Northampton General Hospital
NHS Trust

Public Trust Board

Thursday 29 November 2018

09:30

Board Room
Northampton General Hospital

Northampton General Hospital NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 29 November 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 Zeidler	**Verbal**
	2.	Declarations of Interest	Note	Mr P Zeidler	**Verbal**
	3.	Minutes of meeting 27 September 2018	Decision	Mr P Zeidler	**A.**
	4.	Matters Arising and Action Log	Note	Mr P Zeidler	**B.**
	5.	Patient Story	Receive	Executive Director	**Verbal**
	6.	Chairman's Report	Receive	Mr P Zeidler	**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 S Oke	**E.**
10:30	**OPERATIONAL ASSURANCE**				
	10.	Finance Report	Assurance	Mr P Bradley	**F.**
	11.	Workforce Performance Report including 1. Flu Vaccination Update 2. Nurse Recruitment & Retention	Assurance	Mrs J Brennan	**G.**
11:00	**FOR INFORMATION & GOVERNANCE**				
	12.	Operational Performance Report	Assurance	Mr C Holland	**H.**
	13.	Annual Fire Safety Report	Assurance	Mr S Finn	**I.**
	14.	Healthcare Partnership Update	Assurance	Mr C Pallot	**J.**
11:40	**COMMITTEE REPORTS**				
	15.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler	**K.**
	16.	Highlight Report from Quality Governance Committee	Assurance	Mr J Archard-Jones	**Verbal.**
	17.	Highlight Report from Workforce Committee	Assurance	Ms A Gill	**L.**
	18.	Highlight Report from Hospital Management Team	Assurance	Mr C Holland	**M.**

Time	Agenda Item		Action	Presented by	Enclosure
12:00	**19.**	**ANY OTHER BUSINESS**		Mr P Zeidler	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held at 09:30 on Thursday 31 January 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 27 September 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	Director of Finance
	Mr J Archard-Jones	Non-Executive Director
	Ms A Gill	Non-Executive Director
	Ms S Oke	Director of Nursing, Midwifery & Patient Services
	Mr M Metcalfe	Medical Director
	Ms J Houghton	Non-Executive Director
	Dr E Heap	Associate Non-Executive Director
	Mr D Noble	Non-Executive Director
	Mr D Moore	Non-Executive Director
In Attendance		
	Mrs J Brennan	Director of Workforce and Transformation
	Mr S Finn	Interim Director of Facilities and Capital Development
	Ms K Palmer	Executive Board Secretary
	Mr C Pallot	Director of Strategy & Partnerships
	Ms C Thorne	Director of Corporate Development Governance & Assurance
	Ms S Watts	Head of Communications
Apologies		
	Mr P Farenden	Chairman

TB 17/18 175 Introductions and Apologies

Mr Zeidler welcomed those present to the meeting of the Public Trust Board. He welcomed Ms S Oke to her first Public Trust Board.

Apologies for absence were recorded from those listed above.

TB 17/18 176 Declarations of Interest

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

TB 17/18 177 Minutes of meeting 26 July 2018

The minutes of the Trust Board meeting held on Minutes of meeting 26 July 2018 were presented for approval.

The Board resolved to **APPROVE** the minutes of the Minutes of meeting 26 July 2018 subject to one amendment raised by Ms Houghton to TB 17/18 162.

TB 17/18 178 Matters Arising and Action Log 26 July 2018

Action Log Item 89

Mrs Brennan confirmed that this would be discussed at the Workforce Committee.

<u>Avery Update</u>

Mr Pallot confirmed that it had been agreed with Avery to add additional information on staffing levels to their monthly quality report to the Trust. They would confirm whether staffing levels were in-line with their establishment and if not, provide an

assurance that patient safety wasn't compromised as a result.

Mr Archard-Jones queried if Avery had the same measures of harm as the Trust. He was informed the measures were different as Avery was a care home however in the contracts there are specified quality levels that are required to be met.

The Board **NOTED** the Action Log and Matters Arising from the 26 July 2018.

TB 17/18 179 Patient Story

Mrs Needham presented Trust Board the patient story.

Mrs Needham shared with the Board a patient story from a patient who was undergoing chemotherapy. The patient was having regular admissions to the emergency assessment bay most cycles whilst also feeling vulnerable and unwell.

The patient described a resent admission when the district nurse had rang the hospital on the patient's behalf. The patient was seen by an 'amazing' junior sister and was admitted to an A&E bed. The patient commented that the junior sister had shown high levels of compassion and clinical excellence. The sister had been 'fantastic' at looking after the patient offering pain relief and cups of tea.

The patient was then transferred to Oncology and was impressed by the HCA on the ward. The HCA had introduced themselves to each patient and asked what the patients needed in a kind manner. The HCA appeared cheerful and calm. The staff nurse was kind, thorough and showed a high level of compassion. This reflected positively on the ward manager and the staff culture on the ward.

The patient had been pleasantly delighted every time they had been admitted during their chemotherapy cycles.

Dr Swart informed the Board that a new Oncology emergency assessment bay would be opening 28 September 2018.

The Board **NOTED** the Patient Story.

TB 17/18 180 Chairman's Report

Mr Zeidler presented the Chairman's report.

Mr Zeidler advised that Mr Farenden had recently attended a NED and Chairman county wide meeting. He had noted that a presentation had been given by Ms A Hillery (CEO - NHFT) on the new country wide system plan. There had been no real sense of assurance that the material plans were of worth.

Mr Zeidler stated that at present recruitment for the Chairman's replacement had been unsuccessful and was out to advert again. It was reported that interim plans are being considered.

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

TB 17/18 181 Chief Executive's Report

Dr Swart presented the Chief Executive's Report.

Dr Swart discussed the work with the University of Leicester and Northampton becoming an Associate Teaching Hospital. This would benefit the Trust's reputation and would help with recruitment.

Dr Swart delivered a Local Health Economy Update to the Board. The Trust had

committed itself to an intensive piece of work for a system Demand & Capacity plan. There would be joint external support for the implementation of a series of schemes to ensure that all county wide health care providers run at more efficient occupancy levels and the patients are helped where possible to stay at home or to be discharged to community settings where this would be the best option.

Dr Swart believed there now to be a detailed understanding of changes needed to be made to the flow of patients and the plan gave specific actions to the providers. It was important to note that discussions were happening and these were moving along better than before.

Dr Swart commented that from the end of August 2018 all stroke patients in the Country would receive care at NGH until they are ready to return home.

Dr Swart stated that during August the Trust's Cardiology team treated their 4000th patient in the Heart Centre and this needed to be celebrated.

Dr Swart advised that the Best Possible Care awards were taking place on 28 September 2018.

Dr Swart remarked on the Winter Heroes Awards that had happened earlier this year and as an extension of this there would be the soon to be launched NGH Everyday Hero Award. This would mirror the Daisy award process.

Dr Swart discussed the Respect & Support Campaign with the Board. It had been noted that the whole NHS struggled with this topic and therefore it is important to take action to address it.

Dr Swart noted areas to look at within the Long Service Awards included how long service within the NHS, not just NGH is celebrated.

Dr Swart reported that information had been sent on this year's flu vaccination. The Trust is to adopt a similar campaign to last year. She had been advised that if member of staff refuses the flu vaccination then a reason needed to be given. Dr Swart believed that uptake of the flu vaccination would be ethically hard to make mandated for all staff. Mr Moore suggested the Board members received their vaccination at the next Trust Board.

Ms Gill queried the number of strains including within this year vaccination. It was confirmed to be four strains. Mrs Brennan highlighted to the Board that if a staff member received their injection at their GP's to inform the Trust and this would be included within the Trust's figures.

Dr Swart commented on Young Healthwatch Northamptonshire and that they would be doing work with an elderly ward following their previous work with the children's wards.

Dr Swart stated that there had been a Nye Bevan media day to publicise the new build. There was a large amount of interest as to whether the unit would help with bed blockers, how the build had been funded and would it solve winter problems.

Dr Swart reported that NGH featured in the recent CQC report that explored how a number of high performing trusts had used a systematic approach to quality improvement to ensure better patient outcomes and performance. There is also likely to be an additional piece on ward accreditation and the improvements it had made at NGH.

Mr Moore noted that the CQC system review required an action plan within 20 days and queried whether this had happened. Dr Swart clarified that it had not been submitted in time however the plan was a joint submission with the other providers and the draft had appeared in last month's Board papers.

Mr Zeidler thanked Dr Swart for the positive recognition of staff as detailed within her Chief Executive's report. He felt this appropriate to celebrate the good that happened at the Trust.

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

TB 17/18 182 Medical Director's Report

Mr Metcalfe presented the Medical Director's Report.

Mr Metcalfe drew the Board to page 22 of the report pack which detailed the significant risks with clinical staffing. He noted that work had to be done to mitigate the risk with medical staffing. All 8 of the additional consultants required to support the Nye Bevan medical model had been recruited. It was reported that across the organisation over the last 12 months the work of the medical recruitment strategy led jointly by the medical and HR directors had begun to deliver meaningful improvements in consultant numbers and saw a net increase of 8.5%.

Mr Metcalfe commented that this had been a joint effort with the HR team with recruiting to these posts.

Mr Metcalfe stated that additional Acute Physician Consultants had been recruited and high risk areas (Oncology, Breast, Radiology and Gastro) had made inroads to recruit to vacancies.

Mr Metcalfe discussed the mortality data detailed on page 24 of the report pack. Whilst the Trust wide mortality indices remained within normal range, there had been a gradual drift towards increased mortality rates. Mr Metcalfe confirmed this would be looked into and addressed.

Mr Metcalfe noted that Urinary tract infection (UTI) had now triggered as an outlier alert. It was reported that UTI is very rarely a true cause of death, however, mortality rates are reported against the recorded diagnosis on admission. This could had contributed towards the outlier alert for UTIs. Mr Metcalfe stressed the importance to code deaths correctly as otherwise it could disproportionate the mortality rate. It was noted that the majority of deaths attributed to UTI had occurred in patients aged over 75 years.

Mr Metcalfe commented that progression had been made with the job plans and medical model for the Nye Bevan Unit. The work had been led by the Medicine Division. There had previously been concerns about the need to backfill the elective activity displaced by the need to commit more time to the emergency medical model.

Mr Metcalfe and Mrs Needham had supported meetings within the Division to address these concerns. It was noted that traction had been made at overcoming anxiety based around the new medical model. This involved looking at how to mitigate the risk and what the expectations are.

Mr Metcalfe advised that the recording of first assessment for venous thromboembolism (VTE) within 14 hours as per NICE guidance remained low. He informed the Board that a recent audit of inpatient wards found that of those patients without a recorded 1st assessment within 14 hours, 92% were receiving prescribed thromboprophylaxis (preventative treatment to prevent clots forming). This appeared

to reflect primarily as a recording issue rather than a care delivery problem.

Mr Metcalfe stated that the rate of hospital acquired thrombosis (HAT) had not increased, nor had the rate at which HAT are deemed preventable upon root cause analysis (performed for all HAT).

Mr Metcalfe remarked that the IT system would implement a forcing function which would see a leap in compliance. As an additional measure Mr Metcalfe would be chairing the Command and Control meetings for VTE. A campaign is to be launched imminently alongside educational support to the doctors and ward staff.

Mr Metcalfe clarified that there would also be intensive interventions with consultants visiting the wards in the morning and the afternoon to check the first assessment are being done.

Ms Gill commented that on a recent Board to Ward she had seen the IT systems that are used. She noted there needed to be one system. Dr Heap concurred with this as she had a similar experience and believed the systems needed to be coupled up. Mr Metcalfe agreed and the Trust is working with the supplier to implement the forcing function.

Ms Oke shared her experience from a previous organisation that when the forcing function was place compliance had increased significantly.

Ms Houghton highlighted the mortality section within the report and queried whether the trends could be reported in this subsection. Mr Metcalfe clarified that this is detailed in his Medical Director report which is presented to the Quality Governance Committee.

Mr Noble expressed his concern that there was several SI's that had passed the completion date and was worried that a trend was forming at not achieving the 45 day standard. Mr Metcalfe clarified that the external target of 60 days is rarely breached and if it does it is usually because it of external input.

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

TB 17/18 183 Director of Nursing and Midwifery Care Report

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

Ms Oke advised that elements of the report had been discussed at the Quality Governance Committee (QGC) and the Workforce Committee.

Ms Oke discussed infection prevention control with the Board due to the previously raised concerns on the numbers of cdiff incidents identified within the first quarter. There had been 11 cdiff incidents year to date which had all been reviewed. Currently there have been no lapses in care identified. Ms Oke confirmed that an action plan had been discussed at QGC and that this plan would be taken forward.

Ms Oke noted the concerns relating to safeguarding that had been discussed at QGC. There would a nurse specialist involved to provide support in particular the increased work with children's safeguarding and learning disabilities.

Ms Oke reported that the Trust had successfully passed the evidence submission for Pathway to Excellence. The Nurse Survey was launched on 11September 2018 which runs for 3 weeks. The survey requires a 60% response rate from registered nurses reporting likely or highly likely to questions asked. There has already been a response rate of 72% achieved.

Ms Oke informed the Board that a Best Possible Care panel is meeting week commencing 01 October 2018 to discuss another nominated ward to achieve Best Possible Care status.

Mr Pallot linked back to matters arising discussion on Avery and noted the Avery data was now included within this report.

Ms Gill commented that she had attended a regional meeting and she believed that Trust had been doing well compared to others in the region on maternity c-section rates. Dr Swart remarked that for the last ten years c-section rates had been a concern. There had been variants of emphasis on different elements of c-sections over this time with recent publication nationally stating that mothers should not have a choice when it came to deciding to have an elective c-section.

Ms Gill asked about the use of hand dryers in relation to infection control and asked if these were on the wards. It was confirmed hand dryers are not on the wards, mainly due to the noise which would be emitted.

Mr Moore noted that the CHPPD metric which was being reported from October would become the prime measure used for safe nurse staffing. He noted appendix 4 and the scale of different CHPPD figures per ward. He asked what a good figure to have was and vice versa was. Ms Oke stated that reporting this would be a national requirement. In October the Trust would report both the fill rate and the October CHPPD. There needed to be further clarity on CHPPD and it was noted that patient acuity affects the outcome of a CHPPD figure.

Mr Moore remarked that there needed to be further understanding of this. Dr Swart concurred that clarity is required and benchmarking data is also needed. It was noted that each ward would have a different standard due to the client mix of that ward.

Mr Archard-Jones expressed his concern in the lack of involvement from Northamptonshire County Council in regards to safeguarding and the additional risk this posed. The Trust is undertaking additional work to cover these risks. Dr Swart stated that the number of safeguarding referrals had increased in recent years and all partners were aware of this.

Mr Noble noted the Friends & Family data for August as the data appeared to reporting at its lowest satisfaction rate in two years. He asked whether this was an area to be concerned on. Ms Oke confirmed she had asked what the absolute response rate was and was doing a piece of work on how the data is collected along with how proactive the ward staff are at obtaining the data.

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

TB 17/18 184 Finance Report

Mr Bradley presented the Finance Report.

Mr Bradley advised that the month 5 financial position showed a positive variance year to date of £22k. This is £16k worse than the position at month 4. As with last month income underperformed, pay overspent, non-pay underspent and the planned monthly release of reserves led to the breakeven position.

Mr Bradley discussed income for the month with the Board. There had been a reduction in stranded and super stranded patients. This has had an impact on the Trust's excess bed days income to a total of £1.8m year to date and is a major contributor to the £2.2m adverse position on income to plan.

He noted that elective activity is below plan by £608k. The STP financial gap income is also a major contributor as to why income is adverse to plan.

Mr Bradley shared the good news with the Trust Board that the Trust had received the contract variation from the CCG for c£1.8m. Of this £0.9m would be played into the month 6 figures. There had been ongoing discussions with NHFT on their part of the offer but these have yet to come to fruition.

Mr Bradley stated that pay overspend is £2.7m year to date after the removal of £3.45m unplanned pay savings. The Agenda for Change wage award arrears to April were paid in August. The agency gap had been breached again in August by £162k mainly in senior medical and admin staff.

Mr Bradley reported that on non pay the Trust was £3.4m underspent year to date of which £1.5m related to excluded drugs and medicines. Some of this is also attributable to a lower case mix and less electivity activity versus plan. The reduction in electives was linked to staff sickness and the admin staff still getting familiar with CAMIS.

Mr Bradley informed the Board that the overspending cost centre escalation process identified a number of areas where reserves were required to be utilised to cover off costs. This included the requirement for additional staff post implementation to support CAMIS, opening of escalation areas and the cost of the system Demand & Capacity Plan.

Mr Bradley drew the Board to page 63 of the report pack which delivered an update on CIPs. The Trust is ahead of plan and expected to meet the target, however there is concern on the delivery of recurrent CIPs which is £2.7m to date. The recurrent forecast is now £9.4m versus £8.9m last month which showed an improvement however still puts the 2019/20 finances at risk.

Mr Bradley noted that the capital plan as shown on page 66 of the report pack was delivering almost as planned which from past experience is unusual as spend often happens late at the end of the year.

Ms Gill commented that outpatients was below on activity as detailed on page 59 of the report pack and queried the factors behind this. Mrs Needham confirmed that included DNA's, staff sickness and vacancies. There are actions to target these areas with a recovery plan in place.

Mrs Brennan noted the YTD CIP delivery for Corporate on page 63 of the report pack was missing the savings agreed within HR and stated that this needed to be tracked.

Mr Moore asked if there was a system gap update for the Board. Mr Bradley informed the Board that there was no further update and that this was work in progress. Dr Swart confirmed she would be highlighting this to NHFT in an upcoming meeting.

Mr Bradley advised that the Trust's monthly external financial assurance meeting with the regulators had been positive.. The meeting had discussed the financial forecast, the in month position and Mr Bradley had asked for any best practice forecast reports that could be shared. It had been noted that there was a significant risk still to the financial position for the rest of the year and that this month was critical.

Mr Bradley had highlighted the issue with excess bed days.

Ms Houghton queried the use of a block contract. Mr Pallot commented that this had been explored previously and would be too much of a risk for the Trust unless it were at a level that removed all financial risk to the organisation.

The Board **NOTED** the Finance Report.

TB 17/18 185 Workforce Performance Report

Mrs Brennan presented the Workforce Performance Report.

Mrs Brennan advised that Substantive Workforce Capacity had increased in August 2018 however Annual Trust turnover for August 2018 had decreased.

Mrs Brennan expressed her concern that Sickness absence for August 2018 had decreased.

Mrs Brennan commented that she had included within the report a Carter update. The areas where most improvement had taken place within the last 6 months are in relation to 'Staff Attrition' and 'We Respect & Support Each Other'. In regards to staff Attrition the exit questionnaire would be linked to quest back to gather more leaving data.

She explained that 'Move don't lose them' would be extended to cover all nurses.

Mrs Brennan reported that the current rate of appraisals and mandatory training recorded for August 2018 had decreased, as had Role Specific Essential Training.

Mrs Brennan stated that the Workforce Race Equality Standard (WRES) 2018 standard had been published on the Trust's website. The key findings were the lack in numbers of BME staff at senior or Board level and bullying had been received more by white staff.

Mrs Brennan updated the Board on the Respect and Support Campaign. The campaign was launched in June 2018. Mrs Brennan described the work undertaken and this is listed on page 75 of the report pack.

Mrs Brennan advised that the Trust had recently been successful in securing funding from NHS Improvement as they are interested in showcasing the Trust's Respect and Support Campaign across the wider NHS. It was noted that NHSI had also asked the Trust to create a toolkit which they would support with. The toolkit would be for national sharing and she informed the Board that she had been asked by present on the topic to Ambulance Service.

Mr Noble drew the Board to Carter Review 1G and noted succession planning Processes. Mrs Brennan stated that the East Midlands were planning a pilot and the Trust was also building their own process. Ms Gill urged that the process was kept simple and suggested the creation of one development goal. Dr Swart concurred with this. Mrs Brennan confirmed that the Trust is currently identifying business critical roles.

Ms Gill commented on the great work on the Respect & Support Campaign. She queried whether senior staff are expected to attend the training detailed within the campaign. Mrs Brennan clarified that senior staff would be expected to attend and that this would be tracked. She would be asking all the Executive Team to attend and Mr Finn had already done so. Mr Finn remarked the training had been good especially the use of the actors.

Mr Moore queried how the Apprentice Levy had been used. Mrs Brennan stated that

it had been mainly used with the nursing workforce and an update is brought to the Workforce Committee. Mr Moore urged the need to use the levy to its full extent.

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

TB 17/18 186 Integrated Performance Report

Mrs Needham presented the Integrated Performance Report taking it as read having already been discussed in detail at Finance, Investment & Performance Committee, Workforce committee and Quality Governance Committee.

Mrs Needham advised that there had been three breaches in mixed sex accommodation in August. These were in MDSU and the Stroke Unit. On MDSU it was an error and in regards to the Stroke breach it was safer to use the stroke beds as all other beds were full. Mrs Needham confirmed that all patients had been moved the following day.

Mrs Needham commented that A&E performance had remained above trajectory in August but this had deteriorated in September to 87.4%. It had been noted that once the school holidays had finished that had been an increase seen in attendees and admissions as well as a slight increase in acuity.

Mrs Needham delivered a cancer update to the Board. She noted that cancer remained challenging. There are currently changes being trialled in Urology with a reduced pathway in place in the form of a one stop shop.

Mrs Needham stated that in regards to 62 days the regulators had asked the Trust to be above 80% for winter. It was noted that August was just below this and she hoped September would be at 80%.

Mrs Needham advised that Breast 2ww had shown significant improvement and performance was at 83%. This was due to additional work and insourcing. It was noted that Dermatology 2ww had seen an increase in performance in month and this would be fully recovered in October. The Quality Governance Committee had been presented a presentation from a Consultant within this Directorate on the ways it was working differently.

Mr Metcalfe discussed Urology with the Board. There is a MTI initiative post within the Directorate. The bottom up approach would benefit the Directorate.

Mrs Needham informed the Board that the Trust is not an outlier for 62 day performance.

Ms Gill remarked on the potential of ambulances treating patients on the spot. Mrs Needham stated that of the approximate 90 attendees per day via ambulance 30 did not require attendance to hospital. A paper was requested to go to Quality Governance committee to provide an update on “the acute hospital as a place of safety” ACTION DN

Mr Archard-Jones was glad 2ww for Breast had shown improvements however did not understand the dramatic change in performance. Mrs Needham clarified that the numbers of referrals by month can fluctuate massively and noted that this month had also seen additional capacity in place.

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

TB 17/18 187 Corporate Governance Report

Mrs Corkerry presented the Corporate Governance Report.

Mrs Corkerry reported on the use of the Trust Seal in accordance with the Trusts Standing Orders (12.3). The Trust seal is used for contracts in excess of the financial limits delegated to the CEO under the Trusts standing financial instructions and for property matters including disposals, acquisitions and leases.

Mrs Corkerry stated that the Trust Seal has **not** been used during Q4 17/18 or Q1 18/19.

Mrs Corkerry advised that under the Trust Standards of Business Conduct policy staff is required to declare any hospitality / gifts received. Regular reminders are given via the Trusts communication mechanism as to staffs responsibilities under this policy. It was noted that during Q4, a letter was sent to Consultants and Senior Trust Staff requesting them to make a return in respect of conflicts of interest (Appendix 1).This was recirculated at the end of Q1 and any staff not making a return were written to with a personal letter requesting compliance.

Mrs Corkerry confirmed that between Jan and March 18 there had been 126 declarations received. It was noted that between April and June 18 there had been 43 Declarations received. This included sponsored lunches for educational sessions where a group of staff make a single declaration. These figures included null returns.

Mrs Corkerry commented that the next steps included any staff that had previously been written to and who had not responded would be given a further opportunity to respond before this would be escalated to their line manager.

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

TB 17/18 188 Healthcare Partnership Update

Mr Pallot presented the Healthcare Partnership Update.

Mr Pallot advised that the HCP Board is starting to assess the counties readiness for an integrated care system. There had been a substantial amount of work undertaken and the plan is in a better place than before. The key is now to move from talking about the plan to delivering it.

Mr Pallot had suggested services that could be used to pilot the plan were those services that could be integrated. The services pulled through would be looked at from a strategic community perspective and would follow an ICS type approach.

Mr Pallot stated that a draft commissioning intentions letter is to be published 30 September. This letter and the recent coding letters would be discussed at the next Finance Investment and Performance Committee.

The Board **NOTED** the Healthcare Partnership Update.

TB 17/18 189 EPRR Core Standards & Assurance 2018/19

Mrs Needham presented the EPRR Core Standards & Assurance 2018/19.

Mrs Needham advised that this was the annual self-assessment assurance report for the EPRR Core Standards. The Trust as a category one responder is expected to respond to a variety of incidents.

Mrs Needham drew the Board to pages 137 – 142 of the report pack which detailed the 64 nationally set core standards. The Trust assessed itself against these standards and rated itself as fully compliant. It was noted that NHSE had also

completed an informal walkthrough on site and on 5 October the Trust would have a final interview with NHSE. After this a formal letter would be issued.

Mr Noble queried the timescale for which the formal letter would be issued. Mrs Needham clarified that this would be 3 – 4 months and this would be brought back to the Board.

Mr Moore asked whether the Trust had a formal testing programme. Mrs Needham confirmed that the Trust did and exercises are completed regularly. The Directorates all have business contingency plans. There is also a Bronze, Silver and Gold structure in place dependant on the incident.

The Board **NOTED** the EPRR Core Standards & Assurance 2018/19.

TB 17/18 190 Highlight Report from Finance Investment and Performance Committee

Mr Zeidler advised that all areas to be noted from Septembers Finance Investment and Performance Committee had been discussed today at Trust Board.

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

TB 17/18 191 Highlight Report from Quality Governance Committee

Mr Archard-Jones advised that all areas to be noted from Septembers Quality Governance Committee had been discussed today at Trust Board. These included –

- Safeguarding concerns
- A QI presentation on the Tele-dermatology Project – it was noted that the system would be tested from the end of October 2018 for 3 months. The CCG Tariff involved would need confirmation. It is to be included in next year's contract.

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

TB 17/18 192 Highlight Report from Workforce Committee

Ms Gill advised that all areas to be noted from Septembers Workforce Committee had been discussed today at Trust Board. These included –

- Respect & Support Campaign
- GMC Trainee Survey – the red flags from the GMC national trainee survey had been discussed. The ownership and accountability of the actions had been assigned to Divisional leads. There would be a further update the November Workforce Committee.
- Nursing Prospectus had been shared and this was noted to be positive.

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

TB 17/18 193 Any Other Business

Mrs S Watts reminded the Trust Board of the Best Possible Care awards to be held the evening on 27 September 2018 at the Park Inn.

Mr Zeidler thanked Ms C Fox (Director of Nursing) and acknowledged the fantastic work she had done at her time at the Trust. She had brought clarity and much needed strategic direction from a nursing perspective whilst in her role.

Date of next Public Board meeting: Thursday 29 November 2018 at 09:30 in the Board Room at Northampton General Hospital.

Mr Zeidler called the meeting to a close at 11:30

Public Trust Board Action Log							Last update	13/11/2018
Ref	**Date of meeting**	**Minute Number**	**Paper**	**Action Required**	**Responsible**	**Due date**	**Status**	**Updates**
Actions - Slippage								
NONE								
Actions - Current meeting								
NONE								
Actions - Future meetings								
NONE								

Northampton General Hospital NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**29 November 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, Associate Director of Communications
Purpose	For information and assurance
Executive summary The report highlights key business and service issues for Northampton General Hospital NHS Trust in recent weeks.	
Related strategic aim and corporate objective	N/A
Risk and assurance	N/A
Related Board Assurance Framework entries	N/A
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	None
Actions required by the Trust Board The Trust Board is asked to note the contents of the report	

Northampton General Hospital NHS Trust

Public Trust Board
29 November 2018

Chief Executive's Report

1. Pathway to Excellence®

Board members will be aware that NGH has become the first hospital in the UK to be awarded Pathway to Excellence Accreditation by the American Nurses' Credentialing Centre (ANCC). This highly sought-after, prestigious award recognises organisations that provide a positive practice environment for their nurses and midwives, which in turn leads to better care and an improved patient experience.

This recognition could not have been achieved without the support of the Northamptonshire Healthcare Charitable Fund and the commitment of our nursing and midwifery team, supported by everyone here at TeamNGH. Achieving Pathway to Excellence Accreditation will help us build on the foundations we have put in place to enable our staff to provide the best possible care.

The recent celebrations, which were attended by Ruth May, Executive Director of Nursing at NHS Improvement, were supported by many members of TeamNGH who shared in the joy and sense of wellbeing that comes being the first hospital to achieve this Award. It is important that we continue to encourage ambition and recognise achievement, whilst understanding the commitment this requires when working under pressure.

We hope to be able to attend the designation ceremony in America early next year and meanwhile will be consolidating the work to date and working on moving forward with further improvement work – as suggested by the 'Pathway' title.

2. Local Health Economy Update

Over the past few months there focus of the Northamptonshire Health and Care Partnership has been on understanding local challenges and their alignment with our organisational and regulatory responsibility. The aim is to increase opportunities to work collectively across pathways and around patients, service users and those we care for as well as their wider support networks.

At the same time we are mindful of the feedback from the CQC that we need to obtain collective clarity and what changes are needed. We are also mindful of the significant challenges in the financial position of our County Council and we are committed to working with NCC and local government to understand the stabilisation plan. Everyone in the health and social care economy remains committed to working together to develop plans and share honest and constructive feedback regarding their feasibility.

The identified priority areas are urgent and emergency care; unifying pathways of care across acute hospitals; reshaping primary, community and social care; and the strategic commissioning model.

Board members will be aware that we are making good progress towards collaborative working and unified pathways of care with our colleagues at KGH; the stroke service is just one example.

One of the most significant pieces of work supported by all partners in health and social care has been the work that started with a look at the capacity and demand across the system and merged into a defined series of work programmes designed to improve urgent care in Northamptonshire. These have involved initiatives to focus on each part of the patient pathway.

For NGH there has been a strong focus on improving the assessment and treatment throughout the hospital and on improving the interface with discharge. The CEOs from across Northamptonshire have met weekly to support this work. We know that this winter will be very challenging but there is no doubt that there is a shared determination to improve the experience of patients and staff in this very pressured environment.

The recent announcement relating to the problems being experienced by Allied Care Homes are likely to further increase pressures in social care and we will be working with commissioning and social care colleagues to mitigate the risks as they emerge. Similarly the risks relating to the financial pressures faced by Northamptonshire County Council have been formally raised and we are working with all our partners to understand and mitigate these.

3. **East Midlands Radiology Consortium (EMRAD)**

NGH is a member of EMRAD, which has recently been announced as one the successful Wave 2 Testbeds launching an 18 month project on using Artificial Intelligence and Deep Learning to support breast screening.

The patient and clinically-led initiative aims to screen and treat more people, supporting service capacity and helping ease workforce pressures; boost public, patient and clinician confidence in using AI technology to assist with diagnosis and improve patient care by minimising errors and ensuring consistency.

As a member of EMRAD we will be working with a number of partners, including the East Midlands Academic Health Science Network and two UK-based enterprises specialising in the field of cutting-edge AI technologies.

This is an exciting and challenging opportunity which has potential to improve the quality of care and reduce the incidence of breast cancer for women in the East Midlands by supporting breast screening services through the use of Artificial Intelligence.

There is a huge national focus on the NHS workforce particularly in cancer care and this initiative will open up the way towards mitigating shortage in the radiology workforce shortages by allowing computer assisted pattern recognition to perform the role of a radiologist in interpreting mammography screening tests.

3. Care Quality Commission

We have been working with colleagues in the CQC to produce a case study on driving improvement at NGH. We have submitted our amendments to the CQC on their draft and are now awaiting advice from their editorial team regarding publication plans.

NGH is taking part in the CQC national urgent and emergency care survey 2018. The survey, which is confidential, takes the form of a paper-based questionnaire that will be posted out to patients who have received care and treatment in our A&E department. The results are expected in the autumn of 2019.

Our next full inspection by the CQC is due in the Spring of 2019. We are aware that there will be changes in the approach taken by the CQC and are carefully watching the focus on these changes and on the new responsibilities of the CQC. A series of briefings for staff is being planned for the New Year. We have previously found it useful to present a compass check on the NHS and NGH. This year, with the announcement of a new 10 year plan for the NHS it will be particularly important to make sense of this for our staff and to explain the concept of system working in some more detail than in the past. We are working with our CQC relationship manager to understand what will be required of us under the new inspection regime in order that we can ensure we are prepared.

4. Working with partners

Partnership working is now a critical part of the work of acute hospitals across the UK. In addition to the partners involved in the HCP we are also exploring better ways of working with other local partners such as St Andrew's Hospital and are currently identifying key pieces of work based around improving patient care and also supporting our staff. These discussions are at an early stage but bring with them some realistic chances of mutual benefit.

5. Our staff

Services in the new Nye Bevan building are now up and running and members of TeamNGH working there have responded positively to implementing new ways of working. As with all new builds there are some initial teething problems as systems and processes bed in, and I am confident that these will quickly be addressed. It has been a real pleasure to speak to so many enthusiastic staff from all professions and to see the reactions of our patients and their relatives. This build is a powerful reminder of the importance of the environment in health care and we are determined to ensure that we continue to develop our estate as part of the work we are doing with Kettering General Hospital so that we can ensure we have a pragmatic and credible estates plan for the future.

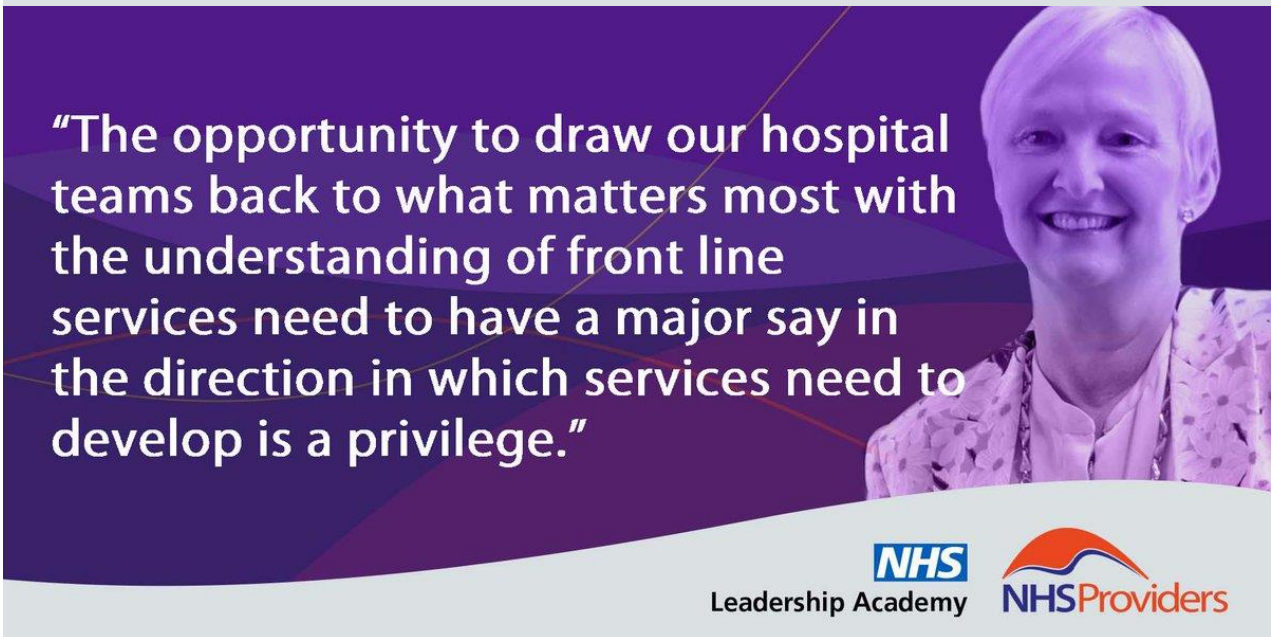
6. NGH in the news

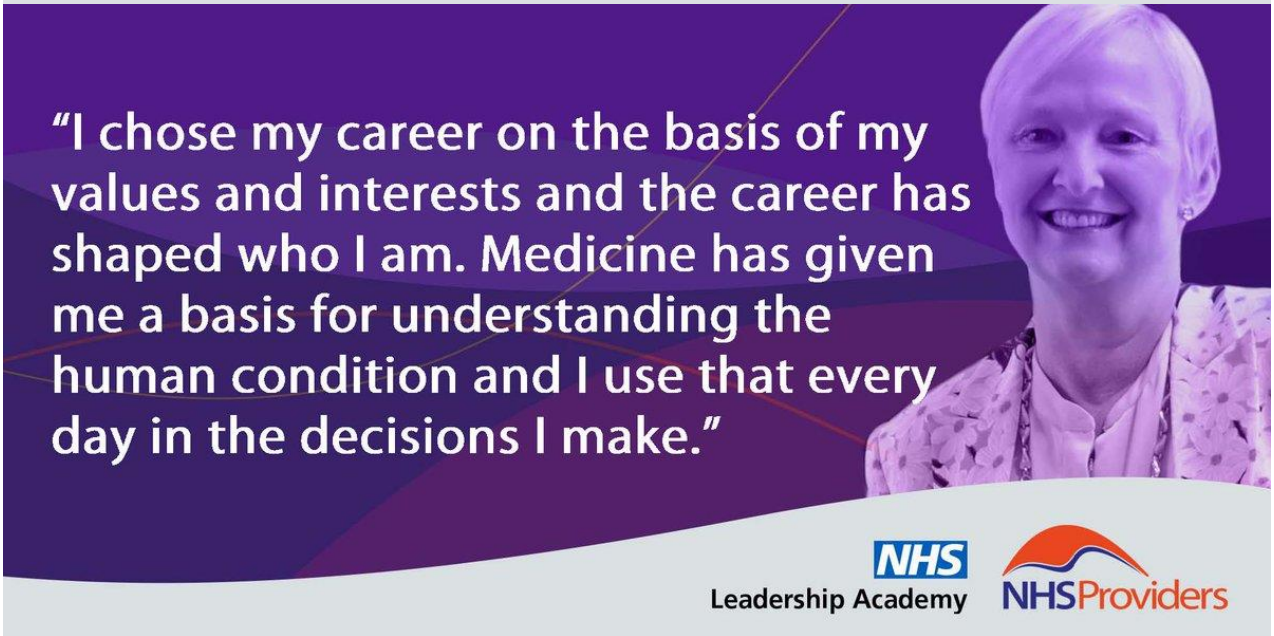
BBC Radio Northampton attended our Pathway to Excellence celebrations and there were interviews with me, Sheran Oke, and Ruth May which featured on the DriveTime show on 12 November 2018. There were also features in the Chronicle & Echo and Nursing Times. There has been national interest in this accreditation and we have received congratulations from NHSI

On 25 October NHS Providers published a blog where I answer questions about my clinical background and the transition into my current role as chief executive. Many of the individual answers to questions have been tweeted and are a reminder of my personal clinical perspective in the CEO role. Although there have been many national expressions of aspirations to encourage clinicians into these senior roles, there have not been huge numbers of clinicians willing to take the step. On the other hand, many CEOs who come through the management route find this emphasis on clinicians unhelpful. In our clinically-led and managed organisation the main emphasis needs to continue to be on mutual respect and support for the skills and perspectives of different types of clinicians and managers and I would hope that we will provide a fertile ground for anyone wishing to develop an interest in clinical leadership or in furthering their career in NHS management and leadership from a different background. The privilege of having the opportunity to make a difference remains something to be cherished even in these times of pressure.

Dr Sonia Swart
Chief Executive

Northampton General Hospital NHS Trust





Northampton General Hospital NHS
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**29th November 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 committee on matters relating to quality improvement, harm and mortality.

In relation to the latter the trust remains in need of an identified non-executive lead for mortality.

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 and action
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 and nominate a non-executive lead for mortality at NGH

Medical Director's Report

29th November 2018

1. Introduction

The purpose of this report is to reflect faithfully upon the quality and safety of the clinical services afforded to our 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. Consultant Job Planning
b. Medical model in the Nye Bevan Building

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

Internally, the challenge to continuing to reduce this risk 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.

Without the medical model changes the Nye Bevan will not deliver its full potential but rather end up in effect as additional ward capacity.

There has been good progress with the clinical teams towards implementing a model with patient care delivered earlier by consultants with more continuity and less reliant on locum staff. In particular the time commitment and rota required to support the model are largely accepted, and the individual services are working though the detail of how to mitigate the gaps which would otherwise appear in the delivery of elective commitments including cancer.

Since the last report to board the impact of Winter has begun to be felt and the extent to which escalation capacity is already in use highlights the imperative of change.

CRR ID	Description	Rating (Initial)	Rating (Current)	Corporate Committee
368	Risk of reduced patient safety when demand exceeds capacity resulting in a risk of non-achievement of Trust targets	20	15	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. This remains a prominent concern amongst the consultant physician workforce in particular.

All 8 of the additional consultants required to support the Nye Bevan medical model have been recruited. Additional consultants, substantive and temporary are being recruited to help balance the need to deliver safe and effective non-elective care with planned speciality commitments.

CRR ID	Description	Rating (Initial)	Rating (Current)	Corporate Committee
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
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
1155	Potentially unable to maintain appropriate staffing levels in theatre areas due to a large amount of staff vacancies	15	15	Quality Governance
1756	Ineffectiveness of the Nye Bevan unit due to ineffectiveness of the medical model, inability to recruit staff substantively, as well as impact of patient flow across the hospital.	20	20	Finance & Performance

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 clinical 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	18
Never Events	2	2	1	0	1	3	1	3	1

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 4 serious incidents reported on STEIS during September and October one of which was a never event in October. These are on track to report by their deadlines and are summarised in the following table;

STEIS/Datix Ref.	STEIS Criteria / SI Brief Detail	Location	45 day completion date
2018/22239 W-94137	Delay in diagnosing perforated oesophagus	ED	15/11/2018

STEIS/Datix Ref.	STEIS Criteria / SI Brief Detail	Location	45 day completion date
2018/23148 W-91224	Failure to diagnose dislocated shoulder	ED	27/11/2018
2018/23139 W-94238	Delay in performing Caesarean Section - Baby transferred for cooling	Sturtridge	27/11/2018
2018/25155	Never Event Wrong site surgery – Breast cancer	Surgery	20/12/2018

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

12 moderate harm incidents were detected during October and November, and these are subject to concise RCA investigations.

3.iii Thematic issues

A notable theme during incidents in September and October has been delayed escalation of deterioration against NEWS criteria. This has been picked up by the POC SIM team in the immediate term with some in situ training for inpatient areas and will be addressed sustainably through the work of the deteriorating patient board.

4. Mortality

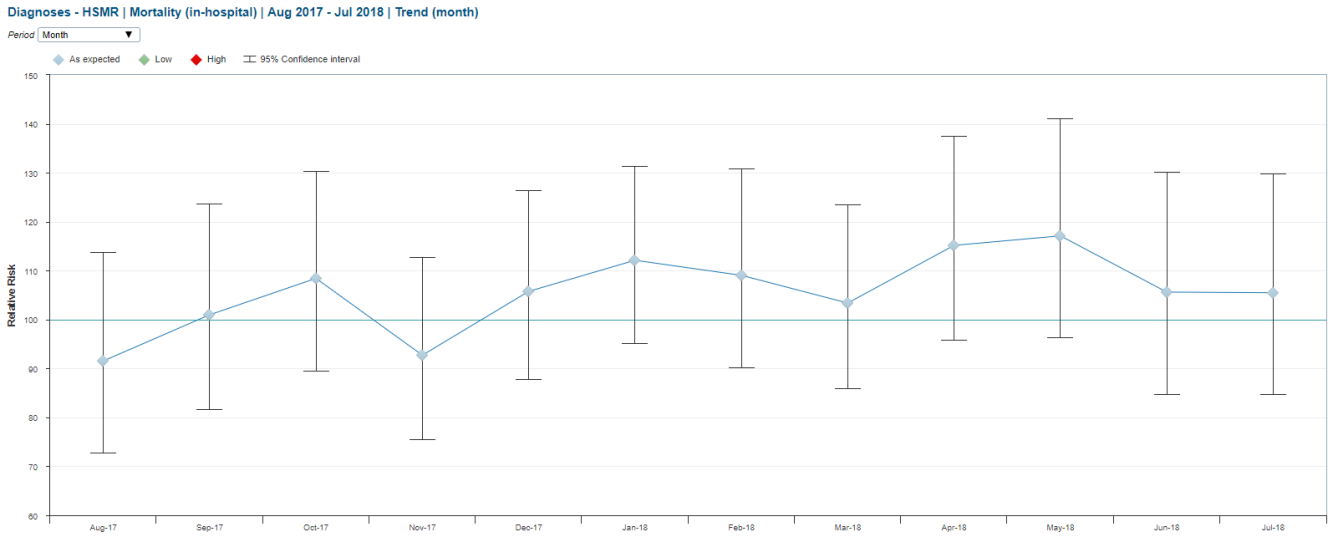
4.1 Summary data

As highlighted in recent board reports there has been a trend towards increasing mortality at NGH over recent months. This has, as anticipated now reached significance for HSMR on a rolling 12 month trend. A more detailed analysis and comparison is therefore presented here in addition to QGC. Similarly the approach to improvement action is expanded upon.

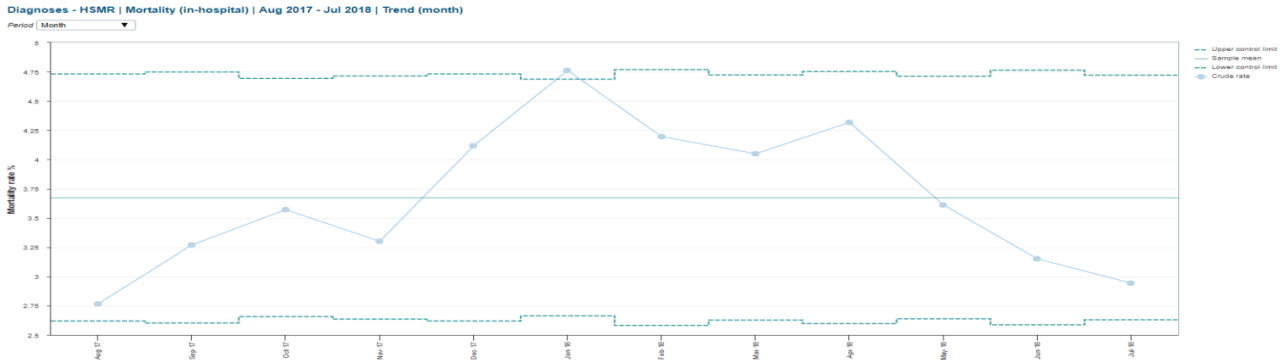
Metric	Result
HSMR	**105.9** 'higher than expected' range (moved banding from 'as expected' this month)
HSMR position vs. peers	The Trust is 1 of 4 Trusts (within the peer group of 8) with an HSMR in the 'higher than expected' range. The crude rate is 3.7% (vs 3.60% for the peer group).
HSMR outlying groups	4 outlying groups • Septicaemia (except in labour) ▪ Secondary malignancies ▪ Cancer of Colon ▪ Urinary tract infections
Coding analysis	• The Trust codes 3.86% of HSMR (Non-Elective) superspells with palliative care vs. 4.01% national average • The Trust has an upper quartile Charlson co-morbidity rate of 24.5% vs. 25% nationally

4.2 Analysis

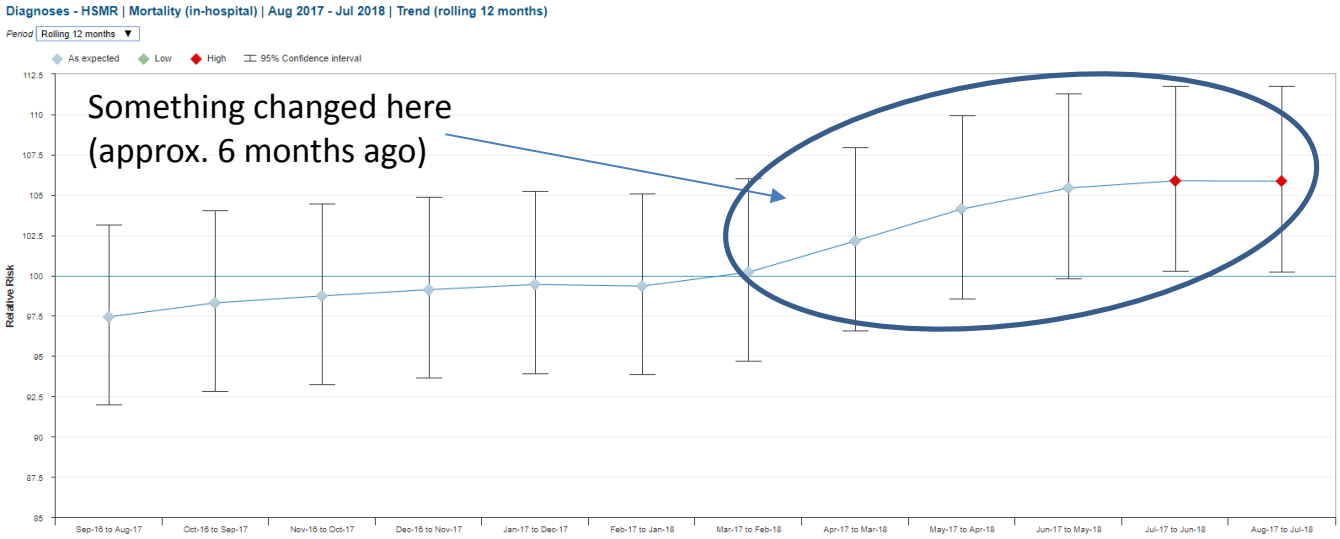
HSMR 12 month trend by month:



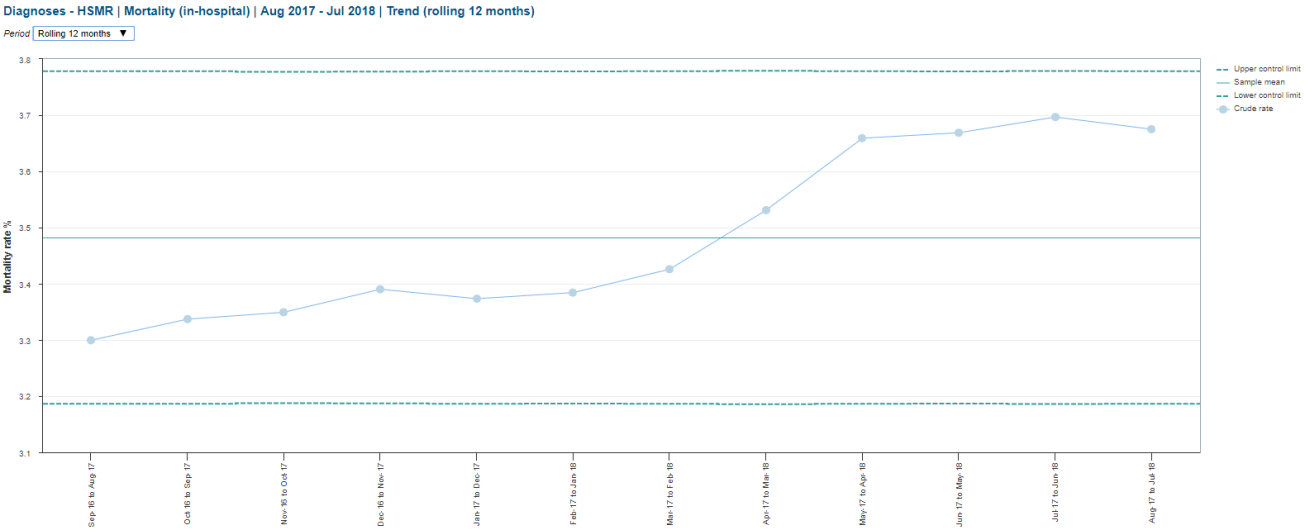
Crude rate 12 month trend by month (HSMR Basket):



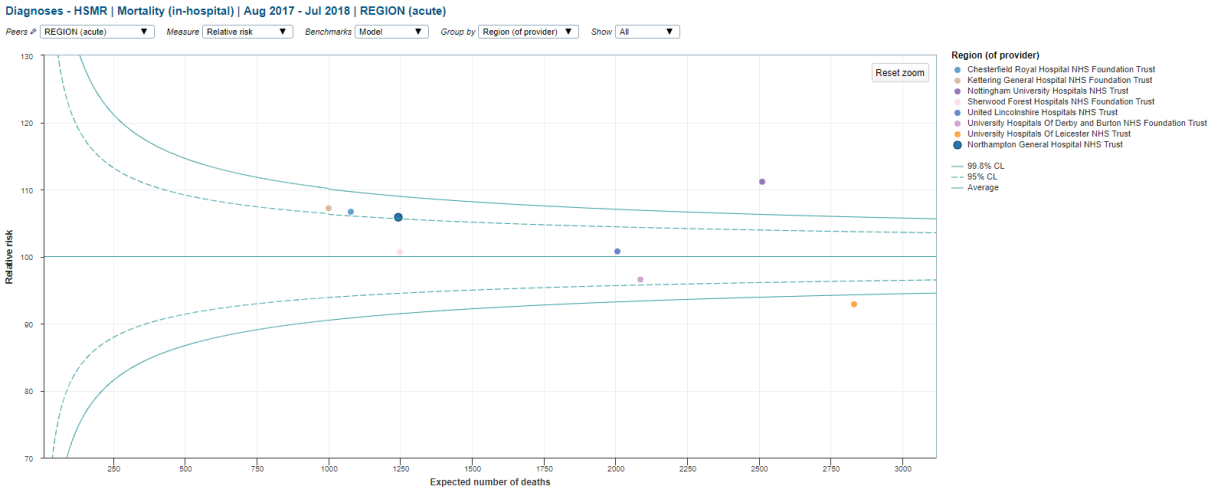
HSMR Rolling 12 months:



Crude rate Rolling 12 months (HSMR Basket):



HMSR peer comparison

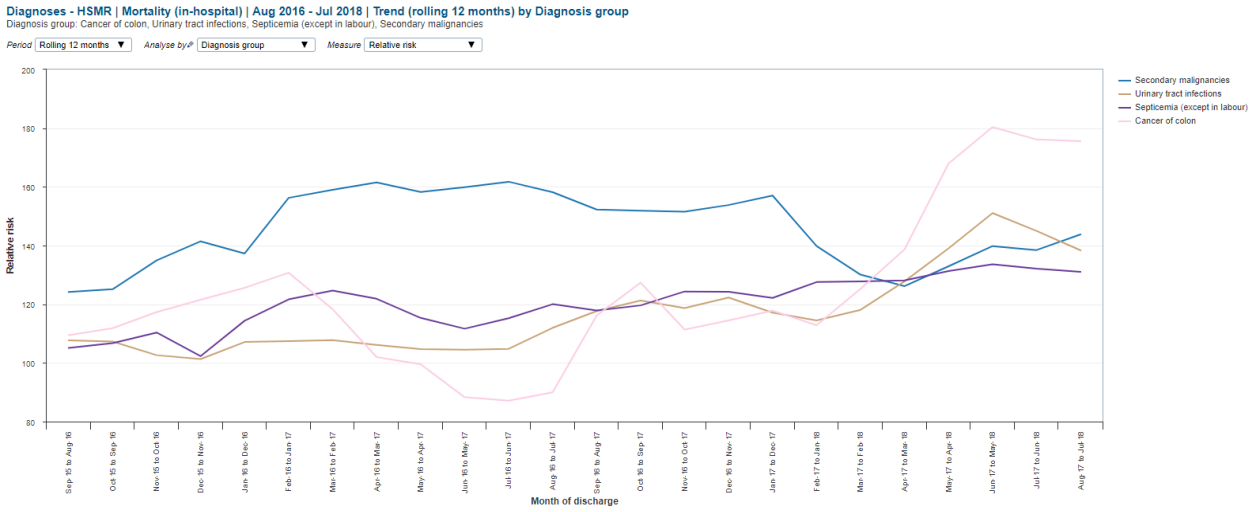


Diagnoses - HSMR | Mortality (in-hospital) | Aug 2017 - Jul 2018 | REGION (acute)

Peers REGION (acute) | Measure Relative risk | Show All

REGION (acute)	Code	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All		400,280	100.0%	402,816	14,252	3.6%	14004.2	3.5%	247.8	101.8	100.1	103.5
Nottingham University Hospitals NHS Trust	RX1	80,305	20.1%	81,095	2,792	3.5%	2511.8	3.1%	280.2	111.2	107.1	115.4
Kettering General Hospital NHS Foundation Trust	RNQ	31,004	7.7%	31,254	1,072	3.5%	999.9	3.2%	72.1	107.2	100.9	113.8
Chesterfield Royal Hospital NHS Foundation Trust	RFS	24,918	6.2%	25,039	1,149	4.6%	1077.1	4.3%	71.9	106.7	100.6	113.0
Northampton General Hospital NHS Trust	RNS	35,809	8.9%	35,866	1,316	3.7%	1243.2	3.5%	72.8	105.9	100.2	111.7
United Lincolnshire Hospitals NHS Trust	RWD	56,930	14.2%	57,092	2,022	3.6%	2006.6	3.5%	15.4	100.8	96.4	105.3
Sherwood Forest Hospitals NHS Foundation Trust	RK5	28,869	7.2%	29,010	1,256	4.4%	1247.8	4.3%	8.2	100.7	95.2	106.4
University Hospitals Of Derby and Burton NHS Foundation Trust	RTG	51,841	13.0%	52,074	2,015	3.9%	2086.5	4.0%	-71.5	96.6	92.4	100.9
University Hospitals Of Leicester NHS Trust	RWE	90,604	22.6%	91,386	2,630	2.9%	2831.3	3.1%	-201.3	92.9	89.4	96.5

HMSR by diagnosis group

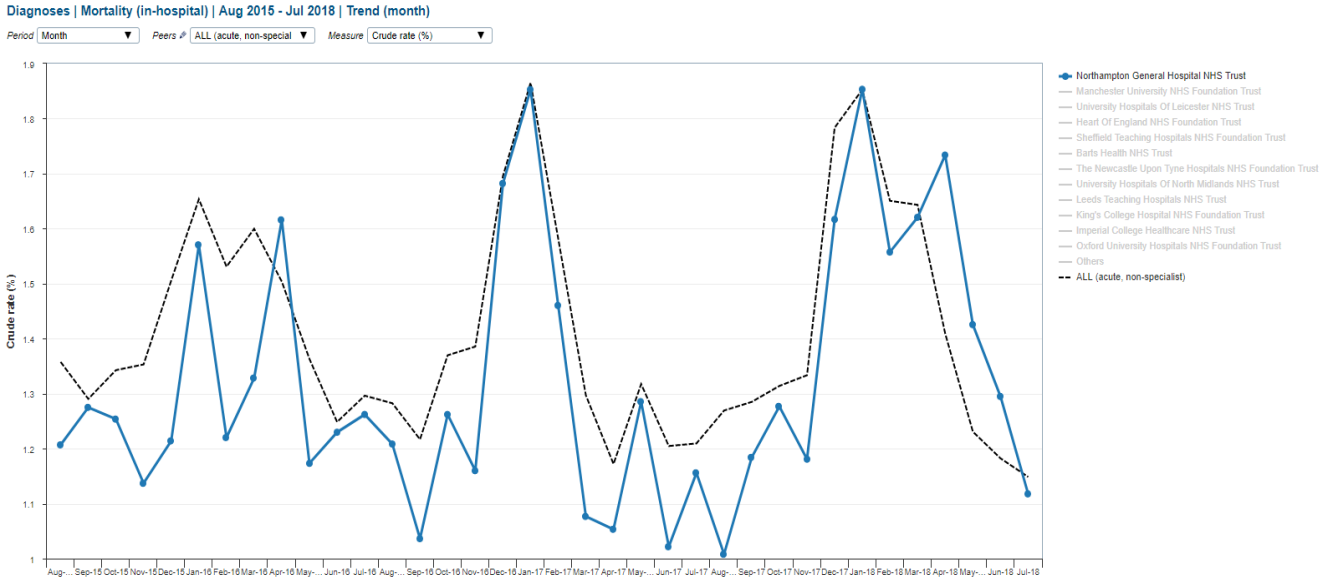


Diagnoses - HSMR | Mortality (in-hospital) | Aug 2017 - Jul 2018 | Diagnosis group

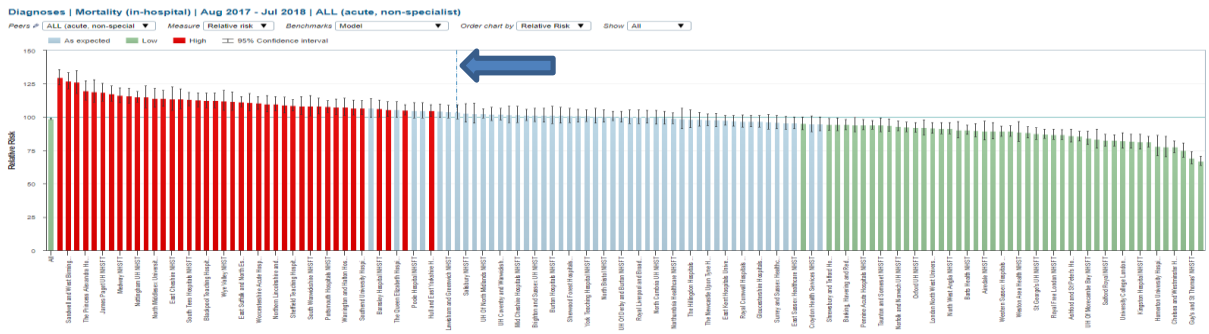
Analyse by Diagnosis group ▼ *Measure* Relative risk ▼ *Show* All ▼

Diagnosis group	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	35,809	100.0%	35,866	1,316	3.7%	1243.2	3.5%	72.8	105.9	100.2	111.7
Septicemia (except in labour)	1,309	3.7%	1,314	283	21.6%	216.1	16.5%	66.9	131.0	116.2	147.2
Secondary malignancies	1,701	4.8%	1,702	47	2.8%	32.7	1.9%	14.3	143.8	105.7	191.2
Cancer of colon	533	1.5%	533	17	3.2%	9.7	1.8%	7.3	175.6	102.2	281.1
Urinary tract infections	1,408	3.9%	1,408	46	3.3%	33.2	2.4%	12.8	138.4	101.3	184.6
Respiratory failure, insufficiency, arrest (adult)	67	0.2%	68	20	29.9%	13.0	19.4%	7.0	153.6	93.8	237.3

All diagnoses crude mortality rate



All diagnoses SMR – national acute trust comparison – rolling year to July 18

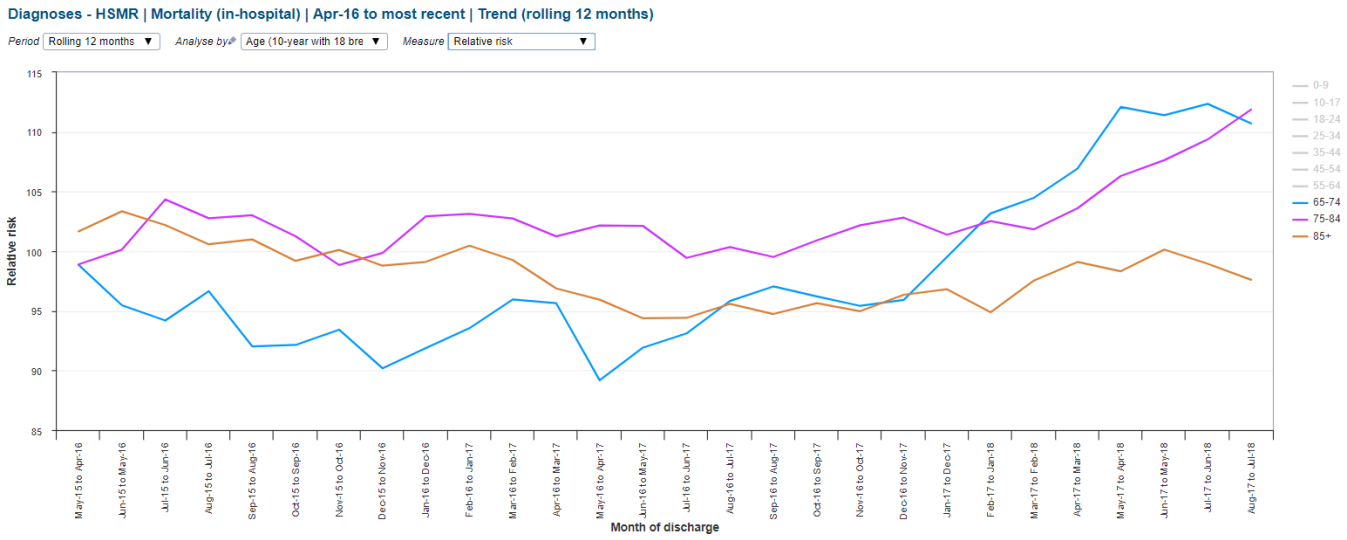


4.3 Approach to investigation

The case mix in terms of comorbidities and palliative care coding appear consistent with previous years reporting and the national picture.

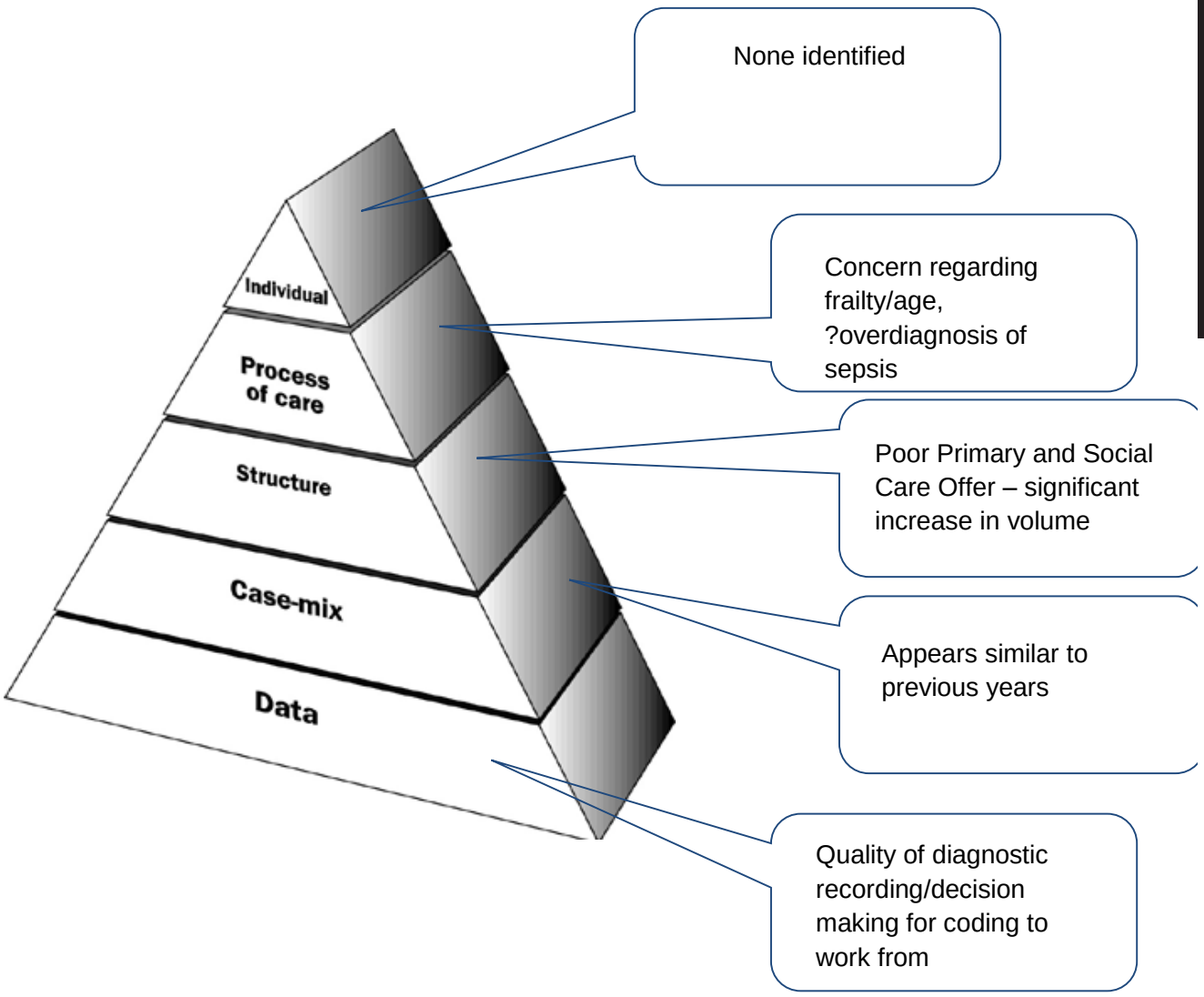
Palliative care coding for secondary malignancies however appears to be lower at NGH than it does nationally.

There are significant increases in mortality for elderly patients;



Urinary tract infections as a cause of mortality are a surrogate marker of frailty related and “social” (as opposed to medical) admissions also.

The local findings are mapped against the recognised pyramid for exploring mortality alerts below (*Lilford et al. Lancet* 2004; **363:** 1147-54).



4.4 Summary of Actions

Mortality review group meetings now chaired by MD. Work streams taken from the key areas identified above;

1. Clinical coding interface – accuracy of diagnosis during primary episode
2. Frailty – actions to be identified through mortality review 12
3. Access to palliative care for secondary malignancy (and coding)
4. Sepsis/UTI over diagnosis

Clinical leads have been identified for each of these and they will set up task and finish groups reporting back into MRG where an overarching action plan will be coordinated.

In addition the deteriorating patient board is focussed on the quality of care we give to our sickest patients (see section 7). Separately a Nye Bevan steering group chaired by the MD meets weekly to address issues relating to care delivery for all our non-elective admissions.

5. Medical workforce

5.1 Consultant Job Planning

Job planning in Medicine Division is progressing to the extent that the divisional director has given a commitment to signing off all the job plans in the division by the 15th of December 2018, and that these will be consistent with delivery of the proposed new medical model in the Nye Bevan building.

It has therefore been agreed between the chief operating officer, director of nursing, divisional director and medical director that the new GIM on call rota will go live in the first week of January 2019 and support the new medical model.

Executive consistency committee (ECC) meetings have continued with the WCOH division and commenced with the surgery division. The directorates within these divisions have progressed their service and team based job plans significantly, and both divisions expect to have progressed to individual consultant job planning meetings and sign off well ahead of the end of the financial year.

5.2 Medical model for Nye Bevan

The mew model with significantly increased consultant commitment to emergency medical care will deliver consultant decision making earlier in a patient's presentation to NGH and improve continuity of care all delivered by substantive consutlants. In order to ensure as smooth a transition as possible to the new model an operational group meeting with strong executive support (medical, nursing, governance) has been instituted weekly. This is also a forum at which safety issues are identified and addressed in assessment prior to the introduction of the new model.

To support the transition into the Nye Bevan building and then the introduction of a new working model within it an associate medical director for emergency care transformation has been appointed.

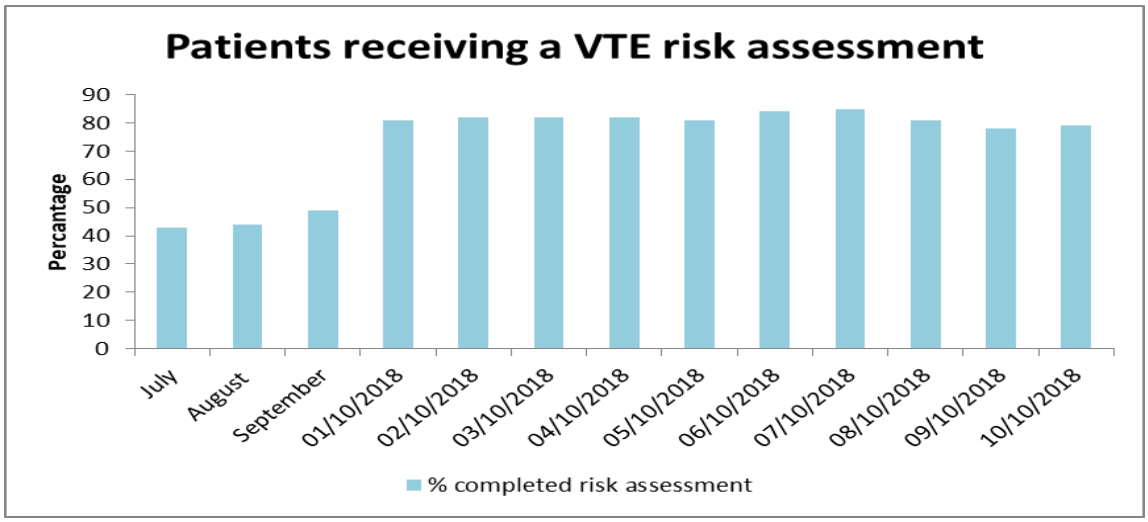
6. Thrombosis

The upgrade to ePMA which will enforce VTE risk assessment is still on track to be provided to the trust during December 2018. It is anticipated that after testing roll out will ocurr in February 2019.

As an interim measure to promote patient safety a “clot busting” campaign was launched with an intensive drive over a fortnight at the beginning of October. During this overdue assessments were reported at the daily safety huddle, and every ward was visited twice a day by a “clot buster” ensuring that the clinical teams were prioritising VTE prophylaxis. A team of volunteers also visited the patients to educate and empower them to ask pertinent questions about their VTE risk and protection.

This has now been scaled back, but all wards continue to have twice weekly visits and assessment data is routinely collected at the safety huddles.

The initial impact has been positive.



7. Deteriorating Patient Board

Following two steering group meetings establishing the scope of work and supporting governance structure, an operational group has been established to roll out the Acute Bundle of Care throughout adult wards, measure effectiveness and receive learning from other governance groups to guide further action.

The operational group reports to the Deteriorating Patient Board, with executive and divisional director oversight of the programme of work. This will report quarterly to QGC, with the first report in December 2018.

It is anticipated that the Acute Bundle of Care will be rolled out in January. During November and December an enabling programme of education around response to NEWS 2 scores is underway and will cover all adult wards.

The terms of reference are appended for reference.

Northampton General Hospital NHS
NHS Trust

Appendix 1

DETERIORATING PATIENT BOARD

TERMS OF REFERENCE

Purpose

The Deteriorating Patient Board **(DPB)** is to ensure there is an effective system of integrated governance, risk management, and internal control across the organization that supports the Deteriorating Patient Operational Group to improve the care of the acute deteriorating adult patient through development and supported delivery of an Acute Bundle of Care (ABC) monitored against a 'standard of care' (SOC) audit tool.

Membership	Medical Director (chair)
	Director of Nursing, Midwifery & Patient services (co-chair)
	Director of Corporate Development, Governance and Assurance
	Deteriorating Patient Medical Lead
	Deteriorating Patient operational group lead (non-medical) (Associate Director Patient safety & Quality Improvement)
	Deputy Director Patient Safety & Quality Improvement
	Divisional Directors (4)
	Associate Directors of Nursing

Quorum, frequency of meetings and required frequency of attendance

No business will be transacted unless 7 members of the DPB are present. A minimum of one chair or co-chair, a minimum of one of chair or co-chair from the Operational group, 2 Divisional Directors (or named consultant deputies), one Associate Director of Nursing, Patient Safety & Quality Improvement representative.

In attendance

In addition to the agreed membership, other directors and officers of the Trust may be asked to attend at the request of the Chair. Only the DPB Chair and relevant members are entitled to be present at a meeting of the DPB, but others may attend by invitation of the Chair of the DPB.

The DPB will meet bi- monthly (6 times a year). Members of the Board are required to attend a minimum of 80% of the meetings held each financial year and not be absent for two consecutive meetings.

Authority

The DPB is authorised by the Board to investigate any activity within its terms of reference and to seek any information it requires from any employee and all employees are directed to co-operate with any request made by DPB.
DPB can also recommend the provision of expert advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Duties

The DPB has two reporting domain sub-groups;

Quality Governance Committee (QGC) (Chaired by a non-executive Director)

Deteriorating Patient Operational Group (Chaired by Consultant Medical lead)

Sub-groups and reporting arrangements

The DPB shall have the authority to establish sub-groups for the purpose of addressing specific tasks or areas of responsibility.

The terms of reference, including the reporting procedures of any sub-committee/groups must be approved by the group and regularly reviewed (at least annually).

The DPB will receive assurance from Deteriorating Patient Board Operational Group and who will then report to QGC.

The DPB will receive assurance and progress regarding:

- Provide / monitor a proactive, comprehensive, coordinated, multi-professional approach to the management of deteriorating patients (Trust-wide)
- Authorise Task and Finish working groups as necessary at the request of the Deteriorating Patient Operational Group.
- Address implementation of local and national drivers that influence practice, recommendations to be based on NICE guidelines (acutely ill patients in hospital) and local Acute Bundle of Care.

- Develop and monitor the implementation and success of the Trusts deteriorating patient and standards of care strategy (in development).
- Review themes of care omissions or errors of deteriorating patients, share among teams and collectively input as appropriate to reduce omissions or errors.
- Direct staff in the Divisions to undertake audit and evaluation activity to establish standard of care practice and improve the quality of care.
- Review the trend analysis of standard of care across the Trust and produce guidance and offer support as necessary.

Authority, accountability and reporting arrangements

The DPB is authorized by QGC to establish a standard of care tool based on an Acute Bundle of Care and implement its use, following validation, in to practice.

The DPB will include a monthly overview of progress which will be included within the Medical Directors report and provide a summary report to QGC on a quarterly basis (3 times a year). The Chair of DPB shall draw to the attention of the Trust Board to any issues that require escalation to the full Trust Board.

The minutes of DPB shall be formally recorded and sent to the group attendees within 10 working days, as well as to the membership. The professional representatives will disseminate the information from the minutes to staff within their chain of command as required.

Requirement for review

These terms of reference will be formally reviewed by the Committee at least annually.

FOI Reminder

The minutes (or sub-sections) of the Board, unless deemed exempt under the Freedom of Information Act 2000, shall be made available to the public, through the meeting papers.

Northampton General Hospital NHS Trust

Report To	**Trust Board**
Date of Meeting	**29 November 2018**

Title of the Report	**Director of Nursing, Midwifery & Patient Services Report**
Agenda item	**9**
Presenter of Report	Sheran Oke, Director of Nursing, Midwifery & Patient Services
Author(s) of Report	Natalie Green – Deputy Director of Nursing (Interim)
Purpose	Assurance & Information

Executive Summary

The paper outlines:

- Safety Thermometer: In October 2018, the Trust achieved 97.89% new harm free care. Overall harm free care was 94.26% against a national picture of 94.12%.
- Maternity Safety Thermometer: In October the overall proportion of women and babies who received combined physical and psychological harm free care was 76.4% which is higher than the national aggregate of 73.4%.
- Pressure Prevention**: 8** patients developed a total of 9 category 2 pressure ulcers, **1** category 3 pressure ulcer, and **9** DTIs on **7** patients, during the reporting period of October.
- Falls: In October there 25 low harm falls, 2 severe harm and 1 catastrophic patient fall. All incidents have had Initial assessments completed and reviewed by the Review of Harm Group. The severe and catastrophic falls are all undergoing comprehensive investigations.
- Friends and Family Test (FFT): In October 91.6% of patients said they would recommend the Trust as a place to receive care
- Avery and Dickens Therapy Unit (DTU): - in DTU there were 3 category 2 pressure ulcers and 4 no harm plus 5 low harm falls. In Avery there were 0 pressure ulcers reported and 4 falls; 2 no harm falls and 1 low harm fall and 1 severe.
- There is an update on the Midwifery, Safeguarding, Pathway to Excellence, Assessment and Accreditation and Nursing and Midwifery Dashboards.
- Overall fill rate in October was RN 94% and HCA 102%.

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) 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

The Committee 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

Quality Governance Committee
November 2018

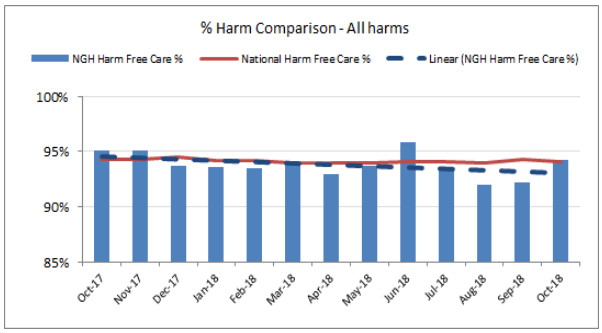
Nursing & Midwifery Care Report

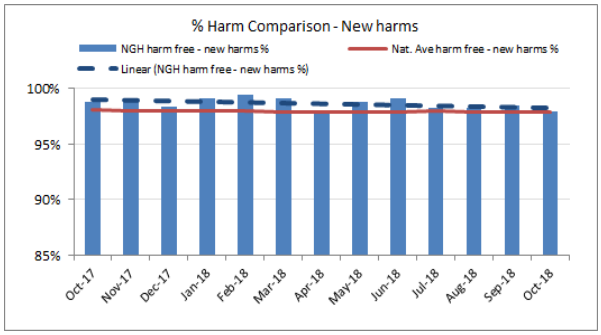
1. Introduction

The Nursing & Midwifery (N&M) Care Report highlights key issues from services, audits and projects during the month of October 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.

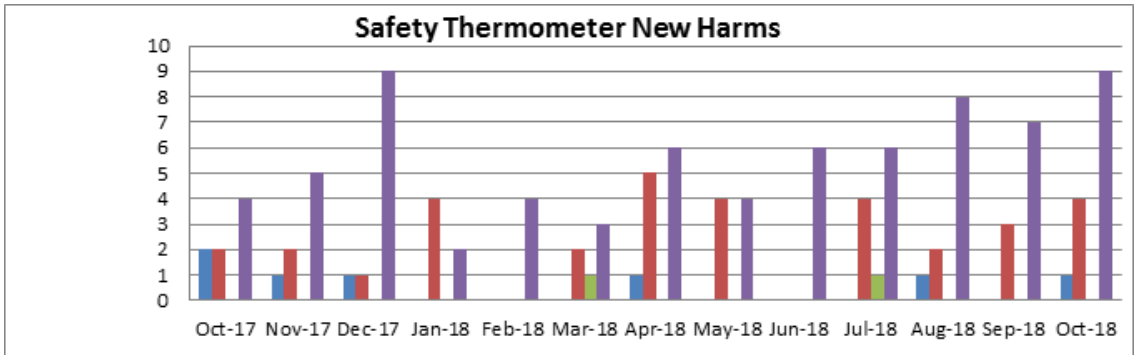
2. NHS Safety Thermometer

The NHS Safety Thermometer is a monthly point prevalence audit. In October 2018, 97.89% of in-patients did not incur any new harm whilst in our care, a slight decrease from September 2018. This is above the national expected threshold of 95%. Overall harm free care was 94.26% which was above the months national average (Appendix 1 provides the National Safety Thermometer Definition)





The new harms reported for October 2018 are illustrated in the graph below. The Matrons and Ward Sisters are aware of the point prevalence audit and review and monitor the results. The results are used in conjunction with the total monthly incidents and are discussed at monthly divisional meetings and included within the dashboard (Appendix 2 – 4).



	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
New CRUTI	2	1	1	0	0	0	1	0	0	0	1	0	1
Falls with harm	2	2	1	4	0	2	5	4	0	4	2	3	4
VTE's	0	0	0	0	0	1	0	0	0	1	0	0	0
New PU's	4	5	9	2	4	3	6	4	6	6	8	7	9

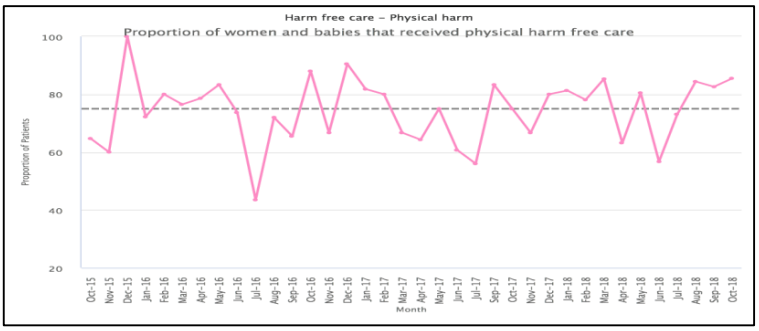
3. Maternity Safety Thermometer

The Maternity Safety Thermometer enables a point prevalent calculation of the proportion of women and babies who received harm free care 'in month'. The numerator is defined as the number of women in whom all of the following harms are absent:

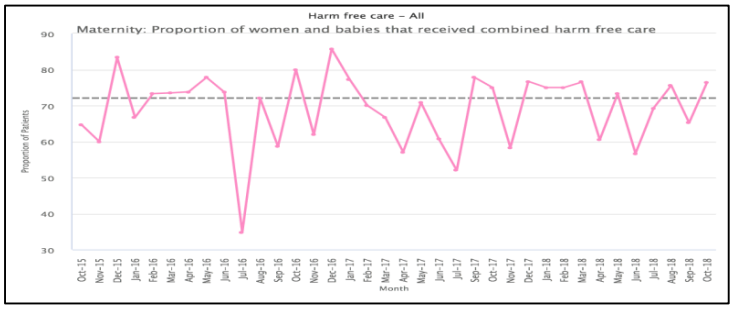
Physical 'harms':
- Maternal infection
- 3rd/4th degree perineal trauma
- PPH of more than 1000mls
- Babies with an Apgar less than 7 at 5 Minutes

Psychosocial Questions: perceptions of safety
- Mothers left alone at a time that worried them
- Concerns about safety during Labour and Birth not taken seriously

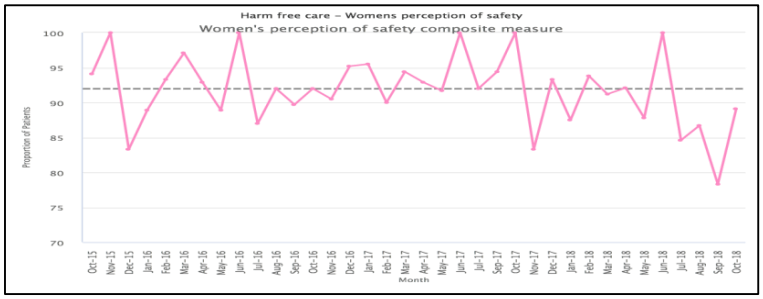
The below graph shows the percentage of harm free care associated with physical harms for October at 85.5% above the national aggregate of 78.8%.



The following graph illustrates that the overall percentage of women and babies who received combined physical and psychological harm free care in October 2018; 76.4% which is above the national aggregate of 73.4%.



The next graph's show the percentage of harm free care associated with psychological harms. The national aggregate of maternal perceptions of safety for October was 89.9%. In October locally women's perception of safety was 89.1%.



4. Pressure Ulcer Incidence

The following wards should be congratulated for making considerable improvements in their Pressure Ulcer harm free days- ROWAN – 357 days, TALBOT BUTLER – 254 days and FINEDON – 215 days

In October 2018, the Tissue Viability Team (TVT) received **387** datix incident reports relating to pressure damage, this is an increase from previous months. Of these **22** were duplicated reports, **38** patients were not seen as they were either not admitted, or they were reported as moisture lesions, or discharged within 48 hours of reporting pressure ulcer (PU) harm, of the remaining incidents reported, **327** were validated by the TVT on the wards or from photographs.

During the reporting period **16** patients were harmed through pressure damage whilst in our care, of these **8** patients developed 9 category **2** pressure ulcers, **1** patient developed category **3** harm, and there were **9** Deep Tissue Injuries reported on **7** patients.

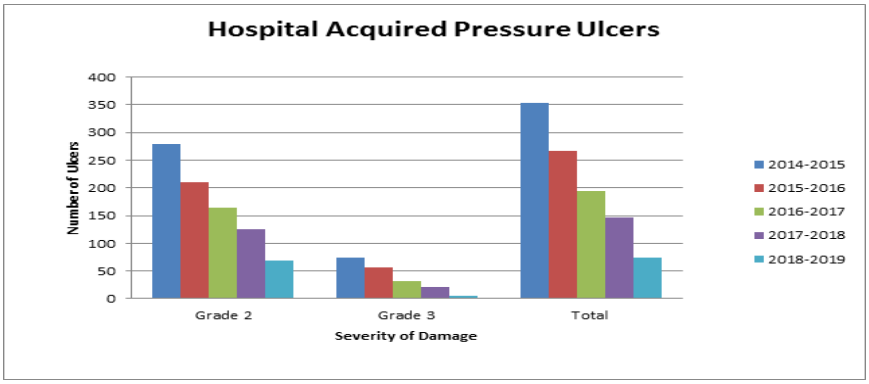
Wards	Category 2	Category 3	DTI
WILLOW			2
COLLINGTREE	2		2
BECKET	5		
QUINTON		1	
HAWTHORN			1
COMPTON	1		
VICTORIA			3
CEDAR			1
KNIGHTLEY	1		

Actions
The TV Team have instigated a number of work streams to reduce the incidence further, these include the production of screen savers to remind staff to check heels and to use preventative equipment, providing more training on the SSKIN documentation, risk assessments and categorisation of pressure ulcers as well as aiming to produce a patient friendly information booklet on prevention. Becket Ward are sourcing different types of oxygen tubing to reduce device related pressure ulcers.

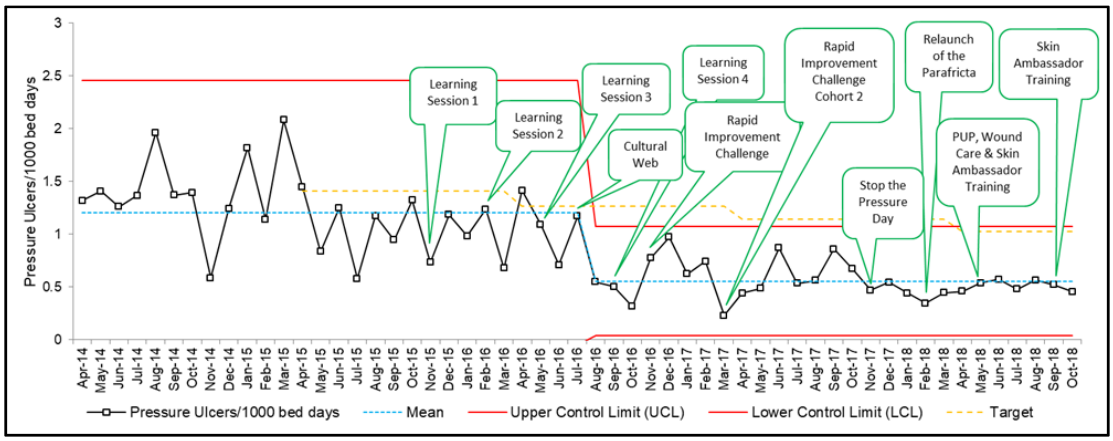
The Tissue Viability Team, are continuing to provide training and support to NGH staff
In October the 1st Northants Tissue Viability Conference was held at the Cripps NGH, The day was really well attended by over 70 staff, with excellent presentations from our nurses and from our colleagues at *Convatec, Biomonde* and *Smith & Nephew.* There were Q&A sessions and shared learning amongst all who attended. Thank you to all the companies who attended and provided stands. Planning has already started for next year's conference.

A 'Trolley Dash' is planned to take place on the 15th November to mark "International Stop the Pressure Day", ward resources will be replenished and a quiz will be made available to the staff. This will also include updates for the staff regarding the new NHSi classification document and recommendations

The following graph demonstrates a continued downward trend in pressure ulcer incidence year on year.

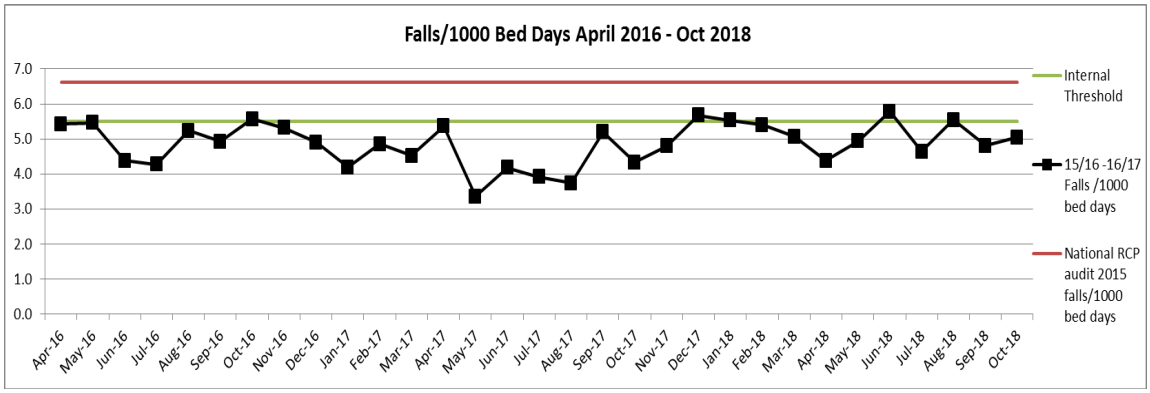


Number of Pressure Ulcers per 1000 bed days
The chart below shows the number of pressure ulcers/1000 bed days this also highlights that the changes being made are leading to statistically significant improvements.

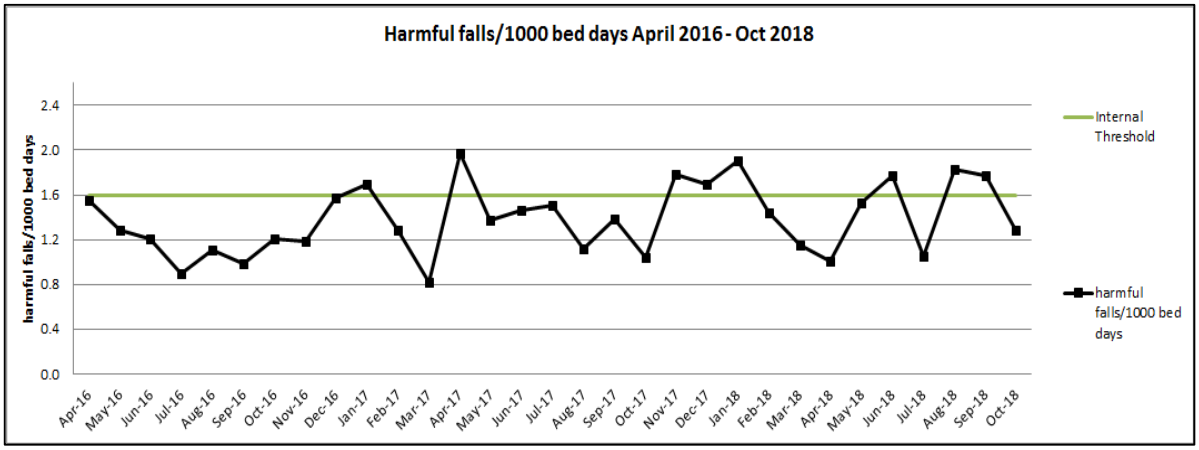


5. Falls

Falls/1000 bed days
There were 110 inpatient falls in total, 82 inpatient patient falls resulted in no harm to the patient. The rate per 1000 bed days is 5.05.



Harmful Falls/1000 bed days including Low, Moderate, Severe and Catastrophic
In October the falls rate per 1000 bed days was 1.29, this is a reduction of 0.48 from the previous month. In total there were 25 low harm falls.



Falls resulting in Moderate, Severe or Catastrophic harm
There was a decrease in moderate, severe and catastrophic falls during October of 0.09 moderate/severe/catastrophic falls/1000 bed days compared to September. In total there were 3 patient incidents recorded.

2 severe harm falls resulted in; 1 patient sustaining a fractured neck of femur and 1 patient sustaining a peri-prosthetic hip fracture. Both patients required surgery due to their injuries. 1 patient slipped due to incontinence on their way to the toilet and 1 patient fell trying to open a toilet door. Both incidents remain under investigation at the time of writing this report. The patient who sustained a peri-prosthetic fracture was awaiting discharge home in an outflow bed when their fall occurred. 1 patient fall resulted in catastrophic harm following the patient sustaining a head injury. The patients fall has had a preliminary case review and has been reviewed by the Review of Harm Group (RoHG). No further level of investigation was required and no lapses in care were identified. The final fall resulted in a catastrophic result, the patient sustained a sub-dural bleed, an initial review has been completed and discussed at RoHG, this is now under investigation.

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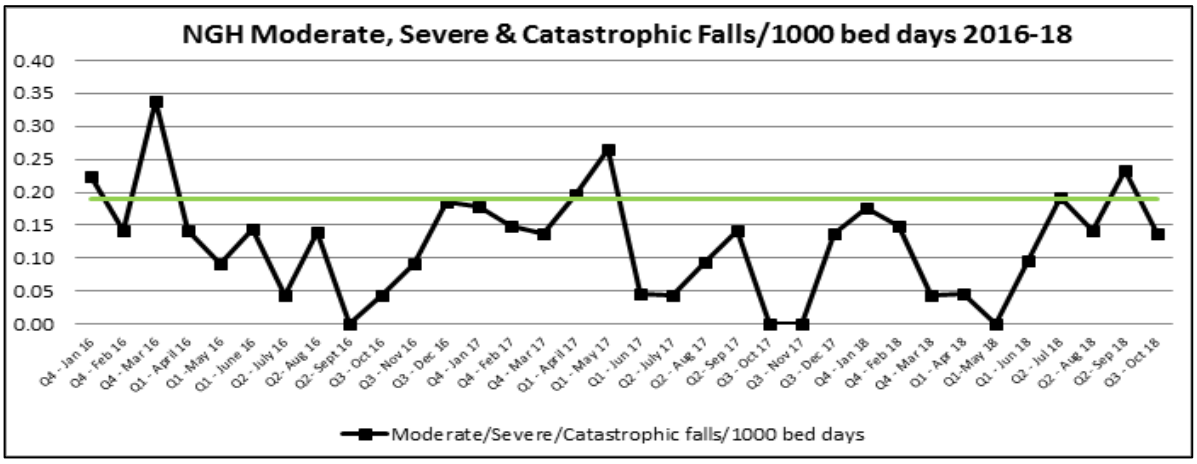
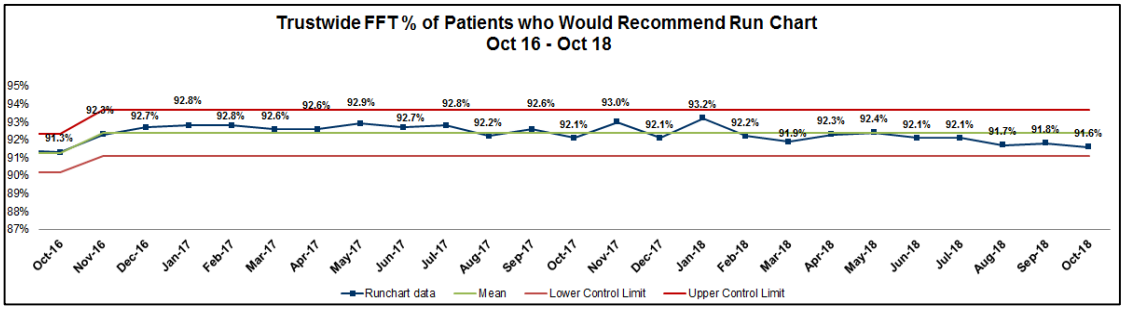
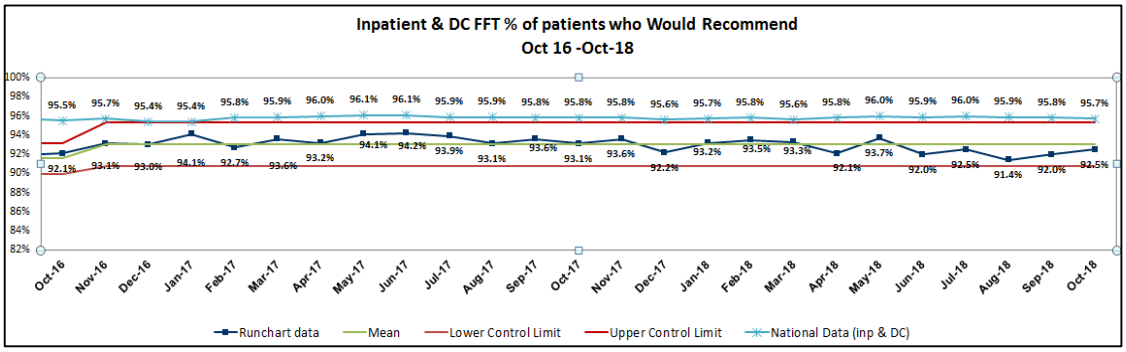


6. FFT Overview - % Would Recommend Run Charts – October 2018

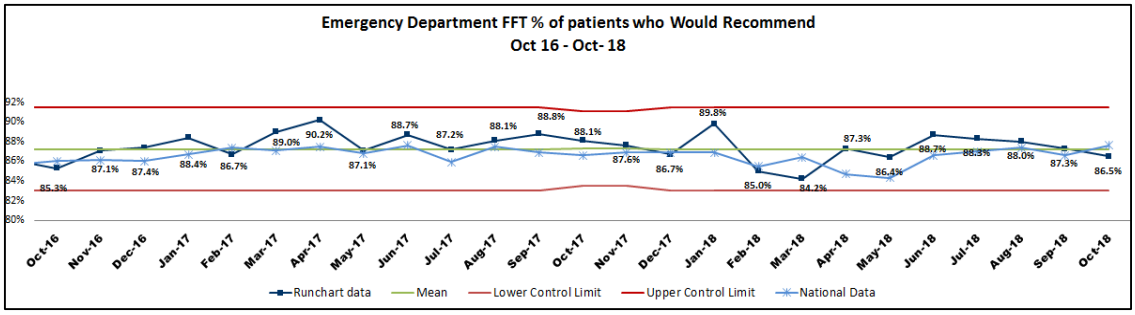
The Trustwide result has slightly decreased from September with a **recommendation rate of 91.6%;** this is just slightly below mean line. Recommendation rates remain within normal variance on statistical analysis.



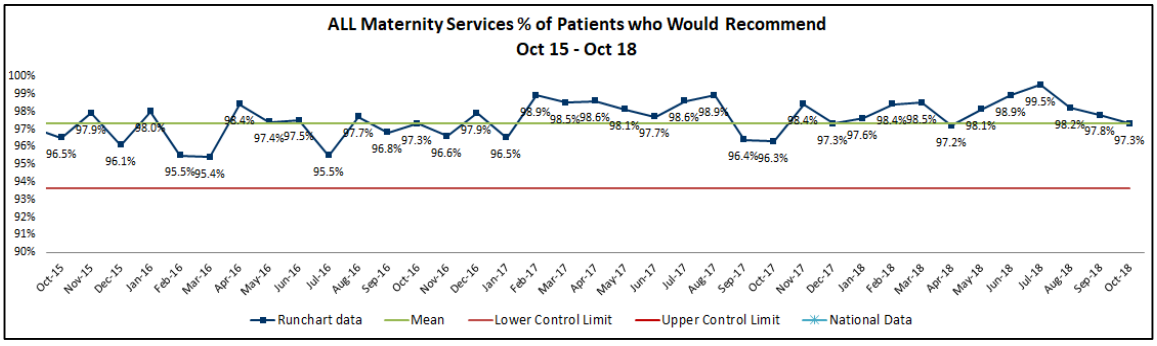
Inpatient and Day Case results have increased slightly in October with a recommendation rate of 92.5%. When comparing August's (most recent available) recommendation rate to the national average recommendation rate, NGH performed 3.2% below the average. This is an increase from 0.5% in September.



The Emergency Department's recommendation result decreased slightly in October to 86.5%. When comparing August's (most recent data available) recommendation rate to the national average, NGH performed 1.1% below the national average (87.6%).



Maternity results have decreased slightly in October with a recommendation rate of 97.3% compared with September's recommendation rate of 97.8%. When comparing August's (most recent available) recommendation rate to the national average recommendation rate, NGH performed 1% below the average. This is a decrease of 0.5% in September.



NHS Improvement has created a FFT Headlines Tool which enables organisations throughout the country to identify how they have performed compared to other organisations. From reviewing the tool for response rates with the most recent data available (August 2018), NGH has performed above the national average for response rates within ED and Inpatient and Day Cases. Births are below the national average and work continues to address this.

Service	NGH Response Rate	National Average Response Rate
Inpatient & DC	28.0%	25.0%
ED	13.7%	12.9%
Births	12.0%	20.3%

This month we have received our 'Tight Time' survey data for quarter 2, these results are currently being distributed to the individual ward areas, Matrons, ADNs and divisions. The areas will develop any actions required, or areas to focus on, which will be discussed in more depth at the December Patient & Carer Experience and Engagement Group.

7. Nursing and Midwifery Dashboards

The Nursing and Midwifery Quality Dashboards, Appendix 3 and 4 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.

Trust wide Overview of the Dashboard

- In October 2018 there was a reduction in the total number of red domains (7) for the general wards, 4 in Medicine, 2 in Surgery and 1 in Womens Childrens and Oncology.
- Compliance with falls and pressure prevention assessment has been focus for the teams with improvement seen, the review continues in the 'collaboratives' and at the 'share and learn' meetings. No areas had any red in these domains.
- Although first impressions is a subjective measure it remains an important aspect and therefore continues to be a focus Trust wide due to the 2 red domains in October a slight improvement from the number of reds in September.

Surgical Division

- The surgical division had 2 red domains – both on Head & Neck 1 due to incomplete care round documentation and the other with regards to first impressions. The Matron and Ward Sister are undertaking a directed piece of work with the team to improve.
- The division had 9 ambers in the remaining domains and another 6 in the area of first impression; the ADN for surgery is concentrating on this aspect at her 1:1 meetings with the Matrons and through the Divisional Council.
- The Ward Sister, Matron and the Associate Director of Nursing (ADN) monitor the results monthly and highlight any specific themes or areas for improvement.

Medicine and Urgent Care Division

- The Medical Division has seen an improvement from last month with only 4 red domains and 27 amber domains on the dashboard.
- 2 relate to care round documentation non-compliance, 1 where protected mealtime was not being undertaken and 1 environmental issue due to the store room door being left unlocked. Each result has been taken up with the Ward Sister and teams to make improvements.
- Compton ward have improved from the previous month when they had 5 reds, those reds have changed to amber with improvements still being made.

- The Ward Sisters, Matrons and ADN monitor the results monthly and highlight any specific themes or areas to improve

Gynaecology Children's and Oncology Division

- Talbot Butler Ward had 1 red domain which was in the area of first impressions. This was due to some areas of the ward feeling cluttered and slightly disorganised, the Matron is working with the leadership team on how to improve these first impressions.
- Paediatric wards had no red domains and 3 ambers
- On the paediatric wards previous areas of concern are again highlighted-falls assessment documentation on Disney and pressure area assessment on Paddington have both improved
- Work is continuing with the 3 amber areas with the Matrons undertaking focussed awareness with the staff and spot audits
- EPIC audits for October show a continuing problem with blood cultures (labels not being added to notes) and hand hygiene. Both these areas have action plans for November.

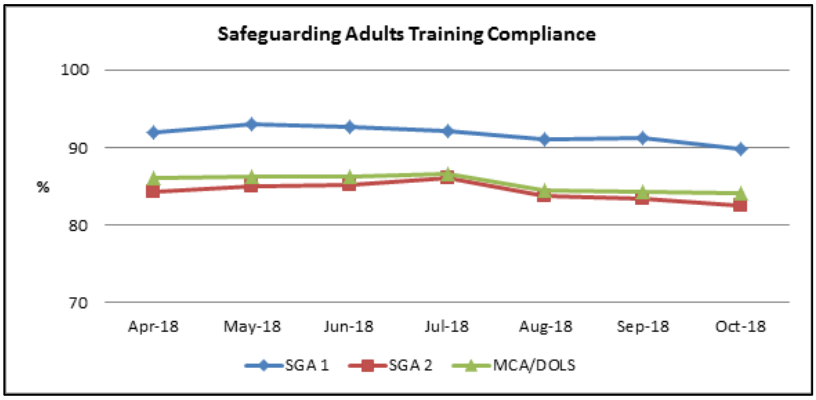
Midwifery

- Following a full review by the ADM and Matrons there were no red or amber areas for midwifery on their QCI's this month.

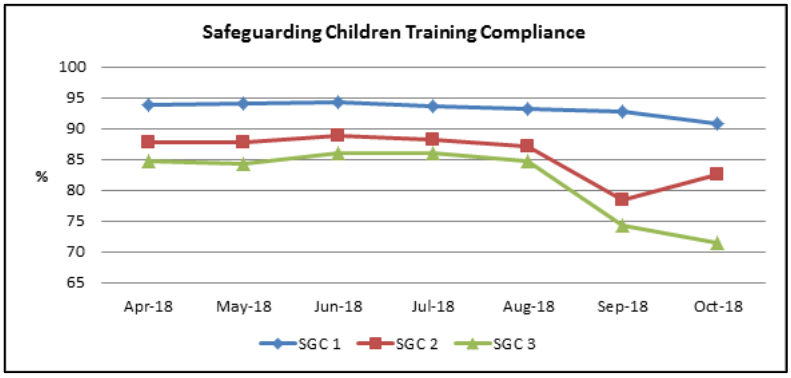
8. Safeguarding

Safeguarding Training Compliance

The training compliance rate of 85% is set as part of the quality schedule set by the Clinical Commissioning Group (CCG) for all safeguarding training. The graph below illustrates the adult safeguarding training compliance for the Trust. There has been a slight decrease in safeguarding level one training (92% to 90%) and safeguarding level two training to (83% to 82%) compared to last month figures. However the compliance for MCA/DoLS training remains at a constant level.



In addition as highlighted in the graph below, safeguarding children level two training has increased this month (78% to 82%) and safeguarding level three has decreased (74% to 71%).

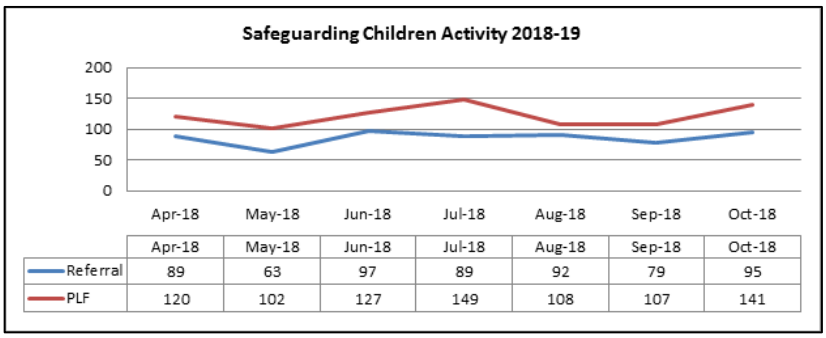


The Deputy Director of Nursing and the Head of Safeguarding met with the Learning and Development Manager to discuss the sudden decrease in safeguarding children training compliance following a recent training needs analysis. Further review of roles and competencies has taken place which includes pharmacy and radiology which should positively influence and re-align training figures for next month. Each area has been spoken to about the requirement to improve their training figures, with the ADNs requested to highlight the shortfall at their divisional meetings.

The Trust and the Clinical Commissioning Group (CCG) as per the Prevent data assurance process. has achieved 90% compliance in Basic Prevent Awareness Training and 96% compliance (1157 staff members out of 1207) in WRAP training. The compliance trajectory is set as 85% and forms part of the quarterly report to NHS England

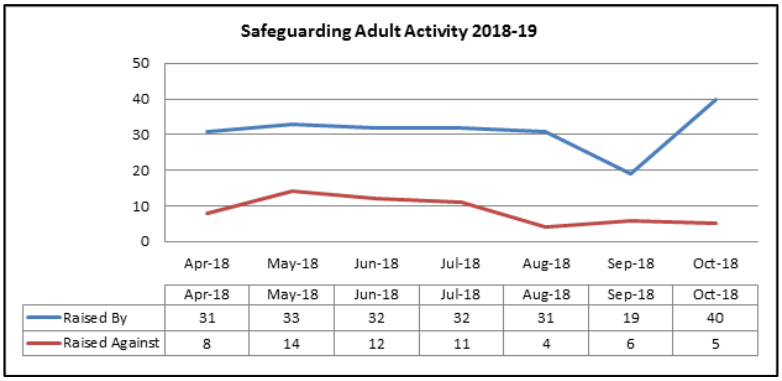
Safeguarding Children and Adult Referrals

The following charts below demonstrate 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 both the number of referrals made to the Multi-Agency Safeguarding Hub (MASH) and the number of PLF's completed in October 2018, although this is not significant.



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Referral	89	63	97	89	92	79	95
PLF	120	102	127	149	108	107	141

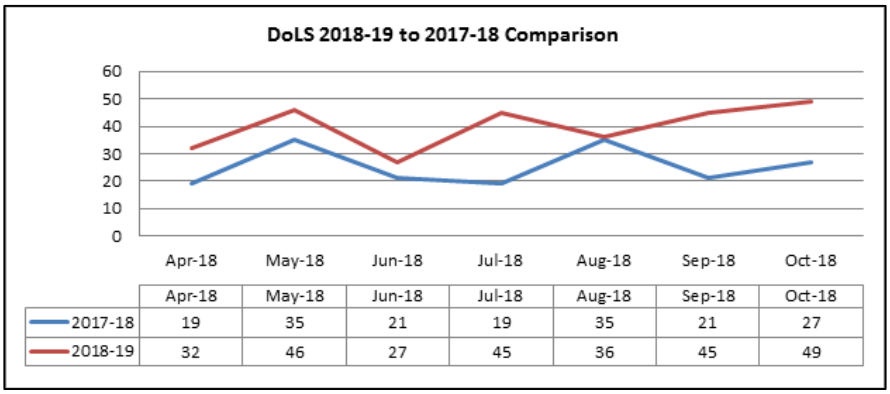
In October there has been a significant increase in the number of safeguarding allegations raised by the Trust and at the same time a slight decrease in the number of safeguarding allegations against the Trust as illustrated in the graph below.



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Raised By	31	33	32	32	31	19	40
Raised Against	8	14	12	11	4	6	5

The Head of Safeguarding has been monitoring referrals closely following concerns that the Local Authority are not notifying the Trust or sending information regarding safeguarding referrals. The current system in place at Northamptonshire County Council does not allow for a copy of the referral to be saved onto the Trust's clinical system or to be printed off. The Trust therefore relies on the Local Authority to supply safeguarding information.

Deprivation of Liberty Safeguards (DoLS)



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
2017-18	19	35	21	19	35	21	27
2018-19	32	46	27	45	36	45	49

DoLS applications for authorisations to Northamptonshire County Council (NCC) under the statutory framework have continued to increase during the reporting period, which provides assurance that legislation is being adhered to by the organisation.

Safeguarding Assurance Activity

Concerns continue to be raised regarding Northamptonshire County Council following their current financial position and the impact this will have on children, young people and adults at risk. In addition, an Ofsted Inspection focussing on the Multi-Agency Safeguarding Hub (MASH) was carried out in October. The outcome of this inspection will be available on 13th November and is likely to highlight major inadequacies which will evoke a full children's services inspection.

The Executive Lead for Safeguarding and the Head of Safeguarding met with senior executive leads across Northamptonshire health economy which included both commissioners and providers. This meeting was facilitated by NHS England. Following this meeting a letter of concern was sent to Ofsted clearly articulating the concerns currently being experienced in safeguarding across Northamptonshire.

The safeguarding team have established a weekly database capturing concerns across safeguarding that had to be escalated to the Local Authority about individual cases or general processes. This is shared with the CCG.

There are three children's Serious Case Reviews (SCR's) and two Safeguarding Adult Reviews (SAR's) in progress. All individuals (apart from one child) had contact with the Trust.

There are five ongoing Domestic Homicide Reviews (DHR's) that are ongoing in the county. Only one individual had contact with the Trust as the other four DHR's occurred in the north of the county.

Risk Register

There are currently three safeguarding risks present on the Patient and Nursing Services risk register:

- 966 – Vulnerable Children and Adults –Graded 20
- 1300 - Authorisation of Deprivation of Liberty Safeguards (DoLS) – Graded 9
- 1305 – Compliance with Safeguarding Training – Graded 12

The risk associated with safeguarding children and adults has been increased to an extreme risk rating during this reporting period to capture the continuing concerns.

Dementia Activity

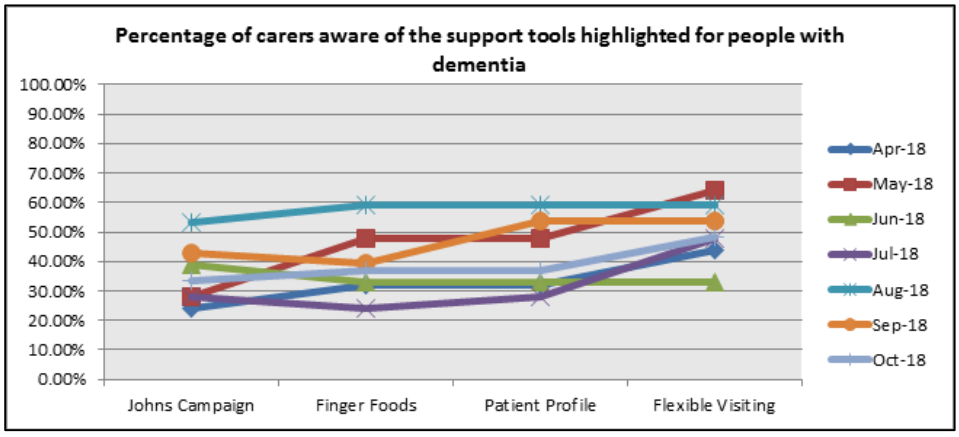
Carer Feedback

In October 2018, 101 people with dementia were identified within the data collection population and 27 returns were received from carers. The qualitative themes from the data collection received are highlighted in the following table:

Abington	Communication with carers was identified as a positive strength with staff being viewed as caring.
Walter Tull / Benham	Communication with carers was identified as a positive strength with staff being viewed as caring. An area highlighted for improvement was communication on discharge
Esther White / Creaton	Staff were viewed as caring. Areas of improvement were identified as communication especially from doctors
EAU / Quinton	Staff were viewed as caring and positive interaction with patients with dementia. Areas of improvement were overall communication with carers and movement of patients with dementia to other wards.
Holcot	Updates about the patient's condition and involvement of care were highlighted. Areas of improvement was abrupt staff, general communication and the environment not being stimulating
Brampton	Communication with carers was identified as a positive strength with staff being viewed as caring. Areas for improvement were identified as attention to basic needs, discharge communication and the use of the patient profile.

The main overarching theme highlights the need for improvement in communication between staff and carers. This information will be shared with the Ward Managers and Matrons and will be monitored by the Dementia Liaison Nurse.

John's campaign continues to be promoted across the Trust. This includes the availability of finger foods, visibility of a patient profile and flexible/open visiting. The following chart highlights the awareness of these interventions for the current year which demonstrates a consistent response rate across all areas.



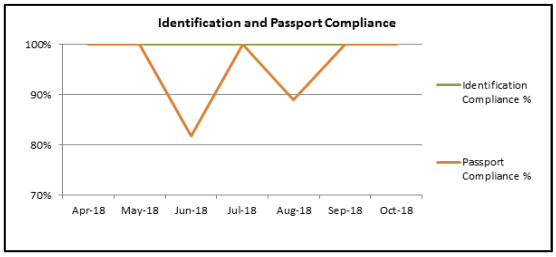
Learning Disability

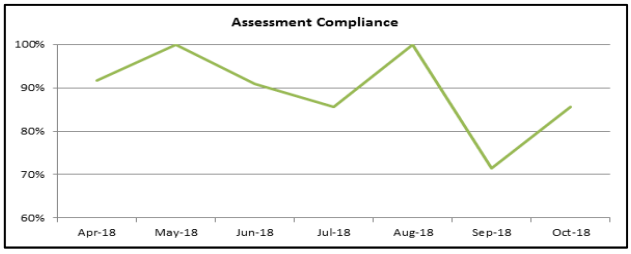
The Learning Disability Quality schedule from the CCG is built around three key components:

- The identification of people with a learning disability who are admitted to hospital; and of those:
- The use of the hospital passport;
- The use of a specific LD admission checklist;

A total of eleven patients with a Learning Disability were admitted to the Trust in October 2018.

100% of patients with a Learning Disability who were admitted to the Trust were identified and 100% of those who required a hospital passport received one within the first twenty-four hours of admission. Assessment compliance was 86% due to one patient not receiving an appropriate assessment. Results are illustrated in the graphs below:





The NHS Quality Checking programme supports individuals with a Learning Disability employed by quality checking agencies to check local NHS facilities, using their own experience. This programme is commissioned by NHS England.

In October 2018 local Quality Checkers, supported by Voiceability inspected Main Theatres and the Trust Pathway for people with a Learning Disability. The feedback report was excellent and comments included:

- *"We could not find or think of anything the service could do better because they have tried to do as much as possible to involve the person with a LD* at all times in their care".
- "*The team find creative ways to work with a patient. Planning is done in a person centred way".*
- *"The team agreed that it would be wonderful if the whole of NGH had this positive approach to people with LD".*

The only area of improvement was a recommendation that all staff receive learning disability training rather than on ad hoc basis. This recommendation for mandatory training was highlighted in the recent Learning Disability Mortality Review (LeDeR) annual report published by central government in May 2018.

9. Maternity Update

- All band 5-6 midwifery and Band 2-3 Maternity Support worker vacancies are now appointed to
- Recruitment is underway for senior midwifery posts; Quality and Safety Midwife, Matron for Maternity Services and the Perinatal Mental Health Midwife
- We are recruiting to new posts funded by Public Health for Immunisation Nurses/Midwives Band 5 to assist with the public health agenda of increasing the uptake of vaccinations in pregnancy for Flu and Whooping Cough and BCG in babies
- Recruitment open evenings are being held to attempt to increase external interest in NGH posts.
- A 'Speed dating' event was held for new starters and student midwives to introduce the senior midwifery team and specialist midwives. The event was highly rated by participants

Local Maternity System (LMS) and Maternity Transformation Programme

The 'Continuity of Carer' staff survey was developed locally to survey the workforce views on new ways of working, in alignment with the Better Births vision and the Maternity Transformational Programme. The survey received an 84% response rate from midwives, maternity support workers and student midwives. Identifying that although a large percentage of the midwifery workforce were concerned about the new ways of working and their home life/work balance, 40% were still willing to pilot new models of working, this is slightly higher than the national rate suggested. Staff engagement events continue in the form of Better Births workshops.

A bid has been submitted to HEE for £25,000 for funds to assist in developing the Midwifery workforce ready for the new ways of working required by Better Births and the Maternity Transformation programme.

The community matron has been seconded to the CCG as the LMS Implementation Midwifery lead to help to help providers to drive the Better Births and national transformation programme and kick start the implementation phase of the LMS plan. The post is a six month secondment (with a view to extending if funding is available past April 2019).

10. Safe Staffing

Overall fill rate for October was 97%, compared to 98% in September and 98% in August. Combined fill rate during the day was 94%, compared with 93% in September. The combined night fill rate was 101% compared with 103% in September. Registered Nurse/Midwife fill rate during the day was 93% and for the night 95%.

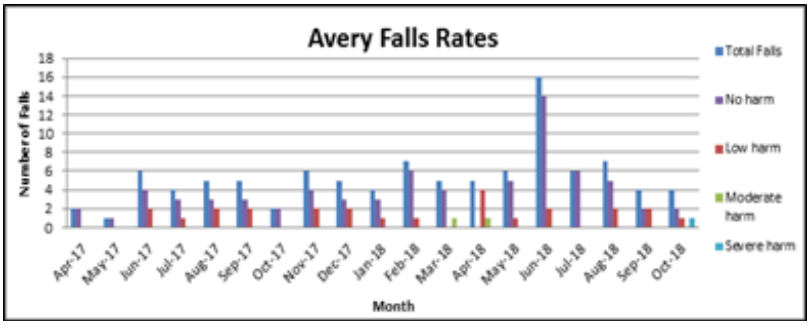
	Day	Night	Overall
RN	93%	95%	94%
HCA	95%	113%	102%
Overall	94%	101%	

Across the general adult wards Care Hours per Patient Day for the month of October was registered practitioner 4.1 and HCA 3.1 (which was the same in September); Trust wide inclusive of midwifery, paediatrics and critical care (which by nature are a higher care hours level) RN/M was 8.7 and HCA 3.7 (which is a slight rise in HCA from September but the same for qualified).

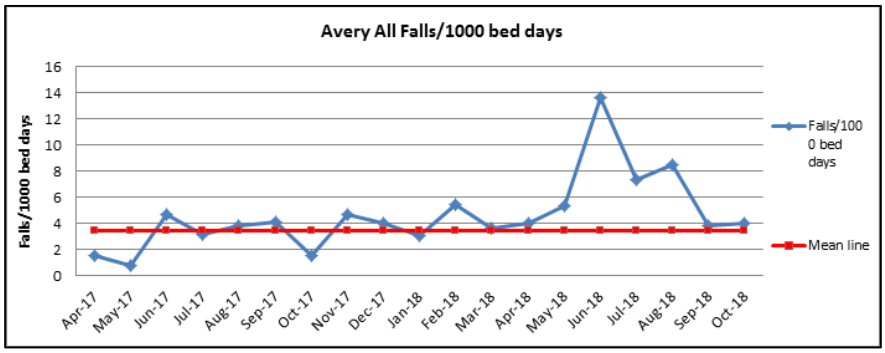
The two wards at Avery and the ward at Dickens Therapy Unit both reported 0 shifts unfilled during October and no staffing related harm to patients.

11. Avery and Dickens Therapy Unit

Avery Data
In October there were 4 inpatient falls. 2 no harm patient falls, 1 low harm patient falls and 1 severe harm patient fall.

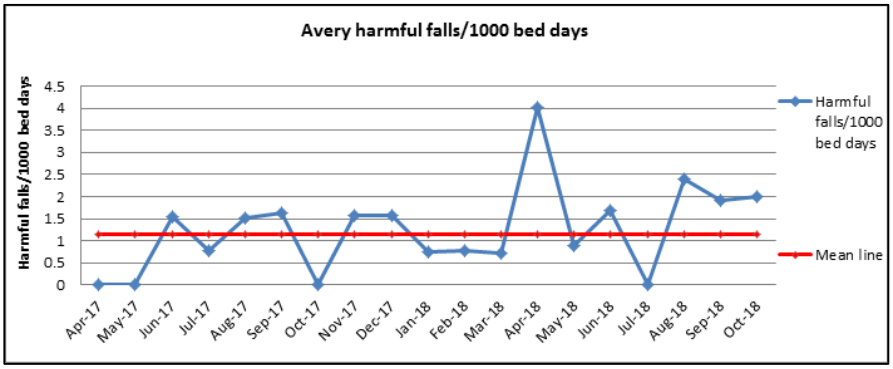


Falls/1000 bed days at Avery
The below graph demonstrates the total number of falls/1000 bed days increased by 0.13 falls/100 bed days in the month of October. There was the same number of incidents recorded but occupancy data was lower.



Avery Harmful falls/1000 bed days Including Low, Moderate, Severe and Catastrophic

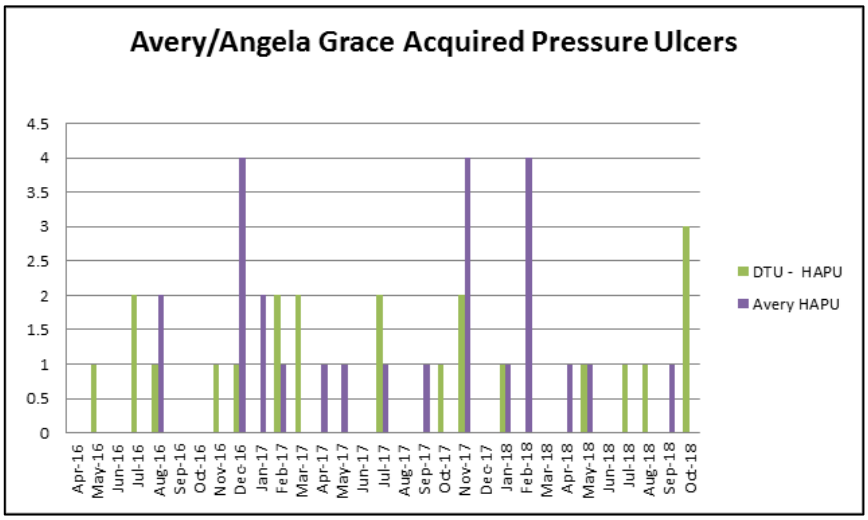
The graph below represents low, moderate, severe and catastrophic falls/1000 bed days. Harmful patient falls increased in October by 0.07 when compared to September. There was 1 low harm patient fall and 1 severe harm patient fall.



Avery/Angela Grace PU Incidence

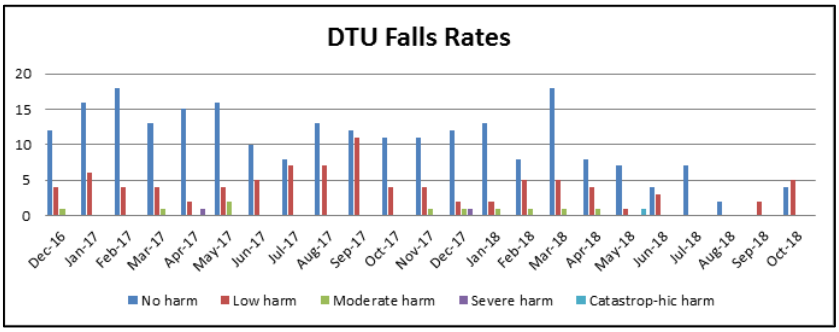
The run chart below represents the number of pressure ulcer harms reported in 2016-2018 to patients in Avery and Dickens Therapy Unit. The TVT continue to report and investigate these harms as per Trust protocol.

During October 2018 there were **3** Category 2 Pressure Ulcers reported on Dickens Therapy Unit (Angela Grace). There was no pressure ulcers reported at Avery in October 2018.
The TV Team continue to ensure that staff at Avery and Angela Grace is invited to our training.



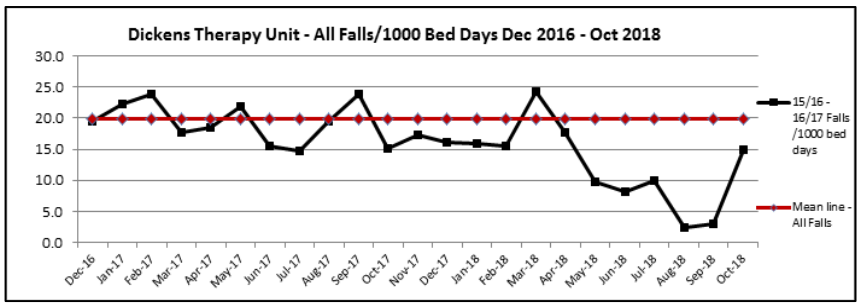
Dickens Therapy Unit

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. Please see the table below for a breakdown of falls incident data at DTU.

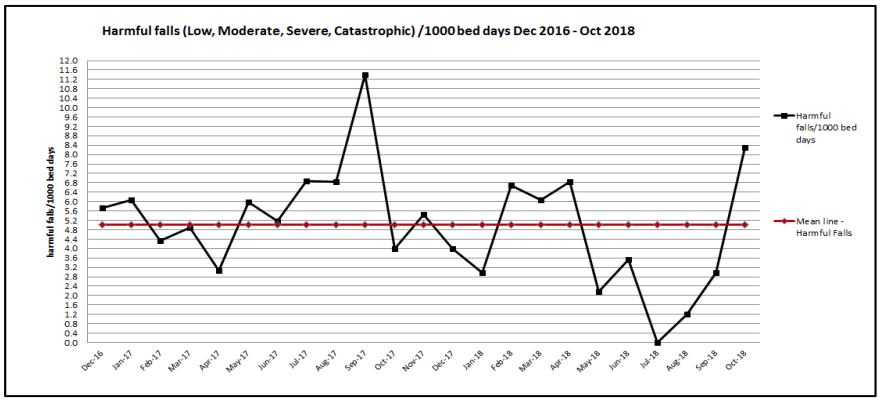


The above graph demonstrates the total number of falls incidents recorded at DTU and the harm that the patient sustained. There were 4 no harm and 5 low harm patient falls at DTU

Falls/1000 bed days at Dickens Therapy Unit
The graph below demonstrates that the total number of patient falls/1000 bed days increased in October 2018 by 11.96. there was an increase in repeat patient fallers which has contributed to the increase in falls recorded at DTU.



DTU Harmful falls/1000 bed days Including Low, Moderate, Severe and Catastrophic
The graph below represents low, moderate, severe and catastrophic falls/1000 bed days. Harmful patient falls increased in October by 5.32 when compared to September 2018. This is due to an increase in low harm patient falls.



12. Pathway to Excellence®

Having successfully passed our evidence submission for Pathway back in July 2018, the final stage for the organisation to gain accreditation was a successful Nurse Survey. This was launched on the 11th September and lasted for 21 consecutive days.

The Trust achieved an 82% response rate, with a more than 75% positive response in 26 out of 28 questions. Within the ANCC papers and published articles (Swartout, E 2010 and Pabico, C 2017) they have referenced the research that has demonstrated that organisations with such environments improve patient satisfaction, safety and outcomes.

Although this framework originated for nurses, it has huge benefits within the wider organisation. Through Shared Decision Making, collaborative working is encouraged and non-nursing staff are very much a part of this. Within our current 23 Shared Decision Making councils we have wide representation from other staff such as housekeepers, pharmacists, health care assistants, physiotherapists, occupational therapists, midwives etc. and this continues to grow. The councils work involves a variety of projects leading change from the frontline, some small, some big, but all benefitting either our patients or staff, and sometimes both.

We are proud to report that NGH are the first to gain this prestigious ISO 9001:2015 (international standard organisation) accreditation. We have had to evidence our work over the past three years to

demonstrate how we fit the criteria to be awarded this international status. We will be continuing to work toward maintaining this accolade in preparation for our next assessment which will be due in Oct 2022. Our thanks go to Northamptonshire Healthcare Charitable Fund for their financial support to enable the process.

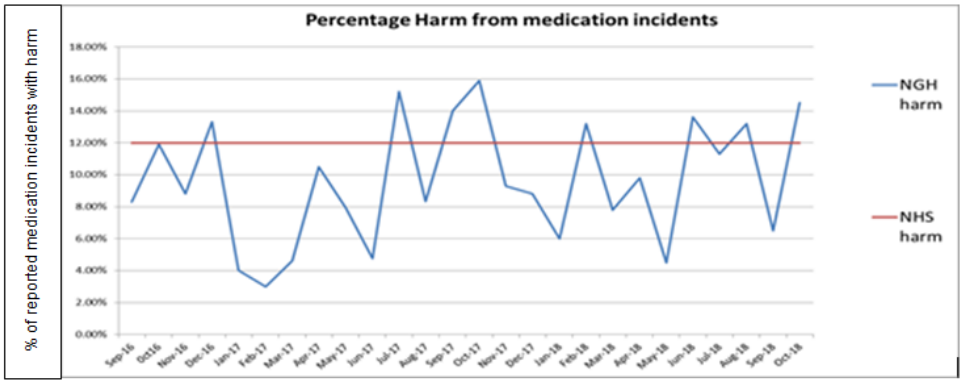
13. Medication Safety

The Medication Safety Group are a sub-group of the Medication Optimisation Group who report to CQEG, within their report are elements directly related to the wards and departments subsequent actions for improvement span the multi-disciplinary team however in the majority, the actions are held at ward level. The areas of focus that are within the report are:

- Returned TTO's
- Medication safe storage
- Datix reporting
- Controlled Drugs monitoring

Improvements have been made in quarter 2 with a reduction in the amount of returned TTO's, the areas of highest returns are discussed and actions put in place through pharmacy with that ward team. Controlled Drug checks have improved as well as the recording of fridge temperatures the area of focus within safe storage is that of the treatment room doors being always locked.

The graph below is a depiction of the number of hospital related medication incidents where a degree of harm has been recorded; this may be due to the fact that a medication was incorrectly prescribed, prescribed and/or given when there was a known allergy, omitted dose of a critical medication etc. All incidents are monitored and investigated by the handler but also discussed at the Medication Safety Group for further shared learning or changes required Trust wide. The individuals involved in any medication incident are spoken with on an individual basis with several options available dependent on the circumstances and if they have been involved previous incidents. Any moderate and above harm will also be investigated through the Review of Harm Group.



14. Assessment and Accreditation

In October, eight clinical areas were assessed. Two wards achieved amber ratings and five wards achieved green ratings. One outpatient department was assessed and achieved a green rating. In October the current status of all adult in-patient wards was, three blue wards, ten green wards, ten amber wards and no red wards. The current status of outpatient departments is - three green departments and 1 amber department. Through the assessment process standard 5 (infection prevention) has shown to be a challenge Trust wide. Work is ongoing supported by the Practice Development Team and the Infection Prevention Team to improve care within this standard with improvements noted in October.

15. Recommendations

The Committee 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 and falls 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 (by asking women questions on women's perception of feelings around safety in labour. 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

Appendix 2

Nursing and Midwifery Dashboard Description

The Nursing & Midwifery dashboard is made up of a number of metrics that provide the Trust with "at a glance" RAG rated position against key performance indicators including the quality of care, patient experience, and workforce resource and outcome measures. The framework for the dashboard was designed in line with the recommendations set out in the 'High Quality Care Metrics for Nursing' report 2012 which was commissioned by Jane Cummings via the Kings Fund.

The Quality Care Indicators (QCI) is first section of the dashboard and is made up of several observational and review audits which are asked undertaken each month for in-patient areas. There are two types of indicators those questions designed for the specialist areas and those for the general in-patients. The specialist areas were designed against their specific requirements, quality measures and national recommendations; therefore as every area has different questions they currently have their own individual dashboards.

Within the QCI assessment there are 15 sections reviewing all aspects of patient care, patient experience, the safety culture and leadership on the ward – this is assessed through a number of questions or observations in these 15 sections. In total 147 questions are included within the QCI assessment, for 96 of the questions 5 patients are reviewed, 5 staff is asked and 5 sets of records are reviewed. Within parts of the observational sections these are subjective however are also based on the '15 Steps' principles which reflect how visitors feel and perceive an area from what they see, hear and smell.

The dashboard will assist the Senior Nursing & Midwifery team in the assessment of achievement of the Nursing & Midwifery objectives and standards of care. The dashboard is made up using four of the five domains within the 2015/16 Accountability Framework. The dashboard triangulates the QCI data, Safety Thermometer 'harm free' care, pressure ulcer prevalence, falls with harm, infection rates, overdue patient observations (Vital Pac), nursing specific complaints & PALS, FFT results, safe staffing rates and staffing related datix. The domains used are:

- Effective
- Safe
- Well led
- Caring

The Matrons undertake the QCI and upload the data by the 3rd of each month. The N&M dashboard is populated monthly by the Information Team and will be ready no later than the 10th of the month. At the monthly Divisional Councils, the previous month's dashboard will be presented in full and Red and Amber areas discussed and reviewed by the senior nursing team. The Associate Directors Nursing / Midwifery will hold the Matrons to account for performance at this meeting and will request actions if performance is below the expected standard. The Matrons and ward Sister/Charge Nurse will have two months to action improvements and assure Divisional Council with regards to the methodology and sustainability of the actions. The Matrons will be responsible for presenting their results at the Directorate Meetings and having 1:1 confirm & challenge with their ward Sisters/Charge Nurse. The Director of Nursing will highlight areas of good practice and any themes or areas of concern via the N&M Care Report.

Appendix 3

Data Input Errors on Quinton & Finedon

Oct-2018	Medicine														WCO		Surgery						
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Allebone	Becket	Benham	Brampton	Collingtree	Compton	Creaton	Dryden	Quinton	Eleanor	Finedon	Holcot	Knightley	Victoria	Talbot Butler	Spencer	Rowan	Willow	Hawthorn	Head & Neck	Abington	Cedar	Althorp
Falls/Safety Assessment	100.%	100.%	100.%	100.%	96.%	84.%	100.%	100.%		93.%		100.%	100.%	90.%	90.%	100.%	93.%	93.%	93.%	87.%	100.%	93.%	97.%
Pressure Prevention Assessment	100.%	100.%	97.%	86.%	97.%	80.%	94.%	100.%		97.%		80.%	100.%	97.%	97.%	100.%	100.%	100.%	100.%	91.%	94.%	100.%	100.%
Nutritional Assessment	100.%	100.%	100.%	97.%	100.%	88.%	93.%	100.%		100.%		96.%	100.%	97.%	87.%	100.%	97.%	93.%	90.%	80.%	97.%	100.%	100.%
Patient Observation and Escalations	100.%	100.%	95.%	94.%	95.%	96.%	95.%	100.%		95.%		96.%	95.%	95.%	95.%	86.%	95.%	100.%	95.%	90.%	100.%	95.%	100.%
Pain Management	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%		100.%		100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%
Nursing & Midwifery Documentation - Quality of Entry	100.%	100.%	100.%	100.%	95.%	83.%	100.%	100.%		97.%		100.%	92.%	95.%	100.%	98.%	100.%	100.%	100.%	93.%	100.%	98.%	100.%
Patient Experience - Protected Mealtimes (PMT) Observations	100.%	100.%	100.%	100.%	50.%	100.%	83.%	100.%		83.%		100.%	83.%	83.%	83.%	83.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%
Patient Experience - Care Rounds Observe patient records	100.%	91.%	100.%	67.%	91.%	100.%	100.%	100.%		100.%		67.%	100.%	100.%	91.%	82.%	100.%	100.%	82.%	73.%	100.%	100.%	82.%
Patient Experience - Environment	80.%	100.%	80.%	100.%	80.%	100.%	100.%	100.%		80.%		100.%	100.%	75.%	80.%	100.%	100.%	80.%	80.%	100.%	100.%	100.%	100.%
Patient Experience - Privacy and Dignity	98.%	95.%	96.%	88.%	90.%	82.%	94.%	98.%		100.%		96.%	99.%	87.%	98.%	94.%	99.%	100.%	90.%	94.%	93.%	86.%	96.%
Patient Safety and Quality	100.%	100.%	100.%	100.%	90.%	89.%	100.%	100.%		100.%		100.%	100.%	100.%	100.%	100.%	100.%	85.%	95.%	95.%	100.%	100.%	100.%
Leadership & Staffing observations	100.%	98.%	100.%	100.%	88.%	88.%	100.%	98.%		98.%		100.%	96.%	95.%	100.%	100.%	98.%	86.%	96.%	92.%	96.%	94.%	98.%
EOL	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%		100.%		100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	96.%	96.%	100.%	100.%
SOVA/LD/Cognitive Impairment	100.%	100.%	100.%	100.%	96.%	100.%	100.%	100.%		100.%		100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%
First Impressions/15 Steps	83.%	100.%	97.%	83.%	83.%	83.%	94.%	100.%		86.%		86.%	80.%	80.%	80.%	80.%	86.%	86.%	80.%	66.%	89.%	80.%	86.%
Safety Thermometer – Percentage of Harm Free Care	92%	92%	94%	97%	88%	71%	93%	96%	93%	100%	100%	79%	76%	94%	100%	86%	100%	87%	93%	100%	100%	90%	100%
Pressure Ulcers – Grade 2 incidence hosp acquired, (Previous Month)	0	5	0	0	2	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Pressure Ulcers – Grade 3 incidence hosp acquired, (Previous Month)	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pressure Ulcers – Grade 4 incidence hosp acquired, (Previous Month)	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	2	0	0	0	0	0	0	0	0	3	0	0	0	2	1	0	0	1	0
Falls (Moderate, Major & Catastrophic)	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	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
HAI – C Diff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Caring																							
Complaints – Nursing and Midwifery	0	1	0	0	0	0	0	1	0	0	1	0	0	1	1	0	1	0	0	0	0	0	0
Number of PALS concerns relating to nursing care on the wards	1	0	0	1	0	0	0	0	0	0	0	1	1	0	1	1	1	1	2	1	0	2	0
Friends Family Test % Recommended	80.0%	100.0%	87.7%	72.0%	94.3%	100.0%	80.0%	96.2%	88.3%	100.0%	89.8%	58.3%	80.0%	80.0%	84.6%	80.7%	88.2%	90.4%	92.0%	92.3%	97.1%	96.0%	95.8%
Well Led																							
Staff Nurse Staffing - Registered Staff (day & night combined)	88%	98%	86%	97%	100%	94%	94%	89%	109%	94%	87%	97%	94%	96%	90%	100%	101%	99%	97%	106%	101%	101%	98%
Staff Nurse Staffing - Support Worker (day & night combined)	107%	100%	106%	108%	97%	95%	94%	111%	138%	98%	119%	110%	111%	136%	92%	96%	102%	103%	99%	131%	113%	108%	88%
Staffing related datix	0	0	0	2	0	0	0	0	3	0	0	1	0	0	0	0	0	0	0	2	0	0	0

Appendix 4

Oct 18	PAEDIATRICS		
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Disney	Paddington	Gosset
Quality & Safety			
Falls/Safety Assessment (Q)	100%	80%	100%
Pressure Prevention Assessment (Q)	100%	60%	92%
Child Observations [documentation] (Q)	100%	100%	97%
Safeguarding [documentation] (Q)	100%	71%	100%
Nutrition Assessment [documentation] (Q)	88%	100%	100%
Medication Assessment (Q)	100%	100%	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
Safety Thermometer – Percentage of Harm Free Care	100%	100%	100.00%
Falls (Moderate, Major & Catastrophic)	0	0	0
HAI – MRSA Bact	0	0	0
HAI – C Diff	0	0	0
Patient Experience			
Friends Family Test % Recommended	98%	89%	100%
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%	100%	100%
Privacy and Dignity (Q)	100%	88%	nil
Management			
Staffing related datix			
Monthly Ward meetings (Q)	100%	100%	100%
Leadership & Staffing observations (Q)	100%	100%	100%

Appendix 5

2018-10		Maternity			
RAG= Red < 60%, Amber 60% to 79% and Green 80% +		**Balmoral**	**Robert Watson**	**MOW**	**ALL MATERNITY**
F	Postnatal Safety Assessment	100.00%	92.86%	100.00%	96.08%
P	Patient Observation Chart	100.00%	100.00%	100.00%	100.00%
M		100.00%	100.00%	100.00%	100.00%
SOVA		Nil	Nil	Nil	Nil
PE	Environment Observations	100.00%	96.30%	100.00%	98.46%
QS	Patient Safety and Quality	95.00%	83.33%	91.55%	91.87%
LS	Leadership & Staffing	100.00%	100.00%	100.00%	100.00%
	Hand Hygiene	100.00%	100.00%	100.00%	100.00%
PE	Patient Experience	90.00%	97.30%	100.00%	95.77%
QS	Safety and Quality	100.00%	100.00%	100.00%	100.00%
LS	Leadership & Staffing	100.00%	100.00%	100.00%	100.00%
W	Ward Environment – First Impressions	Nil	Nil	100.00%	100.00%
	TOTAL	95.37%	93.36%	94.33%	94.18%
	TOTAL OBS & GYNAE	Nil			

Northampton General Hospital NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**29 November 2018**

Title of the Report	Financial Position - Month 7 (FY2018-19)
Agenda item	10
Sponsoring Director	Phil Bradley, Director of Finance
Author(s) of Report	Bola Agboola, Deputy Director of Finance
Purpose	To report the financial position for the month ended October 2018.

Executive summary

The results show a reported year-to-date pre-PSF deficit of £15,363k against a planned pre-PSF deficit of £15,366k, resulting in a small pre-PSF favourable variance of £3k at the end of October.

The full Provider Sustainability Funding (PSF) of £2,895k has been earned for finance, however only £965k of the available £1,241k A&E related PSF has been earned. This is because the Trust missed the A&E trajectory for October and therefore brings the overall post-PSF position at the end of October to an adverse variance of £273k.

Pay is overspent by £3,217k YTD and by £250k in October with the key reasons continuing to be the use of temporary staffing including agency to cover vacancy, long term sickness and enhanced observation.

CIP delivery was £8,708k YTD which is £1,704k better than plan although over half of this is delivered through non-recurrent unplanned pay savings. The challenge for the Trust continues to be to find sufficient recurrent schemes to deliver the CIPs.

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 October 2018 and to review the performance against plan.

Northampton General Hospital
NHS Trust

Financial Position

Month 7 (October 2018)
FY 2018/19

Report to:

Trust Board

November 2018

Content

The Trust managed to deliver its planned pre-PSF deficit with a small surplus of £3k YTD.

However A&E trajectory for October was not met, therefore the Trust missed the associated PSF of £276k, thereby resulting in an overall post-PSF position of £(273)k adverse to plan.

1. Director of Finance Message

This report sets out the Trust's financial position for the month ended 31st October 2018. The results show a reported year-to-date pre-PSF deficit of £15,363k against a planned pre-PSF deficit of £15,366k, resulting in a small favourable variance of £3k .

The full Provider Sustainability Funding (PSF) of £2,895k has been earned for finance, however only £965k of the available £1,241k A&E related PSF has been earned. This is because the Trust missed the A&E trajectory for October.

Therefore the overall post-PSF position at the end of October was an adverse variance to plan of £273k.

As we get closer to winter, the likelihood of recovering this position and potentially meeting the A&E trajectory for the rest of the year is likely to be challenging therefore the remaining A&E associated PSF could be at risk. The value of the A&E PSF in Q3 is £827k and £965k in Q4.

Year to date, income underperformance is £2,524k which is largely to do with an underperformance on excess bed day income which is not sufficiently offset by an increase in day case and elective activity as well as unachieved STP income gap. In October, the income position was a small adverse variance of £89k as we begin to see improvement in Daycase activity.

Following the contract variation of £1.8m of the planned system related £4.6m income, discussions continued to agree a further sum but no progress has been made. At this stage the remaining £2.8m remains at risk and therefore poses a significant pressure to the year-end position.

Pay is overspent by £3,217k YTD and by £250k in October with the key reasons continuing to be the use of temporary staffing including agency to cover vacancy, long term sickness, enhanced observation. Agency spend in October was £1,033k which was £99k higher than the NHSI target of £934k per month. The overspending cost centre reviews are in place and will continue to be used to keep tighter control on costs.

Salary Overpayment at the end of October is £313k.

Other income is £320k favourable in October largely driven by sale of medicines, catering income, car parking income as well as pathology income from tests.

CIP delivery was £8,708k YTD which is £1,704k better than plan although over half of this is delivered through non-recurrent unplanned pay savings. The challenge for the Trust continues to be to find sufficient recurrent schemes to deliver the CIPs target.

Capital remains on plan with a YTD spend of £15,521k and the schemes are reviewed to ensure that the plan for the year will be met..

Table 1: Income and Expenditure Summary

I&E Summary	Actual FY16-17	Actual FY17-18	Annual Plan	In-Month			Year to Date			Recent Months: Actual	
				Plan	Actual	Variance	Plan	Actual	Variance	Sep-18	Aug-18
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	260,328	271,513	288,330	25,426	24,717	(709)	167,709	163,083	(4,627)	23,593	22,619
Other Clinical Income	2,373	5,837	6,737	1,444	1,125	(319)	7,809	7,203	(606)	663	947
Other Income	31,824	20,654	28,690	1,806	2,127	320	12,476	14,375	1,899	2,391	3,294
Total Income	294,525	298,004	323,756	28,676	27,968	(708)	187,995	184,660	(3,334)	26,647	26,860
Pay Costs	(199,813)	(207,233)	(219,838)	(18,316)	(18,565)	(250)	(125,693)	(128,910)	(3,217)	(18,428)	(19,318)
Non-Pay Costs	(94,406)	(103,550)	(109,645)	(9,099)	(8,651)	448	(63,838)	(59,572)	4,266	(8,451)	(8,249)
Unallocated CIPs		0	2,459	(168)		168	(1,789)		1,789		
Reserves/ Non-Rec		0	(1,976)	(27)		27	(542)		542		
Total Costs	(294,219)	(310,783)	(329,001)	(27,610)	(27,217)	393	(191,863)	(188,482)	3,381	(26,879)	(27,567)
EBITDA	306	(12,779)	(5,245)	1,066	752	(314)	(3,868)	(3,822)	46	(232)	(707)
Depreciation	(9,703)	(10,056)	(10,615)	(937)	(938)	(1)	(5,925)	(5,928)	(3)	(833)	(833)
Amortisation	(9)	(9)	(8)	(1)	(1)	(0)	(5)	(5)	(0)	(1)	(1)
Impairments	(1,732)	(4,085)	(1,826)	(0)		0	(0)		0		
Net Interest	(720)	(823)	(1,239)	(106)	(98)	7	(690)	(651)	39	(91)	(97)
Dividend	(3,307)	(2,411)	(1,529)	(127)	(127)	0	(892)	(889)	3	(127)	(127)
Surplus / (Deficit)	(15,165)	(30,164)	(20,462)	(105)	(412)	(307)	(11,380)	(11,295)	85	(1,284)	(1,765)
NHS Breakeven duty adjs:											
Donated Assets	(414)	138	122	25	20	(5)	150	(208)	(358)	(195)	(94)
NCA Impairments	1,732	4,085	1,826	0		(0)	0		(0)		
Surplus / (Deficit) - Normalisec	(13,847)	(25,940)	(18,514)	(80)	(392)	(312)	(11,230)	(11,503)	(273)	(1,479)	(1,859)

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

I&E	Plan	YTD Plan	Actual YTD	Var
	£'k	£'k	£'k	£'k
Pre PSF	(27,705)	(15,366)	(15,363)	3
PSF: Finance	6,434	2,895	2,895	-
PSF: A&E	2,757	1,241	965	(276)
Post PSF	(18,514)	(11,230)	(11,503)	(273)

Table 3: Pre-PSF I&E Performance

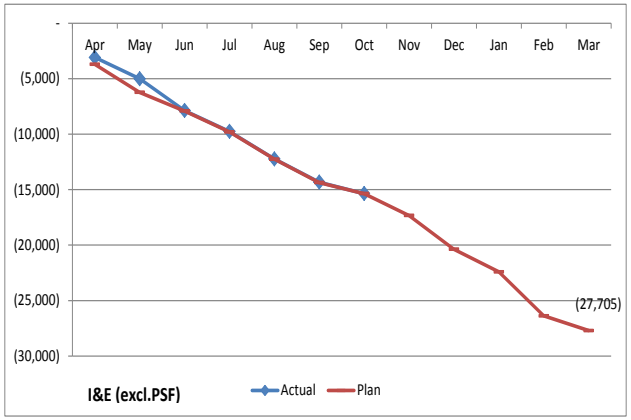
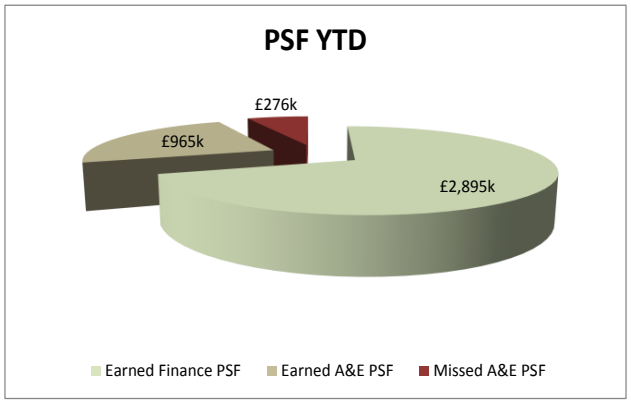


Table 4: PSF YTD Performance



2.1 Clinical Income (YTD)

Month 7 SLA Clinical Income is below plan, with a variance of -£2,524k (excluding pass-through medicines and devices). The YTD underperformance includes significantly reduced XS bed days, without compensating activity in elective inpatients. In addition £1,400k of this underperformance relates to inability to secure a deal regarding planned STP related income.

- A&E activity is above plan by 2.2%, and also shows a casemix variance. An element is subject to coding & counting challenge, which is within the challenge line. This is c.£35k per mth.
- Cost per Case (CPC) is above plan due to Radiotherapy activity (£166k), Critical Care (£159k) and Direct Access volumes (£187k). This is offset by Maternity income now significantly under plan by £296k.
- Day case performance is above plan by 0.4% on activity, and above plan financially (2.3%). Urology is above plan by £145k, with Vascular Surgery +£129k and MaxFax +£138k. These are offset by Oral Surgery (-£134k) and Pain Management (-£109k).
- Elective activity is reporting 15% below the activity plan, 10% financially. This includes adjustments to correct Elective Inpatients to Day Cases, as reported previously. The key under-performance is in General Surgery, T&O and Urology. Planned activity overall is 1.4% below plan, with the financial position 3% below.
- NEL activity is 0.2% above plan, with a positive casemix meaning a 4% favourable variance in income. General Surgery (31%), Cardiology (20%) and T&O (9%) remain the most significant areas above income plan. Stroke benefits from positive casemix. XS bed day income offsets the income over-performance on NEL.
- Outpatients remain below activity plan, reduced to 4.9% (particularly in Ophthalmology (13%) and Cardiology (64%), and under the income plan by 3.3%. OPROCS are 8% above. CaMIS migration has impacted OP activity (see slide 2.2).

Table 5a: Key PoD Trend Analysis

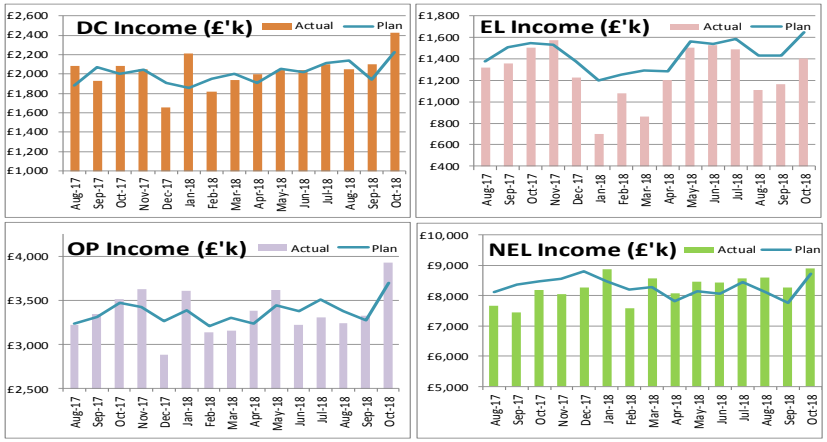


Table 5b: SLA Clinical Income by PoD

SLA Clinical Income	Activity			Finance £000's		
Point of Delivery	Plan	Actual	Variance	Plan	Actual	Variance
AandE	75,111	76,784	1,673	9,622	10,160	538
Block	-	-	-	6,425	6,423	(2)
Cost per Case	1,749,935	1,849,071	99,136	21,984	22,241	257
CQUIN	-	-	-	2,919	2,983	64
Day Cases	23,911	23,764	(147)	14,415	14,750	335
Elective	3,230	2,988	(242)	10,479	9,399	(1,080)
Elective XBDs	737	831	94	197	228	31
Non-Elective	30,657	30,706	48	57,148	59,306	2,158
Non-Elective XBDs	19,213	11,448	(7,765)	4,758	2,409	(2,349)
Outpatient First	33,466	32,692	(774)	5,903	5,773	(130)
Outpatient Follow-up	123,917	116,923	(6,994)	9,875	9,477	(397)
Outpt Procedures	89,949	96,424	6,475	11,040	11,870	831
STP related income				2,300	900	(1,400)
CIP / Other				1,408	0	(1,408)
sub-total	**2,150,126**	**2,241,630**	**91,504**	**158,471**	**155,919**	**(2,552)**
Contract Penalties				(135)	(60)	75
Challenges				(1,050)	(1,096)	(46)
Readmissions				(1,863)	(1,863)	0
MRET				(3,452)	(3,452)	0
Fines & Penalties				**(6,500)**	**(6,472)**	**28**
Subtotal (excl. Excl Meds & Dev.)	**2,150,126**	**2,241,630**	**91,504**	**151,971**	**149,447**	**(2,524)**
Excluded Devices	2,698	1,850	(848)	1,220	905	(315)
Excluded Medicines	4,847	5,570	723	14,518	12,731	(1,788)
Total SLA Clinical Inc	**2,157,671**	**2,249,050**	**91,379**	**167,709**	**163,083**	**(4,627)**

Other Clinical Income	Plan	Actual	Variance
Private Patients	668	474	(194)
Overseas Visitors	78	90	12
RTA / Personal Injury Income	833	685	(148)
PSF Funding	6,230	5,953	(277)
Total Other Clinical Income	**7,809**	**7,203**	**(606)**

2.4 Clinical Income By Commissioner (YTD)

Nene Contract - £537k under performance

The Month 7 position on the Nene contract is £537k under plan (M6: £156k adverse). The Month 7 position will improve as the OP coding is completed. The reductions in month have been due to challenge resolution (-£124k), excluded medicines (-£194k) and continuing low maternity activity and inpatient elective activity.

Key impacts include:

- A&E activity above plan and favourable casemix. As mentioned previously there is a related Coding & Counting challenge which is not reported against the CCG at this stage. The is now c.£35k per month with the value within the main challenge provision, reported in 'Other'
- Planned activity, as reported earlier, was above plan for DC and below for Elective IP in October. The combination is slightly above plan for Nene in the month.
- OPROC activity was above plan in October (+£70k).
- OP activity for Nene was below plan by £25k in month (£453k year to date).
- NEL is the most significant, £2.4m over plan due to favourable casemix. This is partially offset by NEL XS bed day income below plan (£-1.8m).

Specialised Commissioner - £2,213k under performance

The under performance is attributable to excluded devices (-£325k), and excluded medicines (-£1,673k) which will have equivalent underspends. Hep C uptake has slowed dramatically, causing the majority of the variance.

Non-elective activity is also below plan, specifically in Paediatrics and General Medicine. Radiotherapy is the key over-performing area at £209k over plan.

Secondary Dental - £70k over performance

Over-performance on Secondary Dental is in the MaxFax Specialty, £101k over in non-Elective activity and £137k in Planned activity. This is offset by Oral Surgery below plan by £195k.

STP related income- £1,400k under performance

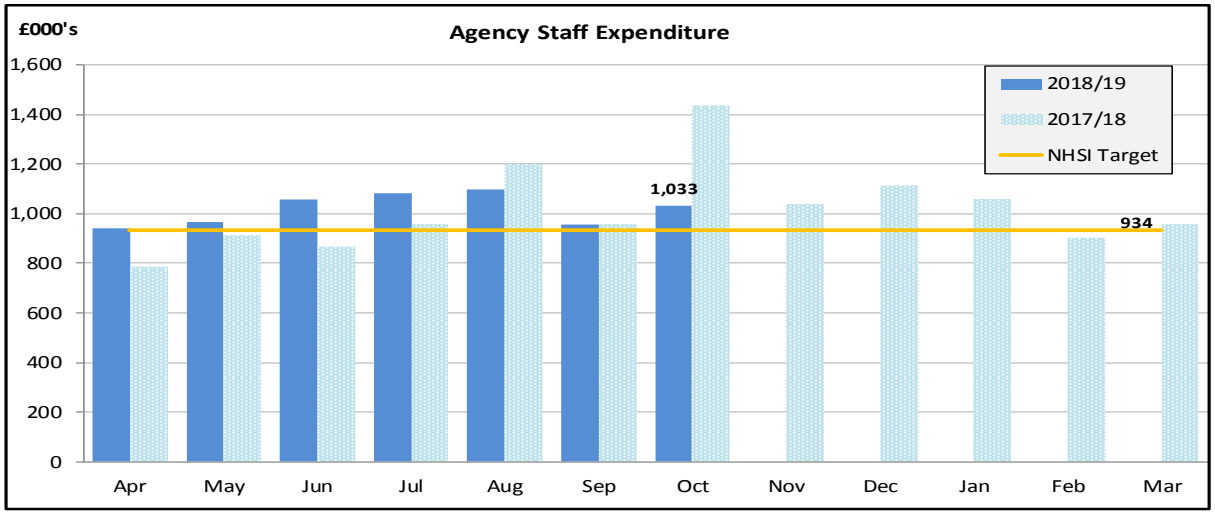
This reflects the current agreement regarding the planned income associated with the STP. Discussions are ongoing to see if further income can be agreed however we are not optimistic that this would be the case.

Table 6: SLA Clinical Income by Commissioner

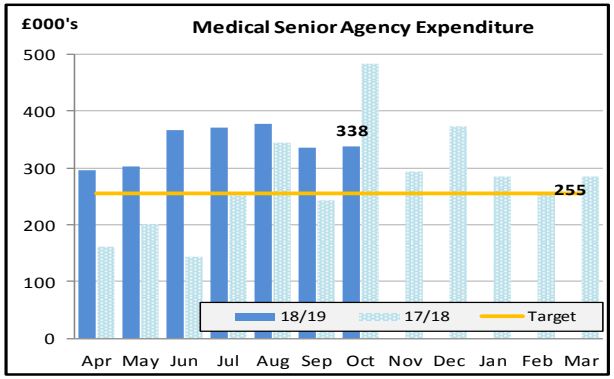
	Finance £000's		
Commissioner	**YTD Plan**	**Actual**	**Variance**
Nene CCG	130,038	129,500	(537)
Corby CCG	1,447	1,520	73
Bedfordshire CCG	427	492	65
East Leicestershire & Rutland CCG	457	426	(31)
Leicester City CCG	30	77	47
West Leicestershire CCG	33	46	13
Milton Keynes CCG	1,776	1,496	(280)
Specialised Commissioning	24,526	22,313	(2,213)
Secondary Dental	3,875	3,945	70
STP related income	2,300	900	(1,400)
NCA / Central / Other	2,800	2,367	(433)
Total SLA Income	**167,709**	**163,083**	**(4,627)**

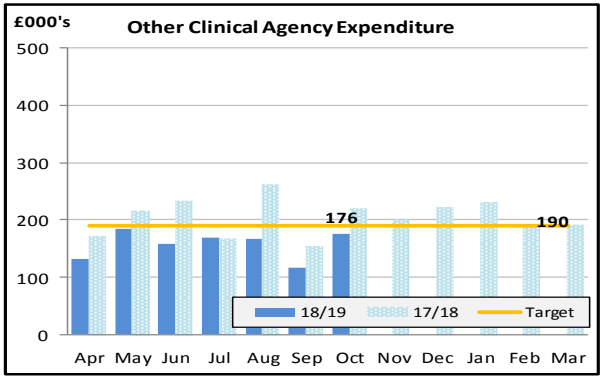
3. Pay

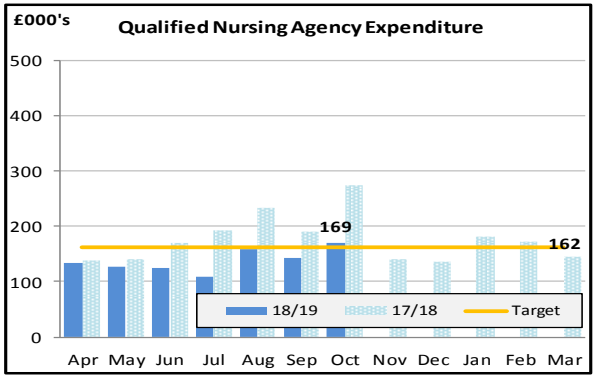
Table 7: Agency Spend

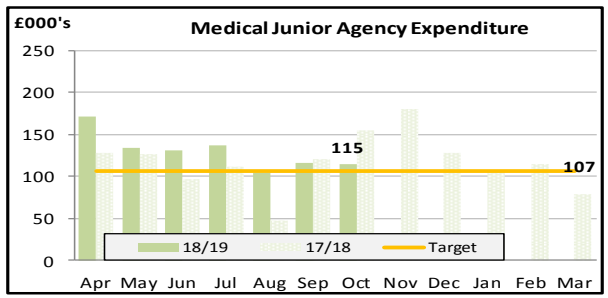


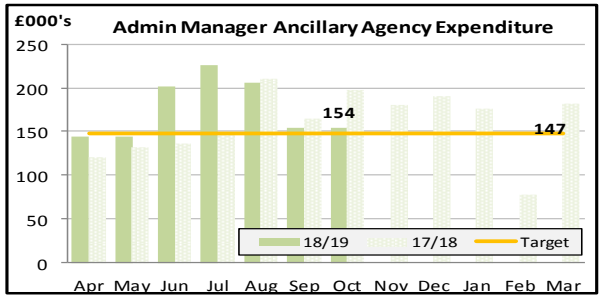
- NHS Improvement issued an expenditure limit of £11.208m for the financial year 2018/19.
- This £934k per month target is equivalent to an 8.1% improvement upon the 17/18 expenditure level. The graphs below apply this reduction equally to all staff groups.
- The most significant increases were seen in Theatre ODP and agency RNs which increased from 30 to 42wte. Half term week saw a 40% increase in agency RN, totalling an extra 4wte across 7 days.
- The Trust run-rate for 18/19 is £84k above the target. This monthly expenditure needs to drop to £816k per month, to meet the NHSI target at year end.

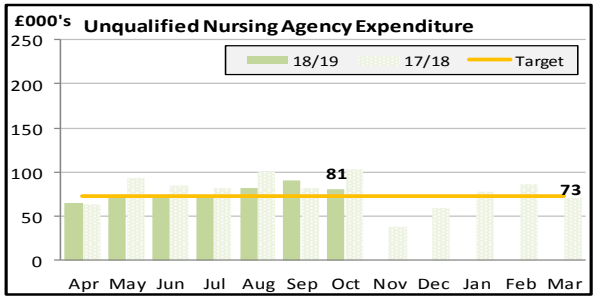








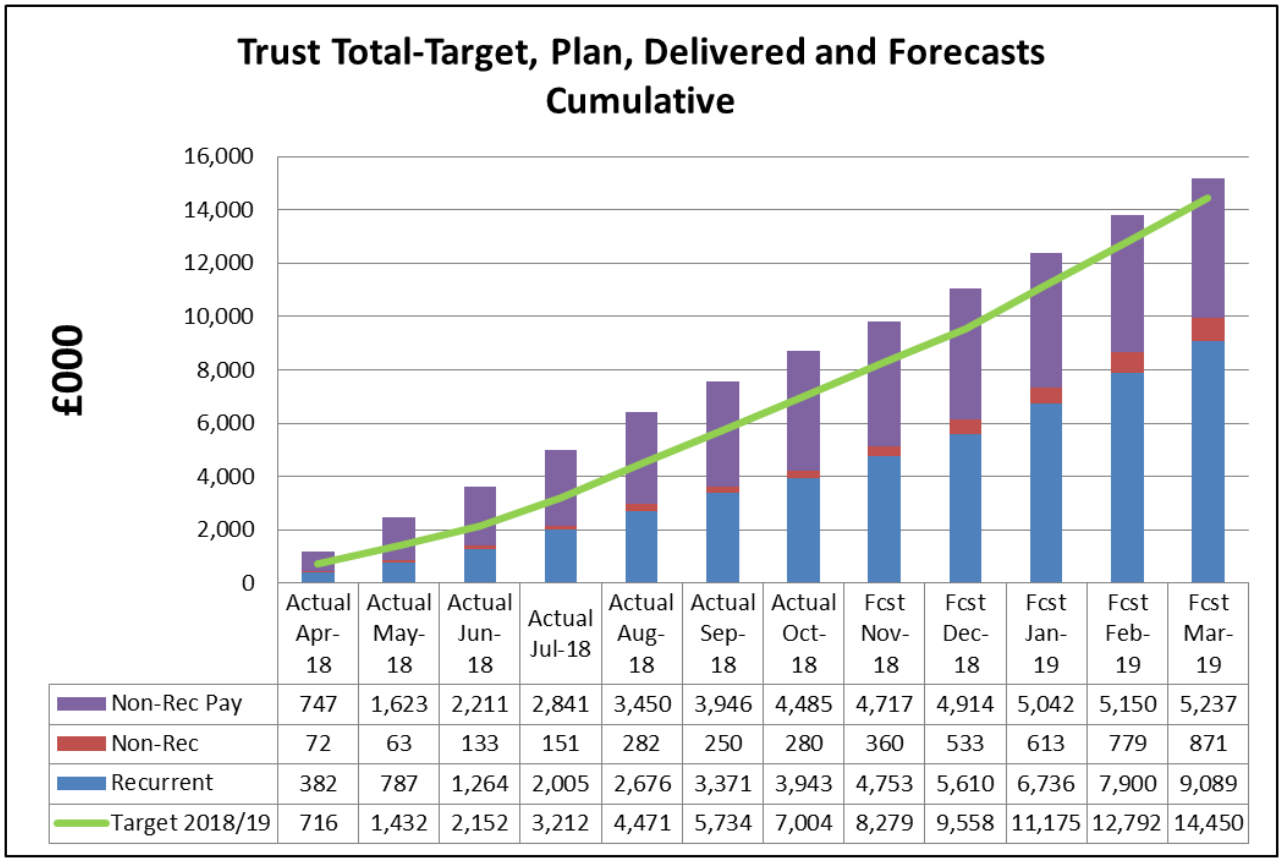




4. CIP

YTD Delivery £000's							
Division	Plan	YTD Plan	YTD Actual Rec	YTD Actual N/R	YTD Actual N/R Pay Underspend	Actual Total	Variance vs plan
SURGICAL DIVISION	3,894	1,887	786	90	1,067	1,943	56
MEDICAL DIVISION	3,815	1,849	957	42	758	1,757	-92
WCOH DIVISION	2,205	1,069	616	28	1,121	1,765	696
CSS DIVISION	1,734	840	805	39	663	1,507	667
HOSPITAL SUPPORT	1,118	542	101	70	876	1,048	506
FACILITIES	1,153	559	677	11	0	689	130
Expenditure Other (Held Centrally)	532	258	0	0	0	0	-258
Trust Total	**14,450**	**7,004**	**3,943**	**280**	**4,485**	**8,708**	**1,704**

LTF £000's							
Division	Plan	LTF Rec	LTF N/R	Actual N/R Pay Underspend	LTF Total	RAG Rated	Variance vs Risk Adjusted
SURGICAL DIVISION	3,894	2,020	157	1,415	3,592	3,298	-596
MEDICAL DIVISION	3,815	2,639	219	1,013	3,871	3,382	-433
WCOH DIVISION	2,205	1,470	106	1,121	2,696	2,631	426
CSS DIVISION	1,734	1,596	54	663	2,314	2,231	497
HOSPITAL SUPPORT	1,118	173	70	1,025	1,269	1,232	114
FACILITIES	1,153	1,136	22	0	1,158	1,141	-13
Expenditure Other (Held Centrally)	532	55	244	0	299	119	-412
Trust Total	**14,450**	**9,089**	**871**	**5,237**	**15,198**	**14,034**	**-416**



	Actual Apr-18	Actual May-18	Actual Jun-18	Actual Jul-18	Actual Aug-18	Actual Sep-18	Actual Oct-18	Fcst Nov-18	Fcst Dec-18	Fcst Jan-19	Fcst Feb-19	Fcst Mar-19
Non-Rec Pay	747	1,623	2,211	2,841	3,450	3,946	4,485	4,717	4,914	5,042	5,150	5,237
Non-Rec	72	63	133	151	282	250	280	360	533	613	779	871
Recurrent	382	787	1,264	2,005	2,676	3,371	3,943	4,753	5,610	6,736	7,900	9,089
Target 2018/19	716	1,432	2,152	3,212	4,471	5,734	7,004	8,279	9,558	11,175	12,792	14,450

Overview of progress, including risks and mitigation taken:

The 2018/19 risk adjusted LTF is currently £14.034m against a target of £14.45m. This represents a negative variance of £416k.

Of the £15.198m forecasted delivery £6.108m (40%) of schemes are non-recurrent. This is predominantly £5.237m vacancies and pay underspend. If this can become recurrent it will mitigate I&E risks otherwise it poses a risk to the 2019/20 financial position.

Cumulative delivery at month 7 totalled £8.708m against a year to date plan of £7.004m. This represents a favourable variance to plan of £1.704m, which is mainly due to £4.485m Non-Recurrent pay general underspend across all divisions.

All divisions are continuing to meet on a regular basis to identify plans to move non-recurrent schemes towards recurrent ones and to build contingency for potential slippage within the schemes.

The Changing Care steering group is also exploring cross cutting transformation themes as a way to potentially mitigate any likely shortfall in this year's savings as well as provide a headstart for next year's CIP planning.

5. Statement of Financial Position

The key movements from opening movements are:

Non Current Assets

- M7 movements include capital additions of £678k, of which £264k relates to purchases of medical equipment, £91k of Calorifier replacement, £81k paediatric works.
- Depreciation - £937k in month as per 2018/19 plan, increase month on month due to Nye Bevan go live.

Current assets

• Inventories - £34k. Increase in Pharmacy (£47k), Gynae Endoscopy (£15k) & Pathology (£6k) is offset by decrease in Heart Centre (£41k) & Supplies Trading (£60k) stockholdings .

• Trade & Other Receivables – £1,252k made up of: Increases in NHS receivables (£348k), Income Accruals (£25k), VAT reclaim (£180k) & Prepayments (£759k). Decreases in Trade receivables (£18k) & Compensation Recovery (RTC & PI Claims) (£45k).

• Cash – Increase of £217k.

Current Liabilities

• Trade & Other Payables - £291k made up of: Decrease in NHS Payables (455k) and Accruals (£1,283k). Increase Trade Payables (£272k), Capital Payables (£75k), Tax, NI & Pension Creditor (£240k) , PDC Dividend (£127k), Interest payable (64k), Other Payables, which includes Net Pay (£269k) & Receipts in Advance (£401k).

•Short term loans - £30k repayment of Salix Loan

Non Current Liabilities

• Finance Lease Payable - £228k. Nye Bevan £218k, Car Park £10k

• Drawdown of deficit funding loan - £2,135k

Financed By

- I & E Account - £412k deficit in month

Table 8: SOFP

TRUST SUMMARY BALANCE SHEET MONTH 7 2018/19	Balance at 31-Mar-18 £000	Current Month Opening Balance £000	Current Month Closing Balance £000	Current Month Movement £000	Forecast end of year Closing Balance £000	Forecast end of year Movement £000
NON CURRENT ASSETS						
OPENING NET BOOK VALUE	153,637	153,635	153,635	0	153,637	0
IN YEAR REVALUATIONS	0	510	510	0	510	510
IN YEAR MOVEMENTS	0	14,840	15,518	678	21,519	21,519
LESS DEPRECIATION	0	(4,991)	(5,928)	(937)	(10,623)	(10,623)
NET BOOK VALUE	153,637	163,994	163,735	(259)	165,043	11,406
CURRENT ASSETS						
INVENTORIES	6,272	6,073	6,039	(34)	6,372	100
TRADE & OTHER RECEIVABLES	16,479	18,993	20,245	1,252	16,988	509
NON CURRENT ASSETS FOR SALE	0	0	0	0	0	0
CASH	1,547	1,677	1,894	217	1,500	(47)
TOTAL CURRENT ASSETS	24,298	26,743	28,178	1,435	24,860	562
CURRENT LIABILITIES						
TRADE & OTHER PAYABLES	22,784	25,121	24,830	(291)	17,959	(4,825)
FINANCE LEASE PAYABLE under 1 year	130	1,114	1,119	5	1,181	1,051
SHORT TERM LOANS	20,748	20,745	20,715	(30)	20,948	200
STAFF BENEFITS ACCRUAL	765	765	765	0	750	(15)
PROVISIONS under 1 year	2,744	1,585	1,582	(3)	1,997	(747)
TOTAL CURRENT LIABILITIES	47,171	49,330	49,011	(319)	42,835	(4,336)
NET CURRENT ASSETS / (LIABILITIES)	(22,873)	(22,587)	(20,833)	1,754	(17,975)	4,898
TOTAL ASSETS LESS CURRENT LIABILITIES	130,764	141,407	142,902	1,495	147,068	16,304
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year	993	11,701	11,473	(228)	11,387	10,394
LOANS over 1 year	52,394	62,702	64,837	2,135	75,555	23,161
PROVISIONS over 1 year	1,001	1,001	1,001	0	1,001	0
NON CURRENT LIABILITIES	54,388	75,404	77,311	1,907	87,943	33,555
TOTAL ASSETS EMPLOYED	76,376	66,003	65,591	(412)	59,125	(17,251)
FINANCED BY						
PDC CAPITAL	120,251	120,251	120,251	0	120,378	127
REVALUATION RESERVE	31,782	32,292	32,292	0	32,768	986
I & E ACCOUNT	(75,657)	(86,540)	(86,952)	(412)	(94,021)	(18,364)
FINANCING TOTAL	76,376	66,003	65,591	(412)	59,125	(17,251)

Table 9: Cashflow

MONTHLY CASHFLOW	ANNUAL TOTAL 2018/19 £000s	ACTUAL 18/19 APR £000s	MAY £000s	JUN £000s	JUL £000s	AUG £000s	SEP £000s	OCT £000s	FORECAST 18/19 NOV £000s	DEC £000s	JAN £000s	FEB £000s	MAR £000s
RECEIPTS													
SLA Base Payments	275,388	22,144	23,385	22,762	22,762	22,762	22,762	23,003	23,228	23,145	23,145	23,145	23,145
Provider Sustainability Funding (PSF)	5,797	0	0	0	2,580	0	1,379	0	0	0	1,838	0	0
SLA Performance (relating to 17/18 activity)	-1,871	479	660	0	0	-112	-2,770	21	0	-150	0	0	0
Health Education Payments	9,762	795	795	795	750	812	27	1,891	779	779	779	779	779
Other NHS Income	15,380	751	564	958	1,012	2,034	1,504	1,662	1,499	1,499	1,299	1,299	1,299
PP / Other (Specific > £250k)	4,983	0	970	316	531	428	708	325	505	300	300	300	300
PP / Other	12,324	1,194	908	1,057	1,001	1,251	601	1,112	1,000	1,000	1,000	1,000	1,200
Salix Capital Loan	775	0	0	0	0	0	0	0	0	0	775	0	0
PDC - Capital	127	0	0	0	0	0	0	0	0	0	127	0	0
Capital Loan	0	0	0	0	0	0	0	0	0	0	0	0	0
Uncommitted Revenue Loan - deficit funding	18,514	4,439	3,143	-1,052	1,276	232	0	2,595	709	2,458	1,561	1,887	1,266
Uncommitted Revenue Loan - PSF funding	9,191	0	0	1,379	613	613	612	919	919	919	1,072	1,072	1,073
Interest Receivable	79	6	5	7	7	7	11	8	6	6	6	6	6
TOTAL RECEIPTS	**350,448**	**29,808**	**30,430**	**26,222**	**30,532**	**28,025**	**24,834**	**31,535**	**28,646**	**29,956**	**31,903**	**29,489**	**29,069**
PAYMENTS													
Salaries and wages	207,437	16,698	16,586	16,804	16,701	18,098	17,653	17,163	17,634	17,680	17,680	17,400	17,340
Trade Creditors	98,091	4,928	9,279	7,229	7,688	9,519	7,586	9,738	8,183	8,727	7,737	9,131	8,347
NHS Creditors	27,172	1,999	2,648	2,370	2,586	2,314	2,946	2,431	2,342	2,418	2,218	1,400	1,500
Capital Expenditure	10,523	1,493	414	1,004	459	739	310	520	803	1,106	2,262	780	634
PDC Dividend	962	0	0	0	0	0	200	0	0	0	0	0	762
Repayment of Revenue Loan - PSF funding	3,217	0	0	0	0	0	0	1,379	0	0	1,838	0	0
Repayment of Loans (Principal & Interest)	2,988	8	11	22	152	775	487	42	35	25	168	778	486
Repayment of Salix loan	62	29	0	0	0	0	3	29	0	0	0	0	0
TOTAL PAYMENTS	**350,453**	**25,156**	**28,938**	**27,429**	**27,585**	**31,445**	**29,184**	**31,302**	**28,998**	**29,956**	**31,903**	**29,489**	**29,069**
Actual month balance	-5	4,652	1,492	-1,207	2,947	-3,420	-4,350	233	-352	1	0	0	0
Cash in transit & Cash in hand adjustment	-43	20	-1	-17	27	-32	18	-16	-42	0	1	0	-1
Balance brought forward	1,547	1,547	6,219	7,710	6,486	9,460	6,009	1,677	1,894	1,500	1,500	1,500	1,500
Balance carried forward	**1,500**	**6,219**	**7,710**	**6,486**	**9,460**	**6,009**	**1,677**	**1,894**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**

- Closing cash balance at the end of October was £1,894k, £607k less than forecast.
- Leicestershire CCGs Final 17/18 Performance invoices/credit notes were settled in October. Outstanding balances with Central Midlands Local Office (£245k credit), Milton Keynes CCG (£82k), & Bedfordshire CCG (£14k) are now forecast in December.
- The SLA base payments from December are at the revised values following Contract Variation adjustments. Nene CCG paid their 'catch-up' invoice in October; Corby CCG has been paid in November.
- Following receipt of Quarter 1 PSF in September, the corresponding Uncommitted Loan has been repaid in October, resulting in a net draw down of £2,135k.
- Receipt from Health Education England in October represents two months & also includes non-recurrent Workforce Development Funding.
- Other NHS Income in October includes Northants Healthcare SLA payments for M1-5 (£480k) & 3 months Research Infrastructure Funding from UHL (£190k).
- Creditor payments were £1,277k more than forecast. This was funded by the higher than anticipated level of NHS & Non-NHS receipts & a lower closing cash balance than forecast.
- Uncommitted Revenue Loan drawdown of £1,628k in November has been approved and is reflected in the forecast.

Table 10: Cash forecast

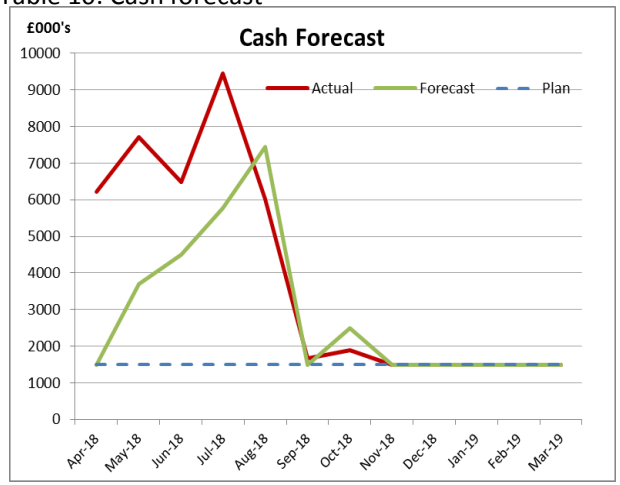


Table 11: Capital

Capital Scheme	Plan 2018/19 £000's	M7 Plan £000's	M7 Spend £000's	Under (-) / Over £000's	Plan Achieved %	Total Actual & Committed £000's	Plan Achieved %
Medical Equipment - MESC Block	630	418	418	0	66%	509	81%
Medical Equipment - CF Specific Forecast	100	40	39	-1	39%	39	39%
EAB Talbot Butler - CF Specific	350	345	344	-1	98%	344	98%
Dexa Scanner - Enabling Costs (Lease)	30	0	0	0	0%	0	0%
CT Simulator Suite	27	27	26	-1	95%	26	95%
Information Technology - Replacement of NPfIT systems inc. CaMIS	658	254	256	1	39%	303	46%
Information Technology	2,987	764	725	-40	24%	946	32%
Estates - Backlog	1,642	1,041	991	-50	60%	1,286	78%
Estates - Statutory	263	87	47	-40	18%	62	23%
Estates - Non Maintenance	398	140	183	44	46%	249	63%
Estates - Ward Refurbishment	725	18	20	2	3%	33	5%
Nye Bevan - Setting Up Costs	296	296	324	28	110%	325	110%
Nye Bevan Assessment Unit (Finance Lease)	12,329	11,760	11,760	0	95%	11,760	95%
Inventory / Ledger Upgrade	32	32	25	-7	78%	28	89%
MRI 1 Enabling Costs	277	277	234	-43	84%	248	90%
SALIX	775	210	129	-80	17%	539	70%
Total - Capital Plan	**21,519**	**15,710**	**15,521**	**-189**	**72%**	**16,698**	**78%**
Less Charitable Fund Donations	-450	-385	-383	2	85%	-383	85%
Less NBV of Disposals	0	0	0	0	0%	0	0%
Total - CRL	**21,069**	**15,325**	**15,138**	**-187**	**72%**	**16,315**	**77%**

Funding Resources	
Internally Generated Depreciation	10,623
Finance Lease - Assessment Unit	12,329
Salix	775
Public WIFI	127
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	**21,069**
Uncommitted Plan	**0**

- The Trust's capital plan of £21,519k at M7, includes Charitable funding of £450k. Total spend and committed total £16,698k, 78% of the overall capital plan.
- Estates excluding the ward refurbishment & Salix schemes have £706k (31%) left of their budget to commit, medical equipment have £121k (19%) and IT excluding CaMIS have £2m (68%) yet to commit.
- IT are reviewing their 18/19 plans to spend the £2m, which includes £0.9m of VDI – virtual desktop infrastructure, this will incur revenue costs of which a business case is being pulled together to identify those costs.
- Nye Bevan Assessment Unit - we are still awaiting the costs to be finalised. Further delays may be incurred due to the lift works.
- The £775k salix plan includes £260k of schemes that have yet to be confirmed with Salix Finance.
- The commitments of £1.2m include £410k for the salix calorifiers, £268k for IT, £389k for Estates and £91k for Medical Equipment.

Receivables and Payables

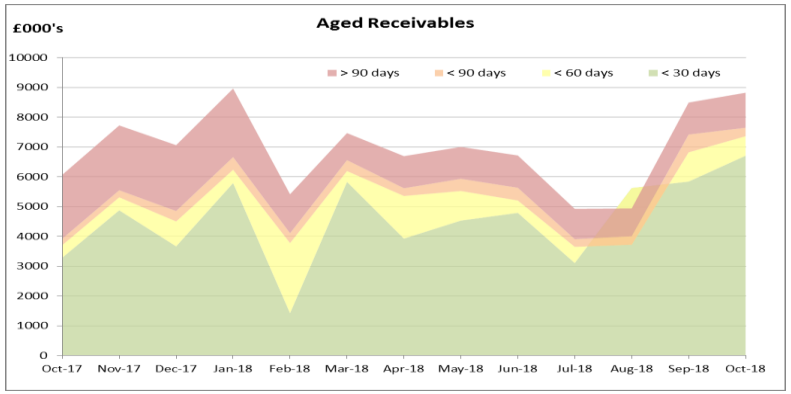
- NHS Receivables – Accruals are included within the 0 to 30 Days Receivables balance. £2,481k relates to PSF funding for Months 4-7.
- NHS over 90 day debt include s University Hospitals of Leicester NHS Trust £41k, Oxford University Hospital NHS Foundation Trust £86k, Kettering General Hospital NHS Foundation Trust £202k, Milton Keynes CCG £82k and £184k NCA's, of which £49k is due from Oxford University Hospitals.
- Non-NHS over 90 day debt includes overseas visitor accounts of £418k ,of which £142k are paying in instalments & a further £244k have been referred to debt collection & private patients accounts of £56k.

Table 12: Receivables and Payables

Narrative	Total at October £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	1,666	496	253	176	740
Receivables NHS	7,161	6,215	401	109	435
Total Receivables	**8,826**	**6,711**	**655**	**286**	**1,175**
Payables Non NHS	(5,053)	(4,984)	(24)	(45)	0
Payables NHS	(655)	(655)	0	0	0
Total Payables	**(5,708)**	**(5,639)**	**(24)**	**(45)**	**0**

Narrative	Total at September £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	1,683	571	293	188	632
Receivables NHS	6,812	5,271	692	410	440
Total Receivables	**8,496**	**5,842**	**984**	**598**	**1,072**
Payables Non NHS	(4,707)	(4,648)	(57)	(2)	0
Payables NHS	(1,110)	(1,110)	0	0	0
Total Payables	**(5,816)**	**(5,757)**	**(57)**	**(2)**	**0**

Table 13: Aged Receivables



Better Payment Practice Code

- All BPPC performance targets were met in October 2018.

Table 14: BPPC

Better Payment Compliance Code - 2018/19

Narrative	July 2018	Aug 2018	Sept 2018	Oct 2018	Cumulative 2018/19
NHS Creditors					
No.of Bills Paid Within Target	151	161	170	199	1,086
No.of Bills Paid Within Period	152	161	170	200	1,088
Percentage Paid Within Target	**99.34%**	**100.00%**	**100.00%**	**99.50%**	**99.82%**
Value of Bills Paid Within Target (£000's)	2,347	1,886	2,481	1,777	14,066
Value of Bills Paid Within Period (£000's)	2,361	1,886	2,481	1,777	14,080
Percentage Paid Within Target	**99.39%**	**100.00%**	**100.00%**	**100.00%**	**99.90%**
Non NHS Creditors					
No.of Bills Paid Within Target	6,023	7,061	5,546	5,382	40,910
No.of Bills Paid Within Period	6,035	7,090	5,567	5,399	41,111
Percentage Paid Within Target	**99.80%**	**99.59%**	**99.62%**	**99.69%**	**99.51%**
Value of Bills Paid Within Target (£000's)	8,163	10,640	8,327	9,326	61,945
Value of Bills Paid Within Period (£000's)	8,251	10,654	8,333	9,345	62,181
Percentage Paid Within Target	**98.93%**	**99.86%**	**99.92%**	**99.80%**	**99.62%**
Total					
No.of Bills Paid Within Target	6,174	7,222	5,716	5,581	41,996
No.of Bills Paid Within Period	6,187	7,251	5,737	5,599	42,199
Percentage Paid Within Target	**99.79%**	**99.60%**	**99.63%**	**99.68%**	**99.52%**
Value of Bills Paid Within Target (£000's)	10,510	12,526	10,808	11,103	76,011
Value of Bills Paid Within Period (£000's)	10,612	12,540	10,814	11,122	76,261
Percentage Paid Within Target	**99.04%**	**99.88%**	**99.94%**	**99.83%**	**99.67%**

6. Risks

Table 15

Risk	Description	Estimated Gross Impact £'m	RAG	Mitigations	Mitigated Impact £'m	Exec Lead
Revenue Risks						
Activity	Slow pace at utilising the beds made available from the reduction in stranded and super-stranded patients, meaning that the loss in excess bed days income is not matched by elective income.	0.5		Utilise locums to fill current gaps where possible. Potential upside with non-pay costs associated with elective activity.	0.3	DN
Activity	Activity growth may be exaggerated as it is modelled on 2017-18 month 8 forecast outturn, which was higher than actual out-turn. In addition, the capacity to deliver the anticipated activity growth is limited, as the estimated bed gap is currently c.45 beds	0.5		Management of escalation areas, discharge schemes and schemes to lower LOS should help minimise this gap. Ring-fence elective wards for delivery of elective activity	0.3	DN
Activity	Challenges within the Northamptonshire county council and the impact of this on social care discharges in order to free up hospital beds. This was a major contributor to the strain on activity and income in 2017-18.	1.0		Leverage influence of NHSI and the newly formed DHSC to support better collaborative working. Plan assumed 1.6% demographic growth in comparison with national planning assumption of 2.3%	0.5	CP
Income	Risk that the income assumed to be deliverable via the STP does not materialise. In order to bridge the gap between the plan and the control total, £4.6m income has been assumed to be deliverable from activity from the STP schemes	2.8		£1.8m (of the overall £4.6m) received and pro-rata included in the M6 position. Collaborative working with STP partners to support income gap delivery. Financial position in line with plan YTD	2.3	PB/CP/DN
Income	Stroke service transfer from KGH may not be fully supported by investment from Nene CCG. In addition, there is potential for losing income from existing non-elective activity.	0.5		To maintain planning funding discussions with Nene CCG to ensure the service can be implemented to current quality standards with limited or nil financial impact	0.1	CP
Income	Accurate capture and coding of activity under PbR rules following implementation of CAMIS.	0.5		Negotiations with the CCG, for example for block values in extreme circumstances or extended deadlines. Robust implementation testing before implementation. Continued discussions and close working with Divisions and EMIS.	0.3	DN
Nye Bevan Unit	Efficacy of the new model for the 60 beds to ensure sufficient discharges to reduce length of stay and prevent escalation into elective wards; in addition to ability to recruit staff substantively for the new unit	0.5		Robust implementation through the working group. The COO has emphasised that the Unit will only open when there is satisfaction about the effectiveness of the new model.	0.3	DN
Escalation ward	Operational pressures may require the escalation ward to be open for more than the 4 months it is budgeted for and may also impact the decant programme	0.4		Effective implementation of the transition to the Nye Bevan unit. Effectiveness of on-going discharge schemes (fixing the flow). Resilience to cope with winter pressures.	0.2	DN
CQUIN	Risk of non-delivery against CQUINs	0.4		Early communication and focus on the delivery requirements. Appropriate resourcing where financially beneficial. CQUIN met in 2017-18, so organisational framework for delivery can be replicated.	0.2	CP
CIP delivery	Delivery of £14.9m CIP target (5%) and possible high proportion delivered as non-recurrent CIPs.	5.1		Management of CIP plans and delivery through the revamped Changing Care model. Realistic plans set for Divisions. Focus on robust CIP delivery. Use of unplanned pay savings mechanism.	2.6	PB
PSF funding	Risk that the Trust may be unable to access all the allocated PSF if it fails to deliver all the financial and performance trajectories.	5.3		Management of operational and financial targets. Realistic plans set for Divisions. Focus of robust CIP delivery.	4.0	DN/PB

Report To	**Trust Board**
Date of Meeting	**28th November 2018**

Title of the Report	**Workforce Performance Report**
Agenda item	**TBC**
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 September 2018.
- Decrease in compliance rate for Mandatory Training, Role Specific Essential Training and Appraisals.
- Update in respect of implementation of new applicant management system.
- Overview of Respect & Support Campaign.
- Update in respect of Staff Survey.
- Update in respect of the Flu campaign.
- Exception Reports for Staff Role Specific Training, Staff Appraisals and Vacancy Rates.

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 – 3.1, 3.2 and 3.3
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (Y/N) No

	Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (Y/N) No
Legal implications / regulatory requirements	No

Actions required by the Committee

The Committee is asked to Note the report.

Northampton General Hospital NHS Trust

TRUST BOARD

THURSDAY 28 NOVEMBER 2018

WORKFORCE PERFORMANCE REPORT

1. Introduction

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

2. Workforce Report

2.1 Capacity

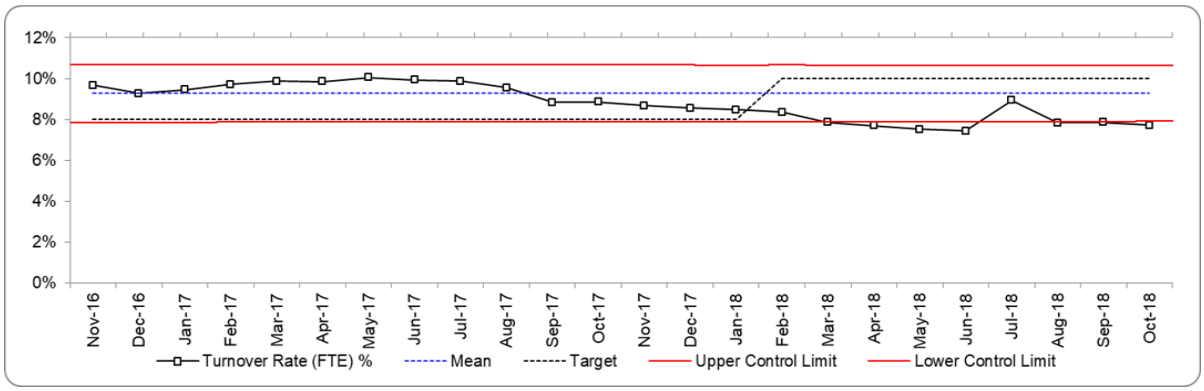
Substantive Workforce Capacity increased by 63.06 FTE in October 2018 to 4498.05 FTE. The Trust's substantive workforce is at 89.41% of the Budgeted Workforce Establishment of 5030.55 FTE. Budgeted Establishment increased by 30.23 FTE.

Trust Turnover

Annual Trust turnover for October 2018 decreased by 0.14% to 7.71%, which is below the Trust target of 10.00%

Turnover within Nursing & Midwifery decreased by 0.23% to 5.59%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust.

Overall Trust Turnover Trend:



Vacancy Rates

The overall Trust vacancy rate for October 2018 is 10.59% against a Trust target of 9%.

The vacancy % rate has increased in October 2018 for Add Prof Sci & Tech and Additional Clinical Services staff groups

There has been a decrease in vacancy rates for Admin & Clerical, Allied Health Professionals, Estates & Ancillary, Healthcare Scientists, Medical & Dental and Nursing & Midwifery staff groups.

The largest decrease in vacancy rates was experienced by Allied Health Professionals which decreased by 5.26% from 7.40% to 2.14%.

The overall Trust vacancy % decreased by 0.72% from 11.31% to 10.59%

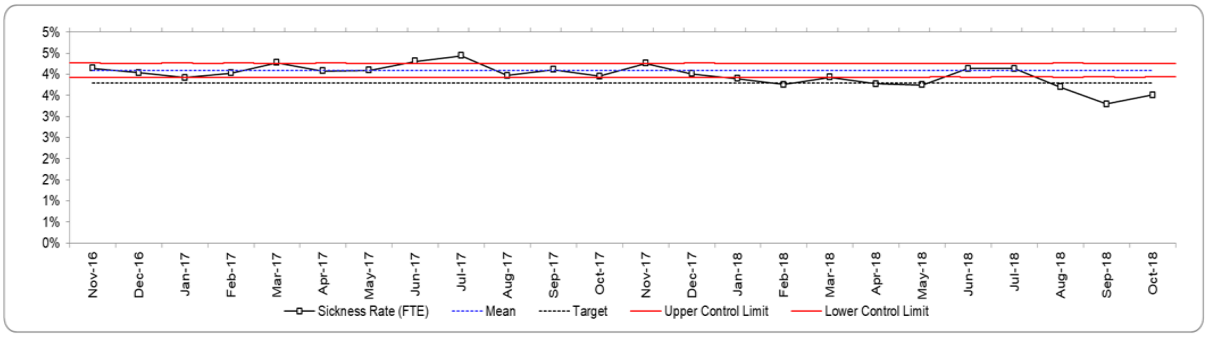
Sickness Absence

Sickness absence for October 2018 decreased from 4.29% to 3.99% which is above Trust target of 3.8%. Medicine & Urgent Care and Clinical Support Services Divisions were the only Divisions under the Trust's target.

Facilities Directorate had the highest sickness rate of 6.74% amongst the directorates.

In total 11 directorate level organisations were below the trust target rate in October 2018 compared to 10 directorates in September 2018.

Overall Trust Sickness Absence Trend:



Flu

The first months data entered into the National Database was 61.6% which is higher than last year at 60.5%. This means we have achieved our 50% CQUIN target in the first month. Flu trolley rounds and the Wednesday clinics in the Cyber café continue. If any department would like a specific visit they are able to arrange one by contacting Occupational Health.

A breakdown of CQUIN thresholds is as follows:

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
<50%	No payment
50% up to 59.99%	25% payment
60% up to 64.99%	50% payment
65% up to 74.99% uptake	75% payment
75% or above	100% payment

Applicant Management System (Trac)

Resourcing & Employment Services have commenced the initial stages of the implementation of an applicant management system developed and provided by an organisation called 'Trac Systems'. 'Trac Systems' provide online software, that will facilitate the Trusts recruitment process from posting a new vacancy, all the way to booking an applicant's induction courses and start date.

The use of the system will enable the Trust to manage its adverts, candidates, pre-employment checks and workload more efficiently.

At present, recruiting managers and the HR Service Centre team rely upon NHS Jobs to advertise and manage the applications received in response to vacancies. The advertising side of the system is good but the functionality is very limited when compared with other systems.

The system is fully compatible with ESR and the Trusts Occupational Health system and will deliver a number of benefits including significantly improved reporting functionality through the provision of information that is available in a variety of easy to read formats, which can be split organisationally or by staff group. This will enable individual departments, divisions and the Trust as a whole to better monitor recruitment activity whilst also achieving greater transparency and understanding of where blockages in the recruitment process arise.

An audit has been arranged to measure the benefits realisation of the system and will commence on 24 November 2018 by measuring current compliance against recruitment KPIs. A further audit will then be undertaken post implementation so that a comparative analysis can be undertaken.

The implementation of Trac has been approved and funded from the IT Capital budget via approval of a costed Business Case submitted to the IT Steering Group and it is anticipated that the system will go live on 23 January 2019.

2.2 Capability

Appraisals, Mandatory Training and Role Specific Essential Training

The current rate of Appraisals recorded for October 2018 is 83.16%; this is a decrease of 1.46% from last month's figure of 84.62%.

Mandatory Training compliance decrease in October 2018 from 88.71% to 87.90% this is a decrease of 0.81% from last month's figure and remains above the Trust target of 85%.

Role Specific Essential Training compliance also decreased in October 2018 to 82.01% from last month's figure of 82.12%.; that is a decrease of 0.11%.

2.3 Culture

Overview of Respect & Support Campaign

Staff Development & Training

As part of the Respect and Support Campaign a range of training has been developed and available for staff as follows:

- **Leading with Respect**: Leading for Respect is for Team Leaders, Managers and people in positions of influence in clinical and non-clinical roles. The training is in two parts: Forum Theatre and Classroom based training. The aim of this session is to ensure managers understand their responsibilities in addressing workplace bullying, harassment and inappropriate behaviours. Since the launch in September approximately 150 staff has attended the training.
- **Challenging Bullying and Inappropriate behaviour:** This training is for staff that do not have line management/supervisory responsibility. The training includes Forum Theatre and classroom based training. The programme aims to raise awareness of bullying and inappropriate behaviours, what the behaviours look like in practice and the options available to challenge these behaviours if staff experience or witness it. Approximately 100 delegates have attended the programme.
- **Courageous Conversations:** A Courageous Conversation programme started in October. This session is for delegates that have attended 'Leading with Respect' or 'Challenging Bullying and Inappropriate Behaviour' and who may need the practical tools required to have a difficult conversation.
- **Resilience Training:** The resilience training is available for all staff across the Trust. It is a programme that has been developed to look at personal emotional resilience, taking time to recognise what depletes and what restores personal resilience. 160 staff have attended the programme.

Respect & Support Helpline

The Respect and Support Helpline is currently being developed. The helpline uses a triage approach to signpost staff to where they can obtain further support. The Respect and Support Helpline will be available in January.

Round Table Informal Mediation

The Round Table informal mediation service is currently being communicated across the Trust. We are looking for Round Table Facilitators across the Trust to support this service. Round Table training will held in December and January.

Round Table informal mediation is a facilitated informal conversation that is offered in order to resolve issues of conflict between two people.

Other Tools

The following have also been developed and are available for staff on the Respect and Support intranet page:

- Feelings log
- Behavioural framework
- Behavioural self-assessment tool

Staff Survey

The 2018 National NHS Staff Survey was launched at the Trust on 8 October and closes on Friday 30 November 2018. This year the number of paper surveys that have been distributed has been increased by providing all ward based nursing staff with a paper version, as feedback from previous surveys found that this group of staff struggled to access the survey via email.

As at 12 November 2018 the response rate is 27.8% (1372 returned). This is below the average response rate for Acute Trusts, which is 32.2%. However when compared to our response rate at the same point in time last year it is 3.2% higher.

3.0 Policies

The procedural documents that were ratified in and uploaded to the intranet in October 2018 were as follows:

- Maternity, Adoption, Paternity & Shared Parental Leave Procedure –minor update

4.0 Assessment of Risk

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

5.0 Recommendations/Resolutions Required

The Committee is asked to note the report.

6.0 Next Steps

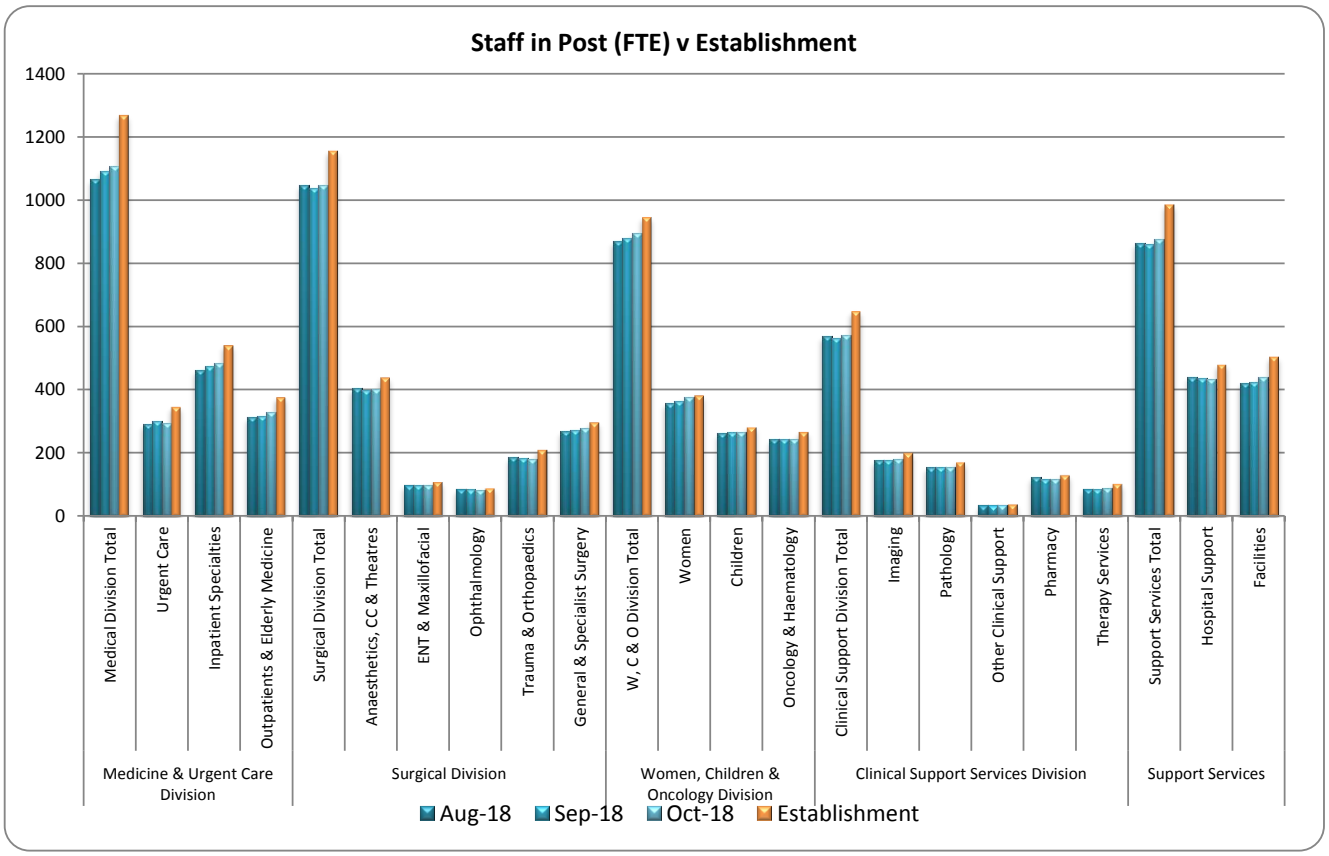
Key workforce performance indicators are subject to regular monitoring and appropriate action is taken as and when required.

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

CAPACITY
Staff in Post

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

Staff in Post (FTE)		Aug-18		Sep-18		Oct-18	Establishment	
Medicine & Urgent Care Division	Medical Division Total	1067.28	↑	1091.93	↑	1107.97	1270.15	87.23%
	Urgent Care	289.88	↑	299.98	↓	292.24	347.27	84.15%
	Inpatient Specialties	461.44	↑	472.78	↑	482.77	542.49	88.99%
	Outpatients & Elderly Medicine	312.96	↑	316.17	↑	328.96	377.39	87.17%
Surgical Division	Surgical Division Total	1046.00	↓	1039.52	↑	1047.28	1157.58	90.47%
	Anaesthetics, CC & Theatres	405.74	↓	397.41	↑	401.55	439.99	91.26%
	ENT & Maxillofacial	96.56	↓	96.15	↑	98.22	109.76	89.49%
	Ophthalmology	83.49	↑	83.50	↓	82.40	90.49	91.06%
	Trauma & Orthopaedics	185.97	↓	183.65	↓	181.57	211.93	85.67%
	General & Specialist Surgery	268.53	↑	273.01	↑	277.74	298.61	93.01%
Women, Children & Oncology Division	W, C & O Division Total	871.41	↑	879.98	↑	894.63	948.24	94.35%
	Women	356.68	↑	363.09	↑	376.76	383.89	98.14%
	Children	262.42	↑	265.51	↓	264.99	283.62	93.43%
	Oncology & Haematology	242.11	↓	241.38	↑	243.68	268.00	90.93%
Clinical Support Services Division	Clinical Support Division Total	568.63	↓	564.47	↑	573.40	650.20	88.19%
	Imaging	175.98	↑	177.50	↑	180.11	201.95	89.19%
	Pathology	153.87	↓	152.70	↑	154.22	173.10	89.09%
	Other Clinical Support	33.02	↑	33.09	↑	35.10	39.02	89.95%
	Pharmacy	121.46	↓	117.01	↓	116.94	131.73	88.77%
	Therapy Services	84.30	↓	84.17	↑	87.03	104.40	83.36%
Support Services	Support Services Total	862.81	↓	859.09	↑	874.77	987.40	88.59%
	Hospital Support	441.27	↓	436.61	↓	433.60	481.64	90.03%
	Facilities	421.54	↑	422.48	↑	441.17	505.76	87.23%
Trust Total		4416.23	↑	4434.99	↑	4498.05	5030.55	89.41%



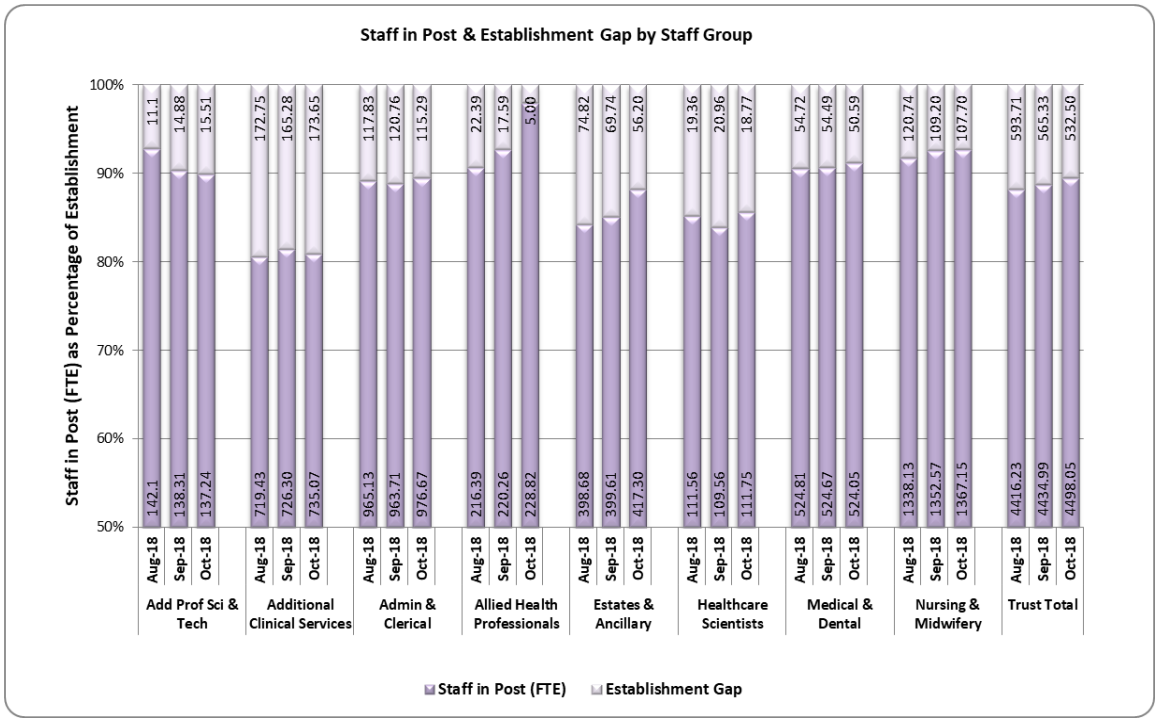
Workforce Committee: Capacity, Capability and Culture Report - October 2018

CAPACITY
Staff Group (FTE v Est)

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

Staff Group Vacancy Rate (Contracted FTE v Establishment)

Staff Group	Aug-18	Sep-18	Oct-18
Add Prof Sci & Tech	7.24%	9.71%	10.15%
Additional Clinical Services	19.36%	18.54%	19.11%
Admin & Clerical	10.88%	11.14%	10.56%
Allied Health Professionals	9.38%	7.40%	2.14%
Estates & Ancillary	15.80%	14.86%	11.87%
Healthcare Scientists	14.79%	16.06%	14.38%
Medical & Dental	9.44%	9.41%	8.80%
Nursing & Midwifery	8.28%	7.47%	7.30%
Trust Total	11.85%	11.31%	10.59%



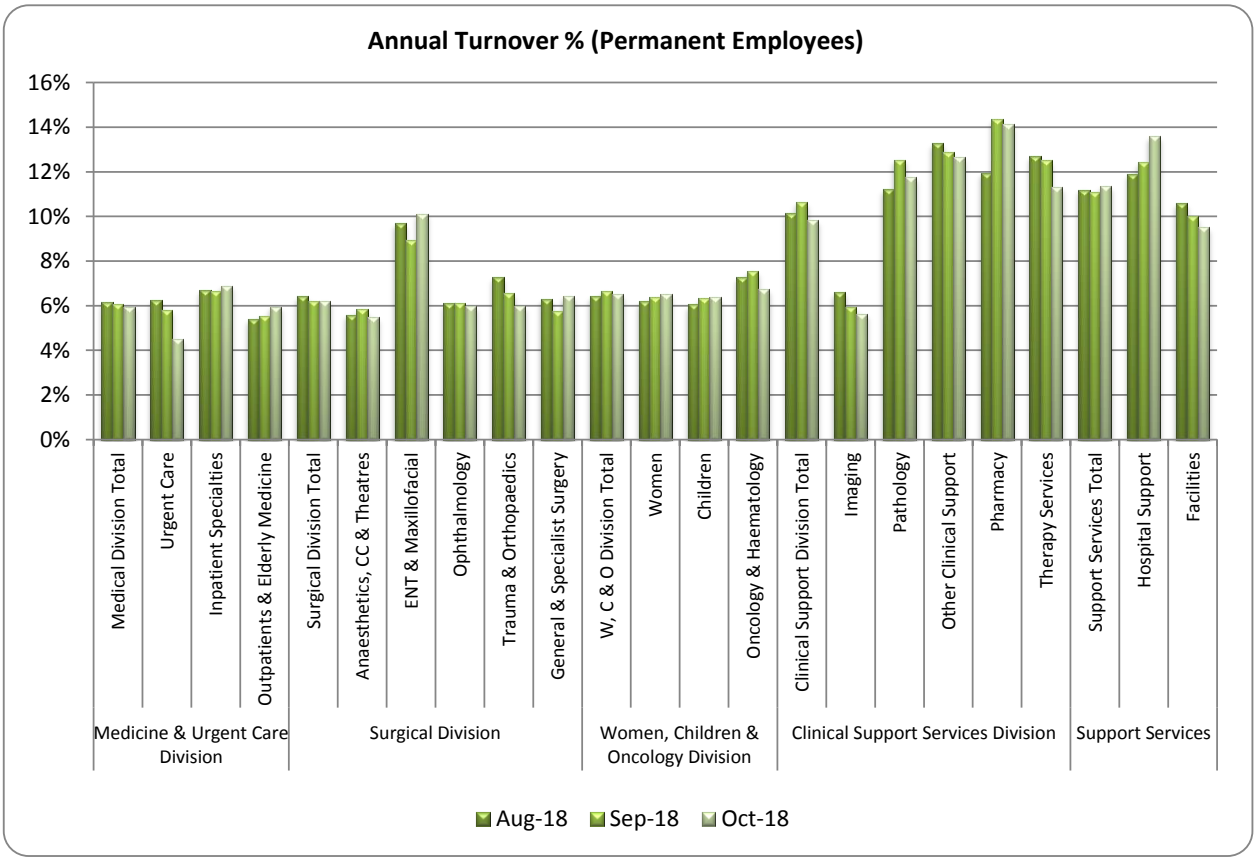
Workforce Committee: Capacity, Capability and Culture Report - October 2018

CAPACITY
Annual Turnover

Figures refer to the year ending in the month stated

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

Annual Turnover (Permanent Staff)		Aug-18	Sep-18		Oct-18	
Medicine & Urgent Care Division	Medical Division Total	6.15%	↘	6.06%	↘	5.95%
	Urgent Care	6.24%	↘	5.80%	↘	4.51%
	Inpatient Specialties	**6.69%**	↘	**6.66%**	↗	**6.89%**
	Outpatients & Elderly Medicine	**5.40%**	↗	**5.55%**	↗	**5.95%**
Surgical Division	Surgical Division Total	6.42%	↘	6.19%	↗	6.20%
	Anaesthetics, CC & Theatres	5.59%	↗	5.84%	↘	5.47%
	ENT & Maxillofacial	9.70%	↘	8.91%	↗	10.12%
	Ophthalmology	6.09%	↗	6.09%	↘	5.97%
	Trauma & Orthopaedics	7.28%	↘	6.57%	↘	5.97%
	General & Specialist Surgery	6.27%	↘	5.74%	↗	6.43%
Women, Children & Oncology Division	W, C & O Division Total	6.41%	↗	6.65%	↘	6.50%
	Women	6.21%	↗	6.39%	↗	6.50%
	Children	6.04%	↗	6.34%	↗	6.37%
	Oncology & Haematology	7.26%	↗	7.56%	↘	6.75%
Clinical Support Services Division	Clinical Support Division Total	10.16%	↗	10.64%	↘	9.82%
	Imaging	6.60%	↘	5.95%	↘	5.63%
	Pathology	11.24%	↗	12.54%	↘	11.77%
	Other Clinical Support	13.28%	↘	12.88%	↘	12.67%
	Pharmacy	11.95%	↗	14.35%	↘	14.15%
	Therapy Services	12.71%	↘	12.51%	↘	11.29%
Support Services	Support Services Total	11.19%	↘	11.11%	↗	11.35%
	Hospital Support	11.91%	↗	12.42%	↗	13.58%
	Facilities	10.59%	↘	10.00%	↘	9.50%
Trust Total		7.83%	↗	7.85%	↘	7.71%



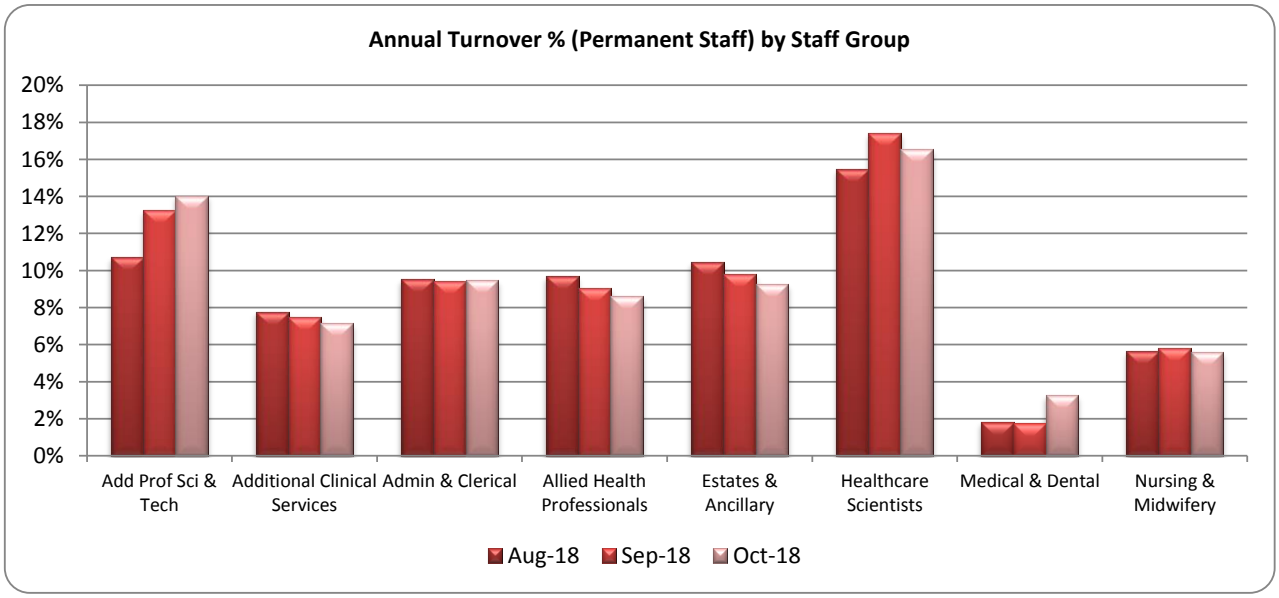
Workforce Committee: Capacity, Capability and Culture Report - October 2018

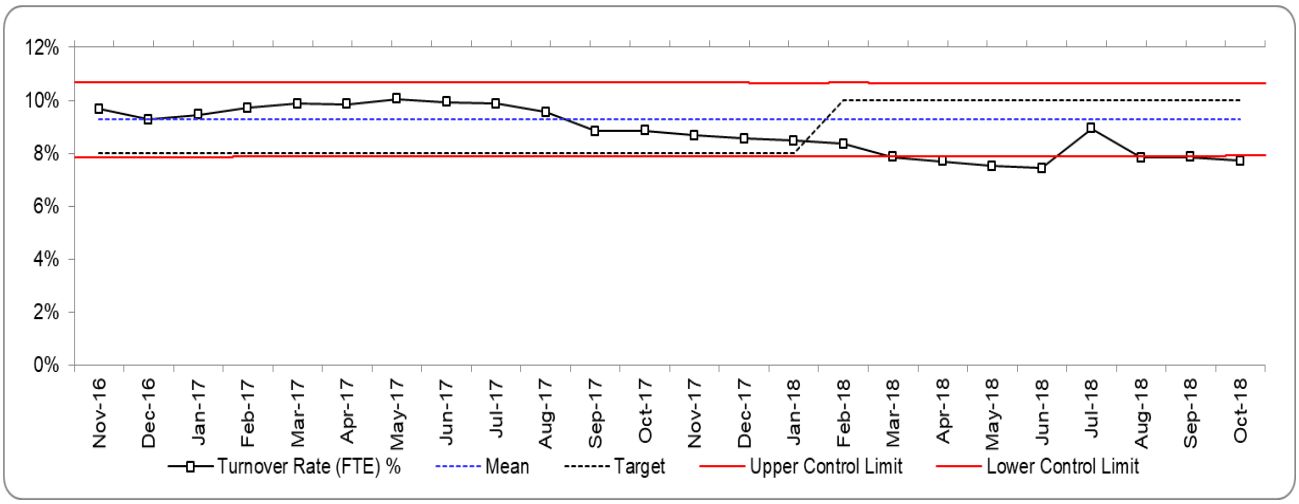
CAPACITY
Turnover by Staff Group

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	Aug-18		Sep-18		Oct-18
Add Prof Sci & Tech	10.69%	↗	13.23%	↗	14.03%
Additional Clinical Services	7.77%	↘	7.50%	↘	7.14%
Admin & Clerical	9.53%	↘	9.42%	↗	9.45%
Allied Health Professionals	9.70%	↘	9.02%	↘	8.62%
Estates & Ancillary	10.46%	↘	9.79%	↘	9.24%
Healthcare Scientists	15.44%	↗	17.42%	↘	16.52%
Medical & Dental	1.83%	↘	1.74%	↗	3.27%
Nursing & Midwifery	5.63%	↗	5.82%	↘	5.59%





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

Capacity:

Substantive Workforce Capacity increased by 63.06 FTE in October 2018 to 4498.05 FTE. The Trust's substantive workforce is at 89.41% of the Budgeted Workforce Establishment of 5030.55 FTE.

Staff Turnover:

Annual Trust turnover for October 2018 decreased by 0.14% to 7.71%, which is below the Trust target of 10.00%.

Turnover within Nursing & Midwifery decreased by 0.23% to 5.59%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust.

Turnover also decreased for the following staff groups:
Additional Clinical Services decreased by 0.36%
Allied Health Professionals decreased by 0.40%
Estates & Ancillary decreased by 0.55%
Healthcare Scientists decreased by 0.90%

The Trust experienced an increase in turnover for the following groups:
Add Prof Sci & Tech increased by 0.80%
Admin & Clerical increased by 0.03%
Medical & Dental increased by 1.53%

Turnover by Division:
Medical Division: turnover decreased by 0.11% to 5.95%
Surgical Division: turnover increased by 0.01% to 6.20%
Women, Children & Oncology Division: turnover decreased by 0.15% to 6.50%
Clinical Support Services Division: turnover decreased by 0.82% to 9.82%
Support Services: turnover increased by 0.24% to 11.35%

Staff Vacancies:

The vacancy % rate has increased in October 2018 for Add Prof Sci & Tech and Additional Clinical Services staff groups

There has been a decrease for Admin & Clerical, Allied Health Professionals, Estates & Ancillary, Healthcare Scientists, Medical & Dental and Nursing & Midwifery staff groups.

Largest decrease experienced by Allied Health Professionals decreasing 5.26% to 2.14%.

The overall Trust vacancy % decreased by 0.72% to 10.59%

Sickness Absence:

Sickness absence for October 2018 decreased from 4.29% to 3.99% which is above Trust target of 3.8%. Medicine & Urgent Care and Clinical Support Services Divisions were the only ones under the Trust's target

Sickness by Division:
Medicine and Urgent Care at 3.72%
Surgery Division at 4.04%
Women, Children & Oncology at 3.83%
Clinical Support Services at 3.36%
Support Services at 4.98%

Facilities Directorate had the highest sickness rate of 6.74% amongst the directorates.

In total 11 directorate level organisations were below the trust target rate in October 2018 compared to 10 directorates in September 2018.

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

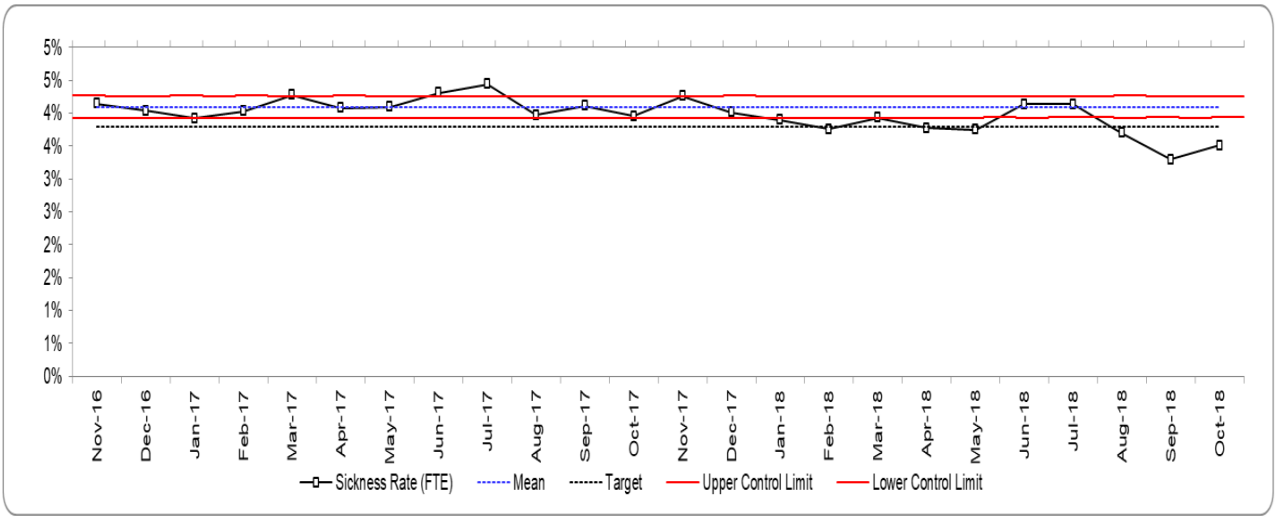
CAPACITY
In-Month Sickness

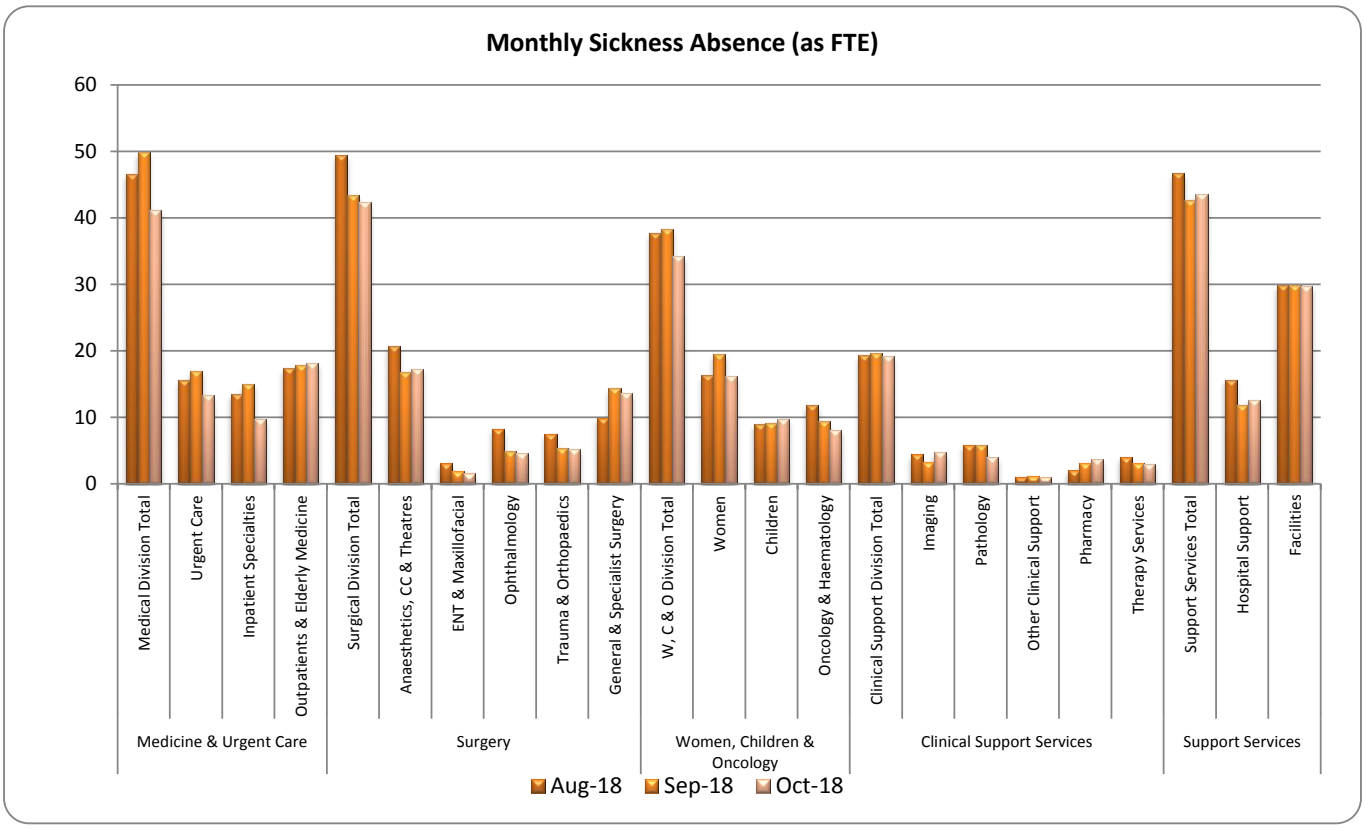
Sickness % RAG Rates:		
> 4.2%	3.8-4.2%	< 3.8%

Monthly Sickness (as FTE)		Aug-18	Sep-18	Oct-18	Oct-18	Short Term	Long Term
Medicine & Urgent Care	**Medical Division Total**	46.53	49.86	41.22	3.72%	1.75%	1.97%
	Urgent Care	15.57	16.95	13.38	4.58%	1.69%	2.89%
	Inpatient Specialties	13.52	14.97	9.75	2.02%	1.57%	0.45%
	Outpatients & Elderly Medicine	17.37	17.83	18.19	5.53%	2.09%	3.44%
Surgery	**Surgical Division Total**	49.48	43.36	42.31	4.04%	2.05%	1.99%
	Anaesthetics, CC & Theatres	20.65	16.82	17.27	4.30%	2.54%	1.76%
	ENT & Maxillofacial	3.06	1.91	1.55	1.58%	1.58%	0.00%
	Ophthalmology	8.30	4.90	4.63	5.62%	2.46%	3.16%
	Trauma & Orthopaedics	7.46	5.34	5.23	2.88%	2.45%	0.43%
	General & Specialist Surgery	9.94	14.44	13.61	4.90%	1.17%	3.73%
Women, Children & Oncology	**W, C & O Division Total**	37.64	38.29	34.26	3.83%	2.23%	1.60%
	Women	16.34	19.44	16.24	4.31%	2.06%	2.25%
	Children	8.95	9.20	9.70	3.66%	2.11%	1.55%
	Oncology & Haematology	11.81	9.38	8.14	3.34%	2.60%	0.74%
Clinical Support Services	**Clinical Support Division Total**	19.33	19.67	19.27	3.36%	2.20%	1.16%
	Imaging	4.38	3.28	4.70	2.61%	2.38%	0.23%
	Pathology	5.82	5.86	4.07	2.64%	1.99%	0.65%
	Other Clinical Support	1.06	1.17	1.05	2.99%	0.70%	2.29%
	Pharmacy	2.08	3.16	3.74	3.20%	1.23%	1.97%
	Therapy Services	3.95	3.07	3.02	3.47%	3.47%	0.00%
Support Services	**Support Services Total**	46.76	42.60	43.56	4.98%	1.77%	3.21%
	Hospital Support	15.67	11.88	12.66	2.92%	1.31%	1.61%
	Facilities	29.93	29.87	29.73	6.74%	2.18%	4.56%
Trust Total	***As FTE***	198.29	192.97	179.47			
	As percentage	4.49%	4.29%		3.99%	1.98%	2.01%

01st November 2017 - 31st October 2018				
Absence Reason	**Headcount**	**Abs Occurrences**	**FTE Days Lost**	**%**
S10 Anxiety/stress/depression/other psychiatric illnesses	434	591	17,753.68	24.2
S98 Other known causes - not elsewhere classified	902	1,168	10,776.02	14.7
S25 Gastrointestinal problems	1354	1,746	5,491.24	7.5
S28 Injury, fracture	224	255	5,165.61	7.0
S11 Back Problems	305	390	4,939.19	6.7

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





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

CAPABILITY

Training & Appraisal Rates

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

Mandatory Training Compliance Rate	Directorate	Aug-18	Sep-18	Oct-18
Medicine & Urgent Care Division	Medical Division Total	84.37%	84.07%	83.78%
	Urgent Care	84.55%	82.98%	83.51%
	Inpatient Specialties	83.03%	82.33%	81.87%
	Outpatients & Elderly Medicine	85.98%	87.54%	86.62%
Surgical Division	Surgical Division Total	88.19%	88.16%	87.20%
	Anaesthetics, CC & Theatres	89.38%	89.66%	88.62%
	ENT & Maxillofacial	85.29%	79.68%	78.17%
	Ophthalmology	86.20%	86.41%	87.93%
	Trauma & Orthopaedics	89.37%	89.81%	89.82%
	General & Specialist Surgery	87.19%	88.37%	86.46%
Women, Children & Oncology Division	W, C & O Division Total	89.05%	88.72%	88.46%
	Women	89.78%	90.02%	89.40%
	Children	89.00%	88.51%	88.68%
	Oncology & Haematology	87.59%	86.55%	86.37%
Clinical Support Services Division	Clinical Support Division Total	93.23%	92.79%	92.70%
	Imaging	93.01%	94.12%	92.44%
	Pathology	96.47%	94.71%	94.44%
	Other Clinical Support	94.57%	95.11%	94.04%
	Pharmacy	93.82%	92.68%	94.14%
	Therapy Services	86.57%	85.76%	87.77%
Support Services	Support Services Total	91.71%	92.33%	90.05%
	Hospital Support	90.88%	92.33%	91.41%
	Facilities	92.48%	92.33%	88.85%
Trust Total		88.81%	88.71%	87.90%

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

CAPABILITY
Training & Appraisal Rates

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

Role Specific Training Compliance Rate	Directorate	Aug-18	Sep-18	Oct-18
Medicine & Urgent Care Division	Medical Division Total	81.09%	79.38%	78.57%
	Urgent Care	81.59%	79.74%	80.35%
	Inpatient Specialties	79.24%	77.06%	76.34%
	Outpatients & Elderly Medicine	83.29%	82.63%	79.81%
Surgical Division	Surgical Division Total	83.68%	82.77%	81.17%
	Anaesthetics, CC & Theatres	83.22%	83.23%	81.88%
	ENT & Maxillofacial	79.30%	71.40%	69.24%
	Ophthalmology	81.17%	79.43%	80.29%
	Trauma & Orthopaedics	87.65%	87.30%	85.68%
	General & Specialist Surgery	83.22%	82.89%	80.50%
Women, Children & Oncology Division	W, C & O Division Total	85.03%	84.56%	84.99%
	Women	84.36%	85.04%	85.47%
	Children	86.92%	86.81%	86.70%
	Oncology & Haematology	83.95%	79.94%	80.70%
Clinical Support Services Division	Clinical Support Division Total	87.70%	80.44%	86.10%
	Imaging	90.47%	88.96%	87.36%
	Pathology	86.39%	67.41%	82.61%
	Other Clinical Support	88.11%	86.39%	87.42%
	Pharmacy	85.50%	66.86%	85.11%
	Therapy Services	85.53%	85.98%	86.43%
Support Services	Support Services Total	86.41%	85.60%	83.62%
	Hospital Support	84.01%	83.07%	81.73%
	Facilities	89.57%	88.97%	86.05%
Trust Total		**83.81%**	**82.12%**	**82.01%**

Capability

Appraisals
The current rate of Appraisals recorded for October 2018 is 83.16%; this is a decrease of 1.46% from last month's figure of 84.62%.

Mandatory Training and Role Specific Essential Training
Mandatory Training compliance decrease in October 2018 from 88.71% to 87.90% this is a decrease of 0.81% from last month's figure and remains above the Trust target of 85%.

Role Specific Essential Training compliance also decreased in October 2018 to 82.01% from last month's figure of 82.12%.; that is a decrease of 0.11%.

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 target was not achieved this month, but work continues to improve current figures.

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

CAPABILITY

Training & Appraisal Rates

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

Appraisal Compliance Rate	Directorate	Aug-18	Sep-18	Oct-18
Medicine & Urgent Care Division	Medical Division Total	83.85%	80.30%	82.10%
	Urgent Care	84.04%	77.89%	83.67%
	Inpatient Specialties	82.47%	78.61%	80.54%
	Outpatients & Elderly Medicine	85.67%	84.84%	82.77%
Surgical Division	Surgical Division Total	87.51%	88.10%	83.49%
	Anaesthetics, CC & Theatres	85.18%	88.12%	83.61%
	ENT & Maxillofacial	71.60%	70.13%	71.60%
	Ophthalmology	84.29%	83.33%	71.01%
	Trauma & Orthopaedics	93.75%	95.95%	93.14%
	General & Specialist Surgery	92.37%	89.16%	83.46%
Women, Children & Oncology Division	W, C & O Division Total	86.97%	85.67%	85.10%
	Women	87.97%	85.46%	86.21%
	Children	88.76%	85.34%	85.02%
	Oncology & Haematology	83.61%	86.15%	83.06%
Clinical Support Services Division	Clinical Support Division Total	85.88%	87.50%	84.46%
	Imaging	88.65%	93.30%	86.49%
	Pathology	87.88%	90.68%	90.18%
	Other Clinical Support	81.08%	78.38%	84.21%
	Pharmacy	85.04%	87.93%	80.65%
	Therapy Services	80.00%	73.63%	75.79%
Support Services	Support Services Total	81.54%	82.97%	81.31%
	Hospital Support	78.04%	82.55%	79.30%
	Facilities	84.72%	83.33%	83.08%
Trust Total		85.04%	84.62%	83.16%

Northampton General Hospital NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**29th November 2018**

Title of the Report	**Flu vaccination for Healthcare Workers**
Agenda item	**11.1**
Presenter of Report	Janine Brennan Director of Workforce & Transformation
Author(s) of Report	Claire Brown OH Manager
Purpose	For assurance and approval that the Trust is addressing the 'best practice' in line with the NHS England (Final Letter) and self-assessment template dated 7th September 'Health Care Worker Flu Vaccination'.

Executive summary

A brief overview of the content of the paper

1. Activity data
2. Flu campaign
3. Data Collection
4. Vaccination declined
5. Trust Self-Assessment

Related strategic aim and corporate objective	Objective 1 – Focus and Quality and Safety. We will avoid harm, reduce mortality and improve patient outcomes through a focus on quality outcomes, effectiveness and safety.
Risk and assurance	Yes – risk of non-vaccinated staff working in high risk areas passing on virus to patients
Related Board Assurance Framework entries	BAF 3.1

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

Actions required by the Trust Board

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

This paper gives information for the required self-assessment by Trusts that is required to be published in its trust board papers before the end of 2018 as per the NHS England letter dated 07/09/2018 to Chief Executives of NHS Trust and Foundation Trusts.
http://www.nhsemployers.org/-/media/Employers/Documents/Flu/20180907-HCW-flu-vaccination-letter-FINAL.pdf

The report is for assurance and approval.

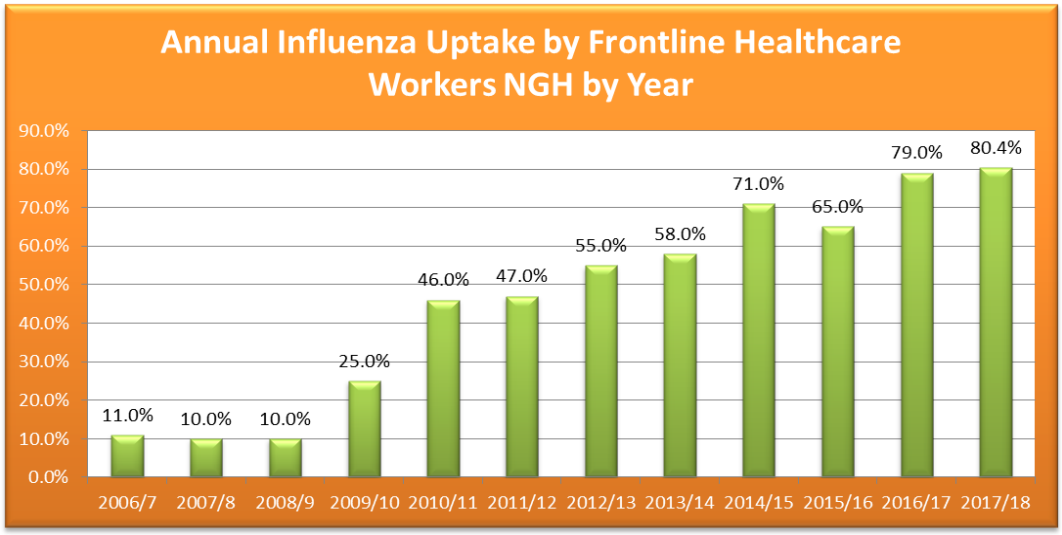
Northampton General Hospital NHS Trust

Trust Board 29th November 2018
Flu Vaccine Update

1. Activity data

The ambition of NHS England in the flu letter dated September 7th 2018 is that 100% of all healthcare workers with direct patient contact to be vaccinated. There are always staff who will not have their vaccine due to personal (including medical) reasons which means that 100% would not be achievable.

The uptake of vaccine at NGH has increased significantly over the past 10 years, but seems to have plateaued in the last two years.



As at the end of October 2018 the vaccination rate stood at 61.6%.

2. Flu campaign

The Occupational Health team at NGH have led a robust programme of vaccination opportunities which has increased the uptake to its highest level in 2017/18 of 80.4%.

The campaign now runs from October to March due to data statistics being provided to the national data set IMMFORM for up to six months which CQUIN target figures are extracted from (*1c Improving staff health and wellbeing: Improving the uptake of flu vaccinations for front line staff within Providers*).

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

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
<50%	No payment
50% up to 59.99%	25% payment
60% up to 64.99%	50% payment
65% up to 74.99% uptake	75% payment
75% or above	100% payment

Planning commences in January each year with the ordering of the vaccine. This overlaps with the previous year's campaign giving a year round project. 5500 doses of vaccine have been secured for this year's programme which includes:-

- Clinics in the Cyber café which commenced on October 8th and run for weeks 1 and 2
- Week 3 to12 – daily trolley visits across site visiting wards and departments with Wednesdays each week as a static clinic in the Cyber Café until Christmas
- Visits to induction and training days
- Bespoke visits to areas on request
- Friday evening and Saturday morning trolley rounds (*this year's improvement for this is to have two trolleys visiting simultaneously for better coverage*)
- Early weekday morning trolley rounds
- Individual appointments in Occupational Health at date/time convenient to the employee
- Normalising the vaccination into all new starters work health assessment on employment

3. Data collection

Significant amounts of data are required for a variety of areas this year including:-

- IMMFORM website – updated each month for the final CQUIN total
- Weekly uptake for Public Health England
- Weekly' declined offer of vaccine' and reasons for Public Health England
- Trust uptake figures communicated to wards and areas via communications team.

The data team in IT have built an all-encompassing spreadsheet to enable each data set to be extracted. However it does take a while to get the data inputted – a two week delay is likely.

The other issue that has to be integrated into the data collection is monthly removal of leavers and addition of new starters; thereby the denominator and numerator will fluctuate slightly.
For the 18/19 season the new employment work health assessment questionnaire has been updated to capture the details such as reasons for declining the vaccine, vaccination received elsewhere etc.:

4. Vaccination Declined

The Flu letter details that for staff that decline to have their vaccine in high risk areas:-

'*Medical and nurse director colleagues will need to undertake an appropriate risk assessment and discuss with their staff and trade union representatives how best to respond to situations where clinical staff in designated high risk areas decline vaccination. 'At a minimum these higher-risk departments include haematology, oncology, bone marrow transplant, neonatal intensive care and special care baby units. Additional areas may be identified locally where there are a high proportion of patients who may be vulnerable, and are receiving close one-to-one to clinical care.'*

1. *In these higher-risk areas, staff should confirm to their clinical director / head of nursing / head of therapy whether or not they have been vaccinated.*

2. *This information (1) should be held locally so that trusts can take appropriate steps to maintain the overall safety of the service, including considering changing the deployment of staffing within clinical environments if that is compatible with maintaining the safe operation of the service.*

A communication is being sent out to staff asking them to inform their Clinical Director/Matron if they work in a high risk area (ITU, Stroke, Oncology, Haematology, and Neonatology) and choose to decline the vaccine. The Matron and Clinical Director will then conduct a risk assessment accordingly.

5. Updated Self-Assessment Healthcare worker flu vaccination best practice management checklist – for public assurance via trust boards by December 2018

A	**Committed leadership**	
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	The ambition of 100% is difficult as there will always be staff that genuinely cannot have the vaccine due to health reasons. Nonetheless we will urge staff where it is safe to do so to have the vaccine. Data capture has commence from the following questions for new starters:- 1. Have you had your vaccine elsewhere – so we can add them into our numbers 2. Reason for not wanting it if applicable – so we can add opt outs to our data Further data capture using individual 'declined' forms will be captured in weeks 3 – 12 of the campaign

A	**Committed leadership**	
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers (1).	5500 doses of vaccine have been received into the Trust for the campaign
A3	Board receive an evaluation of the flu programme 2017-18, including data, successes, challenges and lessons learnt (2,6)	Success 17/18 was for 80.4% which was reported to the board via Director of Workforce & Transformation and further details are included in the Occupational Health Annual Report Challenges discussed at CQUIN meetings and IPC
A4	Agree on a board champion for flu campaign (3,6)	As previous years it would be the Director for Infection Prevention and the Director of Workforce & Transformation
A5	Agree how data on uptake and opt-out will be collected and reported	A comprehensive data collection tool has been developed and is in use - that will populate dashboards to all areas and provide data required for IMMFORM (for the CQUIN) and PHE
A6	All board members receive flu vaccination and publicise this (4,6)	Arranged for October 25th. Communications arrange relevant photo opportunities
A7	Flu team formed with representatives from all directorates, staff groups and trade union representatives (3,6)	Not required – Infection Prevention Control meeting sufficient
A8	Flu team to meet regularly from August 2018 (4)	See above
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and myth busting to be published – sponsored by senior clinical leaders and trade unions (3,6)	Communications Team developed screensavers on the intranet and promoted via facebook
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper (4)	Yes as per B1 and also packs sent to all clinical areas with hard copies for display
B3	Board and senior managers having their vaccinations to be publicised (4)	As per A6
B4	Flu vaccination programme and access to vaccination on induction programmes (4)	Trolley visits to inductions and has also been offered to all new starters as part of their health assessment/vaccination review on commencement
B5	Programme to be publicised on screensavers, posters and social media (3, 5,6)	As per B1
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups (3,6)	Data will be provided once the data collection tool is finalised and data entry has commenced. Time will need to be given to enter the data so it is expected that there will be a two week delay will be standard until the clinics settle
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered (3,6)	Not possible to deliver C1 as this was only detailed in this letter dated 7th September and all peer vaccinators would need to attend an immunisation and vaccination training course.

C	**Flexible accessibility**	
C2	Schedule for easy access drop in clinics agreed (3)	Already planned and communicated
C3	Schedule for 24 hour mobile vaccinations to be agreed (3,6)	24 hour mobile vaccination trolleys not necessary – weekends and evening trolley rounds already planned and communicated
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this (3,6)	Incentives approved and arranged
D2	Success to be celebrated weekly (3,6)	As part of the communications plan as per B1

Northampton General Hospital NHS Trust

Report To	**Trust Board**
Date of Meeting	**28 November 2018**

Title of the Report	**Nurse Recruitment & Retention**
Agenda item	**11.2**
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 update on progress against the Nurse Recruitment Strategy.
Executive summary This report sets out progress to date against Nurse Recruitment Strategy and Nurse Retention.	
Related strategic aim and corporate objective	Focus on Quality and Safety and enable excellence through our people.
Risk and assurance	Failure to recruit and retain sufficient nurses will create safety risks and risks to our ability to continue to provide services to patients.
Related Board Assurance Framework entries	BAF 3.1 / 3.3
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
Legal implications / regulatory requirements	All recruitment would be undertaken in accordance with statutory and regulatory requirements.

Actions required by the Committee

The Committee is asked to note the report

Northampton General Hospital NHS Trust

Trust Board

Nurse Recruitment & Retention

1. Introduction

This report sets out progress made between May & October 2018.

2. Recruitment Progress Report

2.1 Overseas Nurse Recruitment Progress May and October 2018

Key areas to note:

- As at October 2018 there are 55 IELTS cleared Indian Nurses awaiting NMC decision letter. Between May and October 2018 a total of 43 offers were made to overseas nurses.
- 24 overseas recruits arrived from India in total between May and October 2018.

Overseas recruitment: July and September 2018			**In progress**
Number of posts offered	Number of posts accepted	Number of nurses commenced	Number of offers made & accepted awaiting commencement
43	43	24	55

2.2 Local & National Recruitment Progress May and October 2018

Key areas to note:

- Between May and October 2018 a total of 40.52 WTE nurses started work in core and specialist areas with the Trust through recruitment via NHS Jobs.
- Between May and October 2018 a total of 14.80 students started work within core and specialist areas with the Trust.
- Between May and October 2018 nursing capacity was increased by 3.09 WTE as a result of existing nurses increasing their hours.

2.3 Overall Nurse Recruitment Progress between May and October 2018 (Including overseas recruits)

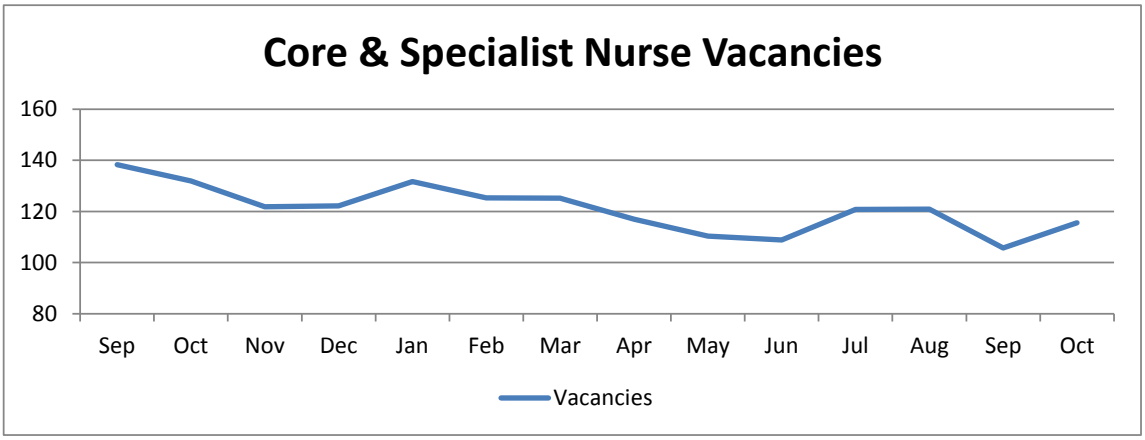
Key areas to note:

- Between May and October 2018 overall nursing capacity increased through new recruits and increases in hours by 82.41 WTE.
- Between May and October 2018 nursing capacity decreased through leavers, decreases in hours by 67.64 WTE.
- Between May and October 2018 core and specialist nursing budgeted establishment was increased by 13.37 WTE.
- Between May and October 2018 nursing capacity therefore saw a net increase of 1.4 WTE.

This has therefore resulted in an overall vacancy factor broken down as follows:

CORE AREAS	**74.81**
SPECIALIST AREAS	**40.58**
TOTAL	**115.39**

A nursing vacancy summary for core and specialist areas over the last 12 months can be seen below. Increases in budgeted establishment have been made in each of the months from July 2018 to October 2018, with the highest increase of 16.84WTE occurring in October 2018.



3. Nurse Recruitment Initiatives

3.1 Recruitment Fairs

A recruitment open day took place for nursing on May 19th, resulting in 8 hires. A further open day took place on October 6th, which resulted in 3 Nurses being appointed on the day and a further 5 interviews scheduled over the following two weeks, of which 3 were appointed taking the total to recruits to 6. Theatres also held a recruitment open day on the 20th October resulting in 1 hire. ITU continue to be active with open days holding one of the 17th October and appointing 1 person.

There is another theatre open day planned for 15th December and the next trust wide open day scheduled for later in January 2019.

3.2 Social Media Update

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

- **LinkedIn :** Between May and October 2018 total followers have risen from 2425 to 2684. The engagement rate on LinkedIn seems to be increasing. Our post for our therapies open day organically reached almost 2.5k with 93 clicks, which means a click through rate of 3.85% which is impressive (a global average would be 0.60%).

- **Twitter:** Between May and October 2018 the total number of followers rose from 251 to 302.

- **Instagram:** Between May and October 2018 followers have increased from 188 to 238.

3.3 Best of Both Worlds Initiative

The Best of Both Worlds initiative has now received further funding (£50k).

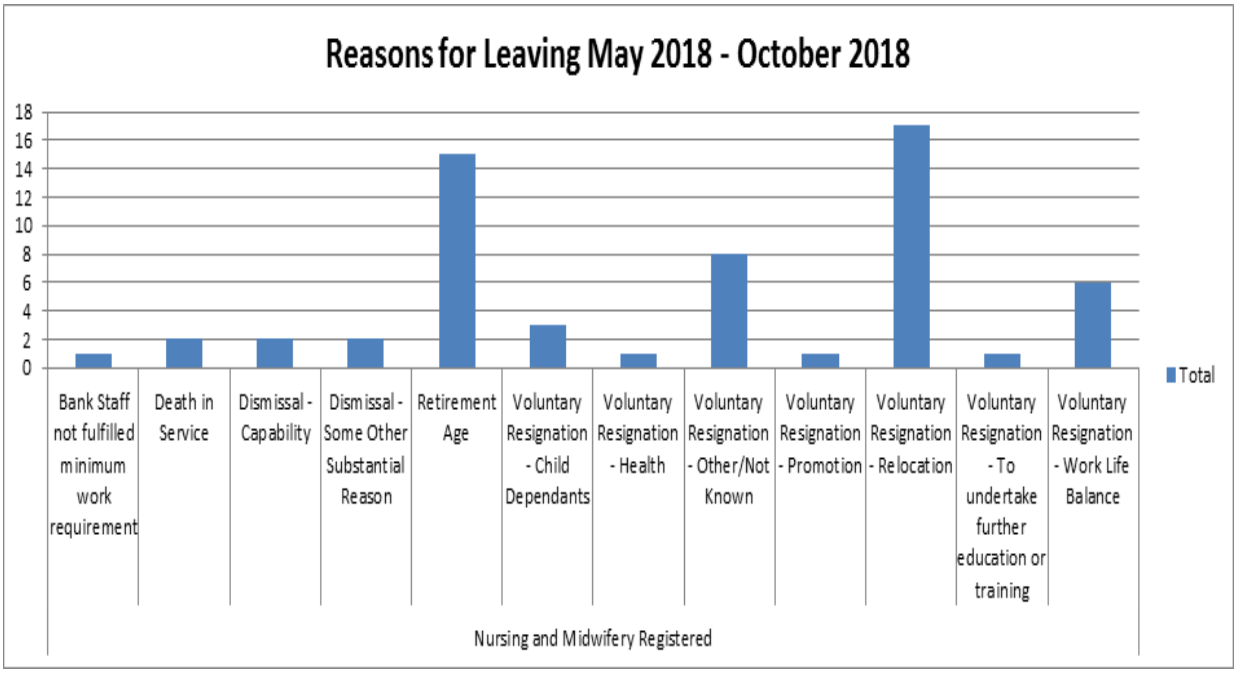
Through BoBW, so far NGH social media has reached 29,200 people with 158 registrations of interest in the open day that took place on 6th October. In addition the following articles have been published in order to promote the Trusts Nurse recruitment strategy:

- http://wellbeingnews.co.uk/wellbeing-and-nursing-recruitment/northampton-general-hospital-will-showcase-career-and-training-opportunities-for-nurses-at-recruitment-day/)
- https://www.recruiter.co.uk/news/2018/10/northampton-general-hospital-holds-open-day-nurses
- http://employernews.co.uk/hr-news/northampton-general-hospital-will-showcase-career-and-training-opportunities-for-nurses-at-recruitment-day

4. Nurse Retention

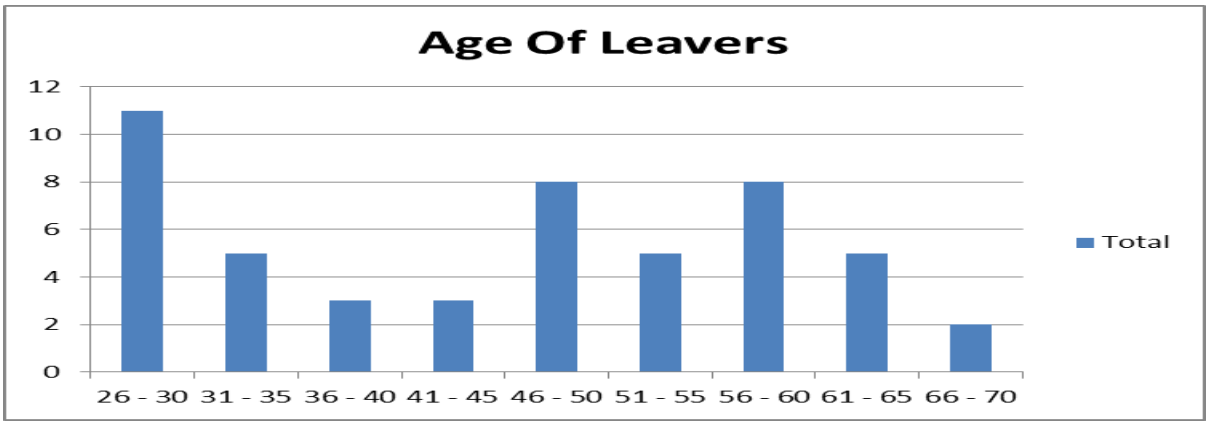
Between May and October 2018 there have been 67.64 nurse leavers from core & specialist areas.

Reasons for leaving over 6 months



In order to retain retirees, analysis is underway to establish if the nurses retiring are coming back to the trust and discussion is underway to promote 'Legacy Nurses' with the aim of developing roles for nurses who have reached retirement age that will enable the retention of their invaluable skills and experience.

Age of Leavers during the last 6 months.



From the 11 nurses ranging from 26-30 age band, 6 are due to relocation, and the remaining reasons range from work life balance, child dependants, and to pursue training opportunities elsewhere.

From the key strategic retention themes which are currently being worked on, the following progress has been made:

Understanding & triangulating our data

- A 'Retention Inbox' (retention@ngh.nhs.uk) has been created during the last quarter and has been promoted to ensure that managers are notifying the HR Retention Specialist earlier to trigger a Stay Discussion to take place.
- Electronic Exit Questionnaire is now operational and Exit Questionnaires will now be automatically sent to leavers during October 2018.

Induction & support

- A new Joiners questionnaire will be automatically and electronically sent out 4 weeks after start date. The first batch of questionnaires will be sent out end of October 2018 followed by an On Boarding questionnaire 8 weeks after start date.

Career Navigation

- The Clinical Development Framework Nurses was launched in August 2018 by the Practice Development Team which will be supported and promoted by the HR Retention Specialist.
- In conjunction with this, Career Development Clinics with the HR Retention Specialist have been advertised through the staff bulletin and 5 Nurses have been in touch to seek assistance with career development at NGH since it was launched and feedback has been positive.

Recognition

- In conjunction with the Communications Department the Long Service Awards process is being reviewed and feedback sought in order to ensure that our longest serving nurses are recognised for their dedication to NGH and that they feel valued.

5. Assessment of Risk

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

6. Recommendations

The Committee is asked to note the report.

7. Next Steps

Actions will continue to be taken in line with the action plan.

	Registered Nurse Recruitment Live Forecast												
Baseline Actual Vacancies (Previous Month Actual Total)	146.85	146.87	146.89	146.91	146.94	148.66	137.63	132.55	116.04	104.40	92.52	89.14	
Actual Vacancies	125.21	116.90	110.34	108.86	120.79	120.92	105.66	115.50	0.00	0.00	0.00	0.00	
	21.64												

	2018									2019			Total
Supply	**Apr**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
Direct International	1.00	1.00	1.00		1.00		2.00		1.00		2.00		**9.00**
Direct Conferences - Fairs						2.00		2.00		2.00			**6.00**
Direct Social Media				2.00	3.00	3.00	5.00	5.00	3.00	3.00	5.00	5.00	**34.00**
Direct NHS Jobs	8.21	8.21	8.21	8.21	8.21	8.21	8.21	8.21	8.21	8.21	8.21	8.21	**98.52**
Direct Student Nurses	3.00	3.00	3.00	0.00	0.00		2.00	14.45	12.72	5.00	1.00	1.61	**45.78**
Direct Employee Referral				1.00	1.00	2.00	1.00	1.00	1.00	2.00			**9.00**
Direct NGH Recruitment Fairs						9.00				8.00		10.00	**27.00**
Agency International	3.00	3.00	3.00	3.00		3.00	3.00	3.00	3.00		3.00	3.00	**30.00**
Agency Domestic	2.00	2.00	2.00	3.00	2.00	3.00	2.00	3.00	2.00	3.00	2.00	3.00	**29.00**
Increase in Hours													**0.00**
Total Supply	**17.21**	**17.21**	**17.21**	**17.21**	**15.21**	**30.21**	**23.21**	**36.66**	**30.93**	**31.21**	**21.21**	**30.82**	**288.30**

Deduction for attrition (15%)	-2.58	-2.58	-2.58	-2.58	-2.28	-4.53	-3.48	-5.50	-4.64	-4.68	-3.18	-4.62	-43.25

Revised Supply	**14.63**	**14.63**	**14.63**	**14.63**	**12.93**	**25.68**	**19.73**	**31.16**	**26.29**	**26.53**	**18.03**	**26.20**	**245.06**

Demand Increase	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
Leavers	12.75	12.75	12.75	12.75	12.75	12.75	12.75	12.75	12.75	12.75	12.75	12.75	153.00
Retirees	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	6.00
Decrease in Hours	1.40	1.40	1.40	1.40	1.40	1.40	1.40	1.40	1.40	1.40	1.40	1.40	16.80
Shift Harmonisation													-
Uplift													-
Demand Increase Total	**14.65**	**14.65**	**14.65**	**14.65**	**14.65**	**14.65**	**14.65**	**14.65**	**14.65**	**14.65**	**14.65**	**14.65**	**175.80**

Registered Nurse Actual Recruitment

Actual Vacancies	125.21	116.90	110.34	108.86	120.79	120.92	105.66	115.5	0	0	0	0	
	2018												Total
Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Supply													0.00
Direct International													0.00
Direct Conferences - Fairs													0.00
Direct Social Media													0.00
Direct NHS Jobs	10.67	3.00	3.22	3.00	9.64	6.43	15.23						51.19
Direct Student Nurses	8.80					14.80							23.60
Direct Employee Referral													0.00
Direct NGH Recruitment Fairs													0.00
Agency International	1.00	2.00	2.00	7.00	0.00	6.00	7.00						25.00
Agency Domestic													0.00
Increase in Hours	0.06	0.49	0.28	0.33	0.77	0.87	0.35						3.15
50	20.53	5.49	5.50	10.33	10.41	28.10	22.58	0.00	0.00	0.00	0.00	0.00	102.94

Demand Increase	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Leavers	7.00	7.89	4.56	15.07	7.65	10.63	12.65						65.45
Retirees	0.53	0.00	1.00	0.53	0.00	0.00	0.92						2.98
Decrease in Hours	1.69	0.36	1.27	0.36	0.89	1.85	2.01						8.43
Shift Harmonisation													0.00
Uplift	3.00	-9.32	-2.81	6.30	2.00	0.36	16.84						16.37
Demand Increase Total	12.22	-1.07	4.02	22.26	10.54	12.84	32.42	0.00	0.00	0.00	0.00	0.00	93.23

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Actual Vacancies	**116.90**	**110.34**	**108.86**	**120.79**	**120.92**	**105.66**	**115.50**	**-**	**-**	**-**	**-**	**-**	**798.97**

Deduction for Attrition	**(2.00)**	**-**	**1.00**	**-**	**-**	**0.51**	**-**						**(0.49)**

Pre-Reg Nurses Awaiting Registrations

Recruitment Source	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
EU Recruitment													0
International		2	6	7	5	4	7						31
Other	1												1

Registered Nurse Recruitment Performance

Year	2018									2019		
Supply	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Direct International												
Direct Conferences - Fairs												
Direct Social Media												
Direct NHS Jobs	2.46	-5.21	-4.99	-5.21	1.43	-1.78	7.02					
Direct Student Nurses	5.80					14.80						
Direct Employee Referral												
Direct NGH Recruitment Fairs												
Agency International	-2.00	-1.00	-1.00	4.00		3.00	4.00					
Agency Domestic												
Increase in Hours	0.06	0.49	0.28	0.33	0.77	0.87	0.35					
Total Supply	**6.32**	**-5.72**	**-5.71**	**-0.88**	**2.20**	**16.89**	**11.37**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Deduction for attrition	**0.58**	**2.58**	**3.58**	**2.58**	**2.28**	**5.04**	**3.48**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Revised Supply	**6.90**	**-3.14**	**-2.13**	**1.70**	**4.48**	**21.93**	**14.85**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

Demand Increase	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Leavers	5.75	4.86	8.19	-2.32	5.10	2.12	0.10					
Retirees	-0.03	0.50	-0.50	-0.03	0.50	0.50	-0.42					
Decrease in Hours	-0.29	1.04	0.13	1.04	0.51	-0.45	-0.61					
Shift Harmonisation												
Uplift	-3.00	9.32	2.81	-6.30	-2.00	-0.36	-16.84					
Demand Increase Total	**2.43**	**15.72**	**10.63**	**-7.61**	**4.11**	**1.81**	**-17.77**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

Actual Vs Forecast*	**8.75**	**10.00**	**4.92**	**-8.49**	**6.31**	**18.70**	**-6.40**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
	33.79											

Year	2018									2019		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Live Forecast	146.85	146.87	146.89	146.91	146.94	148.66	137.63	132.55	116.04	104.40	92.52	89.14
Actual Vacancies	125.21	116.9	110.34	108.86	120.79	120.92	105.66	115.5	0	0	0	0
Vacancy Predictor	142.34	146.87	146.89	146.91	146.94	148.66	137.63	132.55	116.04	104.40	92.52	89.14

Original Forecast - The original forecast is the figures originally agreed for the Nurse Recruitment Pipeline. If we were to succeed in all recruitment methods, these figures show what our vacancies would be each month.

Live Forecast - This takes the current vacancies (from the actual of the previous month) and takes into account any changes made to the forecast to re-calculate the vacancy figure on a monthly basis.

Actual Vacancies - This is the ACTUAL remaining vacancies at the end of each month that we have entered data for.

Vacancy Predictor - The vacancy predictor takes the overall over/under performance figure for all previous months and then adds/subtracts on to the "live forecast" figures to give a trajectory up until March 2016.

Northampton General Hospital NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**29 November 2018**

Title of the Report	**Operational Performance Report**
Agenda item	**12**
Presenter of Report	Mr C Holland (Deputy COO)
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

All exception reports have been discussed at each of the subcommittees of the board (Finance, Investment & Performance, Workforce & Quality governance committees)

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	AUG-18	SEP-18	OCT-18
Quality of Care: Caring	Complaints responded to within agreed timescales	>=90%	98.1%	100.0%	97.3%
	Friends & Family Test % of patients who would recommend: A&E	>=86.6%	87.9%	87.3%	86.4%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	>=95.8%	91.4%	91.9%	92.4%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	>=96.7%	100.0%	100.0%	100.0%
	Friends & Family Test % of patients who would recommend: Outpatients	>=93.9%	93.1%	92.7%	92.3%
	Mixed Sex Accommodation	=0	3	0	0
	Compliments				4,286

	Indicator	Target	AUG-18	SEP-18	OCT-18
Operational Performance	A&E: Proportion of patients spending less than 4 hours in A&E	>=90.1%	91.5%	88.9%	86.7%
	Average Ambulance handover times	=15 mins	00:11	00:14	
	Ambulance handovers that waited over 30 mins and less than 60 mins	<=25	60	118	
	Ambulance handovers that waited over 60 mins	<=10	3	15	
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	=0	16	2	3
	Delayed transfer of care	=23	19	36	10
	Average Monthly DTOCs	<=23	16	34	27
	Average Monthly Health DTOCs	<=7	13	25	25
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	>=93%	70.7%	75.2%	
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	>=93%	31.0%	85.7%	
	Cancer: Percentage of patients treated within 31 days	>=96%	97.5%	94.7%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	>=98%	98.7%	96.7%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	>=94%	97.5%	95.6%	
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	>=94%	100.0%	88.8%	
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	>=85%	80.8%	81.4%	
	Cancer: Percentage of patients treated within 62 days of referral from screening	>=90%	93.7%	100.0%	
	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	>=85%	78.7%	79.0%	
	RTT waiting times incomplete pathways	>=92%	79.9%	80.3%	
	RTT over 52 weeks	=0	0	0	
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	>=99.1%	99.8%		
	Stroke patients spending at least 90% of their time on the stroke unit	>=80%	100.0%	92.7%	94.8%
	Suspected stroke patients given a CT within 1 hour of arrival	>=50%	93.3%	95.0%	97.9%

	Indicator	Target	AUG-18	SEP-18	OCT-18
Quality of Care: Effective	Stranded Patients (ave.) as % of bed base	<=40%	55.0%	57.6%	54.1%
	Super Stranded Patients (ave.) as % of bed base	<=25%	24.6%	26.1%	23.7%
	Length of stay - All	<=4.2	4.2	4.4	4.5
	Emergency re-admissions within 30 days (elective)	<=3.5%	3.2%	3.4%	3.1%
	Emergency re-admissions within 30 days (non-elective)	<=12%	17.0%	16.5%	14.4%
	# NoF - Fit patients operated on within 36 hours	>=80%	82.7%	77.1%	84.6%
	Maternity: C Section Rates	<27.9%	29.8%	28.9%	31.4%
	Mortality: HSMR	100	104	104	106
	Mortality: SHMI	100	98	100	100

	Indicator	Target	AUG-18	SEP-18	OCT-18
Finance and Use of Resources	Income YTD (£000's)	>=0	(2,563) Adv	(2,627) Adv	(3,337) Adv
	Surplus / Deficit YTD (£000's)	>=0	174 Fav	392 Fav	57 Fav
	Pay YTD (£000's)	>=0	(2,744) Adv	(2,967) Adv	(3,221) Adv
	Non Pay YTD (£000's)	>=0	3,388 Fav	3,819 Fav	4,246 Fav
	Bank & Agency / Pay %	<=7.5%	12.4%	12.4%	12.4%
	CIP Performance YTD (£000's)	>=0	1,969 Fav	1,833 Fav	1,704 Fav
	Salary Overpayments - Number YTD	=0	107	112	137
	Salary Overpayments - Value YTD (£000's)	=0	228.7	233.8	285.7
	Maverick Transactions	=0	27		
	Waivers which have breached	=0	0		

	Indicator	Target	AUG-18	SEP-18	OCT-18
Quality of Care: Safe	Never event incidence	=0	0	0	1
	Number of Serious Incidents (SI's) declared during the period		2	3	0
	MRSA	=0	0	0	0
	C-Diff	<=1.75	1	2	0
	MSSA	<=1.1	0	0	2
	VTE Risk Assessment	>=95%	91.3%	93.1%	93.1%
	Harm Free Care (Safety Thermometer)	>=94%	91.8%	93.2%	94.2%
	Number of falls (All harm levels) per 1000 bed days	<=5.5	5.5	4.8	5.0
	Transfers: Patients transferred out of hours (between 10pm and 7am)	<=60	45	47	66
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	>=98%	97.7%	95.7%	96.9%
	Ward Moves > 2 as a % of all Ward Moves	=0%	6.6%	6.1%	5.8%

	Indicator	Target	AUG-18	SEP-18	OCT-18
Leadership & Improvement Capability	Job plans progressed to stage 2 sign-off	>=90%	60.0%	12.5%	15.1%
	Sickness Rate	<=3.8%	4.5%	4.2%	4.0%
	Staff: Trust level vacancy rate - All	<=9%	11.8%	11.1%	10.4%
	Staff: Trust level vacancy rate - Medical Staff	<=9%	9.4%	9.4%	8.8%
	Staff: Trust level vacancy rate - Registered Nursing Staff	<=9%	8.2%	7.4%	7.3%
	Staff: Trust level vacancy rate - Other Staff	<=9%	14.0%	13.7%	12.8%
	Turnover Rate	<=10%	7.8%	7.8%	7.7%
	Percentage of all trust staff with mandatory training compliance	>=85%	88.7%	88.6%	87.8%
	Percentage of all trust staff with role specific training compliance	>=85%	83.8%	82.1%	81.9%
	Percentage of staff with annual appraisal	>=85%	85.0%	84.5%	83.1%

Run Date: 14/11/2018 16:49 Corporate Scorecard Run by: CrockettG

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:
Friends & Family Test	Externally mandated	Quality Governance Committee	October 2018

Performance:

Friends & Family Test % of patients who would recommend: A&E	>=87.6%	87.5%	86.7%	89.7%	85.0%	84.2%	87.2%	86.3%	88.6%	88.3%	87.9%	87.3%	86.4%
Friends & Family Test % of patients who would recommend: Inpatient/Daycase	>=95.7%	93.5%	92.1%	93.2%	93.4%	93.2%	92.1%	93.7%	91.9%	92.5%	91.4%	91.9%	92.4%
Friends & Family Test % of patients who would recommend: Outpatients	>=93.8%	93.2%	93.5%	94.1%	93.7%	93.8%	93.9%	97.8%	92.4%	92.7%	93.1%	92.7%	92.3%

Driver for underperformance:

- The result for Inpatient & Day Case continues to be stable with only small movements each month. The Inpatient & Day Case result is 3.3 % below the national average when comparing October with the most recent national data available.
- The result for Outpatients is 1.5% below the national average when comparing October with the most recent national data available.
- The results for A&E are 1.2% below the national average for the first time in 4 months when comparing October with the most recent national data available.

Actions to address the underperformance:

- The Right Time mini survey and Real-Time surveys are continuing which enable the wards to identify specific areas where further improvements need to be made.

Lead Clinician:	Lead Manager:	Lead Director:
N/A	Emma Wimpress	Sheran Oke

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
MSSA	Internally set	Quality Governance committee	October 2018

Performance:

Indicator:	Target:	NOV-17	DEC-17	JAN-18	FEB-18	MAR-18	APR-18	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18
MSSA	<=1.1	1	1	0	0	0	2	1	0	2	0	0	2
MSSA (Value 1)		1	1	0	0	0	2	1	0	2	0	0	2

Driver for underperformance:	Actions to address the underperformance:
• Two patients have developed an MSSA bacteraemia whilst under our care in August 2018; these were on Willow and Knightley wards • The driver for underperformance is an internally set trajectory for Meticillin Sensitive Staphylococcus aureus (MSSA) of no more than 13 patients develop MSSA for 2018/2019	• Octenilin wound irrigation has now been implemented across the Trust • Post infection reviews have been undertaken for 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

Lead Clinician:	Lead Manager:	Lead Director:
Dr Minassian	Wendy Foster	Sheran Oke

Scorecard - Exception Report

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

Performance:

Indicator:	Target:	NOV-17	DEC-17	JAN-18	FEB-18	MAR-18	APR-18	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18
Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	>=93%	85.9%	93.2%	92.7%	94.5%	89.4%	77.6%	90.8%	69.9%	72.1%	70.7%	75.2%
Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	>=93%	79.1%	96.0%	94.2%	95.3%	80.9%	72.8%	78.1%	23.3%	18.0%	31.0%	85.7%
Cancer: Percentage of patients treated within 31 days	>=96%	96.5%	97.9%	97.6%	97.9%	96.9%	98.7%	97.4%	92.6%	95.4%	97.5%	94.7%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	>=98%	98.7%	98.4%	97.1%	100.0%	88.7%	100.0%	97.1%	100.0%	100.0%	98.7%	96.7%
Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	>=94%	100.0%	100.0%	91.6%	94.7%	85.7%	90.0%	90.0%	78.5%	100.0%	100.0%	88.8%
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	>=85%	90.1%	86.0%	86.2%	77.2%	91.5%	81.1%	81.3%	74.6%	78.2%	80.8%	81.4%
Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	>=85%	100.0%	92.3%	79.1%	78.5%	100.0%	97.7%	87.5%	90.0%	81.2%	78.7%	79.0%

Driver for underperformance:

- Please not any slight variation in figures contained within narrative and as above are due to rounding up/down.
- 2 of the 9 Cancer Waiting Times Standards have been met by the Trust for September 2018.
- The Trust's 62 day performance reached 81.5% against a standard of 85%, above the trajectory of 80% submitted to NHSi, with IPT applied the Trust would show a performance of 82.4%.
- The Trust undertook 102.5 treatments, a 21% increase on the average numbers treated in the past 12 months with a total of 19 breaches, only 3 sites reached the standard, breast, Haematology and skin, with the Lung site just under reaching 84.2%.
- The Trust has not met the 2ww standard for September, reaching 75.2% against a standard of 93%. This was due to skin only reaching 32.3% against the standard, but on a positive note they have shown an 85% increase on August performance.

Actions to address the underperformance:

- With the additional capacity sourced by breast and dermatology the Trust has seen a marked improvement on the 2ww standard from October onwards but patient choice still needs attention across all pathways but particularly in colorectal
- Straight to Test colorectal pathway being scoped, workforce engaged with changes, protocols, capacity and demand, staffing etc all under review, crosses two divisions, medicine and surgery working together
- Job description and advert written for Project Manager role working countywide to deliver RAPID and NOLCP- signed off internally pending banding, out to advert
- Internal Lung meeting Monday held 22/10 in order to identify members of 4 task and finish groups, administration, radiology, pathology and data and review pathway against KGH's
- ADT now live in 2ww office providing direct link from PAS system to Somerset, reducing workload considerably and any associated data input risks. Discussions underway with tertiary providers to implement E-Tertiary referral.
- Breach panel re-convened 23/10/18
- Weekly performance pack automated with support from Information team

• The 2ww breast symptomatic standard has not been met for September reaching 85.7% against a standard of 93%, additional capacity sourced by the breast service has shown a 180% increase on August performance. • The Trust has not met the 31 day first treatment standard reaching 94.7% against the 96% standard, of the 9 breaches 5 were beyond the control of NGH due to patient fitness or patient initiated delays. • The Trust has not met 2 of the 3 subsequent treatment standards. Reaching 96.8 % for drug against the 98% standard, however 28% less drug treatments happened in the month of September compared to August with both breaches due to patient fitness. • Subsequent surgery has reached 88.9% against a standard of 94%, failing by two patients in a small cohort of patients. • The Trust has not met the 62 day consultant upgrade standard, reaching 79.1% against the local standard of 85%. 3 of the 5 breaches were beyond the control of NGH. . • Patients waiting in excess of 62 days on their pathway are 50 as of 02/11/18 • 5 tumour sites have no legacy patients. Urology and Coloreactal have worked very hard to reduce their numbers, but skin, lung and head and neck have seen a steep increase in these patients. • Of the 50 patients, 6 are no cancer and require evidence to close off their pathway, 16 have their treatment planned, 1 is not accepted by NGH as yet from a tertiary provider and 1 is treated awaiting histology, this leaves a balance of 26 patients whch are being reviewed daily in order to expedite their pathways.	and dashboard under development • Data being captured on Somerset to support improvement plans for pathways achieving 28 faster diagnosis standard • Meetings every other month with MDT leads and DM's to be scheduled • Continued daily focus on patients on their pathway in excess of 62 days (legacy)

Scorecard - Exception Report

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

Performance:

Indicator:	Target:	NOV-17	DEC-17	JAN-18	FEB-18	MAR-18	APR-18	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18
Sickness Rate	<=3.8%	4.2%	4.7%	4.8%	4.6%	3.8%	3.7%	3.9%	4.4%	4.6%	4.5%	4.2%	4.0%
Sickness Rate (Value 1)		6094	7115	7284	6298	5807	5409	5814	6363	6961	6787	6193	6049
Sickness Rate (Value 2)		142487	148263	148734	134312	149379	143839	148405	144006	148236	149356	144646	150401

Driver for underperformance:	Actions to address the underperformance:
• There is an overall trend that staff are less resilient due to pressures in the system. • There are high levels of sickness absence related to stress and anxiety • There are a high number of bullying and harassment cases across all divisions	Resilience training continues through the OD team and there is a good uptake on the workshops The HR Corporate Officer together with the Locum Centre Manager have re-categorised some of the reasons for sickness absence so in the future it will be easier to identify work related stress as against personal stress Managers are being advised to continue to support staff through their 121 management meetings The Respect and Support Each Other campaign is gaining momentum with training for managers and staff. Training is progressing for the HR staff in the delivery of the Report to Support telephone line

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Andrea Chown	Janine Brennan.

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	October 2018

Performance and Trajectory:

Indicator:	Target:	NOV-17	DEC-17	JAN-18	FEB-18	MAR-18	APR-18	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18
Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	=0	1	12	17	9	34	11	13	7	6	16	2	3

Driver for underperformance:	Actions to address the underperformance:
• The 3 patients are as follows: 1. The surgeon was new and unable to undertake this type of surgery. 2. The team was unable to contact the patient within the time frame. 3. Administration error due to a new member of staff	1. A comprehensive list of procedure the locum is able to undertake is now available to the booking staff. 2. The booking staff have been reminded that they must offer a new date to the patient within 7 days of the cancellation and if this cannot be achieved this should be escalated to the DM. 3. Further training has been initiated for the new member of staff.

Lead Clinician:	Lead Manager:	Lead Director:
Mike Wilkinson	Fay Gordon	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	October 2018

Performance:

Indicator:	Target:	NOV-17	DEC-17	JAN-18	FEB-18	MAR-18	APR-18	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18
Percentage of all trust staff with role specific training compliance	>=85%	**84.8%**	**84.2%**	**83.9%**	**84.0%**	**84.2%**	**84.6%**	**84.8%**	**84.9%**	**85.1%**	**83.8%**	**82.1%**	**81.9%**
Percentage of all trust staff with role specific training compliance (Value 1)		848	20824	20881	20903	20921	21066	21085	21299	21169	21001	21213	21135
Percentage of all trust staff with role specific training compliance (Value 2)		1000	24707	24859	24857	24831	24898	24863	25058	24861	25056	25831	25779

Driver for under performance:	Actions to address the underperformance:
• 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	• Due to the number of positions being created each month, work continues on looking at a process which makes aligning Role Specific subjects to new positions more efficient and timely. • Promotion on the importance of RSET is included in the appraisal training and the HRBPs are highlighting this to areas with a low % of compliance • Further work has taken place with regards to Safeguarding Children level 2 and 3. These have been amended. Further positions have been identified as not requiring level 3 and this work is currently being undertaken.

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Staff Annual Appraisal Rate	Internally set	Workforce Committee	October 2018

Performance:

Percentage of staff with annual appraisal	>=85%	**84.3%**	**86.0%**	**85.0%**	**86.1%**	**85.1%**	**85.3%**	**86.7%**	**86.7%**	**85.9%**	**85.0%**	**84.5%**	**83.1%**
Percentage of staff with annual appraisal (Value 1)		3764	3818	3798	3785	3812	3825	3888	3866	3844	3789	3697	3728
Percentage of staff with annual appraisal (Value 2)		4464	4438	4468	4396	4477	4479	4481	4455	4471	4455	4370	4484

Driver for underperformance:	Actions to address the underperformance:
• Some areas have waited until the cut-off to notify L&D of the appraisal, even though it may have occurred two months earlier. • Appraisal information is being received after the submission deadline.	• Those areas with the greatest drop in % of compliance have been identified and has been escalated to be raised with the appropriate managers and HRBPs • Training for managers continues which covers the process of submission of data. 1:1's are also being conducted with managers.

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Adam Cragg	Janine Brennan

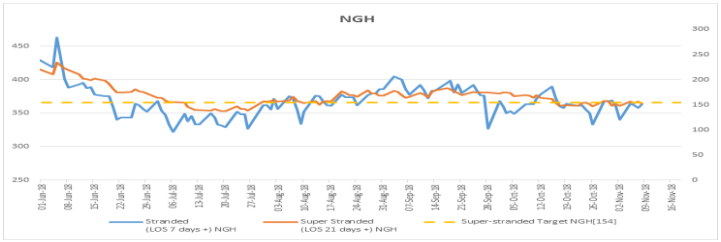
Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Stranded Patients (ave.) as % of bed base	Internally set	Finance, Investment and Performance Committee	October 2018

Performance:

Indicator:	Target:	NOV-17	DEC-17	JAN-18	FEB-18	MAR-18	APR-18	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18
Stranded Patients (ave.) as % of bed base	<=40%						**60.2%**	**62.3%**	**56.5%**	**51.1%**	**55.0%**	**57.6%**	**54.1%**
Stranded Patients (ave.) as % of bed base (Value 1)							406	420	374	338	364	381	358
Stranded Patients (ave.) as % of bed base (Value 2)							674	674	661	661	661	661	661

Driver for underperformance:



- Target set by NHSI of 154 patients >21days LOS (<25% of bedbase) from a baseline of 220 – Target Achieved on October 146 patients
- Internal stretched target set for <40% >7days LOS
- Understanding that the numbers are volatile and without focus can rise
- An increase in acuity as seen in recent weeks (via Vitalpac) has a marked impact on discharge and LOS
- On-going community care capacity with partners; increasing numbers waiting for Rehab 'squeezing the bulge downstream'
- Increased admissions from Urgent care (as we have empty beds are we more inclined to fill them!)
- How do we get away from senior managers overseeing the process whilst keeping momentum?
- The success so far has started to expose the other challenges, we need to be able to flex and move into fixing these as well to maintain momentum

Actions to address the underperformance:

- Weekly senior review with every ward of every patient with a LOS>7 days being carried out
- Discharge element of 'Fixing the Flow'(Trust wide Urgent Care Improvement project) initiative being lead by Nursing Director
- 3 times a week tracking meeting face to face with external Partners
- Exec and Clinical lead top delays meeting to review the longest staying patients in the Trust in place weekly
- Robust use of Choice Policy
- Countywide review of Intermediate care underway (12 month project minimum)
- 'SAFER in 100 days' initiative spreading across the Ward base and fully embedded by Trust QI team
- MADE events carried out in Community units to free up capacity
- Additional Care home beds to come on line during November, 20 beds at Southfields, 20 high level res beds, 6 D&D beds
- SPA process changed so that Integrated Discharge Teams on wards now make the pathway decision of where the patient goes

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

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	October 2018

Performance:

Length of stay - All	<=4.2	4.8	4.9	5.2	5.0	5.3	5.2	4.7	4.4	4.2	4.2	4.4	4.5
Length of stay - All (Value 1)		20513	20587	21761	14413	14085	20624	18214	14392	20695	12765	12029	15678
Length of stay - All (Value 2)		4270	4149	4148	2880	2614	3961	3800	3248	4847	3023	2725	3416

Driver for underperformance:

- REDUCTION OF Av LOS BY 1.0 Day in 4 MONTHS but has crept up by 0.3 days in last two months
- SPA processes continue to slow discharges and ward processes due to assessment times and brokerage
- 18 patients waiting for community rehab units with long waits due to poor flow out of these units esp Stroke
- PDNA referrals started too late in patients journey resulting in delays once medically fit
- PDNA's not updated in a timely fashion when there is a change in the patients situation
- 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
- Overreliance on patients waiting for inpatient investigations and 'green card' referrals that could be done as outpatients

Actions to address the underperformance:

- Weekly review with every ward of every patient with a LOS>7 days being carried out. This has reduced superstranded by >30% in 3 months (220 patients down to 150)
- Discharge element of 'Fixing the Flow' initiative being led by Nursing Director
- 3 times a week tracking meeting face to face with Partners
- Exec led top delays meeting to review the longest staying patients in the trust in place weekly
- SPA process replaced with Integrated Discharge Teams (IDTs) who will agree patients pathway
- Robust use of the Choice Policy
- County wide review of Intermediate care underway (12 month project minimum)
- 'SAFER in 100 days' initiative spreading across the ward base
- 'PDNA to day Zero' PDNA submitted as soon as ward realise patient needs a supported discharge NOT when fit for discharge
- Discharge expectation letter to be produced for all patients on arrival
- Additional community capacity on line from October (20 beds at Southfields) and further 20 beds being sourced for high level residential to be in place end of November, 6 D&D beds at Angela Grace end of November
- MADE event completed on Community units to try and unblock

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

Scorecard - Exception Report

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

Performance:

Indicator:	Target:	NOV-17	DEC-17	JAN-18	FEB-18	MAR-18	APR-18	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18
Average Monthly DTOCs	<=23	26	38	32	38	42	30	42	40	28	16	34	27
Average Monthly Health DTOCs	<=7	9	14	10	13	16	13	37	31	19	13	25	25

Driver for underperformance:

- Lack of social workers in Trust
- Discharge to Assess (DTA) pathway not yet established
- Long waiting times for medical rehabilitation beds/SCC beds and ability to take high level dependency patients
- Delays with patients awaiting brokerage for placement
- Delays in Wards providing accurate patient reflective PDNA's to SPA,
- Inaccurate information on Tracker from SPA
- Lack of medical plans to support discharge
- Some procedures being conducted as inpatients that could be offered as out patient
- Delays in completing TTO's and EDN's
- High Stranded patients
- Wards not fully engaging with Stranded reviews
- No discharge pathway for delirium/dementia patients
- Long delays awaiting provision for high levels of care,
- Family/patient expectation
- Some Wards have a lack of patients knowledge

Actions to address the underperformance:

- NASS currently recruiting to support IDT (Integrated Discharge Team)
- New SCC gatekeeper to work in Trust to support discharges to SCC beds, using one referral,
- IDT in place to support discharge decision from Wards,
- Tracking meetings to challenge and escalate discharges and delays, also to agree DTOC numbers
- Discharge Coordinators to provide support for all medical wards while supporting one surgical ward,
- Reviewing weekly Stranded patient meetings, incorporating action plans, supported by Senior Nursing, Social Services and Therapies
- Secondment post to be advertised to support patients for Avery beds
- Further meeting to review Re-hab, potentially Ward to Ward handover,
- New Intermediate Care model currently being rolled out to community to help prevent hospital admission
- New delirium beds now available to support this cohort of patients,
- CHS to support delirium beds
- New Expectation Leaflet to be laminated for every patients locker
- Increased provision of community care and bedded solutions, Clearing the Backlog

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Maternity C-Section Rates	Externally mandated – benchmarked against 2015/16 national statistics	Quality Governance Committee.	October 2018

Performance:

Indicator:	Target:	NOV-17	DEC-17	JAN-18	FEB-18	MAR-18	APR-18	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18
Maternity: C Section Rates	<27.9%	**27.9%**	**28.6%**	**29.5%**	**27.9%**	**30.9%**	**28.4%**	**31.3%**	**34.1%**	**28.9%**	**29.8%**	**28.9%**	**31.4%**
Maternity: C Section Rates (Value 1)		115	112	124	90	122	110	127	126	122	124	114	118
Maternity: C Section Rates (Value 2)		412	391	420	322	394	387	405	369	421	415	394	375

Driver for underperformance:

- Month to month variation in both the emergency and elective caesarean rates influences the overall caesarean section rate
- Quarterly total CS rate for Q2 = 29.2% (Q1 31.3%)
- This month slight decrease in elective caesarean section rate to below national average. Emergency caesarean section rate remains above the national average

Actions to address the underperformance:

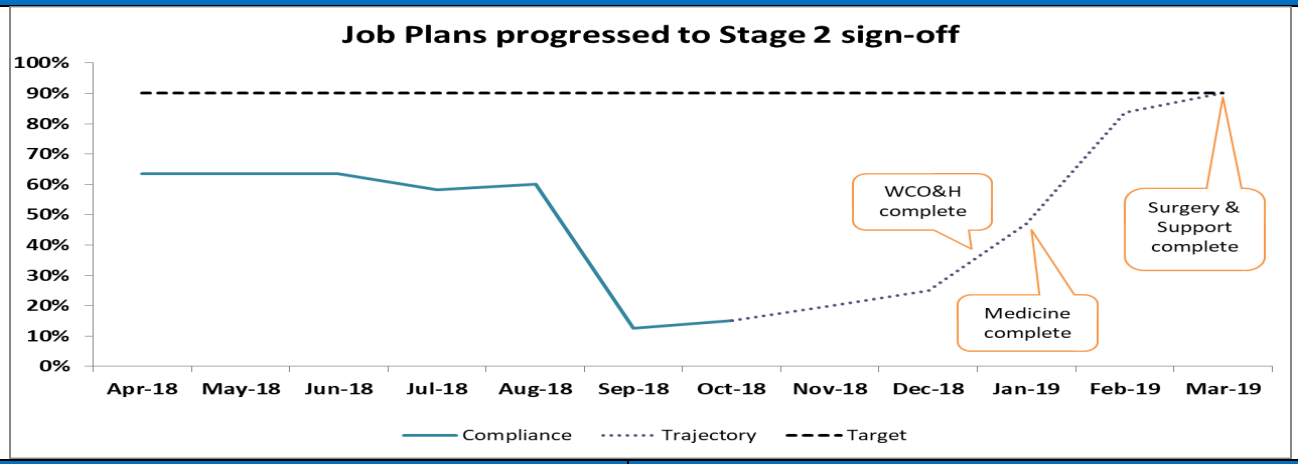
- Request to report Caesarean section rates quarterly rather than monthly due to the month to month variation
- Continue monitoring – discussed at Governance meeting, Consultant meeting and Midwifery Leads meeting
- Ongoing Emergency Caesarean Section reviews to ensure appropriateness of decision making
- Continue with debriefs following all Caesarean Sections – this is now documented on Medway as part of the CS documentation.
- Birth After Caesarean Clinic – ongoing

Lead Clinician:	Lead Manager:	Lead Director:
Mrs Sue Lloyd	Sandra Neale	Dr M Metcalfe

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.	October 2018

Performance:



Driver for underperformance:	Actions to address the underperformance:
• Data rebased in September to reflect compliance in all divisions to date. • Delays within Medicine Division has negatively impacted on other Divisions • Medicine Job Planning paused as agreed at fixing the flow meeting until Quarter 4	• Regular Executive Consistency Committee (ECC) meetings taking place with the Divisions for updates and challenge on progress • Good progress being made with WCO&H and anticipate completion December/January • Process started with Surgery Division and first ECC meeting held. Good engagement, no issues anticipated with completion by the end of the financial year.

Lead Clinician:	Lead Manager:	Lead Director:
Dr Win Zaw	Elizabeth Smillie	Mr Matthew Metcalfe

Scorecard - Exception Report

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

Performance:

Indicator:	Target:	NOV-17	DEC-17	JAN-18	FEB-18	MAR-18	APR-18	MAY-18	JUN-18	JUL-18	AUG-18	SEP-18	OCT-18
Staff: Trust level vacancy rate - All	<=9%	**10.8%**	**11.3%**	**10.1%**	**10.6%**	**10.8%**	**12.1%**	**11.8%**	**12.6%**	**13.2%**	**11.8%**	**11.1%**	**10.4%**
Staff: Trust level vacancy rate - All (Value 1)		533	556	494	529	533	609	592	637	672	592	553	521
Staff: Trust level vacancy rate - All (Value 2)		4901	4903	4890	4942	4939	5018	4994	5035	5057	4998	4978	5010
Staff: Trust level vacancy rate - Other Staff	<=9%	**12.2%**	**12.7%**	**11.6%**	**11.5%**	**11.5%**	**13.2%**	**12.7%**	**13.7%**	**14.4%**	**14.0%**	**13.7%**	**12.8%**
Staff: Trust level vacancy rate - Other Staff (Value 1)		355	367	337	334	332	389	373	409	431	418	409	384
Staff: Trust level vacancy rate - Other Staff (Value 2)		2887	2885	2886	2886	2886	2948	2930	2974	2990	2972	2967	2991

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. • Search Agency engaged to identify Medical Consultants • New Recruitment system to improve and reduce recruitment timelines in early stages of implementation. • Engaged agency to place UK nurses with the Trust • Commence early stages of Employer Value Proposition project to differentiate between the Trust and other employers. • Commenced work on establishing values based recruitment.

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

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**29 November 2018**

Title of the Report	**Annual Fire Safety Report 2017/18 including the Annual Statement of Fire Safety Compliance**
Agenda item	**13**
Presenter of Report	Stuart Finn, Director of Estates and Facilities
Author(s) of Report	Ian Robinson, Head of Estates and Deputy Director of Estates Kevin Frost, Estates compliance Manager
Purpose	For assurance

Executive summary

The report highlights Fire Safety statistics during the past 12 months and provides assurance regarding progress, investment and measures taken during the year to improve Fire Safety resilience within the Trust.

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? Focus on quality & safety
Risk and assurance	The report highlights areas of risk and proposes measures to mitigate those risks
Related Board Assurance Framework entries	BAF 1.7 Risk of failures related to failing infrastructure
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? No Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? No
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? No Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)? No
Legal implications / regulatory requirements	Compliance with the Regulatory Reform (Fire Safety) Order 2005 and compliance with the Department of Health Fire Safety Policy contained within HTM 05-01

Actions required by the Trust Board

The Board is asked to note the actions taken to improve Fire Safety within the Trust during the past 12 months, the Annual Statement of Fire Safety Compliance and to support the ongoing investment and actions to mitigate risks related to Fire Safety on Trust premises.

Northampton General Hospital
NHS Trust

FIRE SAFETY REPORT

April 2017 / March 2018

1. Executive Summary

This report has been produced to provide the Trust Board with an overview of the current position of fire safety and to provide assurance that the Trust is meeting its statutory responsibilities.
All fire safety arrangements and building alterations within the Trust are modelled on the recommendations made by the Department of Health in their Firecode fire safety guidance documents. These are referenced and supported within the Trust's Fire Safety Policy.

In 2013 The Department of Health announced that they no longer require an Annual Certificate of Fire Safety Compliance, but Trusts should implement a similar local certificate – see appendix 1 for the Trust's local annual certificate of compliance.

Northamptonshire Fire and Rescue Service (FRS) last completed a full fire safety audit in 2014 which resulted in a letter to the Trust confirming that all previous actions had been addressed and the Trust's fire safety management arrangements were satisfactory. Two inspections have taken place during 2017, one after a request by the Department of Health following the Grenfell Tower fire and one after a request had been made by the Trust for a re-inspection. The FRS carried out these inspections and provided a written letter of satisfaction.

To provide assurance to the Trust that its fire safety management complies with Health Technical Memorandum 05-01 an independent review was completed in 2014 and again in February 2017 the subsequent report made a number of recommendations which are part of an action plan monitored by the Fire Committee.

1.1 Achievements

- Training completion target is improving although still falls short of the 85% target, which is currently at 81.9%
- Key Performance indicators have been determined for fire training, fire drill completion, and compliance with the Fire Plan. These will be added to the Corporate Score Card in December 18.
- There has been an increase in the number of Fire Wardens and additional training dates have been added to cover this.
- A number of fire safety improvements have been delivered through the Estates capital plan

1.2 Escalations

- There is a requirement to inspect and maintain fire and smoke dampers annually. There is limited assurance that these checks have been completed within the Trust as a number of dampers cannot be inspected as they are installed above asbestos ceilings.
- There have been some inspections of fire doors in blocks 06,07,18,22,33,42,60 and 73. Damaged heat and smoke seals and non-compliant door frames have been highlighted as an issue. £172,000 from the Estates capital plan was invested in repairs during this reporting period. Estates have continuing plans to inspect the remaining fire doors and to carry out repairs and replacements based on the inspection assessment. In addition to the Fire Warden monthly inspections an improved planned preventative maintenance scheme is being introduced to monitor and check all fire doors periodically.

- Currently there is no planned preventative maintenance (PPM) scheme for fire integrity; the 5 yearly inspection is also overdue. There is a lack of inspections of fire integrity which is hindered by the use of asbestos as fire protection. Full assurance cannot be given that it will function correctly in a fire situation. A survey of the fire compartmentation and fire stopping is currently underway and a plan to rectify faults will be included in the Estates capital plan.
- Some of the existing fire detection equipment is no longer available for purchase and requires updating. Replacement with a newer version has been on going but a plan to complete the upgrades over the next 5 years is being developed. Important to note that the system is still fully functional and a stock of replacements is held for any individual device failures.
- A plan to increase the training attendance to meet target 85% minimum is being discussed and monitored through the Fire Committee.

2.0 Policy and Procedures

Fire Safety Policy is currently under review. There is also a Guidance Document to be used with the Fire Policy which will also be reviewed and updated.

3.0 Standards & Compliance including Key Performance Indicators

As an NHS Trust site Fire is covered by HTM 05 as well as the Regulatory Reform (Fire Safety) Order 2005.

The HTM requires an L1 standard of cover for the fire detection system for this type of premises. L1 systems are defined in BS 5839, Fire Detection and Alarm Systems in Buildings. As part of the fire risk assessments, areas have been identified where this is not met eg additional smoke detectors required. These areas are being assessed for the level of action required to meet compliance and will be included in the Estates capital plan.

Emergency lighting is installed against the requirements of BS5266 and areas have been identified as not being fully compliant. These areas have been identified and what level of action is required to make them compliant. A scheme for the installation of additional emergency lighting will be prepared in the next 6 months.

Flashing beacons have been installed in public areas where staff, patients and visitors who may have impaired hearing could be alone during an evacuation. Further review under the fire risk assessments will highlight any further requirements.

Key Performance Indicators

Fire drills are recorded as they are reported to the Fire Safety Adviser.
Fire Evacuation Plans are provided to the Fire Safety Adviser as they are completed for approval and issue.

Both these figures are included on the monthly Fire Compliance Report to Divisional and Directorate Managers, Heads of Departments and Matrons showing their level of compliance.

These are also reported to the Fire Committee and the Trust Health and Safety Committee

KPI Performance at Mar 18	Target	Number Completed
Fire Wardens assigned and trained to work areas	190	176
Annual Fire Drills Completed	190	112
Fire Evacuation Plan Reviews	190	117

4.0 Communication and Stakeholder Engagement

A report on Fire Safety compliance is issued monthly to Divisional and Directorate Managers, Heads of Departments and Matrons showing their level of compliance.

These are also reported to the quarterly meetings of the Fire Committee and six monthly to the Health and Safety Committee.

From December 2018 fire safety compliance will also be added to divisional scorecards.

A programme of internal audits/ inspections is being scheduled for each Fire Safety area which is planned to raise the profile of Fire Safety across the Trust as well as assist areas with their compliance. Additional resource has been brought into the Estates team to support this work.

5.0 Audit, Surveys & Service Reports

An external consultant has been providing the Trust with advice on compliance against Health Technical Memorandum 05 Firecode. He will be formally appointed to act as the Trust Authorising Engineer (Fire) in December 2018. The consultant has been responsible for completing annual audits of the Trust's Fire Compliance.

Planned preventative maintenance of the Trust's fire detection and prevention systems is performed by Estates staff and approved contractors.

Responsibility for fire safety is also held for the Daventry site with arrangements in place to carry out audits/ periodic inspections of this area. This is a PFI building operated and maintained by Property Services

Fire risk assessments are in place for all areas of the site, with the exception of 3, which are in the course of being amended for reissue. Actions identified are being escalated for action.

Currently Wards and Departments are subject to monthly inspection by their appointed Fire Warden with any issues are added to their action plan.
A requirement for an independent audit/ inspection to be carried out by the Fire Safety Adviser to verify the fire safety arrangements are in place has been identified following a CQC audit. These inspections will be added to the monthly Fire KPI Dashboard.

6.0 Incidents

Fire Alarm Detection System

Year	Fires	False Alarms	Unwanted Fire Signals	Misting Activations	Pre-Warnings
2014 – 15	5	57	21	0	78
2015 – 16	5	41	31	2	86
2016 – 17	0	54	15	2	147
2017 - 18	1 ↑	53 ↓	27 ↑	2	125 ↓

- "False Alarms" - where the fire alarm activates but the Fire Service does not attend
- "Unwanted fire signal" - where the alarm activates and the Fire Service attends.
- "Misting activations" relate to the water and gas misting system which is interfaced to the fire alarm system to alert the hospital if it activates.
- "Pre-warnings" - when a detector reaches a certain threshold, but is not sufficient for the detector to go in to full alarm.

Fires

There was one reportable fire in this reporting period.
A fire in Balmoral Ward relating to an oil filled radiator. Cause was found to be misuse of the power lead, in that it was being used to pull the heater around. Extinguished by staff using fire blanket

All activation signals create a call out of the Fire Response Team to investigate.

7.0 Training

Training based on an agreed annual plan which currently involves face to face training, led by the Fire Safety Adviser, e-learning, or completion of a workbook assessed by the Fire Safety Adviser.

YEAR	Induction	Refresh of Knowledge	Mandatory	Ward	W/Book	ELearning	Number Trained	% Trust Compliant
2014 - 15	997	965	1048	605	0	772	4387	67.0
2015 – 16	1060	1725	192	719	111	879	4686	78.2
2016 – 17	1064	1250	196	629	943	1022	5104	80.7
2017 – 18	1055	1234	141	543	1063	1264	5300	81.9

"Number trained" is based on the total number of people trained. For "Trust Compliance" this figure is adjusted to only include Whole Time Equivalents.

Fire Response Team
The Fire Response Team is currently made up of a representative from:-

- Security
- Portering
- Site Management
- Fire Safety Adviser (During normal working hours)
- Estates Electrician (During normal working hours, although the on-call electrician may be called in out of hours if required.)

The following issues are being reviewed:

- Attendance is not consistent and whether out of hours this cover is sufficient.
- Level of training and instruction that the team requires
- The tools necessary for someone to take charge and make the necessary escalations

Estates are working with the operational teams to determine the level of cover required, the training needs of the team and develop escalation plans.

Fire extinguisher training has been identified as an additional requirement for the team. Different training methods are being reviewed and will be delivered within the next 6 months.

8.0 Complaints and Claims

2017 CQC report raised concerns whether fire exits are checked regularly to ensure they are kept clear when required. Although this is a requirement for the Fire Warden to check monthly there is limited assurance in place that this is being carried out. An audit of each area is planned to be carried out by the Fire Safety Adviser. To aid this inspection, a software tool used by Hotel Services is currently being investigated, which could be utilised to perform and record findings against agreed inspection criteria.

9.0 Trends

Although there is no specific pattern identified "False alarm/ Unwanted signals" have increased over the last 12 months, however "Pre-alarm signals" have reduced. In some instances these are repeat activations . Estates will continue to review and take action to prevent further activations.

Training is showing an improvement in the rate of completion, now at 81.7% but still not meeting the Trust target of 85%. Further work is being investigated to identify the issues preventing completion of training.

10.0 Learning

Trend analysis on fire activations is being used to look at ways of reducing false alarms and pre-warnings.

Investigation of incidents are recorded on Datix and show what lessons have been learned. Investigations are discussed at the Fire Committee meeting and also the Trust Health and Safety Meeting.

11.0 Planned Works Completed (this reporting period)

- Fire protection and detection systems completed in new MRI 2 project
- Fire protection completed to timber flooring below Paddington and Disney Wards
- Fire alarm system upgraded and reconfigured by installing new control panel in Oncology and moving existing loops from Althorp and Barratt panels.
- A&E control panel reconfigured by taking loops from South Entrance panel and rewiring into it. Two of these loops have had devices upgraded to Autrosafe V4 with base mounted beacons.
- Inspection and repairs to fire doors in blocks 06,07,18,22,33,42,60 and 73.
- Nye Bevan Building
    - Automatic Fire Suppression system to car park area
    - Automatic fire suppression installed in both assessment ward areas
    - L1 standard fire alarm and detection system installed throughout building – smoke and heat detection in wards and plant room, flame detection in car park.
    - Disabled Refuge areas communication system installed
    - Smoke Vents installed in each stairway.
    - Evacuation chairs being installed in stairways without a lift.
    - On completion Fire Graphics Package will be updated with building layouts and fire detection system equipment.
    - Fire Evacuation Lifts

12.0 Risks, Areas of Concern and Corrective Actions

Risks

Fire Safety is on the Trust Corporate Risk Register. An action plan is in place and is reviewed monthly through the Estates Compliance Group, Facilities Governance group, and reported to the Assurance Risk and Compliance Group.
The Fire Committee also monitors progress.

Risk ID	Risk Title	Approval Status	Opened	Theme	Risk Level
1702	Fire Safety	Final Approval	29/01/2018	Fire	Extreme Risk

General Fire Safety risks include

- Fire Compartmentation - Missing fire stopping, missing fire/ smoke barriers
- Fire Alarm System - Inability to provide consistent programming
- Fire Training and fire response
- Fire Door Sets not validated or certificated and maintained
- Fire Dampers not a full inventory and not part of a maintenance programme and tested
- Lack of management process for emergency lighting
- Fire evacuation plans not audited

Areas of Concern and Corrective Actions

Area of Concern	Corrective Action Planned
Fire Compartmentation - missing fire stopping, missing fire/ smoke barriers	A full survey of the Trust buildings is currently underway. Based on the findings (due Dec 18), areas will be prioritised and contractors appointed to carry out the remedials.
Fire Alarm System - inability to provide consistent programming	Fire alarm system is undergoing updating and remains fully operational. With detection equipment being more difficult to obtain a 5 year programme to replace with new equipment which can be fully programmed to provide an evacuation alarm and a warning to adjacent areas is being developed.
Fire Training and fire response	Review of current training methods to be completed in the next 6 months Fire response team is currently being reviewed to determine where additional training is required.
Fire Door Sets not validated or certificated and maintained	Fire doors have been replaced, repaired and modified and will now be checked that they comply from a fire rating point of view and that seals and closures are present and that enclosures close at the correct rate.
Fire Dampers not a full inventory and not part of a maintenance programme and tested	Fire dampers in some areas are checked and tested and this will be extended to remaining areas and checks carried out and identify where repairs are necessary before March 2018. Areas with restricted access due to asbestos will only be accessed if the asbestos is removed – there will be opportunities during the ward decant programme.
Lack of management process for emergency lighting	Survey has been completed for site and has identified a number of lights for replacements. A contractor will be assigned to complete this over the next 6 months. Planned preventative maintenance will be added to the Work Allocation software for action.
Fire evacuation plans not audited	Estates are investigating software options to provide a suitable platform for carrying out audits of fire compliance and working with wards and departments to increase fire safety awareness.

13.0 Financial including Backlog Cost

A 6-facet survey carried out has revealed backlog costs relating to fire issues as follows:

	ERIC	Next 5 years
External Fire Escape Block 1	£200,000	£200,000
Fire Compartmentation Costs	£2,791,740	£2,791,740
Fire Detection	£1,750	£225,700

These costs do not make any provision for any asbestos removal that may be required to gain access.

Northampton General Hospital NHS Trust

ANNUAL STATEMENT OF FIRE SAFETY COMPLIANCE

NHS Organisation Code: **RNS**	NHS Organisation Name: **Northampton General Hospital NHS Trust**	
I confirm that for the period 1st April 2017 to 31st March 2018, all premises which the Trust owns, occupies or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order 2005, and;		
1	There are no significant risk arising from the fire risk assessments	
OR 2	The Trust has developed a programme of work to eliminate or reduce as low as reasonably practicable the significant fire risks identified by the fire risk assessment	**Y**
OR 3	The organisation has identified significant fire risks, but does NOT have a programme of work to mitigate those significant fire risks*****	
* *Where a programme to mitigate significant risk HAS NOT been developed, please insert the date by which such a programme will be available, taking account of the degree of risk* Date:		
4	During the period covered by this statement, has the organisation been subject to any enforcement action by the Fire and Rescue Authority? If yes, outline the details of the enforcement action in Annex A – Part 1	**N**
5	Does the organisation have any unresolved enforcement action pre-dating this statement? If Yes, outline the details of unresolved enforcement action in Annex A – Part 2	**N**
6	The organisation achieves compliance with the Department of Health Fire Safety Policy, contained within HTM 05-01, by the application of Firecode or some other suitable method	**Y**
7	There is a current fire safety policy in place	**Y**

Fire Safety Manager:	Name: Ian Robinson E-mail: ian.robinson@ngh.nhs.uk
Contact Details:	Telephone: 01604 544740 Mobile:
Chief Executive:	Dr Sonia Swart
Signature of Chief Executive:	
Date:	

Northampton General Hospital NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**29 November 2018**

Title of the Report	**Northamptonshire Health & Care Partnership Update**
Agenda item	**14**
Presenter of Report	Chris Pallot, Director of Strategy and Partnerships
Author(s) of Report	Health and Care Partnership Delivery Support Unit
Purpose	This newsletter is presented to the Board to provide an update on the progress of the Northamptonshire Health and Care Partnership.
Executive summary This newsletter has been produced by the Health and Care Partnership for dissemination across the county. It provides the latest update.	
Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to?
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks
Related Board Assurance Framework entries	BAF – please enter BAF number(s)
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N) If yes please give details and describe the current or planned activities to address the impact.

Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper: No

Actions required by the Board of Director:

The Board of Directors are asked to note the contents of this update.

November 2018

Partnership Update

Northamptonshire
Health and Care Partnership

Welcome to your new-look update newsletter from Northamptonshire Health and Care Partnership, bringing all the latest news and developments from NHCP to our health and social care colleagues across the county.

We've been hugely encouraged by the ways people across our health and care system are embracing collaborative working, and this came under the spotlight at our recent NHCP Development Day in September.

The day brought together representatives from across our Partnership organisations for some really valuable engagement work, and among the highlights were the agreement of our NHCP mission and vision as well as confirmation of our four transformation priorities (more on these below).

Of course we are aware that in Northamptonshire we are working under particularly challenging circumstances relating to finance, capacity and demand - as a county and within our own organisations. However, we are committed to working together to face these challenges as a Partnership and to keeping you updated as we progress.

Read on to find out more about the great work being planned and happening right now throughout our county through joint working between the Northamptonshire NHS, county council and many other partner groups and organisations. We hope you find this update useful and informative.

Thank you
Northamptonshire Health and Care Partnership Board

Introducing… our Partnership mission and vision

MISSION: Empowering positive futures; choose well, stay well, live well

VISION: A positive lifetime of health, wellbeing and care in our community

In simple terms, our mission and vision statements capture what we want to achieve as a Partnership. Our mission defines why we do what we do and our vision shapes where we all want our county to be in the future. They have been developed through engagement with all NHCP partners and were finalised at our Development Day (pictured right) in September.

Now that they are agreed, our mission and vision will be at the heart of everything we do. As we plan and deliver our Partnership work, we must always consider how it aligns with our mission and vision to ensure we're focusing firmly on our shared objective at all times. We have also agreed our collective values which define what is important to us. They are:

- 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.

Partnership colleagues at our September Development Day

Our transformation priorities

If we're to empower a positive future for Northamptonshire, it's vital that we focus on the areas of the health and social care system where we can make the most difference as a Partnership towards a positive lifetime of health, wellbeing and care in our community. We have therefore agreed to focus together on the following four transformation priorities for Northamptonshire:

- Primary, Community and Social Care
- Strategic Commissioning
- Unified Acute Model
- Urgent and Emergency Care

By selecting these priorities, it doesn't mean that other areas of health and care are not important. But we are deliberately focusing on these priorities because we know this is where we can effect the most positive change by working collaboratively, rather than as individual organisations.

Alongside our transformation priorities, we will continue to drive improvements across the system to align with the objectives of the Five Year Forward View as part of our business as usual work. These areas of work include cancer, mental health, maternity, children and young people, health and wellbeing, and learning disabilities.

Latest news

New head for our Digital Transformation Programme

We're delighted to confirm that Nigel Brokenshire has joined our Local Digital Roadmap (LDR) Programme as its new Director.

Nigel (pictured right) joins at an exciting time for the county as we make full use of the digital opportunity available to us. Putting the right information into the hands of health and care professionals to support care for patients and service users through digital technology is a key priority for the county, and we are already making progress in this area.

SHREWD Resilience supports urgent care

SHREWD Resilience is a transformative web-based portal providing a real-time view of system capacity across the whole Northamptonshire health and care economy.

It determines where pressure is building, enabling a swift plan of action to be put in place quickly to alleviate issues across the system. Speedy intervention in the planning of urgent care services improves the care experience for patients and service users.

The system began rollout to urgent care pathway partners in September, starting with a period of training and testing in preparation for the service to go live in full in October. The system will be used as the primary information source to manage the urgent and emergency care process in time to support the easing of winter pressures.

Piloting eConsultation in general practice

As part of our goal to improve access to GP services, we have introduced an on-line eConsultation tool for patients seeking GP support. The tool works by efficiently triaging the patient so they can receive the most appropriate treatment or care. This means that in a GP practice's most busy period, patient demand can be satisfied while reducing the burden on services.

Pilots are currently underway at Rushden Medical Centre, Lakeside, Headlands, Weavers Medical Centre, Saxon Spires, Brook Health Centre, Towcester Medical Centre, Nene Valley and Langham Place surgeries.

Northamptonshire Care Record

If you want to know more about how we are working together to deliver a shared health and care record model for Northamptonshire, please come along to our market engagement day on Friday 23 November at Cripps Post Graduate Medical Centre, Northampton General Hospital.

Email nelcsu.ldrenquiries@nhs.net for further information.

A bit more about our transformation priorities...

Urgent and Emergency Care

As we move towards winter, a great deal of work is being done across our health and care system to prepare our urgent and emergency care services for the pressures to come.

One aspect of this work is around recruitment, where progress is being made to bring more staff into our Intermediate Care Teams.

This will give us more capacity to support patients in crisis so they can leave hospital when they're medically fit to do so and are less likely to need acute care in the first place.

At Northampton General Hospital, the brand new £12m Nye Bevan emergency assessment unit opened in early October.

The unit is designed for patients in need of emergency assessment and will enable staff to properly determine their most appropriate method of treatment, reducing pressure on the busy A&E department and cutting waiting times. Click here to read the latest updates from NGH.

The Partnership is also finalising a winter communications plan to ensure we are ready to respond to seasonal challenges with co-ordinated communications to patients, service users, public, stakeholders and staff.

Among other things this will cover our flu vaccination campaign, messages raising awareness of alternative NHS services when the system is under particular pressure, and advice for coping in extreme weather.

By planning our communications in advance, we can help our staff to focus on delivering patient care at a very busy time of year.

Unified Acute Model

The focus of the Unified Acute model is to look at some of the acute services provided at both Kettering and Northampton General Hospitals, and plan how they can be delivered in a more unified and collaborative way for all Northamptonshire.

The aim is to ensure all patients have equal access to the same standard of high-quality care, wherever they live in the county.

Priority areas identified as part of this work are stroke, cardiology, orthopaedics and MSK, alongside ophthalmology, urology, breast radiology and plastic surgery.

Stroke is the furthest advanced of these, while proposals for the other acute priorities are currently being worked up. The plans include a commitment to retaining core acute services (including A&E, paediatrics, maternity, intensive therapy, general surgery and general medicine) at both hospital sites.

Strategic Commissioning

Strategic Commissioning is a collaborative approach to planning and purchasing health and care services. It seeks to move away from the traditional commissioning model, in which commissioners enter into individual contracts with different providers to serve different needs and objectives.

Under the Strategic Commissioning model, commissioners work closely together to assess the health and care needs of the entire community, and then plan, prioritise, purchase and monitor health services to achieve the best outcomes for all.

It places a firm emphasis on a clear, shared vision for whole populations and focuses more on empowering people to stay well and live healthier lifestyles rather than just tackling illness.

Further updates will be provided in future newsletters.

Primary, Community and Social Care

On 1 October, Northamptonshire became one of the latest counties to offer evening and weekend GP appointments, known as extended access.This means that across the county, GP appointments are now available at a number of "hub" locations until 8pm from Monday to Friday, as well as appointments on Saturdays and Sundays. Patients can book these appointments by contacting their GP and in future it is hoped 111 and hospitals will also be able to directly book patients in for appointments.

One of the big challenges we face in Northamptonshire - and indeed throughout England - is how we help people and communities to look after their own health and wellbeing and be more resilient. There is a lot of informal support available from family, carers, friends and community groups, and building on this could mean that individuals are better able to care for themselves and access support locally if they need it. The Primary, Community and Social Care (PCS) transformation priority group is developing a plan to build on the services already available in Northamptonshire to ensure people are better able to access formal and informal care close to where they live in the community. We are describing this as 'layers of support'.

From this grows formal primary care support (GPs, pharmacies, dentists, opticians) moving out to community services, social care, local councils and acute hospitals. The aim is to provide the right care and support in the right place at the right time. The PCS programme is bringing all this work together into a plan that will be available in late November. We hope to be able to deliver changes in the way everyone works together from early in 2019.

Acute services unifying for excellence in stroke care

The inpatient element of the county-wide hyper-acute and acute stroke service was centralised at NGH from September 2018 to ensure consistency and continuity of care for all patients. Previously, those living in the north of the county transferred to KGH after a hyper-acute episode.

As the county-wide provider NGH will continue to develop its specialist expertise with additional investment identified for therapy and specialist psychology. NGH will also have direct access and sole admission rights for stroke patients into 12 community rehabilitation beds at Isebrook Hospital, Wellingborough. It is also proposed to enhance community support services in the longer term so more patients can return home with support sooner.

KGH will continue to host a Monday-to-Friday transient ischemic attack (TIA) clinic where patients will be assessed for their imminent risk of stroke and given preventive treatment, plus a stroke follow-up clinic for patients in the north of the county. Basing all our hyper-acute and acute stroke services on a single site will ensure Northamptonshire continues to develop excellence in stroke care.

These changes will give all patients across Northamptonshire access to the same high-quality care, wherever they live in the county. It also demonstrates how our two acute hospitals are working collaboratively with NHCP partners to improve patient care.

Support to focus on better health and wellbeing

We're delighted to confirm that Northamptonshire Health and Care Partnership has received an in-principle offer of support from the Government's Life Chances Fund.

This will be used to help us develop and implement a county-wide social prescribing service. Social prescribing is a way of referring people with mental and physical health problems to a range of local, non-clinical services to help them take greater control of their health and wellbeing. Activities are often provided by voluntary and community organisations and can include leisure activities, social groups, exercise and healthy lifestyle advice and support. Further details of this exciting project will be announced in due course.

Collaborative Stakeholder Forum: supporting our public engagement

The purpose of the NHCP Collaborative Stakeholder Forum is to make sure that all the work of the Partnership is properly taking into consideration the views of the public, patients and service users, health and social care staff, the voluntary sector and local government.

All these groups have representation on the Forum, which meets regularly and advises the Partnership Board of chief executives and other leaders from NHCP organisations.

At a recent meeting, the Forum endorsed a new Patient Leadership Programme for Northamptonshire, hosted by the East Midlands Academic Health Science Network (EMAHSN).

This is a free training programme for 30 patient leaders who are involved with any of our county's health and care organisations. Click here for more information.

EMAHSN also hosted a public networking event on Tuesday 16 October for Northamptonshire patients, service users and carers interested in getting involved with decisions about local health and care.

NHCP Lead Angela Hillery was one of the speakers at the event at Kings Park Conference & Sports Centre, Northampton, and there was also an NHCP stand which enabled people to find out more about the Partnership and our work.

Signposting services in Northamptonshire

Through working together and meeting as a Partnership, one of the issues we have been looking at is the way in which Northamptonshire's health and care services are signposted. We have agreed that it would be helpful if a single resource could be developed to enable staff, volunteers and members of the public to easily identify the services that are available for them to access, whether that's in their local neighbourhood or throughout the county.

We have started the process of determining how this system can be developed, what it will look like and how it will be used – and are agreed that a comprehensive and regularly updated directory of all types of service in the health, care and voluntary sectors is the way forward. We will be starting conversations with our partners very soon to discuss how to progress this project, including by making the best use of existing resources in the county.

Your NHCP team

The Northamptonshire Health and Care Partnership brings together leaders from across our county's health and care system, each with a wealth of experience in a range of backgrounds and disciplines. Each transformation priority and workstream is led by an executive sponsor from one of our organisations, supported by a senior responsible officer (SRO).

Partnership and Delivery Support Unit (DSU)

- Angela Hillery (NHFT) **Partnership Lead**
- Dr Miten Ruparelia **Clinical Lead**
- Mike Coupe* **Programme Director**
- Tim O'Donovan **Assistant Programme Director**

Transformation Priority Leads

- **Strategic Commissioning** Sponsor: Toby Sanders (CCGs) (from 1 Nov)
- **Unified Acute Model** Sponsors: Simon Weldon (KGH), Sonia Swart (NGH) SROs: Chris Pallot (NGH), Polly Grimmett (KGH)
- **Primary, Community and Social Care** SRO: David Williams (NHFT)
- **Urgent and Emergency Care** Sponsor: Simon Weldon (KGH)

Workstream Leads

- **Cancer** Sponsor: Sonia Swart (NGH) SRO: Karen Spellman (NGH)
- **Children and Young People** SRO: Jean Knight (NHFT)
- **Health and Wellbeing** Sponsor: Lucy Wightman (NCC Public Health) SRO: Stuart Mallett (DSU)
- **Learning Disabilities** Sponsor: Anna Earnshaw (NCC)
- **Maternity** SRO: Emma Donnelly (CCGs)
- **Mental Health** Sponsor: Sandra Mellors (NHFT)SRO: Catherine O'Rourke (CCGs)

System Enabler Leads

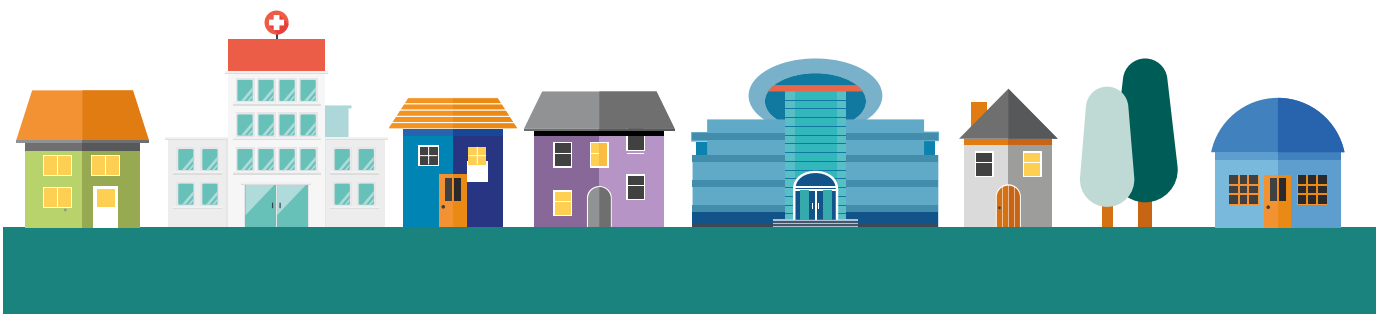
- Mike Coupe (DSU) **Estates**
- Richard Wheeler (NHFT) **Finance**
- Nigel Brokenshire (NEL CSU) **Information Management and Technology**
- Janine Brennan (NGH), Chris Oakes (NHFT and LWAB**) **Workforce**
- Dionne Mayhew (NHFT) **Communications**

* Currently supporting PCS and Estates
** Local Workforce Advisory Board

NHCP website coming soon...

We are currently working on a brand new website for the Northamptonshire Health and Care Partnership, which will be going live in the coming weeks. As well as telling the NHCP story and setting out our objectives and plans, the new website will feature the latest updates on our programmes of work, case studies and publications. Look out for further details of our website launch very soon.

If you have any enquiries or updates to include in future editions of this newsletter, please email: northamptonshire.hcp@nhs.net



COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: *29th November 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 *17th October* 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
- Changing Care
- SLR Report
- Operational performance
- Benefits realisation
- Private Patients Pilot
- 19/20 contract process

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

Key areas of discussion arising from items appearing on the agenda

- **The Trust delivered a financial result on plan for September plan maintaining the YTD plan performance. There continues to be challenges on pay overspend in some areas, balanced by non pay underspends. Income in elective remains below plan.**
- **The Committee received the Changing Care programme report, where we now have 64% of the forecast schemes recurrent which is a step in the right direction.**
- **The trust is revisting of the GIRFT report where there are likely to be further opportunities.**
- **There remains a risk to the plan, predominantly from the System Gap issues.**
- **The Service Line Reporting Report confirmed our reference costs are again c 92 which implies the Trust is efficient when compared to other similar trusts.**
- **A&E performance fell below trajectory for the first time in 6 months, reflecting considerable increases in attendances. Nye Bevan opened and the trust is planning to test the new ways of working over the next few months.**
- **Cancer targets remain challenging, but some improvements from last month.**
- **The Committee reviewed the benefits realisation report and noted several big projects had yet to deliver the anticipated benefits. These are being analysed and if appropriate the investments will be unwound where possible. There are a range of projects that have delivered, in particular the invest to save Estates initiatives through the Salix Loans.**
- **The Committee received a proposal to pilot a Private patients service. This was approved having noted a range of challenges that will be new to the trust and should be monitored.**
- **The committee approved the appointment of a provider for the outsourcing of some diagnostics services, based on the results of a competitive tender, subject to contract review.**
- **The committee noted the proposed process for the 19/20 contract round circulated by NHSI, some of which would be challenging to deliver.**

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

The committee approved the appointment of XXXXXXXX to supply additional diagnostic services.	
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
NHS Trust

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: ***29 November 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 *17 October 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)*
• **Medical Education Quarterly Annual Report** • **Draft Consultant Engagement Strategy**	

Key areas of discussion arising from items appearing on the agenda

- **Medical Education Quarterly Annual Report –** concerns were raised about the training experience of junior doctors, particularly in Oncology. An action plan was submitted to HEEM, but there would be a two month gap before junior trainees returned to the dept. in January. A gap in workforce capacity had created additional pressures, which may have contributed to the poor training experience. 10 of the 12 WTE posts had now been filled. New clinical leadership for Oncology was now in place with a new Educational Lead starting in December. Improving the training experience was key to attracting medical staff to Oncology.
- **Draft Consult Engagement Strategy –** good progress was being made on consultant engagement. Key initiatives included quarterly consultant forums, listening events, working suppers, with some actions implemented as a result of feedback. There was recognition that change was needed, but on-going engagement was key.

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

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
NHS Trust

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: 29th November 2018

Title	**HMT Exception Report**
Chair	**Ms Deborah Needham (Deputy CEO/COO)**
Author (s)	**Ms Deborah Needham**
Purpose	**To advise the Board of the work of the Trust Board Sub committees**

Executive Summary

The Committee met as a workshop on 6th November 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:

1. Divisional scorecards
2. Staff survey – surgery division action plan
3. Therapies strategy
4. Planning update & Estates strategy briefing
5. Quality scorecards workshop

Board Assurance Framework entries
1.1, 1.2, 2.2, 3.1, 3.2,

Key areas of discussion arising from items appearing on the agenda

Divisional Scorecards
The divisional scorecards were highlighted for information. There was one request from the Divisional Director for W,C,O,H&C – to ensure that last minute cancellations of clinics for 2ww patients are minimised.

Staff survey – surgical division action plan
The surgical division presented their staff survey results and brief overview of actions being taken for improvement

Planning update & Estates strategy briefing
Mr Pallot gave an update on the annual planning round including procedure for business case submission.
Mr Finn presented the estates strategy & future plans which have previously been discussed at Trust board.

Quality scorecards workshop
The committee split into their divisional teams and worked on ideas for their own quality scorecards with the expectation that final ideas would be fed back to the QI team within the next 2 weeks to enable the scorecards to be finalised.

Any key actions agreed / decisions taken to be notified to the Board
None

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

All areas of risk regarding quality and performance are covered in Trust Board reports and detailed on the risk register.

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

To note the contents of the report.

Northampton General Hospital NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 29 November 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 Zeidler	**Verbal**
	2.	Declarations of Interest	Note	Mr P Zeidler	**Verbal**
	3.	Minutes of meeting 27 September 2018	Decision	Mr P Zeidler	**A.**
	4.	Matters Arising and Action Log	Note	Mr P Zeidler	**B.**
	5.	Patient Story	Receive	Executive Director	**Verbal**
	6.	Chairman's Report	Receive	Mr P Zeidler	**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 S Oke	**E.**
10:30	**OPERATIONAL ASSURANCE**				
	10.	Finance Report	Assurance	Mr P Bradley	**F.**
	11.	Workforce Performance Report including 1. Flu Vaccination Update 2. Nurse Recruitment & Retention	Assurance	Mrs J Brennan	**G.**
11:00	**FOR INFORMATION & GOVERNANCE**				
	12.	Operational Performance Report	Assurance	Mr C Holland	**H.**
	13.	Annual Fire Safety Report	Assurance	Mr S Finn	**I.**
	14.	Healthcare Partnership Update	Assurance	Mr C Pallot	**J.**
11:40	**COMMITTEE REPORTS**				
	15.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler	**K.**
	16.	Highlight Report from Quality Governance Committee	Assurance	Mr J Archard-Jones	**Verbal.**
	17.	Highlight Report from Workforce Committee	Assurance	Ms A Gill	**L.**
	18.	Highlight Report from Hospital Management Team	Assurance	Mr C Holland	**M.**

Time	Agenda Item		Action	Presented by	Enclosure
12:00	**19.**	**ANY OTHER BUSINESS**		Mr P Zeidler	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held at 09:30 on Thursday 31 January 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).