Northampton General Hospital
NHS Trust

Public Trust Board

Thursday 30 November 2017

09:30

Board Room
Northampton General Hospital

Northampton General Hospital NHS Trust

A G E N D A

PUBLIC TRUST BOARD

Thursday 30 November 2017
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 Farenden	**Verbal**
	2.	Declarations of Interest	Note	Mr Farenden	**Verbal**
	3.	Minutes of meeting 28 September 2017	Decision	Mr Farenden	**A.**
	4.	Matters Arising and Action Log	Note	Mr Farenden	**B.**
	5.	Patient Story	Receive	Executive Director	**Verbal**
	6.	Chairman's Report	Receive	Mr Farenden	**Verbal**
	7.	Chief Executive's Report	Receive	Dr S Swart	**C.**
10:00	**CLINICAL QUALITY AND SAFETY**				
	8.	Medical Director's Report	Assurance	Mr M Metcalfe	**D.**
	9.	Director of Nursing and Midwifery Report	Assurance	Ms C Fox	**E.**
	10.	Fixing the Flow Update	Assurance	Mrs D Needham	**F.**
10:20	**OPERATIONAL ASSURANCE**				
	11.	Finance Report	Assurance	Mr S Lazarus	**G.**
	12.	Workforce Performance Report	Assurance	Mrs J Brennan	**H.**
10:40	**FOR INFORMATION**				
	13.	Integrated Performance Report	Assurance	Mrs D Needham	**I.**
	14.	Medical Recruitment Strategy	Receive	Mrs J Brennan	**J.**
	15.	Sustainability and Transformation Plan Update	Receive	Mr C Pallot	**K.**
	16.	Final CQC Report Outcome	Receive	Ms C Thorne	**L.**
11:20	**COMMITTEE REPORTS**				
	17.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler	**M.**
	18.	Highlight Report from Quality Governance Committee	Assurance	Mr J Archard-Jones	**N.**
	19.	Highlight Report from Workforce Committee	Assurance	Mr G Kershaw	**O.**

Time	Agenda Item		Action	Presented by	Enclosure
	20.	Highlight Report from Hospital Management Team	Assurance	Mrs D Needham	**P.**
11:30	**21.**	**ANY OTHER BUSINESS**		Mr P Farenden	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held at 09:30 on Thursday 25 January 2018 in the Board Room at Northampton General Hospital.

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

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

Northampton General Hospital NHS
NHS Trust

Minutes of the Public Trust Board

Thursday 28 September 2017 at 09:30 in the Board Room at Northampton General Hospital

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

TB 17/18 046 Introductions and Apologies

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

Apologies for absence were recorded from Dr M Cusack, Mr P Zeidler and Mr G Kershaw.

TB 17/18 047 Declarations of Interest

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

TB 17/18 048 Minutes of the meeting 25 May 2017

The minutes of the Trust Board meeting held on 27 July 2017 were presented for approval.

The Board resolved to **APPROVE** the minutes of the 27 July 2017 subject to amendments passed to the Board Secretary.

TB 17/18 049 Matters Arising and Action Log 27 July 2017

The Matters Arising and Action Log from the 27 July 2017were considered.

Action Log Item 74
Mrs Needham confirmed that the report would be presented at the Private Board.

Action Log Item 75
Dr Bisset advised that this was work in progress.

Action Log Item 76
Mrs Brennan stated that this was included under agenda item 11.

Action Log Item 77
The Board were informed that this had been discussed at the August Board of

Enclosure A

Directors.

The Board **NOTED** the Action Log and Matters Arising from the 27 July 2017.

TB 17/18 050 Patient Story

Dr Swart read out a letter that detailed the writer's mother's treatment as an inpatient at the Trust who had unfortunately died. The mother had collapsed at home and following tests the possibility of a stroke had been ruled out. The mother complained of a pain in her side but this was not addressed. Following another collapse the mother attended A&E where her bloods were taken and a scan booked. She was admitted to Angela Grace then subsequently discharged as she was classed as 'medically fit'.

The results of the scan showed that she had wide spread cancer. The writer is angry that her mother was told she was 'medically fit'.

Dr Swart noted that the term 'medically fit' means that there is no more to add in terms of medical care.

The Board **NOTED** the Patient Story.

TB 17/18 051 Chairman's Report

Mr Farenden presented the Chairman's Report.

Mr Farenden commented that his recent Beat the Bug visits were had been very good. The leadership and enthusiasm from the nurse in charge was positive.

Mr Farenden attended the recent Health & Wellbeing Board and noted that there had been little focus on the STP.

Mr Farenden had met with the new Chair of KGH and their Chief Executive with Dr Swart. The outcome of the meeting was that of a positive message on how the two acute Trusts can cooperate on a range of issues.

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

TB 17/18 052 Chief Executive's Report

Dr Swart presented the Chief Executive's Report.

Dr Swart updated the Board on Cancer Alliance. It was noted that nationally it had become difficult to achieve the mandatory cancer standards and from a NGH perspective the Trust was struggling to meet all the cancer access standards. The Trust had the opportunity to become involved in the transformational and strategic agenda with support from the Alliance.

Dr Swart commented that things needed to be done differently. The number of referrals where the patient does not have cancer needed to also be addressed. Dr Swart hoped that within the next few weeks the East Midlands Alliance would receive transformation money to help fund some of the projects.

Dr Swart highlighted that urgent care was one of the Trust's biggest issues and that this needed to be looked at in more detail. The Trust is in the position where it had not been meeting the 4 hour target and flow within the hospital is not how it should be.

Dr Swart attended a meeting with Jeremy Hunt, Simon Stevens, Jim Mackey, Pauline Philips on 18 September where the CEO's of around 60 Trusts were given a clear indication that in view of the expected pressures over this coming winter the

CEO and the Board are to take a greater responsibility in overseeing progress in this important area. The meeting had a large focus on clinical leadership, quality and the safety of the patients.

Dr Swart stated that the Best Possible Care awards were scheduled for the 29 September. The event will celebrate the achievements of staff.

Dr Swart commented that the AGM went very well and followed a good format. It was noted that the use of video clips to be well received.

Dr Swart reported that the Bedside Book Club was awarded the Community Relations Campaign of the Year at the UK Public Sector Communications Awards. The Awards are for all public sector organisations across the UK and are strongly contested.

Mr Noble queried the claim that the UK's cancer survival rates are lower than the EU's cancer survival rates and whether there was any objective evidence behind this claim. Dr Swart commented that the issue is that there can be a long wait for the diagnosis to be established. The UK's access to diagnostics is not as good as some of the EU counties.

Mr Noble noted that the AGM was an excellent event and believed that the presentation should be circulated for staff to see.

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

TB 17/18 053 **Medical Director's Report**

Dr Bisset presented the Medical Director's Report.

Dr Bisset reported that the clinical risks to the Trust are listed on page 20 of the report pack. There are difficulties in staff recruitment for Doctors and there is work ongoing to address this. Dr Bisset commented that the approach given will be to look at medical and nursing shortages together. Mr Farenden asked for a timeframe for an update on the approach. Dr Bisset believed that November would be appropriate.

Action: Medical Director

Dr Bisset reported that there is a national and international shortage therefore it is critical to make NGH appealing to medical staff. It was reported that at a recent Royal College event that NGH sponsored for Radiologist there was 14 expressions of interests received.

Dr Bisset confirmed that Serious Incidents were discussed at the Quality Governance Committee and there is work underway to improve the learning from serious incidents with a need to reach a wider audience. It was noted that mortality was also discussed at QGC and that it remained satisfactory.

Mr Noble challenged the reasons behind the SI for septic shock as an SI of this nature had occurred before. Dr Bisset advised that a review was underway on the SI. The patient had come from another Trust with another diagnosis. Dr Swart stated that shocked sepsis does not always display symptoms. It was confirmed that Sepsis mortality is within expected limits however the numbers have increased therefore a case review will be completed.

Ms Gill suggested the use of a poc sim on the SI. Dr Bisset commented that this was an option to explore.

Action: Medical Director

Mr Archard-Jones queried that as the recent never event investigation had

concluded who brings this together to ensure the end to end process is fit for purpose. Dr Bisset stated that the policy issue around consent would go to the Consent Group and the rest of the actions would be monitored by the Medical Director.

Ms Gill challenged the 4 never events since April and queried whether this was average in comparison to other Trusts. Ms Thorne commented that the CQC believed that the Trust reported too many incidents. Dr Bisset stated that it was reassuring to have a high level of reporting of incidents which are low harm.

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

TB 17/18 054 Director of Nursing and Midwifery Care Report

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

Ms Fox reported on the ongoing pressure ulcer work. A change package is to be implemented in November and will include a stopping pressure ulcers week.

Ms Fox stated that in relation to infection prevention control there had been 12 cases of cdiff year to date with 0 cases in August and 0 in September. In the cases reported there have been no lapses in care and hope that the trajectory would be back on track in November.

Ms Fox updated the Board on MSSA. Ms Fox believed that the work done by the Infection Prevention Control Team had reduced the numbers of patients developing MSSA. The Infection Prevention Control Team are to present their work September 19th 2017 at the Infection Prevention Society Conference.

Ms Fox confirmed that there will be a major focus on fall prevention for this Autumn.

Ms Fox drew the Board to page 43 of the report pack and discussed the reduction of carer questionnaires for August 17. It had also highlighted a general decrease in satisfaction from carers. The newly appointed Dementia Liaison Nurse is reviewing the current process. The graph did not include responses from telephone questionnaires.

Ms Fox delivered an update on the table on page 53 of the report pack which detailed the Quality Care Indicators for Maternity. It was noted that the 0% for Emergency Equipment – Checked Daily was due to the zero tolerance stance the Trust holds. If there is only 1 period that the emergency equipment has not been checked then this would still report as 0%.

Ms Fox advised that the Ward Staffing Fill Rate Indicator was included on page 54 of the report pack. Ms Fox assured the Board that red staffing levels are discussed at the huddle twice daily as well as with the out of hours coordinator for the site time. The departments are challenged at the huddle.

Mr Noble remarked that it was positive that the FFT results for ED were higher than the national average. It noted that that a combination of elements within ED helped this included Age UK, Care & Safety Rounds and the Right Time Survey in ED.

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

TB 17/18 055 Finance Report

Mr Lazarus presented the Finance Report.

Mr Lazarus informed the Board the Finance Report had been discussed in detail at the Finance Committee. The financial position of the Trust for the period ended

August 2017 which was a deficit of £6.3m (£1.5m adverse to plan).

Mr Lazarus drew the Board to page 64 of the report pack which detailed the 'High Level Commissioner Position'. The reported under-performance on the Nene contract has slowed in Month 5, with the M5 position being a £2.209m variance (M4: £2.157m). Mr Pallot advised the Board that the CCG's financial position is challenging and that the CCG are in recovery. The Trust had asked to see the recovery plan for the CCG however this has not been shared. The support unit for CCG had moved.

Ms Gill remarked that the CCG's financial position is a potential risk to the Trust. Mr Pallot confirmed that Trust is going through all their patients to ensure the CCG are unable to make challenges on the contract. Ms Gill queried the size of the risk. Mr Pallot shared his concern that the CCG may use the contract against the Trust as having done so in the past. The risk has been put on the Corporate Risk Register as requested by Mr Farenden at Finance Committee.

Mr Lazarus drew the Board to page 62 of the report pack which presented Agency Staff Expenditure. It was noted that Agency Expenditure had increased in Month 5, with Senior Medical up 80% on average and Other Clinical up 33% on average month this year.

Mrs Brennan shared with the Board how the Trust is managing supply and demand. There had been meetings to discuss the top 20 agency staff which is now focusing on the volume of agency staff. The PMO is meeting the Directorates to help facilitate demand management. There had been negotiations with the LNC with ADH rates and a rate has been agreed. Mrs Brennan has asked the Directorates to negotiate agency rates if the rates appear to increase.

Ms Fox reported that there will be a refresh of the bank recruitment campaign coming into winter. The Trust will also be putting itself forward for a national enhanced care collaborative.

Mr Lazarus thanked the Divisions for their engagement in the financial recovery meetings and believed the Divisions understood the need of these meetings.

Mr Farenden commented that it was good to see a sense of ownership.

The Board **NOTED** the Finance Report.

TB 17/18 056 **Nurse Recruitment and Retention Report**

Mrs Brennan presented the Nurse Recruitment and Retention Report.

Mrs Brennan reported that the overseas recruitment campaign continued and between January 2017 and August 2017, 30 overseas recruits arrived from India and 2 from Romania totalling 32 recruits in total. The EU market has reduced and this has been reflected nationally. Ms Gill queried whether EU staff had left the Trust. Mrs Brennan confirmed that this had not been an issue at present.

Mrs Brennan advised that between January 2017 and August 2017 a total of 20 offers were made to overseas nurses.

Mrs Brennan stated that there are currently 30 IELTS cleared Indian Nurses awaiting NMC decision letter to travel to the Trust and commence employment, 17 of which were offered positions since January 2017.

Mrs Brennan commented that due to the introduction of the Immigration Skills Charge from April 2017 which equates to £8.5k per nurse a different approach is

needed. Ms Clymer queried whether it would be better to use the £8.5k so subsidise training for the nurses at University. Ms Fox highlighted to the Board the potential of NGH becoming an individual nursing school.

Mr Noble asked how this suggestion would be followed up. Ms Fox stated that the HR and the Nursing team are exploring the option with a member of the nursing team negotiating with the local colleges. Mr Noble commented that it would appear that an increase in resources would be needed to support the initiative and believed that the Board should fully understand the whole programme.

Mrs Brennan advised that between January 2017 and August 2017 a total of 46.11 nurses started work in core and specialist areas with the Trust through recruitment via NHS Jobs. Between January 2017 and August 2017 nursing capacity was increased by 5.10 as a result of existing nurses increasing their hours. There are a total of 53 Qualified Nurses in clearance for core and specialist areas, 21 of whom have start dates

Mrs Brennan stated that between January 2017 and August 2017 overall nursing capacity increased through new recruits and increases in hours by 94.21 WTE. Between January 2017 and August 2017 nursing capacity decreased through leavers and decreases in hours by 97.56 WTE. Between January 2017 and June 2017 the establishment was uplifted by 6.86 WTE thus nursing capacity therefore saw a net decrease of 10.21 WTE.

Mrs Brennan discussed nurse recruitment initiatives with the Board. The Trust will restart participating in recruitment fairs and Best of Both Worlds has received some LWAB funding which will be able to support the initiative further.

Mr Finn commented that Riverside House which is to be converted into staff accommodation which will also make the employment at the Trust more appealing.

Ms Gill queried whether career development pathways were explored. Mrs Brennan believed that this would be part of the new HR Specialist Role which will be live from November.

The Board **NOTED** the Nurse Recruitment and Retention Report.

TB 17/18 057 Integrated Performance Report

Mrs Needham presented the Integrated Performance Report.

Mrs Needham advised that the performance report had been discussed at the 3 sub-committees of the Board. Mrs Needham reported that RTT and diagnostics were positive, ambulance handover times below the national average and mandatory training was meeting the internal Trust target.

Mrs Needham stated that urgent care performance in August had increased from July. It was noted that DTOC increased in August and throughout September ranged between 50 – 70 patients. Mrs Needham commented that admissions had reduced in August and although acuity is stable it is still higher than this time last year.

Mrs Needham advised that the urgent care reset and relaunch programme would be discussed at Private Trust Board.

Mrs Needham stated that a lot of effort and time had put into Cancer performance. The regulators had been advised that the Trust should be back on trajectory by November and Mrs Needham believed that this is doable. The legacy patients had significantly dropped to 40 patients and continue to drop daily. Mrs Needham commented that patients are monitored from day 35 onwards with the aim for the

patient to not hit the 62 day wait.

Mrs Needham shared with the Board that 2 senior medical staff attend a Urology NHSI masterclass. The event enabled the medical staff to map out the processes within Urology and she believed the Medical Directors input into this will be valuable.

Mrs Needham reported that MRI and CT scan wait times had reduced. Her biggest concern is the 2ww for breast which is falling outside of this target. There will be additional support from Milton Keynes in 2 week's time.

Mr Archard-Jones commented on the A&E performance of patients not seen within 4 hours at 88.5% and challenged that the patients not seen were non-urgent cases. Mrs Needham stated that the patient could be urgent and the issue is with patient being put into a bed. Dr Swart assured Mr Archard-Jones that no patient is left without any medical input. There are safety checks done every 2 hours, elderly patients are put into a room and patients are given food and drink. The corridor had not been used in the past few months. Mr Archard-Jones queried whether the patients are safe and he was advised that this was correct.

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

TB 17/18 058 **Sustainability and Transformation Plan Update**

Mr Pallot presented the Sustainability and Transformation Plan Update.

Mr Pallot reported that the STP had been paused whilst there was a change in leadership. Mr Pallot and Dr Swart are involved in looking at the new governance processes for the STP. It was noted that the new chair KGH will be positive for collaboration work within the STP. Mr Pallot advised that the MSK proposal is now ready.

Dr Swart discussed the governance structure of the STP with the Board. There is considerable support needed as the CEO's have now been given another tier of management. The key themes are that the Board needed to take a greater role in the STP's with the Chairs involved in the governance structure.

Mr Noble queried the green RAG ratings on pages 104 – 106 as this appeared not to be a correct reflection of the projects listed. Mr Pallot concurred with Mr Noble's view. Mr Archard-Jones challenged the governance behind this report and Dr Swart drew the Board back to the earlier discussion around the governance of the STP needing a refresh.

Mr Noble queried who had the overall responsibility of the STP. Dr Swart commented that this should be the STP lead with discussions with the CEOs. The Board had a lengthy discussion in relation to the credibility of the report and the issue of the whether the number green RAG rated projects is correct.

Mr Farenden queried the timeframes for the projects within the STP. Mr Pallot clarified that this was unclear however the Trust is controlling what it can. +

The Board **NOTED** the Sustainability and Transformation Plan Update.

TB 17/18 059 **EPRR core-standards assessment**

Mrs Needham presented the EPRR core-standards assessment.

Mrs Needham advised that the report is the Trust's self-assessment against the NHS England Core Standards for EPRR. There are 46 areas of criteria with a deep-dive into the Governance standards. Last year the Trust was partially compliant with

training and this year the Trust is fully compliant.

Mrs Needham stated that she attended a challenge meeting with NHS England and noted that she was pleased with the outcome. There will be a written decision in the next 2 months.

Ms Thorne queried the level of training on major incidents. Mrs Needham confirmed all individuals involved are trained. This included the Executive Team and the on-call managers.

The Board **NOTED** the EPRR core-standards assessment.

TB 17/18 060 **Best Possible Care Status**

Ms Fox presented the Best Possible Care Status.

Ms Fox commented that she pleased to bring the paper on Best Possible Care status for Cedar ward to the Board for approval. Ms Fox drew the Board to page 117 – 118 of the report pack which detailed the background and process in which the status is decided.

Ms Gill informed the Board that she had been on judging panel and confirmed that it was an extremely rigorous process. She commented on the good partnership between the nurses and ward doctors.

Ms Fox proposed that she invites the Ward Manager to the next Board for her to be presented a plaque and for the Board to see the presentation she gave to the panel. Ms Fox is going to work the Communication Team to share the positive news.

The Board **SUPPOTED** that Best Possible Care Status would be given to Cedar Ward.

TB 17/18 061 **Corporate Governance Report**

Ms Thorne presented the Corporate Governance Report.

Ms Thorne drew the Board to page 124 of the report pack which listed the number of declarations per quarter. It was noted that Q3 was higher than other quarters and this could be due Christmas.

Ms Thorne informed the Board that there has been a change to the business conduct policy to increase value before a gift needed is to be declared to £25.

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

TB 17/18 062 **Infection Prevention Annual Report**

Ms Fox presented the Infection Prevention Annual Report.

Ms Fox advised that the Board is cited on all issues monthly within the Director of Nursing report. Infection Prevention is also discussed at the Infection Control Steering Group and CQEG.

Ms Fox noted the positive position for the last financial year. There was 0 MRSA, the Trust was on trajectory for cdiff and the flu had been managed well.

Ms Fox anticipated a large national focus on flu this year due the 3 strains expected. The flu campaign will run from week commencing 2nd October and will follow the same campaign as last year of 'Jab and Grab'.

Mr Noble commented that e-coli incidents had increased the last 2 years and queried the factors behind this. Ms Fox stated that this had been a challenge and that a microbiologist had noted that it was difficult to address. There is a Best Practice Plan in place. Mr Finn reported to the Board that the recent PLACE assessment had rated the Trust 99.6% on cleanliness.

The Board **NOTED** the Infection Prevention Annual Report.

TB 17/18 063 **Highlight Report from Finance Investment and Performance Committee**

Mr Farenden confirmed that he would produce a highlight report for August's Board of Directors which will draw out the key issues from the Committee on the 20 September 2017.

The issues from the September Committee were largely the same as the issues noted at the August Committee. The winter plan had been discussed at the September Committee and a level of concern was raised.

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

TB 17/18 064 **Highlight Report from Quality Governance Committee**

Ms Clymer presented the Highlight Report from Quality Governance Committee.

The Board were provided a verbal update on what had been discussed at the Quality Governance Committee meeting held on the 22 September 2017. The report covered any issues of significance, interest and associated actions that were required and had been agreed to be taken forward by the Committee.

Ms Clymer advised of the key points –

- Safeguarding and DoLS were discussed.
- There will be an increased focus on falls.
- Poc-Sim presentation

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

TB 17/18 065 **Highlight Report from Workforce Committee**

The Board noted that there was no September Workforce Committee and the agenda had been carried over to the October Committee.

TB 17/18 066 **Highlight Report from Hospital Management Team**

Dr Swart presented the Highlight Report from Hospital Management Team.

Dr Swart advised that the HMT focused on workshop on the financial recovery plans. The HMT also received an update on cancer performance and annual planning. The deadline for business cases is tomorrow (30 September 17).

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

TB 17/18 067 **Any Other Business**

There was no other business to discuss.

Date of next Public Board meeting: Thursday 30 November 2017 at 09:30 in the Board Room at Northampton General Hospital.

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

Public Trust Board Action Log						Last update	17/10/2017
Ref	**Date of meeting**	**Minute Number**	**Paper**	**Action Required**	**Responsible**	**Due date**	**Status**	**Updates**
Actions - Slippage								
NONE								
Actions - Current meeting								
78	Sep-17	TB 17/18 053	Medical Director's Report	Dr Bisset reported that the clinical risks to the Trust are listed on page 20 of the report pack. There are difficulties in staff recruitment for Doctors and there is work ongoing to address this. Dr Bisset commented that the approach given will be to look at medical and nursing shortages together. Mr Farenden asked for a timeframe for an update on the approach. Dr Bisset believed that November would be appropriate	Dr M Metcalfe	Nov-17	On agenda	
79	Sep-17	TB 17/18 053	Medical Director's Report	Ms Gill suggested the use of a poc sim on the SI for Septic Shock. Dr Bisset commented that this was an option to explore.	Dr M Metcalfe	Nov-17	On agenda	
Actions - Future meetings								
NONE								

Northampton General Hospital NHS
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**30 November 2017**

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

Northampton General Hospital NHS
NHS Trust

Public Trust Board
30 November 2017

Chief Executive's Report

1. **CQC Rating**
   Board members will be aware that the CQC has now published their report and our services are now rated as GOOD overall. The improvement is clearly described in the narrative of the report and can only be the result of a whole hospital effort involving both clinical and non-clinical staff. Our workforce deserves praise and thanks for the improvements made during a period of intense pressure and for their positivity in the case of the scrutiny of the inspection regime.

   We have also received a high level of positive local, regional and national media coverage through TV, radio, print and social media with the sea of green ratings across all our services telling its own story in one picture. Our staff made their voices in support heard through their own social media accounts and I hope that a good many of them, as members of TeamNGH, will be able to join us at our celebration event on Friday 1st December where we will be able to showcase some of the improvements and also consider what more needs to be done and speak to CQC local inspectors about how we continue our improvement journey.

2. **Urgent Care – Fixing the Flow**
   We know at NGH that there is always more we can do to improve and enhance every aspect of our service. Despite the positive CQC description of our A&E department and our urgent care services, urgent and emergency care continues to pose a very significant challenge to us on a number of fronts. We know that although we have resolutely focussed on maintaining patient safety and prioritising the care of patients, the patients we admit are now sicker and often older. Maintaining the standards to which we aspire is becoming increasingly challenging. During recent months this has become more difficult. Despite rigorous attention to bed management and prioritisation according to clinical need, we have not been able to achieve the 4 hour urgent care standard and we have struggled to find beds for patients needing admission.

   We have, therefore, now formally launched a new improvement programme to focus on this issue, galvanising the energy of all our senior teams and our quality improvement teams. The programme of work which is entitled '**Fixing Flow for Best Possible Care**' is based on the same principles and values we have consistently applied to the improvement work around key quality standards and the work that has been done to improve the standards as seen by the CQC. The programme is being led by our COO, MD and DN with the clinical teams from divisions owning specific components of the work. It sets out to use improvement methodology with energy and ideas from the clinical teams on the ground. We have learned from our improvements so far that some of the key success factors for successful embedded change are very transparent and honest, evidence-based conversations, a resolute focus on quality and safety, a continual adherence to our values and specifically a need to ensure that everyone involved understands their own role in delivering care and improving care. To this end these principles are built into the programme.

The overall aim of our programme is to improve the flow of patients through the hospital so they have the right treatment as soon as possible and stay in hospital for the shortest time possible, whilst ensuring our clinical outcomes are good and patient experience is as good as it can be. In order to achieve this we are testing changes in rapid sequence in all parts of the patient's journey. A major feature of the programme relates to increasing the senior medical leadership for the management of urgent care and in maintaining patient safety across the site. This can require some careful balancing of risk in terms of the decisions made so that we minimise any need for patients to wait for admission.

The programme of work will be evaluated on a regular basis. The intention is to reduce length of stay and bed occupancy so we can provide better care. Some of the interventions will, however, be enabling and, as such, more difficult to measure than others.

We intend to continue this programme of work until such time as we have streamlined all our processes, standardised and optimised our approach across the hospital, reduced overall length of stay and thereby released enough capacity to enable us to run all the services our patients need. In this way we will also be demonstrating an improved use of resources

3. **Managing our finances**
We know that, in addition to the real pressure every day in terms of urgent care, we increasingly have a challenge to keep a careful control of our finances. Our financial challenge this year has included a drift away from the planned activity and some cost challenges, particularly around the temporary workforce. That is why it is even more important for us to look carefully at what we have managed to do and achieve over the past three years as we moved from 'Requires Improvement' to 'Good' in our CQC rating. At the same time we must consider why that has worked and how we now need to apply a similar approach to both urgent care and financial management. In simple terms both issues require a united approach from the whole hospital, along with some careful ongoing monitoring of progress in a programme of work that is carefully managed on a weekly basis; both require us to do things differently and both require a change in mind-set for everyone. We are developing a series of financial recovery plans which have been widely communicated to help staff understand that we need to ensure everyone who is part of TeamNGH is aware of their wider role in the hospital and is able to contribute to delivering the most efficient care we can. The view that good quality improvement can also assist in financial recovery needs to become embedded as we make the most use of current information that signposts us to quality driven efficiency such as GIRFT.

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4. **Long Service Awards**
Despite the challenges we face, it is important that we take time to pay tribute to our staff. Our Long Service Awards take place on Monday 18th December, 3pm-5pm in the boardroom. Last year's format of an afternoon tea was well received by all whom attended, so we will be adopting the same approach this year. Twenty-five members of TeamNGH are eligible for their long service award this year and I hope that as many board members as possible will be able to join me to celebrate and recognise the commitment and contribution of our colleagues.

Dr Sonia Swart
Chief Executive

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30 November 2017**

Title of the Report	**Medical Director's Report**
Agenda item	**8**
Sponsoring Director	Matthew Metcalfe, Medical Director
Author(s) of Report	Matthew Metcalfe, Medical Director
Purpose	Assurance

Executive summary

Risk
The principle risks relating from emergency care pressures and medical workforce gaps are presented together with the strategies for addressing them.

Harm
Since the last report to the Board, during the reporting period 01/08/2017 – 31/10/2017, 8 new Serious Incidents have been reported onto STEIS, 4 out with the standard reporting framework. The investigations for these are on track to complete within agreed timeframes. In brief they relate to;

i. Delayed diagnosis of an axillary nerve palsy
ii. Preventable Hospital Aquired Thromosis (HAT)
iii. Maternity cardiac arrest
iv. Delay/failure to monitor cardiac patient

One SI report has been submitted to Nene CCG for closure.

VTE and HAT data are presented as a harm "theme" for which some immediate actions have been undertaken recognising that more work is required.

Mortality
Dr Foster data showed overall mortality expressed as the HSMR remains within the 'as expected' range. Outlier alerts are being investigated in relation to respiratory disease and advanced malignancy.

A completed mortality review for AKI deaths has highlighted in particular the need to improve the management of fluid balance in the trust and a task and finish group is addressing this.

Job Planning
Beginning in the Medical Division, Job Planning for consultants is being refashioned around the priority of emergency flows and the increased resource required during escalation.

Related strategic aim and corporate objective	Be a provider of quality care for all our patients
Risk and Assurance	Risks to patient safety if the Trust does not robustly investigate and identify any remedial actions required in the event of a Significant Incident or mortality alert.
Related Board Assurance Framework entries	BAF 1.4, BAF 1.5, BAF 4.1 and BAF 4.2
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (Y/**N**) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(Y/**N**)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper

Actions required by the Trust Board

The Board is asked to note the contents of this report, details of clinical risks, mortality and the serious incidents declared and identify areas for which further assurance is sought.

Public Trust Board

30 November 2017

Medical Director's Report

1. Introduction

It is a great pleasure to present this inaugural medical director's report as I join the board of Northampton General Hospital NHS trust. The purpose of this report is to reflect faithfully upon the quality and safety of the clinical services afforded to pour patients against our vision of delivering best possible care for all our patients. For ease of access the report is structured;

i. in relation to the principle risks to delivery where these are rated "extreme" (>14)
ii. review of harm, incidents and thematic
iii. mortality and the management of outlier alerts
iv. related topics from the medical director's portfolio on an ad hoc basis

As incoming medical director I have taken the opportunity to review in person many of the groups and committees which oversee the support and development of clinical quality and safety at the trust. This review continues and notably is extending into the divisional governance structures in order to gain an understanding of the interaction between the corporate and divisional governance.

A summary report of observations and recommendations arising from this will be presented to QGC and the board by the end of Q4 2017/18. It is likely that the format of this report will evolve iteratively over the same time course, and feedback in relation to accessibility and content from the board is most welcome.

2. Risk

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

1. Pressure On Urgent Care Pathway

CRR ID	Description	Rating (Initial)	Rating (Current)	Corporate Committee
1286	Frequent and prolonged loss of elective orthopaedic ward for escalation	20	20	Finance & Performance
96	Inconsistent in-patient capacity due to delays in the discharge process resulting in an increased length of stay.	12	16	Finance & Performance
619	Risk to patient safety and of deterioration in condition of the elective Heart Centre patients when they are cancelled due to the Heart centre being utilised as an escalation area	25	16	Quality Governance

731	Risk of not providing a safe and timely haemodialysis service for inpatient and outlier/emergency patients when emergency renal (Northamptonshire Kidney Centre) beds are utilised for outlying patients	20	16	Quality Governance
1194	Delayed discharge on a near daily basis of Critical Care step down patients results in delay admitting new patients to the Unit	15	15	Quality Governance

Taken together these risks reflect the single greatest challenge to the trust in delivering safe high quality care. The trust has accelerated its response to this through the "fixing the flow" programme. This is lead jointly by the Chief Operating Officer, the Medical Director and the Director of Nursing. This programme incorporates previous work streams both local and national (eg "Red to Green" and SAFER) and augmented them with others. The programme is ordered into three cohorts of actions, specifically emergency assessment, discharge and site management. All available resource from the QI and IQE teams has been released to prioritise fixing the flow. The programme is steered through weekly meetings chaired alternately by the three executive leads with a focus on rapid tests of change using standard QI methodology. The programme is in its 4th week at the time of writing.

Examples of initial "treatments" tested during the programme to date include;

i. Rapid transfer of patients from ED and assessment units to base wards.
ii. Introduction of senior medical leadership rota to support the organisation when in escalation.
iii. Timetable of consultants in SPA time available to site team and senior medical staff to call on when additional input required on wards.
iv. Improved distribution of medical on call rotas to reduce referral delays.
v. POC SIM team training sessions delivered to assessment areas to increase and standardise emergency nursing competencies.
vi. Patients admitted from outpatient clinics no longer streamed through Ambulatory Care Centre (ACC), and ACC pathways reviewed.

In addition, the "emergency floor" has been implemented enabling the introduction of new models of emergency care to be tested and refined prior to opening the new 60 bed unit.

2. Difficulties in Securing Sufficient Nursing & Medical Staff

CRR ID	Description	Rating (Initial)	Rating (Current)	Corporate Committee
1348	High number of vacancies in Oncology/Haematology contributing to in-patient and out-patient delays	9	20	Workforce
979	Difficulty in recruiting to the establishment due to local and national shortages of nurses and difficulties associated with overseas recruitment.	16	16	Quality Governance

1155	Potentially unable to maintain appropriate staffing levels in theatre areas due to a large amount of staff vacancies	15	15	Quality Governance & Workforce
92	Risk due to ongoing medical workforce issues including the high use of locums, middle grades requiring ongoing supervision and training and regionally funded posts being lost	20	16	Quality Governance & Workforce
1162	Vacant posts within Gen Med for CT, GP VTS and specialist posts as a result of lower fill rates in the East Midland South for training posts	16	16	Quality Governance & Workforce
1382	Transitioning inexperienced staff within the Medical staffing team to newly implemented processes and procedures is challenging and will take a period of time to embed which has led to inefficiencies and errors such as the recruitment to permanent positions	16	16	Workforce
1558	Theatre vacancies and failure to recruit has resulted in the temporary pull back from operating in Daventry.	16	16	Workforce

In relation to the medical workforce, a strategy to promote recruitment and retention for the trust against the backdrop of national severe medical workforce shortfall has been considered in detail by the workforce committee this month. Key elements of this strategy will include;

1. Incentivise recruitment of non-training non-consultant grades through providing support to specialist registration (CESR programme).
2. Recruit oversees medical graduates (MTI initiative).
3. Proactive programme of over-recruitment.
4. Internal supply through additional duty hours system and medical bank.
5. Improved consultant recruitment.
6. Development of joint clinical and academic posts in partnership with local and regional universities.

The risk section of this report reflects the structure used in previous board reports. The corporate risk register is currently under review and revision. From January 2018 the medical director's report to the board will summarise risks under the following categories;

i. Urgent care
ii. Medical staffing
iii. Performance
iv. Financial control

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 2017/18 YTD, with previous years for comparison.
ii. The number of new serious incidents requiring full root cause analysis (RCA) and moderate harm incidents requiring "concise" RCA since the last trust board. Summary information for new Serious Investigations initiated and submitted to the CCG are provided.
iii. Key thematic issues relating to avoidable patient harm.

3.i Run rate of SI and Never Event investigations

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

3.ii New SI and moderate investigations

There were 8 serious incidents reported on STEIS during September and October, 4 of these "outwith" local investigation processes. The safeguarding team at the trust have confirmed the "outwith" cases present no current risk to patients or staff.

The 4 SI investigations opened during September and October are on track to report by their deadlines and consist of;

i. Delayed diagnosis of an axillary nerve palsy
ii. Preventable Hospital Aquired Thromosis (HAT)
iii. Maternity cardiac arrest
iv. Delay/failure to monitor cardiac patient

The completed SI report on a patient with a fractured calcaneum was submitted to Nene CCG. This was in essence a rare injury and the delayed diagnosis was in part explained by this but there were opportunities to identify it earlier particularly during outpatient review. The learning and actions have been shared with QGC.

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

3.iii Thematic issues

The SI reported in October relating to a preventable HAT was symptomatic of 2 thematic issues prevalent in the trust, specifically poor compliance with VTE risk assessment and prophylaxis and delayed response by staff to requests for statements etc.

The persistent poor compliance with venous thromboembolism (VTE) risk assessment requirements is detailed in the Quality Improvement scorecard. At trust level compliance for first assessment for non-censored patients in October was 83.5% against a national target of 95% with data from real time VITALPAC entries. A review of Q1 Hospital Acquired Thrombosis (HAT) has been completed. Of the 19 HAT episodes identified though radiology and post mortem reports, 14 were found not to have been preventable, and 5 potentially preventable. Five HAT episodes were fatal, all of these deemed unpreventable.

The fatal HAT reported to STEIS in October occurred last year and the delay in identification would have been avoided with better responsiveness to requests for clinical input into the RCA process for the HAT.

VTE and HAT actions

The actions taken by the clinical lead for thrombosis since the last trust board report to improve VTE compliance include;

1. Reminder to all medical staff regarding the recording of VTE assessment on admission with guidance notes. All consultants informed of the avoidable HAT logged with STEIS.
2. Reminder to all nursing staff of the requirement to record weights on admission (for appropriate dosing of prophylaxis when indicated.)
3. Reminder to all medical staff to prescribe mechanical prophylaxis (thrombo-embolic deterrent) (TED) stockings when pharmacological prophylaxis contra-indicated.

The deputy director for Quality Improvement and Patient Safety will generate a weekly report by ward, directorate and division of compliance with VTE excluding censored cases and a trajectory will be set for each where this compliance is below 95%.

Responsiveness actions

The clinical and divisional directors have agreed that it is a reasonable expectation that medical colleagues will respond to requests for statements/information in relation to incidents/complaints within 7 days. Non-compliance will be escalated to the CD and DD concerned at that point. At 14 days the escalation will be to the medical director. The Director of nursing and Chief Operating Officer have agreed to the same timeframes for other staff groups. This will be monitored weekly for incident information requests.

4. Mortality

Mortality rates

HSMR, SHMI and HSMR for weekend/weekdays are all as expected. The data supporting this has been explained and illustrated in reports to the board and QGC frequently, and this is not repeated here. The previously noted divergent trend has reversed, therefore there are no plans to investigate this.

SMR for the 7 high risk diagnoses and for low risk groups are as expected except for acute and unspecified renal failure which is worse than expected, and acute MI and pneumonia which are both better than expected.

Crude mortality was 1.2% for September and 1.3% for October

Palliative care coding is 2.2% (Nationally 2.3%) and Charslon comorbidity scoring is 45.9% (Nationally 49.7%)

There are no specialty or consultant level mortality outliers in the National clinical audit data published in September/October 2017 (National Hip Fracture database, National Joint Registry, National Emergency Laparotomy audit and National Vascular Registry Surgical Outcomes)

Mortality alerts

Mortality alerts under review are;

i. Respiratory failure, insufficiency, arrest (adult)
ii. Secondary malignancies

These reviews will be undertaken by the host directorates supported by the corporate medical and audit teams. Their findings will be reported in due course to QGC and the

A mortality review has concluded into increased Acute Kidney Injury mortality. This has found 23% of cases had poor care with poor fluid management a clear theme. This triangulates with a number of care delivery problems identified in harm incidents recently. After discussion at CQEG a task and finish group was commissioned, led by the deputy medical director, to respond to this as AKI has been an outlier for mortality for 7 consecutive months.

QGC and the board will be appraised of the outputs of this task and finish group.

Job planning for consultants

Our senior medical workforce is an essential enabler to addressing urgent care pathway pressures. The job plans of the consultants in the trust need to be aligned to this pre-eminent clinical priority. This is also necessary to deliver good value for our patients.

By Q1 of 2018/19 the specialities and directorates in medicine division will have built service delivery models which specify the consultant resource required to support emergency flows

under normal circumstances, the additional resource needed to support emergency flows when the trust has escalated to OPEL 4, the input required for elective care and finally the consultant time essential to the governance of the service and the professional requirements of the consultants. Residual SPA time, deemed of low priority for the trust, will be transferred to be used in support of the escalated emergency demand as required or recovered to the directorate budgets as required.

The other divisions will follow this process quarter by quarter through 2018/19. A detailed paper describing the process will be presented to workforce committee in December 2017.

Title of Meeting	**Public Trust Board**
Date of Meeting	**30 November 2017**

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

Executive Summary

This report provides an update and progress on a number of clinical projects and improvement strategies that the Nursing & Midwifery senior team are working on. An abridged version of this report, providing an overview of the key quality standards, will become available on the Trusts website as part of the Monthly Open & Honest Care Report.

- Safety Thermometer, in October 2017 the Trust achieved 98.73% harm free care (new harm) and overall harm free care was 95.09% a slight decrease in last month's percentage.
- Maternity Safety Thermometer, the overall percentage of women and babies who received 'harm' free care in October 2017 was 75.0% above the national aggregate of 71%.
- Pressure Prevention, 11 patients, with 15 PU's were harmed in October 2017 (12 Grade 2 pressure ulcers, 3 unclassified Grade 3 pressure ulcers).
- Infection Prevention, in October 2017 there were:
  - No MRSA
  - 1 MSSA bacteraemia in October.
  - 5 patients were identified with Trust attributable E coli bacteraemia.
  - 1 patient identified with Clostridium Difficile Infection
- Friends and Family Test (FFT), Trust wide results had a slight increase in October 2017 at 92.1%.The September results for inpatient & day cases were 93.3%.
- Falls - in October 2017 there were no moderate, severe and catastrophic falls.
- There is an update on Safeguarding, Assessment and Accreditation, the Nursing and Midwifery Dashboard and Infection Prevention High Impact Intervention Dashboard.
- The report provides a summary of the Safe Staffing for the Trust in. Overall fill rate in October was 102%, and in September it was 103%.

Related strategic aim and corporate objective	Quality & Safety. We will avoid harm, reduce mortality, and improve patient outcomes through a focus on quality outcomes, effectiveness and safety
Risk and assurance	The report aims to provide assurance to the Trust regarding the

Enclosure E

	quality of nursing and midwifery care being delivered
Related Board Assurance Framework entries	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) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper - No

Actions required by the Committee
The Trust Board is asked to discuss and where appropriate challenge the content of this report and to support the work moving forward.

The Trust Board is asked to 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.

Public Trust Board
November 2017

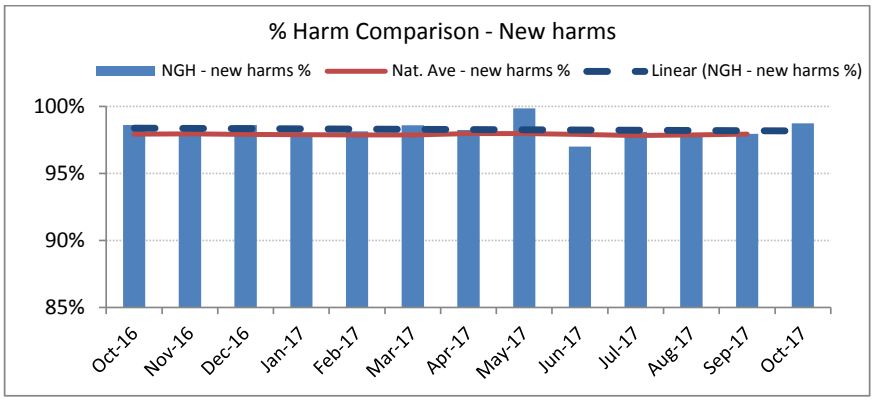
Director of Nursing & Midwifery Report

1. Introduction

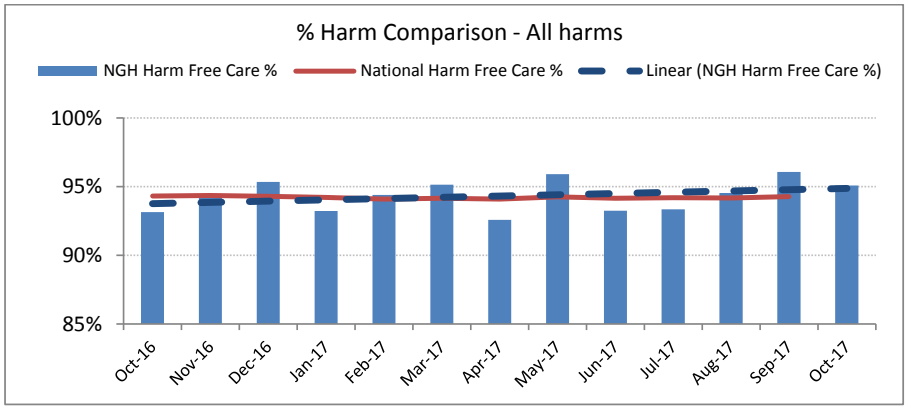
The Director of Nursing & Midwifery (N&M) Report presents highlights from services, audits and projects during the month of October 2017. Key quality and safety standards will be summarised from this monthly report to share with the public on the NGH website as part of the 'Open & Honest' Care report. This monthly report supports the Trust to become more transparent and consistent in publishing safety, experience and improvement data, with the overall aim of improving care, practice and culture.

2. Safety Thermometer

The graph below demonstrates the percentage of new harms attributed to an in-patient stay. In October 2017, the Trust achieved 98.73% harm free care (new harm); with a slight increase to last month's percentage and the second highest percentage since October 2016.



The graph below illustrates overall harm free care was 95.09% in October 2017; this is a decrease to last month, remaining above the national average of 95%. (Appendix 1 provides the National Safety Thermometer Definition).



Enclosure E

3. Maternity Safety Thermometer

The Maternity Safety Thermometer enables the calculation of the proportion of women and babies who received harm free care. This is calculated by dividing the number of women receiving harm free care by the total number of women. The numerator is defined as the number of women in whom all of the following harms are absent: (Appendix 1 provides the Maternity Safety Thermometer Definition).

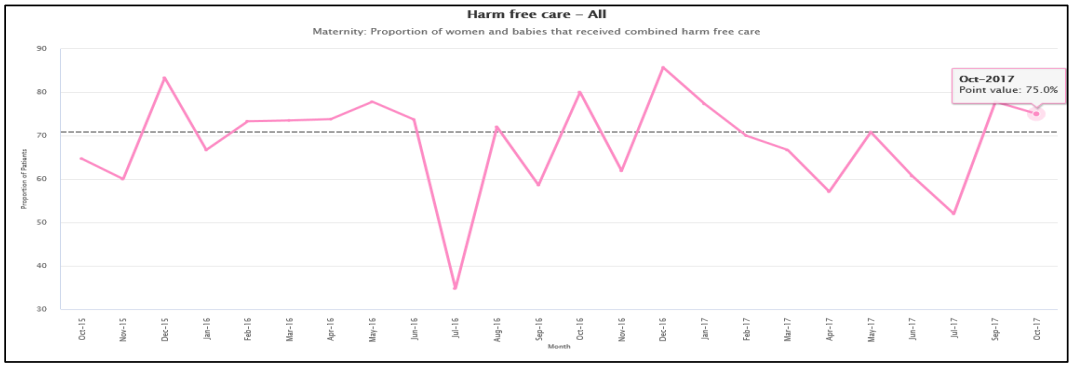
Physical 'harms'

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

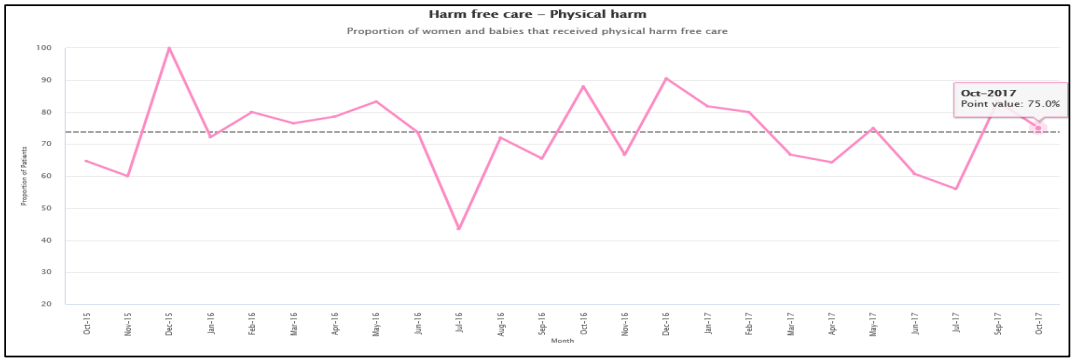
Psychosocial Questions

- Mothers left alone at a time that worried them
- Babies separated from their mother (although this is still measured, it is no longer included in the overall Harm Free Care)
- Concerns about safety during Labour and Birth not taken seriously

The following graph illustrates that the overall percentage of women and babies who received 'harm' free care in October 2017 was above the national aggregate of 71%.

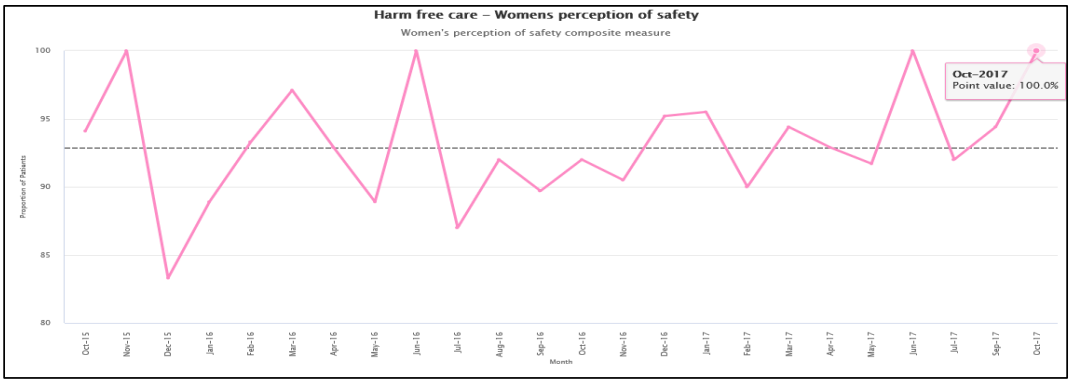


The graph below show the percentage of harm free care associated with physical harm and psychosocial harm (women's perception of safety). For Women experiencing physical harm free care we are above the national aggregate level of 72% with a proportion of 75.0% a decrease to last month.



The graph below demonstrates that all women felt that their concerns about safety during labour and birth were taken seriously and none of them were left alone at a time that worried them. Given that during October, the maternity services experienced extremely high and

sustained levels of activity, this is reassuring to note and has been shared with staff.

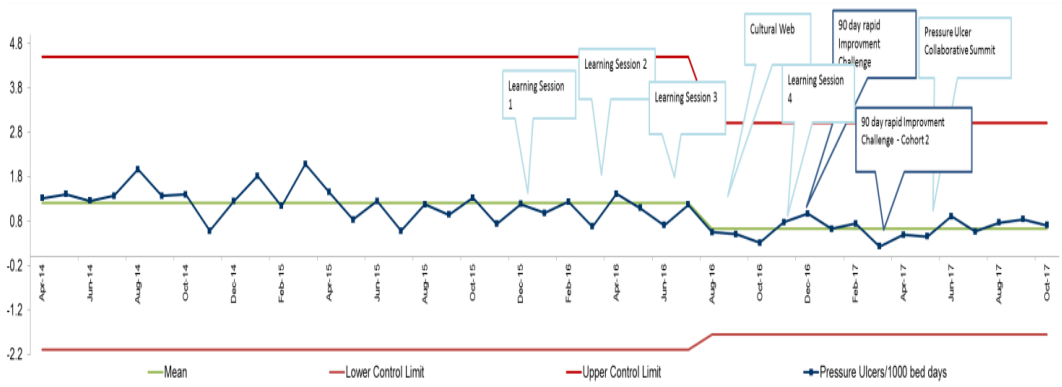


4. Pressure Ulcer Incidence

In October 2017 the Tissue Viability Team (TVT) received, a total of 320 incident reports relating to pressure damage. Of these 28 (9%) were duplicated reports. 32 patients were not seen as either not admitted or discharged within 24 hours of reporting pressure ulcer (PU) harm. Of the remaining incidents reported, 60% were validated by the TVT on the wards; the remainder were validated from photographs.

Number of Pressure Ulcers per 1000 bed days

The chart below shows the number of pressure ulcers/1000 bed days in relation to hospital acquired pressure ulcers by Quality Improvement (QI) methodology, utilising a run chart and demonstrates that changes being made are leading to statistically significant improvements.

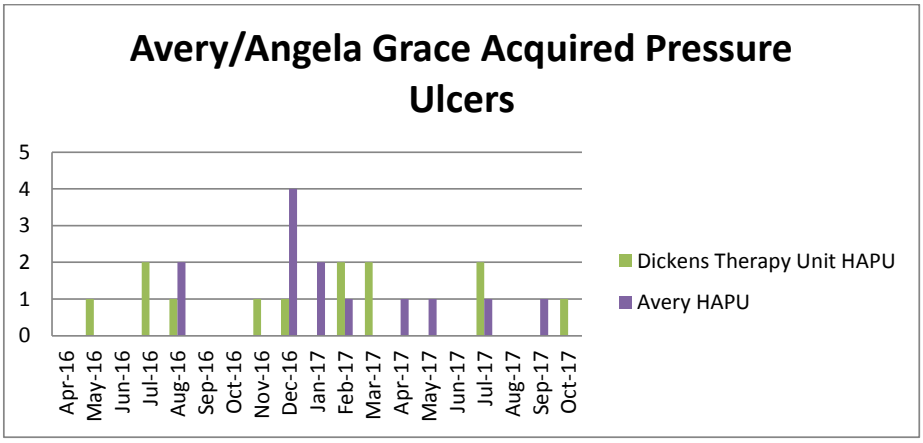


Pressure Ulcer Change Package

This will be officially launched on Wednesday 15th November to coincide with International Stop the Pressure Day (Thursday 16th November). The Change package identifies 7 (steps to success) changes that reduce pressure ulcers when applied reliably to patient care and should address the increase in the mean line above (Per 1000 bed days graph above).

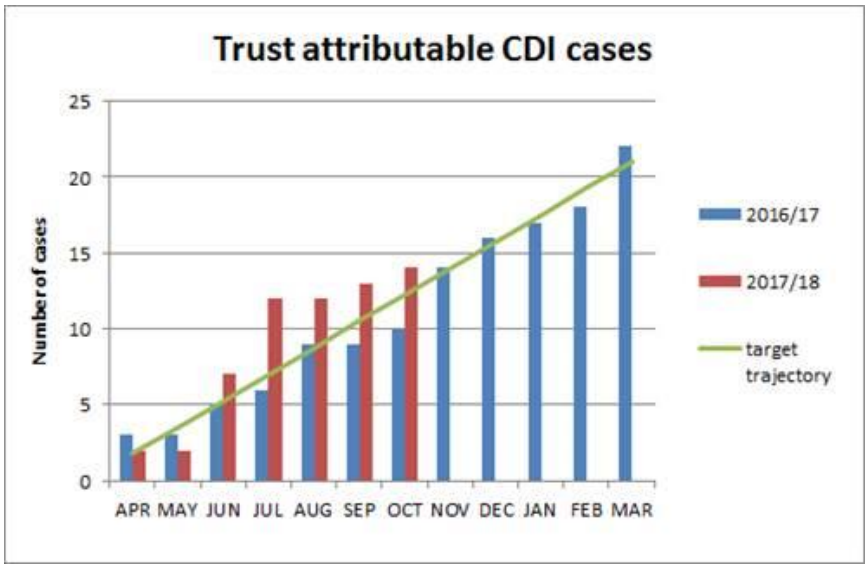
Avery/Angela Grace PU Incidence

The graph below represents the number of pressure ulcer harms reported in 2016-2017 to patients in either Blenheim or Cliftonville Wards (Avery) or Dickens Therapy Unit (Angela Grace). The TVT continue to report and investigate these harms as per Trust protocol. One patient developed a Grade 3 pressure ulcer on Dickens Therapy Unit (DTU) in October.



5. Infection Prevention and Control

Clostridium difficile Infection (CDI)



The above graph shows the number of patients with Trust attributable CDI. For October 2017, there was 1 patient with Trust attributable CDI. This was attributed to Spencer ward who have received enhanced cleaning, an Estate, Domestics and Infection Prevention (EDI) review and the surgical collaborative change package is being rolled out on the ward. A root cause analysis has been completed and no lapses of care have been identified and the report has gone to the CCG for review.

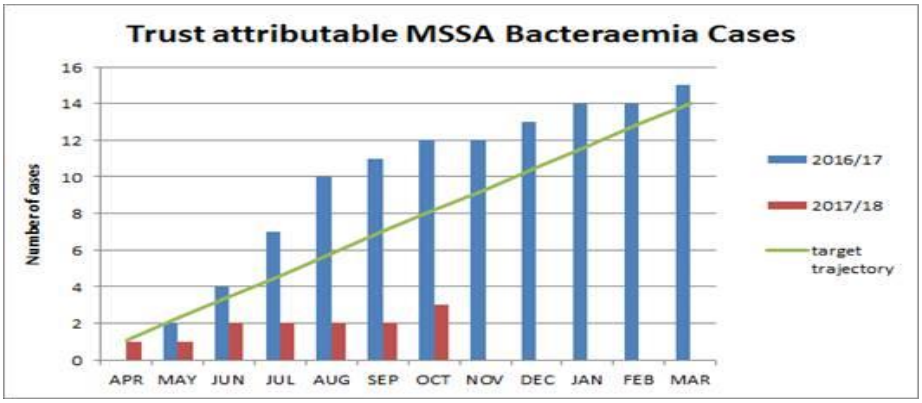
MRSA Bacteraemia

MRSA bacteraemia: there were no Trust attributable MRSA bacteraemia for October 2017.

MSSA Bacteraemia

MSSA bacteraemia: There was 1 Trust attributable MSSA bacteraemia for October 2017. This was attributed to Blenheim ward; the graph below illustrates the cumulative total of

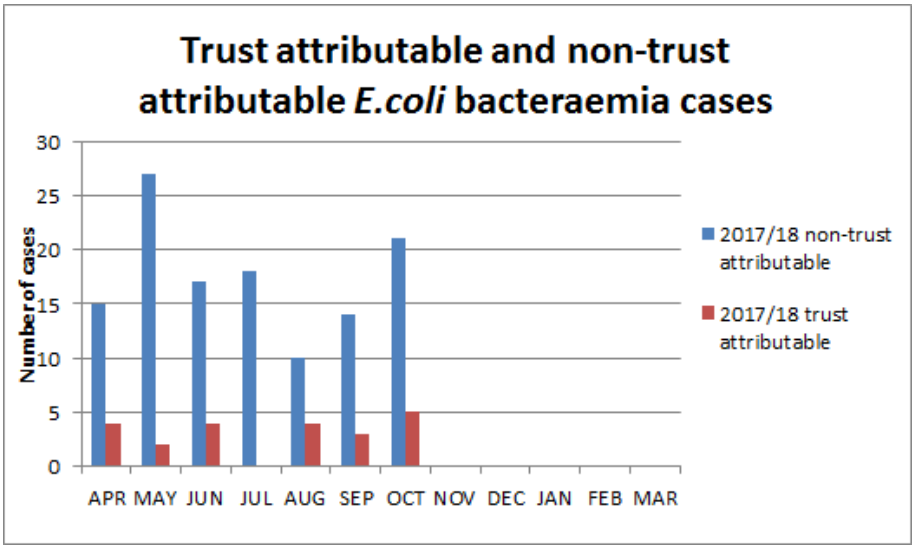
MSSA bacteraemia. The Trust remains under its internal trajectory of 14, with 3 Trust attributable MSSA bacteraemia for the year to date.



***Escherichia coli* (*E.coli*) Bacteraemia**

In June 2017 a decision taken to ask all Clinical Commissioning Groups (CCGs) to reduce *E.coli* bacteraemia by 10% for 2017/18. The local CCG ambition is supported by the Quality Premium and will require a Whole Health Economy approach. Therefore, working in collaboration with Northampton General Hospital IPC Team, Public Health England, Kettering General Hospital IPC Team and the Community Lead IPC Nurse, the CCG has produced a draft *E.coli* action plan which will be reviewed at subsequent whole health economy meetings. The draft *E.coli* action plan is on the agenda for review at the Infection Prevention Steering Group (IPSG) in November 2017.

October 2017 there were 21 non-trust attributable *E. coli* bacteraemia and 5 trust attributable *E.coli* bacteraemia.



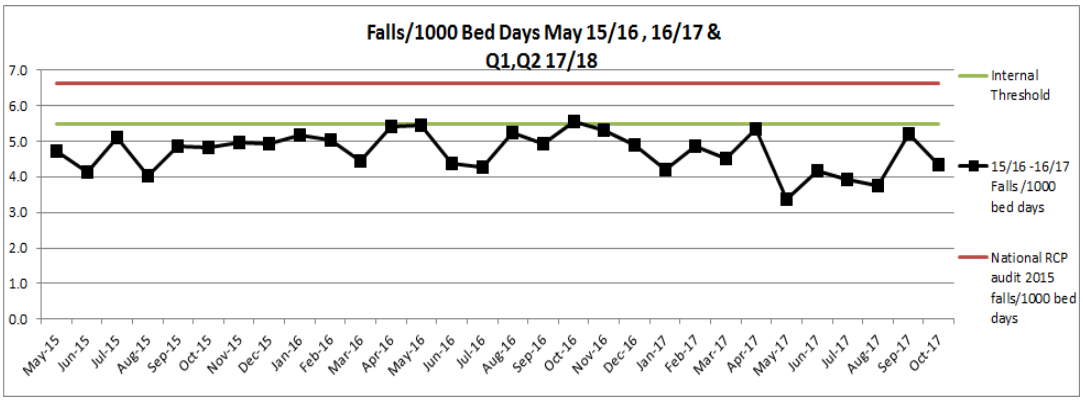
The table below shows the source of *E coli* infection.

Source of Infection October 2017	
Urine	1
Urosepsis	1
Placenta	1
Infected haematoma	1
Unknown	1

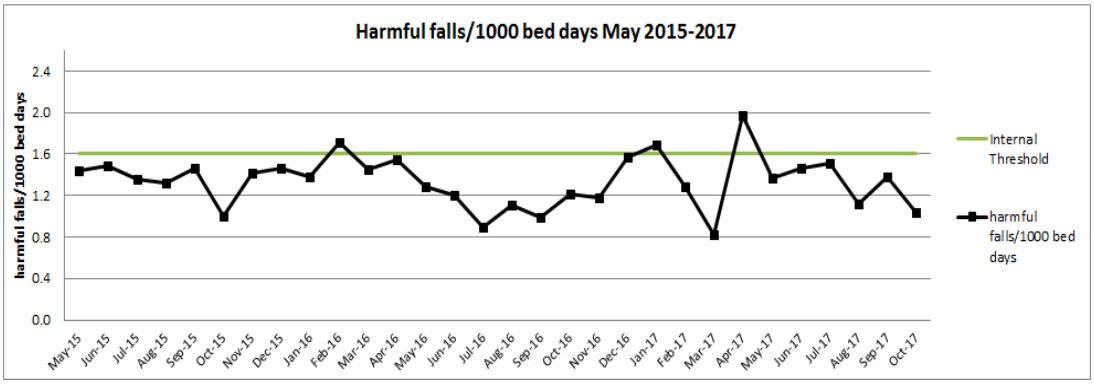
Prevention High Impact Intervention Dashboard
The Trust has been auditing practice using the updated monthly infection prevention high impact interventions since April 2017. The audit continues to populate the dashboard (Appendix 2) which supports continuous quality improvement, development and manages trends, providing safer care for patients. The results from this dashboard, inclusive of a trend analysis are discussed at the monthly Infection Prevention Operational Group (IPOG) and actioned if required by the Matrons. In October IPOG meeting the trend analysis of the dashboard highlighted that wards/departments are not consistently compliant with the High Impact Interventions. There is room for improvement with the insertion of invasive devices on Vital PAC. Matrons are working on improving this with the staff in the clinical areas. The IPCT will continue to meet with individual areas to address the issues raised.

6. Falls Prevention

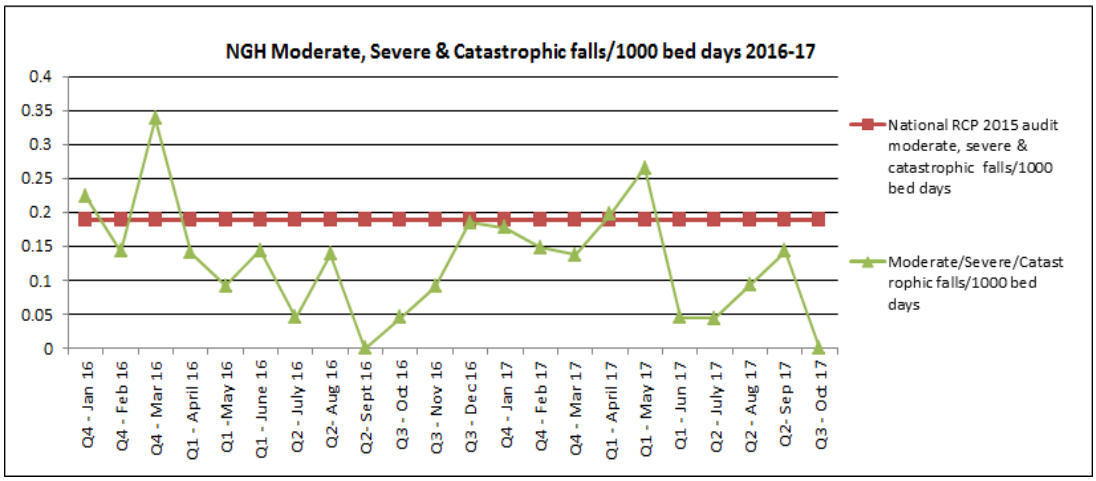
Falls/1000 bed days
The Trust's falls/1000 bed days are below the national average of 6.63/1000 bed days and the internally set trust target of 5.5/1000 bed days. There was a reduction in the number of falls/1000 bed days of 0.87 compared to the previous month of September 2017.



Harmful Falls/1000 bed days including Low, Moderate, Severe and Catastrophic
The recording of harmful falls in this data represents low, moderate, severe and catastrophic harm. Through October 2017 harmful falls/1000 bed days have reduced by 0.34, in total the Trust recorded 1.04 harmful falls/1000 bed days compared to 1.38 harmful falls/1000 bed days in September 2017. The Trust has an internally set target of 1.6 harmful falls/1000 bed days.



Falls resulting in moderate, severe or catastrophic harm
The following graph shows that there were no moderate, severe and catastrophic falls in October 2017.



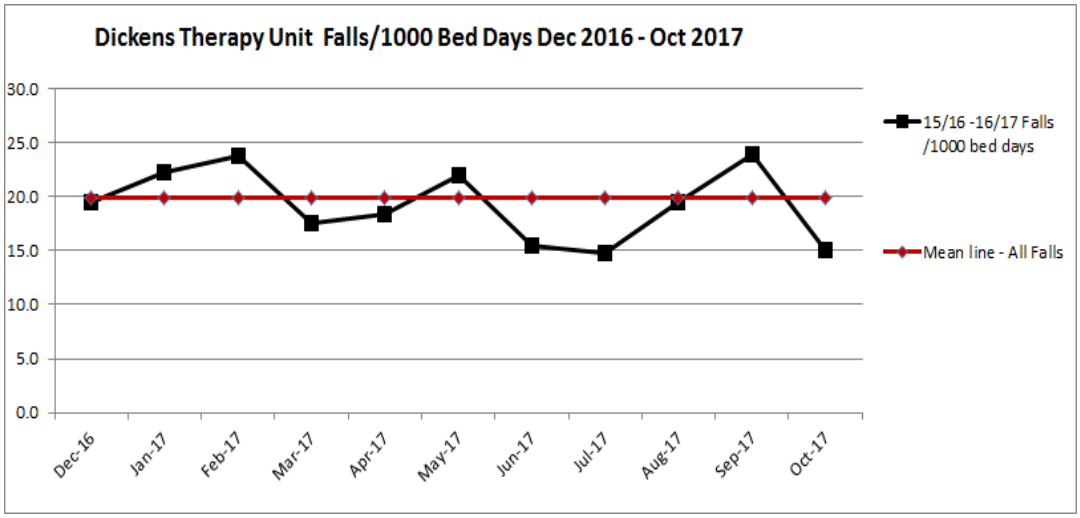
Rapid Improvement Project:
Following the successful completion of a National Improvement project to reduce falls a larger Trust project has been launched. 5 wards are taking part in a 90 day rapid improvement project which focusses on small tests of change through Plan Do Study Act (PDSA) cycles. The overall goal is to reduce falls by 10 percent over the 5 wards.

The project launched at the start of October 2017 and the first feedback session was held at the end of October 2017. Tests of change include new safety huddle questions for staff, identifying patients with falls risk factors differently, new bay tagging education package, grab bags for toilets, issuing of individual walking aids and adjusting bed spaces to accommodate patients' usual routine of getting out of bed.

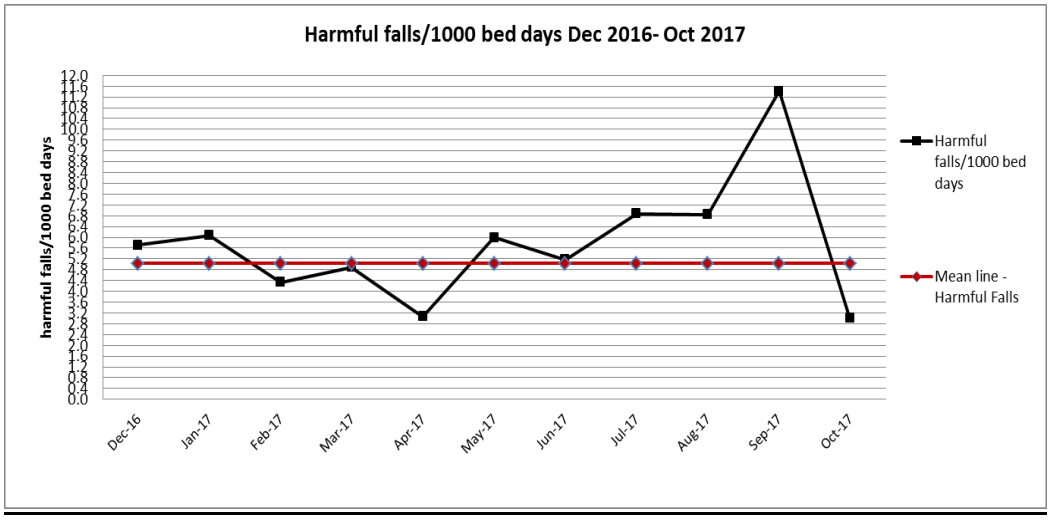
There have been no moderate or severe harm patient falls on the five wards taking part since the launch of the rapid improvement project, in 3 of the 4 weeks monitored there was a reduction in the mean average of falls across the 5 wards.

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. In total 15 patient falls were recorded at DTU; 3 low harm falls and 12 no harm falls. One low harm patient fall is being reviewed to see if severity requires increasing to moderate.

Falls/1000 bed days at Dickens Therapy Unit
The number of patient falls/1000 bed days reduced in October 2017 by 8.83 compared to September 2017.



Harmful falls/1000 bed days Including Low, Moderate, Severe and Catastrophic
The graph below represents low, moderate and severe falls/1000 bed days. Harmful patient falls reduced in October 2017 by 8.4 when compared to September 2017.



7. Nursing and Midwifery Dashboards

The Nursing and Midwifery Quality Dashboards provides 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.

Please see (Appendix 3) for a definition of the Nursing Midwifery Dashboard, (Appendix 4) for the Nursing dashboard, (Appendix 5) for the Paediatric dashboard and (Appendix 6) for the Maternity dashboard. The specialist areas have all updated their QCI questions the IT department are reviewing timeframes for the work to be completed by uploading onto the

HIVE, theatres new QCI's are being uploaded currently and should be ready to use next month.

The QCI for October 2017 demonstrates the following:

Trust wide Overview of the Dashboard

- In October 2017 there were a total of 12 red domains on the QCI dashboard for the general wards, of which 4 were within the domain of first impression a slight increase from last month. First impression has been of high focus for the teams and is also assessed during assessment and accreditation.
- Compliance with falls assessments and pressure prevention assessment has been high focus for the teams with improvement seen, the review continues in the 'collaboratives' and at the 'share and learn' meetings. There are 3 red domains this month one in the category of falls and 2 red domains in Pressure prevention assessment category.

Surgical Division

- There were 4 red domains on the QCI dashboard in October 2017 for Surgery a decrease from last month.
- Head and Neck Ward had 3 red domains, 1 red domain for falls and pressure prevention assessment and one in patient experience protected meal times. For the domain of falls and pressure prevention there were incomplete assessments which in turn led to incomplete nursing care documentation.
- Willow ward had 1 red domain a decrease from last month, for patient safety and quality the emergency equipment had not been checked for one day out of the month.
- Cedar Ward has a grey domain this is down to an inputting error which in turn led to an incomplete section.
- The Ward Sister, Matron and the Associate Director of Nursing (ADN) monitor the results monthly and highlight any specific themes or areas for improvement.

Medical and Urgent Care Division

- Medicine had 8 red areas in October 2017 on the dashboard;
- Victoria Ward, EAU, Allebone Ward, Brampton Ward had 1 red domain each for first impression. The assessors felt the ward scored average on similar questions, the level of coordination on the ward, the general ward environment and the leadership this section is being worked on through their work with assessment and accreditation.
- Holcot ward had 1 red domain for patient experience protected mealtimes it was noted that the tables needed to be free from clutter.
- Eleanor Ward had 1 red domain on care rounds observe patients records which was due to incomplete assessments which in turn led to incomplete nursing care documentation.
- Creaton had 2 red domains,1 for protected mealtime due to one question in the set not being completed and falls assessment which was due to incomplete assessments which in turn led to incomplete nursing care documentation.
- Benham Ward has a grey domain this is down to an inputting error which in turn led to an incomplete section.
- The Ward Sisters, Matrons and the ADN monitor the results monthly and highlight any specific themes or areas to improve.

Gynaecology Children's and Oncology Division

- Talbot Butler and Gynaecology have 0 red domains in October 2017 for the second month running;
- Paediatrics had 4 red domains, 1 on Paddington and Disney Ward for patient overdue observations frequency.
- Gosset Ward should have been 100% following a review of the data for the domains of Friends and Family test and overdue observations.
- The Ward Sisters, Matrons and ADN monitor the results monthly and highlight any specific themes or areas to work on.

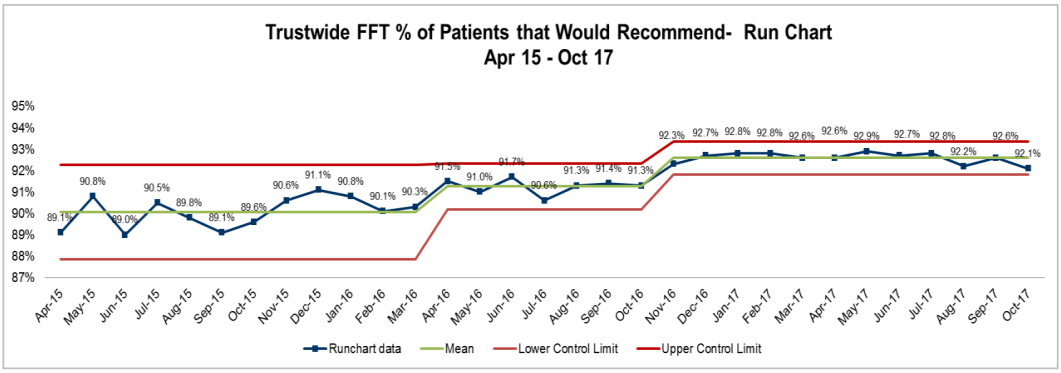
Maternity

- Sturtridge, MOW and Balmoral have 0 Red domains in October 2017.
- Robert Watson Ward has 1 red domain for Postnatal Assessment. This is due to the fact that 4 of the questions within this domain are related specifically to documentation in the Perinatal Institute's Postnatal handheld notes, which were withdrawn in July 2017. All documentation is now on the Medway Clinical IT system and the QCI metrics will be updated to reflect this.

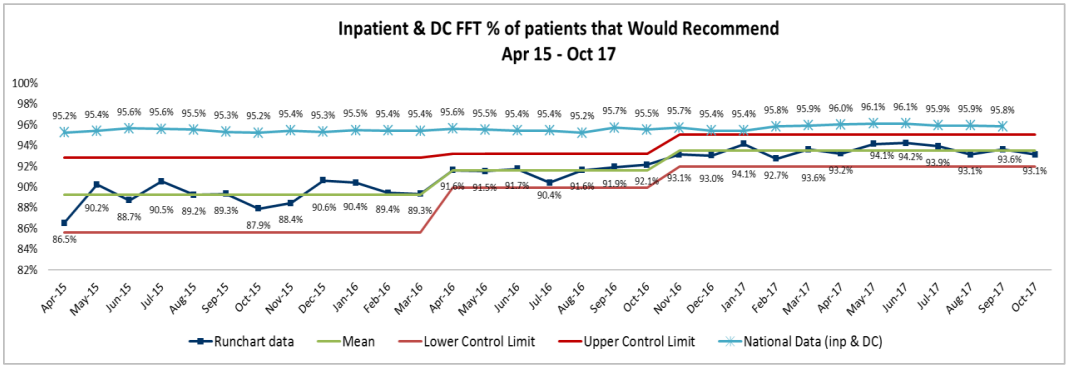
8. Friends & Family Test (FFT)

FFT Overview- % Would Recommend Run Charts

The Trust wide data has remained static for a number of months and October's results of 92.1% fell below the mean of 92.6%. Although this is within normal variation.



Progress has stabilised within Inpatient and Day Case areas and October 2017 as with the Trust wide data, saw a slight decline in the percentage of patients that would recommend. This will be monitored over coming months.

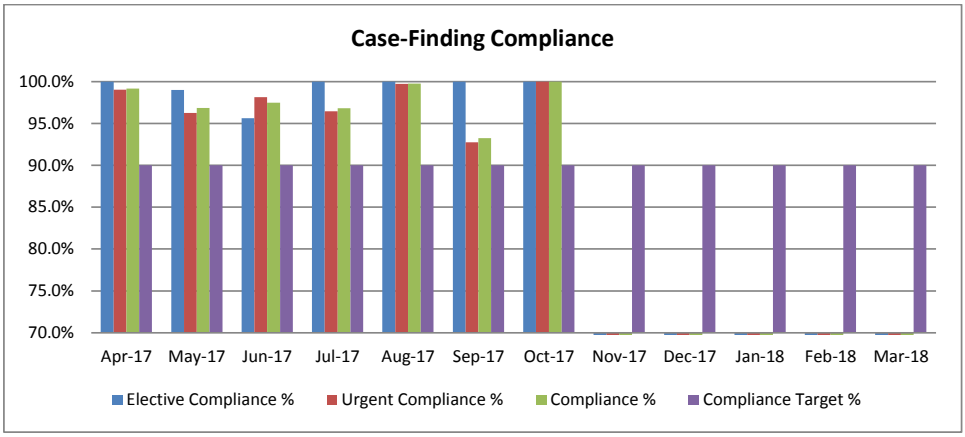


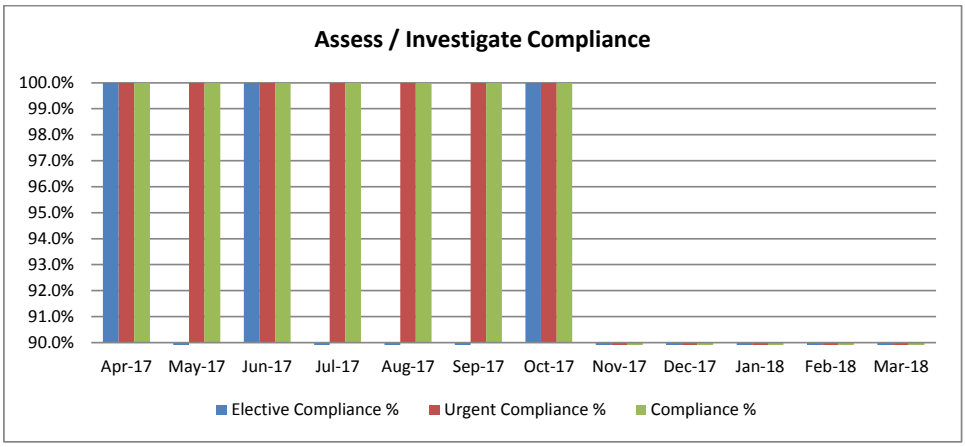
9. Safeguarding

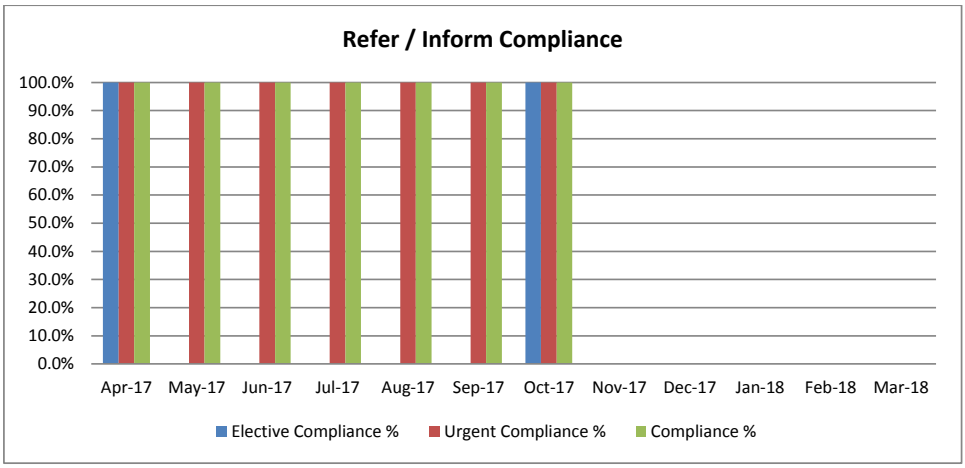
Dementia Activity

Discharge Summaries

There has been an increase in figures over the last month and this is illustrated in the three graphs below which demonstrate 100% compliance has been achieved:







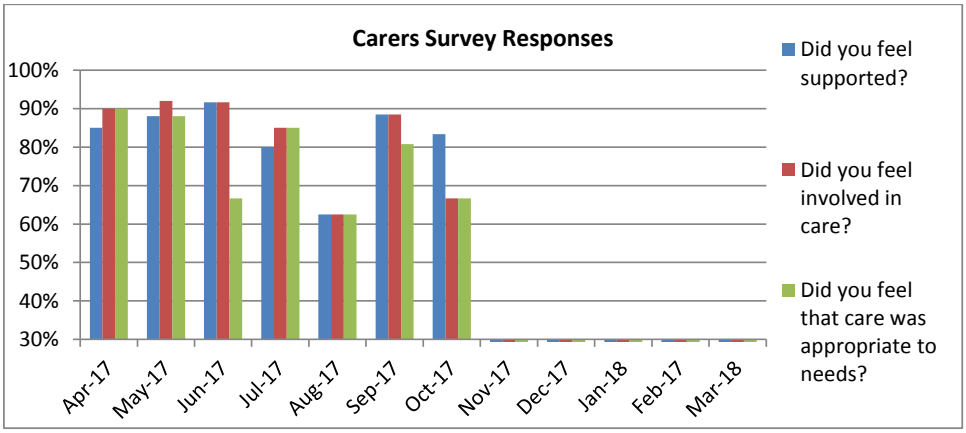
John's Campaign

The carer's survey forms part of the John's campaign and this has been updated to capture a wider view from carers. Eighteen returns were received for October out of ninety questionnaires which were handed to carers which is a disappointing decrease in returns following an uplift in September.

Enclosure E

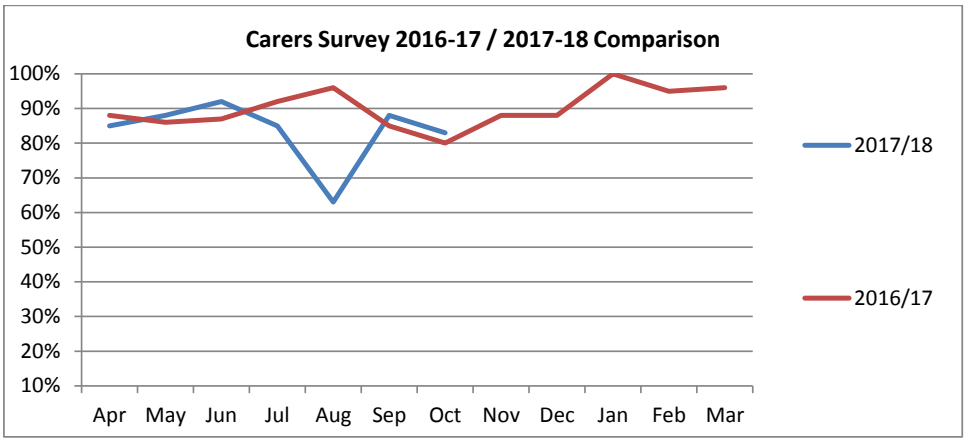
Key information from these returns is highlighted in the graph below and includes:

- 15 (83%) carers felt supported
- 12 (67%) carers felt they were involved in assessing care needs
- 12 (67%) carers felt staff met the patients' needs in relation to their dementia.



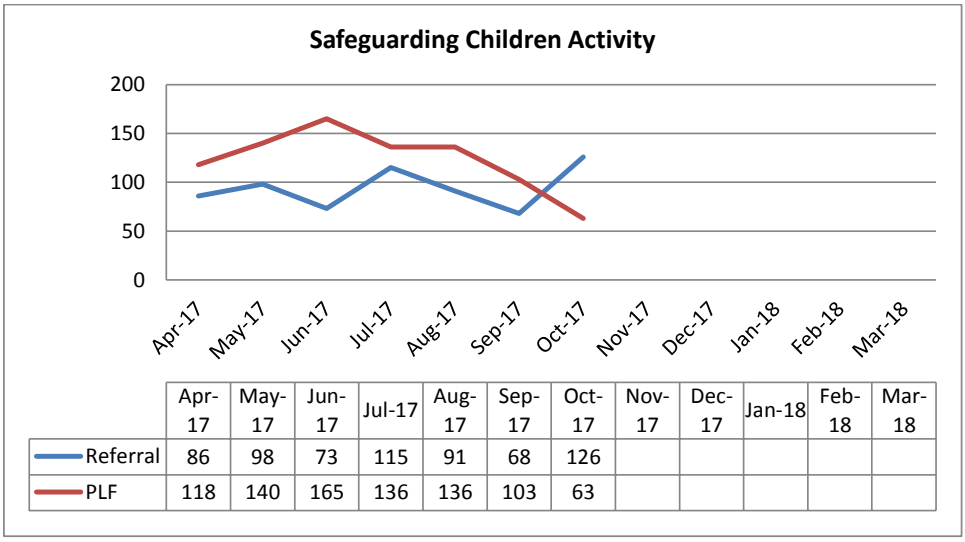
Within the survey if carers highlighted the need more support for their loved one whilst they are in hospital (6 responses in October), the Dementia Liaison Nurse made contact to offer advice and support.

The chart below shows the comparison between 2016/17 and 2017/18 responses.



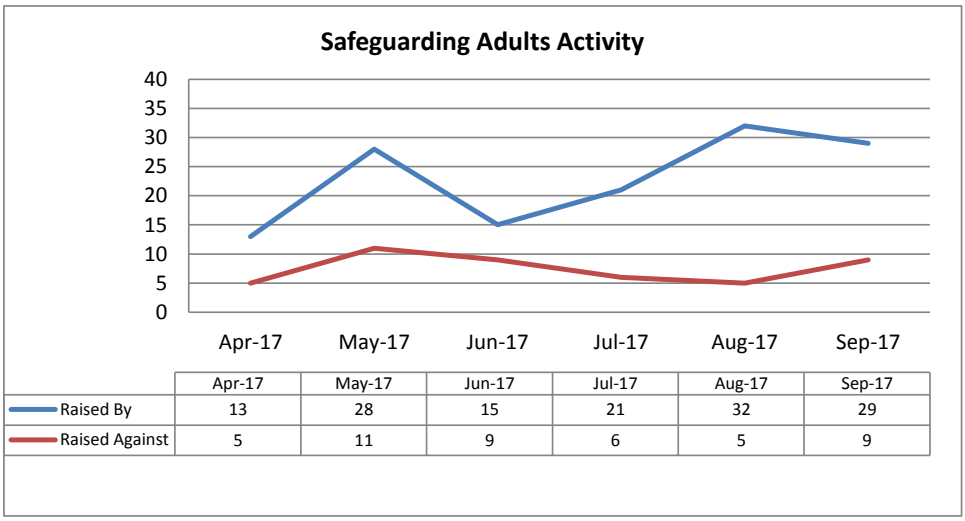
Safeguarding Children and Adult Referrals

The graph below shows the number of referrals made by the Trust in the reporting period for children and young people, at risk of, or suffering significant harm. This includes the number of Paediatric Liaison Forms (PLF's) processed. There has been a significant increase in the number of referrals made to the Multi-Agency Safeguarding Hub (MASH) from last month and a slight dip in the PLF's made. There is no apparent cause for either trend.



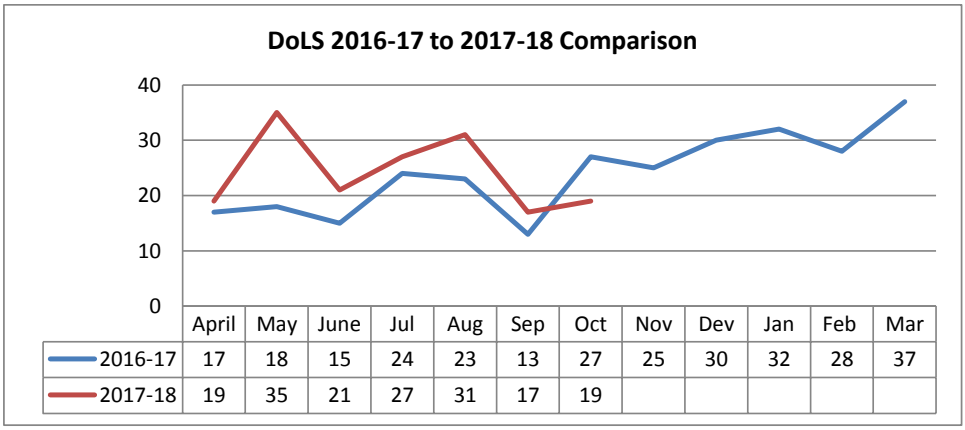
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Referral	86	98	73	115	91	68	126					
PLF	118	140	165	136	136	103	63					

In terms of safeguarding adults' referral activity, there has been a very slight decrease in the number of safeguarding allegations raised by the Trust as illustrated in the graph below. The number of safeguarding allegations raised against the Trust remains at a consistent level.



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Raised By	13	28	15	21	32	29
Raised Against	5	11	9	6	5	9

Deprivation of Liberty Safeguards (DoLS)



	April	May	June	Jul	Aug	Sep	Oct	Nov	Dev	Jan	Feb	Mar
2016-17	17	18	15	24	23	13	27	25	30	32	28	37
2017-18	19	35	21	27	31	17	19					

Applications for authorisations to Northamptonshire County Council (NCC) under the DoLS framework have increased slightly this month, but will be continued to be monitored. Internally all DoLS applications continue to be scrutinised on an individual basis by the safeguarding team to ensure that care is delivered in the least restrictive way possible.

The Government provided an interim response to the Law Commission report on 30th October 2017. The Government welcomed the recommendations to establish a new system and recognises the current DoLS process is "increasingly unsustainable." A final response is expected in Spring 2018.

Section 11 Audit

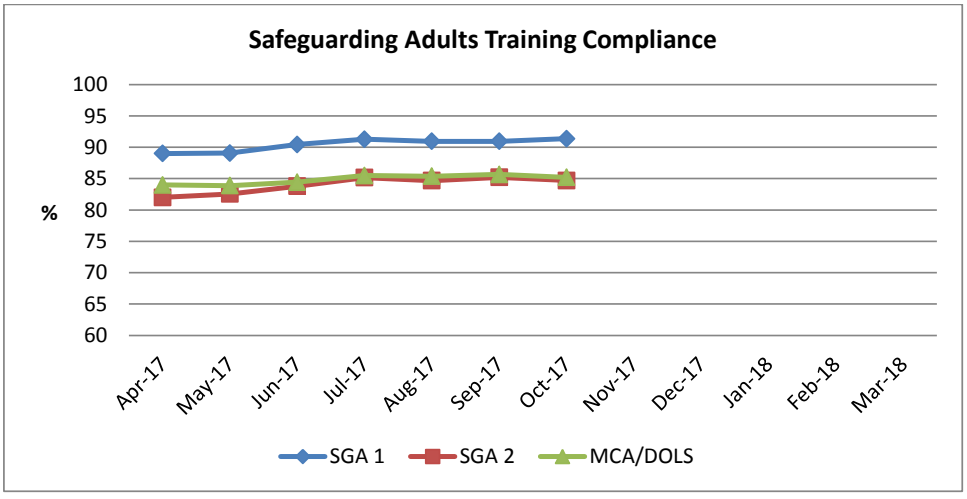
Northamptonshire Safeguarding Children's Board (NSCB) has recently requested all local agencies and organisations who provide services to children and young people to self-assess the extent to which they meet the safeguarding requirements and standards as set out in Section 11 of the Children's Act 2004.

The Trust has completed the Section 11 audit tool and assessed their compliance against strategic and operational responsibilites. All domains are RAG rated green apart from safeguarding level 3 training compliance, the dissemination of the Child Sexual Exploitation (CSE)Toolkit, Prevent WRAP compliance and the revision of the self-harm toolkit/care pathway. These are RAG rated amber.

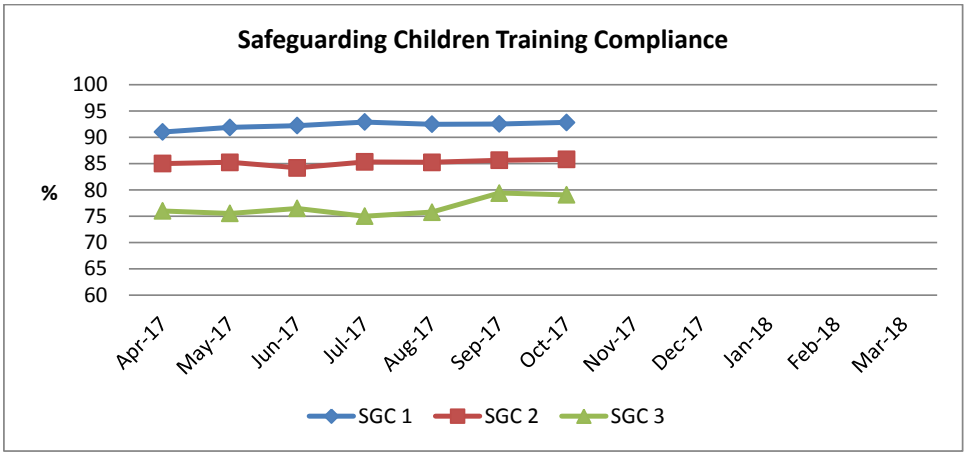
The Trust will be meeting with members of the (NSCB) in December to discuss their findings and learn from their audit. This process contributes to the NSCB scrutiny function and is a means of assessing the extent to which partners are fulfilling their statutory safeguarding obligations.

Safeguarding Training Compliance

The two graphs illustrate the current safeguarding training compliance for the Trust:



Compliance for the Level 1 safeguarding adults, Level 2 safeguarding adults and MCA/DoLS training remain at a constant compliant trend.



The safeguarding team continue to offer safeguarding children level 3 training packages across the Trust to increase the compliance levels from 78% to the expected 85%. A robust training analysis has commenced which includes the review of the training packages to ensure that they are compliant with the Intercollegiate Safeguarding Children and Young People Roles and Competencies Framework (2014) and workforce have been requested to run a report of all positions within the Trust. The Associate Directors of Nursing are meeting with the Head of Safeguarding in December to review and finalise this analysis. A revised training strategy will then be presented to the Safeguarding Assurance Group for ratification in January 2018.

Prevent

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

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

Due to the recent terrorist attacks in this country and across Europe, there has been heightened ministerial interest in Prevent. By quarter three, there is a clear expectation that all NHS Trusts and Foundations Trusts regardless of priority area status will submit the same Prevent assurance data to both their CCG and to NHS England via Unify 2.

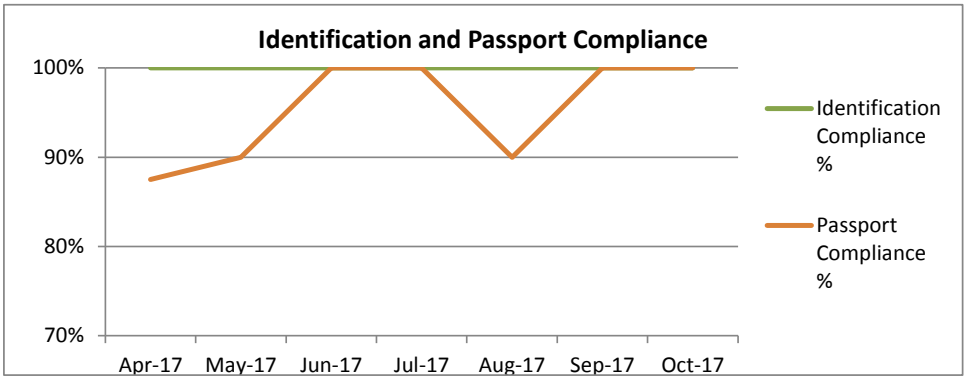
The Trust has currently achieved 90% compliance in Basic Prevent Awareness Training and 39% compliance (293 staff members out of 753) in WRAP training. The safeguarding team acknowledge that improvement in compliance figures need to be improved and therefore an improvement plan has been implemented. This includes weekly training to priority staff.

Learning Disability

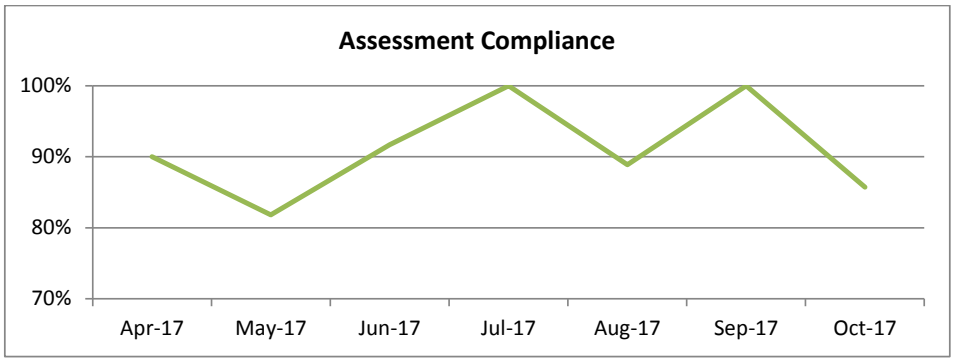
The Learning Disability Quality Schedule for the Trust is built around three key components:

- 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;

In October 2017 eight patients with a learning disability were admitted to the Trust and all were identified and received a hospital passport within 24 hours.



There was a slight drop in assessment compliance (86%) due to one individual not receiving an appropriate assessment as shown in the graph below. However compliance levels as per the Quality Schedule have still been achieved.



11. Assessment and Accreditation – October 2017

The current status of each Adult in patient ward (Appendix 7) demonstrates that we currently have 11 amber wards, 11 green wards and 1 blue 'Best Possible Care Ward' which has been achieved by Cedar ward. Althorp ward have achieved 3 consecutive green assessments and are in the process of applying for Blue ward status. There are currently no red adult inpatient wards in the Trust.

12. Safe Staffing

Overall fill rate for October 2017 was 102%, compared to September it was 103%. Combined fill rate during the day was 98% compared with 99% in September. The combined night fill rate was 107% in October, compared with 109% in September. RN fill rate during the day was 95% in October, 94% in September and for the night it was 96% compared with 97% in September Appendix 8).

13. Regional Safe Staffing data

On a quarterly basis the regional data for Safe Staffing is shared by NHS England. The data provided covers the time period up to and including July 2017. It can be seen that NGH continues to maintain a positive compliance for each category (Appendix 9).

14. Recommendations

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

Appendix 1

Nursing and Midwifery Safety Thermometer Definition

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

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

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

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

Maternity Safety Thermometer

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

Appendix 2

Infection Prevention Percentage Compliance Chart

Directorate	Wards	VAP	Renal Dialysis	Blood Cultures	Pre-OP	Intra-Op	Post_Op	Cleaning Equipment	Isolation	Cannula care - non Vital PAC	Canula care - Vital PAC	Urinary catheter- non Vital PAC	Urinary catheter- Vital PAC	CVAD - non Vital PAC	CVAD - Vital PAC	MRSA Bacteraemia		C-DIF		HHOT						
October 2017		100%= Green 95%-99%= Amber 94%= Red	100%= Green 95%-99%= Amber 94%= Red	100%= Green 95%-99%= Amber 94%= Red	100%= Green 95%=99%= Amber 94%= Red	100%= Green 95%=99%= Amber 94%= Red	100%= Green 95%=99%= Amber 94%= Red	100%= Green 95%=99%= Amber 94%= Red	100%= Green 95%=99%= Amber 94%= Red	100%= Green 95%=99%= Amber 94%= Red	100%= Green 95%=99%= Amber 94%= Red	100%= Green 95%=99%= A mber 94%= Red	100%= Green 95%=99%= A mber 94%= Red	100%= Green 95%=99%= A mber 94%= Red	100%= Green 95%=99%= Amber 94%= Red	< 2 days	> 2 days	< 2 days	> 2 days	Green = 96% - 100% Amber = 88% - 95.9% Red = 87.9% or less						
		VAP	Renal dialysis	Blood Cultures	Pre-op	Intra-op	Post-op	Cleaning equipment	Isolation	Cannula care - Vital PAC	Canula care - Vital PAC	Urinary care - non Vital PAC	Urinary catheter- Vital PAC	CVAD - non Vital PAC	CVAD - Vital PAC	< 2 days	> 2 days	< 2 days	> 2 days	Doctor	NurseINCA	Pharmacist	Phlebotomist	Porter	Therapist	Domestic Staff	Ward
T,A& CC	Critical Care																0		0								
T,A& CC	Critical Care HDU	na	na	na			na	na	na	na		na		na			0		0	95.0%	100.0%	100.0%	na	83.3%	100.0%	90.0%	97.5%
T,A& CC	Critical Care ITU	100.0%	75.0%	33.3%			100.0%	100.0%	100.0%	84.4%		96.3%		84.4%			0		0	100.0%	73.3%	100.0%	na	100.0%	100.0%	80.0%	88.4%
T,A& CC	Danetre DS				na	na	na	na		na		na								Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
T,A& CC	DSU Recovery				100.0%		na	100.0%		100.0%		na								na	100.0%	na		na		na	100.0%
T,A& CC	DSU1					100.0%		100.0%		100.0%		na								100.0%	100.0%	na	na	na	na	na	100.0%
T,A& CC	DSU2					100.0%		100.0%		100.0%		na								100.0%	100.0%	na	na	na	na	na	100.0%
T,A& CC	DSU3					100.0%		100.0%		na		na								100.0%	100.0%	na	na	na	na	na	100.0%
T,A& CC	Eye Theatres				na	93.8%	na	100.0%		na		na								100.0%	100.0%	na	na	na	na	na	100.0%
T,A& CC	Gynae Recovery			na			na	na		100.0%		100.0%		na						na	100.0%	na	na	100.0%	na	na	100.0%
T,A& CC	Gynae Theatres			na		100.0%		100.0%		100.0%		85.7%		na						100.0%	100.0%	na	na	100.0%	na	na	100.0%
T,A& CC	Main Theatre 1			na		100.0%		100.0%		100.0%		100.0%		na						100.0%	100.0%	na	na	100.0%	na	100.0%	100.0%
T,A& CC	Main Theatre 2			na		100.0%		100.0%		100.0%		100.0%		na						100.0%	na	na	na	na	na	na	100.0%
T,A& CC	Main Theatre 3			na		100.0%		100.0%		100.0%		na		na						100.0%	100.0%	na	na	na	na	na	100.0%
T,A& CC	Main Theatre 4			na		100.0%		100.0%		100.0%		100.0%		na						100.0%	100.0%	na	na	na	na	na	100.0%
T,A& CC	Main Theatre 5			na		100.0%		100.0%		100.0%		100.0%		na						100.0%	100.0%	na	na	na	na	na	100.0%
T,A& CC	Main Theatre 6			na		100.0%		100.0%		100.0%		na		na						100.0%	100.0%	na	na	na	na	na	100.0%
T,A& CC	Main Theatre Admission Unit				100.0%			100.0%		na		na		na						100.0%	100.0%	na	na	100.0%	na	na	100.0%
T,A& CC	Manfield Theatre 1			na		100.0%		100.0%		100.0%		na		na						100.0%	100.0%	na	na	100.0%	na	na	100.0%
T,A& CC	Manfield Theatre 2			na		100.0%		100.0%		100.0%		na		na						100.0%	100.0%	na	na	100.0%	na	na	100.0%
T,A& CC	Manfield Theatre 3			na		100.0%		100.0%		100.0%		na		na						100.0%	100.0%	na	na	na	na	na	100.0%
T,A& CC	Manfield Theatre 4			na		100.0%		100.0%		100.0%		na		na						100.0%	100.0%	na	na	100.0%	na	na	100.0%
T,A& CC	Manfield Theatre PAR			na			na	na		90.0%		na		na						100.0%	100.0%	na		100.0%	na	100.0%	100.0%
T,A& CC	PAR			na			na	na		100.0%		na		na													
T,A& CC	Pain Clinic							na		na		na								100.0%	100.0%	na	na	na	na	na	100.0%
T,A& CC	Pre Op Assessment							na		na		na								100.0%	100.0%	100.0%	na	na	na	na	100.0%
T,A& CC	Sturtridge Theatres			na	na	100.0%	na	100.0%		100.0%		100.0%		na			0		0								
GS	Breast Screening																			100.0%	na	na	na	na	na	na	100.0%
GS	Hawthorn			100.0%	na		100.0%	100.0%	100.0%		100.0%		100.0%				0		0	100.0%	100.0%	100.0%	na	100.0%	na	na	100.0%
GS	Integrated Surgery							100.0%												100.0%	100.0%	na	na	na	na	na	100.0%
GS	Rowan			100.0%	100.0%		100.0%	100.0%	100.0%		100.0%		100.0%				0		0	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	na	90.9%
GS	Urology Centre / Urodynamics																			100.0%	100.0%	na	na	na	na	na	100.0%
GS	Willow			na	na		100.0%	100.0%	100.0%		100.0%		100.0%				0		0	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
H&N	ENT OP							na		na		na		na						Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
H&N	Eye OPD/Casualty																			100.0%	100.0%	na	na	na	na	na	100.0%
H&N	Head and Neck Ward			na	na		na	na	na				na				0		0	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
H&N	Maxillofacial																			100.0%	100.0%	na	na	na	na	na	100.0%
H&N	Singlehurst				na	na	na	100.0%	na	33.3%		na		na			0		0	100.0%	100.0%	na	na	na	na	100.0%	100.0%
Medicine	A & E			100.0%	na	na	na	53.8%	71.4%	96.2%		92.0%		na			0		0	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Medicine	ACC							na									0		0	100.0%	100.0%	na	na	na	na	na	100.0%
Medicine	Allebone			na				100.0%	95.7%		100.0%		95.7%		na		0		0	na	100.0%	na	na	na	100.0%	na	100.0%
Medicine	Becket			na				100.0%	100.0%		92.3%		91.7%		na		0		0	na	100.0%	na	na	na	na	na	100.0%
Medicine	Benham			na				100.0%	100.0%		96.9%		91.3%		na		0		0	92.3%	95.7%	100.0%	100.0%	82.4%	100.0%	91.7%	94.4%
Medicine	Brampton			na				na	na		na		na				0		0	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Medicine	Chest Clinic																			40.0%	100.0%	na	na	na	100.0%	na	100.0%
Medicine	Collingtree			na				100.0%	100.0%		97.1%		95.8%		na		0		0	100.0%	100.0%	100.0%	na	na	100.0%	100.0%	100.0%
Medicine	Compton			na				100.0%	na		100.0%		100.0%		na		0		0	100.0%	100.0%	na	na	75.0%	100.0%	100.0%	98.3%
Medicine	Creaton			na				100.0%	100.0%		100.0%		96.7%		na		0		0	100.0%	100.0%	na	100.0%	na	100.0%	na	100.0%
Medicine	Danetre OP																			100.0%	100.0%	na	na	na	na	na	100.0%
Medicine	Dermatology																			100.0%	100.0%	na	na	100.0%	na	na	100.0%
Medicine	Diabetes Centre																			Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Medicine	Dryden/CCU			66.7%	na			100.0%	100.0%				100.0%		94.4%		0		0	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Medicine	EAU			100.0%				100.0%	100.0%		83.9%		100.0%		83.3%		0		0	81.8%	91.2%	100.0%	100.0%	85.7%	100.0%	100.0%	96.4%
Medicine	Eleanor			na				100.0%	na		100.0%		100.0%		na		0		0	100.0%	100.0%	na	100.0%	na	100.0%	100.0%	100.0%
Medicine	Endoscopy				na		na	100.0%		na		na								Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Medicine	Rinedon	na	na	na	na			na	na		na		na		na		0		0	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Medicine	Holcot/Stroke Unit			na				100.0%	na		100.0%		100.0%		na		0		0	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Medicine	Knightley			na				na	na		na		na		na		0		0	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Medicine	Main OP																			100.0%	100.0%	na	na	na	na	na	100.0%
Medicine	Neurophysiology																			100.0%	100.0%	na	na	na	100.0%	na	100.0%
Medicine	Northampton Heart Centre			na	na		na	na		75.0%		na		na						100.0%	100.0%	na	na	na	na	na	100.0%
Medicine	OP CEM																			Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Medicine	Rheumatology																			Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Medicine	Victoria			na	na		na	na	na		na		na		na		0		0	na	92.0%	100.0%	na	na	na	100.0%	93.9%
T&O	Abington			na	na		100.0%	na	na		100.0%		100.0%		na		0		0	100.0%	100.0%	100.0%	100.0%	100.0%	na	100.0%	100.0%
T&O	Althorp			na	100.0%		100.0%	100.0%	na		100.0%		100.0%		na		0		0	100.0%	100.0%	na	100.0%	100.0%	100.0%	100.0%	100.0%
T&O	Cedar			na	66.7%		100.0%	100.0%	na		100.0%		na		100.0%		0		0	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
T&O	Fracture clinic																			100.0%	100.0%	na	na	100.0%	na	na	100.0%
T&O	Manfield DSU				100.0%		100.0%	100.0%		95.0%		na		na						100.0%	100.0%	na	na	na	100.0%	na	100.0%
Oncology& Haematology	Anticoagulant OP																			na	100.0%	na	100.0%	na	na	100.0%	100.0%
Oncology& Haematology	Brachytherapy																										
Oncology& Haematology	Chemo Suite																			100.0%	100.0%	100.0%	na	100.0%	na	100.0%	100.0%
Oncology& Haematology	Haematology OP																			100.0%	100.0%	na	100.0%	na	na	na	100.0%
Oncology& Haematology	LINACS																			Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Oncology& Haematology	Oncology Sim CT scanner																			Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Oncology& Haematology	Talbot Butler	na	na	100.0%	na		na	100.0%	100.0%		100.0%		100.0%		100.0%		0		0	100.0%	100.0%	na	na	100.0%	na	na	100.0%
Paediatrics	Disney			100.0%			100.0%	100.0%	100.0%	100.0%		na		100.0%			0		0	100.0%	100.0%	na	na	100.0%	100.0%	na	100.0%
Paediatrics	Gosset			100.0%			na	100.0%	na	100.0%		na		na			0		0	100.0%	100.0%	na	na	na	na	na	100.0%
Paediatrics	Paddington			100.0%			na	100.0%	100.0%	100.0%		100.0%		100.0%			0		0	100.0%	100.0%	100.0%	na	na	na	na	100.0%
Paediatrics	PAU			100.0%				100.0%		100.0%							0		0	89.5%	95.7%	na	na	na	na	na	92.9%
Radiology	Radiology											na		na						na	na	na	na	na	na	na	100.0%
Clinical Support Services	Blood Taking Unit							na												na	na	na	100.0%	na	na	na	100.0%
O&G	Balmoral							100.0%		na		na		na			0		0	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
O&G	Colposcopy																			na	100.0%	na	na	na	na	na	100.0%
O&G	Gynae DSU				na	na	na	na		na		na		na						Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
O&G	Gynae OP																			Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
O&G	Maternity Day Unit							na	na	na		na		na						Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
O&G	Maternity Obs Ward			na	na		100.0%	100.0%	na	100.0%		100.0%		na			0		0	100.0%	100.0%	na	na	na	na	na	100.0%
O&G	Robert Watson			na	na			na	na	71.4%		na		na			0		0	100.0%	100.0%	na	na	100.0%	100.0%	na	100.0%
O&G	Spencer			na	na		100.0%	75.0%	100.0%		90.6%		100.0%		na		0		0	100.0%	100.0%	100.0%	na	100.0%	na	100.0%	100.0%
O&G	Sturtridge Ward			na				100.0%		100.0%		100.0%		na			0		0	87.5%	100.0%	na	na	100.0%	100.0%	na	96.2%
O&G	Uro Gynae																			100.0%	100.0%	na	na	na	na	na	100.0%
	TRUST POSITION																0		0	98.7%	99.3%	100.0%	99.0%	96.3%	100.0%	97.9%	99.1%

Appendix 3

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 (Vitalpac), 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 4

Oct-2017	Medicine														WCO		Surgery						
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Allebone	Becket	Benham	Brampton	Collingtree	Compton	Creaton	Dryden	EAU	Eleanor	Finedon	Holcot	Knightley	Victoria	Talbot Butler	Spencer	Rowan	Willow	Hawthorn	Head & Neck	Abington	Cedar	Althorp
Falls/Safety Assessment	100.%	100.%	100.%	93.%	93.%	100.%	100.%	100.%	93.%	100.%	93.%	100.%	93.%	87.%	97.%	100.%	87.%	93.%	97.%	73.%	93.%	100.%	93.%
Pressure Prevention Assessment	100.%	100.%	91.%	100.%	100.%	100.%	73.%	97.%	100.%	94.%	97.%	80.%	97.%	100.%	91.%	100.%	100.%	100.%	100.%	62.%	94.%	80.%	100.%
Nutritional Assessment	100.%	90.%	100.%	97.%	97.%	100.%	93.%	100.%	93.%	97.%	100.%	90.%	97.%	93.%	97.%	93.%	93.%	93.%	93.%	100.%	100.%		100.%
Patient Observation and Escalations	100.%	90.%	95.%	95.%	95.%	95.%	100.%	100.%	95.%	100.%	100.%	95.%	86.%	95.%	95.%	95.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%
Pain Management	100.%	100.%	100.%	100.%	100.%	100.%	80.%	100.%	100.%	100.%	100.%	86.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%
Nursing & Midwifery Documentation - Quality of Entry	97.%	95.%	98.%	83.%	100.%	88.%	95.%	97.%	100.%	97.%	93.%	92.%	95.%	82.%	93.%	100.%	100.%	97.%	95.%	100.%	95.%	100.%	100.%
Medication Assessment	100.%	100.%		100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	96.%	100.%	80.%	100.%	100.%	100.%	96.%	100.%	100.%	100.%	100.%
Patient Experience - Protected Mealtimes (PMT) Observations	83.%	83.%	83.%	100.%	100.%	100.%	50.%	100.%	100.%	83.%	100.%	67.%	100.%	83.%	83.%	83.%	100.%	100.%	100.%	50.%	100.%	100.%	83.%
Patient Experience - Care Rounds Observe patient records	91.%	100.%	91.%	100.%	100.%	100.%	82.%	100.%	100.%	55.%	100.%	91.%	100.%	100.%	100.%	100.%	100.%	86.%	91.%	100.%	100.%	100.%	100.%
Patient Experience - Environment	100.%	100.%	100.%	80.%	100.%	100.%	80.%	100.%	100.%	100.%	100.%	100.%	100.%	80.%	100.%	100.%	80.%	80.%	80.%	80.%	100.%	100.%	100.%
Patient Experience - Privacy and Dignity	99.%	93.%	87.%	95.%	96.%	98.%	94.%	94.%	91.%	99.%	100.%	97.%	99.%	100.%	98.%	91.%	96.%	94.%	94.%	95.%	96.%	96.%	100.%
Patient Safety and Quality	86.%	100.%	95.%	100.%	100.%	100.%	90.%	100.%	95.%	100.%	100.%	90.%	90.%	100.%	100.%	100.%	100.%	78.%	95.%	86.%	90.%	95.%	93.%
Leadership & Staffing observations	98.%	92.%	100.%	96.%	98.%	98.%	96.%	100.%	88.%	100.%	98.%	96.%	96.%	94.%	92.%	100.%	96.%	95.%	96.%	94.%	98.%	100.%	100.%
EOL	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%
SOVA/LD/Cognitive Impairment	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	96.%	100.%	96.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%	100.%
First Impressions/15 Steps	69.%	100.%	83.%	74.%	97.%	83.%	80.%	86.%	71.%	80.%	89.%	80.%	80.%	77.%	100.%	94.%	86.%	80.%	80.%	83.%	100.%	100.%	86.%
Safety Thermometer – Percentage of Harm Free Care	92.9%	92.3%	96.3%	100.0%	90.0%	77.8%	100.0%	92.0%	87.5%	100.0%	93.8%	82.8%	100.0%	94.4%	100.0%	100.0%	93.3%	100.0%	96.6%	100.0%	100.0%	93.1%	100.0%
Pressure Ulcers – Grade 2 incidence hosp acquired, (Previous Month)	0	2	0	0	2	0	0	0	0	0	1	1	0	0	0	0	1	0	1	0	1	2	0
Pressure Ulcers – Grade 3 incidence hosp acquired, (Previous Month)	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	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	0	1	0	0	0	0	0	0	0	0	3	0	0	2	0	0	0	0	0
Falls (Moderate, Major & Catastrophic)	0	0	0	0	0	0	0	0	0	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	1	0	0	0	0	0	0	0
Patient Overdue Observations frequency - <7%	6.8%	8.0%	9.7%	10.8%	8.8%	7.2%	4.4%	6.1%	11.0%	7.8%	11.6%	6.5%	13.3%	7.4%	8.1%	12.2%	7.4%	7.0%	9.2%	7.4%	5.7%	6.5%	4.8%
Caring																							
Complaints – Nursing and Midwifery	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
Number of PALS concerns relating to nursing care on the wards	1	1	0	0	1	0	0	1	3	0	1	0	1	1	0	2	2	2	0	0	2	1	0
Friends Family Test % Recommended	70.0%	87.5%	91.5%	100.0%	89.2%	100.0%	88.2%	100.0%	90.6%	100.0%	96.8%	75.0%	85.7%	0.0%	94.4%	89.7%	77.8%	93.0%	89.2%	93.3%	90.0%	100.0%	98.7%
Well Led																							
Staff Nurse Staffing - Registered Staff (day & night combined)	89%	96%	97%	97%	99%	101%	97%	102%	95%	97%	92%	97%	97%	91%	88%	115%	100%	98%	99%	111%	100%	100%	92%
Staff Nurse Staffing - Support Worker (day & night combined)	109%	99%	172%	151%	132%	159%	118%	95%	156%	104%	121%	191%	111%	178%	110%	133%	98%	99%	106%	111%	103%	102%	91%
Staffing related datix	1	1	0	1	1	0	0	0	0	1	1	0	2	0	0	0	0	0	0	0	0	0	0

Appendix 5

Oct 17	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%	100%	100%
Child Observations [documentation] (Q)	100%	100%	100%
Safeguarding [documentation] (Q)	67%	100%	100%
Nutrition Assessment [documentation] (Q)	100%	92%	100%
Medication Assessment (Q)	100%	92%	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 Overdue Observations frequency - <7%	73%	82%	
Patient Experience			
Friends Family Test % Recommended	79.7%	91.0%	0.0%
Complaints – Nursing and Midwifery	0	0	0
Number of PALS concerns relating to nursing care on the wards	0	0	1
Call Bells responses (Q)	100%	nil	100%
Patient Safety & Quality Environment Observations Observe patient records (Q)	100%	100%	100%
Privacy and Dignity (Q)	95%	92%	100%
Management			
Staffing related datix	0	0	0
Monthly Ward meetings (Q)	100%	100%	100%
Leadership & Staffing observations (Q)	100%	93%	100%

Ward Overall Results
0
2

Enclosure E

Appendix 6

Oct.17

Quality Care Indicators - Nurse & Midwifery	MATERNITY			
RAG: RED - <80% AMBER - 80-89% GREEN - 90+% * QCI Peer Review	Balmoral	Robert Watson	MOW	Sturtridge
Quality & Safety				
Postnatal Safety Assessment (Q)	100%	20%	100%	100%
SOVA/LD (Q)	Nil	Nil	Nil	Nil
Patient Observation Chart (Q)	91%	100%	100%	100%
Medication Assessment (Q)	100%	100%	100%	100%
Environment Observations (Q)	100%	100%	100%	100%
HAI – MRSA Bact	0	0	0	0
HAI – C Diff	0	0	0	0
Emergency Equipment – Checked Daily (Q)	100%	100%	100%	100%
Patient Quality Boards (Q)	100%	100%	100%	100%
Controlled Drug Checked (Q)	Nil	100%	100%	100%
Patient Experience				
Complaints – Nursing and Midwifery	0	0	0	0
Call Bells responses (Q)	100%	100%	100%	100%
Patient Experience (Q)	85%	80%	78%	76%
Patient Safety and Quality (Q)	100%	89%	100%	100%
Leadership & Staffing (Q)	100%	100%	100%	80%
Management				
Staffing related datix	0	3	1	3
Monthly Ward meetings (Q)	100%	100%	100%	100%
Saftey and Quality (Q)	100%	100%	100%	100%
Leadership & Staffing (Q)	92%	94%	94%	100%

Ward Overall Results

0
4

Appendix 7

Assessment and Accreditation Results - Current Status October 2017

Overall Result	1 Safety Culture	2 Patients feel safe/Safe-guarding	3 Safe Environment	4 Medicines Mgmnt	5 Infection Control	6 Nutrition & Hydration	7 Skin integrity	8 Elimination	9 Pain	10 Hygiene	11 Person Centred Care	12 End of Life Care	13 Communication	14 Effective Mgmt	15 Assurance
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Appendix 8

Ward Staffing Fill Rate Indicator (Nursing, Midwifery & Care Staff) — **October 2017**

Ward name	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)				Actions/Comments	Red Flag
	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall		
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Key: Below 80% Shift Fill Rate Target; 80% and Above Shift Fill Rate Target									
Abington Ward (NOF)	1,909.42	1,893.67	1,399.75	1,379.75	1,058.00	1,069.50	1,069.50	1,160.00	99.2%	98.6%	101.1%	108.5%	848	3.5	3.0	6.5		
Allebone Ward (Stroke)	1,621.43	1,435.07	1,129.08	1,119.88	1,426.00	1,288.00	713.00	882.25	88.5%	99.2%	90.3%	123.7%	863	3.2	2.3	5.5		
Althorp (T&O)	946.00	856.50	659.00	582.75	713.00	667.00	345.00	333.50	90.5%	88.4%	93.5%	96.7%	243	6.3	3.8	10.0		
Barratt Birth Centre	1,822.25	1,713.75	720.15	421.42	1,414.50	1,223.50	662.25	480.67	94.0%	58.5%	86.5%	72.6%	144	20.4	6.3	26.7	2.89 wte MSW vacancy - recruitment ongoing. Staff redeployed to other areas of maternity dependant on activity / acuity.	None
Becket Ward	2,035.50	1,856.25	1,413.25	1,308.00	1,782.50	1,794.00	713.00	791.75	91.2%	92.6%	100.6%	111.0%	800	4.6	2.6	7.2		
Benham (Assess Unit)	1,775.50	1,672.50	887.50	1,354.00	1,426.00	1,435.75	713.00	1,403.00	94.2%	152.6%	100.7%	196.8%	777	4.0	3.5	7.5		
Brampton Ward	1,406.50	1,331.50	1,064.25	1,213.25	1,069.50	1,069.50	713.00	1,477.00	94.7%	114.0%	100.0%	207.2%	878	2.7	3.1	5.8		
Cedar Ward (TRAUMA)	1,891.42	1,897.17	1,774.25	1,779.00	1,069.50	1,073.25	1,069.50	1,108.50	100.3%	100.3%	100.4%	103.6%	906	3.3	3.2	6.5		
Collingtree Medical (40)	2,380.50	2,338.25	1,773.25	2,029.00	1,782.50	1,770.50	713.00	1,265.00	98.2%	114.4%	99.3%	177.4%	1225	3.4	2.7	6.0		
Compton Ward	1,059.67	1,084.60	734.75	1,017.00	713.00	714.25	356.50	713.00	102.4%	138.4%	100.2%	200.0%	555	3.2	3.1	6.4		
Creaton SSU	1,654.00	1,573.00	1,678.00	1,701.25	1,069.50	1,058.00	701.50	1,115.50	95.1%	101.4%	98.9%	159.0%	856	3.1	3.3	6.4		
Disney Ward	1,902.00	1,572.00	962.25	850.50	1,046.50	945.75	356.50	356.50	82.6%	88.4%	90.4%	100.0%	298	8.4	4.1	12.5		
Dryden Ward	1,656.50	1,669.75	954.50	884.25	1,414.50	1,449.00	713.00	700.75	100.8%	92.6%	102.4%	98.3%	797	3.9	2.0	5.9		
EAU New	2,139.00	2,010.58	1,067.92	1,515.75	1,782.50	1,705.25	1,069.50	1,828.65	94.0%	141.9%	95.7%	171.0%	925	4.0	3.6	7.6		
Eleanor Ward	1,079.00	1,021.50	707.25	717.00	713.00	713.00	713.00	764.75	94.7%	101.4%	100.0%	107.3%	331	5.2	4.5	9.7		
Finedon Ward	2,147.00	1,877.85	356.50	412.75	1,069.50	1,069.50	356.50	448.50	87.5%	115.8%	100.0%	125.8%	491	6.0	1.8	7.8		
Gosset Ward	2,527.75	2,600.70	553.25	491.25	2,311.50	2,235.75	345.75	277.50	102.9%	88.8%	96.7%	80.3%	363	13.3	2.1	15.4		
Hawthorn & SAU	1,958.85	1,912.50	1,069.50	1,097.83	1,426.00	1,430.17	966.00	1,059.75	97.6%	102.6%	100.3%	109.7%	890	3.8	2.4	6.2		
Head & Neck Ward	1,057.70	1,164.35	711.50	693.50	931.50	1,048.75	356.50	493.75	110.1%	97.5%	112.6%	138.5%	424	5.2	2.8	8.0		
Holcot Ward	1,409.00	1,338.42	1,411.50	2,043.50	1,067.50	1,069.00	713.00	2,022.67	95.0%	144.8%	100.1%	283.7%	890	2.7	4.6	7.3		
ITU	5,015.25	4,522.28	713.75	692.75	4,600.23	4,255.73	690.00	678.50	90.2%	97.1%	92.5%	98.3%	362	24.2	3.8	28.0		
Knightley Ward (Medical)	692.25	708.92	881.25	874.83	1,069.50	1,001.75	356.50	501.50	102.4%	99.3%	93.7%	140.7%	644	2.7	2.1	4.8		
Paddington Ward	2,333.00	1,939.50	1,055.75	987.50	2,093.00	1,749.25	621.00	602.58	83.1%	93.5%	83.6%	97.0%	388	9.5	4.1	13.6		
Robert Watson	1,068.00	1,152.75	1,295.50	992.25	1,046.50	997.50	1,069.50	772.03	107.9%	76.6%	95.3%	72.2%	538	4.0	3.3	7.3	5.19 wte MSW vacancy. Recruitment ongoing. Staff redeployed to other areas of maternity dependant on activity / acuity.	None
Rowan (LSSD)	1,966.33	2,001.92	1,069.50	1,038.25	1,773.75	1,754.08	713.00	713.00	101.8%	97.1%	98.9%	100.0%	915	4.1	1.9	6.0		
Spencer Ward	1,273.50	1,434.25	903.75	1,083.25	897.00	1,071.25	701.50	1,058.75	112.6%	119.9%	119.4%	150.9%	646	3.9	3.3	7.2		
Sturtridge Ward	4,220.70	3,807.17	1,930.25	1,516.25	4,175.00	3,775.00	1,414.50	1,192.75	90.2%	78.6%	90.4%	84.3%	544	13.9	5.0	18.9	3.33 wte MSW vacancy. Recruitment ongoing. Staff redeployed as required dependant on activity / acuity.	None
Talbot Butler Ward	2,565.00	2,129.25	1,376.50	1,341.92	1,426.00	1,402.58	708.50	947.00	83.0%	97.5%	98.4%	133.7%	853	4.1	2.7	6.8		
Victoria Ward	1,196.00	1,033.00	707.25	1,070.50	713.00	713.00	356.50	828.00	86.4%	151.4%	100.0%	232.3%	555	3.1	3.4	6.6		
Willow Ward (+ Level 1)	2,317.25	2,346.83	1,059.25	1,013.42	2,139.00	2,017.67	713.00	741.92	101.3%	95.7%	94.3%	104.1%	861	5.1	2.0	7.1		

Appendix 9

Safer Staffing Report

Qualified & HCA Summary

Daytime Fill Rates - Registered Midwives/Nurses

	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Bedford Hospital NHS Trust	93.85%	94.36%	96.21%	96.15%	91.78%	95.75%	94.17%	93.99%	94.75%	94.48%	93.90%	94.01%
East and North Hertfordshire NHS Trust	91.32%	94.73%	95.37%	97.53%	95.32%	96.57%	95.19%	94.26%	96.14%	96.31%	95.74%	94.13%
Hertfordshire Partnership NHS Foundation Tru	99.62%	101.11%	103.65%	103.36%	100.40%	101.30%	100.60%	98.76%	104.56%	103.72%	103.86%	98.74%
Kettering General Hospital NHS Foundation Tr	94.80%	96.04%	97.71%	97.43%	95.26%	94.94%	96.04%	95.17%	94.17%	97.56%	93.91%	91.71%
Leicestershire Partnership NHS Trust	104.75%	105.60%	104.67%	106.79%	101.89%	103.66%	100.35%	99.73%	103.77%	105.19%	99.26%	99.60%
Lincolnshire Partnership NHS Foundation Trust	105.73%	108.17%	104.56%	105.24%	111.79%	105.09%	100.81%	109.25%	113.96%	101.32%	96.68%	105.67%
Luton and Dunstable Hospital NHS Foundation	92.14%	92.88%	91.60%	93.79%	92.67%	93.76%	92.63%	92.47%	92.78%	93.30%	91.81%	92.10%
Milton Keynes Hospital NHS Foundation Trust	87.34%	89.62%	90.70%	95.48%	94.95%	93.82%	94.17%	93.88%	85.25%	86.79%	85.18%	85.07%
Northampton General Hospital NHS Trust	**91.35%**	**92.70%**	**93.40%**	**96.57%**	**95.26%**	**96.06%**	**94.71%**	**95.45%**	**95.28%**	**97.40%**	**96.53%**	**95.23%**
United Lincolnshire Hospitals NHS Trust	87.56%	88.48%	94.08%	94.33%	92.52%	92.42%	92.19%	92.93%	90.84%	91.56%	90.42%	88.20%
University Hospitals of Leicester NHS Trust	89.37%	89.86%	90.02%	89.30%	90.11%	91.59%	91.57%	89.83%	90.25%	90.32%	89.91%	89.36%
West Hertfordshire Hospitals NHS Trust	92.95%	93.90%	93.67%	95.13%	92.77%	92.56%	90.04%	88.33%	88.00%	89.43%	89.20%	89.30%
The Princess Alexandra Hospital NHS Trust	73.28%	76.71%	79.66%	83.71%	79.72%	76.22%	83.91%	79.24%	77.36%	79.76%	78.87%	77.24%

Daytime Fill Rates - HCA Staff

	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Bedford Hospital NHS Trust	95.51%	94.90%	89.27%	93.17%	91.2%	101.15%	109.05%	96.85%	104.22%	106.79%	104.92%	108.74%
East and North Hertfordshire NHS Trust	107.49%	101.53%	101.48%	98.57%	95.90%	100.43%	99.24%	100.62%	104.31%	94.80%	91.47%	93.31%
Hertfordshire Partnership NHS Foundation Tru	116.20%	111.73%	110.91%	111.79%	116.28%	117.35%	110.57%	117.07%	109.90%	116.82%	112.22%	123.37%
Kettering General Hospital NHS Foundation Tr	101.67%	102.87%	104.19%	99.38%	97.54%	94.75%	96.27%	97.23%	99.32%	95.53%	94.84%	93.19%
Leicestershire Partnership NHS Trust	210.15%	199.55%	210.70%	206.90%	198.64%	195.75%	198.78%	199.23%	190.48%	196.58%	187.84%	190.74%
Lincolnshire Partnership NHS Foundation Trus	98.67%	89.29%	93.13%	98.29%	92.52%	100.29%	96.30%	100.74%	99.62%	85.02%	87.48%	101.19%
Luton and Dunstable Hospital NHS Foundation	95.14%	94.27%	95.45%	94.93%	94.36%	92.61%	94.16%	95.28%	93.42%	94.52%	93.94%	94.82%
Milton Keynes Hospital NHS Foundation Trust	119.16%	115.88%	108.90%	96.70%	99.85%	99.27%	98.64%	100.90%	112.78%	110.41%	119.78%	114.92%
Northampton General Hospital NHS Trust	**107.27%**	**108.64%**	**110.24%**	**107.04%**	**107.80%**	**110.65%**	**110.36%**	**113.12%**	**112.82%**	**110.35%**	**107.62%**	**108.08%**
United Lincolnshire Hospitals NHS Trust	99.14%	98.52%	96.85%	97.04%	93.81%	95.35%	97.61%	96.18%	99.31%	100.02%	99.28%	100.57%
University Hospitals of Leicester NHS Trust	94.68%	90.97%	91.95%	93.25%	91.40%	89.75%	91.10%	87.36%	96.69%	91.59%	87.87%	92.99%
West Hertfordshire Hospitals NHS Trust	97.59%	98.20%	97.84%	101.10%	101.53%	103.78%	103.38%	106.51%	109.58%	107.08%	100.85%	103.71%
The Princess Alexandra Hospital NHS Trust	85.90%	87.12%	89.23%	88.13%	89.85%	86.15%	86.39%	84.04%	86.87%	81.60%	74.28%	73.45%

Night-time Fill Rates - Registered Midwives/Nurses

	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Bedford Hospital NHS Trust	99.28%	98.66%	100.35%	101.51%	98.63%	103.50%	102.26%	101.20%	100.55%	101.55%	100.46%	98.92%
East and North Hertfordshire NHS Trust	95.95%	97.91%	98.45%	98.60%	95.68%	97.57%	95.81%	95.19%	95.48%	95.09%	94.35%	94.79%
Hertfordshire Partnership NHS Foundation Tru	101.46%	100.49%	101.88%	98.67%	99.23%	101.38%	99.39%	99.59%	101.09%	102.61%	101.11%	99.23%
Kettering General Hospital NHS Foundation Tr	99.16%	99.09%	99.25%	100.06%	97.29%	97.76%	98.98%	98.67%	98.21%	97.88%	98.03%	98.31%
Leicestershire Partnership NHS Trust	103.49%	103.20%	102.22%	102.43%	100.58%	101.38%	102.47%	102.53%	102.56%	100.48%	101.27%	101.01%
Lincolnshire Partnership NHS Foundation Trust	100.08%	103.58%	101.46%	103.02%	105.31%	105.69%	103.12%	102.53%	102.21%	100.21%	99.35%	100.05%
Luton and Dunstable Hospital NHS Foundation	97.01%	97.88%	97.64%	97.80%	97.61%	98.24%	98.72%	98.23%	97.31%	98.63%	99.04%	98.48%
Milton Keynes Hospital NHS Foundation Trust	100.27%	99.88%	103.85%	104.85%	103.57%	102.03%	102.38%	101.97%	100.27%	100.69%	102.09%	100.61%
Northampton General Hospital NHS Trust	**94.10%**	**95.52%**	**95.79%**	**96.83%**	**95.60%**	**97.81%**	**96.46%**	**96.08%**	**95.46%**	**97.03%**	**97.28%**	**96.43%**
United Lincolnshire Hospitals NHS Trust	96.81%	96.24%	98.40%	98.45%	97.72%	98.46%	99.35%	98.07%	94.10%	93.80%	93.02%	91.70%
University Hospitals of Leicester NHS Trust	94.97%	95.46%	96.70%	95.94%	96.98%	97.58%	97.22%	96.16%	96.98%	96.53%	95.92%	95.39%
West Hertfordshire Hospitals NHS Trust	96.24%	97.71%	96.89%	97.87%	95.07%	94.48%	94.36%	95.27%	93.79%	94.42%	92.70%	93.55%
The Princess Alexandra Hospital NHS Trust	78.97%	82.31%	83.94%	86.66%	87.03%	84.39%	99.48%	99.53%	104.18%	96.50%	97.32%	97.17%

Night-time Fill Rates - HCA Staff

	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Bedford Hospital NHS Trust	110.62%	111.78%	112.01%	112.63%	114.21%	121.93%	120.63%	115.57%	110.52%	110.54%	112.58%	117.84%
East and North Hertfordshire NHS Trust	111.63%	117.01%	116.15%	112.93%	111.63%	114.44%	113.73%	113.23%	112.80%	106.47%	108.20%	112.25%
Hertfordshire Partnership NHS Foundation Tru	124.67%	116.67%	118.67%	122.85%	125.65%	127.56%	114.88%	127.11%	122.89%	126.01%	123.44%	136.83%
Kettering General Hospital NHS Foundation Tr	112.36%	115.44%	111.82%	105.77%	98.84%	104.52%	105.45%	106.86%	105.89%	105.37%	101.87%	103.14%
Leicestershire Partnership NHS Trust	206.84%	207.59%	211.94%	195.53%	186.34%	198.69%	190.49%	188.96%	177.41%	179.63%	172.91%	177.45%
Lincolnshire Partnership NHS Foundation Trus	110.94%	104.79%	102.58%	107.40%	101.26%	103.60%	109.10%	110.44%	109.31%	95.28%	96.22%	106.93%
Luton and Dunstable Hospital NHS Foundation	98.01%	97.45%	97.55%	98.08%	96.30%	95.64%	96.39%	97.45%	97.48%	97.38%	94.65%	96.29%
Milton Keynes Hospital NHS Foundation Trust	135.56%	128.45%	128.50%	119.31%	121.37%	124.11%	117.97%	124.56%	141.23%	136.84%	143.26%	147.74%
Northampton General Hospital NHS Trust	**129.46%**	**135.01%**	**135.46%**	**131.59%**	**133.06%**	**142.66%**	**146.93%**	**144.59%**	**138.83%**	**138.38%**	**137.23%**	**135.86%**
United Lincolnshire Hospitals NHS Trust	98.77%	98.24%	100.52%	100.21%	98.09%	100.41%	99.43%	100.36%	101.02%	100.16%	100.24%	99.91%
University Hospitals of Leicester NHS Trust	98.21%	96.80%	94.24%	95.60%	96.07%	95.79%	97.77%	94.68%	100.19%	99.07%	93.15%	100.21%
West Hertfordshire Hospitals NHS Trust	104.07%	107.94%	102.82%	101.34%	106.32%	105.40%	105.47%	108.22%	112.42%	108.92%	101.16%	100.97%
The Princess Alexandra Hospital NHS Trust	98.69%	99.02%	102.26%	101.74%	98.63%	100.82%	96.35%	95.96%	93.18%	83.35%	80.84%	87.35%

Overall Fill Rates

	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Bedford Hospital NHS Trust	97.98%	98.05%	98.17%	99.35%	96.62%	102.58%	102.94%	99.48%	100.37%	101.03%	100.55%	101.74%
East and North Hertfordshire NHS Trust	98.24%	99.69%	99.99%	99.89%	97.46%	99.75%	98.37%	98.04%	99.63%	96.84%	95.85%	96.34%
Hertfordshire Partnership NHS Foundation Tru	112.15%	108.94%	109.85%	110.63%	112.02%	113.59%	107.83%	112.61%	110.59%	113.75%	111.47%	117.11%
Kettering General Hospital NHS Foundation Tr	100.12%	101.27%	101.79%	99.84%	96.89%	97.02%	98.22%	98.30%	98.24%	98.31%	96.42%	95.54%
Leicestershire Partnership NHS Trust	153.86%	151.40%	155.06%	152.20%	145.62%	147.33%	146.00%	145.94%	143.03%	145.30%	139.64%	141.44%
Lincolnshire Partnership NHS Foundation Trust	103.75%	99.66%	99.47%	102.98%	101.12%	103.02%	101.57%	105.35%	106.04%	93.30%	93.36%	103.62%
Luton and Dunstable Hospital NHS Foundation	95.09%	95.32%	95.07%	95.86%	95.03%	95.10%	95.33%	95.55%	94.98%	95.76%	94.80%	95.25%
Milton Keynes Hospital NHS Foundation Trust	102.64%	102.06%	102.00%	100.75%	101.13%	100.44%	99.85%	100.91%	101.63%	101.50%	103.66%	102.98%
Northampton General Hospital NHS Trust	**100.40%**	**102.17%**	**102.95%**	**103.34%**	**102.80%**	**106.21%**	**105.33%**	**105.76%**	**104.68%**	**105.38%**	**104.42%**	**103.56%**
United Lincolnshire Hospitals NHS Trust	93.97%	93.99%	96.64%	96.73%	94.83%	103.02%	96.19%	95.95%	94.98%	95.20%	94.40%	93.48%
University Hospitals of Leicester NHS Trust	92.80%	92.20%	92.50%	92.43%	92.69%	95.64%	93.51%	91.35%	94.34%	93.04%	91.27%	92.77%
West Hertfordshire Hospitals NHS Trust	96.43%	97.89%	96.78%	98.02%	97.12%	97.19%	96.20%	96.85%	97.55%	97.26%	94.31%	95.20%
The Princess Alexandra Hospital NHS Trust	80.72%	83.29%	85.56%	87.78%	86.31%	83.70%	89.60%	87.31%	87.95%	84.50%	82.26%	82.42%

Key
<90%
90% - 95%
>95% <150%
>150%

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30 November 2017**

Title of the Report	**Fixing the Flow update1 – November 2017**
Agenda item	**10**
Presenter of Report	Deborah Needham, Chief Operating Officer / Deputy CEO
Author(s) of Report	Russell Brazier - PMO, Deborah Needham
Purpose	For information/Assurance

Executive summary

The paper provides an update on the new fixing flow programme which supersedes the urgent care working groups work plan.

The programme is split into 3 work streams and using an agile methodology there are tests of change in rapid progress with the aim of reducing overall length of inpatient stay and creating better flow for patients throughout the adult beds.

Related strategic aim and corporate objective	Focus on quality & safety
Risk and assurance	Finance, Patient experience, Reputation
Related Board Assurance Framework entries	1.2, 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? (N) Is there potential, for or evidence that, the proposed decision/document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)

Legal implications / regulatory requirements	None

Actions required by the Board

- The Board is asked to note the contents of the report
- Seek further information as required to provide assurance

Northampton General Hospital NHS Trust

FIXING THE FLOW
UPDATE – NOVEMBER 2017

1. Introduction

Fixing the Flow is our internal programme to improve patient flow across the hospital and address exit block from A&E.

Some of the barriers to optimum bed flow are external and we continue to work with our health and social care partners to address those issues. However, there are steps we can take that will make a significant difference to how efficiently we operate for the more simple discharges.

The key outcomes we are focusing on are:

- The standardisation across the hospital of operational practices for admissions, ward rounds and discharge processes
- Robust & better information
- Planning for discharge as soon as a patient is admitted

NGH has struggled to achieve the A&E 4hr target for several years and over the past few months performance is deteriorating and on average remains below the national target and below 90%.

Both NHSI and NHSE have asked all acute providers to ensure bed occupancy is below 92% prior to Christmas and then through quarter 4.

Due to our gap in capacity given the current activity we will be unable to reach 92% bed occupancy however a decrease in ALOS and reduction in patients admitted will give opportunity for the occupancy to reduce.

We've made many efforts to improve, with some success, but the rate of success has been out-stripped by growing demand of older, sicker patients who stay longer and require more intense support post discharge.

2. Governance of the programme

The programme was launched on 30th October 2017 and is split into 3 work streams which each have executive oversight. The programme board is meeting weekly and is jointly chaired in turn by the Medical Director, Nursing Director and Chief Operating Officer (COO).

Each work stream has several "treatments" in place and using an agile methodology tests of change are implemented and fed back each week with associated metrics were necessary. The programme is intended to ensure rapid change is implemented without the need to analyse, look at, review or think about; for example.

The planned overall impact from the 2 main work streams is:

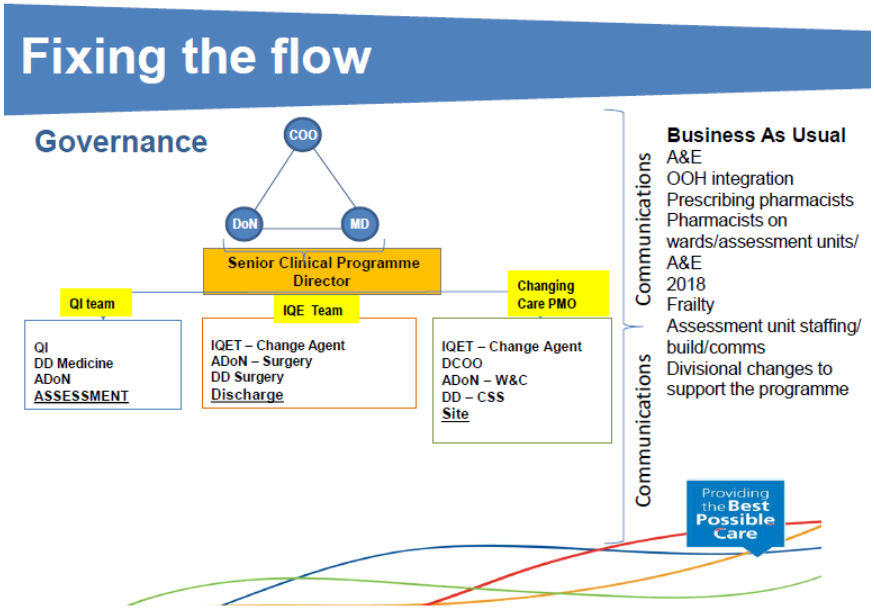
Assessment: A reduction in conversion to admission from the assessment units by 10% by March 2018, with an interim target of 2.7% by Christmas 2017.

Discharge: A reduction in ALOS of 0.7d by Christmas 2017.

In addition the winter schemes which are being led through the AE delivery board are expected to reduce ALOS by 10 days for the complex discharge patients.

Site & Information: The expectation of this work stream is a reduction in 4hr breaches overnight and smoother more rapid flow during the day.

Figure 1 – Governance



A senior Clinical Programme Director has been appointed and is starting on 2nd January 2018.This role will be key in not only ensuring the programme moves at pace but also providing the much needed joint work across nursing, medical staff and managers.

3. The Work streams & treatments

The most recent treatments and an example of weekly updates are attached in appendix 1 for information.

4. Impact & occupancy

The planned bed numbers from December through to March will increase due to MDSU swinging to take NEL from January 2018.

The impact of the 2 work streams and the external scheme assumptions are highlighted in figure 3 with the overall impact on bed numbers and occupancy.

Figure 3

Incorporating deficit of 49	
Required Occupancy Level	**96%**

	2017/18			
	December	**January**	**February**	**March**
Bed Numbers (G&A)	666	666	666	666
Additional Beds in Manfield DSU		12	12	
Additional Beds in Assessment Hub				
Revised Bed Number	666	678	678	666
Bed Deficit	**49**	**37**	**37**	**49**
Bed Requirement @ 100% Occupancy	715	703	703	715
Reduction in conversions of 2.7% (97.3% conversion rate)	-10	-10	-10	-10
Reduction in LOS of 10 days	-23	-23	-23	-23
Reduction in LOS of 0.7	-15	-15	-15	-15
Revised Deficit	**1**	**-11**	**-11**	**1**
Revised Bed Requirement	667	655	655	667
Revised Occupancy	**100.0%**	**96.6%**	**96.6%**	**100.2%**
Additional Bed Savings Required for 96% Occupancy	**1**	**-23**	**5**	**29**
Reduction of 50% in Elective Activity	28	28		
Daily system complex discharge tracking				
No routine diagnostics - Dec/ Jan				

In addition to the FTF programme additional schemes will be in place through Christmas and into January 2018 in line with expectations from NHSE.

Christmas plan: 11– 24 December 2017
Perfect week in place
Reduced IP elective activity by 50%
Additional IP diagnostics for cardiology, endoscopy & radiology
Daily system complex discharge tracking

Post-Christmas surge: 27 December – 14 January 2018
No routine diagnostics
Every medical ward every day – 1 consultant (reduced OP)
Limit AL
Daily system complex discharge tracking
No IP elective activity apart from urgent / Cancer
No IP elective activity 27,28,29 Dec
Discharge facilitators all wards
Consultants on call based in assessment areas

4. Summary & risks

The FTF programme has been in place for 3 weeks and whilst some tests of change have been made and implemented it is too early to see the overall benefit to patient flow, occupancy & the A&E target.

The risks associated with the programme are:

1. Insufficient time due to competing priorities and “managing the day” for our teams to implement the changes required.

Mitigation: Routine meetings and some non-urgent tasks will be reviewed to ensure this programme takes priority. (Patient safety will not be affected)

2. Additional “must do’s” from NHSI/NHSE are asked for which will take valuable resource away from the programme.

Mitigation: These will be reviewed and if applicable added to the programme

3. The programme fails to deliver quick wins and staff become demotivated to support change

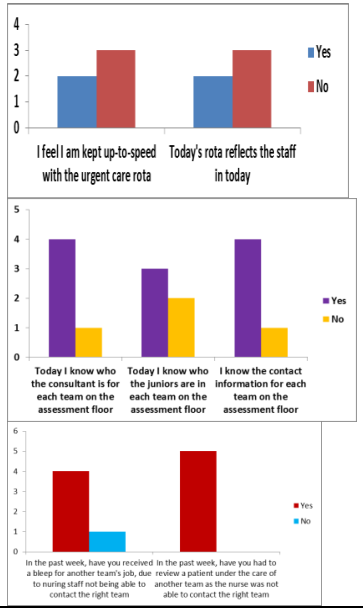
Mitigation: Good communication daily & weekly via the executive team on changes being implemented & progress with the overall aims.

Fixing the Flow

20th November 2017

Assessment

SMART aim: By March 2018, to reduce the number of patients on EAU/Benham by 10% from the April 16-Sept 17 baseline.

Treatment	What we said we'd do	What we did	Performance	Next Steps
Treatment 1a WORKFORCE: Increase senior decision making and review for OPEL 3 and OPEL 4	Evaluate impact identify and address non-compliance 15th Nov. Re-evaluate staff knowledge of current rota 15th November	Trial commenced on 10th Nov for a sign in register for each medical team on the assessment units to sign in by 8.30am in the site office confirming name, contact details and team allocation. Determined compliance on the sign in sheet. Re-evaluated staff knowledge and asked for their ideas on what could be improved in relation to site team meeting.	0% compliance 10th - 13th Nov 	Relaunch with support of Urgent Care CD, Urgent Care manager and deputy COO Re-evaluate impact by a point prevalence audit on 24th Nov. Identify improvement, in order to establish best practice for assessment floor. Determine compliance with recirculation of rota

Fixing the Flow

Treatment	What we said we'd do	What we did	Performance	Next Steps
Treatment 1b WORKFORCE: PA re-allocation during periods of high demand (OPEL 3 and 4)	Output from the review to be discussed and confirmed at November workforce committee and change of practice agreed, with a SOP for when we are on OPEL 3 and OPEL 4. Develop a 'decision maker' rota for MD, AMD and DDs as well as a CTA rota for all consultants with non-mission-critical SPA time for OPEL 3 and OPEL 4. Implementation date 4th Dec.	On track Rota developed for MD, AMD and DD to re-allocate consultants during OPEL 3 and 4. Call to arms rota developed. Communication circulated by MD 16th Nov.	Data to follow: No. of Cons Vs. No. released	Ahead of schedule rota will be trialled Mon 20th Nov.
Treatment 1c WORKFORCE: Professional Standards	Revised professional standards agreed. These will be recirculated w/c 27th Nov.	Previous version of professional standards circulated to all consultants, and feedback was requested by 10th Nov. Revised professional standards in	9 revised professional standards agreed.	Identify the key metrics in collaboration with Performance team to determine compliance to the relaunched standards.

Fixing the Flow

Treatment	What we said we'd do	What we did	Performance	Next Steps
	Professional standards will be relaunched and implemented on 4th December.	draft. Relaunch of professional standards ahead of schedule – 20th Nov.		Evaluate compliance to relaunched standards w/c 4 Dec
Treatment 2a ASSESSMENT FLOOR BEST PRACTICE: Rapid Transfer	Complete the trial Evaluate the compliance for 30 minute transfers during the trial. Obtain lessons learnt from staff 14th Nov. Evaluate the impact of the Rapid Transfer trial with a view to repeat/business as usual.	Mon 13th trial Rapid Transfer, with increased senior support to facilitate safe transfer.	No transfers completed due to lack of base ward capacity.	Repeat RT trial date (23rd/24th November 2017). Best practice paperwork to trialled.
Treatment 2b ASSESSMENT FLOOR BEST PRACTICE: Communication	Identify demand for iPhones for 24/7 coverage on assessment units. This will replace bleep	Identified demand IT have been informed.	10x junior/Pas in day 6xnight staff (1x SpR, 1x ward SpR, 2x SHO, 1xSHO haem/onc when available, 1xFY1 when	Other options to be explored, i.e. Vocera. Action HM to update and advise.

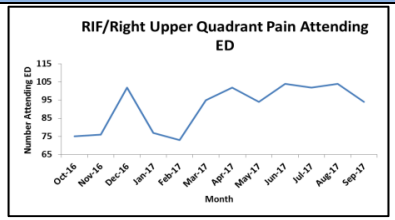
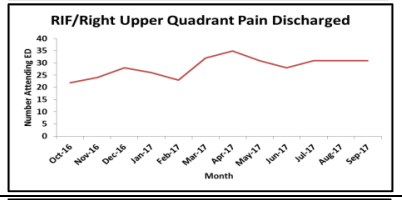
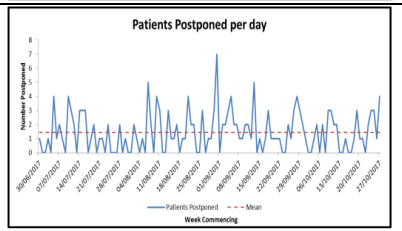
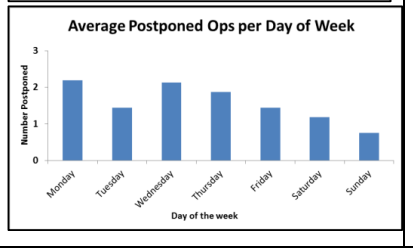
Fixing the Flow

Treatment	What we said we'd do	What we did	Performance	Next Steps
	and iPad usage. Inform IT of demand and confirm go-live date.		available) 2x spare 18 total Recharge station also required for iPhone.	
Treatment 2c ASSESSMENT FLOOR BEST PRACTICE: Training the urgent floor team	Produce training calendar for all non-medical urgent care staff Quantify impact of poc sims on technical ability. Repeat cycle.	PD lead in ED developing bespoke training sessions for urgent care floor. Awaiting first poc sim 30th Nov.	4 training sessions arranged during the next two weeks Data to follow post 30/11/17	Monitor training compliance Quantify impact of poc sims on technical ability. Repeat cycle.

Fixing the Flow

Treatment	What we said we'd do	What we did	Performance	Next Steps
Treatment 3: ACC Efficient use of ambulatory care	Confirm the specialty of all outpatient clinics admitting to ED/ACC Date to be confirmed for PLT presentation.	Collected and analysed data on OP to IP conversion, broken down by OP and IP specialties. PLT presentation confirmed 14th March 2018.	**OP referrals to ED/ACC** Plastic Surgery = 23 Fracture = 15 Gynae = 7 Cardiology = 5 Gen Surg = 5 T&O = 3 Clinical Onc = 3 Clinical haem = 2 Stroke = 2 Urology = 2 Gen Med = 1 Dermatology = 1 Diabetic Medicine = 1 Respiratory = 1 MaxFax = 1 **Total = 72**	Monitor OP attending ACC prior to admission who require clerking. Data w/c 4th Dec. Confirm the specialty of all outpatient clinics admitting to MAU Inform specialties admitting to MAU to identify alternative location to fully clerk their patients and contact site team directly for a bed on the base wards
Treatment 4a SURGICAL ASSESSMENT Managing surgical demand differently	Review current hot clinics and hot slots in surgery division Review capacity and demand for OP and daycase surgical treatment for all specialties Identify location of SAU, capacity required and confirm date of PDSA cycle.	Determined the number of Hot Clinics and Hot Slots current run in the surgery division. Identified consultants supporting surgery hot clinic. Met with Urology Consultant 17/11/17 to discuss development of urology hot slot or clinic. Location identified for SAU – Hawthorn. 2 trollies for SAU as initial PDSA.	Mr Kang, Mr Evans, Mr Khalil, Mr Finch, Mr Ihedioha, Mr Pereira and Ms Brown support surgery hot slot.	Evaluate the number of patients seen in hot clinics and hot slots. Confirm staffing resource for trial date. FTF to confirm support for SAU.

Fixing the Flow

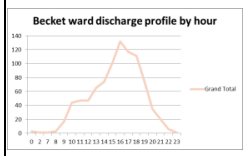
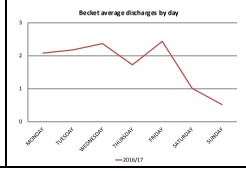
Treatment	What we said we'd do	What we did	Performance	Next Steps
Treatment 4b SURGICAL ASSESSMENT Right Iliac Fossa Pathway	Identify availability of ultrasound equipment and resource. Monitor number of patients with RIF pain, attending and discharged from ED.	Pathway further refined. Ultrasound equipment and resource not confirmed. Confirmed number of patients with RIF and Right Upper Quadrant pain admitted and discharged from ED	 	Confirm ultrasound resource and equipment Confirm and circulate RIF pathway. Agree implementation date. Further analysis of RIF and Right Upper Quadrant data.
Treatment 4c SURGICAL ASSESSMENT	Further analysis of postponed patients Develop an escalation protocol to raise awareness and escalate pending emergency cases to complete today's emergency work today.	Further analysis completed on number of postponed. Developed a weighted escalation protocol to ensure today's work is done today. Daily Bed Meeting Agenda amended to reflect all Emergency Theatre Capacity	 	CD to approve escalation protocol. Communicate to all consultants and Managers within Surgical Division. Implement new process from Monday 20th November Establish reason for patients being delayed until the next day. Monthly dashboard to be distributed.

Fixing the Flow

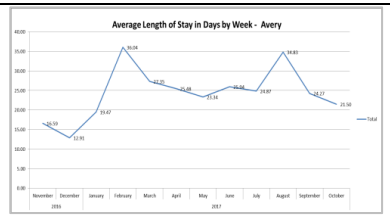
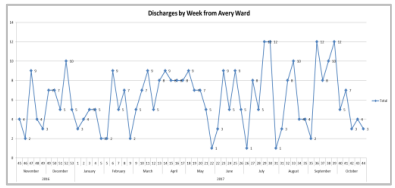
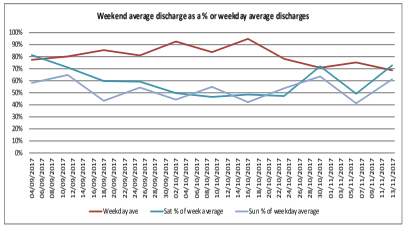
Treatment	What we said we'd do	What we did	Performance	Next Steps
Treatment 5: MENTAL HEALTH SUPPORT AND ASSESSMENT: Identify the demand for patients requiring mental health support in the assessment areas	Identify a cohort of patients who can be treated in a non-medically acute environment.	Confirm robust pathways for streaming of adult and adolescent mental health patients. Worked with strategy colleagues to address a demand for CAMHS support. Identified the current mental health support provided by mental health liaison team co-located in COA. Identified a 1 hour response rate for patients in ED and assessment units (inpatients on base wards will be seen in one day)		Evaluate impact of section 136 which will be implemented 11th December 2017. ED lead to confirm update in collaboration with the police.
Treatment 6: NHSI Emergency Care Improvement Programme	Collect baseline data using compliance tool from NHSI Confirm date and resource.	System wide resource required to complete audit. This will be considered outside of the FTF workstream. EMAS conveyance data sent to NHSI 16/11/17.		SAFER and R2G to be presented to medical staff committee on 12th Jan. MSM to confirm.

Fixing the Flow

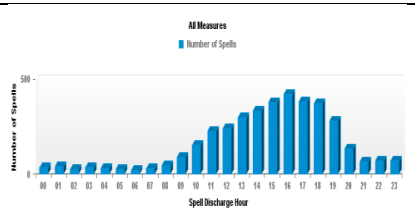
Discharge

Treatment	What we said we'd do	What we did	Performance	Next steps
Discharge information at huddle – re-establish celebration (EW) Early Bird Discharge Lounge Total Discharge (EW)	What's the mechanism for celebrating staff going the extra mile Agree the process for capturing the information to improve our early bird discharge rate	Based on the trial and staff feedback we need to go in a different direction Amend the quadrant boards based on feedback Spencer, Dryden & Beckett are trialling the new quadrant board to gather the data (Planned v actual)	Testing on 3 wards – Present the data next week	Who to own the data and the process moving forward Testing the new board / measurement on the wards this week Gather feedback on the trial
Criteria led discharge (NG)	Design and Implement criteria led discharge Agree the AHP roles and process to support CLD	Raghu met with consultants to deliver a trial on Beckett Adapt the NHSI SOP for NGH Describe a competency statement and add it to the SOP Ward training plan agreed with Bev Al-Azzawi CLD form designed Met with Liz Aldridge to discuss therapies role	 Discharges via CLD by time of the day  Discharges by CLD by day of the week	Plan communications to the ward team with ward manager 17.11 Sign off the process and documents with senior stakeholders 24.11 Measurements in place 17.11.2017 Bev Al-Azzawi to provide 1-2-1 nurse overview/training 20.11 & 23.11 Trial starts on Becket 27.11

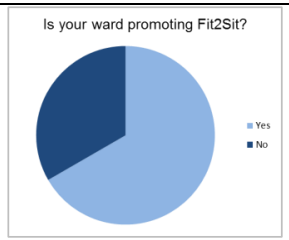
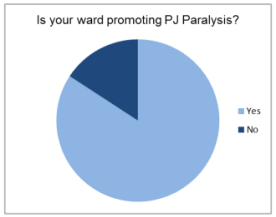
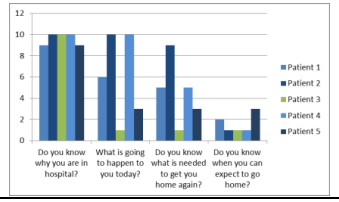
Fixing the Flow

Avery model review (HL)	Amend the inclusion and exclusion criteria create checklist and communicate out Meet with Therapies	Criteria and checklist amended, further work to be done on this Met with therapies to discuss capacity issues Reviewed our data and requested data per day	 • There is a significant increase from 13 days in Dec 16 to 36 days in Feb 17. • The average LoS for last 12 months was 24.51 days 	Further work to be done on criteria and checklist Plan the trial for 2 wards to self-assess referrals. Process map the 'Perfect Day' (including realistic occurrences) with the therapies team Identify specific times for reviewing the patients at a board round with GP's Start Mon, Wed, Fri nurse visits from Wednesday.8
Weekend discharge (FB)	Weekend discharges equates to 85% of the average weekly discharge rate Weekend discharge team to be substantive and rostered	Test of change V2 Met with Carl to discuss joint working with the site work stream to address system issues Discussion with Paul Saunders, Dr Raghuraman, Fiona Barnes on Tuesday to discuss clinical		Update weekend plan to reflect last weekend's trial changes Action plan to be created with actions spanning nursing and site team SB speak to Rachel Westwood to include pharmacy prescriber in the trial

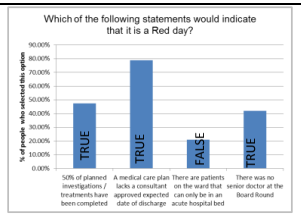
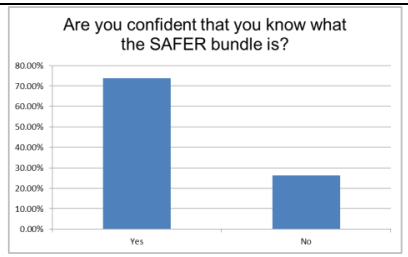
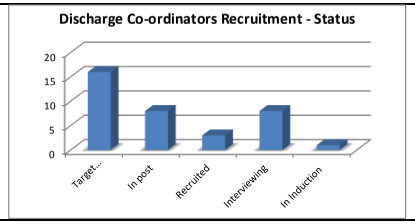
Fixing the Flow

		involvement / engagement Met with Neil Buckley to understand rota Weekend discharge sticker process communicated and stickers given out at huddle Update weekend plan to reflect last weekend's trial changes		
Ward Ownership (MC)	Deliverables: • Partnership working • Sharing best practice Enabler	Met with 5 of the ward partnerships identifying more best practice List completed of partnerships for all wards Met with SI Team to discuss context of work stream	Best practice identified to date: • Dedicated co-ordinator protected role • Regular 1:1s Sister/Consultant Lead • Joint access to shared drive medical rotas for junior doctors • Attendance to mortality & morbidity reviews for shared learning • COW on every ward round	Drafting best practice guidelines document Develop a questionnaire to all ward partnerships around current working relationships
Future workforce changes (MC)	Deliverables: Test market for advanced nurse practitioners	Advert live with CF to sign off		Go – Live Waiting response of market test for next 2 weeks Measure the number of hits and interest

Fixing the Flow

PJ Paralysis / Fit to sit (DS)	Agree comms plan Identify champions for each ward Meet with CB to discuss sustainability and measures	Screensaver and comms plan detailed and going live 20.11 (F2S) (27.11 PJP) (R2G 4.12) Champions per ward nominated Posters designed for ward level comms and disseminated out at huddle 20.11 Communicated with Carol Bradley to discuss how the to sustain and measure compliance ED have ordered new chairs to promote fit2sit	 **30%** of ward staff surveyed don't have a clear understanding of F2S.  **15%** of ward staff surveyed don't have a clear understanding of PJ Paralysis.	Meeting 23.11 with therapies to agree action plan, compliance tool, comms plan, roles & responsibilities for the ward champions with Liz Aldridge Discuss the quadrant board and how this links with ward accreditation 23.11
Red to Green(DS)	Agree the method to manage and sustain the participation and performance (Ward accreditation?)	Trial continues on head & neck ward Red/Green 'Face' cards. Met with current project steering group to ensure previous lessons learnt –		Meet with CD's in medicine on 21.11 to discuss engagement and plan to move forward Obtain agreement from the board on method of delivery.

Fixing the Flow

	Trial Red/Green face cards on wards Handover from Changing Care	Met with Andy Aldridge NHSI discussed method of delivery and sustainability		Move trial into Althorpe ward Once delivery method confirmed, set action plan for implementation. Update the ward champions
SAFER (DS) Focus on F in this work stream S - Senior Review. A –Expected Discharge Date (EDD) F - Flow by 10am E – Early discharge. R – Review. (MDT) >7 days stranded patients	Gap analysis of baseline on wards	Gap analysis complete Met with Andy Aldridge 17.11	 **32%** of staff surveyed don't know that patients should have received a senior review by 12pm. (In line with the SAFER bundle guidelines)	Quick wins identified and action plan to be agreed 22.11 To focus the EDD on the ward boards. Add in plus days this week
Discharge co-ordinators	Recruit to full establishment Confirm roles and how the discharge co-ordinators interact and work with the	Vacancies continue to be advertised Interviews for 8 co-ordinators arranged for 21.11 Roles and responsibilities have been drafted First new Discharge		An SOP of how the team will work is in development Draft a new advert focusing on clinical skills to attract internal HCA population.

Fixing the Flow

	ward/external teams	Coordinator, induction complete and now on the wards		Arrange a meeting with Comms to generate a screensaver, design a poster to communicate roles and expectations and status on recruitment to the ward teams

Fixing the Flow

Site

Treatment	What we said we'd do	What we did	Performance	Next Steps
On-call rotas and responsibilities **Owner DN & DS**	Review the current SOP	Reviewed the current SOP and made changes to On call manager/Director and site manager roles	NA	Circulate & implement
Test bed managers in assessment units **Owner CH**	Put senior site manager into the Assessment hub (EAU and Creaton) and one in site office	Awaiting ward move 09/11/2017 Planned PDSA cycle 20/11/2017 for 1 week	• Transfers out each day from assessment areas. • Improved discharges each day • Increased rapid transfer within 30 mins to base wards • Reduction in patients staying >48 hours • No patients returning to assessment from base wards	Secure volunteers for the 5 day shifts. Plan process and data capture with team and agree evaluation process post **PDSA First shifts start on Monday 20th on Benham Ward. S Cole and J Smith to lead**
Predictive information for the site team **Owner HM**	Start using daily discharges on white board	Bed managers updating white boards every 2hrs and LOS issues being challenged with wards	N/A	Review current predicted info which site use each day and agree forward plan (HM) RB to meet with HM to track progress.
Daily Information **Owner HM**	Go live with A&E dash board	A&E dashboard screen saver now up and running	Daily information can be tracked and measured	
Test 2 site managers at night **Owner CH**	Trial additional site manager to improve flow process overnight	Suggested that once the ward move has taken place and settled to action the treatment for a trial period target would be end November	• Patients allocated to the right beds and the right time, • % of overnight breaches of from 7pm to 7am • Numbers of empty assessment	**Test date to be confirmed – W/B 27th November. Still on plan subject to resolving staffing issues**

Fixing the Flow

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<td>spaces each morning
• No patients returning to assessment from base wards
• Reduction in patients staying >48 hours</td>
<td></td>
</tr>
<tr>
<td>Emergency floor
Owner CH</td>
<td>Ward move to take place on Thurs 9th Nov 2017</td>
<td>Move took place as planned with all stakeholders working well to ensure there was no risk to patient's safety.</td>
<td>
<table>
<tr><td>Discharges before 10am</td><td>10%</td></tr>
<tr><td>Discharges before 12pm</td><td>20%</td></tr>
<tr><td>Readmission rate</td><td><5%</td></tr>
<tr><td>Zero length of stay (24hrs)</td><td><10%</td></tr>
<tr><td>Patients LoS over 72hrs</td><td><5%</td></tr>
<tr><td>Average Length of Stay</td><td>48hrs</td></tr>
<tr><td>Number of admissions before 10am</td><td>3</td></tr>
<tr><td>Number of admissions before 12pm</td><td>6</td></tr>
<tr><td>% consultant review within 14hrs (6-8hrs when in dept)</td><td>95%</td></tr>
</table>
</td>
<td>Snagging issues to be resolved W/B 13.11.17
Complete
Permanent location for Cardiac Research Nurses to be resolved W/B 13.11.17
Complete
First week data metrics to be reviewed for improved flow
In progress
Agreed date to trial assessment bay on EAU for primary care arrivals With the wards now moved should this stream of work move to assessment work stream to progress the internal workings of the unit?</td>
</tr>
</table>

Northampton General Hospital NHS
NHS Trust

Report To	**TRUST BOARD**
Date of Meeting	**30 November 2017**

Title of the Report	Financial Position - October (FY17-18)
Agenda item	11
Sponsoring Director	Simon Lazarus, DoF
Author(s) of Report	Bola Agboola, Deputy DoF
Purpose	To report the financial position for the period ended October 2017/18.

Executive summary

This report sets out the financial position of the Trust for the period ended October 2017 – a pre-STF deficit of £13.9m which was £2.3m adverse to plan. The STF conditions were not met and have resulted in missed STF income of £2.8m. Therefore the total year to date adverse variance to plan was £5.1m.

The key issues for this report are:

- Activity has improved considerably in October. The improvement in activity and income gives an early indication that the income actions in the Trust's financial recovery plan (FRP) are working. We will continue to monitor this and report the position appropriately.
- Pay position deteriorated in month, mainly due to unachieved CIP and increased spend on agency costs. The YTD favourable variance on agency costs reduced from £1.2m in month 6 to £0.8m. The Trusts newly implemented Vacancy Control Panel will be targeting savings in this area.
- No STF income was assumed in this month's position; therefore the YTD total remains £1.1m.
- Due to the further deterioration of the Trust's financial position, it is strongly recommended that the Board considers whether it should revise the forecast outturn at the earliest opportunity.

Related strategic aim and corporate objective	Financial Sustainability
Risk and assurance	The recurrent deficit and I&E plan position for FY17-18 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

Enclosure G

Actions required by the Board

The Board is asked to note the financial position for the period ended October 2017/18 and to consider whether the forecast outturn should be revised.

Northampton General Hospital NHS
NHS Trust

Financial Position

Month 7 (October)
FY 2017/18

Report to:
Trust Board
November 2017

Enclosure G

Content

1. Overview

	RAG	This Month Oct	Last Month Sep	Change
I&E Position				
Actual in Month Position (£000's)		(2,057)	(2,900)	843
In-Month Position - Variance to Plan (£000's)	⊗	(1,771)	(1,824)	53
Year to Date Position - Variance to Plan (£000's)	⊗	(5,142)	(3,340)	(1,802)
Forecast End of Year I&E Position (£000's)		(13,546)	(13,546)	0
STF YTD Actual (£'000)		1,111	1,111	0
STF - Variance to Plan (£000's)	⊗	(2,811)	(1,939)	(872)
EBITDA %	⊗	-2.9%	-2.7%	-0.2%
Income				
Elective variance to plan (£000's)	⊗	(597)	(584)	(13)
Daycase variance to plan (£000's)	⊗	(455)	(533)	78
Non-Elective variance to plan (£000's)	⊗	(2,011)	(1,718)	(293)
Outpatients variance to plan (£000's)	✓	176	69	107
MRET Penalty - YTD Variance to Plan (£000's)	✓	0	0	0
Readmissions - YTD Variance to Plan (£000's)	✓	0	0	0
Contract Fines & Penalties - Variance to Plan (£000's)	!	(18)	(18)	0
Operating Costs				
Pay - YTD variance to plan (£000's)	⊗	(2,058)	(1,332)	(725)
Agency Staff Costs - YTD variance to Cap (£000's)	✓	826	1,243	(417)
Non-Pay - YTD variance to plan (£000's)	⊗	(435)	198	(633)
Cost Improvement Schemes				
Year to Date Variance to Plan (£000's)	⊗	(589)	(42)	(547)
Forecast Delivery (£000's)	⊗	10,521	10,532	(11)
Capital				
Year to date expenditure (£'000s)		3,500	3,093	407
% of annual plan Committed	✓	63%	59%	4%
Annual Capital Expenditure Plan (£000's)		13,205	13,205	0
Cash				
Closing Cash Balance (£000's)		1,967	3,845	(1,878)
New PDC / borrowing (£000's)		5,912	5,942	(30)
Debtors Balance > 90 days (£000's)	✓	2,145	1,916	(229)
Creditors % > 90 days	✓	0%	0%	0%
Cumulative BPPC - by volume (%)	✓	99.4%	99.4%	0.1%

Key issues

This report sets out the financial position of the Trust for the period ended October 2017 – a pre-STF deficit of £13.9m which is £2.3m adverse to plan. STF trajectories have been met only in Q1 therefore this has resulted in missed STF income of £2.8m year to date. The cumulative year to date adverse variance is £5.1m.

Income

- Activity has improved considerably in October and has had a positive impact on the YTD adverse variance (£2.4m compared to £2.2m in month 6). The improvement in activity and income gives an early indication that the income actions in the Trust's financial recovery plan (FRP) are working and we will continue to monitor this over the coming months.
- The challenges highlighted in previous reports such as increased length of stay, acuity and limited capacity remain, however it is expected that the Urgent Care reset program ("Fixing the Flow") should help with managing these challenges.
- A forecast report has been prepared under separate cover and estimates the likely forecast outturn for the Trust, as well as describes the financial recovery actions identified to date.

Pay

- Pay position was an adverse variance of £2.06m YTD (M6: £1.33m). The position in month 6 included non-recurrent credit of £0.3m relating to apprenticeship levy reclassification, therefore the month on month movement would be £0.4m. This mainly relates to increased spend on temporary staffing mainly agency.
- Agency spend remained below the NHSI target but worsened in-month - £0.8m YTD (M6: £1.2m).

Non-pay & Reserves

- Non-pay position was adverse to plan by £435k (M5:£198k fav.). The in-month movement was mainly due to unachieved CIP as well as increase in outsourced histopathology work (due to staff vacancies).
- The Trust's financial recovery plan is increasing its focus on non-pay and targeting a reduction in non-pay.
- Unspent reserves of £1.2m (M5: £1.1m) contributed to the I&E position.

Capital

- The Trust achieved a committed capital spend of 63% (M5: 59%) of its overall plan.

Liquidity

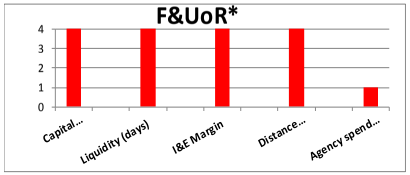
- The Trust continued to access deficit financing as planned, but because it is currently off-plan, we are starting to experience cashflow difficulties requiring tight cash management.
- STF funding of £1.1m (M6:£1.1m) is included in the position.
- A strong rating of over 99% on BPPC performance was maintained. The Trust was recently reported to be one of the few "top invoice payers in 2016-17" in the country, by the Health Service Journal .

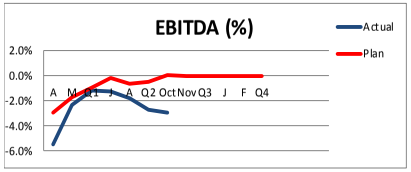
NHSI rating

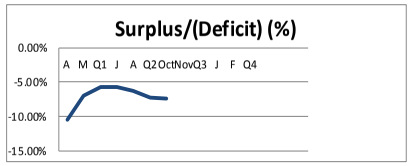
- The Trust continued to score "3" against the Finance and Use of Resources metrics.

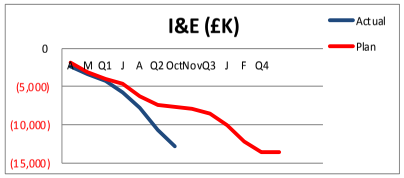
2. KPI & Trend Analysis

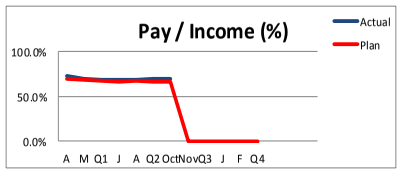
1. Key Metrics

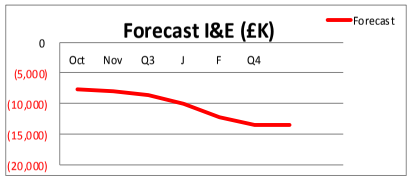




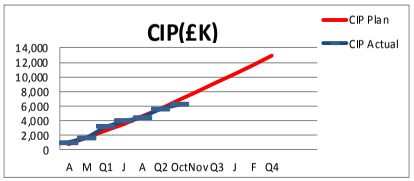


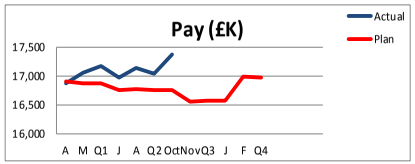


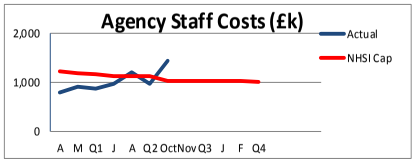


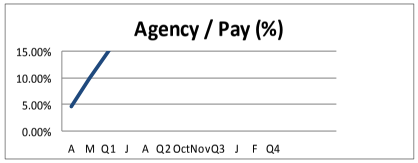


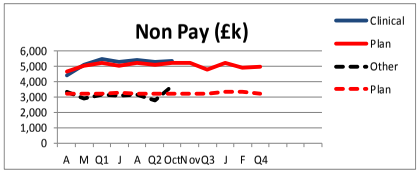
2. I&E Performance

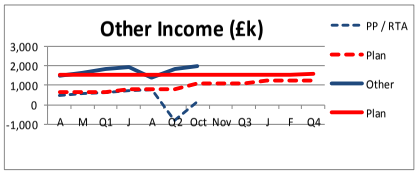




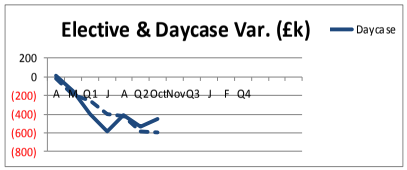


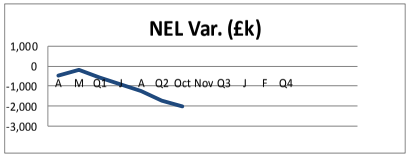


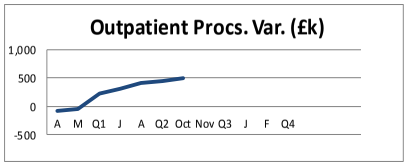


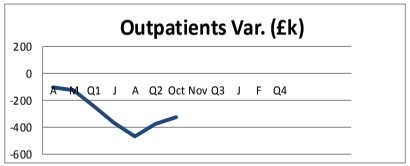


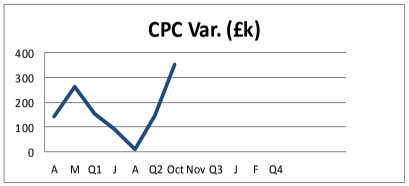
3. SLA Income

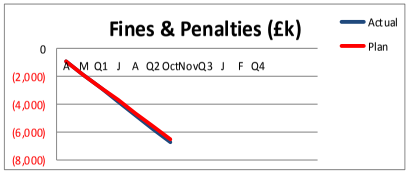




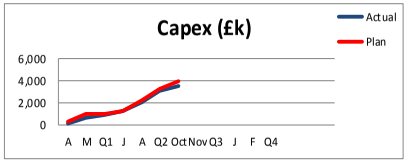


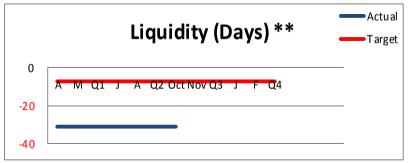


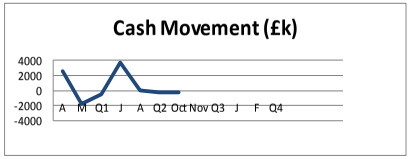


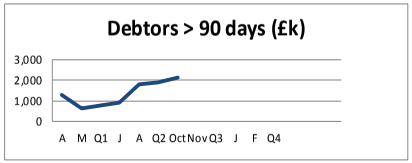


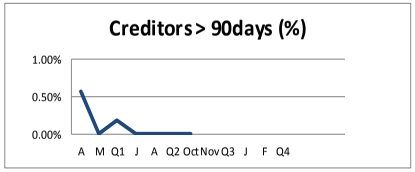
4. Working Capital

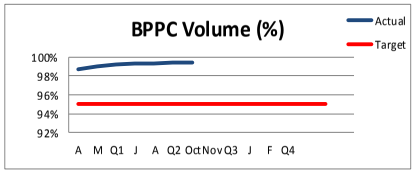












** F&UoP = Finance and Use of Resources metrics*

*** The liquidity gap is supported by access to Revolving Working Capital Funding and STF Funding*

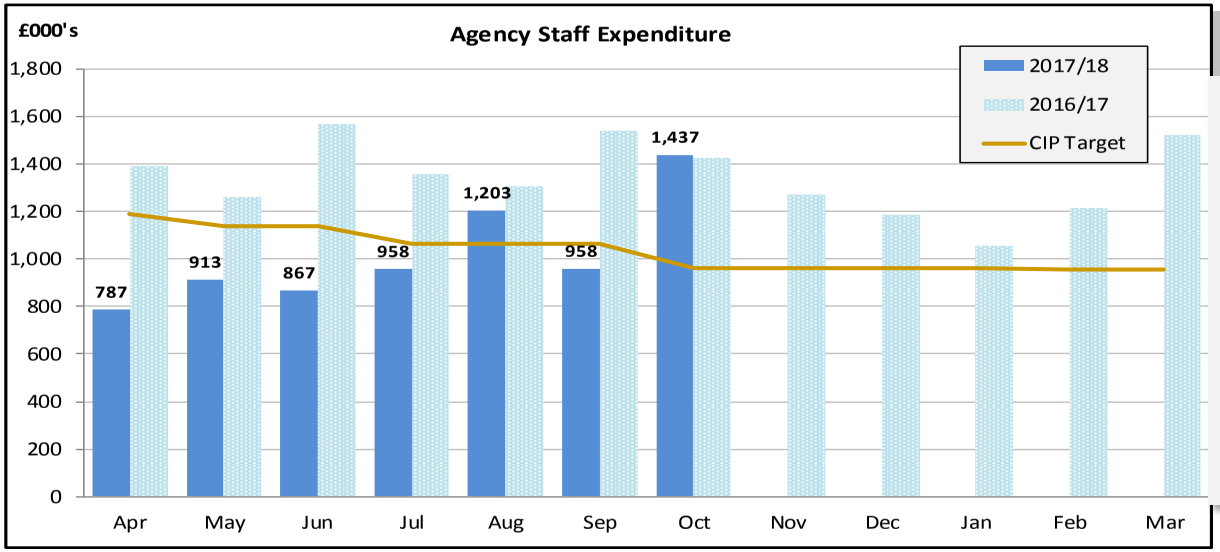
3.0 Income and Expenditure Position

I&E Summary	Actual FY16-17	Annual Plan	YTD plan	Actual FY17-18	Variance to Plan	Oct 17	Sep 17
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SLA Clinical Income	260,328	274,325	160,703	158,321	(2,382)	23,290	22,242
Other Clinical Income	2,373	11,435	5,492	2,506	(2,986)	185	(802)
Other Income	31,824	18,282	10,631	12,128	1,497	1,967	1,811
Total Income	294,525	304,042	176,826	172,955	(3,872)	25,441	23,250
Pay Costs	(199,813)	(201,400)	(117,526)	(119,584)	(2,058)	(17,369)	(17,034)
Non-Pay Costs	(94,406)	(99,391)	(57,964)	(58,399)	(435)	(9,048)	(8,020)
Reserves/ Non-Rec		(3,246)	(1,232)	0	1,232	0	0
Total Costs	(294,219)	(304,037)	(176,723)	(177,984)	(1,261)	(26,417)	(25,054)
EBITDA	306	5	104	(5,029)	(5,133)	(977)	(1,804)
Depreciation	(9,703)	(10,205)	(5,796)	(5,796)	(0)	(843)	(837)
Amortisation	(9)	(9)	(5)	(5)	(0)	(1)	(1)
Impairments	(1,732)	(1,826)	(1,569)	(1,039)	530	0	0
Net Interest	(720)	(790)	(461)	(453)	8	(69)	(65)
Dividend	(3,307)	(2,669)	(1,557)	(1,565)	(8)	(223)	(224)
Surplus / (Deficit)	(15,165)	(15,494)	(9,284)	(13,888)	(4,604)	(2,112)	(2,931)
NHS Breakeven duty adjs:							
Donated Assets	(414)	122	64	55	(9)	55	31
NCA Impairments	1,732	1,826	1,569	1,039	(530)	0	0
I&E Position (breakeven duty)	(13,847)	(13,546)	(7,651)	(12,793)	(5,142)	(2,057)	(2,900)

Key Issues

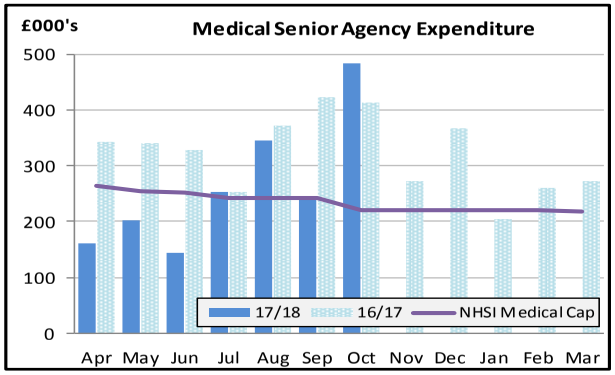
- This month we see a marked improvement in activity levels in comparison to September. These are early signs that the Trust's financial recovery actions as regards income is working but we will continue to monitor this. The improvements are especially noticeable in Daycases and elective activity. It is expected that the recent launch of the Urgent Care reset programme should continue to support improved flow through the hospital and enable improvement in elective and non-elective activity.
- STF is the main reason for the adverse variance on 'Other clinical income' and includes the loss of £2.8m relating to missed operational and financial performance STF trajectories.
- Pay costs increased in October mainly due to temporary staffing costs. Agency costs will be subject to the newly implemented Vacancy Control Panel, which is part of the Trust's FRP.
- Non Pay costs: The increase in month is partly due to increase in outsourced histopathology work (due to staff vacancies), unachieved CIP as well as the effect of non-recurrent adjustments in September. Centralised control over non-clinical non-pay spend has been implemented.

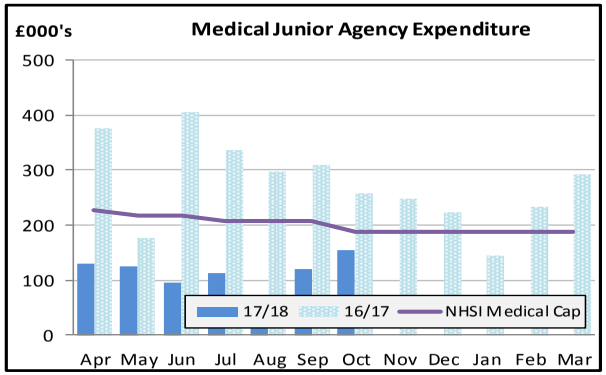
3.1 Agency Staff Expenditure

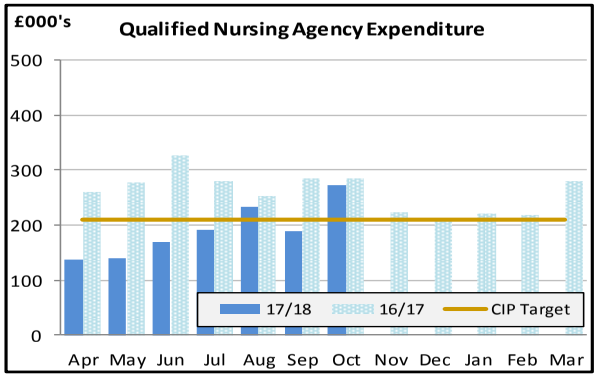


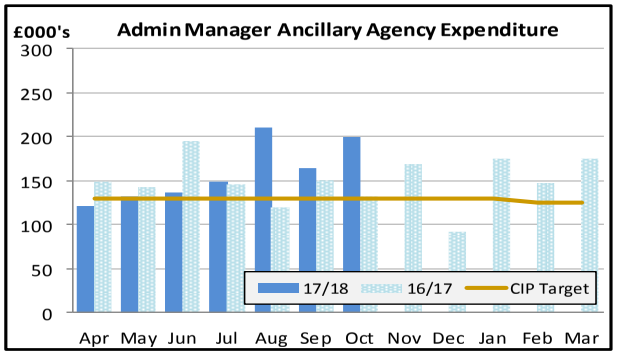
Key Issues

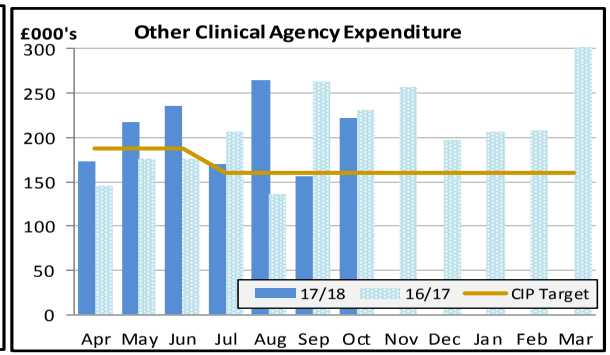
- The Trust total expenditure full year target for agency staff is £13.04m (£7.9m YTD target).
- At the end of Month 7 the Trust was £0.8m below this target (£1.2m in month 6). In month, the spend increased by c.£0.4m above the run-rate.
- The increase was due to spend on the medical outlier team, cover for staff vacancies and increase in the nursing team.
- The medical outlier team was implemented to improve the flow for winter and is being reviewed for its effectiveness.
- The Financial Recovery plan will be increasing focus on temporary staff pay spend, and the Vacancy control panel is being set up to target these areas.

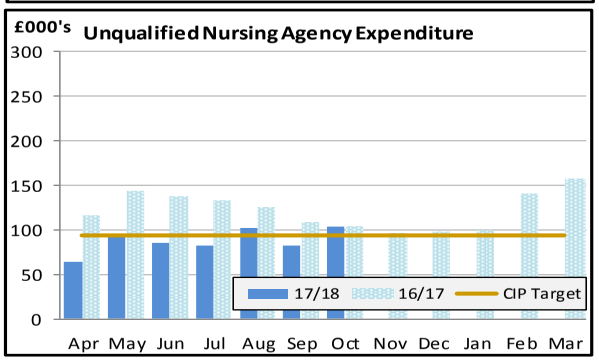












4.0 Clinical Income

SLA Clinical Income	Activity			Finance £000's		
Point of Delivery	Plan	Actual	Variance	Plan	Actual	Variance
AandE	71,062	70,338	(724)	9,048	8,884	(164)
Block	-	-	-	8,261	8,298	37
Cost per Case	1,677,098	1,703,470	26,372	18,851	19,204	353
CQUIN	-	-	-	2,845	3,048	202
Day Cases	24,092	23,446	(646)	14,408	13,953	(455)
Elective	3,697	3,131	(566)	10,533	9,910	(623)
Elective XBDs	666	800	134	168	193	26
Excluded Devices	-	1,739	1,739	1,230	1,240	11
Excluded Medicines	-	505	505	12,544	13,129	585
Non-Elective	32,201	29,942	(2,259)	58,572	55,226	(3,347)
Non-Elective XBDs	12,957	19,011	6,054	3,265	4,601	1,336
Outpatient First	36,473	33,500	(2,973)	6,401	5,880	(522)
Outpatient Follow UP	117,046	120,528	3,482	9,396	9,595	199
Outpt Procedures	85,970	87,140	1,170	10,110	10,609	499
CIP / Other				1,569	1,271	(297)
SLA Clinical Income	**2,061,261**	**2,093,549**	**32,288**	**167,201**	**165,040**	**(2,161)**
Contract Penalties				(132)	(151)	(18)
Challenges				(1,050)	(1,253)	(203)
Readmissions				(1,863)	(1,863)	0
MRET				(3,452)	(3,452)	0
Fines & Penalties				**(6,498)**	**(6,719)**	**(222)**
Total SLA Clinical Income	**2,061,261**	**2,093,549**	**32,288**	**160,703**	**158,321**	**(2,382)**

Other Clinical Income	Finance £000's		
	Plan	Actual	Variance
Private Patients	659	500	(159)
Overseas Visitors	78	184	106
RTA / Personal Injury Income	833	711	(122)
STF Funding	3,922	1,111	(2,811)
Total Other Clinical Income	**5,492**	**2,506**	**(2,986)**

SLA Clinical Income
£2,382k adv.

SLA Clinical Income has shown a significant improvement in month. Although the overall adverse variance is £2.4m, the in-month adverse variance was £138k, compared to run-rate of £374k. Overall, YTD activity remains below target in most areas, but the Trust's financial recovery plan is starting to make a positive contribution to the recovery of activity.

Cost Per Case
£353k fav.

CPC remains above plan due to Direct Access over-performance, with further improvements vs plan in critical care, maternity, chemo and radiotherapy income.

CQUIN
£202k fav.

CQUIN: The position includes the schemes achieved for Q1 and the accrual for the expected Q2 CQUIN. It also includes £0.6m YTD relating to 0.5% CQUIN for achieving the 2016-17 control total. The recognition of this income in current year remains under discussion with NHSI who are discussing with NHSE; therefore it remains a risk to the position.

Daycases
£455k adv.

The Month 7 position shows an improvement against plan of £40k.
DC activity increased by 5.8% from September, which was above plan by 2.5%. The main specialties responsible for this increase were general surgery, plastics and urology, as they recovered from low activity levels in September.

Elective
£623k adv.

Elective income also improved compared to September (about 5.6% up), but remains 6% below the financial plan. T&O accounts for £349k of the under performance.

Non-Elective
£2,011k adv.

NEL activity is 7% below plan at Mth 7.
Non elective income also improved significantly in comparison to September with 325 more discharges (9% increase). This was mainly due to an increase in Paediatrics as well as the resulting effect of admissions from increased A&E attendance.

Outpatients
£176k fav.

Outpatients continue to outperform plan. OPROCS are driving the financial benefit.

Fines & Penalties
£222k adv.

Readmissions and MRET have been negotiated as blocks in 17/18, so will stay on plan. Challenges are under increased pressure and will be a key focus in Q3.

Other Clinical Income
£2,986k adv.

The adverse positon on Other clinical income was mainly driven by the loss of STF funding as a result of missing the relevant trajectories. Private patients and Overseas patients income are also below plan.

4.1 High Level Commissioner Position

Commissioner	Finance £000's YTD Plan	Actual	Variance
Nene CCG	126,241	123,314	(2,927)
Corby CCG	1,687	1,514	(174)
Bedfordshire CCG	375	419	44
East Leicestershire & Rutland CCG	445	455	10
Leicester City CCG	34	57	23
West Leicestershire CCG	38	31	(7)
Milton Keynes CCG	1,764	1,744	(20)
Specialised Commissioning	22,185	23,559	1,374
Herts & South Midlands LAT	4,195	3,707	(488)
NCA / Central / Other	3,740	3,521	(219)
Total SLA Income	**160,703**	**158,321**	**(2,382)**

Nene Contract - £2,927k under performance
Significant under-performance on the Nene contract slowed during Month 7, with the core PODs all seeing improvements from September activity levels. The October position was £2.9m adverse which is a marginal increase of £47k from the September position.

The adverse variance is largely within the main PODs;
- DC £73k favourable (M6: £119k adverse)
- EL £861k adverse (M6: £817k adverse)
- NEL £2,136k adverse (M6: £1,989k adverse). This is excluding XS bed days.

In October, daycases picked from a low performance in September particularly in General Surgery, Plastics, Urology and Ophthalmology .
Elective activity was below plan -£71k, although a significant improvement on run-rate. NEL was above plan (+£93k), including XS bed days.
Recovery plans will also be further reviewed and built into Commissioner forecasts.

Specialised Commissioner - £1,374k over performance
An over-performance of £1.374m YTD was reported in October.
This is accounted for by excluded medicines expenditure (£1.4m). Elective over-performance of £533k is now being offset by under plan NEL activity (-£427k – in General Medicine and Neo-nates) and DC (-£214k – in Cardiology and Neurology) . We are continuing discussions with the Commissioner on excluded medicines as they look to lower the spend.

Herts & SM LAT (Secondary Dental) - £488k under performance
As with Nene this is largely across main POD's; DC (£135k), EL (£165k) and NEL (£126k).

Other local Commissioners have seen minimal movement to the their variance against plan.

4.3 STF Funding

I&E	Plan	YTD Plan	Actual YTD	Var
	£'k	£'k	£'k	£'k
Pre STF	(22,261)	(11,573)	(13,904)	(2,331)
STF	8,715	3,922	1,111	(2,811)
Post STF	(13,546)	(7,651)	(12,793)	(5,142)

Key issues

- The Trust missed the eligibility criteria for both finance and operational elements of the STF in month 7 and therefore has missed a total of £2.8m year to date (M6: missed STF £1.9m).
- If the Trust is able to recover the pre-STF control total in Q3, the finance element of the STF would be earned cumulatively.

5. Statement of Financial Position

TRUST SUMMARY BALANCE SHEET MONTH 7 2017/18	Balance at 31-Mar-17 £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	159,809	159,809	159,809	0	159,809	0
IN YEAR REVALUATIONS	0	(2,597)	(2,597)	0	(5,434)	(5,434)
IN YEAR MOVEMENTS	0	3,204	3,611	407	13,175	13,175
LESS DEPRECIATION	0	(4,954)	(5,797)	(843)	(10,205)	(10,205)
NET BOOK VALUE	159,809	155,462	155,026	(436)	157,345	(2,464)
CURRENT ASSETS						
INVENTORIES	5,770	6,712	6,651	(61)	5,494	(276)
TRADE & OTHER RECEIVABLES	23,887	15,935	17,236	1,301	24,020	133
NON CURRENT ASSETS FOR SALE	0	0	0	0	0	0
CASH	1,621	3,845	1,967	(1,878)	1,500	(121)
TOTAL CURRENT ASSETS	31,278	26,492	25,854	(638)	31,014	(264)
CURRENT LIABILITIES						
TRADE & OTHER PAYABLES	24,112	25,001	26,229	1,228	27,314	3,202
FINANCE LEASE PAYABLE under 1 year	124	124	124	0	130	6
SHORT TERM LOANS	20,334	20,334	20,334	0	1,889	(18,445)
STAFF BENEFITS ACCRUAL	753	753	753	0	800	47
PROVISIONS under 1 year	4,808	2,233	2,086	(147)	3,500	(1,308)
TOTAL CURRENT LIABILITIES	50,131	48,445	49,526	1,081	33,633	(16,498)
NET CURRENT ASSETS / (LIABILITIES)	(18,853)	(21,953)	(23,672)	(1,719)	(2,619)	16,234
TOTAL ASSETS LESS CURRENT LIABILITIES	140,956	133,509	131,354	(2,155)	154,726	13,770
NON CURRENT LIABILITIES						
FINANCE LEASE PAYABLE over 1 year	1,121	1,061	1,050	(11)	991	(130)
LOANS over 1 year	30,489	36,431	36,401	(30)	63,006	32,517
PROVISIONS over 1 year	1,055	1,055	1,055	0	750	(305)
NON CURRENT LIABILITIES	32,665	38,547	38,506	(41)	64,747	32,082
TOTAL ASSETS EMPLOYED	108,291	94,962	92,848	(2,114)	89,979	(18,312)
FINANCED BY						
PDC CAPITAL	119,258	119,258	119,258	0	120,116	858
REVALUATION RESERVE	37,392	35,838	35,838	0	33,716	(3,676)
I & E ACCOUNT	(48,359)	(60,134)	(62,248)	(2,114)	(63,853)	(15,494)
FINANCING TOTAL	108,291	94,962	92,848	(2,114)	89,979	(18,312)

Key Movements

The key movements from last month are:

Non Current Assets

- In Year M7 Movements include capital additions of £0.4m.
- Depreciation - £0.8m in month as per 2017/18 plan.

Current assets

- Inventories - £61k. Decrease in Heart Centre & Pharmacy stockholding (£128k) offset by increase in Supplies Central Store (£66k).
- Trade & Other Receivables – £1.3m. Increase in NHS SLA Performance Accruals (£0.6m). Increase in Prepayments (£0.5m) - CNST, Business Rates & Apprenticeship Levy. HMRC Partial Exemption VAT Claim for 16/17 £0.2m.

•Cash – Decrease of £1.9m. Capital Loan funding drawn down in September utilised for October Creditor payments. Repayment of STF element of Revenue Loan to DH (£1.2m).

Current Liabilities

- Trade & Other Payables - £1.2m movement includes increase of £1.4m in Payables, offset by £0.5m decrease in accruals. Increase in PDC Dividend accrual (£0.3m).

•Provisions - £147k. Release of Clinical Excellence Awards unutilised.

Non Current Liabilities

- £30k – Repayment of Salix Capital Loans

Financed By

- I & E Account - £2.1m deficit in month

6. Capital Expenditure

Capital Scheme	Plan 2017/18 £000's	M7 Plan £000's	M7 Spend £000's	Under (-) / Over £000's	Plan Achieved %	Total Actual & Committed £000's	Plan Achieved %
Refurbished MRI (Loan)	570	0	0	0	0%	641	113%
Imaging Replacement Rooms (Loan)	651	337	300	-37	46%	605	93%
2nd MRI (Loan)	2,309	757	751	-5	33%	2,204	95%
Replacement Imaging Equipment Other Spend	0	0	26	26	0%	26	0%
Replacement NPfIT Systems	1,090	128	116	-12	11%	733	67%
Stock / Inventory System (Loan)	282	63	61	-2	22%	140	50%
Chemo Appeal	100	100	91	-9	91%	101	101%
Contingency	332	0	0	0	0%	0	0%
Medical Equipment Sub Committee	756	268	261	-7	35%	268	35%
Estates Sub Committee	3,252	1,193	1,032	-161	32%	2,337	72%
IT Sub Committee	2,363	869	647	-222	27%	980	41%
Assessment Unit	755	0	26	26	3%	26	3%
A&E GP Streaming	858	257	257	0	30%	298	35%
Salix	87	87	42	-44	49%	51	58%
Total - Capital Plan	**13,405**	**4,059**	**3,612**	**-447**	**27%**	**8,411**	**63%**
Less Charitable Fund Donations	-200	-111	-111	0	56%	-121	61%
Less NBV of Disposals	0	0	0	0	0%	0	0%
Total - CRL	**13,205**	**3,948**	**3,500**	**-447**	**27%**	**8,290**	**63%**

Funding Resources	
Internally Generated Depreciation	10,205
Finance Lease - Assessment Unit	0
Capital Loans - Refurbished MRI	570
Capital Loans - 2nd MRI	2,309
Capital Loans - Imaging Replacement Rooms	651
Capital Loans - Stock / Inventory System	282
A&E GP Streaming	858
Salix	87
Capital Element - Finance Lease (Car Park Decking)	-124
Capital Loan - Repayment	-1,551
Other Loans - Repayment (SALIX)	-82
Total - Available CRL Resource	**13,205**
Uncommitted Plan	**0**

Key Issues

- The Trust spend is £3,612k at M7, which is 27% of the overall Capital Plan.
- Actual spend plus the Commitments totals £8,411k, therefore at M7 63% of the Capital Plan has been spent or committed.
- Commitments of £4,799k include the Radiology Imaging Equipment of £2,399k. Room F works are going well and still on target for completion by the end of November. The 2nd MRI contractors are still forecasting completion by Christmas, the MRI equipment is being delivered and craned in situ by mid-November. The refurbishment of the existing MRI will follow in Qtr 4.
- Replacement of PAS (NPfIT) the new CaMIS system originally had a go live date of 16th October, but this has now been delayed.
- The Assessment Unit had a planned handover date of May 2018, this has been delayed by a few weeks due to an unexpected BT cable running through the site. Over the next month the ward modules will be delivered to site. The £755k above represents the Trust's spend on 'setting up' costs - IT & Equipment.
- A&E GP Streaming - works are ongoing and scheduled GP start date is 29th November 2017. External works will continue after that date but the facility can be used. The £858k is the total awarded to the Trust as part of the Department of Health's easing A&E winter pressures scheme.

7. Receivables, Payables and BPPC Compliance

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	1,032	351	113	74	493
Receivables NHS	5,039	2,937	308	143	1,652
Total Receivables	**6,071**	**3,288**	**422**	**217**	**2,145**
Payables Non NHS	(5,803)	(5,732)	(72)	0	0
Payables NHS	(1,021)	(1,021)	0	0	0
Total Payables	**(6,824)**	**(6,753)**	**(72)**	**0**	**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	1,228	277	332	77	541
Receivables NHS	4,407	2,046	484	503	1,375
Total Receivables	**5,635**	**2,323**	**816**	**580**	**1,916**
Payables Non NHS	(4,190)	(4,183)	0	(8)	0
Payables NHS	(1,157)	(1,157)	0	0	0
Total Payables	**(5,347)**	**(5,339)**	**0**	**(8)**	**0**

Receivables and Payables

- NHS Receivables – Accruals are included within the 0 to 30 Days Receivables balance.
- NHS over 90 day debt has increased to £1.7m. This includes £1.0m 2017/18 CQUIN Risk Reserve invoiced to Nene CCG, which remains in query. NHS Property Services £78k, which is part of an ongoing dispute, £246k of 16/17 over-performance invoices and £173k NCA's.
- Non-NHS over 90 day debt includes Overseas visitor accounts of £415k, of which £133k are paying in instalments and 45% of the balance passed to debt collection agency to recover. £32k relate to private patients, 78% of which is under contract query with insurance providers.

Better Payment Compliance Code - 2017/18

Narrative	April 2017	May 2017	June 2017	July 2017	August 2017	Sept 2017	Oct 2017	Cumulative 2017/18
NHS Creditors								
No.of Bills Paid Within Target	170	244	157	162	160	142	134	1,169
No.of Bills Paid Within Period	174	244	157	162	161	143	134	1,175
Percentage Paid Within Target	**97.70%**	**100.00%**	**100.00%**	**100.00%**	**99.38%**	**99.30%**	**100.00%**	**99.49%**
Value of Bills Paid Within Target (£000's)	2,073	2,547	1,378	2,458	1,840	1,688	1,589	13,574
Value of Bills Paid Within Period (£000's)	2,075	2,547	1,378	2,458	1,872	1,688	1,589	13,608
Percentage Paid Within Target	**99.90%**	**100.00%**	**100.00%**	**100.00%**	**98.31%**	**99.98%**	**100.00%**	**99.75%**
Non NHS Creditors								
No.of Bills Paid Within Target	5,005	6,087	7,329	6,186	7,201	6,363	6,825	44,996
No.of Bills Paid Within Period	5,068	6,130	7,369	6,201	7,246	6,401	6,844	45,259
Percentage Paid Within Target	**98.76%**	**99.30%**	**99.46%**	**99.76%**	**99.38%**	**99.41%**	**99.72%**	**99.42%**
Value of Bills Paid Within Target (£000's)	7,543	7,985	9,652	8,354	8,905	8,539	8,838	59,817
Value of Bills Paid Within Period (£000's)	7,589	8,008	9,679	8,362	9,155	8,593	8,847	60,232
Percentage Paid Within Target	**99.40%**	**99.71%**	**99.73%**	**99.91%**	**97.27%**	**99.37%**	**99.90%**	**99.31%**
Total								
No.of Bills Paid Within Target	5,175	6,331	7,486	6,348	7,361	6,505	6,959	46,165
No.of Bills Paid Within Period	5,242	6,374	7,526	6,363	7,407	6,544	6,978	46,434
Percentage Paid Within Target	**98.72%**	**99.33%**	**99.47%**	**99.76%**	**99.38%**	**99.40%**	**99.73%**	**99.42%**
Value of Bills Paid Within Target (£000's)	9,616	10,532	11,031	10,812	10,745	10,227	10,427	73,391
Value of Bills Paid Within Period (£000's)	9,664	10,555	11,057	10,820	11,027	10,282	10,436	73,840
Percentage Paid Within Target	**99.51%**	**99.78%**	**99.76%**	**99.93%**	**97.45%**	**99.47%**	**99.91%**	**99.39%**

Better Payment Practice Code

- The BPPC performance was achieved for all targets in October.
- The Trust was recently reported by the Health Service Journal to be one of the few "top invoice payers in 2016-17" in the country.

8. Cashflow

MONTHLY CASHFLOW	Annual £000s	ACTUAL APR £000s	MAY £000s	JUN £000s	JUL £000s	AUG £000s	SEP £000s	OCT £000s	FORECAST NOV £000s	DEC £000s	JAN £000s	FEB £000s	MAR £000s
RECEIPTS													
SLA Base Payments	266,217	22,512	21,345	23,165	22,083	21,975	22,014	22,015	22,014	22,014	23,051	22,014	22,014
STF Funding	7,352	81	0	0	3,545	0	1,111	0	0	0	0	0	2,615
SLA Performance/ Other CCG Investment	3,492	873	-23	273	677	30	1,417	0	0	246	0	0	0
Health Education Payments	9,625	762	809	785	785	822	822	808	800	808	808	808	808
Other NHS Income	11,731	801	1,125	596	1,279	835	593	1,002	1,000	1,000	1,000	1,000	1,500
PP / Other (Specific > £250k)	2,778	610	273	313	346	327	225	279	404	0	0	0	0
PP / Other	13,310	1,044	1,258	1,072	1,276	835	986	1,043	996	1,200	1,200	1,200	1,200
Salix Capital Loan	87	0	0	87	0	0	0	0	0	0	0	0	0
PDC - Capital	858	0	0	0	0	0	0	0	298	560	0	0	0
Capital Loan	3,611	0	0	0	0	0	1,047	0	0	2,014	0	0	550
Revenue Support Loan	0	0	0	0	0	0	0	0	0	0	0	0	0
Uncommitted Revenue Loan - deficit funding	13,546	3,116	-32	979	523	1,703	1,076	286	301	606	1,488	2,201	1,299
Uncommitted Revenue Loan - STF funding	8,715	436	436	435	581	581	581	872	872	871	1,017	1,017	1,016
Interest Receivable	21	2	2	2	2	2	2	2	2	2	1	2	2
TOTAL RECEIPTS	**341,343**	**30,237**	**25,193**	**27,707**	**31,096**	**27,109**	**29,874**	**26,307**	**26,688**	**29,321**	**28,565**	**28,242**	**31,004**
PAYMENTS													
Salaries and wages	197,261	15,598	16,340	16,890	16,382	16,237	16,374	16,533	16,708	16,560	16,460	16,460	16,720
Trade Creditors	93,814	6,781	7,037	9,122	7,802	8,059	8,032	7,762	7,681	9,345	5,311	8,797	8,084
NHS Creditors	21,901	2,079	2,300	1,403	2,458	2,279	1,791	1,766	1,942	1,942	1,942	1,000	1,000
Capital Expenditure	13,177	843	1,243	810	643	663	575	944	615	1,463	2,991	1,303	1,085
PDC Dividend	2,647	0	0	0	0	0	1,305	0	0	0	0	0	1,342
Repayment of Revenue Loan - STF funding	10,215	2,425	0	0	0	2,284	141	1,158	149	0	1,743	0	2,315
Repayment of Loans (Principal & Interest)	2,332	0	0	0	92	513	448	8	3	11	118	682	456
Repayment of Salix loan	91	21	0	0	0	0	38	29	0	0	0	0	3
TOTAL PAYMENTS	**341,438**	**27,747**	**26,920**	**28,226**	**27,377**	**30,034**	**28,703**	**28,201**	**27,098**	**29,321**	**28,565**	**28,242**	**31,005**
Actual month balance	-95	2,490	-1,727	-519	3,719	-2,925	1,170	-1,894	-410	0	0	1	0
Cash in transit & Cash in hand adjustment	-26	32	-29	48	-34	-22	21	17	-58	-1	1	-1	0
Balance brought forward	1,621	1,621	4,143	2,387	1,915	5,600	2,653	3,845	1,967	1,500	1,500	1,500	1,500
Balance carried forward	**1,500**	**4,143**	**2,387**	**1,915**	**5,600**	**2,653**	**3,845**	**1,967**	**1,500**	**1,500**	**1,500**	**1,500**	**1,500**

Key Issues

- The Trust has been able to manage its cashflow despite the financial position being off plan. However, the cash position is becoming more challenging and we have started to apply restrictions to supplier payments.
- Payment from Nene CCG in respect of the £1.0m 2017/18 Cquin Risk Reserve continues to be forecast to be received in January.
- Outstanding Performance invoice payments from Milton Keynes CCG & Central Midlands Region Office are forecast to be received in December.
- Following receipt of £1.1m Qtr 1 STF funding from NHS England in September, the £1.3m corresponding borrowing has been offset against the October & November Uncommitted Revenue Loan entitlements. This resulted in a zero net cash draw down in October.
- DH has approved a further drawdown of £1.0m in November against the Uncommitted Interim Revenue Support Facility (ISUCL). This is a net drawdown to include repayment of the remaining borrowing in respect of the Qtr 1 STF funding.
- The Trust is continuing to assume repayment of the Qtr 2 STF Loan Funding in January. This will be reviewed monthly & discussed with NHSI.
- It is recommended that the Trust reconsiders whether it can meet its control total as soon as possible, as the cash support associated with lost STF can only be discussed with NHSI after the financial forecast has been revised.
- DH has approved a Capital PDC draw down of £0.3m in November. This supports the expenditure incurred on the A & E GP Streaming. The balance of the £858k funding is forecast to be drawn down in December.

9. Conclusion

Key Points:

- The Trust missed its pre-STF financial control by £2.3m and also lost operational and financial performance-related STF of £2.8m, culminating in a £5.1m adverse variance to plan.
- There has been considerable improvement in activity and income in comparison to previous months. Although this is only indicative of one month's data, it gives an early indication that the Trust's Financial recovery plan (FRP) actions relating to income is likely to be effective.
- Pay is adverse to plan as a result of increased temporary staffing costs. Agency spend is lower than the NHSI target YTD but well over the monthly target. The trust is therefore implementing centralised control which would apply to all long term agency requests except for urgent single shift cover requests in A&E overnight.
- The scope of the centralised vacancy control panel will include agency and bank staffing in addition to substantive posts.
- In view of the further deterioration in the Trust's financial position, it is recommended that the Board considers whether it should revise the forecast outturn. The financial recovery paper is designed to help inform this decision and includes the required protocol for this.

Report To	**Public Trust Board**
Date of Meeting	**30 November 2017**

Title of the Report	**Workforce Performance Report**
Agenda item	**12**
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 an increase in sickness absence from September 2017.
- Increase in compliance rate for Mandatory Training and slight decreases in compliance rates for Role Specific Essential Training and Appraisals.
- Flu Campaign Update
- Staff Survey Update
- Exception Reports for Staff Role Specific Training, Staff Appraisals, Vacancy Rates and Sickness Absence.

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	

Enclosure H

Framework entries	BAF – 2.1, 2.2 and 2.3
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (Y/N) No 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 Board

The Board is asked to Note the report.

Trust Board

Thursday 30 November 2017

Workforce Performance Report

1. Introduction

This report identifies the key themes emerging from October 2017 performance and identifies trends against Trust targets. It also sets out current key workforce updates.

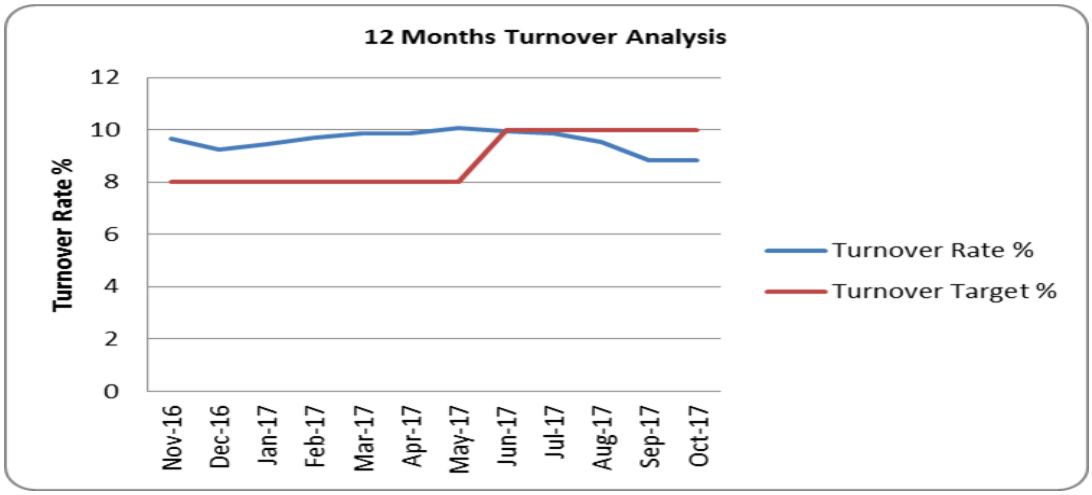
2. Workforce Report

2.1 Capacity

Substantive Workforce Capacity increased by 43.85 FTE in October 2017 to 4388.36 FTE. The Trust's substantive workforce is at 89.96% of the Budgeted Workforce Establishment of 4878.38 FTE.

Trust Turnover

Annual Trust turnover for October 2017 remained at 8.84%, which is below the Trust target of 10%.



Turnover within Nursing & Midwifery increased by 0.32% to 6.63%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust.

Turnover also increased for Additional Clinical Services by 0.49% to 8.60%. Turnover decreased for Additional Professional Scientific and Technical, Admin and Clerical, Allied Healthcare Professionals, Healthcare Scientists, Estates and Ancillary and Medical and Dental staff groups.

- Medical Division: turnover increased by 0.14% to 7.91%
- Surgical Division: turnover increased by 0.40% to 7.62%
- Women, Children & Oncology Division: turnover decreased by 0.17% to 8.33%
- Clinical Support Services Division: turnover increased by 0.15% to 10.65%
- Support Services: turnover decreased by 0.58% to 10.61%

Vacancy Rates

The vacancy % rate has increased in October for Additional Professional Scientific and Technical, Admin & Clerical and Allied Health Professionals.

There has been a decrease for Additional Clinical Services, Estates & Ancillary, Healthcare Scientists, Medical & Dental and Nursing and Midwifery. The largest decrease seen by Medical and Dental, Healthcare Scientists followed by Nursing and Midwifery staff groups:

- Medical and Dental decreased by 2.68% to 13.52%
- Healthcare Scientists decreased by 1.74% to 11.79%
- Nursing and Midwifery decreased by 1.50% to 8.42%

Sickness Absence

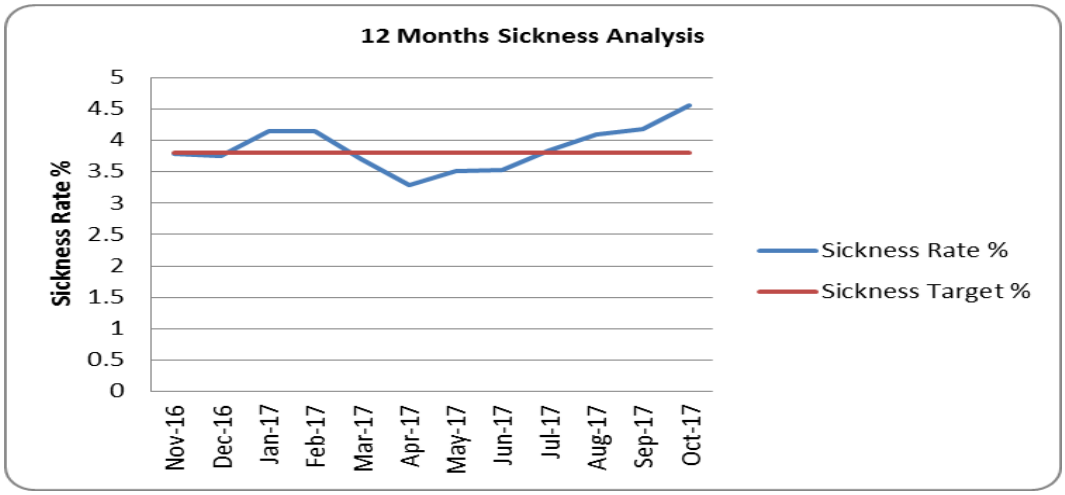
Sickness absence for October 2017 increased from 4.18% to 4.56% which is above Trust target of 3.8%. Only Clinical Support Division was below Trust target at 3.65%. All other divisions were above target:

- Medicine and Urgent Care at 5.99%
- Surgery Division at 3.83%
- Women, Children & Oncology at 4.80%
- Support Services at 4.07%.

Medicine and Urgent Care continues to have the highest sickness rate at 5.99% amongst all divisions.

Outpatients & Elderly Medicine showing the highest sickness rate of 7.01% amongst the directorates

In total 8 directorate level organisations were below the trust target rate in October 2017 compared to 11 directorates in September 2017.



Flu Campaign

The flu campaign is now in its 7th week and take-up is at 68.1%. We hope to achieve our target of 70% in the next two weeks.

There are more planned visits, late evening and early morning trolley rounds to do, and a warm reception was received from all areas during the very late trolley round from 6pm– 12am on the 10th November.

There have been over 350 nurse hours used, and over 300 visits carried out so far during this campaign, with over 60 miles walked with the trolleys.

2.2 Capability

Appraisals, Mandatory Training and Role Specific Essential Training

The current rate of Appraisals recorded for October 2017 is 84.44%; this is an increase of 1.13% from last month's figure of 83.31%.

Mandatory Training compliance decreased in October 2017 from 87.19%, to 87.17% this is a decrease of 0.02% from last month's figure and remains above the Trust target of 85%.

Role Specific Essential Training compliance decreased in October 2017 to 84.25% from last month's figure of 84.36%.; that is a decrease of 0.11%.

2.3 Culture

Staff Survey

The 2017 NHS Staff Survey was launched at the Trust on 9 October 2017 and sent out to 4802 eligible members of staff. Most staff were invited to take part in the survey via a personal email to their Trust email account. The remaining members of staff received a paper version of the survey. As at 14 November 2017 the response rate is 24.6% (1183 employees). The response rate by Division is:

Locality	Eligible Sample	Respondents	Response Rate
Surgical Division	1136	183	16.1%
Medical Division	1121	182	16.2%
Women Children & Oncology Division	995	288	28.9%
Clinical Support Services Division	684	246	36.0%
Support Services	866	284	32.8%

When compared to the 2016 Staff Survey the response rate at this point in the survey is about the same.

The survey closes on Friday 1 December 2017 and we expect some initial data in late December/early January 2018, followed by our official results in February.

4.0 Policies

The procedural documents that were ratified in and uploaded to the intranet in October 2017 were as follows:

- Disciplinary Policy – full review
- Internal Secondment Policy – minor update
- Management of Sickness Absence Policy – minor update

5.0 Assessment of Risk

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

6.0 Recommendations/Resolutions Required

The Board is asked to note the report.

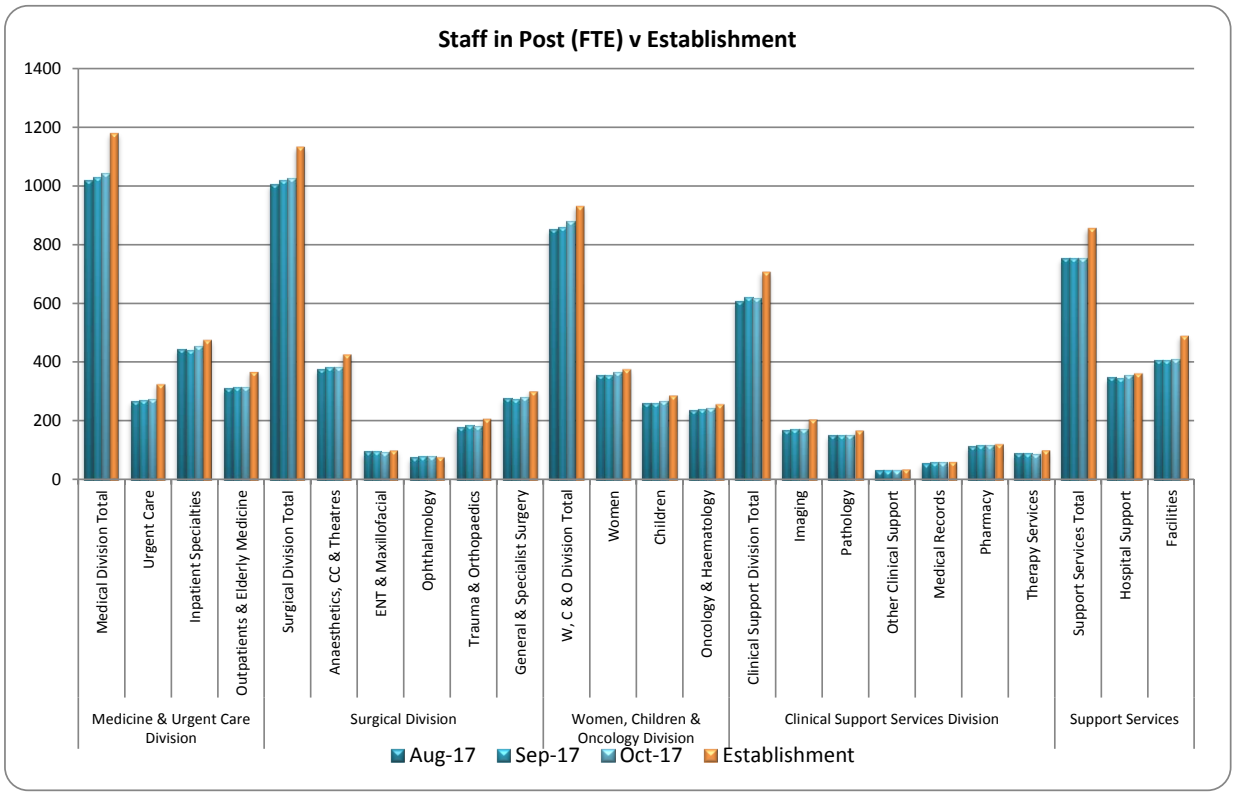
7.0 Next Steps

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

CAPACITY
Staff in Post

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

Staff in Post (FTE)		Aug-17		Sep-17		Oct-17	Establishment	
Medicine & Urgent Care Division	Medical Division Total	1021.76	↑	1029.56	↑	1042.13	1180.21	88.30%
	Urgent Care	265.93	↑	271.49	↑	272.46	328.97	82.82%
	Inpatient Specialties	444.14	↓	441.58	↑	455.24	478.33	95.17%
	Outpatients & Elderly Medicine	310.69	↑	315.49	↓	313.43	369.91	84.73%
Surgical Division	Surgical Division Total	1006.30	↑	1021.67	↑	1025.83	1133.89	90.47%
	Anaesthetics, CC & Theatres	376.73	↑	383.99	↑	384.31	429.36	89.51%
	ENT & Maxillofacial	94.97	↑	96.21	↓	93.66	103.20	90.76%
	Ophthalmology	75.57	↑	78.57	↑	79.57	79.82	99.69%
	Trauma & Orthopaedics	178.49	↑	183.68	↓	181.96	210.53	86.43%
	General & Specialist Surgery	275.73	↓	274.41	↑	280.53	304.18	92.22%
Women, Children & Oncology Division	W, C & O Division Total	853.29	↑	860.03	↑	878.87	933.04	94.19%
	Women	356.21	↑	356.84	↑	366.81	379.51	96.65%
	Children	259.53	↑	261.48	↑	267.00	289.76	92.15%
	Oncology & Haematology	235.61	↑	239.77	↑	244.07	260.92	93.54%
Clinical Support Services Division	Clinical Support Division Total	607.06	↑	620.98	↓	619.71	710.44	87.23%
	Imaging	169.08	↑	171.61	↑	171.72	208.46	82.38%
	Pathology	150.42	↑	150.62	↑	151.62	170.83	88.75%
	Other Clinical Support	31.22	↑	32.82	↓	32.74	38.30	85.48%
	Medical Records	53.96	↑	60.01	↓	58.88	64.03	91.96%
	Pharmacy	113.69	↑	116.62	↑	116.66	124.83	93.46%
	Therapy Services	88.69	↑	89.29	↓	88.09	103.99	84.71%
Support Services	Support Services Total	755.03	↓	753.17	↑	753.74	858.45	87.80%
	Hospital Support	347.12	↓	345.29	↑	354.79	365.54	97.06%
	Facilities	407.91	↓	407.88	↑	408.95	492.91	82.97%
Trust Total		4302.54	↑	4344.51	↑	4388.36	4878.38	89.96%



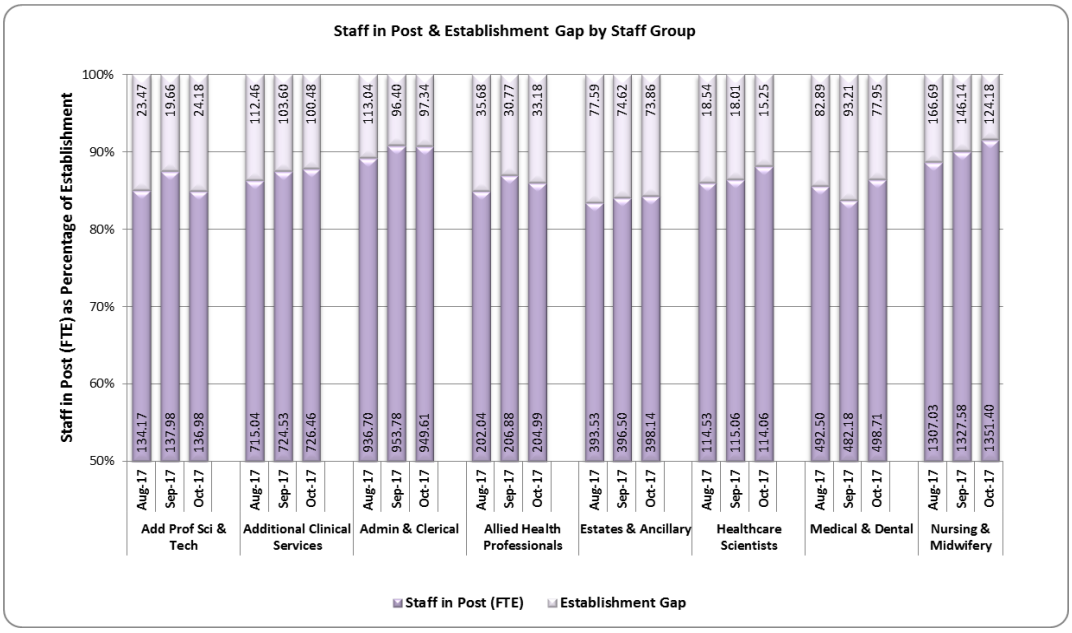
Enclosure H

CAPACITY
Staff Group (FTE v Est)

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

Staff Group Vacancy Rate (Contracted FTE v Establishment)

Staff Group	Aug-17	Sep-17	Oct-17
Add Prof Sci & Tech	14.89%	12.47%	15.00%
Additional Clinical Services	13.59%	12.51%	12.15%
Admin & Clerical	10.77%	9.18%	9.30%
Allied Health Professionals	15.01%	12.95%	13.93%
Estates & Ancillary	16.47%	15.84%	15.65%
Healthcare Scientists	13.93%	13.53%	11.79%
Medical & Dental	14.41%	16.20%	13.52%
Nursing & Midwifery	11.31%	9.92%	8.42%

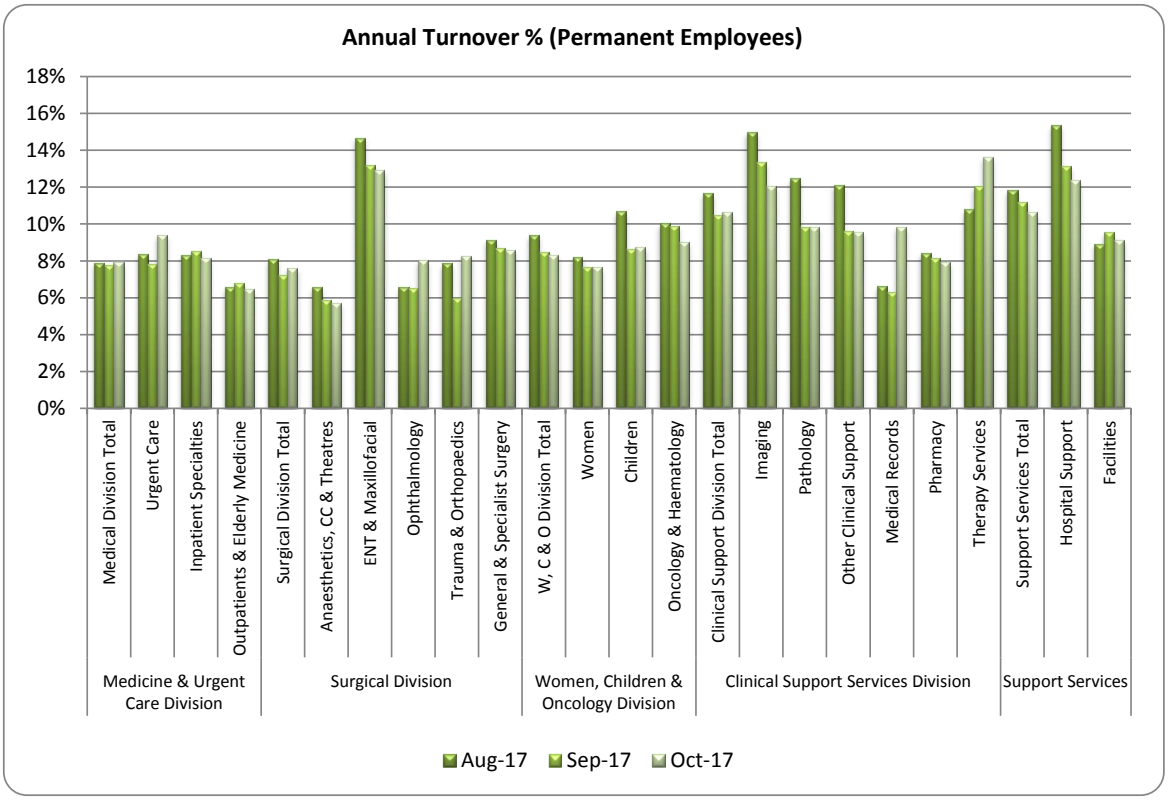


CAPACITY
Annual Turnover

Figures refer to the year ending in the month stated

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

Annual Turnover (Permanent Staff)		Aug-17		Sep-17		Oct-17
Medicine & Urgent Care Division	Medical Division Total	7.88%	↘	7.77%	↗	7.91%
	Urgent Care	8.38%	↘	7.82%	↗	9.37%
	Inpatient Specialties	8.33%	↗	8.51%	↘	8.17%
	Outpatients & Elderly Medicine	6.58%	↗	6.79%	↘	6.43%
Surgical Division	Surgical Division Total	8.08%	↘	7.22%	↗	7.62%
	Anaesthetics, CC & Theatres	6.56%	↘	5.88%	↘	5.72%
	ENT & Maxillofacial	14.67%	↘	13.19%	↘	12.95%
	Ophthalmology	6.55%	↘	6.49%	↗	8.05%
	Trauma & Orthopaedics	7.85%	↘	5.96%	↗	8.24%
	General & Specialist Surgery	9.15%	↘	8.69%	↘	8.57%
Women, Children & Oncology Division	W, C & O Division Total	9.42%	↘	8.50%	↘	8.33%
	Women	8.21%	↘	7.65%	↘	7.64%
	Children	10.67%	↘	8.65%	↗	8.73%
	Oncology & Haematology	10.03%	↘	9.90%	↘	9.02%
Clinical Support Services Division	Clinical Support Division Total	11.66%	↘	10.50%	↗	10.65%
	Imaging	15.00%	↘	13.34%	↘	12.07%
	Pathology	12.50%	↘	9.85%	↘	9.82%
	Other Clinical Support	12.12%	↘	9.60%	↘	9.58%
	Medical Records	6.62%	↘	6.32%	↗	9.82%
	Pharmacy	8.40%	↘	8.17%	↘	7.91%
	Therapy Services	10.78%	↗	12.07%	↗	13.65%
Support Services	Support Services Total	11.84%	↘	11.19%	↘	10.61%
	Hospital Support	15.38%	↘	13.16%	↘	12.40%
	Facilities	8.90%	↗	9.55%	↘	9.12%
Trust Total		9.55%	↘	8.84%	↗	8.84%



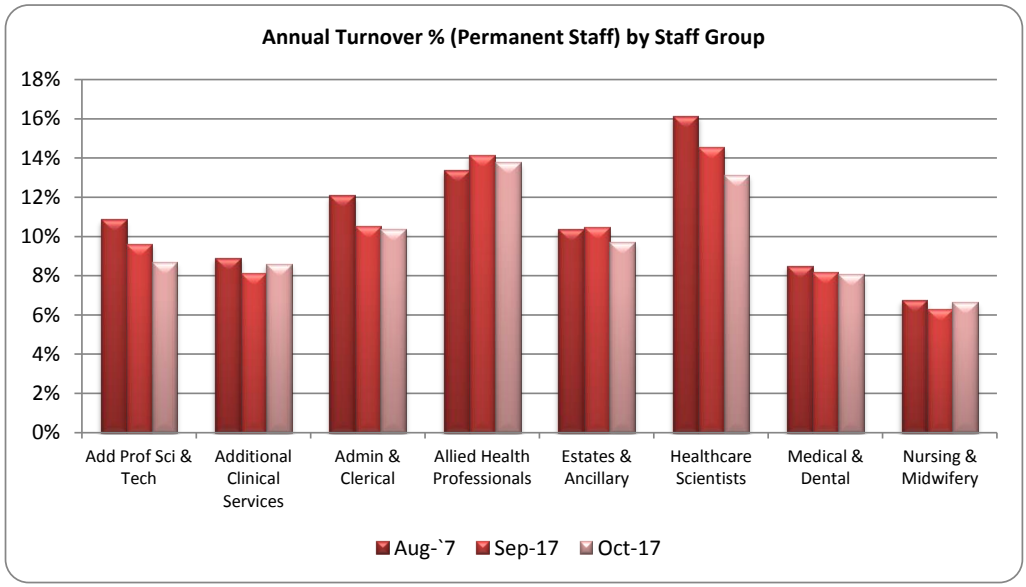
Enclosure H

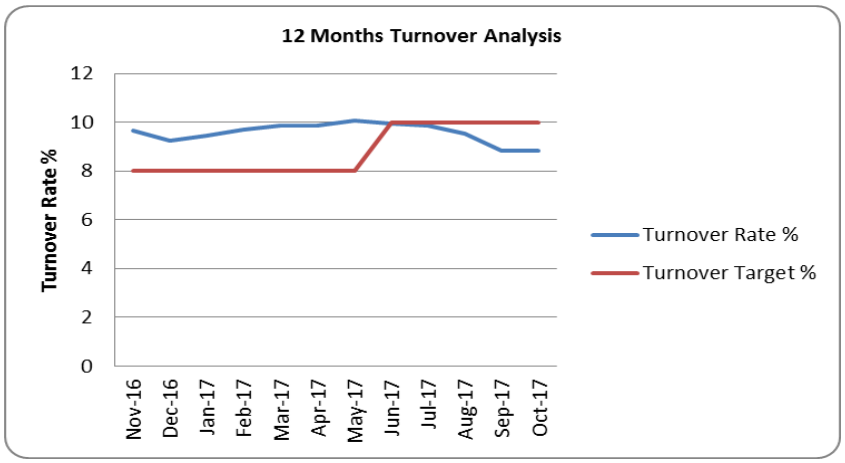
CAPACITY
Turnover by Staff Group

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-`7		Sep-17		Oct-17
Add Prof Sci & Tech	10.86%	↘	9.62%	↘	8.68%
Additional Clinical Services	8.92%	↘	8.11%	↗	8.60%
Admin & Clerical	12.09%	↘	10.53%	↘	10.40%
Allied Health Professionals	13.38%	↗	14.13%	↘	13.77%
Estates & Ancillary	10.36%	↗	10.45%	↘	9.73%
Healthcare Scientists	16.15%	↘	14.58%	↘	13.15%
Medical & Dental	8.48%	↘	8.18%	↘	8.05%
Nursing & Midwifery	6.76%	↘	6.31%	↗	6.63%





Capacity: Substantive Workforce Capacity increased by 43.85 FTE in October 2017 to 4388.36 FTE. The Trust's substantive workforce is at 89.96% of the Budgeted Workforce Establishment of 4878.38 FTE.

Staff Turnover: Annual Trust turnover for October 2017 remained at 8.84%, which is below the Trust target of 10%. Turnover within Nursing & Midwifery increased by 0.32% to 6.63%; the Nursing & Midwifery figures are inclusive of all nursing and midwifery staff employed in various roles across the Trust. Turnover also increased for Additional Clinical Services by 0.49% to 8.60%. Turnover decreased for Additional Professional Scientific and Technical, Admin and Clerical, Allied Healthcare Professionals, Healthcare Scientists, Estates and Ancillary and Medical and Dental staff groups.

Medical Division: turnover increased by 0.14% to 7.91%
Surgical Division: turnover increased by 0.40% to 7.62%
Women, Children & Oncology Division: turnover decreased by 0.17% to 8.33%
Clinical Support Services Division: turnover increased by 0.15% to 10.65%
Support Services: turnover decreased by 0.58% to 10.61%

Staff Vacancies: The vacancy % rate has increased in October for Additional Professional Scientific and Technical, Admin & Clerical and Allied Health Professionals.

There has been a decrease for Additional Clinical Services, Estates & Ancillary, Healthcare Scientists, Medical & Dental and Nursing and Midwifery. The largest decrease seen by Medical and Dental, Healthcare Scientists followed by Nursing and Midwifery staff groups:

Medical and Dental decreased by 2.68% to 13.52%
Healthcare Scientists decreased by 1.74% to 11.79%
Nursing and Midwifery decreased by 1.50% to 8.42%

Sickness Absence: Sickness absence for October 2017 increased from 4.18% to 4.56% which is above Trust target of 3.8%. Only Clinical Support Division was below Trust target at 3.65%. All other diviisons were above target:

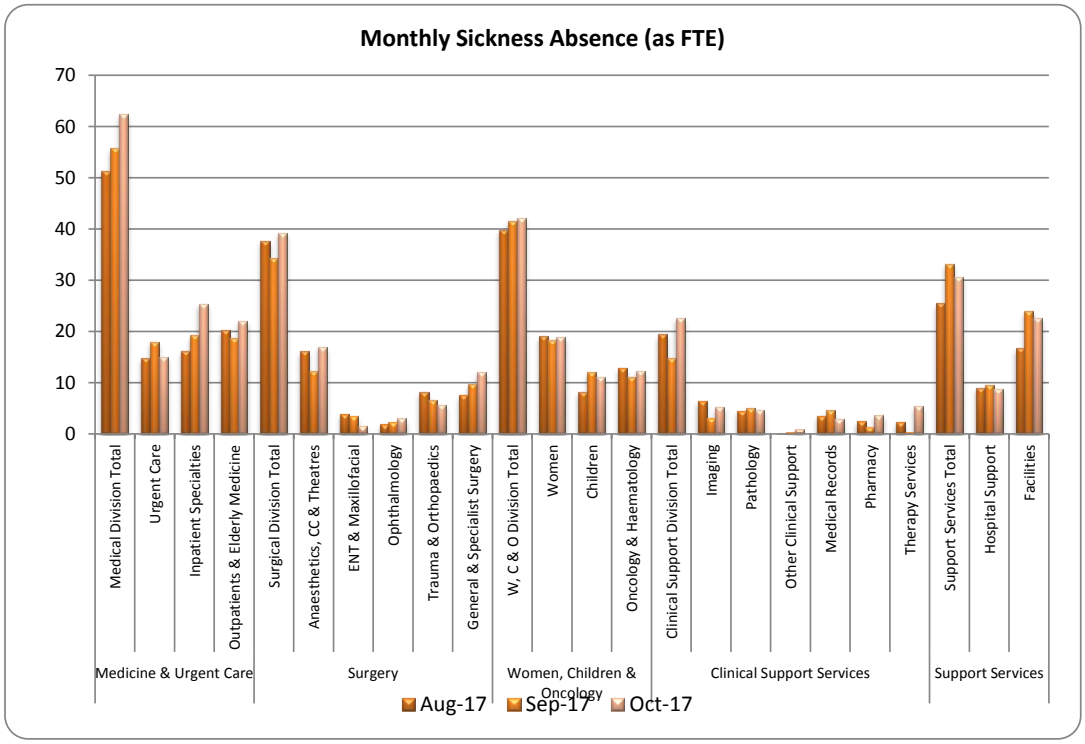
Medicine and Urgent Care at 5.99%
Surgery Division at 3.83%
Women, Children & Oncology at 4.80%
Support Services at 4.07%.

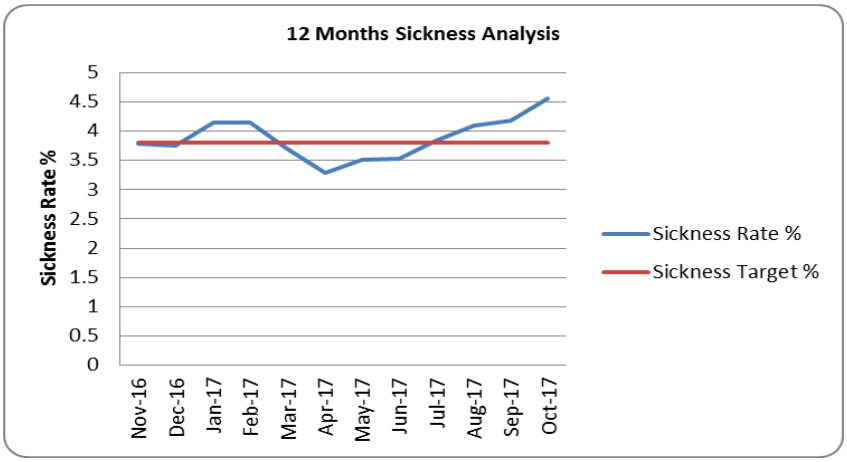
Medicine and Urgent Care continues to have the highest sickness rate at 5.99% amongst all divisions.
Outpatients & Elderly Medicine showing the highest sickness rate of 7.01% amongst the directorates.
In total 8 directorate level organisations were below the trust target rate in October 2017 compared to 11 directorates in September 2017.

CAPACITY
In-Month Sickness

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

Monthly Sickness (as FTE)		Aug-17	Sep-17	Oct-17	Oct-17	Short Term	Long Term
Medicine & Urgent Care	**Medical Division Total**	51.29	55.70	62.42	5.99%	2.87%	3.11%
	Urgent Care	14.81	17.97	15.01	5.51%	1.00%	4.52%
	Inpatient Specialties	16.26	19.21	25.36	5.57%	3.58%	1.99%
	Outpatients & Elderly Medicine	20.19	18.65	21.97	7.01%	3.51%	3.50%
Surgery	**Surgical Division Total**	37.74	34.33	39.29	3.83%	2.70%	1.13%
	Anaesthetics, CC & Theatres	16.16	12.17	16.95	4.41%	3.39%	1.01%
	ENT & Maxillofacial	3.93	3.46	1.58	1.69%	0.62%	1.07%
	Ophthalmology	1.83	2.36	2.98	3.75%	1.71%	2.04%
	Trauma & Orthopaedics	8.16	6.54	5.64	3.10%	2.13%	0.97%
	General & Specialist Surgery	7.53	9.69	12.03	4.29%	3.15%	1.14%
Women, Children & Oncology	**W, C & O Division Total**	39.85	41.54	42.19	4.80%	1.95%	2.84%
	Women	19.02	18.38	18.85	5.14%	1.78%	3.37%
	Children	8.12	12.00	11.08	4.15%	1.85%	2.31%
	Oncology & Haematology	12.77	11.10	12.28	5.03%	2.34%	2.69%
Clinical Support Services	**Clinical Support Division Total**	19.37	14.78	22.62	3.65%	2.85%	0.80%
	Imaging	6.41	3.17	5.20	3.03%	2.47%	0.56%
	Pathology	4.51	5.05	4.62	3.05%	2.61%	0.45%
	Other Clinical Support	0.11	0.40	0.83	2.54%	0.14%	2.40%
	Medical Records	3.49	4.56	2.90	4.92%	3.22%	1.69%
	Pharmacy	2.46	1.28	3.60	3.09%	3.09%	0.00%
	Therapy Services	2.33	0.40	5.45	6.19%	4.47%	1.72%
Support Services	**Support Services Total**	25.44	33.14	30.68	4.07%	1.90%	2.17%
	Hospital Support	8.89	9.56	8.76	2.47%	0.99%	1.49%
	Facilities	16.68	23.98	22.57	5.52%	2.73%	2.79%
Trust Total	***As FTE***	175.97	181.60	200.11			
	As percentage	4.09%	4.18%		4.56%	2.47%	2.08%


Monthly Sickness Absence (as FTE)
70
60
50
40
30
20
10
0
Medical Division Total
Urgent Care
Inpatient Specialties
Outpatients & Elderly Medicine
Surgical Division Total
Anaesthetics, CC & Theatres
ENT & Maxillofacial
Ophthalmology
Trauma & Orthopaedics
General & Specialist Surgery
W, C & O Division Total
Women
Children
Oncology & Haematology
Clinical Support Division Total
Imaging
Pathology
Other Clinical Support
Medical Records
Pharmacy
Therapy Services
Support Services Total
Hospital Support
Facilities
Medicine & Urgent Care
Surgery
Women, Children & Oncology
Clinical Support Services
Support Services
Aug-17
Sep-17
Oct-17


12 Months Sickness Analysis
Sickness Rate %
5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Sickness Rate %
Sickness Target %

Enclosure H

CAPABILITY

Training & Appraisal Rates

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

Mandatory Training Compliance Rate	Directorate	Aug-17	Sep-17	Oct-17
Medicine & Urgent Care Division	Medical Division Total	84.01%	83.46%	82.74%
	Urgent Care	84.17%	83.04%	82.98%
	Inpatient Specialties	82.12%	81.67%	79.65%
	Outpatients & Elderly Medicine	86.38%	86.20%	86.77%
Surgical Division	Surgical Division Total	85.74%	85.19%	85.34%
	Anaesthetics, CC & Theatres	84.86%	84.68%	84.04%
	ENT & Maxillofacial	88.09%	83.28%	84.61%
	Ophthalmology	91.93%	87.43%	88.44%
	Trauma & Orthopaedics	83.58%	84.51%	84.74%
	General & Specialist Surgery	85.53%	86.26%	86.84%
Women, Children & Oncology Division	W, C & O Division Total	88.33%	88.30%	88.49%
	Women	88.33%	88.74%	88.74%
	Children	90.90%	90.91%	90.85%
	Oncology & Haematology	85.23%	84.47%	85.24%
Clinical Support Services Division	Clinical Support Division Total	92.77%	92.02%	91.88%
	Imaging	90.27%	91.17%	89.12%
	Pathology	94.21%	93.98%	93.39%
	Other Clinical Support	92.78%	93.50%	90.74%
	Medical Records	93.70%	85.54%	93.67%
	Pharmacy	94.95%	93.70%	93.90%
	Therapy Services	91.67%	92.30%	91.22%
Support Services	Support Services Total	88.76%	89.57%	90.10%
	Hospital Support	88.10%	89.35%	90.02%
	Facilities	89.30%	89.75%	90.16%
Trust Total		87.42%	87.19%	87.17%

CAPABILITY
Training & Appraisal Rates

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

Role Specific Training Compliance Rate	Directorate	Aug-17	Sep-17	Oct-17
Medicine & Urgent Care Division	Medical Division Total	81.80%	82.71%	81.87%
	Urgent Care	80.84%	82.60%	81.69%
	Inpatient Specialties	80.53%	81.17%	79.22%
	Outpatients & Elderly Medicine	84.64%	84.99%	85.95%
Surgical Division	Surgical Division Total	83.71%	83.72%	84.54%
	Anaesthetics, CC & Theatres	83.71%	84.69%	85.66%
	ENT & Maxillofacial	79.89%	76.67%	79.73%
	Ophthalmology	82.32%	78.81%	82.68%
	Trauma & Orthopaedics	85.50%	85.71%	87.14%
	General & Specialist Surgery	83.93%	84.15%	83.10%
Women, Children & Oncology Division	W, C & O Division Total	86.54%	87.02%	86.74%
	Women	86.29%	87.17%	86.35%
	Children	89.79%	90.76%	90.25%
	Oncology & Haematology	81.89%	80.66%	82.17%
Clinical Support Services Division	Clinical Support Division Total	85.89%	85.69%	85.28%
	Imaging	85.79%	86.90%	86.55%
	Pathology	91.72%	90.94%	91.00%
	Other Clinical Support	87.60%	90.84%	88.15%
	Medical Records	92.54%	86.30%	86.11%
	Pharmacy	84.82%	80.51%	82.02%
	Therapy Services	82.81%	83.28%	81.89%
Support Services	Support Services Total	80.58%	81.58%	82.07%
	Hospital Support	85.26%	87.22%	88.10%
	Facilities	75.19%	75.08%	75.15%
Trust Total		83.93%	84.36%	84.25%

Capability

Appraisals
The current rate of Appraisals recorded for October 2017 is 84.44%; this is an increase of 1.13% from last month's figure of 83.31%.

Mandatory Training and Role Specific Essential Training
Mandatory Training compliance decreased in October 2017 from 87.19%, to 87.17% this is a decrease of 0.02% from last month's figure and remains above the Trust target of 85%.

Role Specific Essential Training compliance decreased in October 2017 to 84.25% from last month's figure of 84.36%.; 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 was not done but work continues to achieve this level of compliance.

CAPABILITY
Training & Appraisal Rates

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

Appraisal Compliance Rate	Directorate	Aug-17	Sep-17	Oct-17
Medicine & Urgent Care Division	Medical Division Total	83.00%	81.62%	82.61%
	Urgent Care	87.13%	90.39%	87.64%
	Inpatient Specialties	81.53%	77.51%	80.96%
	Outpatients & Elderly Medicine	81.23%	79.13%	80.37%
Surgical Division	Surgical Division Total	84.01%	85.70%	86.53%
	Anaesthetics, CC & Theatres	80.94%	84.45%	82.93%
	ENT & Maxillofacial	76.54%	72.62%	74.70%
	Ophthalmology	75.68%	89.04%	85.14%
	Trauma & Orthopaedics	92.90%	88.51%	93.60%
	General & Specialist Surgery	87.14%	88.84%	91.53%
Women, Children & Oncology Division	W, C & O Division Total	84.35%	85.67%	85.11%
	Women	82.71%	87.75%	85.26%
	Children	85.55%	83.15%	86.67%
	Oncology & Haematology	86.08%	85.29%	83.82%
Clinical Support Services Division	Clinical Support Division Total	80.57%	84.22%	83.89%
	Imaging	79.77%	79.31%	74.16%
	Pathology	85.80%	86.34%	84.66%
	Other Clinical Support	91.18%	80.56%	70.27%
	Medical Records	80.60%	90.41%	87.50%
	Pharmacy	75.00%	79.70%	87.22%
	Therapy Services	77.00%	92.08%	98.00%
Support Services	Support Services Total	78.99%	79.50%	83.96%
	Hospital Support	76.84%	78.33%	82.25%
	Facilities	80.65%	80.41%	85.31%
Trust Total		**82.32%**	**83.31%**	**84.44%**

Northampton General Hospital NHS
NHS Trust

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Staff Vacancy Rate	Internally set	Workforce Committee	October 2017

Performance:

Indicator	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Staff: Trust level vacancy rate - All	<=9%	10.6%	10.9%	10.7%	10.7%	10.6%	11.1%	11.4%	11.9%	12.5%	12.6%	11.6%	10.9%
Staff: Trust level vacancy rate - Medical Staff	<=9%	11.0%	9.9%	9.0%	9.7%	10.0%	10.7%	11.2%	10.0%	13.9%	14.4%	16.1%	13.5%
Staff: Trust level vacancy rate - Other Staff	<=9%	10.8%	11.0%	10.9%	11.0%	11.1%	13.8%	13.5%	13.6%	13.4%	13.2%	11.9%	11.9%

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 • Practice Development continue to forge links with local University to recruit Students • Dedicated roles within HR for recruitment and retention • More structured approach to Medical Staffing recruitment & resourcing • Increased use of social networking and web site development to maximise the exposure of the Trust to potential candidates. • Increase usage of apprenticeship schemes • Overseas recruitment for nurses continues • Attendance at job fayres to enhance Trust brand and maximise recruitment

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

Northampton General Hospital NHS
NHS Trust

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Staff Annual Appraisal Rate	Internally set	Workforce Committee	October 2017

Performance:

Indicator	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Percentage of staff with annual appraisal	>=85%	80.8%	82.0%	85.3%	84.4%	84.2%	83.6%	85.0%	85.0%	84.1%	82.3%	83.3%	84.4%

Driver for underperformance:	Actions to address the underperformance:
• Unprecedented demand on Clinical Services. • High Nursing vacancies within clinical areas. • Introduction of new paperwork • Some areas have waited until the cut-off to notify L&D of the appraisal, even though it may have occurred two months earlier.	• Continue to embed appraisal process into all areas, providing 1:1 support through regular monthly meetings with some directorates or as requested. • Identification of specific areas that have experienced of a decrease in appraisal compliance and the provision of support and guidance. • Training sessions are being provided to explain the new paperwork and to reiterate the process for notifying L&D of appraisals that have occurred.

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

Northampton General Hospital NHS
NHS Trust

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Staff Role Specific Training Rate	Internally set	Workforce Committee	October 2017

Performance:

Indicator	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Percentage of all trust staff with role specific training compliance	>=85%	77.1%	78.1%	79.0%	79.7%	81.2%	81.0%	81.0%	81.8%	82.6%	83.9%	84.3%	84.2%

Driver for under performance:	Actions to address the underperformance:
• Lack of awareness of Role Specific subjects due to these being separated from the previous list of 23 Mandatory subjects. • 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	• Increase awareness of the importance of undertaking RSET as well as mandatory training through the appraisal training. • Work continues in aligning Role Specific subjects to new positions as they are created. • We have been informed that RSET cannot be set against assignment and has to be set against position. Additional work will need to be carried out to ascertain if there is another way. • Safeguarding Children TNA is being reviewed over the next couple of months.

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

Northampton General Hospital NHS
NHS Trust

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Staff Sickness Rate	Internally set	Workforce Committee	October 2017

Performance:

Indicator	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Sickness Rate	<=3.8%	3.7%	3.7%	4.0%	4.0%	3.6%	3.2%	3.5%	3.5%	3.8%	4.1%	4.0%	4.5%

Driver for underperformance:	Actions to address the underperformance:
• Sickness absence for October 2017 increased significantly from 4.0% to 4.5% • Initial analysis suggests that short term absence has increased in most divisions and in surgery doubled. The reasons given demonstrate this is due to seasonal disorders and therefore it remains a key driver • In Women's and Children's long term sickness is high but there is a mixture of long and short term sickness in the Medicine division. Outpatients has seen the biggest increase this month	Staff reaching the Trust's sickness absence policy triggers are being met with formally with HR presence The Sickness Absence policy is currently under review and a likely change to quicken the process is that HR Advisors may no longer be present at first formal stages HR Advisors however continue to meet with managers where there is high sickness in their department and some of the long term sickness cases in particular in Women's and Children's are near completion In the Medicine Division an action plan has been developed to support managers and sickness absence is high on the agenda at the Medicine DMT

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

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30 November 2017**

Title of the Report	**Operational Performance Report**
Agenda item	**13**
Presenter of Report	Deborah Needham Chief Operating Officer / Deputy Chief Executive
Author(s) of Report	Lead Directors & Deputies Cancer – Sandra Neale Urgent Care – Paul Saunders
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

There is a separate report for both urgent care and cancer performance

Related strategic aim and corporate objective	Focus on quality & safety
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks N Risk of not delivering performance standards Associated fines Patient experience Reputation
Related Board Assurance Framework entries	BAF – 1.2, 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? (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	Are there any legal/regulatory implications of the paper (N)

Actions required by the Board

The Board is asked to:

- Note the performance report
- Seek areas for clarification
- Gain assurance on actions being taken to rectify adverse performance

Northampton General Hospital NHS Trust Corporate Dashboard 2017-18

Corporate Scorecard

Glossary **Targets & RAG**

	Indicator	Target	AUG-17	SEP-17	OCT-17
Quality of Care: Caring	Complaints responded to within agreed timescales	>=90%	90.6%	90.2%	100.0%
	Friends & Family Test % of patients who would recommend: A&E	>=86.9%	88.1%	88.8%	88.1%
	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	>=95.6%	93.1%	93.5%	93.1%
	Friends & Family Test % of patients who would recommend: Maternity - Birth	>=96.1%	100.0%	97.3%	95.6%
	Friends & Family Test % of patients who would recommend: Outpatients	>=93.3%	92.3%	92.9%	92.2%
	Total deaths where a care plan is in place	>=50%	46.7%	54.1%	62.1%
	Mixed Sex Accommodation	=0	0	0	0

	Indicator	Target	AUG-17	SEP-17	OCT-17
Operational Performance	A&E: Proportion of patients spending less than 4 hours in A&E	>=95%	89.4%	86.9%	86.5%
	Average Ambulance handover times	=15 mins	00:13	00:13	00:13
	Ambulance handovers that waited over 30 mins and less than 60 mins	<=25	68	90	107
	Ambulance handovers that waited over 60 mins	<=10	2	11	15
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	=0	2	2	1
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	>=93%	86.8%	69.9%	
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	>=93%	48.6%	12.1%	
	Cancer: Percentage of patients treated within 31 days	>=96%	97.6%	97.5%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	>=98%	97.0%	94.5%	
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	>=94%	94.5%	97.1%	
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	>=94%	100.0%	90.0%	
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	>=85%	75.1%	83.4%	
	Cancer: Percentage of patients treated within 62 days of referral from screening	>=90%	88.0%	95.6%	
	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	>=85%	80.0%	66.6%	
	RTT waiting times incomplete pathways	>=92%	92.0%	92.1%	
	RTT over 52 weeks	=0	0	0	
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	>=99.1%	99.9%	99.6%	99.6%
	ASI Management	<=4%	34.3%	32.4%	32.0%

	Indicator	Target	AUG-17	SEP-17	OCT-17
Quality of Care: Effective	Stranded patients >=75yrs (LOS > 7 DAYS)	<=45%	52.6%	52.0%	50.5%
	LOS > 7 Days	<=45%	10.5%	11.4%	11.4%
	Length of stay - All	<=4.2	4.6	4.9	4.8
	Emergency re-admissions within 30 days (elective)	<=3.5%	3.4%	3.5%	2.5%
	Emergency re-admissions within 30 days (non-elective)	<=12%	16.0%	15.9%	12.8%
	# NoF - Fit patients operated on within 36 hours	>=80%	83.3%	75.0%	95.8%
	Stroke patients spending at least 90% of their time on the stroke unit	>=80%	97.7%	94.1%	98.2%
	Suspected stroke patients given a CT within 1 hour of arrival	>=50%	90.1%	89.4%	91.3%
	Maternity: C Section Rates - Total	<27.1%	29.5%	27.6%	21.8%
	Mortality: HSMR	100	95	95	96
	Mortality: SHMI	100	96	99	99
	Crude Death Rates	1	0.9%	1.1%	1.2%

	Indicator	Target	AUG-17	SEP-17	OCT-17
Finance and Use of Resources	Income (£000's)	>=0	4 Fav	(2,035) Adv	(604) Adv
	Surplus / Deficit (£000's)	>=0	(355) Adv	(1,869) Adv	(1,521) Adv
	Pay (£000's)	>=0	(365) Adv	(302) Adv	(725) Adv
	Non Pay (£000's)	>=0	(143) Adv	303 Fav	(633) Adv
	Bank & Agency / Pay %	<=7.5%	12.2%	13.1%	14.6%
	CIP Performance YTD (£000's)	>=0	(327) Adv	(193) Adv	(668) Adv
	Salary Overpayments - Number YTD	=0	140	172	197
	Salary Overpayments - Value YTD (£000's)	=0	178.9	209.5	236.2
	Waivers	=0	3	6	0
	Waivers which have breached	=0	1	1	0

	Indicator	Target	AUG-17	SEP-17	OCT-17
Winter Pressures	Operations cancelled due to bed pressures	=0	2	10	5
	Patients who need to be readmitted if transport arrives too late	=0	5	14	12
	Average Monthly DTOCs	<=23	62	49	33
	Delayed transfer of care	=23	59	44	22

	Indicator	Target	AUG-17	SEP-17	OCT-17
Quality of Care: Safe	Never event incidence	=0	0	0	0
	Number of Serious Incidents Requiring Investigation (SIRI) declared during the period	=0	2	2	6
	MRSA	=0	0	0	0
	C-Diff	<=1.75	0	1	1
	MSSA	=0	0	0	1
	VTE Risk Assessment	>=95%	97.0%	96.7%	95.3%
	Harm Free Care (Safety Thermometer)	>=94.28%	94.5%	96.0%	95.0%
	Dementia: Case finding	>=90%	99.7%	92.7%	100.0%
	Dementia: Initial diagnostic assessment	>=90%	100.0%	100.0%	100.0%
	Number of falls (All harm levels) per 1000 bed days	<=5.5	3.7	5.3	4.3
	Transfers: Patients transferred out of hours (between 10pm and 7am)	<=60	30	33	16
	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	>=98%	100.0%	100.0%	100.0%
	Ward Moves (>2) Context	=0%	4.1%	4.7%	4.2%
	Ward Moves (>2)	=0	139	158	151

	Indicator	Target	AUG-17	SEP-17	OCT-17
Leadership & Improvement Capability	Job plans progressed to stage 2 sign-off	>=90%	47.9%	56.3%	41.1%
	Sickness Rate	<=3.8%	4.1%	4.0%	4.5%
	Staff: Trust level vacancy rate - All	<=9%	12.6%	11.6%	10.9%
	Staff: Trust level vacancy rate - Medical Staff	<=9%	14.4%	16.1%	13.5%
	Staff: Trust level vacancy rate - Registered Nursing Staff	<=9%	11.3%	9.9%	8.4%
	Staff: Trust level vacancy rate - Other Staff	<=9%	13.2%	11.9%	11.9%
	Turnover Rate	<=10%	9.5%	8.8%	8.8%
	Percentage of all trust staff with mandatory training compliance	>=85%	87.4%	87.1%	87.1%
	Percentage of all trust staff with role specific training compliance	>=85%	83.9%	84.3%	84.2%
	Percentage of staff with annual appraisal	>=85%	82.3%	83.3%	84.4%

Run Date: 14/11/2017 15:45 Corporate Scorecard Run by: FrancisS

Northampton General Hospital NHS
NHS Trust

Northampton General Hospital NHS Trust

Corporate Scorecard

Delivering for patients:
2017/18 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.

The arrows within this report are used to identify the changes within the last 3 months reported, with exception reports provided for all measures which are Red, Amber or seen to be deteriorating over this period even if they are scored as green or grey (no target); identify possible issues before they become problems.

Each indicator which is highlighted as red 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:
A&E: A&E Performance	Externally mandated	Finance, Investment and Performance Committee	October 2017

Performance:

Indicator	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
A&E: Proportion of patients spending less than 4 hours in A&E	>=95%	83.3%	83.2%	81.3%	78.1%	86.7%	87.4%	85.3%	88.7%	88.5%	89.4%	86.9%	86.5%

Driver for underperformance:	Actions to address the underperformance:
<u>Specialty waits</u> Adhering to professional standards still remains and issue in relation to A & E underperformance. Responsiveness of clinical teams to specialties is not consistent and embedded. <u>Bed capacity</u> Bed capacity within Trust still remains a daily challenge. A major challenge is the availability of empty beds being aligned with a request for beds during our peak activity times. In addition, identifying patients for early discharge, particularly before 11am remains a concern within our assessment areas and medical wards. • Vacancies within medical staffing equating to 10 WTE across all SHO, MG and Consultant (1x SHO going through clearance) • Increasing acuity • Exit Block • Increased complexity through >65 years age group • Increased ambulance conveyances that are subsequently discharged home.	• Please see Urgent Care report

Lead Clinician:	Lead Manager:	Lead Director:
Dr T Dyer	Paul Saunders	Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Average Ambulance Handover Times	Externally mandated	Finance Investment and Performance Committee	October 2017

Performance:

Indicator	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Ambulance handovers that waited over 30 mins and less than 60 mins	<=25	220	247	147	303	159	91	141	139	88	68	90	107
Ambulance handovers that waited over 60 mins	<=10	21	36	35	61	23	12	12	19	7	2	11	15

Driver for underperformance:

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

Actions to address the underperformance:

- In absence of HALO, crews to be requested to double up. This action is ongoing and is being monitored daily.
- Clinical guidance being written to support crews remotely with GP advice between 0800-2300hrs, awaiting access to System One escalated to CCG- On track to be delivered 29/11/17.
- Early escalation to EMAS silver to request HALO should the need arise.- Daily escalation in place.
- Discussion with EMAS Regional Operations Manager (ROM) to ensure admission avoidance MDT message is put out to crews, and to make aware of Trust pressures. Daily escalation in place when on OPEL4 or during increased demand.
- Early escalation to EMAS/Ops room if multiple ambulance arrivals in quick succession (10 or more per hour). Daily escalation in place when on OPEL4 or during increased demand.
- If Trust status OPEL 4 corridor to be staffed to support ambulance turnaround. Daily escalation in place.
- Ambulance arrival screen now live in resus area, this allows for early planning of critically unwell patients and also nurses are able to handover crews without leaving resus area.
- Trackers to escalate all ambulance delays approaching 25 minutes. Action is ongoing and monitored daily.
- Black Breaches information requested daily from EMAS so they can be validated Monthly validation of report.
- Ambulance Handover to be implemented on PAU/Maternity On track started 15/08/17, implementation complete, reduction seen in PAU/Maternity ambulance delays.

	• Ongoing work with EMAS on patients who are conveyed to NGH and subsequently discharged home (44%). Ongoing work with EMAS clinical teams to explore use of ACC for appropriate non critical pathways. Two pathways to be opened to paramedic crews (PE, Headache) as a 6 week trial ~~31/10/17~~, also exploring ambulatory rapid access chest pain pathway, (expected live date November 2017). • Escalation flow chart implemented within ED – completed 25/7/17. • Inappropriate attendances including trauma patients escalated to AOM (Quality).

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Stranded patients >75yrs (LOS > 7 DAYS)	Internally set	Finance, Investment and Performance Committee	October 2017

Performance:

Indicator	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Stranded patients >75yrs (LOS > 7 DAYS)	<=45%	55.5%	55.6%	52.6%	56.2%	51.7%	49.3%	52.3%	49.4%	49.7%	52.6%	52.0%	50.5%

Driver for underperformance:	Actions to address the underperformance:
• High numbers of Delayed Transfers of Care (DTOC) resulting in high numbers of 'stranded' patients across Northamptonshire • Pathway for Dementia patients to Angela Grace beds is no longer in place. Reduced Delirium diagnoses with inpatients but only small part-time team remains. • High numbers of complex discharge patients. • DE Nursing and package of care waits high • Restructure in Social care tracking system significantly changed, SPA and tracking still under review. • Increasing costs of residential care leaving vacancies in region. This is resulting in families being very reluctant to move patients out promptly or afford top ups needed. • SCC beds open but not at full capacity.	• Focus Matron Group for SAFER bundle within the trust and embedding continues. Red to Green implemented aims to ensure all patients have a senior review daily. • Executively chaired top delays meetings to review the longest staying patients in the trust continue weekly. Consultant and ward manager will present case to exec led panel for support and challenge in progressing the patient's pathway. Good weeks achieved becoming more consistent with social services committed now. Staff attendance good. • Clinical engagement requested. • Training continues organised across wards by Discharge team around Trust Discharge Policy to reduce internal delays further. • Discharge Matron taken on the Stranded patient meeting with support and clear process. .

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Ward Moves > 2	Internally set	Finance, Investment and Performance Committee	October 2017

Performance:

Indicator	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Ward Moves (>2)		124	142	122	124	163	102	132	132	144	139	158	151
Ward Moves (>2) Context		3.8%	3.9%	3.7%	3.9%	4.5%	3.5%	3.7%	3.9%	4.0%	4.1%	4.7%	4.2%

Driver for underperformance:	Actions to address the underperformance:
• High Medical bed occupancy and increasing LOS >21 days driving the use of outlier areas. The use of outlier areas puts this figure higher however we are using les escalation areas with MDSU closed to bedded patients • Some patients moved to accommodate infection control precautions. • Fracture NOF patients moved to ensure best practice received on specialist ward • Stroke patients moved to Stroke to ensure best practice received on specialist ward	• Focus on Fixing the Flow Trust wide Exec led programme to reduce LOS and improve flow started in October • Two medical teams recruited to review outlying patients (commenced October 2017) • Group set up to produce Site manager and Capacity coordinators daily SOP to create a more consistent and robust operational daily rhythm and process of inpatient capacity management this subsequently reducing unnecessary patient moves with right bed first time. (October 2017) • Ward coordinators continue Pull model where specialty wards identify and “pull” their specialty patients from A&E admitting wards often following consultant priority patient lists. This usually means patients are seldom moved again. (ongoing August 2017) • Meet with infection control speciality nurses to prioritise requested patient moves and side room occupancy due to infection (October 2017)

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:
Friends and Family Test % - Inpatient/Daycase	Externally mandated	Quality Governance Committee	October 2017

Performance:

Indicator	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Friends & Family Test % of patients who would recommend: Inpatient/Daycase	>=95.6%	93.0%	92.9%	94.0%	92.7%	93.6%	93.2%	94.1%	94.1%	93.9%	93.1%	93.5%	93.1%
Friends & Family Test % of patients who would recommend: Maternity - Birth	>=96.1%	99.0%	98.8%	97.9%	98.6%	94.0%	100.0%	100.0%	95.5%	100.0%	100.0%	97.3%	95.6%
Friends & Family Test % of patients who would recommend: Outpatients	>=93.3%	92.6%	93.2%	93.0%	93.7%	92.7%	92.5%	93.5%	92.8%	92.9%	92.3%	92.9%	92.2%

Driver for underperformance:	Actions to address the underperformance:
• It is evident when reviewing the data that the results for Inpatient & Day Cases have stabilized and work needs to be undertaken to ensure the momentum of the upward trajectory previously seen, continues. • October saw an increase in recommendation rates for Inpatient/Day Case areas, Outpatients and Births when compared with September 17.	• Two local surveys are undertaken with ward specific data produced and circulated. This has provided areas with specific improvement areas to focus on based around the national inpatient survey. As this is based on the things which are the most important to patients it is likely to have a positive impact on FFT as an overall barometer for satisfaction. • A number of projects are going to take place based on the survey results detailed above. This is likely to have an impact on scores for the FFT. This includes a deep dive into communication issues with triangulation between the FFT, PALS concerns and Complaints.

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Cancer Access Targets	Externally Mandated	Finance, Investment and Performance Committee	October 2017 for Validated September 2017

Performance:

Indicator	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	>=93%	96.4%	97.7%	96.1%	98.2%	96.5%	90.3%	85.9%	91.9%	87.8%	86.8%	69.9%
Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	>=93%	96.0%	95.0%	95.5%	98.4%	94.1%	85.2%	72.8%	50.9%	63.0%	48.6%	12.1%
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	>=98%	100.0%	98.3%	98.4%	95.8%	96.8%	100.0%	98.4%	94.1%	98.3%	97.0%	94.5%
Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	>=94%	81.8%	100.0%	88.2%	93.3%	100.0%	100.0%	90.9%	88.8%	81.8%	100.0%	90.0%
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	>=85%	81.6%	85.9%	80.4%	79.6%	76.3%	80.2%	72.9%	74.5%	74.5%	75.1%	83.4%
Cancer: Percentage of patients treated within 62 days of referral from Consultant Upgrade	>=85%	83.3%	100.0%	100.0%	70.0%	100.0%	84.6%	86.6%	83.3%	80.0%	80.0%	66.6%

Driver for underperformance:	Actions to address the underperformance:
• Please see F&P Report • Please note national figures are reported below, difference in decimal point rounding • 2ww Referrals – 70% • 2ww Breast Symptomatic – 12.2% • Subsequent Treatment Drug – 94.6% • 62 Day Consultant Upgrade- 66.7%	Please see separate report

Lead Clinician:	Lead Manager:	Lead Director:
Position currently vacant	Stephanie Buckley / Sandra Neale	Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Medical Job Planning	Externally mandated	Workforce committee.	October 2017

Performance:

Indicator	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Job plans progressed to stage 2 sign-off	>=90%	4.3%	51.5%	66.3%	74.3%	76.5%	0.0%	0.0%	0.0%	0.0%	47.9%	56.3%	41.1%

Driver for underperformance:	Actions to address the underperformance:
• Job planning not performing against timeframe of Trust trajectory	• Recovery plan implemented, job planning re-set. • Initial Directorate level assurance meetings held during October to ensure accuracy of job plans in line with Trust requirements. • Follow up meetings taking place during November to ensure actions completed. • Meetings will continue until Directorate job plans are awaiting 3rd stage sign off and await Assurance Panel review.

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

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Staff Role Specific Training Rate	Internally set	Workforce Committee	October 2017

Performance:

Indicator	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Percentage of all trust staff with role specific training compliance	>=85%	77.1%	78.1%	79.0%	79.7%	81.2%	81.0%	81.0%	81.8%	82.6%	83.9%	84.3%	84.2%

Driver for under performance:	Actions to address the underperformance:
• Lack of awareness of Role Specific subjects due to these being separated from the previous list of 23 Mandatory subjects. • 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.	• Increase awareness of the importance of undertaking RSET as well as mandatory training through the appraisal training. • Work continues in aligning Role Specific subjects to new positions as they are created. • We have been informed that RSET cannot be set against assignment and has to be set against position. Additional work will need to be carried out to ascertain if there is another way. • Safeguarding Children TNA is being reviewed over the next couple of months.

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:
Staff Annual Appraisal Rate	Internally set	Workforce Committee	October 2017

Performance:

Indicator	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Percentage of staff with annual appraisal	>=85%	80.8%	82.0%	85.3%	84.4%	84.2%	83.6%	85.0%	85.0%	84.1%	82.3%	83.3%	84.4%

Driver for underperformance:	Actions to address the underperformance:
• Unprecedented demand on Clinical Services. • High Nursing vacancies within clinical areas. • Introduction of new paperwork • Some areas have waited until the cut-off to notify L&D of the appraisal, even though it may have occurred two months earlier.	• Continue to embed appraisal process into all areas, providing 1:1 support through regular monthly meetings with some directorates or as requested. • Identification of specific areas that have experienced of a decrease in appraisal compliance and the provision of support and guidance. • Training sessions are being provided to explain the new paperwork and to reiterate the process for notifying L&D of appraisals that have occurred.

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:
Staff Vacancy Rate	Internally set	Workforce Committee	October 2017

Performance:

Indicator	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Staff: Trust level vacancy rate - All	<=9%	10.6%	10.9%	10.7%	10.7%	10.6%	11.1%	11.4%	11.9%	12.5%	12.6%	11.6%	10.9%
Staff: Trust level vacancy rate - Medical Staff	<=9%	11.0%	9.9%	9.0%	9.7%	10.0%	10.7%	11.2%	10.0%	13.9%	14.4%	16.1%	13.5%
Staff: Trust level vacancy rate - Other Staff	<=9%	10.8%	11.0%	10.9%	11.0%	11.1%	13.8%	13.5%	13.6%	13.4%	13.2%	11.9%	11.9%

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 • Practice Development continue to forge links with local University to recruit Students • Dedicated roles within HR for recruitment and retention • More structured approach to Medical Staffing recruitment & resourcing • Increased use of social networking and web site development to maximise the exposure of the Trust to potential candidates. • Increase usage of apprenticeship schemes • Overseas recruitment for nurses continues • Attendance at job fayres to enhance Trust brand and maximise recruitment

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:
Staff Sickness Rate	Internally set	Workforce Committee	October 2017

Performance:

Indicator	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Sickness Rate	<=3.8%	3.7%	3.7%	4.0%	4.0%	3.6%	3.2%	3.5%	3.5%	3.8%	4.1%	4.0%	4.5%

Driver for underperformance:	Actions to address the underperformance:
• Sickness absence for October 2017 increased significantly from 4.0% to 4.5% • Initial analysis suggests that short term absence has increased in most divisions and in surgery doubled. The reasons given demonstrate this is due to seasonal disorders and therefore it remains a key driver • In Women's and Children's long term sickness is high but there is a mixture of long and short term sickness in the Medicine division. Outpatients has seen the biggest increase this month	• Staff reaching the Trust's sickness absence policy triggers are being met with formally with HR presence • The Sickness Absence policy is currently under review and a likely change to quicken the process is that HR Advisors may no longer be present at first formal stages • HR Advisors however continue to meet with managers where there is high sickness in their department and some of the long term sickness cases in particular in Women's and Children's are near completion • In the Medicine Division an action plan has been developed to support managers and sickness absence is high on the agenda at the Medicine DMT

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 2017

Performance and Trajectory:

Indicator	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	=0	0	2	2	1	1	1	3	1	0	2	2	1

Driver for underperformance:	Actions to address the underperformance:
ENT: patient cancelled as notes were not available	ENT: • Establish whose role and responsibility it is to ensure all notes are present for theatre lists within ENT. Cross off the theatre list for notes present and missing • Escalate to medical records 48 hrs prior to list of missing notes with ENT line manager copied in • if notes still missing with 24 hours to go establish if there is a realistic chance of them being found, unit to also check their area • Discuss case with surgeon and anaesthetist (if applicable) if case can proceed with a pack made up of last letters and pre op notes • If case cannot proceed contact patient to inform them operation is regrettably cancelled to avoid inconvenience to the patient and a 28 day breach • Locate notes before case is rebooked and complete a datix form

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

Scorecard - Exception Report

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Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
ASI Management	Externally mandated	Finance, Investment and Performance Committee	October 2017

Performance:

Indicator	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
ASI Management	<=4%	24.3%	30.1%	26.6%	30.0%	34.8%	33.3%	30.7%	39.0%	37.1%	34.3%	32.4%	32.0%

Driver for underperformance:	Actions to address the underperformance:
• Demand on services • Polling ranges on e-referral not aligned to demand • Poor administration and management of clinics; i.e. not opening slots to E-referral, using ad-hoc clinics rather than permanent and not managing new to follow up demand • Us of locum staff rather than permanent – these cannot be mapped to e-referral • Cultural – consultants not wanting their clinics open to e-referral, concerns about its effectiveness	• Training with all admin staff • Polling ranges extended in key areas • Improved reporting, now able to see which clinics are not open on e-referral that should be • Outpatient programme manager working with individual areas to identify and open clinic slots. To date this work has been completed in ENT, Ophthalmology, Maxillo-Facial, Nephrology, Cardiology and T&O. Other areas are partially completed and aim to be by the end of the week. • New service ID's being set up for 2WW clinics • Communication with Consultant body to facilitate opening new slots on e-referral and not holding for paper referrals.

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 Delayed Transfers of Care	Externally mandated	Finance, Investment and Performance Committee	October 2017

Performance:

Indicator	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Average monthly DTOC's	<=23	N/Avail	N/Avail	N/Avail	N/Avail	N/Avail	65	58	68	56	62	49	33

Driver for underperformance:	Actions to address the underperformance:
• The system has seen a large rise in acutely unwell patients leading to a rise in patients requiring support on discharge • Delays in social services assessment • Long delays due to community availability/resources • Large delays in waiting time for medical rehabilitation beds and ability to take high level dependency patients • Large number of patients with brokerage awaiting funding decisions • Delays in SPA telephone call handling for new referrals and updates and subsequent pathway decisions for patients • Delays in SPA due to systems and processes	• Overnight care model in place – CCG have recognised need to fund for winter pressures • Recruitment commenced for 11 discharge co-ordinators on every ward – first round of recruitment complete with 6 staff offered and accepted posts, 3 of these have commenced this Month • Twice weekly tracking meetings to challenge and escalate discharges and delays, also to agree DTOC numbers • Daily updates emailed to SPA for all patents on the Tracker • Memorandum of Understanding of DTOC agreed at Outflow October. • Stranded patient reviews weekly with senior level engagement • Identify potential patients for Avery beds earlier in admission pathway (fixing flow) • Trusted Assessor Pilot commenced 01/09/2017 for existing nursing home residents to return home without additional assessment by nursing home (10 homes in Northampton and South involved) • Monitor those waiting for medical rehabilitation beds and ensure they still require this pathway via daily tracking by discharge team • Focus on weekend discharges and encourage recording of weekend plans within medical notes • Pilot of email version of PDNA commenced 18/09/2017 to reduce lengthy phone call to SPA

		• Further pilot a dynamic electronic version of the PDNA • SPA funding for weekend opening agreed by CCG (October 2017) • ECIP are currently supporting with patient flow and discharge processes • Winter schemes in place & agreed trajectory being managed by the AE delivery board
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 2017

Performance:

Indicator	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Length of stay - All	<=4.2	4.6	5.2	4.5	5.3	4.6	4.2	4.9	4.3	4.9	4.8	5.0	4.8

Driver for underperformance:	Actions to address the underperformance:
• Improved LOS on previous month • SPA processes continue to slow discharges • Delayed Transfers of Care (DTOC) continue to fall with the drive towards meeting our DTOC trajectory • Low number of supported discharges by partner organizations average 25 per week but have increased to circa 30 per week due to daily conference calls • High numbers of patients in the 21+ days LOS (220 patients) compared to other trusts outside of Northamptonshire • Variation in discharge process – lack of empowerment and decision making, handoffs, repeated assessment, process not starting until patient medically fit, processes stopped due to not being medically fit • Reliance on beds and almost no vacancies in ETPR care homes at present; Insufficient capacity within the home support services • Lack of home support increases demand on bedded solutions resulting in inappropriate placements and increased LOS	• Outflow group is leading the programmes of work across Northamptonshire • Discharge element of 'Fixing the Flow' initiative being led by Nursing Director • New Trusted Assessor Route rolled out to improve PDNA process with SPA • Trial of electronic referral of PDNA to begin in September with Abington as the pilot ward • Exec led top delays meeting to review the longest staying patients in the trust in place weekly being strengthened with new DD medicine • Deep dive reviews of all wards by senior manager and clinicians to scrutinise medical plans and ensure they are being followed up robustly • Daily 'tracking' sign off meetings between HPT, discharge team and wards • Robust use of the Choice Policy • County wide review of Intermediate care underway (12 month project minimum) • External deep dives of wards agreed with NHFT to identify if there are patients that they could pull out of NGH. Holcot ward will be first to trial • Avery to be clinically overseen by a GP surgery from November to provide more consistent medical cover and drive LOS down • Revised criteria for Avery being developed to improve flow into the unit

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:
Patients who need to be readmitted if transport arrives too late	Internally set	Finance, Investment and Performance Committee	October 2017

Performance:

Indicator	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Patients who need to be readmitted if transport arrives too late	=0	0	0	0	2	0	0	0	0	8	5	14	12

Driver for underperformance:	Actions to address the underperformance:
TASL new transport provider has not provided the level of service expected <u>Significant delays for transport pick up in October</u> • 3-4 hours = 36 patients affected • 4-5 hours = 15 patients affected • 5-6 hours = 3 patients affected • 6+ hours = 1 patients affected (Above figures are expected to be greater as this does not include any direct phone bookings made by wards/departments, out of hours journeys, outpatient bookings as TASL software only includes online bookings)	• CCG and TASL meetings are being held to address the underperformance • Transport issues are being escalated via the CCG through transport manager • Private ambulance crew employed to cover patients affected, reviewed weekly, finishing 10th November. • 14 Private wheelchair taxi service used to prevent delays in discharge and prevent re-bedding of patients

Lead Clinician:	Lead Manager:	Lead Director:
Not Applicable	Tim Meade	Deborah Needham

Scorecard - Exception Report

Metric underperformed:	Externally mandated or internally set:	Assurance Committee:	Report period:
Number of Serious Incidents Requiring Investigation (SIRI) declared during the period	Externally mandated	Quality Governance Committee	October 2017

Performance and Trajectory:

Indicator	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Number of Serious Incidents Requiring Investigation (SIRI) declared during the period	=0	0	1	2	1	1	0	0	1	0	2	2	6

Driver for underperformance:	Actions to address the underperformance:
• Benham – alleged abuse (2017/26068)	• Benham – alleged abuse (2017/26068) **Awaiting report back from Joanne Smith on 15/11.**
• Surgery - 1 x Rowan HAT (2017/25178)	• Surgery – 1 x Rowan HAT (2017/25178) Originally being investigated as Comprehensive but a Hospital Associated Thrombosis review has deemed the outcome as 'preventable' as low molecular weight heparin was not commenced when Rivaroxaban was suspended due to gastrointestinal bleed. The VTE risk assessment was also incomplete
• Surgery - 1 x Willow alleged abuse (2017/26171)	• Surgery - 1 x Willow alleged abuse (2017/26171) No further police investigation but cannot be downgraded by trust yet as to be discussed at RoHG. We have to report any alleged sexual and/or physical abuse under the CCG SI framework.
• Surgery - 1 x outpatients alleged abuse (2017/24698)	• Surgery - 1 x outpatients alleged abuse (2017/24698) Under police investigation so we cannot carry out any local investigation, if police close the investigation as unfounded then the SI is downgraded. We have to report any alleged sexual and/or physical abuse under the CCG SI framework

• Obstetrics – maternity cardiac arrest (2017/25305) • Cardiology – PE patient on Dryden (2017/25788)	• <u>Obstetrics – maternity cardiac arrest (2017/25305)</u> This has been as an SI and has had its first panel meeting 13/11/17. It was also discussed at ROHG on the 13/11/17, with no immediate lessons identified. Currently waiting for a final statement from the anaesthetic department. • <u>Cardiology – PE patient on Dryden (2017/25788)</u> This incident is currently under investigation as an SI and a team of investigators have been allocated.

	Lead Manager:	Lead Director:
Dr Raghuraman/Dr Wilkinson/Mr Von Widekind	Paul Saunders/Fay Gordon/Sandra Neale	Matt Metcalfe

Report To	**Public Trust Board**
Date of Meeting	**30 November 2017**

Title of the Report	**Medical Resourcing Strategy**
Agenda item	**14**
Presenter of Report	Janine Brennan, Director of Workforce & Transformation
Author(s) of Report	Janine Brennan, Director of Workforce & Transformation Adam Cragg, Head of Resourcing & Employment Services
Purpose	For Decision
Executive summary The strategy sets out the demand and supply factors influencing medical recruitment and outlines a medical recruitment strategy to cover the period until March 2021.	
Related strategic aim and corporate objective	Focus on Quality and Safety
Risk and assurance	Failure to recruit sufficient doctors will create safety risks and risk to our ability to continue to provide services to patients. The financial cost of implementing such a strategy creates a risk to our overall financial position.
Related Board Assurance Framework entries	BAF – 2.1, 2.2 and 2.3
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (Y/N) No 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

Enclosure J

Legal implications / regulatory requirements	No

Actions required by the Board

The Board is asked to Note the report.

NORTHAMPTON GENERAL HOSPITAL

MEDICAL STAFF RECRUITMENT STRATEGY

1. INTRODUCTION

The Trust's overarching vision is to "Provide the best possible care". In order to achieve this vision the Trust must have in place a workforce sufficient in numbers and skills to meet the needs of patients.

Competition in the marketplace for Junior, Middle Grade and Career grade doctors across the spectrum has been gathering intensity as more private healthcare organisations enter the marketplace. Activity in the acute sector increases and there are insufficient doctors in training in some specialties.

Nationally, evidence from NHS Improvement on Clinical Staff Shortages (February 2016) demonstrates that since 2007 numbers in the Consultant Workforce have expanded beyond the increase in activity over the same period but shortages remain evident in some individual specialties. It is important to note that it is cited by NHSI that current shortages of consultants and other doctors in some specialities may in part reflect a desire to improve quality by increasing consultant-delivered care faster than supply can respond. Several Royal Colleges have issued guidelines in this area.

The aspects of a specialty that attract newly qualified doctors are complicated and inevitably subject to individual preferences relating to a range of motivators that extend beyond potential NHS and non NHS earnings. For example, the Keogh review found that too few doctors choose to specialise in emergency medicine because of the nature of the work and the working conditions.

NHSI report that recruitment challenges for Consultants and an increase in spending on temporary locums are prevalent within the mainstream specialties of emergency medicine, acute general medicine and diagnostic services.

The shortages identified at a national level by NHSI broadly reflect the recruitment challenges faced by Northampton General Hospital in that the difficult to recruit to areas and areas with the highest spend on temporary locums are:

- Acute General Medicine including Stroke & Geriatrics
- Emergency medicine
- Radiology
- Oncology

With the NHSI evidence and guidance in mind and as a result of pay grades being standardised across NHS Trusts, the principle area of focus in terms of differentiating Northampton General Hospital from other Trusts rests on non-pay points wherever possible and an ability to reach and appeal to an audience that is not necessarily looking for a change in post.

As such this strategy outlines the plan for Medics recruitment at NGH for 2018/19-2020/21.

2. RECRUITMENT OVERVIEW

Recruitment strategies are primarily driven by the forces of demand and supply. A comprehensive recruitment (and resourcing) strategy is required when supply and demand are out of balance, as is the case currently.

Demand: Staffing levels and skill mix are determined by the Divisions using internal professional judgement and Royal College guidelines. This creates the baseline Medical staffing 'Demand'; however demand is also driven by turnover of staff and other factors such as demand that arises over and above identified staffing levels, maternity leave and the introduction of new technologies or expansion of services.

Supply: Primarily supply for medical posts within the national marketplace is through newly qualified doctors. Traditionally turnover in Consultant posts is low, therefore aiming recruitment initiatives at the entry point of the market and retaining staff represents a key challenge in reducing medical vacancies for the future. Another potential area of supply is to recruit from overseas.

3. NGH DEMAND AND SUPPLY

Demand

At NGH, demand in certain specialties outstrips the supply significantly as shown the detailed vacancy data at appendix 2.

Whilst there will inevitably be fluctuations in these vacancies, these specialties consistently represent the harder to recruit areas for NGH and the areas in which there are the highest number of vacancies and greatest bank and agency costs.

Turnover amongst Consultant and Middle Grade Doctors is traditionally low and Consultant and Middle Grade Doctors tend to be extremely stable staff groups. From the point of view of supply and demand this represents both an opportunity and a challenge for NGH in that whilst recruitment activity is unlikely to be undermined through high turnover, it presents a challenge in attracting Consultant and Middle Grade to the Trust from other employers. Nationally, NHS Digital reports that turnover for Consultant and Middle Grade Doctors (not including junior doctors) was 7.35%. This is the lowest of all NHS staff groups nationally and Consultant and Middle Grade Doctors are also detailed as having the highest stability index which stood at 92.57%.

Supply

The supply of Junior Doctors to nationally recognised posts (i.e. those that attract a National Training Number (NTN)) is provided through the Deanery. Shortages of Junior Doctors supplied through the Deanery increase the demand for Trust Grade Doctors to be employed to cover the shortfall.

As a result of low turnover and insufficient numbers of Junior Doctors being allocated from the Deanery, it is clear that the labour market will continue for some years to be increasingly short of producing qualified doctors sufficient to satisfy demand, thus necessitating the consideration of recruitment outside of the national labour market.

The supply of Trust Grade positions is predominantly reliant upon Doctors who wish to discontinue a training grade and take up a permanent Trust Grade position and the Trusts ability to attract those doctors from existing employers.

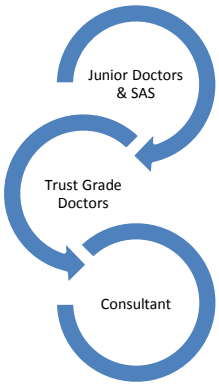
The supply of Consultants is reliant upon the Trusts ability to attract Junior Grade Doctors that are successful in obtaining their Certificate of Completion of Training (CCT) or Doctors that obtain a CCT via a different route or attracting qualified Consultants from other Trusts to come and work at NGH. The relatively low turnover of Consultants nationally poses a significant challenge in attracting Consultant Grade Doctors.

To supplement our substantive workforce we rely on the supply of doctors via agencies. This creates further supply problems as the agencies employ Doctors at an enhanced rate of remuneration.

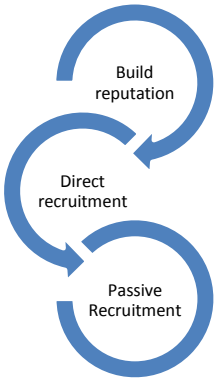
4. RECRUITMENT STRATEGY

In a tight labour market it is essential that we have layers of recruitment strategies as a single strategy will not suffice. This will be made up of our core and underpinning recruitment strategies as follows:

Our core recruitment strategies



Our underpinning recruitment strategies



4.1 Core Recruitment Strategies

A detailed plan for each of the initiatives below can be found at Appendix 1 of this document.

Junior Doctors

The extent to which the Trust can control the numbers of Junior Doctors allocated is extremely limited. However there is an ongoing requirement to foster good relations with Deanery and also to ensure that Junior Doctors enjoy a first class employment and educational experience at NGH. In doing so NGHs reputation is enhanced and the possibility of attracting Doctors at Trust and SAS Grade and Consultant level is maximised.

Trust & SAS Grade Doctors

The attraction of Trust and SAS Grade Doctors is essential not only to fill Middle Grade Rotas but also to cover gaps that are left through the short-fall of Junior Doctor allocations from the Deanery.

Due to national Terms and Conditions, the extent to which NGH is in a position to redesign remuneration is limited and therefore the following alternative ways of attracting Trust Grade Doctors must be utilised.

- **Certificate of Eligibility for Specialist Registration (CESR)**

  The certificate of eligibility for specialist registration is a route to the Specialist Register for those Doctors that have not fulfilled the training requirements for them to take up honorary, fixed term or substantive positions as a Consultant within the NHS. The register is maintained by the GMC.

  The benefits of undertaking this approach are two-fold in that through advertising this as an opportunity at NGH, it will attract Middle Grade Doctors who wish to return to training to the Trust. Equally it will enable the Trust to succession plan Middle Grade Doctors into vacant Consultant posts upon completion of CESR.

An associated educational and potential rotation programme will need to be developed to facilitate this and can be promoted as a 'unique selling point' to attract candidates and also enhance the Trusts reputation as an employer of choice for doctors.

- **Medical Training Initiative**

  The Medical Training Initiative (MTI) is designed to enable a small number of International Medical and Dental Graduates to the UK to experience training and development in the NHS for up to two years. Through encouraging support for the MTI schemes, the Trust will be able to attract good doctors from abroad, which in turn can support developing nations with their provision of healthcare.

  The utilisation of MTI will enable the Trust to fill known gaps arising from any shortfall in the allocation of Junior Doctors from Deanery and also supplement the recruitment of Middle Grade Doctors to vacancies within those specialties that have sufficient capacity to provide training.

  Training capacity not required for planned training numbers as a result of vacancies is made available for overseas doctors who meet the required eligibility criteria. The placements filled by doctors in the MTI scheme are approved by the local deanery/Local Education & Training Board (LETB) and may also need to be approved by the relevant Royal College. The Academy of Medical Royal Colleges acts as the UK Visa Sponsor to enable participants to apply for a Tier 5 Government Authorised Exchange Scheme visa from the Home Office.

  This will require the proactive and coordinated identification of MTI opportunities throughout the Trust and ensuring that consideration of a vacancy's suitability for a MTI placement is a routine element of the Trusts approach to resourcing middle grade doctors.

- **Proactive development of a Specialty Medical Recruitment Plan/Over-Recruitment**

  An analysis of historical allocation gaps from the deanery will enable and inform a recruitment plan to be devised in a way that takes accounts of the anticipated deficit of allocated doctors. In order to ensure gaps in capacity are minimised and a reduction in the need for agency cover is achieved, pools of candidates can be proactively recruited within each specialty to enable a flexible workforce that can rotate to fill gaps arising from the deanery allocation. In doing so it is necessary to note that this would effectively treat the anticipated deanery gaps as established vacancies and as such the appointment to these posts is effectively 'over-recruiting' or recruiting above budgeted establishment. However, from historical analysis and the national shortage of doctors alluded to earlier it is clear that gaps are inevitable and it is proposed that only a proportion of the anticipated WTE gaps are recruited to. This would enable a flexible workforce that minimises agency spend and supports continuity of care. It may also compliment both the CESR and MTI aspects of the recruitment strategy detailed above.

- **Creating an internal supply**

  In order to enable greater flexibility to cost effectively cover medical vacancies, further relief on supply can be made by maximising opportunities to utilise the additional hours arrangements with substantively employed doctors.

  In order to supplement the additional hours undertaken to cover gaps by substantively employed doctors the Trust will develop and market its own Medical Bank.

Consultants

Whilst Consultant recruitment will continue and enhancements can be made to Trust brand and reputation with a view to attracting candidates in the short term, it will be essential for the Trust to ensure that the ability to attract candidates is supplemented in the following ways.

- Succession plan in a way that pro-actively identifies Consultant vacancies that can be filled by doctors that the Trust successfully supports through the CESR process.
- Continue to monitor recruitment hotspots and develop innovative approaches to fill posts including development of strategic alliances where appropriate e.g. radiology, cancer services and shared community/acute posts in difficult to recruit areas such care of the elderly.
- Develop the Trusts research and development portfolio to attract consultants who are active in these areas and enable the development of services.
- Develop innovative roles to attract high calibre applicants e.g. roles which provide opportunities for education or roles that deliver services to more than one specialty/area e.g. ED consultants with a special interest in care of the elderly or pre-hospital care.
- Explore ways of innovative ways of configuring job plans that provide flexibility for Consultants to use programmed activity in an area of special interest for them.
- Ensure proactive and responsive management of the consultant appointments process.
- A targeted recruitment campaign aimed towards doctors that are soon to be qualified SPRs will be devised.
- In order to retain SPRs through to Consultant level and to enable the development of a succession plan a nurturing strategy for SPRs will be explored.
- Review recruitment processes for Consultant level candidates in order to attract and appoint those candidates of the highest calibre.

International Recruitment

With some of the supply gaps that are faced nationally, international recruitment for the foreseeable future will be one of the only ways to find the right talent to fill gaps. Equally, due to the need to ensure there is sufficient capacity to support the afore-mentioned CESR and MTI recruitment strategies through the need to provide training, it will be necessary to recruit from overseas.

This is not a quick fix as it will take some candidates many months to actually arrive at the trust due to the detailed screening and process they will have to go through to register with the GMC.

Some key elements when recruiting overseas doctors are as follows:

- Include a contractual clause that requires them to pay back travel and any other additional relocation costs in the event that they do not stay with the trust for a period of 24 months.
- Require a rebate from the Recruitment Agency if they do not remain for a specified period of time
- Provide effective orientation and induction programmes in order to aid retention

Provide pastoral care through the Trusts Retention Specialist in order to positively integrate them into NGH community activities e.g. organise 'welcome to our overseas staff' seminars and events to help them quickly integrate with NGH clinical practice and the NGH community.

4.2 Underpinning Recruitment strategies

Active Recruitment

In order for people to know we have open posts, it will be necessary for the Trust to get the roles into the marketplace and ensure that they look attractive. This also relates to the consideration of ways of working to make role attractive to the external audience, whilst at the same time also widening our spread and penetration into the marketplace. This can be achieved by expanding upon the basic communication through advertising on NHS jobs and British Medical Journal adverts through the utilisation of a host of

social medias and on line presence such as sites like Doctors.net and eshots and more specialist websites, journals and attendance at conferences / CPD events. Taking this kind of approach will allow the Trust to not only recruit directly at events, but also build profile and start building a larger future talent pool. A key component of this will be placing greater emphasis on the need to use doctor's to recruit doctor's through our senior clinicians and utilising their networks and subject knowledge to sell the Trust as an employer of choice. Enabling the Trusts consultants' to play a prominent role at these events and to talk charismatically, passionately and concisely about the career opportunities at NGH will require them to become equipped with the skills and materials necessary to achieve this which will supported and coordinated by the Trusts Clinical Resourcing Manager. Social Media training is also something that can be provided to consultants and doctors to better enable them to promote opportunities at the Trust and help them to fill their vacancies.

Passive recruitment

Building the Trusts brand (see below) and network building will help build a talent pool for the future. This will include landing pages and campaign pages on different Medias through to the sponsorship of events or conferences, where the aim will be to increase brand recognition as well as handle some more basic active recruitment. The aim of this is to start addressing the medium term needs rather than the recruitment challenges that are immediately faced. This will require ensuring the Trust is portrayed in a way to future candidates that for their next move in 18 months to 2 years, Northampton General Hospital is not only a valid and reputable employer, but the Trust is breaking new ground and has exciting career paths.

Building future talent pools is critical in making passive recruitment work. This is done by building network of talent in the marketplace through promotion at conferences and CDP events and social media networking such as LinkedIn.

Build Reputation

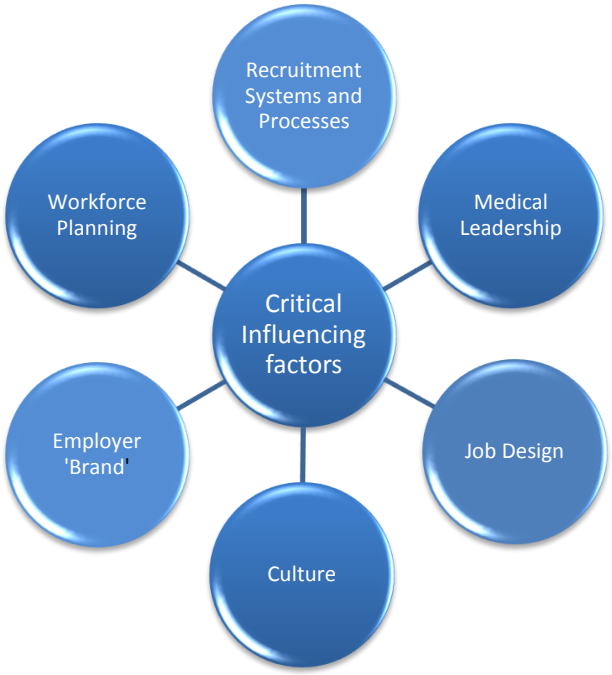
'Employer Value Proposition' (EVP) is a critical factor in building reputation as it creates the starting point for the journey. EVP is a process whereby the Trust will utilise its doctors to inform how best to enhance branding and reputation in a way that will make the Trust an attractive place to work for doctors.

Crisp and clean messaging across specialties to the Trusts target markets is imperative as is ensuring that the organisation knows and understands our unique selling points. This entails building a knowledge base of what is important to candidates and how the Trusts values reflect that. An example of this may be, promoting a programme of investment that resulted in the best and most up to date technology in certain areas and describing how that investment aligns to Trust values.

5. ENABLERS/CRITICAL INFLUENCING FACTORS (CIF)

In addition to supply and demand factors the Trust needs to pay attention to factors that directly and/or indirectly influence supply and demand. These key areas are often referred to as 'enablers' (or they can be inhibitors) as they are the fundamental building blocks upon which high quality recruitment is based.

These CIF include:



Each of the enabling factors identified above acts as a lens through which actions and interventions that could enhance or inhibit recruitment.

Employer Brand

The Trust will define its employer proposition identifying why people should want to work at NGH – this will become a brand that we will be used specifically to target local, national and international recruitment activity.
The Trust will develop a new "candidate pack" that provides employees with information on the Trust, its culture and values as well as local area information.

The branding, particularly in relation to Trust values will be embedded in and drive selection decisions.

Job Design

The rotas for junior medical staff have recently been redesigned in line with the new 2016 junior doctor contract. This provides for minimum rest periods and maximum working hours/patterns. However we recognise there is still much to do so we will identify basic clinical and admin. tasks that could be delegated to others and review the ability to create new roles to provide support to junior medical staff.

In addition, work will be undertaken to redesign roles for Consultants Trust Grade and Junior Doctors that will enable rotational programmes with a view to attracting candidates for medical vacancies.

Workforce Planning

We will introduce a vacancy forecasting tool that will enable us to predict future vacancies to enable recruitment planning to be designed around this.

Medical Leadership

We currently have a medical led organisational structure however we will build this into our recruitment process as part of the EVP so that, particularly for consultants they can see they have a leadership career pathway should they wish to develop into this arena.

Culture

Our Organisational Effectiveness strategy encompasses our medical workforce. To support this further work is underway on shaping the culture in a way that is more inclusive of our medical workforce and builds on work being undertaken in response to our recent GMC survey.

Recruitment Systems and Processes

The speed of the recruitment pipeline is critical to the success of any enhancements we make to the front end loading of candidates into the process. Close monitoring of the process will be needed and 'keep warm' programmes and processes put in place to minimise drop out of candidates from shortlist through to on boarding and their first day in post. A review of our recruitment process is currently underway and a Standard Operating process is under development.

6. MEASURING RECRUITMENT IN THE TRUST

The Trusts overall aim will be to minimise disruption to service by having the right doctors in the right place. In order to do this effectively, it will be imperative to look into a recruitment metrics "dash board" so that it will be possible to easily track and monitor the success of campaigns and any reduction in vacancies across the trust.

- Vacancy factor
- Time to recruit metrics
- Number of applicants per post
- Recruitment source
- Cost per hire

7. CONCLUSION

This strategy outlines the issues and potential solutions for medical recruitment at Northampton General Hospital.

Whilst the medical workforce is relatively stable, expansion of services, increases in the standards of care expected and the significant costs associated with medical agency cover require the Trust to think progressively in terms of how gaps in the workforce are addressed and how the Trust positions itself in the modern day job market.

8. RECOMMENDATION

The Trust Board is asked to support the proposed approaches to Medical recruitment and the associated investment in building employer brand whilst re-positioning itself to compete for candidates within the 21st century job market.

It is essential for the Trust to differentiate itself against our competition in the Local, National and international marketplace, by ensuring a knowledge base of the market to know who the local doctors are and creating a talent pool of national doctors by building our reputation and ensure that international doctors have a smooth and easy on boarding.

Enclosure J

APPENDIX 1 : MEDICAL RECRUITMENT ACTION PLAN

Recruitment Initiative	Action	Responsible Person	Timescale for completion
Certificate of Eligibility for Specialist Registration (CESR)	Establish Priority Specialties and positions to target for CESR	Medical Director/Divisional Directors/Head of Resourcing/Clinical Resourcing Manager	Dec-17
	Establish threshold of capacity available to train new recruits	Divisional Directors/Director of Medical Education	Jan-18
	Establish training requirements for those expected to train	Clinical Resourcing Manager/Director of Medical Education	Jan-18
	Engage Agency to identify permanent eligible candidates	Clinical Resourcing Manager	Jan-18
	Develop marketing materials	Clinical Resourcing Manager/Divisional Directors	Feb-18
	Establish set interview panel and availability	Clinical Resourcing Manager/Divisional Directors	Mar-18
	Commence assessment of candidates	Medical Staffing/Nominated Appointing Officers	Apr-18
Medical Training Initiative	Establish Priority Specialties and positions to target for MTI	Medical Director/Divisional Directors/Head of Resourcing/Clinical Resourcing Manager	Dec-18
	Establish threshold of capacity available to train new recruits	Divisional Directors/Director of Medical Education	Jan-18
	Establish training requirements for those expected to train	Clinical Resourcing Manager/Director of Medical Education	Jan-18
	Obtain Deanery/LETB/Royal College Approval for nominated posts	Director of Medical Education/Medical Staffing	Feb-18
	Engage Agency to identify eligible candidates	Clinical Resourcing Manager	Jan-18
	Develop marketing materials (see advertising plan and resources)	Clinical Resourcing Manager/Divisional Directors	Feb-18
	Establish set interview panel and availability	Clinical Resourcing Manager/Divisional Directors	Mar-18
	Commence assessment of candidates	Medical Staffing/Nominated Appointing Officers	Apr-18

Recruitment Initiative	Action	Responsible Person	Timescale for completion
Proactive development of a Specialty Medical Recruitment Plan/Over-Recruitment	Undertake Analysis of historical allocation gaps from deanery	Medical Staffing	Dec-17
	Devise a recruitment plan that takes account of anticipated deficit	Clinical Resourcing Manager	Jan-18
	Obtain agreement to recruit above establishment	Divisional Directors/Director of Finance	Feb-18
	Develop marketing materials (see advertising plan and resources)	Clinical Resourcing Manager/Divisional Directors	Feb-18
	Establish set interview panel and availability	Clinical Resourcing Manager/Divisional Directors	Mar-18
	Commence assessment of candidates	Medical Staffing/Nominated Appointing Officers	Apr-18
International Recruitment	Establish Priority Specialties and positions suitable for international Recruitment	Medical Director/Divisional Directors/Head of Resourcing/Clinical Resourcing Manager	Dec-17
	Establish threshold of capacity available to train and support new recruits	Divisional Directors/Director of Medical Education	Jan-18
	Establish Budget by specialty to recruit from overseas (Incl. Relocation)	Divisional Directors/Finance	Feb-18
	Develop pastoral support programme	HR Reward & Retention Specialist	Jan-18
	Develop marketing materials (see advertising plan and resources)	Clinical Resourcing Manager	Feb-18
	Engage Agency to identify overseas candidates	Clinical Resourcing Manager	Jan-18
	Negotiate a rebate from the Recruitment Agency in the event of Doctors leaving within a 12 month period	Clinical Resourcing Manager	Jan-18
	Devise diarised interview dates and panels	Divisional Directors/Clinical Resourcing Manager	Mar-18
	Commence assessment of candidates	Medical Staffing/Nominated Appointing Officers	Apr-18
	Develop and agree contractual clause that requires overseas recruits to pay back relocation costs in the event that they leave the Trust within a 24 month period.	Head of Resourcing/Deputy Director of HR	Dec-17

Recruitment Initiative	Action	Responsible Person	Timescale for completion
Consultant	Workforce profile/Succession plan in a way that pro-actively identifies Consultant vacancies that can be filled by doctors that the Trust successfully supports through the CESR process.	Divisional Directors/HR Business Partners/Clinical Resourcing Manager/Head of Resourcing & Employment Services/Workforce Information	Jan-18
	Explore the development of strategic alliances where appropriate e.g. radiology, cancer services and shared community/acute posts in difficult to recruit areas such care of the elderly.	Medical Director/Divisional Directors/Director of Strategy & Partnerships	On-going
	Explore the development of the Trusts research and development portfolio to attract consultants who are active in these areas.	Medical Director	On-going
	Explore the Development of innovative roles to attract high calibre applicants e.g. roles which provide opportunities for education or roles that deliver services to more than one specialty/area e.g. ED consultants with a special interest in care of the elderly or pre-hospital care.	Medical Director/Divisional Directors	On-going
	Explore innovative ways of configuring job plans that provide flexibility for Consultants to use programmed activity in an area of special interest for them.	Medical Director/Divisional Directors	On-going
	Plan targeted recruitment campaign for soon to be qualified SPRs	Divisional Directors/Clinical Resourcing Manager	Jan-18
	Develop nurturing strategy for SPRs approaching CCT	Divisional Directors	Jan-18
	Review Consultant level recruitment process to attract and appoint the highest calibre of candidates.	Medical Director/Head of Recruitment	Jan -18
Build Reputation/EVP	Establish Project/Task & Finish Group	Medical Director/Clinical Resourcing Manager	Dec-17
	Review current marketing materials	Clinical Resourcing Manager/Nominated Doctors	Jan-18

	Develop Focus Group Themes	Clinical Resourcing Manager/Nominated Doctors	Feb-18
	Publicise Focus Group Themes	Clinical Resourcing Manager	Mar-18
	Run Focus Groups	Clinical Resourcing Manager/Nominated Doctors	Apr-18
	Collate data	Clinical Resourcing Manager	May-18
	Formulate Medical Brand	Clinical Resourcing Manager/Nominated Doctors	Jun-18
	Produce/Update materials and social media in line with Medical Brand	Clinical Resourcing Manager	Jul-18
	Utilise Medical Brand (including on Best of Both Worlds microsite)	Clinical Resourcing Manager	Aug-18
	Develop and roll out Social Media Training for Doctors	Clinical Resourcing Manager	April 2018
Junior Doctors	Forge closer links and engage with Deanery	Medical Director	On-going
Job Design	Identify basic clinical and admin tasks that could be delegated to others	Divisional Directors	February 2018
	Review ability to create new roles to provide support to junior staff Review the extent to which rotational programs can be designed to attract candidates at Consultant, Trust Grade and Junior Doctor levels.	Divisional Directors Divisional Directors	April 2018 April 2018
Workforce Planning	Develop and introduce a vacancy forecasting tool to predict future vacancies	Head of Resourcing & Employment Services	April 2018
Measuring Recruitment	Develop recruitment metrics for inclusion in Recruitment Dashboard	Head of Resourcing & Employment Services	February 2018

Appendix 2

		Budget for Recuitment 2017/18								Vacancy (Contracted - Budget)							
Directorate / Department	Cost Centre	Cons WTE	SAS WTE	ST3+ WTE	ST1/2 & CT1/2 WTE	FY1/2 WTE	Trust Grades WTE	GPVTS WTE	Total WTE	Cons WTE	SAS WTE	ST3+ WTE	ST1/2 & CT1/2 WTE	FY1/2 WTE	Trust Grades WTE	GPVTS WTE	Total Vacancy
General Surgery																	
GI SURGERY MEDICAL STAFF	22100	7.50	0.00	7.00	2.00	5.00	2.00	0.00	23.50	0.13	0.00	0.00	3.00	(1.00)	(1.00)	0.00	1.13
UROLOGY MEDICAL STAFF	22101	6.00	0.00	2.00	2.00	4.00	1.00	0.00	15.00	(0.28)	0.00	2.00	0.00	0.00	0.00	0.60	2.33
BREAST SURGERY MEDICAL STAFF	22103	3.00	0.00	0.00	0.00	0.00	1.00	0.00	4.00	0.83	0.00	0.00	0.00	0.00	(1.00)	0.00	(0.18)
VASCULAR SURGERY MEDICAL STAFF	22107	6.00	0.00	3.00	0.00	4.00	2.00	0.00	15.00	0.00	0.00	(2.00)	0.00	1.00	(1.00)	0.00	(2.00)
PLASTIC SURGERY MEDICAL STAFF	22160	2.00	0.00	0.00	0.00	0.00	2.00	0.00	4.00	0.00	0.00	1.00	0.00	0.00	(1.00)	0.00	0.00
BREAST CARE DEPARTMENT	25553	0.00	0.10	0.00	0.00	0.00	0.00	0.00	0.10	0.00	(0.10)	0.00	0.00	0.00	0.00	0.00	(0.10)
General Surgery Total		**24.50**	**0.10**	**12.00**	**4.00**	**13.00**	**8.00**	**0.00**	**61.60**	**0.68**	**(0.10)**	**1.00**	**3.00**	**0.00**	**(4.00)**	**0.60**	**1.18**
Anaesthesia & Critical Care																	
ANAESTHETICS MED S & SECS	27101	40.43	7.00	10.00	9.00	1.00	14.00	0.00	81.43	(0.03)	(0.38)	(0.72)	0.33	2.00	(3.00)	0.00	(1.79)
Anaesthesia & Critical Care Total		**40.43**	**7.00**	**10.00**	**9.00**	**1.00**	**14.00**	**0.00**	**81.43**	**(0.03)**	**(0.38)**	**(0.72)**	**0.33**	**2.00**	**(3.00)**	**0.00**	**(1.79)**
ENT & MAXFAX																	
MAXILLOFACIAL MED S & SECS	38101	5.00	2.40	2.00	8.00	0.00	1.18	0.00	18.58	(1.38)	1.60	0.00	(1.00)	0.00	(1.18)	0.00	(1.96)
ENT MED STAFF & SECS	39101	3.00	2.00	1.00	1.00	1.00	3.00	1.00	12.00	1.00	(1.00)	0.00	0.00	0.00	(2.00)	(1.00)	(3.00)
ENT & MAXFAX Total		**8.00**	**4.40**	**3.00**	**9.00**	**1.00**	**4.18**	**1.00**	**30.58**	**(0.38)**	**0.60**	**0.00**	**(1.00)**	**0.00**	**(3.18)**	**(1.00)**	**(4.96)**
Opthalmology																	
OPHTHAL MED STAFF & SECS	26101	8.91	3.00	2.00	1.00	1.00	7.00	1.00	23.91	1.00	(0.60)	(2.00)	2.00	0.00	1.00	(1.00)	0.40
Opthalmology Total		**8.91**	**3.00**	**2.00**	**1.00**	**1.00**	**7.00**	**1.00**	**23.91**	**1.00**	**(0.60)**	**(2.00)**	**2.00**	**0.00**	**1.00**	**(1.00)**	**0.40**
Trauma & Orthopaedics																	
T & O MEDICAL STAFF	33101	14.40	0.00	7.00	6.00	3.00	5.50	1.00	36.90	(0.80)	0.00	(3.00)	(3.00)	0.00	0.50	(1.00)	(7.30)
Trauma & Orthopaedics Total		**14.40**	**0.00**	**7.00**	**6.00**	**3.00**	**5.50**	**1.00**	**36.90**	**(0.80)**	**0.00**	**(3.00)**	**(3.00)**	**0.00**	**0.50**	**(1.00)**	**(7.30)**
Surgical Care Management																	
SURGICAL CARE MANAGEMENT	72192	1.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	(1.00)	0.00	0.00	0.00	0.00	0.00	0.00	(1.00)
Surgical Care Management Total		**1.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**1.00**	**(1.00)**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**(1.00)**
Surgical Division		**97.24**	**14.50**	**34.00**	**29.00**	**19.00**	**38.68**	**3.00**	**235.42**	**(0.53)**	**(0.48)**	**(4.72)**	**1.33**	**2.00**	**(8.68)**	**(2.40)**	**(13.47)**

		Budget for Recuitment 2017/18								Vacancy (Contracted - Budget)							
Directorate / Department	Cost Centre	Cons WTE	SAS WTE	ST3+ WTE	ST1/2 & CT1/2 WTE	FY1/2 WTE	Trust Grades WTE	GPVTS WTE	Total WTE	Cons WTE	SAS WTE	ST3+ WTE	ST1/2 & CT1/2 WTE	FY1/2 WTE	Trust Grades WTE	GPVTS WTE	Total Vacancy
Urgent Care																	
A & E MED STAFF & SECS	34101	11.00	0.00	6.00	4.00	2.00	17.90	4.00	44.90	(2.05)	2.00	(2.00)	(1.00)	(1.00)	(5.95)	(4.00)	(14.00)
URGENT CARE MEDICAL STAFF	34102	4.00	0.00	2.00	6.00	2.00	4.00	0.00	18.00	(4.00)	0.00	(2.00)	(6.00)	(2.00)	(4.00)	0.00	(18.00)
AMBULATORY CARE	34235	1.24	0.00	0.00	0.00	0.00	0.00	0.00	1.24	(1.24)	0.00	0.00	0.00	0.00	0.00	0.00	(1.24)
Urgent Care Total		**16.24**	**0.00**	**8.00**	**10.00**	**4.00**	**21.90**	**4.00**	**64.14**	**(7.29)**	**2.00**	**(4.00)**	**(7.00)**	**(3.00)**	**(9.95)**	**(4.00)**	**(33.24)**
Inpatient Specialties																	
GEN MEDICINE MEDICAL STAFF	54101	0.00	0.00	1.00	2.00	3.00	3.00	2.00	11.00	2.00	0.80	4.00	14.00	11.09	0.60	(2.00)	30.49
CARDIOLOGY MEDICAL STAFF	57145	7.90	0.00	4.00	2.00	1.00	1.00	1.00	16.90	(1.10)	1.00	(3.00)	(1.00)	0.00	(1.00)	(1.00)	(6.10)
RESPIRATORY MEDICAL STAFF	57149	5.00	0.00	3.00	1.00	2.00	0.00	1.00	12.00	(1.30)	0.00	(1.00)	0.00	(2.00)	0.00	(1.00)	(5.30)
GASTROENTEROLOGY MEDICAL STAFF	57151	7.60	0.00	1.00	2.00	2.00	0.00	0.00	12.60	(1.00)	0.00	1.00	(1.00)	(2.00)	0.00	0.00	(3.00)
NEPHROLOGY MEDICAL STAFF	58101	2.00	0.00	2.00	2.00	0.00	0.00	0.00	6.00	0.00	0.00	(1.00)	(0.30)	0.00	0.00	0.00	(1.30)
Inpatient Specialties Total		**22.50**	**0.00**	**11.00**	**9.00**	**8.00**	**4.00**	**4.00**	**58.50**	**(1.40)**	**1.80**	**0.00**	**11.70**	**7.09**	**(0.40)**	**(4.00)**	**14.79**
Outpatient Specialties																	
ELDERLY / STROKE MEDICAL STAFF	54105	13.00	0.00	3.00	4.50	6.00	5.00	2.00	33.50	(6.00)	0.00	0.00	(2.50)	(2.00)	(5.00)	(2.00)	(17.50)
DERMATOLOGY	55101	3.00	1.07	1.00	1.00	0.64	1.00	0.00	7.71	0.00	(0.85)	0.00	0.00	(0.46)	(1.00)	0.00	(2.30)
RHEUMATOLOGY	57101	4.00	0.00	1.00	1.00	0.00	0.00	0.00	6.00	0.00	0.00	0.70	(1.00)	0.00	0.00	0.00	(0.30)
DIABETES & ENDOCRIN. MEDSTAFF	57147	4.55	0.00	0.00	0.00	0.00	0.00	0.00	4.55	(0.80)	0.00	1.00	0.00	0.00	0.00	0.00	0.20
NEUROPHYSIOLOGY	57445	1.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	(0.62)	0.00	0.00	0.00	0.00	0.00	0.00	(0.62)
NEUROLOGY	57447	2.18	0.00	0.00	0.50	0.00	0.00	0.00	2.68	0.82	0.00	0.00	(0.50)	0.00	0.00	0.00	0.32
Outpatient Specialties Total		**27.73**	**1.07**	**5.00**	**7.00**	**6.64**	**6.00**	**2.00**	**55.44**	**(6.60)**	**(0.85)**	**1.70**	**(4.00)**	**(2.46)**	**(6.00)**	**(2.00)**	**(20.21)**
Medical Care Management																	
MEDICAL CARE MANAGEMENT	72195	0.80	0.00	0.00	0.00	0.00	0.00	0.00	0.80	(0.80)	0.00	0.00	0.00	0.00	0.00	0.00	(0.80)
Medical Care Management Total		**0.80**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.80**	**(0.80)**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**(0.80)**
Medical Division		**67.27**	**1.07**	**24.00**	**26.00**	**18.64**	**31.90**	**10.00**	**178.88**	**(16.09)**	**2.96**	**(2.30)**	**0.70**	**1.63**	**(16.35)**	**(10.00)**	**(39.46)**

		Budget for Recuitment 2017/18								Vacancy (Contracted - Budget)							
Directorate / Department	Cost Centre	Cons WTE	SAS WTE	ST3+ WTE	ST1/2 & CT1/2 WTE	FY1/2 WTE	Trust Grades WTE	GPVTS WTE	Total WTE	Cons WTE	SAS WTE	ST3+ WTE	ST1/2 & CT1/2 WTE	FY1/2 WTE	Trust Grades WTE	GPVTS WTE	Total Vacancy
Child Health																	
PAEDIATRICS MED S & SECS	44101	20.59	1.00	8.00	7.00	3.00	4.00	4.00	47.59	(2.54)	(1.00)	1.36	(2.00)	0.00	0.00	(3.00)	(7.18)
CHILD GENETICS	45146	1.50	0.00	0.00	0.00	0.00	0.00	0.00	1.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
COMMUNITY DOCTORS	45151	0.00	2.00	0.00	0.00	0.00	0.00	0.00	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Child Health Total		**22.09**	**3.00**	**8.00**	**7.00**	**3.00**	**4.00**	**4.00**	**51.09**	**(2.54)**	**(1.00)**	**1.36**	**(2.00)**	**0.00**	**0.00**	**(3.00)**	**(7.18)**
Obstetrics & Gynaecology																	
OBS & GYNAE MEDICAL STAFF	48101	14.10	0.00	6.00	4.00	3.00	3.78	3.00	33.88	(2.20)	0.00	(0.53)	1.00	(1.00)	3.92	(3.00)	(1.81)
Obstetrics & Gynaecology Total		**14.10**	**0.00**	**6.00**	**4.00**	**3.00**	**3.78**	**3.00**	**33.88**	**(2.20)**	**0.00**	**(0.53)**	**1.00**	**(1.00)**	**3.92**	**(3.00)**	**(1.81)**
Oncology & Clinical Haematology																	
ONCOLOGY MEDICAL STAFF	62101	8.23	4.10	3.00	1.00	1.00	1.00	0.00	18.33	1.17	(4.10)	2.68	1.00	0.00	(1.00)	0.00	(0.25)
CLINICAL HAEM M S & SECS	63101	3.22	0.00	2.00	2.00	2.00	0.00	0.00	9.22	0.38	0.00	(0.31)	(1.00)	(1.00)	0.00	0.00	(1.93)
Oncology & Clinical Haematology Total		**11.45**	**4.10**	**5.00**	**3.00**	**3.00**	**1.00**	**0.00**	**27.55**	**1.55**	**(4.10)**	**2.37**	**0.00**	**(1.00)**	**(1.00)**	**0.00**	**(2.18)**
W&C & Oncology Division Management																	
W&C & ONCOLOGY DIVISION MGMT	72194	0.80	0.00	0.00	0.00	0.00	0.00	0.00	0.80	(0.80)	0.00	0.00	0.00	0.00	0.00	0.00	(0.80)
W&C & Oncology Division Management Total		**0.80**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.80**	**(0.80)**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**(0.80)**
Womens, Childrens & Oncology Division		**48.44**	**7.10**	**19.00**	**14.00**	**9.00**	**8.78**	**7.00**	**113.32**	**(3.99)**	**(5.10)**	**3.20**	**(1.00)**	**(2.00)**	**2.92**	**(6.00)**	**(11.97)**

		Budget for Recuitment 2017/18								Vacancy (Contracted - Budget)							
Directorate / Department	Cost Centre	Cons WTE	SAS WTE	ST3+ WTE	ST1/2 & CT1/2 WTE	FY1/2 WTE	Trust Grades WTE	GPVTS WTE	Total WTE	Cons WTE	SAS WTE	ST3+ WTE	ST1/2 & CT1/2 WTE	FY1/2 WTE	Trust Grades WTE	GPVTS WTE	Total Vacancy
Pathology																	
MICROBIOLOGY MAIN	64121	2.15	0.00	0.00	0.00	0.00	0.00	0.00	2.15	(0.15)	0.00	0.00	0.00	0.00	0.00	0.00	(0.15)
HISTOPATHOLOGY MAIN	64231	6.00	0.00	0.00	1.00	0.00	0.00	0.00	7.00	(4.05)	0.00	0.00	(1.00)	0.00	0.00	0.00	(5.05)
GENERAL HAEM PAY	64341	1.38	0.00	0.00	0.00	0.00	0.00	0.00	1.38	(1.38)	0.00	0.00	0.00	0.00	0.00	0.00	(1.38)
GENERAL BIOCHEMISTRY PAY	64451	0.80	0.00	0.00	0.00	0.00	0.00	0.00	0.80	0.20	0.00	0.00	0.00	0.00	0.00	0.00	0.20
Pathology Total		**10.33**	**0.00**	**0.00**	**1.00**	**0.00**	**0.00**	**0.00**	**11.33**	**(5.38)**	**0.00**	**0.00**	**(1.00)**	**0.00**	**0.00**	**0.00**	**(6.38)**
Radiology																	
RADIOLOGY MED STAFF	65101	20.60	0.80	2.00	0.00	0.00	0.00	0.00	23.40	(8.60)	0.60	0.00	0.00	0.00	0.00	0.00	(8.00)
Radiology Total		**20.60**	**0.80**	**2.00**	**0.00**	**0.00**	**0.00**	**0.00**	**23.40**	**(8.60)**	**0.60**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**(8.00)**
Therapies																	
ARTIFICIAL LIMB FITTING SERV	71541	0.50	0.00	0.00	0.00	0.00	0.00	0.00	0.50	(0.50)	0.00	0.00	0.00	0.00	0.00	0.00	(0.50)
Therapies Total		**0.50**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.50**	**(0.50)**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**(0.50)**
Research & Development																	
CLINICAL TRIALS	71251	0.00	1.20	0.00	0.00	0.09	0.00	0.00	1.29	0.00	(0.80)	0.00	0.00	0.00	0.00	0.00	(0.80)
Research & Development Total		**0.00**	**1.20**	**0.00**	**0.00**	**0.09**	**0.00**	**0.00**	**1.29**	**0.00**	**(0.80)**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**(0.80)**
Medical Education																	
UNDERGRADUATE TRAINING	71135	0.00	0.00	0.00	1.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00	(1.00)	0.00	0.00	0.00	(1.00)
Medical Education Total		**0.00**	**0.00**	**0.00**	**1.00**	**0.00**	**0.00**	**0.00**	**1.00**	**0.00**	**0.00**	**0.00**	**(1.00)**	**0.00**	**0.00**	**0.00**	**(1.00)**
Clinical Support Division Management																	
CLINICAL SUPPORT DIVISION MGMT	72196	0.60	0.00	0.00	0.00	0.00	0.00	0.00	0.60	(0.60)	0.00	0.00	0.00	0.00	0.00	0.00	(0.60)
Clinical Support Division Management Total		**0.60**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.60**	**(0.60)**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**(0.60)**
Clinical Support Division		**32.03**	**2.00**	**2.00**	**2.00**	**0.09**	**0.00**	**0.00**	**38.12**	**(15.08)**	**(0.20)**	**0.00**	**(2.00)**	**0.00**	**0.00**	**0.00**	**(17.28)**
Hospital Support																	
CLINICAL AUDIT	71125	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
QUALITY IMPROVEMENT	71140	0.25	0.00	0.00	0.00	0.00	0.00	0.00	0.25	(0.25)	0.00	0.00	0.00	0.00	0.00	0.00	(0.25)
SAS GRADE CPD	71180	0.00	0.10	0.00	0.00	0.00	0.00	0.00	0.10	0.00	(0.10)	0.00	0.00	0.00	0.00	0.00	(0.10)
MED STAFF - GP PLACEMENT	71195	0.00	0.00	0.00	0.00	5.00	1.00	0.00	6.00	0.00	0.00	0.00	0.00	0.00	(1.00)	0.00	(1.00)
OCCUPATIONAL HEALTH	74545	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Hospital Support Total		**0.25**	**0.10**	**0.00**	**0.00**	**5.00**	**1.00**	**0.00**	**6.35**	**(0.25)**	**(0.10)**	**0.00**	**0.00**	**0.00**	**(1.00)**	**0.00**	**(1.35)**
Trust Medics Total		**245.23**	**24.77**	**79.00**	**71.00**	**51.73**	**80.36**	**20.00**	**572.09**	**(35.94)**	**(2.92)**	**(3.82)**	**(0.97)**	**1.63**	**(23.11)**	**(18.40)**	**(83.53)**

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30 November 2017**

Title of the Report	**Sustainability and Transformation Plan Update**
Agenda item	15
Sponsoring Director	Chris Pallot, Director of Strategy & Partnerships
Author(s) of Report	Chris Pallot, Director of Strategy & Partnerships
Purpose	To provide an update on the Sustainability and Transformation Plan (STP)

Executive Summary

This paper provides an update on progress with implementing the STP in Northamptonshire and is the same as that being presented to all organisations across the county. Following the reset of the STP, the Delivery Support Unit is working on the creation of a standard suite of monthly reports to be reviewed at the Partnership Board and which is intended to provide a common update for briefing Boards.

In the interim, the current Programme Directors' Report is available as a stop gap measure and form the basis of this paper.

In terms of the scheduled care programme. The green status is a reflection of the development of implementation plans but will need to be adjusted in the next report to reflect delays to orthopaedics and the loss of a programme manager who was on secondment from the CCG.

Related strategic aim and corporate objective	Which strategic aim and corporate objective does this paper relate to? Strengthen our Local Clinical Services
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks: Yes
Related Board Assurance Framework entries	BAF – 3.1 and 3.2
Equality Impact Assessment	Is there potential for, or evidence that, the proposed decision/ policy will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential for or evidence that the proposed decision/policy will affect different population groups differently (including possibly discriminating against certain groups)?(N)
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper: No

Enclosure K

Actions required by the Trust Board/Committee

The Board is asked to note the update report.

Northamptonshire STP Partnership Board Meeting – 24 October 2017			
Report Title	**Programme Directors Report**		
Date	**20 October 2017**		
Number	**STPPB-17-05**	**Lead Director**	**Mike Coupe STP and Corporate Programmes Director**
Author	**Clare Hodgson, Deputy Programme Director and Bhavna Gosai, Head of DSU**	**Clinical Director**	**Matthew Davies, Clinical Director**

Report Summary	This report updates the Board on progress made during the last period. Key points to note: • The overall delivery status (process) is positive and significant progress has been made this month on programme planning. • Work remains ongoing to identify and establish both internal system and external resources for the programme • A proposed Governance Framework for the partnership will be presented to the STP / ACS Partnership Board on 24th October • A stakeholder workshop 'Working Together in Partnership' was held on 27th September • Northampton Carers have won Pathway Innovation of the Year at the National primary Care Awards for their Breathing Space service			
Purpose	☐ **Decision**	☐ **Discussion**	☐ **Approval**	☒ **Information**
Recommendation	The Board is asked to note this report for information.			

STP Objectives	Openness and transparency
Conflicts of Interest Mitigation Actions	Is there a Conflict of Interest either real or perceived? This is the recommended action to be agreed by the Chair at the beginning of the meeting (or ideally prior to the meeting): ☒ No conflict identified ☐ Conflict noted, conflicted party can participate in discussion but not in decision ☐ Conflict noted, conflicted party can remain but not participate ☐ Conflict noted, conflicted party leave for the discussion and decision
Legal Compliance Mitigation Actions	Has the paper highlighted any legal compliance issues of which partner organisations need to be aware? If yes, pls summarise
Health and Well Being implications	No additional health and wellbeing implications have been identified by this report
Care and Quality Implications	No additional care and quality implications have been identified by this report
Finance / Resource Implications	No additional finance and resource implications have been identified by this report

Programme Directors Report October 2017

Programme Management, Delivery and Planning

The delivery status of the overall programme is described in detail at appendix 1. The overall delivery status (process) is positive and significant progress has been made this month on programme planning.

Work is underway to strengthen and align national priorities described in the *Forwards View Next Steps* documentation to existing STP delivery. Theses priorities include:

- Cancer
- Mental Health
- Primary, Community and Social Care
- Urgent Care.

STP Resources

The programme director and financial lead are working closely to secure local resources and prioritise recruitment to support roles across the programme.

Bina Kakad has joined the DSU on an interim basis supporting financial modelling and business case development. Nicola Ensor will be joining the team on secondment from NHSI to support the Urgent and Emergency Care workstream.

We are currently working with the East Midlands Clinical Senate to develop an offer of support to the Clinical Advisory Group for the provision of independent input and advice for both the development and clinical assurance of new care models.

STP Governance

A proposed Governance Framework has been developed and submitted to the STP/ACS Partnership Board as a separate paper.

Working Together in Partnership

65 stakeholders from 22 organisations came together to begin to discuss and develop a collective understanding of the priorities for Northamptonshire. Attendees re-established and refreshed networks across the system and began a conversation about how to better work together across Northamptonshire on the four key priorities during 2017/18 and 2018/19, identifying key next steps. It was identified that there is requirement to refresh stakeholder engagement and communication on the ambitions of the wider STP programme and people are enthusiastic about being more closely involved in next steps.

Other news

a. Red Cross

Northamptonshire STP has been praised in a letter from the Red Cross for its focus on prevention. An excerpt is below and the full letter and report are available as Appendices 2a and 2b.

"We wanted to congratulate you on your sustainability and transformation plans very strong understanding and emphasis of prevention. As outlined in the report, we were also pleased to see Northamptonshire's plan highlighting the importance of investing in non-clinical interventions and the voluntary sector."

b. National Primary Care Awards

Northamptonshire Carers won the Pathway Innovation of the Year at the 2017 National Primary Care Awards for Breathing Space, a community based service to improve the health and wellbeing of patients with chronic respiratory disease in Northampton and Daventry. The team, including respiratory nurse, GP, social care and psychiatric nurse, see affected people and their carers in community venues. Outcomes include a 35% reduction in hospital admissions and A&E attendances for attendees compared to others.

The press release from Northamptonshire Carers is included at Appendix 3.

Appendix 1

Project Name	Update as at 11 October 2017	RAG
Health and Wellbeing		
Building resilient communities through volunteering and social action	VCSE Common Assurance Process – Draft PID completed Beginning socialisation of 4-tier assurance framework with VCSE sector Volunteer link - Business Case approved by STP Board and Clinical Scrutiny Group awaiting investment decision	
Improving population mental health and wellbeing though social prescribing	Socialisation approach around Social Prescribing policy statement begun via successful Health and Wellbeing Board Engagement session held on 28th September (57 participants from all-sector organisations across the Northamptonshire system) Social Prescribing Model - Business Case approved by STP Board and Clinical Scrutiny Group awaiting investment decision Social Impact Bond Expression of Interest to 'Life Chances Fund' submitted and awaiting decision on progression to full application Business Case to VCSE Health and Wellbeing Fund around themed Social Prescribing - due November 2017 and in development Secured £20k from Health Education England to develop Social Prescribing learning materials for Clinicians - subject to confirmation. Initial scoping meeting held with University of Northampton around development of virtual and/or face-to-face learning materials Application to join the NCVO: Increasing Voluntary Sector Involvement in Health Transformation Programme was submitted on 6th October – Delegate list agreed with individuals and drawn from key stakeholder organization executive officers.	
Systematic personalised and proactive presentations at scales	County-wide prevention programmes, MECC and Social Marketing - Business Case approved by STP Board and Clinical Scrutiny Group awaiting investment decision Developing areas for an integrated approach to meeting citizens needs alongside District and Borough Councils Sustainable Development Unit – ongoing network development and identification of key initial target areas Social Marketing approach around hypertension under development Behaviour Change - No further work over the period, but will become element of social marketing approach.	
Clinical preventative services	Optimising clinical care and supporting earlier diagnosis of Long Term Conditions - Business Case approved by STP Board and Clinical Scrutiny Group awaiting investment decision	
Primary, Community and Social Care		
Same day primary care	Roll out underway with primary care homes/GP networks/'at scale' models beginning to launch. Physiotherapy, mental health and nurse practitioner pathways being tested. Care navigation rollout underway countywide. OD sessions facilitated by West Wakefield team. 55% of practices have completed training and are in a position to go live. Ambition is that all practices will be live by Dec 1st.	
Collaborative care team	GP Federations are working with Primary Care homes to roll out CCTs. MDTs are incorporated with the delivery model.	

Diabetes care package	Workshop held last month on the new models of care for diabetes. Diabetes Treatment and Care MOU signed by all parties. Final contract variation for community diabetes MDT prepared.	
Intermediate care	Work on Strategic Outline Case has commenced with support from Finance & BI. Includes case for change and baseline activity and finance information, and high level projected changes in light of new model. Project timescales to be revisited in light of delay in accessing Finance support.	
Acute & Secondary Care		
Inflow	All projects are in planning and implementation stage. A&E streaming live at both Trusts	
Internal flow	All projects within internal flow continue to deliver the projects.	
Outflow	Systm one now live to support the Single Point of Access for supported Discharges. All other projects are currently being implemented. The projects are aligned to the Winter DToC Programme	
Dermatology	14 GP Dermatology community clinics underway in the south each month, further expressions of interest been expressed by 5 practices across the county. The next phase is to develop the service in the north of the county	
Cardiology	Draft business cases for cardiology are being finalised by the trusts to be presented at the next scheduled care board meeting.	
Orthopaedics	National guidance has been issued to the CCGs to establish a MSK service by December 2017. Project plan is currently in development working with commissioners Existing rheumatology and orthopaedics group amalgamated. Business case for MSK in development across the county.	
Ophthalmology	Planning for PEARS (Primary Eye Assessment and Referral Scheme) – known as MECS (minor eye conditions service elsewhere) where patients will be referred to a single point for minor eye conditions and where appropriate, directed to an accredited Optometrist for assessment and treatment in the community. CCGs are scoping the options for the referral management and assessing the financial costs.	
Pathology	The pathology teams across both KGH and NGH have met with East Midlands Pathology team to agree a service model to support NHSO recommendation for a hub and spoke model for pathology service with 29 networks nationally.	

BritishRedCross

PREVENTION IN ACTION

How prevention and integration are being understood and prioritised locally in England

Authored by Olivia Field
Researched by Nahzley Anvarian and Olivia Field

Refusing to ignore people in crisis

Enclosure K


#PreventReduceDelay

Contents

Important Note to Reader:
This document is large. It is not intended to be read from cover to cover but as a reference document. All readers should consult the 'Reflections and recommendations' section.

INTRODUCTION

The British Red Cross has been working in the space between home and hospital since before the NHS was established. Our UK health and social care services today include: lower-level support enabling people to continue living independently at home; A&E discharge support; helping people home from hospital; transport to and from hospital; short term mobility aids, like a wheelchair; first aid education; new services to tackle loneliness and social isolation; and more.

All of these services help prevent a situation escalate and enable people to regain their confidence and independence. It is this unique position, working within both the community and in hospitals that enables us to understand where people are falling through the gaps. Through this work we see first-hand what works and what does not, and use this insight and evidence to shape our advocacy and policy development.

We see too many people having to reach the point of health and social care crisis before they receive support. As such, we have long been calling for a shift towards prevention. Seemingly small interventions, such as the provision of a short-term wheelchair, a simple home adaptation or even help with the shopping, can be the difference between living independently at home, and being admitted to a care home or hospital.

We are delighted, therefore, that the ambition to shift towards a truly preventative system has been enshrined in both social care and in health: in law via the Care Act (2014) and emphasised in the NHS Five Year Forward View and its Next Steps document, respectively. Since April 2015, the Care Act has placed a duty on local authorities to ensure a range of services that prevent, reduce and delay the need for care and support are available in their area. Local authorities also have to consider whether people could benefit from preventative services, before they determine if they are eligible for statutory support. In practice, this means people with lower level needs should be able to access services that would help prevent them falling into crisis. A system that ensures people with lower-level needs can access services that prevent, reduce and delay the need for further care is good for the individual and the public purse.

Yet our system still largely focuses on reacting to, rather than preventing, crises. Research carried out by the Red Cross in 2015, a year after the Care Act's prevention duty came into force, found that Parliament's vision for prevention was not being fully realised. While the majority of local authorities reported making changes to the structures and processes that framed their provision of preventative services, such as the creation of new boards, roles, strategies and guidance, this had rarely translated into enhanced provision. We also found that some

local authorities were conflating their duty to provide information and advice with their duty to prevent needs for care and support. There also seemed to be no consistent understanding of exactly what 'prevention' is and how to put it into action. This is despite the Care Act's statutory guidance defining the term, using the triple definition of prevention.

To us, a truly preventative system would prioritise prevention at every stage of a condition (before, during and after). So, over two years since both the NHS Five Year Forward View and the Care Act came into force, we wanted to see whether the prioritisation and understanding of prevention has improved at a local level.

Since our last report, there have also been some significant changes to the way health and social care services are planned. Every locality in England now has a sustainability and transformation partnership (STP) and plan,[1] which are critical to transforming health and social care at a local level. For this year's report, we have taken the new opportunity to assess prevention in STPs as well as repeating a review of joint health and wellbeing strategies and local authority Freedom of Information (FOI) responses.

We have also looked beyond prevention to health and social care integration, which we believe to be critical to ensuring the funding and provision of preventative interventions in local health and social care systems. Single budgets, for example, mean savings would return to the same pot and benefit both the NHS and local authorities from cost-efficiencies. Integration also has the potential to eradicate the often false distinction between people's 'health' and 'social care' needs. This distinction all too often results in people falling through the gaps. As with prevention, we wanted to gain a better understanding of how integration is being prioritised and actioned locally.

1 Sustainability and transformation plans (STPs) are local plans setting out how the NHS Five Year Forward View will be implemented in 44 areas of England. For more information, please see page 16.

What is prevention?

The Care Act's triple definition of prevention:

- **Primary prevention** is about minimising the risk of people developing needs.
- **Secondary prevention** is about targeting people at high risk of developing needs and intervening early.
- **Tertiary prevention** is about minimising deterioration and the loss of independence for people with established needs or preventing the reoccurrence of a health and social care crisis.

(See full definition and example in appendix one).

What is integration?

'For care to be integrated, organisations and care professionals need to bring together all of the different elements of care that a person needs.'

– Monitor, now NHS Improvement, 2014

The Department of Health has adopted National Voices' definition of integrated care as 'person-centred, coordinated care' and developed what it feels like from the service-user's perspective:

'My care is planned with people who work together to understand me and my carer(s), put me in control, coordinate and deliver services to achieve my best outcomes.'

Likewise the Care Act's statutory guidance notes:

'The vision is for integrated care and support that is person-centred, tailored to the needs and preferences of those needing care and support, carers and families.'

As this research will demonstrate, however, there are different interpretations of what exactly needs to happen to achieve health and social care integration. Equally, the scale and pace of integration looks different from place to place.

REFLECTIONS AND RECOMMENDATIONS

Overall reflections

It is widely accepted that prevention and integration should sit at the heart of the sector's plans to innovate and adapt to new challenges, including financial. This research shows that, for the most part, both are being strived for at a local level. However, as previous British Red Cross studies have shown, there is no consistent understanding of exactly what 'prevention' is and how to put it into action. This also seems to be the case with regard to 'integration'.

Freedom of Information (FOI) responses indicate that local authorities are engaging with the Care Act's triple definition of prevention, but this terminology has yet to be fully embraced by health and wellbeing boards (HWBs) or sustainability and transformation partnerships (STPs).

We believe the triple definition of prevention is just as useful for the NHS, public health, and voluntary and community sector, as it is for adult social care. It's vital to ensuring preventative services are made available across the life course and pathology of a condition or illness. Sharing the same language will become increasingly important as we move towards increased integration and cross-working.

The FOI responses, joint health and wellbeing strategies, and sustainability and transformation plans review, indicate that prevention is a key consideration in local decision making, including commissioning.

However, interventions aimed at minimising the effect of disability or deterioration for people with established or complex health conditions (tertiary prevention), are still not being emphasised as much as primary and secondary prevention. In some cases, they are forgotten altogether. Many HWBs in particular are yet to place importance on preventative measures that could stop the deterioration or reoccurrence of a health or social care-related crisis by providing lower-level support.

Local authorities are generally working to meet their new responsibilities under the Care Act. **However, responses demonstrate a mixed level of understanding about both the prevention and integration duties, as well as ambition.**

Innovative solutions to preventing, reducing and delaying the need for care and support do not seem to be as ground breaking as the legislation intended. And examples of health and social care integration still seem to be small at scale. Given the huge financial pressures on local authorities, this is perhaps not so surprising.

We are concerned that some local authorities are still sometimes conflating their duty to provide information and advice with their duty to prevent needs for care and support. We will not achieve a truly preventative system by providing information and advice alone. We will not sufficiently improve outcomes for people and their carers, nor will we release the associated cost efficiencies and savings. **The proposed green paper on social care could provide a good opportunity to look again at what is needed to make the Care Act's vision for prevention a reality.**

Some local authorities seem to be 'cooperating' rather than 'integrating' with health services. Yet, the duty to co-operate (under Sections 6 and 7 of the Care Act) and the duty to integrate (under Section 3 of the Care Act) are distinct. Different interpretations of health and social care integration as well as scale and pace are also evident in STPs. **The proposed green paper also provides a good opportunity to explore what is meant by integration and what we want it to achieve. Is the aim to simply work better together? Is it to pool budgets? Or is it to go much further and combine our systems in a way that no longer distinguishes between 'clinical' and 'social' needs?**

The sustainability and transformation planning process no doubt provides another opportunity to see a real shift towards prevention as well as integration. Our review found, after all, that the

understanding and prioritisation of prevention in sustainability and transformation plans is generally very strong. We must make sure, however, that these plans for transformation can be put into practice on the ground. The same financial pressures that have encouraged this theoretical shift towards prevention might also be one of the key barriers to achieving these latest plans for prevention. We know, for example, that a large proportion of the sustainability and transformation budget has so far been spent on plugging deficits.

Indeed, FOI responses, joint health and wellbeing strategies, and sustainability and transformation plans emphasise the practical difficulties of shifting resources away from crisis intervention to prevention as well as integrating care in the current economic climate. **We hope this report supports this transition. We also encourage local decision makers to continue to explore ways of overcoming these challenges and to share useful learning.**

KEY FINDINGS

Prevention

- **Prevention is an evident consideration in local strategies and plans.** All joint health and wellbeing strategies and sustainability and transformation plans mention prevention.
- **Yet, the term 'prevention' is still understood differently across the country.** This is despite the Care Act's triple definition of prevention.
- **Thirty-seven per cent of joint health and wellbeing strategies still do not incorporate a full understanding of prevention.** Prevention should be seen as an ongoing consideration and not a single activity or intervention.
- **All too often, local authorities and health and wellbeing boards fail to recognise the importance of interventions aimed at minimising deterioration and the loss of independence for people with established needs, or preventing the reoccurrence of a health and social care crisis (i.e. 'tertiary' types of prevention).** Many understand prevention only as minimising the risk of people developing care and support needs (primary prevention), or as targeting people at high risk of developing needs (secondary prevention).
- **Sustainability and transformation plans generally prioritise prevention very strongly.** Nevertheless, they too place more emphasis on primary and secondary prevention. With over 15 million people in England living with a long term condition (such as diabetes and dementia) accounting for 70 per cent of the money we spend on health and social care,[2] as well as an ageing population, tertiary types of preventative interventions are becoming increasingly important. Stretched funds may also be putting these promising plans for prevention at risk.
- **Local authorities have responded to Section 2 of the Care Act ('preventing needs for care and support') in a range of ways.**
- **There has been clear progression since the last series of FOI responses we received towards the end of 2015 enquiring after Section 2 of the Act, with, in many cases, a clear shift from planning to implementation.** Around a half of local authorities now report 'developing or investing in new services that prevent, reduce or delay'.
- **However, the overall impression was that local authorities' responses still demonstrate a mixed level of understanding about the prevention duties, as well as ambition.** While some local authorities have identified and met unmet need by investing in new, innovative developments that prevent, reduce or delay, others are yet to develop a local approach to prevention.
- **In some cases, local authorities are still conflating their duty to provide information and advice with their duty to prevent needs for care and support.** These are two distinct duties, which should be distinguished in local strategies and plans.

Integration

- **Local authorities and sustainability and transformation partnerships also demonstrate an inconsistent level of understanding of 'integration' as well as ambition.** This is despite government plans for full integration by 2020.
- **Local authorities have also responded to Section 3 of the Care Act ('promoting integration of care and support with health services etc.') in a range of ways,** from pooling budgets to integrating services to integrating management structures.
- **Yet, few actions have been done at scale.**
- **And, in some cases it seems local authorities are 'cooperating' rather than 'integrating' with health services.** The duties to co-operate (under Sections 6 and 7 of the Care Act) and the duty to integrate (under Section 3 of the Care Act) are distinct.
- **Local decision makers across the board emphasise both the need to invest in prevention and integration as well as the practical difficulties of doing this, especially in the current economic climate.** This Red Cross report is intended to help decision makers make this transition. It provides a national picture of local developments, and highlights areas of good practice.

2 Department of Health (May 2015), 2010 to 2015 government policy: long term health conditions: gov.uk/government/publications/2010-to-2015-government-policy-long-term-health-conditions/2010-to-2015-government-policy-long-term-health-conditions

KEY RECOMMENDATIONS

Prevention

We want preventative services to be made available to everyone, regardless of level of need or ability to pay:

- **Local authorities should implement the full ambition of the Care Act's prevention duties.**
- **Every health and wellbeing board and sustainability and transformation partnership** should *fully* incorporate and prioritise prevention in their strategies and plans. Prevention is about more than just stopping a condition or illness arising. It is about preventing, reducing and delaying needs and associated costs.
- **The Government should look again at what resources are required to enable local authorities to implement their prevention duties in a meaningful way.**
- **The Government should also ensure that sustainability and transformation plans are equipped with the necessary funds to truly invest in transformation.**
- **The proposed upcoming green paper on social care should explore whether the Care Act's prevention duty in its current form goes far enough in realising the prevention vision.** For example, there is no individual entitlement to access preventative services, suggesting a preventative system is a nice-to-have rather than a must-have.

Integration

We want to see an integrated health and care system where nobody falls through the gaps:

- **The Government should better define what is meant by health and social care integration at a local level, so that local decision makers understand the scale and pace to which they should aspire.**
- **As part of its proposed green paper on social care, the Government should explore what is needed to make integration work in practice, at both a local and national level.** This should involve an exploration of the resources needed to achieve the full ambition of integration as well as whether a legislative framework, as implemented in Scotland, is needed to aid the process.
- **In the meantime, local authorities should seek to move beyond 'cooperation' to 'integration' with health, using the sustainability and transformation partnership process as a vehicle to drive this transformation forward.**

CONTEXT

Pressures on health and social care

While it has long been recognised that 'prevention is better than cure', England's health and social care system has largely focussed on reacting to crises rather than preventing them.

Britain's population is ageing fast and more people are living with multiple long-term conditions. More than one in 12 of the population is projected to be aged 80 or over by mid-2039.[3] In 2012, the Department of Health projected a rise of those with multiple long-term conditions to 2.9 million in 2018 from 1.9 million in 2008.[4]

Despite this, between 2010 and 2015 **adult social care budgets were reduced** by £4.6 billion, representing 31 per cent of real terms net budgets.[5] And **the number of older people receiving local authority-funded social care has fallen**, dropping by 26 per cent between 2009 and 2013/14 (the last year for which comparable data is available).[6]

These cuts adversely affect the NHS. Delayed transfers of care from hospitals due to social care have also risen by 65 per cent since 2011.[7] In 2015, 88 per cent of NHS Trust finance directors and 80 per cent of clinical commissioning group (CCG) finance leads felt funding pressures on local authorities were adversely affecting the performance of health services in their local health economy.[8]

Health and social care are under real pressure. The 2014 NHS Five Year Forward View warned of a £30 billion funding gap in the health budget by the end of the decade.[9] Adult social care was estimated to be facing a funding gap of £4.3 billion (29 per cent of the budget)[10] over the same period.

The Government has responded to these warnings in numerous ways over the last few years. Most recently, the Conservative 2017 election manifesto recommitted to increasing 'NHS spending by a minimum of £8 billion in real terms over the next five years, delivering an increase in real funding per head of the population for every year of the parliament'.[11] They have also given local authorities the power to increase social care funding by raising council tax. A two per cent council tax precept was announced in 2015[12] and powers to increase this again to three per cent in 2017-18 and 2018-19, provided increases do not exceed six per cent in total before 2019-20, were announced again in 2016. Two hundred and forty million pounds of new homes bonus money was also made available to adult social care as part of the 2017 to 2018 local government finance settlement.[13] The government then announced an additional £2 billion will be given to councils in England over the next three years for adult social care in the Spring Budget 2017.

Despite this additional funding, the Association of Directors of Adult Social Services (ADASS) estimates adult social care in England will face a £2.3 billion funding gap by 2020. The ADASS budget survey 2017 found that 'only nine of the 138 Directors who responded feel at all optimistic about the future financial state of the local health and care economy in their own areas.'[14]

In response to this year's ADASS budget survey, the Chairman of the Local Government Association's Community Wellbeing Board, Councillor Izzi Seccombe said:

3 ONS (October 2015), National population projections, 2014-based Statistical Bulletin: ons.gov.uk/ons/dcp171778_420462.pdf
4 Department of Health (2012), Long Term Conditions Compendium of Information, Third Edition: gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf
5 ADASS (June 2015), ADASS Budget Survey 2015: adass.org.uk/uploadedFiles/adass_content/policy_networks/resources/Key_documents/ADASS%20Budget%20Survey%202015%20Report%20FINAL.pdf
6 The Care Quality Commission (October 2016), The state of health care and adult social care in England 2015/16: cqc.org.uk/sites/default/files/20161019_stateofcare1516_web.pdf
7 House of Commons Library briefing paper (February 2017) NHS Indicators; England
8 The King's Fund (October 2015), Quarterly Monitoring Report: qmr.kingsfund.org.uk/2015/17/
9 NHS (October 2014), Five Year Forward View: england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
10 LGA & ADASS (October 2014), Adult social care funding: 2014 state of the nation report: local.gov.uk/documents/10180/5854661/Adult+social+care+funding+2014+state+of+the+nation+report/e32866fa-d512-4e77-9961-8861d2d93238
11 The Conservative and Unionist party (2017), THE CONSERVATIVE AND UNIONIST PARTY MANIFESTO 2017: eu-west-2.amazonaws.com/manifesto2017/Manifesto2017.pdf
12 Chancellor George Osborne's Spending Review and Autumn Statement 2015 speech (25 November)
13 Department for Communities and Local Government (February 2017), Final local government finance settlement 2017 to 2018
14 ADASS (2017), ADASS BUDGET SURVEY 2017: adass.org.uk/media/5994/adass-budget-survey-report-2017.pdf

"...the £2 billion of extra funding announced in the Spring Budget, while helpful to councils in meeting some short term pressures, is not a long-term solution and still leaves councils facing a £2.3 billion funding gap by 2020…

…Adult social care is at a tipping point, and unless urgent action is taken we will continue to see more and more of the consequences of underfunding that we have seen in recent years, particularly care providers either handing back contracts to councils or ceasing trading altogether."[15]

Something needs to change

One way to ease the pressure is to invest in preventative services and integrate care…

"It is only with this greater focus on prevention and integration that both the NHS and care and support can respond to the financial pressures of an ageing population."[16]

– Earl Howe

It pays to spend on prevention. Investing in preventing minor situations escalating into crises is more cost-effective than picking up the pieces. This principle applies across health and social care and should span our lifetimes. It should also be enshrined in universal public health campaigns, right up to the management of chronic illnesses and long-term conditions.

Directors of adult social care recognise this. The Association of Directors of Adult Social Services (ADASS) has identified 'moving towards prevention and early intervention', as the most important priority area for making savings in 2017/18.[17]

There is good evidence of these cost savings. An independent economic analysis of British Red Cross lower-level preventative services by the London School of Economics and Political Science, identified cost savings related to a reduced need for care and support equivalent to £880 per person.[18]

The Local Government Association's prevention spending model concluded that handyperson services have a return of £1.13 for every £1 invested and telehealth care has a return of £2.68 for every £1 invested.[19]

Similarly, the Department of Health's Mental Health Strategy 2011 estimated that its plans to expand the provision of talking therapies services would 'be strongly cost saving to the overall public purse, with a net saving of an estimated £302m,' representing a public sector saving of £1.75 for every £1 spent.[20]

Public Health England recently found that tackling loneliness through volunteering and social activities among older people also saves money: every £1 invested results in an estimated saving to society of £1.26 (over five years).[21]

Yet, while local authorities see prevention as a key source of savings for the future, spend on prevention is decreasing. It only forms 6.3 per cent of local authorities' budgets in 2017/2018 (a reduction of 6.7 per cent from the previous year).[22] As ADASS explains:

'As budgets reduce it becomes harder for councils to manage the tension between prioritising statutory duties towards those with the greatest needs and investing in services that will prevent and reduce future needs.'[23]

In 2016, ADASS identified 'integration' as the second most important priority area for making savings over three years, after 'moving towards prevention and early intervention'. **This year, however, only 40 per cent identified 'integration of health and social care' as 'very important' in making savings compared to 82 per cent in 2016.** Prevention, better procurement and shifting

15 Chairman of the Local Government Association's Community Wellbeing Board, Cllr Izzi Seccombe (28 June 2017)
16 Earl Howe (29 July 2013), publications.parliament.uk/pa/ld201314/ldhansrd/text/130729-0001.htm#1307296000176
17 ADASS (2017), ADASS BUDGET SURVEY 2017: adass.org.uk/media/5994/adass-budget-survey-report-2017.pdf
18 Personal Social Services Research Unit, LSE & Research, Evaluation and Impact team, British Red Cross (January 2014), An Analysis of the Economic Impacts of the British Red Cross Support at Home Service: pssru.ac.uk/archive/pdf/dp2869.pdf
19 Personal Social Services Research Unit, LSE & Research, Evaluation and Impact team, British Red Cross (January 2014), An Analysis of the Economic Impacts of the British Red Cross Support at Home Service: pssru.ac.uk/archive/pdf/dp2869.pdf
20 The Department of Health (February 2011), Talking therapy services – impact assessment: gov.uk/government/publications/talking-therapies-impact-assessment
21 Public Health England (August 2017), PHE highlights 8 ways for local areas to prevent mental ill health: gov.uk/government/news/phe-highlights-8-ways-for-local-areas-to-prevent-mental-ill-health
22 https://www.adass.org.uk/media/5994/adass-budget-survey-report-2017.pdf
23 ADASS (2017), ADASS BUDGET SURVEY 2017

activity to cheaper settings all assumed more importance than integration.[24]

NHS England also identified prevention as a priority in its Five Year Forward View:

'…the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health.'[25]

Several preventative programmes have been implemented as a result of this plan including, but not limited to, falls prevention initiatives being undertaken by fire services and a large-scale diabetes prevention programme.

In 2017, further preventative programmes were announced in the Next Steps on the NHS Five Year Forward View,[26] ranging from NHS health checks for people at high risk of cardiovascular disease to working with employers to keep employees with a health condition in work, to designing a common approach to self-care and social prescribing.

Legislative background

The importance of both prevention and integration is recognised in national policy and practice.

Prevention

In 2014 the ambition to shift towards a truly preventative system was enshrined in law. **Section 2 of the Care Act, that came into force in April 2015, places a duty on local authorities to ensure the provision of services that prevent, reduce or delay the need for care and support.**[27] Prevention is also a key component of the NHS Five Year Forward View, a shared vision for the NHS that notably calls for 'a radical upgrade in prevention and public health',[28] as well as its follow up plan, Next Steps on the NHS Five Year Forward View.[29]

Historically, preventative services were only available to people with needs that met council eligibility thresholds. This meant that in the large majority of areas, people were required to have 'substantial' or 'critical' needs before they could access preventative services like reablement.

During the passage of the Care Bill, the British Red Cross argued that this wasn't sufficiently preventative. We wanted preventative services to be available to everyone who may benefit from them, so that fewer people reach the point of crisis. **Under Section 9(6)(b) of the Care Act, local authorities now have to consider whether people could benefit from preventative services when carrying out a needs assessment, before a determination is made as to their eligibility.**[30] And, as noted in the statutory guidance:

'Where the local authority judges that the person may benefit from such types of support [services that prevent, reduce or delay the need for support], it should take steps to support the person to access those services.'[31]

The Red Cross also advocated strongly for prevention to be clearly defined. We were concerned that because the term is understood differently across the country, there was a need to be explicit about what 'prevention' entails, in order to support local authorities to fulfil their new duty effectively. We were pleased that three equally important forms of prevention were written into the statutory guidance (see appendix one).

Integration

Under Section 3 of the Care Act (2014), local authorities also have a duty to promote the integration of care and support with health and health-related services where it considers this would:

- promote the wellbeing of adults with care and support needs or of carers in its area
- contribute to the prevention or delay of the development of needs of people
- improve the quality of care and support in the local authority's area, including the outcomes that are achieved for local people.[32]

24 ADASS (2017), ADASS BUDGET SURVEY 2017: adass.org.uk/media/5994/adass-budget-survey-report-2017.pdf
25 NHS (October 2014), NHS Five Year Forward View: england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
26 NHS (March 2017) Next steps on the NHS Five Year Forward View: england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf
27 Care Act 2014, Section 2: legislation.gov.uk/ukpga/2014/23/section/2/enacted
28 NHS (October 2014), NHS Five Year Forward View: england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
29 NHS (March 2017) Next steps on the NHS Five Year Forward View: england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf
30 Care Act 2014, Section 9(6)(b): http://www.legislation.gov.uk/ukpga/2014/23/section/9/enacted
31 Department of Health (October 2014), Care and Support Statutory Guidance, Chapter 6 (6.62)
32 Care Act 2014, Section 3: legislation.gov.uk/ukpga/2014/23/section/3/enacted

This is in addition to a general duty to cooperate with relevant partners under Section 6 of the Care Act and a duty to cooperate with relevant partners in specific cases under Section 7 of the Act.

The Care Act was not the first time integrated working between health and social care has been encouraged under English law. The Health and Social Care Act (2012), for example, placed a duty on clinical commissioning groups (CCGs) to promote integration between both health services and health-related and social care services where it considers doing so would improve the quality of services or reduce inequalities.[33] It also established health and wellbeing boards that have a duty to encourage integrated working.[34] The National Health Service Act (2006) and the Health Act (1999) also provided an enabling framework for the pooling of NHS and local authority budgets.[35]

In addition to legislation, various initiatives set out to further encourage integration have been implemented.

These include, but are not limited to, the Better Care Fund, a single-pooled NHS and local authority budget; 25 integrated care 'pioneers' that were chosen to be supported by national bodies to implement particularly ambitious and innovative approaches to integrate care; new integrated models of care introduced by the NHS Five Year Forward View; the devolution of an integrated health and social care budget of over £6 billion in Greater Manchester and opportunities for other areas to work towards a similar agreement; sustainability and transformation partnerships (STPs); and more recently the creation of accountable care systems (ACSs). ACSs are evolved versions of STPs that may evolve into accountable care organisations (ACOs) 'where the commissioners in that area have a contract with a single organisation for the great majority of health and care services and for population health in the area.'[36]

While these steps are promising, legislative change might be necessary to take the integration agenda forward at scale. The Department of Health confirmed earlier this year that it is working with NHS England to consider 'what further changes could be made to secondary legislation to support more integrated, place-based approaches to health and social care,' as well as 'whether further amendments to the section 75 partnership regulations would support local areas to extend the benefits of partnership working as they take forward their integration vision.'[37]

A recent Institute for Public Policy Research (IPPR) report, 'Sustainability and Transformation Plans: what, why and where next?', concluded that amending Section 75 of the NHS Act 2006 would indeed be necessary 'to better enable the pooling of budgets and commissioning functions locally.'[38] They also called on government to 'consider the creation of new national legislation to give the regional (STP) level a formal role in the system, codify place-based health and care, soften emphasis on organisational silos, and move from competition to collaboration.'[39]

33 Health and social care act 2012, Section 26 (14Z1) ("Duty as to promoting integration"): legislation.gov.uk/ukpga/2012/7/section/26/enacted
34 Health and social care act 2012, Section 194 ("Establishment of Health and Wellbeing Boards"): legislation.gov.uk/ukpga/2012/7/section/194/enacted
35 National Health Service Act (2006), Section 75 ("Arrangements between NHS bodies and local authorities"): legislation.gov.uk/ukpga/2006/41/section/75
36 NHS (March 2017) Next steps on the NHS Five Year Forward View: england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf
37 Department of Health & Department of Communities and Local Government (March 2017), 2017-19 Integration andBetter Care Fund: Policy Framework: gov.uk/government/uploads/system/uploads/attachment_data/file/607754/Integration_and_BCF_policy_framework_2017-19.pdf
38 Smith J (2016) Sustainability and Transformation Plans (STPs): What, why and where next?, IPPR. ippr.org/publications/stps
39 Smith J (2016) Sustainability and Transformation Plans (STPs): What, why and where next?, IPPR. ippr.org/publications/stps

A shared language

The Care Act clearly recognises that prevention is about more than just stopping something arising. It is about preventing, reducing and delaying needs and associated costs.

While public health interventions and reablement services are generally recognised as preventative, there is much more to prevention than these alone. And while public health initiatives – such as diabetes and obesity prevention – are gathering pace, not enough attention is being paid to other preventative measures.

It is not possible to prevent everything entirely, so it's important that preventative approaches and interventions are adopted across the life course and pathology of a condition or illness. The triple definition of prevention helps us do this.

Yet, while the triple definition of prevention has been adopted by adult social care through the Care Act, it was notably not mentioned in the NHS Five Year Forward View or its more recent Next Steps document.

The Red Cross is pleased that both sides of the coin recognise the need to shift from reaction to prevention. However, unless we share a common language, we cannot be confident that we are all talking about the same thing. **With plans to integrate health and social care by 2020,[40] sharing the same definition will prove ever more important in effectively working together to make prevention a reality.**

40 HM Treasury (25 November 2015), Spending review and autumn statement 2015: gov.uk/government/publications/spending-review-and-autumn-statement-2015-documents/spending-review-and-autumn-statement-2015#a-sustainable-health-and-social-care-system-1

Legislation to enable health and social care integration in Scotland

The Public Bodies (Joint Working) (Scotland) Act 2014, provides a legislative framework for health and social care integration in Scotland. The legislation came into effect in April 2016 and new Integration Authorities now have responsibility for over £8 billion of funding for local services, previously separately run by NHS Boards and local authorities. Under the Act, health boards and local authorities have a choice between two integration models. They can either:

- delegate between each other, often referred to as a 'lead agency' arrangement, or
- can delegate to a third body called the 'Integration Joint Board'.

A little over a year since the Act came into force, a recent Nuffield Trust report found there to be a few teething problems and concerns for the future, primarily around there being 'a risk that the financial situation will undermine the best aspects of the Scottish NHS before they can be brought to bear in addressing it.' Nevertheless, all in all it concluded that these models have appeared 'to shift local and national attention away from structure towards relationships, specific changes and performance' – exactly what most believe integration is supposed to achieve.

The same report noted that having legislation behind integration gives Scottish Integration Authorities 'a much firmer legal standing and a clearer role for local government than English STPs.' It also acted as a sort of '"catalyst", important primarily for its initial effect and for areas lagging behind.'[41]

Health and wellbeing boards

Under the Health and Social Care Act (2012) each top tier and unitary authority in England had to establish a health and wellbeing board in order to improve health and wellbeing and reduce inequalities. As a minimum, they are made up of one local elected representative, a local healthwatch representative, a representative of each local clinical commissioning group, the local authority director for adult social services, the local authority director for children's services, and the director of public health.

One of their core responsibilities is to carry out a joint strategic needs assessment and develop a joint health and wellbeing strategy that meets the needs identified in that assessment. Both should 'sit at the heart of local commissioning decisions, underpinning improved health, social care and public health outcomes for the whole community.'[42] The Care Act's statutory guidance reiterates the importance of these strategies, noting that they 'should be informed and emphasise preventative services that encourage independence and wellbeing, delaying or preventing the need for acute interventions.'[43]

Health and wellbeing boards have also played a key role in the development of Better Care Fund plans. The £5.3 billion Better Care Fund (previously called the Integration Transformation Fund) created a local, single-pooled NHS and local authority budget to encourage health and social care integration. The previous Chancellor committed an extra £1.5 billion to the Better Care Fund by 2019-20 as part of its 'radical, local-led plan to create an integrated health and social care system by 2020,'[44] during his 2015 Spending Review.

Leaders of the social care sector were concerned about the time frame of this funding, noting that it does not reach 'levels of any significance until towards the end of this parliament.' They also warned this puts 'the delivery of the NHS Five Year Forward View and the Care Act at risk.'[45] More recently, the Better Care Fund has also been criticised for not achieving its principal financial or service targets over 2015-16.[46]

41 Nuffield Trust (July 2017) Learning from Scotland's NHS: nuffieldtrust.org.uk/files/2017-07/learning-from-scotland-s-nhs-final.pdf
42 Department of Health (2011), Joint strategic needs assessment and joint health and wellbeing strategies explained: gov.uk/government/uploads/system/uploads/attachment_data/file/215261/dh_131733.pdf
43 Department of Health (October 2014), Care and Support Statutory Guidance, Chapter 4 (4.53)
44 HM Treasury (25 November 2015), Spending review and autumn statement 2015: gov.uk/government/publications/spending-review-and-autumn-statement-2015-documents/spending-review-and-autumn-statement-2015#a-sustainable-health-and-social-care-system-1
45 Joint letter for the Chancellor and Secretaries of State, from Care and Support Alliance, Association of Directors of Adult Social Services, Care Provider Alliance, NHS Confederation (December 2015): careandsupportalliance.com/social-care-sector-response-to-the-spending-review/#sthash.eS0VEpiv.dpuf
46 National Audit Office (February 2017) Health and social care integration: nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf

Sustainability and transformation plans

Sustainability and transformation plans (STPs) are local plans setting out how the NHS Five Year Forward View will be implemented in 44 areas of England. As such they set out ways to close the health and wellbeing gap, the care and quality gap, and the finance and efficiency gap. As place-based plans, they 'must cover all of areas of CCG and NHS England commissioned activity', as well as 'better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies.'[47]

They should also have been developed collaboratively with local leaders from across the board including: 'clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government through health and wellbeing board.'[48] There have been concerns, however, that such collaboration has not actually happened. A Local Government Association poll found, for example, that the majority of councillors felt they had 'not been involved with shaping, commenting on or approving the NHS's 44 sustainability and transformation partnerships (STPs).'[49] STPs have also been criticised for proposing controversial changes to hospital services as well as for initially producing unviable plans, resulting in the deadline for submission repeatedly being pushed back.[50]

Despite these criticisms, they are now considered by some health and social care thought leaders as 'the best opportunity for the NHS and its partners to plan together for the future.'[51] At the same time, as recognised by IPPR, challenges persist. These include a deficiency in leadership, funding pressures resulting in money for transformation being used to plug deficits and STPs having no statutory powers to drive through reform.[52]

47 NHS (December 2015), Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21: england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf
48 NHS (December 2015), Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21: england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf
49 LGA (5 July 2016), Lack of confidence in STPs, councils warn: local.gov.uk/about/news/lack-confidence-stps-councils-warn
50 Smith J (2016) Sustainability and Transformation Plans (STPs): What, why and where next?, IPPR. ippr.org/publications/stps
51 King's Fund (May 2016), What are STPs and why do they matter? big election questions: kingsfund.org.uk/publications/articles/big-election-questions-stps
52 Smith J (2016) Sustainability and Transformation Plans (STPs): What, why and where next?, IPPR. ippr.org/publications/stps

RESEARCH OBJECTIVES

Research objectives

The aim of this research study was to explore the extent to which local authorities, sustainability and transformation partnerships, and health and wellbeing boards across England recognise and prioritise the Care Act's understanding of prevention, as well as to better understand how and to what extent local decision makers are integrating health and social care. For more detail on our research objectives, please see appendix two.

Methodology

To achieve the research objectives we:

- reviewed joint health and wellbeing strategies for the fourth year in a row
- reviewed sustainability and transformation plans for the first time
- made a Freedom of Information (FOI) request of all English local authorities for the second year running (although this year we added some additional questions around identifying preventative services and unmet need as well as integration).

Please see appendix two for the detailed methodology.

How is integration being understood and prioritised locally?

The following sections on integration will demonstrate there are different interpretations of what exactly needs to happen to achieve health and social care integration at a local level. Equally, the scale and pace of integration looks different from place to place.

What do local authorities say they are doing to integrate with health?

The following section reflects on the 138 responses we received to question six of our Freedom of Information (FOI) request:

Question 6. What actions has your council taken to comply with Clause 3 of the Care Act 2014 ('Promoting integration of care and support with health services etc.') Please give details.

While several local authorities responded that they had either not yet taken any steps or are still in the early stages of developing a plan, the majority have taken action to comply with Section 3 of the Care Act.

From integrating management structures to setting up multidisciplinary teams to pooling budgets, **local authorities reported taking a wide range of actions to promote health and social care integration.**

This is in keeping with the Care Act's guidance that notes:

'There are many ways in which local authorities can integrate care and support provision with that of health and related provision locally. Different areas are likely to find success in different models. Whilst some areas may pursue for integrated organisational structures, or shared funding arrangements, others may join up teams of frontline professionals to promote multi-disciplinary working.'[53]

Usually, however, these actions seem to be small in scale, often only affecting a small number of people or services, or only targeted at one group of people with a specific condition or illness. For example, solely integrating community equipment or developing a joint strategy only for people with dementia. This suggests that government plans for full integration by 2020 might be 'over-optimistic',[54] as was also reported in a February 2017 National Audit Office report on health and social care integration.

In some cases, local authorities have only reported 'working closely' or 'building relationships' with health-related staff. This is undoubtedly important and clearly sits underneath the local authority's duties under Sections 6 and 7 of the Care Act to 'co-operate generally' and to 'co-operate in specific cases'. **However, ambitions to integrate should go further than mere cooperation.[55]**

More information on how local authorities are integrating with health:

At the strategic level, local authorities have reported integrated planning (with many referring to their local sustainability and transformation plans and joint health and wellbeing strategies), integrated commissioning frameworks and teams, integrated management structures, integrated services and pooled budgets.

At the level of the individual service, local authorities have reported recruiting and training individual care coordinators, multi-disciplinary teams, better information sharing and the co-location of different teams and care professionals in places such as hospitals and general practice surgeries. As noted within the Care and Support Statutory Guidance these, 'would not necessarily require structural integration – for example, organisations merging –

53 Department of Health (August 2017), Care and Support Statutory Guidance, Chapter 15 (15.11)
54 National Audit Office (February 2017) Health and social care integration: nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf
55 "'Co-operation', like integration, can be achieved through a number of means, and is intended to require the adoption of a common principle, rather than to prescribe any specific tasks." Department of Health (August 2017), Care and Support Statutory Guidance, Chapter 15 (15.19)

but a seamless service, from the point of view of the person, could be delivered by staff working together more effectively.'[56]

Local authorities also report to have **combined and aligned processes**, such as single assessments.

The most prevalent examples mentioned by local authorities in responses to question six include pooling budgets (with many reflecting on their work via the Better Care Fund), joint commissioning, integrated services and integrated or multidisciplinary teams.

Pooled budgets are typically being used for prevention services, including dementia support and reablement and reducing delayed transfers of care and residential, care home and emergency admissions. With many drawing on the Better Care Fund, these focuses are not surprising. As guidance on integration and the Better Care Fund prepared by the Department of Health and the Department for Communities and Local Government in March 2017 explains:

'…areas have flexibility in how the Fund is spent over health, care and housing schemes or services, but need to agree how this spending will improve performance in the following four metrics: Delayed transfers of care; Non-elective admissions (General and Acute); Admissions to residential and care homes; and Effectiveness of reablement.'[57]

While the Better Care Fund has so far not achieved its main financial or service targets, by, for example, reducing emergency admissions or delayed transfers of care, there has been an improvement in reduced permanent admissions of older people to residential and nursing care homes as well as an increased proportion of older people still at home 91 days after being discharge from hospital receiving reablement or rehabilitation services.[58] **Importantly, the National Audit Office found that the Better Care Fund has improved joint working 'with more than 90 per cent of local areas agreeing or strongly agreeing that delivery of their plan had improved joint working.'[59] This is further reflected by the fact that so many responses to question six (over 50) drew on their Better Care Fund plans.**

Typical examples of jointly commissioned and integrated services include: community equipment, services for carers, dementia and mental health services, learning disability services, intermediate care, and reablement and rehabilitation.

Multidisciplinary or integrated teams, made up of various health and care professionals as well as the voluntary and community sector, were mentioned over 150 times within responses to question six in over 40 per cent of replies. These teams were often based in hospitals to enable safe discharge, with many referring to their 'discharge to assess'/ or 'home first' models. 'Discharge to assess', or 'home first' applies to cases where:

'…people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.'[60]

Such teams also commonly consisted of 'crisis response' or 'emergency' teams working in the community to prevent hospital admissions, often for those with the most complex needs or the top two per cent of those continually admitted into acute settings. Sometimes the multi-disciplinary teams mentioned were for specific conditions or illnesses. Other times, they were responsible for patients with a certain level of need in a defined geographical place.

Some of these responses captured the importance of co-locating (at least for some of the week), relationship building, shared care records and regular meetings to enable efficient and collaborative multi-disciplinary working.

56 Department of Health (August 2017), Care and Support Statutory Guidance, Chapter 15 (15.13)
57 Department of Health & Department of Communities and Local Government (March 2017), 2017-19 Integration and Better Care Fund: Policy Framework: gov.uk/government/uploads/system/uploads/attachment_data/file/607754/Integration_and_BCF_policy_framework_2017-19.pdf
58 National Audit Office (February 2017) Health and social care integration: nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf
59 National Audit Office (February 2017) Health and social care integration: nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf
60 Department of Health & NHS England et al. QUICK GUIDE: DISCHARGE TO ASSESS: nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf

Recommendations:

- **Those local authorities yet to do so** 'must ensure the integration of care and support provision, including prevention with health and health-related services' as per Section 3 of the Care Act 2014.
- **Health and social care local decision makers** should look to be more ambitious in their plans for integration and go beyond 'joint working' and 'cooperation'.
- Given the range of different actions local decision makers have taken to integrate health and social care as well as the different levels of progression, **the Department of Health and Department for Communities and Local Government** should continue to promote good practice and facilitate shared learning with regard to integration.

How are sustainability and transformation plans planning to integrate health and social care?

The NHS Planning Guidance (2015) instructed sustainability and transformation plans (STPs) 'to cover better integration with local authority services, including, but not limited to, prevention and social care.'[61] It is therefore not surprising that **the ambition to integrate health and social care is explicitly drawn on, albeit to different extents, in every plan.**

Notably, only six plans mention the Care Act despite it being 'the most significant reform of care and support in more than 60 years.'[62] This is compared to 41 mentioning the NHS Five Year Forward View, 34 mentioning vanguards and 19 mentioning the Better Care Fund. This might reflect a reported lack of local authority involvement in some areas.[63]

Nevertheless, the interdependency of health and social care was consistently drawn on, with several noting the importance of protecting and increasing social care budgets in order to sustain the NHS. North West London's STP notes, for example, 'To ensure that the NHS can be sustainable long term we need to protect and invest in social care and in preventative services, to reduce demand on the NHS and to support the shift towards more proactive, out of hospital care. This includes addressing the existing gap and ensuring that the costs of increased social care that will result from the delivery areas set out in this plan are fully funded.'[64]

As such, the importance of integration was highlighted in numerous plans. As reflected in the FOI responses, STPs typically hope health and social care integration will enable a shift towards a preventative and person-centred system. They also hope it will reduce delayed transfers or care and emergency admissions as well as improve efficiencies by, for example, avoiding duplication.

However, as we concluded via our FOI analysis, STPs also seem to place a varied emphasis on both the importance and understanding of integration, with some primarily talking about better collaboration rather than integration.

How STPs propose to integrate care:

STPs set out ways they wish to achieve the ambitions set out above. For example, several plans noted how integration could better enable prevention by, for example, realigning commissioning incentives:

'We recognise that increased investment can only do so much to increase prevention capacity. Therefore, using the STP as a vehicle, we will realign commissioning incentives for the NHS and local government, ensuring that resources flow to the area of the health economy where it will have the biggest impact, irrespective of commissioner. At minimum, this means sharing the risk and reward of commissioning prevention schemes between health and local authorities.'

– South East London STP[65]

61 NHS England (December 2015) Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21: england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdfCare and Support Minister, The Rt Hon Norman Lamb (15 May 2014).

62 Care and Support Minister, The Rt Hon Norman Lamb (15 May 2014).

63 The King's Fund (November 2016) Sustainability and transformation plans in the NHS: How are they being developed in practice? kingsfund.org.uk/sites/default/files/field/field_publication_file/STPs_in_NHS_Kings_Fund_Nov_2016_final.pdf

64 North West London (October 2016) Sustainability and Transformation Plan: Our plan for North West Londoners to be well and live well: healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/nwl_stp_october_submission_v01pub.pdf

65 South East London (October 2016) Sustainability and Transformation Plan: ourhealthiersel.nhs.uk/Downloads/Strategy%20documents/South%20East%20London%20STP%20October%202016.pdf

As well as how integration could better enable person-centred care by, for example, improved information sharing and shared care records:

'Proactive and person-centred care relies on there being one single care plan owned by the patient and their family, one electronic care record accessible by all, one set of best practice protocols all can adopt, and one route through which expert opinion can be accessed day or night. This means we need to share knowledge systematically. We will do this by providing appropriately secure access to patient records to all frontline staff providing direct care, be they the person's usual team or an out-of-hours or urgent response team, and by building stronger relationships between GPs, hospitals, domiciliary care workers, and care homes to speed up discharges.'

– Cambridgeshire & Peterborough STP

'Person-centred' care was explicitly mentioned in 28 of the 44 plans, with a further ten at least mentioning 'personalising' care. Other ways listed to achieve such care include: building services around the person by tailoring their care to their individual goals, personal care budgets, integrated teams, care navigators and so on.

As in the FOI responses, integrated and multi-disciplinary teams, often for people with complex conditions, were consistently mentioned in the plans. STPs often hope to reduce delayed transfers or care and emergency admissions via these teams.

Other listed ways areas plans to integrate health and social care include but are not limited to: joint commissioning, pooling budgets, integrating services, changing governance structures, joint care planning, single assessments, single points of access, and integrated personal health and care budgets.

In order to enable integration, STPs highlighted the importance of strong leadership to drive through cultural change with some appointing a health and social care integration director, ensuring social care and prevention are adequately funded, aligning incentives, objectives and outcomes, enabling better information sharing with several highlighting the importance of integrated care records and making better use of the voluntary sector.

Recommendations:

- **Sustainability and transformation** partnerships should clearly set out what they mean by integration, what they want integration to achieve, and what is needed to make it work in practice.
- **Sustainability and transformation partnerships** should draw on key social care policy and practice developments, such as the Care Act (2014) as much as those typically associated with 'health'.
- **The Government** should better define what is meant by health and social care integration as well as what is needed to make it work in practice to help facilitate plans for full integration. This should include learning from good and bad practice elsewhere, such as the UK's devolved nations.

Place-based health

Local and national decision makers see STPs as the vehicle for driving forward the place-based health agenda. Place-based health is about planning for care driven by whole systems rather than individual organisations.

To really achieve place-based health, some STPs as well as FOI responses, noted the importance of greater collaboration not just between health and social care but between community services, housing providers, business, the voluntary sector and so on. As illustrated by the Place-Based Health Commission's report, 'Get well soon: reimagining place-based health', place-based health starts at the point of view of people and place rather than services. It notes:

'If we ask a person "what health services do you want?" the answer might well be clinical and focussed on a more efficient experience. But if we ask that same person "what would help you to enjoy life more?" the answer would be different: perhaps about their lived experience at home, in the community and at work, and their hopes for the future.'

Starting with the latter question 'requires the NHS to broaden its focus and build stronger bridges to people', which 'would involve bringing expertise from local government, community pharmacy, the voluntary, community and social enterprise sector, housing providers and other local services together to effectively confront the broader drivers of poor health.'[66]

66 The Place-Based Health Commission (March 2016) Get well soon: reimagining place-based health: nlgn.org.uk/public/wp-content/uploads/Get-Well-Soon_FINAL.pdf

How is prevention being understood and prioritised locally?

How are sustainability and transformation plans planning to prevent, reduce and delay the need for care?

Sustainability and transformation plan labels

All 44 STPs were read and labelled accordingly:

- Very strong: 35 (80 per cent)
- Strong: 5 (11 per cent)
- Neither strong or weak: 4 (9 per cent)

- Prevention is mentioned in all STPs.
- 32 mention prevention within their 'priorities', and only four did not mention prevention in their priorities, principles or vision.
- Of the 42 that had some sort of summary (an executive summary/ foreword/ plan on a page etc.), 39 mention prevention.
- Eight plans have adopted the triple definition of prevention fully, with eighteen adopting it in part (usually only using the terminology 'primary' and 'secondary').
- Only six plans refer to the Care Act (2014).

An overview

Although STPs seem to place greater importance on primary and secondary types of prevention, the understanding and, especially prioritisation of prevention is mainly very strong. It seems the financial pressure on our health and social care system is encouraging a stronger emphasis on prevention. As noted by **North West London's plan**: 'To ensure that the NHS can be sustainable long term we need to protect and invest in social care and in preventative services, to reduce demand on the NHS and to support the shift towards more proactive, out of hospital care.'[67]

At the same time, the same financial pressures might be one of the key barriers to achieving their plans for prevention. As noted by the Kings Fund, '…developing new models of health and social care takes time and resources – both of which are in short supply.'[68] Notably, £1.8 billion (86 per cent) of the £2.1 billion of the Sustainability and Transformation Fund for 2016-17 was spent on meeting provider deficits.[69] With such stretched funds, local authorities spend on prevention[70] and public health has also been reducing.[71]

There is also generally a very strong emphasis on enabling people to live more independently at or closer to home. However, as the Kings Fund warns:

'Services outside of hospitals are also under strain – with growing pressures in general practice, district nursing, mental health, and adult social care. In this context, proposals in STPs to reduce capacity in acute hospitals will only be credible if there are coherent plans to provide alternatives in the community. This will require additional investment in these services.'[72]

Prevention

Prevention is consistently prioritised throughout the plans. All plans mention prevention and all but four include prevention in their vision, goals, priorities, approaches, principles or values. Prevention is drawn upon as a way to reduce each of the three gaps highlighted in the NHS Five Year Forward View: the health and wellbeing gap, care and quality gap, and funding and efficiency gap.

For the most part, plans emphasise the importance of examples of all three types of preventative interventions (primary, secondary and tertiary). Thirty-five out of 44 plans were

67 North West London (October 2016) Sustainability and Transformation Plan: Our plan for North West Londoners to be well and live well: healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/nwl_stp_october_submission_v01pub.pdf 67
68 The King's Fund (21 February 2017) Sustainability and transformation plans (STPs) explained: kingsfund.org.uk/topics/integrated-care/sustainability-transformation-plans-explained
69 National Audit Office (February 2017) Health and social care integration, Department of Health, Department for Communities and Local Government and NHS England nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf
70 ADASS (2017), ADASS BUDGET SURVEY 2017: adass.org.uk/media/5994/adass-budget-survey-report-2017.pdf
71 https://www.kingsfund.org.uk/press/press-releases/big-cuts-planned-public-health-budgets
72 https://www.kingsfund.org.uk/topics/integrated-care/sustainability-transformation-plans-explained

labelled 'very strong', meaning prevention is not only a key component of the plan, but the importance of lower-level/tertiary types of prevention are emphasised in addition to primary and secondary examples. Examples of all three types of prevention are also intended to be available before, during and after crisis point for a range of people, conditions and illnesses. The remaining were either labelled 'strong' or 'neither weak nor strong'.

The tertiary types of prevention mentioned range from short-term intensive support to help people get back on their feet after a stay in hospital, to support to self-care or self-manage long-term conditions in order to avoid further complications.

Primary and secondary examples typically include lifestyle interventions and health education, such as smoking cessation, initiatives to tackle obesity and alcoholism, and programmes to increase physical activity as well as ambitions to increase immunisation rates, screenings and, in particular, the early detection of cancer.

STPs often set out plans to better target people at-risk of developing needs or complications, such as older people. For example, **Coventry and Warwickshire's STP,** highlights a couple of targeted programmes in South Warwickshire, including an over 75s programme that seeks to develop holistic care plans and increase engagement in the at-risk over 75s population to 'identify needs earlier and avoid emergency admission'. They have also set up a hydration project that targets patients with catheters and promotes good hydration to prevent community visits and avoid further complications.[73]

However, overall, plans place more importance on primary and secondary types of prevention than tertiary types (those aimed at minimising deterioration and the loss of independence for people with established needs or preventing the reoccurrence of a health and social care crisis). This is partly reflected by the fact that 14 of the 18 plans that have adopted the triple definition in part are only using the language 'primary' and 'secondary'. **Some of these, however, seem to have conflated 'secondary' and 'tertiary' prevention into 'secondary prevention'.**

In other cases, examples of tertiary preventative interventions are mentioned but not under the umbrella of 'prevention'. Yet, with such a focus on prevention under both the NHS Five Year Forward View and the Care Act, recognising their preventative value is an important step to ensuring their provision.

Sharing a common language is also an important step to effectively working together to make prevention a reality. As noted by **Dorset**:

'Our two Health and Well-being Boards will be central to this work ['prevention at scale'] and are currently refreshing their Joint Health and Well-being Strategies to align with this plan... **They will provide a common framework and language so that all our partners from across health and social care, the voluntary sector and the independent sector, can understand how they can contribute to this work.'**[74]

The lesser importance placed on tertiary preventative interventions, echoes the NHS Five Year Forward View and more recent next steps document,[75] which, mainly focus on primary types of prevention (such as public health education) as well as secondary (such as health checks and flu vaccinations). In fact, tertiary types of prevention have received little explicit recognition at a national NHS level. The triple definition has also been largely overlooked by health, with neither the NHS Five Year Forward View nor its Next Steps document adopting this language in full. But it should be just as useful to the NHS as adult social care and public health, as it helps ensure people's needs don't escalate at any stage of their condition (before, during or after).

It is therefore pleasing that eight local plans have adopted the Care Act's triple definition of prevention fully. Take for example, **Lincolnshire's STP**, which commits to 'primary, secondary and tertiary prevention being integral to **all** of [their] clinical redesign programmes'.[76] The majority of the other plans give appropriate recognition to the importance of interventions aimed at minimising the effect of disability or deterioration for people with established or complex health conditions, as well as those that prevent the reoccurrence of a crisis. However they do not use the same triple definition.

73 Coventry & Warwickshire (December 2017) Sustainability & Transformation Plan: uhcw.nhs.uk/clientfiles/File/STP.PDF

74 Dorset, Our Dorset Sustainability and Transformation Plan for local health and care: dorsetccg.nhs.uk/Downloads/aboutus/Our%20Dorset%20STP/Our%20Dorset%20Substainability%20and%20Transformation%20Plan%2020%2004%2017.pdf

75 HS (March 2017) Next steps on the NHS Five Year Forward View: england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

76 Lincolnshire, Lincolnshire Sustainability and Transformation Plan: lincolnshirehealthandcaredotorg.files.wordpress.com/2017/07/stp-full-plan-20161212-web.pdf pg.9

With so many people already living with a long term condition,[77] as well as an ageing population, these types of preventative interventions are essential in ensuring as many people as possible can live as independently as possible.

Ensuring local plans prioritise prevention in its entirety is a first step towards shifting to a truly preventative health and care system. However, whether or not the vision for prevention set out in these plans will be achieved is yet to be seen. Plans do, however, commit to certain activities to help guide this process. These include but are not limited to: properly investing in prevention; working with the voluntary and community sector more; making better use of and investing in technology; looking beyond just health and care to the wider determinants of health, such as employment, housing and poverty; working with other parts of the system; aligning health and social care payment mechanisms and incentives; developing shared outcomes frameworks for prevention; pooling budgets; hiring prevention leads; and systematically writing prevention into contracts, service level agreements and business plans.

Recommendations:

- **Sustainability and transformation partnerships** should fully adopt the Care Act's triple definition of prevention into their plans in order to help ensure preventative interventions are prioritised across the life course and pathology of a condition or illness.
- **NHS England** should lead the way and incorporate the triple definition of prevention into the next iteration of the NHS Five Year Forward View. In the meantime, it should communicate the importance of tertiary as well as primary and secondary preventative interventions.
- **The Government** should review the resources needed to make the prevention vision set out in STPs a reality. New initiatives need new resources to avoid money being spent on plugging deficits rather than on transformation.

77 Department of Health (May 2015), 2010 to 2015 government policy: long term health conditions: gov.uk/government/publications/2010-to-2015-government-policy-long-term-health-conditions/2010-to-2015-government-policy-long-term-health-conditions

Voluntary and community sector

All STPs mention the voluntary sector, with almost all plans explicitly referring to the value the voluntary and community sector brings in improving the system, particularly with regard to prevention. For example, **Herefordshire and Worcestershire's STP**, recognises 'the depth of understanding that the [voluntary and community] sector can bring and the significant benefits of prevention' as well as its 'vital role in reducing demand on formal services such as unplanned hospital admissions for example through care navigation/bridging roles, peer support and group activities'. As such it commits 'to find[ing] ways to tap into the energy, enthusiasm and innovation of the VCS in a coordinated manner, including a simplification of the commissioning process to enhance the contribution that the VCS can make…'[78]

Some STPs, such as Northamptonshire's, noted the importance of investing in the [voluntary, community and social enterprise] sector in order to 'build VCSE capacity & capability to shift non-clinical & wider determinant activity out of primary & secondary care…'[79] As noted by **Shropshire and Telford and Wrekin**, the voluntary, along with the private and independent sector, are also 'feeling under pressure.'[80]

Likewise, the importance of non-clinical (or non-medical) interventions has been highlighted in several plans. Shropshire and Telford and Wrekin note: 'There is an increasing recognition that non-clinical approaches have a crucial part to play in supporting people in the community and that voluntary and community organisations have an important role.'[81]

Indeed, social prescribing was consistently cited as a way to improve a population's health and wellbeing. **South Yorkshire and Bassetlaw** want to build on a successful social prescribing service for people with long-term conditions in Rotherham that 'targets the top 5% of patients at risk of hospitalisation using a process that helps to identify those most at risk of a hospital admission and the judgement of their

78 Herefordshire and Worcestershire (November 2016), Draft Sustainability and Transformation Plan: hacw.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=120702

79 Northamptonshire (October 2016) Northamptonshire's Sustainability and Transformation Plan (STP) for the Health and Social Care system through to March 2021: neneccg.nhs.uk/resources/uploads/STP_Submission_Final_Draft_071216.pdf

80 Shropshire and Telford & Wrekin (October 2016) Sustainability and Transformation Plan: sath.nhs.uk/wp-content/uploads/2016/11/Shropshire-and-Telford-Wrekin-STP-Full.pdf

81 Shropshire and Telford & Wrekin (October 2016) Sustainability and Transformation Plan: sath.nhs.uk/wp-content/uploads/2016/11/Shropshire-and-Telford-Wrekin-STP-Full.pdf

GP.' As part of this, 'non-medical interventions have been identified for over 5000 patients with significant success, saving money and improving outcomes.'[82]

Recommendation:

> **Sustainability and transformation partnerships** yet to do so, should explore the potential added value of non-clinical interventions and personnel.

How are health and wellbeing boards planning to prevent, reduce and delay the need for care?

Joint health and wellbeing strategy labels:

All 151[83] health and wellbeing boards' joint health and wellbeing strategies were read and labelled accordingly:

- Very strong: 61 (40 per cent)
- Strong: 34 (23 per cent)
- Neither strong or weak: 50 (33 per cent)
- Weak: 5 (3 per cent)
- Very weak: 1

- Prevention is mentioned in all joint health and wellbeing strategies.
- In total, 125 strategies include prevention in their vision, goals, priorities, approaches, principles or values.
- It's the 'primary approach/principle/value' of 11 strategies and listed as an 'approach/principle/value' in another 45 (a decrease of 21 since last year).
- Fifty-six strategies mention prevention within their 'priorities', five in their 'goals' and eight in their 'visions'. This has slightly increased.
- Of the 121 that had some sort of summary (an executive summary/foreword/ plan on a page or separate summary strategy), 84 (69 per cent) mention prevention. This is similar to last year.
- Only 17 joint health and wellbeing strategies use the full triple definition of prevention.
- Some strategies have not been updated since 2014 or 2013 and only around a quarter (41) mention the Care Act (or Care Bill) and just 10 mentioned the NHS Five Year Forward View.

An overview

Our 2016 review of joint health and wellbeing strategies saw an improvement in the understanding and prioritisation of prevention from the previous two years. Yet, prevention is understood and prioritised similarly to last year. Each of our measures has seen slight increases and decreases since last year's review. The number of strategies labelled 'very strong' has increased slightly by two per cent. Likewise, the number of strategies labelled 'weak' or 'very weak' has decreased from eight to six. And, while the number of those that include prevention in their vision, goals, priorities or summary has increased slightly, the number of those that include prevention in their approaches, principles or values has decreased by 15 per cent.

This stagnation could be due to the previous several years' particularly strong national push for prevention, which has quietened down a little over the last year. These included, the Care Act (2014) coming into force, the transfer of public health responsibilities to local government and Public Health England, the NHS Five Year Forward View, and the Better Care Fund.

There's still a way to go. Around a third (56) of the 151 strategies have been labelled 'neither strong nor weak', 'weak' or 'very weak', meaning 37 per cent still do not incorporate a full understanding of prevention or emphasise the importance of taking a preventative approach. Many of these strategies understand prevention only as minimising the risk of people developing care and support needs (primary prevention), or as targeting people at high risk of developing needs (secondary prevention).

82 South Yorkshire and Bassetlaw , Health and care in South Yorkshire and Bassetlaw: Sustainability and Transformation Plan: smybndccgs.nhs.uk/application/files/1514/8037/0832/South_Yorkshire_and_Bassetlaw_Sustainability_and_Transformation_Plan.pdf

83 While there are 152 local authorities with responsibility for adult social care, Bournemouth and Poole share a Health and Wellbeing Board.

Recommendation:

> **Health and wellbeing boards** should *fully* incorporate and prioritise prevention in their joint health and wellbeing strategies. A well-rounded understanding of prevention should be clearly emphasised throughout the strategy and across the life course and pathology of a range of conditions or illnesses mentioned.

The Care Act, NHS Five Year Forward View and Better Care Fund

Some strategies have not been updated since 2014 and only around a quarter (41) mention the Care Act (or Care Bill) despite it being 'the most significant reform of care and support in more than 60 years.'[84]

Only nine of the 41 that mention the Care Act (or Care Bill) explicitly refer to the prevention duty (Section 2 of the Care Act). However, others mention the Care Act putting greater responsibilities on local authorities, including 'an increased focus on prevention'.

Of the 41 strategies that mention the Care Act (or Care Bill), 35 (88 per cent) were labelled 'very strong' or 'strong'. This indicates that the Care Act (when engaged with properly) has likely had a positive influence on the prioritisation and understanding of prevention.

Thirty-nine, in comparison to just ten last year, mention the NHS Five Year Forward View. The increase in the number of strategies that explicitly recognise the relevance of this national plan may be due to the fact that sustainability and transformation plans, developed over the course of the last year, set out plans to take this national strategy forward at a local level. This is, of course, in addition to an ever-increasing push for health and social care integration.

Sixty-seven per cent (26) of the strategies that mention the NHS Five Year Forward View were labelled 'very strong' or 'strong'. This is similar to the overall stat of 63 per cent. As such, there is no obvious correlation between engaging with it and a high-rating label. Perhaps this is because the Forward View fails to emphasise the importance of tertiary preventative interventions in the same way it emphasises primary and secondary.

Fifty-four strategies mention the Better Care Fund in comparison to just 37 the year before and six the year before last. This could be because Better Care Fund plans have also further developed over the course of the year.

Recommendation:

> **Health and wellbeing boards** should update their joint health and wellbeing strategies regularly so that they include key policy and practice developments.

The triple definition of prevention

While two-thirds of the strategies have been labelled 'very strong' or 'strong', **only 17 joint health and wellbeing strategies use the full triple definition of prevention (either primary, secondary, tertiary/prevent, reduce, delay/both terminologies). This is a slight increase from only 12 the year before but there is still a long way to go.**

A further 68, up from 46 last year, use this terminology in part. For example, only talking about 'delaying and reducing the need for care and support'. In other cases, only the terms 'primary' or 'secondary prevention' are mentioned.

Confusion as to what constitutes primary, secondary or tertiary prevention was evident in some of the strategies. Some strategies appear to conflate 'secondary' and 'tertiary' prevention into 'secondary prevention'.

The British Red Cross does not want the sector to be diverted by discussions about which interventions sit where, so long as preventative interventions are being adopted before, during and after a health and social care crisis. Indeed, there is no hard and fast rule as to where each preventative intervention sits. As the statutory guidance explains, 'services can cut across any or all of these three general approaches'.[85] **However, using the triple definition of prevention is a useful way**

84 Care and Support Minister, The Rt Hon Norman Lamb (15 May 2014).
85 Department of Health (August 2017) Care and Support Statutory Guidance, Chapter 2 (2.5

to ensure preventative interventions are being adopted across the life course and the pathology of a condition or illness.

Bournemouth and Poole's strategy makes the case for implementing prevention at scale, noting that closing the health and wellbeing gap 'will require a sustained focus on prevention over many years, at sufficient scale and reach, to really make a difference.' It also clearly defines 'prevention at scale' as encompassing all three types of prevention:

'By "prevention at scale" we mean that we must take a comprehensive approach, including the wider determinants of health and wellbeing, and including activity at primary, secondary and tertiary levels of prevention and at every stage in life.'[86]

Some health and wellbeing boards have used their own terminology. In some cases the terms applied cover all three types of prevention, but in many cases do not. For example, sometimes tertiary prevention is captured solely as 'reablement', 'self-care', 'specialist' or 'long term care'. However, tertiary prevention is more than just reablement or 'self-care' and applies to more than those with long term or specialist needs. They should encompass all those interventions aimed at minimising deterioration and the loss of independence for people with established needs or those that seek to prevent the reoccurrence of a health and social care crisis.

Various strategies also include a definition or explanation as to what is meant by 'wellbeing'. These definitions vary despite 'wellbeing' being defined under Section 1(2) of the Care Act.

Recommendations:

- **Health and wellbeing boards** should incorporate the Care Act's triple definition of prevention into their joint health and wellbeing strategies.
- **Health and wellbeing boards** are encouraged to look to define 'wellbeing' using the Care Act's definition set out in Section 1 of the Care Act.[87]

Minimising the loss of independence for those with existing needs

The importance of primary and secondary preventative interventions is still emphasised much more than tertiary types of preventative interventions.

And in some cases it's not clear this third type of prevention is recognised at all.

In some cases, lower-level tertiary preventative interventions are mentioned (for example, reablement/care in the home/support to self-manage/home adaptations/ assistive technologies/ respite for carers etc.) but aren't recognised as preventative. **Recognising their preventative value is an important step to ensuring their provision.** Under Section 2 of the Care Act, local authorities must ensure the provision of preventative services. And under Section 9(6)(b) they must assess whether people who do not meet the national eligibility threshold would benefit from such services.

Tertiary types of preventative service are sometimes only referred to in the context of mental health, long term conditions or older people. While many strategies set out a life-course approach, prevention and early intervention are often only emphasised at the beginning or end of that course. They also tend to mention tertiary preventative services towards the latter stages of life. However, as **Warrington's** strategy notes a 'preventative approach needs to be focussed on enabling people to maintain their independence and enabling them to regain it at any age'.[88]

Recommendations:

- **Health and wellbeing boards** should prioritise and emphasise all three types of prevention across the life course.
- **Health and wellbeing boards** should pay special attention to explicitly recognising the value of tertiary prevention interventions.

86 Bournemouth and Poole (September 2016) Health & Wellbeing Strategy Refresh 2016 – 2019: bournemouth.gov.uk/councildemocratic/AboutYourCouncil/AboutYourCouncilDocs/BPHWB/BPJHWS.pdf

87 Care Act 2014, Section 1(2): legislation.gov.uk/ukpga/2014/23/section/1/enacted

88 Warrington Health and Wellbeing Board, Warrington Health and Wellbeing Strategy 2015 – 18: warringtontogether.co.uk/media/1017/health-and-wellbeing-2015-18-low-res.pdf

What do local authorities say they are doing to ensure preventative services?

We received responses to 148 out of 152 Freedom of Information (FOI) requests. The responses varied in detail as well as content.

An overview

Local authorities have responded to Section 2 of the Care Act in a range of ways, including developing or investing in new services that prevent, reduce or delay, enhancing or expanding existing preventative services and changing their approaches to commissioning.

Despite financial pressures, some have allocated new funds or looked for ways to increase the number of people accessing preventative services by, for example, not charging for them. **The importance of shifting towards prevention is undoubtedly recognised by most local authorities, with some noting it to be 'at the core of their transformation programmes'.**

However, the overall impression was that local authorities' responses demonstrate a mixed level of understanding about the new prevention duties, as well as ambition. There has been clear progression since the last series of FOI responses we received towards the end of 2015, with, in many cases, a clear shift from planning to implementation.

Almost a half of the FOI responses mentioned 'the development or investment in new services'. Nevertheless, innovative developments have been patchy and for the most part have not been as ground breaking as we had hoped. This is despite the Care Act 'embracing innovation and flexibility, unlike previous legislation that focussed primarily on traditional models of residential and domiciliary care'.[89]

Responses to question one

What actions your council has taken to comply with Clause [Section] 2 of the Care Act 2014 ('Preventing needs for Care and Support').

Similar themes to our 2016 research were identified within the responses to question one. These included: working with the voluntary and community sector; working across departments; integrating with health; developing or investing in new services; the expansion or enhancement of existing services; reviewing services; revised guidance or training; the creation of new boards, roles, teams, programmes, strategies, plans, policies or priorities; revised procedures; implementing new approaches; identifying needs and services, funds, information and advice.

Various other themes mentioned in responses to question one that may enable local authorities to carry out their new prevention responsibilities, but are not necessarily results in themselves, are listed in appendix three.

New services and the expansion or enhancement of existing ones

Almost half of the FOI responses mentioned 'the development or investment in new services'. This was the most recurrent theme within responses to question one. Over 80 different services were mentioned, including but not limited to:

- telecare alarm systems;
- sensors for bed and chair occupancy
- temperature and falls detection
- care navigation for people with both non-eligible and eligible needs
- home adaptations
- integrated community equipment
- training in food hygiene and first aid
- domiciliary care
- home from hospital

89 LGA (August 2015) Guide to the Care Act 2014 and the implications for providers: local.gov.uk/documents/10180/6869714/L14-759+Guide+to+the+Care+Act.pdf/d6f0e84c-1a58-4eaf-ac34-a730f743818d

- advocacy
- debt management
- active walking
- cooking and singing
- proactive falls prevention
- community-based transport
- good neighbour schemes
- and befriending services.

Several local authorities wrote about being more proactive by investing in initiatives that seek people at-risk of falling into health and social care crisis. For example, **Lewisham's** Community Falls pathway has being redesigned to prevent the numbers of falls and fall-related injuries for people over 65 by establishing a community-based falls team. As explained within their FOI, 'The Community Falls Team will utilise a screening tool to better identify people at risk and will provide proactive outreach into the community, primary care and care homes. Physical activity programmes for people who have fallen or who are at risk of falls.'

A couple of FOI responses also drew on initiatives that seek to identify and then support people at imminent risk of being admitted to hospital in order to prevent this from happening. Others spoke about partnerships with fire brigades to support the prevention agenda by carrying out 'safe and well checks' as part of their own safety checks when visiting local people.

A fifth of all responses mentioned developing and investing in services specifically for carers. The Care Act's prevention duty applies to all adults, including carers. As per section 2.3 of the Care and Support Statutory Guidance, this should include 'those who may be about to take on a caring role or who do not currently have any needs for support, and those with needs for support which may not be being met by the local authority or other organisation.'

Most of these responses were vague with regard to what these services look like, stating 'support for carers'. However, more specific examples included: awareness raising among local employers and providing them with access to a range of initiatives to help them support carers; 'Carers' Cards' that provide access to discounts and offers on health and wellbeing activities; sitting services; a rapid response service that supports cared-for people in the event of unforeseen unavailability of carers in an emergency; support line services; befriending; and peer support. Seed funding being made available directly to carers to develop their own support groups was also mentioned.

Earl Howe made clear that Section 2 of the Care Act was intended to encourage innovation:

"We want local authorities to be truly innovative in the services offered in their area."[90]

Last year, we were disappointed that the 'new' services identified were not particularly innovative.[91] **This year, however, we were pleased to read about some innovative, lower-level preventative interventions (including some of those mentioned above).** Despite the cuts local authorities have faced over the last several years they clearly recognise the importance of continuing to invest in services that prevent, reduce or delay the need for care and support.

Nevertheless, these new, innovative services rarely seem to be available at-scale. Rather, they are often described as available solely for one particular group of people, for example, older people or people with a particular condition or illness. They are also sometimes only available in one part of the local authority's area. **Indeed, such examples are still far and few between.**

Local authorities also wrote about having 'expanded or enhanced existing services' in light of the prevention duty. This ranged from redesigning services so that they are more preventative to improving their accessibility. Similar to last year, reablement was included under this theme. For example, extending the reablement offer to support not only people discharged from hospital but also people in the community who would benefit from a period of reablement. Other examples of services that have typically been extended or expanded include handyperson schemes, occupational therapy, falls prevention, assistive technology, and information and advice.

90 Earl Howe, The Parliamentary Under-Secretary of State at the Department of Health (3 July 2013): publications.parliament.uk/pa/ld201314/ldhansrd/text/130703-0003.htm

91 For example, telecare and handyperson services were referred to in various responses. While they both have clear preventative value, they should not be new to local authorities. In April 2006, the government invested £80 million into the Preventative Technology Grant that focussed on increasing the numbers of people able to remain independent with telecare. Similarly, the Department for Communities and Local Government introduced a handypersons grant in 2009/10 allocating approximately £13 million in 2009/10 and £17 million in 2010/11 to English local authorities.

Several local authorities described opening up services to new cohorts of people and making them available prior to a full social care assessment. Others describe opening up services to anybody who makes a request. For example, **Doncaster** created a 'wellbeing' service open to 'anyone who would wish to receive informal, low level support on any grounds that would benefit them, covering from minor home adaptations to finance advice and engaging with communities.'

Recommendations:

- **The Department of Health, Department for Communities and Local Government, Local Government Association and the Association of Directors of Adult Social Services** should work together to review 'opportunities for shared learning' to help local authorities be 'truly innovative in the services offered in their area.'[92]
- **Despite budget constraints, local authorities should continue to look for ways to invest in 'a broad range of (preventative) interventions, as one size will not fit all.'[93]**

Information and advice

The second most commonly recurrent theme within responses to question one was 'information and advice'.

The prevalence of information and advice within the FOI responses is not so surprising. The sixth Care Act stocktake found that '81 per cent of councils report that their arrangement for the provision of information and advice are effective, with the remainder developing but not yet fully effective.' The provision of information and advice was also reported to have made the largest positive difference to practice and culture within the local authority.[94]

Despite this, however, a Think Local Act Personal (TLAP) survey completed by 1,181 people aged 18 and over in September 2016, found that less than a quarter of people who had looked for information in the last year said it was easy to find and just over half found it 'quite' or 'very' difficult to find. It also found that accessing information and advice was harder for those that don't receive any support. Sixty-seven per cent of respondents who didn't receive any support reported finding it hard to access as opposed to 32 per cent of those that were receiving support.[95]

The information and advice referred to was focussed on a range of issues, primarily available services but also new policies and new rights. Local authorities report providing information and advice in a variety of ways (including booklets, written fact sheets, newsletters and videos), but primarily via 'universal' websites, that have sometimes been complemented by a self-assessment tool, and improved directories for health and care professionals to offer information and advice both face-to-face, particularly for those making assessments, and via the telephone (often the local authority's first point of call centre).

Last year we concluded that, in some cases, Section 2 ('preventing needs for care and support') and Section 4 ('information and advice') of the Care Act were being conflated. With some responses to question one only touching on new or improved information and advice services this year, it seems this conflation still sometimes applies.

Information and advice is recognised within the Care and Support Statutory Guidance as a 'vital component of preventing or delaying people's need for care and support.'[96] **However, while good quality information and advice may be necessary for effective prevention, providing information and advice is not sufficient to fulfil the prevention duty.**

As chapter two of the Care and Support Statutory Guidance makes clear, Section 2 of the Care Act is about ensuring the provision of a range of services that prevent, reduce or delay the need for care and support.

The information and advice developments referred to within responses often centre upon use of the internet. **However, it is important to remember the discrepancy between younger and older generations' use of the internet.** For example, the ONS Quarterly Internet Access Update in 2014

92 Earl Howe, The Parliamentary Under-Secretary of State at the Department of Health (3 July 2013): publications.parliament.uk/pa/ld201314/ldhansrd/text/130703-0003.htm
93 Department of Health (August 2017), Care and Support Statutory Guidance, Chapter 2 (2.42)
94 LGA (November 2016), Care Act Implementation: Results of Local Authority Stocktake 6: local.gov.uk/sites/default/files/documents/results-local-authority-s-ecd.pdf
95 TLAP (June 2017) Care Act 2014 survey results: Exploring the impact of the Care Act on the lives of people with care and support needs: thinklocalactpersonal.org.uk/_assets/Resources/TLAP/CareActSurveyResults-002.pdf
96 Department of Health (October 2014) Care and Support Statutory Guidance, Chapter 3 (3.1)

found that while only one per cent of 16 to 24 year olds had never used the internet, 63 per cent of the over 75s had never been online. Section 4 of the Care Act is clear that information and advice must be 'accessible to, and proportionate to the needs of, those to whom it is being provided.'[97]

Nevertheless, local authorities also highlighted other means of providing better information and advice. **Derby** told us, for example, about their community-led support approach, 'Talking Points'. This initiative provides the opportunity for local people to have a conversation with social care at an earlier stage by offering drop in sessions in their local area for people requiring information and advice on social care issues.

In some cases local authorities have acknowledged the value of ensuring the information and advice provided is meeting people's needs. For example, **Shropshire** informed us that up to 80 per cent of people who contact their first point of contact centre are provided with information and advice that enables them to obtain the informal support to meet their needs in their local community. They know this by providing a ring back service after two weeks to ensure that the information and support that has been provided met people's needs.

Importantly, Shropshire also made clear that they make individuals aware they are entitled to a full assessment of their needs under the Care Act. Under the Care Act, 'local authorities must undertake an assessment for any adult with an appearance of need for care and support, regardless of whether or not the local authority thinks the individual has eligible needs or of their financial situation.'[98]

Recommendations:

- **Local authorities** should clearly distinguish between their separate duties to provide information and advice and to provide preventative services within their local plans and strategies.
- **Local authorities** must be mindful that many adults and older people do not have the basic skills to use the internet.

Investing in prevention

Freedom of Information (FOI) responses, joint health and wellbeing strategies, and sustainability and transformation plans explicitly recognise resources need to be shifted from reactive to preventative spend. However, there is demonstrated uncertainty about how to go about doing this.

Several FOI responses mentioned utilising funding from the Better Care Fund to enable people to live independently. Others have created prevention-focussed funds, budgets or grants for individuals and community groups to develop community-led prevention and self-care support offers. Others intend to gradually shift resources from reactive to preventative spend.

The Southwark and Lambeth Early Action Commission (set up to find local ways of taking early action and preventing problems) noted in its final report:

'The only way to ensure a significant move towards early action is to commit to an incremental funding shift.'[99]

As a precursor to doing this, it recommends 'classifying spending' to distinguish reactive from preventative spend. Knowing whether money is being spent on preventing or coping with problems 'makes it possible to plan and scrutinise the transition to early action and to understand the trade-offs between prevention and downstream services.'[100] The triple definition of prevention can be a useful tool in doing this.

The Local Government Information Unit (LGiU) recognised that one of the biggest barriers to prevention is indeed 'a lack of clarity around what constitutes preventative activity, how this links to outcomes and how much money councils spend on it overall.'[101] In partnership with the British Red Cross and Mears, they therefore piloted an approach to mapping preventative spend against one of Camden council's key outcomes. At the end of the pilot, LGiU published a toolkit for other local authorities to do the same.[102]

97 Care Act 2014, Section 4: legislation.gov.uk/ukpga/2014/23/section/2/enacted
98 Department of Health (August 2017) Care and Support Statutory Guidance, Chapter 6 (6.13)
99 NEF, Southwark & Lambeth Early Action Commission (November 2015) Local early action: how to make it happen: b.3cdn.net/nefoundation/a5845188d1801a18bc_3nm6bkn3b.pdf
100 NEF, Southwark & Lambeth Early Action Commission (November 2015) Local early action: how to make it happen:b.3cdn.net/nefoundation/a5845188d1801a18bc_3nm6bkn3b.pdf
101 LGiU (October 2013), Tracking your preventative spend: a step-by-step guide: lgiu.org.uk/2013/10/16/tracking-your-preventative-spend-a-step-by-step-guide/
102 LGiU (October 2013), Tracking your preventative spend: a step-by-step guide: lgiu.org.uk/2013/10/16/tracking-your-preventative-spend-a-step-by-step-guide/

Recommendations:

- **Local authorities** should commit to shifting a percentage of their resources towards prevention. In doing so, they may find the recommendations set out in the Southwark and Lambeth's Early Action Commission's report, 'Local early action: how to make it happen', useful.[103]
- **Local authorities** can use LGiU's toolkit to track and better understand their preventative spend.[104]

An asset-based/strengths-based approach

Several FOI responses, as well as joint health and wellbeing strategies and sustainability and transformation plans, mention moving towards 'an asset-based approach'.

The terms 'strengths-based approach' and 'asset-based approach' are often used interchangeably. The Care and Support Statutory Guidance uses the terminology 'strengths-based approach' and instructs local authorities to 'consider what else other than the provision of care and support might assist the person in meeting the outcomes they want to achieve' when carrying out assessments. In doing so, 'authorities should consider the person's own strengths and capabilities, and what support might be available from their wider support network or within the community to help.'[105]

This approach should be centered on the individual, co-production[106] and maximising independence. **It must not be seen as a default alternative to statutory services.** Most importantly, family and friends should not be expected, and must not be pressured, to take on caring responsibilities. The guidance notes:

103 NEF, Southwark & Lambeth Early Action Commission (November 2015) Local early action: how to make it happen: b.3cdn.net/nefoundation/a5845188d1801a18bc_3nm6bkn3b.pdf
104 LGiU (October 2013), Tracking your preventative spend: a step-by-step guide: lgiu.org.uk/2013/10/16/tracking-your-preventative-spend-a-step-by-step-guide/
105 Department of Health (August 2017), Care and Support Statutory Guidance, Chapter 6 (6.63)
106 '"Co-production" is when an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered. Such interventions can contribute to developing individual resilience and help promote self reliance and independence, as well as ensuring that services reflect what the people who use them want.' (Department of Health (August 2017), Care and Support Statutory Guidance, Chapter 2 (2.20))

'Any suggestion that support could be available from family and friends should be considered in light of their appropriateness, willingness and ability to provide any additional support and the impact on them of doing so. It must also be based on the agreement of the adult or carer in question.'[107]

A strengths-based approach should also recognise the value of the voluntary sector and community groups. **Local authorities recognise this: the importance of working with the voluntary and community sector was highlighted in numerous responses to question one.**

As reflected in the FOI responses, local authorities are increasingly looking to the voluntary sector and community groups to carry out a variety of functions, from promoting wellbeing to providing lower-level preventative support to those whose needs don't meet the eligibility threshold.

Charging

The Care Act regulations prohibit local authorities from charging for intermediate care (including reablement) provided for up to six weeks, and minor aids and adaptations up to the value of £1,000.

While the Care and Support (Preventing Needs for Care and Support) Regulations 2014[108] allow local authorities to charge for certain preventative services, facilities or resources, the guidance warns of the risks this may have on uptake:

'Where a local authority chooses to charge for a particular service, it should consider how to balance the affordability and viability of the activity with the likely impact that charging may have on uptake.'[109]

Several local authorities have carried our charging policy consultations and decided not to exercise these charging powers – at least in certain circumstances.

Technology could play a huge role in prevention.

For example, the UK's national weather service, 'Healthy Outlook', is helping people with chronic obstructive pulmonary disease (COPD) to self-manage their illness by sending warning texts about local weather conditions and providing simple health advice. While the evidence base is still emerging, the alerts should prove useful 'given that extreme temperatures, humidity and/or viruses in the air can aggravate the ill health of people who have COPD and increase hospital admissions.'[110] Similarly, a mobile phone-based malaria case reporting pilot in Botswana has 'improved the accuracy, timeliness and geographic pinpointing of confirmed malaria cases.'[111] This has proved to be a 'critical' element of its elimination programme.

107 Department of Health (August 2017), Care and Support Statutory Guidance, Chapter 6 (6.4)
108 The Care and Support (Preventing Needs for Care and Support) Regulations 2014, Regulation 4(a): legislation.gov.uk/uksi/2014/2673/pdfs/uksi_20142673_en.pdf
109 Department of Health (August 2017), Care and Support Statutory Guidance, Chapter 2 (2.56)
110 Phil Hope with Sally-Marie Bamford, Stephen Beales, Kieran Brett, Dr Dylan Kneale, Michael Macdonnell and Andy McKeon (Report of the Ageing Societies Working Group 2012), Creating Sustainable Health and Care Systems in Ageing Societies, Case Study 10
111 Malaria Journal (October 2012), Toward malaria elimination in Botswana: a pilot study to improve malaria diagnosis and surveillance using mobile technology: malariajournal.com/content/11/S1/P96

Working with partners to prevent, reduce and delay

The importance of working with the voluntary and community sector as well as with other bodies (such as the NHS, police and businesses) or departments (from housing to education) as a way to prevent, reduce and delay the need for care and support was highlighted in around a third of responses to question one.

This aligns with the Care and Support Guidance that notes:

"Preventing needs will often be most effective when action is undertaken at a local level, with different organisations working together to understand how the actions of each may impact on the other."[112]

Local authorities have also started to move beyond joint working to integration, as explored earlier on under the section on integration. Numerous responses to question one noted the particular importance of health and social care integration with regard to successful prevention, with some noting that 'a strategic shift to prevention requires a 'whole system' approach – this is not just about health and social care.'

Several local authorities within **Greater Manchester** touched on their devolution deal, which has given the region control over an integrated health and social care budget of over £6 billion. As noted by **Oldham**: 'We are developing relationships across this economy to deliver a single, integrated approach to prevention as part of a wider, more ambitious approach to co-ordinating agencies that together can most effectively help prevent, reduce or delay the development of care and support needs for individuals.'

The devolution of integrated health and social care budgets provides a real opportunity to properly invest in prevention. This is partly because both local authorities and the NHS would benefit financially from doing so. As noted by the Local Government Association:

'It is (also) difficult for local authorities to build a business case to invest their scarce resources in initiatives where the financial benefits accrue to other agencies such as the NHS or the benefits system...'[113]

At the same time, integration should eradicate the sometimes false distinction between people's 'health' and 'social care' needs. Distinguishing between such needs all too often results in no statutory agency taking responsibility for the person or service in question. As a result, we see too many people are falling through the gaps and too many people's needs escalating when they needn't be.

The provision of short-term wheelchair loans is just one example of this. There is currently no clearly defined duty for their statutory provision in England despite being included as an example of secondary prevention in the Care Act's statutory guidance.[114] Research demonstrates that they can prevent and delay people's need for health, social care and support, and reduce the level of need that already exists.[115] This is largely because of the false distinction between clinical and social needs for short-term wheelchairs resulting in a disagreement as to where the responsibility should sit.

Recommendation:

- **Devolved areas** should seize the opportunity to eradicate the false distinction between people's clinical and social needs, and to return prevention savings to a single integrated budget.
- **Local leaders** should ensure prevention (in all its forms) is a key aspect of all health and social care devolution deals going forward.

112 Department of Health (August 2017), Care and Support Statutory Guidance, Chapter 2 (2.32)
113 LGA (September 2015), Prevention: A shared commitment: local.gov.uk/documents/10180/6869714/Prevention+-+A+Shared+Commitment+(1).pdf/06530655-1a4e-495b-b512-c3cbef5654a6
114 Department of Health (August 2017), Care and Support Statutory Guidance, Chapter 2 (2.8)
115 McNulty, Carter and Beswick (July 2015), Putting the wheels in motion: Assessing the value of British Red Cross short-term wheelchair loan: British Red Cross redcross.org.uk/~/media/BritishRedCross/Documents/About%20us/BRC%20Wheels%20in%20Motion%20-%20July%202015.pdf

Have local authorities developed a local approach to prevention?

As per Section 2.23 of the Care and Support Statutory Guidance ('Developing a local approach to preventative support'), local authorities should have developed a local approach to prevention.[116] A hundred and four local authorities (up from 88 last year) confirmed they have developed a local approach to prevention. Thirty-one marked they are in the process of doing so and one confirmed they have not developed such an approach.

Ninety-five (over 90 per cent) of the 104 local authorities that have developed an approach to prevention clearly specify and include a range of examples of all three types of prevention. Notably, this has doubled since last year. It seems progress is being made, albeit slowly.

Over two years since the Care Act came into force we would have expected all local authorities to have developed and implemented a local approach to prevention.

Have local authorities developed a commissioning strategy for prevention?

Disappointingly, only around 40 per cent (57) of local authorities confirmed they have developed a commissioning strategy for prevention as per Section 2.24[117] of the statutory guidance and a further 49 are in the process of doing so.

Almost a fifth (30) have not developed a commissioning strategy for prevention, some of whom explained they have instead refreshed existing commissioning strategies to capture prevention or developed new ones that are not specific to prevention.

Twenty-seven local authorities confirmed their commissioning strategies (either old, new, specific to prevention, or general) do not specify and include a range of examples for all three types of prevention.

Recommendations:

- **Those local authorities** yet to do so should develop a local approach to prevention. This approach should clearly specify and include a range of examples of all three types of prevention set out in chapter two of the current Care and Support Statutory Guidance ('Preventing, reducing or delaying needs').
- **Those local authorities yet to do so** should develop a commissioning strategy for prevention or at least update their existing commissioning strategies to reflect the changes made through the Care Act. These should clearly specify and include a range of examples of all three types of prevention.

Have local authorities identified services, facilities and resources that prevent, reduce or delay needs?

Findings

- Seventy-nine per cent (117) of the 148 of those that responded confirmed they have already identified services, facilities and resources available in their area, which could support to prevent, reduce or delay needs.
- Thirteen per cent (19) are in the process of doing so identifying such services.
- The remaining 12 either responded that they had not gone about identifying preventative services or didn't answer the question.

Section 2.26 of the Care and Support Statutory Guidance ('Developing a local approach to preventative support') notes 'the importance of identifying the services, facilities and resources that are already available in their area, which could support people to prevent, reduce or delay needs.' This exercise helps local authorities understand the breadth of available local resources as well as any gaps, which should in turn, 'form part of the overall local approach to preventative activity', including what 'further steps it should itself take to promote the market or to put in place its own services'.[118] **Despite this, not all English local authorities have identified such services.**

116 According to this Section, 'local authorities should develop a clear, local approach to prevention which sets out how they plan to fulfil this responsibility, taking into account the different types and focus of preventative support…'

117 According to this Section, 'a local authority's commissioning strategy for prevention should consider the different commissioning routes available, and the benefits presented by each.'

118 Department of Health (August 2017), Care and Support Statutory Guidance, Chapter 2 (2.26)

Several local authorities further emphasised the importance of doing this, noting that having an up-to-date directory was essential in moving towards having a single point of access as well as for social prescribing.

Others have gone on to invest in specific preventative services they identified as missing. Most have compiled this information onto databases for internal use or for providers and social care assessors, with others having made, or intending to make, the information available publically, either via their websites, apps, noticeboards, flyers, factsheets or interactive resource maps. Some local authorities have used, or intend to use, these publically available directories for supported self-assessment tools.

While some local authorities reported identifying both commissioned and non-commissioned services, others only reported creating a directory of commissioned services. This is despite the Care and Support Statutory Guidance instructing local authorities to look further than council, or CCG-funded services:

'Where the local authority does not provide such types of preventative support itself, it should have mechanisms in place for identifying existing and new services, maintaining contact with providers over time, and helping people to access them. **Local approaches to prevention should be built on the resources of the local community, including local support networks and facilities provided by other partners and voluntary organisations.'**[119]

Others seem to have only focused on identifying preventative services for particular groups, usually older people. **It is important to remember, however, that local authority's responsibilities for prevention apply to *all* adults.**

Some local authorities reflected how time-intensive identifying services beyond those directly commissioned by the local authority as well as for all adults, including carers, adults with no needs at all as well as adults both with and without eligible needs, can be. **Importantly, the need to continually identify services and update their directories was highlighted in numerous responses.**

How have local authorities identified these services, facilities and resources?

Local authorities report identifying preventative services in a range of ways.

The following three steps have often been taken:

1. allocating responsibility, by, for example, hiring officers with a specific remit to look for new services and keep directories up-to-date
2. stakeholder engagement, with many noting the importance of on-going engagement with community and existing providers and groups
3. gathering information by, for example, consultations, workshops, mapping prevention exercises, online sharing forums and so on.

For more details on these three steps, please see appendix four.

Recommendations:

- **Those local authorities yet to do** so should identify services, facilities and resources in their area that prevent, reduce or delay needs. This should form part of their overall local approach to prevention.
- As part of this, **local authorities** should identify, as far as possible, both commissioned and non-commissioned services, facilities and resources that prevent, reduce and delay needs. This should cover services, facilities and resources for people who do not have any current needs for care and support, adults with needs for care and support, whether their needs are eligible and/or met by the local authority or not, as well as for carers.

Have local authorities identified unmet need?

Findings

- Forty-nine per cent (73) have identified unmet need.
- Forty-one per cent (60) are in the process of doing so.

119 Department of Health (August 2017), Care and Support Statutory Guidance, Chapter 2 (2.27)

- Five confirmed they have not done so.
- The remaining did not answer the question.

As per section 2.30 of the Care and Support Statutory Guidance 'local authorities must consider how to identify 'unmet need' - for example, those people with needs which are not currently being met, whether by the local authority or anyone else.' This is again considered 'crucial to developing a longer-term approach to prevention that reflects the true needs of the local population.' **Despite this, only about half of all English local authorities confirmed they have done this.**

While several of the 60 local authorities that responded, 'the council is in the process of doing so' rightly noted this was because identifying such need is an ongoing process, it seems the others have not yet considered exactly how they will go about this, or have not yet implemented their relevant plans.

How have local authorities identified unmet need?

Ninety-two local authorities fed back how they have identified, or are in the process of identifying 'unmet need' as per section 2.30 of the Care and Support Statutory Guidance ('Developing a local approach to preventative support'). This responsibility has been carried out in a range of ways. These include primary research, drawing on local and national data, and working in partnership. For more detail please see appendix five.

Recommendations:

- **Those local authorities yet to do so** should identify unmet need in their areas. This identification should form part of their overall local approach to prevention.
- As part of this, **local authorities** should identify not only needs not being met by themselves but by anyone else.

Examples of unmet need

Some of the responses gave examples of the types as well as specific groups of people with unmet needs that they have identified in their area. The most commonly cited examples include people who are socially isolated, people being discharged from hospital, as well as people with non-eligible, low-level care and support needs. Other areas of unmet need mentioned are linked to money worries, housing, fuel poverty, falls, sensory impairment, end of life care, mental health, drugs and alcohol, lack of affordable transport services (particularly for wheelchair users), a lack of low-level support (specifically in rural locations), early intervention dementia services, and befriending services.

Addressing unmet need

The Freedom of Information (FOI) responses indicate local authorities are relying heavily on the voluntary and community sectors to meet unmet need. As one local authority observed:

'Although there is no new money to meet these needs, there are opportunities to work with a number of VCS organisations and with communities to try to find ways to address these needs.'

Despite stretched funds, some local authorities reported commissioning new services or programmes as a direct result of identifying unmet need. Services cited include social prescribing, frailty services, community navigation services and village agents, self-management and self-care services, supported signposting, peer support for carers including carers groups, mindfulness training and walking groups, information and advice, services helping people home from hospital, and low level support at home, including providing and installing equipment to support independence.

LONELINESS AND SOCIAL ISOLATION

The importance of tackling loneliness[120] and social isolation[121] has been emphasised across the board – in FOI responses, sustainability and transformation plans and joint health and wellbeing strategies.

- Just over half (26) sustainability and transformation plans mention loneliness and/or social isolation.
- Over 100 out of 151 joint health and wellbeing strategies mention loneliness and/or social isolation.[122]
- FOI responses have taken specific actions to reduce loneliness and social isolation as a way to comply with Section 2 of the Care Act.

Research[123] suggests that one in five people are always or often lonely in the UK. **Without the right support, loneliness can transition from a temporary situation to a chronic issue. This has a damaging effect on health as well as our hard-pressed statutory services.** As reflected in **County Durham's** joint health and wellbeing strategy (JHWS):

'People with stronger social networks are more likely to be healthier and happier. Those with weaker social networks can become isolated and, as a result, more likely to experience poor physical and mental health…Earlier interventions could help prevent some of the negative effects of social isolation.'

The Care Act's statutory guidance recognises this, and includes approaches to reduce loneliness or isolation, such as befriending schemes and linking people into community activities, as a preventative example.

Examples of approaches to reduce loneliness and social isolation

While many FOI responses, STPs and JHWSs include an ambition to reduce loneliness and social isolation without explaining how they intend to do this, some have given specific examples of approaches they will or are already taking. **These generally include: befriending, community navigators, social group schemes (such as getting people involved in their local parks and green spaces and libraries), marketing campaigns, social prescribing, mentoring and volunteering.**

Amongst the FOIs, STPs and JHWSs, there has been a general tendency to focus efforts on reducing loneliness and social isolation on older people. However, loneliness and social isolation do not only affect older people. In reality, they can affect people at all ages. There are particular groups of people particularly at-risk of becoming lonely. The Jo Cox Commission on Loneliness[124] has been highlighting some of these groups over the last year. In addition to older people, these have included: men, carers, disabled people, refugees, children, and parents.

Research sponsored by the British Red Cross and the Co-op, entitled 'Trapped in a Bubble',[125] also shows that life transitions can be key triggers for loneliness. Such triggers could include becoming a young new mum, developing mobility limitations or health issues, being recently divorced or separated, becoming an empty nester or retiree, or being recently bereaved.

A wide range of risk factors for loneliness has been captured in **Reading's JHWS**, which notes: 'Most research in this area [loneliness] has focused on

120 Loneliness is a feeling that occurs when there is something lacking in a person's social relationships, or when the quality or frequency of their relationships with other people is less satisfying than they would like.

121 Social isolation is when someone lacks social ties or social integration. While social isolation can cause loneliness, you can be isolated without feeling lonely or vice versa.

122 In 2013, the Campaign to End Loneliness found that over half of all health and wellbeing boards with published strategies (53 per cent) had not recognised that loneliness and/or isolation are issues that need addressing: campaigntoendloneliness.org/wp-content/uploads/downloads/2013/06/Ignoring-the-health-risks-a-review-of-health-and-wellbeing-boards1.pdf

123 Kantar Public supported by British Red Cross and Co-op (2016), Trapped in a bubble: an investigation into triggers for loneliness in the UK: redcross.org.uk/~/media/BritishRedCross/Documents/What%20we%20do/UK%20services/Co_Op_Trapped_in_a_bubble_report_AW.pdf

124 Jo Cox Commission on Loneliness: jocoxloneliness.org/

125 Kantar Public supported by British Red Cross and Co-op (2016), Trapped in a bubble: an investigation into triggers for loneliness in the UK: redcross.org.uk/~/media/BritishRedCross/Documents/What%20we%20do/UK%20services/Co_Op_Trapped_in_a_bubble_report_AW.pdf

the elderly population. However, loneliness can be a health risk at any age.' They then list some additional known risk factors for loneliness. These include: 'living alone; not being in work; poor health; loss of mobility; sensory impairment; language barriers; communication barriers; bereavement; lack of transport; living in an area without public toilets or benches; lower income; fear of crime; high population turnover; becoming a carer.'[126]

They plan to use this information to help them reach those most at risk of loneliness so that they can offer them 'direct support to improve the quality of people's community connections as well as the wider services which help these relationships to flourish – such as access to transport and digital inclusion.'

The other groups identified amongst the three document analyses were carers, with several drawing on their respite offer for carers as well as social care users, disabled people, and people with mental health conditions. A couple highlighted services set up to reduce loneliness amongst men. For example, **Brighton & Hove's FOI** response noted: 'In recognition of the isolation experienced by men, especially unemployed and newly retired men, a Men's Shed has recently been set up in East Brighton offering opportunities for men to come together to 'make and mend'.'

Several documents reflected how difficult it can be to identify people who are lonely or social isolated not least because, as **Bracknell Forest** wrote in their JHWS 'people find it hard to say they are lonely Barnet'. This means 'people could miss out on services and support which might help them feel less alone and more involved with the community in which they live.'[127]

Nevertheless, knowing that life triggers increases the chance of loneliness can help improve identification. Others, like **Barnet**, seek to improve identification through their healthy living pharmacies, hospital discharge teams and substance misuse treatment services.

Local decision makers also do not always know which interventions work best. With this in mind, **Bracknell Forest** intends to improve how they measure the effectiveness of interventions by, as recommended by the Campaign to End Loneliness, 'asking the same questions repeatedly over a number of years' and ensuring that 'any organisation offering services that might impact positively on loneliness will be asked to carry out an annual survey using the questions determined by the working group. If the service is one commissioned by the council or the CCG, this will be written into the contract.'[128]

Recommendations:

- **Local and national health and social care decision makers** should recognise that loneliness and social isolation can affect all ages.
- **Local health and social care decision makers** should focus on life transitions as one way to identify people at risk of loneliness and/or social isolation.
- **Local health and social decision makers yet to do so**, should ensure services that prevent, reduce and delay loneliness and social isolation are available in their areas.
- **The Government** should prioritise better understanding of what interventions that set out to reduce loneliness and social isolation are most effective for all age groups.

126 Reading Health and Wellbeing Board, Reading's Joint Health and Wellbeing Strategy: consult.reading.gov.uk/css/hwbstrategy/user_uploads/reading-health-and-wellbeing-strategy-2017-20-consultation-draft-v.10.pdf

127 Bracknell Forest Health and Wellbeing Board (December 2015) Bracknell Forest Health and Wellbeing Strategy 2016 – 2020: bracknell-forest.gov.uk/sites/bracknell/documents/seamless-health-2016-2020.pdf?VbHtb6FT0hPqbPRCL2RPD9jMojnYt52q

128 Bracknell Forest Health and Wellbeing Board (December 2015) Bracknell Forest Health and Wellbeing Strategy 2016 – 2020: bracknell-forest.gov.uk/sites/bracknell/documents/seamless-health-2016-2020.pdf?VbHtb6FT0hPqbPRCL2RPD9jMojnYt52q

WHAT THIS ALL MEANS FOR ADULTS IN ENGLAND

The new duties and responsibilities reiterated throughout this research report are important steps in ensuring fewer people fall into crisis. However, they will only truly mean something when more people are able to access services that prevent, reduce and delay their needs for care and support. The same applies to the strategies, policies and approaches labelled 'strong' or 'very strong'. This research therefore only tells part of the story.

While there is no individual entitlement to preventative services under the Care Act, there is a duty on local authorities to ensure the provision of preventative services and assess whether people could benefit from these services before a determination has been made as to their eligibility. When adults would benefit from a preventative intervention, they should expect support from their local authority to access those services.

This research study does not tell us whether more people are accessing preventative services, as the Care Act intended. However, the number of FOI responses still focusing solely upon the provision of 'information and advice' rather than of 'prevention' services suggests this ambition, at least in some areas, is yet to be realised. The fact that local authority spend of prevention has also reduced since the Act came into force, also suggests this.

Recommendations:

- **The Department of Health** should look into the legislation's impact on people. We hope this research serves as a useful foundation with regard to implementation of the prevention duties.
- **As part of the proposed upcoming green paper on social care, the Government** should look again at what else is needed to make the prevention vision a reality. This should include a further exploration of the resources local authorities need to implement the prevention duty in a meaningful way as well as whether the Care Act's prevention duty in its current form goes far enough in ensuring people's need for care and support is prevented wherever possible.

APPENDIX ONE:
the triple definition of prevention

PREVENT:
primary prevention / promoting wellbeing

Primary prevention is aimed at people who have no particular health or care and support needs. The intention is to help a person avoid developing needs for care and support, or help a carer avoid developing support needs.

Primary prevention includes universal policies such as health promotion, first aid learning, dementia-friendly communities, enhancing factors that are known to help protect all people (e.g. having a sense of belonging, enjoying good relationships, housing and good physical health), raising awareness initiatives such as National HIV Testing Week, universal services such as community activities that prevent social isolation, universal vaccinations (e.g. polio vaccine) …

REDUCE:
secondary prevention / early intervention

Secondary prevention is more targeted. Interventions are aimed at people who have an increased risk of developing health or care and support needs, or at carers with an increased risk of developing support needs. The goal is to help slow down or reduce any further deterioration, to prevent further needs from developing.

Secondary prevention includes short-term provision of wheelchairs, handyman services, 'social prescribing' services, telecare, earlier diagnosis, e.g. The NHS Health Check programme/ screenings etc., more targeted vaccinations (e.g.. the flu jab given to people over 65)...

DELAY:
tertiary prevention

Tertiary prevention is aimed at minimising the effect of disability or deterioration for people with established or complex health conditions. The goal is to support people to regain confidence and skills, and to manage or reduce need where possible. For people who have already reached the point of crisis, the goal is also to prevent that reoccurring.

Tertiary prevention includes reablement, rehabilitation, bed-based intermediate care, outpatient diabetic and vascular support, support to self-manage conditions, medical adherence programmes, home adaptations, assistive technology...

APPENDIX TWO:
research objectives and methodology

By doing this research, we specifically, wanted to answer the following questions:

- Is prevention a key consideration in local decision making, including commissioning?
- And if so, does the understanding of 'prevention' encompass all three tiers (primary, secondary and tertiary) including support services for people with lower-level needs?
- Since the Care Act came into force in April 2015, has there been an improvement in the prioritisation and understanding of prevention?
- How are local authorities, health and wellbeing boards and sustainability and transformation partnerships putting prevention into action?
- How well do local authorities' local approaches to prevention and their commissioning strategies reflect the Care Act's guidance on preventing, reducing and delaying needs?
- Whether local authorities' have identified preventative services and unmet need in their areas and if so, how?
- How local authorities, health and wellbeing boards and sustainability and transformation partnerships are putting integration into action?

We have previously undertaken a review of joint health and wellbeing strategies three years running. Each time we concluded that the term 'prevention' is understood differently across the country. In both 2013/14 and 2014/15 many strategies understood prevention only as minimising the risk of people developing care and support needs in the first place (primary prevention) or as targeting people at high risk of developing needs (secondary prevention).

In 2015/2016 we saw an improvement in the understanding and emphasis of prevention, as defined by the Care Act (2014). Nevertheless, 37 per cent of joint health and wellbeing strategies still did not incorporate a full understanding of prevention. With this in mind, we wanted to explore whether there has been a further improvement in health and wellbeing boards' understanding of prevention in light of the Care Act's triple definition of prevention now being in force for over two years as well as how well sustainability and transformation plans understand and emphasise prevention according to the Care Act.

Methodology

When reading the joint health and wellbeing strategies and sustainability and transformation plans, we wanted to know:

- Whether prevention was mentioned at all.
- Whether prevention was mentioned in the summary (if there was one).
- Whether prevention was mentioned in the vision/ aim.
- Whether prevention was mentioned as a priority.
- Whether prevention was mentioned as a principle, approach or value.
- Whether the Care Act (Care Bill), Better Care Fund or NHS Five Year Forward View were mentioned.
- How strong its focus on prevention was, and whether its focus was in line with the Care Act's statutory guidance (each strategy was labelled very strong, strong, neither strong nor weak, weak, or very weak).

The purpose of two to five was to determine whether there is any sort of emphasis on prevention. Generally, joint health and wellbeing strategies and sustainability and transformation plans have an overriding 'vision' or 'aim', a set of 'priorities' (usually between three and five but sometimes more) and some guiding 'principles', 'approaches' or 'values'. These tend to frame the strategies and indicate their main areas of focus.

The purpose of six was to help determine whether national policy and practice developments have translated into local plans.

The purpose of seven was to evaluate whether its

interpretation of prevention was in-line with the Care Act's statutory guidance. The labels (very strong, strong, neither strong nor weak, weak, very weak) were ascribed according to whether prevention was a key element of the strategy and whether prevention seemed to encompass lower-level/ tertiary types of support as well as primary and secondary examples.

Very strong: Prevention is a key component of the strategy or plan. It is either part of the vision, appears as a priority, principle, approach or features in the summary. The prevention that is emphasised clearly encompasses lower-level/tertiary types of support as well as primary and secondary examples. These types of preventative services are available before, during and after crisis point for a range of people and health problems.

Strong: Prevention is a key component of the strategy or plan. It appears as either part of the vision, as a priority, principle, approach, or features in the summary. Prevention is in part understood as early intervention and lower-level support. Although there is recognition of the importance of these services, they are often focused solely on one stage of the person's illness, rather than before, during and after. A strong recognition of the importance of lower-level preventative services but often only to one group of people, e.g. people with dementia, rather than all people who may benefit.

Neither strong nor weak: Prevention is probably mentioned as a principle, approach, priority (or component of one) or features in the summary. However, it is not clear that prevention has been wholly emphasised or understood in Care Act terms. Although there may be an obvious commitment to shifting towards prevention and early intervention, it is unclear whether this encompasses preventative lower-level support.

Weak: Although prevention is mentioned, or may exist as a component of a priority, principle, approach, or may feature in the summary, it clearly only focuses on preventing a problem from arising through awareness raising or education (e.g. preventing underage pregnancy by investing in sexual education).

Very weak: No emphasis of any kind on prevention.

It's important to note that some joint health and wellbeing strategies were due to be reviewed while completing this project and were subject to change. Moreover, they ranged in length, detail and had different timeframes. The combination of these factors makes the labels attributed to the strategies subjective and presumably temporary. Therefore, these results are intended to provide a guide as to the strength of strategies' focus on prevention, as well as a guide to the year-on-year trend.

When reviewing the sustainability and transformation plans, we also checked whether health and social care integration was explicitly mentioned and analysed how each partnership plans to go about doing this.

In addition, FOI requests were sent to all local authorities to see how they are implementing Section 2 and Section 3 of the Care Act. The following questions were asked:

1. What actions has your council taken to comply with Clause 2 of the Care Act 2014 ('Preventing needs for Care and Support')?
2. a) Have you developed a 'local approach to prevention' as per Section 2.23 of the Care and Support Statutory Guidance ('Developing a local approach to preventative support') updated in February 2017?
   - Yes
   - No
   - The council is in the process of developing one

   b) Does your local approach clearly specify a range of examples of all three types of prevention set out in chapter two of the Care and Support Statutory Guidance ('Preventing, reducing or delaying needs')?
   - Yes
   - No
3. a) Have you developed a 'commissioning strategy for prevention' as per 2.24 of the Care and Support Statutory Guidance (within 'Developing a local approach to preventative support')?
   - Yes
   - No
   - The council is in the process of developing one

b) Does this commissioning strategy clearly specify a range of examples of all three types of prevention set out in chapter two of the Care and Support Statutory Guidance ('Preventing, reducing or delaying needs')?

- Yes
- No

4. a) Have you identified 'services, facilities and resources that are already available in your area, which could support to prevent, reduce or delay needs' as per section 2.26 of the Care and Support Statutory Guidance ('Developing a local approach to preventative support')?
   - Yes
   - No
   - The council is in the process of doing this

   b) If yes, how did you identify these services, facilities and resources?
5. a) Have you identified 'unmet need' as per section 2.30 of the Care and Support Statutory Guidance ('Developing a local approach to preventative support')?
   - Yes
   - No
   - The council is in the process of doing this

   b) If yes, how have you done this?
6. What actions has your council taken to comply with Clause 3 of the Care Act 2014 ('Promoting integration of care and support with health services etc.'). Please give details.

APPENDIX THREE:
other themes in responses to question one

Various other themes mentioned in responses to question one may enable local authorities to carry out their new prevention responsibilities but are not necessarily results in themselves. These include:

- Reviewing their guidance and training.
- Creating new prevention-focussed boards, teams and roles.
- Revising their procedures. For example how they carry out assessments to better incorporate prevention as well as be more person-centred or how they evaluate their services, with one local authority noting: 'Measuring outcomes for preventative schemes is not straightforward and involves long-term data collection.').
- In some cases, local authorities have entirely restructured adult social care, offering a single point of access for both service users and professional for adult health and social care enquiries, assessments, services and referrals.
- Developing new strategies or plans.
- Reviewing their existing services.
- Identifying local preventative services and needs (detailed further under questions four and five).

APPENDIX FOUR: how have local authorities identified preventative services, resources and facilities?

Allocating responsibility

Some local authorities have hired officers with a specific remit to look for new services and keep their directory up-to-date. Others have assigned this line of work to specific prevention-focused or 'community coordination-type' teams or existing bodies, such as Healthwatch. Elsewhere, new steering groups have been set up to carry out this work.

Stakeholder engagement

Responses highlighted the importance of on-going engagement with community and existing providers and groups. Several specific groups were repeatedly mentioned as important sources of information. These include local neighbourhood teams, community connectors/navigators, commissioning leads, community and faith groups and occupational therapists. Around a fifth of the responses also explicitly mentioned working closely with the voluntary sector on this line of work.

Gathering information

Local authorities acquired this information in range of ways. Through, for example, consultations with service-users, providers, professionals, forums and steering groups, online searches, networking, hosting 'mapping prevention' stakeholder engagement events and workshops, call outs for information at relevant forums, a request to other local authority departments to also identify the activities they undertake that have a preventative aspect to them and, in a couple of cases, local authorities have linked up with social work students at universities to map local assets.

In addition, several local authorities have set up online sharing points, where providers can post details about their own services. It was noted this still involves ongoing engagement with stakeholders, promotion and encouragement to submit information.

Finally, several local authorities have drawn on their existing joint strategic needs assessments (JSNAs) and joint health and wellbeing strategies carried out by health and wellbeing boards. As instructed within the Department of Health's statutory guidance on joint strategic needs assessments and joint health and wellbeing strategies, JSNAs should 'consider what assets local communities can offer in terms of skills, experience, expertise and resources.'[129]

129 Department of Health (2012) Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies: gov.uk/government/uploads/system/uploads/attachment_data/file/223842/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf

APPENDIX FIVE: how have local authorities identified unmet need?

Primary research

A couple of local authorities have carried out qualitative research to identify unmet need, including Walsall that told us they have carried out a number of 'Deep Dive' initiatives looking at significant numbers of cases of unmet need in detail. These 'Deep Dives' have followed a rigorous panel process that seeks to identify unmet need on a case by case basis.

Drawing on local and national data

Several local authorities reported drawing on national and local datasets and sources. At a national level, these include: the census, the English Longitudinal Study of Ageing, Projecting Older People Population Information (POPPI) and Projecting Adult Needs and Service Information (PANSI). As part of a two pronged approach to identifying unmet need, involving both an analysis of population needs as well as the needs of service-users known to the local authority, **Oxfordshire** commissioned the London School of Economics to provide a model of needs in their area that they use as their basis and update it accordingly:

'The model looked at needs based on information from the census and other national sources (such as the English Longitudinal Study of Aging). We then looked at provision of care including local authority provision (from our own records) and informal provision (estimated from national sources such as the Census and private provision based on local intelligence. This identified the proportion of care needs met by each sector (and the proportion of unmet needs).'

For service-users known to the local authority, they use the figures generated by the national social care users' survey, which asks service recipients if, after they have received services, they still have needs across eight different areas (personal care; food and drink etc.) They then monitor this and compare the results with previous years and other councils.

In keeping with section 2.329 of the Care and Support Statutory Guidance that instructs local authorities to 'draw on existing analyses such as the Joint Strategic Needs Assessment', a fifth of the 92 responses also mentioned drawing on their JSNAs as part of this identification. A tenth of the responses mentioned using their market position statements to identify unmet need.

Working in partnership

Most responses involved some sort of partnership working to help identify unmet need, most commonly with the voluntary sector as well as GPs. This is in accordance with the Care and Support Statutory Guidance that recommends local authorities 'work with the NHS to identify carers, and work with independent providers including housing providers and the voluntary sector, who can provide local insight into changing or emerging needs beyond eligibility for publically-funded care.'[130]

Partnership working has enabled some local authorities to capture projected levels of need they might have otherwise been unable to do. For example, Luton reports working with clinical commissioning groups (CCGs) and partners to track frailty amongst their GP registered population to assess future need.

The importance of on-going stakeholder engagement was also consistently highlighted as an important way to understand unmet need. Some reported carrying out co-production workshops with stakeholders such as carers, service-users, the voluntary sector and small enterprises. In addition to attending relevant partnership board meetings, forums, and events, other examples included, holding information hubs in hospital canteens to better engage with staff with caring responsibilities and hosting a prevention-specific conference.

Another important source of information highlighted was feedback directly from a range of providers, professionals and service-users. For example, providers are being asked to share their knowledge

130 Department of Health (August 2017), Care and Support Statutory Guidance, Chapter 2 (2.31)

of unmet need via contract monitoring processes and to include an analysis of unmet need as part of the rationale for their commissioning proposals. Customer services were identified as an important source of information as were service-users' surveys. In addition, social workers are often being asked to feedback on needs that they cannot meet, sometimes in a dedicated space on assessment forms.

A few spoke solely about identifying unmet need as part of the assessment process. While this is no doubt an important source of information, it may not be sufficient to identifying unmet need alone. Not least because this responsibility is supposed to extend beyond those already known to the local authority. In addition, a recent TLAP survey found that only around a quarter of their respondents felt that the council always or frequently listened to their wants and needs.[131]

131 TLAP (June 2017) Care Act 2014 survey results: Exploring the impact of the Care Act on the lives of people with care and support needs: thinklocalactpersonal.org.uk/_assets/Resources/TLAP/CareActSurveyResults-002.pdf

Enclosure K

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Prevention in Action 2017 report

Dear Angela Hillery,

Please find attached a copy of the British Red Cross ***Prevention in Action 2017: How prevention and integration are being understood and prioritised locally in England*** report.

We wanted to congratulate you on your sustainability and transformation plans very strong understanding and emphasis of prevention. As outlined in the report, we were also pleased to see Northamptonshire's plan highlighting the importance of investing in non-clinical interventions and the voluntary sector. The British Red Cross believes the importance of non-clinical interventions, such as the provision of short-term wheelchairs, support at home and services that help reduce loneliness and social isolation need to be better recognised.

Your plan also clearly recognises and emphasises the value of preventative approaches across the life course or across the pathology of a range of illnesses or conditions.

The report also looked at joint health and wellbeing strategies and local authority Freedom of Information responses. Unfortunately, we have found that such good practice is not consistently mirrored across the board. While it is clear that steps are being made to achieve both prevention and integration at a local level, progress is for the most part slow and varied. As previous British Red Cross studies have shown, there is no consistent understanding of exactly what 'prevention' is and how to put it into action.

There are also evident different interpretations of what 'health and social integration' should entail across the country. While some areas are pooling budgets, others simply aspire to closer working arrangements.

As you will see from our report, we hope the sustainability and transformation planning process can act as a catalyst for prevention as well as integration. Our review found that the understanding and prioritisation of prevention in sustainability and transformation plans is generally very strong. We must now make sure these plans for transformation can be put into practice on the ground. We know, for example, that there are practical difficulties in shifting resources away from crisis intervention to prevention, as well as difficulties integrating care, given the current economic climate.

This report is intended to help decision makers make this transition, despite these challenges, by providing a national picture of local developments, and highlighting areas of good practice. At the same time, it calls on Government to look again at what resources are required to enable local authorities to realise both the health and social care prevention and integration agendas in a meaningful way on the ground.

If you would like more information about any of the above or about British Red Cross's own preventative services and service models we would be happy to meet with you to discuss.

Congratulations once again for your measures, which we believe will help ensure fewer people fall into a health or social care crisis.

With best wishes,

Olivia Field
Policy and Advocacy Manager

Justin Prescott
Operations Manager – Independent Living

Appendix 3

Press Release from Northampton Carers

Northamptonshire Carers Breathing Space Press Release – 20th October 2017

Northamptonshire Carers are pleased to announce that our Breathing Space Project won the Pathway Innovation of the Year at the National Primary Care Awards. The award was presented at the National Motorcycle Museum in Birmingham on Wednesday 18th October 2017.

The service for those living with COPD (chronic obstructive pulmonary disease) and their carers. Groups meet fortnightly in Daventry and Northampton but alongside our more traditional support group approach, we work alongside health professionals who offer expert advice on the condition, how to manage it and how to look after your wellbeing.

> "We are very proud of the team for the work they do and what this service has achieved. It's great for Innovation in Northamptonshire to be recognised in this way and this type of community asset based approach has great potential for other Health conditions in the future.
> Services that effectively support people and their carers and are easily accessible for them are vital going forward.
> Key to its success is the partnership working and coproduction with patients and their carers."
> - Mark Major, CEO, Northamptonshire Carers.

COPD affects over 12,000 people in Northamptonshire and we are hoping that this success will enable us to expand the service throughout the county and in to other long term health conditions. The project has been able to show a 39% reduction in take up of secondary health care services by our group members. This has potential cost savings for the NHS as well as improving the health and wellbeing of patients and their carers.

This success has been a huge team effort so we'd like to thank Pat Downer for coordinating the project. Also of Northamptonshire Carers are Sarah Drage and Linda Tiffney along with Peer Supporters Lynette Cromwell, Sally Fisk, Hayley Gyles and Steve Kimber. The Breathing Space project is co-produced with colleagues from the NHS and we would like to extend our thanks to them for their hard work and dedication: Jennifer Keech, Emma Ryan and Lynn Burgess from Northampton General Hospital's RESTART team; Giles West from Northamptonshire Healthcare Foundation Trust; Tim O'Donovan from Nene Clinical Commissioning Group; and Vicky Lord, Project Moderator from Coventry University. We would also like to take this opportunity to thank the members and volunteers who have enabled this project to win this prestigious award.

Northampton General Hospital NHS
NHS Trust

Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**30 November 2017**

Title of the Report	**Care Quality Commission (CQC) Inspection Quality Report Nov 2017**
Agenda item	**16**
Presenter of Report	Catherine Thorne Director of Corporate Development, Governance and Assurance
Author(s) of Report	Catherine Thorne Director of Corporate Development, Governance and Assurance
Purpose	To inform the Board of the Trust's rating and findings of inspection in respect to the statutory requirement to meet the Essential Standards of Quality and Safety as defined in the Health and Social Care Act and regulated by the Care Quality Commission.

Executive summary

Following an initial inspection of four core services in Feb 2017 the CQC then returned to undertake a further inspection within the Trust between 25 and 27 July and on 9 August 2017.

The CQC's team of inspectors, which included a variety of specialists and experts by experience, found a number of improvements had taken place since it was last inspected in 2014 when the Trust was rated as Requires Improvement.

The trust is now rated as Good overall with regard to all five of the questions CQC asks during inspections - whether services were safe, caring, effective, responsive and well-led.

Several areas of outstanding practice were highlighted during CQC's inspection, including:

- The geriatric emergency medicine service (GEMS) was outstanding in terms of providing awareness of and responding to the needs of patients within this group and developing a service that provided a multi-agency approach.
- The emergency department (ED) worked with external organisations to develop an on-site psychiatric liaison service within the ED, 24 hours a day, seven days a week.
- The ED was actively working with local educational institutions to develop courses that were specific to areas difficult to recruit to such as geriatric and paediatric emergency medicine and the ED had a robust leadership development programme in place.
- Staff were focused on continually improving the quality of care and the patient experience. We saw evidence that the service was committed to improving the care of elderly patients, such as those living with dementia.

- The end of life care service had piloted, evaluated, and fully implemented an end of life companion volunteer scheme for dying patients who may not have any visitors.
- The 'Chit Chat' group was set up by the maternity service in 2016 to facilitate antenatal education, parenting advice and peer support for women with additional needs, including learning disabilities or anxiety. Staff said these meetings were twice weekly, well attended and had been nominated for two national awards - one of which had been won at the time of CQC's inspection.

There were also a number of areas where the trust needed to make improvements, including:

- Continue to review and monitor discharges delayed for over eight hours in critical care and report incidents and mixed sex breaches.
- Monitor mandatory training of staff to ensure compliance with the trust's target including annual refresher training relating to safeguarding adults and safeguarding children.
- Continue to monitor caesarean rates and perinatal mortality rates in the maternity and gynaecology service.
- Continue to monitor and review the impact of patients admitted to paediatric wards with mental health issues.
- Continue to monitor controlled drugs are effectively stored in outpatient areas and that fire exits are accessible at all times.

The Trust has a developed an improvement plan to oversee the implementation of improvement activity and this is monitored by a task and finish group chaired by the Director of Corporate Development Governance and Assurance. This group provides a monthly report on progress to the Quality Governance committee.

Related strategic aim and corporate objective	All
Risk and assurance	Failure to meet statutory requirements can lead to improvement notices, fines and / or prosecution and in extremis withdrawal of Trust services
Related Board Assurance Framework entries	All
Equality Analysis	Is there potential for, or evidence that, the proposed decision/document will not promote equality of opportunity for all or promote good relations between different groups? (/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)
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)?(Y/N)
Legal implications / regulatory requirements	The Trust has a statutory obligation to meet the Care Quality Commission's Essential Standards of Quality and Safety

Actions required by the Trust Board
The Board is asked to note that the Trust has been rated as GOOD in the Care Quality Commissions inspection

Northampton General Hospital NHS Trust

Quality Report

Cliftonville
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Website: www.northamptongeneral.nhs.uk

Date of inspection visit: 25, 26 and 27 July and 9 August 2017
Date of publication: 08/11/2017

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Good
Are services at this trust safe?	Good
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Good
Are services at this trust well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Northampton General Hospital NHS Trust is an 800-bedded acute trust with one main hospital, Northampton General Hospital (NGH). There are approximately 713 general and acute beds with 60 maternity beds, and 18 critical care beds. The trust employs 4,875 staff, including 531 doctors, 1,487 nursing staff and 2,857 other staff.

We carried out this inspection as part of our routine focused inspection programme. We completed a short notice focused inspection on the 25 to 27 July 2017 and an unannounced inspection on 9 August 2017.

We determined the extent of this focused inspection following a review of information gathered and the findings from our previous inspection. This included an analysis of the trust's performance and information from stakeholders. The hospital was previously inspected under our comprehensive methodology in January 2014, when the overall rating was requires improvement.

We found the trust has taken significant action to meet the concerns raised from the January 2014 inspection, particularly in establishing an inclusive and supportive staff culture with a clear focus on patient safety.

We rated the four core services we inspected (critical care, maternity and gynaecology, children and young people and outpatients and diagnostic imaging) as good overall. Combining these core service ratings with the ratings for the other four services we last inspected in February 2017, the overall rating for the hospital was good. All five key questions were rated as good (safe, effective, caring, responsive and well-led). We have included some of the findings of the February 2017 inspection in this report to reflect our judgements about the trust overall.

We found that:

- The trust's leadership team were established and experienced members of staff and staff described the leadership team as approachable, cohesive, and inclusive.
- Leaders had a shared purpose, strove to deliver and motivate staff to succeed. Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the trust's culture.
- The trust had a model of clinical leadership that was understood by staff we spoke with and showed excellent engagement with the consultant, medical and nursing bodies.
- The focus on safe patient care, despite the significant operational pressures during the days of the inspection, was clearly evident in all areas and from all staff we spoke with.
- The trust was very proactive in engaging with staff. Almost all staff were very positive about the leadership of the board and senior managers. The level of staff support, respect and commitment to each other was clearly evident in all areas. Staff referred to the 'Team NGH' spirit and culture and were proud of this.
- Overall, almost all staff expressed high levels of satisfaction and were proud to work for the trust. Staff reported feeling respected, valued, supported and appreciated.
- The leadership teams were cohesive and inclusive and were focused on delivering safe, high quality care and treatment for all patients. Staff believed in the leadership of the hospital and were proud of the organisation and its culture.
- Staff were friendly, professional, compassionate, and helpful to patients in all interactions that we observed. All patients told us that the staff had been caring towards them and all spoke positively about the staff in all areas inspected.
- Patients and their relatives were supported during their stay within critical care services and staff provided opportunities to discuss care and treatment. This was delivered in a way that promoted dignity and confidentiality at all times.
- There was a positive culture towards reporting incidents and learning from these to improve patient safety in all areas inspected.
- There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained. The design, maintenance, and use of facilities, premises, and equipment generally met all patients' needs. The environment of the entire estate (despite some parts being over 275 years old) was extremely well maintained.
- Medicines were generally stored and handled in line with the hospital's medicines management policy.

Summary of findings

- There were effective processes in place to ensure that adults and children in vulnerable circumstances were safeguarded from abuse. Staff spoken to in all areas were aware of the processes to identify and respond to patient risk and there were systems in place to monitor and manage risks to patient safety.
- Medical and nurse staffing levels met patients' needs at the time of the inspection.
- Policies were based on national guidance produced by National Institute for Health and Care Excellence (NICE) and the royal colleges. Pain of individual patients was assessed and managed appropriately.
- Patients' outcomes were being measured and were generally in line with national average. Action plans were in place to drive improvements.
- The emergency department had a recovery plan to improve performance to meet the national standard for patients being seen by a doctor within four hours following arrival, which had been agreed with local commissioners and other stakeholders. Performance had declined and was below the national average.
- There was clear evidence and data upon which to base decisions and look for improvements and innovation. The unit participated in the Intensive Care National Audit and Research Centre (ICNARC) audit and performed better or as expected in six out of eight indicators.
- The critical care outreach team provided 24 hour cover seven days a week and assisted with the monitoring and treatment planning of deteriorating patients throughout the hospital, ensuring risks were responded to appropriately.
- The children and young people's service performed well in in a number of national audits including the National Neonatal Audit (2015) and the Epilepsy 12 audit (2014). Gosset ward was working towards achieving Bliss accreditation.
- The maternity and gynaecology service completed the national maternity safety thermometer and monitored safety performance through clinical dashboards.
- There were systems and processes in place to ensure that staff had the necessary qualifications, skills, knowledge and competencies to do their jobs. Effective multidisciplinary working was clearly evident throughout the departments and services.
- There were appropriate processes and systems in place to ensure that information needed to deliver care and treatment was available to relevant staff in a timely manner.
- Patient's consent was obtained in line with trust policy and statutory requirements.
- Services had been planned to take into account the needs of different people, for example, on the grounds of age, disability, gender or religion.
- The hospital staff worked with a variety of stakeholders and commissioners to plan delivery of care and treatment. There was a focus in providing integrated pathways of care, particularly for patients with multiple or complex needs.
- Access to services was generally effective and timely. Care and treatment was only cancelled or delayed when absolutely necessary.
- Appointments were prioritised according to referral requests from GPs with urgent requests and cancer referrals booked within two weeks. The imaging department prioritised reporting higher risk examinations not seen by other clinicians.
- The hospital consistently met the referral to treatment standards over time.
- Waiting times for diagnostic procedures were lower than England average
- Due to ongoing bed capacity issues in the hospital, the hospital had implemented safety driven bed escalation and management process to address patient flow concerns in the hospital. This kept patients safe, even at times of significant pressure on bed capacity.
- Despite very high bed occupancy over time and on the days of the inspection, the commitment to the safety and quality of care and treatment for patients was clearly demonstrated by all staff at all levels.
- The hospital had a well-defined process for the management of medically outlying patients. The hospital's discharge team supported staff with complex discharge arrangements and senior managers were continually working to improve patient flow out of hospital.
- The service managed complaints swiftly, openly and constructive as part of a co-ordinated patient feedback system.

Summary of findings

- The trust's strategy and supporting objectives were stretching, challenging and innovative while remaining achievable and with full consideration of effective use of resources.
- The trust had a well-developed staff health and wellbeing strategy and a variety of healthy lifestyle initiatives were available for all staff to access.
- Full and effective fit and proper person checks were in place.
- Generally effective governance arrangements were in place. There were structured meetings to review all aspects of performance, quality and risks and high risks were escalated through the services.
- Service risk registers generally reflected the risks within the service and there was evidence of ownership, mitigations having being implemented and ongoing monitoring.
- Performance in national audits and benchmarking with regional and national peers was consistently used to drive improvements in services.
- There was a well-developed quality improvement programme at the hospital, which trained staff in quality improvement and service improvement methodology and achieved improved outcomes for patients.
- Innovative approaches were used to gather feedback from patient services and the public, including people in different equality groups. Rigorous and constructive challenge from patients, the public, stakeholders, and regulators was welcomed and seen as a vital way of holding services to account.
- The leadership team drove continuous improvement and staff were accountable for delivering change. Safe innovation was celebrated. There was a clear, proactive approach to seeking out and embedding new ways of working and new models of care.

However, we also found:

- The critical care unit did not comply with the Department of Health's Health Building Note 04-02 critical care unit's standards; however, this had been risk assessed and was under review. Refurbishment plans were in place to address this.
- Mandatory training compliance did not always meet the trust target in some areas. Some staff in some areas were not up to date on annual safeguarding training. Overall, the trust compliance was meeting its target of 85%.
- There were not always effective systems in place regarding the storage and handling of medicines in some areas we inspected. The trust took immediate action to address this once we raised it with them.
- We found concerns about the fire exit in the fracture clinic. This had been addressed by the unannounced inspection and we found the service had also reviewed all fire exits throughout the service.
- The maternity service had had higher than expected caesarean rates and perinatal mortality rates over time. Whilst actions and mitigating actions had been taken, these had not always improved outcomes. The service continued to monitor and assess these potential risks to patients.
- Hospital wide bed capacity affected the ability of the critical care service to discharge patients to wards at the most appropriate time. Over eight hour delayed discharges were higher than the national average, however, action had been taken and improvement observed for patients waiting 24 to 48 hours.
- Single sex accommodation in critical care was not always maintained due to hospital wide bed pressures. Action was taken to protect patients' dignity at all times.

We saw several areas of outstanding practice including:

- The geriatric emergency medicine service (GEMS) was outstanding in terms of providing awareness of and responding to the needs of patients within this group and developing a service that provided a multi-agency approach at the front door.
- Physician associate programmes were being developed to provide a larger group of decision-making clinicians and provide developmental opportunities for staff.
- The emergency department (ED) worked with external organisations to develop an on-site psychiatric liaison service within the ED, 24 hours a day, seven days a week.
- The ED was actively working with local educational institutions to develop courses that were specific to areas that were difficult to recruit to such as geriatric and paediatric emergency medicine and the ED had a robust leadership development programme in place.
- In the Sentinel Stroke National Audit Program (SSNAP) the hospital was rated as band A overall (A being the best and E the worst), in the April to June 2016 audit, which indicated a world-class stroke service.

Summary of findings

- We visited patients being cared for in two out of the three care homes that the hospital used to place patients that were fit for discharge and awaiting their return back to the community. There was a weekly consultant led ward round once a week for these patients and a hospital doctor also visited both homes on three other days of the week. We saw in all there was excellent level of clinical oversight and detailed records of all input from the service's doctors.
- Staff were focused on continually improving the quality of care and the patient experience. For example, we saw evidence that the service was committed to improving the care of elderly patients, such as those living with dementia. Colour-coded bays were evident on some of the wards we visited and finger food boxes had been introduced, which made it easier for patients to eat when they wanted and helped them to maintain independence. Directorate leads told us of plans that were being developed in collaboration with primary care and community services to support the care of elderly patients at home.
- The end of life care service had piloted, evaluated and fully implemented an end of life companion volunteer scheme for dying patients who may not have any visitors. The service had support from the local community in caring for patient at the end of their life.
- The ED had developed an end of life care room that was situated adjacent to the resuscitation area. There was a specific pathway and guidance for managing these situations when the patient was a child or young person. The ED had developed a specific continuation of care record for patients who were in the end of life care room; this included ensuring that they had received consultation and timely review for symptom control.
- The trust had a duty of candour sticker that would be placed into the patient's notes when the duty of candour had been applied. This included, for example, staff name, date, name of person/patient receiving information, account of incident, details of incident and if an apology was offered.
- Two members of the critical care team had been nominated for the 'Best Possible Care' Awards. Patients and those close to them, as well as work colleagues, voted for staff members who had gone above and beyond to exceed expectations and had made a real difference to patient care.
- The 'Chit Chat' group was set up by the maternity service in 2016 to facilitate antenatal education, parenting advice and peer support for women with additional needs, including learning disabilities or anxiety. Staff said these meetings were two weekly and very well attended. This group meeting initiative had been nominated for two national awards and had won one at the time of the inspection.
- The maternity service reviewed and evaluated the provision of multi-disciplinary training when the service was chosen as one of the 10 pilot sites for enhancing patient safety. As part of the pilot, the service chose to concentrate on the fetal monitoring and team working and skills drills sections with the outcome that the service was able to deliver these training programmes completely internally (including Practical Obstetrics Multi-professional Training (PROMPT).
- Gosset ward was working towards achieving Bliss accreditation. This means the ward had undertaken exceptional work through the involvement of parents to encourage bonding with these very special babies which has helped to build the evidence for Bliss accreditation.
- Staff had developed an assessment tool to improve the monitoring and assessment of baby's skin on Gosset ward. The ward was working with neonatal services from across the world (Canada and Turkey) to further develop the tool.
- The recruitment of 1.7 WTE advanced neonatal nurse practitioners (ANNP) onto the medical neonatal rota was helping to address recruitment issues in relation to junior doctors.
- The superintendent sonographer was very passionate about their service and had developed an excellent team which provided image quality assurance and peer review. They were able to detect team members' weaknesses and pair them with other sonographers to help them develop. The ultrasound department conducted many audits and feed these back to ultrasound community in England.

However, there were also areas of poor practice where the trust needs to make improvements. The trust should:

- Review pharmacy provision to meet the needs of the critical care service and be in line with national guidance.

Summary of findings

- Continue to review and monitor over eight hour delayed discharges in critical care and report incidents and mixed sex breaches using the electronic reporting system.
- Monitor staff mandatory training to ensure compliance with the trust's target including annual refresher training for safeguarding adults at level two and safeguarding children level two and three.
- Continue to monitor caesarean rates and perinatal mortality rates in the maternity and gynaecology service.
- Review multidisciplinary support to critical care services to ensure national best practice is following, in relation to therapy support.
- To monitor allergy testing ampules ensuring use within their recommended expiry dates.
- The trust should consider improving the facilities for parents to stay overnight on paediatric wards.
- Continue to monitor and review the impact of patients admitted to paediatric wards with mental health issues.
- Continue to monitor and review the effect on children's services due to the limited availability of psychologist support, particularly for children with long term conditions.
- Continue to monitor controlled drugs are effectively stored in outpatient areas.
- Continue to monitor fire exits are accessible at all times.

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

Background to Northampton General Hospital NHS Trust

Northampton General Hospital NHS Trust (NGH) is an 800-bedded acute trust. There are approximately 713 general and acute beds with 60 maternity beds, and 18 critical care beds. The trust employs 4,875 staff, including 531 doctors, 1,487 nursing staff and 2,857 other staff.

It has an income of approximately £250 million and a workforce of around 4,1875 staff. It provides general acute services to a population of 380,000 and a hyper-acute stroke, vascular and renal services to people living throughout the whole of Northamptonshire. The trust is also a cancer centre, delivering cancer services to a wider population of 880,000 in the whole of Northamptonshire, and parts of Buckinghamshire.

The hospital has dedicated beds at the Cliftonville Care Home, Spencer Care Home, and Angela Grace Care Home for patients who no longer require acute inpatient care. NGH are responsible for the medical care of patients transferred to one of the care homes with all nursing care and management being the responsibility of the home.

For 2016/17, the trust's financial position was a deficit of £10.5 million as of December 2016. This was better than predicted.

We determined the extent of the inspection following a review of information gathered and the findings from our previous inspection. This included an analysis of the trust's performance and information from stakeholders. The trust was previously inspected in January 2014, when the overall rating was requires improvement. We rated the end of life services as inadequate.

We spoke with a range of staff, including black and minority ethnic staff, nurses, junior doctors, consultants, midwives, healthcare assistants, student nurses, administrative and clerical staff, allied health professions, porters, and the estates team. We also spoke with staff individually as requested.

The inspection team inspected the following four core services at Northampton General Hospital.

- critical care.
- children and young people.
- maternity and gynaecology.
- outpatient and diagnostic imaging services.

We did not inspect urgent and emergency care, medical care (including older people), surgical care or end of life care as we had inspected these core services in February 2017. However, we have included some of the findings in this report to reflect our judgements about the trust overall.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Bernadette Hanney, Care Quality Commission (CQC). The Inspection Manager was Phil Terry and the trust's relationship inspector was Justine Eardley.

The team included seven CQC inspectors, one CQC pharmacist inspector and a variety of specialists including consultants, senior nurses, and trust wide governance experts.

How we carried out this inspection

To get to the heart of patients experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Summary of findings

We carried out this inspection as part of our routine focused inspection programme completed a short notice focused inspection on the 25 to 27 July 2017 and an unannounced inspection on 9 August 2017.

Before visiting, we reviewed a range of information we held about Northampton General Hospital and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group, NHS improvement, the General Medical Council, the Nursing and Midwifery Council, the royal colleges and the local Healthwatch.

We talked with patients and staff from all areas and departments. Some patients and staff shared their experience by email or telephone.

We held drop in sessions with a range of staff. These included nurses, doctors, consultants, health care assistants, allied health professionals, administrative and clerical staff, porters and the estates team, and black and minority ethnic staff. We also spoke with staff individually as requested.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Northampton General Hospital.

What people who use the trust's services say

In the 2016 CQC inpatient survey, the trust performed about the same as other trusts for all categories, with the exception of patients views of doctors (8.01 out of a maximum of 10) and also discharges processes (6.54 out of a maximum of 10), where the trust performed worse than other trusts.

This survey looked at the experiences of 77,850 people who received care at an NHS hospital in July 2016. Between August 2016 and January 2017, a questionnaire was sent to 1,250 recent inpatients at each trust. Responses were received from 487 patients at Northampton General Hospital NHS Trust.

Facts and data about this trust

The trust employs 4,875 staff, including 531 doctors, 1,487 nursing staff and 2,857 other staff.

For 2016/17, the trust's financial position was a deficit of £10.5 million as of December 2016. This was better than predicted.

The trust has beds spread across various core services including:

- 739 General and acute beds.
- 60 Maternity beds.
- 18 Critical Care beds.

Activity

Bed occupancy on the days of inspection was 104%. Bed occupancy has been in line with the England average between Quarter 3 2015/16 and Quarter 4 2016/17.

Between February 2016 and January 2017 the trust had:

- 116,773 A&E attendances.
- 91,271 Inpatient admissions.
- 560,061 Outpatient appointments.
- 4,539 births.
- 1,401 deaths.

Population served

The trust provides hospital care for a population of 380,000. The local population from April 2015 to March 2016 was predominantly white (86%), with 3% Asian, 2.5% black and 1.2% mixed.

Northamptonshire is a centrally situated county incorporating a mix of urban and rural areas. The population density is in the lowest 25% of upper tier authority areas within England. In spite of this, the county has seen one of the most significant levels of growth during the past 30 years, well in excess of national and regional growth trends. Whilst the population has grown across all broad age groups, this has been particularly high in those aged 65 and above. This is expected to continue in projections to 2021, with particular emphasis on the group aged 70 years and above. In spite of this

Summary of findings

growth at the top end of the age profile, the proportion of those aged 65 and above within Northamptonshire remains comparatively low against the national profile, with the child population (0-15 years) comparatively high.

Deprivation

Socio-economic deprivation is considered to represent an important health determinant. This is supported by the notable difference, which has been recorded between life expectancy in the most deprived and the most affluent areas of England. The extent of socio-economic deprivation in Northamptonshire is not as considerable as other parts of England, but specific pockets can be identified, particularly in the Corby and Northampton areas. Deprivation has a tendency to be concentrated in urban areas of the county. Health deprivation however has a higher occurrence at the most significant level in the county than overall deprivation. This is found within areas of Corby, Northampton, and to a lesser extent Kettering. The link between health deprivation and other forms of deprivation considered determinants is by no means explicit. Whilst 57% of those areas experiencing health deprivation amongst the top 30% in England also recorded similarly high levels of income deprivation, for environment deprivation, this was 22% and for barriers to services was just 8%.

Population age

The majority of local population in April 2015 to March 2016 was 18 to 74 year (67%) with a further 21% over 75 years. Data shows that the age of the local population is stable and similar to data collected in April 2014 to March 2015.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? **We rated safe as good because:** We rated the four core services we inspected (critical care, maternity and gynaecology, children and young people, and outpatients and diagnostics) as good for safe. Combining these core service ratings with the ratings for the other four services we last inspected in February 2017, the overall rating was good. We found that: • Significant improvements had been made in establishing a safety culture across the hospital and this was reflected in all the core services we inspected and by all staff. • The trust had a systematic approach to the reporting and analysis of incidents. There were plans in place to manage risks identified to prevent future incidents and opportunities to prevent or minimise harm were reviewed. • There was a positive culture towards reporting incidents and learning from these to improve patient safety. • The trust met the requirements of the Duty of Candour regulation and there was evidence of good ownership by senior leaders within clinical teams. • Staff were confident reporting safeguarding concerns and were given support with this. Policies and procedures for safeguarding were in place and reflected local and national guidance. • Medical and nurse staffing across the trust was appropriate for the services delivered and in line with relevant guidance. • Appropriate systems were in place to assess risk and to recognise and respond to deteriorating patients. • The medical oversight of the 'fit for discharge' patients in local care homes used by the trust was excellent. • The service provided critical care outreach 24 hours seven days a week with support for deteriorating patients throughout the hospital wards. • The trust simulation team was used by critical care services to reconstruct scenarios based on common errors that occurred in healthcare. Staff we interviewed spoke positively about the learning and told us it enhanced patient safety and experience. • Safety thermometer data from the last 12 months reported 100% of "harm free" care in the child health directorate.	Good

Summary of findings

- The outpatient service carried out harm reviews for patients waiting for 45 weeks and over. Staff held weekly referral to treatment (RTT) performance meetings where all aspects of the patient pathway were discussed, including the validation of all patients waiting over 18 weeks.
- The design, maintenance, and use of facilities and premises met patients' needs. The maintenance and use of equipment kept patients safe from avoidable harm.
- Improvements had been made in some areas in the outpatient environment, which included the expansion of the chemotherapy suite and new equipment in the diagnostic imaging department.
- Standards of cleanliness and hygiene were well maintained in all wards and areas visited.
- Generally, appropriate systems for the handling and storage for medicines were in place.
- Suitable equipment was available to meet patient needs, and had been well maintained.
- Issues we had raised at the last inspection regarding reassessment of patients' venous thromboembolism (VTE) risk at 24 hours following admission had been addressed.

However:

- Mandatory training compliance did not always meet the trust target in some areas. Some staff in some areas were not up to date on annual safeguarding training. Overall, the trust compliance was meeting its target of 85%.
- There were not always effective systems in place regarding the storage and handling of medicines in some areas we inspected. The trust took immediate action to address this once we raised it with them.
- We found concerns about the fire exit in the fracture clinic. This had been addressed by the unannounced inspection and we found the service had also reviewed all fire exits throughout the service.

Duty of Candour

- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.

- All staff were aware of their responsibility to be open, transparent, and honest and gave examples of when they had offered patients and relatives an apology. Staff were aware of the trust's policy and their requirement to apply Duty of Candour for any incident that was investigated and categorised as moderate or above and knew the thresholds for when Duty of candour processes were triggered.
- Our observation of records showed that when things went wrong patients, and their relatives, were offered a verbal and written apology and complied with Duty of Candour processes. This also included arranging local meetings and support for patients and relatives. Trust policies referred to Duty of Candour and detailed clearly how staff should manage incidents or complaints taking duty of candour into consideration.
- We reviewed ten serious incidents and medium incident reports, which showed clear evidence of Duty of Candour maintained by the trust. The reports showed that there were clear apologies and explanation to patients and their loved ones. The trust had also arranged for one incident investigation report to be reviewed by an external specialist for an independent review. The trust offered individuals to assist patients and their families to participate with investigation processes and offer explanations. We saw that copies of final investigation reports were shared with patients and their families.
- We saw Duty of Candour stickers available for staff to place in patients noted when incidents had occurred and Duty of Candour had been completed. The use of these was audited by the trust's governance team. Duty of candour was reported on quarterly to the trust's governance committee.

Safeguarding

- Overall, staff told us they felt confident reporting safeguarding concerns and were given support with this. Policies and procedures for safeguarding were in place and reflected local and national guidance.
- The trust had safeguarding policies and procedures available to staff on the intranet, including out of hours contact details for hospital staff. The trust had positive engagement with both the adult and children's local safeguarding children boards.
- Staff received training and had an effective understanding of their responsibilities in relation to safeguarding of vulnerable adults and children. Staff were able to explain safeguarding arrangements, and when they were required to report issues to protect the safety of vulnerable patients. Staff had access to the

Summary of findings

trust's safeguarding team and they told us they were helpful and responsive. Staff were able to tell us how they would report concerns through the trust's procedures and they knew who they should contact.

- The safeguarding team took proactive steps to minimise potential abuse of children by reviewing all attendances by children to the emergency department within 24 hours.
- The safeguarding team actively reviewed all nationally published serious case reviews and took learning from these to reflect upon and change trust practices and policies. The safeguarding leads were actively involved in cross-county work regarding the recognition of domestic violence and appropriate support for patients affected.
- There was information relating to female genital mutilation and child sexual exploitation on the trust's intranet. All staff that we spoke with were aware that there were arrangements in place to safeguard women and children at risk and told us that the topic had been covered during safeguarding training.
- Some staff had undergone PREVENT training in line with the government's strategy to ensure that individuals are safeguarded from radicalisation. The training was planned as a mandatory topic in the service's 2017/18 training action plan.
- Staff told us that the hospital safeguarding team delivered bespoke training for staff in the emergency department and provided appropriate information on the dedicated intranet page regarding topics such as child sexual exploitation and female genital mutilation. Staff said the safeguarding team very visible in the department and were always available to give advice. There was a named safeguarding midwife who supported staff whenever required.
- At the time of our inspection, the specific child abduction policy was still in draft and awareness was lacking in some areas of the service. The trust took immediate action to address this once we raised it as a concern. On our unannounced inspection, we saw laminated flow charts on paediatric wards detailing staff actions in the event of child abduction, which related to the child abduction policy, which was available on the trust intranet.
- The intercollegiate document 'Safeguarding children – Roles and competencies for healthcare staff' published by the Royal College of Paediatrics and Child Health (RCPCH) 2014 provides guidance on the level of safeguarding training required for different staff groups. The document states that 'All clinical staff working with children, young people and/or their parents/ carers and who could potentially contribute to assessing,

planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns' should be trained in safeguarding for children levels one, two and three'.

- Trust wide safeguarding training was offered either as mandatory, planned/cluster training or bespoke training which was offered across the month for staff. The trust safeguarding compliance rates for July 2017 were:
  - Safeguarding Adults Level 1 – 92%.
  - Safeguarding Adults Level 2 – 85%.
  - MCA – 85%.
  - Safeguarding Children Level 1 – 93%.
  - Safeguarding Children Level 2 – 85%.
  - Safeguarding Children Level 3 – 76%.
- In maternity and gynaecology service, at the time of our inspection, 84% of nursing and midwifery staff and 84% of medical staff had completed safeguarding children's level three training against a target of 85%. The service had an on-going action plan to deliver safeguarding level three training in line with guidance. As of July 2017, 62% of nursing and midwifery staff and 62% of medical staff had completed safeguarding adults' level two training against a target of 85%. The service had an on-going action plan to deliver safeguarding level two training in line with guidance.
- In the children and young people's service, a review of staff training data in June 2017 identified 81% of nursing staff had completed children's level three safeguarding training. This was below the trust target of 85%. However, all staff told us they had attended safeguarding level three training. Staff also said there was a delay in uploading training activity onto the training database. Training data for doctors in June 2017 identified 94% of doctors had completed level three safeguarding training.
- The trust was in the process of reviewing the appropriate number of staff in the outpatient's service that had the required levels of children's safeguarding training in line with the 'Intercollegiate document on safeguarding children and young people' (March 2014). For example, staff within the integrated surgery department who were involved in the assessment and treatment of children were trained to level two only. Senior nursing staff were trained to level three. Nurses we spoke with who had direct contact with children said they had been told by safeguarding leads that they required to be trained to level two. Staff said they had access to a level three trained colleague for all clinics.
- In outpatients, senior managers told us that when staff had a concern about a child or a family in an outpatient clinic,

Summary of findings

support was obtained from the person in charge. This may be the ward sister or their deputy who had undertaken the appropriate level of training according to the Intercollegiate Document. These safeguarding arrangements were supported by immediate access to a safeguarding professional, available during core working hours (8am to 6pm), who was able to respond to concerns and offer support and advice.

- Training statistics provided by the trust showed that 89% of nursing staff had completed level two safeguarding children and 86% safeguarding adults training level two. We saw 70% of nursing staff had up to date training in safeguarding children level three. The trust's internal target for this training was 85%. The information for doctors showed 68% had safeguarding adults level two training, 72% had safeguarding children's training level two and 64% had safeguarding children level three. We saw that further training dates were being arranged to address this shortfall.
- Senior managers said a discussion was held at the trust's Safeguarding Assurance Meeting in July 2017 to discuss the compliance of level three safeguarding training as it was felt that the trust was attempting to train more staff at this competency level than was required as per the Intercollegiate Document. The associate directors of nursing and the safeguarding team had been tasked to review the safeguarding roles and responsibilities across the trust in line with the Intercollegiate Document to confirm the correct number of staff requiring this training.

Incidents

- The trust reported incidents through an electronic database, which was easily accessible for staff and located on the trust intranet. The governance team managed incident reporting though the Strategic Executive Information System (STEIS).
- Departments had a monthly dashboard that was used to set the targets for safety performance and also used nurse sensitive indicators such as compliance with infection control protocols and care associated risk assessments. The dashboards also included the numbers of incidents and complaints, which were discussed at governance meetings and as 'hot topics' at daily nursing and medical safety huddles. Our observations and discussions with staff at all levels confirmed that they were aware of the 'hot topics' within their department.

Summary of findings

- The director of nursing, midwifery and patient services had introduced a ward accreditation system that RAG rated (which stands for the traffic light systems of red, amber, green) the quality of care provided in all in-patient wards with all wards progressing to achieve best possible care.
- There was a positive culture towards reporting incidents and learning from these to improve patient safety. Staff at all levels understood their responsibility to report incidents both internally and externally. All staff had access to the hospital's electronic system for reporting incidents and staff that we spoke with described the process they followed.
- There were four never events reported from June 2015 to May 2016. A never event is a serious incident that is wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should be implemented by all healthcare providers. The never events included wrong site surgery, an incorrect tooth extraction, the insertion of incorrect lens and the retention of a foreign body. We reviewed the investigations and learning from these incidents and identified that the investigations were thorough and learning needs had been identified. Defined actions had been implemented including clinic notes being signed off in conjunction with patients' notes, an update, and roll out of theatre standards in line with national safety standards, and revision of all relevant standard operating procedures. The trust's medical director also hosted a shared learning event for all surgery staff in 2016.
- Between May 2016 and April 2017, the trust reported one incident which was classified as a never event. It was a surgical invasive procedure incident meeting serious incident criteria. We reviewed the investigation report and action plan regarding this latest never event and found that appropriate actions had been taken to learn lessons from this latest incident.
- In accordance with the Serious Incident Framework 2015, the trust reported 11 serious incidents (SIs) which met the reporting criteria set by NHS England between May 2016 and April 2017. Of these, the most common type of incident reported as 'all other categories' with three incidents.
- There were 4,959 incidents reported to National Reporting and Learning System between March 2016 and February 2017, with 10 severe harm incidents, 36 moderate harm, 1,061 low harm and 3,849 no harm incidents reported. There were eight deaths reported by the trust over the period.
- Data showed that the trust was within the lowest 25% for reporting incidents, with an average reporting time of 83 days, compared to 26 days for all similar trusts from April 2016 to

Summary of findings

September 2016. At the time of inspection, the trust reported that from August 2016 to January 2017 the time taken to upload an incident was 83 days, however this was not necessarily the time taken to report the incident. The governance team reported that they provide the divisional teams with information relating to delays in incident final approval and sign off at quarterly quality governance meetings.

- The trust had reviewed their serious incident policy to include the development of investigation panels and openly shared with local commissioners the initial assessments of incidents that were taken to the weekly internal 'Review of Harm Group' to determine whether a full serious incident investigation was required. This enabled a standardised approach to incidents occurring within the trust and the identification of any trends.
- Service leads regularly reviewed and updated the associated action plans. We saw that the incidents and learning was shared across the organisation, though the trust "Quality Street" governance magazine and at team meetings. Service leads openly discussed the incidents and the actions taken to prevent reoccurrence.
- The trust board reviewed the number of serious incidents and never events at each board meeting comparing current and historic data. This included the type of incident, overview of investigation and the identification of any learning for sharing. The governance team completed a serious incidents trend analysis for all serious incidents and never events from November 2015 to June 2016. This identified the common factors between incidents to enable learning. The report was shared with the divisional leads and trust board.
- Mortality and morbidity meetings were conducted monthly and there was an effective process in place to disseminate information to staff at all levels. Mortality and morbidity meetings were peer reviews of the care and treatment patients received with the objective to learn from them. Consultants identified those patients from the previous month to review and identify areas of learning. Minutes were circulated to ensure all staff had access to the cases discussed and junior doctors told us the learning was positive. Staff at all levels were invited to attend and relevant information was available on the trust's intranet, and hard copies were available in clinical areas for staff.
- The maternity and gynaecology service met the Royal College of Obstetrics and Gynaecology (RCOG) 'Improving Patient Safety' they held a monthly meeting to review perinatal and maternal mortality and morbidity. It was attended by the multidisciplinary team members. We saw the minutes and

lessons learnt were shared widely across the service. New clinical indicator maternity dashboards were developed and implemented. The information provided within the dashboards enabled the service to identify priority areas for improving the outcomes for women and their babies.

- The trust had implemented a learning from deaths policy, which had been ratified by the trust's board in July 2017 and was reviewing patients' deaths in accordance with the NHS National Quality board 'National Guidance on Learning from Deaths' guidance (March 2017). The trust had a system for reviewing deaths in accordance with this guidance, using the recommended structured judgement review tool, and was collating information in preparation for reporting data gathered in the first quarter to the trust board.
- Trust NHS Safety Thermometer data showed that, from December 2015 to December 2016, there had been a significant reduction in the number of acquired pressure ulcers. In December 2015 there were 17 reported in comparison to six in December 2016. This had followed a downward trend across the period.
- A 'Rapid Pressure Ulcer Prevention Turnaround Project' had been running on four wards since November 2016. The quality assurance and improvement matrons and the tissue viability team completed an SSKIN (SSKIN is a nationally recognised five step model for pressure ulcer prevention) compliance audit across inpatient wards to monitor compliance.
- Data from the Patient Safety Thermometer showed that the trust reported 111 new pressure ulcers, 22 falls with harm and 14 new urinary tract infections in patients with a catheter between April 2016 and April 2017.
- There were no cases of MRSA reported between May 2016 and April 2017 . NHS trusts have a target of preventing all MRSA infections, so the trust met this target within this period. Additionally, the trust reported 15 meticillin susceptible staphylococcus aureus (MSSA) infections and 21 Clostridium Difficile infections over the same period.
- The trust simulation team were used by critical care services to reconstruct scenarios based on common errors that occurred in healthcare. Staff we interviewed spoke positively about the learning and told us it enhanced patient safety and experience.
- Issues we had raised at the last inspection had been addressed. During our last inspection in February 2017, we found that medical and surgical wards were not compliant with the National Institute for Health and Care Excellence (NICE) standard regarding reassessment of patients' venous thromboembolism (VTE) risk at 24 hours following admission.

Summary of findings

The VTE reassessments were not always recorded due to the hospital's transition from paper based records to the new electronic observation system. We raised this with the trust at the time and they took immediate action to address this issue.

- On this inspection, we looked at 21 VTE assessments and reassessments in four wards and found 95% had been completed and reviewed within 24 hours. This was a significant improvement on the findings of the last inspection. We brought the patient record missing the VTE assessment to the attention of the nurse in charge of the ward and senior management. The nurse took steps to immediately inform the doctors to address this. Senior management returned to the ward later the same day and the VTE assessment had been completed and the appropriate treatment prescribed.

Staffing

- Medical and nurse staffing across the trust was appropriate for the services delivered and in line with relevant guidance. Patients' needs were met effectively at the time of the inspection.
- For June 2017, the trust's substantive workforce capacity increased by 9.52 whole time equivalent (WTE) posts to 4,322.51 WTE. The trust's substantive workforce was at 89% of the budgeted workforce establishment of 4,871.31 WTE.
- The annual trust staff turnover decreased by 0.12% to 9.94% in June 2017, which was below the trust target of 10%. Turnover within nursing and midwifery decreased by 0.30% to 6.89%.
- Turnover in other areas was:
  - Medical Division: turnover increased by 0.02% to 8.14%.
  - Surgical Division: turnover decreased by 0.7% to 8.99%.
  - Women, Children & Oncology Division: turnover decreased by 0.56% to 8.61%.
  - Clinical Support Services Division: turnover increased by 0.33% to 12.83%.
  - Support Services: turnover increased by 2.76% to 12.45%.
- The vacancy percentage rates had increased for:
  - Administration and clerical staff.
  - Allied health professionals.
  - Estates and ancillary staff.
  - Healthcare scientists.
  - Nursing and midwifery staff.
- Healthcare scientists' staff group has seen the largest vacancy rate increase of 3.85% to 23.36%. Nursing & Midwifery staff group vacancy had slightly increased from 10.35% to 10.47%.
- The vacancy percentage rates had decreased for:
  - Additional professional scientific and technical staff.

  - Additional clinical services staff.
  - Medical and dental staff groups.
- Additional Professional Scientific and Technical staff group had seen the largest vacancy rate decrease of 2.85% to 15.31%.
- The 'Safe Nurse Staffing Report' to the trust's board showed that the overall fill rate for June 2017 was 95%.
- The trust's sickness levels from August 2016 to June 2017 were similar to the England average, and followed a similar trend. Sickness absence in April 2017 decreased from 3.70% to 3.29%, which was below trust target of 3.8%. Senior managers told us this was the lowest it has been for a number of years. Sickness absence for June 2017 increased slightly from 3.51% to 3.53%, which is below the trust target of 3.8%. All divisions were below the trust target except for Support Services at 4.11% and the Facilities Directorate showed the highest sickness rate of 5.75% (within that division).
- Nursing staffing was planned up to 12 weeks in advance and reviewed regularly including on a daily basis to allow senior staff the opportunity to allocate staff to different areas depending on skill mix.
- Nursing staffing levels in the hospital were discussed at regular intervals throughout the day at departmental and hospital-wide bed management, twice-daily safety huddles, and capacity meetings. There was an effective staffing escalation protocol in place and senior managers and clinical site supervisors monitored the hospital's staffing levels throughout the day and night.
- The planned daily consultant cover in the emergency department was below national recommendations of 16 hours per day as 14 hours cover was provided per weekday. Medical staffing for middle grade and junior doctors met the needs of patients at the time of the inspection. There was a designated consultant in charge on a daily basis.
- As of July 2017, across the whole trust the WTE medical agency staff usage was 9.02. Leaders of the medical service explained that they were aware of this and were actively recruiting and looking to create more attractive posts to reduce the vacancy rate. The risks related to medical staffing was entered on the risk register for medical services and actions related to recruitment and retention were documented.
- The proportion of consultant staff working at the hospital was about the same as the England average and the proportion of junior (foundation year one to two) staff was lower than the England average. Medical staffing levels and skill mix were planned in advance and were in accordance with relevant guidance to ensure patients received safe care and treatment.

Summary of findings

- There were clear processes in place for the induction of temporary medical staff. This included a corporate and local induction for locums, which included statutory and mandatory training checks and local orientation.
- The workforce committee reviewed staffing levels across the organisation at regular intervals. The committee had oversight of all strategies relating to workforce and reviewed progress against plans at each meeting. In January 2017, there were 130 actual full time nurse vacancies against the predicted 128 across the organisation. To address the deficit in trained nurses, the trust had completed recruitment programmes across Europe, India, and the Philippines. We were told that from October 2016 to December 2016, 15 overseas nurses had accepted posts and were awaiting clearance. There were also 47 nurses awaiting Nursing and Midwifery Council decision letters to enable employment within the trust.
- The trust was also part of the 'Best of Both Worlds' innovation. Thiswas an innovative recruitmentcampaign launched by the trust at withthe other three leadinghealthcareproviders inNorthamptonshirein partnership with theUniversity of Northampton, to attract staff to relocate to live and work in Northamptonshire. The campaign aimed to put Northampton, Kettering and Northamptonshire firmly on the map as a top destination for all staff including new and experienced medical and nursing professionals to develop their careers.
- The trust were in the process of recruiting a retention of staff manager to assist overseas workers to orientate to the hospital and community. Orientation programmes include assistance with language and colloquialisms, orientation to shopping facilities, housing, and hobbies.
- The trust had also introduced an apprenticeship scheme designed to 'grow their own registered nurses' from health care assistants. Options were being considered as to how this would implemented across the divisions.
- Local community induction for overseas staff was completed in conjunction with a robust training programme, which enabled new staff to complete internal training and skills updates prior to commencing on the wards. All new staff completed a three-week supernumerary period under close supervision and mentorship. To ensure staff satisfaction with their new post, the trust completed a post commencement check with all staff to ensure they have been placed in their preferred location. This has assisted with the retention of overseas workers, with a fall in numbers of staff leaving from 12% to 0% in December 2016.
- Agency staffing was closely monitored by the trust, and in December 2016, the trust reported that total agency staff

expenditure for 2015/16 was £17.4 million. NHS Improvement required all trusts to cap agency expenditure. Northampton General Hospital has seen a three-month drop in expenditure from September 2016, however overall expenditure exceeds the cap by £2.5 million.

- Trust wide mandatory training compliance was 87% for June 2017. This was above the trust target of 85%.
- Appraisal compliance was 85% trust wide for June 2017. This was in line with the trust's target.
- The trust had a revalidation officer who ensured that all clinical staff requiring revalidation was completed. The trust had systems and procedures in place to support the process for all doctors who required revalidation. The aim of revalidation is to ensure that all doctors are up to date and remain 'fit to practice'.
- For critical care, the national core standards state that there should be at least one WTE band 8A specialist clinical pharmacist for each single level three bed and for every two level two beds. The pharmacy team were aware of the shortfall and a business case had been put forward which, if successful, would ensure standards were being met.
- The midwifery staffing ratios were monitored and were reported through the maternity dashboard on a monthly basis. At the time of our inspection, the ratio was 1:29.
- We saw that the planned and actual consultant rota provided 64 hours consultant presence per week on the delivery ward. No locum staff were being used at the time of inspection.
- A paediatric acuity tool calculated safe staffing ratios in line with the Royal College of Nursing safer staffing guidance in children's services. Staffing levels were continually reviewed to reflect the changing dependency needs of children and young people. Skill mix on the wards was 70/30. This meant 70% of the team were qualified nurses and 30% were health care support workers (HCAs).
- During the February 2017 inspection, we visited patients being cared for in two out of the three care homes that the hospital used to place patients that were fit for discharge and awaiting their return back to the community. There was a weekly consultant led ward round once a week for these patients and a hospital doctor also visited both homes on three other days of the week. We reviewed 10 patients' records and saw in all there was excellent level of clinical oversight and detailed records of all input from the service's doctors. Care home staff said there was positive relationship with the hospital doctors.

Medicines

Summary of findings

- Generally, appropriate systems for the handling and storage for medicines were in place. Medicines, including intravenous fluids and gases, were appropriately stored and access was restricted to authorised staff.
- There was a proactive, supportive and visible inpatient pharmacy service with effective multi-disciplinary working. The trust pharmacy team undertook leadership on medicines and medicine use within the trust. A seven-day service was available which included access to medicines and pharmacist advice if needed when the pharmacy was closed.
- Arrangements were in place to check patients' medicine requirements on admission. This was carried out by a team of pharmacists and Medicine Management Technicians by taking a detailed medicine history, undertaking medicine reconciliation on admission to hospital and checking for any contra-indications or unsafe prescribing. NICE guidance sets medicine reconciliation at 95% within 24 hours of admission; however, the trust rate was 63% (April 2016 to March 2017). Medicine Reconciliation was on the pharmacy risk register primarily due to pharmacy staffing levels; however, the risk had been reduced by the implementation of the seven-day pharmacy services.
- Controlled drugs (CDs) are a group of medicines which are subject to strict legislative controls due to their potential for abuse and harm.
- We found that CDs were generally stored appropriately. This included when patients brought in their own CDs. We checked CD records and found that administration and storage were documented correctly. Ward stocks of CDs were reconciled on a daily basis. We found some areas where trust policy for medicines' storage had always been followed: the trust took immediate action regarding this and this had been rectified by our unannounced inspection.
- At the February 2017 inspection, the trust did not have a system in place to de-nature CDs. This issue was raised at the time of the inspection and denaturing kits were provided immediately to address this issue. On this inspection, we found appropriate systems were in place regarding denaturing CDs. CDs were denatured at ward level before being disposed of into waste containers. This is in line with Home Office advice and the Safer Management of Controlled Drugs: a guide to good practice in secondary care 2007 (DoH) or Healthcare Waste Regulations (DoH).

- Checks to ensure that any known allergies or sensitivities to medicines were recorded accurately on patients' prescription charts within 24 hours of admission. This information is important to prevent the potential of a medicine being given in error and causing harm to a patient.
- We found that fridge temperatures were generally being checked and recorded on a daily basis on most wards. There were some deviations from trust policy regarding checks on medication fridges but once we raised this with senior managers during the inspection, this was addressed immediately.
- The trust pharmacy department was open seven days per week with clinical pharmacists and technicians working weekdays at ward level. An out of hours' cupboard was available for staff to access medications in an emergency. On-call pharmacists also provided telephone advice out of hours.
- The trust had a current medicines' management policy, which was reviewed and updated with national guidance regularly.
- Medication errors were reviewed as part of the Medicines Safety Group to identify learning or trends. We saw that information gathered at this group was shared with the trust through the medicines' optimisation committee. A Medication Safety Thermometer audit was undertaken for allergy documentation, medicine reconciliation and omitted doses of medication. The results of these audits were discussed at the monthly 'Medication Safety Group' as well as directorate governance meetings and 'Clinical Quality Effectiveness Group'. The introduction of an Electronic Prescribing Medication Administration (EPMA) system had helped to reduce the number of recorded omitted doses. The Medication Safety Group action plan included reducing medication omissions as a high priority with a trust wide improvement project planned to start in September 2017. The Medication Safety Thermometer is a nationally developed audit tool. The audit tool was used at the trust to collect data relating to allergy documentation, medicines' reconciliations, and omitted doses of medicines (not documented and unavailable).
- The trust also used the NHS England Medicines Optimisation dashboard, which is viewed by external organisations to monitor and benchmark organisations in relation to medicines optimisation. The Medicines Optimisation dashboard supports NHS organisations by highlighting variations in local practice and provoking discussion on how they compare with other organisations. It is not a performance measurement tool and there are no targets. The trust used this information to drive improvements in patient safety.

Summary of findings

- Medicine incidents or trends in any medication issues were reviewed and discussed at the monthly 'Medication Safety Group' which then reported to the 'Medicine Optimisation Committee'. There were no reported medication related never events. When a medicine incident was reported there was full discussion with documented learning available. Learning from medicine incidents was shared and cascaded to staff in a consistent way.
- In the Medication Safety report (incorporating Medicines Optimisation data) for quarter one (April 2017 to June 2017), we saw that the proportion of patients with Medicine Allergy status documented on chart performance was 97%, in line with the trust target. The percentage of patients with an omitted medicine the day before (not documented) performance was 10%, slightly worse than the trust target of 7%.
- The trust were in the process of implementing an electronic prescribing system (EPMA). At the time of inspection, the system had been implemented in inpatient areas only, with plans to extend the provision of EPMA to the emergency department and assessment wards.
- The trust had an antimicrobial resistance and stewardship programme.
- Daily checks were in place to ensure emergency medicines were available and safe to be used. This ensured that the Guidance from the Resuscitation Council (November 2016) was followed.
- In response to the national inpatient survey results stating that patients do not routinely receive explanations of their medication and side effects before leaving hospital the trust have implemented a poster to prompt patients about medication side effects. The posters included information about medication information leaflets, and speaking to nursing staff and the pharmacist for further information.
- We saw action was taken to reduce medication errors in critical care. A standardised risk assessment was used and a library of medicines had been uploaded directly onto the medicine infusion pumps that provided an extra safety check.
- There was an effective system in place to share learning and updates in the maternity and gynaecology service. This included 'Stork Talk', where managers would update staff as well as review knowledge skills and keep up to date. For example, a recent update on the safe destruction of controlled drugs was discussed.
- However, in children's outpatients, we found 30 allergy-testing ampules were out of date, the oldest going back to 2015. The trust took immediate action to address this once we had raised

it as a concern. Pharmacy staff had planned to include the checking of allergy testing ampules in their organisational reviews. A review had been undertaken to check expiry dates of all medicines stored in outpatient areas.

- The trust had completed a safe and secure storage of medicines review in January 2017 to March 2017. The overall compliance for the trust was 85%, which was recognised by the trust as needing improvement. Plans were in place to address this.

Are services at this trust effective?
We rated effective as good.

Good

We rated the four core services we inspected (critical care, maternity and gynaecology, children and young people, and outpatients and diagnostics) as good for effective. Combining these core service ratings with the ratings for the other four services we last inspected in February 2017, the overall rating was good. We found that:

- Evidence based care and treatment within the trust was effective and based on national guidance.
- Patients' outcomes were being measured and were generally in line with national average. Action plans were in place to drive improvements.
- The Hospital Standardised Mortality ratio (HSMR) was in line with the expected rate.
- In the Sentinel Stroke National Audit Program (SSNAP) the hospital was rated as band A overall (A being the best and E the worst), in the April to June 2016 audit, which indicated a world-class stroke service.
- The service performed well in a number of other national audits, including the Myocardial Ischaemia National Audit and the National Lung Cancer Audit. We saw improved performance on previous audit results and action plans were in place where outcomes were less positive than expected.
- In the 2016 Patient Reporting Outcomes Measures (PROMS), the hospital generally performed better than the England average apart from some mixed outcomes for hip and knee replacements.
- Staff had the clinical skills, knowledge, and experience they needed to carry out their roles effectively. Staff were supported to maintain and further develop their professional skills and knowledge.
- There was effective multidisciplinary working and we saw positive collaborative working to improve patient care and service provision in all areas visited.

Summary of findings

- The service was working towards delivering sustainable seven-day services in line with its clinical strategy, with a focus on compliance with the key clinical standards.
- Staff generally understood the importance of consent and mental capacity and delivered care in accordance with legislation.

However:

- The National Hip Fracture Database audit showed the risk-adjusted 30-day mortality rate fell within the expected range nationally, but the audit's other outcomes were worse than the national average. Plans were in place to address this.
- The trust had a higher than expected risk of readmission for elective and non-elective admissions.
- The end of life service did not have the all the processes and information to manage current and future performance at the time of our February 2017 inspection. The trust had taken action to address this
- The maternity service had had higher than expected caesarean rates and perinatal mortality rates over time. Whilst actions and mitigating actions had been taken, these had not always improved outcomes. The service continued to monitor and assess these potential risks to patients.

Evidence based care and treatment

- Evidence-based guidance was used to develop how care and treatment was delivered throughout the hospital. Almost all policies were up to date, reflected national guidance and staff said they were accessible via the trust's intranet.
- There was a clear programme of audits conducted in regards to compliance to organisational standards and protocols. There was a lead consultant and senior nurse responsible for managing each departments annual audit calendar.
- In accordance with National Institute for Health and Care Excellence (NICE) and other national bodies, such as the British Thoracic Society, Royal College of Physicians, and National Cardiovascular Outcomes Research, the trust was involved in data collection for numerous national audits. This included chronic obstructive pulmonary rehabilitation, rheumatoid and early inflammatory arthritis, cardiac rhythm management, cardiac arrest, heart failure, Parkinson's, falls and fragility fracture (including hip fractures), and renal replacement therapy. We saw evidence that audit findings and recommendations were shared within the clinical specialities

and changes to local practice were made, when indicated. Guidance from other professional associations, such as the Association for Perioperative Practice (AfPP) had been implemented.

- The trust had developed a number of evidence-based, condition-specific care pathways to standardise and improve patient care and service flow. In stroke services, for example, there were care pathways for patients who were thrombolysed (a treatment to dissolve dangerous clots in blood vessels, improve blood flow, and prevent damage to tissues and organs) and patients who were not thrombolysed.
- The emergency department (ED) had developed a comprehensive falls' bundle that was based on a combination of National Institute of Health and Care Excellence (NICE CG56, 2007) and best practice guidelines for patients who have fallen from a standing height.
- The ED had developed electronic initial assessment tools (IATs) based on NICE guidelines and Royal College of Emergency Medicine (RCEM) clinical standards (RCEM, 2014). The IATs were mapped to each presenting symptom to the ED and contained guidance on tests that were required for specific symptoms and what conditions symptoms could be related to.
- The ED met most of the standards set out in the intercollegiate document 'Standards for children and young people in emergency care settings' (Royal College of Paediatric Child Health, 2012).
- Departments used the 'sepsis six' care bundle and active cancer sepsis care bundle pathways in line with RCEM guidelines and the UK Sepsis Trust (2014) for adults and children. These pathways are to aid those delivering care with the rapid recognition and treatment of severe sepsis. Care bundles are a group of best evidence based interventions to support improved outcomes.
- Pain scores had been recorded in all patient records that we reviewed and analgesia administered in a timely manner. Pain scores were recorded on initial assessment and the ED used a pain-scoring tool for adults that were based on the World Health Organisation's (WHO) 'pain ladder' on a scale from one to 10. Patients' nutrition and hydration needs were generally assessed and met in accordance with national guidance.
- Endoscopic procedures were carried out in line with national guidance and best practice. The Joint Advisory Group on Gastrointestinal Endoscopy (JAG) found that endoscopy services met the accreditation standards, which include

Summary of findings

policies, practices, and procedures. JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the Global Rating Scale (GRS) standards.

- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations and national guidelines, including Royal College of Surgeons (RCS) standards for emergency surgery.
- Medical device implants were recorded on the National Joint Register to ensure outcomes for patients undergoing joint replacement surgery were monitored.
- The critical care service used a combination of national guidelines and policy to determine the care and treatment provided. These included guidance from the National Institute for Health and Care Excellence (NICE), Intensive Care Society, the Faculty of Intensive Care Medicine and the Midlands Critical Care and Trauma Network.
- Following the removal of the "Liverpool Care Pathway" (LCP) nationally, the trust had developed a replacement called the dying person's care plan (DPCP). The DPCP was embedded on all wards across the trust.
- The hospital had received the UNICEF (United Nations Children's Fund) Baby Friendly Initiative accreditation for its maternity department. The Baby Friendly Initiative, set up by UNICEF and the World Health Organisation, is a global programme which provides a practical and effective way for health services to improve the care provided for all mothers and babies. The Baby Friendly award is given to hospitals that are deemed to have best practice standards in place to strengthen mother-baby relationships and to support mothers who chose to breastfeed.

Patient outcomes

- The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the number of deaths at a hospital is higher or lower than would be expected. The trust's HSMR for the 12-month period January 2016 to December 2016 was 'as expected', with a value of 97.4.
- The Summary Hospital-Level Mortality Indicator (SHMI) is a nationally agreed trust-wide mortality indicator that measures whether the number of deaths both in hospital and within 30 days of discharge is higher or lower than would be expected. The trust's SHMI for the 12-month period January 2016 to December 2016 was 'as expected', with a value of 0.96.

Summary of findings

- In the Sentinel Stroke National Audit Program (SSNAP) the hospital was rated as band A overall (A being the best and E the worst), in the April to June 2016 audit, which indicated a world-class stroke service.
- The service performed well in a number of other national audits, including the Myocardial Ischaemia National Audit and the National Lung Cancer Audit. We saw improved performance on previous audit results.
- The trust was a mortality outlier for complications of surgical procedures or medical care and biliary tract disease. The trust had effective plans in place and progress regarding these actions was monitored by senior managers to ensure changes were embedded to improve outcomes for patients. We reviewed the actions the trust had taken to review and understand reasons why the outliers had been identified and saw that effective and detailed actions had been taken to address these concerns.
- In the 2016 Patient Reporting Outcomes Measures (PROMS), the hospital generally performed better than the England average apart from some mixed outcomes for hip and knee replacements.
- The hospital performed better than the England average in the 2015 Bowel Cancer Audit. The hospital performed in line with the England average in the National Emergency Laparotomy Audit 2016 and the 2015 National Vascular Registry.
- The National Hip Fracture Database audit showed the risk-adjusted 30-day mortality rate fell within the expected range nationally, but the audit's other outcomes were worse than the national average.
- The trust reported consultant-specific data as part of the 'Everyone Counts' NHS England programme that is aimed at enabling members of the public to access information about outcomes after surgery. There were seven specialties that were included in the programme, such as vascular, colorectal, and urological surgery. The consultant outcomes reported were all within the expected range.
- Critical care services could demonstrate continuous patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC). A dedicated staff member was in post to support ICNARC data collection and reporting. The designated ICNARC data clerk collected performance and outcome measures for critical care patients and uploaded information into a national database. Data collected from the audit was analysed and actions taken to improve patient experience and outcomes.

Summary of findings

- ICNARC data for the period 1 April 2016 to 31 March 2017 showed that the critical care unit performed as expected and slightly better than similar organisations in eight out of the ten quality indicators. This included the number of unit-acquired blood infections, the number of non–clinical transfers to another unit, and out of hour's discharges to the wards.
- The trust had historically had a high caesarean section rate and was consistently higher than national average for some years. Actions had been put into place to ensure that women and babies received safe, appropriate, evidenced based care, which was not only based on national guidance but on their individual specific needs.
- The third Maternal, Newborn and Infant Clinical Outcome Review Programme' (MBRRACE) audit was published in June 2017. This looked at UK perinatal deaths for births from January to December 2015. The service was in the process of reviewing the audit outcomes and reviewing its action plan based on the previous audits. The stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was again up to 10% higher than the average for the comparator group.
- This third MBRRACE report reflected the service had a higher than average perinatal mortality over a period of time. The service had analysed the findings of this report and carried out detailed case reviews to understand these outcomes. We were provided with comprehensive actions plans that showed the range of actions the service was taking to improve outcomes for all patients. The service had incorporated the MBRRACE findings into its Maternity Safety Improvement Plan and Saving Babies Lives Action Plan. We saw the actions had been taken.
- A multi-disciplinary detailed local review was held in July 2017 to try to assess the deaths that were potentially avoidable and investigate local factors that might explain the rates being reported. Three areas of focus were identified:
  - Overall reporting system: what the service reported, the level of report, who the service reported to.
  - Relationship between neonatal and obstetrics teams with more MDT working and joint review of cases.
  - Intrapartum management with regards to recognition of the stages of labour and recognition of deviations from planned care and potential outcomes.
  - To review training needs analysis of staff in the service.
- Other actions taken included:
  - A review of reporting system had taken place and the clinical quality and safety midwife was the main point of contact

with MBRRACE to ensure robust, consistent and clear reporting. The service was awaiting the national tool for reporting this data which was due for general release to trusts later in the year.
  - A working group had been developed to improve communication and development of a service improvement plan between the maternity and neonatal services.
  - The service was to carry out a review of intrapartum monitoring in conjunction with the East Midlands Clinical Network.

- In the National Neonatal Audit 2015, 71% of babies born under 33 weeks at the trust were receiving mother's milk, either exclusively or as part of their feed at time of discharge from the unit compared to the national average of 58%.
- The trust took part in the National Care of the Dying Audit of Hospitals (NCDAH) 2014 to 2015. The results were published in March 2016. The trust achieved four of the eight organisational key performance indicators (KPIs). The service had produced an action plan to address the shortfalls and issues raised by the NCDAH (2014 to 2015).

Multidisciplinary working

- Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team working to deliver coordinated patient care.
- All relevant staff, teams and services were involved in assessing, planning and delivering care and treatment. Staff worked collaboratively to understand and meet the range and complexity of peoples' needs. For example, multidisciplinary meetings included physiotherapists and occupational therapists.
- There was daily communication between discharge co-ordinators, nurses and therapists, so that discharges were planned and delivered effectively.
- Staff could access the learning disability lead, critical care outreach team, pain management team, social workers, and safeguarding teams for advice and support.
- Staff worked with the critical care outreach team and hospital at night team to provide clinical support for deteriorating patients. There was an escalation policy for patients who required immediate review, for example, those with sepsis.
- Staff communicated with community health teams where necessary, for example, when discharging older patients with complex needs. Discharge letters were sent that included information from risk assessments, such as skin pressure

Summary of findings

damage. In the community, we were told of effective multidisciplinary teamwork between community midwives, health visitors, GPs and social services. The teams worked closely together, the community team told us they often provided cover for the hospital during peaks in activity.

- Care was delivered in a co-ordinated way when different teams or services were involved. The specialist palliative care team had established close links with other providers in the local area of end of life care, including the local hospice, primary care providers, and community nurses.
- In the Dickens therapy Unit (based at one of the three care homes that the hospital had provided beds for those patients assessed as 'fit for discharge'), we saw that the hospital's therapists were on site in the care home on Mondays to Fridays to provide a high level of therapy support for the hospital's patients. Staff at the two care homes we visited reported positive relationships with the hospital's staff to ensure those patients needs were being met.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Staff generally understood the guidance and legislation relevant to consent and informed decision-making. Patients were supported to make decisions as required by legislation and guidance, including the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).
- The trust's consent policy outlined staff responsibilities when obtaining consent. Staff showed us how they access the policy on the trust's electronic system. The policy was in date and reflected legislation and guidance.
- Staff we spoke with confirmed they had received MCA and DoLS training. Staff were able to describe the relevant consent and decision making requirements relating to MCA and DoLS and understood their responsibilities to ensure patients were protected.
- The hospital used four nationally recognised consent forms. For example, there was a consent form for consenting adult patients, another for patients who were not able to give consent for their operation or procedure, one for children and another for procedures under a local anaesthetic. Staff we spoke with were aware of the consent forms and knew when each should be used.
- Trust wide staff compliance with mental capacity act training was 85%, which met the trust target.
- There was not always a clear record of discussions about DNAPCR with patients who had capacity. Mental capacity

assessments were not always clearly recorded to underpin decisions about DNACPR. We raised this as a concern during the February 2017 inspection, and the trust took urgent actions to clarify with all staff the procedure for recording patient's capacity status as well as carrying out further audits to ensure this was being complied with. Data from the trust showed that compliance has improved.

- The resuscitation team had developed an action plan from the most recent documentation audit results. The action plan identified commonly missed information and the specialty with most missed information. The resuscitation team fed back the audit information to each specialty and carried out targeted training sessions when necessary.
- Staff demonstrated how Gillick competence and Fraser guidelines related to the consent process in their practice. Gillick competency and Fraser guidelines refer to children (less than 16 years of age) and as to whether they are able to consent to their own medical treatment, without the need for parental permission or knowledge.
- Completion of certificates for terminations, in line with the Abortion Act (1967) and Abortion Regulations (1991), was carried out by two clinicians, which was in line with the legislation.

Are services at this trust caring?
We rated caring as good.

Good

We rated the four core services we inspected (critical care, maternity and gynaecology, children and young people and outpatients and diagnostics) as good for caring. Combining these core service ratings with the ratings for the other four services we last inspected in February 2017, the overall rating was good. We found that:

- Staff were friendly, professional, compassionate, and helpful to patients in all interactions that we observed.
- Patients told us that the staff had been caring towards them and all spoke positively about the staff.
- Staff spoke about their patients in a caring and compassionate manner and respected patients' dignity at all times, even when the wards and clinical areas were very busy.
- Staff communicated with patients and their loved ones in ways to help them understand their care and treatment.
- Staff were aware of the impact that a patient' care, treatment or condition could have on their wellbeing and on those close to them both emotionally and socially.
- Feedback from patient surveys was generally very positive.

Summary of findings

- We saw positive examples of staff understanding the personal and social needs of their patients and family in the children and young people's service.

Compassionate care

- Staff were friendly, professional, compassionate and helpful to patients at all times.
- Staff used humour when appropriate and respected patient's individual preferences, habits, culture, faith, and background.
- Patients told us that the staff had been caring towards them and all spoke positively about the staff.
- Staff spoke about their patients in a caring and compassionate manner and respected patients' dignity at all times, even when the wards and clinical areas were very busy.
- During our inspection, we observed care being delivered by nursing, medical, therapy, and auxiliary staff interacted with patients in a positive caring manner. This included addressing patients by name, introducing themselves by name, actively listening, speaking politely and respectfully, and coming to the patient's level when they were in beds and chairs. We found all patients had nurse call bells within reach and these were answered in a timely manner by staff.
- Staff stressed to us that their primary concern was to ensure all patients received the best possible care. Staff confirmed that when they assessed patients' needs they took into account personal, cultural, social, and religious needs. Staff spoke about their patients with empathy, compassion, and courtesy. Many referred to discussions they had had with the patient and family members.
- We observed staff treating children with patience and compassion to put them at ease. Patients and those accompanying them were treated with respect.
- We saw outstanding examples of staff understanding the personal and social needs of their patients and family in the children and young people's service.
- We saw that Friends and Family Test results were regularly reviewed and shared with staff, and actions were taken to improve performance. The trust's Friends and Family Test performance (% recommended) was generally lower than the England average between April 2016 and March 2017. In latest period, March 2017, trust performance was 94 % compared to an England average of 96%. The trust reported that the percentage of patients who would recommend inpatient and day-case services had improved month-on-month from April to June 2017.

Summary of findings

- Between July 2016 and June 2017, the hospital's maternity Friends and Family Test (FTT) performance (% recommended) was better than the England average in all four areas of maternity. In the inpatient children's service FFT performance for the period February to April 2017, was just below the performance target of 94% and in the children's outpatient service was just above the performance target.
- The hospital participated in the National Cancer Patient Experience Survey 2015, which was published in July 2016. From April to June 2015, 703 eligible patients from the trust received the survey, and 483 questionnaires were returned completed. This represented a response rate of 69%, which was better than the national response rate of 66%. The trust scored in line with the national average for 40 of the 46 indicators relevant to hospital care, treatment, and staff. The trust scored better than the national average for two indicators, which were staff assisted patients to get financial help and free prescriptions. However, the trust scored worse than the national average for four indicators, which included patients felt they were always treated with dignity and respect by staff, and were told who to contact if they were worried following discharge. On a scale of zero (very poor) to 10 (very good), patients gave an average satisfaction score of 8.5, which was slightly lower than the national average of 8.7. The service had developed a detailed action plan in response to the results. We saw evidence that the majority of actions had been completed.
- The surgery service gathered feedback through a local patient experience survey. We saw actions to improve areas that received low scores.
- We saw from the National Care of the Dying Audit 2016 that the trust performed the same as the England average on the clinical indicator that patients were given an opportunity to have concerns listened to.
- The trust performed better than the England average in the Patient-Led Assessments of the Care Environment (PLACE) 2016 for assessments in relation to privacy, dignity, wellbeing and facilities, and the same as the England average for food. The patient-led assessment of the care environment audit (PLACE) for 2016 showed the trust scored better than the England average for how the environment supported the delivery of care for privacy, dignity, and wellbeing. The trust scored an average of 90%, while the England average was 84%.
- The trust August 2016 inpatient survey showed that there had been an improvement in patients reporting positively about treatment with respect and dignity (8.8 to 9.0), although this was in line with national average.

Summary of findings

Understanding and involvement of patients and those close to them

- Patients told us that they had felt involved in their care and treatment. We saw that patients were kept informed about the treatment plans at all times.
- Patients generally knew which doctor was looking after them and what diagnostic tests were being carried out.
- Staff spoke about the importance of keeping patients informed of waiting times and plans for care and treatment. Staff communicated with patients and their loved ones in ways to help them understand their care and treatment. This included adjusting the pace of their speech and recognising when patients may need extra support to communicate such as translation services.
- Staff in the ED had arranged for volunteers to attend the department and provide support and information for patients who may have social needs.
- Relatives were kept informed of plans for patients' admission or discharge as appropriate.
- We were provided with feedback about the end of life service from July to September 2016. We saw there had been 337 adult deaths at the hospital. Of these, 299 had been managed by the bereavement service. We saw the almost all families were satisfied with the level of care their loved ones had received. There were two negative concerns in relation to issues that had occurred on the wards.
- New staff nurses could be identified by a daisy badge which was worn for one year post commencement in post. This enabled patients to identify less experienced nurses.

Emotional support

- Staff told us that they would take the time to support patients and their loved ones if they were faced with distressing news. Staff were aware of the impact that a patient's care, treatment or condition could have on their wellbeing and on those close to them both emotionally and socially.
- Staff were fully aware of how to make referrals to adult and children's mental health services when required. Staff working with children and young people were aware of the support that parents needed when children attended the ED.
- Staff referred patients and their loved ones to bereavement counselling services and support networks for carers and dependents.

- Staff had awareness of patients with complex needs and when to provide them with additional support to minimise the potential of them becoming anxious or distressed. Staff signposted patients and relatives to appropriate external organisations and charities when required.
- Staff advised patients how they could access an independent advocacy service to assist with communications with the trust.
- Therapy staff conducted access visits at home to ensure stroke patients and their families had appropriate support in place to enable them to manage their health, care, and wellbeing, and maximise their independence. Clinical nurse specialists, such as stoma care nurses, provided emotional support and advice to patients and those close to them. Patients received specialist support when coming to terms with adaptions in their everyday lives and were encouraged to manage their own health.
- Staff supported patients and their relatives to use the chaplaincy service, which provided spiritual care and religious support for patients, carers and relatives as needed. Multi-faith options were available.
- Staff referred relatives to the patient advice and liaison service (PALS), bereavement service and chaplaincy services as required. The bereavement service was available Monday to Friday and was located within the hospital. Staff spoke highly of this patient support service.
- Staff in the chaplaincy team worked closely with the bereavement midwife based in the hospital maternity department. They arranged and delivered a regular remembrance service for those whose babies and children had miscarried or died. This was provided approximately every two months, and was supported by a national stillbirth and neonatal death charity. We saw a wide range of people attended this.
- The team also provided an annual remembrance service at a local church, for families and friends of adults who had died in the hospital.
- We saw that an organ donation link nurse directly promoted and supported staff and relatives with the organ donation programme.
- Children were cared for at the end of their lives in a dedicated room as part of the pathway. Bereavement support was provided on the paediatric wards, Gosset ward and in the community. The Snowdrop Suite (on the maternity unit) was dedicated to supporting bereaved parents and their relatives.

Are services at this trust responsive?
We rated responsive as good because:

Good

Summary of findings

We rated the four core services we inspected (critical care, maternity and gynaecology, children and young people, and outpatients and diagnostics) as good for responsive. Combining these core service ratings with the ratings for the other four services we last inspected in February 2017, the overall rating was good. We found that:

- The trust worked proactively with a variety of stakeholders and commissioners to plan delivery of care and treatment. There was a focus in providing integrated pathways of care, particularly for patients with multiple or complex needs.
- Due to ongoing bed capacity issues in the hospital, the service had implemented safety driven bed escalation and management process to address patient flow concerns in the hospital. This kept patients safe, even at times of significant pressure on bed capacity.
- Despite very high bed occupancy over time and on the days of the inspection, the commitment to the safety and quality of care and treatment for patients was clearly demonstrated by all staff at all levels.
- The hospital had a well-defined process for the management of medically outlying patients.
- The hospital's discharge team supported staff with complex discharge arrangements and senior managers were continually working to improve patient flow out of hospital.
- Whilst some night moves for patients were made due to the bed capacity issues, appropriate risk assessments were carried out.
- The trust had clear systems and processes in place to meet the needs of patients with complex conditions such as those living with dementia or a learning disability.
- Excellent initiatives were in place to improve care for those living with a dementia.
- The geriatric emergency medicine service (GEMS) was outstanding in terms of providing awareness of and responding to the needs of patients within this group and developing a service that provided a multi-agency approach at the front door.
- From November 2015 to October 2016, the monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was better than the England average and no patients waited more than 12 hours from the decision to admit until being admitted. In June 2017, performance against this four hour measure was 88%, in line with the England average of 89%.

- From October 2015 to September 2016, the number of patients whose operation was cancelled on the day and not rebooked within 28 days of surgery was 2%, below the England average of 8%.
- Patients had timely access to initial assessment, with 97% of patients referred to the palliative care team seen within 24 hours, between February 2016 and January 2017.
- The trust managed complaints swiftly, openly and constructively as part of a co-ordinated patient feedback system. The trust considered its handling of complaints to be fundamentally important in building its relationship with the public.

However:

- Hospital wide bed capacity affected the ability of the service to discharge patients to wards at the most appropriate time. Over eight hour delayed discharges were higher than the national average, however, action had been taken and improvement observed for patients waiting 24 to 48 hours.
- Single sex accommodation in critical care was not always maintained due to hospital wide bed pressures. Action was taken to protect patient's dignity at all times.
- The end of life care service did not collect information on the percentage of patients who died in their preferred location or about the numbers of patients who were rapidly discharged, but had access to this information from an external source. Plans were in place for the service to address this.

Service planning and delivery to meet the needs of local people

- We saw that the needs of the local population were used to inform how services were delivered. For example, we saw that key demographics such as age and lifestyle factors were included in plans to expand urgent care facilities as a part of the overall strategy to reduce admissions via the emergency department (ED).
- The ED had undergone a re-design and expansion programme, which started in 2014 and was based on the increasing levels of activity and attendances to the ED. The increase in capacity meant that the ED was able to form a dedicated area within majors for frail elderly patients. This area was called the geriatric emergency medicine service (GEMS) and consisted of five rooms within close proximity to a toilet that was accessible and adapted for patients with physical disabilities.
- A consultant in ED had started developing the geriatric emergency medicine service (GEMS) in 2014 to make the ED

Summary of findings

'frail friendly' and to improve staffs' skills in geriatric emergency medicine. The GEMS was outstanding in terms of providing awareness of and responding to the needs of patients within this group and developing a service that provided a multi-agency approach at the front door. The emergency department had recently appointed a GP to work within the ED and develop their urgent care provision.

- Due to ongoing bed capacity issues in the hospital, the service had implemented a safety driven bed escalation process to address patient flow concerns in the hospital. Working with local commissioners, the hospital had purchased 77 beds in three nearby care homes for older people. Medical care and clinical oversight was provided by the hospital and personal and nursing care by the care home staff. All patients transferred to these beds were assessed as being medically 'fit for discharge' and most were awaiting either social care packages of care or a return to their own homes. This arrangement had created extra bed capacity for the hospital and was designed to focus inpatient 'acute' beds on those unwell patients being admitted to the hospital.
- The hospital's senior staff had focused on enhanced working relationships with the local council to improve processes for effective discharge processes that involved social care funding, availability of domiciliary care support for people living in their own homes and housing issues for homeless patients.
- The hospital had taken part in a 12 week trial with the local community NHS trust to assess and discharge patients with cognitive impairments using an evidence-based delirium pathway. Senior managers said this had proven successful in helping facilitate appropriate and safe discharges for some patients with complex needs who had been in hospital for a long time and was being looked at as part of the countywide plans to facilitate discharges.
- The trust's chief operating office held weekly meetings with peer colleagues across Northamptonshire to discuss health and social care pressures and actions that could be taken to improve care and treatment across the county. We were told by commissioners and stakeholders that this collaborative working had improved how the trust looked at the capacity and demands of care needs and were looking forward at promoting care within the community and reduce the number of patients attending the emergency department.

- The trust was planning to join some speciality services with other local acute trusts to improve the quality of service provided and senior managers were proactive in the development of cross county pathways of care designed to improve timely access and outcomes for patients.
- Children's outpatient appointments were held in dedicated paediatric facilities. Age appropriate play areas were in place for children and young people and were well supplied with toys and games. There was access to a play specialist if required. Clinics were held by acute and community paediatricians in general paediatrics and in some sub-specialties, for example, diabetes, cystic fibrosis, epilepsy, endocrinology and functions such as the shoe clinic. Visiting specialists from tertiary centres held local clinics in the outpatient department. Children's pre-operative assessments were held in the children's outpatient department.
- The service improvement team worked collaboratively with the complaints team to identify where internal processes could be improved. This resulted in a workshop with the complaints team and divisional representatives in November 2016. The workshop identified several key areas for improvement which included poor access to medical notes, directorates being given too long to respond, insufficient administration staff to coordinate processes, the need for additional complaints training and the need for improvement in local resolution. Actions identified included a room being dedicated to medical notes associated with complaints to enable access, a reduction in internal timescale, the sharing of good practice the production of a complaints workbook to assist with staff development and understanding and the relaunch of the 4C's (Comments, Concerns, Complaints and Compliments).

Meeting people's individual needs

- There was a Christian chapel on site. It was a quiet space where people of all faiths and none could pray or reflect. However, there was little attempt to make the area inclusive to those of other faiths.
- The maternity department had two bereavement midwives who provided support to women and those close to them. We saw there was a specialist room called the snowdrop nursery that had been refurbished by a bereavement charity. The snowdrop nursery had a courtyard for women to use and was sensitively designed, with a dedicated entrance and exit for families. Staff supported women to collect mementos such as photographs, footprints and handprints and provided information about making a memory box for parents.

Summary of findings

- The hospital had a Macmillan cancer support information centre to ensure that people affected by cancer had access to comprehensive and appropriate information and support. The centre was open from 9am to 5pm, Monday to Friday. The service offered a drop-in service for information and support, as well as health, financial and life management advice. The team at the centre could refer to other healthcare professionals, provided details of local and national support services and organisations, details about complementary therapies and outreach sessions in the community.
- The information centre offered a team of experts and trained volunteers to answer questions, provide information regarding local support groups and help with the financial problems cancer can create. Patients and those close to them were able to access booklets, leaflets and other sources of information, free of charge.
- The hospital had leaflets available for relatives, for example, leaflets explaining procedures to be undertaken after the death of a patient. Leaflets for carers about end of life care at the hospital and information about decisions about cardiopulmonary resuscitation were also available. Staff told us leaflets could be provided in other languages, large print, and braille and in an audio format on request. Staff also told us they had access to translator services. The patient advice and liaison service (PALS) could book professional interpreters for patients.

Dementia

- The trust had worked collaboratively with the local NHS mental health trust to provide a dementia and mental health service within the hospital. The team had developed several projects to improve patient experience including introduction of finger foods, flexible visiting for carers, reclining chairs for each ward to enable relatives to stay overnight, activity boxes, dementia and buddy volunteers trained in dementia awareness.
- The trust had reported an improvement in the patient led assessment of environment for dementia care in with 82.3% from February 2017 to June 2017, in comparison to a national average of 75%.
- In the surgery service, theatre staff arranged for carers to accompany the patient to theatre where they had specific needs, such as a learning or sensory disability. Staff told us of one occasion were a patient with a learning disability required more than one procedure by different consultants and these were both done at the same time, to prevent the patient returning to the hospital.

- The trust had a named dementia lead and learning disability lead. Staff confirmed they were able to readily access these staff to discuss any concerns and to receive advice.
- The 'butterfly' scheme was used to discreetly identify patients living with a dementia. The use of the symbol enabled staff to identify patients who had a dementia diagnosis and ensure additional care and support were available.
- The surgical department took part in 'John's Campaign' for patients living with dementia. John's Campaign promotes hospitals to allow carers of patients living with dementia to stay with them in hospital, particularly during meal times as eating and drinking can be difficult for some of these patients when in hospital. Staff provided carers with food so that they could eat with their relative and felt that it had a positive effect on the patients' wellbeing.
- The discharge lounge had been specifically designed to cater for patients with a cognitive impairment.

Access and flow

- The trust admitted 91,271 patients from February 2016 to January 2017. There were 560,061 attendances to outpatients and 116,773 attendances to the emergency department. This was an increase in attendances across all areas in comparison to data collected for April 2015 to March 2016.
- We saw a strong operational team, who were forward thinking and actively sought answers for issues that may arise relating to capacity. There were clear criteria and processes for the opening of additional beds, with each decision risk assessed by the appropriate clinical lead. During our inspection, the trust was under considerable pressure due to increased activity. We saw that the team responded well to the additional demands, remained calm and methodically prioritised actions.
- The hospital held a safety huddle meeting two times a day. A representative from each ward and department attended these meetings. We observed a safety huddle during our inspection. Staff highlighted any staffing issues, capacity issues, potential discharges and patients who were not in the appropriate speciality ward. At these meetings, the commitment to the safety and quality of care and treatment for patients was clearly demonstrated and all staff worked towards this positively.
- Patient flow and bed capacity meetings were held up to five times a day with senior staff focusing on safe and effective patient flow throughout the hospital. There was a clear focus

Summary of findings

on safe, supported, appropriate discharge and all staff worked positively to improve patient flow. The hospital had a well-defined process for identifying patients for discharge for the next day.

- Bed occupancy was reported to be at 104% on one day of our February 2017 inspection and frequently over the past year, the hospital had had bed occupancy rates over 95%. At peak demand times, this represented an average of 9% of the bed base at the hospital.
- The hospital had a well-defined policy and process for the management of medically outlying patients and senior staff monitored the number of outliers throughout each day to ensure there was appropriate clinical oversight and appropriate nurse staffing levels.
- There were areas and departments in the trust that would be used for inpatients when there were significant bed pressures. These were called escalation areas or beds. These were areas that were not usually used for inpatients. The trust had a policy to guide staff regarding this and risk assessments were carried out. There were also clear guidelines regarding the types of patient that would be acceptable for the escalation areas. During our inspection, there were escalation beds open across the trust, including the Heart Centre, Beckett, Holcott, Brampton, Willow and Collingtree wards.
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED. The hospital failed to meet this target from January 2016 to December 2016 and was below the England average for eight out of the 12 months. Overall, for that period the ED achieved 87% against an England average of 90%. The ED had a recovery plan to improve performance to this target, which had been agreed with local commissioners and other stakeholders. Senior staff told us that there were a number of contributing factors to the failure to meet the target, which included an increase in attendances and other trust wide issues. In June 2017, performance against this four hour measure was 88%, in line with the England average of 89%.
- Performance against the four-hour performance standard was a part of the urgent care overall improvement plan and was discussed at board level. It was recognised that performance against this target was affected by other factors in the trust and the wider care network, such as delayed transfers of care and patients that were waiting in inpatient areas whilst they waited for appropriate care to be arranged in the community.

Summary of findings

- From May 2016 to April 2017, the trust's referral to treatment time (RTT) for non-admitted pathways for patients treated within 18 weeks was 95% and this was better than the England average of 90%. For July 2017, performance was 92%, in line with the England average. The trust has been consistently above the England average and, where the England average had seen a gradual decline in performance, the trust had seen a gradual improvement in performance. A total 22,468 patients were waiting for an appointment with half that number of patients waiting less than seven weeks.
- In terms of cancer waiting times standards for quarter one 2017/18 (April 2017 to June 2017), the trust performed:
  - Two week wait for first appointment was 89%, below the England average of 93%.
  - For the cancer standard of first treatment in 31 days of decision to treat, performance was at 98% which was better than the England average of 97%.
  - For the cancer standard for the 62 days GP referral to commencement of treatment, performance was 70%, below the England average of 80%. This was comparable with the previous quarter.
- The services' dashboards for June 2017 showed improved performance in all of these standards:
  - The two week wait for first appointment performance standard was 93%, in line with national standard.
  - For the cancer standard of first treatment in 31 days of decision to treat, performance was at 97%, above the standard of 96%.
  - For the cancer standard for the 62 days GP referral to commencement of treatment, performance was 91%, above the national standard of 85%.
- The hospital's proportion of cancelled operations as a percentage of elective admissions for the period January 2017 to March 2017 was 2% greater than the England average of 1.1%.
- From January 2017 to March 2017, 1.7% of patients whose operation had been cancelled on the day were not rebooked to be treated within 28 days. This was lower than the England average for the same period at 8%.
- In April 2017, only 0.5% of patients were waiting over six weeks for a diagnostic test and this was better than the national average of 1.8%. As of June 2017, the service's dashboard showed 100% of patients were seen within six week.
- For June 2017, the proportion of clinics where the patient did not attend was 7% and this was same as the England average

Summary of findings

of 7%. The service had plans to develop appointment scheduling to include an appointment reminding system, which contacts patients in advance by the patients preferred method.

- From March 2015 to February 2016, patients at the trust had a higher than expected risk of readmission to hospital for non-elective and elective admissions. The elective speciality clinical oncology was notably higher than the expected. Whereas, the elective specialty of general medicine was lower than expected. The hospital explained that they were working to reduce readmissions through a variety of programmes.
- Hospital wide bed capacity affected the ability of the service to discharge patients to wards at the most appropriate time. Over eight hour delayed discharges were higher than the national average, however, action had been taken and improvement observed for patients waiting 24 to 48 hours.
- Single sex accommodation in critical care was not always maintained due to hospital wide bed pressures. Action was taken to protect patient's dignity at all times.
- Patients had timely access to initial assessment in the end of life care service, with 97% of patients referred to the palliative care team seen within 24 hours, between February 2016 and January 2017. The end of life care service did not collect information on the percentage of patients who died in their preferred location or about the numbers of patients who were rapidly discharged, but had access to this information from an external source. Plans were in place for the service to address this.

Learning from complaints and concerns

- Reported complaints were handled in line with the trust's policy. Staff directed patients and relatives to the Patient Advice and Liaison Service (PALS) if they were unable to deal with their concerns directly. Information was available in the main hospital areas on how patients could make a complaint. The PALS provided support to patients and relatives who wished to make a complaint.
- The trust complaints' department and the PALS were managed separately by two managers who worked collaboratively to ensure patient and carer satisfaction. We saw that patients and carers were encouraged to share their comments or concerns and when necessary these were escalated and investigated by appropriate staff.
- The patient and carer experience and engagement group completed quarterly reviews of all complaints and concerns raised with the trust. The February 2017 report on showed that

the trust had received 405 complaints from April to December 2016, which was fewer than April 2015 to December 2015 when the trust had received 439 complaints. The report outlined trends and themes such as complaints regarding care, communication, discharge planning and delays in treatment. The report also identified complaints against the main location and division. There was no trend in the location of complaint, with inpatient services receiving the most complaints (25) in April to June 2016, trauma and orthopaedic service receiving the most complaints (24) in July to September 2016 and urgent care receiving the most complaints (24) in October to December 2016.

- In February 2017, there were 11 trust complaints with the Parliamentary and Health Service Ombudsman (PHSO). The role of the PHSO is to investigate and act upon complaints where individuals feel that they were treated unfairly or dissatisfied with the outcome of local complaints process. Of the 11 complaints, the trust were awaiting a decision from the PHSO whether nine complaints were to be investigated, one had been partially upheld with a local action plan being devised and one was closed as not upheld.
- There was a robust system in place for the investigation and writing of complaint responses. Complaints were investigated by the most appropriate clinical lead, and the information was shared with the complaints officer who compiled the trust response. The proposed response letter was reviewed by a member of the patient advice and liaison team whose responsibility was to ensure ease of reading as a non-clinical expert. Each complaint required sign off by the chief executive officer and at least one director. For example, the chief executive officer and the director of nursing, midwifery and patient services would sign off a complaint about nursing care.
- We saw that 93% of complaints were responded to within the timescale agreed by the complaints manager and patient/ relative.
- Action plans for learning from complaints were logged on a trust wide database. Staff responsible for actions were required to provide evidence of completion. Actions were rated as red (timescale exceeded), amber (on target) and green (complete) and tracked by the complaints team.
- The complaints' team devised quarterly division reports that outlined the number and type of complaint, details of themes and actions and details of any learning. The divisional leads were responsible for the sharing of the information and the ownership of the meetings.

Summary of findings

- The complaints' team had experimented in ways of capturing feedback from patients and their families about the complaints process. A trial was carried out by sending surveys to complainants through the clinical audit team, several weeks after the complaint closure and with response letters. The team had found that responses to the questionnaire had varied. The team were planning to revert back to sending surveys though the clinical audit team.
- Complaints that had safeguarding concerns were investigated in conjunction with the safeguarding team.
- Notice boards on the wards included 'You said' 'We did', in response to patient comments. For example on some wards, such as Willow and Hawthorn wards, patients had complained about the noise level at night. As a result, a sleep well pack was given to patients who had difficulty sleeping at night, which included earplugs and an eye mask.

Are services at this trust well-led?
We rated well-led as good.

Good

We rated the four core services we inspected (critical care, maternity and gynaecology, children and young people, and outpatients and diagnostics) as good for well led. Combining these core service ratings with the ratings for the other four services we last inspected in February 2017, the overall rating was good at hospital level. Urgent and emergency care was rated as outstanding for well led at that inspection.

We rated well led as good at trust level reflecting the clear vision and leadership provided at this level. We found the trust had taken significant action to meet the concerns raised from the January 2014 inspection, particularly in establishing an inclusive and supportive staff culture with a clear focus on patient safety. We found that:

- The trust's leadership team were established and experienced members of staff and staff described the leadership team as approachable, cohesive, and inclusive. Leaders had a shared purpose, strove to deliver and motivate staff to succeed. Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the trust's culture.
- The trust had a model of clinical leadership that was understood by staff we spoke with and showed, on the whole, excellent engagement with the consultant, medical and nursing bodies.
- The focus on safe patient care, despite the significant operational pressures during the days of the inspection, was clearly evident in all areas and from all staff we spoke with.

Summary of findings

- There was a trust vision and this was underpinned by objectives and plans that staff understood and were able to describe. The trust had a well-developed and established set of values that were recognised by almost all staff and were fully embedded in the way that all services were delivered.
- The trust's strategy and supporting objectives were stretching, challenging and innovative while remaining achievable and with full consideration of effective use of resources.
- A systematic approach was taken to working with other organisations to improve care outcomes, to tackle health inequalities and obtain positive outcomes for all patients in the local community.
- There were comprehensive systems in place to report and learn from risk with effective systems for identifying, capturing and managing issues and risks at team, directorate and organisation level in all services.
- Potential risks to patient safety and the quality of care and treatment for all patients due to increased pressures on bed capacity had been recognised and effective systems were embedded to maximise patient safety.
- Performance in national audits and benchmarking with regional and national peers was generally used to drive improvements in services.
- There was a well-developed quality improvement programme at the hospital, which trained staff in quality improvement and service improvement methodology and achieved improved outcomes for patients.
- The standard of the divisional risk registers was consistent and we were assured that there was effective divisional ownership and scrutiny. Action plans following serious incidents were completed and monitored effectively.
- The trust was proactive in engaging with staff. Almost all staff were very positive about the leadership of the board and senior managers. The level of staff support, respect and commitment to each other was clearly evident in all areas. Staff referred to the 'Team NGH' spirit and culture and were proud of this. Staff were proud of the organisation as a place to work and spoke highly of the culture.
- There were consistently high levels of constructive engagement with staff, including all equality groups. Staff at all levels were actively encouraged to raise concerns.
- Since the CQC visit in 2014, the trust had seen a consistent and positive improvement in its overall NHS Staff Survey results, which had resulted in significant improvements in staff engagement and overall satisfaction at work.

Summary of findings

- The trust had a well-developed staff health and wellbeing strategy and a variety of healthy lifestyle initiatives were available for all staff to access.
- Innovative approaches were used to gather feedback from patient services and the public, including people in different equality groups. Constructive challenge from patients, the public, stakeholders, and regulators was welcomed and seen as a vital way of holding services to account.
- The leadership team drove continuous improvement and staff were accountable for delivering change. Safe innovation was celebrated. There was a clear, proactive approach to seeking out and embedding new ways of working and new models of care.
- Full and effective fit and proper person checks were in place.
- There was an understanding of the Duty of Candour amongst almost all staff, and the trust had a being open policy. The role of the Freedom to Speak Up Guardian was well embedded in the trust.
- Fire safety processes were effective.

However:

- We saw that the trust was in the process of redeveloping the corporate risk register. We saw that the current format was not categorised or prioritised according to subject or severity. This meant that several risks relating to the same or similar issues appeared in different places in the risk register, such as staffing; therefore it was difficult to see the overall risk.
- Whilst we identified some potential risks to patient safety during the inspection, prompt actions were taken by the trust leadership team immediately to address those areas and risks that needing improving.

Leadership of the trust

- The trust had an established executive board with all members having worked within the trust in their current positions for at least 18 months. The executive team worked collaboratively to manage the trust and provide safe, high quality care for all patients. All leaders spoke highly of their peers and of all staff in the trust.
- The trust's leadership team were established and experienced members of staff and staff described the leadership team as approachable, cohesive and inclusive. Leaders had an inspiring shared purpose, strove to deliver and motivate staff to succeed. Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the trust's culture.

Summary of findings

- The chief executive officer (CEO) particularly was seen by staff as highly visible and approachable by all staff. Visibility amongst the rest of the board was reported as very positive. The CEO was widely regarded by external stakeholders as being a strong leader who took swift, appropriate actions to manage service pressures without compromising the safety and quality of patient care and treatment as well as actively driving forward the trust's improvement agenda.
- The trust operated a clinically led model of leadership, which aimed to create more local decision-making and ensure greater collaboration between medical, clinical and managerial staff. Clinically led models of leadership have been shown to produce better results and improve the quality and safety of care provision. The level of constructive challenge between clinicians on the executive team was evident. The level of challenge from non-clinicians and non-executive directors was not fully captured on the trust papers presented to board, but there was evidence in the trust's various sub-group meeting minutes of challenge.
- We reviewed the quality governance committee meetings, for October, November and December 2016. Minutes from these meetings showed varied level of challenge to the executive directors, with 13 queries and two challenges in October 2016, five queries and one challenge in November 2016 and three queries and one challenge in December 2016. The director of corporate development, governance and assurance told us that the executive board had been working with the non-executive directors to identify areas for learning. The board had recently appointed two new non- executive directors.
- The medical, nursing and governance directors had clearly defined roles and responsibilities. The medical director was the lead for patient safety, quality and clinical effectiveness, with responsibilities that included the leadership of the medical staff, the resuscitation services, safety academy and quality improvement programmes. The director of nursing, midwifery and patient services was the lead for patient experiences, with responsibilities for complaints, practice development, safer nursing staffing and primary care and clinical commissioning group liaison. The director of corporate development, governance and assurance was responsible for medico-legal services, health and safety, compliance and information governance. Their role was also to support the medical and nursing directors in the improvement in quality of care.

Summary of findings

- Our discussions with leaders and senior managers confirmed that they understood the challenges to providing safe patient care. They were taking actions to address these challenges such as developing services to meet the needs of different patient groups.
- Senior managers and staff at all levels and grades told us that their main aim was to keep patients safe and provide the best care and treatment possible. This focus on safe patient care, despite the significant operational pressures during the days of the inspection, was clearly evident in all areas and from all staff we spoke with.
- The staff survey in July 2016 reported that 34% of staff reported positively about communication between senior management and staff, which was a 5% improvement from previous staff surveys.
- Nursing staff spoke positively about the director of nursing, midwifery and patient services, stating that their enthusiasm had promoted a renewed energy for development. Ward sisters and junior sisters managed the wards on a day-to-day basis and were supported in their duties by matrons. All ward sisters spoken with told us that clinical leads and matrons were accessible, supportive and visible. We observed matrons attending wards to support staff, discuss activity and share any issues that had arisen.
- We saw that leaders of services encouraged supportive relationships among staff through developing 'buddy' programmes for new starters and encouraging shared learning amongst staff groups.
- The trust had embarked on a leadership training programme and some senior nursing and medical staff were taking part in the programme. This meant there were comprehensive and leadership development strategies in place to ensure the delivery and development of a positive culture within the department.
- Leaders had taken action to drive improvements since the last inspection. At the February 2017 inspection, not all patients' records were stored appropriately but the trust took immediate action to address this concern by providing lockable note trollies for all clinical areas. We found all records stored appropriately on this inspection in all areas visited. We also found that significant improvements had been made in the completion and 24 hour review of patient's venous thromboembolism risk assessments.

Vision and strategy

Summary of findings

- The trust had a vision, which was widely acknowledge by the whole staff team. The trust vision was 'To provide the best possible care for all our patients' and the values were to '…put patient safety above else…aspire to excellence…reflect, learn and improve…respect and support each other'. Staff told us that the trust's values were important to ensure that the patient was at the centre of everything they did.
- Services had well defined strategic plans that set out defined realistic objectives for the future development and sustainability of the departments and was in line with the trust's overall strategy. There was a coherent strategy for engaging with key partners. The strategy and supporting objectives were stretching, challenging and innovative while remaining achievable and with full consideration of effective use of resources.
- We saw the trust operational plan for 2016/17, which had identified areas within the divisions as priorities. This included delivering excellence in the care of the elective patient, focusing on dedicated orthopaedic and ophthalmology services to increase quality, reduce clinical variation, and provide centres of excellence in the county.
- Plans had been developed through staff engagement exercises and consultation meetings. All staff we spoke with were aware of the strategy and their role in achieving it; this included having the opportunity to feedback and contribute to plans.
- The director of facilities and estates and the estates team had a complete oversight of the premises and facilities at the hospital and had a comprehensive estates' strategy 2015 to 2020 in place. The environment of the entire estate (despite some parts being over 275 years old) was extremely well maintained. There were also detailed plans for a rolling programme of ward maintenance and refurbishments for the next two years.
- Staff told us about the immediate plans to develop the urgent care facilities through external partnership working and the long-term plans for developing staff and existing services. Staff spoke positively about the recent appointment of a GP in the emergency department and the potential impact that would have in terms of opportunities for shared learning and governance arrangements.
- Specialist palliative care and ward staff told us end of life care was a high priority for the trust. The hospital had a three-year strategy for end of life care for adults for 2017 to 2019 to achieve its priorities and deliver good quality care. The strategy set out the trust's commitment to support the provision of safe,

Summary of findings

responsive, effective, compassionate, and well-led care for patients recognised to be in the last year of life. This included those whose recovery was uncertain and those who were in the last days and hours of life.

- Each strategy objective had defined work streams with designated leads and individual action plans. For example, a key area was refining the streaming process to ensure that patients were being seen by the most appropriate service including referrals to external services. This was in line with NHS England Sustainability and Transformation Programmes and the Keogh report 'Transforming urgent and emergency services in England' published in November 2013.
- A systematic approach was taken to working with other organisations to improve care outcomes, to tackle health inequalities and obtain positive outcomes for all patients in the local community. Commissioners and stakeholders spoke positively about the way senior managers of the trust engaged with partners about the wide health and social care economy challenges in the county and were proactive in designing new pathways of care to improve access and outcomes for all patients.
- Progress against the strategy was monitored and discussed at divisional meetings with updates disseminated via departmental meetings and the trust's intranet.
- Senior staff attended trust wide multi-disciplinary meetings that fed through to executive level and the trust's board.
- The director of nursing, midwifery and patient services had implemented a ward accreditation scheme, whereby wards were monitored on a number of objectives, such as audit results, number of complaints, number of infections, response time for investigations and safeguarding referrals. The objectives and the wards ability to maintain targets generated a ward rating. Nursing staff told us that the accreditation scheme had encouraged the teams to develop ways in maintaining quality care and meeting target, this promoted a "healthy competition" between wards, with ward sisters aiming to be the first outstanding ward in the trust.
- Under the trust's health and well-being strategy, a programme was under design on building resilience and senior staff saw this as a key way to support staff in dealing with challenging situations. The trust's organisational development team had implemented the 'Rainbow Risk' process based on the trust values to facilitate staff diagnosing their preferred style of working and to establish mechanisms for interactions that draw the full potential out of relationships at work in a meaningful

and insightful way. The 'Rainbow Risk' process was short, simple, creative, and universally accessible, and senior staff said it had lasting positive effects on relationships and communication at work.

- The trust delivered and supported leadership and management development programmes including:
- The Francis Crick senior leadership programme (phase two). This was an 18-month development programme focused initially on the leaders in the clinically led structure. This programme covered managing quality and quality improvement, leading people, managing change, strategic effectiveness and financial effectiveness.
- The consultant development programme continued and aimed to engage and enthuse staff around topics of importance including quality improvement.
- Plans were in place to make the Royal College of Nursing leadership programme be available.
- The trust's organisational development team were in the process of developing a new management and leadership development for middle managers for bands 5 to 7 and equivalent roles across the trust The programme was due to available in 2018 and was intended to include transformational core modules with transactional/job specific options for managers to select. The programme was also to include a service improvement project that aims to further embed the trust values.

Governance, risk management and quality measurement

- Governance and performance arrangements were proactively reviewed and adapted to take into account national best practice. There was a governance system in place and monthly meetings were held and these were well attended by staff at all levels.
- There was an effective understanding of performance that integrated the needs of other areas in the trust and the needs of the community whilst focusing on patient safety and quality improvements within the department. The trust had devised a quality improvement strategy, which had been formally approved to be launched in February 2017.
- Monthly directorate governance meetings were held, which fed into monthly divisional governance meetings, who in turn reported to the trust governance group. We reviewed directorate and divisional governance minutes, which showed incidents, risks, audits, safety and quality improvements, clinical effectiveness, and patient experience were discussed and areas for improvement identified.

Summary of findings

- Any potential serious incidents within a service were escalated to the trust governance team and reviewed at the weekly review of harm group meeting. If an incident was declared as a serious incident an appropriate senior member of staff would be appointed to lead the investigation and conduct a root cause analysis.
- The governance team had changed the root cause analysis investigation process for incidents by forming a cohort of specially trained individuals who would lead an investigation panel to conduct a root cause analysis. The team also included experts both internally and externally to establish the root cause and make recommendations from the learning identified. Previously investigations were completed by a designated senior nurse and clinician allocated by the governance team. The trust had recognised that the resource this provided made conducting a robust root cause analysis challenging.
- Services had a robust audit programme in place to ensure they were continuously improving their patient care. This programme was informed by national guidance, patterns of incidents and patient outcomes. Findings from audits were shared with staff through a variety of means, such as team meetings, safety huddles, and communication folders.
- Each ward maintained a nursing quality and performance dashboard, designed in line with recommendations set out in the 'High Quality Care Metrics for Nursing' report (2012). Patient data was audited monthly against quality care indicators, which included falls/safety assessment, pressure prevention assessment, and patient observation and escalations. A traffic light system was used to flag performance against agreed compliance thresholds. The data was reviewed monthly at the nursing and midwifery board and any red and amber areas were discussed and reviewed by the senior nursing team. Areas of variable or poor performance were discussed at trust board and divisional meetings and actions were taken to improve.
- Quality matrons assisted with the development of wards and clinical areas. Their responsibilities were to identify a baseline of each clinical area and then assist the team to develop systems and processes to improve standards. In conjunction with this, the director of nursing midwifery and patient services had introduced a ward accreditation scheme. This included the review of aspects of care and performance to identify where there were pressures and areas for improvement. Each ward was rated as red, amber, or green according to performance against trust targets and standards. For example, a green rating

would require audits to be completed in a timely manner, show achievement of targets, staff would need to be compliant with mandatory training, and there could be no outstanding actions for investigations and complaints.

- Each specialty within surgery held its own clinical governance meetings. We reviewed minutes of these which included incidents, complaints, audits, policy updates and training. These meetings that were well attended by members of the multidisciplinary team and minutes were available for those that could not attend. The department managers held team meetings within specific wards and theatres to cascade information. Most departments had daily staff huddles at handover to share information such as recent incidents, complaints, new policies and any relevant updates.
- Local risk registers generally reflected the risks within services and there was evidence of ownership, mitigations having being implemented and ongoing monitoring. Significant issues that threatened the delivery of safe and effective care were identified, and risks management including assessment, mitigating action and review was demonstrated.
- We saw that the trust was in the process of redeveloping the corporate risk register. We saw that the current format was not categorised or prioritised according to subject or severity. This meant that several risks relating to the same or similar issues appeared in different places in the risk register, such as staffing; therefore it was difficult to see the overall risk. There were also inconsistencies in the scoring of risks before and after mitigation. The trust governance lead was fully aware of the limitations of the risk register in its current format and told us that the risk register had been developed since our last inspection and required further user training and organisation. There had recently been changes to the governance team to enable one individual to be responsible for the production of an enhanced register.
- We saw that the quality governance committee meeting minutes in November and December 2016 did not evidence a review of the risk register and board assurance framework as per terms of reference, which documented that they should be reviewed at this committee monthly. However the chief executive advised that these were reviewed once a quarter and a wider range of the minutes reflected this.
- According to the trust's well-led framework gap analysis carried out in January 2017, to meet the requirements of NHS Improvements well-led framework, the revised Board Assurance Framework received internal audit opinion of substantial assurance in 2016 and had been revised to include indications

Summary of findings

as to the level and type of assurance on which the trust board was relying. The trust's risk management strategy and implementation plan had been approved and the trust's clinical audit strategy and plan was place. The clinical audit function was now aligned within the governance division to provide improved support. The trust's clinical audit and effectiveness group had been strengthened with greater clinical representation and leadership.

- We saw that the trust had an effective structure for reporting and escalation, with specialists groups reporting into speciality committees and to the trust board. For example, the waste management group reported into the estates' governance group, the health and safety committee and then the quality governance committee and trust board. We saw evidence from meetings, which confirmed that information was shared up to, and down from trust board. The trust has a comprehensive audit calendar, which identified a risk of the month.
- The Commissioning for Quality and Innovation (CQUINs) payment framework encourages care providers to continually improve how care is delivered and to achieve transparency and overall improvements in healthcare. In 2016/17, the trust fully achieved six out of eight CQUINs to drive improvements in services. These included the CQUINS for end of life pathways, dementia discharge summaries, delayed transfer of care, acquired kidney disease and for staff health and wellbeing. The trust fully achieved the CQUIN for sepsis screening and antibiotic administration in the emergency department in 2016/17, but only partially achieved it for antibiotics given in inpatient wards. Another CQUIN, for reduction in antibiotic use per 1,000 patient admissions, was partially achieved.
- The trust had a number of nationally accredited services, including full accreditation for the endoscopy service under theJoint Advisory Groupon gastrointestinalendoscopy (JAG). JAG was established in 1994 under the auspices of the Academy of Medical Royal Colleges. The trust was also licensed by the Human Tissue Authority and the Medicines and Healthcare Products Regulatory Agency and compliant with the United Kingdom Accreditation Service(UKAS) Clinical Pathology Accreditation scheme. UKAS is the sole national accreditation body recognised by the government to assess the competence of organisations that provide certification, testing, inspection and calibration services. It evaluates these conformity assessment bodies and then accredits them where they are found to meet the internationally specified standard.
- There was a well-developed quality improvement programme at the hospital, which trained staff in quality improvement and

service improvement methodology. The trust's 'Making Quality Count' development programme enabled teams to come together and work on a quality improvement project using a 'learning through doing' approach. This approach had delivered a number of improvements in practice and clinical care. Staff said these projects had improved services for both patients and staff significantly. Recent quality improvement work had been submitted to the International Forum on Safety and Quality in Health Care where 25 posters had been accepted for presentation. One of these projects was also shortlisted for a national award.

- In 2017, the Improving Quality Efficiency (IQE) team supported one of the nursing sisters to win the trust's 'Achieving Best Care Award for Innovation' by redesigning the patient flow into and through the pre-operative assessment unit. Further to this they were supporting pre-operation by streaming the fit and healthy at outpatient's clinic so as they did not need a preoperative consultation. The IQE team also worked with the maternity service to improve patient outcomes in the diabetic clinic from a waiting time of over three hours to be seen in a multidisciplinary clinic. By redesigning the flow of the clinic, staff were able to reduce patient waiting times by 52 minutes. The trust's 'Making Quality Count' development programme enabled teams to come together and work on a quality improvement project using a 'learning through doing' approach. These projects had improved services to patients and staff significantly.
- We reviewed fire safety risk processes in a number of clinical areas and found that all fire safety equipment and processes were effective and in date. Risk assessments were thorough and were reviewed frequently. In accordance with trust procedures, regular checks of fire safety equipment and environmental checks were carried and documented. The trust had also carried out of review of all high rise buildings on site to ensure no risks due to building 'cladding' were present. Governance processes surrounding fire safety were well established and effective.

Culture within the trust

- Overall, almost all staff expressed high levels of satisfaction and were proud to work for the trust. Staff reported feeling respected, valued, supported and appreciated. Staff were proud of the organisation as a place to work and spoke highly

Summary of findings

of the culture. There were consistently high levels of constructive engagement with staff, including all equality groups. Staff at all levels were actively encouraged to raise concerns.

- All staff we met were welcoming, friendly, and helpful. It was evident that staff cared about the services they provided and were proud to work at the trust. All staff we spoke with were committed to providing the best possible care for patients. Staff felt there was a positive working culture and all teams and wards reported good team working. Staff referred to the 'Team NGH' spirit and culture. This mutual respect and support for each other was clearly evident in all areas.
- Nursing staff told us they felt respected and valued and reported very positive relationships with consultants. Staff agreed there was a culture of openness and honesty throughout the service. Multidisciplinary teams worked collaboratively and were focused on improving patient care and service provision.
- The culture of the trust was centred around 'patient safety first' and staff felt that they were not under pressure to achieve targets at the detriment of patient care. Staff told us that when the emergency department (ED) was experiencing high levels of demand it was seen as a hospital wide issue and staff from other specialities worked within ED to keep the doors open for patients. We saw this clear focus on patient safety by all staff at all times during the inspection, even when the ED was under considerable pressure due to the increased number of attendances. The level of staff support, respect, and commitment to each other was clearly evident in all areas.
- The trust had a well-developed staff health and wellbeing strategy and a variety of healthy lifestyle initiatives were available for all staff to access. Staff spoke highly of these initiatives which underpinned the trust's commitment to promoting a healthy workplace.
- Since the CQC visit in 2014, the trust had seen a consistent and positive improvement in its overall NHS Staff Survey results, which has resulted in a significant decrease in the number of key findings that were in the bottom 20% of all acute trusts.
  - In 2012, 24 out of 28 of the staff survey outcomes were in the bottom 20% nationally for acute trusts.
  - In 2014, 18 out of 28 of the staff survey outcomes were in the bottom 20% nationally for acute trusts.
  - In 2016, only two out of 32 of the staff survey outcomes were in the bottom 20% nationally for acute trusts, 26 were in line with the national average, and four were in the top 20% nationally.

Summary of findings

- Likewise, the overall staff engagement score had improved over the same time period, rising to 3.83 in 2016 and the trust's senior managers attributed this improvement to:
  - The employee engagement strategy.
  - The trust's values.
  - Developing and engaging staff around quality improvement.
  - Implementing a clinically led structure and leadership development.
  - Stability within the executive team.
  - Clear focus on staff engagement and motivation.
- The trust's score of 3.83 was average when compared with trusts of a similar type. This was an improvement from the previous year.
- The trust introduced listening and learning events, for all staff. The format of which varies between informal events, workshops and question time events. These were reported as being well attended. The director of nursing, midwifery and patient services told us that these events had been used to formulate and share the nursing strategy, which was launched in December 2016. It was reported that over 1,000 nurses had contributed to the development of the strategy.
- "Dare to share" events had been introduced in 2016. These were open events, which staff could attend to hear about incidents that had occurred across the organisation. The initial meeting was so successful, that a large venue was required for the following meetings. Staff who attended the events were asked to comment on what they were taking back to the wards following the meetings.
- Staff attending the CQC drop in sessions were largely positive about the trust, their colleagues and their achievement. We heard representatives from all areas detailing changes to their service and plans for future developments. This included the estates department's plans to increase green spaces within the hospital site in line with the mental health initiatives for 2017.
- Staff were proud to be associated with the trust and spoke positively of their colleagues.
- Senior managers said the reduction in staff sickness absence was linked to good management, morale and motivation despite the considerable pressures that staff were under.
- A new appraisal system was being introduced and workshops were held to support it. The value 'Aspire to Excellence' was to be included within appraisals to encourage staff to identify one improvement within their area, which they could instigate. There was training on the methodology and this was designed to help build all staff's quality improvement appetite. Staffs' objectives were agreed to meet the trust's priorities.

Summary of findings

- The Freedom to Speak Up review by Sir Robert Francis into whistleblowing in the NHS concluded that there was a serious issue in the NHS that required urgent attention if staff are to play their full part in maintaining safe and effective services for patients. A number of recommendations were made to deliver a more consistent approach to whistleblowing across the NHS, including the requirement for all organisations to appoint a Freedom to Speak Up Guardian and the development of a single national integrated whistleblowing policy to help normalise the raising of concerns. The trust had followed all these recommendations and staff could access the Freedom to Speak Up Guardian in confidence. We saw that quaterly reports were prepared highlighting the main themses arising from contact with the Freedom to sepak Up Guardian. We saw actions had been taken including improvements made regarding non-invasive ventilation therapy and a review of maternity midwifery staffing, including a follow up assurance audit by the trust's internal auditors.

Equalities and Diversity – including Workforce Race Equality Standard

- In July 2014, the Equality and Diversity Council agreed new work to ensure employees from black, minority and ethnic (BME) backgrounds had equal access to career opportunities and received fair treatment in the workforce. There were two measures in place the equality and diversity system 2 (EDS2) and the workforce race equality standard (WRES) to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010.
- A practice and professional development forum had been organised to ensure staff from all backgrounds received an assessment of training and development needs and were given opportunities to meet those needs. The percentage of staff receiving equality and diversity training was in line with national averages.
- There was effective support for a diverse community by providing extensive interpreter and translation service, including for sign language. Information had been provided in easy read and picture-based formats for patients with learning disabilities.
- In the 2016 staff survey, the trust performed in line with the England average for the percentage of staff from black, minority and ethnic (BME) backgrounds experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months, at 26% compared to 26%. The percentage of BME staff

experiencing harassment, bullying or abuse from staff in last 12 months was 23% compared to 27% nationally. It was better than the England average for the percentage of BME staff believing that the organisation provided equal opportunities for career progression or promotion at 72% compared to 76%: this was much less than for white staff at 88%. It performed better than the national average of 14% of BME staff who in the 12 last months had personally experienced discrimination at work from manager/team leader or other colleagues at 12%. However, this was significantly higher than for white staff at 6%.

Fit and Proper Persons

- The fit and persons requirement (FPPR) for directors was introduced in November 2014. It is a regulation that intends to make sure senior directors are of good character and have the right qualifications and experience
- There were comprehensive mechanisms in place for the fit and proper person test for newly appointed executives and board members with a clearly defined policy in place to govern this process.
- We reviewed eight director's files to assess compliance against fit and proper person legislation and all the required checks had been carried out. The trust also carried out audits of staff files to ensure appropriate documentation was in place. An effective policy was in place regarding all required checks and documentation and linked to the trust's recruitment policy.

Public engagement

- Innovative approaches were used to gather feedback from patients' services and the public, including people in different equality groups. Rigorous and constructive challenge from patients, the public, stakeholders, and regulators was welcomed and seen as a vital way of holding services to account.
- One of the trust's aims was to work with patient groups and friends and family test (FFT) data to understand the needs of patients and improve the customer service aspect of care. Ways of engaging with the local community and all patients were highlighted in the trust's 'Patient Experience and Engagement Strategy 2015 to 2018'.
- Staff within all services recognised the importance of gathering the views of patients and actively sought feedback. We saw FFT questionnaires, and patient comment cards available in all areas we visited. Since 2015, a number of further methods were developed to obtain patient feedback, including:

Summary of findings

  - An online survey with over 50 languages was available. The online survey link was displayed throughout organisation in the two most popular languages after English, in Northampton.
  - Children and young people's online survey included within any text messages to parents as an additional opportunity for the child or young person to give their feedback. This includes three different survey options depending on the age of the child.
  - An electronic tablet device was set up within radiology.
  - An online survey set up for community maternity enabling the midwives to have the survey on their work mobile telephones.
  - Easy read postcards made available.
- The hospital had developed a suite of postcards bespoke to the trust and the different services which collected FFT responses (inpatients, maternity, outpatients/day case, and paediatrics). Postcards also contained important demographic questions enabling the organisation to identify recommendation rates in line with protected characteristics and demographic groups.
- Each month a spreadsheet was created by the information team, which detailed every service's response rates and recommendation rates. All responses were rated in relation to the most recent national averages at the time when the spreadsheet was produced. The spreadsheet was circulated trustwide. The trust used the patient experience headlines tool, developed by NHS Improvement to understand how its services were performing against the national and local area averages. The information team also triangulated negative feedback from FFT responses to data from the complaints' team in order to better understand areas to improve. We saw this was detailed in reports to the divisions
- Wards displayed 'infograms', which contained information on how each ward was performing in relation to FFT results. The infograms were produced monthly and included the FFT response rate, the percentage of patients who would and would not recommend the service, patient comments, and learning from feedback received. For example, 93% of patients recommended the hospital for April 2017 with 5,272 patients responding. This information as then broken down per divisions, per clinical area. Patient comments included, "The staff on Dryden ward manage to combine a friendly outlook along with a very professional approach. Although extremely

busy, nothing is too much trouble. As well as providing outstanding care, the team is able to maintain a high level of cleanliness throughout the ward". This was in in December 2016.

- The trust had developed 'real-time' and 'right-time' surveys, based on questions used in the National Inpatient Survey and areas that matter most to patients when they are in hospital. Four inpatient wards piloted the real-time survey from August 2016 and a further three wards from October 2016. The survey report was made available to ward managers on the same day the results were collected, which would enable staff to make immediate changes for the benefit of patients. Updates regarding the survey were included within the quarterly reports to patient and carer experience and engagement group (PCEEG). The survey resulted in some positive examples of how the feedback had been used to make immediate changes. For example:
  - Following patient feedback, lamps had been installed in all of the side rooms within Talbot Butler Ward as patients stating that it was difficult to read.
  - Creaton Ward had a number of comments relating to patients not sleeping well on the ward. Staff held two team meetings where they have discussed this and increased the use of the trust's sleep well packs.
- The 'right-time' survey was introduced in October 2016. Questionnaires were sent to 600 adults who had attended as an inpatient around one to two weeks following their discharge. We saw evidence that the results of the survey were discussed at the PCEEG in February 2017.
- From September to December 2016, the information team selected and contacted 100 recent inpatients to invite them to a listening event. Following the invite 13 patients agreed to attend the "always event" and nine attended on the day. The day was attended by 12 staff members and the trust's patient representative who acted as facilitators for workshops. The workshop aims were to identify "what patients always want". Some common themes were identified during discussions, which included waiting times, appointments not running to schedule and waiting times for pharmacy. The group agreed on four "always events" which were most important to them. These consisted of:
  - Teach back will always be used to ensure you understand information given at discharge.
  - You will always be treated with kindness, respect and dignity.
  - You will always be listened to.

Summary of findings

  - Staff will always do everything they can to control your pain.
- In January 2017, a patient engagement event was held entitled 'Quality Conversation - A Winter Warmer'. An invitation was sent out to over 1,700 members of the hospital inviting them to attend the evening. The evening had presentations by senior staff and executive team members and these were followed by the opportunity to talk with the presenters and a number of other members of the senior team. Information stands were created especially for the event by different services including falls, volunteers' services, infection prevention, dementia care, and a number of others. Stands were also held by external services to the organisation including Healthwatch and local charities. Hot Soup and rolls were provided for attendees alongside tea and coffee. The event was also attended by the local radio station. Thirty people attended the event and feedback from the event was positive. Patients, carers and families were all given the opportunity to write down any Improvements which the trust should focus on and also any areas in which the trust does particularly well.
- The trust had also engaged with Young Healthwatch to arrange an 'enter and view' visit in October 2017. Young Healthwatch is for children and young people from the age of eleven to twenty four and has the same function as Healthwatch generally in terms of shaping and developing health and social care services and the 'enter and view' powers.
- The trust's 2016 "Quality Street" magazine included sections on learning from patient feedback. The trust analysed information shared through patients' feedback from complaints, friends and family test, patient advice and liaison service (PALS) and online reviews to identify the trends.
- The trust had established good links with numerous volunteer organisations, charities, and national support groups, such as Macmillan, Age UK, Northamptonshire Cancer Partnership, and Pets as Therapy team.
- Each month positive feedback received into the organisation was collated into a spreadsheet, divided into divisions. This included feedback received from:
  - Friends and Family Test.
  - Online review sites.
  - Social Media outlets.
  - Chief executive's office.
  - Directly into wards/services.
  - PALS office.
  - Complaints office.
- This was circulated throughout the trust and staff said this was really positive. Due to the compliment collation project success,

it was awarded a 2016 Patient Experience Network National Award (PENNA) in March 2017 at a national ceremony. As winners, the head of patient experience and engagement was given the opportunity to present the work undertaken around Compliments to the attendees of the Conference.

Staff engagement

- Staff told us they felt actively engaged and involved in the planning and delivering services. The directorate leads gave us examples of where staff had worked collaboratively to improve the service. For example, more day case procedures were carried out over the winter period, when bed pressures were increased, to reduce the number of admissions to the wards. Further examples included the 'infograms', which were created by staff on the band six development programme.
- Staff told us of innovative ways that the trust were using to facilitate staff raising ideas and solutions. Protected time was given to the project called 'pathway to excellence'.
- The trust had taken prove staff morale via the 'compliments collation'. Positive feedback was collated on a monthly basis and shared within the divisions. In December 2016, the medicine division received over 1,400 positive comments from FFT, online reviews, thank you cards and formal letters. This initiative had been shortlisted for a patient experience national award due to the positive effect it had on staff morale. The awards were to be announced in March 2017.
- Staff described monthly ward meetings taking place. Minutes were available to staff who were unable to attend. Staff also received daily updates regarding on any issues affecting the ward and/or trust at safety huddle meetings.
- The trust staff survey showed some improvements from 2015 to 2016. However, rates for Black and Minority Ethnic (BME) staff were slightly worse than rates for white staff. For example, 26% BME staff reported experiencing harassment, bullying, or abuse from patient's relatives or the public in the last 12 months in comparison to 29% white staff. This was an improvement from 30% in 2015.
- From the 2016 survey results, out of the 32 key findings, the trust performed better than other trusts in four questions (in the top 20%), about the same as other trusts in 26 questions and worse than other trusts in two questions (in the worse 20%).
- The four questions for which the trust performed better than other trusts were:

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1. Percentage of staff appraised in the last 12 months (91% compared to the England average of 87%)
2. Quality of non-mandatory training, learning or development (4.11 compared to the England average of 4.05).
3. Staff motivation at work (3.99 compared to the England average of 3.94).
4. Effective team working (3.81 compared to the England average of 3.75).

- The questions for which the trust performed worse than other trusts were:

1. Percentage of staff satisfied with the opportunities for flexible working patterns (46% compared to the England average of 51%).
2. Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse (39% compared to the England average of 45%).

Innovation, improvement and sustainability

- The leadership team drove continuous improvement and staff were accountable for delivering change. Safe innovation was celebrated. There was a clear, proactive approach to seeking out and embedding new ways of working and new models of care.
- We saw that the discharge lounge provided four side rooms for patients who were unable to sit out for transfer and two separate waiting areas. One was for general patients whilst the other provided a quiet area for patients with dementia. The quiet area was manned at all times to ensure patient safety. Patients could be transferred to the department after their morning medication to prepare for discharge. Staff were able to assist with washing and dressing, provided meals, and coordinated the discharge.
- Mandatory training had been reviewed to include a face-to-face review of knowledge. This process involved staff attending a session where there knowledge and understanding of mandatory topics was assessed through questioning. Staff who did not pass the session were required to complete the full training programmes, whereby staff who successfully passed the assessment did not have to repeat the training and were reassessed the following year.
- Staff were focused on continually improving the quality of care and the patient experience. For example, we saw evidence that the service was committed to improving the care of elderly patients, such as those living with dementia. Colour-coded bays were evident on some of the wards we visited and finger food

boxes had been introduced, which made it easier for patients to eat when they wanted and helped them to maintain independence. Directorate leads told us of plans that were being developed in collaboration with primary care and community services to support the care of elderly patients at home.

- The trust was also actively fundraising in order to transform a room in the elderly medicine centre into a therapy suite. This suite would include pop-up reminiscence rooms that can turn any care space into a therapeutic and calming environment.
- Improvements to quality and innovation were recognised and rewarded through the annual staff 'best possible care' awards. Within the awards scheme there were categories for patient experience, patient safety, clinical team of the year and innovation in practice. Dryden ward had been nominated for the 2016 patient safety award and the innovation in practice award.
- In 2016, the trust became the first British trust to sign up for pre-intent programme for the 'Pathway to Excellence' accreditation with an internally recognised nursing credentialing centre. Two submissions were accepted for poster presentation at the 2017 international pathway conference in the United States of America. The trust was also linking in with two other English NHS trusts to work collaboratively.
- The trust was also a member of East Midlands Patient Safety Collaborative, part of the national programme in the NHS to drive improvements in patient safety. The vision for the National Patient Safety Collaborative' programme is to create a comprehensive, effective, and sustainable collaborative improvement system that will support the development of a culture of continual learning and improvement in patient safety across England over the next five years as a minimum.
- The trust was selected as one of eleven national pilot sites for creating nursing associates. In December 2015, the government announced a plan to create a new nursing support role. This new role is for these nursing associates to work alongside care assistants and registered nurses to deliver hands-on care, focusing on ensuring patients continue to get the compassionate care they deserve. Its introduction has the potential to transform the nursing and care workforce with clear entry and career progression points.
- The geriatric emergency medicine service (GEMS) had been introduced in 2014 and had been developed to meet the needs of patients with complex needs and also provided a learning platform for staff.

Summary of findings

- Physician associate programmes were being developed to provide a larger group of decision-making clinicians and provide developmental opportunities for staff.
- The ED was actively working with local educational institutions to develop courses that were specific to areas that were difficult to recruit to such as geriatric and paediatric emergency medicine.
- The trust had published an article inside a national journal on the commissioning for quality and innovation (CQUIN) in end of life care provision. The need for communication skills training for staff had been clearly demonstrated through the end of life care CQUIN. The service had put in a successful bid to Health Education East Midlands (HEEM) for funding for training, and the county lead nurses for EOLC education were developing a collaboration that included social care, to take the training agenda forward.
- There had been a number of innovative approaches to the underpinning and embedding the use of the amber care bundle, for example, an amber care bundle patient information booklet. The amber care bundle supports shared decision making during times of clinical change andprovides a systematic approach to managing the care of hospital patients who are facing an uncertain recovery and who are at risk of dying in the next one to two months. The service had implemented case-note stickers to support ward staff in preventing inappropriate patient bed moves for dying patient.
- The hospital had taken part in a 12-week trial with the local community NHS trust to assess and discharge patients with cognitive impairments using an evidence-based delirium pathway. Senior managers said this had proven successful in helped facilitate appropriate and safe discharges for some patients with complex needs who had been in hospital for a long time and was being looked at as part of the countywide plans to facilitate discharges.

Overview of ratings

Our ratings for Northampton General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	☆ Outstanding	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Our ratings for Northampton General Hospital NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good	Good	Good	Good	Good	Good

Outstanding practice and areas for improvement

Outstanding practice

- The geriatric emergency medicine service (GEMS) was outstanding in terms of providing awareness of and responding to the needs of patients within this group and developing a service that provided a multi-agency approach at the front door.
- Physician associate programmes were being developed to provide a larger group of decision-making clinicians and provide developmental opportunities for staff.
- The emergency department (ED) worked with external organisations to develop an on-site psychiatric liaison service within the ED, 24 hours a day, seven days a week.
- The ED was actively working with local educational institutions to develop courses that were specific to areas that were difficult to recruit to such as geriatric and paediatric emergency medicine and the ED had a robust leadership development programme in place.
- In the Sentinel Stroke National Audit Program (SSNAP) the hospital was rated as band A overall (A being the best and E the worst), in the April to June 2016 audit, which indicated an excellent stroke service.
- We visited patients being cared for in two out of the three care homes that the hospital used to place patients that were fit for discharge and awaiting their return back to the community. There was a weekly consultant led ward round once a week for these patients and a hospital doctor visited both homes on three other days of the week. We saw in all there was excellent level of clinical oversight and detailed records of all input from the service's doctors.
- Staff were focused on continually improving the quality of care and the patient experience. For example, we saw evidence that the service was committed to improving the care of elderly patients, such as those living with dementia. Colour-coded bays were evident on some of the wards we visited and finger food boxes had been introduced, which made it easier for patients to eat when they wanted and helped them to maintain independence. Directorate leads told us of plans that were being developed in collaboration with primary care and community services to support the care of elderly patients at home.
- The end of life care service had piloted, evaluated, and fully implemented an end of life companion volunteer scheme for dying patients who may not have any visitors. The service had support from the local community in caring for patient at the end of their life.
- The ED had developed an end of life care room that was situated adjacent to the resuscitation area. There was a specific pathway and guidance for managing these situations when the patient was a child or young person. The ED had developed a specific continuation of care record for patients who were in the end of life care room; this included ensuring that they had received consultation and timely review for symptom control.
- The trust had a duty of candour sticker that would be placed into the patient's notes when the duty of candour had been applied. This included, for example, staff name, date, name of person/patient receiving information, account of incident, details of incident and if an apology was offered.
- The 'Chit Chat' group was set up by the maternity service in 2016 to facilitate antenatal education, parenting advice and peer support for women with additional needs, including learning disabilities or anxiety. Staff said these meetings were two weekly and very well attended. This group meeting initiative had been nominated for two national awards and had won one at the time of the inspection.
- The maternity service reviewed and evaluated the provision of multi-disciplinary training when the service was chosen as one of the 10 pilot sites for enhancing patient safety. As part of the pilot, the service chose to concentrate on the fetal monitoring and team working and skills drills sections with the outcome that the service was able to deliver these training programmes completely internally (including Practical Obstetrics Multi-professional Training or PROMPT).
- Gosset ward was working towards achieving Bliss accreditation. This means the ward had undertaken exceptional work through the involvement of parents to encourage bonding with these very special babies, which had helped to build the evidence for Bliss accreditation.

Outstanding practice and areas for improvement

- Staff had developed an assessment tool to improve the monitoring and assessment of baby's skin on Gosset ward. The ward was working with neonatal services from across the world (Canada and Turkey) to further develop the tool.
- The recruitment of 1.7 WTE advanced neonatal nurse practitioners (ANNP) onto the medical neonatal rota was helping to address recruitment issues in relation to junior doctors.
- The superintendent sonographer was very passionate about their service and had developed an excellent team which provided image quality assurance and peer review. They were able to detect team members' weaknesses and pair them with other sonographers to help them develop. The ultrasound department conducted many audits and feed these back to ultrasound community in England.

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: *30 November 2017*

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

Executive Summary

The Committee met on *18 October 2017* 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)*
• Financial performance/recovery plan • Changing Care • SLR • STP update • Operational Performance	

Key areas of discussion arising from items appearing on the agenda

- Adequacy and ownership of recovery plans
- Concerns surrounding urgent care performance
- Concerns surrounding Cancer target performance
- Concerns surrounding occupancy targets and DTOC

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

- Refocus on financial recovery
- Ensure broader ownership of financial challenge
- Launch of urgent care reset programme

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

No new issues

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

On agenda

Enclosure M

COMMITTEEHIGHLIGHT REPORT

Report to the Trust Board: *30 November 17*

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

Executive Summary

The Committee met on *20 October 2017* to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items:	**Board Assurance Framework entries** *(also cross-referenced to CQC standards)*
Corporate scorecard Opthalmology Update Cancer Update Health and Safety Duty of Candour	

Key areas of discussion arising from items appearing on the agenda

Stroke team performance
Breast2ww waiting time
Opthalmology improved performance

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

Detailed report from EMRAD to be brought back.

PPH incident investigation report to be brought back.

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

None

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

None

Enclosure N

Northampton General Hospital NHS
NHS Trust

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: *30 November 17*

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

Executive Summary

The Committee met on *18 October 17* 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)*
• Workforce performance • Nurse recruitment/safe nurse staffing • Medical Education quarterly report • Freedom to Speak Up report • Occupational Health Annual Report	

Key areas of discussion arising from items appearing on the agenda

- Challenges around both medical and nursing recruitment. Loss of value from overseas nurse recruitment.
- Consultant interview process.
- Initiatives to improve Junior Doctors experience.
- Improvement in the Occupational Health service.

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

- Change of Responsible Officer from Dr M Cusack to Mr M Metcalfe.

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

- Already on agenda.

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

COMMITTEE HIGHLIGHT REPORT

Report to the Trust Board: 30th November 2017

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

Executive Summary

The Committee met on 7th November 2017 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**
1. Highlight report 2. Cancer performance & plan update 3. Capital programme update 4. Fixing flow update 5. PAS update 6. Revised Terms of reference 7. Finance workshop	1.1, 1.2, 2.2, 3.1, 3.2,

Key areas of discussion arising from items appearing on the agenda

Verbal report – information only

A summary briefing was provided by the Deputy CEO on:

a. Recent NHSI quarterly review meeting for Finance, A/E, Quality and Cancer performance
b. NHSE escalation for A/E meetings
c. Emergency floor changes for Benham, Creaton & EAU
d. CQC rating being published the following day

Cancer performance & plan update

A paper was presented which had been discussed at the October finance, performance & investment committee.

- Legacy patients reduced to 11
- Reduced diagnostic wait times
- Concerns for breast 2ww and actions being taken

Capital programme

A verbal update was provided by the Director of Finance on the capital programme formulation and timescales for 2018, further updates would be provided at the meeting in November 2017.

PAS

A verbal update was provided by the COO on the current position, challenges with diagnostic and OP waiting list monitoring and likely go live in 2018.

Fixing flow

A verbal update was provided by the Medical Director on the new urgent care programme,

Enclosure P

the 3 main work streams and treatments. The anticipated impact was discussed and the meeting members asked for engagement & ideas.

Revised Terms of Reference
The annual review of the terms of reference which will include a monthly update on the capital programme & the inclusion of the clinical directors to every meeting.

Finance workshop
A verbal update on the current financial position was provided by the FD

The meeting attendees were split into 3 groups to discuss new ideas to generate income and/or reduce cost.

A list of ideas was generated and a discussion regarding vacancy control at divisional level.

Divisional scorecards
Where included for information

Any key actions agreed / decisions taken to be notified to the Board
An updated financial recovery plan will be presented to the board in November which will include the worked up actions arising from HMT.

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 30 November 2017
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 Farenden	**Verbal**
	2.	Declarations of Interest	Note	Mr Farenden	**Verbal**
	3.	Minutes of meeting 28 September 2017	Decision	Mr Farenden	**A.**
	4.	Matters Arising and Action Log	Note	Mr Farenden	**B.**
	5.	Patient Story	Receive	Executive Director	**Verbal**
	6.	Chairman's Report	Receive	Mr Farenden	**Verbal**
	7.	Chief Executive's Report	Receive	Dr S Swart	**C.**
10:00	**CLINICAL QUALITY AND SAFETY**				
	8.	Medical Director's Report	Assurance	Mr M Metcalfe	**D.**
	9.	Director of Nursing and Midwifery Report	Assurance	Ms C Fox	**E.**
	10.	Fixing the Flow Update	Assurance	Mrs D Needham	**F.**
10:20	**OPERATIONAL ASSURANCE**				
	11.	Finance Report	Assurance	Mr S Lazarus	**G.**
	12.	Workforce Performance Report	Assurance	Mrs J Brennan	**H.**
10:40	**FOR INFORMATION**				
	13.	Integrated Performance Report	Assurance	Mrs D Needham	**I.**
	14.	Medical Recruitment Strategy	Receive	Mrs J Brennan	**J.**
	15.	Sustainability and Transformation Plan Update	Receive	Mr C Pallot	**K.**
	16.	Final CQC Report Outcome	Receive	Ms C Thorne	**L.**
11:20	**COMMITTEE REPORTS**				
	17.	Highlight Report from Finance Investment and Performance Committee	Assurance	Mr P Zeidler	**M.**
	18.	Highlight Report from Quality Governance Committee	Assurance	Mr J Archard-Jones	**N.**
	19.	Highlight Report from Workforce Committee	Assurance	Mr G Kershaw	**O.**

Time	Agenda Item		Action	Presented by	Enclosure
	20.	Highlight Report from Hospital Management Team	Assurance	Mrs D Needham	**P.**
11:30	**21.**	**ANY OTHER BUSINESS**		Mr P Farenden	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held at 09:30 on Thursday 25 January 2018 in the Board Room at Northampton General Hospital.

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

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