of Finance and there had been a number of audits/investigations initiated, with outcomes due later this quarter.

9. **ANY OTHER BUSINESS**

9.1 **Feedback from Governors**

Mr Wolliscroft provided feedback to the meeting and said that as his background is in health estates, he would be very happy to offer help to the Trust.

9.2 **Feedback from Nominated Lead Governor**

Mr Talbot said that he struggled with the amount of information provided to support this meeting’s agenda, confirming that he did not consider the agenda needed to cover any additional issues than were already discussed.

10. **DATE & TIME OF NEXT MEETING**

- 09:00am
- 28th February 2018
- Boardroom, Glebe House