Northampton General Hospital
NHS Trust

Public Trust Board

Thursday 31 May 2018

09:30

Board Room
Northampton General Hospital

Northampton General Hospital NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 31 May 2018
09:30 in the Board Room at Northampton General Hospital

Time	Agenda Item		Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2.	Declarations of Interest	Note	Mr P Farenden	**Verbal**
	3.	Minutes of meeting 29 March 2018	Decision	Mr P Farenden	**A.**
	4.	Matters Arising and Action Log • Abington and Althorp Ward – Best Possible Care Status Presentation	Note	Mr P Farenden	**B.**
	5.	Patient Story	Receive	Executive Director	**Verbal**
	6.	Chairman's Report	Receive	Mr P Farenden	**Verbal**
	7.	Chief Executive's Report	Receive	Dr S Swart	**C.**
10:00	**CLINICAL QUALITY AND SAFETY**				
	8.	Medical Director's Report	Assurance	Mr M Metcalfe	**D.**
	9.	Director of Nursing and Midwifery Report	Assurance	Ms C Fox	**E.**
10:20	**OPERATIONAL ASSURANCE**				
	10.	Finance Report	Assurance	Mr P Bradley	**F.**
	11.	Workforce Performance Report	Assurance	Mrs J Brennan	**G.**
10:50	**FOR INFORMATION & GOVERNANCE**				
	12.	Integrated Performance Report	Assurance	Mrs D Needham	**H.**
	13.	Communication Strategy	Assurance	Mrs S Watts	**I.**
	14.	Northamptonshire Health and Care Partnership Update	Assurance	Mrs K Spellman	**J.**
	15.	Quality Account	Approve	Mr M Metcalfe	**To follow.**
11:10	**COMMITTEE REPORTS**				
	16.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler	**K.**
	17.	Highlight Report from Quality Governance Committee	Assurance	Mr J Archard-Jones	**L.**
	18.	Highlight Report from Workforce Committee	Assurance	Ms A Gill	**M.**

Time	Agenda Item		Action	Presented by	Enclosure
	19.	Highlight Report from Audit Committee	Assurance	Mr D Noble	**Verbal.**
	20.	Highlight Report from Hospital Management Team	Assurance	Dr S Swart	**Verbal.**
11:30	**21.**	**ANY OTHER BUSINESS**		Mr P Farenden	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held at 09:30 on Thursday 26 July 2018 in the Board Room at Northampton General Hospital.

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).

Northampton General Hospital NHS
NHS Trust

Minutes of the Public Trust Board

Thursday 29 March 2018 at 09:30 in the Board Room at Northampton General Hospital

Present		
	Mr P Zeidler	Non-Executive Director and Vice Chairman(Chair)
	Dr S Swart	Chief Executive Officer
	Mrs D Needham	Chief Operating Officer and Deputy Chief Executive Officer
	Mr P Bradley	Interim Director of Finance
	Mr J Archard-Jones	Non-Executive Director
	Mr D Noble	Non-Executive Director
	Ms A Gill	Non-Executive Director
	Ms C Fox	Director of Nursing, Midwifery & Patient Services
	Mr M Metcalfe	Medical Director
In Attendance		
	Ms C Thorne	Director of Corporate Development Governance & Assurance
	Mr C Pallot	Director of Strategy & Partnerships
	Mrs J Brennan	Director of Workforce and Transformation
	Mr S Finn	Interim Director of Facilities and Capital Development
	Ms K Palmer	Executive Board Secretary
Apologies		
	Mr P Farenden	Chairman
	Dr E Heap	Associate Non-Executive Director

TB 17/18 113 Introductions and Apologies

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

Apologies for absence were recorded from Mr Farenden and Dr Heap.

TB 17/18 114 Declarations of Interest

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

TB 17/18 115 Minutes of the meeting 25 January 2018

The minutes of the Trust Board meeting held on 25 January 2018 were presented for approval.

The Board resolved to **APPROVE** the minutes of the 25 January 2018.

TB 17/18 116 Matters Arising and Action Log 25 January 2018

The Matters Arising and Action Log from the 25 January 2018 were considered.

Action Log Item 82
Mr Archard-Jones confirmed that this had been discussed at Quality Governance Committee.

Action Log Item 83
Mr Needham reported that this had been presented at Februarys Board of Directors.

Action Log Item 84
Mr Needham advised that this had been presented at Februarys Board of Directors.

The Board **NOTED** the Action Log and Matters Arising from the 25 January 2018.

TB 17/18 117 Patient Story

Dr Swart shared with the Trust Board the patient story.

Dr Swart advised that she had received a letter written by an employee of EMAS. The individual had attended the Trust on 2 March 18 to transfer a Paediatric patient to Oxford.

The individual had admiration for the nurse manager on shift that had started at 8am and was due to finish at 4pm, it was currently 7pm. The Nurse Manager was adamant to accompany the patient and did not return to the Trust until 11.30pm. Her enthusiasm and commitment were noted as outstanding. The individual would be honoured if this Nurse Manager looked after a member of her family.

The Board **NOTED** the Patient Story.

TB 17/18 118 Chairman's Report

Mr Zeidler presented the Chairman's Report.

Mr Zeidler stated that he had recently attended an STP Board on the Chairman's behalf. He was disappointed not to see a huge amount of evidence that the STP had progressed in terms of deliverables 9 month's on from the reset.

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

TB 17/18 119 Chief Executive's Report

Dr Swart presented the Chief Executive's Report.

Dr Swart discussed the recent death in A&E. She noted that this could be quite demotivating for the staff and it further highlighted the raised risk to patient safety.

Dr Swart stated that the Winter Heroes feature continued with nominations still being received.

Dr Swart advised that the Care Quality Commission – System Review had been paused. Dr Swart thanked Ms Thorne for her hard work on this. The review is too look at the interaction between social care, general primary care, acute health services and community health services dealing with people who are more than 65 years old.

Dr Swart informed the Board that NHSE had made contact with the MP's due to the recent death in A&E.

Dr Swart reported that the number of volunteers at NGH continued to grow.

Dr Swart shared with the Board that the Trust attended the Northamptonshire Partners' Apprenticeship Awards on 8 March 2018. A member of NGH staff who worked in the volunteers' office had won Apprentice of the year 2018.

Mr Archard-Jones noted the reference to patients staying longer within the Chief Executive's Report and asked for further clarity on this. Dr Swart stated that stranded, super stranded and delayed transfer of care patients overlap. It was noted that some of these patients are waiting for complex packages of care.

Dr Swart advised that 70% of delays are related to social care. Mrs Needham is facilitating a piece of analysis on this. It was reported that in January 2017 the Trust had 18 social workers on site and in January 2018 the trust had 4 social workers on site. It is taking patients over 4 weeks at times to be assigned a social worker.

Dr Swart commented that there is increased scrutiny on the CCG to commission pathways out of the hospital. If social care needs are discussed at the front door then

the wait at the end of treatment would not be as long.

Dr Swart stated that social care and domiciliary care provision needed to be looked at to establish whether there is enough finance for it or whether it had been mismanaged.

Ms Gill noted that from a staff point of view, the death in A&E must have been upsetting and she asked what had been done to support the staff. Dr Swart confirmed that they had been given a debrief.

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

TB 17/18 120 Medical Director's Report

Mr Metcalfe presented the Medical Director's Report.

Mr Metcalfe noted that fatigue and strain from front line staff. In relation to the recent death in A&E he had a difficult conversation with his clinical counterpart at the CCG. Due to significant delays and the effect on patient outcomes he had asked for a surge response.

Mr Metcalfe stated that he was advised that there was a process to follow. Mr Metcalfe then attended a Strategic Quality meeting with NHSE, providers and the CCG regarding the lack of a surge response.

Ms Fox advised that she attended the Clinical STP meetings. On the next agenda system wide response to GOLD was to be discussed. Dr Swart commented that there is a new Chair of this group and the recent incident in A&E has upped the need for a better plan for the year. It was noted that it was important that the Clinical Group kept attention on this.

Mr Zeidler asked for the consequences of the Nye Bevan building on both Angela Grace and Avery beds. He asked would these beds be commissioned by other providers. Mrs Needham stated that she, the CCG and Mr Pallot were meeting to discuss this.

Mr Metcalfe discussed the assessment areas within the Fixing the Flow programme with the Trust Board. He acknowledged the hard work that the Deputy Medical Director Dr G Raghuraman had done with HR to substantially close the gaps in Junior Medical Staff.

Mrs Brennan updated the Trust Board on the potential for the Trust to recruit to CESR posts. These posts were for oversea qualified doctors who are unable to get onto the UK register. The conversion rates for these doctors are traditionally low due to the experience needed and the lengthy process.

A proposal to develop a regionwide CESR programme is to be submitted to HEE for funding.

Mr Metcalfe commended Dr G Raghuraman on his hard work and enthusiasm to help the medical workforce try deal with the emergency pressures.

Mr Metcalfe stated that there had been discussions on how to manage emergency patient flow and shorten length of stay. A bottom up approach was taken on how to deliver the care required. A number of proposed models were shared with the Medicine division and a vote had been taken.

Mrs Needham reported that moving into the Nye Bevan building was estimated for late summer however different ways of working would commence now. There will be

new paperwork and different pathways. The handover is on the 28 June 2018 and it was agreed that there would be a workshop at future Board to be clear on the new ways of working within the Nye Bevan unit. This will include understanding of all the benefits, risks and new opportunities.

Ms Gill drew the Board to page 24 of the report pack CRR ID 1611. She asked if there were plans in place to address this. Mr Pallot informed the Board that he would gather information on this and report back.

Action: Mr C Pallot

Mr Noble queried the two Serious Incidents (SI) for Information Governance (IG) breaches and asked where these would be monitored. Ms Thorne stated that it is a new requirement to put IG breaches onto STEIS as it would then be reported to the Information Commissioner and a SIRO report would also go to the Quality Governance Committee (QGC). The breaches were also reported in the Information Governance report to QGC in March 18.

Mr Noble noted the Wrong lens insertion SI and believed that there had been one similar to this in the past. Mr Metcalfe confirmed that this was correct and despite the changes put in place this had still happened. The safety checks were in place and had been followed. Mr Metcalfe had conducted a Theatre safety walkabout in eyes and believed that the safety culture there to be good.

Mr Zeidler queried whether the reporting of IG breaches onto STEIS changed anything else. Ms Thorne clarified that it would not.

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

TB 17/18 121 Director of Nursing and Midwifery Care Report

Ms Fox presented the Director of Nursing and Midwifery Care Report.

Ms Fox stated that Infection Prevention and Control performance was good.

Ms Fox reported that Pressure Ulcers reported during Quarter 3 2017/2018 continued a downward trend in Pressure Ulcer harms year on year. There was a 46% reduction on the number of Grade 3 harms and 17% reduction in Grade 2 when compared with the cumulative total for the same period in 2016/2017.

Ms Fox advised that the safety thermometer showed overall harm free care at 93.51% in February 2018.

Ms Fox had raised previous concerns on falls. These continued to be monitored.

Ms Fox commented that Friends and Family Test (FFT) had declined to 92.2%. There had been a reduction in ED responses which had impacted the Trust wide results. Ms Fox is waiting to see if this is would be mirrored nationally.

Ms Fox reported that the Trust had currently achieved 93% compliance in Basic Prevent Awareness Training and 81% compliance (902 staff members out of 1112) in WRAP training.

Dr Swart stated that she had attended a Prevent event ''Move up to Critical'. She will meet with the Mrs Needham and the Emergency Pressures Team to share the information from this.

Mrs Needham noted that it was good to see that level 3 safeguarding training compliance had been maintained.

Ms Gill queried if the Trust had experienced a large number of influenza cases. Ms Fox commented that the Trust had managed the cases well. Public Health England now believed that that the double peak had been seen and cases would now tail of.

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

TB 17/18 122 Finance Report

Mr Bradley presented the Finance Report.

Mr Bradley advised that the Trust was adverse in month by £0.7m which was mainly due to lower than expected levels of non-elective income. With the addition of the lost STF of £1m the in-month net position was £1.7m away from plan.

Mr Bradley clarified that this meant that the Trust's pre-STF financial position year to date was an overspend of £25.7m which was £5.7m away from target. It was noted that year to date £6.6m of STF income had now been missed putting the Trust at £12.3m away from the agreed control total plan.

Mr Bradley discussed cash flow with the Board. The delayed payments at the end of February 2018 totalled £2.9m and these had been paid on 01 March 2018. There had been discussions with NHSI in regards to accessing cash. The Trust received additional cash in February and March which will cover the Trust's most likely outturn position.

Mr Bradley stated that in March the CCG had paid the 0.5% CQUIN. The Trust had not been informed this payment would be made and therefore had borrowed the £1m in cash to cover this however this will affect interest charges.

Mr Bradley advised that the formal Business Plan and Budgets would be presented to the April Board.

Mr Bradley discussed the 2018/19 Control Total. It was noted that with a 5% real savings target applied the Trust would still be £13.4m away from the control total. It was noted that to achieve the control total set within the two year plan the Trust would need to achieve a +10% savings target. The Trust had asked Mark Mansfield what flex is there for the Trust to alter their control total

Mr Bradley stated that there had been weekly meetings with the Divisions to discuss next year's savings.

Mr Bradley reported that a desktop revaluation on the site had been completed and showed £24m less than the current indices. Mr Bradley will go through this with the external auditors as it would bring the depreciation down by £300k.

Mrs Needham commented that the weekly changing care group meetings were making a difference. The Divisions are showing engagement and it felt different to previously.

Mr Archard-Jones remarked on the budget setting. The pressure would not reduce and will likely continue to increase. Mr Archard-Jones queried what could be done to ensure a safe service is run within budget.

Mr Bradley clarified that the outturn plus real savings target of 5% is the minimum the Trust can commit to. The budget will be set so it is possible to achieve. There will be requests to change the contract on how urgent care and winter is funded.

The Board **NOTED** the Finance Report.

TB 17/18 123 Workforce Performance Report

Mrs Brennan presented the Workforce Performance Report.

Mrs Brennan advised that in regards to KPI's it had been a positive month. Mrs Brennan stated that Substantive Workforce Capacity increased and turnover decreased. It was noted that the report included a pie chart which showed the breakdown of staff groups.

Mrs Brennan reported that sickness absence for February 2018 decreased from 4.90% to 4.65% however this was still high. She drew the Committee to page 62 of the report pack which listed the top 5 reasons for staff sickness with Anxiety/stress/depression/other psychiatric illnesses being the highest reason. This is largely indicative of the pressures staff were feeling.

Mrs Brennan commented that Appraisals, Mandatory Training and Role Specific Essential Training compliance had all increased.

Mrs Brennan discussed the staff survey with the Board. It was noted that nationally of the 33 key indicators there were 22 that showed deterioration. At NGH staff engagement and motivation had increased, with only 5 of the 33 indicators showing deterioration. She confirmed she would bring an update to the **April Workforce Committee** which would include a detailed analysis**.**

Mrs Brennan informed the Board of the changes to the agenda for change pay system. There would be a change in the pay structure for bands 1 to 9. There would no longer be a band 1 and there would only be 2/3 pay points per band. The outcome will be known in June with potential implementation in July.

Mrs Brennan noted that the Trust would need to track the full cost including pension cost increases.

Mrs Brennan commented that the new CEA awards scheme had been agreed. The multiplier would change from 0.2 to 0.3 and awards would only be available for up to 3 years.

The Board had a discussion on the number of females compared with males who received CEA awards. The Board noted the need to encourage more females to apply for CEA awards and Mr Metcalfe believed that this was a legitimate area to address.

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

TB 17/18 124 Integrated Performance Report

Mrs Needham presented the Integrated Performance Report.

Mrs Needham informed the Board that the performance report had been discussed in detail at the relevant sub-committees.

Mrs Needham advised that A&E performance decreased in February to 80.8%. The main reasons for this were increased lengths of stay and increased numbers of patients waiting for care in the community.

In March performance had improved to 83.26% despite a very challenging first two weeks of the month and performance had improved over the last two weeks. Mrs Needham stated that acuity had decreased as had the number of patients admitted over the age of 75. The number of patients with flu had also decreased.

Although DTOC remained high, today the Trust was at 83.7% and had been at OPEL

1 for the majority of the week.

Mrs Needham reported that due to poor A&E performance in February NHSE had requested another meeting with the CEO and Nene. This occurred on the 9 March 2018 however due to the death in A&E the meeting had been overshadowed by this incident.

Dr Swart remarked that the recent MADE event had uncovered internal issues within the Trust which are being addressed.

Mrs Needham discussed Northamptonshire Social Care with the Board. There are in excess of 25 patients waiting or in the process of waiting to be assessed by Northamptonshire Social Care. Over the last month the Trust had not seen a decrease in numbers despite asking for additional support. Ms Fox highlighted that 25 patients was equivalent to 1 ward worth of patients.

Mrs Needham commented that everyone is aware of the issues at Northamptonshire County Council. It appeared that decisions are being delayed and this is impacting on the Trust's patients.

Ms Fox reported on Safer in 100 days and the discharge element of this. There are 5 wards which are involved. The ward doctor, ward sister and AHP's are invited to attend discussions on this programme. The number of patients discharged by midday had increased.

Ms Fox expressed her concern at the harm caused to patients who stay in the organisation longer than required or are not in the correct place. She shared with the Board that Nottingham Hospital had added a section to their Datix's which captured the deconditioning of patients.

Mrs Needham delivered a Cancer update to the Board.

Mrs Needham stated that despite a good month for Cancer in December 17 the Trust had deteriorated into January 18. The Trust met the 62 day target in January however did not meet this in February at 77.3%. It was noted that March is expected to meet the target and is currently at 88.4%.

Mrs Needham reported that the main challenge at present is capacity within outpatients especially in the pathways which are generally challenged which are Urology, Head & Neck, Lung, Upper GI, Lower GI and Dermatology.

Mrs Needham informed the Board that additional capacity is being put into place and patients are being managed on a day to day basis. Lung and lower GI pathways are being reviewed with changes to be completed by the end of April.

Mrs Needham highlighted to the Trust Board that Mixed Sex Accommodation performance had deteriorated in February with 235 breaches recorded. This is due to criteria for assessment units being relaxed to release pressure.

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

TB 17/18 125 Highlight Report from Finance Investment and Performance Committee

Mr Zeidler presented the Highlight Report from Finance Investment and Performance Committee (FIPC).

The Board were provided a verbal update on what had been discussed at the Finance Investment and Performance Committee meeting held on the 21 March 2018. The report covered any issues of significance, interest and associated actions

that were required and had been agreed to be taken forward by the Committee.

Mr Zeidler advised of the key points –

- Changing Care Programme – It was encouraging to hear the proposed changes to the Changing Care Programme going forward.
- Control Total Letter had been discussed.
- Contract negotiations had been discussed.
- Business Case on staff accommodation had been discussed and FIPC recommended approval to the Board.

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

TB 17/18 131 Highlight Report from Quality Governance Committee

Mr Archard-Jones presented the Highlight Report from Quality Governance Committee.

The Board were provided a verbal update on what had been discussed at the Quality Governance Committee meeting held on the 23 March 2018. The report covered any issues of significance, interest and associated actions that were required and had been agreed to be taken forward by the Committee.

Mr Archard-Jones advised of the key points –

- IG training compliance target had been met.
- Positive maternity patient survey results.
- VTE deterioration which Mr Metcalfe is monitoring.

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

TB 17/18 132 Highlight Report from Workforce Committee

Ms Gill presented the Highlight Report from Workforce Committee.

The Board were provided a verbal update on what had been discussed at the Workforce Committee meeting held on the 21 March 2018. The report covered any issues of significance, interest and associated actions that were required and had been agreed to be taken forward by the Committee.

Ms Gill advised of the key points –

- Midwifery staffing was reported at 1:29 which was achieved by short term mitigation actions.
- Awaiting feedback from Birth Rate Plus.
- HealthRoster “SafeCare” Implementation Plan discussed.
- Nurse Trainees - the Student Nurse Cohort for March 2018 had seen 8 fewer nurses than normal.
- The University had been unsuccessful in their accreditation application for trainee Nurse Associates.

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

TB 17/18 133 Highlight Report from Audit Committee

Mr Noble presented the Highlight Report from Audit Committee.

The Board were provided a verbal update on what had been discussed at the Audit Committee meeting held on the 26 March 2018. The report covered any issues of significance, interest and associated actions that were required and had been agreed to be taken forward by the Committee.

Mr Noble advised of the key points –

- Board Assurance Framework and Corporate Risk Register – It was encouraging to see a lot of evidence and risk management with risks raised appropriately.
- Annual Report and Accounts – Good progress had been made.
- Going Concern letter.
- There were 4 limited assurance audits – Estate procurement, Clinical Audit, Health & Safety checklists and authorisation of medical staffing timesheets. Mr Finn is to deliver an update at the May Audit Committee on Estates procurement.
- The management of business case approvals following discussion on the additional costs incurred by PAS.

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

TB 17/18 134 Highlight Report from Hospital Management Team

Dr Swart presented the Highlight Report from Hospital Management Team.

Dr Swart stated that HMT followed a workshop format and had also included a back to basics Finance update.

Mr Finn had presented the Riverside Accommodation business case in which the HMT had recommended approval to the Finance, Investment & Performance Committee.

The Board **NOTED** the Highlight Report from Hospital Management Team.

TB 17/18 135 Any Other Business

Best Possible Care Status – Abington Ward

Ms Fox commented the third Best Possible Care status panel had met due to Abington Ward achieving 3 greens.

It was noted that Abington Ward were to take on piece of work on VTE which would include streamlining the process and this would be shared widely.

Ms Gill endorsed the recommendation for Best Possible Care Status for Abington Ward following her inclusion in the panel.

Mr Noble queried the red safeguarding rating for the ward and asked whether a ward would be able to achieve Best Possible Care status due to this. Ms Fox reminded Mr Noble that the Board had previously agreed that a ward could have a maximum of 2 reds and still achieve Best Possible Care Status.

The Board **AGREED** to award **Abington Ward** Best Possible Care status.

Date of next Public Board meeting: Thursday 31 May 2018 at 09:30 in the Board Room at Northampton General Hospital.

Mr P Zeidler called the meeting to a close at 11:35.

Public Trust Board Action Log						Last update	16/04/2018
Ref	**Date of meeting**	**Minute Number**	**Paper**	**Action Required**	**Responsible**	**Due date**	**Status**	**Updates**
Actions - Slippage								
NONE								
Actions - Current meeting								
85	Mar-18	TB 17/18 120	Medical Director's Report	Ms Gill drew the Board to page 24 of the report pack CRR ID 1611. She asked if there were plans in place to address this. Mr Pallot informed the Board that he would gather information on this and report back.	Mr Pallot	May-18	On agenda	**update in Matters Arising**
Actions - Future meetings								
NONE								

Report To	**Public Trust Board**
Date of Meeting	**31 May 2018**

Title of the Report	**Chief Executive's Report**
Agenda item	***7***
Presenter of the Report	Dr Sonia Swart, Chief Executive
Author(s) of Report	Dr Sonia Swart, Chief Executive and Sally-Anne Watts, Head of Communications
Purpose	For information and assurance
Executive summary The report highlights key business and service issues for Northampton General Hospital NHS Trust in recent weeks.	
Related strategic aim and corporate objective	N/A
Risk and assurance	N/A
Related Board Assurance Framework entries	N/A
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	None
Actions required by the Trust Board The Trust Board is asked to note the contents of the report	

Northampton General Hospital NHS Trust

Public Trust Board
31 May 2018

Chief Executive's Report

1. NHS70

It would be hard to escape the fact that the NHS celebrates a milestone birthday this year and, at the same time, we celebrate 225 years of providing healthcare from this site.

There are number of national NHS 70th anniversary events which include services at Westminster Abbey and York Minster on 5 July, along with a number of NHS70-themed television programmes, documentaries and newspaper features, and national awards. The events and activities have three key objectives:

- To thank NHS staff for their hard work and commitment, profiling their skills, experience and successes and celebrating their diversity, whilst recognising the challenges they face
- To look back over the last 70 years of the NHS, celebrating key technological, scientific, medical and workforce developments and breakthroughs
- To look forward and build confidence among staff and the public about the long-term future of the NHS, recognising that the way care is delivered will continue evolve, with a particular focus on innovation and technology

Here at NGH we are now holding our AGM on the afternoon Friday 6 July – a change from the planned date of 5 July to avoid a clash with national events. The AGM provides us with an opportunity to look back as well as, importantly, to look forward. Our archive volunteers are putting together a display and we will host a tea party/barbecue for those attending the AGM. All staff members will receive a voucher for a free cake and hot drink to celebrate the NHS's birthday. We are also marking a 70-day countdown to the anniversary by celebrating 70 different jobs at NGH with individual profiles, a feature in Insight and adding to our history boards located on North Street to bring them up to date as they were developed to celebrate 60 years of the NHS and NGH.

2. Our staff

Nominations for this year's Best Possible Care Awards are now open. The awards ceremony will take place at The Park Inn, Northampton on the evening of Friday 28 September 2018, hosted by Willy Gilder from BBC Radio Northampton.

I hope that as many board members as possible will be able to attend this event, which is highly regarded and much appreciated by our staff. The Best Possible Care Awards offer us an opportunity to recognise and celebrate the members of TeamNGH, and our volunteers, who go above and beyond what is expected of them in their day-to-day roles.

Events like this would not be possible without the commitment of the Northamptonshire Healthcare Charitable Fund, which enables us to provide additional support that makes a real difference for our staff, our patients and their families.

It is important that we don't rely on one event a year to recognise and reward members of TeamNGH who go above and beyond in their efforts to provide the best possible care and also demonstrate a real commitment to our values. Board members will be aware of the DAISY Awards for nurses and midwives that were introduced last year. We are now developing a corresponding set of Awards for both clinical and non-clinical staff (not nurses or midwives) which will be launched in the coming months.

Effective staff engagement continues to be a high priority and it is therefore important to note the continuing improvement year on year on staff engagement scores for the last four years. There is always more to do however and our ambitions to improve the support of our core values and the health and wellbeing of staff will remain high on the agenda in the development of further plans.

3. Our stakeholders

I met with Andrew Lewer, MP for Northampton South, on 6 April. This was our first meeting since he was elected last year. I was pleased to be able to update him on recent developments such as our new MRI suite and progress on our new 60 bed assessment unit. Mr Lewer was keen to understand the effectiveness of our partnership working and he suggested that it may be helpful for him to host a meeting of leaders of health and social care providers to enable an understanding of perspectives.

Chris Heaton-Harris, MP, had requested a visit to our haematology department as he had received a letter from a constituent highly praising the care he had received. I, and several members of the team from the department, were delighted to show Mr Heaton-Harris around the facility on 6 April when he had the opportunity to speak with both staff and patients.

4. Care Quality Commission – System Review

The Care Quality Commission (CQC) have confirmed that the system-wide review of the Northamptonshire health and social care system will take place towards the end of May. The review sets how to determine how well we all work together to meet the needs of older people and will help us to develop a plan to improve the care that we give and the way that we give it.

The review team will be talking patient pathways and undertaking focus groups from 21 to 25 May and will be on site from 21-24 May. I am confident that members of TeamNGH will do all they can to enable the review team to understand systems and processes. We will be encouraging our staff at all levels to to provide feedback of their experiences of working with our partners in health and social care by providing anonymised online feedback via the CQC's relational audit.

5. The Northamptonshire Health and Social Care Partnership

We continue to support the various work programmes in this partnership as the programme of work is reset. The biggest challenge in terms of work programmes remains the transformation of urgent and emergency care where we have struggled to consistently meet demand and patients expectation. The system has now agreed to support a full system demand and capacity plan which will assist us in this regard and help to inform longer term commissioning decisions.

With recent changes in the leadership at KGH we are also in the process of resetting the work programme that has variably been called 'clinical collaboration' or the 'acute unified model', which generally refers to the collaborative working between KGH and NGH. Our clinical teams have done a significant amount of groundwork supported by managerial teams from both hospitals and we now feel ready to take this work to a different level that firmly embraces the need for acute providers to work together in order to ensure services are sustainable for the future.

6. National announcement

In March 2018 the Prime Minister made a commitment to coming forward with a long term plan for the NHS. This is an important announcement and it is likely that it will include a funding commitment for the next decade as well as proposals for how this funding might be used.

A series of consultation events is currently underway and the hope is that there will be a realistic funding commitment and a realistic ask in terms of what is achievable over an agreed period of time. All CEOs have been invited to a series of roundtable events on this topic.

7. **CQC good practice case study**
On 30 April I and other members of TeamNGH were interviewed by the CQC who are preparing a good practice case study describing our journey from 'requires improvement' to 'good'. The case study is due to be published towards the end of June. The team were particularly interested in our approach to quality improvement and the culture changes that underpin this.

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Dr Sonia Swart
Chief Executive

Northampton General Hospital NHS
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**31 May 2018**

Title of the Report	**Medical Director's Report**
Agenda item	**8**
Presenter of Report	Matthew Metcalfe – Medical Director
Author(s) of Report	Matthew Metcalfe – Medical Director
Purpose	For assurance

Executive summary

This report presents an update to the Board on matters relating to harm, mortality and quality of care. The quality improvement foci for this report are VTE/HAT and medical workforce.

Related strategic aim and corporate objective	Corporate Objective 1: Focus on Quality and Safety – We will avoid harm, reduce mortality, and improve patient outcomes through a focus on quality outcomes, effectiveness and safety
Risk and assurance	For Assurance
Related Board Assurance Framework entries	BAF 14

Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
Legal implications / regulatory requirements	CQC Fundamental Standards – Safe External Review/Accreditation body : Nene and Corby Clinical Commissioning Group (CCG). Duty of Candour Requirements

Actions required by the Board

The Board is asked to note the contents of this report

Medical Director's Report

31st May 2018

1. Introduction

The purpose of this report is to reflect faithfully upon the quality and safety of the clinical services afforded to pour patients against our vision of delivering best possible care for all our patients. For ease of access the report is structured;

i. in relation to the principle risks to delivery where these are rated "extreme" (>14)
ii. review of harm, incidents and thematic
iii. mortality and the management of outlier alerts
iv. related topics from the medical director's portfolio on a rotational basis, this month;
a. VTE/HAT compliance
b. Medical workforce

2. Risk

The principle risks to delivering high quality and timely patient care rated 15 and over are grouped below as follows.

2.1 Urgent Care

At the time of writing the urgent care pressures in the organisation have abated significantly since the last medical director's report to board. This is reflected in the reduced risk ratings in the table below around elective surgical cancellations in orthopaedics and threats to patient safety due to excessive emergency demand with hospital "outflow block". In relation to planning for next winter, the actions required of other partners are coordinated through the urgent care delivery board. In addition the May meeting of the Clinical Strategy Group to the HCP has undertaken to set out requirements for an enhanced emergency response when overcrowded hospitals represent a direct increased risk to patient safety and submit these to the urgent and emergency care board. They will then "stress test" the response against likely winter scenarios.

The challenge to continuing to reduce these risks lies principally in delivering a more efficient medical model for urgent care before next winter whilst doing everything possible to engage our consultants in this priority.

The increase in risk around nursing establishment reflects the need to recruit to an increased overall urgent care nursing establishment to deliver safe and efficient patient flows in the Nye Bevan building.

Without the medical model changes and nursing establishment uplift the is a risk that the Nye Bevan will not deliver its full potential but rather end up in effect as additional ward capacity.

CRR ID	Description	Rating (Initial)	Rating (Current)	Corporate Committee
1280	Safe nursing establishment in Urgent Care	9	16	Quality Governance & Workforce
1286	Frequent and prolonged loss of elective orthopaedic ward for escalation	20	16	Finance & Performance
368	Risk of reduced patient safety when demand exceeds capacity	20	16	Quality Governance

2.2 Clinical Staffing

Medical workforce gaps require re-distribution of relative clinical risk and absolute financial risk when responding to emergency pressures as a result of having to take down elective and outpatient activity to support safe emergency care. There is an associated risk to workforce morale.

The deputy medical director for workforce and urgent care continues to lead an enhanced medical recruitment campaign to mitigate the key risks. The scope of this work has been broadened to incorporate high risk clinical areas outside medicine, for example oncology. The metrics for this will be agreed through medical staffing recruitment and retention board and presented to workforce committee in July.

CRR ID	Description	Rating (Initial)	Rating (Current)	Corporate Committee
1348	High number of vacancies in Oncology/Haematology contributing to in-patient and out-patient delays	9	20	Quality Governance
551	Patients may receive suboptimal care at weekends due to reduced numbers of staff being available to provide full 7 day working.	16	16	Quality Governance
979	Difficulty in recruiting to the establishment due to local and	16	16	Quality Governance

	national shortages of nurses and difficulties associated with overseas recruitment.			
1188	Turnover within nursing from core and specialist areas is high. The net result of this is that despite the recruitment strategy there is little gain in nursing capacity in core and specialist areas. Poor retention in core and specialist areas leads to low staff morale and therefore this poses an even greater risk to staffing levels. Should the risk arise in that if recruitment comes more problematic our Trust turnover levels within core and specialist areas would result in a reduction in nursing capacity. This would come at a time when there is a requirement to increase capacity due to the 60 bedded unit.	16	16	Workforce
1280	Inability to maintain effective service levels due to reduced numbers of nursing workforce for the existing bed base within the Directorate which could result in a reduced standard of care and patient safety. This is consistent across the Medicine and Urgent Care division.	9	16	Quality Governance and Workforce
1518	The Trust has difficulty in recruiting to the establishment due to local and national shortages of medical staff and difficulties associated with overseas recruitment	16	16	Workforce
659	Availability of recovery staff for spinal/ epidural LSCS, and staffing in Sturtridge theatres	15	15	Workforce
1199	30-70% of prescriptions on admission are unintentionally different from the medicines patients were taking before admission [NICE/NPSA/2007/PSG001]. • Inadequate capacity of pharmacy to review each admitted patient's prescriptions & correct anomalies. • Inadequate capacity of pharmacy in admission areas to review each patient within 24 hours.	15	15	Quality Governance

1155	Potentially unable to maintain appropriate staffing levels in theatre areas due to a large amount of staff vacancies	15	15	Quality Governance
1441	Reduction of training posts in Cardiology	10	15	Workforce
1455	Reduction in students/trainees coming into the profession and potentially not staying within the profession could reduce the number of registered nurses to work on the wards/departments.	20	15	Quality Governance

3. Harm

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

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

3.i Run rate of SI and Never Event investigations

	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19
Serious Incidents	27	55	78	115	93	11	13	18	1
Never Events	2	2	1	0	1	3	1	3	0

Of note the SI framework has been updated in January 2018 and this has changed the thresholds slightly. This is unlikely to result in the same step change in numbers of SI reported as when the 2015 framework was introduced.

3.ii New SI and moderate investigations

There were 3 serious incidents reported on STEIS during March and April. These are on track to report by their deadlines and consist of;

i. Delayed treatment in patient who died
ii. Management plan (inadequate)
iii. Failure to act on adverse images

There have been no further Never Events. Recognising the pattern of events to have occurred in relation to surgical cases, significant progress has been made in reviewing and improving surgical safety policies, and it is intended to relaunch these with associated programmes of communication and education from July.

During January and February three SI reports were submitted to the CCG for closure. The learning and actions arising have been shared through divisional governance meetings, CQEG and QGC.

16 moderate harm incidents were detected during March and April, and these are subject to concise RCA investigations. This is a significant reduction from January and February (29) and the number of investigations breaching the internal target of 60 days from declaration to completion is reducing accordingly.

3.iii Thematic issues

No new themes have been identified through RoHG since the last board report. The issues previously identified relating to inadequate recognition and response to the deteriorating patient have been triangulated with other sources including mortality outlier alerts and quality schedule compliance data. A summary of the approach to these is included under the mortality section.

4. Mortality

4.1 Mortality summary data

All trust level indices for mortality rates, SMR, HSMR (overall, weekday and weekend) and SHMI continue to run below average and in the expected ranges.

4.2 Mortality Alerts/Significant Variation under review

There are 4 continuing outlier alerts (acute kidney injury, respiratory failure, septicaemia, and secondary malignancies). There is one new outlier alert for enteritis and ulcerative colitis. Case series reviews have or are being completed for these in

the usual way and reported up through QGC. The new alert pertains to 4 cases and it is unlikely that themes will be identified from reviewing this number.

It is noted that all four of the continuing outlier alerts are consistent with opportunities to reduce clinical variation in early recognition and adequate response to the deterioration of a patient's condition. This triangulates with findings through review of harm incidents and end of life reviews. A Deteriorating Patient Board will be established to deliver a coordinated response to this common cause. This will report through CQEG to QGC.

5. Compliance with NICE guidance 89 – VTE/HAT

In light of updated NICE guidance (March 2018), a review of which patients require formal assessment has been undertaken. A significant proportion of the denominator has been removed. This is because it is explicit in the guidance that patients who are not admitted to a hospital bed are deemed low risk and are not included. Previously this cohort of patients has been included in the denominator as compliant with the quality standard due to their low clinical risk and therefore exemption from the requirement of formal assessment. Also in the new guidance, the assessments should happen assessment "as soon as possible after admission to hospital or by the time of the first consultant review". 7 day services standards state that the first consultant review must occur within 14 hours and therefore future data will be collected to reflect this, with graphs demonstrating first assessment within14 hours, greater than 14 hours and not assessed.

The impact of these changes will alter our reported compliance from circa 80% at present to circa 50% in future, subject to an improvement trajectory.

Consensus has been reached through the executive and divisional clinical leads at CQEG in May on the essential driver for substantial and sustained improvement in compliance with VTE assessment. Specifically this requires an IT solution whereby a "forcing function" is introduced to the electronic prescribing system (ePMA) precluding prescription of any medicines until the assessment has been completed for admitted patients. This approach is supported by the chief pharmacist. The Chief Information Officer has committed to take a paper with a work plan, a time line and associated costings for this to CQEG in June 2018. Other work streams to improve compliance will continue, and the primary responsibility for VTE assessment remains with the medical teams. However, without this degree of IT enablement it is considered unlikely that significant sustained improvements will be delivered.

6. Medical workforce

6.1 Consultant Job Planning

The total number of consultant job plans paying over the maximum permitted in the job planning policy has dropped from 54 to 48 through Q3 and Q4 2017/18, equating to an 11% reduction. The total number of programmed activities (PA – 4 hours during normal working week, 3 hours at anti-social times) has reduced from 52.5 to 47.25 (10% reduction). This reduction has largely been achieved through a review of the job plans of the senior medical leadership, and a strict policy of authorising no further job plans over 12 PA either for new appointees or on annual review of existing plans (the maximum permitted in the policy).

The pace of change will accelerate under the new approach to job planning policy whereby quarter by quarter, each division reviews its service plans and thereby is able to deliver coordinated and efficient plans focussed upon service and organisational priorities. This process for the medicine division is approximately a month behind schedule due to the need to maximise consultant engagement with the process.

It remains the intention that by close of 2018/19 there will be no consultant job plans over 12PA.

6.2 Appraisal and Revalidation

Compliance with the annual appraisal process for Q4 of 2017/18 for doctors connected to NGH as their “designated body” is at 96%. The remaining 5 doctors are subject to the usual escalation.

16 doctors were due for revalidation in the same quarter, and 11 have had a recommendation to revalidate, and 5 a recommendation to defer pending further information (a neutral act).

Internal audit of medical appraisal continues to drive improvements through feedback at appraiser forums.

6.3 Recruitment and Retention

A coordinated approach to medical recruitment lead jointly by the director of HR and the deputy MD has developed promotional material for the NGH brand tailored to medical staff. Priority is given to the recruitment of physicians who are able to support the acute medical emergency take. Oncology and radiology are the next priority areas identified due to the significant shortfall on establishment and the impact upon patient care.

Report To	**Public Trust Board**
Date of Meeting	**31 May 2018**

Title of the Report	**Director of Nursing, Midwifery & Patient Services Report**
Agenda item	**9**
Presenter of Report	Carolyn Fox, Director of Nursing, Midwifery & Patient Services
Author(s) of Report	Debbie Shanahan – Associate Director of Nursing
Purpose	Assurance & Information

Executive summary

A brief overview of the content of the paper

- **Safety Thermometer:** In April 2018 the Trust achieved 98.03% harm free care (new harm). Overall harm free care was 92.95%
- **Maternity Safety Thermometer:** The overall percentage of women and babies who received 'harm' free care in April 2018 was 60.5%, below the national aggregate for the first time in several months
- **Pressure Prevention:** 7 patients developed a total of 8 grade 2 pressure ulcers in April 2018. There were 2 Unclassified Grade 3 harms validated during the reporting period
- **Infection Prevention**: In April 2018 there were:
  0 trust attributable MRSA bacteraemia
  2 trust attributable MSSA bacteraemia
  1 patient was identified with Trust attributable *E coli* bacteraemia
  5 patients were identified with Trust attributable Clostridium difficile infection (CDI)
- **Falls:** In April 2018 there was 1 moderate harm patient which is being investigated
- There is an update on the Midwifery, Nursing and Midwifery Dashboards
- **Friends and Family Test (FFT):** In April 2018 92.3% of patients said they would recommend the Trust
- **Safeguarding**: The Trust has currently achieved 92% compliance in Basic **Prevent** Awareness Training and 93% compliance for **WRAP** training
- **Medicine Management**: In April 2018 there were 73 medication incidents and the Trust was below the national average for percentage harm from medication incidents
- **Safe Staffing**: Overall fill rate in April was 102%.
- **Avery and Dickens Therapy Unit:** Summary of the nursing metrics.
- Overview of projects led by the PNS team

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? Quality & Safety.

	We will avoid harm, reduce mortality, and improve patient outcomes through a focus on quality outcomes, effectiveness and safety
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks The report aims to provide assurance to the Trust regarding the quality of nursing and midwifery care being delivered
Related Board Assurance Framework entries	BAF – please enter BAF number(s) BAF 1.3 and 1.5
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper? No

The Trust Board is asked to:

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

- Support the on-going publication of the Open & Honest Care Report on to the Trust's website which will include safety, staffing and improvement data

Northampton General Hospital NHS Trust

Public Trust Board
31 May 2018

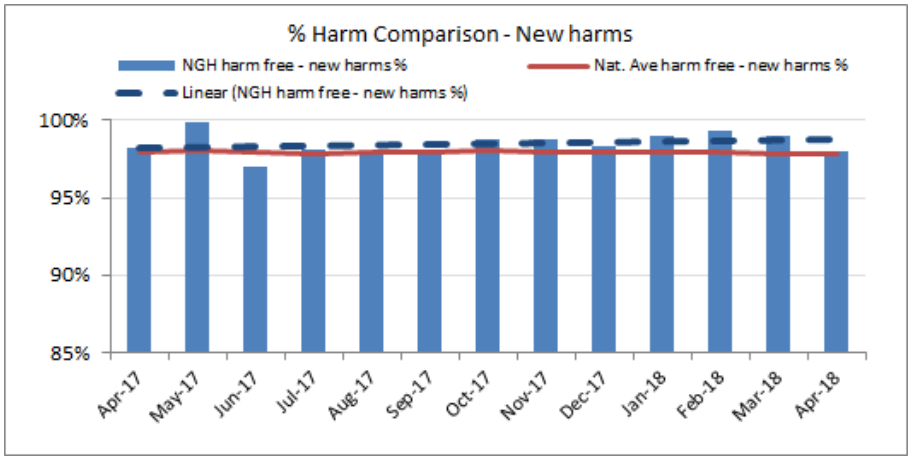
Director of Nursing, Midwifery & Patient Services Report

1. Introduction

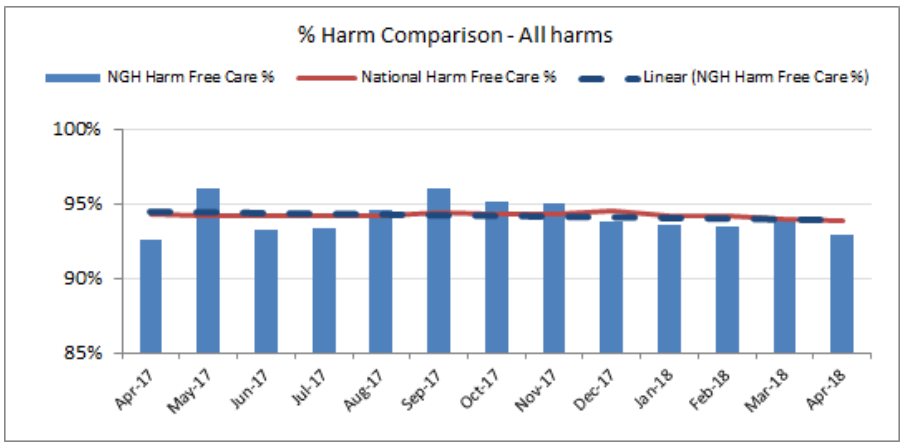
The Director of Nursing, Midwifery & Patient Services Report presents highlights from services, audits and projects during the month of April 2018. Key quality and safety standards will be summarised from this monthly report to share with the public on the NGH website as part of the 'Open & Honest' Care report. This monthly report supports the Trust to become more transparent and consistent in publishing safety, experience and improvement data, with the overall aim of improving care, practice and culture.

2. Safety Thermometer

The graph below shows the percentage of new harms attributed to an in-patient stay. In April 2018, the Trust achieved 98.03% harm free care (new harm); a decrease from March 2018.



The graph below illustrates overall harm free care was 92.95 % in April 2018, a decrease from March 2018 all harm figures of 94.07%. (Appendix 1 provides the National Safety Thermometer Definition)

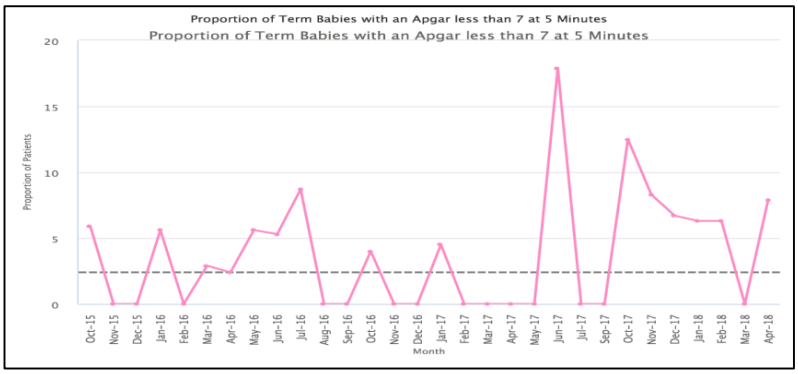


3. Maternity Safety Thermometer

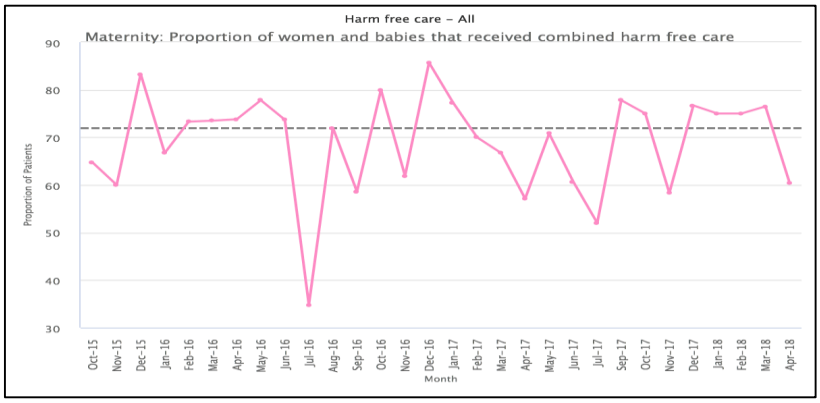
The Maternity Safety Thermometer enables the calculation of the proportion of women and babies who received harm free care. (Appendix 1 provides the Maternity Safety Thermometer Definition).

Post-Partum Haemorrhage (PPH) were above the national proportions for April 2018 as demonstrated in the graph below. There are no apparent themes or increases in Datix reporting. Incidents of harm are continuously monitored through the Directorate and through the Review of Harm Group. PPHs are part of an on-going quality improvement programme in the Directorate.

The 'Proportion of term admissions' to the Neonatal unit are examined and reported locally and regionally. Term babies with Apgar's of less than 7 at 5 minutes were above the national proportions for April 2018 as demonstrated in the graph below.



The proportion of women and babies that received combined; physical and psychological harm free care was 60.5%. Incidents of harm are continuously monitored and there are no clear themes or increases in Datix reporting.. To note and highlight that the Maternity Safety Thermometer uses a point prevalence method and monthly variance is expected and can be seen in the charts.

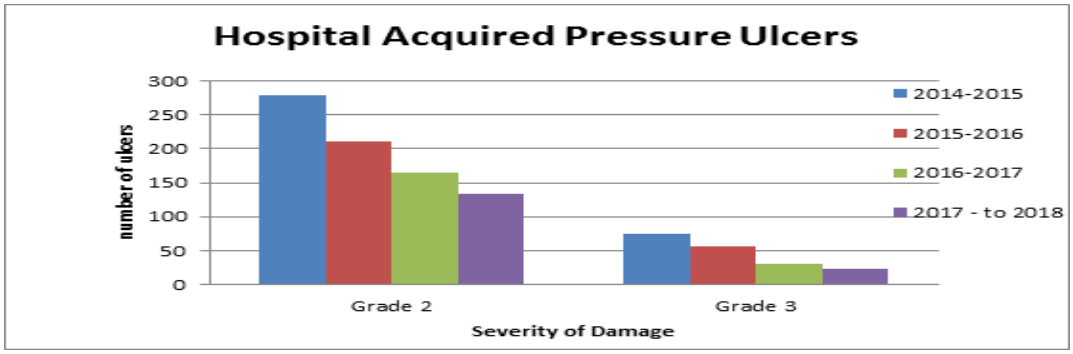


4. Pressure Ulcer Incidence

In April 2018, the Tissue Viability Team (TVT) received a total of 270 datix incident reports relating to pressure damage, which remains largely consistent from previous months. In April 2018 17 were duplicated reports, 31 patients were not seen as they were either not admitted, or they were discharged within 48 hours of reporting pressure ulcer (PU) harm, or reported as grade 1 or moisture lesion. Of the remaining incidents reported, 222 were validated by the TVT on the wards or from photographs.

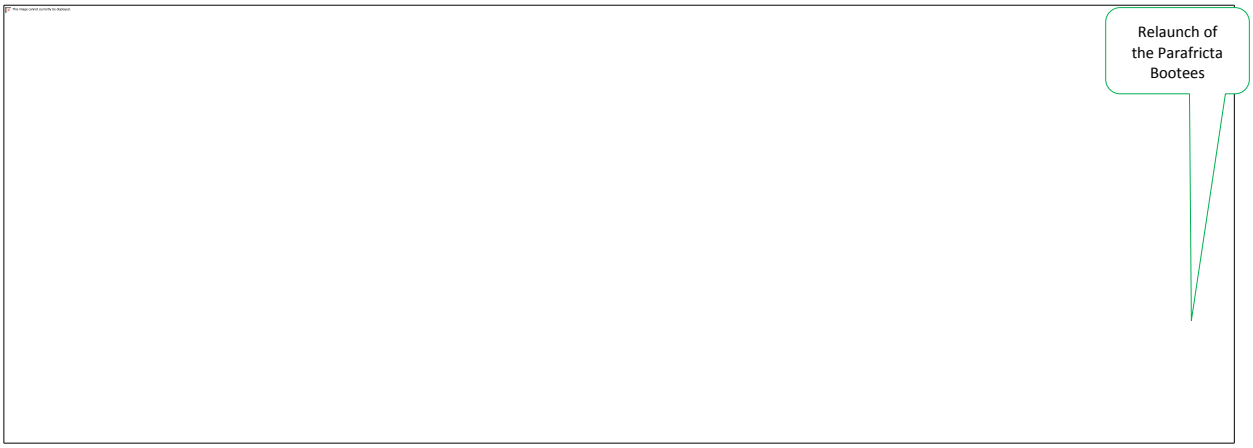
7 patients developed a total of 8 grade 2 pressure ulcers in April 2018. There were 2 Unclassified Grade 3 harms validated during the reporting period.

The following graph demonstrates the continued downward trend in all hospital acquired pressure ulcer harms year on year.



Number of Pressure Ulcers per 1000 bed days

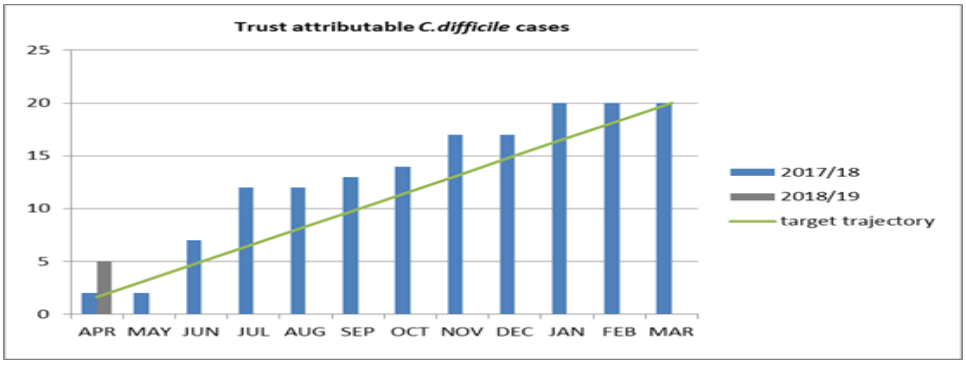
The chart below shows the number of pressure ulcers/1000 bed days in relation to hospital acquired pressure ulcers. This is reported utilising a run chart and demonstrates that changes being made are leading to statistically significant improvements.



5. Infection Prevention and Control

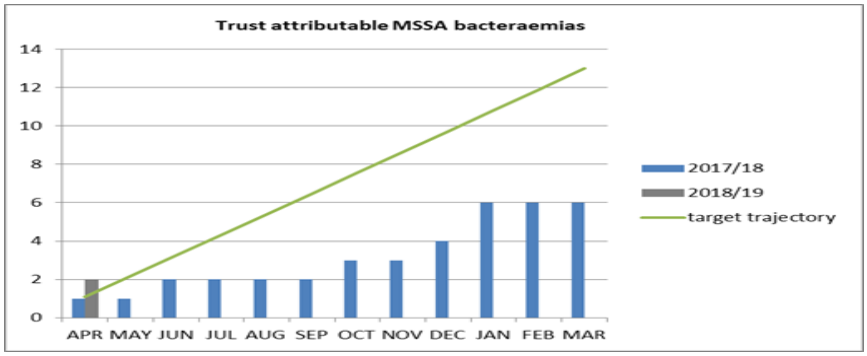
Clostridium Difficile Infection (CDI)

As demonstrated in the following graph 5 patients had Trust attributable CDI in April 2018. The trajectory for 2018/19 is 20. All patients have had a post infection review (PIRs) which are being reviewed by the Clinical Commissioning Group (CCG) and to date there have been no lapses in care.



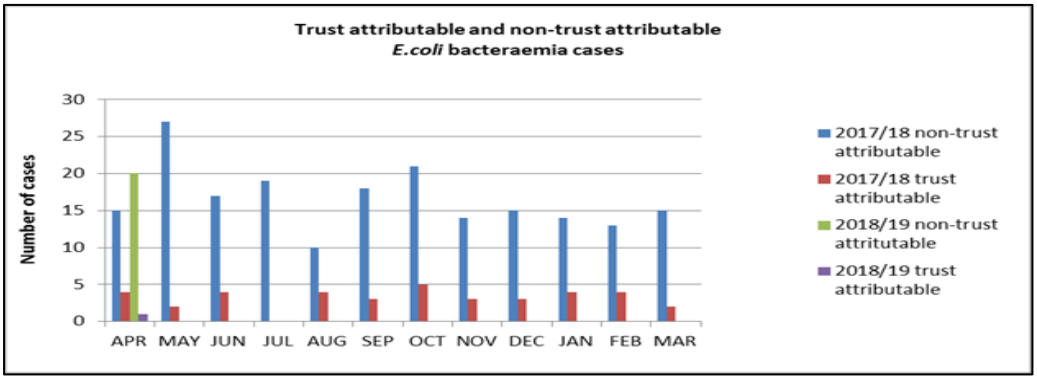
MRSA Bacteraemia and Colonisations
MRSA bacteraemia: 0 Trust attributable MRSA bacteraemias for April 2018.
MRSA colonisations: 1 Trust attributable MRSA colonisation for April 2018.

MSSA Bacteraemia
MSSA bacteraemia: 2 Trust attributable MSSA bacteraemias for April 2018. All MSSA bacteraemia are reviewed by the Infection Prevention Control Team (IPCT) to ensure no lapses in care or learning. The graph below shows a cumulative total of MSSA bacteraemia for 2018/19. The Trust has set an internal trajectory of 13 MSSA bacteraemias for 2018/19.



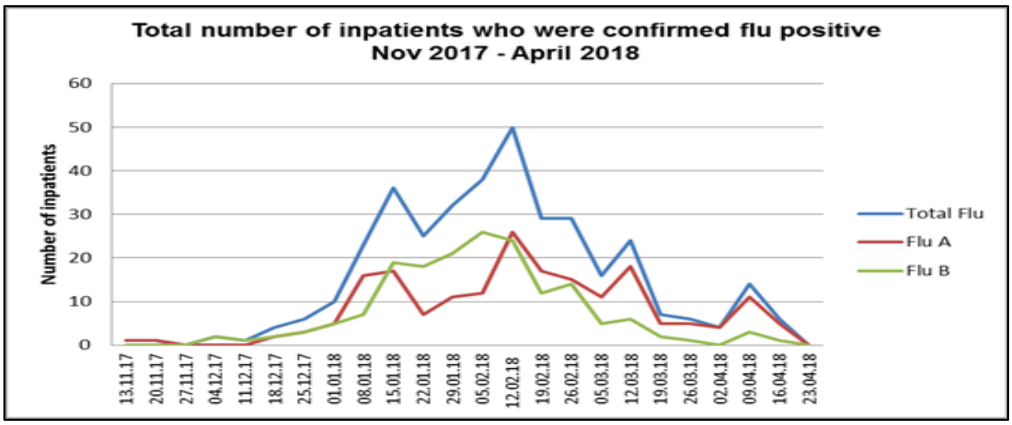
Escherichia coli (E.coli) Bacteraemia
The local CCG ambition for 2018/19 is currently being finalised. Collaborative working will continue between Northampton General Hospital IPC Team, Public Health England, Kettering General Hospital IPCT, the Community Lead IPC Nurse and the CCG to deliver the E.coli action plan that was commenced in 2017/18. This will continue to be reviewed at subsequent Whole Health Economy meetings that all of the above parties attend. Internally the 2018/19 Gram-negative forward plan was approved by Infection Prevention Strategic Group in March 2018 had work has commenced by the IPCT in April 2018.

In April 2018, there were 20 non-Trust attributable E.coli bacteraemia and 1 Trust attributable E.coli bacteraemia. This is shown in the graph below:



Influenza Update

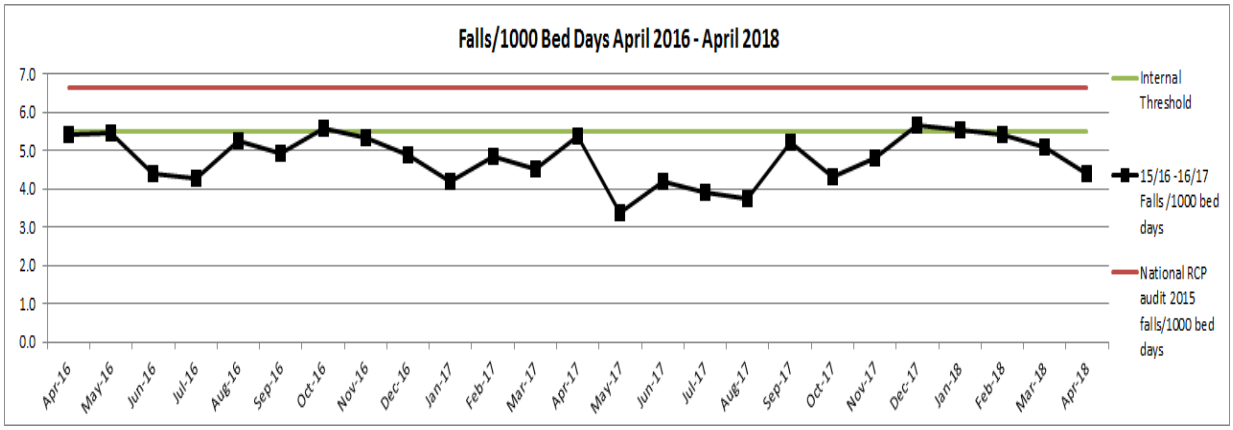
The IPCT are working closely with the microbiology laboratory, the admission wards and the Site Management Team to ensure patients with suspected flu are isolated on admission or as soon as possible if already admitted. On the 30th April 2018 there had been a total of 381 patients identified with either influenza A or B since November 2017. There remains one flu positive inpatient in the Trust as shown in the graph below; the flu season has now drawn to a close.



6. Falls

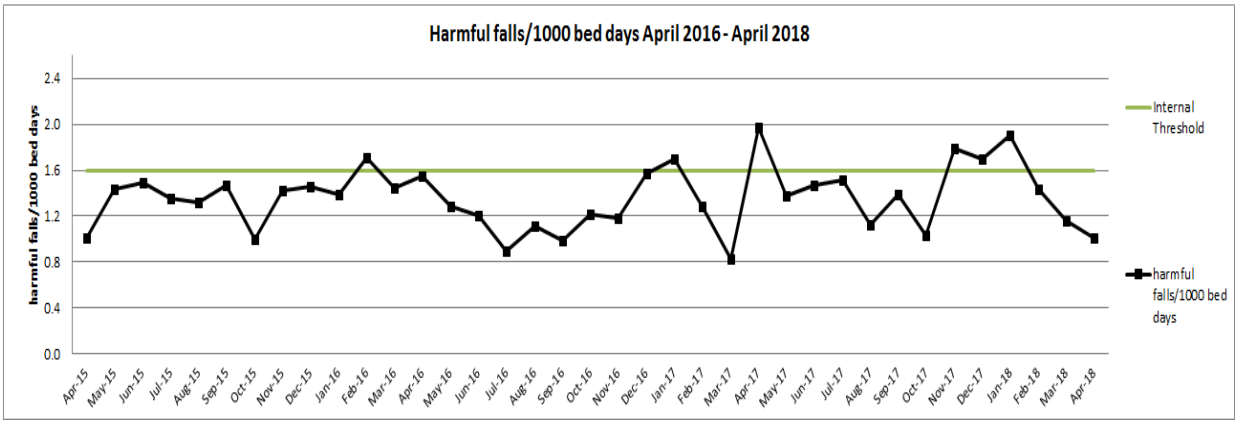
Falls/1000 bed days

The Trust's falls/1000 beds days are below the national average of 6.63/1000 bed days and below the Trust internally set trust target of 5.5/1000 bed days. There was reduction in the number of falls/1000 bed days for April 2018 of 0.7 compared to the previous month of March 2018.



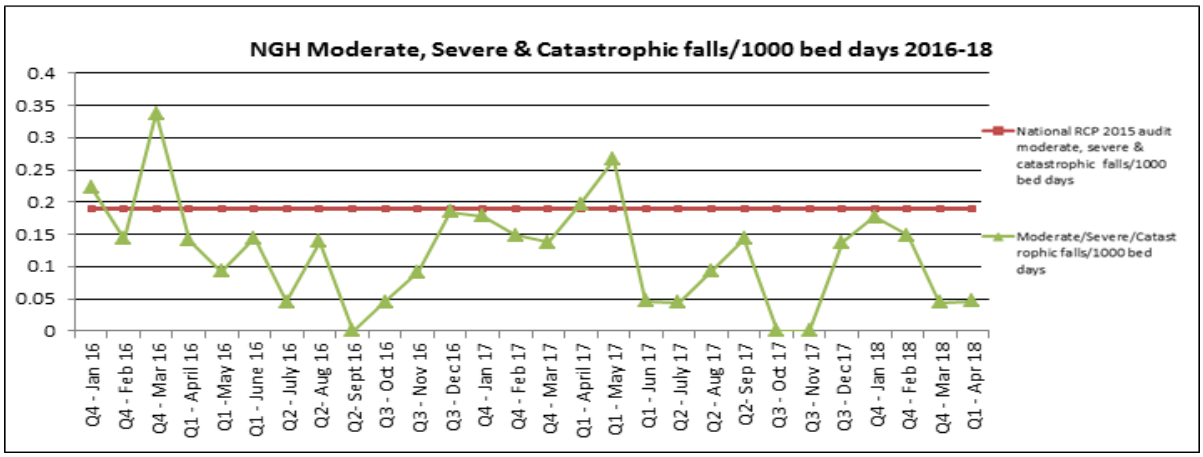
Harmful Falls/1000 bed days including Low, Moderate, Severe and Catastrophic

The recording of harmful falls in this data represents low, moderate, severe and catastrophic harm. Through April 2018 harmful falls/1000 bed days have decreased by 0.15. In total, the Trust recorded 1.01 harmful falls/1000 bed days. This is below the Trust's internally set target of 1.6.



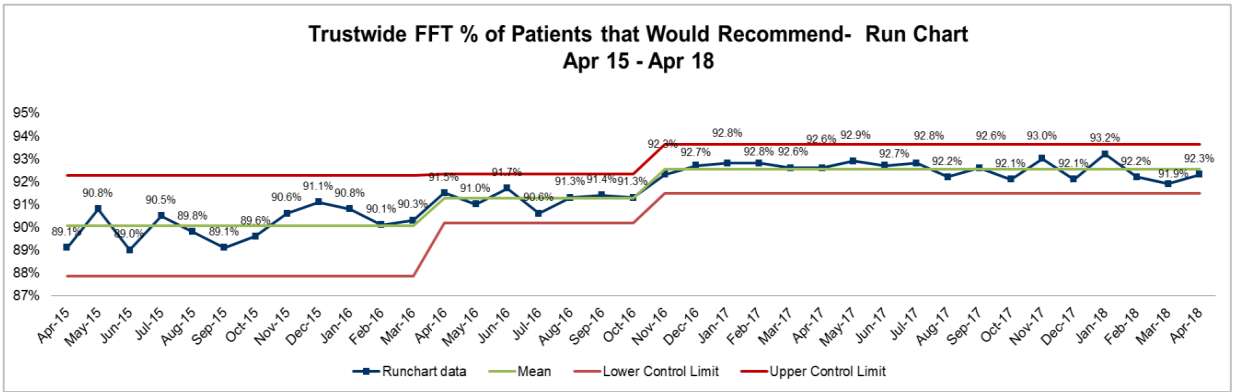
Falls resulting in Moderate, Severe or Catastrophic harm

The following graph represents moderate, severe and catastrophic falls/1000 bed days. There has been an increase of 0.01 during April 2018 compared to the previous month of March 2018. The Trust remains below the national threshold of 0.19. In total there was; 1 moderate harm patient fall.

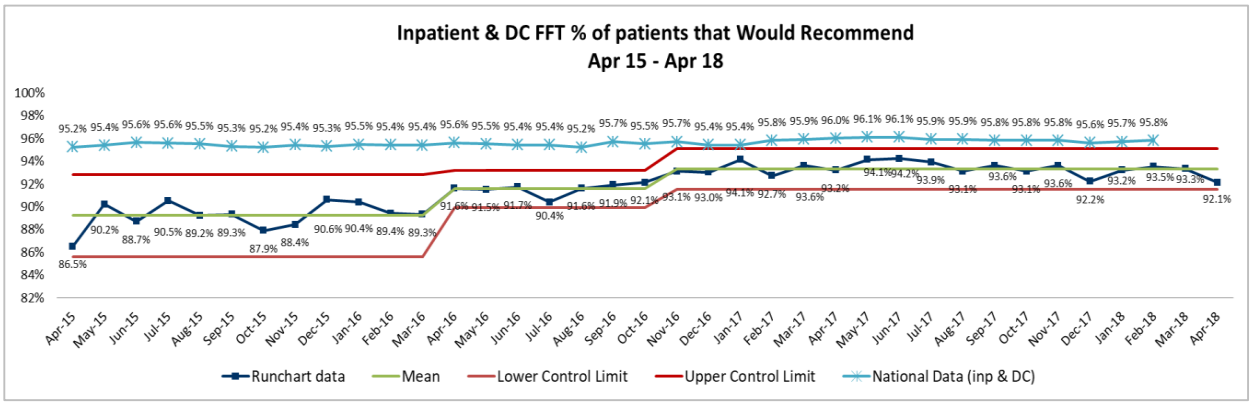


7. FFT Overview- % Would Recommend Run Charts

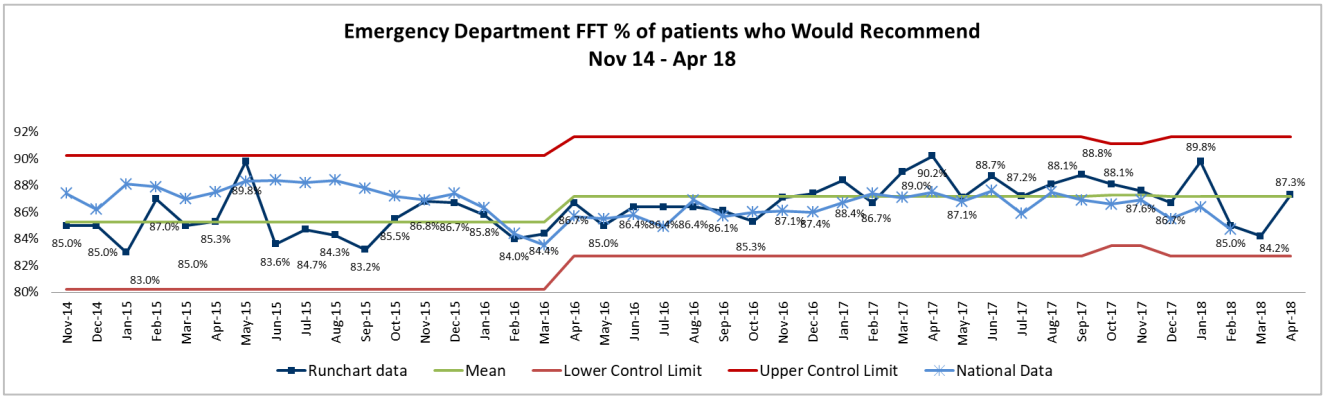
Trust wide data improved slightly in April 2018; however it is still below the mean line. Recommendation rates are still within normal variance. Improvements seen within ED are likely to have impacted the Trust wide results. With Trust Pressures seen over the winter months easing, it is likely that results will continue to rise.



Inpatient and Day Case results have depreciated in April 2018 with recommendation rates of 92.1%. When comparing February's (most recent available) recommendation rate to the national average recommendation rate, NGH performed 3.7% below the average.



Emergency Department recommendation results have increased within April 2018 following a number of months of depreciation. When comparing February's (most recent data available) recommendation rate to the national average, NGH performed 2.6% above the national average (84.7%).



8. Nursing and Midwifery Dashboards

The Nursing and Midwifery Quality Dashboards, Appendix 3, 4 and 5, provide triangulated data utilising quality outcome measures, patient experience and workforce informatics. With the implementation of the Best Possible Care 'Assessment and Accreditation' process, a review of the Quality Care Indicators (QCI) has taken place as planned with a reduction in the number of questions asked. The proposal is to further reduce the QCI dashboard once the Assessment & Accreditation Programme is fully established and 'rolled-out' across the Trust.

The QCI for April 2018 demonstrates the following:

Trust wide Overview of the Dashboard

- In April 2018 there were a total of 4 red domains on the QCI dashboard for the general wards
- Compliance with falls assessments and pressure prevention assessment has been high focus for the teams with improvement seen, the review continues in the 'collaboratives' and at the 'share and learn' meetings. There were no red domains this month in the category of falls and pressure prevention assessment category.
- First impressions of the ward remains a focus Trust wide due to the amounts of red and amber domains

.

Surgical Division

- The surgical division have no red domains on the QCI dashboard in April 2018 for the 3rd month running. The surgical division has 11 amber domains, with focus required on first impressions
  The Ward Sister, Matron and the Associate Director of Nursing (ADN) monitor the results monthly and highlight any specific themes or areas for improvement.

Medical and Urgent Care Division

- Medicine has had 3 red domains in April 2018 on the dashboard a huge decrease from previous months. A specific theme for the Division is first impressions which is being addressed with the Ward Sisters and Matrons
- Creaton Ward EAU had a red domain, for environment this was due to an inputting error
- Eleanor Ward had 1 red domain for incompletion of the care round documentation
- Knightley Ward had 1 red domain 1st for first impression; at the time of the audit the ward appeared busy and cluttered

Gynaecology Children's and Oncology Division

- Talbot Butler Ward had 1 red and 1 amber domain in April 2018, the red domain was for patient experience – for incompletion of care round documentation and amber for first impression
- Spencer had no red domains
- Childrens had no red domains for April 2018, attention has been focused on nursing documentation due to the amber domains for document assessment
  The Ward Sisters, Matrons and ADN monitor the results monthly and highlight any specific themes or areas to improve.

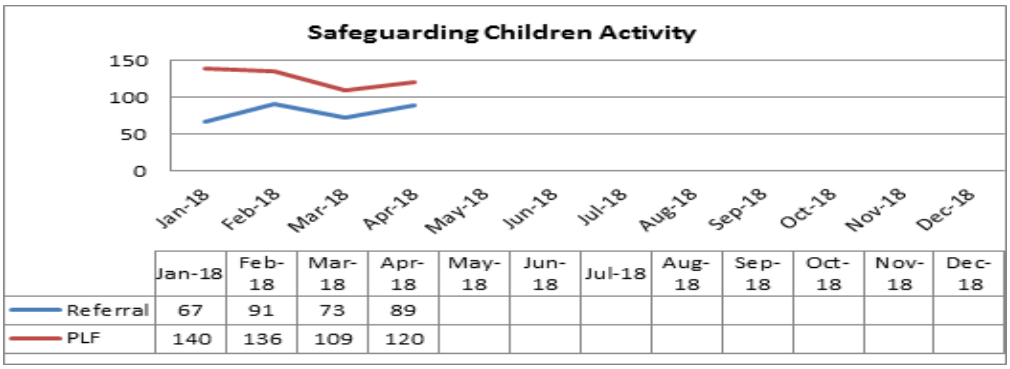
Maternity

- Robert Watson had 2 red domains one for not checking the Emergency equipment on a daily basis and the other red domain was for not checking controlled drugs daily. There were two days when the equipment & Controlled drugs were not checked.
- Maternity Observation Ward had 1 red domain for not checking the Emergency equipment on a daily basis. There were two days when the equipment was not checked.
  The Ward Sisters, Matrons and ADN monitor the results monthly and highlight any specific themes or areas to improve.

9. Safeguarding

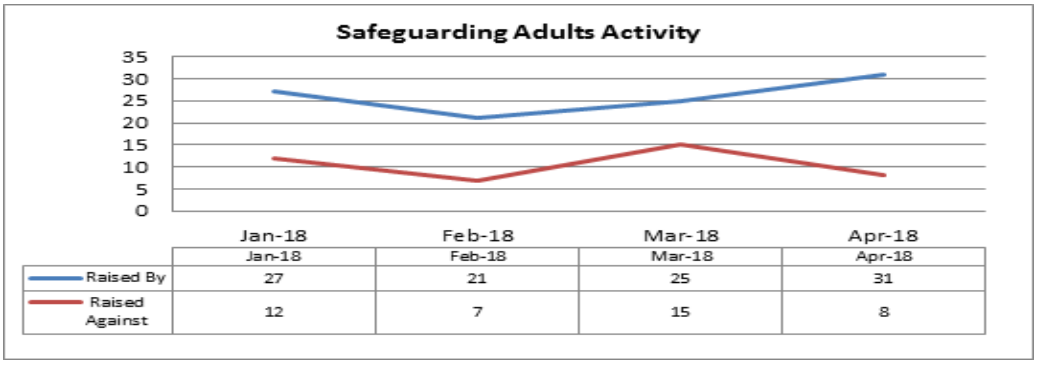
Safeguarding Children and Adult Referrals

The graph below shows the number of referrals made by the Trust in the reporting period for children and young people, at risk of, or suffering significant harm. This includes the number of Paediatric Liaison Forms (PLF's) processed. There has been a slight increase in the number of referrals made to the Multi-Agency Safeguarding Hub (MASH) and the number of PLF's completed in April 2018.



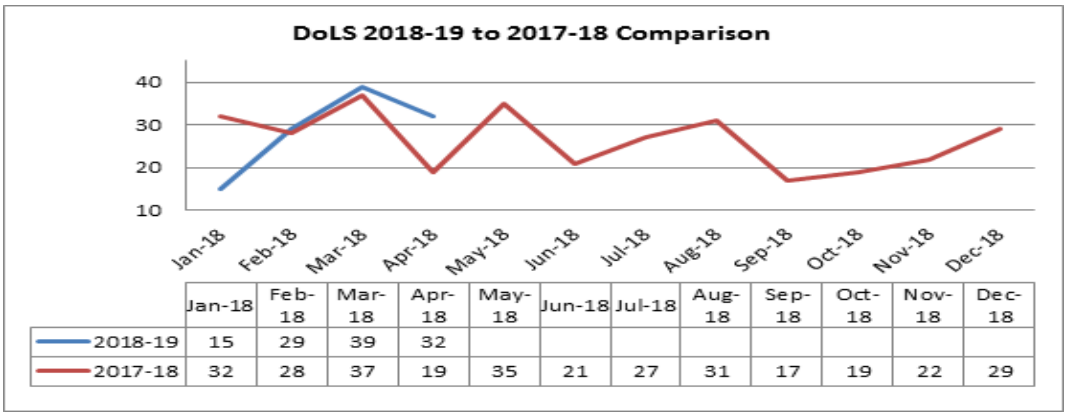
	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Referral	67	91	73	89								
PLF	140	136	109	120								

In terms of safeguarding adults' referral activity, there has been a slight increase in the number of safeguarding allegations raised by the Trust and a significant decrease in the number of safeguarding allegations against the Trust in April 2018. There is no identifiable cause for this trend.



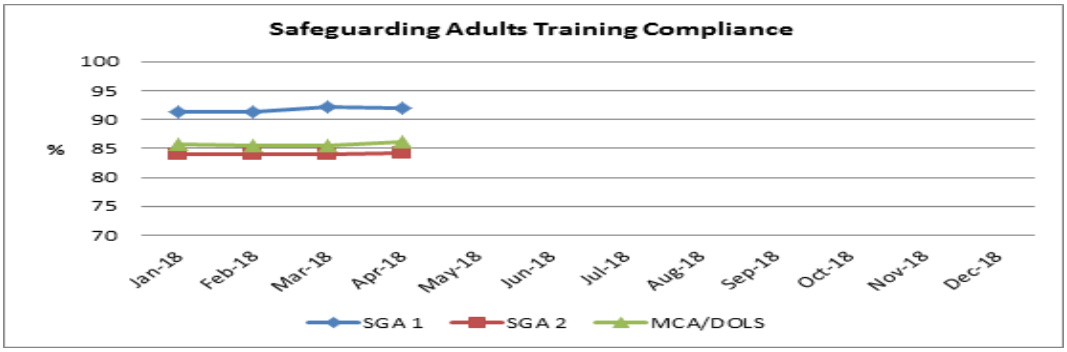
	Jan-18	Feb-18	Mar-18	Apr-18
Raised By	27	21	25	31
Raised Against	12	7	15	8

Deprivation of Liberty Safeguards (DoLS)
Applications for authorisations to Northamptonshire County Council (NCC) under the DoLS framework have slightly increased during the reporting period as shown in the following graph.

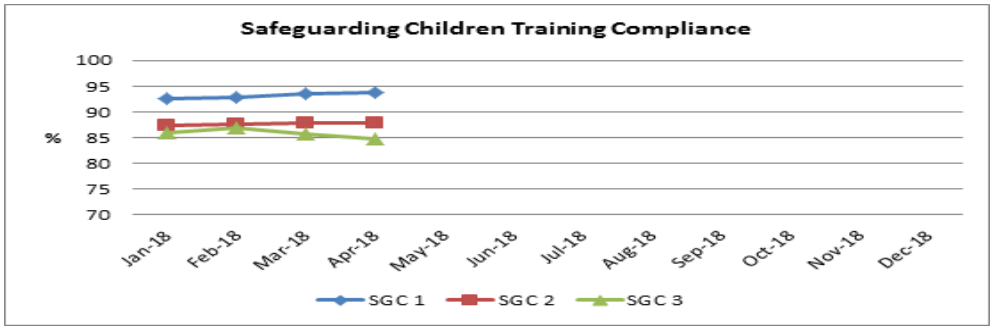


	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
2018-19	15	29	39	32								
2017-18	32	28	37	19	35	21	27	31	17	19	22	29

Safeguarding Training Compliance
The following two graphs illustrate the safeguarding training compliance for the Trust for April 2018:



Compliance for the level one safeguarding adults remains at a constant compliant trend. Level two safeguarding adults and MCA/DoLS training remains at 84%. The Safeguarding Team are concentrating on obstetrics and gynaecology, oncology and urgent care as the areas that require training updates.



Safeguarding children level one and two training remains compliant. Level three training has slightly decreased during this reporting period. Wards/departments have been identified to promote training opportunities to encourage the expected 85% compliance.

Prevent

Prevent is part of the Government counter-terrorism strategy Contest and aims to reduce the threat to the United Kingdom from terrorism by stopping people becoming terrorists or supporting terrorism.

The Prevent Duty 2015 requires all specified authorities including NHS Trusts and Foundation Trusts to ensure that there are mechanisms in place for understanding the risk of radicalisation and how to seek appropriate advice and support.

The Trust has currently achieved 92% compliance in Basic Prevent Awareness Training and 93% compliance (1051 staff members out of 1128) in WRAP training. This information forms part of the quarterly report to NHS England and the CCG as per the Prevent data assurance process.

10. Medication Safety

This is the first time that medication safety has been included in the Nursing and Midwifery Report. Over the coming months this section will be refined.

In April 2018 there were 73 medication incidents as demonstrated in the table below, 35 were in the Medical and Urgent Care Division, 15 in the Surgical Division and 23 in the Womens, Children and Oncology Haematology Division. Of those 59 were related to non-controlled drugs and 14 were controlled drugs.

Number of Medications Incidents Reported by Category	Medication and Urgent Care	Surgery	Womens, Children, Oncology, Haematology & Cancer Services	Total
Medication (Non-Controlled Drugs)	28	10	21	59
Medication (Controlled Drugs)	7	5	2	14
Total	**35**	**15**	**23**	**73**

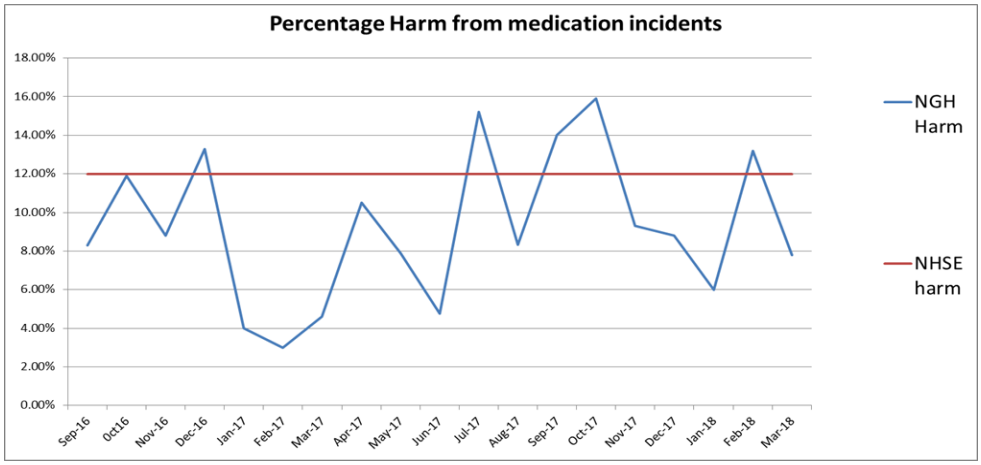
The top three medication incidents in April 2018 were omitted or wrong dose, patient receiving drugs intended or prescribed for another patient as illustrated in the following table.

Number of Medications Incidents Reported by Sub-Category	Medication and Urgent Care	Surgery	Womens, Children, Oncology, Haematology & Cancer Services	Total
Administration – Drugs Omitted	-	1	5	6

Administration – Wrong Dose	4	-	3	7
Prescribing – Patient Received Drugs Intended/Prescribed For Another Patient	2	4	-	6

Following datix being submitted for medication incidents the Corporate Governance Team, depending on the severity of the incident, will request an IAF and in turn the incident will be discussed the Review of Harm Group (ROHG). Depending on the outcome at the ROHG an investigation will be commissioned. All medication incidents are discussed at Directorate and Divisional Governance and risk meetings and learning shared.

Trends for Medication Incident Reporting
The graph below, illustrates that the Trust is usually below the National Health Safety Executive (NHSE) average for level of harm. In March 2018 (latest data) the Trust was below the national average at 8% for medication incidents.



In Q4, 5 patients missed “critical medicines”, these medicines should not be omitted or delayed. These drugs include diabetic and anticoagulation medication. Following datix being submitted for medication incidents, the Corporate Governance Team depending on the severity of the incident, will request an IAF and in turn the incident will be discussed the Review of Harm Group (ROHG). Depending on the outcome at the ROHG an investigation will be commissioned. All medication incidents are discussed at Directorate and Divisional Governance and Risk Meetings and learning shared.

11. Nursing Services Update

Pathway to Excellence®
Our submission for evidence for Pathway (which includes 64 elements of performance) based on our processes and front line staff accounts of how we meet the Pathway Standards (shared decision making, leadership, safety, quality, wellbeing and professional development) are due June 1st 2018.

Dependent then on the success of our appraisal process (usually a 2 month period) we will then be reviewed for suitability for Pathway Survey (nurse survey); the survey requires a 60% response rate with 75% of responses falling within a positive category. Survey may fall around Aug-Sept 2018time. Staff engagement is therefore vital for the success of this survey process. Plans are in place for a ‘mock survey’ in May to gauge areas response rates and feedback provided.

In May 2018 we had two staff members present at the International Pathway conference held in West Palm Beach, Florida USA, where they shared their work towards improving vacancy rates, staff orientation process and how staff recognition has boosted morale and improved recruitment.

Our team also attended an international group meeting, to aid in networking and sharing with our Australian and European counterparts. Australia has the second largest number of Pathway designated organisations after the USA and were therefore vital to liaise with.

We currently have a paper accepted for publication [Nursing Times] due before September 2018 highlighting us as the first UK organisation to pursue this accreditation process. We are also part of a national group NAME-UK (Nursing and Midwifery Excellence UK), in addition to the success of our March 2018 event held at the Trust we are joined with a number of UK organisations now looking to embed the Magnet and Pathway to Excellence programmes, culminating in a London event in September 2018, including a list of high profile national nursing leaders. This is a great opportunity to highlight the achievement already made by the Trust, being the furthest ahead within the accreditation process and have been invited to present on this in London.

Director of Nursing Junior Fellows
From June 2018 we are looking forward to the appointment of two new positions that have allowed 1 day release (within a full time post) to work on developing projects that align to the Pathway to Excellence Standards. Our two candidates will receive a mentoring and coaching programme with elements of leadership learning incorporated into it. They will be given an opportunity to have 'mentor' time with the Senior Nursing leadership team to aid them with their projects and they will be carefully supported to ensure they reach their set goals. It is anticipated that these projects can then be disseminated through presentation and publication with support of the senior leadership team. To ensure the longevity of this 12 month post, a standard operating procedure (SOP) has been written and is pending approval from Nursing and Midwifery Board in May 2018.

12. Maternity Update
Perinatal Mortality Review Tool (PMRT)
The Trust has started to use the national Perinatal Mortality Review Tool (PMRT) which was commissioned by the Department of Health as part of the national work to achieve the Secretary of State's ambition to reduce the stillbirth and neonatal death rate by 50% by 2025.
The tool supports the:

- Review of all perinatal deaths in a robust, objective, systematic and standardised way;
- Identification of why babies die and learn lessons to improve the care provided to future parents;
- Engagement of parents in the review process, to establish their perspectives on the care they received and any concerns they have, and provide them with as full and accurate an explanation as possible as to why their baby died;
- Participation in a national standardised approach to learn more about why babies die so that resources can be targeted at the causes and any shortfalls in care at local, regional and national levels. The PMRT is a bespoke, web-based system which is fully integrated with the MBRRACE-UK perinatal mortality surveillance data collection system.

Maternity and Neonatal Safety Collaborative MatNeoQI (NHSI)
The Trust is participating in Wave 2 of the MatNeoQI programme, the launch event was early May 2018. The collaborative is led by the NHSI Patient Safety team and is a three-year programme, and covers all maternity and neonatal services across England.
MatNeoQI Aims to:

- Support maternal and neonatal care services to provide a safe, reliable and quality healthcare experience to all women, babies and families across maternity care settings in England
- Create the conditions for continuous improvement, a safety culture and a national maternal and neonatal learning system.
- Contribute to the national ambition of reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 20% by 2020.

A multi-disciplinary team from Northampton will undertake enhanced QI training and development at 3 day workshops held throughout the year and is expected to deliver a Maternity and/or Neonatal safety improvement project supported by the NHSI patient safety team and the local Board Level Maternity Safety Champions.

Professional Midwifery Advocates and A-EQUIP
The Official launch of the Professional Midwifery Advocate service was 10th May. The PMAs will deliver the A-EQUIP new model of restorative clinical supervision. A-EQUIP aims to: facilitate a continuous improvement process that values midwives, enhances health and well-being, builds their personal and professional resilience and contributes to the provision of high quality of care and quality improvement. The new model of restorative clinical supervision is employer led and non-regulatory. The requirement to deliver midwifery supervision is written into the NHS Standard contract 2017-18.

13. Safe Staffing

It is an ongoing requirement of NHS England that all NHS Trust Boards receive a monthly report relating to nurse staffing levels. Overall fill rate for April 2018 was 102% compared to March 101% and 103% in February. Combined fill rate during the day was 99% compared with 97% in March. The combined night fill rate was 106% compared with106% in March. RN fill rate during the day was 96% and for the night 97% (appendix 5).

In line with the National Quality Board 'Safe, sustainable and productive staffing – An improvement resource for adult inpatient wards in acute hospitals' January 2018 recommendation 7 states:

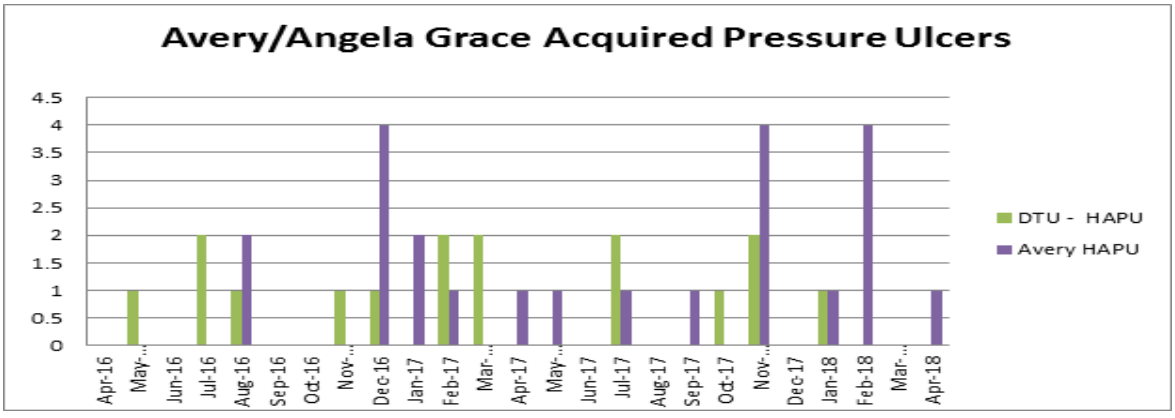
A local dashboard should be in place to assure stakeholders regarding safe and sustainable staffing. The dashboard should include quality indicators to support decision-making.

To enable the timely triangulation of our quality indicators from our Matrons dashboard, which incorporates the Quality Care Indicators, we have included the dashboard within the Safe Staffing paper in appendix 2,3,4. The staff staffing compliance, along with the 'red flags' (National Institute Clinical Excellence, 2016), is displayed at the bottom of the dashboard. The review of the monthly dashboard is undertaken by the Associate Directors of Nursing through their Council meetings and in one-to-one meetings with the individual Matrons.

14. Avery and Dickens Therapy Unit

Pressure Ulcer Incidence
The following graph represents the number of pressure ulcer harms reported in 2016-2018 to patients in either Blenheim, Cliftonville Wards (Avery) or Dickens Therapy Unit (Angela Grace).

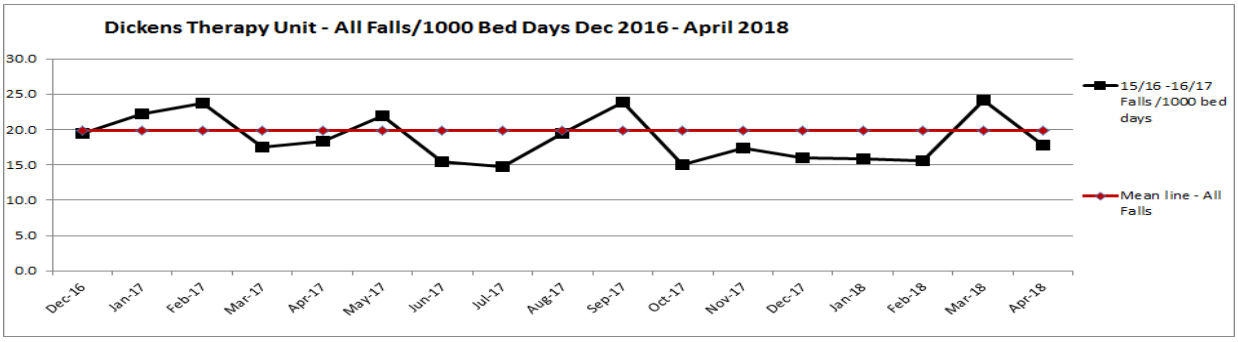
There was one 1 Grade 2 Pressure Ulcer reported on Blenheim Ward during April 2018. The TVT continue to report and investigate these harms as per Trust protocol.



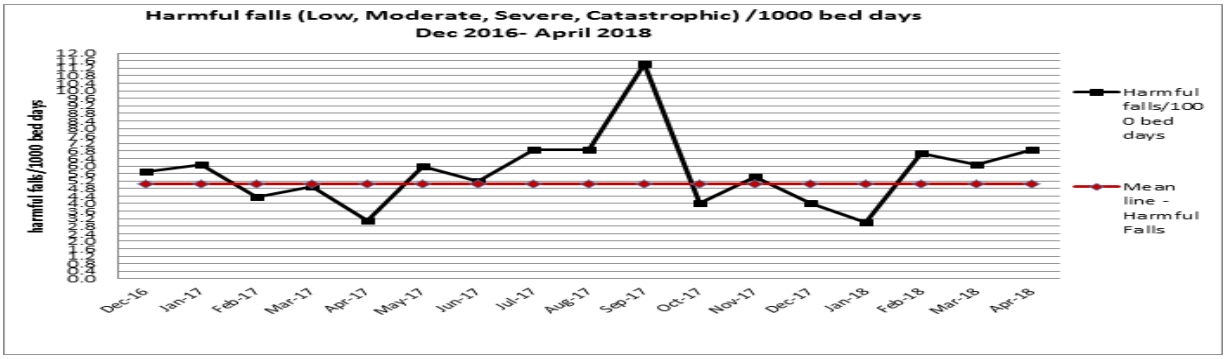
Infection Prevention
There were no MRSA colonisations, MRSA bacteraemias, MSSA bacteraemias, *C.difficile* infections or *E.coli* bacteraemias at Dickens or Avery in April 2018.

Falls
The bed days calculated for Dickens Therapy Unit (DTU) have not previously been counted in the existing bed day's data used to report the Trust's falls/1000 bed days so have been calculated separately. In total 13 patient falls were recorded at DTU; 1 moderate harm patient fall resulting in fractured ribs, 4 low harm patient falls and 8 no harm patient falls for the month of April 2018.

Falls/1000 bed days at Dickens Therapy Unit
The number of patient falls/1000 bed days decreased in April 2018 by 6.46 compared to March 2018.

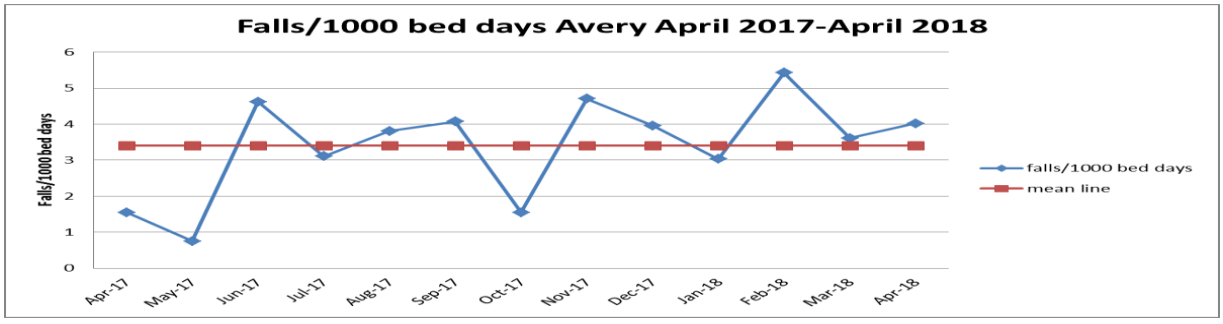


DTU Harmful falls/1000 bed days Including Low, Moderate, Severe and Catastrophic
The graph below represents low, moderate and severe falls/1000 bed days. Harmful patient falls increased in April 2018 by 0.78 when compared to March 2018.



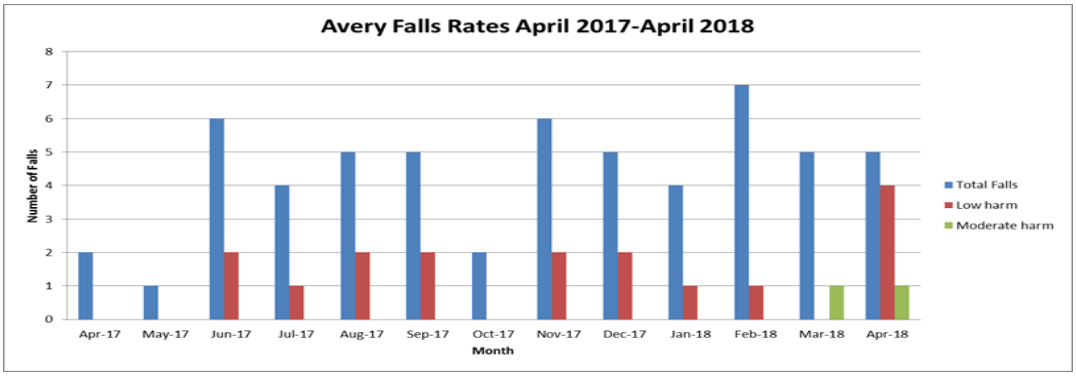
Falls/1000 bed days at Avery
The number of inpatient falls at Avery have previously been calculated within the Trust's falls rates. The graphs below demonstrate inpatient falls/1000 bed days for Avery over the last year using only Avery occupied bed days data.

The falls/1000 bed days are below the national average of 6.63/1000 bed days and below the Trust internally set trust target of 5.5/1000 bed days over the last year.



Harmful Falls/1000 bed days including Low, Moderate, Severe and Catastrophic
The recording of harmful falls in this data represents low, moderate, severe and catastrophic harm. In April 2018 there was 1 moderate harm fall and 4 low harm falls. This is represented in the following graph. All falls at Avery are reviewed and investigated as per policy.

The graph below demonstrates the total number of inpatient falls and the number of harmful inpatient falls at Avery between April 2017 and April 2018. In April 2018 there were more low harm patient falls recorded, these are where patients require minor first aid or enhanced observations.



15. Recommendations

The Trust Board is asked to note the content of the report, support the mitigating actions required to address the risks presented and continue to provide appropriate challenge and support.

Appendix 1

Nursing and Midwifery Safety Thermometer Definition

The Department of Health introduced the NHS Safety Thermometer *"Delivering the NHS Safety Thermometer 2012"* the initiative was also initially a CQuIN in 2013/14 to ensure the launch was sustained throughout the nation. The NHS Safety Thermometer is used nationally but is designed to be a local improvement tool for measuring, monitoring, and analysing patient harms and developing systems that then provide 'harm free' care. Developed for the NHS by the NHS as a point of care survey instrument, the NHS Safety Thermometer provides a 'temperature check' on harm that needs be used alongside Trusts data that is prevalence based and triangulated with outcome measures and resource monitoring. The national aim is to achieve 95% or greater harm free care for all patients, which to date the national average is running at 94.2%.

The NHS Safety Thermometer has been designed to be used by frontline healthcare professionals to measure a 'snapshot' of harm once a month from pressure ulcers, falls with harm, and urinary infection in patients with catheters and treatment for VTE. All inpatients (including those patients in theatres at the time but excluding paediatrics) are recorded by the wards and the data inputted onto the reporting system, on average NGH reports on 630+ patients each month. Once the information is validated by the sub-group teams it is uploaded onto the national server to enable a comparator to be produced.

The Safety Thermometer produces point prevalence data on all harms (which includes harms that did not necessarily occur in hospital) and 'new' harms which do occur whilst in hospital – in the case of falls, VTE and CRUTI the classification of 'new' means within the last 72 hours, this is slightly different for pressure damage as 'new' is categorised as development that occurred in our care post 72 hours of admission to hospital and is recorded throughout the patient stay on the Safety Thermometer. Therefore pressure damage is the only category that if the patient remains an in-patient for the next month's data collection it is recorded as 'new' again.

NGH has a rigorous process in place for Safety Thermometer data collection, validation and submission. Four sub-groups for each category exist and are led by the specialists in the area; they monitor their progress against any reduction trajectory and quality schedule target. For pressure damage all harms are recorded on datix throughout the month (not just on this one day) reviews are undertaken to highlight any lapses in care, every area with an incident attends the Share and Learn forums to analyse further the incident and to develop plans for areas of improvement and future prevention.

Maternity Safety Thermometer
The Maternity Safety Thermometer is a measurement tool for improvement that focuses on: perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. The tool allows teams to take a temperature check on harm and records the number of harms associated with maternity care, but also records the proportion of mothers who have experienced 'harm free' care. This is a point of care survey that is carried out on a single day each month on 100% of postnatal mothers and babies. Data are collected from postnatal wards, women's homes and community postnatal clinics. The safety thermometer has only just been implemented in the community midwifery service. Highlighted is the data for maternal perception of safety and isolation in labour.

Appendix 2

Apr-2018	Medicine														WCO		Surgery							
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Allebone	Becket	Benham	Brampton	Collingtree	Compton	Creaton	Dryden	EAU	Eleanor	Finedon	Holcot	Knightley	Victoria	Talbot Butler	Spencer	Rowan	Willow	Hawthorn	Head & Neck	Abington	Cedar	Althorp	General Wards
Falls/Safety Assessment	100.%		100.%	100.%		100.%	93.%	100.%	97.%	97.%	100.%	100.%	97.%	100.%	93.%	100.%	100.%	100.%	100.%	97.%	93.%	93.%	100.%	90.%
Pressure Prevention Assessment	97.%		97.%	100.%		100.%	100.%	97.%	97.%	100.%	100.%	97.%	100.%	100.%	97.%	97.%	100.%	100.%	97.%	100.%	94.%	94.%	94.%	90.%
Nutritional Assessment	100.%		100.%	100.%		100.%	100.%	97.%	100.%	100.%	97.%	100.%	97.%	100.%	93.%	100.%	97.%	83.%	87.%	97.%	97.%	93.%	100.%	89.%
Patient Observation and Escalations	95.%		95.%	95.%		100.%	95.%	100.%	95.%	100.%	95.%	95.%	86.%	95.%	95.%	95.%	94.%	100.%	100.%	90.%	95.%	100.%	90.%	87.%
Pain Management	100.%		100.%	100.%		100.%	100.%	100.%	100.%	87.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	91.%
Nursing & Midwifery Documentation - Quality of Entry	98.%		100.%	88.%		87.%	97.%	98.%	95.%	97.%	100.%	97.%	100.%	85.%	90.%	100.%	100.%	98.%	98.%	88.%	95.%	100.%	97.%	87.%
Medication Assessment	100.%		100.%	100.%		100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	96.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	91.%
Patient Experience - Protected Mealtimes (PMT) Observations	100.%		100.%	100.%		100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	83.%	100.%	83.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	90.%
Patient Experience - Care Rounds Observe patient records	100.%		100.%	100.%		100.%	82.%	100.%	100.%	73.%	100.%	100.%	100.%	100.%	55.%	100.%	100.%	100.%	91.%	100.%	100.%	100.%	100.%	87.%
Patient Experience - Environment	100.%		100.%	100.%		100.%	60.%	100.%	100.%	100.%	100.%	100.%	100.%	80.%	100.%	100.%	80.%	80.%	80.%	100.%	100.%	100.%	100.%	86.%
Patient Experience - Privacy and Dignity	96.%		96.%	99.%		95.%	84.%	96.%	98.%	88.%	99.%	99.%	96.%	98.%	92.%	96.%	95.%	94.%	95.%	100.%	100.%	96.%	100.%	88.%
Patient Safety and Quality	100.%		100.%	100.%		100.%	90.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	90.%	100.%	90.%	100.%	90.%	100.%	90.%	100.%	100.%	89.%
Leadership & Staffing observations	100.%		98.%	100.%		98.%	96.%	98.%	100.%	100.%	100.%	100.%	100.%	98.%	98.%	100.%	96.%	98.%	98.%	98.%	96.%	96.%	100.%	90.%
EOL	100.%		100.%	100.%		100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	91.%
SOVA/LD/Cognitive Impairment	96.%		100.%	100.%		100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	91.%
First Impressions/15 Steps	83.%		94.%	80.%		91.%	80.%	80.%	80.%	80.%	86.%	89.%	77.%	80.%	80.%	100.%	86.%	83.%	83.%	86.%	94.%	100.%	97.%	79.%
Safety Thermometer – Percentage of Harm Free Care	96.4%	92.3%	85.7%	100.0%	90.2%	83.3%	92.9%	96.2%	90.3%	100.0%	94.1%	86.2%	81.0%	94.4%	96.4%	93.8%	100.0%	80.8%	96.7%	100.0%	89.3%	92.9%	100.0%	93.0%
Pressure Ulcers – Grade 2 incidence hosp acquired, (Previous	0	3	0	0	1	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	1	0	0	7
Pressure Ulcers – Grade 3 incidence hosp acquired, (Previous	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	2
Pressure Ulcers – Grade 4 incidence hosp acquired, (Previous	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pressure Ulcers -sDTI's incidence hosp acquired	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Falls (Moderate, Major & Catastrophic)																								0
HAI – MRSA Bact	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
HAI – C Diff	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	2	1	1	0	0	0	5
Patient Overdue Observations frequency - <7%																								
Caring																								
Complaints – Nursing and Midwifery																								0
Number of PALS concerns relating to nursing care on the wards	0	0	1	2	1	0	0	0	3	0	0	1	2	1	0	0	1	1	2	1	3	0	1	20
Friends Family Test % Recommended	90.0%	95.1%	88.9%	76.9%	81.3%	100.0%	88.3%	94.5%	88.9%	81.3%	93.5%	58.3%	75.0%	33.3%	94.7%	87.7%	94.3%	94.3%	91.7%	91.7%	96.6%	94.7%	97.4%	92.1%
Well Led																								
Staff Nurse Staffing - Registered Staff (day & night combined)	89%	98%	98%	95%	104%	103%	90%	90%	120%	90%	95%	96%	94%	98%	89%	101%	99%	98%	98%	108%	101%	97%	100%	98%
Staff Nurse Staffing - Support Worker (day & night combined)	106%	107%	170%	126%	119%	157%	129%	100%	152%	110%	115%	153%	150%	163%	96%	99%	115%	107%	107%	139%	109%	104%	106%	123%
Staffing related datix	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1

Appendix 3

Apr 18	PAEDIATRICS		
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Disney	Paddington	Gosset
Quality & Safety			
Falls/Safety Assessment (Q)	100%	69%	100%
Pressure Prevention Assessment (Q)	100%	67%	96%
Child Observations [documentation] (Q)	89%	94%	97%
Safeguarding [documentation] (Q)	67%	100%	100%
Nutrition Assessment [documentation] (Q)	74%	100%	100%
Medication Assessment (Q)	100%	90%	100%
Pressure Ulcers – Grade 2 incidence hosp acquired	0	0	0
Pressure Ulcers – Grade 3 incidence hosp acquired	0	0	0
Pressure Ulcers – Grade 4 incidence hosp acquired	0	0	0
Pressure Ulcers - sDTI's incidence hosp acquired	0	0	0
Falls (Moderate, Major & Catastrophic)	0	0	0
HAI – MRSA Bact	0	0	0
HAI – C Diff	0	0	0
Patient Experience			
Complaints – Nursing and Midwifery			
Number of PALS concerns relating to nursing care on the wards			
Call Bells responses (Q)	100%	100%	nil
Patient Safety & Quality Environment Observations Observe patient records (Q)	100%	70%	100%
Privacy and Dignity (Q)	100%	94%	100%
Management			
Staffing related datix			1
Monthly Ward meetings (Q)	100%	100%	100%
Leadership & Staffing observations (Q)	97%	83%	100%

Appendix 4

Quality Care Indicators - Nurse & Midwifery	MATERNITY			
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Balmoral	Robert Watson	MOW	Sturtridge
Quality & Safety				
Postnatal Safety Assessment (Q)	100%	79%	100%	84%
SOVA/LD (Q)	Nil	Nil	Nil	Nil
Patient Observation Chart (Q)	100%	100%	100%	100%
Medication Assessment (Q)	100%	100%	100%	100%
Environment Observations (Q)	100%	96%	100%	100%
HAI – MRSA Bact	0	0	0	0
HAI – C Diff	0	0	0	0
Emergency Equipment – Checked Daily (Q)	100%	0%	0%	100%
Patient Quality Boards (Q)	100%	100%	100%	100%
Controlled Drug Checked (Q)	Nil	0%	nil	100%
Patient Experience				
Complaints – Nursing and Midwifery	0	0	0	0
Call Bells responses (Q)	100%	100%	nil	100%
Patient Experience (Q)	86%	76%	100%	84%
Patient Safety and Quality (Q)	100%	64%	67%	100%
Leadership & Staffing (Q)	100%	93%	100%	100%
Management				
Staffing related datix		1	1	1
Monthly Ward meetings (Q)	100%	80%	100%	100%
Saftey and Quality (Q)	94%	100%	100%	83%
Leadership & Staffing (Q)	100%	75%	100%	100%

Appendix 5

Safe Staffing Data for April 2018

Ward Staffing Fill Rate Indicator (Nursing, Midwifery & Care Staff) — April 2018

Ward name	Day: Registered midwives/nurses		Day: Care Staff		Night: Registered midwives/nurses		Night: Care Staff		Day: Average fill rate - registered nurses /midwives (%)	Day: Average fill rate - care staff (%)	Night: Average fill rate - registered nurses / midwives (%)	Night: Average fill rate - care staff (%)	Care Hours Per Patient Day (CHPPD): Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall	Actions/Comments	Red Flag
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours										
Abington Ward (NOF)	1,797.00	1,831.17	1,369.00	1,434.50	1,035.00	1,035.00	1,022.25	1,183.25	101.9%	104.8%	100.0%	115.7%	821	3.5	3.2	6.7		
Allebone Ward (Stroke)	1,564.00	1,351.08	1,105.70	1,097.50	1,380.00	1,256.25	690.00	813.25	86.4%	99.3%	91.0%	117.9%	840	3.1	2.3	5.4		
Althorp (T&O)	879.75	882.75	676.50	666.25	644.00	646.00	356.50	425.50	100.3%	98.5%	100.3%	119.4%	275	5.6	4.0	9.5		
Becket Ward	1,967.00	1,924.25	1,367.50	1,375.00	1,725.00	1,689.75	690.00	828.00	97.8%	100.5%	98.0%	120.0%	780	4.6	2.8	7.5		
Benham (Assess Unit)	1,713.00	1,644.25	862.50	1,271.50	1,380.00	1,386.25	690.00	1,369.67	96.0%	147.4%	100.5%	198.5%	744	4.1	3.5	7.6		
Brampton Ward	1,360.50	1,229.17	1,030.25	1,105.00	1,035.00	1,035.00	690.00	1,065.50	90.3%	107.3%	100.0%	154.4%	842	2.7	2.6	5.3		
Cedar Ward (TRAUMA)	1,815.00	1,731.67	1,712.25	1,691.50	1,029.83	1,030.33	1,035.00	1,159.50	95.4%	98.8%	100.0%	112.0%	868	3.2	3.3	6.5		
Collingtree Medical (40)	2,298.50	2,469.67	1,716.50	1,745.10	1,723.75	1,720.00	690.00	1,127.00	107.4%	101.7%	99.8%	163.3%	1219	3.4	2.4	5.8		
Compton Ward	1,011.25	1,063.50	707.92	955.25	690.00	690.00	344.75	701.25	105.2%	134.9%	100.0%	203.4%	538	3.3	3.1	6.3	Risk assessment undertaken by matron escalated appropriately and staff moved due to another highly acute area. Care prioritised and although delays occurred no harm came to the patients from those delays.	1 x Other Staffing issues
Creaton SSU	1,597.75	1,605.17	1,033.00	1,290.50	1,725.00	1,391.17	1,035.00	1,387.50	100.5%	124.9%	80.6%	134.1%	740	4.0	3.6	7.7		
Disney Ward	1,807.50	1,685.75	925.50	850.17	1,035.00	982.33	345.00	356.50	93.3%	91.9%	94.9%	103.3%	307	8.7	3.9	12.6		
Dryden Ward	2,067.75	1,725.00	931.50	885.50	1,378.75	1,378.75	690.00	734.25	83.4%	95.1%	100.0%	106.4%	775	4.0	2.1	6.1		
EAU New	1,677.50	1,866.70	1,617.25	2,016.25	1,035.00	1,380.00	690.00	1,496.17	111.3%	124.7%	133.3%	216.8%	942	3.4	3.7	7.2		
Eleanor Ward	1,028.75	856.50	685.50	739.75	690.00	690.00	690.00	770.50	83.3%	107.9%	100.0%	111.7%	336	4.6	4.5	9.1		
Finedon Ward	2,070.00	1,902.75	359.25	452.00	1,035.00	1,035.00	345.00	356.25	91.9%	125.8%	100.0%	103.3%	480	6.1	1.7	7.8		
Gosset Ward	2,525.10	2,599.93	489.00	431.50	2,311.50	2,252.33	241.50	186.25	103.0%	88.2%	97.4%	77.1%	353	13.7	1.8	15.5	Due to short term sickness 4 night shift,s in the month of April, were not covered. No patient came to any harm.	
Hawthorn & SAU	1,896.50	1,835.33	1,035.00	1,076.83	1,380.00	1,373.50	931.50	1,035.75	96.8%	104.0%	99.5%	111.2%	863	3.7	2.4	6.2		
Head & Neck Ward	1,037.50	1,060.75	345.00	402.33	874.00	995.00	345.00	559.00	102.2%	116.6%	113.8%	162.0%	384	5.4	2.5	7.9		
Holcot Ward	1,347.00	1,256.50	1,372.17	1,651.75	1,033.75	1,033.75	690.00	1,501.92	93.3%	120.4%	100.0%	217.7%	857	2.7	3.7	6.4		
Knightley Ward (Medical)	669.50	652.75	853.00	1,055.00	1,035.00	943.00	345.00	741.58	97.5%	123.7%	91.1%	215.0%	624	2.6	2.9	5.4		
Paddington Ward	2,324.75	2,116.58	999.75	868.75	1,932.00	1,745.00	644.00	586.75	91.0%	86.9%	90.3%	91.1%	300	12.9	4.9	17.7		
Rowan (LSSD)	1,894.30	1,901.67	1,035.00	1,148.92	1,725.00	1,683.75	690.00	841.08	100.4%	111.0%	97.6%	121.9%	869	4.1	2.3	6.4		
Spencer Ward	1,308.25	1,329.67	1,026.00	999.50	1,035.00	1,038.00	1,035.00	1,049.50	101.6%	97.4%	100.3%	101.4%	599	4.0	3.4	7.4		
Talbot Butler Ward	2,490.50	2,087.08	1,339.75	1,200.50	1,380.00	1,348.25	690.00	745.50	83.8%	89.6%	97.7%	108.0%	811	4.2	2.4	6.6		
Victoria Ward	1,155.75	1,114.25	690.00	1,001.50	690.00	690.00	345.00	690.00	96.4%	145.1%	100.0%	200.0%	531	3.4	3.2	6.6		
Willow Ward (+ Level 1)	2,221.75	2,198.02	1,020.50	1,020.53	2,070.00	1,993.25	689.25	802.75	98.9%	100.0%	96.3%	116.5%	843	5.0	2.2	7.1		
													Total Average CHPPD			7.9		
ITU	4,974.25	4,576.42	764.17	669.67	4,519.50	4,302.92	690.00	580.00	92.0%	87.6%	95.2%	84.1%	402	22.1	3.1	25.2		
													Total Average CHPPD			25.2		
Barratt Birth Centre	1,722.75	1,607.40	664.00	522.00	1,380.00	1,307.92	690.00	591.50	93.3%	78.6%	94.8%	85.7%	138	21.1	8.1	29.2	MSW's are rotated to areas of need during the shift to maintain mother & baby safety. Programme of recruitment is on-going.	
Robert Watson	1,038.00	1,219.83	1,263.75	1,182.42	1,035.00	995.00	1,021.25	790.17	117.5%	93.6%	96.1%	77.4%	458	4.8	4.3	9.1	MSW's are rotated to areas of need during the shift to maintain mother & baby safety. Programme of recruitment is on-going.	
Sturtridge Ward	4,168.25	3,920.33	1,844.42	1,496.75	4,068.75	3,823.83	1,311.00	1,204.33	94.1%	81.2%	94.0%	91.9%	519	14.9	5.2	20.1		
													Total Average CHPPD			19.5		
													Total Average CHPPD Trust wide			9.6		

Key:
- Below 80% Shift Fill Rate Target
- 80% and Above Shift Fill Rate Target

Northampton General Hospital NHS Trust

Report To	**TRUST BOARD**
Date of Meeting	**23rd May 2018**

Title of the Report	Financial Position - April (FY18-19)
Agenda item	10
Sponsoring Director	Phil Bradley, Interim Director of Finance
Author(s) of Report	Bola Agboola, Deputy Director of Finance
Purpose	To report the financial position for the month ended April 2018.

Executive summary

This report sets out the Trust's financial position for the month ended 30th April 2018. The results show a reported pre-PSF deficit of £3,095k against the plan pre-PSF deficit of £3,710k, which is a favourable variance of £615k. The favourable variance is made up of: Other income £207k, Non-Pay £203k, Reserves £227k.

Additionally, the planned Provider Sustainability Funding (PSF) trajectories were achieved and therefore PSF funding of £460k has been accrued in month 1. PSF replaces STF as from April 2018.

The in-month position can be summarised as:

- **Clinical income**: SLA Clinical Income is favourable to plan by £53k, with good performance across most PoDs.
- **Other income**: The favourable variance of £207k relates to increased catering income, increased pathology test as well as one-off sale of 'due to expire medicines'.
- **Pay**: Pay is overspent by £549k due to over-establishment of medical and nursing staff, including spend on the medical outliers team as well as over-establishment of nursing staff on some medical wards, escalation and supernumerary.
- **Agency ceiling**: The NHSI target of £934k was exceeded by £7k in month 1, as a result of making a one-off payment which was previously in dispute relating to agency on-call payments.
- **Non-Pay**: Non Pay expenditure is £203k favourable with key variances including underspend against RTT backlog outsourcing, underspend against equipment maintenance and staff advertising.

Related strategic aim and corporate objective	Financial Sustainability
Risk and assurance	The recurrent deficit and I&E plan position for FY18-19 signals another challenging financial year and the requirement to maintain the financial discipline required to deliver the agreed control total.
Related Board Assurance Framework entries	BAF 3.1 (Sustainability); 5.1 (Financial Control); 5.2 (CIP delivery); 5.3 (Capital Programme).
Equality Impact Assessment	N/A
Legal implications / regulatory requirements	NHS Statutory Financial Duties

Actions required by the Board

The Board is asked to note the financial position for the month ended April 2018 and to review the performance against plan.

Northampton General Hospital
NHS Trust

Financial Position

Month 1 (April)
FY 2018/19

Report to:

Trust Board

May 2018

Content

1. Director of Finance Message

The Trust performed better than plan in April and delivered a favourable variance to plan of £615k.

PSF trajectories were met resulting in income of £460k being earned.

This report sets out the Trust's financial position for the month ended 30th April 2018. The results show a reported pre-PSF deficit of £3,095k against the plan pre-PSF deficit of £3,710k, which is a favourable variance of £615k. The favourable variance is made up of: Other income £207k, Non-Pay £203k, Reserves £227k.

Additionally, the planned Provider Sustainability Funding (PSF) trajectories were achieved and therefore PSF funding of £460k has been accrued in month 1. PSF replaces STF as from April 2018.

The in-month position is summarised below:

Clinical income: SLA Clinical Income is favourable to plan by £53k, with good performance across most PoDs. The adverse variance on pass through medicines of £78k (matched by non-pay) brings the overall variance to £25k adverse.

Other income: The £207k favourable variance relates to increased catering income, increased pathology test as well as one-off sale of 'due to expire medicines'.

Pay: Pay is overspent by £549k due to over-establishment of medical and nursing staff, including spend on the medical outliers team as well as over-establishment of nursing staff on some medical wards, escalation and supernumerary.
The adverse variance arises after applying the Pay underspend CIP mechanism which means that underspent cost centres lose their budget non-recurrently and is applied towards the Division's CIPs. In month 1, pay underspends of £747k has been applied across the Divisions.

Agency ceiling: The NHSI target of £934k was exceeded by £7k in month 1, as a result of making a one-off payment which was previously in dispute relating to agency on-call payments .

Non-Pay: Non Pay expenditure is £203k favourable with key variances including underspends against RTT backlog outsourcing, equipment maintenance and staff advertising. The favourable variance on pass through medicines of £78k (matched by income) brings the total variance to £283k.

Reserves: Reserves is unspent and contributed £227k to the in-month favourable position.

CIPs: Delivery of £1,201k against plan of £716k, although £747k of this was due to non-recurrent pay underspend.

Cash: Cash balance at the end of April was £6.1m; £4.6m more than plan. This was due to drawing down more loan than required due to the timing of drawdown submission being earlier than when the plan was finalised as well as the low level of supplier payments in April due to the large number of payments made in March.

Capital: Capital spend in M1 is £140k more than plan due to accelerated spend on a few schemes (including estates compliance) but is expected to get back to plan later in the year.

Single oversight framework: The Trust continues to score "3" against the "finance and use of resources" metric.

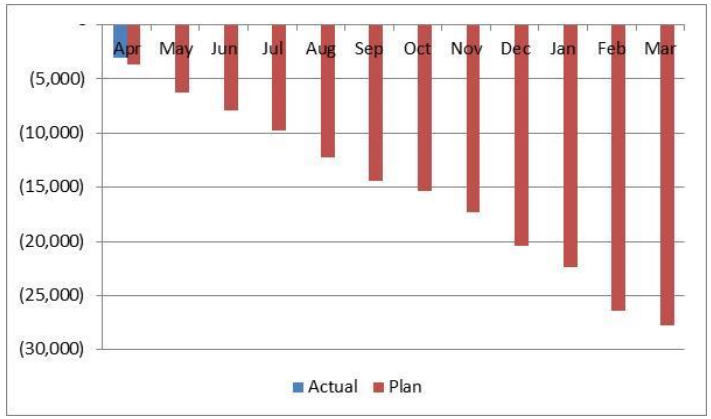
Table 1: Income and Expenditure Summary

I&E Summary	Annual Plan	In-Month			Year to Date			Recent Months: Actual	
		Plan	Actual	Variance	Plan	Actual	Variance	Mar 18	Feb 18
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	286,113	22,344	22,319	(25)	22,344	22,319	(25)	22,454	21,219
Other Clinical Income	11,898	686	652	(34)	686	652	(34)	1,982	408
Other Income	21,229	1,758	1,965	207	1,758	1,965	207	2,101	1,554
Total Income	319,240	24,787	24,935	148	24,787	24,935	148	26,537	23,182
Pay Costs	(219,508)	(17,398)	(17,937)	(539)	(17,398)	(17,937)	(539)	(17,456)	(17,534)
Non-Pay Costs	(110,094)	(8,898)	(8,615)	283	(8,898)	(8,615)	283	(9,753)	(8,604)
Unallocated CIPs	8,094	(492)		492	(492)		492		
Reserves/ Non-Rec	(3,057)	(227)		227	(227)		227		
Total Costs	(324,565)	(27,016)	(26,552)	464	(27,015)	(26,552)	463	(27,210)	(26,138)
EBITDA	(5,325)	(2,228)	(1,616)	612	(2,228)	(1,616)	611	(673)	(2,956)
Depreciation	(10,615)	(830)	(830)	(0)	(830)	(830)	(0)	(894)	(896)
Amortisation	(8)	(1)	(1)	(0)	(1)	(1)	(0)	(1)	(1)
Impairments	(1,826)	(0)		0	(0)		0	(8,362)	
Net Interest	(1,239)	(89)	(85)	3	(89)	(85)	3	(9)	(72)
Dividend	(1,529)	(127)	(127)	0	(127)	(127)	0	126	(52)
Surplus / (Deficit)	(20,542)	(3,275)	(2,660)	615	(3,274)	(2,660)	615	(9,813)	(3,976)
NHS Breakeven duty adjs:									
Donated Assets	122	25	25		25	25		138	84
NCA Impairments	1,826	0		(0)	0		(0)	8,362	
Surplus / (Deficit) - Normalised	(18,594)	(3,250)	(2,635)	615	(3,249)	(2,635)	615	(1,312)	(3,892)

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

I&E	Plan	YTD Plan	Actual YTD	Var
	£'k	£'k	£'k	£'k
Pre PSF	(27,785)	(3,710)	(3,095)	615
PSF	9,191	460	460	-
Post PSF	(18,594)	(3,250)	(2,635)	615

Table 3: Pre-PSF I&E Performance



2. Clinical Income

Month 1 SLA Clinical Income is on plan, with a favourable variance of £53k (excluding pass-through medicines and devices). Variances within the individual points of delivery were relatively minor, only Non-Elective income with a significant financial over-performance, offset by under-performance on XS bed days income.

Cost per Case (CPC) is above plan due to Direct Access volumes, Critical Care activity and Radiotherapy. This is offset by Maternity and BPT.

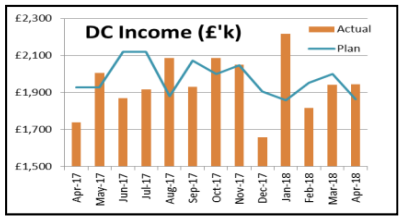
Day case performance is up 3% on activity, 4% financially. Vascular (+£26k) and Plastic Surgery (+£15k) are exceeding plan, as are Gen Med (+£43k) and Cardiology (+£27k). General Surgery is under plan by £72k.

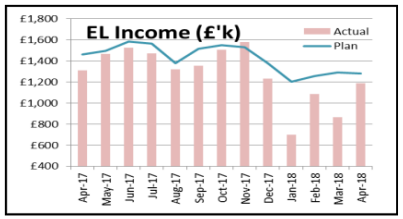
Elective activity is above plan by 2%, but casemix means under financial plan by £90k. The casemix variance is particularly relevant in T&O, affected by Althorp closures in early April as well as shortfall in RTT outsourcing (matched by non-pay underspend).

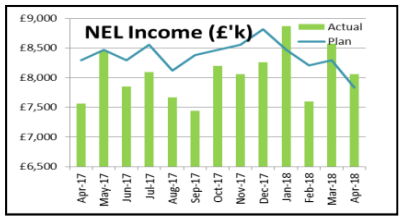
NEL activity was 6% below plan, but positive casemix resulted in 3% favourable variance in income. General Surgery (21%) and Cardiology (51%) were the most significant areas above plan, with Gen Med and Stroke benefitting from casemix.

Outpatients start the year above plan by 3%, with the Surgical Division providing the majority of the over-performance. OPROCS are 5% above plan, attributable to Ophthalmology activity.

Table 4: Key PoD Trend Analysis







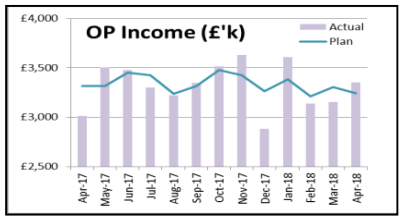


Table 5: SLA Clinical Income by PoD

SLA Clinical Income	Activity			Finance £000's		
Point of Delivery	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
AandE	10,600	10,396	(204)	1,358	1,364	6
Block	-	-	-	906	906	(0)
Cost per Case	235,232	257,573	22,341	3,007	3,069	62
CQUIN	-	-	-	417	417	(0)
Day Cases	3,186	3,270	84	1,910	1,994	83
Elective	401	409	8	1,276	1,187	(90)
Elective XBDs	96	165	69	26	42	16
Non-Elective	4,225	3,971	(254)	7,830	8,059	229
Non-Elective XBDs	2,623	1,936	(687)	650	420	(230)
Outpatient First	4,651	4,553	(98)	820	811	(9)
Outpatient Follow-up	16,656	17,402	746	1,327	1,406	78
Outpt Procedures	12,074	12,645	571	1,482	1,528	46
CIP / Other				148	0	(148)
sub-total	**289,744**	**312,320**	**22,576**	**21,158**	**21,202**	**44**
Contract Penalties				(19)	(10)	9
Challenges				(150)	(150)	0
Readmissions				(266)	(266)	0
MRET				(493)	(493)	0
Fines & Penalties				**(929)**	**(919)**	**9**
Subtotal (excl. Excl Meds & Dev.)	**289,744**	**312,320**	**22,576**	**20,229**	**20,282**	**53**
Excluded Devices	362	249	(113)	165	112	(53)
Excluded Medicines	651	813	162	1,950	1,925	(25)
Total SLA Clinical Incor	**290,757**	**313,382**	**22,625**	**22,344**	**22,319**	**(25)**

Other Clinical Income	Plan	Actual	Variance
Private Patients	95	51	(45)
Overseas Visitors	11	10	(1)
RTA / Personal Injury Income	119	131	12
PCF Funding	460	460	0
Total Other Clinical Income	**686**	**652**	**(34)**

2. Clinical Income By Commissioner

Nene Contract - £229k over performance
The opening position on the Nene contract is £229k over plan.

Key impacts are seen in Critical Care, following the discharge of a long term patient and a full bed base in April, and in non-elective activity casemix was favourable. These are partially offset by NEL XS bed day income below plan, and elective activity and casemix.

Specialised Commissioner - £134k under performance
The under performance is attributable to excluded devices (-£30k) which will have an equivalent underspend.
Non-elective activity is also below plan by £120k, specifically in Paediatrics, Cardiology and General Medicine. We are reviewing Commissioner allocation as these are similar areas to over performance in the Nene contract.

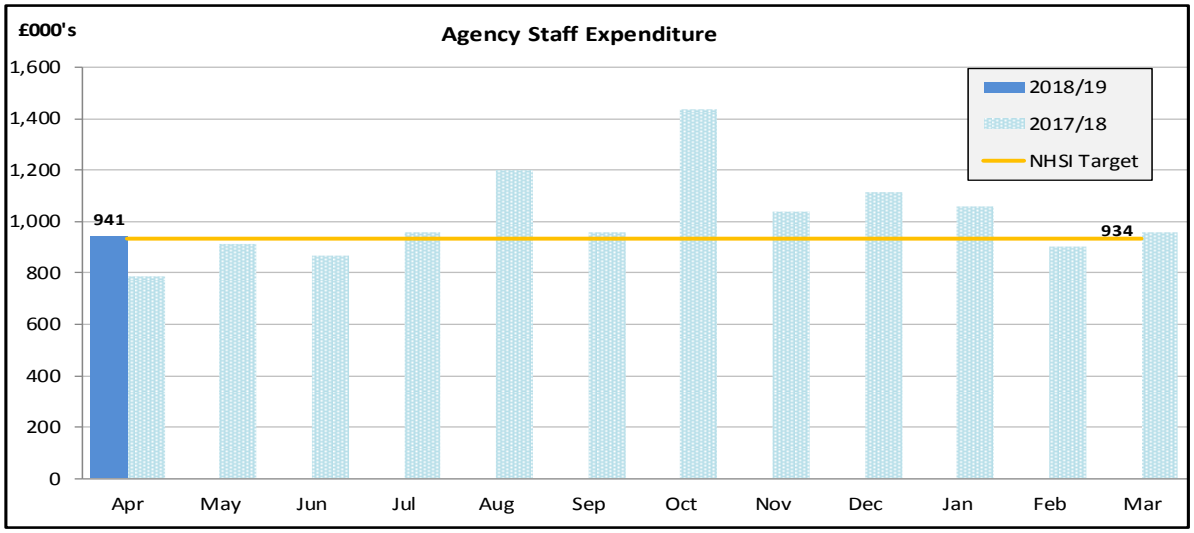
Secondary Dental - £41k over performance
Over-performance on the Secondary Dental is in the MaxFax Specialty, £30k over in non-Elective activity and £11k in OP and OPROCs.

Other - £157k under performance
£148k of this relates to Productivity CIPs.

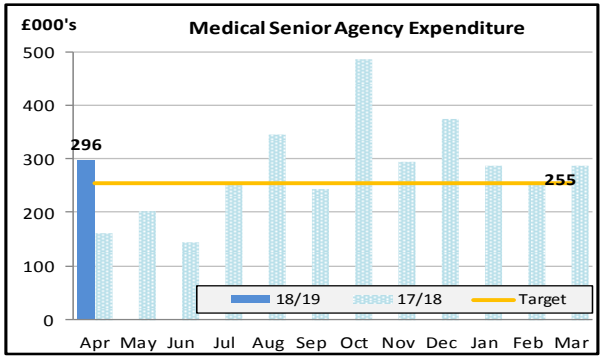
Table 6: SLA Clinical Income by Commissioner

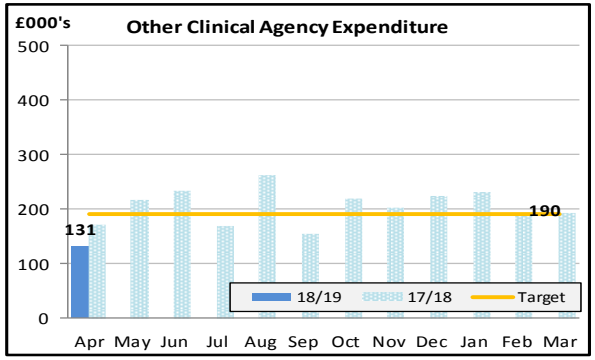
	Finance £000's		
Commissioner	**YTD Plan**	**Actual**	**Variance**
Nene CCG	17,567	17,796	229
Corby CCG	212	222	9
Bedfordshire CCG	58	69	11
East Leicestershire & Rutland CCG	62	80	18
Leicester City CCG	4	6	2
West Leicestershire CCG	4	2	(2)
Milton Keynes CCG	241	199	(42)
Specialised Commissioning	3,331	3,197	(134)
Secondary Dental	531	572	41
NCA / Central / Other	333	176	(157)
Total SLA Income	**22,344**	**22,319**	**(25)**

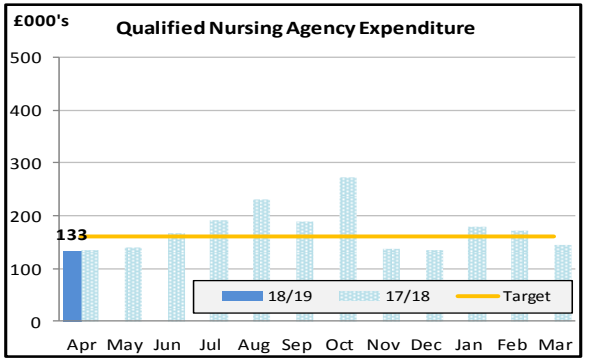
Table 7: Agency Spend

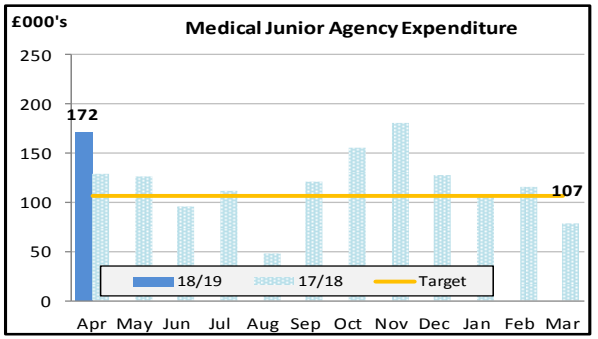


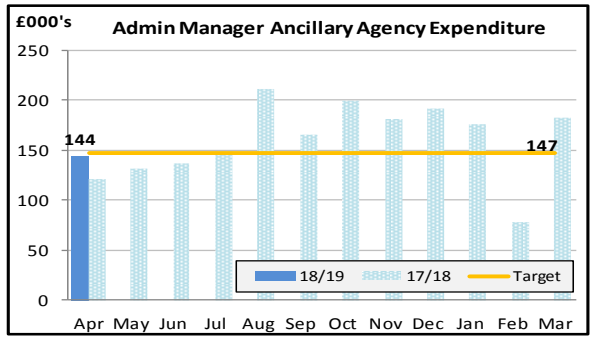
- NHS Improvement issued an expenditure limit of £11.208m for the financial year 2018/19.
- This £934k per month target is equivalent to an 8.1% improvement upon the 17/18 expenditure level. The graphs below apply this reduction equally to all staff groups.
- April 2018, saw higher than target expenditure in both Senior & Junior Medical staff. £65k in senior relates to 17/18 Clinical Haematology on-call payments which had previously been disputed which have now been resolved and paid.

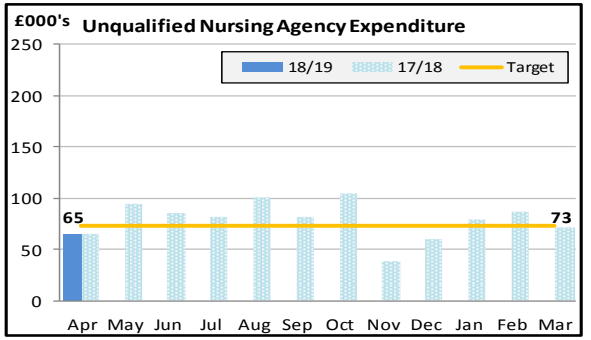












6. Statement of Financial Position

The key movements from opening movements are:

Non Current Assets

- M1 movements include capital additions of £276k, of which £164k relates to IT spend including CaMIS .
- Depreciation - £830k in month as per 2018/19 plan.

Current assets

• Inventories - £175k made up of: Decrease in Pharmacy (£74k) and Heart Centre (£101k).

• Trade & Other Receivables – £104k made up of: Decrease in NHS Receivables (678k), Increase in VAT reclaim (£302k), Increase in Prepayments: CNST & annual maintenance agreements (669k) .

• Cash – Increase of £4,672k. Decrease in Creditor payments following high level of spend in March. £0.7m Revenue Loan drawn down in April in excess of revised April plan profile will be repaid in June.

Current Liabilities

• Trade & Other Payables - £2,319k made up of: Increase in Trade Payable s (£1,290k), Accruals & other Payables (£2,169k), Receipts in Advance (£171k) & PDC Dividend (£210k), offset by decrease in Capital Payables (£1,521k).

Non Current Liabilities

• Drawdown of Revenue Loan. (£4,439k). Repayment of Salix Loan (£30k)

Financed By

- I & E Account -£2,660k deficit in month

Table 8: SOFP

TRUST SUMMARY BALANCE SHEET MONTH 1 2018/19	Balance at 31-Mar-18	Current Month			Forecast end of year	
		Opening Balance	Closing Balance	Movement	Closing Balance	Movement
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	153,637	153,637	153,637	0	153,637	0
IN YEAR REVALUATIONS	0	0	0	0	387	387
IN YEAR MOVEMENTS	0	0	276	276	21,126	21,126
LESS DEPRECIATION	0	0	(830)	(830)	(10,623)	(10,623)
NET BOOK VALUE	153,637	153,637	153,083	(554)	164,527	10,890
CURRENT ASSETS						
INVENTORIES	6,272	6,272	6,097	(175)	6,372	100
TRADE & OTHER RECEIVABLES	16,479	16,479	16,583	104	16,988	509
NON CURRENT ASSETS FOR SALE	0	0	0	0	0	0
CASH	1,547	1,547	6,219	4,672	1,500	(47)
TOTAL CURRENT ASSETS	24,298	24,298	28,899	4,601	24,860	562
CURRENT LIABILITIES						
TRADE & OTHER PAYABLES	22,784	22,784	25,103	2,319	19,272	(3,512)
FINANCE LEASE PAYABLE under 1 year	130	130	130	0	1,181	1,051
SHORT TERM LOANS	20,748	20,748	20,748	0	20,948	200
STAFF BENEFITS ACCRUAL	765	765	765	0	750	(15)
PROVISIONS under 1 year	2,744	2,744	2,734	(10)	1,997	(747)
TOTAL CURRENT LIABILITIES	47,171	47,171	49,480	2,309	44,148	(3,023)
NET CURRENT ASSETS / (LIABILITIES)	(22,873)	(22,873)	(20,581)	2,292	(19,288)	3,585
TOTAL ASSETS LESS CURRENT LIABILITIES	130,764	130,764	132,502	1,738	145,239	14,475
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year	993	993	982	(11)	11,387	10,394
LOANS over 1 year	52,394	52,394	56,803	4,409	74,327	21,933
PROVISIONS over 1 year	1,001	1,001	1,001	0	1,001	0
NON CURRENT LIABILITIES	54,388	54,388	58,786	4,398	86,715	32,327
TOTAL ASSETS EMPLOYED	76,376	76,376	73,716	(2,660)	58,524	(17,852)
FINANCED BY						
PDC CAPITAL	120,251	120,251	120,251	0	120,251	0
REVALUATION RESERVE	31,782	31,782	31,782	0	32,645	863
I & E ACCOUNT	(75,657)	(75,657)	(78,317)	(2,660)	(94,372)	(18,715)
FINANCING TOTAL	76,376	76,376	73,716	(2,660)	58,524	(17,852)

Table 9: Cashflow

MONTHLY CASHFLOW	Annual £000s	ACTUAL APR £000s	FORECAST 18/19 MAY £000s	JUN £000s	JUL £000s	AUG £000s	SEP £000s	OCT £000s	NOV £000s	DEC £000s	JAN £000s	FEB £000s	MAR £000s
RECEIPTS													
SLA Base Payments	274,485	22,144	22,940	22,940	22,940	22,940	22,940	22,940	22,940	22,940	22,940	22,940	22,940
STF Funding	8,554	0	0	2,580	0	0	1,379	0	0	1,838	0	0	2,757
SLA Performance (relating to 17/18 activity)	976	479	496	0	0	0	0	0	0	0	0	0	0
Health Education Payments	9,539	795	795	795	795	795	795	795	795	795	795	795	795
Other NHS Income	11,750	750	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
PP / Other (Specific > £250k)	971	0	971	0	0	0	0	0	0	0	0	0	0
PP / Other	14,395	1,195	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200
Salix Capital Loan	860	0	0	0	0	0	50	0	120	690	0	0	0
Uncommitted Revenue Loan - deficit funding	18,514	4,439	3,143	-1,052	1,276	1,843	1,502	74	1,053	2,122	961	2,898	255
Uncommitted Revenue Loan - STF funding	9,191	0	0	1,379	613	613	612	919	919	919	1,072	1,072	1,073
Interest Receivable	26	6	2	2	2	2	2	2	2	2	2	2	2
TOTAL RECEIPTS	**349,261**	**29,808**	**30,548**	**28,844**	**27,826**	**28,393**	**29,480**	**26,930**	**28,029**	**31,506**	**27,970**	**29,907**	**30,022**
PAYMENTS													
Salaries and wages	202,270	16,698	17,028	16,776	16,776	17,038	16,776	16,776	17,038	16,776	17,038	16,776	16,776
Trade Creditors	106,505	4,941	12,816	11,209	7,583	8,091	8,054	7,032	8,049	10,717	7,793	10,972	9,248
NHS Creditors	21,582	2,048	1,993	1,993	1,993	1,993	1,993	1,993	1,993	1,993	1,993	800	800
Capital Expenditure	10,426	1,431	1,156	1,045	1,323	499	790	882	939	160	992	586	624
PDC Dividend	968	0	0	0	0	0	0	203	0	0	0	0	765
Repayment of Revenue Loan - STF funding	4,545	0	0	0	0	0	1,379	0	0	1,838	0	0	1,328
Repayment of Loans (Principal & Interest)	2,901	8	11	22	152	772	486	8	11	22	154	774	481
Repayment of Salix loan	68	29	0	0	0	0	3	36	0	0	0	0	0
TOTAL PAYMENTS	**349,266**	**25,156**	**33,004**	**31,044**	**27,826**	**28,393**	**29,480**	**26,929**	**28,030**	**31,505**	**27,970**	**29,908**	**30,022**
Actual month balance	-5	4,652	-2,456	-2,200	0	0	0	1	-1	1	0	-1	0
Cash in transit & Cash in hand adjustment	0	-44	44	0	0	0	0	0	0	0	0	0	0
Balance brought forward	1,504	1,504	6,112	3,700	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500
Balance carried forward	**1,500**	**6,112**	**3,700**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**

- The Trust ended April with £6,112k cash balance; £4,612k more than planned. This was due to drawing down more loan than required due to the timing of drawdown submission being earlier than when the plan was finalised (this will be re-profiled for the June drawdown). In addition, the high level of payments made in March meant that the number of supplier invoices due for payment in April was lower than usual.
- Nene CCG's SLA was paid as per the agreed 18/19 contract value. All other SLAs have been paid at the 17/18 rate. These will be adjusted in May/June.
- A number of Quarter 3 Performance invoices were paid in April. The remainder are forecast to be received in May. Cash settlement of 17/18 Performance with Nene CCG is expected in July once final activity, challenges, etc have been reconciled. Final performance with other Commissioners will also be invoiced to the same timescale.

Table 10: Cash forecast

Table 11: Capital

Capital Scheme	Plan 2018/19 £000's	M1 Plan £000's	M1 Spend £000's	Under (-) / Over £000's	Plan Achieved %	Total Actual & Committed £000's	Plan Achieved %
Medical Equipment - MESC Block	630	-6	-6	0	-1%	60	10%
Medical Equipment - CF Specific Forecast	100	0	0	0	0%	0	0%
Dexa Scanner - Enabling Costs (Lease)	30	0	0	0	0%	0	0%
Information Technology - Replacement of NPfIT systems inc. CaMIS	792	130	130	0	16%	287	36%
Information Technology	2,726	0	34	34	1%	229	8%
Estates - Backlog	1,194	1	17	16	1%	663	56%
Estates - Statutory	520	0	73	73	14%	175	34%
Estates - Non Maintenance	616	0	0	0	0%	33	5%
Estates - Ward Refurbishment	725	0	0	0	0%	0	0%
Nye Bevan - Setting Up Costs	296	10	28	18	9%	44	15%
Nye Bevan Assessment Unit (Finance Lease)	12,329	0	0	0	0%	0	0%
Inventory / Ledger Upgrade	32	0	0	0	0%	1	3%
MRI 1 Enabling Costs	277	0	0	0	0%	258	93%
SALIX	860	0	0	0	0%	0	0%
Total - Capital Plan	**21,127**	**135**	**276**	**140**	**1%**	**1,750**	**8%**
Less Charitable Fund Donations	-100	0	0	0	0%	0	0%
Less NBV of Disposals	0	0	0	0	0%	0	0%
Total - CRL	**21,027**	**135**	**276**	**140**	**1%**	**1,750**	**8%**

Funding Resources	
Internally Generated Depreciation	10,623
Finance Lease - Assessment Unit	12,329
Salix	860
Capital Element - Finance Lease (Car Park Decking)	-130
Capital Loan - Repayment	-1,835
Capital Element - Finance Lease (Assessment Unit)	-752
Other Loans - Repayment (SALIX)	-68
Total - Available CRL Resource	**21,027**
Uncommitted Plan	**0**

- The Trust capital plan at the start of the year is £21,127k including Charitable Funds of £100k.
- Spend in M1 was £140k more than plan due to accelerated spend on a few schemes (including estates compliance) but is expected to get back to plan later in the year.
- Schemes that have carried over from 2017/18 include, CaMIS, NYE Bevan, Inventory System & MRI 1 Enabling costs.
- CaMIS has a planned start date of 4th June 2018. Budget for 2018/19 totals £622k. Month 1 spend includes £41k of capitalised salaries.
- Medical Equipment includes a VAT adjustment for -6k associated with the purchase of stroke telemedicine system.
- No Charitable Spend in Month 1.

Receivables and Payables

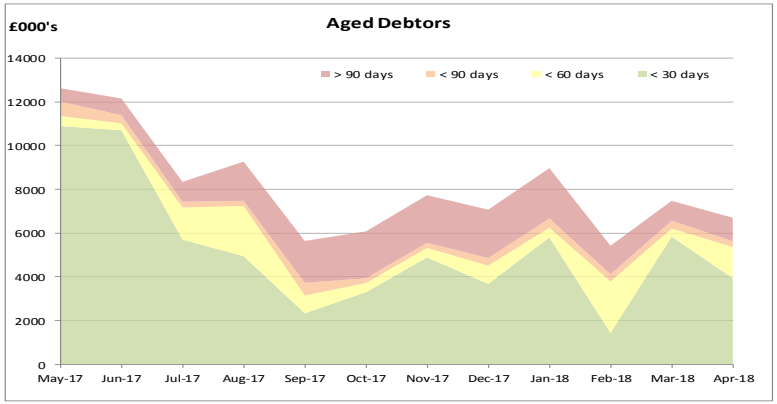
- NHS Receivables – Accruals are included within the 0 to 30 Days Receivables balance.
- Outstanding SLA performance invoices issued in March are included within the 31 to 60 days NHS Receivables Balance.
- NHS over 90 day debt include University Hospitals of Leicester NHS Trust £64k, Oxford University Hospital NHS Foundation Trust £37k, Kettering General Hospital NHS Foundation Trust £50k and NHS Property Services £78k, which is part of an ongoing dispute, and £127k NCA's.
- Non-NHS over 90 day debt includes overseas visitor accounts of £303k of which £163k are paying in instalments, private patients accounts of £42k, BMI Three Shires £89k and Alliance Medical £209k.

Table 12: Receivables and Payables

Narrative	Total at April £000's	0 to 30 Days £000's	31 to 60 Days £000's	61 to 90 Days £000's	Over 90 Days £000's
Receivables Non NHS	1,859	542	567	62	689
Receivables NHS	4,838	3,387	865	198	388
Total Receivables	**6,697**	**3,928**	**1,432**	**260**	**1,077**
Payables Non NHS	(4,741)	(4,734)	0	(6)	0
Payables NHS	(1,012)	(1,012)	0	0	0
Total Payables	**(5,753)**	**(5,747)**	**0**	**(6)**	**0**

Narrative	Total at March £000's	0 to 30 Days £000's	31 to 60 Days £000's	61 to 90 Days £000's	Over 90 Days £000's
Receivables Non NHS	1,955	987	120	221	627
Receivables NHS	5,516	4,846	245	143	281
Total Receivables	**7,471**	**5,833**	**365**	**365**	**908**
Payables Non NHS	(4,576)	(4,565)	(8)	(4)	0
Payables NHS	(1,410)	(1,410)	0	0	0
Total Payables	**(5,986)**	**(5,974)**	**(8)**	**(4)**	**0**

Table 13: Aged Receivables



Better Payment Practice Code

- All BPPC performance targets were met in April 2018.

Table 14: BPPC

Narrative	April 2018	Cumulative 2018/19	Cumulative 2017/18
NHS Creditors			
No.of Bills Paid Within Target	99	99	1,657
No.of Bills Paid Within Period	99	99	1,737
Percentage Paid Within Target	**100.00%**	**100.00%**	**95.39%**
Value of Bills Paid Within Target (£000's)	1,432	1,432	18,540
Value of Bills Paid Within Period (£000's)	1,432	1,432	18,914
Percentage Paid Within Target	**100.00%**	**100.00%**	**98.02%**
Non NHS Creditors			
No.of Bills Paid Within Target	3,887	3,887	65,047
No.of Bills Paid Within Period	3,953	3,953	66,308
Percentage Paid Within Target	**98.33%**	**98.33%**	**98.10%**
Value of Bills Paid Within Target (£000's)	6,884	6,884	86,373
Value of Bills Paid Within Period (£000's)	6,954	6,954	91,760
Percentage Paid Within Target	**99.00%**	**99.00%**	**94.13%**
Total			
No.of Bills Paid Within Target	3,986	3,986	66,704
No.of Bills Paid Within Period	4,052	4,052	68,045
Percentage Paid Within Target	**98.37%**	**98.37%**	**98.03%**
Value of Bills Paid Within Target (£000's)	8,316	8,316	104,914
Value of Bills Paid Within Period (£000's)	8,386	8,386	110,674
Percentage Paid Within Target	**99.17%**	**99.17%**	**94.80%**

7. Single Oversight Framework (SOF)

The Single oversight framework includes scoring for "finance and use of resources". The Trust continues to score "3" against this metric.

Table 15: SOF

Criteria		Score	Weight	Weighted Score
Capital Service capacity (times)	-2	4	20.00%	0.80
Liquidity (days)	-31	4	20.00%	0.80
I&E Margin	-11%	4	20.00%	0.80
Distance From Plan	19%	1	20.00%	0.20
Agency spend (distance from cap)	1%	2	20.00%	0.40
Overall Score				3.0

Finance and use of resources metrics

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

Note: brackets indicate negative numbers

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

Northampton General Hospital NHS Trust

Report To	**Trust Board**
Date of Meeting	**31 May 2018**

Title of the Report	**Workforce Performance Report**
Agenda item	**11**
Presenter of Report	Janine Brennan, Director of Workforce & Transformation
Author(s) of Report	Adam Cragg, Head of Resourcing & Employment Services
Purpose	This report provides an overview of key workforce issues

Executive summary

- The key performance indicators show an increase in contracted workforce employed by the Trust, and a decrease in sickness absence from March 2018.
- Increase in compliance rate for Mandatory Training, Appraisals and Role Specific Essential Training.
- Summary of the LWAB Workshop held in March 2018
- Key Highlights in relation to Nurse Recruitment
- Key Highlights in relation to Nurse Retention
- Medical Recruitment Action Plan update

Related strategic aim and corporate objective	Enable excellence through our people
Risk and assurance	Workforce risks are identified and placed on the Risk register as appropriate.
Related Board Assurance Framework entries	BAF – 2.1, 2.2 and 2.3
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (Y/N) No

	If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (Y/N) No If yes please give details and describe the current or planned activities to address the impact.
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper

Actions required by the Workforce Committee

The Committee is asked to Note the report.

Northampton General Hospital NHS Trust

TRUST BOARD

THURSDAY 31 MAY 2018

WORKFORCE PERFORMANCE REPORT

1. Introduction

This report identifies the key themes emerging from April 2018 performance and identifies trends against Trust targets. It also sets out current key workforce updates.

2. Workforce Report

2.1 Capacity

Substantive Workforce Capacity increased by 13.21FTE in April 2018 to 4419.08FTE. The Trust's substantive workforce is at 87.86% of the Budgeted Workforce Establishment of 5029.84 FTE. This percentage is slightly lower than in recent months due to an increase in budgeted establishment from 1 April 2018.

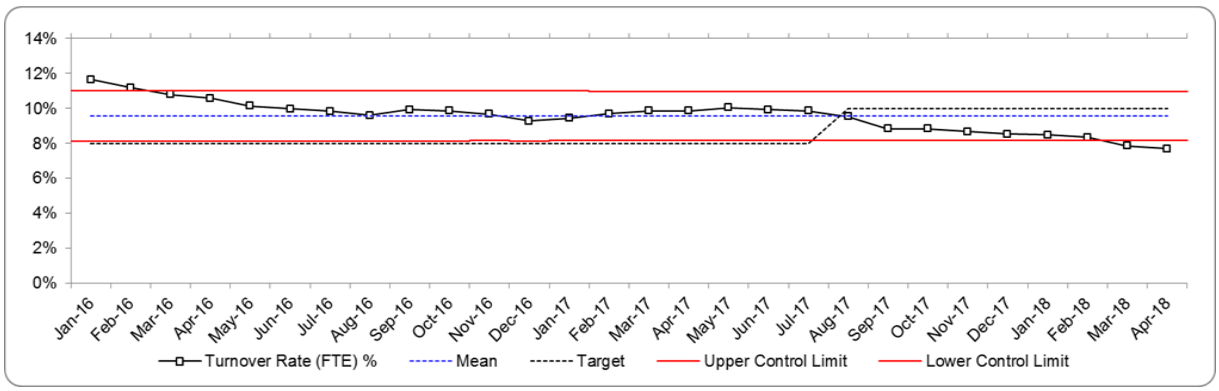
Trust Turnover

Annual Trust turnover for April 2018 decreased by 0.17% to 7.69%, which is below the Trust target of 10%

Turnover within Nursing & Midwifery decreased by 0.28% to 5.72%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust.

Turnover also decreased for Add Prof Sci & Tech by 2.58%; Allied Health Professionals by 0.64%; Healthcare Scientists by 0.01% and Medical & Dental by 2.07%.

Turnover increased for Additional Clinical Services by 0.37%; Admin & Clerical by 0.14% and Estates & Ancillary by 0.41%.



Vacancy Rates

The overall Trust vacancy rate for March 2018 is 12.14% against a Trust target of 9%. The vacancy % rate has decreased in April 2018 for Add Prof Sci & Tech; Additional Clinical Services and Medical & Dental.

There has been an increase for Admin & Clerical; Allied Health Professionals; Estates & Ancillary; Healthcare Scientists and Nursing & Midwifery.

The largest decrease in vacancy rates was experienced by Add Prof Sci & Tech, decreased by 3.25% to an overall figure of 8.79%

Sickness Absence

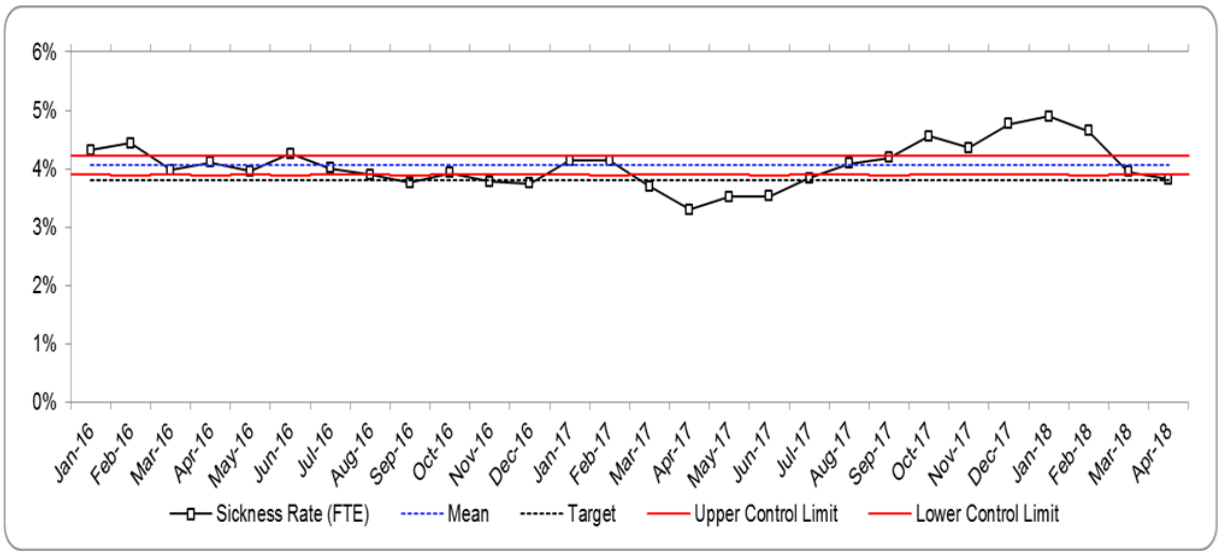
Sickness absence for April 2018 decreased from 3.95% to 3.82% which is just above Trust target of 3.8%.

Only Surgical and Clinical Support Services Divisions were under the Trust's target

Sickness by Division:

- Medicine and Urgent Care at 4.09%
- Surgery Division at 3.34%
- Women, Children & Oncology at 3.87%
- Clinical Support Services at 3.18%
- Support Services at 4.50%.

Amongst the directorates, the Facilities Directorate had the highest sickness rate of 5.36%.



LWAB Workshop

On the 28 March 2018 a LWAB workshop was undertaken to enable the LWAB membership to evaluate progress made to date on the various workforce themes and to develop ideas and then agreement on LWAB priorities for 2018/19 to inform the LWABs future work plan. A full breakdown of the feedback arising from the workshop can be found at appendix 1.

Nurse Recruitment

Social Media Update

The Trusts presence on various social media platforms continues to grow and a summary in this regard is as follows:

- **LinkedIn:** total followers 2349, which is 90 followers up from last report.

- **Twitter:** total followers 213 which has increased by 46 followers during the last quarter. In the last 7 days we have earned 2302 'impressions'. An 'impression' is the number of times a specific 'Tweet' is delivered to people streams and thus a metric to gauge the reach of advertising nursing posts through Twitter.

- **Instagram:** The Trust now has 162 followers on Instagram, up by 31 followers during the last quarter.

- **Glassdoor:** Glassdoor is a website where employees and former employees anonymously review companies and their management. The Trust has had 7 comments left on our company reviews, dating back to 2014. 6 comments were positive and 1 negative which was posted in 2014. The resourcing team are encouraging new starters to leave feedback.

Best of Both Worlds Initiative

The Best of Both Worlds initiative has now used the money allocated to it by HEE. Discussions are currently underway as to whether there is more funding available with HEE in order to fund the continuation of the marketing of the microsite and vacant positions. As of March 2018 the Best of Both Worlds initiative had reached 4 million people through page impressions and readership circulation with advertising, articles and interviews.

Recruitment from the Armed Forces

The following ways to attract appropriately qualified ex-armed forces personnel to come and work at the Trust are currently being explored as follows.

- Career Transition Partnership: This is an Outplacement Support facility for armed forces personnel seeking a new career. CT partnership accounts have been created for the Trust to advertise nursing jobs there. There is a particular opportunity to attract ODPs through this route.

- Step into Health: This is a NHS led scheme aimed at recruiting ex-armed forces personnel and is currently being considered as a means of recruiting qualified nursing staff to the Trust.

Recruitment Fairs

On 20 January 2018 a Trust wide Recruitment Fair took place resulting 11 offers of which 8 were recruited to Urgent Care.

On 24 February a Recruitment Fair took place specifically for Urgent Care, which resulted in five offers to qualified nurses.

A number of further Nurse Recruitment Fairs have been arranged for specific areas .

Nurse Retention

An analysis over the last three years of the Trusts qualified nurse leaver's top reasons for leaving has been undertaken to enable us to target reasons for this turnover.

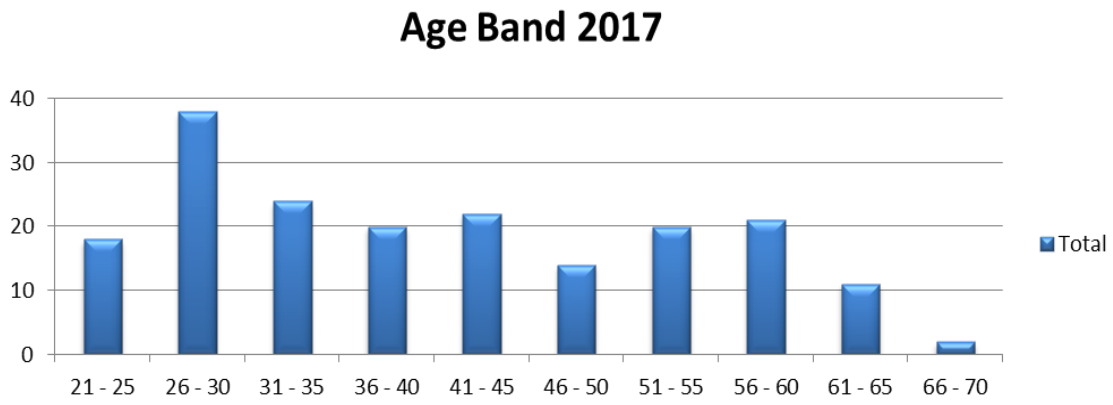
	2015	%	2016	%	2017	%
Voluntary Resignation - Relocation	52	17.51	42	20.59	40	21.1
Voluntary Resignation - other/Not Known	68	22.90	35	17.16	9	4.74
Retirement Age	35	11.78	24	11.76	23	12.1
Voluntary Resignation - Work Life Balance	20	6.73	13	6.37	15	7.89
Voluntary Resignation - Adult & Child Dependent's	10	3.37	3	1.47	6	3.16
Voluntary Resignation - Promotion	8	2.69	5	2.45	5	2.63

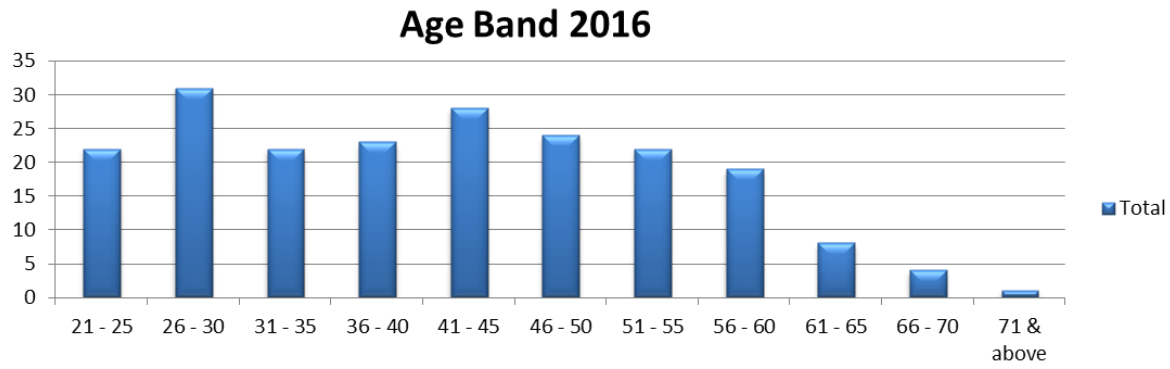
The highest reasons for leaving has been relocation and other/Not Known. An amendment has been made on leaver's termination and the other/Not known option removed in order to enhance the Trusts ability to identify the actual reasons for leaving.

Exit Questionnaires

Work is underway to launch a new Exit Questionnaire process via a system due to be implemented shortly called 'Questback'. Once implemented, the system will automatically send links to potential leavers asking them to complete an Exit Questionnaire and this will allow us to have intelligent management data in the form of a Dashboard regarding the reasons for leaving. The functionality of the system would also enable the Trust to contact leavers 6-12 month after their departure to see how they are getting on and to make them aware of job opportunities at NGH. The early stages of the systems implementation are underway and the content of the Exit Questionnaire is the process of being agreed for inclusion on the system.

Age Profile Analysis Leavers





The trends detailed above show that those nurses leaving within the age range of 21-30 has remained relatively high over the last two years. The recent Staff Survey also indicated that Staff Engagement of this age group as being the lowest which raises concern. We will work to target these age groups and set up focus groups to gather more information. Coaching and mentoring them will also be looked into in aid to help us retain them and most importantly, Listen to them and work on the feedback.

Draft Health & Care Workforce Strategy for England to 2027

A national workforce strategy for England was released for consultation the details of which were submitted to the Workforce Committee on 23 May 2018. Contributions to the consultation were made to NHS Employers via the East Midlands HR Directors Network, LWAB and NHS Improvement.

Medical Staffing Audit

An audit was conducted into Medical Staffing in September 2017, which was subsequently followed up with second audit conducted in December 2017 which provided limited assurance in respect of the improvements required. A further audit was conducted in April 2018 which demonstrated significant improvement and Medical Staffing has been removed from the risk register as a result. Further details of this latest audit were submitted to the Workforce Committee on 23 May 2018.

Medical Recruitment

Regular monthly medical recruitment meetings have commenced and the actions detailed within the attached medical recruitment action plan have been discussed and updated.

Specific priorities have been identified by the medical recruitment group and the action plan has been refined to focus on these particular areas. Having scoped this work out, the associated deadlines for completion of the tasks have been revised accordingly.

2.2 Capability

Appraisals, Mandatory Training and Role Specific Essential Training

The current rate of Appraisals recorded for April 2018 is 85.35%; this is an increase of 0.20% from last month's figure of 85.15%.

Mandatory Training compliance increased in April 2018 from 88.01% to 88.60% this is an increase of 0.59% from last month's figure and remains above the Trust target of 85%.

Role Specific Essential Training compliance also increased in April 2018 to 84.62% from last month's figure of 84.25%.; that is an increase of 0.37%.

2.3 Culture

An action plan has been developed to support the Respect & Support campaign which will be launched in June 2018.

3. Assessment of Risk

Managing workforce risk is a key part of the Trust's governance arrangements.

4. Recommendations/Resolutions Required

The Trust Board is asked to note the report.

5. Next Steps

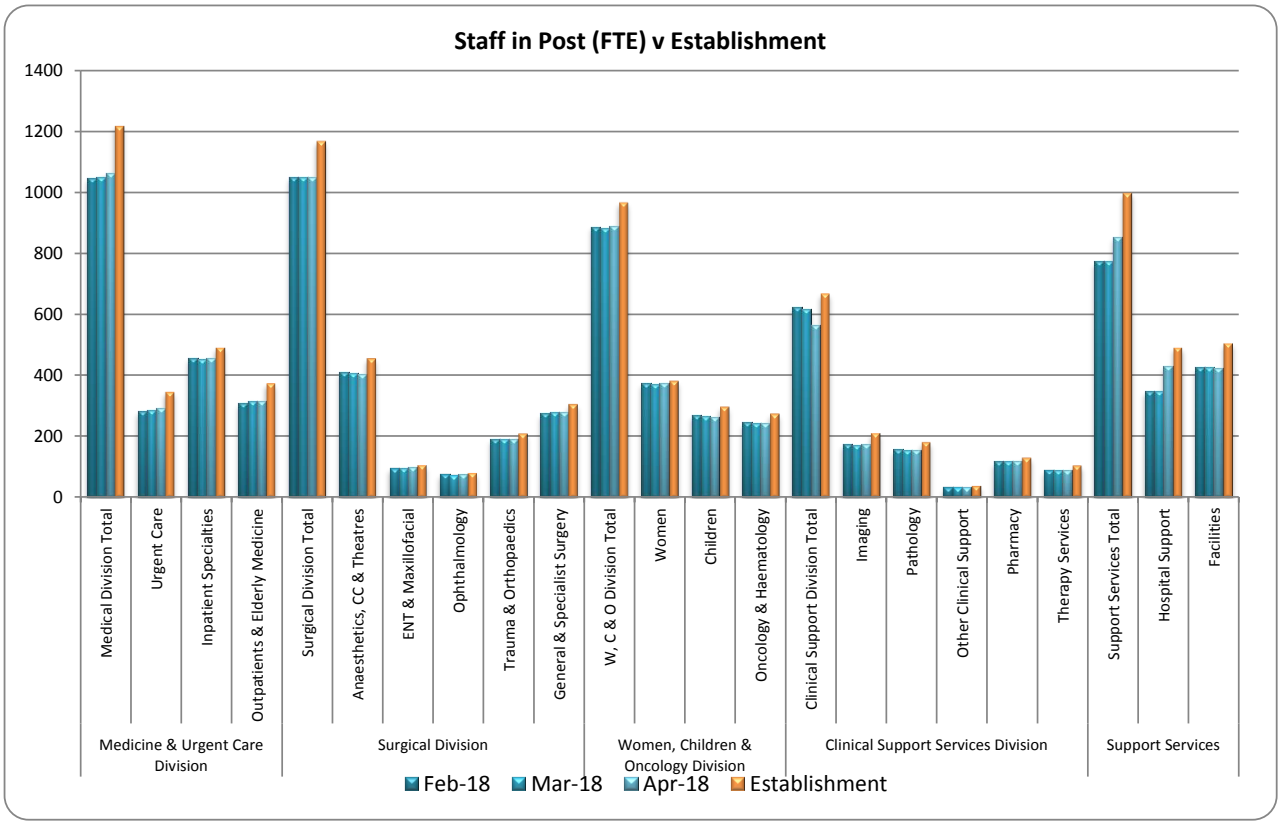
Key workforce performance indicators are subject to regular monitoring and appropriate action is taken as and when required.

Workforce Committee: Capacity, Capability and Culture Report - April 2018

CAPACITY
Staff in Post

Establishment RAG Rates:	< 88%	88-93%	> 93%

Staff in Post (FTE)		Feb-18		Mar-18		Apr-18	Establishment	
Medicine & Urgent Care Division	Medical Division Total	1048.07	↑	1051.97	↑	1063.91	1219.53	87.24%
	Urgent Care	281.48	↑	284.09	↑	292.52	347.56	84.16%
	Inpatient Specialties	456.78	↓	453.37	↑	455.80	492.89	92.47%
	Outpatients & Elderly Medicine	308.81	↑	313.51	↑	314.59	376.08	83.65%
Surgical Division	Surgical Division Total	1050.86	↓	1050.66	↓	1049.83	1170.12	89.72%
	Anaesthetics, CC & Theatres	409.57	↓	407.42	↓	402.44	456.71	88.12%
	ENT & Maxillofacial	95.01	↑	96.41	↑	98.88	107.67	91.84%
	Ophthalmology	76.21	↓	72.57	↑	73.57	81.82	89.92%
	Trauma & Orthopaedics	190.99	↓	190.68	↓	189.78	210.22	90.28%
	General & Specialist Surgery	273.27	↑	277.77	↑	279.35	306.90	91.02%
Women, Children & Oncology Division	W, C & O Division Total	887.85	↓	881.42	↑	888.01	969.20	91.62%
	Women	373.24	↓	371.83	↑	373.01	383.06	97.38%
	Children	268.40	↓	265.14	↓	262.85	298.09	88.18%
	Oncology & Haematology	244.22	↓	242.45	↓	241.75	275.92	87.62%
Clinical Support Services Division	Clinical Support Division Total	624.64	↓	617.45	↓	564.24	670.78	84.12%
	Imaging	174.97	↓	170.59	↑	172.21	212.53	81.03%
	Pathology	155.30	↓	153.50	↑	154.56	182.23	84.82%
	Other Clinical Support	32.72	↑	32.72	↓	32.18	38.97	82.58%
	Pharmacy	115.59	↑	116.78	↑	118.90	131.30	90.56%
	Therapy Services	89.18	↓	86.98	↓	86.38	105.75	81.68%
Support Services	Support Services Total	772.75	↑	773.76	↑	853.09	1000.21	85.29%
	Hospital Support	348.36	↑	348.53	↑	430.66	492.77	87.40%
	Facilities	424.38	↑	425.22	↓	422.42	507.44	83.25%
Trust Total		4413.78	↓	4405.87	↑	4419.08	5029.84	87.86%



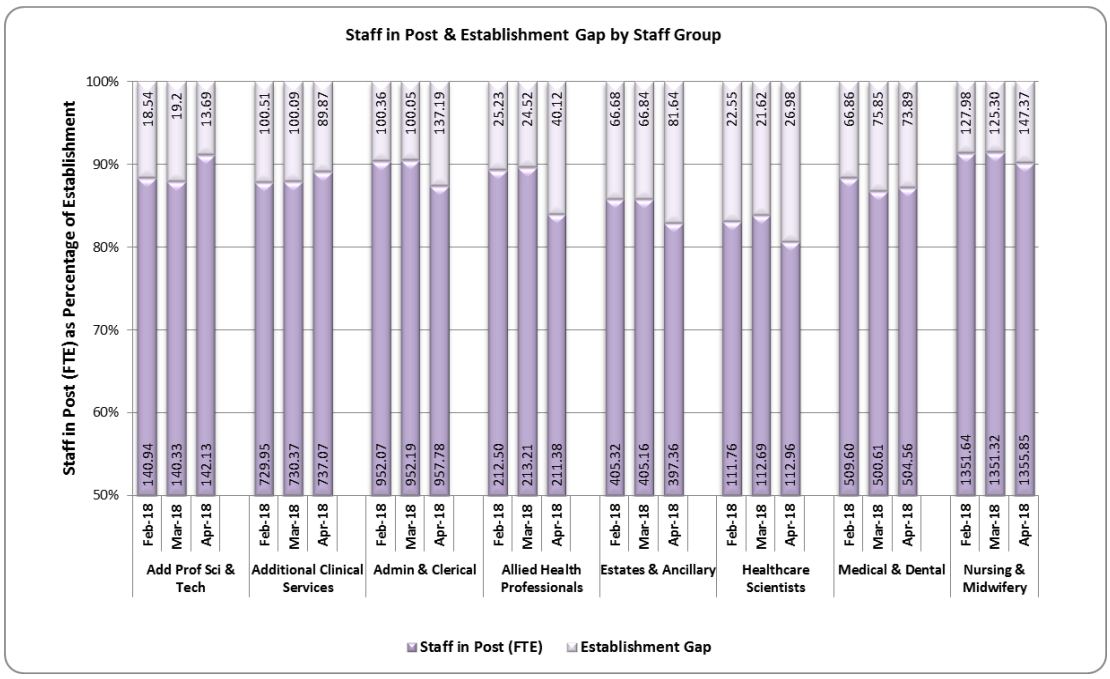
Workforce Committee: Capacity, Capability and Culture Report - April 2018

CAPACITY
Staff Group (FTE v Est)

Vacancy RAG Rates:	> 10%	9 - 10%	< 9%

Staff Group Vacancy Rate (Contracted FTE v Establishment)

Staff Group	Feb-18	Mar-18	Apr-18
Add Prof Sci & Tech	11.62%	12.04%	8.79%
Additional Clinical Services	12.10%	12.05%	10.87%
Admin & Clerical	9.54%	9.51%	12.53%
Allied Health Professionals	10.61%	10.32%	15.95%
Estates & Ancillary	14.13%	14.16%	17.04%
Healthcare Scientists	16.79%	16.10%	19.28%
Medical & Dental	11.60%	13.16%	12.77%
Nursing & Midwifery	8.65%	8.49%	9.80%



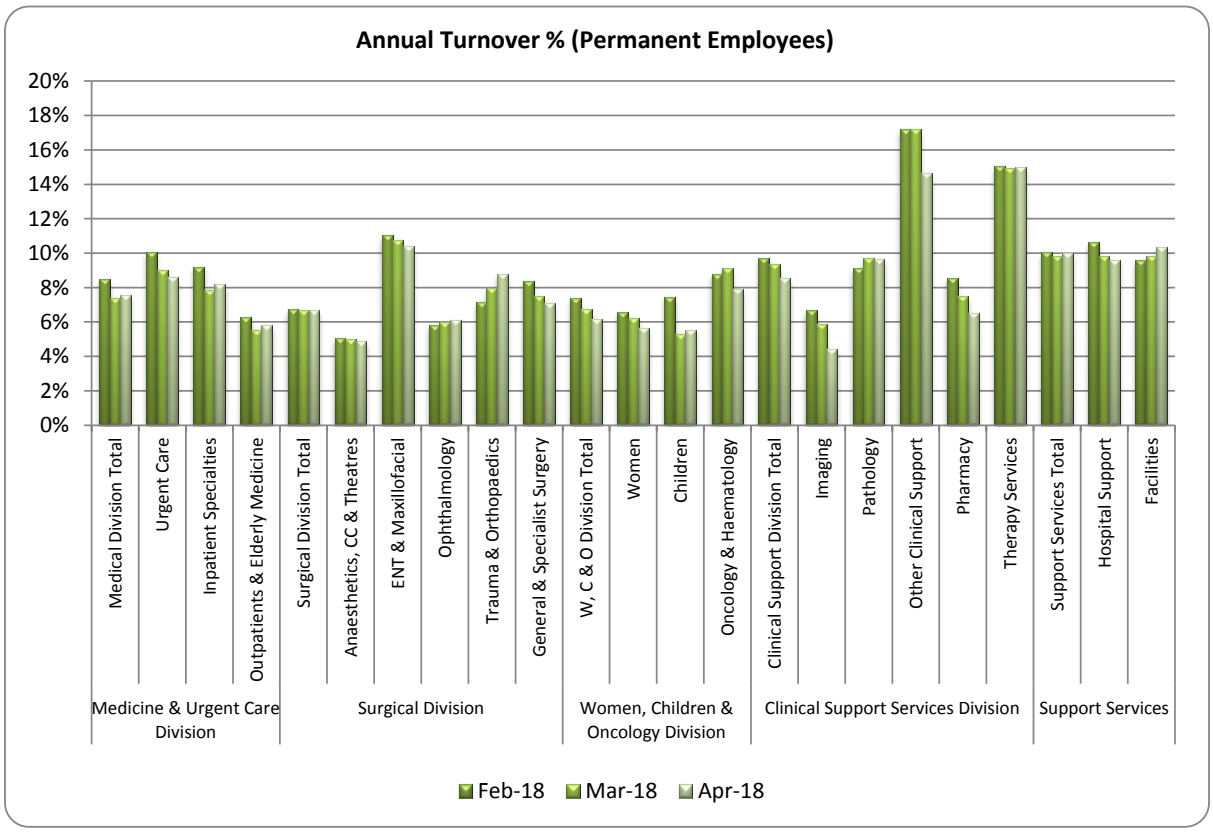
Workforce Committee: Capacity, Capability and Culture Report - April 2018

CAPACITY
Annual Turnover

Figures refer to the year ending in the month stated

Turnover RAG Rates:		
> 12%	10 - 12%	< 10%

Annual Turnover (Permanent Staff)		Feb-18	Mar-18		Apr-18	
Medicine & Urgent Care Division	Medical Division Total	8.47%	↘	7.41%	↗	7.53%
	Urgent Care	10.06%	↘	9.00%	↘	8.62%
	Inpatient Specialties	**9.17%**	↘	**7.85%**	↗	**8.17%**
	Outpatients & Elderly Medicine	**6.26%**	↘	**5.54%**	↗	**5.81%**
Surgical Division	Surgical Division Total	6.76%	↘	6.69%	↗	6.69%
	Anaesthetics, CC & Theatres	5.04%	↘	5.01%	↘	4.90%
	ENT & Maxillofacial	11.04%	↘	10.78%	↘	10.37%
	Ophthalmology	5.84%	↗	5.98%	↗	6.12%
	Trauma & Orthopaedics	7.15%	↗	7.97%	↗	8.77%
	General & Specialist Surgery	8.37%	↘	7.48%	↘	7.12%
Women, Children & Oncology Division	W, C & O Division Total	7.40%	↘	6.71%	↘	6.19%
	Women	6.56%	↘	6.20%	↘	5.66%
	Children	7.43%	↘	5.29%	↗	5.51%
	Oncology & Haematology	8.76%	↗	9.14%	↘	7.90%
Clinical Support Services Division	Clinical Support Division Total	9.69%	↘	9.37%	↘	8.54%
	Imaging	6.68%	↘	5.89%	↘	4.44%
	Pathology	9.12%	↗	9.72%	↘	9.65%
	Other Clinical Support	17.22%	↗	17.22%	↘	14.64%
	Pharmacy	8.53%	↘	7.48%	↘	6.53%
	Therapy Services	15.07%	↘	14.93%	↗	14.98%
Support Services	Support Services Total	10.05%	↘	9.82%	↗	9.99%
	Hospital Support	10.62%	↘	9.84%	↘	9.59%
	Facilities	9.58%	↗	9.80%	↗	10.32%
Trust Total		8.35%	↘	7.86%	↘	7.69%



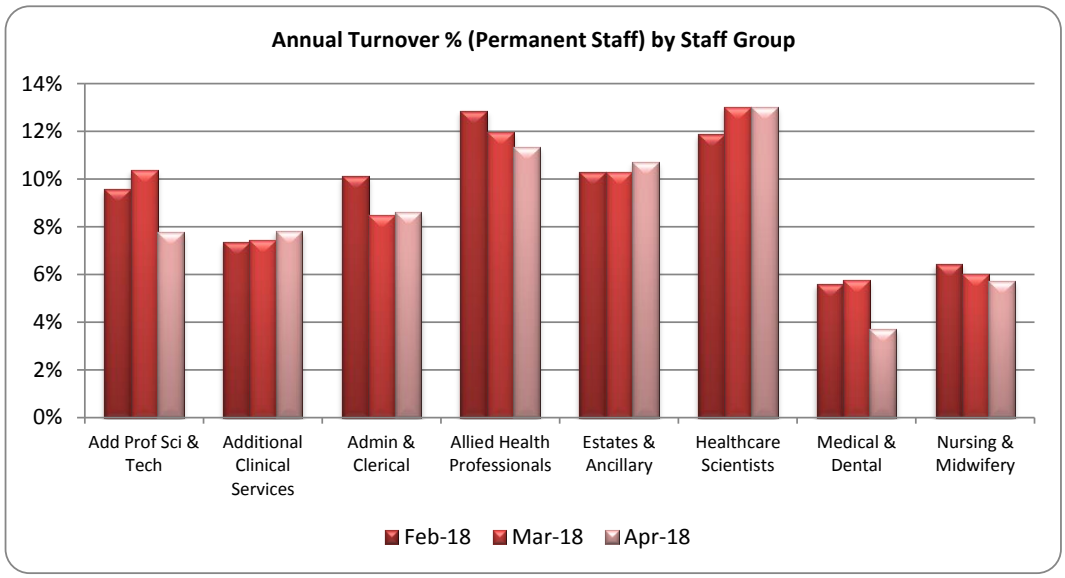
Workforce Committee: Capacity, Capability and Culture Report - April 2018

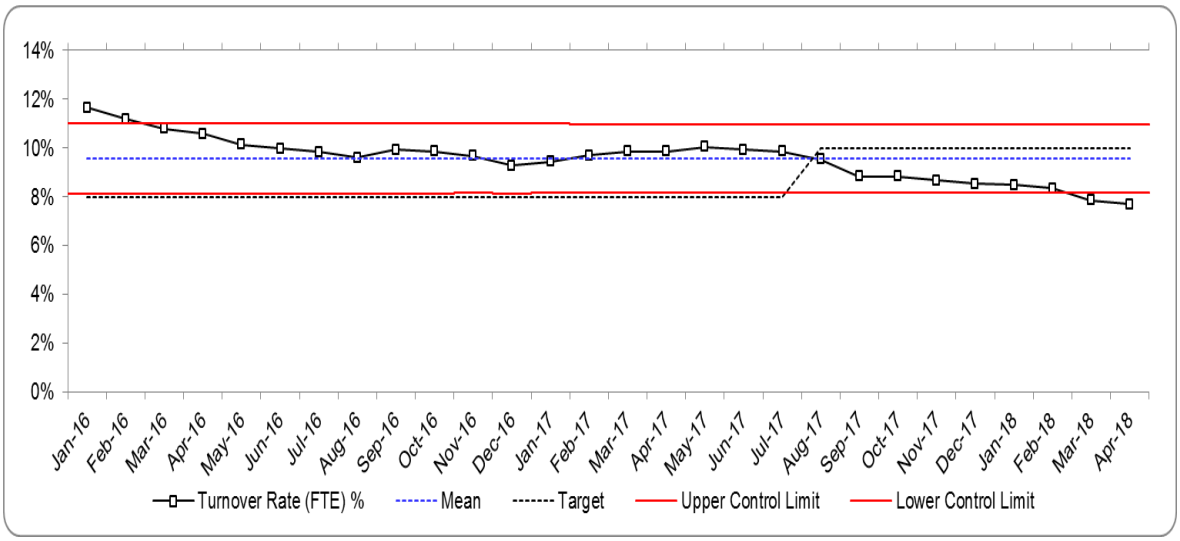
CAPACITY
Turnover by Staff Group

Turnover RAG Rates:		
> 12%	10 - 12%	< 10%

Annual Turnover Rate for Permanent Staff *Figures refer to the year ending in the month stated*

Staff Group	Feb-18		Mar-18		Apr-18
Add Prof Sci & Tech	9.58%	↗	10.36%	↘	7.78%
Additional Clinical Services	7.36%	↗	7.44%	↗	7.81%
Admin & Clerical	10.13%	↘	8.46%	↗	8.60%
Allied Health Professionals	12.85%	↘	11.97%	↘	11.33%
Estates & Ancillary	10.27%	↗	10.28%	↗	10.69%
Healthcare Scientists	11.90%	↗	13.02%	↘	13.01%
Medical & Dental	5.58%	↗	5.76%	↘	3.69%
Nursing & Midwifery	6.43%	↘	6.00%	↘	5.72%





Workforce Committee: Capacity, Capability and Culture Report - April 2018

Capacity:
Substantive Workforce Capacity increased by 13.21FTE in April 2018 to 4419.08FTE. The Trust's substantive workforce is at 87.86% of the Budgeted Workforce Establishment of 5029.84 FTE.

Staff Turnover:

Annual Trust turnover for April 2018 decreased by 0.17% to 7.69%, which is below the Trust target of 10%. Turnover within Nursing & Midwifery decreased by 0.28% to 5.72%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust. Turnover also decreased for Add Prof Sci & Tech by 2.58%; Allied Health Professionals by 0.64%; Healthcare Scientists by 0.01% and Medical & Dental by 2.07%.

Turnover increased for Additional Clinical Services by 0.37%; Admin & Clerical by 0.14% and Estates & Ancillary by 0.41%.

Turnover by Division:
Medical Division: turnover increased by 0.12% to 7.53%
Surgical Division: turnover remained the same at 6.69%
Women, Children & Oncology Division: turnover decreased by 0.52% to 6.19%
Clinical Support Services Division: turnover decreased by 0.83% to 8.54%
Support Services: turnover increased by 0.17% to 9.99%

Staff Vacancies: The vacancy % rate has decreased in April 2018 for Add Prof Sci & Tech; Additional Clinical Services and Medical & Dental.

There has been an increased for Admin & Clerical; Allied Health Professionals; Estates & Ancillary; Healthcare Scientists and Nursing & Midwifery.

Largest decrease experienced by Add Prof Sci & Tech, decreasing 3.25% to 8.79%.

Sickness Absence:

Sickness absence for April 2018 decreased from 3.95% to 3.82% which is just above Trust target of 3.8%. Only Surgical and Clinical Support Services Divisions were under the Trust's target

Sickness by Division:
Medicine and Urgent Care at 4.09%
Surgery Division at 3.34%
Women, Children & Oncology at 3.87%
Clinical Support Services at 3.18%
Support Services at 4.50%.

Facilities Directorate had the highest sickness rate of 5.36% amongst the directorates.

In total 10 directorate level organisations were below the trust target rate in April 2018 compared to 10 directorates in March 2018.

Workforce Committee: Capacity, Capability and Culture Report - April 2018

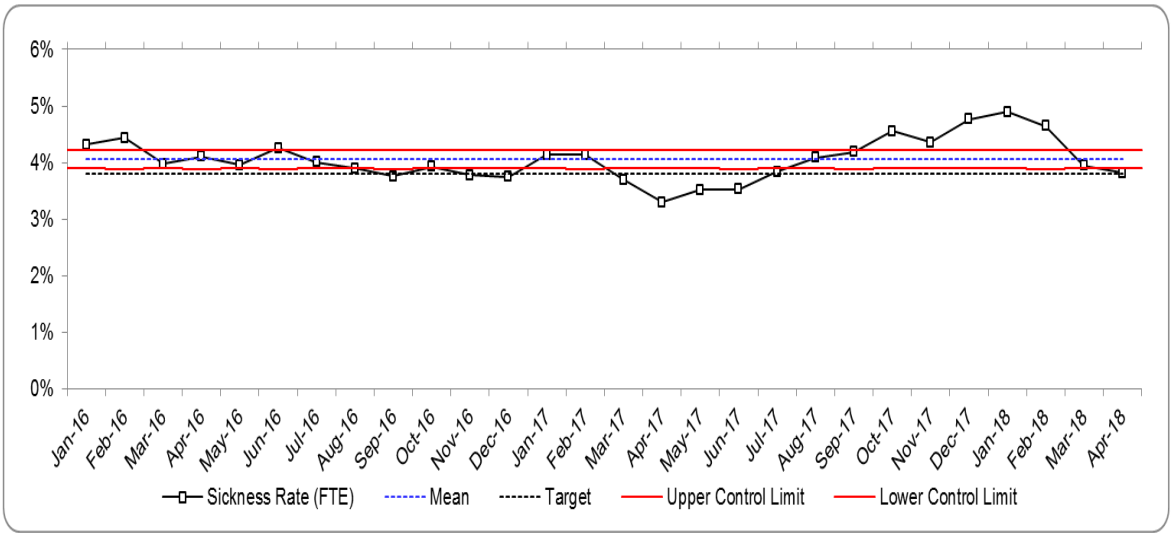
CAPACITY
In-Month Sickness

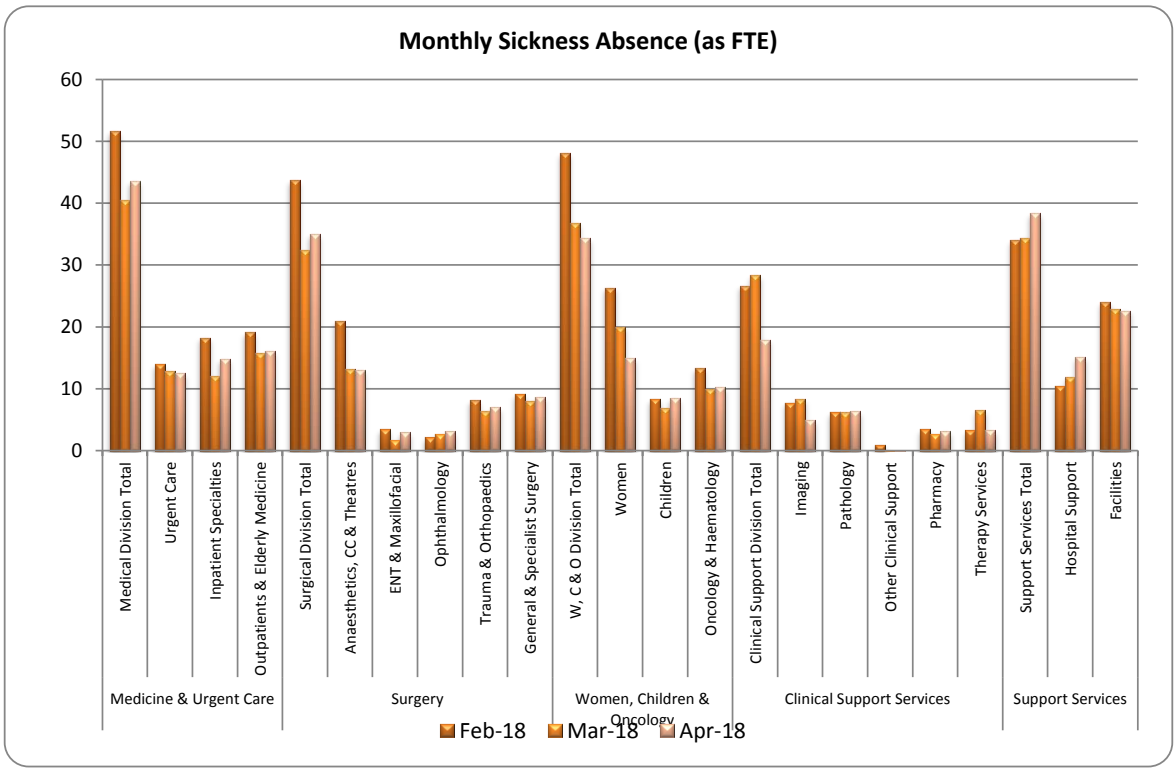
Sickness % RAG Rates:		
> 4.2%	3.8-4.2%	< 3.8%

Monthly Sickness (as FTE)		Feb-18	Mar-18	Apr-18	Apr-18	Short Term	Long Term
Medicine & Urgent Care	**Medical Division Total**	51.57	40.40	43.51	4.09%	2.38%	1.71%
	Urgent Care	13.99	12.78	12.55	4.29%	1.61%	2.68%
	Inpatient Specialties	18.27	12.01	14.86	3.26%	2.30%	0.96%
	Outpatients & Elderly Medicine	19.21	15.71	16.08	5.11%	3.22%	1.89%
Surgery	**Surgical Division Total**	43.72	32.47	35.06	3.34%	1.57%	1.78%
	Anaesthetics, CC & Theatres	20.89	13.12	12.96	3.22%	1.65%	1.57%
	ENT & Maxillofacial	3.42	1.73	2.96	2.99%	0.96%	2.03%
	Ophthalmology	2.13	2.69	3.10	4.21%	2.00%	2.21%
	Trauma & Orthopaedics	8.16	6.44	6.98	3.68%	1.21%	2.48%
	General & Specialist Surgery	9.15	8.03	8.60	3.08%	1.69%	1.39%
Women, Children & Oncology	**W, C & O Division Total**	48.03	36.84	34.37	3.87%	1.76%	2.11%
	Women	26.35	20.04	14.92	4.00%	1.63%	2.38%
	Children	8.37	6.92	8.44	3.21%	1.87%	1.34%
	Oncology & Haematology	13.33	9.94	10.30	4.26%	1.62%	2.64%
Clinical Support Services	**Clinical Support Division Total**	26.67	28.34	17.94	3.18%	1.85%	1.33%
	Imaging	7.77	8.38	4.93	2.86%	1.11%	1.75%
	Pathology	6.29	6.20	6.37	4.12%	2.39%	1.73%
	Other Clinical Support	0.98	0.06	0.05	0.16%	0.16%	0.00%
	Pharmacy	3.43	2.71	3.13	2.63%	1.94%	0.68%
	Therapy Services	3.36	6.57	3.31	3.83%	2.87%	0.96%
Support Services	**Support Services Total**	34.08	34.43	38.39	4.50%	1.84%	2.66%
	Hospital Support	10.45	11.88	15.12	3.51%	1.33%	2.17%
	Facilities	24.06	22.88	22.64	5.36%	2.27%	3.09%
Trust Total	***As FTE***	205.24	174.03	168.81			
	As percentage	4.60%	4.60%	3.95%	3.82%	1.89%	1.92%

	1st May 2017 - 30th April 2018			
Absence Reason	**Headcount**	**Abs Occurr**	**FTE Days Lo**	**%**
S10 Anxiety/stress/depression/other p	406	560	15,647.5	22.4
S98 Other known causes - not elsewhe	907	1,200	10,190.2	14.6
S28 Injury, fracture	238	276	5,587.9	8.0
S25 Gastrointestinal problems	1370	1,802	5,266.6	7.5
S11 Back Problems	331	446	5,053.8	7.2

Workforce Committee: Capacity, Capability and Culture Report - April 2018





Workforce Committee: Capacity, Capability and Culture Report - April 2018

CAPABILITY
Training & Appraisal Rates

Training & Appraisal RAG Rates:		
< 80%	80 - 84.9%	> 85%

Mandatory Training Compliance Rate	Directorate	Feb-18	Mar-18	Mar-18
Medicine & Urgent Care Division	Medical Division Total	83.18%	84.39%	85.16%
	Urgent Care	85.62%	85.39%	86.26%
	Inpatient Specialties	79.46%	81.78%	81.92%
	Outpatients & Elderly Medicine	86.18%	87.06%	88.61%
Surgical Division	Surgical Division Total	85.42%	85.86%	86.07%
	Anaesthetics, CC & Theatres	85.57%	87.22%	87.37%
	ENT & Maxillofacial	80.35%	81.35%	85.45%
	Ophthalmology	91.35%	92.23%	91.64%
	Trauma & Orthopaedics	84.10%	85.89%	85.73%
	General & Specialist Surgery	86.03%	83.46%	83.02%
Women, Children & Oncology Division	W, C & O Division Total	88.14%	89.39%	89.87%
	Women	88.59%	89.36%	89.72%
	Children	88.34%	90.15%	91.67%
	Oncology & Haematology	87.12%	88.52%	87.73%
Clinical Support Services Division	Clinical Support Division Total	92.22%	93.52%	93.45%
	Imaging	90.38%	92.39%	92.82%
	Pathology	95.74%	95.69%	96.34%
	Other Clinical Support	93.37%	96.02%	95.11%
	Pharmacy	92.64%	93.38%	93.73%
	Therapy Services	87.47%	89.66%	88.66%
Support Services	Support Services Total	89.32%	89.54%	91.26%
	Hospital Support	92.00%	91.90%	91.64%
	Facilities	87.20%	87.68%	90.92%
Trust Total		**87.15%**	**88.01%**	**88.60%**

Workforce Committee: Capacity, Capability and Culture Report - April 2018

CAPABILITY
Training & Appraisal Rates

Training & Appraisal RAG Rates:		
< 80%	80 - 84.9%	> 85%

Role Specific Training Compliance Rate	Directorate	Feb-18	Mar-18	Apr-18
Medicine & Urgent Care Division	Medical Division Total	82.06%	82.23%	82.05%
	Urgent Care	84.19%	83.86%	83.61%
	Inpatient Specialties	78.85%	79.12%	78.93%
	Outpatients & Elderly Medicine	84.48%	84.97%	84.92%
Surgical Division	Surgical Division Total	84.70%	84.69%	85.06%
	Anaesthetics, CC & Theatres	85.14%	84.74%	85.09%
	ENT & Maxillofacial	81.40%	81.32%	81.95%
	Ophthalmology	83.62%	86.52%	87.14%
	Trauma & Orthopaedics	86.41%	87.27%	87.57%
	General & Specialist Surgery	83.79%	83.17%	83.54%
Women, Children & Oncology Division	W, C & O Division Total	85.64%	85.56%	85.77%
	Women	84.39%	84.35%	84.23%
	Children	88.40%	88.94%	90.18%
	Oncology & Haematology	84.56%	83.46%	82.86%
Clinical Support Services Division	Clinical Support Division Total	85.13%	85.95%	88.19%
	Imaging	86.10%	87.02%	88.73%
	Pathology	90.09%	89.20%	90.37%
	Other Clinical Support	82.98%	90.78%	92.70%
	Pharmacy	84.37%	84.37%	83.86%
	Therapy Services	81.25%	81.80%	87.71%
Support Services	Support Services Total	82.88%	83.85%	84.73%
	Hospital Support	84.29%	85.17%	85.80%
	Facilities	81.09%	82.19%	83.36%
Trust Total		**84.09%**	**84.25%**	**84.62%**

Capability

Appraisals
The current rate of Appraisals recorded for April 2018 is 85.35%; this is an increase of 0.20% from last month's figure of 85.15%.

Mandatory Training and Role Specific Essential Training
Mandatory Training compliance increased in April 2018 from 88.01% to 88.60% this is an increase of 0.59% from last month's figure and remains above the Trust target of 85%.

Role Specific Essential Training compliance also increased in April 2018 to 84.62% from last month's figure of 84.25%.; that is an increase of 0.37%.

The target compliance rates for Appraisals, Mandatory, and Role Specific Training have all been set at 85%, which should have been achieved by March 2015; this was not done but work continues to achieve this level of compliance.

Workforce Committee: Capacity, Capability and Culture Report - April 2018

CAPABILITY
Training & Appraisal Rates

Training & Appraisal RAG Rates:		
< 80%	80 - 84.9%	> 85%

Appraisal Compliance Rate	Directorate	Feb-18	Mar-18	Apr-18
Medicine & Urgent Care Division	Medical Division Total	81.85%	82.15%	81.88%
	Urgent Care	86.08%	87.36%	86.27%
	Inpatient Specialties	76.34%	78.24%	78.05%
	Outpatients & Elderly Medicine	85.39%	82.59%	82.86%
Surgical Division	Surgical Division Total	88.33%	88.35%	90.09%
	Anaesthetics, CC & Theatres	89.12%	90.00%	91.73%
	ENT & Maxillofacial	66.23%	64.56%	69.14%
	Ophthalmology	95.77%	95.71%	94.29%
	Trauma & Orthopaedics	94.97%	91.11%	94.38%
	General & Specialist Surgery	87.14%	89.43%	90.76%
Women, Children & Oncology Division	W, C & O Division Total	87.42%	85.62%	85.39%
	Women	87.75%	86.23%	86.09%
	Children	88.06%	88.39%	87.69%
	Oncology & Haematology	86.86%	82.23%	82.64%
Clinical Support Services Division	Clinical Support Division Total	89.09%	87.00%	89.31%
	Imaging	88.64%	85.56%	87.29%
	Pathology	81.99%	89.63%	91.52%
	Other Clinical Support	78.38%	70.27%	86.11%
	Pharmacy	95.04%	92.91%	91.41%
	Therapy Services	93.88%	89.00%	87.76%
Support Services	Support Services Total	84.89%	83.21%	81.74%
	Hospital Support	81.79%	81.68%	80.04%
	Facilities	87.32%	84.36%	83.24%
Trust Total		86.10%	85.15%	85.35%

APPENDIX 1 : MEDICAL RECRUITMENT ACTION PLAN

Recruitment Initiative	Action	Responsible Person	Timescale for completion	Update
Certificate of Eligibility for Specialist Registration (CESR)	Establish Priority Specialties and positions to target for CESR	Medical Director/Divisional Directors/Head of Resourcing/Clinical Resourcing Manager	June 2018	Clinical Resourcing Manager gathering information to establish potential posts that can be converted to CESR position in conjunction with a review of vacancies. An overview of current CESR positions will also be established locally.
	Contact LWAB regarding possible submission of Business Case for a regional CESR project coordinator	Director of Workforce	April 2018	Complete.
	Formulate a specification for a regional CESR project Coordinator who may be based at NGH in readiness for a potential bid to LWAB for funding.	Director of Medical Education	May 2018	
Medical Training Initiative	Establish Priority Specialties and positions to target for MTI	Medical Director/Divisional Directors/Head of Resourcing/Clinical Resourcing Manager	June 2018	AB to liaise with CDs from each specialty to determine particular threshold for each area. Colleges also to be contacted to identify numbers of MTI candidates available so they can be mapped to eligible positions identified within each specialty.
	Obtain Deanery/HEE/Royal College Approval for nominated posts	Director of Medical Education/Medical Staffing	September 2018	As required.

Recruitment Initiative	Action	Responsible Person	Timescale for completion	UPDATE
Proactive development of a Specialty Medical Recruitment Plan/Over-Recruitment	Undertake Analysis of historical allocation gaps from deanery	Medical Staffing	May 2018	Complete
	Devise a recruitment plan that takes account of anticipated deficit	Clinical Resourcing Manager	July 2018	
International Recruitment	Establish Priority Specialties and positions suitable for international Recruitment	Medical Director/Divisional Directors/Head of Resourcing/Clinical Resourcing Manager	June 2018	6 middle grade overseas candidates recruited for Medicine and an overall recruitment plan devised and agreed. Clinical Resourcing Manager liaising with other Divisions to establish need and capacity. Other specialties identified to date are: Oncology (5) Radiology (3) Intensivist (1)
	Develop pastoral support program	HR Reward & Retention Specialist	May 2018	In progress – Welcome Booklet devised and pastoral care handed over from Medical Staffing.
	Develop and agree contractual clause that requires overseas recruits to pay back relocation costs in the event that they leave the Trust within a 24 month period.	Head of Resourcing/Deputy Director of HR	April 2018	ACr met with AC 17 April 2018 and wording currently being drafted.

Recruitment Initiative	Action	Responsible Person	Timescale for completion	Update
Consultant	Workforce profile/Succession plan in a way that pro-actively identifies Consultant vacancies.	Divisional Directors/HR Business Partners/Clinical Resourcing Manager/Head of Resourcing & Employment Services/Workforce Information	August 2018	Clinical Resourcing Manager in discussions with each specialty and age profiling analysis to be undertaken. Divisional Directors to provide soft intelligence regarding forecast retirements by July 2018.
	Explore the development of the Trusts research and development portfolio to attract consultants who are active in these areas.	Medical Director	On-going	
	Task & Finish Group to be established to explore the Development of innovative roles to attract high calibre applicants e.g. roles which provide opportunities for education or roles that deliver services to more than one specialty/area e.g. ED consultants with a special interest in care of the elderly or pre-hospital care.	Medical Director	August 2018	Divisional Directors to nominate participants by August 2018.
	Plan targeted recruitment campaign for soon to be qualified SPRs	Clinical Directors and Director of Medical Education.	July 2018	
	Develop nurturing strategy for SPRs approaching CCT and formalize an associated 'Keep Warm' programme.	Clinical Resourcing Manager	Sept 2018	
	Review Consultant level recruitment process to attract and appoint the highest calibre of candidates.	Deputy HRD to develop range of options & pro's and con's.	January 2019	
Build Reputation/EVP	Establish Project/Task & Finish Group	Medical Director/Clinical Resourcing Manager	July 2018	Clinical Resourcing Manager identifying participants.
	Review current marketing materials	Clinical Resourcing Manager/Nominated Doctors	August 2018	Initial marketing documents completed with interim branding (Stands and adverts etc). standard recruitment brief (inc JD / PS in final stages)
	Develop Focus Group Themes	Clinical Resourcing Manager/Nominated Doctors	Aug 2018	Preparatory work being developed
	Run Focus Groups	Clinical Resourcing Manager/Nominated Doctors	Sept 2018	
	Collate data	Clinical Resourcing Manager	Oct 2018	
	Formulate Medical Brand	Clinical Resourcing Manager/Nominated Doctors	Nov 2018	(Interim brand developed)
	Start production of updated materials and social media in line with Medical Brand	Clinical Resourcing Manager	Dec 2018	Complete for interim brand
	Develop and roll out Social Media Training for Doctors	Clinical Resourcing Manager	Sept 2018	Liaising with NHS Elect for early stages of training development.

Recruitment Initiative	Action	Responsible Person	Timescale for completion	
Job Design	Identify basic clinical and admin tasks that could be delegated to others	Divisional Directors	Sept 2018	To be revisited at next meeting
	Review ability to create new roles to provide support to junior staff Review the extent to which rotational programs can be designed to attract candidates at Consultant, Trust Grade and Junior Doctor levels.	Divisional Directors Divisional Directors	April 2018 April 2018	To be revisited at next meeting
Workforce Planning	Develop and introduce a vacancy forecasting tool to predict future vacancies	Head of Resourcing & Employment Services	June 2018	In progress
Measuring Recruitment	Develop recruitment metrics for inclusion in Recruitment Dashboard	Head of Resourcing & Employment Services	June 2018	KPIs reviewed and now being refined. Discussions underway for implementation of candidate tracking software which would provide management information reports.

Appendix 1

Northamptonshire
Local Workforce Action Board

Wednesday 28th March 2018. 12:30 to 15:30

Francis Crick House (Boardroom)

WORKSHOP OUTLINE

Purpose of the workshop is to;

- The LWAB membership to evaluate progress made to date.
- To develop ideas and then agreement on LWAB priorities for 2018-19 to inform the LWAB's future work plan.

Take time out to think about plan moving forward, what we want to achieve, share people's ideas, evaluate plans and ideas.

Themes	Where are we now?	In a perfect world?	How do we get there?
Attraction and Retention	• Apprenticeship work, careers events & linking with schools • Best of both worlds (unclear on what impact it had, but has been positive) • Positive work around GP attraction e.g. GPN videos	• 2% vacancy factor – clinically • 7.5% Health staff turnover and University attraction • 27.8% turnover in social care and ASPIRE to 20% • 5 applicants for every post • Regional and national profile as apprenticeship provider and leading innovation in this field • Joint centre of excellence for CPD • Marketing / solutions linked to	• Create a package to attract students to Northants University e.g. train and work in Northants for 3 years & 2 years employment and get a financial incentive and job guarantee • Attracting people into the county at the right time in their career • Develop a system wide retention strategy to reduce turnover • Integrated approach in Schools to

		national campaign • Proud of our county's H & S care system	promote health and social care as employer / career of choice • Marketing - Careers events (NHS Care – Joint events) - Co-ordinated work experience - Apprenticeships – integrated across H & S - Access to different communities in Northants - Guarantee a job - Marketing and explaining - Role models – e.g. videos, creative and resourcing • Research + Innovation- becoming a centre of excellence as way of attracting people to Northants
Organisational Development and Leadership	• Engaging and communicating with groups, what workforce needs are and how it integrates with LWAB • Nurse associate –creative, focus on job roles • Coaching and leadership – links into retention, clinical leaders review • Coaching and mentoring – to investigate further in 18/19 (positive approach)	• Lowest % rates in the country for sickness / work related stress – health & social care • Structured / facilitated dialogue / masterclasses on leadership across the sector drawing on leading practice – aim to build trust within and across the system, and collaborative working "coalition of the willing" • Staff engagement score of 4.5/5 • CQC ratings – all health and social care are good or outstanding and "I got great care" • Mentor role models	• Research and develop a "millennial" strategy • Social care & primary care placements – mentors provided by health care • Change the way LWAB functions – more action focused and link to STP work and who leads on what & membership (OD of the LWAB) • Event to share what we're all doing regarding workforce strategy and management • Sharing headline data e.g. trust vacancy, T/O, primary care, social care, University no's

		• No student debt • Increase mentorship and coaching • Role models – allocated at induction • Flexibility and support for staff • Northants H &S care services "ICS" • Patient involvement and engagement / staff engagement is excellent	• Joint training (funded by HEE) for resilience training and toolkits to support staff (Pool resources to support this e.g. Skills for Care & HEE) • Clarity on FYFV etc. targets and approach e.g. - who's picking it up? - What can we do to support? - Funding - Sharing data including with University 'produce and reactive' • System approach to coaching and mentoring of nursing and other staff • Explain to SRO's around new role applications / new way of working - What do they need / commissions? - Modelling approach across system
New roles and new ways of working	• Nursing associates / apprenticeship projects / clinical and non-clinical roles (e.g. junior doctor administrators) • ASPIRE – routes into nursing • Range of supporting GPs "other roles"	• Collective system management (not ICS) • Unified employment/system models • Portfolio careers, opportunities, development • Opportunities for rotation / placement tied into job roles • Continuity and easier navigation through care pathways	• Enhanced care in care homes in clinical skills e.g. practice educators in care homes e.g. teach insulin administration (work across health & social care) • Supporting more integrated working e.g. nurse rotational posts, apprenticeships • ACP – apprenticeship route approved, system approach, no's?

		• "single point of contact" – named clinicians / advocacy	• Support bank/agency spend as a collective?
Supply and Education Commissions	• Integrated working / modelling primary care • Agreed workforce strategy for system • Increased placements in nursing, EMAS (joint working)	• Articulated mutually agreed expectations between University and employers and common purpose. Joint working with great relationships and absolute clarity for the University on what the Trusts/organisations want the University to recruit • Supply = Demand	• Develop local commissioning plan for students and apprenticeships • University review way recruit students i.e. not recruited to NGH, KGH, NHFT etc – but to Northamptonshire • Address students living costs through money to help with placements etc. • Agreed placement strategy and culture
Education and LBR	• Success around fellowship – in terms of introductions • LBR allocations / funding from 18/19 • MECC (app, training, 'credit card' resource) and Apprenticeships promoting	• Training provider for NVQ level 3 & 4 • Students say "great learning and placement opportunities and feel part of the system" • Education to match their individual aspirations • Equality in training and development	• Cross sector courses – e.g. leadership programs "academy"
Any Other Thoughts?	• Increasing communication and Engagement • Combined Health and Social Care comms • Sharing data / supply – what does it look like? What will be going in/out in terms of training etc	• Well resourced across Health and Social care • Work vs life • Excellent care, right place right time (this underpins on all themes above)	

Northampton General Hospital NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**31st May 2018**

Title of the Report	**Operational Performance Report**
Agenda item	**12**
Presenter of Report	Mrs D. Needham (COO/ Deputy CEO)
Author(s) of Report	Directors & Deputy Directors
Purpose	For information / assurance

Executive summary

The paper is presented to provide information and assurance to the committee on all national and local performance targets via the integrated scorecard.

Each of the indicators which is red rated has an accompanying exception report

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? Focus on quality & safety Enabling excellence through our people
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks Assurance only
Related Board Assurance Framework entries	BAF – please enter BAF number(s) 1.1, 1.2, 3.1, 3.2, 3.3
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics

	differently (including possibly discriminating against certain groups/protected characteristics)? (N) If yes please give details and describe the current or planned activities to address the impact.
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper – No

Actions required by the Trust Board

The committee is asked to:

1. Note the report
2. Seek areas of clarification as required

Northampton General Hospital NHS Trust Corporate Dashboard 2018-19

Corporate Scorecard

Glossary **Targets & RAG**

	Indicator	Target	FEB-18	MAR-18	APR-18
Quality of Care: Caring	Complaints responded to within agreed timescales	>=90%	100.0%	100.0%	92.6%
	Friends & Family Test % of patients who would recommend: A&E	>=84.7%	85.0%	84.2%	87.2%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	>=95.8%	93.4%	93.2%	92.1%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	>=96.6%	100.0%	100.0%	97.9%
	Friends & Family Test % of patients who would recommend: Outpatients	>=94.1%	93.7%	93.8%	93.9%
	% deaths where a care plan is in place	>=50%	64.1%	67.9%	65.5%
	Mixed Sex Accommodation	=0	234	252	0

	Indicator	Target	FEB-18	MAR-18	APR-18
Operational Performance	A&E: Proportion of patients spending less than 4 hours in A&E	>=95%	80.8%	85.0%	90.0%
	Number of ambulances (Total)		2,005	2,134	2,140
	Average Ambulance handover times	=15 mins	00:13	00:13	00:14
	Ambulance handovers that waited over 30 mins and less than 60 mins	<=25	219	179	80
	Ambulance handovers that waited over 60 mins	<=10	42	23	11
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	=0	9	34	12
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	>=93%	94.5%	89.4%	
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	>=93%	95.3%	80.9%	
	Cancer: Percentage of patients treated within 31 days	>=96%	97.9%	96.9%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	>=98%	100.0%	88.7%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	>=94%	96.8%	100.0%	
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	>=94%	94.7%	85.7%	
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	>=85%	77.2%	91.5%	
	Cancer: Percentage of patients treated within 62 days of referral from screening	>=90%	92.3%	95.4%	
	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	>=85%	78.5%	100.0%	
	RTT waiting times incomplete pathways	>=92%	89.4%	87.4%	
	RTT over 52 weeks	=0	0	0	
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	>=99.1%	99.7%	99.8%	
	ASI Management	<=4%	30.1%	28.4%	26.4%
	Stroke patients spending at least 90% of their time on the stroke unit	>=80%	75.4%	74.5%	79.5%
	Suspected stroke patients given a CT within 1 hour of arrival	>=50%	84.6%	87.7%	90.6%

	Indicator	Target	FEB-18	MAR-18	APR-18
Quality of Care: Effective	Stranded patients >=75yrs (LOS > 7 DAYS)	<=45%	56.2%	53.4%	54.6%
	LOS > 7 Days	<=45%	12.7%	12.4%	12.0%
	Length of stay - All	<=4.2	5.0	5.3	5.3
	Emergency re-admissions within 30 days (elective)	<=3.5%	2.8%	3.0%	2.9%
	Emergency re-admissions within 30 days (non-elective)	<=12%	15.0%	13.9%	10.2%
	# NoF - Fit patients operated on within 36 hours	>=80%	86.9%	96.0%	93.1%
	Maternity: C Section Rates	<27.9%	27.9%	30.9%	28.4%
	Mortality: HSMR	100	0	97	99
	Mortality: SHMI	100	96	97	97
	Crude Death Rates	1	1.5%	1.6%	1.5%

	Indicator	Target	FEB-18	MAR-18	APR-18
Finance and Use of Resources	Income YTD (£000's)	>=0	(7,080) Adv	(3,436) Adv	148 Fav
	Surplus / Deficit YTD (£000's)	>=0	(6,135) Adv	(12,070) Adv	615 Fav
	Pay YTD (£000's)	>=0	(5,127) Adv	(5,872) Adv	(539) Adv
	Non Pay YTD (£000's)	>=0	(2,304) Adv	(3,864) Adv	283 Fav
	Bank & Agency / Pay %	<=7.5%	12.8%	12.9%	11.7%
	CIP Performance YTD (£000's)	>=0	(782) Adv	(934) Adv	485 Fav
	Salary Overpayments - Number YTD	=0	298	322	24
	Salary Overpayments - Value YTD (£000's)	=0	377.8	457.8	22.1
	Waivers	=0	8	12	10
	Waivers which have breached	=0	1	1	2

	Indicator	Target	FEB-18	MAR-18	APR-18
Quality of Care: Safe	Never event incidence	=0	0	0	0
	Number of Serious Incidents (SI's) declared during the period	=0	4	3	1
	MRSA	=0	0	0	0
	C-Diff	<=1.75	0	0	5
	MSSA	<=1.1	0	0	2
	VTE Risk Assessment	>=95%	96.3%	96.5%	96.5%
	Harm Free Care (Safety Thermometer)	>=94%	93.5%	94.0%	92.9%
	Dementia: Case finding	>=90%	100.0%	100.0%	95.7%
	Dementia: Initial diagnostic assessment	>=90%	100.0%	100.0%	100.0%
	Number of falls (All harm levels) per 1000 bed days	<=5.5	5.4	5.0	4.3
	Transfers: Patients transferred out of hours (between 10pm and 7am)	<=60	83	109	45
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	>=98%	96.3%	96.3%	100.0%
	Ward Moves > 2 as a % of all Ward Moves	=0%	4.9%	4.9%	4.8%
	Ward Moves (>2)	=0	165	185	167

	Indicator	Target	FEB-18	MAR-18	APR-18
Leadership & Improvement Capability	Job plans progressed to stage 2 sign-off	>=90%	74.3%	75.7%	63.5%
	Sickness Rate	<=3.8%	4.6%	3.8%	3.7%
	Staff: Trust level vacancy rate - All	<=9%	10.6%	10.8%	12.1%
	Staff: Trust level vacancy rate - Medical Staff	<=9%	11.5%	13.1%	12.7%
	Staff: Trust level vacancy rate - Registered Nursing Staff	<=9%	8.6%	8.4%	9.8%
	Staff: Trust level vacancy rate - Other Staff	<=9%	11.5%	11.5%	13.2%
	Turnover Rate	<=10%	8.3%	7.8%	7.6%
	Percentage of all trust staff with mandatory training compliance	>=85%	87.1%	88.0%	88.5%
	Percentage of all trust staff with role specific training compliance	>=85%	84.0%	84.2%	84.6%
	Percentage of staff with annual appraisal	>=85%	86.1%	85.1%	85.3%

Run Date: 16/05/2018 10:05 Corporate Scorecard Run by: JohnsonCJ

Northampton General Hospital NHS Trust

Corporate Scorecard

Delivering for patients:
2018/19 Accountability Framework for NHS trust boards

The corporate scorecard provides a holistic and integrated set of metrics closely aligned between NHS Improvement and the CQC oversight measures used for identification and intervention.

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

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
ASI Management	Externally mandated	Finance, Investment and Performance Committee	April 2018

Performance:

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	Apr-18
ASI Management	< =4%	33.3%	30.7%	39.0%	37.1%	34.3%	32.4%	32.0%	25.2%	24.1%	23.7%	30.1%	28.4%	26.4%

Driver for underperformance:	Actions to address the underperformance:
• Demand on services and not enough capacity • Poor administration and management of clinics; i.e. not opening slots to E-referral, using ad-hoc clinics rather than permanent and not managing new to follow up demand • Use of locum staff rather than permanent – these cannot be mapped to e-referral • Cultural – consultants not wanting their clinics open to e-referral, concerns about its effectiveness.	• Worked with key areas to identify and open as many clinics on e-referral. Over 700 slots opened. Polling ranges extended in all areas. • Communication to all key stakeholders about the upcoming paper switch off programme and need to open appointments on e-referral. • Continue to understand further details about cause of ASI's and implement changes. • Opening more clinics where possible on E-referral • Please note – targets not met for CQUIN.

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Mr Carl Holland	Mrs Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Cancer Access Targets	Externally Mandated	Finance, Investment and Performance Committee	April 2018 for Validated March 2018

Performance:

Indicator	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	>=93%	85.9%	91.9%	87.8%	86.8%	69.9%	78.7%	85.9%	93.2%	92.7%	94.5%	89.4%
Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	>=93%	72.8%	50.9%	63.0%	48.6%	12.1%	31.2%	79.1%	96.0%	94.2%	95.3%	80.9%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	>=98%	98.4%	94.1%	98.3%	97.0%	94.5%	98.8%	98.7%	98.4%	97.1%	100.0%	88.7%
Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	>=94%	90.9%	88.8%	81.8%	100.0%	90.0%	94.7%	100.0%	100.0%	91.6%	94.7%	85.7%

Driver for underperformance:	Actions to address the underperformance:
• Please refer to F&P report • Please note difference in national reporting due to rounding up/down • 2ww referrals was 89.5% • 2ww breast symptomatic was 81%	

Lead Clinician:	Lead Manager:	Lead Director:
	Mrs Stephanie Buckley/Mrs Sandra Neale	Mrs Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Clostridum difficile Infection Trust attributable (post 3 days)	CDI Externally Mandated	Finance, Investment and Performance Committee	April 2018

Performance:

Indicator	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
C-Diff	<=1.75	0	5	5	0	1	1	3	0	3	0	0	5

Driver for underperformance:	Actions to address the underperformance:
Patient safety, to protect patients from acquiring a hospital acquired infection	• Post Infection Reviews (PIR's) are performed on all patients that develop *Clostridium difficile* infection post 3 days after their admission to Northampton General Hospital Trust. These PIR meetings include the ward Sister, the Consultant microbiologist, the Consultant or a member of the medical team for that specific patient, antimicrobial pharmacist and a member of the Infection Prevention team and the learning from the reviews are shared at the monthly Infection Prevention Operational Group meeting. • All completed PIRs are sent to the Clinical Commissioning Group for review to identify if there is a lapse in care. • The Trust has re-commenced a CDI collaborative involving the surgical wards, promoting antimicrobial stewardship, stool sampling and isolation of patients.

Lead Clinician:	Lead Manager:	Lead Director:
Dr Minas Minassian	Mrs Wendy Foster	Dr Minas Minassian

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Harm Free Care (Safety Thermometer)	Externally mandated	Quality Governance Committee	April 2018

Performance:

Indicator	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Harm Free Care (Safety Thermometer)	>=94.0%	95.9%	93.2%	93.3%	94.5%	96.0%	95.0%	95.0%	93.7%	93.6%	93.5%	94.0%	92.9%

Driver for underperformance:	Actions to address the underperformance:
This month our point prevalence has demonstrates that: • 1 patient developed a catheter related UTI • 5 patients fell during the reporting period • 6 patient developed pressure ulcers.	• As part of each specialty there is a root cause analysis process that will enable learning from the harm caused to our patients. • For the increase in the number of patients that have fallen there is a thematic review of the patients with a harmful fall begin undertaken by Falls Prevention Consultant.

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Mrs Fiona Barnes	Ms Carolyn Fox

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Length of stay - All	Internally set	Finance, Investment and Performance Committee	April 2018

Performance:

Indicator	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Length of stay - All	<=4.2	4.9	4.3	4.9	4.8	5.0	4.8	4.8	4.9	5.2	5.0	5.3	5.3

Driver for underperformance:

- SPA processes continue to slow discharges and ward processes due to assessment times and brokerage
- Current Financial pressures at NASS will only exacerbate the issue of timely discharge
- Delayed Transfers of Care (DTOC) fell over winter but have begun t rise (circa 50 patients at present)
- Low number of supported discharges by partner organizations average 35 per week
- High numbers of patients in the 21+ days LOS (220 patients)
- Variation in discharge process – lack of empowerment and decision making, handoffs, repeated assessment, process not starting until patient medically fit, processes stopped due to not being medically fit
- Reliance on beds and almost no vacancies in care homes at present; Insufficient capacity within the home support services
- Lack of home support increases demand on bedded solutions resulting in inappropriate placements and increased LOS
- 150 Live PDNA's in the SPA

Actions to address the underperformance:

- Outflow group is leading the programmes of work across Northamptonshire:
- Successful MADE event run dropped the 'super stranded' >21 days LOS by 15% but numbers starting to rise (Second MADE event took place at the end of March)
- Discharge element of 'Fixing the Flow' initiative being led by Nursing Director
- 3 times a week tracking meeting face to face with Partners
- New PDNA document trailed first week of March (13 pages to 5 pages)
- Exec led top delays meeting to review the longest staying patients in the trust in place weekly
- Employed further 11 Discharge Coordinators to support Wards. 6 appointed and further interviews planned in Feb
- Deep dive reviews of all wards by senior manager and clinicians to scrutinise medical plans and ensure they are being followed up robustly
- Robust use of the Choice Policy
- County wide review of Intermediate care underway (12 month project minimum)
- SPOT purchase of care home beds once assessment completed by NASS
- 'SAFER in 100 days' initiative spreading across the ward base

Lead Clinician:	Lead Manager:	Lead Director:
Not applicable	Mr Carl Holland	Mrs Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Job plans progressed to stage 2 sign-off	Externally mandated	Quality Governance Committee.	April 2018

Performance:

Indicator	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Job plans progressed to stage 2 sign-off	>=90%	0.0%	0.0%	0.0%	47.9%	56.3%	41.1%	54.5%	63.9%	71.6%	74.3%	75.7%	63.5%

Driver for underperformance:	Actions to address the underperformance:
• Job planning not performing against timeframe of Trust trajectory	• Divisional Directors to progress with respective Clinical Directors in Surgery, W.C.O.H and Clinical Support • Service planning progressing to ensure job plan reflective of speciality activity requirements

Lead Clinician:	Lead Manager:	Lead Director:
Dr Win Zaw	Ms Sue Jacobs	Mr Matthew Metcalfe

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Average Monthly Delayed Transfers of Care	Externally mandated	Finance, Investment and Performance Committee	April 2018

Performance:

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	Apr-18
Delayed transfer of care	<=23	59	90	66	3	59	44	22	25	29	39	27	52	26
Average monthly DTOC's	<=23	65	58	68	56	62	49	33	26	38	32	38	42	30
Average Monthly Health DTOC's	<=7	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail	12	9	14	10	13	16	13

Driver for underperformance:

- The system continues to see a rise in acutely unwell patients leading to a rise in patients requiring support
- Delays in social services assessment continue
- Lack of social workers in Trust and continuity
- Discharge to Assess (DTA) pathway not yet fully available
- Long delays due to community availability/resources
- Large delays in waiting time for medical rehabilitation beds and ability to take high level dependency patients
- Large number of patients waiting to be referred to brokerage for funding decisions,
- Delays in Wards sending accurate patient reflective PDNA's to SPA,
- Delays in SPA due to Systems and processes
- Tracker produced from SPA not supporting discharge,
- Internal delays with PDNA's referred to SPA
- Ward Board Rounds
- Ensuring discharge plan for every patient
- Delays in completing TTO's and EDN's
- High Stranded patients

Actions to address the underperformance:

- Use of CHS brokerage for self-funding patients
- Use of Dickens therapy unit for reduce demand on care in community
- Overnight care model in place – CCG have recognised need to fund for winter pressures
- Recruiting 11 discharge co-ordinators, – 7 currently in post, 4 still in process with HR,
- Three weekly tracking meetings to challenge and escalate discharges and delays, also to agree DTOC numbers
- Daily updates emailed to SPA for all patents on the Tracker
- Memorandum of Understanding of DTOC agreed at Outflow 08/09/2017
- Super Stranded patient reviews weekly with senior level engagement, new Coordinators to help lead on reviewing 7 day Stranded patients
- Identify potential patients for Avery beds earlier in admission pathway
- Trusted Assessor Pilot commenced 01/09/2017 for existing nursing home residents to return home without additional assessment by nursing home (10 homes in Northampton and South involved)
- Monitor those waiting for medical rehabilitation beds and ensure they still require this pathway via daily tracking by discharge team

• Discharge to commence on admission • High numbers of referrals to dementia and delirium team	• Focus on weekend discharges and encourage recording of weekend plans within medical notes • Pilot of email version of PDNA to commence 18/09/2017 to reduce lengthy phone call to SPA • New shorter PDNA commenced on 05/03/18 • Electronic version of PDNA to be introduced • New internal Tracker being reviewed • 'Safer in 100 Days' being rolled out on all Wards (promoting Board Rounds/Plans for every Patient) • Stranded Patient reviews commence on 4 Wards to support and escalate any delays • Spot purchase beds being used to support social services discharges • SCC beds being used to support those patients waiting for POC's

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Mrs Jane Ajeto	Mrs Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Staff Role Specific Training Rate	Internally set	Workforce Committee	April 2018

Performance:

Indicator	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Percentage of all trust staff with role specific training compliance	>=85%	81.0%	81.8%	82.6%	83.9%	84.3%	84.2%	84.8%	84.2%	83.9%	84.0%	84.2%	84.6%

Driver for under performance:

- Lack of insight into the importance of Role Specific Training due to not being called Mandatory
- Positions not being aligned to Role Specific Training subjects
- System (OLM) not flexible enough to report on staff requirements to undertake RSET and having the lowest dominator being set at position level not assignment level

Actions to address the underperformance:

- Due to the number of positions being created each month, work commences on looking at a process which makes aligning Role Specific subjects to new positions more efficient and timely.
- The Safeguarding Children team completed reviewing their 3 levels of training and aligning this to the job positions in the Trust. However, due to the time this work took to complete, a further list of positions has been provided on 19 April 2018 which details the positions that had been created since the first list.
- The Falls Prevention Lead has completed their analysis in reviewing the staff aligned to this training. However, due to the time this took, the Lead has requested a new list to work on, which was provided on 26 April 2018.

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Ms Becky Sansom/Mr Adam Cragg	Mrs Janine Brennan

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Staff Vacancy Rate	Internally set	Workforce Committee	April 2018

Performance:

Indicator	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Staff: Trust level vacancy rate - All	<=9%	11.4%	11.9%	12.5%	12.6%	11.6%	10.9%	10.8%	11.3%	10.1%	10.6%	10.8%	12.1%
Staff: Trust level vacancy rate - Medical Staff	<=9%	11.2%	10.0%	13.9%	14.4%	16.1%	13.5%	11.8%	13.1%	13.2%	11.5%	13.1%	12.7%
Staff: Trust level vacancy rate - Registered Nursing Staff	<=9%	10.3%	10.4%	10.7%	11.3%	9.9%	8.4%	7.9%	8.1%	8.7%	8.6%	8.7%	9.8%
Staff: Trust level vacancy rate - Other Staff	<=9%	13.5%	13.6%	13.4%	13.2%	11.9%	11.9%	12.2%	12.7%	11.6%	11.5%	11.5%	13.2%

Driver for underperformance:	Actions to address the underperformance:
• There is a national shortage of nursing staff along with a shortage within other professional allied specialities & medical staff.	• Trust Open Days in difficult to recruit areas • Nurse recruitment action plan has been refreshed. • Increased use of social networking and web site development to maximise the exposure of the Trust to potential candidates. • Overseas recruitment for nurses continues • Medical Recruitment Strategy and Action Plan being implemented. • New Recruitment system to improve and reduce recruitment timelines in early stages of implementation.

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Mr Adam Cragg	Mrs Janine Brennan.

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Average Ambulance Handover Times	Externally mandated	Finance, Investment and Performance Committee	April 2018

Performance:

Indicator	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Ambulance handovers that waited over 30 mins and less than 60 mins	<=25	141	139	88	68	90	107	139	228	244	219	179	80
Ambulance handovers that waited over 60 mins	<=10	12	19	7	2	11	15	37	56	97	42	23	11

Driver for underperformance:

- Acuity still remains high across some specialties within the Trust; this has seen a marked increase.
- Bed capacity within Trust still remains a daily challenge. A major challenge is the availability of empty beds being aligned with requests for beds during our peak activity times. In addition, identifying patients for early discharge, particularly before 11am remains a concern within our assessment areas and medical wards.
- Multiple ambulance arrivals within a short periods cause spikes in demand and our ability to deliver performance is comprised.
- Fast Response Cars booking mobile to hospital and not calling clear at scene, thus showing as a delay when transporting resource has been cleared.
- Ambulance Turnaround screen has not been recognising some crews pins, thus showing as delays. This remains an ongoing problem, although reducing.
- At times of increased departmental capacity crews are unable to offload and handover within set timeframes.
- Inappropriate trauma patients being conveyed to NGH.

Actions to address the underperformance:

- In absence of HALO, crews to be requested to double up. This action is ongoing and is being monitored daily.
- Clinical guidance being written to support crews remotely with GP advice between 0800-2300hrs, awaiting access to System One escalated to CCG-
- Early escalation to EMAS silver to request HALO should the need arise.- Daily escalation in place
- Discussion with EMAS Regional Operations Manager (ROM) to ensure admission avoidance MDT message is put out to crews, and to make aware of Trust pressures. Daily escalation in place when on OPEL4 or during increased demand
- Early escalation to EMAS/Ops room if multiple ambulance arrivals in quick succession (10 or more per hour). Daily escalation in place when on OPEL4 or during increased demand
- If Trust status OPEL 4 corridor to be staffed to support ambulance turnaround. Daily escalation in place
- Ambulance arrival screen now live in resus area, Fit area and Consultants office this allows for early planning of critically unwell patients and also nurses are able to handover crews without leaving resus area.
- Trackers to escalate all ambulance delays approaching 25 minutes. Action is ongoing and monitored daily.
- Black Breaches information requested daily from EMAS so they can be validated Monthly validation of report

	• Ambulance Handover to be implemented on PAU/Maternity On track started 15/08/17, implementation complete, reduction seen in PAU/Maternity ambulance delays • Ongoing work with EMAS on patients who are conveyed to NGH and subsequently discharged home (37%). Ongoing work with EMAS clinical teams to explore use of ACC for appropriate non critical pathways. Two pathways to be opened to paramedic crews (PE, Headache) as a 6 week trial also exploring ambulatory rapid access chest pain pathway. • Escalation flow chart implemented within ED – completed 25/7/17 • Inappropriate attendances including trauma patients escalated to AOM (Quality)

Lead Clinician:	Lead Manager:	Lead Director:
Dr Tristan Dyer	Mr Paul Saunders	Mrs Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Number of Serious Incidents (SI's) declared during the period	Externally mandated	Quality Governance Committee	April 2018

Performance:

Indicator	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Number of Serious Incidents (SI's) declared during the period	=0	0	1	0	2	2	6	3	1	1	4	3	1

Driver for underperformance:	Actions to address the underperformance:
• Failure to act on adverse images.	• Benham/Abington of which the investigation is ongoing.

Lead Clinician:	Lead Manager:	Lead Director:
	Mr Paul Saunders	Mrs Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Friends & Family Test	Externally mandated	Quality Governance Committee	April 2018

Performance:

Indicator	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Friends & Family Test % of patients who would recommend: Inpatient/Daycase	>=95.8%	94.1%	94.1%	93.9%	93.1%	93.5%	93.1%	93.5%	92.1%	93.2%	93.4%	93.2%	92.1%
Friends & Family Test % of patients who would recommend: Outpatients	>=94.1%	93.5%	92.8%	92.9%	92.3%	92.9%	92.2%	93.2%	93.5%	94.1%	93.7%	93.8%	93.9%

Driver for underperformance:

- It is evident when reviewing the data that the results for Inpatient & Day Cases have stabilised, with only small movements each month. Inpatient & Day Case areas are sitting 3.7% below the national average when comparing April with the most recent national data available.
- Outpatients performed .2% below the national average.

Actions to address the underperformance:

- It has also been identified through the Right Time that Discharge is a consistent theme of dissatisfaction within Inpatient areas. A project focussing on co-design with patients has begun and is expected to last around 10 months. It is expected that over the course of the project that improvements should begin to be made within the FFT results.
- Further work is being explored about staff & attitude and behaviour, which continues to be a consistent negative theme.
- A listening event was held in April with patients that had been inpatients within our assessment units. This was a really positive event and the learning from which is being shared with the teams to enable them to make direct changes to patient care. Further listening events are planned to ensure the hospital continues to coproduce change.

Lead Clinician:	Lead Manager:	Lead Director:
N/A	Ms Rachel Lovesy	Ms Carolyn Fox

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Ward Moves > 2	Internally set	Finance, Investment and Performance Committee	April 2018

Performance:

Indicator	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Ward Moves (>2) as a % of all Ward Moves	=0%	3.7%	3.9%	4.0%	4.1%	4.7%	4.2%	4.0%	4.1%	4.3%	4.9%	4.9%	4.8%
Ward Moves (>2)	=0	132	132	144	139	158	151	147	146	158	165	182	166

Driver for underperformance:	Actions to address the underperformance:
• High medical intake and reduced elective surgery has meant patients being moved into elective surgery beds with the Heart Centre and MDSU opened in the evenings • High acuity of patients has meant move moves to specialist wards due to clinical need • High acuity of patients has meant move moves to specialist wards due to clinical need • High number non elective patients requiring specialist interventions resulting in a back log and unable to put on extra lists to accommodate resulting in long in patient stay	• Senior consultant decision makers to ED to manage patients there and not admit unless unavoidable • 'fixing the flow' actions underway to reduce emergency pressures • Where possible extra list run to accommodate specialist interventions • Deep dive on wards to support multidisciplinary decision making

Lead Clinician:	Lead Manager:	Lead Director:
Not applicable	Mr Carl Holland	Mrs Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Stroke patients spending at least 90 % of their time on the stroke unit	Externally mandated	Quality Governance Committee.	April 2018

Performance:

Indicator	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Stroke patients spending at least 90% of their time on the stroke unit	>=80%	94.0%	95.8%	100.0%	97.7%	94.1%	98.2%	83.0%	91.9%	78.1%	75.4%	74.5%	79.5%

Driver for underperformance:

- The situation is a little better than March BUT the main issue remains, the lack of an open back door to maintain flow through the stroke pathway.

This is due to a reduction in:

- The number of patients repatriated to KGH, compounded by the lack of provision of speech and language therapy at KGH, meaning we will not send patients who have significant SLT needs.
- Delayed discharges due to wait for social care assessments and provision of packages of care and wait for Community Stroke beds at Isebrook Hospital.
- We currently have fewer medical patients being placed on the Stroke wards but this often impacts at night when our last bed is used by Site for a medical patient, meaning that the inevitable stroke referral that arrives soon after cannot access a stroke bed. Patients are spending longer on Eleanor Ward (usual LOS 4 days) while we wait to move them to Allebone. This means that stroke patients with a short length of stay are receiving their care on the Admissions Wards

Actions to address the underperformance:

- The Stroke Team continue to work with the Site Team to try to ring fence 2 stroke beds on Eleanor Ward at all times, although this has been impossible to achieve in the last month.
- We are meeting with the Directorate manager on 03/05/18 to explore other ways of maintaining our bed base for Stroke.
- The Stroke MDT work together to complete PDNA's and has been working with the Safer in 100 days project during April.

Lead Clinician:	Lead Manager:	Lead Director:
Dr Mel Blake	Mr Paul Saunders	Mr Matthew Metcalfe

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Maternity C-Section Rates	Externally mandated	Quality Governance Committee.	April 2018

Performance:

Indicator	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Maternity: C Section Rates - Total	<27.1%	27.0%	28.3%	29.0%	29.5%	27.6%	21.8%	27.9%	28.6%	29.5%	27.9%	30.9%	28.4%

Driver for underperformance:

- Total CS rate amber

Attached is a copy of the paper presented to the Quality Governance Committee in April 2018. This demonstrates that overall, the CS at NGH is in keeping with the national average. There will be variation from month to month so it would be beneficial if we could look at quarterly rather than monthly data. The most recent HES data gives an overall CS rate of 27.9 per cent in 2016-17 and we request that our dashboard changes to reflect this. The Quality Governance Committee were assured by the report and have taken this off the agenda, to be monitored by the division and via our monthly dashboard. The monitoring that we have in place, including the reviews of all women undergoing CS, will continue.

QGC CS - April 2018.doc

Actions to address the underperformance:

- Continue monitoring – discussed at Governance meeting, Consultant meeting and Midwifery Leads meeting.
- Ongoing Emergency Caesarean Section reviews to ensure appropriateness of decision making. Recent focus on primiparous women undergoing IOL who required emergency CS.
- CTG interpretation– working as part of East Midlands maternity Network to introduce physiological CTG interpretation. New guidance is in development and there will be a focus on CTG training.
- Matron – Intrapartum Lead to work on labour ward to support normality and provide challenge and support in clinical decision making.
- Continue with debriefs following all Caesarean Sections – this is now documented on Medway as part of the CS documentation.
- Ongoing Elective Caesarean Section audits – good compliance
- Birth After Caesarean Clinic – ongoing.

Lead Clinician:	Lead Manager:	Lead Director:
Mrs Sue Lloyd/Mr Owen Cooper	Miss Heather Gallagher/Mrs Sandra Neale	Mr Matthew Metcalfe

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Stranded patients >75yrs (LOS > 7 DAYS)	Internally set	Finance, Investment and Performance Committee	April 2018

Performance:

Indicator	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Stranded patients >=75yrs (LOS > 7 DAYS)	<=45%	52.3%	49.4%	49.7%	52.6%	52.0%	50.5%	52.2%	56.6%	54.2%	56.2%	58.8%	55.5%

Driver for underperformance:

- Increasing numbers of Delayed Transfers of Care (DTOC) resulting in:
- High number of stranded patients over 7 days.
- High numbers of 'stranded' patients across Northamptonshire
- Reduced Delirium pathway as contract is only for 15 patients at a time 'on the books'
- High numbers of complex discharge patients.
- DE Nursing and package of care waits high.
- Outflow beds difficult to fill due to restrictive criteria.
- Limited movement of community beds currently 20 empty SCC beds
- Stroke repatriation pathway has limited capacity.
- High number of patients being admitted to the trust from nursing/residential homes
- DTA (Discharge to Assess Pathway) not fully functioning

Actions to address the underperformance:

- Executively chaired top delays meetings to review the longest staying patients in the trust continue weekly. Consultant and ward manager will present case to exec led panel for support and challenge in progressing the patient's pathway.
- Discharge Matron taken on the Stranded patient meeting with support and clear process.
- D&D capacity issues being picked up system wide via the CCG
- Head of Capacity helping to focus support in meetings again.
- CCG senior nurse reviewing all care home patients in hospital daily
- Extra support to be given to the outflow bed base. Daily board rounds and more support with MDT will be undertaken by the Discharge Matron.
- Discharge Matron reviews all patients with ward staff and is working on a daily basis with CCG.
- Safer in 100 Days being rolled out on all Wards
- Newton Europe currently completing a review of 'stranded patient notes and conclusions awaited
- Discharge coordinators appointed and allocated to all wards as they are appointed and trained (13wte funding agreed)

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Mrs Naomi Walters	Mrs Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
MSSA	Internally set	Finance, Investment and Performance Committee	April 2018

Performance:

Indicator	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
MSSA	<=1.1	0	1	0	0	0	1	1	1	2	0	0	2

Driver for underperformance:	Actions to address the underperformance:
• Two patients developed a MSSA bacteremia while under our care in April 2018 on Rowan and Collingtree wards. • Our internal ceiling for 2018/19 is 13 patients.	• Post infection reviews have been undertaken for both patients to understand the learning • The MSSA work stream of the HCAI reduction plan continues to be implemented across the Trust and includes surveillance and treatment of patients with a local MSSA infection • The Octenisan Administration Record is having a final format by the Desk Top Publishing Team and will then be utilised on the wards where prophylactic Octenisan is administered to all patients to protect them from infection (Hawthorn, Rowan, Willow and Dryden) as per the MRSA Policy.

Lead Clinician:	Lead Manager:	Lead Director:
Dr Minas Minassian	Mrs Wendy Foster	Dr Minas Minassian

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	Externally mandated	Finance, Investment and Performance Committee	April 2018

Performance and Trajectory:

Indicator	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	=0	3	1	0	2	2	1	1	12	17	9	34	12

Driver for underperformance:

- **Ophthalmology**
  11DTTAWW on 2/2/2018 pt added to the IPWL. TCI 9/3/2018 (date TCI offer made 12/2/2018). TCI 9th March 2018 Cancelled due to equipment not available Lacricath Paeds list on 16/3 & 6/4 converted to adult list due to no beds on Disney ward Mr Fearnley A/L 23/3 & B/H 30/3, still awaiting confirmation regarding the Lacricath. TCI 20/4/2018 Pt admitted treatment complete.

- **T&O:** The services was unable to offer the patient a date prior to the breach due to the ward being closed to elective admissions due to urgent care pressures.

- **Surgery:**
  Patient referred from GP – 23rd Jan 2018. Initial appointment – 7th Feb 2018. TCI 21st Mar 2018 – list overran – 28day breach 18.4.18. Patient offered dates within 28days but declined wants TCI May. TCI 9th May 2018 – list overran. New TCI 17th May 2018

- **Oral/Max Fax Surgery:**
  All seven patients breached as a consequence of the surgeon calling in sick for the list.

- **ENT:** Both patients were unable to be re booked within 28 days

Actions to address the underperformance:

- **Ophthalmology**
  Plan going forward to avoid incident again is for all clinicians to be reminded that if they need specialist equipment for theatre then they are to discuss these requirements with the theatre manager well in advance of the list. Also an electronic waiting list form with mandatory equipment field to complete would help.

- **T&O:** No further actions

- **Surgery:**
  No narrative of actions to address underperformance provided.

- **Oral/Max Fax Surgery**
  No further action

- **ENT:** The importance of escalating to the DM and then

due capacity constraints.	Divisional manager has been reinforced.

Lead Clinician:	Lead Manager:	Lead Director:
Mike Wilkinson	Fay Gordon	Deborah Needham

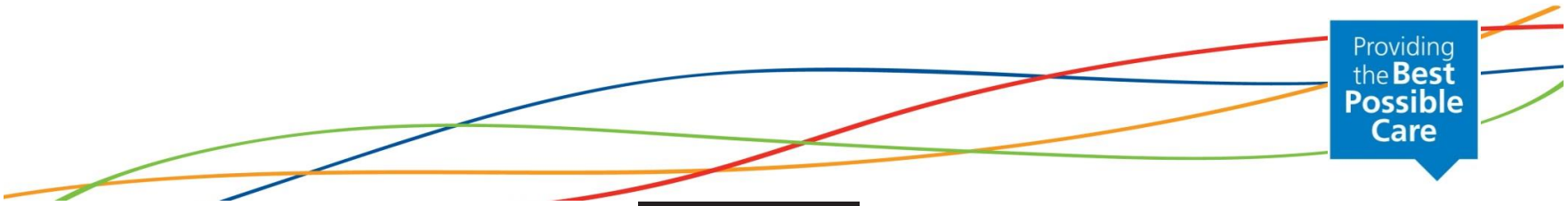
Northampton General Hospital NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**31 May 2018**

Title of the Report	**2018-2021 communications strategy**
Agenda item	***13***
Presenter of the Report	Sally-Anne Watts, Head of Communications
Author(s) of Report	Sally-Anne Watts, Head of Communications
Purpose	For assurance
Executive summary The report sets out our 2018-2021 communications strategy	
Related strategic aim and corporate objective	The communications strategy supports delivery of all the trust's strategic aims and corporate objectives
Risk and assurance	N/A
Related Board Assurance Framework entries	1.4, 2.1, 3.1, 3.3, 4.2
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	None
Actions required by the Trust Board The Trust Board is asked to note the contents of the report	

Northampton General Hospital NHS Trust

Communications Strategy 2018-2021



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Introduction

The 2018-2021 communications strategy builds on the foundations put in place through the previous three year communications strategy.

Over the next three years the aim is to consolidate our progress and move towards becoming an organisation which promotes and provides opportunities for staff, patients and the public to engage with the us in the ways they want to.

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

- A challenging financial situation
- Managing demand for hospital services
- Engagement on transformational change projects, whether they involve a single department, a hospital-wide initiative or a collaborative partnership

At the same time, however, we know there is more work to do to improve the effectiveness of our communication and engagement with key stakeholders and this is reflected in our strategic priorities.

What this means

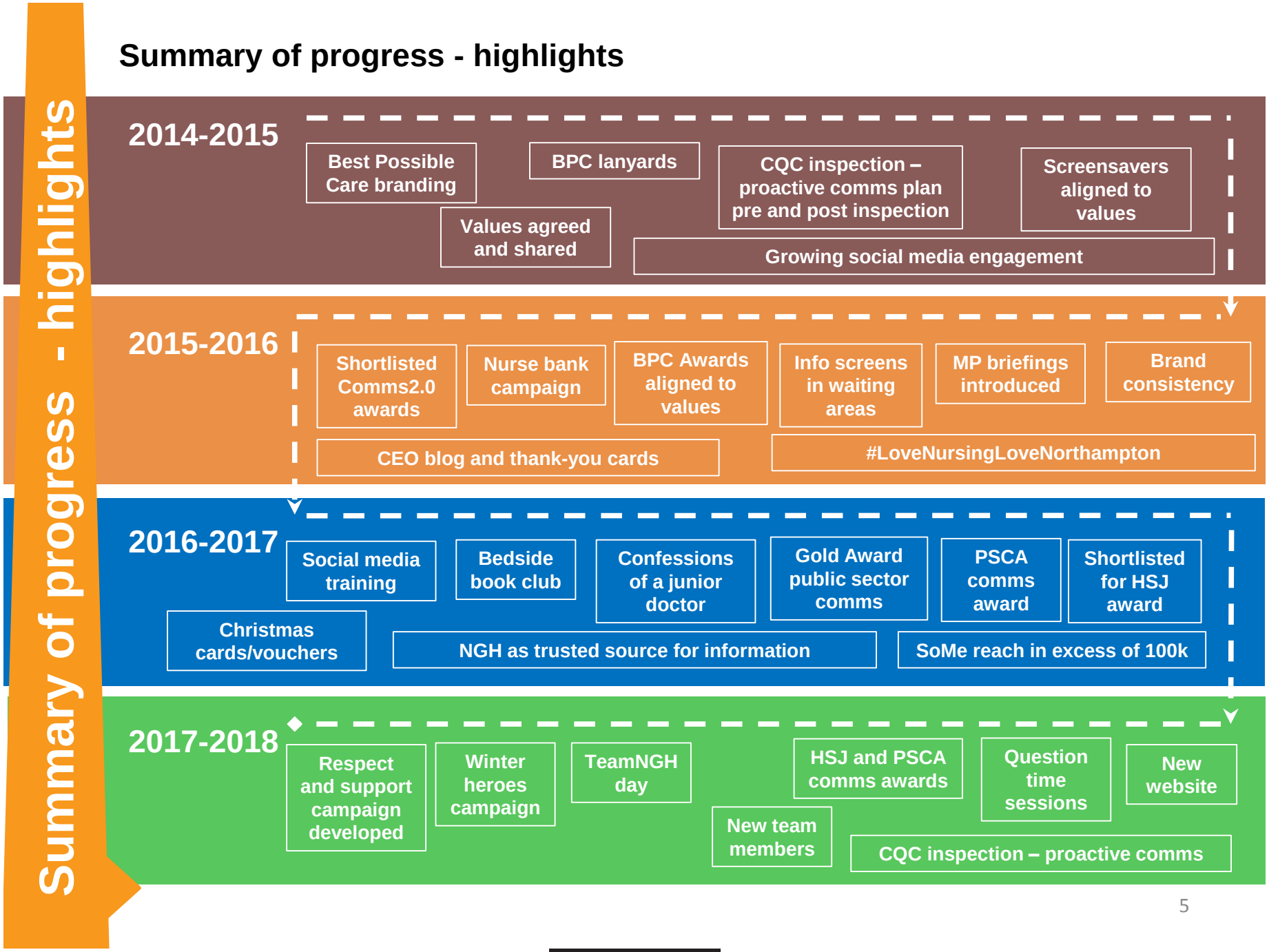
- Subject-based communications are the norm; proactive rather reactive communication
- Context setting and expert advisers – we help people understand their role – and ours - within the wider organisation, healthcare community and NHS. And how we can most effectively use our communication expertise and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

Summary of progress

Summary of progress against 2014-2017 communications strategy

Then	Now
• Reactive communications	• Proactive, planned communications activity
• Unsystematic and mostly one-way staff communications throughout the organisation	• Good progress made towards implementing robust, systematic and effective two-way staff communication
• Weak brand and corporate image	• Strong brand and corporate image #TeamNGH
• Publication of outcomes and performance data not easily accessible/understood	• Good progress made towards publishing outcomes so they can be easily understood
• Some patient and public engagement/ involvement in service improvement and development	• Actively seeking patient and public involvement to improve and enhance service provision
• Variable relationships with stakeholders	• Work continues to develop strong and effective relationships with stakeholders
• Limited involvement in public health messaging	• Proactive role in public health messaging
• Unsystematic involvement with key stakeholders	• Active partner in local stakeholder communications; established relationships with local influencers
• Limited campaign planning	• Award-winning, planned, targeted communications campaigns with measurable outcomes
• Limited use of social media	• Effective use of social media with strong digital/social presence

Summary of progress - highlights



Components of the strategy

Components of the 2018-2021 communications strategy

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

Six key components underpinned by the following principles:

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

Understanding and ownership of our values

1. Embed understanding and ownership of our values

Aim

To achieve understanding and ownership of our shared values throughout the organisation

Summary of progress

- #TeamNGH adopted as accepted nomenclature
- #TeamNGH Day
- Staff recognition - Best Possible Care Awards – year on year increase in nominations
- Winter Heroes
- Recruitment campaigns aligned to our values

Our strategic priorities

- Maintain alignment of our communications messages with our values
- Bring our values to life by sharing examples from TeamNGH members
- Identify opportunities to celebrate and share staff achievements/service developments/awards

Tactics

- NGH Care Awards – launched in 2018 for non-nursing and midwifery staff and aligned to our values
- Values to underpin revised brand guidelines for 2018
- Respect and support campaign planned for 2018
- Winter heroes 2019

KPIs

- Award nominations
- Staff FFT and national survey – percentage of staff who would recommend NGH as a place to work

Involve and inform staff in our vision and direction

2. Involve and inform staff in the vision and direction of the organisation

Aim

Inspire staff to contribute their expertise to transformation and change, while working closely with NHS and social care partners to promote the rationale and objectives behind collaborative projects

Summary of progress

- Monthly core brief well attended
- Bi-monthly question time sessions launched during 2017
- Weekly bulletin
- Social media
- Funding secured for mobile-accessible online staff portal

Our strategic priorities

- Extend ways in which members of TeamNGH may engage with one another – launch of TeamNGH portal
- Identify opportunities to share examples of where team working has led to service change and improvement for the benefit of staff and/or patients

Tactics

- TeamNGH staff portal launches June 2018
- Review and refresh The Street – NGH intranet
- Review and refresh our weekly bulletin
- Insight features on services and staff to extend reach and promote understanding
- Support service information and celebration events
- Staff sharing experience to feature as part of Question Time sessions
- Support for award nominations and award register
- Blogs and vlogs for context and bringing topics to life

KPIs

- Number of staff signed up to TeamNGH portal
- Staff FFT and national survey – percentage of staff who would recommend NGH as a NGH place to work

Develop and improve our social and digital media channels

3. Develop and improve our digital and social media channels

Aim

Develop and improve our digital and social media channels to extend engagement with all stakeholders, to assist with operational objective delivery and to support our patient engagement strategy

Summary of progress

- 11.5k Facebook followers – average weekly reach in excess of 50k (1.5k reviews)
- 4k Twitter followers
- Instagram – 1.2k followers
- Pinterest – 100 followers

Our strategic priorities

- Ensure staff have the skills and knowledge they need to manage the social media channels they use
- Minimise reputational risk

Tactics

- Establish TeamNGH Digital Academy
- Create meaningful content
- Social media policy and guidelines

KPIs

- Number of staff who part of the TeamNGH Digital Academy
- Reach and engagement on social media channels
- Impact of social media engagement where it is part of an agreed campaign

Enhance and improve our communication with patients and the public

4. Enhance and improve our communication with patients and the public

Aim

Ensure patients and the public are aware of service developments and staff achievements, and that they are informed of opportunities to be involved in what we do and provide their input and feedback

Summary of progress

- Communications support and input to events for members and the public
- Growth of the number of engaged followers on social media channels, measures by the numbers of likes, shares, favourites and re-tweets
- Strong links with BBC Radio Northampton
- 100% response rate to direct messages received via social media channels

Our strategic priorities

- Improve communication with members
- Improve communication with GPs
- Improve stakeholder communication
- Audience segmentation to ensure messages are delivered in most efficient and cost-effective way

Tactics

- Campaign planning
- Quarterly member newsletter
- Quarterly GP newsletter
- Bi-monthly stakeholder updates
- Create meaningful content

KPIs

- Click-throughs and engagement on newsletters, which will be hosted on our website so we can monitor analytics. This information will be used to inform which articles and features are of most interest so we deliver meaningful communication

Work closely with local partners to provide joined-up communications

5. Work closely with local partners to provide joined-up communications

Aim

Work closely with local NHS, health and social care providers to provide joined-up communications that are in line with and support national campaigns, empower local people to make informed health choices and assist in managing demand for hospital-based services

Summary of progress

- Quarterly briefings with MPs
- Executive meetings with key influencers, locally, regionally and nationally
- County-wide communications group re-established
- Member of Northamptonshire Health and Care Partnership communications group

Our strategic priorities

- Work with partners to ensure consistency of messages and extend their reach
- Ensure context, explanation and examples are incorporated into messages

Tactics

- Refresh stakeholder database
- Targeted communication using most appropriate method
- Identify agreed partner spokespersons
- Create meaningful content

KPIs

- Consistent messages in county-wide media
- Social message reach and engagement

Protect and enhance our reputation as a leader in innovation

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

Aim

Protect and enhance our reputation as a leader in innovation, education and research to help retain and attract staff, particularly in areas where recruitment is difficult

Summary of progress

- #TeamNGH, #LoveNursingLoveNorthampton
- Nurse bank recruitment campaign
- Conference posters
- Award celebrations
- Collateral to support recruitment events
- Winter heroes

Strategic priorities

- Introduce awards for non-nursing and midwifery staff
- Identify opportunities to promote NGH staff, services and developments
- Develop web content to showcase services and innovation

Tactics

- Create meaningful, audience-specific content
- Insight features on awards won
- Promote use of NGH awards register to capture award nominations and successes

KPIs

- Staff survey and SFFT – number of staff recommending NGH as a place to work and receive care
- Awards/conference posters
- Number and quality of job applicants
- Staff turnover/retention

How we will measure our progress and success

How we will measure our progress and success

- Campaign outcomes aligned to agreed metrics and objectives
- Staff survey feedback
- Internal communications audit
- Staff take-up and development of TeamNGH mobile communications portal
- Levels of engagement via social media channels
- Number of staff joining our digital communications academy
- Reach and engagement with new GP newsletter, member newsletter and stakeholder bulletin

Our priorities

- Reputation, reputation, reputation
- Staff engagement and morale
- Meaningful content
- Planned and proactive communication
- Upskilling
- Engagement – helping audiences to make connections
- Stakeholder relations
- Measurement and KPIs

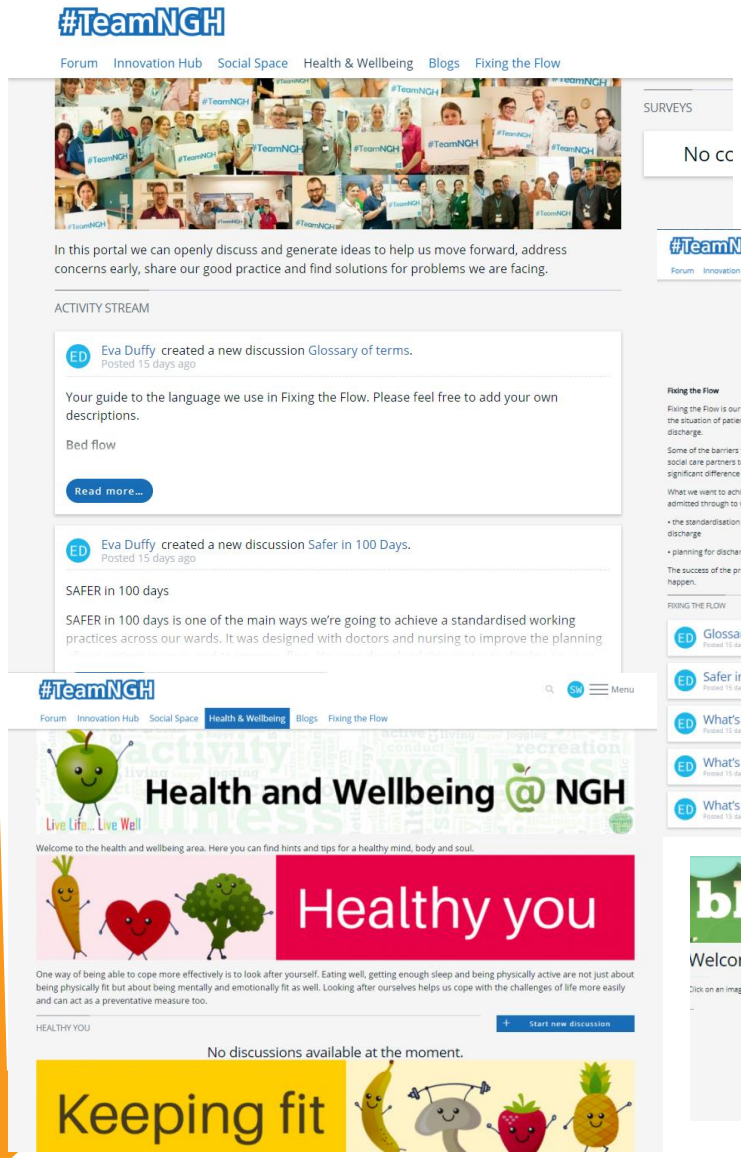
Where we want to be

Where we want to be

Now	The Future
• Proactive, planned communications activity • Good progress made towards implementing robust, systematic and effective two-way staff communication • Strong brand and corporate image #TeamNGH • Good progress made towards publishing outcomes so they can be easily understood • Actively seeking patient and public involvement to improve and enhance service provision • Work continues to develop strong and effective relationships with stakeholders • Proactive role in public health messaging • Active partner in local stakeholder communications; established relationships with local influencers • Award-winning, planned, targeted communications campaigns with measurable outcomes • Effective use of social media with strong digital/social presence	• Proactive, planned, audience-specific, multi-channel communications activity • Robust, systematic and effective internal communication channels where conversations flow in both directions • #TeamNGH - #TeamNorthamptonshire • Outcomes easily available online • Strong and effective working relationships with stakeholders • Flexible and adaptive use of communication channels • Devolved ownership of content in some areas which is managed by individuals who are equipped with the skills and knowledge they need to do this effectively • Closer working with health and care partners to promote consistency and clarity of message and extend audience reach

Team NGH Staff portal

TeamNGH staff portal



Northampton General Hospital NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**31 May 2018**

Title of the Report	**Health and Care Partnership – Programme Directors Report**
Agenda item	**14**
Presenter of Report	Chris Pallot, Director of Strategy and Partnerships
Author(s) of Report	Mike Coupe, Programme Director
Purpose	This report is presented to the Board to provide an update on the progress of the Northamptonshire Health and Care Partnership

Executive Summary

The report;

- Seeks confirmation that partner Boards have reviewed and approved the statement of underpinning principles, values and behaviours
- Provides feedback on the system review meeting held with NHS England on 13 April and highlights changes in system performance since July 2017
- Updates Boards on workstream progress
- Alerts partner Boards to change to the cycle of Partnership Board meetings to allow space and time for development activities
- Briefs partner Boards on system financial tactics for 2018/19
- Updates partner Boards on the roll out of the programme plan and the development of an estates strategy and the development of bids for Wave 4 STP capital

Related Strategic Aim and Corporate Objective	Which strategic aim and corporate objective does this paper relate to? Strengthen our Local Clinical Services
Risk and Assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks: Provides assurance on risks

Related Board Assurance Framework Entries	BAF – please enter BAF number(s) 3.1 and 3.2
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N) If yes please give details and describe the current or planned activities to address the impact.
Legal Implications / Regulatory Requirements	Are there any legal/regulatory implications of the paper: No

Actions Required by the Board

The Board is asked to note the update and in particular has approved the statement of underpinning principles, values and behaviours.

NORTHAMPTONSHIRE HEALTH AND CARE PARTNERSHIP

TO:	**PARTNER BOARDS**
FROM:	**PROGRAMME DIRECTOR**
SUBJECT:	**2 MAY 2018**
DATE:	**PROGRAMME DIRECTOR'S REPORT**

1. Introduction

The report

- Seeks confirmation that partner Boards have reviewed and approved the statement of underpinning principles, values and behaviours
- Provides feedback on the system review meeting held with NHS England on 13 April and highlights changes in system performance since July 2017
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- Briefs partner Boards on system financial tactics for 2018/19
- Updates partner Boards on the roll out of the programme plan and the development of an estates strategy and the development of bids for Wave 4 STP capital.

2. The Principles, Values and Behaviours Underpinning the Partnership

The paper at Appendix 1 has been reviewed and approved by the Partnership Board. The Partnership Board has asked that, where this has yet to happen, partner Boards also review and approve the paper and that CEOs/ Chairs to confirm approval with the Programme Director.

3. NHS England Review and System Performance

The performance of the system and its work programme was the subject of a formal review with NHS England on April 13. The feedback was positive. A copy of the follow up letter from NHS England is at Appendix 2.

Set out below is an updated dashboard which sets out the April 2018 position and compares it with the July 2017 position:

METRIC	July 2017 SCORE	April 2018 SCORE	Target
Delayed Transfers of Care rate	12.063	7.55	3.50%
Cancer: patient experience score	8.5	8.5	8.75+
Cancer: 62 day waits	79.2%	87.3%	85%
Cancer: % of cancers diagnosed at stage 1 or 2	56.8%	56.8%	54.3%
Mental Health: early intervention in psychosis – 2 week waits	96.1%	100%	50%
Mental Health: improving access to psychological therapies recovery	39.9%	42%	50%

rate			
General Practice: patient satisfaction with opening times	74.8%	74.8%	77.8+%
General Practice: extended access	0%	0%	26.6%
Hospital Performance: HCAI – c.difficile	8.9	3.3	0
Hospital Performance: MRSA	0	0	0
Hospital Performance: providers in special measures	yes	yes	yes
Hospital Performance: RTT performance	84.9%	87.3%	92%
Hospital Performance: A&E waiting time performance	84.1%	80.8%	95%

Of the 13 KPIs above, system performance since July 2017 has improved in 6 areas, remained static in 6 areas (noting that no improvement was required 2 of these areas) and declined in one area.

4. Workstream Progress

Urgent & Emergency Care

RAG status: Amber

Commentary:

- The UEC workstream held a planned workshop to establish the model of urgent care and develop the priorities for delivery.

- Work is now complete and ready for implementation in relation to the revised governance structure within the UEC workstream. Meetings will commence April 2018 and the task and finish groups supporting transformation identified.

- A Data group has being convened to look at developing a dashboard to provide assurance and overview of the UEC system performance and proactive modelling to ensure appropriate capacity and response to surges in demand. The Dashboard is in final development for review at the UEC Board meeting in April 2018.

RAG status rationale: Capacity and demand plan required to move the workstream forward and specific resources required, which includes administration and senior analytical support.

Primary, Community & Social Care

RAG status: Amber

Commentary:

- The Strategic Outline Case will be issued to the workstream Delivery Board on 10 April, for discussion on 17 April, which completes the initial phase of the workstream plan.

- The Delivery Board will need to agree the extent to which the next phase of the plan (Outline Business Case development) can be progressed in advance of the planned Strategic Review in the summer, and secure the resources to take this forward.

RAG status rationale: The SRO role will be vacant from 17 April, however this may not be an issue if work is deferred until the Strategic Review has taken place.

Mental Health

RAG status: Amber

Commentary:

- The programme continues to have a specific focus on the development of an outcome framework and following initial formal engagement with patients, carers and professionals in recent months a full set of "I statements" has been produced.
- Work is now being undertaken to develop the metrics that support this framework and a set of draft KPIs will be presented at the Mental Health Transformation Board.
- Alongside the core delivery indicators for the system, taken from the Mental Health 5 Year Forward view (MH5YFV), the following 4 areas have been agreed as priorities:

    - System wide Crisis Pathway
    - Specialist Newly Commissioned Services
    - Transition from Children to Adult Services
    - Mapping the gaps for those service users who don't align to current pathways or services

RAG status rationale: Whilst the outcome framework project progresses well the overall status is rated as Amber given the lack of update regarding health & social care pooled funding and the need to fully understand the challenges for 2018/19 as a result of the latest planning guidance.

Cancer

RAG status: Amber

Commentary:

NATIONAL CANCER TRANSFORMATION FUNDING

- 75% of the national transformation funding for Q1 and Q2 18/19 for Early Diagnosis and Living with Cancer, has been approved and will be released June '18. We are currently

awaiting a further update from the East Midlands Cancer Alliance (EMCA) to confirm the actual amount and next steps.

EARLY DETECTION PRIORITY PROJECTS - FIT

- Work is progressing well with the local pathway for Faecal Immunochemical Testing (FIT) in primary care, which has been agreed in principle by key clinical stakeholders. The East Midlands Cancer Alliance (EMCA) regional project team met 08.03.18 and agreed to develop guidelines which will outline the mandatory/variable elements of the pathway to inform implementation – it is anticipated that these will be shared early April.

RAG rationale: Awaiting national transformation funding release from the Cancer Alliance details including funding amount and timing of release. Dependant on the timing of this will effect timescales and implementation.

Health & Wellbeing

RAG status: Green
Commentary:

- Social Impact Bond (SIB) application to the Life Chances Fund is due to be submitted at the end of April.
- A successful engagement workshop was held on 12th March, where 30+ stakeholders and potential partners, drawn 50:50 from the statutory and non-statutory sectors, had the opportunity to hear our current plans and added their own challenges and inputs.
- Work continues with the University of Northampton Institute of Social Innovation and Impact to maximize the learning from the SIB development process, to engage with the public around our proposals and to develop an evaluation methodology.

Children & Young People

RAG status: Amber
Commentary:

- A planned SEND programme has been scoped and progressing.
- Workstream scope has been aligned with Northamptonshire JNSA.
- PMO resource secured to begin the mapping exercise with dates to be agreed.
- Young Healthwatch questionnaire for use to ascertain CYP views on mental health and well-being services in Northamptonshire has been agreed and due for cascade at the end of April 2018.
- Local and National guidance has been collated and aligned with scope of programme

Maternity

RAG status: Red

Commentary:

- Version 3 of the local maternity service plan submitted to NHS England in February 2018
- Feedback focused on a Lack of an integrated detailed finance plan to support implementation
- Mitigating action is additional project management resource has been secured to focus on developing a more detailed and integrated finance and workforce plan

•Resubmission of the plan 25th May

RAG rationale given: The current RAG status has been given on the basis of current submission, however whilst recognising the excellent system wide engagement including securing 2 engagement licences to ensure continued bespoke engagement of service users, mothers, clinicians and key stakeholders.

Learning Disabilities

RAG status: Red

Commentary:

- First draft of the WDD due w/c 16/4/18

5. Partnership Board Meeting Cycle

Recognising the importance of the development of a strategic framework for the partnership against which the outputs of the workstreams can be tested and of further work on principles, values and behaviours, it has been agreed that the Board continues to meet every month but that formal meetings take place every two months ie

- May Board: formal meeting
- June Board: development session
- July Board: formal meeting etc.

The June Board will be run as a development session with Angela Peddar to explore the Devon experience of partnership working and the development of an Integrated Care System.

6. System Financial Tactics 2018/19

The Partnership Board has asked that CEOs work together to ensure that the system's financial gap is minimised to ensure delivery of control totals at a global level and so retain STF monies.

7. Programme Rollout

Preliminary work on the design of the 'reconciliation event' has suggested that three days will be required split into

- 1 x 2 day workshop on the themes of clinical and financial sustainability
- 1 x 1 day workshop on workforce, estates and IT implications.

The Partnership has agreed dates as follows:

- Workshop #1: Wednesday 11 and Thursday 12 July
- Workshop #2: Tuesday 4 September.

It is expected that NHS England will shortly confirm the requirement for the production of a 'robust draft' of a system Estates Strategy and bids for Wave 4 STP capital funds by mid July. To support this, the Delivery Support Unit has brought on board a dedicated project manager, accelerated the work of contractors (Essentia and Northmore) on mapping the estates baseline, projecting future demand based and meeting NHS England's requirements regarding technical submissions, and arranged a workshop for all stakeholders in May to identify the key elements of the system strategy. Provider Directors of Estates and primary care colleagues with an interest in/responsibility for community building stock will be closely involved, as will local government planners.

8. Recommendation

Partner Boards are asked to :

- Confirm that they have reviewed and approved the statement of underpinning principles, values and behaviours
- Note the feedback on the system review meeting held with NHS England on 13 April and changes in system performance since July 2017
- Note the progress made by workstreams
- Note the change to the cycle of Partnership Board meetings
- Note system financial tactics for 2018/19
- Note the progress made in the roll out of the programme plan and the actions taken/ proposed to support the development of a system estates strategy and the development of bids for Wave 4 STP capital.

NHS England

By e-mail

Angela Hillery
Northamptonshire STP Lead

NHS England, Midlands & East
2 – 4 Victoria House
Capital Park
Fulbourn
Cambridge
CB21 5XB

Tel: 01223 730001

18th April 2018

Dear Angela

Thank you for meeting with me to discuss the STP. I was very impressed with the progress that has been made and we discussed the following points;

1. The governance reset has been completed and you have recently rebranded the STP as the Northamptonshire Health and Care Partnership.

2. You recognise that as the integrated care workstream develops you will merge the system development on commissioning development and accountable care.

3. There have been welcome improvements in overall service delivery across Northamptonshire in RTT, HCAI, IAPT, EIP, cancer waits and DTOC since July 2017

4. The system has agreed to undertake a demand and capacity planning exercise.

5. The primary and community services work looks very promising. You are hoping to find a simple way to reflect the strategy in commissioner's contracts.

6. The situation in NCC is still volatile and if Commissioners are appointed you will be reaching out to them to ensure a collaborative approach in areas of joint interest.

7. The system is forecast to miss its control total by £20m in 2017/18. There is currently a £18m gap between local organisation plans and the sum of the control totals for 2018/19 and the system projects a collective deficit of £26.5m for the current financial year, noting that any STF funding loss across the system would increase this deficit further.

8. The alignment of contracts and plans has followed a robust process – there is some technical tidying up to be completed but you do not anticipate any problems in completing the exercise by the end of the month if all partners support the necessary work required.

9. There has been some progress on the unified Acute model

High quality care for all, now and for future generations

We discussed three main areas for follow-up;

1. The primary and community workstream looks very promising. You have split the work into a SOC, OBC and FBC stages. It would be helpful to receive a summary of the key conclusions covering;

   - Agreed service model
   - Workforce implications, particularly for GPs and how these vary from GPFV assumptions
   - Activity impact on acute services
   - Locality/PCH geographical units
   - Estates and capital requirements – it is essential that this is done for the June/July capital submissions
   - Finances and affordability

   You will advise when this high level summary will be available.

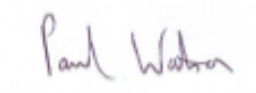
2. The system's financial difficulties are not dissimilar to elsewhere but do need resolving. The system would benefit from a high level financial strategy setting out how the remaining deficit will be eliminated. Although the existing workstreams will help close the gap, neither of us felt that they would be sufficient by themselves.

3. Now that KGH has a substantive CEO, the work on a definitive model for acute services can be discussed further and proceed at full steam. It is essential that the system agrees a service model that will achieve clinically and financially sustainable hospital services. This may well involve difficult decisions on the level of service duplication that can be sustained over the two sites but it is imperative that these decisions are taken soon.

I was very pleased with how the STP is progressing. We will meet again to discuss the three points above and I would also value the opportunity to visit the County to meet with you and your Chief Officer colleagues.

Thank you for your leadership in this important work.

Yours sincerely



Dr. Paul Watson
Regional Director (Midlands and East)

CC: Elliot Howard-Jones - Director of Commissioning Operations, Central
Jeff Worrall, Delivery and Improvement Director, NHS Improvement
Carole Dehghani, Accountable Officer Corby & Nene CCGs

High quality care for all, now and for future generations

APPENDIX ONE

PRINCIPLES, VALUES AND BEHAVIOURS

This paper presents a proposed set of collective principles, values and behaviours for the Northamptonshire Sustainability and Transformation Partnership and a proposed implementation plan, for approval by the STP Programme Board. The need for a set of agreed principles, values and behaviours has previously been agreed by the STP Programme Board and these proposals have been developed by a group of non-executive and executive leaders from all of the main relevant statutory organisations in Northamptonshire, with facilitation support from NHS Improvement.

PRINCIPLES

We agree that our overarching principle is to deliver a population-based and person-centred health and care model within our available collective resources. We agree that this principle, to serve patients and our population, overrides all individual or organisational self-interest.

The key **system development** principles that we are committed to are to:

- Work collaboratively and deliver on today's business whilst also delivering transformation for the future
- Take bold decisions and implement change at pace
- Be inclusive in the views we seek and the ways we work
- Deliver improvements in the quality, experience and integration of services
- Focus on evidence, outcomes and prevention.

The key **system leadership** principles that we are committed to are to:

- Act as a single leadership team, coordinating system improvements for the benefits of the local population and care users
- Develop and communicate a clear and engaging vision
- Focus on solutions and build a supportive environment that encourages our staff to embrace change
- Resolve conflict locally and swiftly but use agreed escalation channels where necessary
- Share information and present a single voice and a united position to our regulators.

The key **system finance** principles that we are committed to are to:

- Commission and provide services within our collective financial envelope
- Work towards operating with a system control total
- Align resources and focus on reducing cost across the system

- Develop new payment mechanisms to align incentives and share risks fairly
- Explore and develop pooled budgets across health and social care.

VALUES

We hold the following **values in common**, and will follow these values in the work we do:

- Our patients and our local population come first
- We work together in an open and accountable way
- We trust, challenge and support each other
- We do what we say we will do.

BEHAVIOURS

All members of the STP Programme Board have signed up to a set of behaviours to help address the issues facing the Programme Board and deliver improved outcomes and care for the local population and care users. We have also agreed a corresponding set of behaviours that are considered to be unhelpful.

Helpful behaviours	Unhelpful behaviours
We hold robust and honest face to face conversations	We send critical and unhelpful emails
We speak up in meetings and have open and constructive debate	We don't speak up and then voice critical views outside of meetings
We agree expectations and hold each other to account	We are unclear about expectations and don't challenge each other
We take personal responsibility for sorting things out	We complain to others and expect them to sort things out
We foster a can-do and risk taking approach	We are fearful and accept a collective sense of helplessness
We celebrate successes collectively and learn from failure	We focus only on the negatives and blame each other
We support and uphold decisions made by the Programme Board	We seek to undermine decisions and ignore them or try and get them changed
We support each other, especially in difficult times	We look after ourselves and distance ourselves from any trouble

IMPLEMENTATION PLAN

Agreeing a set of principles, values and behaviours means nothing if they are not enacted. The following actions are therefore proposed to ensure all parties are fully signed up to the principles, values and behaviours and mechanisms are in place to track progress and, where necessary, take corrective action.

Publishing and publicising the agreed principles, values and behaviours

- The agreed principles, values and behaviours will be published and publicised extensively
- A paper will be taken to the Board/Governing Body of each organisation, seeking their support for the principles, values and behaviours and the agreed implementation plan
- A paper will be taken to all committees and sub-committees reporting in to the STP Programme Board, notifying them of the agreed principles, values and behaviours and requiring them to update their terms of reference to reflect these
- The agreed principles, values and behaviours and agreed implementation plan will be discussed and approved by regulators and the Health and Wellbeing Board and their approval sought for their role in supporting an enabling environment and in providing and receiving feedback on implementation

Membership and conduct of meetings

- At the start of all cross-organisational meetings there will be a brief discussion on whether all necessary views are represented and any corrective steps agreed
- Chairs of cross-organisational meetings will encourage everyone to speak out and be clear that that is the expectation
- The closing agenda item of cross-organisational meetings will be a quick discussion on whether people feel the agreed principles, values and behaviours have been adhered to

Periodic reviews

- Every three months, the STP Programme Board will review the performance of the STP against the agreed principles, values and behaviours
- This will be used as an opportunity to highlight learning and good practices and celebrate successes jointly, as well as resolving any issues
- Consideration could also be given to establishing a process for nominating individuals for a "commendation"

Staff surveys

- A staff survey panel will be agreed and will be surveyed, using Survey Monkey, every three months to establish their view on the adherence to the agreed principles and behaviours; a progress report will then be prepared for consideration by the STP Programme Board at its quarterly review

- Two questions on principles and behaviours will be included in the regular staff surveys for all staff and the results reported back to the STP Programme Board

Independent Chair

- The Independent Chair will have a specific personal objective to oversee the implementation of the agreed principles, values and behaviours
- Where the Independent Chair is concerned about the behaviours of an individual they will raise that concern directly with the Chair of the organisation the individual works for, who will then ensure that that concern is discussed directly with the individual and reflected in their next performance review and, where appropriate, any performance related pay
- Every three months the Independent Chair will meet with the Chairs of the individual organisations to review progress on the adherence to the agreed principles, values and behaviours, identify successes and agree any necessary actions
- Every six months the Independent Chair will prepare a report for the STP Programme Board providing their assessment of adherence to the agreed principles and behaviours and the actions they have taken to improve things, together with proposed future actions for consideration by the STP Programme Board

Personal objective setting

- The Chairs of each individual organisation will ensure that the personal objectives of all of the senior managerial and clinical leaders in their organisation include at least one specific relevant objective on system leadership principles, values and behaviours

External review

- The regulators and the Health & Wellbeing Board will be given a specific remit to provide feedback to the Independent Chair on their assessment of each organisation's adherence to the agreed principles, values and behaviours, citing specific examples wherever possible
- In assessing future performance of the STP and any associated sign-off, regulators will be asked to pay due regard to the agreed principles, values and behaviours and comment on their assessment of their implementation

Escalation processes

- Where an individual wishes to raise a concern in relation to the agreed principles, values and behaviours about someone in another organisation they should ask their Chief Executive to discuss the matter with the Chief Executive of the other organisation
- If there is a difference of view between the two Chief Executives, the matter should be escalated to the Accountable Officer of the STP to resolve with the two Chief Executives

- If the Accountable Officer is unable to resolve the matter it should be escalated to the Independent Chair who will seek to resolve the matter with the two respective Chairs
- If there is a concern regarding any of the Chief Executives or the Accountable Officer of the STP it should be raised directly with their Chair

Organisational development

- In parallel with the above, a programme of organisational development for the Chairs and Chief Executives will be initiated
- This will include a learning session on holding challenging conversations and the development of a set of personal pledges

RECOMMENDATIONS

The STP Programme Board is asked to discuss the proposals contained in this paper and to agree or amend the proposed set of principles, values and behaviours and the proposed implementation plan, including the development of an organisational development programme for the Chairs and Chief Executives.

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: *31st May 2018*

Title	**Finance Committee Exception Report**
Chair	**Phil Zeidler**
Author (s)	**Phil Zeidler**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met on *25th April* to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:

- Finance report
- Internal Turnaround Plan
- Changing Care
- 18/19 Budget
- Operational performance
- Radiology Procurement
- Committee effectiveness
- Business Case Approvals
- PAS Update

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

Key areas of discussion arising from items appearing on the agenda

- The Trust ended the year off plan by [£9.8m] YTD, £4.8m of this is underperformance and the remainder of £5m is lost STF funding due to the underperformance.
- The Internal Turnaround Plan has been developed in response to this underperformance and will be shared with NHSI.
- Changing Care programme report, having been adjusted based on the committees challenges of the last few months, revealed £4.9m delivery for the year of which £3.1m was recurrent, against a plan of £12.9m. The committee received details of next years plan, which has identified £9.2m to date against a target of £12.9m. It was noted this still did not include any information on any Qipp or STP schemes.
- 18/19 Budget and Control Total, having received positive support from NHSI still has some £4.6m risk in current plan. The Committee recommended the Board sign up to the proposed revised Control Total subject to successful outcome of systemwide discussions.
- A&E performance remains under pressure but has improved, with a notable drop in admission rates from last year. The committee requested some analysis on 7 day returns to ensure the Trust was not turning away patients inappropriately. Cancer targets have remained broadly positive.
- The committee approved a short tender process to ensure the Trust received VFM in respect of the proposed Radiology Partnership.
- The committee acknowledged the feedback from the Committee effectiveness review, themes of which will be discussed at Board to ensure we address them
- The Business case for plans to achieve COPD BPT and Activity on Referral scheme were approved, and the revised business case for the Community endoscopy plan was recommended for approval by the Board.
- The PAS system will finally go live in June after a dress rehearsal in May. The committee

acknowledged the risks of this complex implementation, and was satisfied they had been mitigated as far as possible.	
Any key actions agreed / decisions taken to be notified to the Board • Business Case Approvals	
Any issues of risk or gap in control or assurance for escalation to the Board • The Board should assess the outcome of the system wide discussions regarding contract and control totals and consider the Risk of accepting the proposed 18/19 control total.	
Legal implications/ regulatory requirements	The above report provides assurance in relation to CQC Regulations and BAF entries as detailed above.
Action required by the Board The Committee recommends the Board approval the revised business case for Community Endoscopy	

Northampton General Hospital NHS
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COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: ***31 May 2018***

Title	**Quality Governance Committee Exception Report**
Chair	**John Archard-Jones**
Author (s)	**John Archard-Jones**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met on *20 April 2018* to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:	**Board Assurance Framework entries** *(also cross-referenced to CQC standards)*
Corporate Scorecard for Quality Quality Improvement Scorecard Nursing & Midwifery Report Medical Director's Report Draft Quality Account Prioritisation of Patients Health and Safety Update	

Key areas of discussion arising from items appearing on the agenda

Patient safety: Mr Metcalfe stated the Fixing the Flow programme helped improve the quality of care for patients. This included the initiatives of consultants at the front door, the way consultants deliver care and the changing of job plans.
It was noted that changes to the ways of working inevitably introduced some risk and that it was a matter of balance.
Discussion on the 3 Never Events in Theatres. These Never Events would drive further improvements and increase patient safety culture. There is to be a theatre safety bundle Trust-wide launch and Mr Metcalfe confirmed that he would also complete theatre safety walks.
PPH and C section Rate
The committee was reassured by the update and congratulated Dr Lloyd on the reports.

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

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

None

Legal implications/	The above report provides assurance in relation to CQC

regulatory requirements	Regulations and BAF entries as detailed above.
Action required by the Board	

Northampton General Hospital NHS
NHS Trust

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: 31 May 2018

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

Executive Summary

The Committee met on *18th April 2018* to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:	**Board Assurance Framework entries** *(also cross-referenced to CQC standards)*
• **Nurse Recruitment and Retention** • **Trainee Nursing Associates** • **Staff Survey** • **Safe Working Hours doctors/dentists**	

Key areas of discussion arising from items appearing on the agenda

- **Nurse Recruitment/Retention**: Continues to be challenging (reflective of the national picture) with the Trust experiencing a net decrease of 3.07 WTE in nursing capacity between January 2018 and March 2018. A number of recruitment initiatives being explored, including recruitment from the armed forces. Retention data being collected with a Recruitment and retention report due in July.
- **Trainee Nursing Associate Programme:** challenges experienced with the programme, which was currently out for consultation on the role. Apprenticeships were not yielding the numbers expected and there had been a decline in trainee student numbers across the Region. This needed to be reflected in the Trust's Recruitment and Retention strategy.
- **Staff Survey:** Overall staff engagement, whilst not seeing a statistically significant improvement (as was the case in 2017) had improved from 3.83 in 2016 to 3.85, which ranks the trust as 'better than average' when compared to acute trusts.
- **Quarterly report on safe working hours doctors/dentists in training:** Despite considerable pressures, this group were adhering to their rostered hours with only marginal increases reported. Continual support needed for this group, with representatives being recruited for the junior doctor forum.
- **Corporate Risk Register :** updated with one new risk added and two risks de-escalted.
- **BAF Review:** No changes reported

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

- **Nurse Recruitment and Retention Strategy due July 2018**

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

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

Action required by the Board

Northampton General Hospital
NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 31 May 2018
09:30 in the Board Room at Northampton General Hospital

Time	Agenda Item		Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr P Farenden	**Verbal**
	2.	Declarations of Interest	Note	Mr P Farenden	**Verbal**
	3.	Minutes of meeting 29 March 2018	Decision	Mr P Farenden	**A.**
	4.	Matters Arising and Action Log • Abington and Althorp Ward – Best Possible Care Status Presentation	Note	Mr P Farenden	**B.**
	5.	Patient Story	Receive	Executive Director	**Verbal**
	6.	Chairman's Report	Receive	Mr P Farenden	**Verbal**
	7.	Chief Executive's Report	Receive	Dr S Swart	**C.**
10:00	**CLINICAL QUALITY AND SAFETY**				
	8.	Medical Director's Report	Assurance	Mr M Metcalfe	**D.**
	9.	Director of Nursing and Midwifery Report	Assurance	Ms C Fox	**E.**
10:20	**OPERATIONAL ASSURANCE**				
	10.	Finance Report	Assurance	Mr P Bradley	**F.**
	11.	Workforce Performance Report	Assurance	Mrs J Brennan	**G.**
10:50	**FOR INFORMATION & GOVERNANCE**				
	12.	Integrated Performance Report	Assurance	Mrs D Needham	**H.**
	13.	Communication Strategy	Assurance	Mrs S Watts	**I.**
	14.	Northamptonshire Health and Care Partnership Update	Assurance	Mrs K Spellman	**J.**
	15.	Quality Account	Approve	Mr M Metcalfe	**To follow.**
11:10	**COMMITTEE REPORTS**				
	16.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler	**K.**
	17.	Highlight Report from Quality Governance Committee	Assurance	Mr J Archard-Jones	**L.**
	18.	Highlight Report from Workforce Committee	Assurance	Ms A Gill	**M.**

Time	Agenda Item		Action	Presented by	Enclosure
	19.	Highlight Report from Audit Committee	Assurance	Mr D Noble	**Verbal.**
	20.	Highlight Report from Hospital Management Team	Assurance	Dr S Swart	**Verbal.**
11:30	**21.**	**ANY OTHER BUSINESS**		Mr P Farenden	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held at 09:30 on Thursday 26 July 2018 in the Board Room at Northampton General Hospital.

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).